

# Strategic directions for improving Adolescent Health in South-East Asia Region



**World Health  
Organization**

Regional Office for South-East Asia



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## Foreword



The South-East Asia Region of WHO has about 350 million adolescents comprising about 22% of the population. Adolescents are an important family, societal and national asset. This phase of life is full of opportunities and health challenges.

It is estimated that nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours initiated during adolescence. Their health and nutrition status also has an inter-generational effect on their offspring. Early marriage and early childbearing among girls is common in several Member States and is associated with two to five times higher maternal mortality, as compared to women in their twenties. Early sexual activity associated with a low condom use rate exposes adolescents to the risks of STIs and HIV, unintended pregnancy, unsafe abortion and its complications. While under-nutrition and anaemia are a public health concern in the adolescent age group in many Member States of the Region, over-weight and obesity are also increasingly seen in children and adolescents. Drug and substance abuse among adolescents is an emerging problem.

To respond to these public health issues in adolescents, WHO has successfully advocated with the Member States and relevant stakeholders for development of adolescent health programmes in the Region. Most Member States have initiated implementation of adolescent health programmes with the technical assistance from WHO. The document, “Strategic directions for improving Adolescent Health in South-East Asia Region” has been developed in consultation with Member States and experts from the Region. It is intended to provide guidance to policy and decision makers in Member States of the Region to further expand and support their national adolescent health programmes. I am confident that it would serve as a useful guide to help address the common challenges and opportunities related to adolescent health.

A handwritten signature in black ink that reads "Samlee Plianbangchang". The signature is written in a cursive, flowing style.

Dr Samlee Plianbangchang  
Regional Director



## Introduction

The World Health Organization defines an adolescent as an individual between 10-19 years of age. There are about 350 million adolescents comprising about 22% of the population in countries of the South-East Asia Region (SEAR). Adolescents are not a homogenous population. They exist in a variety of circumstances and have diverse needs. The needs of adolescents are determined by age (early, middle and late adolescence), sex (males / females), marital status, residence (urban / rural), schooling, socio-cultural environment, and economic status.

Adolescence is a period of rapid growth and development in an individual marking a change from childhood to adulthood. The transition involves dramatic physical, sexual, psychological and social developmental changes, all taking place at the same time. New capacities are acquired and new situations are faced as they grow up. These situations create many opportunities for development but also pose risks to their health and well-being.

The immediate family environment, peers, societal norms, and the environment at school and the workplace influence the development of adolescents' personality, capacities and vulnerabilities.

Adolescence is generally perceived to be a healthy period of life since mortality is quite low in this age group. However, this is deceptive since adolescents are faced with several public health challenges that are, of course, different from the ones that they faced when they were children.

### Why invest in adolescents?

Adolescents must be considered an important family, societal and national asset. This phase of life can be regarded as the last opportunity for nurturing before adulthood. Using this opportunity can contribute to prosperity while neglect will have serious repercussions on the individual's health and well being as well as an adverse effect on the national economy and development.

- Higher investments in education, health (including reproductive and sexual health), and job skills in adolescents will lead to greater productivity during the later years of adolescence and adult life.
- Behaviour patterns acquired during adolescence e.g. sexual activity, use of tobacco, alcohol and other substances, eating habits and dealing with risks and conflicts affect adulthood adversely. Adolescence provides opportunities to prevent the adoption of health-damaging behaviour and thus contribute to savings by reducing expenditure on current and future treatment and contribute to productivity as healthy adults. Provision of appropriate services, information and skills to adolescents is important to reduce their risks and vulnerabilities.
- Delaying the age at marriage and empowering adolescents to take rational decisions about having children who are appropriately spaced will contribute to smaller healthier families and slower population growth. This is particularly relevant for some countries in the Region where early marriage is common and fertility levels remain high.

## Global commitments to adolescent health

To uphold the adolescent's health and rights, national governments have endorsed several global commitments during the last 20 years. These include:

- The 1989 Convention on the Rights of the Child includes human rights of children and adolescents. Freedom from discrimination, abuse and exploitation; participation in decisions affecting their lives; access to education, health information and services for their well-being are a part of the commitment.
- In 1994, several governments pledged to address the reproductive needs and rights of adolescents at the International Conference on Population and Development (ICPD).
- In 1995, at the Fourth World Conference on Women in Beijing, several governments reaffirmed this commitment and placed special emphasis on the girl child.
- The Millennium Summit in 2000 identified the Millennium Development Goals (MDGs) and identified targets for young people (10-24 years). Those relevant to adolescents include the following:
  - Eradicate extreme poverty and hunger (MDG 1)
  - Achieve universal primary education (MDG 2)
  - Promote gender equality and empower women (MDG 3)
  - Improve child health (MDG 4)
  - Improve maternal health, including universal access to sexual and reproductive health (MDG 5)
  - Combat HIV/AIDS, and other diseases (MDG 6)
- Recognizing the vulnerabilities of young people to HIV/AIDS, the United Nations General Assembly Special Session on HIV/AIDS (2001), outlined a number of goals and targets focusing on young people (including adolescents). The targets in UNGASS include the following:
  - By 2010 ensure that 95% of young people (15-24 years) have access to the information they need to reduce their vulnerability to HIV.
  - By 2010 ensure that 95% of young people have access to skills they need to reduce their vulnerability to HIV.
  - By 2010 ensure that 95% of young people have access to the services they need to reduce their vulnerability to HIV.
  - By 2010, HIV prevalence among young people to be reduced by 25%.

In the recently (10 June 2011) adopted Resolution the UN General Assembly has expressed grave concern that young people between the ages of 15 and 24 years account for more than one third of all new HIV infections, with some 3,000 young people becoming infected with HIV each day, and noted that most young people still have limited access to good quality sexual and reproductive health programmes. The Assembly recognizes that the deadlines for achieving key targets and goals set out in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS have now expired and that many countries have been unable to fulfill their pledges to achieve them. The resolution has stressed the urgent need to recommit to those targets and goals and commit to new, ambitious and achievable targets and goals.

## Purpose of the document

The document “Strategic directions for improving Adolescent Health in South-East Asia Region” is for policy and decision makers in Member States of SEAR to design and support their national adolescent health programmes. The document would serve the Member States as a useful guide to help address the common challenges and opportunities related to adolescent sexual and reproductive health and protect the rights of adolescents. This document is not intended to be prescriptive and it:

- Identifies the challenges and opportunities with regard to adolescents based on the health situation and risk profile of adolescents in Member States in the Region
- Recognizes that there is a great diversity in the situation of adolescents and challenges faced by them, variable strength of health systems, as well as the demographic and cultural variations amongst the Member States and that the national policies and programmes have to be guided accordingly.
- Promotes a rights-based approach for adolescents and recommends a focus on special groups whose needs are likely to be greater.
- Advocates for sustained political commitment and a supportive policy environment to promote adolescent health and development.
- Underscores the need for reorganizing value-added services for adolescents in the existing health systems and health programmes.
- Makes a compelling case for adoption of a public health approach adolescent health within the health sector.
- Recommends a standards-based approach for maintenance and monitoring of quality of adolescent health services.
- Emphasizes the need to engage the community and empower adolescents in order to keep them healthy and improve their care-seeking behaviour when required.
- Stresses the importance of engaging various stakeholders in the health sector and other sectors to promote adolescent health and development in a synergized and sustained manner.
- Highlights the role of research to support adolescent health programmes for successful expansion.

## Situation of adolescents in the South-East Asia Region

(Please refer to Annex I for detailed Regional Fact Sheet)

### Demographic situation:

- There are about 350 million adolescents in the South-East Asia Region. They constitute 15%-26% of the population in countries in the Region.
- **Early marriage** for girls is common in some countries of the Region. More than 66% of girls in Bangladesh, 51% in Nepal, 47% in India and about 22% in Indonesia are married by 18 years.
- The **total fertility rate** in the Region contributed by 15-19 year old girls varies from 5%-20% among member countries.

### Health situation of adolescents:

- Mortality rates among adolescents in the Region are generally lower than those observed in children or in older age groups. Globally, 97 % of deaths among 10-24-year-olds in 2004 occurred in low-income and middle-income countries, almost two-third of these in Sub-Saharan Africa and South-East Asia.
- In South-East Asia maternal causes of death (haemorrhage, sepsis, abortion complications) account for a higher proportion of deaths among females. Among males, injury-related deaths (traffic accidents, violence, fire-related injuries and drowning) account for a high proportion of deaths.
- Under-nutrition and anaemia are a public health concern in the adolescent age group in the Region.
- Early childbearing is a public health priority in several SEAR countries. Early pregnancy has higher chances of adverse reproductive health outcomes like high Maternal Mortality Ratio and Infant Mortality Rate. Adolescent women are two to five times more likely to die due to causes related to pregnancy and childbirth as compared to women in their twenties. Neonatal and infant mortality rates are higher among women aged <20 than among 20-29-year-olds.

Considering that adolescent fertility remains high in some countries and is associated with higher maternal as well as infant mortality, this age group is significantly responsible for contributing to population momentum and a high MMR and IMR in the Region.

- **Unmet needs for contraception** in married adolescents are high in Nepal, Maldives and India, with higher rates in women aged 15-19 than their older counterparts.
- **HIV prevalence among youth** (15-24 years) ranges between 0.01% to 1.32%; more than one-third of new HIV infections are reported in the age group 15-24 years.
- In many countries, **prevalence of STIs** is high in young people. In Bangladesh, more than 50% of the patients who sought treatment at formal facilities were young people. In Thailand, new STI cases reported among students have increased from 3% in 2000 to 10% by 2004.

## Behaviours among adolescents:

- **Initiation of sexual activity** among adolescents could be as early as 13 years in some adolescents. Early sexual activity exposes adolescents to the risks of STIs and HIV in addition to the risk of unintended pregnancy.
- About 95% of new HIV infections in young people in Asia are in young sex workers, young men who have sex with men (MSMs) and young injecting drug users (IDUs). In Myanmar almost 53% of female sex workers aged 15-19 years were HIV positive in 2006. Of the total reported AIDS cases among IDUs in Indonesia, more than 40% were in the 15-24 year age groups.
- **Low condom use** characterizes a vast majority of sexual encounters among adolescents in the Region. Condom use by sexually active male secondary students in Thailand with female sex workers was found to be 43% while it was less than 40% for all other partner types as well. In India, Bangladesh, Nepal and Sri Lanka not more than 52% of young males used condoms at the last high risk sex.
- **Drug and substance abuse** among adolescents is an emerging problem. The Global Youth Tobacco Survey showed a high prevalence of tobacco use in young people in SEAR. Injecting drug use among adolescents and young people has also increased in the Region. In Maldives, the maximum number of cases of drug abuse was found in the age group of 16-24 years. In Nepal, half of the 50 000 injecting drug users were between 16-25 years.

## Knowledge of sexual and reproductive health issues among adolescents:

- **The knowledge of contraceptives** among adolescents is high in the Region, exceeding 90% among married adolescent females in almost all the countries but the contraceptive use rate is very low indeed.
- Though **most** young people have **heard of HIV/AIDS**, comprehensive **knowledge of transmission and prevention is low and misconceptions are widespread**. In India, 84.9% of youth had heard of HIV/AIDS, but only half of them were aware of two correct methods of prevention. In Maldives, more than 96% of youth have heard of HIV/AIDS however only 51% of young women and 62% of young men knew two methods of HIV prevention.
- **Awareness of STIs** and its symptoms is also generally low. In Sri Lanka 58%, in India 29% and in Timor-Leste 4% of adolescents were aware of STIs. Most young people **do not perceive the risk for STIs and HIV**.
- **Awareness of risk does not necessarily translate into safe behaviours**. In Indonesia (Merauke) though 88% of young men were aware of condoms for HIV prevention, only 15% used a condom at the last commercial sex encounter. In India, 52% reported using a condom at the last casual sex while only 34% reported consistent condom use with all partners. In Nepal, more than 90% youth knew where to get condoms, less than 10% used it with any partner.

## Implications of epidemiological situation

Many of the health problems of adolescents described above, are behaviour dependent and are interrelated. Sexual behaviour and gender relations, use of substances, dealing with conflicts and risks often have common roots.

Preventive interventions for these behaviours are the same. Such interventions ensure positive personal growth and development. Healthy development of adolescents underlies prevention of adolescent health problems.

Provision of a safe and supportive environment that ensures sustained inputs for healthy and full development of adolescents is crucial. Several players in society like parents, families, teachers, society at large, and governments must contribute towards this.

A number of ministries and departments – health, education, social welfare, law and justice, etc. – need to work together and with civil society (including adolescents and their families) and community-based organizations to address the needs and problems of adolescents. The Ministry of Health must assume a central role for developing and sustaining a multi-sectoral response to promote adolescent health and development.

## National response to adolescent health in SEAR:

At many places, the information and services needed by adolescents are not available or are not accessible. Although services, providers trained in reproductive health and HIV/AIDS and supplies may be available in the countries, adolescents and young people hesitate to use these services. Health care providers have limited capacity to deal effectively and sensitively with adolescent clients. Biased and judgmental attitudes of providers, lack of privacy and confidentiality act as significant barriers to care-seeking behaviour. Health care providers need capacity building to enable them to help a client who is 16 years and not six or 26 years old. The other common reasons for not using existing health services are lack of awareness, shyness or embarrassment, financial constraints, distance, and concern about the negative / unsympathetic attitude of health providers.

- A supportive policy environment is important to enhance access and coverage of the desired services for adolescents. Laws and policies in some countries remain indifferent to the sexual and reproductive health needs of adolescents. In some countries access to condoms, contraceptives, voluntary counseling and testing services and abortion services are restricted due to age (legally minors) and marital status. It is important to have clear policy guidelines within the existing legal framework to support access to services by adolescents especially the ones below the legal age of consent. Sri Lanka and Bangladesh have conducted a national review of laws and policies for adolescent health using WHO tools. The review revealed policy gaps that have been identified for advocacy with policy makers to redress the situation so that access by adolescents to the available services can be enhanced.
- Initial steps have been taken towards developing adolescent health programmes in several Member States in the Region like Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste. National strategy on adolescent health has been developed in Bangladesh, India, Indonesia, Myanmar, and Nepal. The main focus of programmes has been sexual and reproductive health, including HIV. Increased attention is needed to address unhealthy lifestyles, mental health and violence. One reason for inadequate attention to such issues may be that we do not have national level data on these conditions.

- To improve the access for adolescent clients to services National standards for adolescent friendly health services have been developed in Bangladesh, India, Indonesia, Nepal, Thailand and Timor Leste.
- National adaptation of the Global adolescent health training package has been carried out in several Member States and they have started building capacity of the health care providers for delivering appropriate services in a sensitive and non-judgmental manner. Adolescent friendly health services are being rolled out in the countries in a phased manner.

## Guiding principles

'Strategic Directions for improving Adolescent Health in the Region' seek to promote certain guiding principles while developing national adolescent health programmes in the countries. Adoption of these guiding principles would ensure that the health services developed for adolescents are ethical, equitable, rights-responsive and technically sound. The guiding principles include the following:

- The Member States should recognize heterogeneity of adolescent population based on age, sex, marital status, social class and cultural differences. This necessitates flexible approaches (one size would not fit all) to respond appropriately to the differing needs of different groups of adolescents.
- The thrust of the health sector would be on evidence-based interventions that are likely to have maximum public health impact. These interventions would be selected based on local epidemiological considerations and scaled up through the adoption of best practices.
- The health services would be made more attractive and adolescent-friendly through adoption of well-recognized attributes.
- It is recognized that the health sector has a crucial role in provision of health services, however, the action of other sectors such as education, social welfare, media etc. are crucial especially for (a) risk reduction (b) vulnerability reduction and (c) improved care seeking. The health sector would support such sectors to develop a multi-sectoral approach that addresses the determinants of health of adolescents.
- The enormous potential of adolescents would be utilized through their involvement and engagement right from planning the programme through implementation, monitoring and evaluation.
- The 'Strategic Directions' promote an approach that upholds the rights of all adolescent groups regardless of age, marital status, gender, and religion or class criteria. This approach acknowledges that priority should be given to the marginalized and disadvantaged groups of adolescents who are most vulnerable, whose rights are often ignored and calls for a more equitable distribution of resources in their favour while formulating policies and programmes.
- Gender issues need to be taken into account in adolescent health and development since deep-rooted gender stereotyping and differentials result in health risks. This is a special need in countries where disparities exist. Needs of male and female adolescents identified based on relevant data would be the basis for planning and programming.

# Goal and objectives

## Goal

Adolescents in the WHO South-East Asia Region enjoy the highest standards of health and development whereby they are nurtured to live their life to its full potential while ensuring that their needs and rights are fulfilled and respected.

## Objectives

- Provide assistance to formulate/refine national policy and strategy to promote adolescent health services using a rights-based approach.
- Strengthen availability and use of strategic information to guide formulation of policies to support development of an adolescent health programme and monitoring its implementation.
- Increase access of adolescents to appropriate health services through adoption of an adolescent-friendly approach.
- Identify and strengthen the role of the health sector in delivering good quality services for adolescents that meet their needs.
- Strengthen and sustain partnership with related sectors to help adolescents optimize the achievement of their full potential and, at the same time, reduce the risks and vulnerabilities.

## Targets

WHO would propose to work with Member States to achieve the following targets over the next five years:

- Increase early identification and appropriate management of pregnancy among adolescents by 50%.
- Reduce the unmet needs for contraceptives by 30% among married adolescents (15-19 year group).
- Increase the rate of condom use by 50% during casual sex in the 15-24 year group.
- Decrease the incidence of anaemia by 50% among adolescent girls and boys (10-19 year group).
- Reduce the incidence of STIs and HIV by 20% in the 15-24 year group.

## Role of the health sector in promoting adolescent health: '4S' Framework

Many things need to be done by many sectors to improve adolescent health and development. The health sector has a crucial role to play, through a range of actors, including government bodies, nongovernmental organizations (NGOs) and the private sector. The health sector should make effective contributions within such multi-sectoral response. WHO has articulated the '4 S' framework to enunciate the health sector's role in adolescent health and development. The framework is consistent with the well recognized six blocks of the health system while guiding the specificity of the approach to adolescent health programming.

### Strategic information

**Aim:** *Improving the collection, analysis, interpretation and dissemination of the data that are required for advocacy, policies and programmes*

The lack of accurate and up-to-date data on the health of adolescents hinders well informed policy and programme formulation. In many countries, some data on adolescent health are gathered in research studies, national or sub-national surveys, and in established health information systems (HIS). However, the results and analyses are not routinely available and consequently do not inform policy and programme development.

DHS data mostly include married women from 15-49 years leaving out men, unmarried women and younger adolescents (10-14 years). Data on health outcomes, behavioural outcomes, determinants of these behaviours, as well as outcomes of programmatic actions are generally not disaggregated by age and sex.

#### **What are the implications for action by the health sector?**

Ministries of health should facilitate the systematic collection, analysis, dissemination and use of data – disaggregated by age and sex – on various aspects of adolescent health – for the purposes of advocacy and informing relevant policy and programme development.

### Supportive evidence-informed policies

**Aim:** *Synthesizing, disseminating and contributing to the evidence base for policies (and programmes) that have an impact on the health and development of adolescents*

In several countries, national policies typically identify adolescents as an important group to address in situation analyses, but rarely specify what needs to be done to address the needs and problems that are identified. Even when national sexual and reproductive health (SRH) and HIV strategies contain policy statements enabling programmatic actions, they do not contain guiding statements informed by evidence.

#### **What are the implications for action by the health sector?**

National adolescent health strategies should include enabling and guiding policy statements (based on sound evidence) on what programmatic actions need to be carried out and how they should be implemented in order to effectively address the specific needs and problems of adolescents.

### **Strengthen services for adolescents**

***Aim:** Increasing young people's access to, and use of appropriate health services and commodities that respond to a number of priority health conditions*

In most countries, health services are provided to the general population including adolescents by hospitals and clinics run by the government, by NGOs and by individuals and organizations in the private sector. A range of barriers hinder the use of health services by adolescents. To respond to this, in many countries, NGOs are involved in providing health services that are intended to specifically respond to the needs of adolescents, and to be “friendly” to them.

These initiatives are often small in scale and limited in duration. With some notable exceptions, they are of uncertain quality.

#### ***What are the implications for action by the health sector?***

Ministries of health should play a leadership role in guiding the provision of health services to adolescents, both within and outside the government.

They should put in place initiatives grounded in national programmes, aimed at expanding the coverage and improving the quality of health services for adolescents, especially those who are more likely to face health and social problems, in order to achieve clearly defined health outcomes.

### **Strengthening collaboration with other sectors**

***Aim:** Mobilizing and supporting other sectors to maximize their contributions to adolescent health and development, both what they can do to strengthen the health sector response and what the health sector can do to support their actions*

In some places, other sectors (such as education and youth) and civil society bodies (such as faith-based institutions) do not make the essential contributions to adolescent health by providing health information and education, in building life skills, in empowering adolescents and in mobilizing communities to respond to the needs of their adolescents.

#### ***What are the implications for action by the health sector?***

1. The health sector (and specifically ministries of health) should engage with other sectors and civil society bodies to actively contribute to addressing adolescent health issues, and supporting them to do so using evidence-based approaches.
2. Other sectors and civil society bodies should make their contributions to the health and development of adolescents, in collaboration with the health sector.

## I. Strategic information

Evidence-based policies and programmes need to be developed on the basis of evidence from evaluation, research and reviews. Collecting, analyzing and using information is important to prepare evidence-based policies and programmes, building advocacy and for partnerships with other sectors. The database is usually derived from the national health management information system, national demographic and health surveys (DHS) and special surveys and studies carried out on the health of adolescents / young people. A framework is needed for monitoring and evaluation. To strengthen the programme monitoring key indicators that are specific, measurable and verifiable need to be identified at the national level. Globally, indicators on HIV among young people and reproductive health have been identified.

In many Member States, age and sex disaggregated national and sub-national data relating to the sexual and reproductive health of adolescents are not available posing problems in addressing the key policy and programme issues. Mechanisms are required to strengthen the HMIS to ensure collection of accurate and complete information, regular reporting, timely analysis and a system of feedback to help improve the services.

It is important to ensure that the national demographic health surveys and other large-scale surveys incorporate questions to obtain key information related to adolescent health including SRH and that the analysis is age-and sex-disaggregated. Men, unmarried women and adolescents of age group 10-14 years are not covered under the DHS in many countries. The DHS may not analyze the data by age disaggregation and is of limited use for the adolescent health programme. Some countries have carried out a secondary subset analysis of the DHS raw data for the age groups 15-19 and 20-24 years that has been very helpful in planning the services for adolescents. In 2007, WHO-SEARO and Member States reviewed, analyzed and consolidated information in the form of fact sheets that can form the basis for informed policy and strategic decisions. Countries may plan special surveys to understand the status and needs of 10-19 years old boys and girls (unmarried and married)

Studies carried out by institutions and researchers on adolescent sexual and reproductive health that are relevant to the programme and provide information that is not usually included in HMIS or national demographic and health surveys should also be reviewed. An annual departmental and external programme review at national and sub-national levels should be organized once every few years to take stock of coverage and quality of AFHS. WHO has developed tools for assessment of coverage and quality of AFHS that can be adopted / adapted by the Member States.

## II. Supportive policy environment

Adolescent health, especially sexual and reproductive health, has been ignored or is not explicit in national policies. Even in countries where a policy exists in support of adolescent health, it is not translated into practice because it is considered a sensitive issue by some influential social, political or religious groups. Nevertheless, Member States have endorsed several international and global commitments, yet, the political and administrative will for adolescent health continues to be insufficient. This may also be due to poor / insufficient information on the health indicators because of lack of national age-and sex-disaggregated data or lack of analysis of existing information. This leads to an erroneous belief that all adolescents are healthy as well as a lack of appreciation of risks and vulnerabilities that the adolescents face. Additionally, there is a presumption that all or most of the needs of adolescents are already included in the national policy and programmes.

In such a situation, a policy environment that is based on evidence is crucial to support adolescent health programmes in the countries. There is significant epidemiological evidence related to major public health problems related to adolescents in the Region (refer Annex) that demands attention to develop adolescent health programmes in Member States.

Policy must provide for adequate financial resources to ensure scaling-up of adolescent health services to cater to the needs of all groups of adolescents. In addition to domestic resources mobilization of additional resources may be required from non-health sectors, bilateral and multilateral agencies and partners.

### **Review of existing laws and policies for adolescent health**

There are several contentious issues such as legality of early marriage, consent for services and treatment procedures by legally minor clients, provision of contraception (including emergency contraception) to unmarried adolescents, pregnancy termination etc. which create barriers to access required services.

The existing laws, policies and guidelines relevant to the health and development of adolescents should be reviewed in consultation with adolescents' representatives. This would help identify major policy gaps that can be subsequently addressed to improve access to services. WHO tools for reviewing laws and policies have been effectively used by Sri Lanka and Bangladesh in the Region to strengthen their plans for adolescent health services.

### **Advocacy**

Through mobilization of the media and 'influencers' a wide audience should be targeted through messages that advocate for the rights of adolescents to seek and receive health information and services. The numerous benefits of investing in adolescent health for national development and productivity should be highlighted. Successful case studies and experiences should be documented and used to advocate for scaling up adolescent health services.

Relevant information should be collated to position adolescent health and development as a human rights issue. Help of influencers, goodwill ambassadors and champions for adolescents should be sought for ongoing advocacy for including adolescent health and development in the national development agenda.

### **Engaging partners for policy change and endorsement**

It is important to work in collaboration with partners within the health sector and outside like departments of education, social welfare, sports, legal, labour and employment among others. The success of the policy and strategy would depend on its endorsement by the health sector and by a wide range of partners and stakeholders. Key stakeholders should be involved through a broad-based consultation process involving the government (health and other key sectors), the private sector, NGOs, civil society and the "gatekeepers" of adolescents to evolve a policy and a consensus should be developed on key issues. The policy should encourage use of the existing resources from all concerned sectors and an effort should be made to mobilize additional resources jointly.

## **III Strengthen services for adolescents**

While several services relevant for adolescents, e.g. management of pregnancy, distribution of contraceptives, medical termination of pregnancy, voluntary testing and counselling for HIV, management of STI including HIV/AIDS, micronutrient supplementation and immunization etc. exist in the countries, provision for adolescents is not explicit.

There are only a few differences between the clinical interventions and services that are required for adolescents and the general healthcare provision that may be available under the national reproductive health programme in the countries.

However, the difference lies in the ways in which such services are designed and delivered to meet the needs of adolescent clients. In other words, the difference is not about 'what' but about 'how' such services would be delivered to meet the needs of adolescents. This qualitative dimension of adolescent health services is the critical element that determines whether the proposed services are able to attract adolescent boys and girls and retain them as clients.

Such efforts to increase access to health services can be successful and have a desirable impact only when these are combined with provision of information about the availability of services. The impact also depends on the ability of such information and services to convince and motivate adolescents to adopt healthy behaviours, reduce their risks and vulnerabilities and readily seek timely care when needed.

The needs of adolescents may be somewhat diverse depending on their age, marital status and level of maturity. These needs are greater amongst special groups of adolescents (differently able adolescents, street children, abused adolescents, adolescents in employment, young sex workers, males who have sex with males, drug users/addicts etc.). Such adolescents are economically deprived or dependent and their access to services may be even more restricted. Affordability deserves special consideration for such groups of adolescents. Specific models of service delivery may be needed to reach out to such highly vulnerable groups of adolescents.

### **Range of health services to be provided to adolescents**

The health facilities should provide a comprehensive package of services that combines curative, preventive and promotive services. The decision to provide a range of services to adolescents will be guided by the needs perceived by adolescents and the local health priorities. Such services should either be available on site, through outreach services or through referral services. As per their present context, the countries may consider the following while deciding on the service package.

- Information on growing up (adolescence phase) and common related concerns and for prevention of health risk behaviours.
- Management of common concerns like, menstruation, masturbation, nocturnal emission, acne etc.
- Counselling to address psycho-social issues, stress and anxiety.
- Prevention and management of under-nutrition and micro-nutrient deficiencies.
- Management of mental health problems.
- Prevention and management of pregnancy among adolescents through contraceptive provision, skilled care during pregnancy and childbirth, and safe abortion services as needed.
- Prevention and management of STIs and HIV.
- Care of people living with HIV/AIDS.
- Prevention and management of use of alcohol, tobacco and other substances.

The first few services are especially relevant for 10-14 years age group and the later ones down the list are more relevant for 15-19 years age group.

### **Provision of information as part of service package**

Access to age-appropriate and timely information helps adolescents to make informed choices to keep themselves healthy and to reduce their risks and vulnerabilities. At the same time they should be provided an enabling environment (safe and supportive environment) to feel empowered to use the knowledge and put it into practice. This would facilitate behavioural change among adolescents, which then needs to be sustained.

Such information needs to be provided by parents, families and peer groups as well as entities and providers in sectors like media, education, social development, youth and health among others.

### **Role of the health sector in information provision**

The health sector has the responsibility for providing accurate information that is suitable for adolescents, which respects their rights, is timely, age-appropriate, and gender-specific and takes into consideration the needs of special groups of adolescents. The information should also be culture- sensitive. Such information should be able to empower the adolescents to remain healthy and reduce their risk and vulnerabilities to communicable and non-communicable diseases as well as encourage them to utilize the health services.

Such a package of information for adolescents should, depending on local priorities, include:

- (a) Knowledge on healthy eating and healthy lifestyles as well as timely help / care seeking.
- (b) Knowledge of facilities that provide good quality health services to adolescents.
- (c) Knowledge of legal and support services.
- (d) Importance of continued education, delaying marriage and delaying the first pregnancy beyond 19 years.
- (e) Negotiation skills to delay sexual engagement and practice safer sex including the correct use of condoms.
- (f) Skills to resist peer pressure regarding use of tobacco, alcohol and other substances.

The health services should include provision of information as a part of the service package. This will attract more adolescents who are more likely to be satisfied with such services. Satisfied adolescents would influence their peers to use these services when needed. Health care providers who provide sexual and reproductive health services have to be trained and motivated to use such an information package. In addition, the information has to be tailored to the needs of the adolescent clients during interaction with them in the hospitals, health centers and outreach settings. Such information also needs to be delivered in settings like schools and the community through peer-led and other approaches.

The gatekeepers and providers in other sectors (education, women and child development, youth and sports, etc.) should also use these basic elements of the information package. The health sector has to support other sectors for providing technically correct information to the adolescents. The role of other sectors is covered under the section on strengthening other sectors and partnerships.

Additionally, the success of adolescent health programmes depends on collaboration between different programmes in the health sector. It would be necessary to find a niche for adolescent health by working together with programmes related to HIV/AIDS, reproductive health and contraception including making pregnancy safer, mental health and nutrition.

## AFHS - Adolescent Friendly Health Services

For many adolescents who need sexual and reproductive health services, such as appropriate information, contraception and treatment for sexually transmitted infections, these are either not available or are provided in a way that makes adolescents feel unwelcome and embarrassed. Health services have to be sensitive to the needs and developmental attributes of adolescents to be able to attract them. To address these issues, a number of initiatives have been developed and implemented, globally, that have made it easier for adolescents to obtain good quality health services that they need, in other words to make health services “adolescent-friendly”.

To be considered adolescent-friendly, services should have the following characteristics:

**Equitable:** All adolescents, not just certain groups, are able to obtain the health services they need.

**Accessible:** Adolescents are able to obtain the services that are provided.

**Acceptable:** Health services are provided in ways that meet the expectations of adolescent clients.

**Appropriate:** The health services that adolescents need are provided.

**Effective:** The right health services are provided in the right way and make a positive contribution to the health of adolescents.

Provided in the Annex II is a detailed list of adolescent-friendly characteristics that could contribute to making health facilities and other points of health service delivery attractive for adolescents. The characteristics are organized according to the five broad dimensions of quality listed above. (World Health Organization 2009)

National programmes should take the responsibility for expansion and sustainability. The programme’s sustainability cannot be assured if the adolescent-friendly health services (AFHS) are implemented as small pilot projects dependent on donor support.

### Demand generation for services amongst adolescents

It is a common observation that many adolescents do not seek health services for the concerns and health problems that they may be facing. They may not be sure of their own concerns or whether they need any help at all. They may be unaware of the place from where they can seek the services. To generate demand it is necessary to create awareness of when to seek health services from health centres/hospitals or health care providers. The demand for use of health services by adolescents will not increase until they have a supportive environment around them and the health facilities. The “gate keepers” like parents, peers, teachers and others who they constantly interact with can provide this support. Supportive environment also includes assistance in meeting the costs incurred for the services used.

The following actions facilitate access by adolescents to quality health services:

- Ensure availability of health care providers.
- Identify the training needs and standardize the guidelines and protocols.
- Equip and supply all service delivery points on an ongoing basis.
- Design service delivery points taking into account privacy, confidentiality, affordability and an enabling environment.
- Establish suitable links with service delivery points for referral that should be equally adolescent friendly.
- Establish coordination with popular NGOs and private providers and develop partnerships to ensure practice of uniform standards in the government, private and NGO sectors.
- Strengthen the information system and feedback.
- Create awareness among adolescents on when, where and how to seek services
- Create an enabling environment in the community to promote timely care seeking by adolescents.

### Standards of AFHS

As described above Adolescent Friendly Health Services can be distinguished by some physical and functional attributes of the health facility, the methods adopted by healthcare providers for provision of services and by the approaches for creating demand for such services. The criteria of friendliness described above can be paraphrased and grouped as 'standards' of quality for the adolescent health services. Such standards specify the organization of delivery of health care services that are designed to attract adolescent clients. Implementation and maintenance of such standards is likely to improve access to services and their utilization by adolescents, especially by those most at risk. Considering that the standards contribute to quality of services, their assessment also provide the means for systematic verification of the quality of services from the perspectives of the clients, providers and the health system.

Countries are expected to develop such standards through a consultative process involving all stakeholders including adolescents and young people. An example of such national standards is provided in the box.

## India: National standards for AFHS

### 1. Health facilities provide the specified package of health services that adolescents need

This standard seeks to ensure that the specified package of health services is provided. In many places, health facilities do not provide adolescents with the health services they need. Often, general health complaints are used as an entry point to provide the required sexual and reproductive health services. This standard seeks to ensure that the specified package of health services is in fact provided.

### 2. Health facilities deliver effective health services to adolescents

In many places, health services are not provided effectively by service providers for a variety of reasons viz. service providers are not in place, they do not have the required competencies, the required supplies, equipment and basic amenities are not available etc. This standard therefore stresses that health facilities are well equipped to deliver services to adolescents as per their need/s.

### 3. Adolescents find the environment at health facilities conducive to seek services

Adolescents will not seek health services if the physical environment and procedures are not appealing to them. This standard focuses on ensuring that a reasonably conducive environment exists in health facilities for adolescents to access these services.

### 4. Service providers are sensitive to the needs of adolescents and are motivated to work with them

Due to a variety of reasons, e.g. judgmental attitudes of service providers, adolescents do not seek health services. Service providers are to be technically competent and motivated to provide services to adolescents as per their need/s. This standard seeks to ensure that the service providers imbibe and demonstrate appropriate attitudes and behaviour to reassure the adolescents in addressing, their needs. The standard therefore seeks to address issues relating to service providers attitudes and motivation.

### 5. An enabling environment exists in the community for adolescents to seek the health services they need

In many situations, community members (especially parents) are not aware of the value of providing sexual and reproductive health services to adolescents. They do not believe that adolescents should have access to these health services. This deters service providers from providing health services to adolescents, and deters adolescents from seeking the same. The standard seeks to address these environment-building factors.

### 6. Adolescents are well informed about the availability of good quality health services from the service delivery points.

Adolescents are generally not aware of where they can get good quality health services. The standard seeks to address the gaps in knowledge and awareness among adolescents on health, sexual and reproductive health issues and emphasizes the importance of seeking quality services in time from the service delivery points.

### 7. Management systems are in place to improve/sustain the quality of health services.

Data that is gathered at sub-centres, primary health centres and community health centres is generally sent to a higher authority for analysis. Often no feedback is received. Only rarely is the data used locally to address problems and take remedial measures leading to an improvement in quality. This standard focuses on the importance of monitoring systems to ensure that interventions are effectively implemented as planned and that appropriate feedback mechanisms are in place.

In addition to providing health services at the health facilities options of providing health services at other locations and through outreach approaches should be explored. School-linked and workplace-linked clinics for adolescents / young people should be considered depending on the capacities in the health system. Where the private sector is prominent, the practitioners should also be encouraged to provide adolescent friendly health services. The national standards that the countries develop would be applicable to all such service delivery models and thus assure good quality of such services across the board. Additionally, the standards would equally apply to HIV / STI services for adolescents / young people that are provided in the countries.

## **Implementation of Adolescent Friendly Health Services**

### **Implementation guidelines**

Once the national standards have been decided the MoH should develop implementation guidelines to provide operational guidance for organizing adolescent friendly health services in the identified health facilities. The guidelines should provide actions to be taken at the national, state (provincial), district and health facility levels to operationalize good quality health services for adolescents including demand generation and monitoring of the implementation.

### **Capacity building of health care providers**

The healthcare providers need knowledge about the adolescence phase of life (how adolescents think, take decisions and behave) and need to develop positive attitude to be supportive, sensitive and non-judgmental towards the adolescents. They need to acquire skills of inter-personal communication and skills for clinical management of common health conditions with which the adolescents commonly present to the clinics. WHO has developed an 'Orientation Programme' for health care providers for management of health problems of adolescents. Adolescent Job Aids that include clinical algorithms for standard management of common adolescent health problems have also been developed. Countries can adapt and use these tools for capacity building of healthcare providers.

### **Ensuring uninterrupted supply and access to commodities**

Depending on the package of services decided, an uninterrupted supply of medicines, equipment and commodities (e.g. weighing scale, BP apparatus, IFA tablets, vaccines, contraceptives, condoms, equipment for RH services, IEC material etc.) must be ensured. It must also be ensured that the adolescents can easily access all of these with ease and comfort.

### **Monitoring the services**

As the adolescent friendly health services are rolled out as per the national standards it is crucial to monitor the quality and coverage of such services. The service records maintained at the health facilities should be so designed as to provide utilization data related to numbers of clients (by age and sex) who visited the clinics and with what problems, as well as what services were provided at site and through referral to these clients. Such service data should be collected and analyzed at local (health facility level), district, provincial and national levels. Additionally, periodic assessment of quality and coverage of such services should also be considered. WHO has developed tools for assessment of quality and coverage that can be adapted by the countries as per their national standards.

## IV. Strengthening collaboration and partnerships

WHO, UNFPA and UNICEF Joint Framework for adolescent health and development recommends the following main inputs to promote adolescent health and development:

- Information and life skills
- Services and counselling
- Safe and supportive environment
- Opportunities to contribute and participate

Several sectors and players in society need to contribute to meet these needs towards the development and health of adolescents. These include, among others, Health sector, Education sector, Youth and sports, Law and judicial sector, Media, Civil society, Adolescents / young people themselves, Parents and families.

The following matrix indicates the respective roles of different sectors depending on their relative strengths: (+++ means main responsibility; ++ means significant role and + means enabling role).

	Health sector	Education sector	Media	Other sectors: parents, peers, civil society, labour, criminal-justice, social services, etc.
Information and life skills	+	+++	++	++
Health services and counselling	+++	+	+	+
Safe and supportive environment	+	++	++	+++
Opportunities to participate	+	+	+	++

Behavioural change among adolescents is more likely to be brought about by actions outside the health system. It is crucial to develop collaboration with the education sector for addressing the school students and other social sectors as well as a sustained collaboration with local self-governments and developmental programmes to reach out to out-of-school adolescents and special groups.

The health sector has a stewardship role in promoting health and development of adolescents/ young people as well as to strive towards collaboration among the various sectors. This effort should encourage adolescents to reinforce positive behaviour and to tackle the negative influences in their lives. They will then be better prepared to deal with problems in adulthood.

### School programmes

The students are a captive and interested audience for institutionalizing health education programmes in schools and colleges. The advantage of going through the school system is that the students can be exposed to the content in a structured way right from the primary stage all the way to the secondary stage and even in the college setting.

Collaboration should be developed and sustained between the department of health and department of education to develop and implement plans to organize education of adolescents on subjects identified jointly. The objective should be to provide age-appropriate knowledge and skills to students based on their age and sex.

Appropriate changes in the curriculum and integration with the teaching of existing subjects would contribute to sustainability. Success can be further enhanced by including an evaluation of the knowledge and skills within the examination system.

Adolescents are generally very comfortable in discussing personal and sensitive matters with their peers. A peer education approach may be considered as an option in such situations. The involvement of teachers and of peer groups is not mutually exclusive and must be complementary. Peer group education may be particularly successful in dealing with 'personal and sensitive' issues relating to sexuality, substance abuse, etc.

Sometimes, this evidence-based intervention faces resistance owing to prevailing sensitivity to issues related to sexuality. The resistance could be based on a common misperception that sexuality education can promote sexual behaviour. It is a good practice to develop school-based sexuality education programmes in consultation with students, teachers, parents and opinion leaders in the community. In the first phase, it may as well be prudent to implement the programme in selected settings and monitor it closely. The successful experiences can subsequently be used as best practice for scaling-up.

The following interventions and approaches are useful in school settings:

- Train the school teachers and build their skills and sensitivities towards the needs of adolescents. Remove the myths and help teachers overcome their hesitation to discuss the subjects related to sexuality, reproductive health, and contraception.
- Develop a suitable curriculum and integrate it with the teaching of other subjects like sociology, civics, economics etc.
- The use of an interactive and participatory approach is likely to be more effective than a didactic approach. However, this requires more skills, innovation and motivation among teachers.
- Actively involve the students through debates, elocution contests, slogan competitions, drawing and painting competitions.
- Consider regular visits by trained health workers to help in assessment of health status; implementation of public health programmes e.g. vaccination, mid-day meals, micronutrient supplementation, provision of sanitary napkins etc. as well as provision of counselling services. Trained health workers can also conduct group sessions with students and teachers periodically to answer their questions related to 'sensitive' issue of sexuality that teachers may feel shy to deal with.
- A referral linkage with the adolescent friendly health services must be established to provide access to desired services when needed.

### ***Programmes for out-of-school adolescents***

In many countries and within countries, a large proportion of adolescents are out of school owing to poor enrollment and a high drop out. The needs of the out-of-school adolescents may be greater than those who go to school since the dropouts are amongst the disadvantaged and marginalized groups.

Additionally, adolescents who live in remote and inaccessible areas, street children, migrants, physically disabled or mentally challenged, young men having sex with men, young people who inject drugs and those engaged in paid sex are special groups and need greater attention.

The out-of-school programmes are more challenging and resource intensive. There is a need for innovation to achieve success. The approaches that may be considered are (a) peer group and youth group involvement (b) strengthening of communication and counselling services in workplace settings, (c) behaviour change communication through various media channels and inter-personal communication and (d) NGO-led services.

In large countries, and in diverse population groups, different models should be developed through research and evidence developed on what works and is scalable.

### ***Research issues in Adolescent Health***

Countries should strengthen national policies and programmes based on the existing evidence and research should be mounted for any evidence-gaps. For example, countries may need to focus on behaviour research for adolescents / young people, studies on cost effectiveness of interventions, and evolving output-and outcome-based indicators for monitoring.

Needs of special groups of adolescents are often ignored in the national policy. The national policy needs to recognize the diversity of adolescents based on age, sex, marital status and social circumstances and take into consideration the rights of the marginalized population and special groups at risk.

In countries where an adolescent health programme is already being implemented, there is a need to document evidence on effective implementation models and operational issues. Research would also be important to evaluate the best practices that can guide expanding and scaling up the national programme.

In many countries programmes covering HIV/AIDS, reproductive health, mental health, etc, are pursuing research. It is important to advocate with the researchers to include key issues relating to adolescent health in their research agenda.

Capacity development in research should be a priority. The academic institutions engaged in research on adolescent health should be networked and a system evolved to share research findings with the programme.

## Monitoring implementation

### Monitoring of adolescent health services

It is important to evolve a monitoring mechanism, preferably within the existing system, to monitor the progress in provision of AFHS. Key indicators should be selected through a consultative process. Such indicators can be included in the service register, supervisory checklist and management information system as appropriate. In addition to monitoring utilization of services by adolescents at the facility level, it is important to monitor the quality and coverage of AFHS. Standard tools and guidelines to monitor the quality and coverage are available and could be adapted for use in national programmes.

Investment in adolescent-friendly health services is hampered by the lack of information on utilization of services that is disaggregated by age, sex, marital status etc. Currently, the monitoring of adolescent programmes is not result/output based. This makes it difficult to convince the policy makers and stakeholders to continue their commitment.

### Service register

Each health facility is to maintain an AFHS Service Register, which will collect data on pre-decided information. The information from the service register should be compiled and analyzed on a monthly basis to identify corrective actions, if any, and submitted to the district headquarter. Service registers may include the following indicators.

Total number of clients in a month: 10-14 years: Male and Female 15-19 years: Male and Female
No. of walk-in adolescent clients
No. of adolescent clients referred to the health facility - from school - from NGO - from others
No. of adolescents referred to higher facilities
No. of new pregnancies below 20 years registered during the month (married/unmarried)
No. of adolescent pregnant women attending ANCs
No. of adolescent pregnant women delivering in the institution
No. of adolescent girls availed safe abortion services (married/unmarried)
No. of adolescent girls and boys accessed contraceptive services by method (condoms, OCP, ECP, IUD)
No. of adolescent girls and boys availed RTI/STI treatment
Number of activities for community / adolescent mobilization held in the month in schools and in the community

## **Indicators in the management information system**

Key indicators related to the provision of adolescent friendly health services must be included in the management information system is in operation in the country. Some of the following indicators could be considered:

- Total number of adolescent boys and girls attended
- Number of adolescent pregnant women registered for ANC
- Number of adolescent pregnant women who have delivered in institutions/health facilities
- Number of adolescent boys and girls provided contraceptives (by methods)
- Number of adolescents provided safe abortion services (if legal)
- Number of adolescent boys and girls provided STI treatment

## **Supervisory checklist**

Programme managers could periodically use checklists during their supervisory visits in order to assess adherence to desired standards. The district manager could do this monitoring once in three months.

## **Periodic assessment of quality and coverage of services:**

It is important to assess quality and coverage of the AFHS being provided. Some of the input, process and output criteria related to each national standard could be assessed to determine the quality of the services. Generic tools for assessment of quality and coverage have been developed by WHO that can be adopted / adapted by the countries. Such an assessment could be carried out once every year.

## **National demographic and health surveys**

National demographic and health surveys are carried out by the countries every few years. Key adolescent health related indicators must be introduced into these and more importantly, the data must be analyzed to obtain age and sex desegregation for understanding the situation of the adolescent age group. Many times the age group 10-14 years may not be addressed in these surveys. Countries may like to commission special rapid surveys to get the desired data to fill in such knowledge gap.

## **Monitoring programme targets**

Depending on the country's decision regarding specific targets a periodic assessment of related indicators would need to be considered.

Five year targets	Possible indicators (Some of these are possible in existing HMIS, DHS etc.)
Early identification and management of adolescent pregnancy increased by 50%	<ul style="list-style-type: none"> <li>• Proportion of pregnant adolescents who were registered for ANC in the first trimester</li> <li>• Proportion of pregnant adolescents who received four ANCs, TT immunization and IFA tablets</li> <li>• Proportion of adolescents who had institutional delivery</li> </ul>
Reduce unmet needs for contraceptives amongst 15-19 year-olds by 30%	<ul style="list-style-type: none"> <li>• Proportion of health facilities and outreach facilities that provide contraceptives to 15-19-year-olds</li> <li>• Proportion of adolescents out of all clients who received a contraceptive from health facilities</li> <li>• Increase in the condom uptake by 15-19-year-olds from outreach and health facilities</li> </ul>
Increase the use rate of condoms by 50% in the last casual sex amongst 15-19 year-olds	<ul style="list-style-type: none"> <li>• Proportion of males in the age group who used a condom during the last high-risk sexual encounter</li> <li>• Proportion of 15-19-year-olds in special groups (MSM, CSW, IDU) who used a condom during the last high-risk sexual encounter</li> </ul>
Decrease the incidence of anaemia amongst 10-19-year-old boys and girls by 50%	<ul style="list-style-type: none"> <li>• Proportion of adolescents (boys and girls) who received a complete course of iron and folic acid tablets</li> </ul>
Reduce the incidence of HIV/STI amongst 15-19 year-olds by 20%	<ul style="list-style-type: none"> <li>• Proportion of adolescents who had used a condom during the last sexual encounter</li> <li>• Proportion of patients aged 15-19 years with STI receiving treatment</li> </ul>

## To summarize

The adolescent age group (10-19 years) constitutes about 22% of the population in the SEA Region of WHO. Adolescents are generally considered healthy since mortality in this age group is low. However, mortality patterns alone do not describe the health status of this large section of population.

Since, adolescents are at the stage of growing and developing they need holistic support to complete this important task in the life course. They are likely to have several issues related to growing up like acne, body image, masturbation, menstrual problems, sexual issues and psycho-social issues that, in the event of remaining unaddressed, make them vulnerable to health risk behaviours that have a lifelong adverse impact on health.

Adolescents face several health problems which are much different from what they faced as children. Common adolescent health problems in the South-East Asia Region are related to nutrition (anaemia, under-nutrition), early pregnancy and childbirth (related high maternal and infant mortality), reproductive tract infections, sexually transmitted infections and HIV, substance use and injuries.

Existence of such public health priorities makes a compelling case for investing in adolescent health programme in the countries. There is an economic case as well since healthy adolescents and young people would effectively contribute to national productivity. In any case, the countries have obligations to fulfill the rights of adolescents to remain healthy.

Although adolescents face a variety of problems they are not able to access health services because of a variety of barriers, like, personal developmental attributes (shyness, embarrassment and inability to recognize the need and communicate); absence of designated services for adolescents, lack of privacy and confidentiality at existing services; and busy, judgmental providers. The existing health services, however, can be made attractive for adolescents by removing these barriers.

There are many players in society who can contribute to adolescent health and development. Political leadership, opinion makers, religious leaders, parents and families are responsible for providing a safe and supportive environment. The education department, family, media, sports and popular stars etc. have a responsibility to ensure provision of information to adolescents and developing their psycho-social skills. Fulfilling these needs significantly contributes to prevention of health problems. The health sector, of course, has the direct responsibility of providing health services and counselling.

Within the multi-sectoral response the health sector needs to assume a stewardship role. The health sector's role has been enunciated through the '4S' framework. It articulates tangible contributions that the health sector must make in the areas of collecting and using Strategic information for planning and monitoring implementation of adolescent health service; Supportive policy environment and advocacy that backs appropriate response to promote adolescent health; delivery of Services comprising information for increasing awareness and promoting healthy behaviours, demand generation for services, provision of adolescent friendly health services (including provision of information and counselling) and commodities (like contraceptives), and Strengthening of collaboration with other sectors.

Governments must mobilize adequate financial resources for scaling-up of adolescent friendly health services from domestic funds as well as from external sources, as may be required.

For organizing health services for adolescents the countries should develop national standards based on well recognized adolescent friendly attributes through a consultative process. Such standards will guide operationalization of adolescent friendly health services while assuring good quality of services. Countries must put in place mechanisms to monitor the implementation of adolescent health programmes through their existing MIS and DHS as well as through specific assessments, surveys and studies.

It is hoped that this document will provide broad guidance on developing and effectively implementing strong adolescent health programmes in the countries based on the locally prevailing context and priorities.

## Annex. I

### Regional Fact sheet:

#### Situation of adolescents in the South-East Asia Region

Adolescents constitute a sizeable segment of the total population in Member States of the South-East Asia Region. The proportion varies from 15% to 26% of the total country population<sup>1</sup> (Figure 1).

**Figure1: Proportion of adolescents (10-19 years) in SEAR countries**



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2010 Revision*, <http://esa.un.org/unpd/wpp/index.htm>

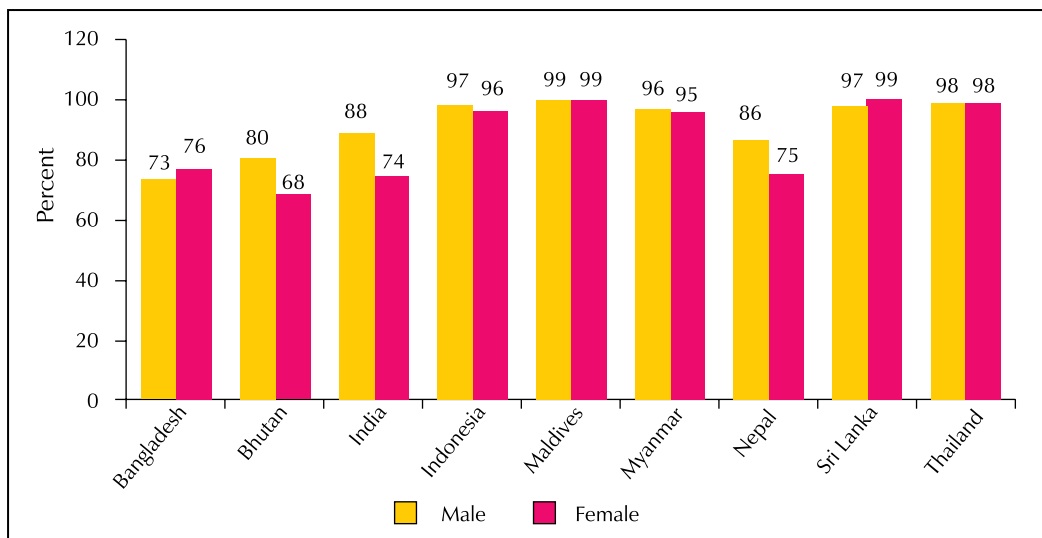
These variable situations as well as inter-country and intra-country differences present multifaceted challenges to programming for adolescent health.

#### Education

Educational opportunities influence the quality of life of adolescents including health, and prospects for development.

<sup>1</sup> World Population Prospects: *The 2010 Revision*, <http://esa.un.org/unpd/wpp/index.htm>

**Figure 2: Youth (15-24 years) literacy rates in SEAR, 2004-2008**

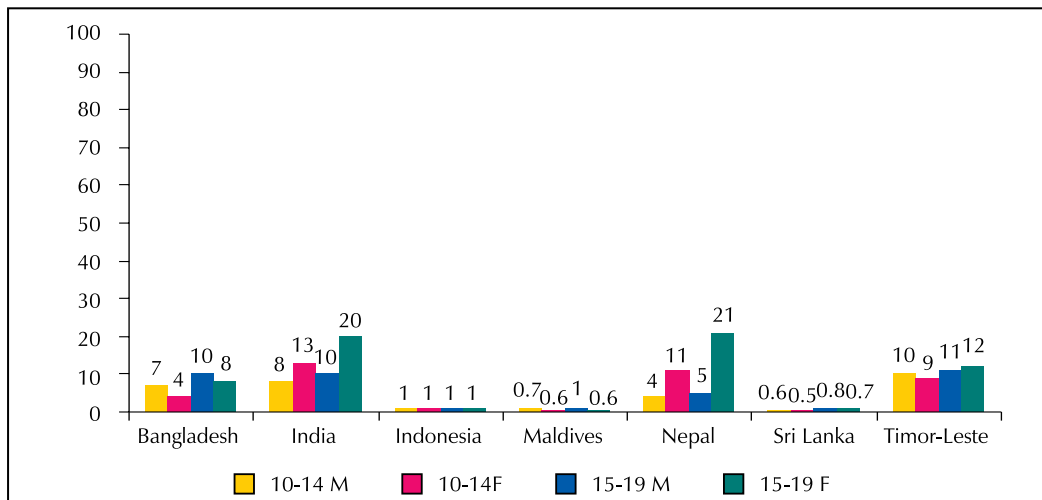


Source: The State of the World’s Children 2011. Adolescence An Age of Opportunity. UNICEF

Literacy among youth has been steadily increasing in the Region ranging, at present, from 68% to 99%. While literacy is almost universal in countries like Maldives, Myanmar, Sri Lanka and Thailand, it is lower in countries like Bangladesh, Bhutan, India and Nepal especially among young women (Figure 2).

Different patterns can also be observed in educational attainment among adolescents in the South-East Asia Region. While a higher proportion of adolescents are educated in Thailand, Sri Lanka, Myanmar, Maldives and Indonesia, a large proportion of adolescents are illiterate in Bangladesh, India and Nepal (Figure 3). Though educational attainments are improving for both males and females in these countries, inequality in access to and completion of education is evident.

**Figure 3: Adolescents with no education**



Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Maldives 2009; Nepal DHS 2006; Sri Lanka DHS 2005-06; Timor-Leste DHS 2009-10

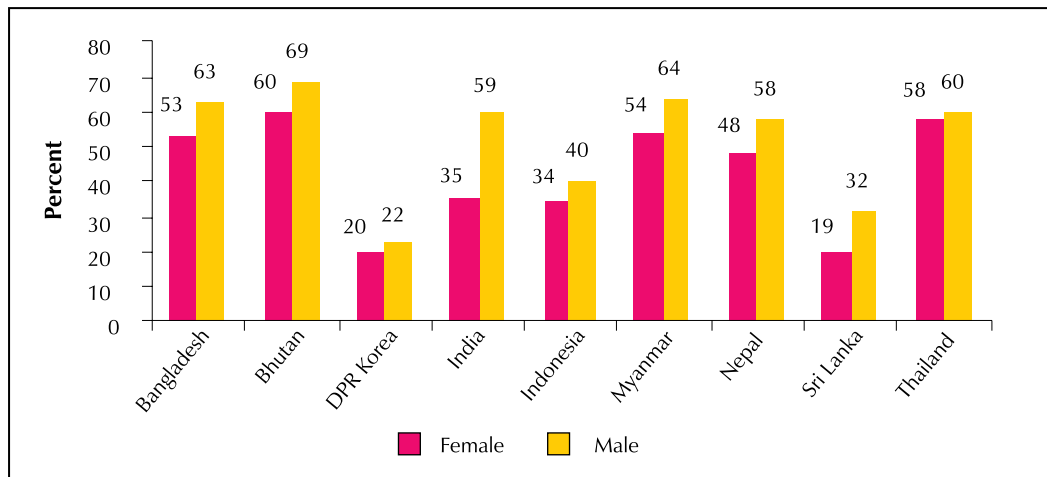
More females than male adolescents remain uneducated and fewer adolescent females complete secondary and/or higher education. 2 Gender disparities are evident in school enrolment, school attendance and attainment of higher levels of education. Early marriage also interrupts education of females. Urban/rural gaps are also remarkable in many countries in the Region.

## Employment

Extreme poverty amongst population groups in Member States of the Region forces adolescents to take up employment and prevents them from attending or continuing school. In Bangladesh 18% of boys and 5% of girls in the age group of 10-14 years are employed. In Nepal 27% of young adolescents (10-14 years) were reported to be in the labour force<sup>2</sup>.

Overall, a large number of adolescents (19% to 69%) are working, with the percentage of economically active adolescent males being higher than females (Figure 4).

**Figure 4: Percentage of economically active adolescents (ages 15-19 years)**



Source: The World Youth 2006 Data Sheet, Population Reference Bureau, Washington DC

## Mortality patterns

As in other regions, mortality rates among adolescents in the Region are generally lower than those observed in children or in older age groups. However, many adolescents in the Region die prematurely every year from problems or illnesses that are either preventable or treatable. Systematic analysis of global patterns of mortality among young people (Lancet Vol. 374 September 12, 2009) suggests that 97 % of deaths among 10-24-year-olds in 2004 occurred in low-income and middle-income countries, almost two-third of these in Sub-Saharan Africa and South-East Asia. Pronounced increases in mortality rates were recorded from early adolescence (10-14 years) to young adults (20-24 years), 2.4 times higher among the latter age group. In South-East Asia maternal causes of death (haemorrhage, sepsis, abortion complications) account for a higher proportion of deaths among females. Among males, injury-related deaths (traffic accidents, violence, fire-related injuries and drowning) account for a high proportion of deaths.

<sup>2</sup> Adolescent Health Fact Sheets 2007. WHO-SEARO

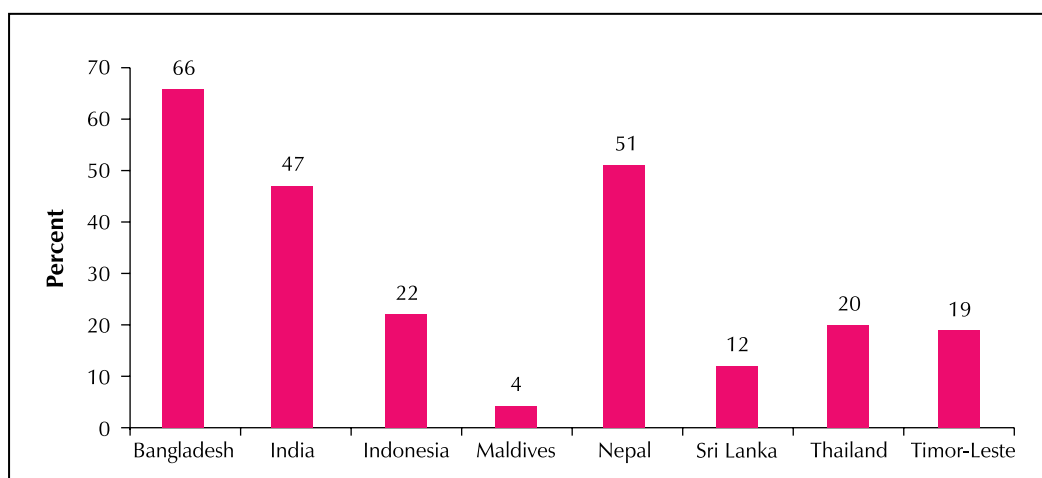
In some countries, adolescents face problems of early marriage and childbearing which endangers the life of both the child and the mother. Young girls are married with older men who are likely to have earlier, multiple sexual experiences. This exposes the young wives to STI and HIV. In other countries, a progressive increase in age of marriage increases the possibility of pre-marital sexual activity. If unprotected, sexual activity is associated with unwanted pregnancies and abortions as well as sexually transmitted diseases including HIV/AIDS. Smoking, alcohol and substance abuse, violence and injuries, exposure to hazardous work and sexual exploitation also pose a serious threat to adolescent health and development. Disadvantaged and marginalized groups are particularly at risk.

## Reproductive health

### Early marriage

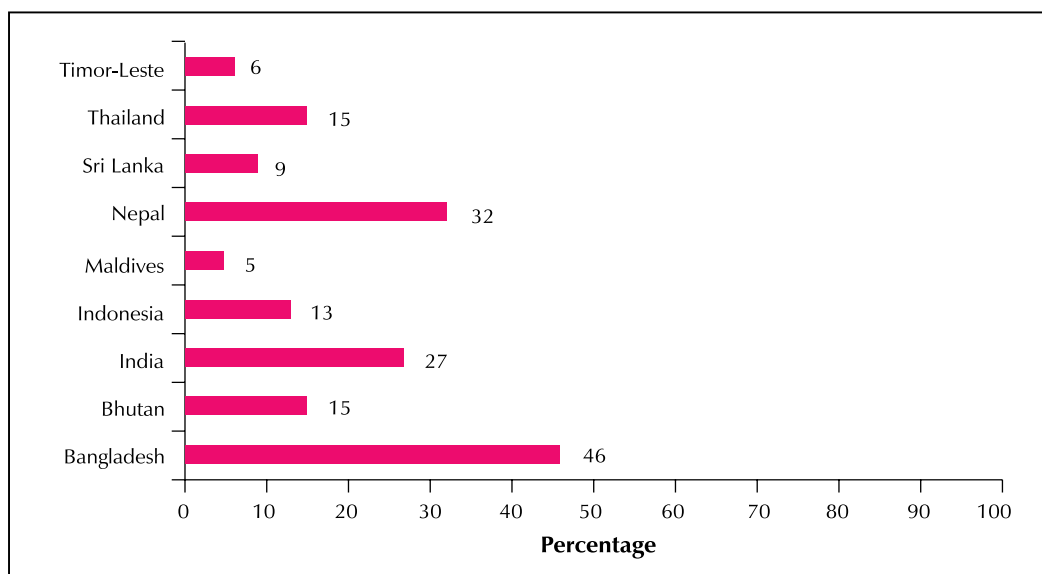
The age of marriage is rising in most South-East Asian countries. However, early marriage for girls remains the norm in some. About 66% of girls in Bangladesh, 51% in Nepal, 47% in India, and about 22% in Indonesia and 19% in Timor-Leste are married by 18 years of age (Figure 5). More than 21% of girls in Bangladesh, 18.2 % of girls in India and 10.2% of girls in Nepal are married by 15 years.<sup>3</sup>

**Figure 5: Percentage of women aged 20-24 years married by 18 years of age**



Sources: Bangladesh DHS 2007, India NFHS-3 2005-06, Indonesia DHS 2007, Maldives DHS 2009; Nepal DHS 2006, Sri Lanka DHS 2006, Thailand -Thailand Multiple Indicator Cluster Survey 2005 – 06, Timor- Leste DHS 2009-10

<sup>3</sup> BDHS 2007, India NFHS-3 2005-06, NDHS 2006

**Figure 6: Percentage of currently married adolescents aged 15-19 years**

Source: Sources: Bangladesh DHS 2007, India NFHS-3 2005-06, Indonesia DHS 2007, Maldives DHS 2009; Nepal DHS 2006, Sri Lanka DHS 2006, Thailand -Thailand Multiple Indicator Cluster Survey 2005 – 06, Timor- Leste DHS 2009-10

Data from the Country DHSs and MICS reports a range of 5% to 46% of married adolescents aged 15-19 years in the Region (Figure 6).

A strong correlation exists between early marriage and factors like education, place of residence and socio-economic status of the family. Early marriages are more common in rural areas and among the poor sections of the population. Educated girls tend to get married later as compared to those who are less educated, out of school or uneducated.<sup>4</sup>

Early marriage followed by early pregnancy exposes them to higher reproductive health risks. Access for young women to contraception is limited as well. Married adolescent girls often have limited autonomy and are not empowered to take decisions. They are often unable to obtain health care because of dependence for expenses and the need for permission for seeking health care from a spouse or in-laws. These barriers further aggravate the risks of maternal mortality and morbidity.

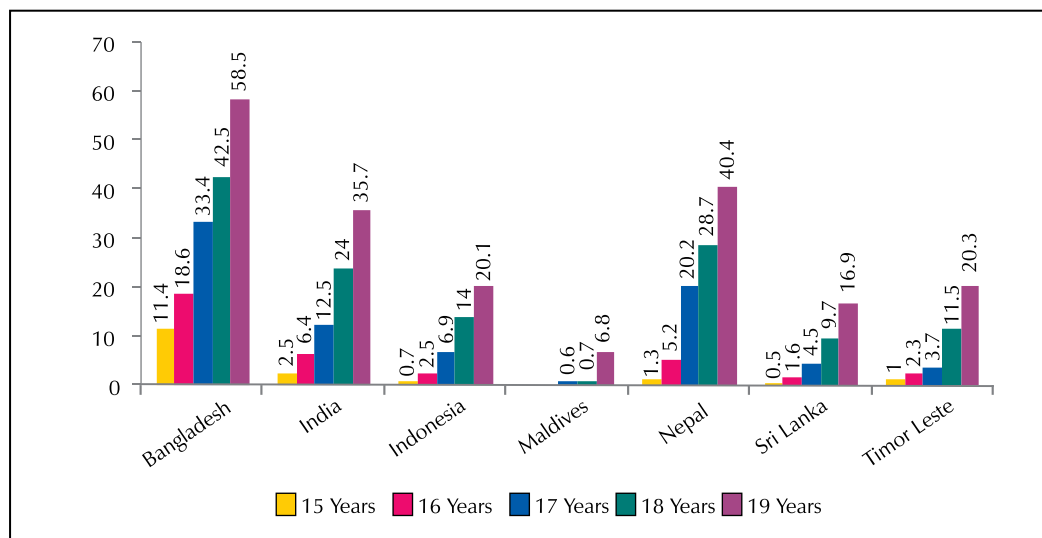
### **Pregnancy and childbearing**

Globally the highest adolescent birth rates are found in countries where the age of marriage is low. In the South-East Asian countries where age of marriage is low in many countries, adolescents becoming mothers is not uncommon. The highest proportions of births among adolescents are in Bangladesh and Nepal and lowest in Sri Lanka (Figure 7). In Bangladesh more than 11% girls begin childbearing by 15 years of age and almost 59% of them become mothers by the age of 19 years. The total fertility rate in the Region contributed by women in the age group 15-19 years varies from 5% to 20%.<sup>5</sup>

<sup>4</sup> Early Marriage, A Harmful Traditional Practice A Statistical Exploration 2005, UNICEF

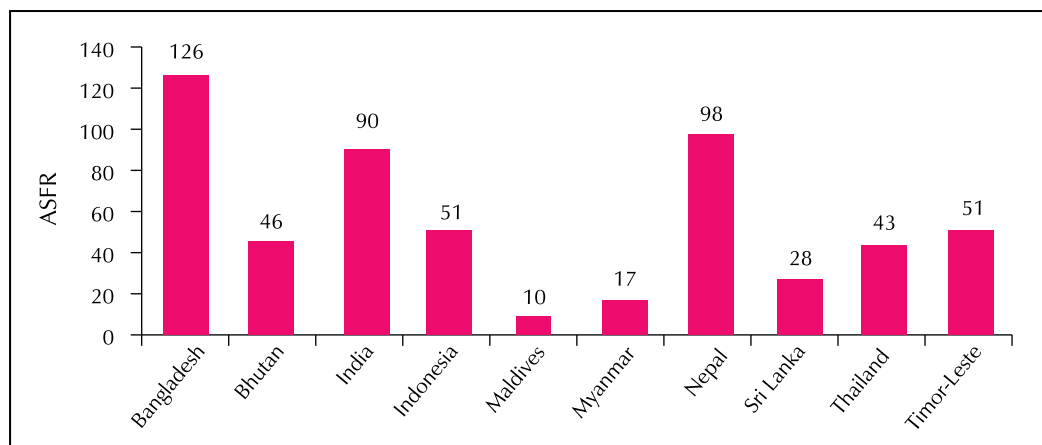
<sup>5</sup> Population and Development indicators for Asia and the Pacific 2001. [www.unescap.org/esid/psis/population / database/data\\_sheet/2001/table2.htm](http://www.unescap.org/esid/psis/population/database/data_sheet/2001/table2.htm) and Population Reference Bureau (2000). The World's Youth 2000. Washington, DC

**Figure 7: Percentage of married adolescents aged 15-19 years who have begun childbearing**



Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Nepal DHS 2006; Maldives 2009; Sri Lanka DHS 2005-06; Timor-Leste DHS 2009

**Figure 8: Birth rate among adolescents in SEAR (live births per 1000 women)**



Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Maldives DHS 2009; Myanmar FRHS 2007; Nepal DHS 2006; Sri Lanka DHS 2005-06; Timor-Leste DHS 2003; Thailand and Bhutan-The State of the World's Children 2011. Adolescence An Age of Opportunity. UNICEF

The adolescent childbearing rate in the Region ranges from 10 (Maldives) to 126 (Bangladesh) live births per 1000 women aged 15-19 years in (Figure 8).

Young women and their children face serious risks from early pregnancy and childbearing. The adverse health consequences include damage to the reproductive tract, high maternal mortality ratio, pregnancy complications, increased perinatal and neonatal mortality and high incidence of low birth weight. Adolescent girls between the ages of 15 and 19 are twice as likely to die during pregnancy or childbirth as compared to women in their 20s. For those under 15 years, the risks are five times higher.

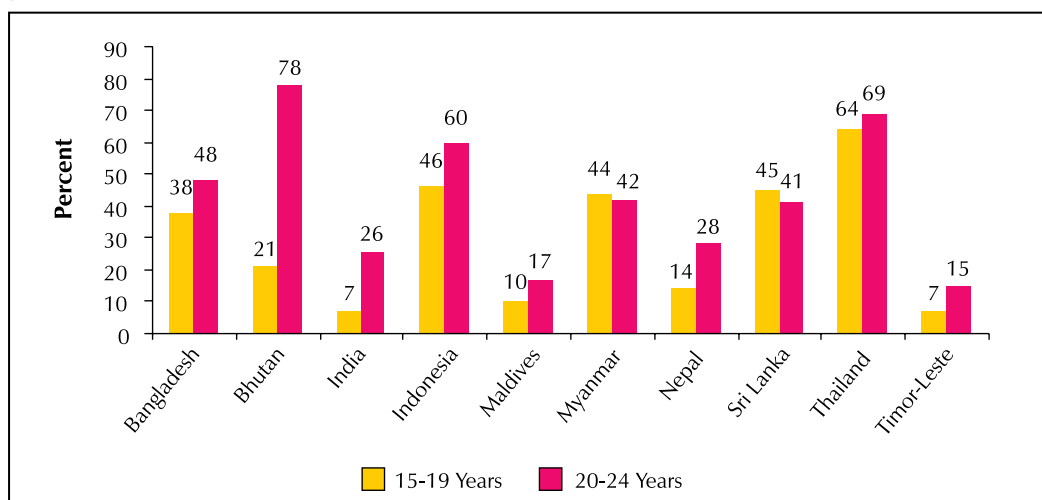
Neonatal and infant mortality rates are higher among women aged <20 than among 20-29-year-olds. The neonatal mortality rate in India is 34.2 per 1000 live births for women aged 20-29 years as compared to 54.2 per 1000 live births for those aged <20 years (NFHS 3; 2005-06). In Bangladesh it is 37 for women aged 20-29 years and 58 for those <20 years. In Nepal it is 32 for women aged 20-29 years and 55 for those aged <20 years. The infant mortality rate in Bangladesh is 60/1000 live births for women aged 20-29 years and 86/1000 live births for those <20 years; in Nepal it is 50/1000 live births for women aged 20-29 years and 83/1000 live births for those aged less than 20 years.

### Low contraceptive use

Across the Region, the level of knowledge of contraceptives exceeds 90% among married females in almost all the countries. Older and married adolescents are more likely to know about contraceptives than their younger and unmarried counterparts. A national survey in Sri Lanka showed that only 28% of 14-16-year-olds had ever heard of contraceptive methods compared to 64% of 17-19 year olds. In general, more boys were aware of contraceptive methods than girls. Knowledge of contraception was better among out-of-school adolescents than school-going ones.<sup>2</sup>

Data from the Region reveal that the proportion of married adolescents, who use contraception, remains low in several countries and the unmet needs are high. The contraceptive prevalence rate varies from 7% to 78% (Figure 9). The figure also indicates that across countries adolescent girls (15-19 years) are less likely than women over 20 years to use contraceptive methods. Often, young married adolescent girls are discouraged from using any family planning methods until the birth of their first child. A few studies that have explored contraceptive or condom use by unmarried adolescents reveal that the use is infrequent and young women report lower use than men.

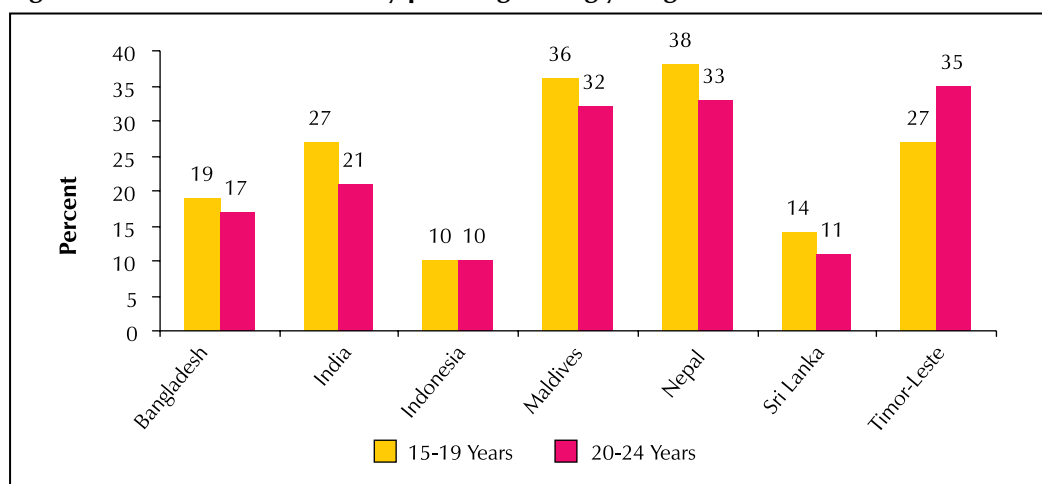
**Figure 9: Contraceptive use (modern methods) among married 15-19-year-old and 20-24-year-old women**



Source: Bangladesh DHS 2007, Bhutan Living Standard Survey 2007, National Statistical Bureau, Royal Government of Bhutan (age group 20-29), India NFHS-3 2005-06, Indonesia DHS 2007, Nepal DHS 2006, Sri Lanka DHS 2006, Maldives DHS 2009; Myanmar Country Report on 2007 Fertility and Reproductive Health Survey, Union of Myanmar, Ministry of Immigration and Population, Department of Population and UNFPA; Timor-Leste DHS 2009-10.

Adolescents have a high unmet need for contraception (Figure 10). Indicates that more than one third of young women in Nepal and Maldives, about a quarter in Timor-Leste, about 20% in Bangladesh, 21%-27% in India and 10% in Indonesia have an unmet need for family planning. In almost all of these countries the unmet need for family planning is higher among adolescents (15-19 years) as compared to those aged 20 years and above. The high unmet needs among adolescents and their high level of knowledge of contraception indicate that both married and unmarried young people face significant barriers to contraception.

**Figure 10: Unmet need for family planning among young women**



Source: Bangladesh DHS 2007, India NFHS-3 2005-06, Indonesia DHS 2007, Nepal DHS 2006, Sri Lanka DHS 2006, Maldives DHS 2009; Timor-Leste DHS 2009-10.

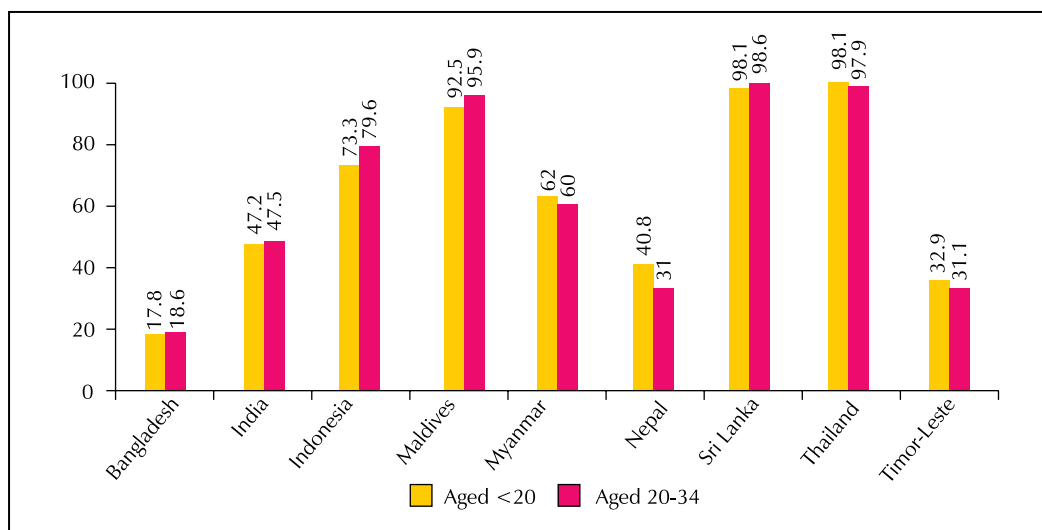
A number of obstacles inhibit contraceptive and condom use by adolescents. The possible barriers include a lack of accessible services and personnel; a policy that is not supportive for contraceptives especially amongst unmarried adolescents; lack of method choices; lack of knowledge about the safety, effectiveness and availability of choices; side effects and insufficient follow-up; inadequate confidentiality and privacy and providers' lack of understanding or sensitivity to their needs. Consequently, a substantial proportion of adolescents risk unwanted pregnancy, unsafe abortions, higher risk of maternal morbidity and mortality and exposure to STIs including HIV.

A key element of the essential package of safe motherhood interventions is childbirth care. WHO's Recommended Interventions for Improving Maternal and Newborn Health encompass care during labor and delivery and immediate postpartum care of mother. Important indicators of quality childbirth care are whether skilled personnel attended the birth, and whether the mother gave birth in a well-equipped health care facility.

Information from DHSs show mixed findings. Use of skilled delivery care by adolescents is highly variable across countries. At the national level, use of skilled delivery care by adolescents ranges from about 18% in Bangladesh to 98% in Sri Lanka and Thailand (Figure 11). In 3 of 9 countries with a recent DHS, adolescents were less likely than women ages 20-34 to have skilled attendance at birth. However, these differences were relatively small, generally a couple of percentage points.

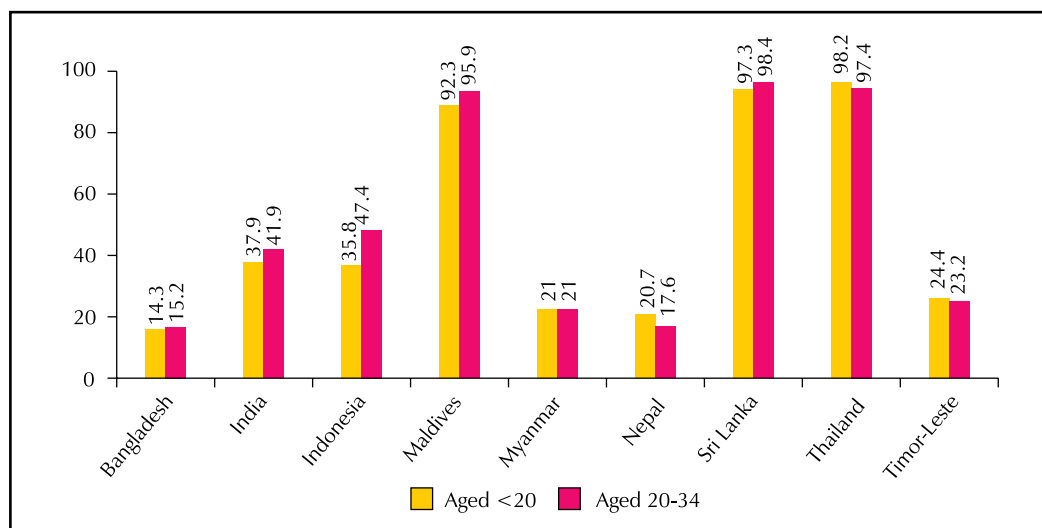
Findings comparing place of delivery are similar, with adolescents in 5 of 9 countries less likely to give birth in a health facility (Figure 12). In Myanmar, Nepal, Thailand and Timor-Leste adolescents were more likely to use delivery care.

**Figure 11: Use of skilled delivery care, adolescents vs. older women**



Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Nepal DHS 2006; Sri Lanka DHS 2006-07; Timor-Leste DHS 2009-10; Maldives DHS 2009; Myanmar FRHS 2007; Thailand MICS 2005-06

**Figure 12: Birth in health facility, adolescents vs. older women**



Source: Bangladesh DHS 2007; India NFHS-3 2005-06; Indonesia DHS 2007; Nepal DHS 2006; Sri Lanka DHS 2006-07; Timor-Leste DHS 2009-10; Maldives DHS 2009; Myanmar FRHS 2007; Thailand MICS 2005-06

### Abortion

Many adolescents face unplanned and unwanted pregnancy. Such pregnancies may be due to early and unprotected sexual activity, lack of knowledge about basic facts of reproduction or lack of information and access to contraceptives. Unwanted pregnancies among adolescents often result in unsafe abortions in hazardous conditions. Also, abortion is illegal in many countries except under certain circumstances, leading to the use of “hidden” and unsafe services. The risk of abortion-related morbidity is higher in cases of unwed adolescents since most of them are clandestine and likely to be unsafe. Large-scale reliable data related to abortions among adolescents is not available.

## Nutritional Status

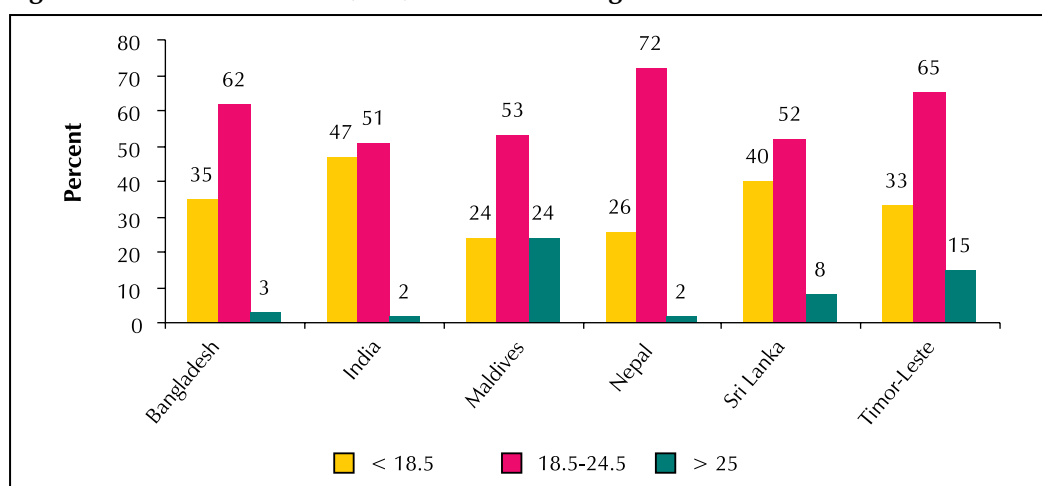
Adolescence is a period of rapid physical growth. It is the last chance for the individual to catch up. The main nutritional problems affecting adolescents in the Region include: under-nutrition, and anaemia. Iodine deficiency is also common among adolescents having implications on their physical and cognitive development.<sup>6</sup>

The body mass index (BMI) is used to measure thinness and obesity. A cut-off point of 18.5 is used to define thinness or acute under-nutrition, and a BMI of 25.0 or above usually indicates overweight or obesity. More than one-third of adolescents in the region are undernourished or thin (Figure 13). Low pre-pregnancy BMI is a risk factor for poor birth outcomes and obstetric complications.

Micronutrient deficiency especially iron deficiency anaemia is a major problem amongst adolescents in several countries of the Region. The NHFS-3 data from India reveals that almost 56% of ever-married females aged 15-19 years and 30% of males in the same age group suffer from some form of anaemia. The Household Survey 2001 in Indonesia showed that, nationally, 30% of adolescent girls suffered from anaemia.

With improvement in economic conditions, dietary habits and lifestyles are changing. Because of this change, over-nutrition and predisposition to chronic diseases in adults are emerging as challenges in some countries in the Region. The GSHS Indonesia 2007 found that 5.8% students were at risk of becoming overweight (i.e., at or above the 85th percentile, but below the 95th percentile for body mass index by age and sex) and 1.3% were overweight. According to the GSHS Thailand 2008, more than 4% students were overweight and 10% students were at risk for becoming overweight. Male students (12.7%) had a higher tendency than female students (7.6%) for becoming overweight. The problem of over-nutrition is increasing in the urban and well-to-do populations in some countries while under-nutrition is a common problem amongst the poor and rural/urban slum residents.

**Figure 13: Nutritional status (BMI) of adolescents aged 15-19**



Source: Bangladesh DHS 2007, India NFHS-3 2005-06, Nepal DHS 2006, Sri Lanka DHS 2006, Maldives DHS 2009; Timor-Leste DHS 2009-10.

<sup>6</sup> Strategies for adolescent health and development in South –East Asia Region, WHO-SEARO, December 1998.

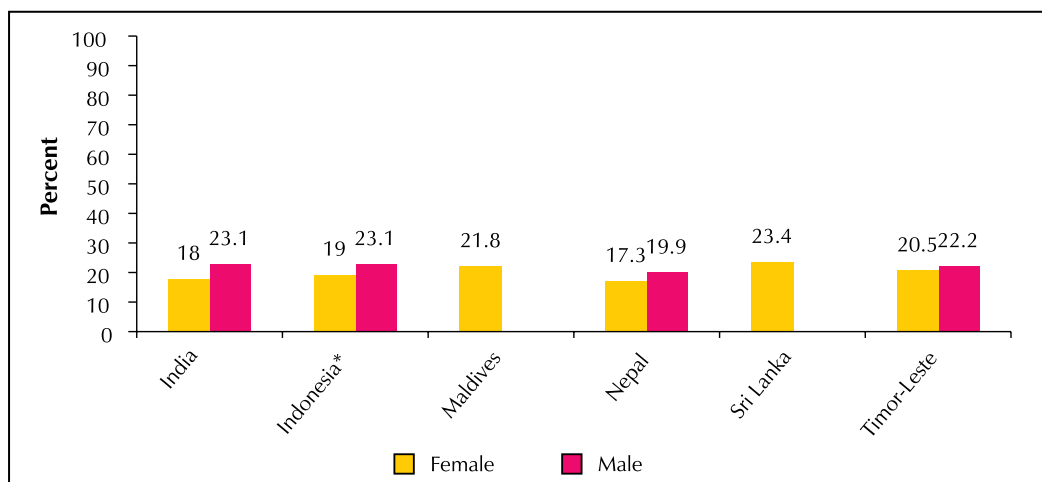
### Early sexual activity

Throughout the Region, cultural norms and religious beliefs generate different attitudes towards males and females with respect to adolescent sexuality and sexual practices. Sexual activity often takes place in the context of highly unequal gender relations, limited information on sexual and reproductive health adding to the vulnerability of adolescents.

Data from different surveys and studies reveal that for many adolescents in the Region sexual activity begins early. Marriage marks the onset of early sexual activity among a large majority of young females in some Member States. On the other hand with the increasing age at marriage, there is a growing evidence of premarital sexual activity among adolescents. Early onset of menarche, rising age of marriage and greater exposure to national and international media are some of the contributing factors to early sexual debut.

The situation in Thailand, Sri Lanka and Bhutan is different from the situation in India and Bangladesh. The National Behavioural Surveillance survey of Thailand among secondary school students (2004) indicates that the average age of first sex among sexually active 8th grade students was 13 years for both boys and girls.<sup>7</sup>

**Figure 14: Median age at sexual debut among women**



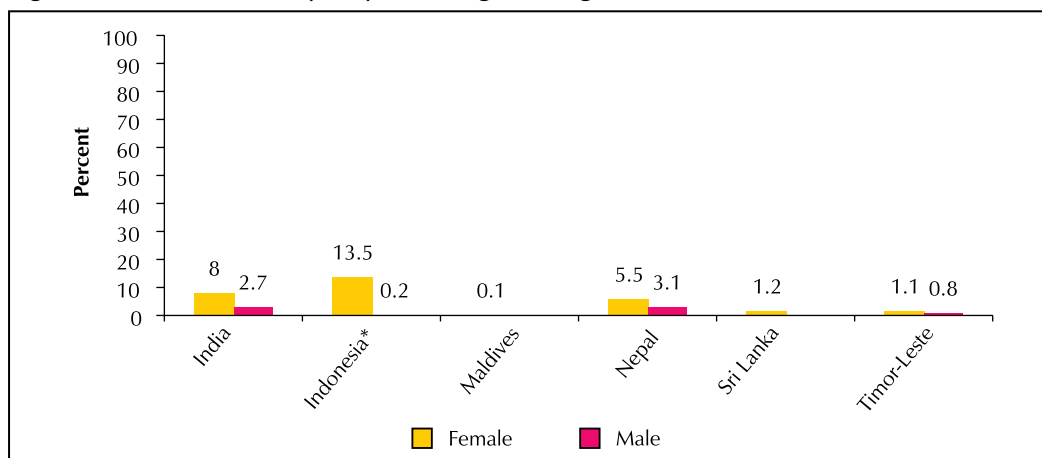
\* Ever married women and currently married men

Source: India NFHS-3 2005-06, Indonesia DHS 2007; Nepal DHS 2006, Sri Lanka DHS 2006, Maldives DHS 2009; Timor-Leste DHS 2009-10.

However, recent DHSs of a few member countries reported that the median age of sexual debut ranges from 17-23 years among women and 20-23 years among men (Figure 14). The age of sexual debut of women mostly coincides with the median age of marriage showing that women generally begin sexual intercourse at the time of their first marriage.

Country DHSs also showed that a small proportion of adolescents start their sexual activity as early as before 15 years of age (Figure 15). Early age of first sex is substantially lower among men as compared to women.

<sup>7</sup> Bureau of Epidemiology, Department of Communicable Disease Control, Ministry of Public Health. Report on the HIV/AIDS Situation in Thailand, 2004

**Figure 15: Sexual debut by 15 years of age among women and men**

\* Ever married women and currently married men

Source: India NFHS-3 2005-06, Indonesia DHS 2007; Nepal DHS 2006, Sri Lanka DHS 2006, Maldives DHS 2009; Timor-Leste DHS 2009-10.

In Thailand, studies during 2005-2007 show an increasing percentage of youth engaging in sex at a younger age. For instance, there was an increase from 0.3% to 0.8% among males and 0.2% to 0.6% among females in vocational school during 2005-2007 while from 9% to 14% among military recruits during the same period. On the other hand, nearly a quarter (24%) of the Thai 11th-grade male students (median age 17 years) were sexually active and had sex mostly with a lover or casual acquaintances; 2% had sex with a female sex worker in the past year and 2.1% with other males.<sup>8</sup>

### STIs/HIV/AIDS

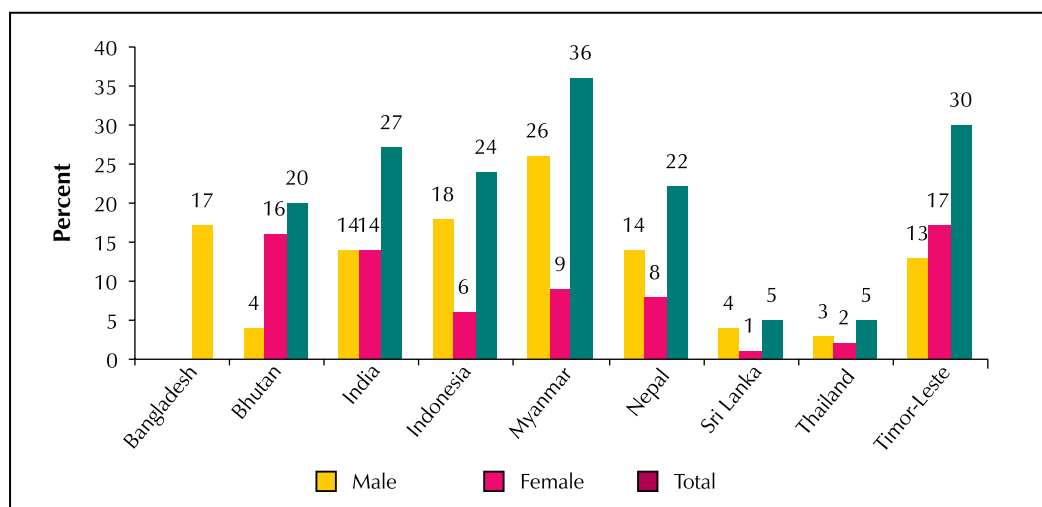
HIV prevalence is relatively low in the Region; however, the sheer size of the population translates into absolute numbers that are very high. India, Indonesia, Myanmar, Nepal and Thailand account for a majority of the estimated HIV burden. Bangladesh, Bhutan, Maldives, Sri Lanka and Timor-Leste together represent less than 1% of total HIV infections in the Region. There is now increasing evidence that HIV epidemics are largely concentrated among population sub-groups with high risk behaviours, namely, sex workers and their clients, injecting drug users (IDUs) and men who have sex with men (MSM).

Young people account for 24%-36% of the population in countries of the Region and thereby constitute a significant proportion of people at risk of HIV.<sup>9</sup> South-East Asia and the Pacific have the second highest prevalence with an estimated 1.27 million youth living with HIV.<sup>10</sup> The percentage of HIV positive youth among the HIV population ranges from 5% to 36% in SEAR countries. However, in terms of absolute numbers, India, Nepal, Myanmar and Indonesia have the highest numbers of youth infected with HIV (Figure 16).

<sup>8</sup> UNGASS Country Progress Report: Thailand 2009

<sup>9</sup> Young people and HIV/AIDS, factsheets. WHO, Regional Office for South-East Asia, 2006. <http://www.searo.who.int/en/Section13/Section1245/Section2262.htm>

<sup>10</sup> Asia Pacific Regional Review of HIV (UNAIDS, WHO, UNICEF, ADB).

**Figure 16: Percentage of youth among HIV population in SEAR countries**

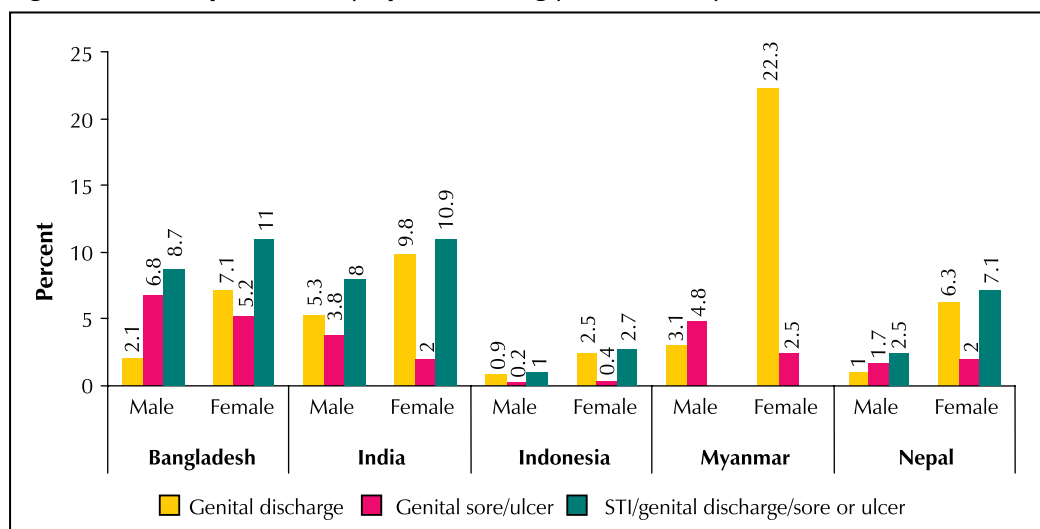
Source: HIV Surveillance Data 2009, National HIV/AIDS Control Programmes, Ministries of Health of Bangladesh, Bhutan, India, Indi, Indonesia, Myanmar, Nepal, Sri Lanka, Thailand, Timor. \* (For India and Myanmar, the age range is 15-29 years)

Multiple factors increase young people's vulnerability to HIV. These factors include experimentation and risk-taking behaviours, lack of knowledge about HIV/AIDS, lack of education and life skills, poor access to health services and commodities, early sexual debut, early marriage, social norms, gender inequality, sexual coercion and violence, trafficking and other forms of exploitation and abuse.

Adolescent girls are particularly at high risk for STIs and HIV. Biologically, women are more than three times more vulnerable to HIV infection than men. Moreover, poverty, gender inequality, and socio-cultural norms increase young women's vulnerability. Young women are unable to negotiate with their partners on abstinence, monogamy, or condom use.

STIs are potent co-factors that amplify transmission and facilitate the spread of HIV. They are also sensitive markers of high-risk sexual activity that can indicate where HIV may be spreading. STI rates are high in the South-East Asia Region though the patterns are variable. Some countries have high rates of ulcerative STIs while others have high rates of gonorrhoea and chlamydia.<sup>11</sup>

<sup>11</sup> Source- Stop AIDS – Keep the promise. Scaling up services for populations in need. World Health Organization, Regional Office for South-East Asia, New Delhi, 2006

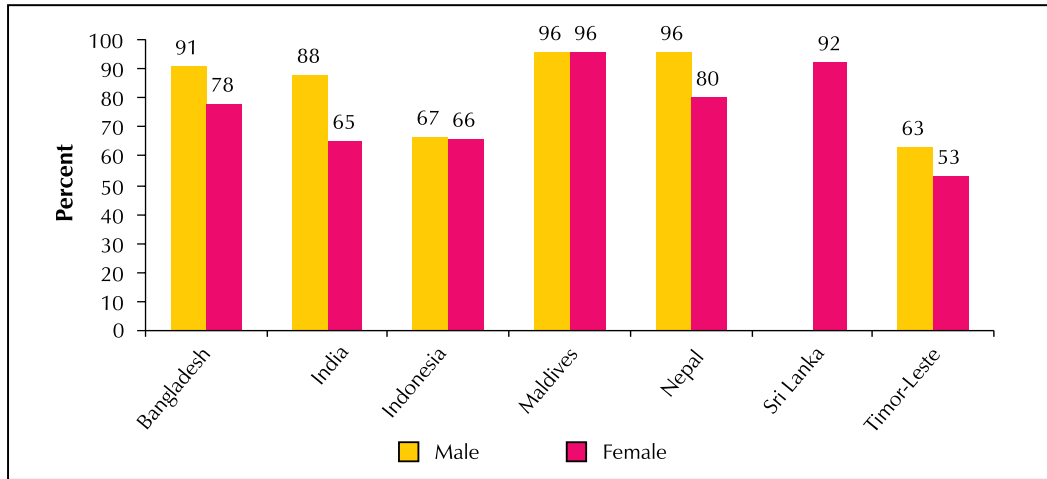
**Figure 17: Self-reported STI symptoms among youth (15-24 years)**

Source: Bangladesh DHS 2007; India National Family Health Survey-3, 2005-06; Indonesia DHS 2007; Maldives DHS 2009 (Preliminary report); National AIDS Programme, Ministry of Health, Myanmar: Dissemination Workshop on Findings of HSS & BSS 2007/08; Nepal DHS 2006-07.

The number of young people reporting symptoms of STIs shows not only the presence of disease but also the extent to which people are affected. Self-reported STI symptoms among youth in Bangladesh, India, Indonesia, Myanmar and Nepal ranged from 1% to 22.3%. More young women than men reported having a STI or its symptoms in Bangladesh (11%), India (10.9%), Indonesia (2.7%) and Nepal (7.1%). The genital ulcer/sore was reported more by men with about 7% in Bangladesh and 3.8% in India. Prevalence of abnormal genital discharge among young women is higher than men as evidently reported in Myanmar (22%), India (10%) and Bangladesh (7%) (Figure 17). Proportions of sexually active youth who self reported the signs of STIs in Maldives were 19% in Male and 23% in Lammu.<sup>12</sup>

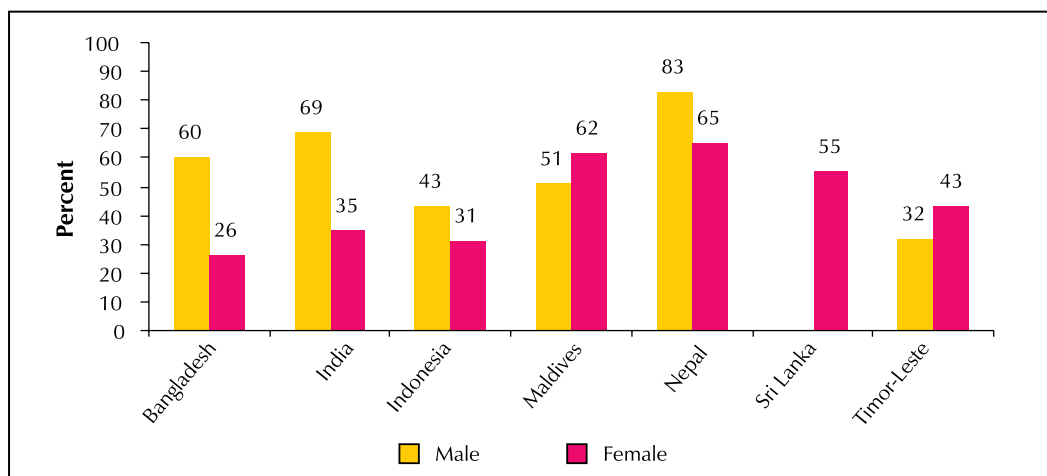
Awareness level among young people regarding HIV/AIDS is generally high in the Region, though it varies across countries. In most countries young people have heard of HIV/AIDS, the awareness level ranging from 53% to 96%. The percentages of young people who have heard of HIV/AIDS in countries like Bangladesh, Maldives, Nepal and Sri Lanka are higher than in other Member States in the Region. However, in a few countries, more young men than young women have heard of HIV/AIDS (Figure 18).

<sup>12</sup> Biological and Behavioural Survey of Maldives 2008

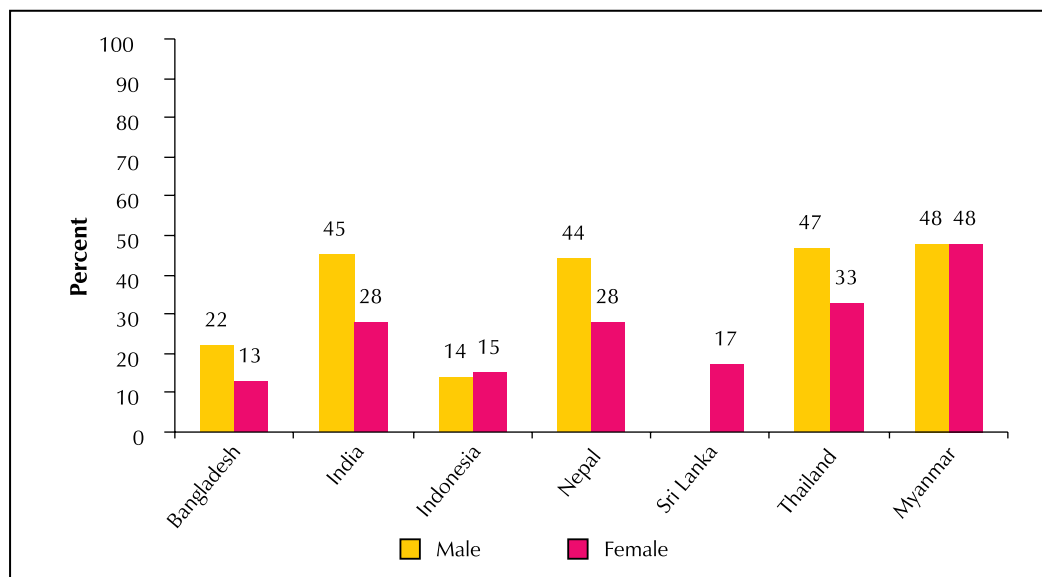
**Figure 18: Heard about HIV/AIDS among youth (15-24 years)**

Source: Bangladesh DHS 2007; Indonesia DHS 2007; India National Family Health Survey-3, 2005-06; Maldives DHS 2009; Nepal DHS 2006-07; Sri Lanka DHS 2006-07; Timor Leste DHS 2009-10

Indicators generally used for measuring the knowledge of HIV prevention methods are the consistent use of condoms, limiting sexual intercourse to one uninfected partner, and abstaining from sexual intercourse. Despite a high percentage of young people who have heard of HIV/AIDS in the Region, there are many who do not have adequate knowledge about the methods of HIV prevention. Among youth who have heard of HIV, 26% to 83% knew at least two methods of prevention across countries in the Region. Comparatively, Maldives, Nepal and Sri Lanka have a higher percentage of young people who know at least two methods of HIV prevention than in other Member States. Indonesia and Timor-Leste have the lowest percentage of young people who know about prevention methods. Knowledge of HIV prevention among young women in Bangladesh, India, Indonesia and Nepal is lower than those of their men counterparts, whereas the young women in Maldives and Timor-Leste have slightly better knowledge than men (Figure19).

**Figure 19: Knowledge of youth (15-24 years) on at least two methods of HIV prevention**

Source: Bangladesh DHS 2007; India National Family Health Survey-3, 2005-06; Indonesia DHS 2007; Maldives DHS 2009; Nepal DHS 2006-07; Sri Lanka DHS 2006-07; Timor Leste DHS 2009-10

**Figure 20: Comprehensive knowledge of HIV/AIDS among young people aged 15-24 years**

Source: UNGASS Country Progress Reports of Bangladesh, Indonesia, Myanmar 2009; Youth of India- Situations and Needs 2006-07, MoFHW, Govt. of India; Sri Lanka DHS 2006-07; Thailand-HIV/AIDS in the South-East Asia Region 2009, WHO Regional Office for South East Asia

Comprehensive knowledge of HIV requires a person to know both about the methods of its prevention, and the commonly held wrong beliefs about HIV transmission. Though most young people have heard of HIV/AIDS in the Region, less than half of them have comprehensive knowledge<sup>13</sup> about HIV. Only close to one-half of youth in Myanmar and Thailand, and about one-fifth of youth in Bangladesh, Indonesia and Sri Lanka have comprehensive knowledge about HIV transmission (figure 20). Misconceptions about transmission and prevention of HIV are widespread, and many young people do not believe that they are at risk of acquiring HIV. For instance, in Myanmar, only 38% of young people could identify ways of preventing HIV and 48% could reject major misconceptions. Due to these wrong beliefs, young women were less likely than young men to have comprehensive knowledge of HIV.<sup>14</sup> In Bangladesh, around 62% of young women and 54% of young men believe that a person can get AIDS by sharing food with the infected person.<sup>15</sup> Over two-third of men (71%) and women (76%) in Indonesia believe that HIV can be transmitted by mosquito bites.<sup>16</sup> Similarly, around two-third of young women and one-half of young men in Nepal, and about one-half of ever-married young women in Sri Lanka have the misconception that mosquitoes can transmit HIV.<sup>17</sup> It is noteworthy to observe that lower comprehensive knowledge among youth is attributable to

<sup>13</sup> Definition of comprehensive knowledge used by most countries is the knowledge of two methods of preventing HIV (condom use and single partner relation), rejection of common misconceptions about HIV transmission (HIV transmission through mosquito bites, sharing food or hugging) and knowledge of whether a healthy-looking person can have HIV.

<sup>14</sup> Report of situation analysis of population and development, reproductive health and gender in Myanmar (UNFPA, 2010).

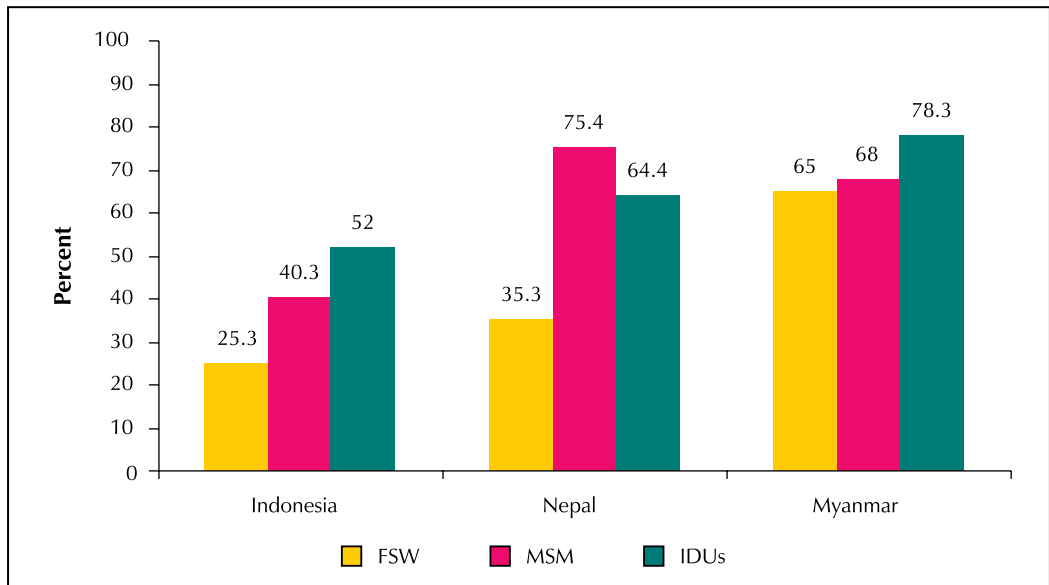
<sup>15</sup> Demographic and Health Survey 2007, Bangladesh

<sup>16</sup> Young Adult Reproductive Health Survey 2007, Indonesia

<sup>17</sup> Demographic Health Survey 2006, Nepal and DHS Sri Lanka 2006-07

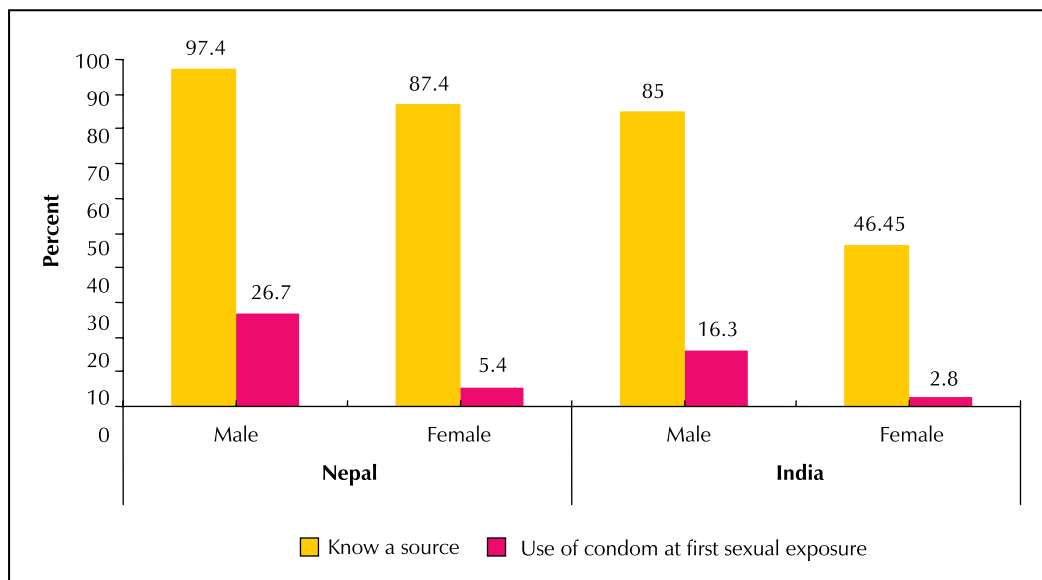
their inability to reject major misconceptions about HIV transmission even though they would still have heard and known about HIV and its prevention methods. Equipping young people with comprehensive knowledge of HIV is a pre-requisite to make them understand sufficiently about HIV transmission and methods of prevention, and consequently to bring about a positive change in their sexual behaviour.

**Figure 21: Comprehensive knowledge among the most-at-risk population aged below 25 year**



Source: UNGASS Country Progress Reports of Indonesia, Nepal and Myanmar 2010

As mentioned earlier, some young people are more vulnerable to HIV across countries. The UNGASS country reports of Indonesia, Nepal and Myanmar show that comprehensive knowledge of HIV among most-at-risk populations (MARPs), namely young sex workers, young men having sex with men and young injecting drug users aged less than 25 years is much less than in those aged more than 25 years (Figure 20). Among MARPs in these three countries, young female sex workers are the least informed on HIV. Only 25% of female sex workers in Indonesia, 35% in Nepal and 65% in Myanmar had comprehensive knowledge on HIV (Figure 21).

**Figure 22: Knowledge of source and use of condoms at first sexual exposure among youth (15-24 years)**

Source: India NFHS-3 2005-06; Nepal DHS 2006

At times even when young people are aware of HIV/AIDS and its prevention methods, they lack access to prevention programmes and the resources needed to protect against the infection. In Nepal, though more than 97% of young men knew a condom source only about 27% used condoms at their first sexual exposure. Similarly in India, of 85% young men who were aware of a condom source only around 16% used it. Condom use among young women was reported to be extremely low compared to their awareness level of a condom source (Figure 22).

In Indonesia, only 11% of women and men aged 15-24 years reported knowing a place where they could get condoms on their own. More young people in the age group 20-24 years knew from where to get condoms on their own than the age group of 15-19 years. There was a significant difference between young males and females who could get condoms on their own (22.1% compared to 0.3% respectively). Most young women felt ashamed to buy condoms and did not want to report about it when asked.<sup>18</sup>

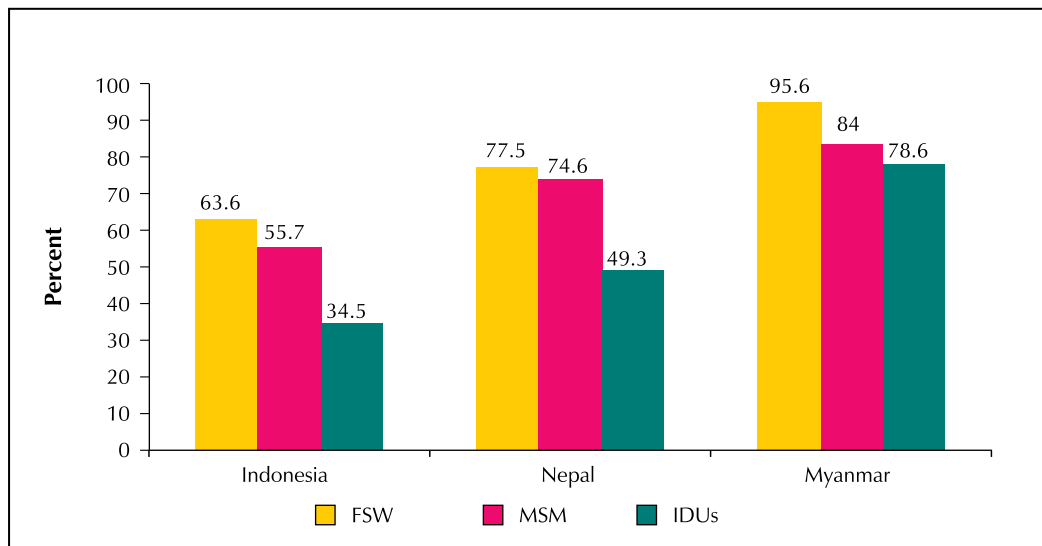
The recent study by the Government of India “Youth in India: Situation and Needs 2006-07” reveals that condom usage in pre-marital sexual relationships is almost non-existent, with only 13% of young men and 3% of young women reporting its usage. In Bhutan, out-of-school young boys and girls who were exposed to multiple partners almost half of them did not use a condom during their last sexual act.<sup>19</sup>

Among the MARPs in Indonesia aged less than 25 years, about 64% of sex workers and about 56% of MSM used condoms with their most recent clients. Condom use among the young IDUs was the lowest (34.5%) as compared to other MARPs. Younger MARPs had lower condom use in Indonesia, Nepal and Myanmar as compared to those aged more than 25 years. In Nepal and Myanmar, condom use among IDUs was also the lowest among MARPs (Figure 23).

<sup>18</sup> UNGASS Country Progress Report: Indonesia 2008-09

<sup>19</sup> Ministry of Health (IECH) and UNICEF: Exploratory Study on HIV/AIDS Issues affecting Out-of-school Youth in Bhutan, 2004.

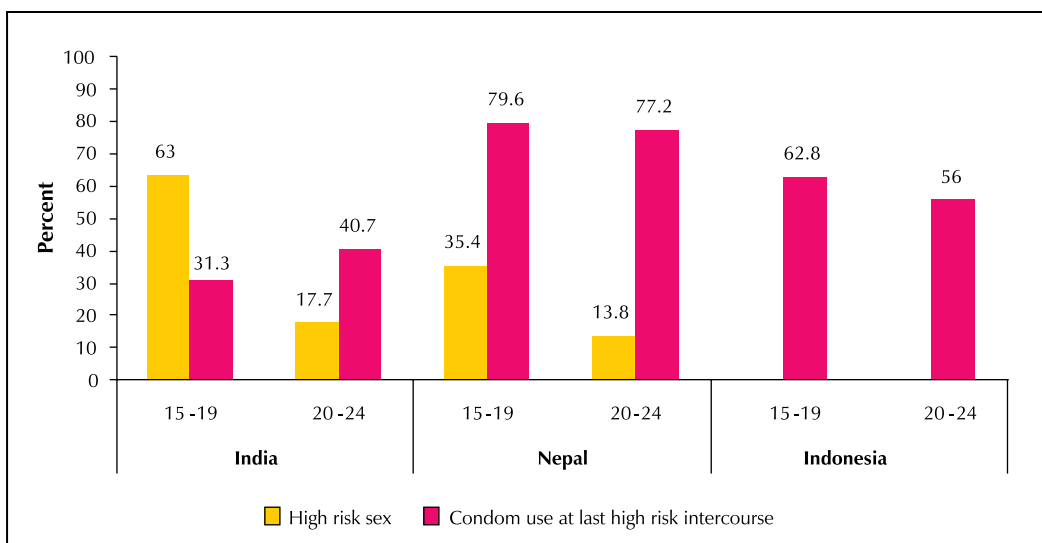
**Figure 23: Use of condom among the most-at-risk young people (<25 years) with their most recent clients**



Source: UNGASS Country Progress Reports of Indonesia, Nepal and Myanmar 2010

National survey data from India and Nepal show that adolescents are more vulnerable to high risk behaviour compared to youth aged 20-24 years. In India, almost two-third of young boys aged 15-19 years had experienced high risk sex while their condom use was only 31%. More than one-third of adolescent boys had high risk sex while only over one-tenth of men aged 20-24 years were exposed to the high risk sex. The condom use among the young men who had high risk sex in Indonesia and Nepal is higher than those in India (Figure 24).

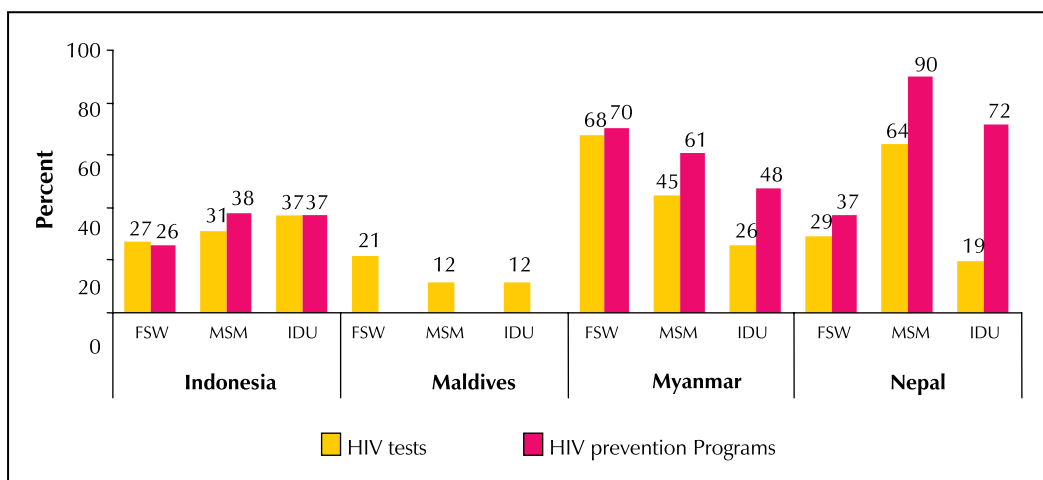
**Figure 24: Experience of high-risk sex and use of condom at last high-risk intercourse among young men (15-24 years)**



Source: India National Family Health Survey-3 2005/06; Nepal DHS 2006; Indonesia DHS 2007

For a variety of reasons, access of young people to services remains inadequate. In most countries, young people have limited access to health services compared to people in the older age groups. Even though the vulnerability of the most-at-risk youth populations to HIV is higher, they remain largely unreached. As a national response to the HIV epidemic, countries in the South-East Asia Region are vigorously supporting HIV prevention, care and treatment services. Eight out of 11 Member States have a national policy on HIV testing and counselling with approximately 10 million people being tested in 2008.<sup>20</sup> Even though there are many surveys and progress reports on provision of VCT, PPTCT and ART services, the age-disaggregated information for young people in most countries is not available.

**Figure 25: Most-at-risk young people below 25 year who were tested for HIV were reached by HIV prevention programme**



Source: UNGASS Country Progress Reports of Indonesia, Maldives, Myanmar and Nepal 2010

HIV testing is referred to as the first step to treatment and care services. This testing service is not easily available to young people in most countries. In Bhutan, only 12% of in-school youth and 15% of out-of-school youth have ever had an HIV test.<sup>21</sup> The proportion of the most-at-risk young people (FSW, MSM, IDU) who were tested for HIV in SEAR countries varies widely. Maldives and Indonesia have a lower proportion of most-at-risk young population who were tested for HIV receives in comparison to the young MARPs in Myanmar and Nepal. Except for Myanmar, less than one third in Indonesia and Nepal, and less than a quarter of female sex workers in Maldives were tested for HIV. Among men having sex with men (MSM), only 12% in Maldives, 31% in Indonesia, 45% in Myanmar and 64% in Nepal received were tested while the HIV tested among injecting drug users (IDUs) is the lowest in Maldives (12%) and Nepal (19%). (Figure 25)

HIV prevention programmes also do not adequately reach the most-at-risk population of young people. Only 26% among FSW, 38% of MSM and 37% of IDUs in Indonesia had been reached by the prevention programmes. However, proportions of most-at-risk young people receiving HIV prevention interventions are relatively higher among FSW and MSM in Myanmar, and MSM and IDU in Nepal.

<sup>20</sup> The work of WHO in the South-East Asia Region, Biennial Report of the Regional Director, 2010

<sup>21</sup> Behavioral Surveillance Survey 2009-10, National HIV/AIDS and STI Programme, Ministry of Health, Bhutan

In order to reduce the vulnerability of young people to HIV infection, a few countries in the Region such as Bangladesh, India, Indonesia, Maldives, Myanmar, Sri Lanka and Thailand have initiated life skill based HIV/AIDS education in formal schools and community institutions. Such initiatives are taking place at a slower pace given the Region's cultural and traditional sensitivities.

In an effort to reach young people, Bhutan, Bangladesh, India, Sri Lanka and Thailand have established Adolescent/Youth Friendly Health Services (AYFHS) through which reproductive health and HIV-related services are provided. However, currently, services are limited.

### **Sexual abuse, exploitation and trafficking**

Adolescents in the Region are also victims of sexual abuse and exploitation. A large number of adolescent boys, girls and young women are forced into prostitution or are trafficked within countries or across borders. It is estimated that in India two out of five sex workers are less than 18 years. A study in Pokhara (Nepal) on female sex workers revealed that 59% of the sex workers were young girls aged between 10-19 years.<sup>22</sup>

Sexual abuse and exploitation have long-term implications for adolescent health and development. Such experiences are traumatic and can adversely affect subsequent behaviour and relationships. There are also many mental health related consequences such as depression, anxiety, suicidal thoughts as well as risk of unintended pregnancies, abortion and STIs/HIV.<sup>23</sup>

### **Drug and substance abuse**

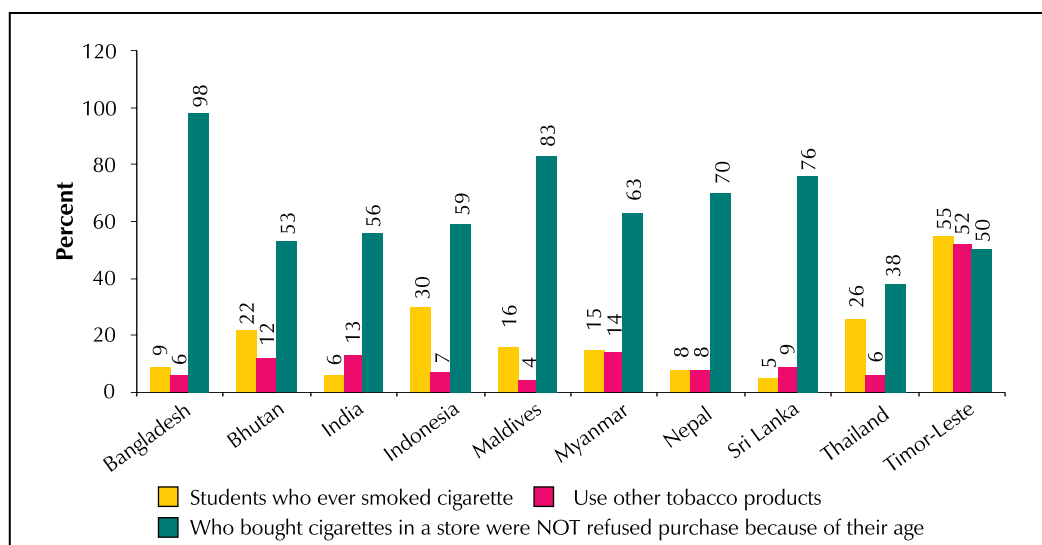
Drug and substance abuse among adolescents has emerged as a major cause of concern in recent years. The Global Youth Tobacco Survey (2007-2009) showed a high prevalence of tobacco use in school students aged 13-15 years. It also revealed that a large proportion of adolescents smoked their first cigarette before the age of 10 years. Adolescents have easy accessibility to cigarettes/other forms of tobacco. Almost all adolescents in Bangladesh and 70% in Nepal and more than 75% in Sri Lanka and Maldives were able to purchase tobacco products with ease and were not refused in spite of their young age (Figure 26). Some of the other factors identified with increasing tobacco use was the increased levels of exposure to second-hand smoke and constant reinforcement from the media.

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<sup>22</sup> HIV/AIDS and young people, factsheets. WHO, Regional Office for South-East Asia, New Delhi, 2006

<sup>23</sup> Sex without consent, Young people in developing countries. Shireen J. Jejeebhoy, Iqbal Shah, Shyam Thapa, 2005.

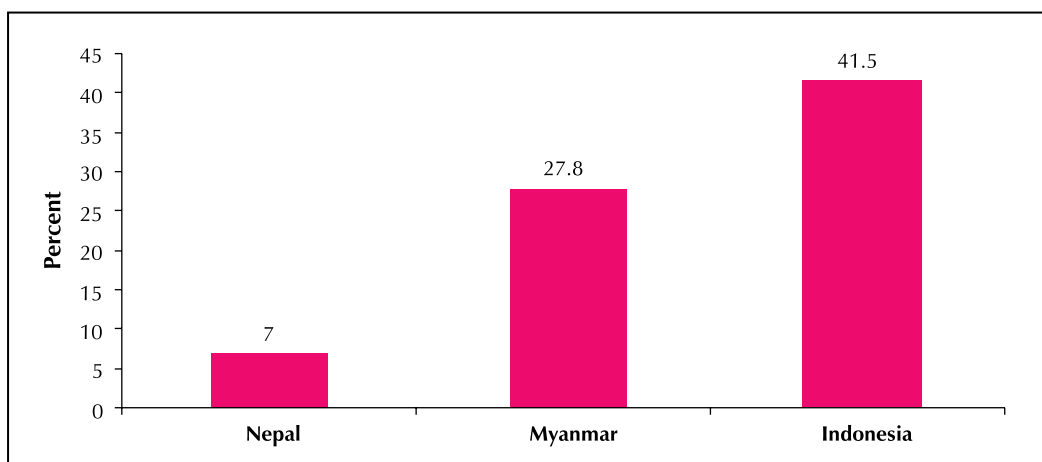
**Figure 26: Tobacco use among adolescents (13-15 years) in SEAR**



Source: Global Youth Tobacco Survey (GYTS)- 2009

In recent years injecting drug use among young people has been increasing in the Region. The UNGASS Country Report of Indonesia (2008/09) and Myanmar shows that the proportion of young intravenous drug users aged less than 25 years who were HIV positive was 42% and 27.8% respectively, which is significantly high. In Nepal, 7% of young IDUs aged below 25 years were HIV positive (Figure 27).

**Figure 27: IDUs aged below 25 years who are HIV positive**



Source: UNGASS Country Progress Reports of Indonesia, Nepal and Myanmar 2010

Many adults who are current IDUs took their first injections at a much younger age. Close to two-third of IDUs in Indonesia had their first injection when they were below 21 years old, and about a quarter of them had it within the age range of 22-25 years. In Maldives, the proportion of IDUs is very small (0.2%), but the risk of HIV transmission is high since all the IDUs share unsterile needles or syringes.<sup>24</sup> Over 5% of Maldivian students had shared needles to inject any drug during their life. Drug injecting practices were found to be three times more in the A tolls (7.1%) than in Male (2.4%) and male students were more likely to inject drugs than female students.<sup>25</sup> A recent survey in Nepal shows many IDUs are young people. About 62% of IDUs in Pokhara, 48% in Kathmandu, 51% in Eastern Terai and 36% in Western Terai were all aged less than 25 years. More than half of the IDUs had started injecting by the time they were 19 years. A majority of the IDUs had started injecting more than five years ago.<sup>26</sup>

The BSS 2006 of India shows that the onset of injecting drug use in ten Indian cities began in adolescence for a large proportion of the population aged 16-25 years. In Delhi alone, 11% of IDUs reported starting injecting drug use by the age of 15 years. In Myanmar, the trend shows that HIV prevalence among IDUs aged 15-24 years has remained significantly high over the past five years (2003-2008). Almost one third of IDUs aged 15-24 years were HIV positive in 2008. Trends also show that HIV prevalence among young IDUs has remained higher than among young female sex workers since 2000.

While data on consumption of alcohol and psychoactive drugs among adolescents is limited, the recent Global School-Based Student Health Survey (GSHS) from some countries suggest that alcohol and other drug use is on the increase among both boys and girls. The factors underlying adolescent use of alcohol and drugs relate to curiosity, peer pressure, trendy practices, response to family problems and lack of awareness of the consequences.

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<sup>24</sup> Ministry of Health and Family: First Biological and Behavioural Survey on HIV/AIDS in the Maldives-2008 Fact sheet

<sup>25</sup> Global School-based Student Health Survey 2009, Ministry of Education, Maldives

<sup>26</sup> Fact Sheet; IBBS 2009, Injecting Drug Users, Round IV; USAID Nepal

## Annex. II

<b>ADOLESCENT-FRIENDLY CHARACTERISTICS</b>	
<b>EQUITABLE:</b> All adolescents, not just certain groups, are able to obtain the health services they need	
<b>Characteristic</b>	<b>Definition</b>
Policies and procedures are in place that do not restrict the provision of health services on any terms.	No policies or procedures restrict the provision of health services to adolescents on the basis of age, sex, social status, cultural background, ethnic origin, disability or any other area of difference.
Health-care providers treat all adolescent clients with equal care and respect, regardless of status.	Health-care providers administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
Support staff treat all adolescent clients with equal care and respect, regardless of status.	Support staff administer the same level of care and consideration to all adolescents regardless of age, sex, social status, cultural background, ethnic origin, disability or any other reason.
<b>ACCESSIBLE:</b> Adolescents are able to obtain the health services that are provided	
<b>Characteristic</b>	<b>Definition</b>
Policies and procedures are in place that ensure that health services are either free or affordable to adolescents.	All adolescents are able to receive health services free of charge or are able to afford any charges that might be in place.
The point of health service delivery has convenient hours of operation.	Health services are available to all adolescents during convenient times of the day.
Adolescents are well-informed about the range of available reproductive health services and how to obtain them.	Adolescents are aware of what health services are being provided, where they are provided and how to obtain them.
Community members understand the benefits that adolescents will gain by obtaining the health services they need, and support their provision.	Community members (including parents) are well-informed about how the provision of health services could help adolescents. They support the provision of these services as well as their use by adolescents.
Some health services and health-related commodities are provided to adolescents in the community by selected community members, outreach workers and adolescents themselves.	Efforts are under way to provide health services close to where adolescents are. Depending on the situation, outreach workers, selected community members (e.g. sports coaches) and adolescents themselves may be involved in this.

<b>ACCEPTABLE:</b> Health services are provided in ways that meet the expectations of adolescent clients	
<b>Characteristic</b>	<b>Definition</b>
Policies and procedures are in place that guarantees client confidentiality.	<p>Policies and procedures are in place that maintain adolescents' confidentiality at all times (except where staff are obliged by legal requirements to report incidents such as sexual assaults, road traffic accidents or gunshot wounds, to the relevant authorities). Policies and procedures address:</p> <ul style="list-style-type: none"> <li>– registration – information on the identity of the adolescent and the presenting issue are gathered in confidence;</li> <li>– consultation – confidentiality is maintained throughout the visit of the adolescent to the point of health service delivery (i.e. before, during and after a consultation);</li> <li>– record-keeping – case-records are kept in a secure place, accessible only to authorized personnel;</li> <li>– disclosure of information – staff do not disclose any information given to or received from an adolescent to third parties such as family members, school teachers or employers, without the adolescent's consent.</li> </ul>
The point of health service delivery ensures privacy.	The point of health service delivery is located in a place that ensures the privacy of adolescent users. It has a layout that is designed to ensure privacy throughout an adolescent's visit. This includes the point of entry, the reception area, the waiting area, the examination area and the patient-record storage area.
Health-care providers are non-judgmental, considerate, and easy to relate to.	Health-care providers do not criticize their adolescent patients even if they do not approve of the patients' words and actions. They are considerate to their patients and reach out to them in a friendly manner.
The point of health service delivery ensures consultations occur in a short waiting time, with or without an appointment, and (where necessary) swift referral.	Adolescents are able to consult with health-care providers at short notice, whether or not they have a formal appointment. If their medical condition is such that they need to be referred elsewhere, the referral appointment also takes place within a short time frame.

The point of health service delivery has an appealing and clean environment.	A point of health service delivery that is welcoming, attractive and clean.
The point of health service delivery provides information and education through a variety of channels.	Information that is relevant to the health of adolescents is available in different formats (e.g. posters, booklets and leaflets). Materials are presented in a familiar language, easy to understand and eye-catching.
Adolescents are actively involved in designing, assessing and providing health services.	Adolescents are given the opportunity to share their Experiences in obtaining health services and to express their needs and preferences. They are involved in certain appropriate aspects of health-service provision.
<b>APPROPRIATE:</b> The health services that adolescents need are provided	
<b>Characteristic</b>	<b>Definition</b>
The required package of health care is provided to fulfil the needs of all adolescents either at the point of health service delivery or through referral linkages.	The health needs and problems of all adolescents are addressed by the health services provided at the point of health service delivery or through referral linkages. The services provided meet the special needs of marginalized groups of adolescents and those of the majority.
<b>EFFECTIVE:</b> The right health services are provided in the right way and make a positive contribution to the health of adolescents	
<b>Characteristic</b>	<b>Definition</b>
Health-care providers have the required competencies to work with adolescents and to provide them with the required health services.	Health-care providers have the required knowledge and skills to work with adolescents and to provide them with the required health services.
Health-care providers use evidence-based protocols and guidelines to provide health services.	Health service provision is based on protocols and guidelines that are technically sound and of proven usefulness. Ideally, they should be adapted to the requirements of the local situation and approved by the relevant authorities.
Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients.	Health-care providers are able to dedicate sufficient time to work effectively with their adolescent clients.
The point of health service delivery has the required equipment, supplies, and basic services necessary to deliver the required health services.	Each point of health service delivery has the necessary equipment, supplies, including medicines, and basic services (e.g. water and sanitation) needed to deliver the health services.





