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Adolescent and Youth Reproductive Health in the Asia and Near East Region

Status, Issues, Policies, and Programs

Karen Hardee
Pamela Pine
Lauren Taggart Wasson

January 2004

POLICY

POLICY is funded by the U.S. Agency for International Development under Contract No. HRN-C-00-00-00006-00, beginning July 7, 2000. The project is implemented by Futures Group International in collaboration with Research Triangle Institute (RTI) and the Centre for Development and Population Activities (CEDPA).

ISBN 0-9605196-9-6

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Acknowledgments

POLICY Occasional Papers are intended to promote policy dialogue on family planning, reproductive health, and HIV/AIDS issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations. An up-to-date listing of POLICY publications is available on the web at www.policyproject.com. Copies of these publications are available at no charge.

This paper provides a synthesis of the findings from a 13-country study of adolescent and youth reproductive health issues, policies, and programs on behalf of the Asia/Near East Bureau of the U.S. Agency for International Development (USAID). The reports were researched and written by:

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Karen Hardee oversaw the project, and Lily Kak and Elizabeth Schoenecker from USAID and Ed Abel and Koki Agarwal from POLICY provided support. Karen Hardee, Pamela Pine, Lauren Taggart Wasson, and Nancy McGirr reviewed and edited the country reports. Felicity Young, Jeff Sine, and Don Levy were helpful in locating consultants to write the profiles. Katie Abel assisted with compiling and analyzing the country data. The STARH Program (Sustaining Technical Achievements in Reproductive Health), under the direction of Gary Lewis and Adrian Hayes from the Johns Hopkins Center for Communication Programs, supported the preparation of the Indonesia country report.

Views expressed in this paper do not necessarily represent those of USAID.

Executive Summary

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

Most young people in the ANE region begin their sexual lives within marriage, although, as the age at marriage in the region rises, an increasing number of young people are beginning to engage in sex before marriage. While programs can and should promote delayed sexual initiation, young people—regardless of when sexual activity begins—need to be adequately prepared for their sexual lives and relationships instead of "being kept in the dark" until marriage. Programs can help prepare young people for sexual relationships by increasing their understanding of sexuality and the choices they can make to protect their reproductive health. Correspondingly, addressing adolescent and youth reproductive health necessitates a multisectoral approach—one that focuses on decreasing girls' vulnerability, promoting gender equity and schooling, and expanding life options for both females and males. Each of the 13 countries needs to make more progress in this regard.

Nonetheless, the ANE region has achieved social, policy, and programmatic progress, with some countries demonstrating substantially more progress than others. Some countries' adolescent and youth populations have greater knowledge of reproductive health, improved access to information and services, and better overall life circumstances as a result of policies and programs designed to address their reproductive health needs. Other populations of young people, however, have seen little progress and therefore are at greater risk of early pregnancy, gender-based violence, and sexually transmitted infections (STIs), including HIV, and have limited options for education and other life choices.

The social and cultural context pertaining to young people differs considerably among the 13 countries, but the assessments found several universal challenges in the region. These challenges include the paucity of research and data on the age group, particularly with regard to rural and minority adolescents and youth; insufficient

attention to enormous gender disparities; lack of information and services available to young people (including married adolescents and youth), often leading to unwanted pregnancy and disease; weak or nonexistent policies directly addressing adolescent and youth reproductive health; and small-scale and generally weak programs, even where national and other policies exist. In addition, the global environment in terms of both information (e.g., from films and television) and resources (e.g., dependence on foreign aid) has had both positive and negative effects on the status of adolescent and youth reproductive health throughout the region.

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

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

Young people are often left out of discussions about policies and programs that affect them. Youth must be actively involved in both discussing the issues facing their generation and developing solutions that meet their needs for good reproductive health.

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

Adolescent and youth reproductive health remains a politically and socially sensitive topic; policymakers are often reluctant or unable to develop multisectoral policies that address adolescent and youth reproductive health. Stakeholders need to advocate to policymakers based on an understanding of existing laws and policies. Youth and adolescent reproductive health advocates should encourage development of relevant laws, policies, and guidelines to ensure adequate protection and promotion of adolescent and youth reproductive health and attention to associated social issues, such as gender equity in education and the economy. The support of an individual, high-profile political figure can be crucial to improving a country's adolescent and youth reproductive health policies and programs. This person's advocacy and action can catalyze high-level discussion and even effect change.

3. ***Educate policymakers, teachers, parents, community leaders, and young people to change public opinion about the importance of meeting youth and adolescent reproductive health needs.***

It is essential to reach—through the appropriate means—village and community leaders and religious and opinion leaders so that they, in turn, can influence community members, families,

and parents. In most countries, the appropriate message may be one underscoring the "healthy development of youth." Young people should be fully engaged in the development of messages and the "packaging" of information for adolescents and youth.

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

4. Promote communication in families.

For change to occur, the gap between sociocultural norms and the realities of adolescent and youth reproductive health must be narrowed. Parents need to realize that social norms are changing, such that many adolescents and youth are sexually active. Parents also need accurate reproductive health information and must become comfortable discussing reproductive health topics so that they can help and teach young people and support appropriate policies and programs. Parents can be a great source of assistance and information for their adolescent children, who want their first exposure to information on sexual and reproductive health to come from their parents. Parents can also be strong advocates on a political level.

One way to educate parents is through their children's education. Young people could take information home to their parents to engage their families in discussions about sexual relationships and to educate their parents, who may have incomplete or inaccurate knowledge. Faith-based organizations (FBOs) can also facilitate information exchange within families. FBOs have succeeded in addressing the HIV/AIDS pandemic in Africa; perhaps that model has a place for reaching young people in the ANE region.

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

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

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

Reproductive health education in schools needs to be designed to make young people (and teachers) knowledgeable and comfortable with the information. The most effective curricula are comprehensive and cover the biological and social aspects of reproductive health. Adequately trained peer educators can be useful additions to adolescent and youth reproductive health education programs. Adolescents and young people should also have access to information

through community clinics, satellite clinics, premarital counseling, family welfare centers, schools, peer education, local youth forums, mass media, clubs, and so forth.

Service providers at all levels need to be trained in all aspects of adolescent and youth reproductive health. Each country should also examine the possibility of developing or strengthening links between various services, such as between clinics/pharmacies and youth activities, to achieve an integrated approach to adolescent and youth reproductive health. Often, NGOs have more flexibility than governments in providing information and services to young people. Governments and donors should consider providing more support to NGOs to undertake adolescent and youth development work.

7. Develop and promote evidence-based programs.

To promote adolescent and youth reproductive health, programs should draw on existing information on what works. The resultant knowledge should be disseminated widely and applied in developing and implementing adolescent and youth reproductive health education programs. Despite the availability of some information, all of the country reports pointed to the need for more research to inform program efforts. Countries differ in the type of research needed, but, at a minimum, research should focus on various segments of society, including underserved, minority, and rural populations—those most at risk for poor reproductive health outcomes.

Abbreviations

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

Introduction

Adolescents and young people[1] are at the beginning of their sexual and reproductive lives; they are also the next generation of parents. How they undergo preparation for this journey has tremendous implications for their own lives as well as for national reproductive health outcomes, including fertility, safe motherhood, and sexually transmitted infections (STIs), particularly HIV/AIDS. In the Asia and Near East (ANE) region, as in other parts of the developing world, approximately one in four persons is between the ages of 15 and 24 years. Governments throughout the region have agreed that adolescents and youth should be accorded access to good reproductive health through information and service provision. The 1994 International Conference on Population and Development (ICPD) *Programme of Action* emphasized a holistic concept of reproductive health that included adolescent and youth reproductive health as an integral component. The *Programme of Action* noted that signatory "countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information, and care."[2] In addition, United Nations member states agreed to the Millennium Development Goals to reduce poverty, which include young people's need for gender equity, education, safe pregnancy, and reduction in the spread of STIs and HIV/AIDS.[3]

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

The assessments examined each country's social context and status, policies, and programs regarding adolescent and youth reproductive health and made recommendations for future action. Adolescent and youth reproductive health status and the sociocultural and political influences that shape it vary among the countries, making it difficult to tackle adolescent and youth reproductive health as a single ANE regional issue. However, the assessments found several universal themes within the region that may be addressed to improve adolescent and youth reproductive health status throughout Asia and the Near East. These challenges include the paucity of research and data on the age group, particularly with regard to rural and minority adolescents and youth; insufficient attention to enormous gender disparities;

lack of information and services available to young people (including married adolescents and youth), often leading to unwanted pregnancy and disease; weakness or absence of policies directly addressing adolescent and youth reproductive health; and small-scale and generally weak programs, even where national and other policies are in place. In addition, the global environment in terms of both information (e.g., from films and television) and resources (e.g., dependence on foreign aid) has had both positive and negative effects on the status of adolescent and youth reproductive health throughout the region.

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

Demographic and Social Context of Adolescent and Youth Reproductive Health

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

Demographic Profile, 2000–2020

In all, the 13 countries in Asia and the Near East were home to 354 million young people in 2002. The region's countries vary dramatically in population size, from Jordan with approximately 5 million people to India with more than 1.03 billion. Correspondingly, Jordan has approximately 1 million youth (ages 15 to 24 years) compared with 200 million in India. In five of the countries—Jordan, Nepal, Pakistan, the Philippines, and Yemen—youth populations will continue to grow through 2020. In Bangladesh, Cambodia, Egypt, India, Indonesia, and Morocco, the size of the youth populations will start to decline after 2015. The size of the youth populations in Sri Lanka and Vietnam will begin to decline before 2015.

Social Context

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

The assessments noted the social subordination of girls and the resultant inequity and discrimination to which they are subjected. During childhood, households expect girls to perform more domestic chores than boys, allowing

adolescent boys to enjoy more leisure time and to focus more on their studies. The assessments also noted that adolescence marks a period in which boys enjoy increased social mobility as girls' social mobility is curtailed. Adolescent girls are kept closer to home, especially in some Islamic countries that practice *purdah* norms, which separate the sexes and restrict females socially—particularly after adolescence and puberty.

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

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

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

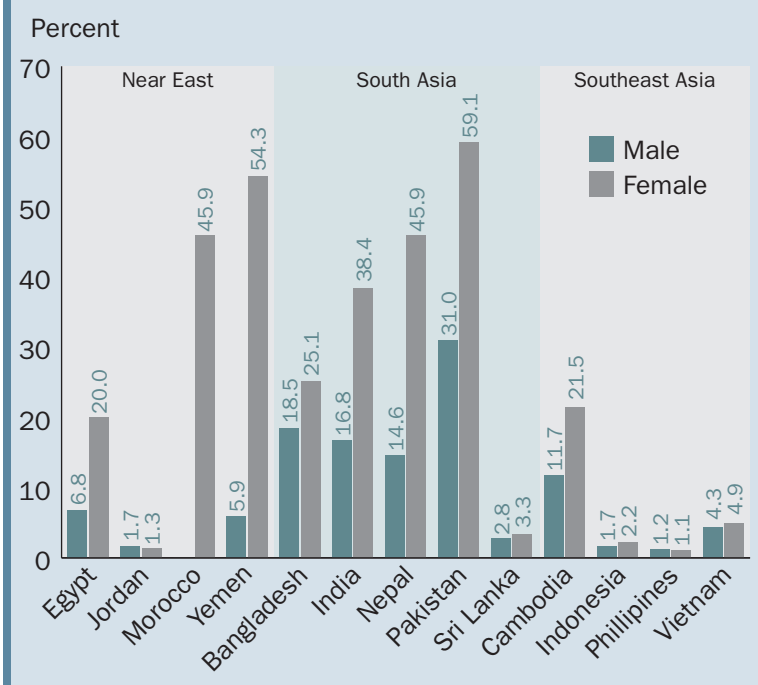
Southeast Asia. In Cambodia, "marriage and domestic labor are viewed as the primary goals for girls, and young girls are often removed from school to care for younger siblings and help with household and agricultural tasks."[12] In Indonesia, "the girl children in the family have to be trained to be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

The subordinate position of females in all 13 countries is also manifest in gender-based violence, noted explicitly in Bangladesh, Cambodia, Jordan, Pakistan, and the Philippines, although its extent is unknown. The Bangladesh assessment highlighted physical and sexual violence perpetrated on girls and women, including marital rape, which is not uncommon in that country.[15] The Cambodia assessment noted that the rape of girls younger than 12 and adolescent girls is sometimes used as a means to force marriage and that the violence often continues after marriage.[16] The Jordan assessment describes a "culture of silence" that results in most domestic violence in Jordan going unreported.[17] Jordanian females may also be victims of honor killings, in which a male family member kills a female for a crime, such as adultery, to restore honor to the family. Females have little recourse against such violence.

Education

While educational attainment is rising for both females and males throughout the region, inequality in access to and completion of education is apparent in most of the countries. More female than male youth remain uneducated (see Figure 1), and fewer young females have completed secondary and/or higher education. In several countries, the magnitude of young females' educational

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



Note: The Morocco country report did not include data on the percentage of adolescent boys with no education.
Sources: Demographic and Health Surveys or other national reproductive health survey, various years. Egypt (2000); Jordan (1997); Morocco (1995); Yemen DMCHS (1997); Bangladesh (2000); India NFHS (1999); Nepal (2001); Pakistan (1991); Sri Lanka Department of Census and Statistics (2000); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

disadvantage is remarkable. In Yemen, for example, 54 percent of female youth has no education compared with 6 percent of males. Data for Cambodia, India, Nepal, and Pakistan also indicate great gender gaps in educational attainment. In Cambodia, by age 15, the male school enrollment rate is 50 percent higher than that of females.[18] In Nepal, even though the government adopted a policy in 1990 of free education for all children through the seventh grade and places special emphasis on the need to educate girls, a significant gap remains between educational attainment for boys and girls.[19]

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

The country assessments also noted an urban-rural gap with regard to education. In Indonesia, for example, after the first nine years of compulsory education for both girls and boys, the gap widens, with 60 percent of young people ages 15 to 19 years no longer in school in rural areas compared with 33 percent in urban areas.[20]

These gaps exist despite many countries' education policies. Egypt, Indonesia, Jordan, Sri Lanka, and Yemen have formulated and put in place policies that make some level of education compulsory for males and females. Bangladesh, Cambodia, and Morocco state, respectively, that education is equally available to females and males, accessible to all, and a universal right. However, in reality, not all children are able to attend school in these countries. In Cambodia, for example, education is free, but teachers charge extra fees to supplement their paltry salaries. In Vietnam, the government no longer subsidizes school fees. Therefore, in both countries, many children cannot afford to attend school, and, often, girls in rural areas are pulled out of school.

The level of education of young women worldwide has direct relevance to reproductive health as well as to issues of broader gender equity. Women's education is related to use of family planning and reproductive health outcomes; worldwide increases in education are linked with higher contraceptive use, smaller family size, and better birth outcomes.

Employment

Young people of both sexes share some employment trends. Several country assessments noted that unemployment rates are highest among youth and thus identified underutilization of young people's time as a concern. Many young people who work do so to help their families, often without pay. In all of the countries, young females have far fewer employment opportunities compared with young males. In Egypt, for example, one-half of young males and one-sixth of young females work.[21] Both young males and females in Morocco have difficulty finding jobs; however, the areas in which they seek and obtain jobs differ, with young females working in factories and young males

providing manual labor.[22] In Bangladesh, a larger percentage of females work in agriculture than in manufacturing.[23] In Vietnam, more females than males ages 15 to 29 years work in the state sector of socialist enterprises.[24]

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

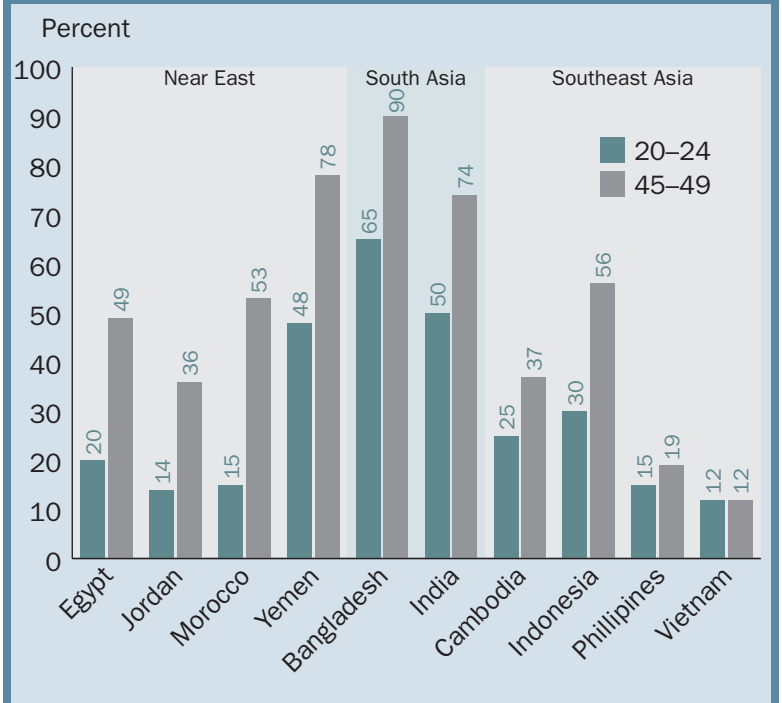
Marriage and Childbearing

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

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

Childbearing often begins soon after marriage. The percentage of young women that has given birth by age 20 ranges from 17 percent in Jordan and Morocco to more than 60 percent in Bangladesh (see Figure 3). Still, just as the age at marriage

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



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

is rising in most countries, age at first birth is rising among young women compared with their mothers' generation in all countries except Vietnam and Yemen.

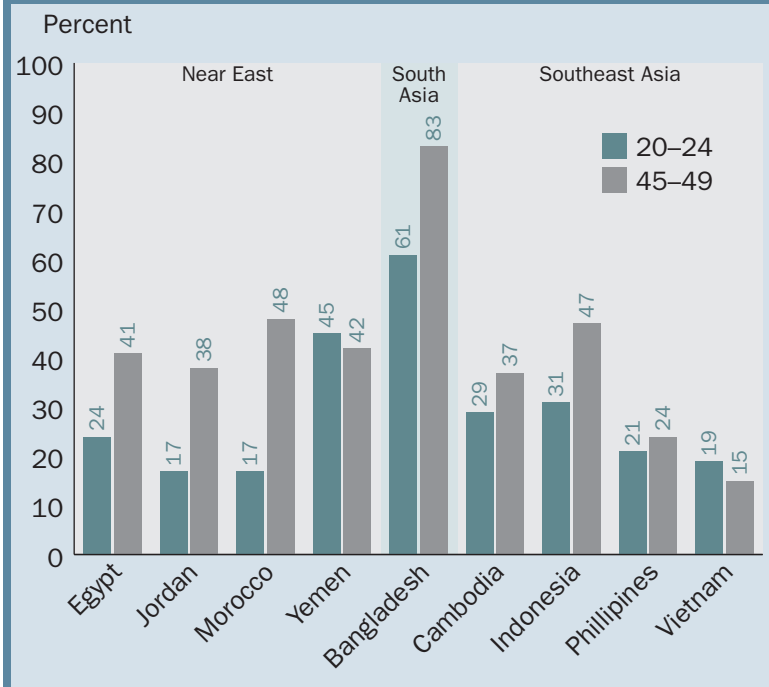
Adolescent and Youth Sexuality

Throughout the region, cultural norms and religious beliefs dictate different attitudes toward males and females with respect to adolescent and youth sexuality and sexual practices. For females, only sex within marriage is considered socially acceptable; tradition continues to place a premium on female virginity at the time of marriage. In Morocco, for example, the bride's father declares to the groom, per the current marriage certificate, "I give you as a bride my daughter who is still a virgin."[29] In Cambodia, "adolescent girls are expected to uphold the virtue and honor of their family by taking care of their reputation and maintaining not only their actual virginity but also their imputed sexual reputation."[30]

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

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

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



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

Adolescent and Youth Reproductive Health Issues

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

Lack of Knowledge about Sexuality and Reproductive Health

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

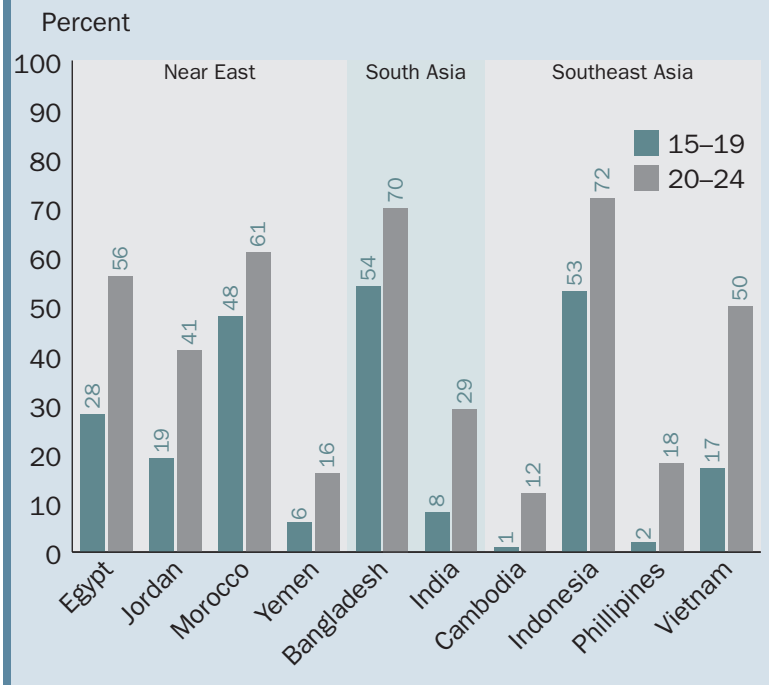
For the most part, parents are uncomfortable and socially proscribed from discussing sex with their children. Teachers and health care providers, like parents, are sometimes uncomfortable teaching adolescents and youth about sex. In addition, because many parents themselves have had little education about sex and teachers may not have sufficient training to teach reproductive health education properly, neither parents nor teachers necessarily have good-quality information to convey to adolescents and youth.

Beyond issues of discomfort and social taboo, many adults do not want to discuss sex with unmarried adolescents and youth because they worry that providing information

encourages premarital sexual activity, even though recent evaluations of sex education programs worldwide have concluded that such programs do not promote or lead to increased sexual activity.[37] Some adults therefore prefer maintaining the ignorance of adolescents and youth, believing that they will get the information they need at the proper time—at the time of marriage. However, married couples may remain uninformed because sex is still a sensitive topic such that there are few opportunities for discussion or education.

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

Figure 4. Ever-Use of a Modern Family Planning Method among Married Females Ages 15 to 19 and 20 to 24 Years in Selected ANE Countries, Various Years



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

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

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

Low Contraceptive Use

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

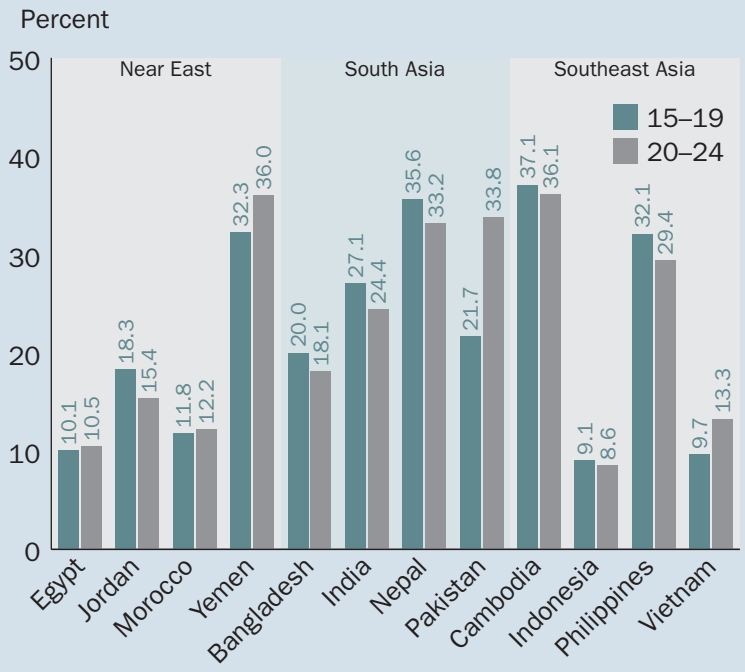
Incomplete or inaccurate information may affect contraceptive use. For example, despite high levels of modern method knowledge, confusion exists among Jordanian adolescents and youth because of misunderstandings about Islam's position on modern contraception. Some Filipinos believe that contraceptives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

Social stigmas associated with contraception also create barriers. Many countries strongly pressure adolescents and youth to hide their sexuality, especially from their parents. Young people do not want to be caught obtaining or possessing contraception. Furthermore, owing to the social premium placed on girls' virginity, many young females want to appear naïve with regard to sex. In Vietnam, many girls do not negotiate contraceptive use with their boyfriends so that they can maintain the impression of their sexual innocence. Condom use among young people in the Philippines is almost nonexistent, probably because young people associate condoms with STI and HIV/AIDS prevention rather than with pregnancy prevention.[45] Filipinos often consider condoms the tool of prostitutes or promiscuous girls. The same holds true in Cambodia.

High Unmet Need for Contraception

The unmet need for contraception[46] is generally high among young females in the ANE region, particularly in the age groups 15 to 19 years and 20 to 24 years, ranging

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



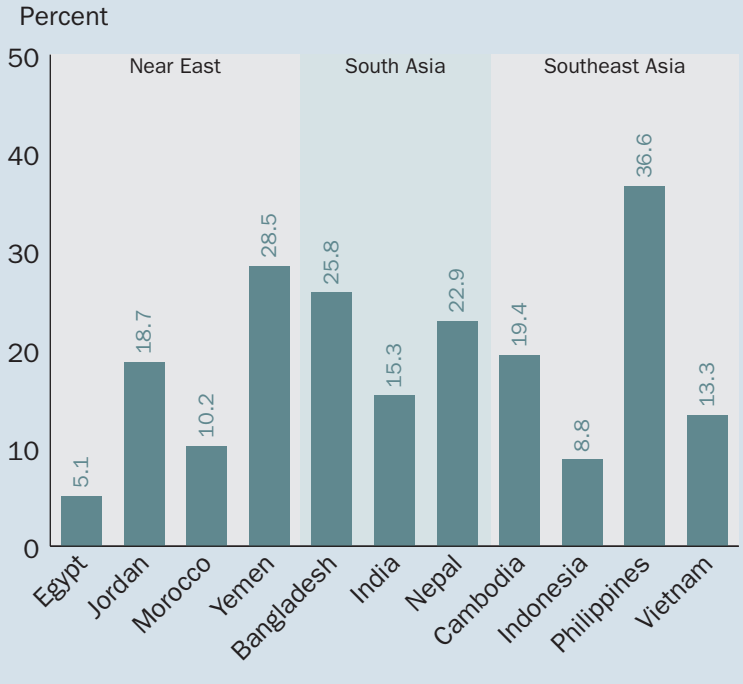
Note: Only the countries for which data were available were included in this figure.

Source: Demographic and Health Surveys or other national reproductive health surveys, various years: Egypt (2000); Jordan (1997); Morocco (1995); Yemen (1997); Bangladesh (2000); India (1999); Nepal (2001); Pakistan (1995); Cambodia (2000); Indonesia (1997); Philippines (1998); Vietnam (1997).

from around 9 percent in Indonesia to over 35 percent in Cambodia (see Figure 5). Unmet need for family planning among young females in union is highest in Cambodia, Nepal, Pakistan, the Philippines, and Yemen. Unmet need translates into unintended pregnancies and the risk of abortion and maternal morbidity and mortality in addition to exposure to STIs/HIV.

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

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



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

Abortion

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

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

STIs and HIV/AIDS

HIV prevalence among youth in the ANE region is low overall but rising, particularly in Cambodia, India, Nepal, and Vietnam (see Figure 7). Most countries have similar HIV prevalence rates among young males and females, although Cambodia, India, and Vietnam

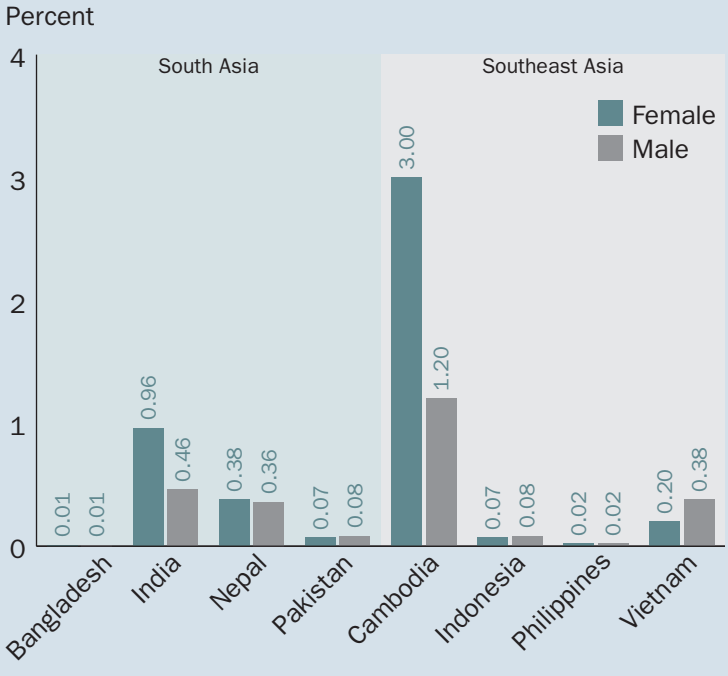
are exceptions due in part to the predominant modes of transmission in these countries. Young females in Cambodia and India have higher HIV prevalence because of prostitution. In Vietnam, young males have higher HIV prevalence because most infection in the country is associated with injecting drug use, which is more common among boys.

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

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

Young people engaging in premarital sex often engage in high-risk sex, increasing their chances of contracting STIs or HIV. They know little about preventing infection and often do not have access to condoms. Even with knowledge and access, however, many adolescents and youth do not obtain condoms because of the stigma associated with condoms, sexual activity, and, among young females, knowledge about safer sex. Young people may also be misinformed by cultural myths that lead them to unsafe sexual practices. For example, popular Moroccan beliefs

Figure 7. HIV Prevalence Estimates among Youth Ages 15 to 24 Years in Selected ANE Countries, 2001

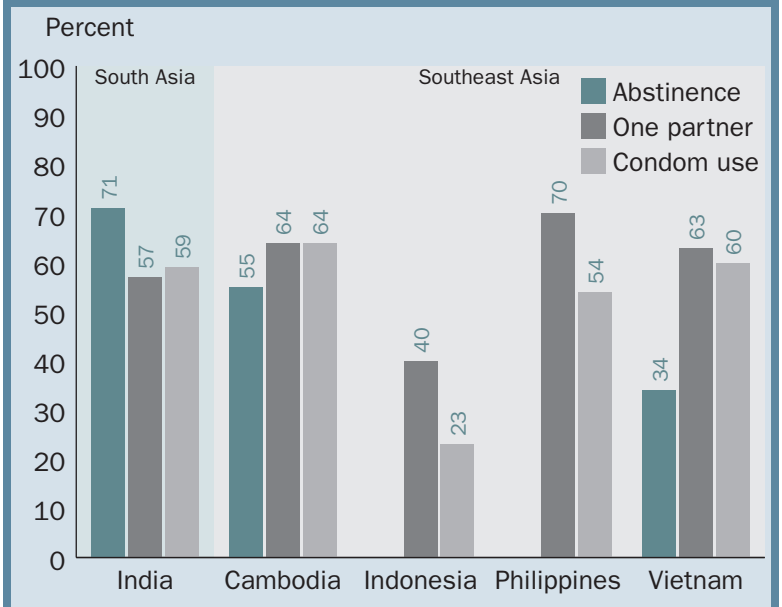


Note: Only countries for which data were available were included in this figure. These estimates represent the "high" estimates for HIV prevalence among this age group.
Source: UNICEF, UNAIDS and WHO, "Young People and HIV/AIDS: Opportunities in Crisis." www.unicef.org/pubsgen/youngpeople-hivaids.pdf.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

hold that females harbor STIs and that HIV is most common among females as a result of their debauchery.[54] Consequently, Moroccan males seem to be exempt from STI prevention responsibilities.[55]

Adolescents and youth face significant barriers to health-seeking behavior for STIs and HIV infection. With STIs and HIV/AIDS highly stigmatized in ANE countries, young people hesitate to seek advice or care when they may have been infected. In addition, many adolescents and youth do not have access to reproductive health services.

Figure 8. Knowledge of Prevention Methods among Youth Ages 15 to 24 Years in Selected ANE Countries, 2001



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

Sexual Abuse, Exploitation, and Prostitution

Young females and males in the region are too frequently the victims of sexual abuse and exploitation. While only a few country assessments pointed to the issue, the problem may in fact be more widespread. In Pakistan, child sexual abuse is prevalent within homes and communities and may be rooted in the culture, reflecting an encouraged child-adult power imbalance.[56] *Bachabazi*—older males providing adolescent boys with education, clothing, and care in exchange for sex—is a frequent practice in Pakistan's North-West Frontier Province.

Adolescent prostitution is a problem in most countries; only the Egypt and Yemen assessments did not specifically address it. In Cambodia, adolescent girls are sometimes sold into prostitution by their families or boyfriends or are pressured to become prostitutes because of financial and social obligations to the family.[57] It seems that many prostitutes in the countries included in the study begin work during adolescence. In India, for example, two out of five prostitutes are younger than 18[58] and have had limited education about contraception and disease prevention. Prostitutes are often not able to negotiate safer sex with their clients. In addition, young prostitutes are often victims of sexual violence.

Legal and Policy Environment for Adolescent and Youth Reproductive Health

While all 13 countries included in the ANE regional assessment have put in place policies that affect young people, some countries, such as India and Jordan, have set forth several policies even as others, such as Yemen, have adopted just a few policies. Only India and the Philippines have promulgated specific adolescent and youth reproductive health policies.

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

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

Near East

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

To this point, however, Egyptian policies have delivered a mixed message regarding

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

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

Source: Data from Soubbotina, Tatyana P. and Katherine Sheram. 2000. *Beyond Economic Growth: Meeting the Challenges of Global Development.* Washington, D.C.: World Bank.

adolescent and youth reproductive health. While numerous ministries and their policies address issues pertinent to adolescents and youth, Egypt does not yet have a clear or consistent definition of adolescence. In addition, Egypt's population policy focuses explicitly on young female adults' need for health care

before marriage, including premarital examinations and counseling. The country's prevalent attitude is that the best way to protect children and young adults from engaging in unacceptable behaviors, such as premarital sex, is not to provide them with any information on these practices. While Ministry of Health and Population services and university clinics and hospitals are available to people of all ages and school health programming is prevalent in Egypt (preventive health care, including check-ups, vaccinations, and curative and rehabilitation services are provided through the School Health Insurance System), the range of services does not include reproductive health care. In addition, no scheme comparable to the School Health Insurance System covers out-of-school youth, although, as of 1998, several ministries were discussing ways to provide health insurance to these young people.[59] The limited reproductive and sexual health education received by young people has been and continues to be the responsibility of families.[60] Laws and policies do exist that address specific issues, such as motherhood and abortion, the right to maternity leave,[61] and protection "against unsafe abortion";[62] however, the exact parameters of the abortion issue, for example, are not entirely clear. The next few years should provide a clearer picture of Egypt's commitment to adolescent and youth reproductive health.

Jordan. Important policies address adolescents and youth, and four ministries, a specialized committee for youth within the Parliament, and two specialized councils are responsible for responding to the needs of Jordan's adolescents and youth. The Jordanian National Population Commission has also developed the first National Reproductive Health and Life Planning Youth Communication Strategy, which covers the period 2000 to 2005. The strategy is introducing innovative approaches to cross-generational communication by targeting two important audiences: primary audiences, consisting of married and unmarried youth ages 15 to 24 years, and secondary audiences, consisting of parents and family members, educators and school social workers, government officials and decision makers, and religious leaders.[63] The policy on the age at marriage was successfully changed in 2001 from 15 and 16 years for girls and boys, respectively, to 18 years for both (except in specific cases that are left to a judge to decide). Various other policies, particularly those developed in recent years, focus on the health and well-being of society in general. They include Public Health Act No. 21 of 1972, which obligates the Ministry of Health to do everything in its power to safeguard the health of citizens; a 2001 royal decree establishing the National Council for Family Affairs; successive national socioeconomic development plans, such as the 1999–2003 plan stressing improvements in health with specific objectives in all health areas, including maternal and child health;[64] and the Labor Law and Civil Service By-law, which entitles working females to fully paid maternity leave and time for breastfeeding for one year.[65] Their Majesties King Abdullah and Queen Rania are according high priority to these and other areas affecting adolescent and reproductive health, such as family violence, thereby providing hope for improvements in adolescent and youth reproductive health.

Nonetheless, Jordan lacks a clear or consistent definition of adolescence; thus,

developing a specific policy on adolescent and youth reproductive health in Jordan remains difficult. Existing policies may also be inadequate. For example, the country lacks specific provisions for first-time or adolescent mothers (even though working females are entitled to maternity leave). In addition, while Jordan's National Population Strategy explicitly addresses young people's need for reproductive health education, reproductive and sexual health education is minimal in schools and often nonexistent within families owing to prevailing attitudes and a focus on familial protection.

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

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

Yemen. Yemen's Population Policy explicitly addresses young adults through its provisions for reproductive health education and services, including antenatal care, immunization, and family planning services.[69] However, the policy lacks clear and consistent definitions with regard to adolescents and youth and related policy direction even while other policies address adolescents and youth and the numerous ministries involved with their issues. As a result, programming remains limited.

The government has attempted to address issues related to adolescent and youth reproductive health by, for example, issuing the 1991 Presidential Decree that established the National Council for Childhood and Motherhood; devoting an entire chapter of the current five-year plan (2001–2005) to motherhood and childhood; enacting Civil Service Law No. 19 (1991), which entitles working women to maternity leave and reduced work days while pregnant and breastfeeding; and issuing the 1999 decree (No. 59) establishing the General Strategy for Youth, Adolescents, and Sport (2000–2004), which aims to provide a planned and scientific base for ensuring the infrastructure necessary to make headway on youth-oriented issues. In addition, Yemen has committed itself to the National Strategy for Integrating Youth into Development (1998). The strategy presents

an analysis of issues, provides recommendations for addressing the needs of adolescents and youth, identifies strategic actions, and supports the development of subcommittees to coordinate and follow up on activities. The strategy also stresses the importance of providing information to decision makers. In addition, a youth strategy helps provide a basis for action on issues defined in the ICPD. Other policies on adolescent and youth reproductive health in Yemen address the legal age at marriage, which is 15 years.

South Asia

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

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

India. Since the early 1990s, India's national government has developed 12 bills, plans, or policies that deal with children, the girl child, labor, population, and youth. In addition, some Indian states have developed their own population policies and policies on women, with some state governments emphasizing concerns about adolescent and youth health and development. At the time the India report was written, India's National Health Policy of 2000 was undergoing final preparation. It highlights adolescent and youth health as a strategic focus in achieving sociodemographic goals. The policy aims to ensure that young people's need for information, counseling, population education, and accessible and affordable contraceptive services is met; that food supplements and nutrition services are available; and that the legislation on

restraint of child marriage is enforced. The population policy also stresses that reproductive health services for adolescent girls and boys are especially needed in rural areas, where adolescent marriage and pregnancy are most prevalent. The policy underscores the need for programs that encourage delayed marriage and childbearing as well as the need for education about the risks of unprotected sex.[70]

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

Nepal. As in many countries, support and numerous initiatives along with barriers sum up the status of adolescent and youth reproductive health in Nepal. However, the country has made progress over the past decade with regard to policy. The Prime Minister formulates and monitors all development programs, including the reproductive health program; as a result, the issue commands the highest level of government involvement. In addition, since the mid-1990s, reproductive health has received a boost from the creation of the ministries of Population and Environment and Women, Children, and Social Welfare. The existing population policy focuses on gender equity and population management through good governance and on the need to address demand for family planning among couples. It also articulates the need to alleviate poverty, accelerate economic development, decentralize, and develop public/private partnerships. The National Reproductive Health Strategy, adopted in 1998, identifies adolescent and youth reproductive health as a central component of integrated health services. The National Adolescent Health and Development Strategy, adopted in 2000, aims to improve the health and socioeconomic status of adolescents through access to information and services; the steps the government takes to implement the strategy warrant attention. In addition, the National IEC Strategy includes an adolescent component while the National Safe Motherhood Plan, which targets a 15-year period beginning in 2002, emphasizes improved access to and use of services for women during pregnancy, childbirth, and postpartum in order to prevent maternal death. The latter focuses on developing basic and essential obstetric care throughout the country by working in tandem with community facilities. Further, abortion may soon become legal in certain circumstances. Unmarried adolescents and youth had been legally prohibited from receiving FP/RH care until the recent passage of a policy by the National Reproductive Health Program Steering Committee that allows unmarried adolescents and youth to obtain family planning services. The policy changes the requirement for service providers to ascertain whether a client is married. To

ensure equity, policy also needs to address girls' empowerment issues.

Pakistan. As in other predominantly Muslim countries, religious beliefs and traditions in Pakistan have an intricate relationship with state structures and institutions, although other geopolitical and cultural influences also affect adolescent and youth reproductive health. Policy planners are only just beginning to conceptualize adolescence in Pakistan, and research is in the preliminary stages. With an official refusal to inform the public about sexual issues, only a small number of NGOs or health practitioners make reproductive health information available and only by means of limited outreach. The National Health Policy, developed nearly a decade ago, states that reproductive health and health education will be among the MOH's priority programs; however, the policy includes no reference to providing information about sexuality. Progress on both the provision of health education and sexuality has been stalled since that time.

Sexual exploitation is a significant adolescent and youth reproductive health problem, but policies do not adequately address it. No law specifically prohibits child sexual abuse. In addition, while sodomy is punishable by up to 10 years in prison, vaginal or oral penetration or any other sexual violence to a child is punishable by only up to two years.[71] Weaknesses in the law, such as the lack of a clear definition of child, arguably facilitate child prostitution. Child trafficking is a well-known problem in South Asia, but recommendations made by the Working Group on Youth Development in preparation for the Ninth Five-Year Plan (1998–2003) do not mention the need to combat child sexual abuse/exploitation or trafficking by addressing its underlying causes. The Hudood Ordinances of 1979 continue to help create an unsafe environment where, for example, if a victim charges rape and cannot prove it, he or she can be charged with illegal sex outside of marriage and receive the maximum punishment.

Sri Lanka. Sri Lanka needs to devote more attention to policy and legal matters, although it has clearly made some progress. After the 1994 ICPD, the government of Sri Lanka appointed an intersectoral task force charged with formulating a national population and reproductive health policy and an action plan. In 1997, the National Health Council and the Cabinet Ministers approved the Population and Reproductive Health Policy. The policy stipulated eight goals to be achieved within 10 years, with a focus on several issues, including reducing fertility, ensuring safe motherhood, achieving gender equity, increasing public awareness of population and reproductive health issues, promoting responsible adolescent and youth behavior, and improving population planning. In addition, over the past decade, Sri Lanka has strengthened its policies addressing the protection of mothers, children, and adolescents and youth and has devoted greater attention to the protection of the girl child. However, the country has yet to deal at all or adequately with numerous issues.

Southeast Asia

Cambodia. Cambodia has no explicit adolescent and youth reproductive health policies in place, but it addresses

adolescent and youth reproductive health activities in other policy areas. The country's pronatalist policies of the 1980s were reversed in the early 1990s under a maternal health rationale. Policies and laws enacted within the last decade include the National Safe Motherhood Policy (1997), a fairly liberal abortion law (1997), and the Birth Spacing Policy (1995), resulting in widespread dissemination of contraceptives and contraceptive information.[72] Correspondingly, knowledge of family planning is high in Cambodia—92 percent of all women and 96 percent of married women know of a contraceptive method—and contraceptives are used for both birth spacing and limiting.[73]

Cambodia imposes no legal barriers to the implementation of adolescent and youth reproductive health activities; however, substantial infrastructure barriers and a vast gulf between policy and implementation, particularly in rural areas, limit the delivery of needed services. The focus on curative rather than preventive health continues in Cambodia,[74] and, given that Cambodia's MOH and other relevant ministries do not yet recognize the need for an adolescent and youth reproductive health policy, adolescent and youth reproductive health activities remain the province of other policy areas (e.g., maternal and child health policy, population/birth spacing policies, gender equity, and equality policies). The problem of HIV/AIDS in Cambodia and the perilous state of maternal and child health mean that policy has focused on these areas. Cambodia needs to adopt a clear focus on adolescence if it is to address adequately the problems of adolescents and youth, maternal and child health, and HIV/AIDS.

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

Philippines. The Philippines set forth a number of direct (e.g., those specifically designed to influence population, health and reproductive health, adolescent and youth reproductive health, and HIV/AIDS) and indirect policies (e.g., those focusing on educational policies). The 1987 Constitution states that it is the "right and duty" of parents to ensure the welfare of

and instill proper moral development in their children.[76] It also specifies that the state has an obligation to help parents in this endeavor. Such emphasis has set the tone and focus for much of the policy and programming targeted to adolescent and youth reproductive health in the Philippines, which has been described as "indirect and cautious."[77] Some positive developments are underway. For example, the Adolescent and Youth Health Policy (2000) recognizes adolescents and youth ages 10 to 24 years as the priority population in terms of pressing health needs. The policy provides guidance for youth-friendly health service center development, stipulates the availability of contraceptive services and supplies, and supports the integration of the Adolescent and Youth Health Development Program into the health care system with a focus on IEC, advocacy, technical capacity, services, partnerships, and improved data collection. Another important development was the National Family Planning Policy, which earned the approval of the Department of Health in 2000 and stresses the importance of family planning as a health and poverty reduction intervention.

Vietnam. In Vietnam, sexual activity among adolescents and youth has increased along with a reported rise in gender-based violence. In the past, Vietnam did little to address adolescent and youth reproductive health in population and family planning policies—no development of national adolescent and youth reproductive health programs and no institutionalization of programming despite the lack of substantial legal barriers. More recently, though, in what was an important step in policy and program development, Vietnam publicly recognized the shortcomings of its approach.

The government has provided support for and approved the development of a National Strategy on Reproductive Health for 2001–2010, with adolescent and youth reproductive health identified as the second among seven outstanding problems that the new reproductive health program must address. The strategy is intended to improve adolescent and youth reproductive health through education, counseling, and provision of reproductive health services. It includes a focus on providing information on healthy sexuality. The strategy supports the provision of information through the schools and underscores the importance of providing counseling and medical assistance to adolescents and youth, including contraceptive methods, safe abortions, and treatment of reproductive tract infections (RTIs), and of paying particular attention to the needs of rural and remote areas. Related policies that exist or are in development include the safe motherhood master plan integrating adolescent and youth reproductive health components; the strategy for healthy living and life skills education for children, adolescents, and youth (through capacity building for teachers and others and the development of partnerships between various societal sectors); and support for local NGOs working with adolescent and youth reproductive health education and service provision. Nonetheless, the lack of impact and monitoring and evaluation indicators for adolescent and youth reproductive health will present difficulties for planning and implementing programs and assessing progress.

Adolescent and Youth Reproductive Health Programs

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

Near East

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

Even though NGOs are highly regulated by the Egyptian government, some carry out important work with adolescent and youth reproductive health. For example, the New Horizons Project is proving successful in breaching the reproductive health information gap among adolescents and youth and may be a model for other programs in Egypt and elsewhere. New Horizons is a "non-formal education program designed to demystify and communicate essential information in the areas of basic life skills and reproductive health" to girls and young women. The community-based and demand-driven project is designed to address the specific needs articulated by its target population: illiterate girls and young women in villages. Most are ages nine to 20 years; however,

New Horizons now also involves young women and mothers as old as 25. It is also targeting boys. Thus far, 16,000 girls have completed the thorough, 100-hour program. The project is active in all the governorates/provinces of Upper Egypt and is expanding into Lower Egypt. It is low-cost and proving sustainable, with local organizations taking the initiative to request training, participate in educator training, and subsequently carry out the program. A project evaluation is undergoing completion.[80] In general, more leeway for programming is needed if the NGO sector is to be successful.

Jordan. To date, few public programs in Jordan address adolescent and youth reproductive health; as a result, unmarried youth do not receive reproductive health services from the public sector. However, the 1994 ICPD was a catalyst for action on reproductive health such that NGOs in Jordan have become active since that time. Jordan has broadened the nation's strategy for achieving its population objectives by, for example, involving governmental and nongovernmental organizations in supporting the expanded availability of reproductive health information to adolescents and youth. To reduce the gender gap, the strategy also stresses female education and calls for increased employment opportunities for women.

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

Beyond the health sector, groups such as the Higher Council for Youth (leadership program), the Ministry of Education (involvement in productive activities for

girls and boys), and the Jordan University of Science and Technology (awareness-raising workshops on various topics, including women's issues) are undertaking programmatic initiatives.

Morocco. Although Morocco adopted a focus on reproductive health education nearly three decades ago following the 1974 international population conference in Bucharest, reproductive health programs specifically targeting adolescents and youth still consist primarily of population and health education efforts. A population education coordinating body has been operating since the mid-1970s and brings together the Moroccan Family Planning Association and the ministries of the Interior, Public Health, Employment and Social Affairs, Youth and Sports, and Education. The Ministry of Youth and Sports and the Ministry of Education carry out formal health education, and other ministries provide informal health education.[82] The Ministry of Youth and Sports's programming includes reproductive and sexual health education through summer camps, sports clubs, youth centers in poorer neighborhoods, and other institutions. One component of the program reached more than 100,000 youth in 1997–1998 alone. In association with the Association Marocaine de Planification Familiale (AMPF), the Ministry of Youth and Sports provides information through 340 public sector youth houses around the country and supports endeavors that assist in enhancing discussion and communication on adolescent and youth reproductive health. The Ministry of Youth and Sports is also involved in IEC campaigns specifically designed for Moroccan youth through youth festivals and the Internet. The Ministry of Public Health is also active in programming. For example, it organized a Week on Reproductive Health in 2000 that reached 1.2 million youth with health messages and is now planning to focus on young adults by instituting peer and other education efforts to influence sexual behaviors.[83] With acknowledgment from the Ministry of Youth and Sports that Moroccan youth are now typically sexually active long before marriage, governmental agencies recognize the need for additional programs that address reproductive health.[84]

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

The nongovernmental sector has more liberty than the public sector to act on adolescent and youth reproductive health.[87] The Association de Lutte Contre le SIDA, a well-respected, Casablanca-based organization, has been bringing topics such as STIs and HIV/AIDS, high-risk sexual behaviors, sex work, and other sensitive but pressing issues to the attention of policymakers and the public through awareness-raising and advocacy efforts. The Institution Nationale de Solidarité avec les Femmes en Detresse helps single mothers and their children by providing an in-depth adult education curriculum in reproductive health. The PASA Project of Association Marocaine de Solidarité et le Développement has an exemplary community-based, needs-driven social development program similar to the New Horizons Project in Egypt[88] (see Egypt above); it provides in-depth adult education on reproductive health to communities after first working to gain their trust. Other NGO initiatives are also underway or planned, including a large, comprehensive program that could effectively begin to fill in sexual and reproductive health services and information gaps in the national family planning and education sectors. The focus of the plan is on the integration of women in development; it concentrates on reproductive health, with provision for reproductive health counseling and youth programming.

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

South Asia

Bangladesh. The government of Bangladesh identified adolescent and youth health and education as both a priority and a challenge; to face the challenge, it incorporated adolescent and youth health and education into its Health and Population Sector Program. With a focus on providing more services, the government expects an overall increase in the quantity and quality of information and services available through a network of clinics at the community, thana (upazilla), and district levels. However, without additional efforts from other agencies, the improvements to be delivered through the Health and Population Sector Program are unlikely to make significant contributions to achieving results in the area of adolescent and youth reproductive health during the life of the program (1998–2003).

Fortunately, government and NGO collaboration is filling some of the gaps. Nearly 200 NGOs work with adolescents

and youth in some capacity.[91] Their activities include vocational training for skill development, microcredit programs, leadership training, family life education (FLE), sex education, reproductive health services, personal hygiene education, and legal assistance in cases of violence and abuse against women. Many NGOs are developing and most are disseminating materials.

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

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

activities later in life. This scheme has been extended to 3.9 million adolescent girls throughout the country.

Several NGO and other sector programs are also addressing adolescent and youth issues, including the Department of Education, Scouts and Guides organizations, Ministry of Labor, and Ministry of Social Justice and Empowerment. The Department of Education program, for example, focuses on achieving universal coverage of primary education through decentralized planning and management, decentralized target setting, community mobilization, and district- and population-specific planning. The numerous foreign and indigenous NGOs working in the country, such as the Population Council, the Health Institute for Mother and Child in New Delhi, the Healthy Adolescents Project in India, the International Center for Research on Women, the Society for Social Uplift through Rural Action, Planned Parenthood Federation, and CEDPA, are all working on various aspects of adolescent and youth health issues as well. The Society for Social Uplift through Rural Action, based in Jagjit Nagar, Himachal Pradesh, for example, regularly undertakes training programs, seminars, workshops, and courses for capacity building among women's groups, local governing councils, and adolescent and youth girls' groups. Activities are geared toward imparting a broad understanding of reproductive health.

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

NGOs are active at the grassroots level. The Family Planning Association of Nepal, one of the largest NGOs in Nepal, is engaged in advocacy, IEC, and providing services to young people. It integrates adolescent and youth reproductive health services with other reproductive health services that are provided through the association's clinics. Other NGOs, including the Ama Milan Kendra, focus on issues such as male involvement and

working with young females to make informed decisions regarding social, economic, and health needs and rights. PHECT-Nepal provides safe motherhood, family planning, and STI services to adolescents and youth in one municipality. Sunaulo Pariwar Nepal, a local NGO affiliated with Marie Stopes International, provides youth-friendly services through one of its clinics in the far western region of Nepal and is extending similar services to other parts of the country through its clinics.

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

The NGO sector is addressing some adolescent and youth reproductive health issues. The Family Planning Association of Pakistan has targeted young people and is currently preparing the groundwork for an initiative aimed at addressing the knowledge and attitudes of young adults toward reproductive and sexual health in order to influence their behavior in favor of the small family norm and responsible parenthood.[94] Treatment for postabortion complications has been pioneered by Marie Stopes Society, which also provides traditional family planning services, and furthered by the Behbud Welfare Association. UNAIDS, UNICEF, and UNFPA are including education and awareness about STIs and HIV/AIDS in their programs, and UNICEF aims to train nongovernmental and health workers in prevention and counseling techniques.[95] In addition, a few small, local NGOs have taken up the challenge to raise awareness about HIV/AIDS to a broad population, including, to a limited extent, adolescents and youth.

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

Sri Lanka. Achievements in the health sector in Sri Lanka have been impressive, although the country has devoted little attention to the health of young people, particularly with regard to sexual and reproductive health. It has yet to institute an organized program for providing information to adolescents and youth.

The existing adolescent and youth reproductive health programs are implemented through the Department of Health, the Department of Education, the National Youth Service Council, and NGOs, which, collectively, have undertaken a number of important initiatives. A project initiated by the Family Planning Association of Sri Lanka

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

Southeast Asia

Cambodia. In the absence of strong barriers to adolescent and youth reproductive health programming in Cambodia, several types of organizations have taken on the challenge of developing programs. School curricula have recently undergone revision to incorporate reproductive health and HIV/AIDS information into the science and social studies curricula. However, teachers need

additional training to ensure that they present the material properly. In addition, many students do not benefit from the materials provided in later grades because numerous years of schooling are still the exception rather than the rule. Various local and international NGOs are working nearly unconstrained on the provision of information and services, some focusing directly on adolescent and youth reproductive health and others working on areas related to it. Some NGOs have even incorporated "adolescent- and youth-friendly" services, with separate waiting rooms for young people. Innovative informational programming is not unusual; radio phone-in programs and question-and-answer newspaper and journal columns are seen regularly.

Indonesia. Adolescent and youth reproductive health in Indonesia continues to center around education, largely to the neglect of addressing the need for services. While programming in reproductive health has been available for many years and a number of adolescent and youth reproductive health-related programs are identifiable, there is some question as to the extent of their reach, services, and efficacy, as they are not implemented nationally. Sectors providing programming include the National Family Planning Coordinating Board, the Department of Health, the Department of Social Welfare, the Department of Religion, and the Department of National Education. Existing programming is limited to schools. In Jakarta, West Java, and Yogyakarta, some schools have provided adolescent and youth reproductive health education.[98] Such schools integrate adolescent and youth reproductive health education into other subjects, such as biology, social studies, and religion, which address topics of marriage and sexuality. Teachers who received training in counseling deliver the courses.

In 2000, Ibu Khofifah Indar Parawansa, the former Minister of Women's Empowerment and Head of the National Family Planning Board, initiated both a new Adolescent and Reproductive Rights Protection Directorate within the National Family Planning Coordinating Board and a division responsible for adolescent and youth reproductive health within the state Ministry of Women's Empowerment. In addition, she advocated for allowing pregnant students to finish their schooling and for providing "emergency contraceptives" in certain circumstances.[99] Her proposals met with considerable dissent; however, in large part due to Indar Parawansa's persistence, policymakers in the health and education departments held discussions on the need to emphasize the importance of including reproductive health education in the school curriculum. Impetus for programming seems to be growing, with the MOH having developed and implemented peer education programs and the Department of Religious Affairs

having focused on efforts to develop reproductive health education for religious schools.[100] In addition, owing in part to the progress that government offices are making, NGO programming has been able to "take off" to a larger degree; NGOs are less constrained by government policies and regulations and tend to be more adolescent- and youth-friendly, although they need better documentation and evaluation procedures.

Philippines. The Philippines Local Government Code mandates that local government units provide family planning and health programs. The Philippines has put in place a number of programs that have tried to focus attention on both increasing the understanding of the RH needs of adolescents and youth and delivering services for young people. The programs need additional management capability, technical skills, and resources if they are to serve a broad population effectively. In addition, key informants expressed concern about the willingness of government workers to provide adolescent and youth reproductive health services. According to one informant, the reality is that unmarried teens asking for contraceptive services or information from a clinic will receive services at the moral discretion of the health care provider. Noteworthy are the National HIV/AIDS Prevention and Control Program, which targets several age groups; Population Awareness and Sex Education, which is a population and sexuality education program specifically targeted at out-of-school youth; Commission on Population of the Adolescent and Reproductive Health (ARH) Program, which identifies adolescence as one of its five programmatic areas and focuses on reducing the incidence of early marriage and teenage pregnancy, among other issues; and a program conducted by the Family Planning Association of the Philippines that stipulates that all individuals of reproductive age (specified as persons ages 15 to 44 years) have the right to information, counseling, physical examinations, and contraceptive supplies, specifically condoms or contraceptive pills.

Vietnam. Since the early 1990s, Vietnam has developed and implemented some adolescent and youth reproductive health programs and activities, including school- and community-based efforts, in different areas of the country. However, most of these programs and activities have focused primarily on IEC and have not extended to the provision of contraceptives or other reproductive services. Since 1988, with support from UNFPA and the United Nations Educational, Scientific and Cultural Organization (UNESCO), the school curriculum has included family life and sexuality education and population education, which are usually integrated into biology or other subjects and have been available primarily for students in grades 10 through 12. Unfortunately, teachers have

been uncomfortable with the subject matter and thus have often delivered the information in the form of moralistic lectures that can quickly lose young people's interest. The most recent programming in schools has been more successful, such as the National Education and Training Program on Reproductive Health and Population Development, which included a training component for teachers.

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

Summary

Table 2 provides a snapshot of the strength of policies and programs related to adolescent and youth reproductive health in the 13 countries of the ANE region, including the extent to which political commitment to adolescent and youth reproductive health exists, the presence of school-based FLE programs and other information programs and services for young people, whether NGOs are active in adolescent and youth reproductive health activities, and whether programs are multisectoral and gender-focused.

Adolescent and youth reproductive health issues remain politically sensitive in all countries, primarily because governments do not want to be perceived as encouraging young people to engage in sex before marriage. That sensitivity manifests itself, however, as a mismatch between the information needs of young people and general population education programs, FLE programs, and family discussions that do not directly address sexuality and family planning. In some of the countries, STI/HIV/AIDS topics are slowly finding their way into school-based FLE programs. In other countries, such as Indonesia, the government recognizes the need for making available more specific information; however, it lacks the political will to do so. Nonetheless, the political will to address adolescent and youth reproductive health is emerging in Southeast Asia, which accounts for fewer legal and policy barriers to reaching young people. At the same time, governments in the Near East and South Asia remain conservative in dealing with adolescent and youth reproductive health, although some surprising policy developments have occurred; for example, in Nepal, unmarried adolescents and youth are no longer prohibited from receiving services (although substantial operational policy barriers exist for young people actually receiving the services).

Information programs for young people cover a range of topics, but again tend to consist of general messages about responsible parenthood. Parents are considered the most appropriate conduit for

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

Country	Political Commitment[iii]	Family Life Education[iv]	Information	Services	NGOs Working in A&YRH[v]	Multi-sectoral focus	Gender Focus
Near East							
Egypt	*** Growing	***	**	**	Small/ Growing	***	***
Jordan	**	***	**	**	Small/ Active	***	—
Morocco	*	*** FLE/ Population Education Focus	*** Starting to include HIV	**	Small/ Active	**	***
Yemen	** Recent	—	*	*	Small	***	—
South Asia							
Bangladesh	**** Growing	*** NGO-driven	***	***	Active	***	***
India	***	**	**	**	Small/ Active	***	***
Nepal	**	*** FLE/ Population Education Focus	**	**	Small/	***	**
Pakistan	*	*** FLE/ Population Education Focus	*	*	Small/ Active	—	—
Sri Lanka	***	***	**	**	Small/ Active	***	***
Southeast Asia							
Cambodia	** Emerging	*** New	*** Including HIV	**	Small/ Active	***	—
Indonesia	** Emerging	** Recognize Need	**	**	Small/ Active	**	**
Philippines	*** Mixed	***	** Including HIV	**	Small/ Active	***	—
Vietnam	** Emerging	***	** Including HIV	**	Small/ Active	***	***

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

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

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

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

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

delivering information about sexuality and reproductive health to their adolescents and teens but generally do so only at the time of marriage; in reality, though, parents provide little information. Typically operated by NGOs, some regular and peer counseling programs provide young people with more detailed information on sexual and reproductive health. Married adolescents and youth can receive services in all countries; however, in many places, young women are discouraged or not allowed to receive family planning until they have had at least one child. With the growing awareness of STIs/HIV/AIDS, the topic of infection is slowly being introduced to young people, again mostly by NGOs.

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

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

Operational Barriers to Adolescent and Youth Reproductive Health

National policies directly influence operational policies—the "rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services."[101] Operational polices in turn shape public sector regulations, which in their turn help shape health systems management. Ultimately, this chain of events affects reproductive health service delivery. Thus, when a break in the chain occurs, as is common in the ANE region, problems arise in the effort to develop or implement adolescent and youth reproductive health programs.

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

An obvious problem exists where national policies that directly address adolescent and youth reproductive health are nonexistent. Informational barriers contribute to the policy vacuum. Often, governments have not yet tackled even the definition of adolescence, as is the case in Yemen. The ANE region evidences a general lack of research on adolescent and youth reproductive health and the needs of adolescents and youth, particularly among underserved and minority groups. Several reports, including those of Nepal, the Philippines, Sri Lanka, and Yemen, mention the paucity of research. The Sri Lanka assessment notes that the country lacks data on teenage pregnancies, abortions, contraceptive use, child abuse, and gender-based violence. These are sensitive issues but, as noted in the Sri Lanka assessment, "as long as data are scarce and the severity of adolescent and youth RH issues is not made known to the public, political commitment for a coherent policy initiative will be hard to achieve. In the long run, this could prove to be the

greatest operational barrier to adolescent and youth RH."[102] Social barriers often foster operational policy barriers. Traditional or religious values and norms may impede discussion of adolescent and youth reproductive health issues and limit support for policy development. Policymakers, stakeholders, including parents, and society at large are often uncomfortable with or not interested in changing mores; they either have difficulty addressing or refuse to address the pressing problems of adolescent and youth reproductive health, believing that such problems are best dealt with by the family alone or not at all. Some leaders maintain a stance of "official denial."[103]

Even where policies are in place, barriers at other points in the chain often undermine good adolescent and youth reproductive health. Resources—informational, human, operational, and commodities—are a problem throughout the ANE region. The lack of sustained support means that both government and NGO programs are implemented for only a limited time and that lessons learned are rarely shared. In countries such as Yemen, a scarcity of Arabic-language materials and other objective references with regard to adolescent and youth reproductive health obviously poses a barrier. In addition, training of service workers and counselors is relatively rare in the region. The issue of abortion services is difficult to address in most nations, and where services exist, providers may think that counseling is an unnecessary or nonessential component.[104] Bureaucrats often oppose moves toward decentralized authority and thus inhibit timely decisions, appropriate action, and the provision of services during the wait for central government approval for action. In the Philippines, for example, central government officials do not yet consider decentralized authority legitimate. Coordination between public and NGO groups is also often lacking in the ANE countries, limiting the learning that could be available to others and preventing the integration of reproductive health, family planning, and treatment of STIs and HIV. At the same time, NGOs often experience difficulty in obtaining commodities such as condoms. Finally, the ANE region relies heavily on foreign aid, which could, in the short and long terms, put overall programming, which is already in jeopardy, at further risk.

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

The lack of information and education is a barrier in and of itself. It prevents young people's understanding of what is happening to them, the changes they will encounter as they enter their adult years, and how best to care for themselves and future generations. The information young people do receive tends to be of a general nature, often because parents and community leaders fear that sex education will promote sexual behavior at an early age. Young people throughout the region, however, indicate that they would prefer to receive more specific information on sexual and reproductive health. As for segments of populations with low literacy levels—a common situation throughout the region—many adolescents and youth may not be able to access available

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

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

reproductive health information, thus pointing to the need to develop basic infrastructure and education in order to address adolescent and youth reproductive health in the region. However, where education is the norm rather than the exception, as is the case in certain countries or segments of the population, problems with school administrators, teachers, or others in positions to reach adolescents and youth are not uncommon as the educational systems resist the teaching of reproductive health, as is the case in Jordan.

Most countries fail to provide services that either include adolescents and youth or are directed specifically at them. In no country are unmarried youth particularly welcome in public sector clinics, and some countries either maintain the illegality of providing reproductive health services to unmarried adolescents or make access extremely difficult. Where private clinics exist, services are often unaffordable and inaccessible to the average person—and certainly to the average young person.[105] This is the case even in countries such as Morocco, Sri Lanka, and Vietnam, where

sexual mores continue to change. Where services are available for young people, quality barriers may exist. For example, clinics may lack privacy and confidentiality for adolescents and youth. They may also lack professional staff, resulting in poor treatment of young people. Insensitive interview questions or poor counseling skills often make the critical period of contact with adolescents and youth difficult and uncomfortable and can deter young people from seeking services. In many ANE countries, NGOs have tried to overcome these barriers by implementing programs that meet the needs of sexually active unmarried youth.

Recommendations

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

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

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

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

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

Policymakers, lawmakers, and stakeholders are too often inadequately informed about the conditions and specific and special needs of young people and the consequences of not addressing them. Adolescent and youth reproductive health remains a politically and socially sensitive

topic; policymakers are often reluctant or unable to develop multisectoral policies that address adolescent and youth reproductive health. Stakeholders need to advocate to policymakers based on an understanding of existing laws and policies. Advocacy must be premised on human rights principles and take into account various social, economic, and religious points of view. Youth and adolescent reproductive health advocates should encourage development of relevant laws, policies, and guidelines to ensure adequate protection and promotion of adolescent and youth reproductive health and attention to associated social issues, such as gender equity in education and the economy. Training is also needed so that key individuals can adequately motivate and lead their constituencies and assist in disseminating policy information to other relevant groups, such as community leaders and service providers.

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

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

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

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

4. Promote communication in families.

As policymakers and teachers receive information and training, parents cannot be forgotten. For change to occur, the gap

between sociocultural norms and the realities of adolescent and youth reproductive health must be narrowed. Because premarital sex is inappropriate according to many countries' cultures or religions, families often do not realize or choose not to acknowledge that young people are increasingly sexually active and that, as the age of marriage rises, young people find themselves increasingly exposed to premarital sexual activity. The lack of acknowledgment hinders policy and programmatic responses to addressing adolescent and youth reproductive health.

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

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

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

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

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

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

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

premarital counseling, family welfare centers, schools, peer education, local youth forums, mass media, clubs, and so forth.

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

Existing policies and programs are often limited by lack of sustainability, narrow scope, and short time frames. While time-bound efforts can be advantageous in forcing policymakers and stakeholders to revisit and revise policies and programs frequently and regularly, shorter time frames can also prove a liability to sustainability. Funding shortages plague most programs. In addition, few programs have sufficiently wide scope to reach a great number of young people. For example, many programs are concentrated in urban areas or schools, neglecting rural or out-of-school adolescents and youth. Many are small-scale projects or pilot projects that work with small groups of young people for short periods of time.

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

7. Develop and promote evidence-based programs.

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

Furthermore, taking a youth development approach can be more culturally appropriate than focusing solely on reproductive health. In addition, addressing a range of issues

facing adolescents and young people will likely be more acceptable to young people. Often, young people themselves are often more concerned about education and jobs than about reproductive health.

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

Endnotes

1. The World Health Organization (WHO) defines adolescents as persons 10 to 19 years of age, youth as persons 15 to 24 years of age, and young people as 10 to 24 years. The 13 assessment reports, however, have used varying definitions of adolescents and young people: the Bangladesh, Indonesia, Morocco, Philippines, and Vietnam reports refer to persons 15 to 24 years of age (a category also sometimes termed "young people"); the Egypt, India, Sri Lanka, and Yemen reports refer to persons 10 to 19 years of age; and the Cambodia, Jordan, Nepal, and Pakistan reports refer to persons 10 to 19 years of age as "adolescents" and persons 15 to 24 years of age as "young people." These disparities preclude precise comparisons of age-related research (of which there is little), but important similarities and comparisons still can be examined.
2. ICPD *Programme of Action,* Chapter VII, Section E. www.un.org/ecosocdev/geninfo/population/icpd.htm
3. www.developmentgoals.org
4. Beamish, 2003, p. 3.
5. Almasarweh, 2003, p. 3.
6. Beamish and Tazi Abderrazik, 2003, p. 4.
7. Al-Rabee', 2003, p. 3.
8. Registrar General and Census Commissioner [India], 2001; IIPS, 2000; and Government of Rajasthan, 1995, cited in Gupta, 2003.
9. Khan and Pine, 2003, p. 8.
10. Pradhan and Strachan, 2003, p. 4.
11. De Silva et al., 2003, p. 4.
12. Fordham, 2003, p. 5.
13. Utomo, 2003, p. 4.
14. Hong, 2003, p. 4.
15. Barkat and Ahmed, 2001, cited in Barkat and Majid, 2003.
16. LICHARDO, 2001, cited in Fordham, 2003.
17. Nassar et al., 1998, cited in Almasarweh, 2003.
18. Beaufils, 2000; and Ministry of Education, Youth, and Sports [Cambodia], 1998, cited in Fordham, 2003.
19. MOH [Nepal] et al., 2002, cited in Pradhan and Strachan, 2003.
20. CBS [Indonesia], 1998, cited in Utomo, 2003.
21. Ibrahim et al., 1999, cited in Beamish, 2003.
22. Beamish and Tazi Abderrazik, 2003.
23. MOHFW [Bangladesh], 1998, cited in Barkat and Majid, 2003.
24. GSO [Vietnam], 2000, cited in Hong, 2003.
25. Guessous, 2000, cited in Beamish and Tazi Abderrazik, 2003.
26. Khan and Pine, 2003.
27. Barkat and Majid, 2003.
28. Hull, 2002; Jones, 1994; and Hull and Hull, 1984, cited in Utomo, 2003.
29. Ech-Channa, 2000, p. 145, cited in Beamish and Tazi Abderrazik, 2003, p. 4.

30. Fordham, 2003, p. 5.
31. Fordham, 2003, p. 5.
32. Varga and Zosa-Feranil, 2003.
33. Pachauri and Santhya, 2002.
34. Respondent, cited in Varga and Zosa-Feranil, 2003.
35. Barkat and Majid, 2003, p. 8.
36. De Silva et al., 2003, p. 16.
37. Kirby, 2001; and Grunseit et al., 1997. These two exhaustive reviews of studies on school-based programs concluded that sex education programs do not promote or lead to an increase in sexual activity among young people with regard to either the initiation or frequency of sex. A U.S. study found that HIV programs were more likely to result in a decrease in the number of sex partners and an increase in condom use.
38. Beamish, 2003, p. 9.
39. Utomo, 2003, p. 9.
40. Respondent, cited in Varga and Zosa-Feranil, 2003, p. 6.
41. AMPF/Experdata, 1995, cited in Beamish and Tazi Abderrazik, 2003.
42. Beamish and Tazi Abderrazik, 2003, p. 23.
43. DOS [Jordan] and Macro International, Inc., 1997, cited in Almasarweh, 2003.
44. Almasarweh, 2003, p. 16.
45. Respondent, cited in Varga and Zosa-Feranil, 2003.
46. The data represent sexually active young women in union who wish either to postpone childbearing by at least two years or to have no more children and yet are not using contraception.
47. Marcus study cited in Wilopo et al., 1999, cited in Utomo, 2003.
48. MOH [Vietnam], 2001, cited in Hong, 2003.
49. Goodkind, 1994, cited in Hong, 2003.
50. Government of Bangladesh and UNICEF, 2000, cited in Barkat and Majid, 2003.
51. Ramasubban, 1995, cited in Gupta, 2003.
52. JAFPP, 2001, cited in Almasarweh, 2003.
53. Barkat et al., 2000, cited in Barkat and Majad, 2003.
54. Dialmy, 2000; and AMPF/Experdata, 1995, cited in Beamish and Tazi Abderrazik, 2003.
55. MSP [Morocco] and AIDSCAP, 1997, cited in Beamish and Tazi Abderrazik, 2003.
56. Sahil, n.d., cited in Khan and Pine, 2003.
57. See CARAM, 1999, and Greenwood, 2000, cited in Fordham, 2003.
58. Gupta, 2003.
59. Ibrahim et al., 1999; Shafey, 1998; and UNFPA/MOHP, 2001, cited in Beamish, 2003.
60. Shafey, 1998, cited in Beamish, 2003.
61. Shafey, 1998, cited in Beamish, 2003.
62. Al-Bindari, 2001, cited in Beamish, 2003.
63. JNPC/GS, 2001, cited in Almasarweh, 2003.
64. MOP [Jordan], 1999, cited in Almasarweh, 2003.
65. Labor Law No. 8, 1996; and Civil Service By-law for 1996, cited in Almasarweh, 2003.
66. Dialmy, 2000; Ech-Channa, 2000; and Joutei, 2001, cited in Beamish and Tazi Abderrazik, 2003.
67. Mounabih, 2001; and Reynolds, 1999, cited in Beamish and Tazi Abderrazik, 2003.
68. Beamish and Tazi Abderrazik, 2003, p. 13.
69. National Program of ARH and FP and Child Health (2001–2005), NPC [Yemen]; and. NPC [Yemen], 2001, cited in Al-Rabee', 2003.
70. Government of India, 2000, cited in Gupta, 2003.
71. Sahil, n.d., cited in Khan and Pine, 2003.
72. Chhuan et al., 1997; and MOH [Cambodia], 1998, cited in Fordham, 2003.

73. National Institute of Statistics [Cambodia] et al., 2001, cited in Fordham, 2003.
74. Chhuan et al., 1997, cited in Fordham, 2003.
75. Suharto, 2001, cited in Utomo, 2003.
76. Article II, sec. XII, Constitution of the Republic of the Philippines, 1987, cited in Varga and Zosa-Feranil, 2003.
77. Various key informants, cited in Varga and Zosa-Feranil, 2003.
78. El-Zanaty and Way, 2001, cited in Beamish, 2003.
79. Shafey, 1998; and Ibrahim et al., 1999, cited in Beamish, 2003.
80. Gamal, 2001; CEDPA and Notkin, 2000; and CEDPA, 2000, cited in Beamish, 2003.
81. Ingaz Program, 2001, cited in Almasarweh, 2003.
82. Dialmy, 1998, cited in Beamish and Tazi Abderrazik, 2003.
83. Alami, 2001, cited in Beamish and Tazi Abderrazik, 2003.
84. Mounabih, 2001; and Reynolds, 1999, cited in Beamish and Tazi Abderrazik, 2003.
85. Tyane, 2001, cited in Beamish and Tazi Abderrazik, 2003.
86. AMPF/Experdata, 1995; and Dialmy, 1998, cited in Beamish and Tazi Abderrazik, 2003.
87. Maasri, 2001; Mounabih, 2001; Alami, 2001; and Graigaa, 2001, cited in Beamish and Tazi Abderrazik, 2003.
88. CEDPA and Notkin, 2000, cited in Beamish and Tazi Abderrazik, 2003.
89. Aoyama, 2001, cited in Al-Rabee', 2003.
90. CSO [Yemen] and Macro International, 1998, cited in Al-Rabee', 2003.
91. Hossain et al., 1998, cited in Al-Rabee', 2003.
92. Nath and Barkat, 2000, cited in Al-Rabee', 2003.
93. For administrative purposes, a district is divided into smaller segments with a population of 100,000 to 120,000. The segments are called "blocks."
94. FPAP, n.d., cited in Khan and Pine, 2003.
95. UNICEF, 1998, cited in Khan and Pine, 2003.
96. Gnanissara, 2002, cited in De Silva et al., 2003.
97. UNFPA, 2000, cited in De Silva et al., 2003.
98. Yuwono and Roque, 1999, cited in Utomo, 2003.
99. *Kompas,* 2000; and Media Indonesia Online, 2000, cited in Utomo, 2003.
100. Hasmi, 2001; and Suharto, 2001, cited in Utomo, 2003.
101. Cross et al., 2001.
102. De Silva et al., 2003, p. 17.
103. Tarr, 1996; Tarr and Aggleton, 1999; and Ly Solim et al., 1997, all suggest an increasingly high level of adolescent and youth sexual activity, among girls in particular. In contrast, the Reproductive Health Association of Cambodia, 1999, notes that 26.8 percent of girls and 44.9 percent of boys ages 12 to 25 years are sexually active, although the association assumes that many of these adolescents and youth are likely married. Cited in Fordham, 2003.
104. Population Council, 2000.
105. Belouali and Guédirea, 1998; and MSP [Morocco] and AIDSCAP, 1997, cited in Beamish and Tazi Abderrazik, 2003.

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Photographers: Lauren Goodsmith (p. 26); Todd Shapera (p. 28); Reproductive Health Association of Cambodia (RHAC) (p. 31); Andrea Fisch (p. 32); Cathryn Wilcox/CCP (p. 33).

Production by Communications Development Incorporated, Washington, D.C.

Printed on recycled paper.

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ISBN 0-9605196-9-6