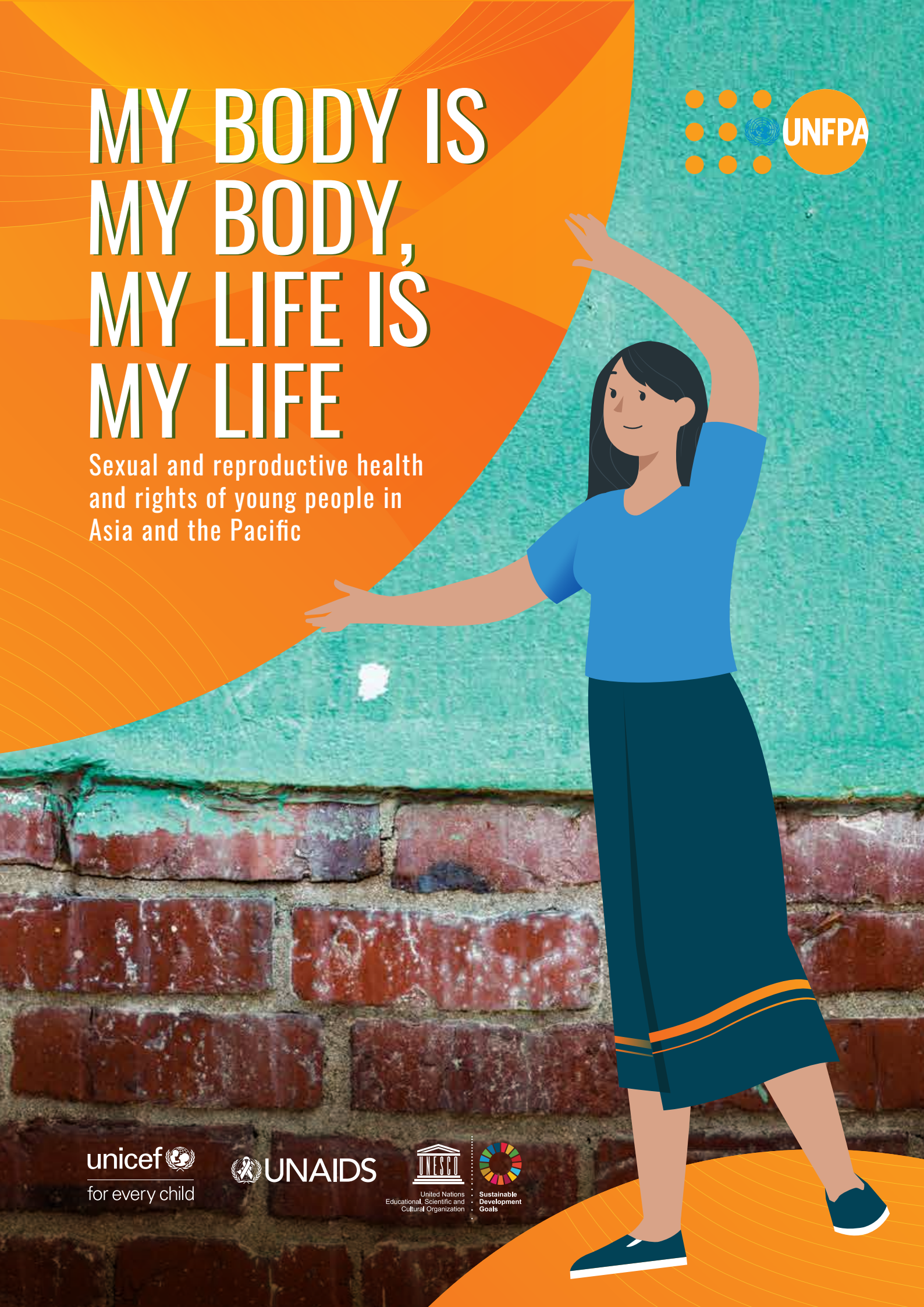
MY BODY IS MY BODY, MY LIFE IS MY LIFE

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



UNFPA

unicef for every child

UNAIDS

United Nations Educational, Scientific and Cultural Organization

Sustainable Development Goals

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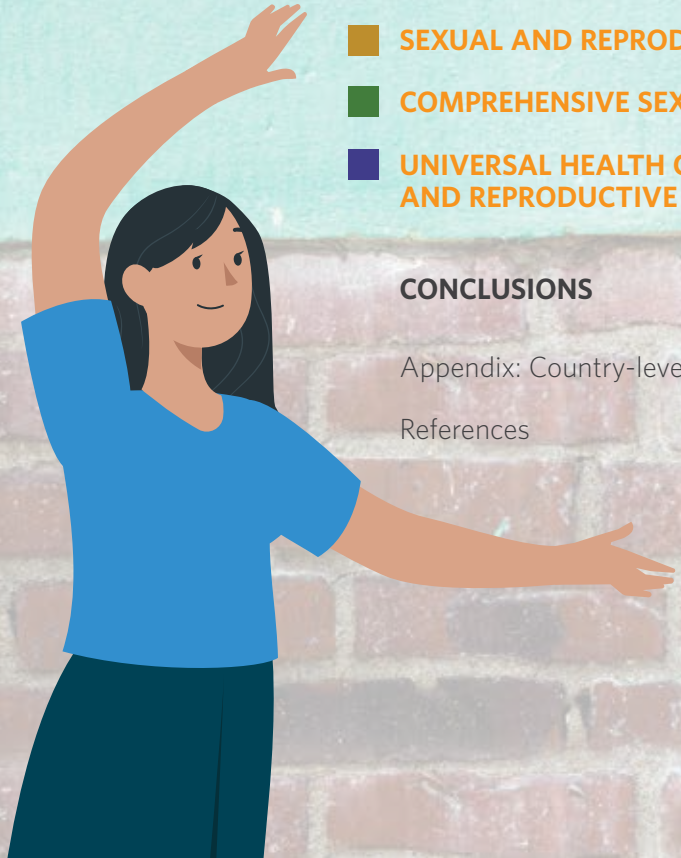

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FOREWORD

"**My body is my body, my life is my life**" - the title of this important report - is a quote from a young person living with a disability in India who, like millions of others, demands and expects to enjoy rights and equality, and to be treated with dignity.

Here in Asia and the Pacific, in 2020, we have nearly one billion young people aged 10-24 traversing the journey between childhood and adulthood. We must support each and every one of them to make informed choices on the most important, including some of the most personal, issues in their lives and to fully exercise their rights.

The report's title reflects as well UNFPA's new strategy on adolescents and youth, "My Body, My Life, My World!", which also supports the implementation of Youth 2030, the United Nations Youth Strategy.

This publication collates the information available on the status of young people's sexual and reproductive health and rights and how well we are supporting. In many areas we still have a long way to go, particularly in meeting the needs of sexually active adolescents. This report documents the gaps in data, policy and programmes in Asia and the Pacific, but above all it underscores how adolescents' evolving capacity and their rights are simply not being realised - to the detriment of their ability to obtain crucial information, take responsible decisions and strengthen their foundation for life.

Since this report was written, we have faced the COVID-19 pandemic which has further reduced young people's access to critical sexual and reproductive health information and services. Post-pandemic we need to urgently regain the momentum we have lost, but we also need to examine our approach and do better in reaching those left behind.

Working ever more closely with young people as genuine partners together we can achieve sexual and reproductive health for all young people so that they can reach their full potential - a key vision under the global mandate of UNFPA.

Mr. Björn Andersson

Regional Director
Asia and the Pacific Regional Office
United Nations Population Fund

September 2020

ACKNOWLEDGMENTS

This review was commissioned by United Nations Population Fund, Asia Pacific Regional Office and conducted by Burnet Institute. Elissa Kennedy, Co-Programme Director Maternal, Child and Adolescent Health, Burnet Institute led the review, undertook the literature and policy review, and wrote the report. Karly Cini, Research Officer, Global Adolescent Health (Burnet Institute) and Nisaa Wulan, Research Officer, Global Adolescent Health (Burnet Institute) undertook the extraction, analysis and preliminary visualisations of quantitative data. Peter Azzopardi, Co-Head, Global Adolescent Health (Burnet Institute), provided guidance on the methodology and analysis and co-authored the report.

The authors wish to acknowledge Elizabeth Milne for undertaking the review of sexual and reproductive health in a digital age and preparing the initial draft of this section. Sincere gratitude also to Josephine Sauvarin, Advisor on Adolescents and Youth, UNFPA Asia Pacific Regional Office, for providing guidance on the methodology and extensive feedback on the draft report, and Maki Akiyama, Programme Analyst, Adolescents and Youth, UNFPA APRO for providing feedback and providing access to key findings from the 2019 sexuality education online youth survey and collating qualitative quotes from young people.

We also wish to acknowledge key inputs from expert reviewers: Heidrun Fritze UNFPA, Jenelle Babb UNESCO, Andrea Irvin UNICEF consultant, Gerda Binder UNICEF, Shirley Mark Prabhu UNICEF, Paba Dharshini Seneviratne UNICEF, Michela Polesana UNAIDS, Ye Yu Shwe UNAIDS, Ingrid Fitzgerald UNFPA, Federica Maurizio UNFPA, Davide DeBeni UNFPA, Catherine Breen Kamkong UNFPA, Latika Maskey Pradhan UNFPA, Nepali Sah UNFPA, Wassana Im Em UNFPA, Junjian Gaoshan UNFPA, Sabrina Khan UNFPA, Shadiya Ibrahim UNFPA, Mai Phan Thi Le UNFPA, Brian Kironde UNFPA, Zahrasadat Mirniam UNFPA, Sandeep Nanwani UNFPA, Vutha Phon UNFPA, Tej Ram Jat UNFPA, Kundur Sathyanarayana UNFPA, Jaya Jaya UNFPA, Abhiram Roy UNFPA, Yadanar UNFPA, Noor Murad UNFPA, Bulganchimeg Bayasgalant UNFPA, Sarah Soysa UNFPA, and Jayamalar Samuel UNFPA.

Quotes from young people included in the report were sourced from the sexuality education online youth survey, focus group discussions supported by IPPF, UNFPA and UNESCO and focus group discussions for the UNICEF 2019 publication "Formative assessment on the needs of adolescents and youth at risk of HIV".

ABBREVIATIONS AND ACRONYMS

AFHS	Adolescent-friendly health service
AIDS	Acquired immunodeficiency syndrome
CSE	Comprehensive sexuality education
DHS	Demographic and Health Survey
DPR of Korea	Democratic People's Republic of Korea
Micronesia	Federated States of Micronesia
GBD	Global Burden of Disease
HIV	Human Immunodeficiency virus
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
Lao PDR	Lao People's Democratic Republic
MICS	Multiple Indicator Cluster Survey
NEET	Not in education, employment or training
PrEP	Pre-exposure prophylaxis for HIV
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SOGI/E	Sexual orientation and gender identity / expression
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA APRO	United Nations Population Fund, Asia Pacific Regional Office
UNICEF	United Nations Children's Fund
UNPD	United Nations Population Division, Department of Economic and Social Affairs, United Nations Secretariat
WHO	World Health Organization

GLOSSARY

Adolescence, youth and young people	A developmental stage of transition from childhood to adulthood: puberty heralds its onset, with social role transition (completion of education/employment/ independent living/marriage/child rearing) signalling adulthood. **"Adolescence"** has historically been defined as coinciding with the ages 10-19 years, with **"Youth"** referring to 15-24 years. **"Young people"** (or adolescents and youth) corresponds to 10-24 years. This period is often divided into early adolescence (10-14 years), late adolescence (15-19 years) and early adulthood (20-24 years).
Early union	An inclusive term that includes child marriage and co-habituation with intimate partner under the age of 18 years.
Traditional child marriage or arranged child marriage	Child marriage which is typically arranged or forced. May be associated with dowry or bride price and with large age disparities between spouses.
Circumstantial child marriage	This is child marriage in response to unintended pregnancy outside of marriage, perceived sexual activity or sexual violence. These marriages can either be arranged or decided by couples themselves.
Love marriage/ peer-led early union	This is child marriage or early union that is consensual and usually with a peer (however some seemingly consensual unions may have an element of coercion). More common in Southeast Asia and Pacific and increasing in some South Asian countries.
Sexual Orientation and Gender Identity/ Expression (SOGI/E)	Sexual Orientation and Gender Identity/ Expression is a term that is inclusive of a broad range of sexual and gender identities, including Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI+).
Cisgender	Cisgender refers to people whose gender identity and expression matches the biological sex they were assigned when they were born. Cisgender bias refers to the effects of making assumptions that a person's gender is the same as the sex they were assigned at birth.

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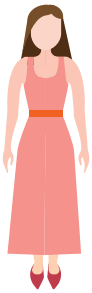
A **snapshot** of young people's sexual and reproductive health in Asia and the Pacific

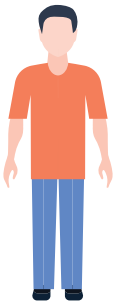
1. There are almost **one billion young people aged 10-24 years** living in 32 low- and middle-income countries in Asia and the Pacific, accounting for **60% of the world's young people**.

2. Across the region, **child marriage and early union** is common. Around **1 in 8 girls** (19 million) and **1 in 50 boys** (4 million) aged 15-19 years are currently married or in union.



1 in 8 girls
19 MILLION

1 in 50 boys
4 MILLION

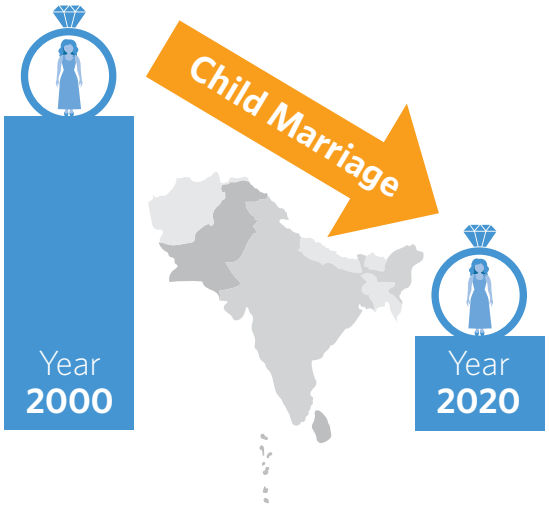


Almost **27 million young women aged 20-24 years were married by the age of 18**.

3. Across the region, **40 million adolescents aged 15-19 years have ever had sex.**
In the Pacific, 22% of unmarried girls and 41% of unmarried boys have had sex.

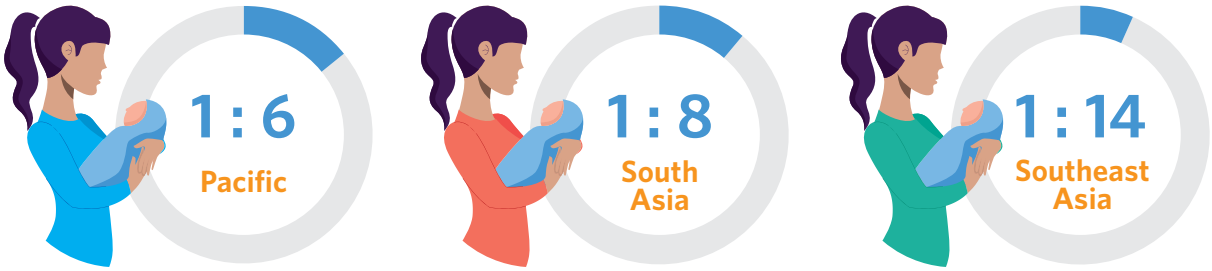
In the majority of countries, **less than half of 15-24 year olds with multiple sexual partners used a condom at last sex,** signifying substantial sexual health risk for both boys and girls.

4. Over the last **two decades the prevalence of child marriage has halved** in South Asia, where there has been a focus on addressing traditional forms of arranged child marriage, but there has been little change in settings where less formal (cohabiting and peer-led) unions are common.



5. There were an estimated **3.7 million births** to 15 -19-year-old girls in the Asia-Pacific region in 2019.

One in six young women in the Pacific, 1 in 8 in South Asia, and 1 in 14 in Southeast Asia have commenced childbearing by the age of 18.



Maternal disorders are the leading cause of death of girls aged 15-19 years in the Pacific, and the second leading cause of death in South Asia.

6. Where adolescent childbearing has occurred largely in context of traditional child marriage (South Asia) adolescent fertility has fallen by around 60% in the last two decades. **However, adolescent fertility in some South Asian countries remains very high,** in the context of low decision-making autonomy of girls with respect to sexual reproductive health, and low use of effective contraception.

In Southeast Asia, some Pacific countries, and Mongolia, adolescent fertility has increased since 2000.

In these settings up to a third of adolescent pregnancies are conceived before marriage, many are unintended, and occur in the context of high unmet need for modern contraception among unmarried sexually active adolescents.

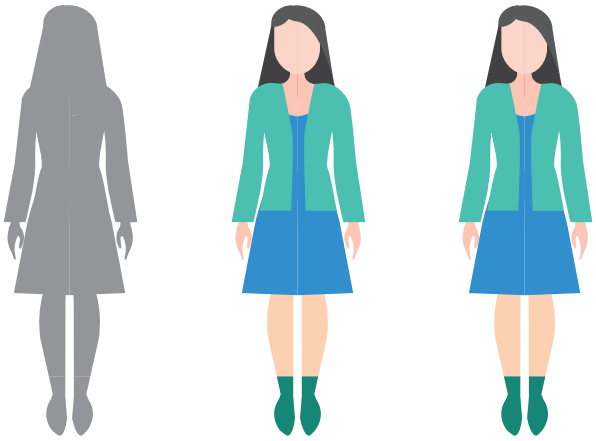
A **snapshot** of young people's sexual and reproductive health in Asia and the Pacific

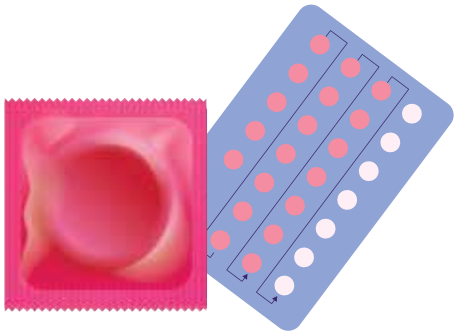
7. Around 1 in 8 births to adolescent girls aged 15-19 years are unintended.

There are an estimated **3.6 million unsafe abortions each year** among women aged 15-24 years.

8. One in three women (34 million) aged 15-24

do not have their demand for family planning satisfied by modern methods.



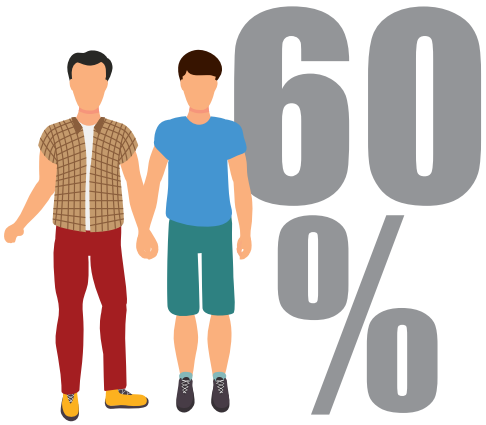


Less than 1 in 4 sexually active unmarried adolescents are using a modern method of contraception.

9. In 2019, 420,000 young people aged 15-24 years were living with HIV, 60% of whom were adolescent boys and young men aged 15-24.

There were an estimated 82,000 new HIV infections among this age group in 2019, accounting for more than a quarter of all new HIV infections in the region. The majority of new HIV infections among young people occurred among young key populations.*

The fastest growing HIV epidemics in the region are among young men who have sex with men. At least 13 countries have laws that impose the need for parental consent for adolescents and young people below 18 years to access HIV testing.



* Young men who have sex with men, young transgender people, young people injecting drugs and young people selling sex.

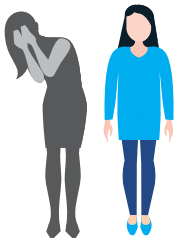
10. Young people with diverse sexual orientation or gender identity/expression continue to face enormous stigma and discrimination, contributing to a high burden of violence and poor SRH.

15 countries
criminalize consensual same-sex sexual activity between men

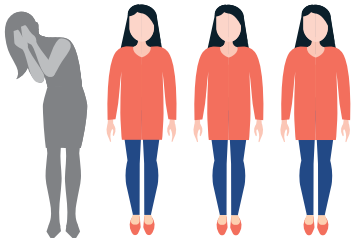
10 countries
do so between women

11. One in two 15-24-year-old women in the Pacific, **1 in 4** in South Asia, and **1 in 6** in Southeast Asia have experienced physical and/or sexual intimate partner violence.

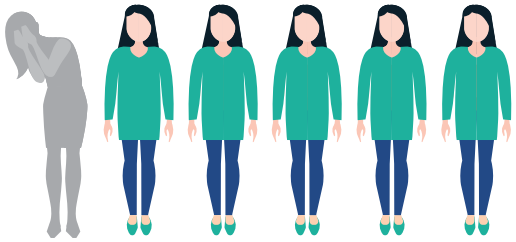
Pacific



South Asia



Southeast Asia



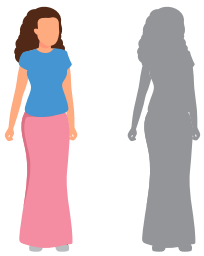
12. Less than a third of 15-24 year olds have comprehensive knowledge of HIV, and

less than 35% of young people report having received SRH information at school.

No country in the region currently provides a comprehensive sexuality education school curriculum that meets international standards.

13. More than **1 in 2** adolescent girls report at least one serious problem accessing health care.

In the majority of countries, fewer than **20%** of adolescents are covered by any health insurance. While there has been progress in defining standards of adolescent-responsive health services, considerable barriers remain and adolescents are often the missing population in universal health coverage.



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OVERVIEW

BACKGROUND

Today's generation of young people is the largest in human history: globally, 1.8 billion people are aged between 10-24 years, accounting for a quarter of the world's population. The overwhelming majority of young people live in low and middle-income countries, and 60% live in Asia and the Pacific.[1]

Adolescence (box 1) is a formative life phase, characterised by substantial physical, emotional, cognitive and social growth and development, during which foundations for health and wellbeing in later life, and for the next generation, are established. This critical transition has significant implications for sexual and reproductive health (SRH).[2] Not only do the physical and hormonal changes of puberty lead to sexual maturity and the physical capacity to have sex and reproduce, but adolescence is also a period of intense social and emotional development during which sexuality, sexual identity, and gender norms, roles and identities are crystalised.[3] It is during this time that many young people first form romantic relationships and commence sexual activity, and when many enter marriage and parenthood.

For these reasons, adolescence brings a heightened need for comprehensive sexuality education, accessible and high quality services, and an enabling policy, legislative and community environment to support a healthy transition into adulthood. Investment in SRH during this life stage brings a triple dividend of benefits, presenting a unique window in which to address norms, behaviours and risks that are not only important for the health and development of young people, but also for SRH across the life course, and for the health of the next generation.[3] Enabling young people to achieve the highest attainable standard of SRH is also a fundamental human right, reflected in international and regional agreements and commitments, and also the focus of several targets of the Sustainable Development Goals (SDGs).[4-6]

Despite these imperatives, young people globally experience a disproportionate burden of poor SRH including high rates of early and unintended pregnancy, sexually transmitted infections (STIs), including HIV, and violence.[7] Two thirds of young people in Asia and the Pacific live in countries where adolescents face a large and complex burden of disease, including a high burden and mortality from poor SRH.[7]

Substantial intersecting barriers limit young people's access to essential information and services, and contribute to SRH risks and harmful practices. These include sociocultural, legislative, regulatory and policy barriers, as well as rigid gender norms impacting on girls, boys and young people with diverse gender identities and expression.[8] Excess SRH risk and poor outcomes have significant implications not only for health, but considerable consequences for education, poverty reduction, and gender equality, for this and future generations.

BOX 1. DEFINITIONS

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

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

"**Young people**" (or adolescents and young adults) corresponds to 10-24 years and is increasingly used to define adolescence as it more reliably captures the social and developmental transitions, including risk factors for poor health. This period is often divided into early adolescence (10-14 years), late adolescence (15-19 years) and early adulthood (20-24 years).

APPROACH AND METHODS

PURPOSE

The purpose of the review was to describe the current status of young people's SRH and rights, and examine key SRH priorities in Asia and the Pacific to support informed policy, programming and advocacy.

OBJECTIVES

The review had two main objectives:

- Describe the current SRH risks, outcomes, and coverage of key interventions for young people aged 10-24 years in low-and middle-income countries in the Asia and Pacific region.
- Review the current evidence, policy and programme approaches related to key SRH priorities in the region: child marriage and early union; adolescent pregnancy; young people with diverse sexual orientation and gender identity; SRH in a digital age; comprehensive sexuality education; and universal health coverage for adolescent SRH.

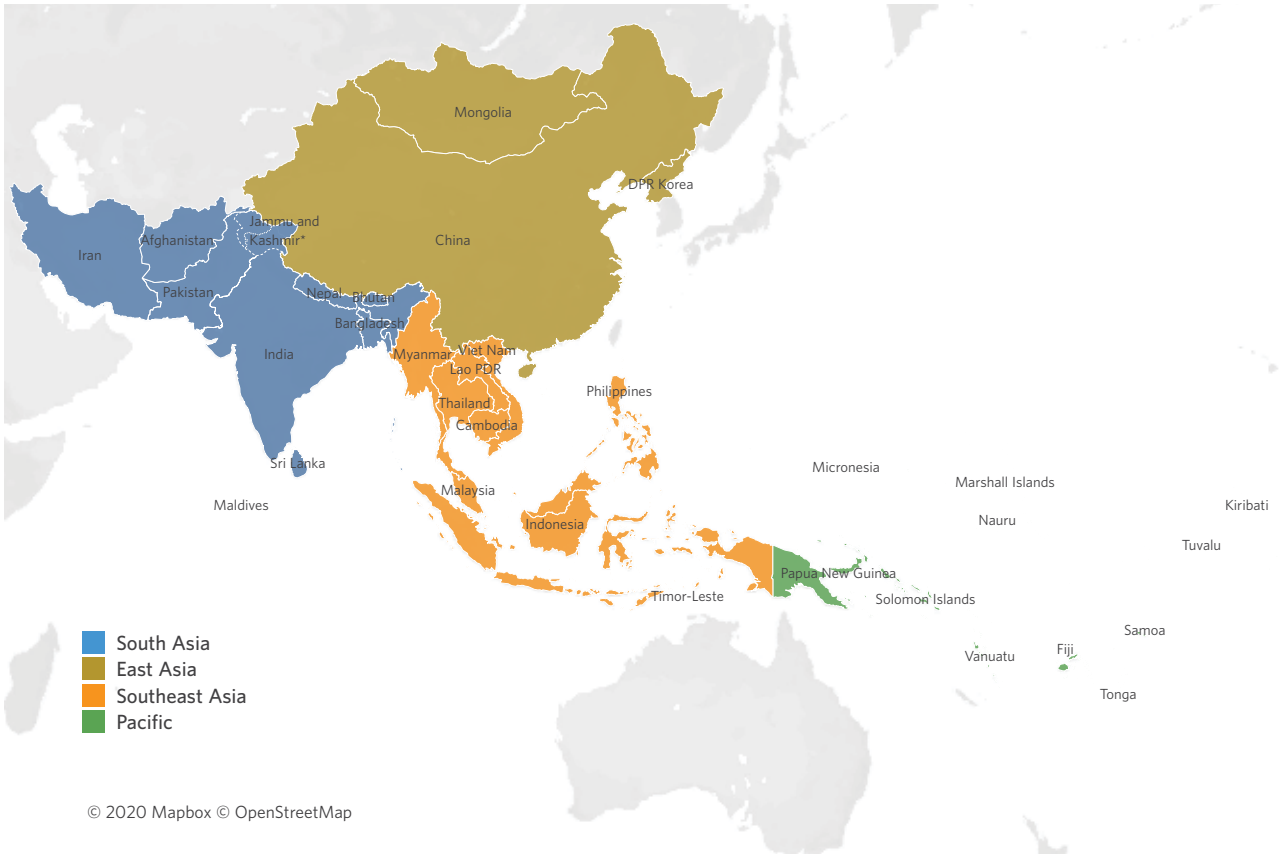
METHODS

1. Review and analysis of national-level data to describe SRH risks, outcomes and determinants

Fifty-nine indicators relevant to young people's SRH and rights in this region were identified following a review of global and regional SRH and indicator frameworks (including the global indicator framework for the SDGs,[9] UNFPA State of the World Population,[10] ICPD Beyond 2014 Monitoring Framework,[9] and WHO reproductive health indicators[11]), and commonly used measures in Demographic and Health Surveys (DHS) and UNICEF Multiple Indicator Cluster Surveys (MICS) that relate to SRH. Key domains related to socio-demographic characteristics, marriage, sexual behaviour, fertility, STIs and HIV, and gender-based violence. Indicator definitions were harmonised with existing global and regional indicators, and modified based on data availability to maximise coverage across countries in the region. The list of indicators was finalised in consultation with UNFPA Asia Pacific Regional Office (UNFPA APRO).

Nationally-representative and comparable data were sought from Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and other reproductive health surveys for each included country. The data sets were pre COVID-19, and therefore data in the report provides a baseline to the expected changes in SRH indicators during COVID-19. Data were also sought from UN agency databases and reports (AIDS Data Hub, International Labor Organisation, Population Reference Bureau, UN Data, UNESCO, UNFPA State of World Population, UNICEF State of the World's Children, World Bank Indicators, World Health Statistics). Where no household or population survey data were available, modelled estimates were sought from the Global Burden of Disease study. Main data sources are summarised in tables 1A and 1B. Where available, data disaggregated by age, marital status, sex, location, education and wealth were also included. Data were analysed using STATA MP 14.2 and visualised using Tableau Desktop 2019.1.7. UNFPA countries were grouped according to the UN Population Division sub-regions (figure 1) and population-weighted sub-regional estimates calculated for selected indicators. The maps within this report are for illustrative purposes only and do not reflect a position by UNFPA or other collaborative organisations on the legal status of any country or territory or the delimitation of any frontiers. For most indicators, data were only available for males and females, with very limited national-level data available for young people with non-cisgender/non-binary identity. Country-level estimates for all indicators are included in appendix.

FIGURE 1. LOW- AND MIDDLE-INCOME COUNTRIES IN ASIA AND THE PACIFIC, BY SUB-REGION



Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

TABLE 1 A. SUMMARY OF MAIN DATA SOURCES BY COUNTRY

Region	Country	Primary data source	Year
South Asia	Afghanistan	DHS	2015
	Bangladesh	DHS	2014
	Bhutan	MICS	2010
	India	DHS	2015
	Iran	MIDHS	2010
	Maldives	DHS	2016
	Nepal	DHS	2016
	Pakistan	DHS	2017
	Sri Lanka	DHS	2016
East Asia	China	NFS	2017
	Mongolia	MICS	2018
	DPR Korea	MICS	2017

TABLE 1 A. SUMMARY OF MAIN DATA SOURCES BY COUNTRY (Continued)

Region	Country	Primary data source	Year
South East Asia	Cambodia	DHS	2014
	Indonesia	DHS	2017
	Lao PDR	LSIS II	2017
	Malaysia	MPFS	2014
	Myanmar	DHS	2016
	The Philippines	DHS	2017
	Thailand	MICS	2015
	Timor-Leste	DHS	2016
	Viet Nam	MICS	2014
Pacific	Fiji	Census	2007
	Kiribati	DHS	2009
	Marshall Islands	DHS	2007
	Micronesia	-	-
	Nauru	DHS	2007
	Papua New Guinea	DHS	2016
	Samoa	DHS	2014
	Solomon Islands	DHS	2015
	Tonga	DHS	2012
	Tuvalu	DHS	2007
	Vanuatu	DHS	2013

TABLE 1 B. SUMMARY OF MAIN DATA SOURCES FOR SELECT INDICATORS

Other indicators	Source	Year
Currently married	UNPD	2019
Adolescent fertility rate	UNPD	2000-2020
Maternal mortality	GBD	2017
Demand for family planning satisfied (all women)	GBD	2017
HIV	UNAIDS	2017-2018
Sexual violence	GBD	2017
Population	UNPD	2019
Urbanisation	UNPD	2018
Poverty	World Bank	2006-2017
Educational attainment	GBD	2017
Out-of-school	UNESCO	2014-2018
Employment	ILO	2010-2018

2. Targeted reviews of peer-reviewed and grey literature

Policy and programmatic priority areas were identified in consultation with UNFPA APRO for more in-depth focus: child marriage and early union; adolescent pregnancy; young people with diverse sexual orientation and gender identity; SRH in a digital age; comprehensive sexuality education; and universal health coverage for adolescent SRH. The purpose of these targeted reviews was to synthesise evidence, policies and programmatic experiences in the region.

Empirical studies published between January 2015 and September 2019 were sought from PubMed, Cochrane Library, Scopus, CINAHL and PsychInfo. Search terms were informed by the UNFPA Strategy on Adolescents and Youth 2013 (box 2). Unpublished or non-indexed reports were sought through general internet searches using Google Scholar and targeted searches of regional UN agency, government and non-government websites with the same terms as above. Policy documents were sought from government websites, UN agencies (including the HIV and Health Clearing House), the Secretariat of the Pacific Community and Youthpolicy.org.

Studies and reports that primarily focused on (or included age-disaggregated data for) young people aged 10-24 years in Asia and/or the Pacific or one of 32 included countries were included. Studies focusing on high-income countries were excluded. Titles and abstracts were screened for eligibility. Data from relevant full text articles or reports were extracted to identify major topic area, type of study, countries included, target population, setting and findings. Findings were organised thematically to synthesise: existing status of SRH-related knowledge, behaviours, outcomes and determinants; policy and programmatic approaches; evidence of effectiveness; and knowledge gaps.

Qualitative quotes from young people were provided by UNFPA and UNICEF.

Limitations

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

BOX 2. SEARCH TERMS

Search terms

Youth OR adolescent* OR teen* OR young adult

AND

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

AND

Sexual health OR Reproductive health OR Sexual behaviour OR Condom OR Marriage OR Union OR Family planning OR Contracept* OR Pregnan* OR Abortion OR Sexually transmitted infection OR STI OR Sexually transmitted disease OR STD OR Sexual activity OR Safe sex OR Puberty OR Sexual violence OR Rape OR Gender-based violence OR Intimate partner violence OR Dating violence OR HIV OR HIV/AIDS OR HPV OR Young key population OR Sexual orientation OR Gender identity OR Gay Or Lesbian OR Same sex OR Bisexual OR Transgender OR Intersex OR Men who have sex with men OR Queer OR Internet OR Online OR Web OR Social media OR Social network*OR Cyber OR Digital OR Cell phone OR Mobile phone OR Mobile app* OR Smart phone OR mHealth OR text*OR SMS OR Computer OR Email OR Blog OR Sext* OR Pornography OR Sex education OR Sexuality education OR Life skills Health service OR Clinic OR Health centre OR Health service access OR Youth-friendly OR Health delivery OR Health financ* OR Adolescent friendly OR School-based health services OR School clinic OR Traditional healer OR Pharmacy OR Youth centre OR Peer counselling OR Health insurance OR Universal health coverage.

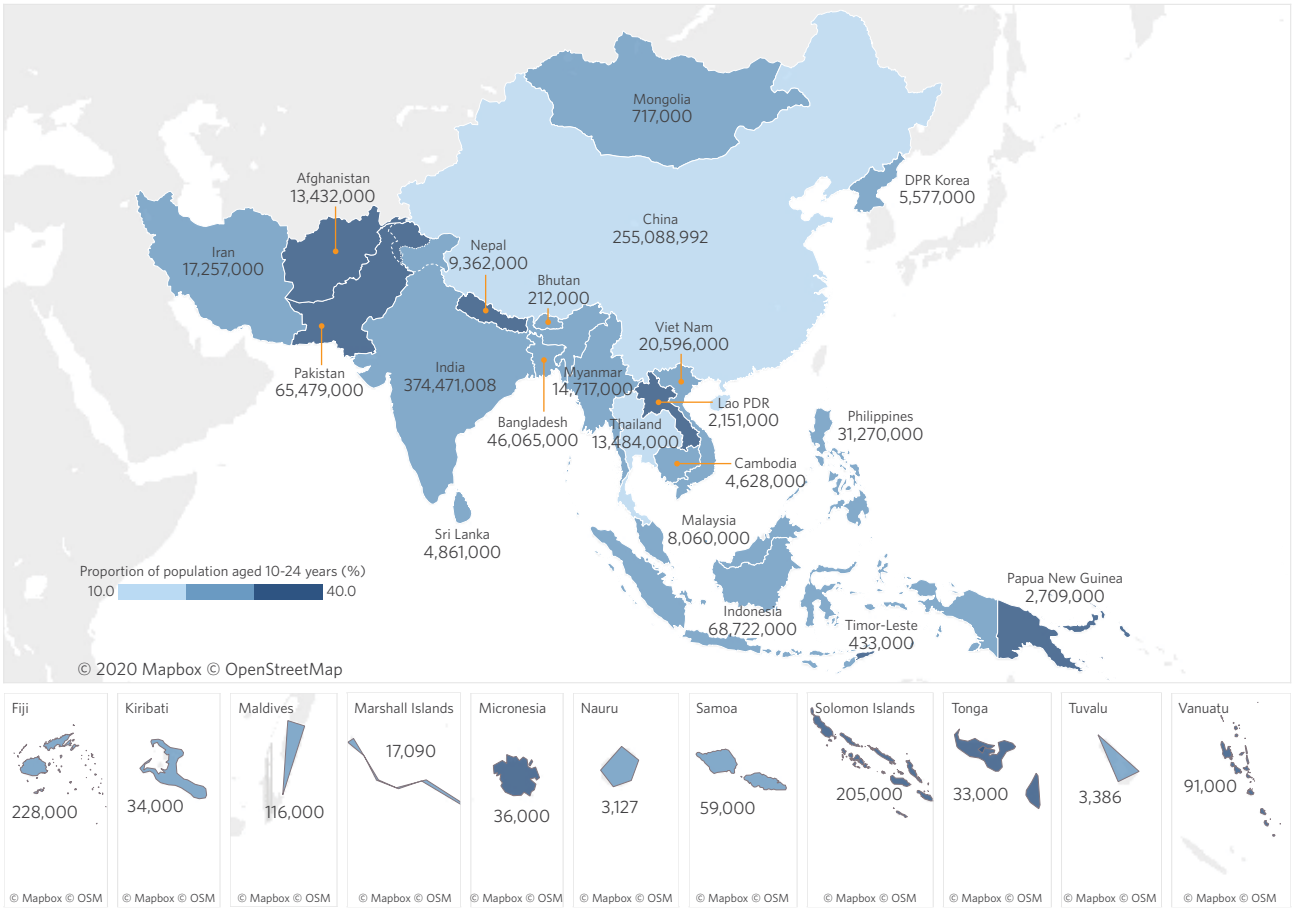
INTRODUCTION TO ASIA AND THE PACIFIC

There are almost one billion young people aged 10-24 years living in low- and middle-income countries in Asia and the Pacific (figure 2), representing 23.7% of people in the Asia Pacific and accounting for 60% of the world's adolescents and young adults. In countries characterised by high but declining total fertility rates and significant gains in child mortality, such as Afghanistan, Pakistan, Nepal, Lao People's Democratic Republic (Lao PDR), Timor-Leste, Papua New Guinea, Federated States of Micronesia (Micronesia), Solomon Islands, Tonga, and Vanuatu, young people make up almost a third of the population.

In Asia and the Pacific, almost
1 in 4 people
are aged between
10-24 years.

FIGURE 2. TOTAL NUMBER AND PROPORTION OF POPULATION AGED 10-24 YEARS

This chart shows the number of young people aged 10-24 years and the population share (in shading). Estimates are provided in the appendix.



Source: UNPD 2019[1]

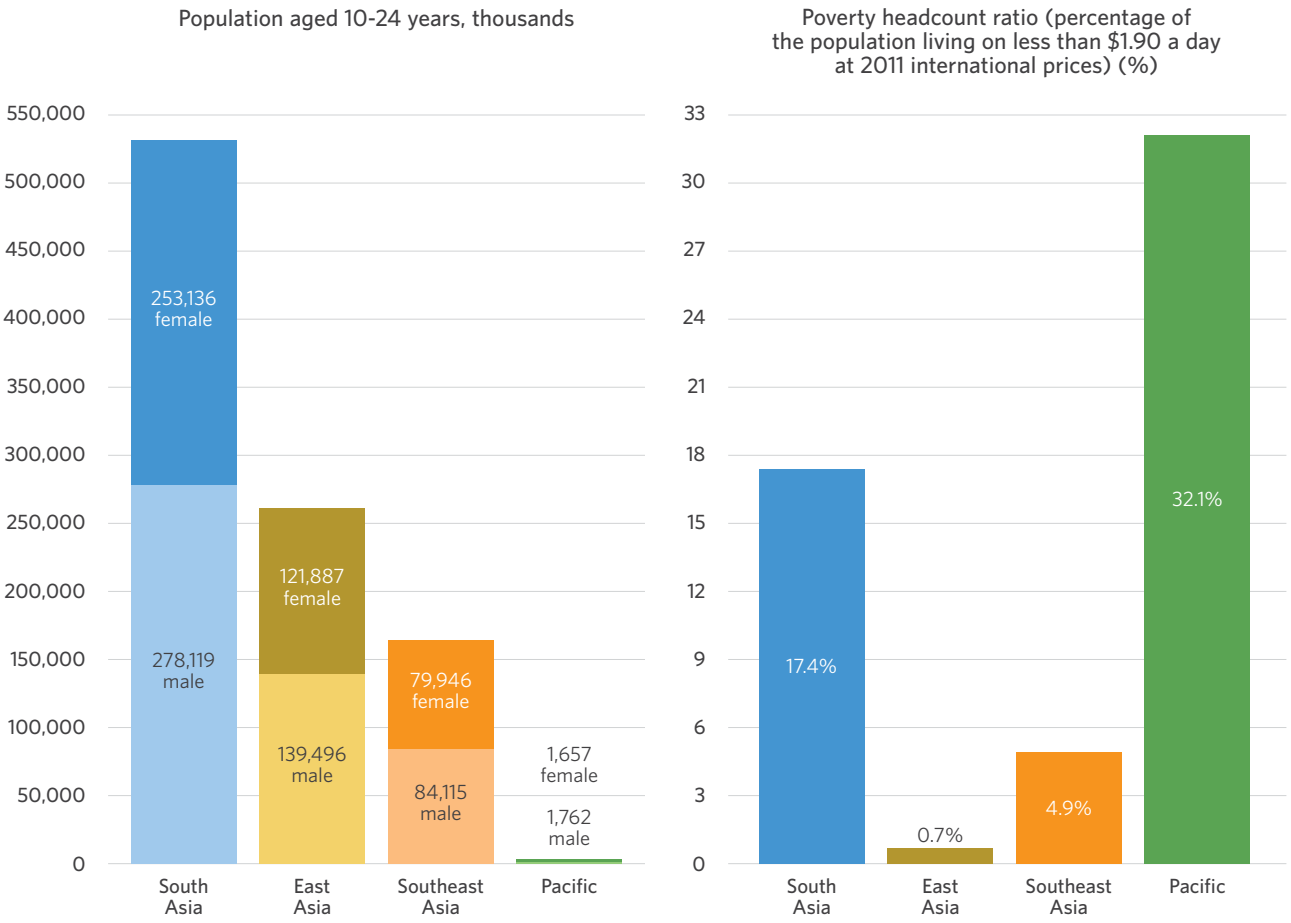
Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

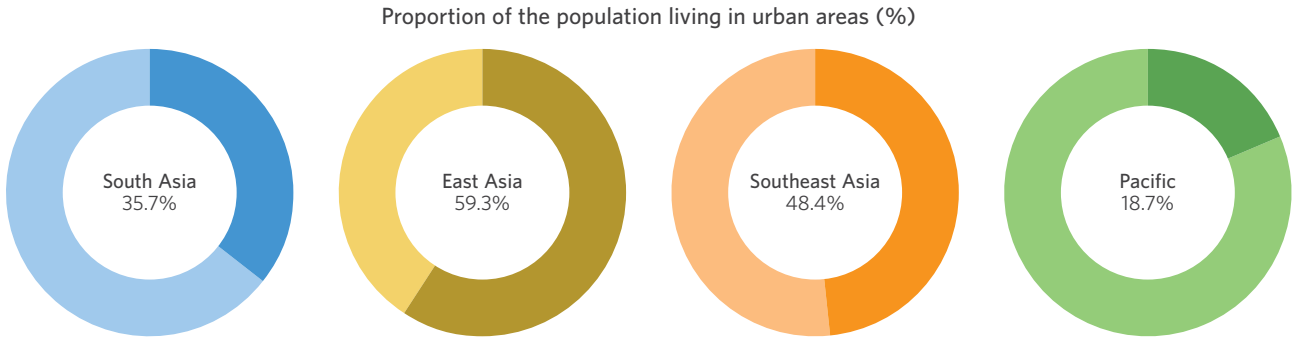

© UNFPA/Asad Zaidi

The majority of young people in South Asia, Southeast Asia and the Pacific live in rural areas (figure 3), however, increasing urbanisation means that much of the growth in the youth population will be in cities. A significant proportion of young people in the Pacific and South Asia live in poverty, with around a third of the population in the Pacific living on less than $1.90 a day (figure 3).

There has been a large amount of progress in improving universal access to education; however, significant inequities still exist in secondary education: the mean years of educational attainment is less than nine in Afghanistan, Bangladesh, Cambodia, Lao PDR, Pakistan and Papua New Guinea, compared with more than 12 years in Sri Lanka, Malaysia and China (appendix). Persistent disparities between male and female adolescents also exist (figure 4). In some countries, particularly those in South Asia, adolescent girls achieve lower rates of educational attainment than boys, and a greater proportion are out-of-school. Despite closing the gap in secondary education in many countries, girls are not transitioning to further training or employment at the same rate as boys. The proportion of girls not in education, training or employment (NEET) is higher than boys in all regions, most notably in South Asia where 50% of girls aged 15-24 years are NEET, five times higher than boys (figure 4).

FIGURE 3. ADOLESCENT AND YOUTH POPULATION BY SEX, URBANISATION, AND BY POVERTY LEVELS





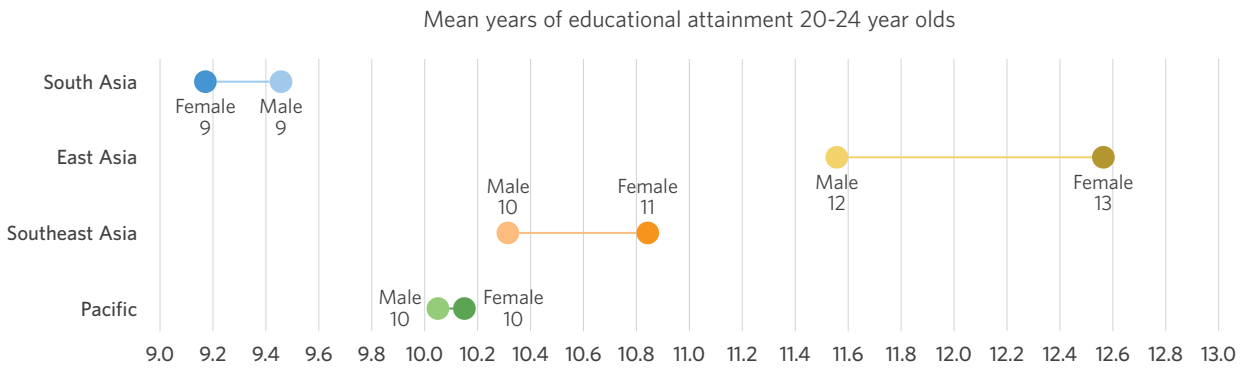
Source: UNPD[1], World Bank[290]

In Asia and the Pacific, **151 million youth are not in education, employment or further training**: 75% of those are girls. In South Asia, around 83 million girls aged 15-24 years are not in education, training or employment.

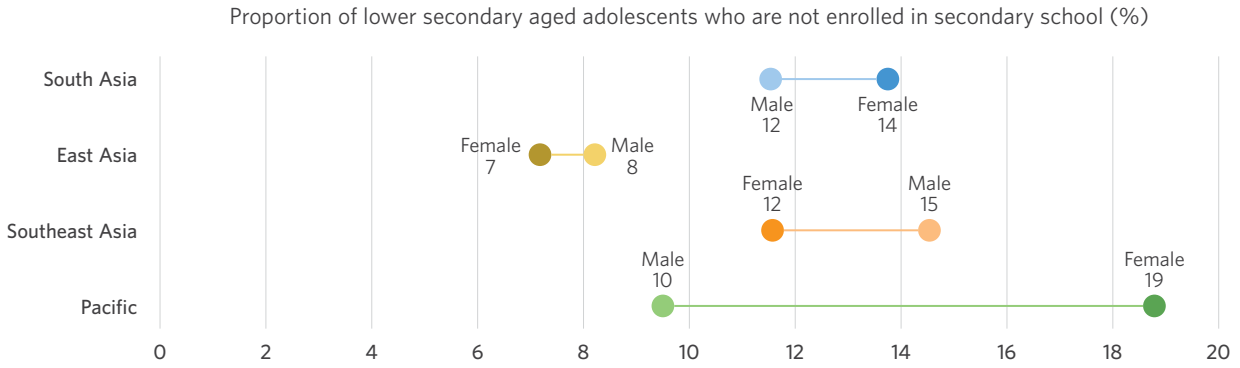
Around **25 million adolescents are not in lower secondary school**.

FIGURE 4. EDUCATION AND EMPLOYMENT

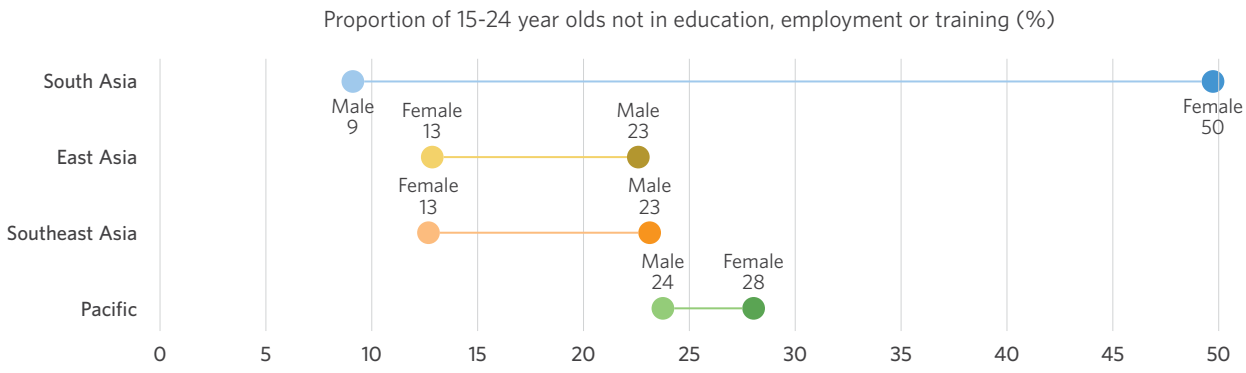
A) Educational attainment



B) Adolescents out-of-lower secondary school



C) Youth not in education, training or employment



Note: Estimate for out-of-school rate for East Asia excludes China.
Source: GBD, UNESCO, ILO.

ADOLESCENT SEXUALITY AND SEXUAL BEHAVIOUR

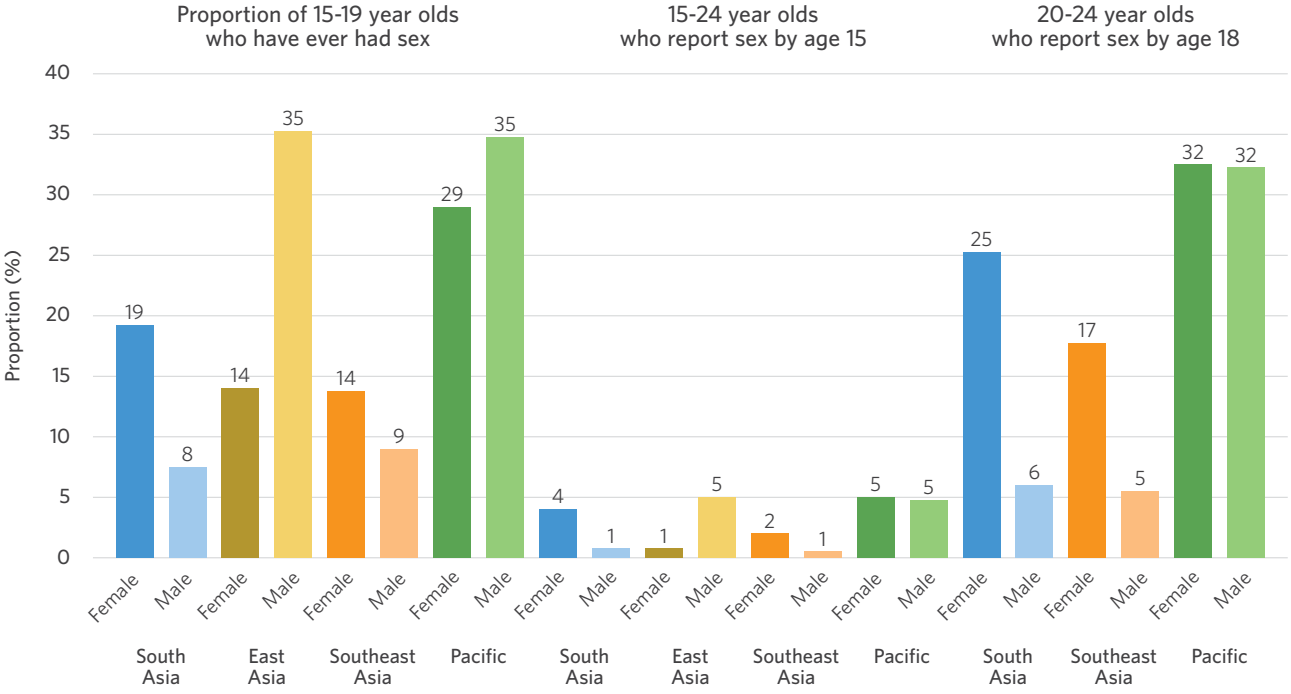
Adolescent sexuality is a normal part of human development.[3] The formation of romantic relationships, development of sexual identity, and the onset of sexual activity are common during adolescence. With access to comprehensive education, information and services, the skills to negotiate safe and consensual sex, and the freedom to make choices without discrimination, stigma and violence, young people can positively navigate this developmental stage while reducing risks of poor health outcomes.[3]

In this region, around 1 in 6 girls and 1 in 10 boys aged 15-19 years have ever had sex, and between 18-32% of girls and 5-32% of boys have had sex by the age of 18 (figure 5). For girls in particular, the onset of sexual activity has traditionally coincided with marriage, and in countries with high rates of child marriage girls are more likely to have ever had sex and to have first had sex at an earlier age than boys. However, with the rising age of marriage and young people's increasingly permissive sociocultural norms and attitudes towards sex and sexuality, an increasing number of adolescents report sex before marriage.[12-15]

40 million adolescents aged 15-19 years in Asia and the Pacific have ever had sex.

1 in 3 young people in the Pacific have had sex by the age of 18.

FIGURE 5. PROPORTION OF YOUNG PEOPLE WHO HAVE EVER HAD SEX AND HAD SEX BY AGE 15 AND 18



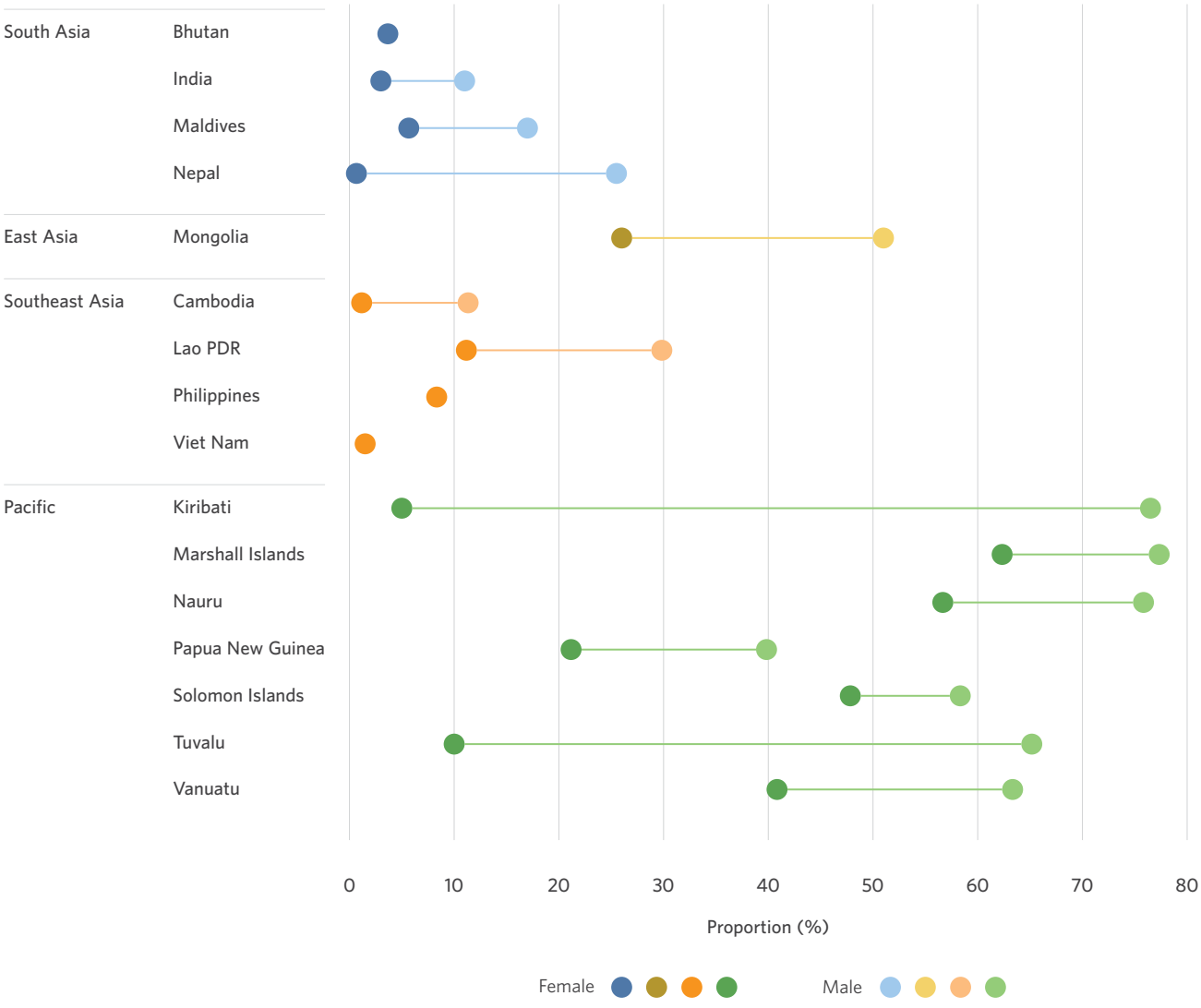
Note: East Asia estimate is for Mongolia only

Source: DHS and MICS

Despite conservative community and sociocultural attitudes towards sex before marriage, a significant number of unmarried young people in this region have had sex. Rates of premarital sex vary considerably between countries, and between boys and girls (figure 6). In all countries with data, boys are more likely to report sex before marriage, reflecting the substantial gendered disparities in norms and attitudes towards adolescent sexuality across the region. Trend data for premarital sex in this region are very limited; however, smaller studies have suggested that young people are increasingly engaging in sexual relationships before marriage, particularly in Southeast Asia, in the context of changing norms and attitudes towards gender and sexuality.[16]

In the Pacific, around **22%** of never-married girls aged **15-24 years** and **41%** of never-married boys have ever had sex.

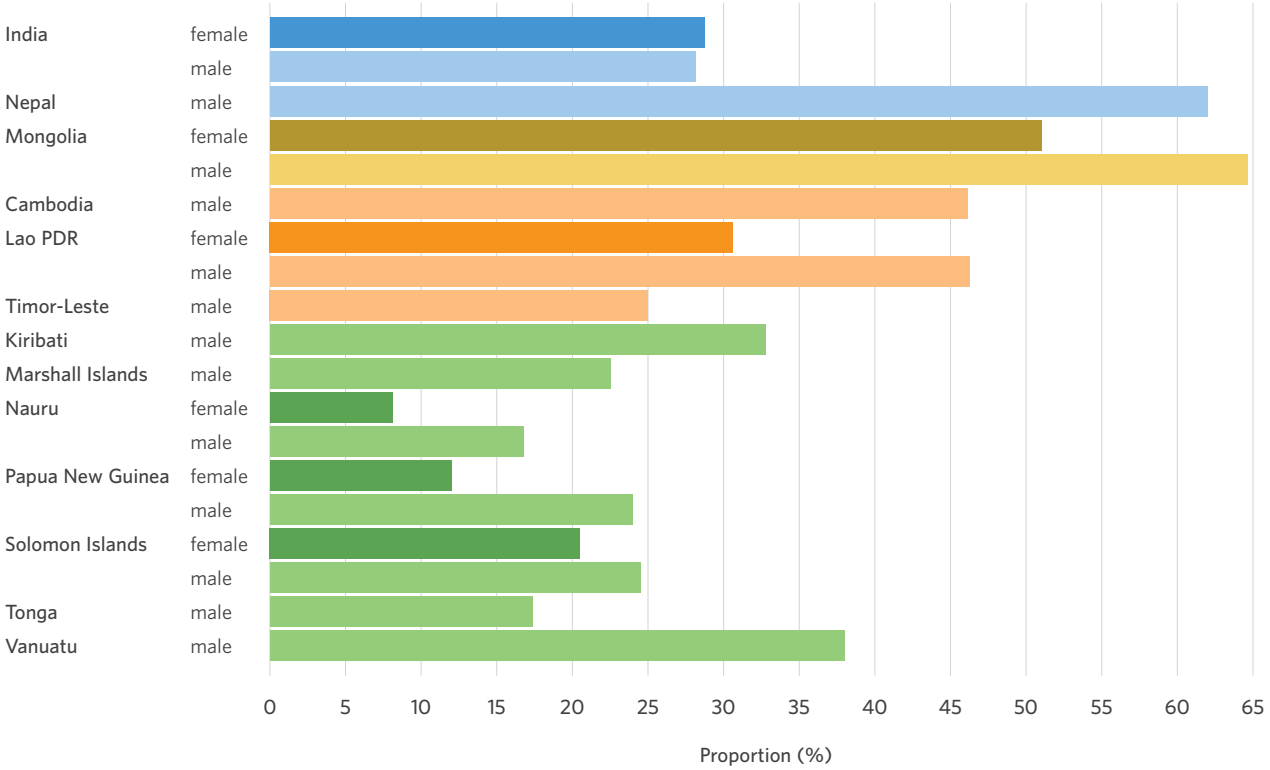
FIGURE 6. PROPORTION OF NEVER-MARRIED 15-24 YEAR OLDS WHO HAVE EVER HAD SEX



Source: DHS and MICS (country estimates provided in appendix)

Girls are more likely to report risk behaviours such as the onset of sexual activity before the age of 15 years, and sex with a partner who is 10 or more years older, most commonly in the context of traditional or arranged child marriage (appendix). However, a greater proportion of boys in this region report having ever paid for sex, and/or sex with multiple partners, particularly in the Pacific where up to half of young men who have ever had sex report two or more partners in the last 12 months (appendix). Boys are more likely to report risky sexual behaviour (more than 2 partners in 12 months); however, they are also more likely to report using a condom at last sex than girls (figure 7). Condom use is low across all countries: with the exception of Mongolia and Nepal, less than half of young people reporting multiple partners used a condom at last sex.

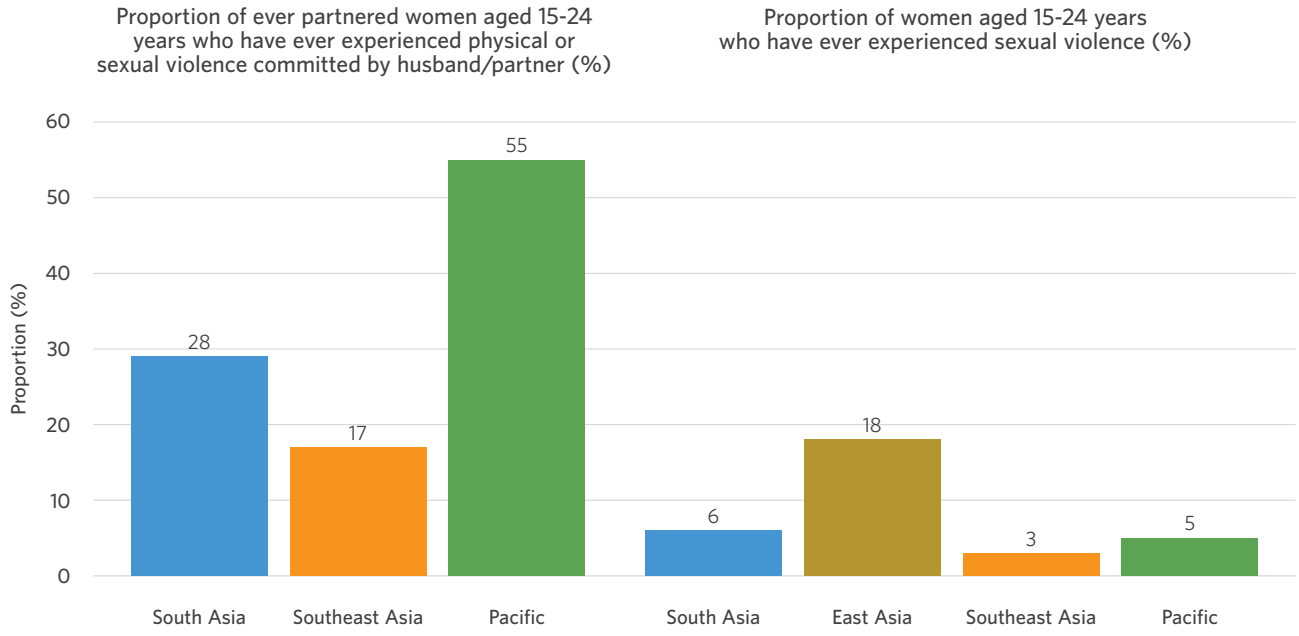
FIGURE 7. CONDOM USE AT LAST SEX AMONG 15-24 YEAR OLDS WHO REPORT TWO OR MORE PARTNERS IN THE LAST 12 MONTHS



Source: DHS and MICS (country estimates provided in appendix)

A substantial proportion of girls have experienced intimate partner or sexual violence (figure 8). More than a third of 15-24-year-old women in Afghanistan, Bangladesh, Papua New Guinea, Timor-Leste, Tonga, Tuvalu and Vanuatu who have ever been partnered have experienced physical or sexual violence from a partner, and more than 10% of adolescent and young women have experienced sexual violence in Bangladesh China, DPR Korea, Kiribati, Maldives, Marshall Islands, and Tuvalu (appendix). Smaller studies from the region indicate that young women living with a disability, young people with diverse sexual orientation and gender identity/expression, and young people who sell sex experience high rates of both intimate partner and non-partner sexual violence.[17-20]

FIGURE 8. INTIMATE PARTNER AND SEXUAL VIOLENCE



Source: DHS and MICS, GBD

Most data related to adolescent sexual activity in this region only measure vaginal intercourse, and there is very little comparable data about broader sexual behaviours of young people, including dating behaviours, oral or anal sex, and very limited data about non-heterosexual sex. Additionally, there is little information about the SRH knowledge, behaviours or outcomes among young adolescents aged 10-14 years.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CHILD MARRIAGE AND EARLY UNION

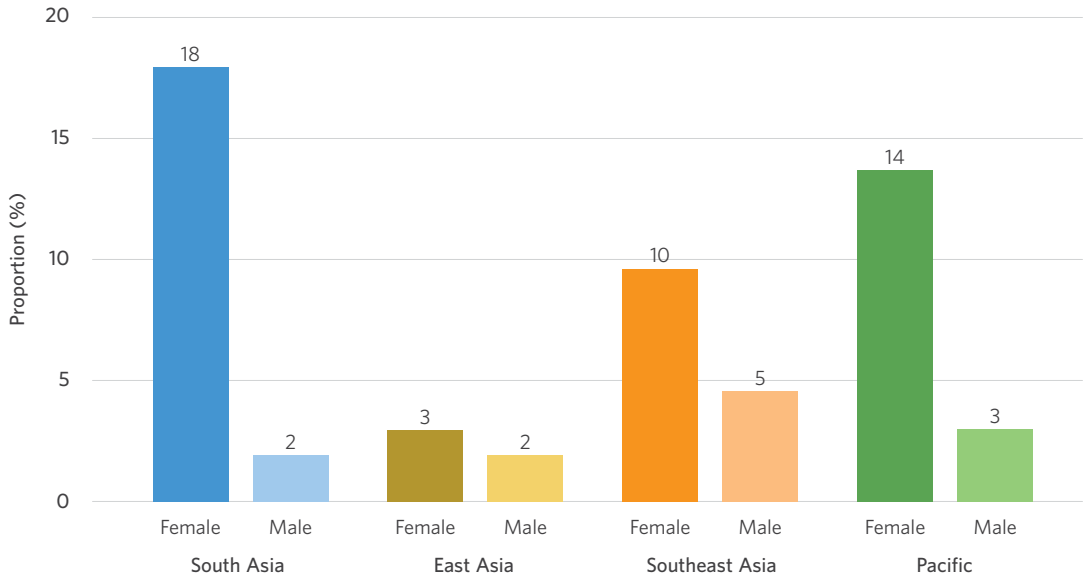
Twenty-three million adolescents aged 15-19 years are currently married or in union. Over 80% are girls, 15 million of whom live in South Asia. Across the region, 1 in 8 adolescent girls aged 15-19 years, and 1 in 50 boys, are currently married or in union (figure 9). Child marriage and early union (formal or informal, before the age of 18 years) is common throughout much of the region, with the highest prevalence in South Asia and some Pacific countries (table 2 and figure 10).

Over the last two decades, there has been a significant decline in child marriage in South Asia, particularly in India where the prevalence of marriage by age 18 has fallen by around half since 2000 (figure 11) – however it remains the country with the largest number of women and girls married by 18 due to the large population. Despite progress, rates of child marriage remain very high in South Asia, most notably in Bangladesh, Nepal and Afghanistan where the prevalence of marriage by 18 is substantially higher than the sub-regional estimate.

Almost 27 million women aged 20-24 years were married or in union by age 18 (excluding China): 23 million of whom live in South Asia

While there has been progress in reducing traditional child marriage in some South Asian countries, the prevalence of child marriage and/or early union has not declined significantly in Southeast Asia and the Pacific. In Thailand, the Philippines and Papua New Guinea, the prevalence of child marriage and/or early union has increased by more than 10% over the last two decades and rates have largely stalled in other countries. As the pattern of unions in these countries may be less formal and/or peer-led, it is likely that child marriage programmes focusing on marriage laws/policies or targeting parental attitudes towards child marriage are unlikely to be successful.[16]

FIGURE 9. PROPORTION OF ADOLESCENTS AGED 15-19 YEARS WHO ARE CURRENTLY MARRIED OR IN UNION



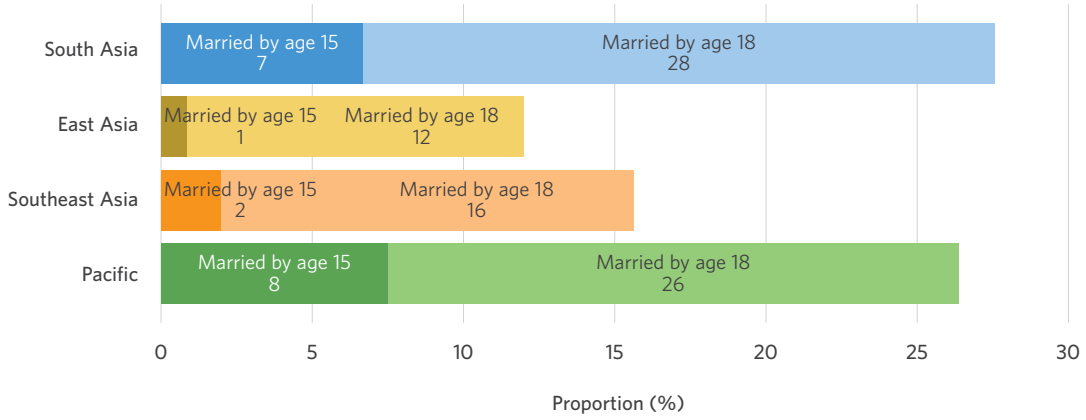
Source: DHS, MICS, UNPD[291]

TABLE 2. TOTAL NUMBER AND PROPORTION OF WOMEN AGED 20-24 YEARS WHO WERE MARRIED / IN UNION BY 18

Region	Country	Proportion (%)	Total number
South Asia	Afghanistan	35	641,712
	Bangladesh	59	4,381,522
	Bhutan	26	9,100
	India	25	14,501,707
	Iran	17	483,990
	Maldives	2	352
	Nepal	40	662,020
	Pakistan	18	1,820,667
	Sri Lanka	10	73,696
East Asia	Mongolia	12	14,040
Southeast Asia	Cambodia	19	142,080
	Indonesia	16	1,780,612
	Lao PDR	33	112,815
	Myanmar	16	380,320
	The Philippines	17	807,840
	Thailand	23	548,550
	Timor-Leste	15	9,387
	Viet Nam	11	383,020
Pacific	Kiribati	20	1,015
	Marshall Islands	26	656
	Nauru	27	127
	Papua New Guinea	27	108,381
	Samoa	11	864
	Solomon Islands	21	5,964
	Tonga	6	280
	Tuvalu	10	51
	Vanuatu	21	2,782

Source: DHS and MICS

FIGURE 10. PROPORTION OF WOMEN AGED 20-24 YEARS MARRIED/IN UNION BY AGE 15 AND 18

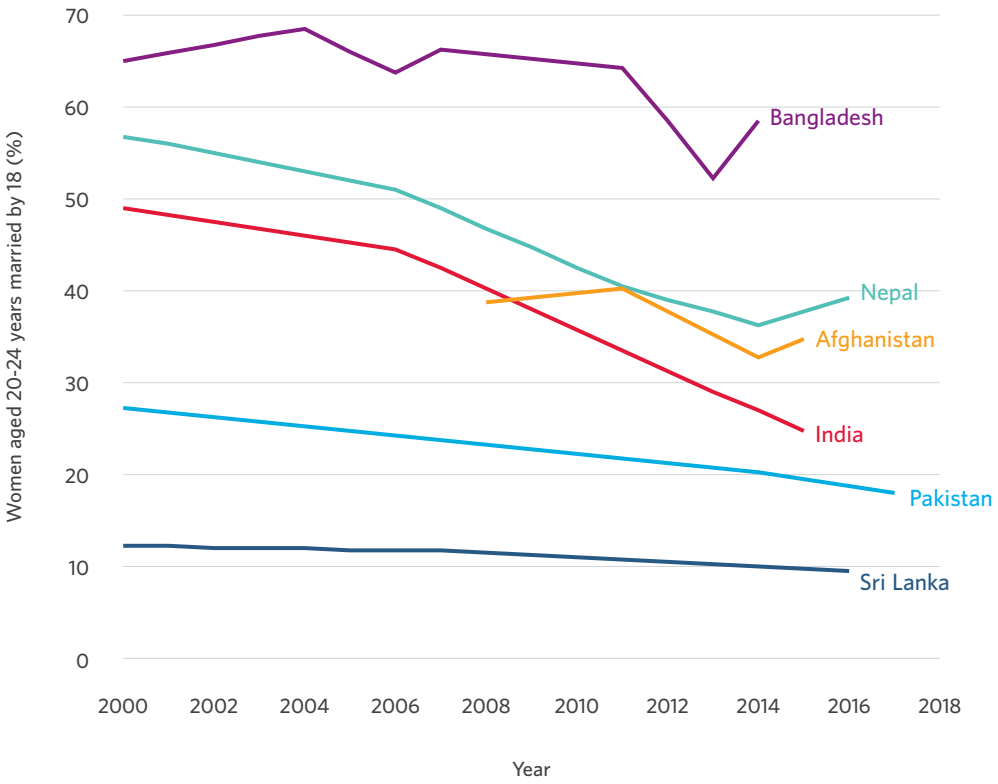


Note: East Asia estimate is for Mongolia only

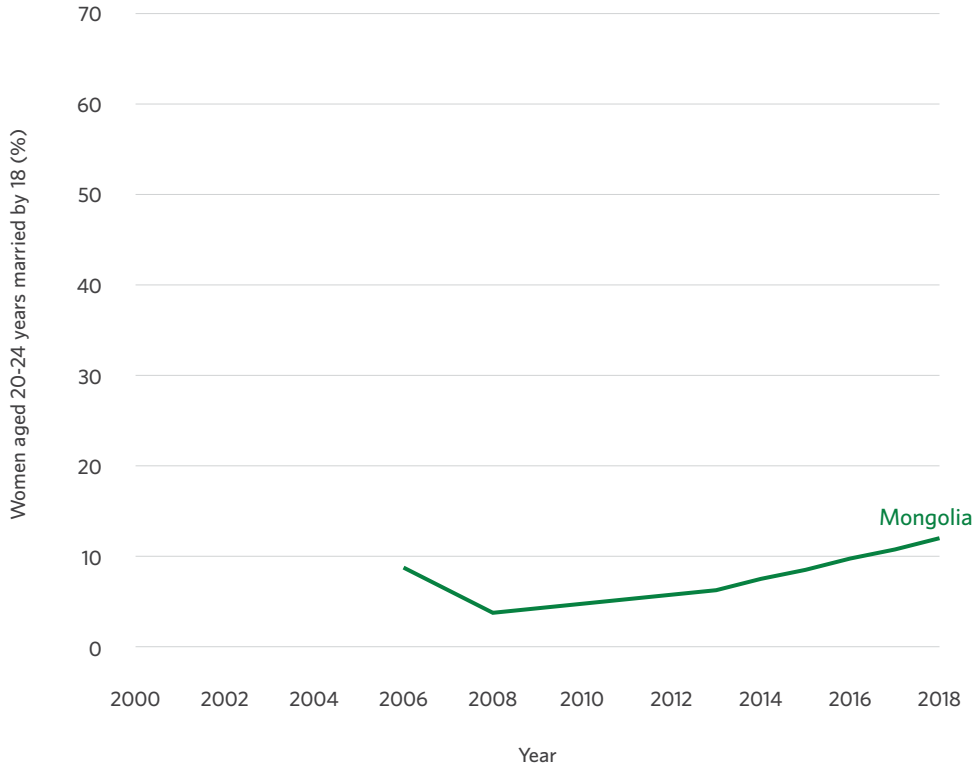
Source: DHS and MICS

FIGURE 11. PROPORTION OF WOMEN AGED 20-24 YEARS MARRIED/IN UNION BY AGE 15 AND 18, 2000 to 2018

South Asia

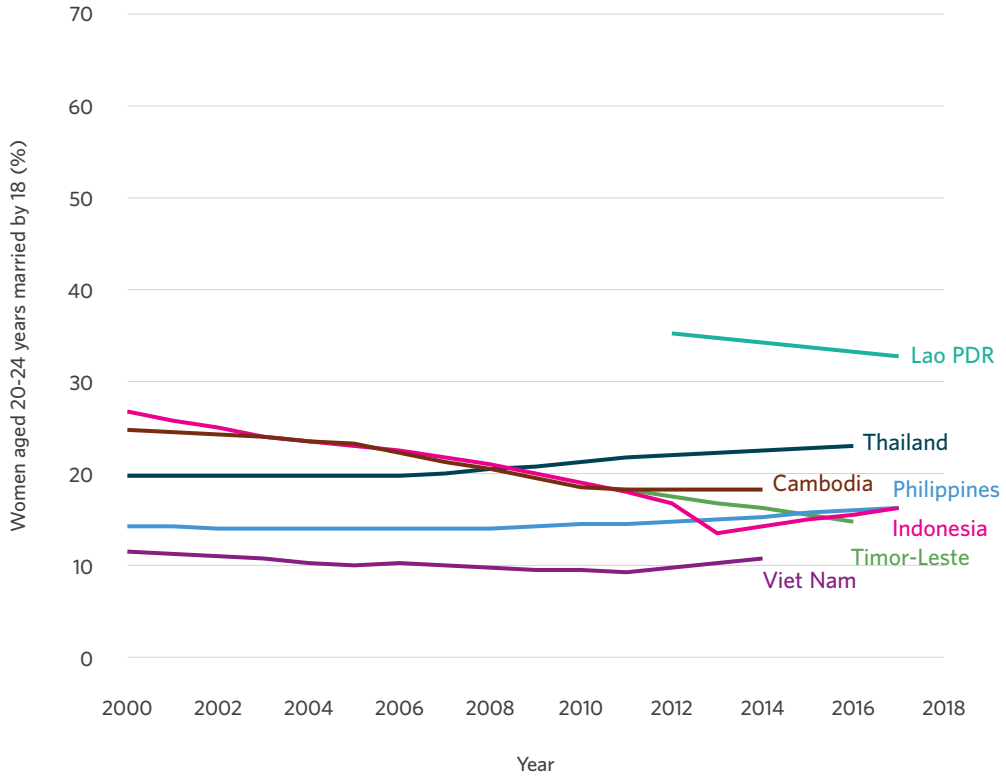


East Asia



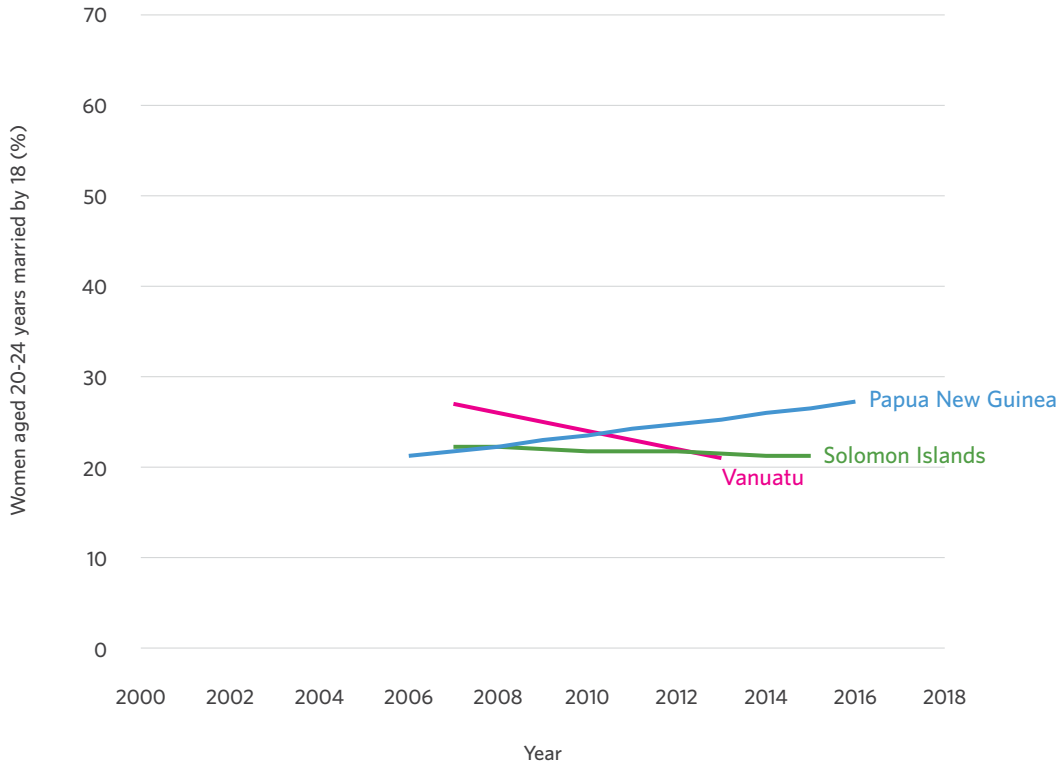
Source: DHS and MICS

Southeast Asia



Source: DHS and MICS

Pacific



Source: DHS and MICS

In all countries, girls living in rural areas, those with less education, and girls from poorer households are more likely to be married or in union. Socio-cultural and religious norms and entrenched gender inequality are critical drivers of traditional arranged child marriage.[21-24] Many of these determinants are common across the region;, however, there is growing understanding that there is considerable diversity in the context and forms of child marriage and early union.[25] While much of the policy focus has been on traditional child marriage (typically arranged or forced), there is increasing recognition that not all early unions are non-consensual or formal. A recent review conducted by UNFPA and UNICEF identified three main typologies of child marriage and early union (noting that these may overlap and exist concurrently within countries): traditional child marriage, love unions, and circumstantial child marriage (box 3).[16]

In Southeast Asia in particular, there is evidence that adolescents are increasingly entering consensual formal or less formal (cohabiting) unions with peers. In the context of changing sociocultural and gender norms, girls' increasing agency with respect to their own sexuality, and young people's increasing experience of dating and premarital sexual activity, young couples may decide to marry or cohabit (in some contexts referred to as 'informal marriage') as part of their early intimate relationships. Where community attitudes towards adolescent premarital sexual activity remain conservative, young couples may enter a more formal union or marriage as a way of legitimising a relationship and avoiding stigma.[26,27] There are also indications that 'love marriages' between young people are becoming increasingly more common in South Asia.[28] While national-level data describing the prevalence of different child marriage typologies are scarce, a recent household survey in Nepal reported that 23% of women had entered self-arranged 'love marriages'.[29]

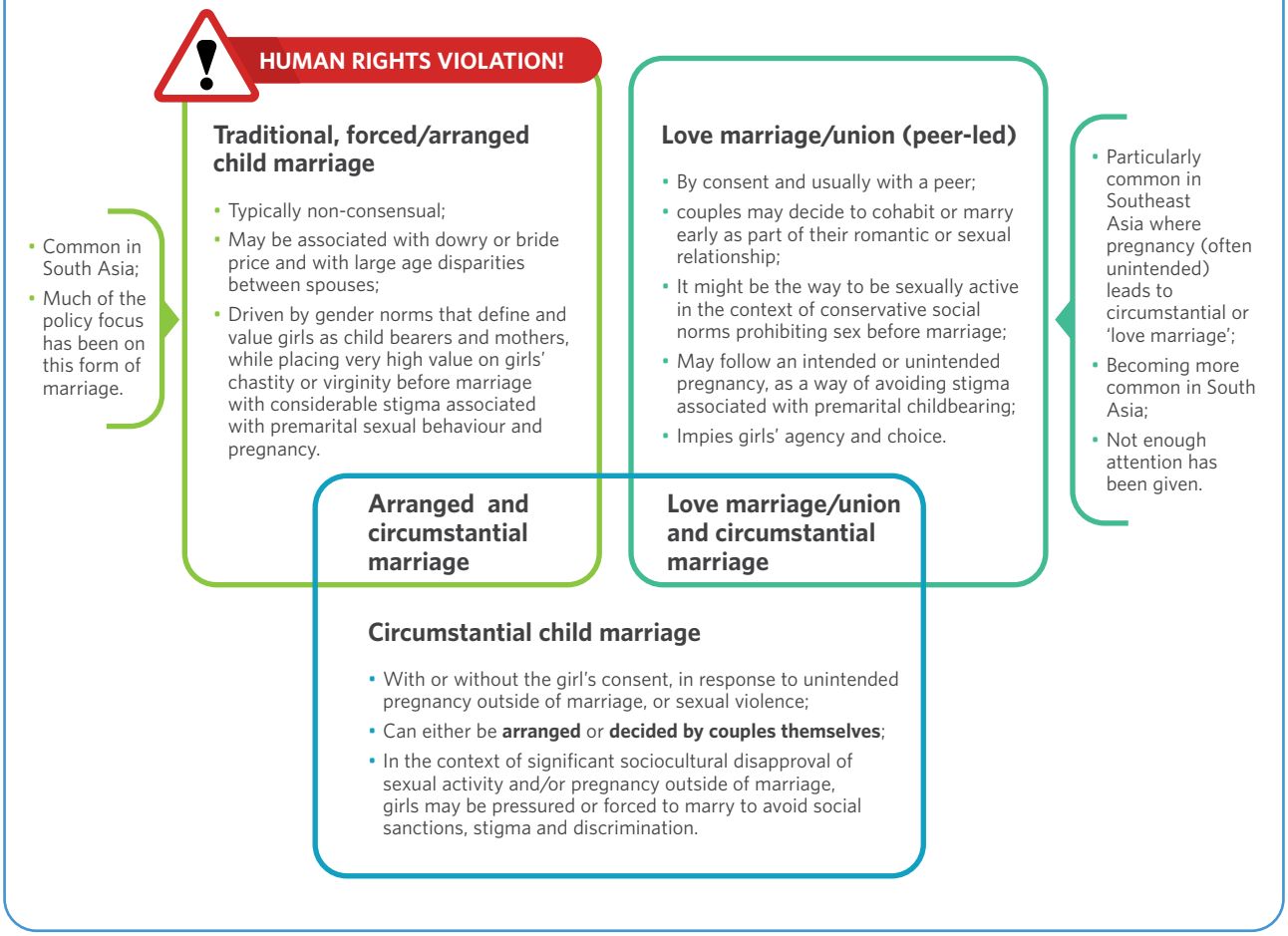
There is also evidence, particularly from Southeast Asia, that a significant proportion of adolescent pregnancies occur before marriage; particularly so in the Philippines (31%), Viet Nam and Lao PDR (23%, see Figure 26).[30] For births in girls under 18, the proportion of pregnancies that occurred before marriage is even higher, with Philippines and Vietnam 32%, Lao 24%, Indonesia 23%, Timor 20% and Cambodia 9%.[29] Pregnancy (often unintended) in these settings often leads to circumstantial child marriage or more formal 'love marriage' to avoid social sanctions associated with premarital pregnancy and/or sexual activity in conservative settings.[30]

In Southeast Asia, between **9-32%** **of adolescent births in girls under 18 were conceived prior to marriage or co-habitation.**

> **"I have talked to them, and they told me to get married when they heard that I was pregnant. Many families demand their daughters not to have sex before marriage. They can love but they cannot have sex."**
>
> (Young female student, Viet Nam)

© UNFPA/Lao PDR

BOX 3. CHILD MARRIAGE AND EARLY UNION TYPOLOGIES



Source: UNFPA/UNICEF[16]

Traditional or forced child marriage is a human rights violation, with significant health, gender and socioeconomic consequences, particularly for girls. It is associated with an increased risk of early pregnancy and gender-based violence, and is a key driver of girls' low educational attainment and diminished socioeconomic opportunities.[31,32] **Circumstantial child marriage also reflects a failure to ensure the SRH and rights of adolescents**, particularly where marriages are coerced or non-consensual. However, consensual early peer unions (informal or formal) imply agency on the part of young people. They, therefore, do not necessarily represent a breach of young people's rights in the same way as forced / non-consensual child marriage. While the specific drivers and impacts of early consensual unions are less well understood and require further research, it is clear that in the context of conservative sociocultural norms and poor access to comprehensive sexuality education and SRH services, these early unions can lead to unintended adolescent pregnancies with consequences for the health and wellbeing of girls and their children.[33-35]

Child marriage and early union overwhelmingly affect adolescent girls. However, available data indicate that around 6% of boys in East-Southeast-Asia/the Pacific and 4% in South Asia were married by 18 years, with the highest prevalence in Lao PDR (11%), Nepal (10%)† and Afghanistan (7%). While less is understood about drivers and impacts on boys compared with girls, child marriage can also lead to early fatherhood and limited education and employment opportunities for boys.[36]

† Nine percent in preliminary findings of Nepal MICS 2019

Strategies to address child marriage and associated harms

There are some shared drivers of child marriage and early union across this region, and therefore some common actions needed to address early marriage and associated poor outcomes for girls. However, greater consideration of the context-specific pathways and influences on child marriage and early union is required, recognising that not all unions are forced or arranged. Policy and programmatic responses to consensual peer unions, and circumstantial marriages, need to be different to those focused on traditional child marriage.[16,25] Effective approaches must consider girls' agency, the context of adolescents' intimate relationships, and their SRH information and service needs to enable healthy and informed decision-making. These approaches must also support girls' choices with respect to their own sexuality and relationships, while empowering them to avoid potential poor health and other outcomes associated with early union.[16] Strategies must also address the underlying sociocultural and gender norms that drive traditional forms of child marriage, as well as conservative norms that contribute to circumstantial marriage and poor SRH outcomes within early peer unions. To do so effectively, there is a need for further research in the region to better understand the context of early unions and related outcomes.

Recent studies of interventions to reduce child marriage in this region are limited, and primarily focused on South Asia in settings of a high prevalence of traditional (arranged) child marriage. Studies in Bangladesh and India have demonstrated that multi-component interventions combining comprehensive sexuality education, life-skills training, and community-based approaches (mobilisation, mass media address sociocultural norms) can improve girls' secondary school entry, participation and completion, and some have demonstrated a reduction in child marriage and early pregnancy.[37-40]

While there are knowledge gaps, it is clear that investment and coordination are required across sectors, reflecting the complex and interrelated drivers of child marriage and early union. A summary of key UNICEF and UNFPA strategies,[41] current initiatives in the region,[42] and global evidence of effective approaches, is provided in box 4.[43,44]

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BOX 4. KEY STRATEGIES TO ADDRESS CHILD MARRIAGE AND ASSOCIATED HARMS

- **Supportive legislative environment:**
  - Enact legislation that prohibits forced marriage, and remove cultural, religious and other exemptions that allow non-consensual marriage before the age of 18 for both girls and boys
  - Ensure marriage legislation and its enforcement recognises and respects the agency of young people of similar age, for adolescents aged 16 or 17 years, to consent to marriage if a competent authority determines it is in their best interest, on legitimate and exceptional grounds on a case by case basis. (CEDAW/C/GC/31-CRC/C/GC/18)
  - Ensure age of consent to sex is set at an age that recognises many young people commence sex during adolescence, so that consensual sexual activity between adolescents who are similar in age is not criminalised (CRC GC20)
- **Address the key drivers of child marriage and early union:**
  - Educate and mobilise families, communities and leaders to address harmful cultural, religious and gender norms
  - Undertake poverty reduction, and provide incentives / economic support to girls and families most at risk of child marriage
  - Increase girls' access to secondary education
  - Improve young people's access to comprehensive sexuality education
  - Improve young people's access to SRH services, including contraceptive services to prevent unintended pregnancy
  - Provide life-skills training and livelihood / employment opportunities for girls
- **Improve support for married girls:**
  - Legal and other supports for married girls seeking protection or justice
  - Improve access to SRH information and services, including to prevent early pregnancy and address gender-based violence within marriage
  - Support return to, or continuation of, education
  - Provide life-skills training and livelihood / employment opportunities

RIGHTS VERSUS PROTECTION: LEGAL AGE OF MARRIAGE, CONSENT TO SEX, AND CONSENT TO MEDICAL TREATMENT

THE LEGAL AGE OF MARRIAGE

There is near-universal political commitment to ending traditional child marriage in Asia and the Pacific, and almost all countries have enacted legislation prohibiting marriage before the age of 18 years. However, laws in seven countries (Afghanistan, Iran, Pakistan, Democratic People's Republic of Korea (DPR Korea), Timor-Leste, Nauru and Papua New Guinea) still allow the marriage of girls less than 18 years (table 3). A further six countries have exemptions (usually on religious or cultural grounds) that allow the marriage of girls before the age of 18, some as young as 12 years or younger. There are considerable differences in the legal age of marriage between girls and boys, reflecting entrenched gender norms that drive the substantial gendered disparities in rates of child marriage in this region.

Understanding the different forms of early marriage and union in the context of adolescent development and agency, is critical to ensuring the implementation of child marriage legislation does not cause harm.

Formal marriage is a potentially life-long legal contract. Traditional, often arranged, child marriage has well documented harmful impacts on adolescents' health and wellbeing and future economic prospects.[44] It generally does not reflect the free will or agency of adolescents, but is coerced or forced in the context of limited autonomy and power. It also disproportionately impacts on girls, and therefore fundamentally reflects gender inequality, girls' lower status, and entrenched discrimination. Legislation to prohibit forced marriage before the age of 18 years for both girls and boys is necessary to prevent the harms associated with traditional child marriage, and to stimulate action to address the sociocultural and gendered drivers of non-consensual early marriage.

However, not all adolescent unions are forced or coerced. There is increasing recognition, even in settings where traditional child marriage remains prevalent, that many adolescents choose to enter into consensual formal marriages or less formal romantic co-habitation relationships. These consensual unions are often between peers of a similar age and reflect agency on the part of young people with respect to their own sexuality.[16,28]

Treating all unions under the age of 18 years as forced and invalid can have harmful consequences. In settings where arranged, traditional arranged marriage is prevalent and there is strong sociocultural disapproval of sex outside of marriage, child marriage legislation may be used to punish adolescents who enter into self-arranged love marriages or unions. Rigid enforcement of legislation may also prevent adolescents in consensual formal or informal unions in other settings from accessing SRH and other services for fear of legal consequences.[16]

Unintended consequences of the law: In the majority of cases in India where the child marriage legislation is being enforced, it is being used by parents to prevent consensual adolescent relationships and marriages that they do not approve of. This has included prosecution of boys for kidnapping and rape under the Penal Code and Protection of Children for Sexual Offences Act, and forced detention of daughters (as mandated for child victims of sexual assault).

Source: Mehra 2019[46]

TABLE 3. CHILD MARRIAGE LEGISLATION IN ASIA AND THE PACIFIC

Country	Legal age of marriage girls	Legal age of marriage boys	Exemptions and exceptions
Afghanistan	16	18	15 for girls with permission from father or a judge
Bangladesh	18	21	Religious personal status laws apply, e.g. 15 for Muslim girl
Bhutan	18	18	
India	18	21	Some exceptions were taken to court under Mohammedan Law or sharia law
Iran	13	15	Marriage before puberty with permission from the guardian and a judge and if considered in the ward's interest
Maldives	18	18	
Nepal	20	20	
Pakistan	16	18	A marriage contracted after the attainment of puberty and before the age of 16 years for females and 18 for males is valid under Muslim law.
Sri Lanka	18	18	16 with parental consent or court order 12 for girls for Muslim marriages; under 12 for girls in Muslim marriage with authorisation of Muslim court;
China	20	22	
DPR Korea	17	18	
Mongolia	18	18	Under 18 if girl or boy declared a person with full legal capacity
Cambodia	18	18	16 with parental consent and if other party is at least 18;
Indonesia	21	21	19 with parental consent. Lower with a court order
Lao PDR	18	18	15 under special circumstances
Malaysia	21	21	18 for males and females with parental consent non-Muslim marriages; 16 for girls if granted by the chief minister with parental consent for non-Muslim marriages; 16 for girls in Muslim marriages; under 16 for girls with permission of sharia court Muslim marriages
Myanmar	18	18	
The Philippines	21	21	18 with parental consent; 15 (puberty) for Muslim marriages in Mindanao; 12 for girls who have reached puberty with order of sharia court for Muslim marriages
Thailand	20	20	Under 20 with parental consent; under 17 with court order
Timor-Leste	17	17	16 with parental consent or authorisation from the civil registrar
Viet Nam	18	20	
Federated States of Micronesia	18	18	16 for girls with parent consent (Kosrae, Chuuk, Pohnpei states;
Fiji	21	21	18 with parental consent or commissioner / magistrate consent
Kiribati	21	21	17 with parental consent or licence provided by a minister
Marshall Islands	18	18	
Nauru	18	18	
Papua New Guinea	16	18	14 for girls and 16 for boys with court order
Samoa	19	21	16 for girls and 18 for boys with parental consent
Solomon Islands	18	18	15 with parental consent or judge / magistrate consent
Tonga	18	18	15 with parental consent
Tuvalu	21	21	18 with parental consent or judge / magistrate consent
Vanuatu	21	21	16 for girls and 18 for boys with parental consent

Sources: UNFPA 2020[289]

Much of the regional and global response to child marriage frames early marriage in the context of forced child marriages. However, there needs to be a distinction between an early consensual union between peers of a similar age, non-consensual union (at any age), and child marriage (marriage of very young adolescents who developmentally do not have the capacity to consent to marriage).[46] There also needs to be recognition, reflected in legislation, that in some cases, such as early pregnancy, it may be in the best interests of the young person to marry. Currently, 12 countries in the region permit marriage of girls and boys under the age of 18 years with parental consent, or permission from an authority (typically a magistrate or minister), often on grounds such as pregnancy, and with the consent or assent of the young person.

Eleven countries in the region have the minimum age of marriage above 18 for females, extending to the age of 21 in seven countries. Whilst these laws have the intention of protection, a higher age of marriage may have unintended consequences in contexts where premarital sex, informal unions and single mothers are stigmatised. Provision of education and employment opportunities to young women are likely to be more effective ways to delay marriage, compared to legislative approaches.

THE LEGAL AGE OF CONSENT TO SEX

Unlike marriage, there is no international agreement on the minimum legal age of consent to sex. Instead, there is recognition of the need to protect children from sexual abuse while also respecting the rights and evolving capacity of young people to self-determination.[44] Legislation concerning age of consent to sex varies in the region (between 12-19 years) and differs for boys and girls within the same country in some settings (table 4). In 15 countries, consensual same-sex activity is criminalised. Some countries have a lower age of consent (China, Philippines) or allow exemptions for consensual sex between young people that are close in age (Vietnam, Timor Leste, Marshall Islands and Nauru).

In five countries, **premarital sex is prohibited and criminalised**, creating a significant barrier for unmarried young people to access SRH information and services.


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TABLE 4. LEGAL AGE OF CONSENT TO SEX AMONG LMIC IN ASIA AND THE PACIFIC

Country	Legal age consent to sex		Legal age consent to same sex	
	Female	Male	Female	Male
Afghanistan	After marriage	After marriage	Illegal	Illegal
Bangladesh	14	Not specified	Not specified	Illegal
Bhutan	18	18	Not specified	Illegal‡
India	18	18	18	18
Iran	After marriage	After marriage	Illegal	Illegal
Maldives	After marriage	After marriage	Illegal	Illegal
Nepal	18	18	Not specified	Not specified
Pakistan	16 (After marriage)	After marriage	Illegal	Illegal
Sri Lanka	16	16	Illegal	Illegal
China	14	14	14	14
DPR Korea	15	Not specified	Not specified	Not specified
Mongolia	16	16	16	16
Cambodia	15	15	15	15
Indonesia§	18	18	Not specified	Not specified
Lao PDR	18	18	18	18
Malaysia	16 (After marriage)	After marriage	Illegal	Illegal
Myanmar	16	16	Not specified	Illegal
The Philippines	12	12	12	12
Thailand	15	15	15	15
Timor-Leste	16 or 14 if not taken advantage of	16 or 14 if not taken advantage of	16 or 14 if not taken advantage of	16 or 14 if not taken advantage of
Viet Nam	16 Sex between 13-15 year old adolescents is not an offence.	16 Sex between 13-15 year old adolescents is not an offence.	16 Sex between 13-15 year old adolescents is not an offence.	16 Sex between 13-15 year old adolescents is not an offence.
Federated States of Micronesia	16 to 18	16 to 18	Not specified	Not specified
Fiji	16	16	16	16
Kiribati	15	15	Not specified	Illegal
Marshall Islands	16 or 14 close in age	16 or 14 close in age	16 or 14 close In age	16 or 14 close in age
Nauru	16 or 13 close in age	16 or 13 close in age	16 or 13 close in age	16 or 13 close in age
Papua New Guinea	16	16	Not specified	Illegal
Samoa	16	16	16	Illegal
Solomon Islands	15	15	Illegal	Illegal
Tonga	15	15	Not specified	Illegal
Tuvalu	15	15	Not specified	Illegal
Vanuatu	15	15	18	18

Source: UNFPA 2020[289], and ILGA 2019[47]

‡ Bhutan Decriminalisation bill before upper house.

§ Indonesia Child Protection Law is 18. Penal code is 15 for girls. Aceh Province: Muslims can only consent to sex after marriage.

In some settings, governments have also introduced, or are considering introducing, legislation to increase the legal age of consent to sex to 18 years or higher, similar to the legal age of marriage. In India, for example, the *Protection of Children from Sexual Offences Act (2012)* criminalises all sexual activity of young people under the age of 18 years. It requires mandatory reporting by all health providers. This includes mandatory reporting of pregnant adolescents as victims of sexual abuse, even if sex was consensual and with a boy of a similar age.[48] Such actions are commonly framed around 'protecting' girls from early pregnancy and sexual violence, however, they are firmly rooted in traditional, conservative attitudes that seek to prohibit sex outside of marriage and limit girls' agency with respect to their own sexuality and SRH. Increasing the legal age of consent to sex can have a number of harmful consequences (box 5).[44]

BOX 5. IMPACTS OF HIGH LEGAL AGE OF CONSENT TO SEX

- High age of consent to sex **fails to recognise the agency of adolescents**, including girls, with respect to their sexuality and SRH, and does not reflect normal adolescent development, or the reality of adolescents' lives
- Punitive laws and other actions to prevent adolescents from engaging in sexual activity are **not effective at reducing premarital sex**, but rather increase the likelihood of risky behaviour and poor SRH outcomes
- Criminalising and stigmatising consensual sex between young people of a similar age and/or premarital sex **creates a substantial barrier to accessing SRH information and services**, that disproportionately impacts on girls and contributes to poor SRH outcomes such as unintended pregnancy, unsafe abortion, and STIs
- Stigmatising (or criminalising) adolescent sexual activity may **contribute to child marriage**, as young people may seek (or be coerced into) marriage as a way of legitimising an intimate relationship and/or avoiding social or legal sanctions

Source: Petroni 2019[44] Girls Not Brides 2019.[49]

The Convention on the Rights of the Child recognises the evolving capacity and maturity of adolescents, and their agency with respect to their sexual lives.[50] In particular "States should avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity." Therefore, the purpose of the legislation is to protect children from sexual abuse and exploitation, and to protect all young people (regardless of age or marital status) from sexual violence, while also respecting the capacity of young people of similar ages to consent to non-exploitative sexual activity. **Legislation should not criminalise consensual sexual activity or romantic relationships between young people less than 18 years who are similar in age (i.e. less than three years difference), nor criminalise behaviour or discriminate on the basis of sexual orientation or gender identity**.[44]

LEGAL AGE OF CONSENT TO MEDICAL TREATMENT, INCLUDING SRH SERVICES

As the age of first marriage increases and more young people engage in sex before marriage, action is required to remove legislative, regulatory and other barriers that limit access to comprehensive SRH information and services – for both married and unmarried young people. In most countries in the region, the legal age of consent to medical treatment is 18 years.[51] Prior to this, young people require the consent of a parent or guardian to access health services, including SRH services. In some settings, married girls may also require the consent of their spouse, religious leader, or other community authority. Such requirements violate young people's right to privacy and confidentiality, and create substantial barriers to accessing SRH services. In the context of significant sociocultural disapproval of premarital sex and/or use of SRH services (such as contraception), young people may not be willing or able to obtain parental consent. Such barriers disproportionately impact on young people who are disengaged from or lack family support, and who are most at risk of poor SRH outcomes.

The Committee on the Rights of the Child calls for legislation, policies and regulations to recognise and respect evolving capacities during adolescence, and adolescents' increasing agency to take responsibility and exercise their rights. This includes their right to confidential and time-sensitive SRH information and services (see panel below) without limitations of parental consent or age restrictions.[50] Reflecting this, many countries in the region have introduced legislation or regulations that allow access to SRH services without parental consent. A number of countries have enacted, or are proposing, legislation to allow adolescents to access HIV testing independently of their parent or guardian, including Afghanistan, Bangladesh, Cambodia, Fiji, Iran, Lao PDR, Marshall Islands, Papua New Guinea, the Philippines, Micronesia, Sri Lanka, Thailand and Viet Nam.[52] (table 5). There are fewer examples of national guidance or legislation removing parental consent for other SRH services, such as contraception. Where laws or regulations exist that support provision of services to 'mature minors', they may not be implemented by health providers who fear ramifications from parents or community, or who are unaware of their legal obligations.[51] This is particularly true in the absence of clear guidance around adolescents' legal rights to access SRH services.

TABLE 5. LEGAL AGE OF CONSENT TO HIV TEST

Country	Legal age consent to HIV test
Afghanistan	16
Bangladesh	Under 18 for adolescents at risk
Iran	15 for boys 13 for girls if mature minor
Nepal	16
Sri Lanka	16
Cambodia	Under 18 if in best interests of the young person
Lao PDR	14
The Philippines	15, under 15 if high risk with social worker/health worker
Thailand	15
Viet Nam	16
Federated States of Micronesia	Over 14
Fiji	Under 18 if mature minor
Marshall Islands	14
Papua New Guinea	12
Vanuatu	Under 18 if mature minor

BOX 6. CRC GENERAL COMMENT NO. 20 ON THE IMPLEMENTATION OF THE RIGHTS OF THE CHILD DURING ADOLESCENCE. 2016[50]

39. States should review or introduce legislation recognizing the right of adolescents to take increasing responsibility for decisions affecting their lives. The Committee recommends that States introduce minimum legal age limits, consistent with the right to protection, the best interests principle and respect for the evolving capacities of adolescents. For example, age limits should recognize the right to make decisions in respect of health services or treatment, consent to adoption, change of name or applications to family courts. In all cases, the right of any child below that minimum age and able to demonstrate sufficient understanding to be entitled to give or refuse consent should be recognized. The voluntary and informed consent of the adolescent should be obtained whether or not the consent of a parent or guardian is required for any medical treatment or procedure. ***Consideration should also be given to the introduction of a legal presumption that adolescents are competent to seek and have access to preventive or time-sensitive sexual and reproductive health commodities and services****. The Committee emphasizes that all adolescents have the right to have access to confidential medical counselling and advice without the consent of a parent or guardian, irrespective of age, if they so wish. This is distinct from the right to give medical consent and should not be subject to any age limit.*

40. The Committee reminds States parties of the obligation to recognize that persons up to the age of 18 years are entitled to continuing protection from all forms of exploitation and abuse. It reaffirms that the minimum age limit should be 18 years for marriage, recruitment into the armed forces, involvement in hazardous or exploitative work and the purchase and consumption of alcohol and tobacco, in view of the degree of associated risk and harm. States parties should take into account the need to balance protection and evolving capacities, and define an acceptable minimum age when determining the legal age for sexual consent. ***States should avoid criminalizing adolescents of similar ages for factually consensual and non-exploitative sexual activity****.*

Key actions to ensure a balance between protecting adolescents from harm and respecting their SRH rights and agency

Adolescents and their agency need to be at the centre of efforts to develop and implement legislation that impacts on their lives.

BOX 7. KEY ACTIONS

- Ensure age of consent to sex is set an age that recognises many young people commence sex during adolescence, so that consensual sexual activity between adolescents who are similar in age is not criminalised
- Enact legislation to prohibit forced marriage and remove exemptions that allow non-consensual child marriage (<18 years)
- Careful enforcement of age of marriage legislation to recognise the agency of older adolescents of similar age to consent to marriage or union under the age of 18
- Enact legislation to prevent child sexual abuse and exploitation
- Enact legislation to prevent sexual violence at all ages, including within marriage
- Decriminalise consensual sex between young people close in age (<3 years)
- Decriminalise consensual same-sex sexual activity
- Remove mandatory requirements for parental consent and ensure legal presumption of competency to access preventive and time-sensitive SRH counselling, commodities and services
- Develop clear policy, regulations and implementation guidance to support health workers to provide confidential SRH services to adolescents

UNDERSTANDING AND ADDRESSING ADOLESCENT PREGNANCY

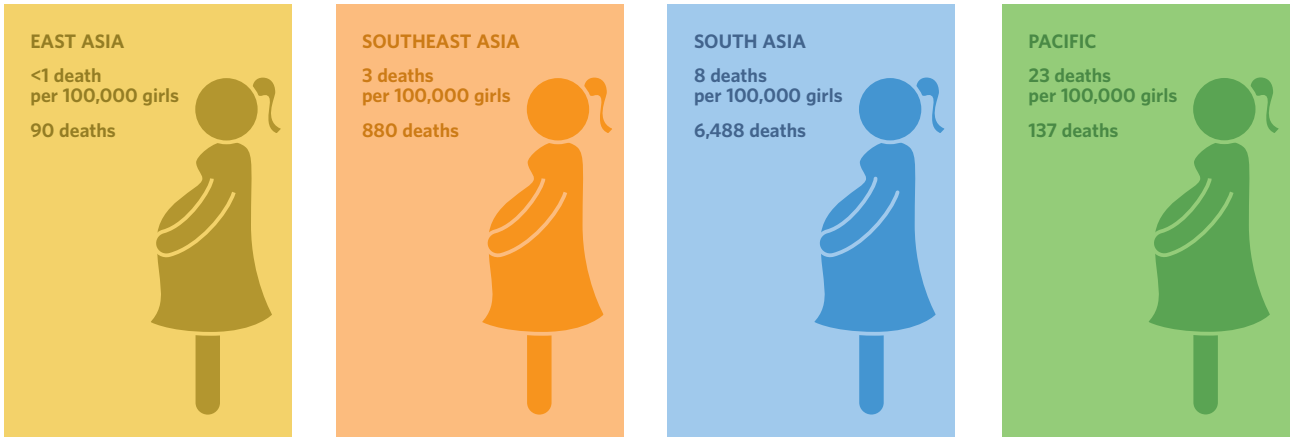
Adolescent pregnancy has profound implications for the health and wellbeing of young people, and that of future generations. Early pregnancy is associated with higher rates of adverse pregnancy outcomes such as preterm birth, low birth weight, and perinatal mortality, compared with births to adult women.[53] In South and Southeast Asia, the newborn mortality rate is 50% higher among babies born to girls less than 18 years compared to 20-29 year olds, and twice as high for adolescent mothers aged less than 16.[54]

Complications of pregnancy and childbirth remain among the leading cause of death for 15-19 year old girls in this region, resulting in an estimated 7,595 deaths in 2017 (figure 12).[55] Maternal disorders are the leading cause of death of adolescent girls in the Pacific, and the second and third leading cause of death in South Asia and Southeast Asia, respectively.[56] Many pregnant adolescent girls also experience high rates of intimate partner violence, and, in the context of premarital pregnancy, substantial stigma and discrimination.[57-59]

Maternal disorders are the leading cause of death of adolescent girls in the Pacific, and the second leading cause of death in South Asia

Adolescent pregnancy also has significant socioeconomic consequences for adolescent girls, including lower educational attainment, and limited employment and economic opportunities.[3, 60] These outcomes can perpetuate a cycle of poor health, disadvantage and gender inequality that impacts not only on adolescent girls but also extends to their families and communities. There is very little information about adolescent boys' experience with early pregnancy, although available studies suggest that many young men are unprepared for fatherhood, and lack knowledge and skills related to maternal and child health despite their traditional role as decision-makers in the family.[61, 62]

FIGURE 12. MATERNAL MORTALITY RATE AND TOTAL NUMBER OF MATERNAL DEATHS AMONG GIRLS AGED 15-19 YEARS (2017)



Source: GBD 2017[55]

ADOLESCENT FERTILITY REMAINS HIGH IN MANY COUNTRIES, AND IS INCREASING IN PARTS OF THE REGION

In 2019 there were over 3.7 million births to adolescent girls aged 15-19 years in Asia and the Pacific (table 6**), with India, Bangladesh, Indonesia, Pakistan, China and the Philippines accounting for over 75% of all adolescent births in the region. Countries in the Pacific have among the highest adolescent fertility rates, with the highest rate in the region reported in Marshall Islands (138 births per 1,000 females 15-19 years). In the Pacific, more than 1 in 6 women aged 20-24 commenced childbearing by age 18, compared with 1 in 8 in South Asia, and 1 in 14 in Southeast Asia (figure 13). The lowest rates of fertility and childbearing are in East Asian countries. Data on childbearing among very young adolescents (<15 years) are scarce. Between 2 and 3% of women aged 20-24 gave birth by age 15 in South Asia and the Pacific. Fertility rates for very young adolescents are only available for Bangladesh where the rate is estimated at 10 births per 1,000 girls aged 10-14years (among the highest in the world).[63]

Every year there are over **3.7 million** births to adolescent girls aged **15-19 years** in Asia and the Pacific.

There is very limited data on adolescent pregnancies (as opposed to births) in this region, although an analysis conducted by Guttmacher Institute estimated there were over 8 million pregnancies to adolescent girls in Asia in 2016, which included 1.2 million miscarriages and 2.4 million induced abortions.[64] While adolescent birth rates are low in China (8 per 1,000 girls), a national survey conducted in 2010 suggested that adolescent pregnancies are common. The survey of almost 11,000 unmarried 15-24 year olds found that 17% of sexually active adolescent girls had experienced a premarital pregnancy, of which 91% ended in abortion.[65]

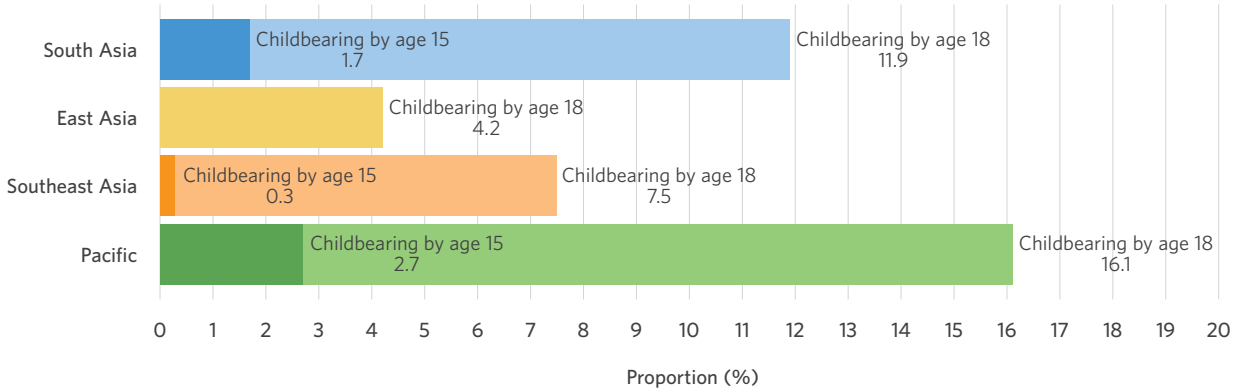
TABLE 6. ADOLESCENT FERTILITY RATE AND TOTAL NUMBER OF ANNUAL BIRTHS TO GIRLS AGED 15-19 YEARS

Region	Country	Births per 1,000 girls 15-19 years	Total number of annual births to girls 15-19 years
South Asia	Afghanistan	69.0	155,388
	Bangladesh	83.0	631,630
	Bhutan	20.2	687
	India	13.2	783,750
	Iran	40.6	109,620
	Maldives	7.8	101
	Nepal	65.1	103,118
	Pakistan	38.8	408,680
	Sri Lanka	20.9	5,838
East Asia	China	7.6	290,616
	DPR Korea	0.3	276
	Mongolia	31.0	4,644
Southeast Asia	Cambodia	50.2	36,495
	Indonesia	47.4	536,094
	Lao PDR	65.4	22,890
	Malaysia	13.4	17,326
	Myanmar	28.5	72,134
	Philippines	54.2	273,981
	Thailand	44.9	95,817
	Timor-Leste	33.8	2,535
	Viet Nam	30.9	159,309
Pacific	Fiji	49.4	1,828
	Kiribati	16.2	81
	Marshall Islands	138.0	381
	Micronesia	13.9	83
	Nauru	69.0	36
	Papua New Guinea	52.7	23,557
	Samoa	23.9	215
	Solomon Islands	78.0	2,652
	Tonga	14.7	74
	Tuvalu	42.0	24
	Vanuatu	49.4	692

** Note that Table 6 data are from UNPD modelled estimates and may vary from national data.

Across the region **1 in 10 women** aged 20-24 years (12 million women) commenced childbearing as a child - by the age of 18 (excluding China).

FIGURE 13. PROPORTION OF WOMEN AGED 20-24 WHO GAVE BIRTH AS CHILDREN (BY AGE 15 AND 18)

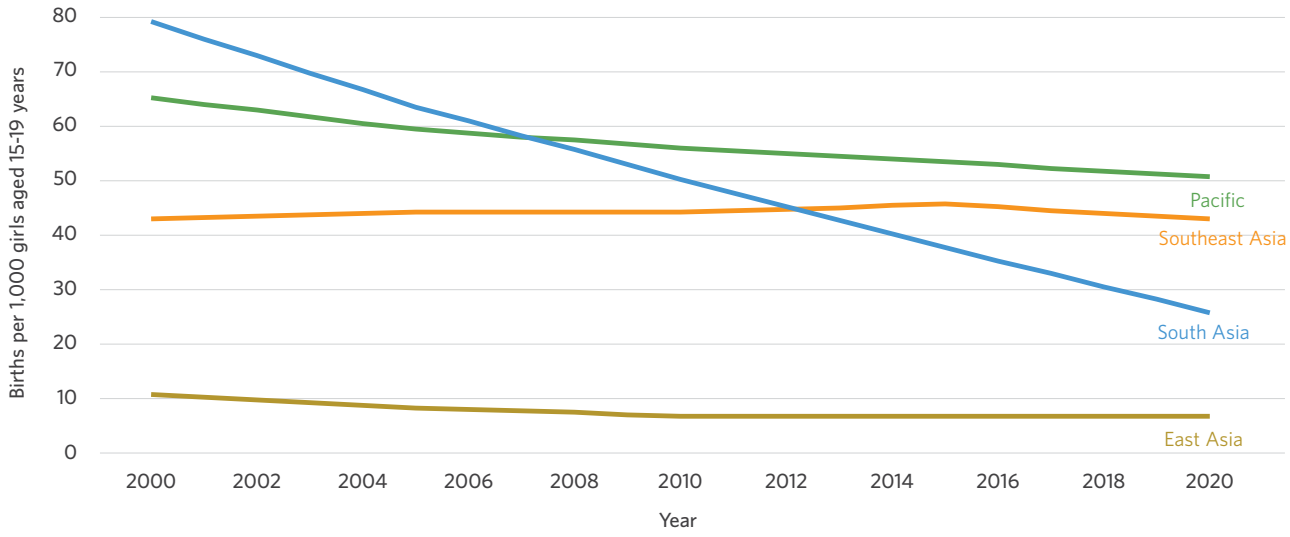


Note: East Asia estimate includes Mongolia only
Source: DHS and MICS

Adolescent fertility rates are now highest in the **Pacific** (51 births per 1,000 girls) and **Southeast Asia** (43 births per 1,000 girls), compared with **South Asia** (26), where there has been a significant reduction in the last two decades, and **East Asia** (7).

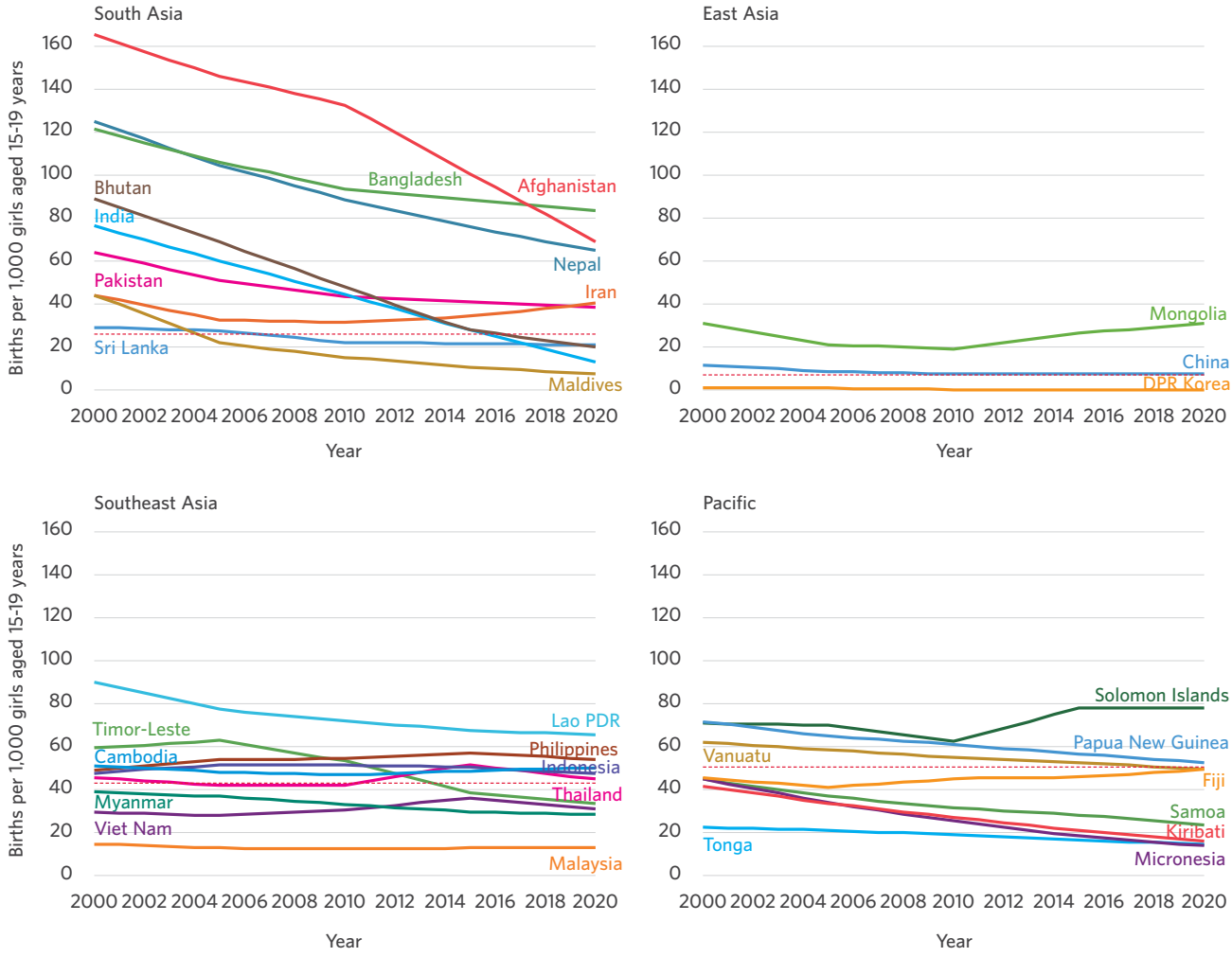
National DHS and MICS estimates of adolescent fertility show fluctuations in rates over the last decade. However, trend data from UNPD indicate that adolescent fertility has declined by more than 60% in South Asia since 2000, most notably in India in the context of falling rates of child marriage (figures 14 and 15). However, fertility rates in Bangladesh, Afghanistan and Nepal remain considerably higher than the sub-regional average. Less progress has been made in the Pacific, where fertility rates have only fallen by around 20% in the last two decades, with increases in the Solomon Islands and Fiji. **Overall, there has been no progress in reducing adolescent fertility in Southeast Asia since 2000:** despite some progress in Lao PDR, Myanmar and Timor-Leste, rates in the UNPD modelled estimates have increased in the Philippines and Viet Nam, and stalled in Thailand, Cambodia, Indonesia and Malaysia. However, more recent survey and birth registration data has shown a decrease in adolescent pregnancy in the Philippines and Thailand. While rates remain low in East Asia, adolescent fertility has increased by 60% in Mongolia since 2010.

FIGURE 14. ADOLESCENT FERTILITY RATES 2000-2020 (MODELLED ESTIMATES)



Source: UNPD[292]

FIGURE 15. TRENDS IN ADOLESCENT FERTILITY RATE BY COUNTRY, 2000-2020 (MODELLED ESTIMATES)



The dotted line indicates the sub-regional adolescent fertility rate for 2020

Source: UNPD[292]

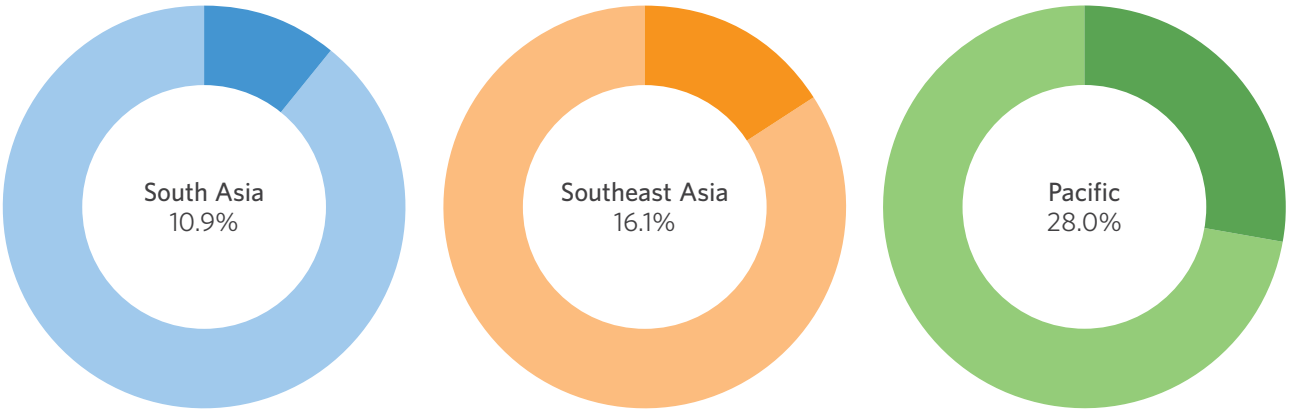
A SIGNIFICANT NUMBER OF ADOLESCENT PREGNANCIES ARE UNINTENDED, PARTICULARLY IN COUNTRIES WITH HIGH AND/OR INCREASING FERTILITY RATES

Not all adolescent pregnancies are intended or wanted. Unintended births are distinct to unintended pregnancies (which have several outcomes including birth, spontaneous and induced abortion), with the Guttmacher institute estimating unintended pregnancies to account for 43% of all adolescent pregnancies. In this region (excluding East Asia) there were **around 440,000 unintended births to adolescent girls in 2019, accounting for around 1 in 8 of all adolescent births** (figure16). The percentage of births that were unintended ranged from 4% in Pakistan and Afghanistan, to over 60% in Marshall Islands, with more than a quarter of births mistimed or unwanted in the Pacific.

In contrast to countries in other regions, in the Pacific, the proportion of births that were unintended is higher among adolescents aged 15-19 years than young women aged 20-24 years (appendix). Unintended births among adolescents age 15-19 years are also high in high fertility settings, such as Bangladesh (22%) and Nepal (20%) and in countries where fertility rates have increased, including the Philippines (29%) and Solomon Islands (33%).

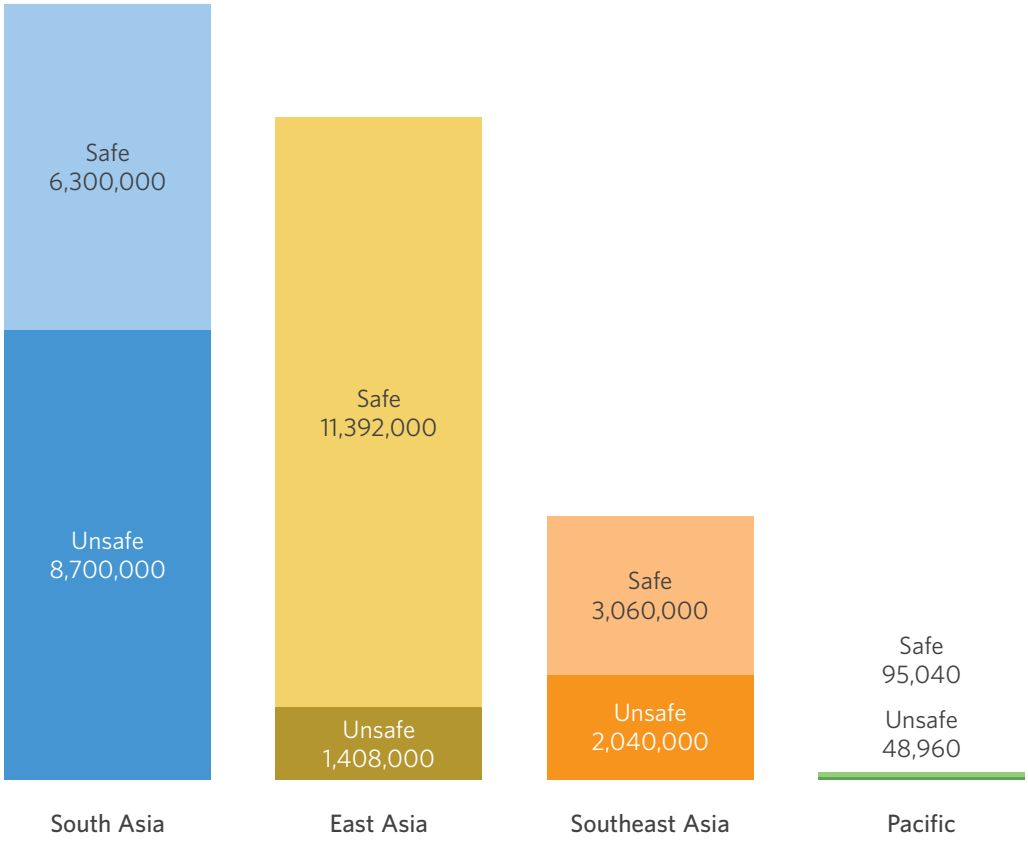
Unintended pregnancy, particularly if it occurs outside of marriage, can have substantial consequences for young people including stigma, social isolation, school expulsion, forced marriage, and in some cases violence and suicide.[66] **It is estimated that 65% of all unintended pregnancies in Asia, and 38% in the Pacific end in induced abortion**, which, in settings where legal abortion is highly restricted and the majority are unsafe, can lead to considerable morbidity and mortality.[67]

FIGURE 16. PROPORTION OF BIRTHS TO 15-19-YEAR-OLD GIRLS THAT WERE UNINTENDED



Source: DHS and MICS

FIGURE 17. TOTAL NUMBER OF SAFE AND UNSAFE ABORTIONS IN 2014 AMONG WOMEN AGED 15-49 YEARS



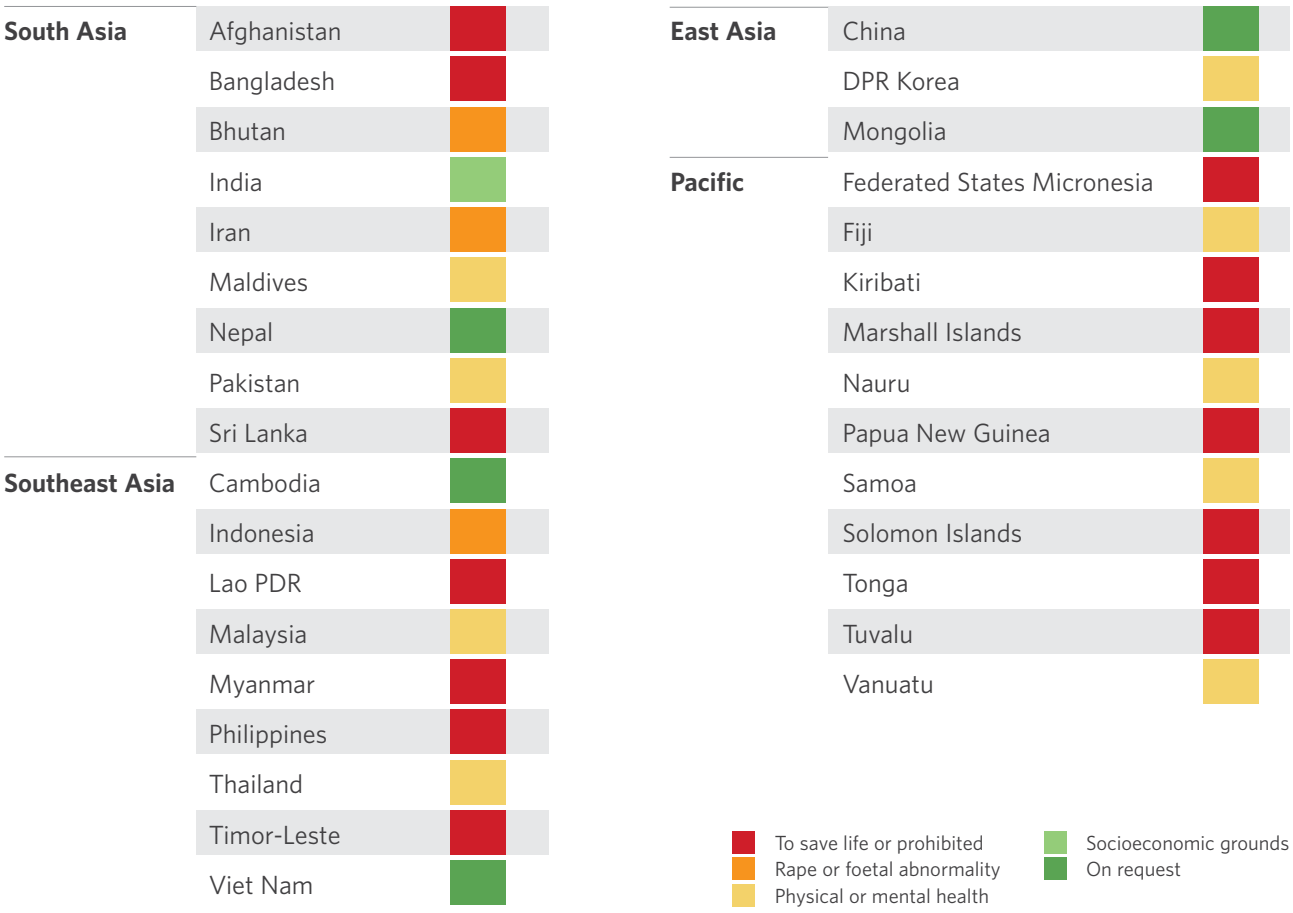
Source: Lancet/Guttmacher 2017

Data on induced abortion are limited, particularly for the Pacific. In 2014, an analysis conducted by the Guttmacher Institute estimated that the total number of induced abortions among women 15-49 years was 12.8 million in East Asia, 15.0 million in South Asia, 5.1 million in Southeast Asia, and 144,000 in Oceania (including Australia and New Zealand). Unsafe abortions accounted for 58% of all induced abortion in South Asia, 40% in Southeast Asia, and 34% in the Pacific (although this includes data form Australia and New Zealand where safe abortion is more accessible)(figure 17).[68] In Asia, almost 5 million women aged 15-49 years were treated for complications of unsafe abortion, and there were 5,400 deaths (6% of all maternal deaths).[64]

Data on induced abortion among adolescents are scarce, particularly for unmarried adolescents. Analysis from 2008 estimated that women under the age of 25 accounted for 34% of all unsafe abortions in Asia (excluding East Asia) (11% among 15-19 year olds and 23% among 20-24).[69] Smaller studies have suggested that in settings where abortion is legal, rates of induced abortion are higher among married, better educated and wealthier adolescents.[70] However in settings where abortion is highly legally restricted, substantial stigma, social pressure, isolation and community sanctions are drivers of unsafe abortion among unmarried girls.[71] In one of the few recent studies from the Pacific, 71% of women accessing post-abortion care in Papua New Guinea (where abortion is highly legally restricted) were aged 15-24 years, and 39% were unmarried.[72]

There are an estimated **3.6 million** unsafe abortions each year among women aged **15-24 years** in Asia (excluding East Asia).

FIGURE 18. ABORTION LEGISLATION



Source: World Abortion Laws[73], UNFPA 2020[289] for DPRK, Fiji, Maldives.
Note: Lao conflicting laws/guidelines on exemptions

Abortion is more likely to be unsafe (conducted by unskilled providers and/or using unsafe methods) in settings where it is highly legally restricted. Fourteen countries only permit abortion to save a woman's life or prohibit it all together; and an additional three countries only allow abortion in the case of rape, incest or foetal abnormality (figure 18).[73]

In addition to legal restrictions, there may also be regulations that prevent some people from accessing government services (such as migrants) or requirements for parental or spousal consent that may prevent young people from seeking care. Even where abortion is more legally accessible, it often remains highly stigmatised which inhibits young people accessing safe services, or delay seeking post-abortion care for complications. Adolescents are more likely to delay seeking an abortion, resort to unsafe providers or unsafe methods, and delay seeking help for complications.[74] Consequently, adolescent and unmarried young women are also at higher risk of abortion-related morbidity and mortality in some settings.[75]

EARLY PREGNANCY OCCURS IN THE CONTEXT OF LOW USE OF EFFECTIVE CONTRACEPTION AND HIGH UNMET NEEDS, PARTICULARLY IN COUNTRIES WITH HIGH AND/OR INCREASING FERTILITY RATES

Use of modern methods of contraception among currently married young women varies considerably in the region (figures 19 and 20), but less than 60% are using an effective method in all countries, with the exception of Thailand. Modern contraceptive prevalence is lowest in South Asia and the Pacific: fewer than 15% of married 15-24 year olds are currently using a modern method in Afghanistan, Pakistan, Maldives, Kiribati, Nauru and Tuvalu. Fewer married adolescents are using modern contraception compared with women aged 20-24 years (appendix).

Around 20% of 15-19-year-old girls who are married or sexually active and want to avoid pregnancy rely on less effective traditional methods of contraception.

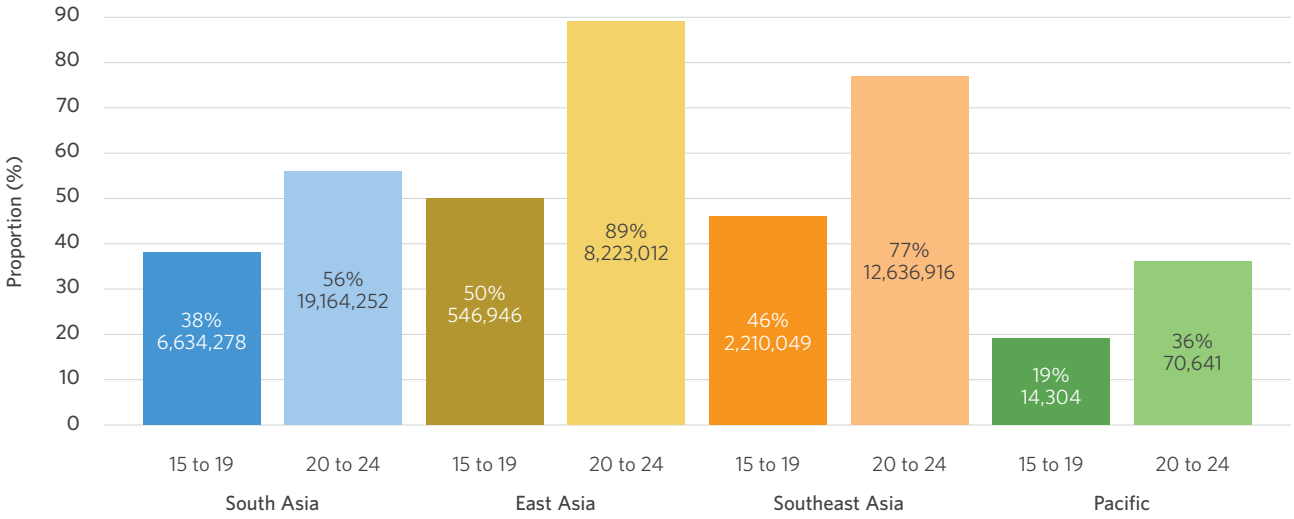
Many adolescents and young women rely on less effective, short-acting methods (condoms, pills) and traditional methods, with the use of highly effective long-acting reversible methods low in many countries.[76]

Misconceptions about contraception and its side effects are a common reason for reliance on traditional methods and discontinuation of modern methods in this age group.[77] Inconsistent and incorrect use are also commonly reported, contributing to contraceptive method failure and unintended pregnancy.[78]

34 million young women aged 15-24 years have an unmet demand for modern contraception.

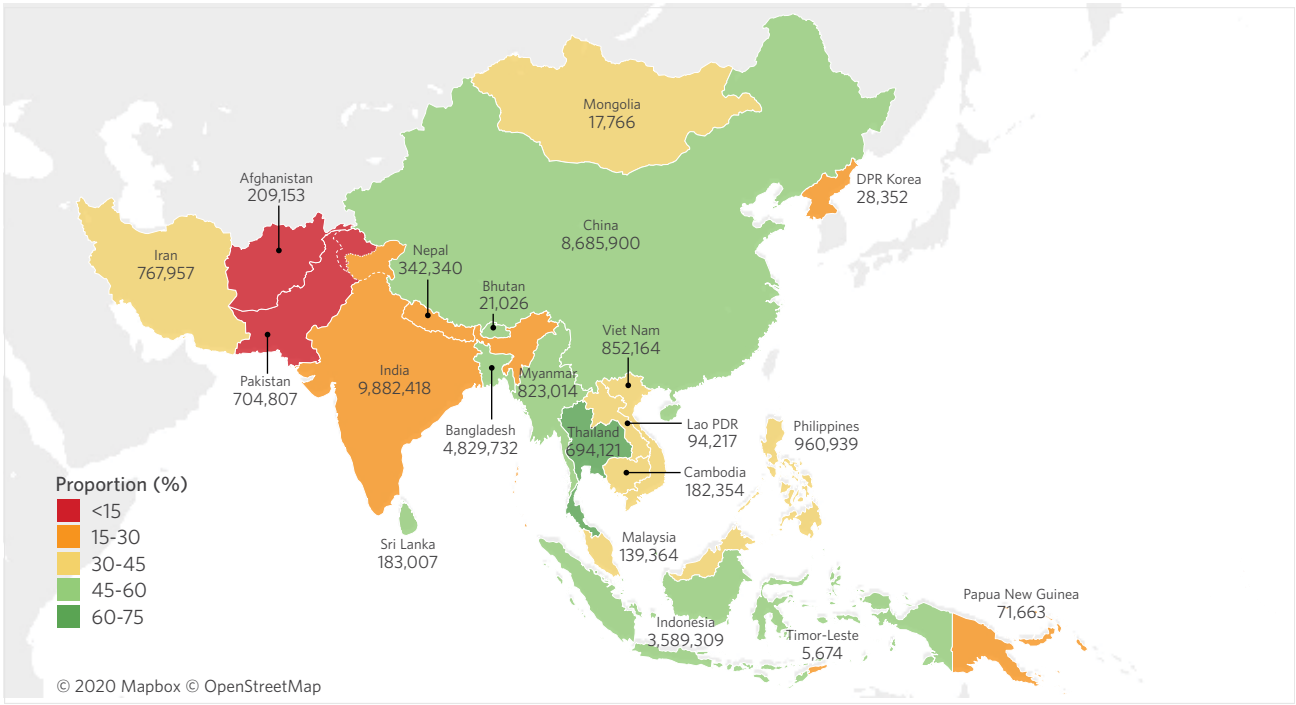
Almost 1 in 3 (31%) of young women aged 15-24 years who have a need for family planning do not have their demand satisfied by modern methods (figures 21 and 22, country level estimates detailed in the appendix). The unmet demand for modern contraception is highest in South Asia and the Pacific, where almost half of all 15-24 year olds with a demand for family planning are not using an effective method. Among married women, adolescents aged 15-19 years have less satisfied demand than young women aged 20-24 years (figure 23).

FIGURE 19. PREVALENCE OF MODERN CONTRACEPTIVE USE AMONG MARRIED YOUNG WOMEN, AND TOTAL NUMBER OF MODERN CONTRACEPTIVE USERS



Source: DHS and MICS

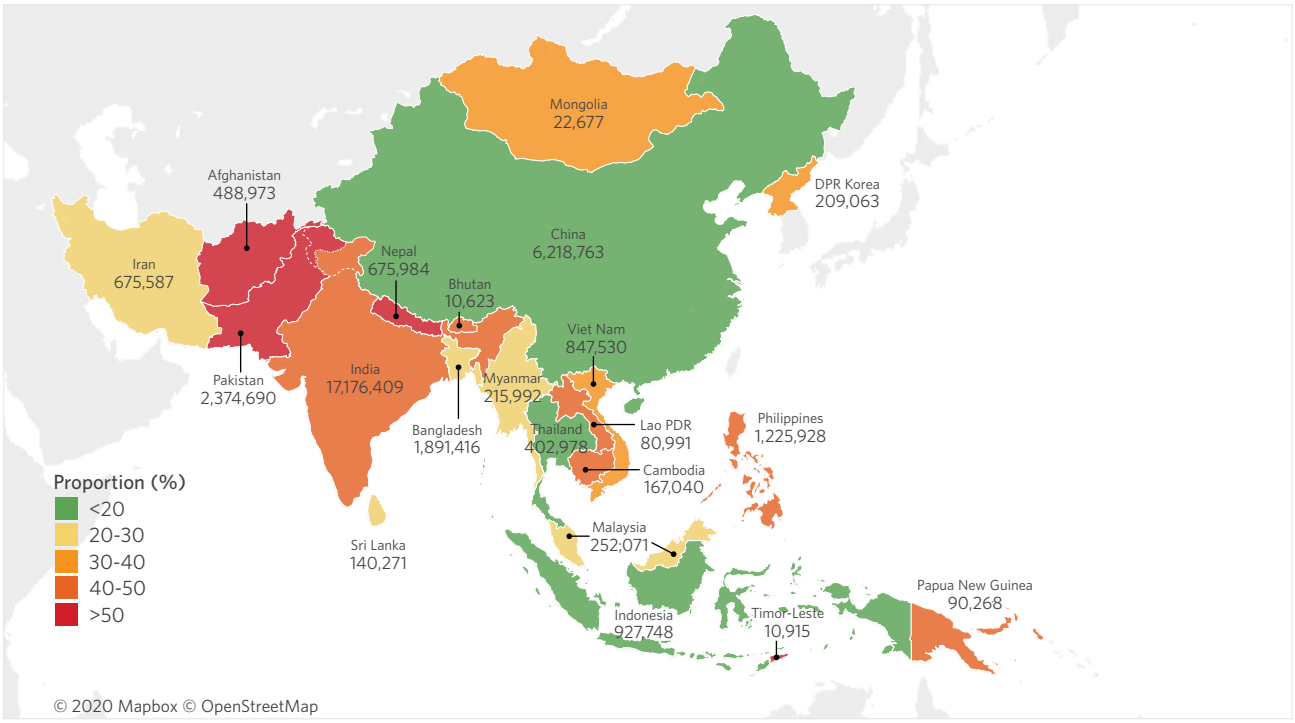
FIGURE 20. TOTAL NUMBER AND PROPORTION OF MARRIED WOMEN 15-24 YEARS CURRENTLY USING A MODERN METHOD OF CONTRACEPTION



Source: DHS and MICS

Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

FIGURE 21. TOTAL NUMBER AND PROPORTION OF 15-24-YEAR-OLD WOMEN WHOSE DEMAND FOR FAMILY PLANNING IS **NOT** SATISFIED BY MODERN METHODS



Source: GBD 2017

Note: United Nations Map No 4170 Rev. 17 (www.un.org/Depts/Cartographic/map/profile/world.pdf);
*Dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

FIGURE 22. TOTAL DEMAND FOR FAMILY PLANNING AMONG 15-24-YEAR OLD WOMEN, AND PROPORTION AND TOTAL NUMBER WHOSE DEMAND IS MET AND UNMET BY MODERN METHODS

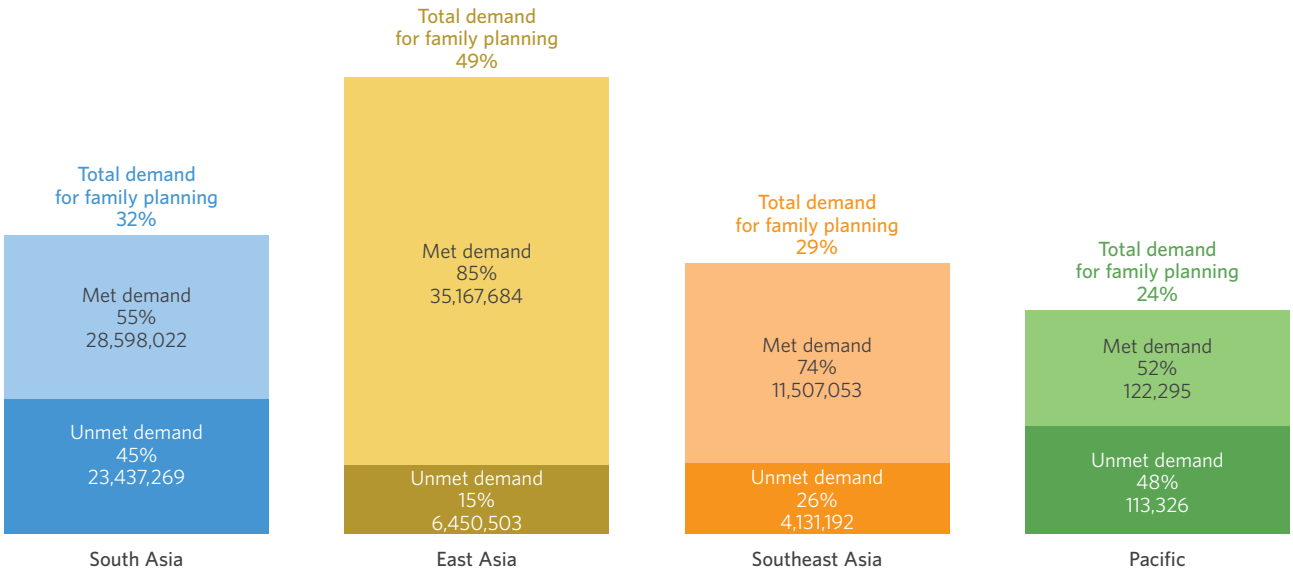
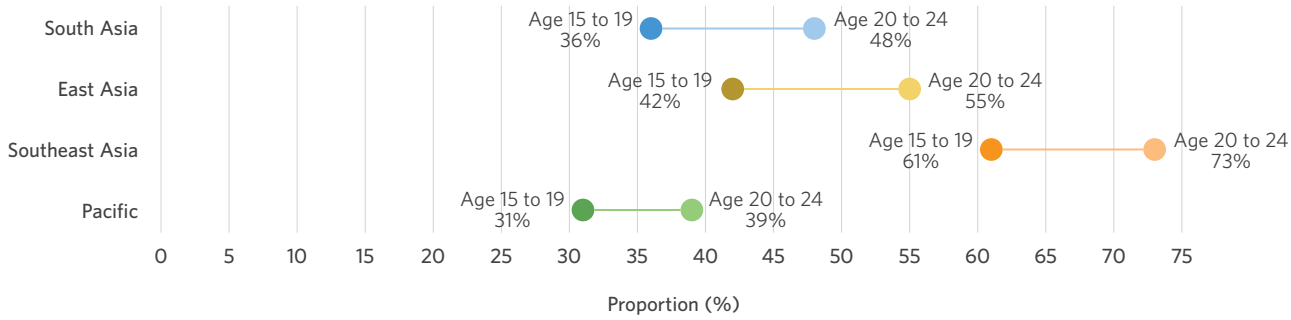


FIGURE 23. PROPORTION OF MARRIED WOMEN AGED 15-24 WHOSE DEMAND FOR FAMILY PLANNING IS SATISFIED BY MODERN METHODS BY AGE GROUP

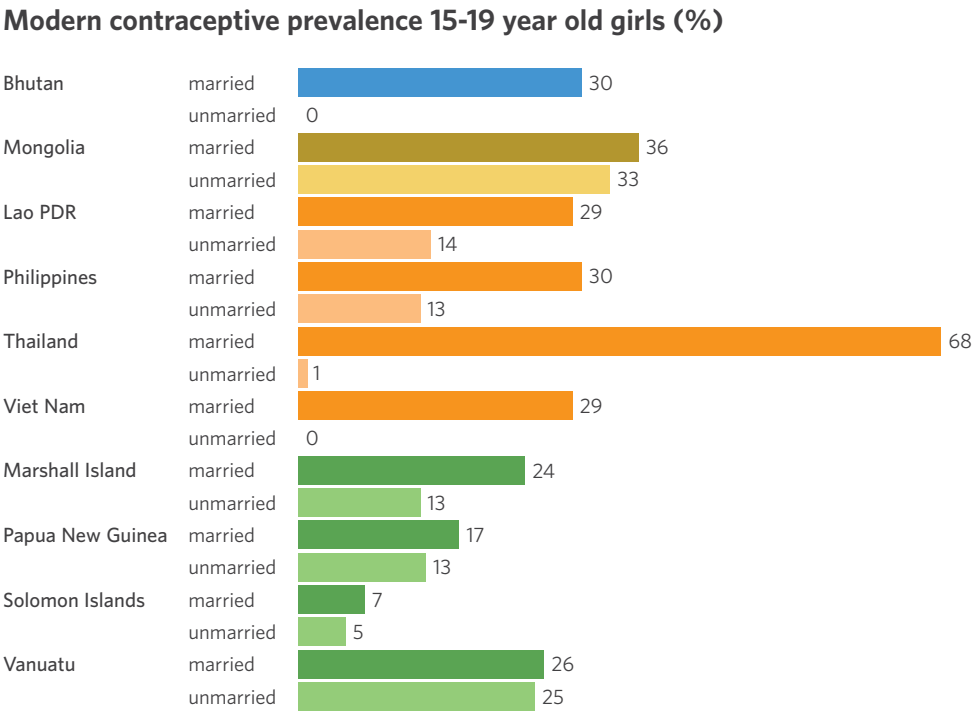


Note: East Asia estimate is for Mongolia only.
Source: DHS and MICS.

There is limited information about contraceptive use by sexually active unmarried adolescents, but available data demonstrate the use of modern methods is low (figure 24).[††] In all countries with available data, **fewer than 1 in 4 sexually active adolescent girls aged 15-19 years are currently using a modern method**, and, with the exception of India, less than half have their demand for family planning satisfied with modern methods.

Use of modern contraception and demand satisfied are particularly low among unmarried sexually active women in those countries where adolescent fertility rates have not declined or are increasing, including the Philippines, Thailand, Mongolia, Viet Nam, and Solomon Islands, suggesting that very poor access to contraceptive services among this group is an important contributor to increasing fertility rates.

FIGURE 24. CONTRACEPTIVE USE AMONG MARRIED VERSUS SEXUALLY ACTIVE UNMARRIED WOMEN

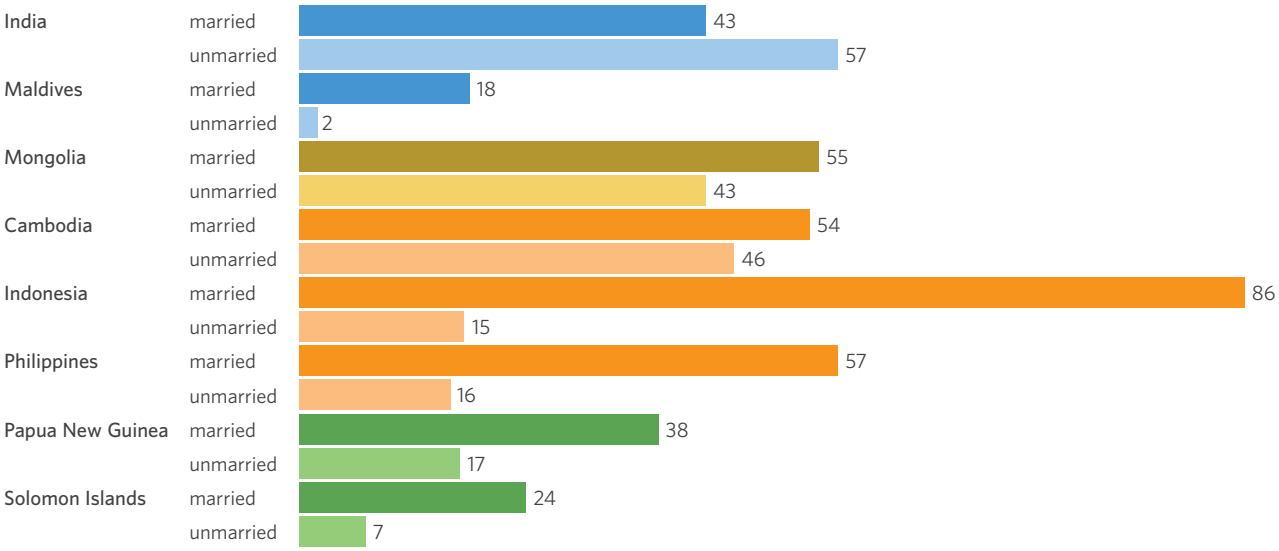


Source: DHS and MICS, microdata[293]

[††] Data for this chart are drawn from UNPD World Contraception Use 2020. For some countries, estimates provided are from the micro-data of available national DHS and MICS surveys and not otherwise available in published reports. Estimates for unmarried adolescents may be based on small non-representative samples.

FIGURE 24. CONTRACEPTIVE USE AMONG MARRIED VERSUS SEXUALLY ACTIVE UNMARRIED WOMEN (CONTINUED)

Demand for family planning satisfied by modern methods among 15-24 year old women (%)



Source: DHS and MICS, microdata[293]

MANY PREGNANT ADOLESCENTS DO NOT RECEIVE ADEQUATE MATERNAL CARE

The majority of pregnant adolescent girls in the region were attended at least once by a skilled antenatal care provider (table 7). However, the proportion of adolescent girls who delivered with a skilled birth attendant or in a health facility is low in several countries, most notably in Bangladesh, where only 42% were attended by a skilled provider, and 36% delivered in a health facility. Access to skilled postnatal care is considerably lower: less than half of girls received postnatal care in Afghanistan, Bangladesh, Pakistan, Indonesia, Lao PDR, Timor-Leste, Kiribati and Papua New Guinea.

There is little information concerning the quality of, or adolescents' satisfaction with maternity care. A recent study published in The Lancet examining mistreatment of women in health facilities during labour in four countries (including Myanmar) found that more than a third of women experienced physical or verbal abuse, stigma or discrimination.[79] **Adolescent girls were almost twice as likely as women over the age of 30 to experience mistreatment**. Other studies from the region have highlighted the need to improve postnatal care for adolescent mothers (and their partners) to help them transition to parenthood. Postnatal support not only needs to focus on high quality care to avoid the poor health outcomes associated with adolescent pregnancy, but also needs to include psychosocial support delivered with compassion and empathy to help young parents rapidly adapt to their new adult roles.[80-82] Repeat pregnancy among adolescents is common, and associated with adverse outcomes. Therefore, there is a critical need for high quality postnatal and post-abortion contraceptive counselling and services for this group.[83-85]

TABLE 7. PROPORTION OF 15-19 YEAR OLDS WHO RECEIVED MATERNAL HEALTH CARE (%)

Region	Country	Antenatal care (at least 1)	Skilled birth attendant	Facility birth	Postnatal care
South Asia	Afghanistan	58.4	53.6	51.5	30.8
	Bangladesh	64.4	41.8	36.1	33.9
	Bhutan	96.0	58.2	57.2	
	India	80.8	85.5	83.9	63.0
	Maldives	99.1	100.0	96.8	89.5
	Nepal	88.0	68.7	68.1	52.7
	Pakistan	84.2	70.2	67.4	48.0
	Sri Lanka	99.2	99.3	99.8	99.8
East Asia	Mongolia	100.0	100.0	100.0	90.9
Southeast Asia	Cambodia	95.7	91.4	85.9	82.0
	Indonesia	95.0	77.0	72.0	76.6
	Lao PDR	74.7	56.4	57.0	37.9
	Myanmar	80.0	60.8	37.3	53.0
	The Philippines	90.5	85.9	79.2	83.0
	Thailand	98.5	99.4	99.4	80.1
	Timor-Leste	79.6	57.8	44.5	30.3
	Viet Nam	90.7	86.9	85.8	82.6
Pacific	Kiribati	91.5	78.1	70.8	49.2
	Marshall Islands	95.7	93.5	82.8	62.8
	Nauru	95.5	90.6	95.7	
	Papua New Guinea	81.4	61.1	60.6	47.1
	Samoa	94.5	86.4	85.6	61.4
	Solomon Islands	95.0	88.2	87.8	61.7
	Tonga	92.3	99.0	100.0	89.9
	Tuvalu		100.0	100.0	
	Vanuatu	76.5	92.5	92.7	78.0

Source: DHS and MICS

THE CONTEXT AND DRIVERS OF ADOLESCENT PREGNANCY ARE COMPLEX

Early childbearing is generally more common among less educated, rural and poorer adolescents (figure 25), and is also higher in countries with increased levels of societal gender inequality.[86] However, the context and drivers of adolescent pregnancy are complex, inter-related and context-specific. A summary of the individual, interpersonal, family, community and societal factors that contribute to early and unintended pregnancy in the region is provided in figure 28. **The majority of adolescent births occur within the context of marriage and early union, and in South Asia traditional child marriage remains among the most significant drivers of early childbearing**. Socio-cultural pressure to prove fertility soon after marriage, son preference, and the limited decision-making autonomy of married adolescent girls, contributes to poor access to, and low use of, contraception and high rates of fertility in these settings (table 8).[87-89] Additionally, a significant proportion of married adolescent girls experience physical and/or sexual intimate partner violence, which is associated with an increased risk of unintended pregnancy.[90]

> **"He [husband] didn't want a baby either. But my father- and mother-in-law wanted one right away, and said we couldn't use birth control."**
>
> (20-year-old woman, Nepal)

TABLE 8. PROPORTION OF MARRIED ADOLESCENT GIRLS 15-19 YEARS WHO CAN REFUSE SEX WITH THEIR HUSBAND, AND WHO ARE INVOLVED IN DECISION-MAKING (%)

Region	Country	Autonomy contraception	Autonomy sex	Autonomy health care	Autonomy visiting friends
South Asia	Afghanistan			40.9	41.8
	Bangladesh			48.9	43.6
	India			60.7	58.7
	Maldives	78.5	65.7	80.9	96.5
	Nepal	88.1	88.7	26.9	19.3
	Pakistan	77.5	41.3	23.6	18.8
	Sri Lanka			80.1	81.9
Southeast Asia	Cambodia			89.2	95.3
	Indonesia	87.6		83.4	81.8
	Myanmar			69.7	81.1
	The Philippines	91.7	83.9	95.1	92.1
	Timor-Leste	94.2	45.6	90.9	88.3
Pacific	Kiribati			45.8	35.4
	Marshall Islands			64.8	60.8
	Samoa			85.5	82.1
	Solomon Islands			82.6	72.3
	Tonga			79.6	67.5
	Vanuatu			73.2	76.4

Source: DHS and MICS

FIGURE 25. PERCENTAGE OF GIRLS AGED 15-19 YEARS WHO HAVE COMMENCED CHILDBEARING, BY WEALTH, EDUCATION AND RESIDENCE, SELECTED COUNTRIES (%)

Source: DHS and MICS

However, **not all adolescent births that occurred in marriage were conceived in marriage**. In Southeast Asian countries, where adolescent fertility rates are increasing or have stalled, up to a third of adolescent births among ever-married 20-29 year old women were conceived prior to marriage (figure 26).[30] Unlike adolescent pregnancies within the context of traditional forms of child marriage, these premarital pregnancies are more common in urban areas, and among girls from wealthier households in Indonesia, the Philippines and Viet Nam (figure 27).

FIGURE 26. PROPORTION OF ADOLESCENT PREGNANCIES AMONG EVER-MARRIED / IN UNION WOMEN AGED 20-29 THAT WERE CONCEIVED PRIOR TO MARRIAGE / UNION (%)

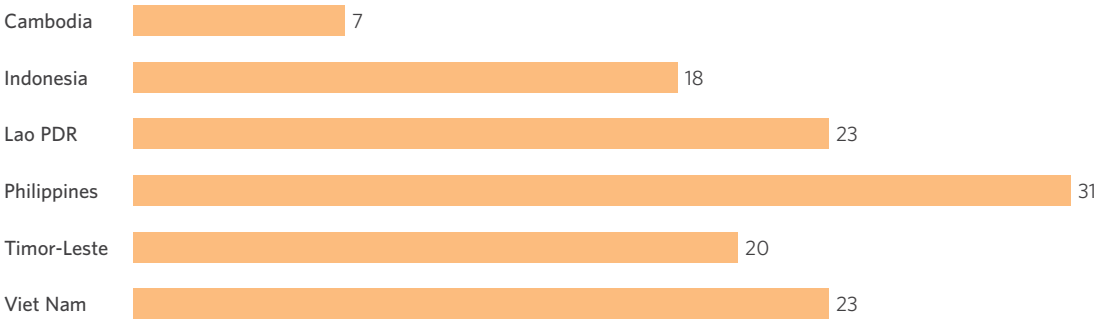
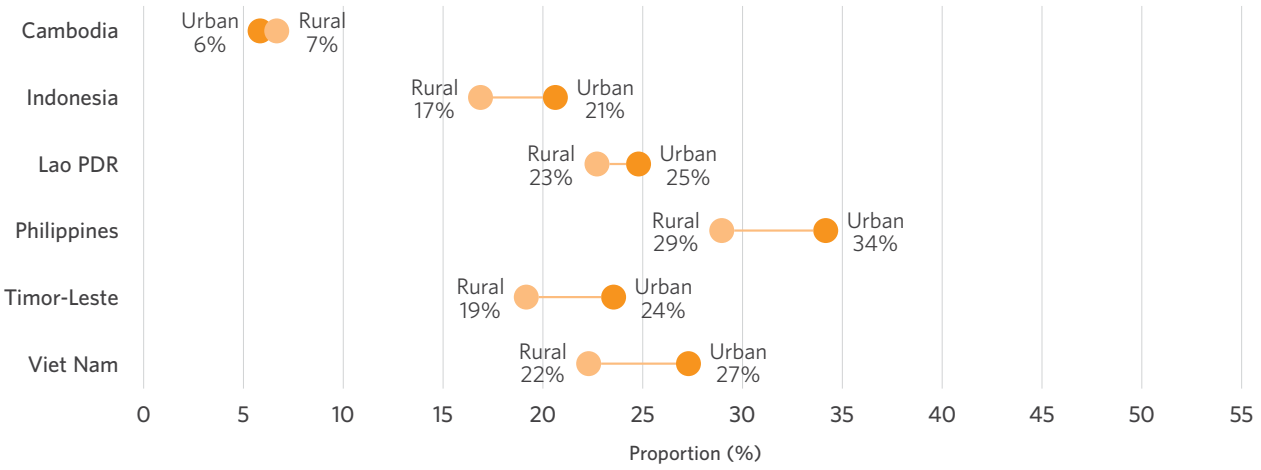
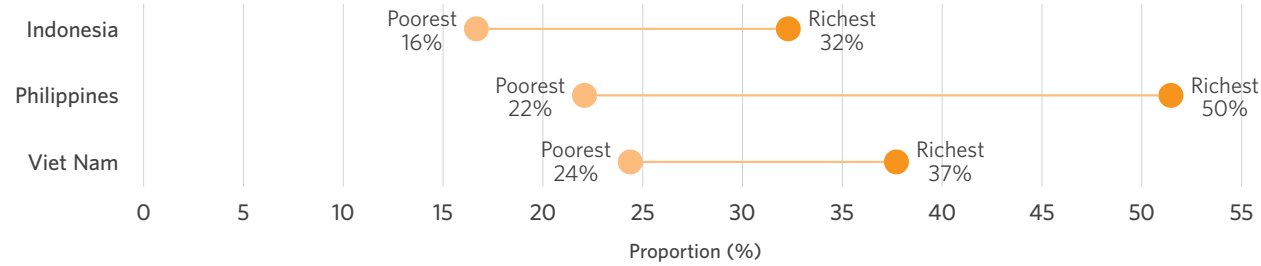


FIGURE 27. PREMARITAL ADOLESCENT CONCEPTIONS AMONG 20-29-YEAR-OLD WOMEN BY RESIDENCE AND WEALTH STATUS

Residence



Wealth



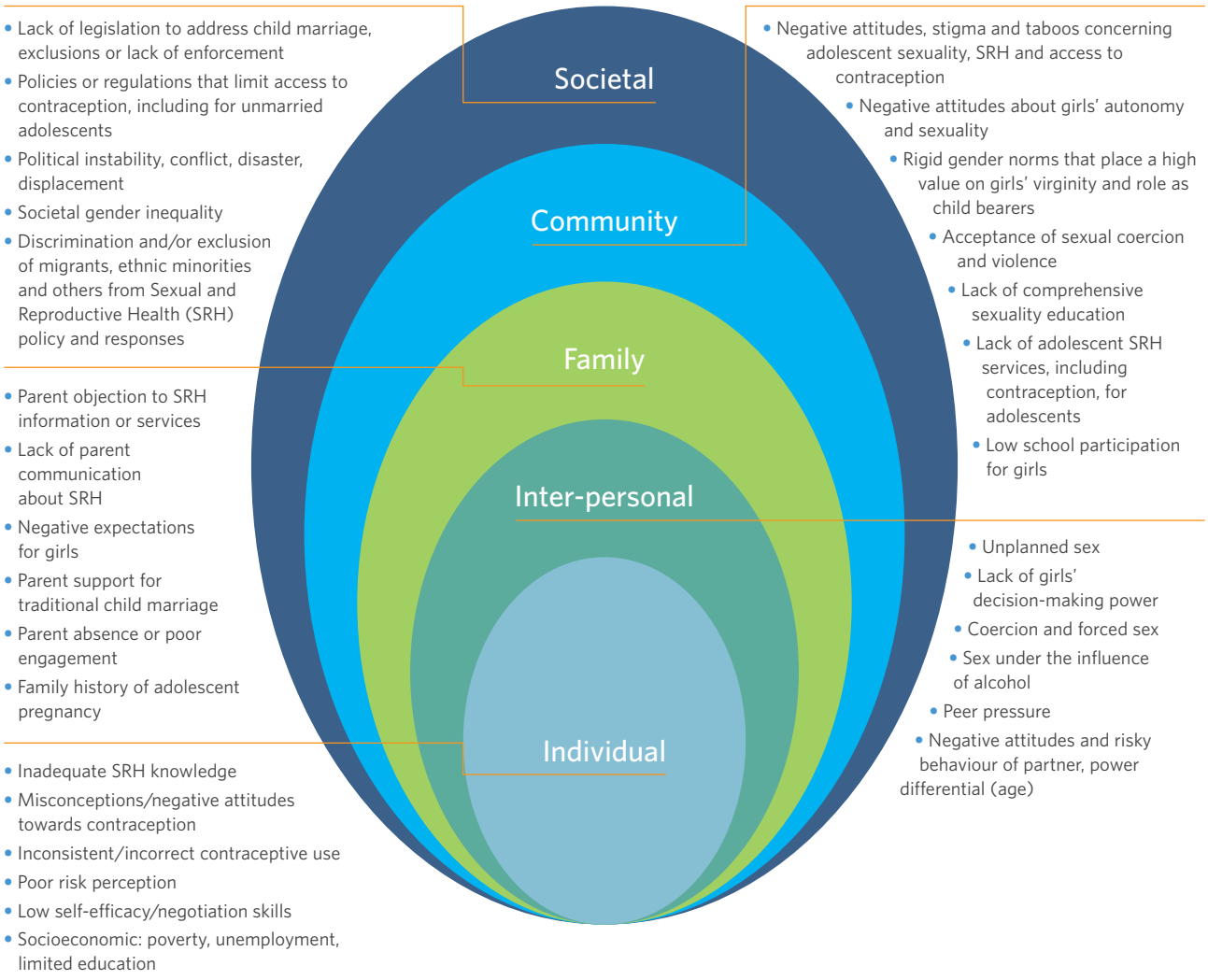
Source: UNICEF 2019[30]

In many Southeast Asian countries, lack of comprehensive sexuality education, limited access to quality contraception services, considerable socio-cultural disapproval of adolescent sexuality, harmful gender norms, and policy and regulatory barriers are major contributors to low use of contraception and girls' limited agency to negotiate safe and consensual sex.[91-94] There has been a particular neglect of the needs of unmarried sexually active adolescents, which is likely to have contributed to the lack of progress.

> **"For us, condoms are too expensive but I only found that the long-term contraception injection was free after I already had my baby"**
>
> (Young woman, Thailand)

> **"I was 15 years old going on 16 when I had my first child. It was never my intention.....I had a boyfriend, he was a bit older than me. He took me out. I was already a bit drunk from work. We drank more. We never meant for this to happen. It was out of control."**
>
> (Young adolescent mother, Thailand)

FIGURE 28. DRIVERS OF ADOLESCENT PREGNANCY



Source: UNFPA /UNICEF 2018[16], UNFPA 2013[99], Chung 2018[100]

Marginalised girls are at particular risk of early and unintended pregnancy. Young female sex workers face considerable barriers to accessing quality, non-judgmental SRH services, including contraception, and report high rates of pregnancy, repeat pregnancy and abortion.[95,96] Higher rates of adolescent pregnancy are also reported among some ethnic groups, particularly in the context of rigid gender norms that promote early childbearing.[97] Exclusion from universal health care policies, poor access to SRH services, conservative sociocultural norms, stigma and discrimination also contribute to high rates of pregnancy among refugee and migrant adolescents in the region.[98]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STRATEGIES TO ADDRESS ADOLESCENT PREGNANCY AND ASSOCIATED HARMS

Addressing adolescent pregnancy requires a comprehensive, youth-centred, multisectoral approach to respond to the interrelated drivers of early pregnancy, and reduce associated adverse outcomes for girls and their infants. Key is the meaningful engagement of young people to understand the factors contributing to pregnancy and identify effective approaches that respond to their needs and take into account their agency. Priority strategies recommended by WHO[101] include interventions to:

- Prevent child marriage
- Prevent early pregnancy through comprehensive sexuality education, improved education participation of girls, and economic and social support programmes
- Increase the use of effective contraception
- Reduce sexual violence
- Prevent unsafe abortion
- Increase access to and quality of maternal health care

Recent studies of interventions to prevent pregnancy from this region are limited, but indicate that a combination of multiple strategies can reduce pregnancy and increase the use of effective contraception. These include comprehensive sexuality education, improved access to and quality of youth-friendly SRH counselling and services, immediate postpartum contraceptive counselling, use of voucher programmes to increase uptake of contraception, strategies to address community-level norms and barriers that contribute to child marriage and/or limit access to SRH services, and approaches to improve school participation among girls.[102-107] Much of the current evidence has focused on preventing adolescent pregnancy in the context of traditional arranged child marriage. There is a need for further research to understand the other pathways and drivers of adolescent pregnancy, and evaluations of strategies to prevent pregnancy, particularly in Southeast Asia and the Pacific, where fertility rates have stalled or are increasing.

A summary of key UN agency strategies,[99,101,108] regional initiatives,[109] and global evidence of effective approaches,[110-112] is provided in box 7.

BOX 8. KEY STRATEGIES TO PREVENT ADOLESCENT PREGNANCY AND POOR HEALTH OUTCOMES

- **Supportive policy and legislative environment:**
  - Legislation that prohibits forced marriage before the age of 18 years for girls and boys
  - Legislation to prevent sexual violence, including within marriage
  - Remove legislative and regulatory barriers to contraceptive services, including limits based on age, parent consent, or marital status
  - Include adolescents and contraceptive services in universal health coverage schemes
  - Ensure inclusion of marginalised adolescents, including migrants, young people with disabilities and those in humanitarian settings
- **Address family and community attitudes, norms and barriers:**
  - Educate and mobilise families, communities and leaders to address harmful cultural, religious and gender norms that promote non-consensual early marriage and/or stigmatise sexually active unmarried adolescents, including through use of mass media
  - Build community support for adolescent SRH services, including contraception
  - Engage parents to improve support for adolescent SRH and increase parent-adolescent communication
  - Engage boys and men to address harmful gender norms that limit girls' agency and contribute to sexual violence and coercion
- **Improve school participation**
  - Increase girls' secondary school participation, including cash transfers for girls most at risk / in the context of low education participation
- **Empower adolescent girls**
  - Life-skills training, including CSE, and livelihood / employment opportunities
  - Safe spaces
- **Improve access to comprehensive sexuality education**
  - Improve coverage and quality of comprehensive sexuality education (for both in-school and out-of-school adolescents), with a focus on building communication and negotiation skills, gender equality, consent and agency, and addressing myths and misconceptions about contraception
- **Increase access to and quality of SRH services, including contraception**
  - Ensure availability of a range of contraceptives, including emergency contraception
  - Promote dual method use (effective modern method and condom use) to prevent unintended pregnancy and STIs
  - Provide competency-based training of providers in non-judgmental contraceptive counselling and services for adolescents
  - Implement and monitor national AFHS standards
  - Remove policies and regulations that require mandatory parental or spousal consent for contraception and comprehensive abortion care
  - Consider voucher schemes or other financing mechanisms to increase uptake and reduce financial barriers
  - Improve the provision and quality of postpartum and post-abortion contraceptive counselling and services
- **Improve support for pregnant adolescents and young parents**
  - Increase access to post-abortion care, and comprehensive safe abortion where legal
  - Improve access to and quality of maternity care
  - Improve access to and quality of postnatal care, including to increase psychosocial and other supports for young parents
  - Support return to, or continuation of, education
  - Life-skills training and livelihood / employment opportunities
- **Strengthen data and research** to inform policies and programmes, particularly understanding the context of adolescent pregnancy outside traditional child marriage, and the needs of sexually active unmarried adolescents

MEETING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION

YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION EXPERIENCE A DISPROPORTIONATELY HIGH BURDEN OF POOR SRH

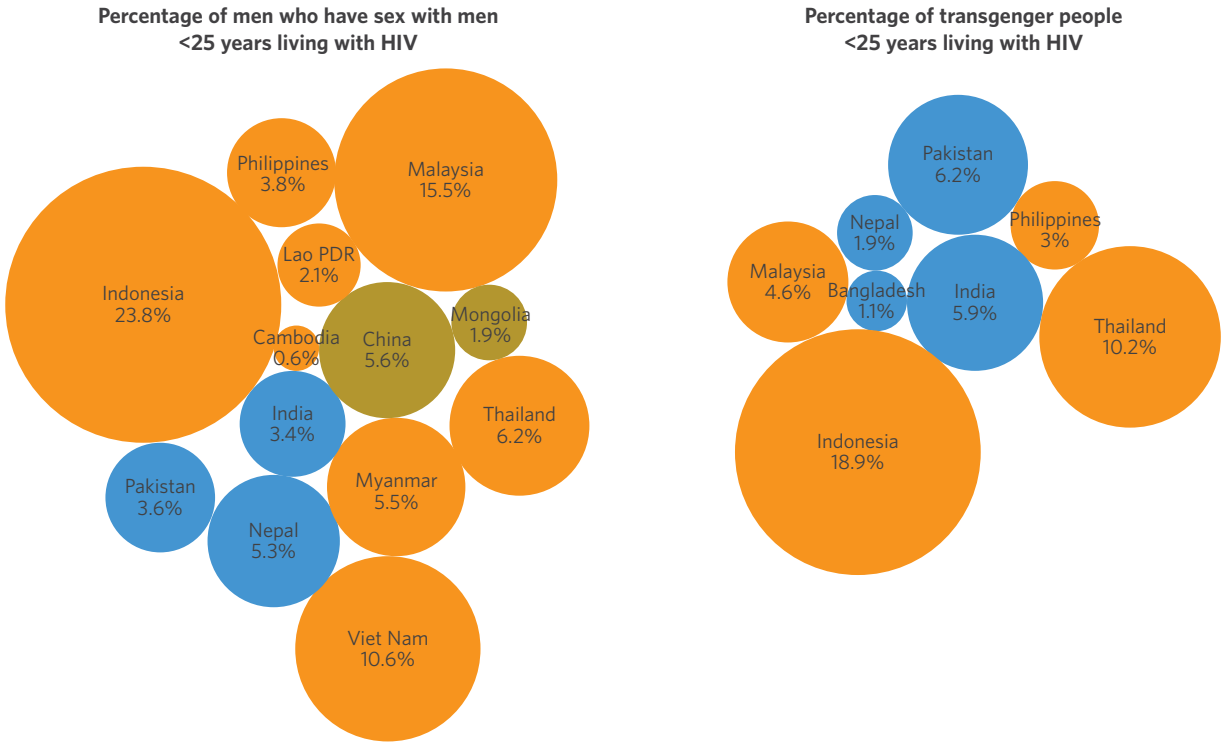
Throughout the region, young people with diverse sexual orientation and gender identity/expression (SOGI/E) experience an excess, and preventable burden of poor SRH. Much of the data and evidence of SRH needs among this population are limited to young men who have sex with men, and young transgender women, with very little information available about the SRH needs of young lesbian and bisexual women, transgender men, intersex young people, or young people with other non-cis/non-binary gender identity/expression. Additionally, much of the focus of available data and studies is on HIV and related risk factors, with less documented about other SRH needs.

Young men who have sex with men, and young transgender people, experience a disproportionate burden of HIV

The vast majority of new HIV infections among young people in Asia and the Pacific occur among key populations[‡‡], including young people with diverse SOGI/E. HIV prevalence is considerably higher among young men who have sex with men and transgender young people than the overall prevalence for 15-24 year olds: 2020 UNAIDS estimates of HIV prevalence for young men who have sex with men range from 0.6% in Cambodia, to 23.8% in Indonesia, and for young transgender people 1.1% in Bangladesh to 18.9% in Indonesia (figure 29).[113]

[‡‡] Young key populations include young men who have sex with men, young transgender people, young people who sell sex, and young people who inject drugs

FIGURE 29. HIV PREVALENCE AMONG YOUNG MEN WHO HAVE SEX WITH MEN AND YOUNG TRANSGENDER PEOPLE



Source: AIDSInfo

Available data indicate that rates of new HIV infection among young people in Asia and the Pacific have declined 23% between 2010 and 2019, and increased in some countries such as Afghanistan, Fiji[§§], Malaysia, Pakistan, Papua New Guinea, Philippines, and Timor-Leste.[114] The fastest growing epidemics in the region are among young men who have sex with men, particularly those living in urban areas.[114] Low levels of HIV knowledge, low risk perception, substance use, marginalisation from education, exposure to high risk settings, and transactional sex contribute to risky sexual behaviour and HIV infection in this region.[115-117]

There are very limited national-level data about STIs among this population. However, smaller studies have indicated that young transgender women and young men who have sex with men have low condom use and high rates of curable STIs, such as syphilis.[118,119]

Rates of physical intimate partner violence, sexual violence and coercion are high among young people with diverse SOGI/E

Recent studies from the Philippines, Myanmar, Thailand and Mongolia reported that between 15% and 50% of men who have sex with men and transgender women have experienced forced sex.[120-122] In Thailand, 18% of all men who have sex with men reported ever experiencing forced sex, and for more than 55%, sexual violence had first occurred during adolescence.[123] In Pakistan, young transgender women described significant violence and sexual abuse, often starting in early adolescence.[124] Around 30% of young men who have sex with men, and bisexual men in China reported intimate partner violence, and coerced sex was strongly associated with inconsistent condom use.[125] Severe stigma and victim-blaming contribute to low care seeking among young people who have experienced physical and/or sexual violence.[126]

[§§] Less than 50 new HIV infections in 2019

Substantial stigma and discrimination create significant barriers that prevent access to SRH information and services, contribute to exclusion and marginalisation, and increase young people's risk of violence and exposure to SRH risks.[114]

A significant proportion of young men who have sex with men report risk behaviours such as multiple partners, non-use and inconsistent use of condoms and transactional sex in some settings.[127-130] In China, a study of young men who have sex with men found that 43% had sex with a partner more than 10 years older, which was associated with non-use of condoms.[131] High rates of substance use (including alcohol and amphetamines), and transactional sex are also associated with risk behaviour and HIV acquisition in this population.[132-134]

> **"I was bullied by ninth grade boys when I was in fifth grade. They teased me and dragged me to a room and tried to take my clothes off. I fought my way out."**
>
> (Young transgender person, Thailand)

In addition to poor SRH, young people with diverse SOGI/E report high rates of psychological distress

In a study in India, two thirds of men who have sex with men, and 91% of transgender women reported psychological distress, which was associated with increased sexual risk behaviour.[135] Studies in China and Thailand demonstrated that suicidal behaviour and self-harm were more common among young people with diverse SOGI/E than their heterosexual and cisgender peers.[136,137] Victimisation, bullying, lack of social support, stigma and discrimination are key drivers of psychological distress and poor mental health, and are commonly experienced by young people with diverse SOGI/E. These factors also contribute to risky behaviour such as substance use and sexual risk-taking.[136,138,139]

YOUNG PEOPLE WITH DIVERSE SOGI/E HAVE A HIGH UNMET NEED FOR NON-JUDGMENTAL, CONFIDENTIAL SRH INFORMATION AND SERVICES

Many young people lack access to comprehensive sexuality education either because they are not engaged with formal education, and/or programmes are predominantly heteronormative and do not adequately address the needs of young people with diverse SOGI/E. Subsequently, low levels of comprehensive HIV knowledge contribute to higher risk sexual behaviour, low risk perception, and poor awareness of SRH services. To fill knowledge gaps and the need for relevant information that can be accessed anonymously, many rely on informal information sources, such as online sources, social media, or peers.[140,141]

> **"The material in the [school sexuality education] module shouldn't be biased towards just one sexual orientation. So far the material is still very cisgender-biased and there's no room for conversations about transgender."**
>
> (23-year-old man, Indonesia)

The coverage of HIV prevention interventions among young men who have sex with men, and transgender people under the age of 25 years is low (table 9). With the exception of Cambodia, less than half were reached with combination prevention interventions in countries with available data, and fewer than 10% in Bangladesh, Pakistan, and Lao PDR. In all countries where data are available, fewer young people than adults over 25 years have been reached by these programmes.

TABLE 9. CONDOM USE, HIV PREVENTION, AND KNOWLEDGE OF HIV STATUS

Region	Country	% young men who have sex with men who report condom use at last sex	% young men who have sex with men who report receiving HIV prevention interventions	% of young men who have sex with men who know their HIV status	% young transgender people who report condom use at last sex	% of young transgender people who report receiving HIV prevention interventions	% young transgender people who know their HIV status
South Asia	Afghanistan	17.0					
	Bangladesh	46.3	3.5	10.0	43.2	28.8	36.4
	India	84.0			81.4		
	Nepal	95.1		90.6	96.2		82.7
	Pakistan	83.3	1.8	44.7	26.9	0.8	24.2
	Sri Lanka	47.0					
East Asia	China	85.4		53.6			
	Mongolia	78.7	23.8	76.5			
Southeast Asia	Cambodia	75.4	19.7	72.9	85.0	87.9	71.8
	Indonesia	88.0					
	Lao PDR	25.2	8.0	8.3			
	Malaysia	66.2	35.6	42.1	68.2	45.7	31.1
	Myanmar	55.0	26.0	30.6			
	The Philippines	38.0	12.2	23.0	37.8	16.2	33.7
	Thailand	84.0	52.8	45.1	80.0	46.8	34.9
	Viet Nam	64.9	28.4	72.7			
Pacific	Papua New Guinea	59.9		58.8			
	Samoa	2.2	100.0	100.0	46.7	100.0	100.0
	Tonga	66.7			77.8		

Source: AIDSInfo

Young people with diverse SOGI/E experience considerable barriers to accessing quality health services. Concerns about confidentiality, discrimination experienced within the health system, lack of health provider competency, young people's low health literacy, and financial constraints are commonly reported as reasons for not accessing public health services.[140-145] In Lao PDR, 75% of young men who have sex with men have avoided seeking health care because of stigma and discrimination.[113] These barriers contribute to low levels of HIV testing (table 9), as well as low retention in care and poor treatment adherence for those living with HIV.[140,146-148]

> **"We hope SRH services could be completely confidential and the service providers will not overestimate the personal life of the patient, and treat young people equally."**
>
> (Young person, China)

Additionally, the lack of comprehensive services and weak linkages with other clinical and social supports are important contributors to poor health outcomes. Young people with diverse SOGI/E can experience multiple needs and vulnerabilities, including substance use, mental health, social isolation, and violence that increase the risk of poor SRH behaviours and outcomes, in addition to being substantial causes of morbidity and mortality in their own right.[144,149] There is also some evidence that some young men who have sex with men and transgender women are not always included in services and interventions that are tailored to the gay community. Young people in Myanmar, Viet Nam and Thailand who did not openly disclose their sexual orientation or gender identity (that is, did not identify publicly as gay or transgender) were reluctant to access such services due to concerns about their own SOGI/E being disclosed, or because they did not feel these services were designed to meet their needs, highlighting the need for a diversification of responses that are inclusive and acceptable.[145,150,151]

National policy and legislation are also critical determinants. **Young people with diverse SOGI/E are largely neglected by existing adolescent health, SRH, and HIV policies and strategies in the region**, which often fail to recognise or address the specific needs and barriers faced by young people.[52,114] Fifteen countries currently criminalise consensual same-sex sexual acts between men, 10 criminalise same sex acts between women, and three have punitive laws that punish transgender people and related behaviour (figure 30).[47] Many countries that do not criminalise consensual same-sex relations still lack legislation prohibiting discrimination on the basis of sexual orientation or gender identity.[152] In addition to contributing to substantial stigma, such laws are additional barriers to young people accessing services for fear of discrimination or arrest.[52]

Fifteen countries currently criminalise consensual same-sex sexual acts between men; 10 criminalise same sex acts between women

Legislation that requires mandatory parental consent is also a major barrier to accessing services, including HIV testing.

Underpinning all these barriers are the substantial and entrenched individual, community and structural stigma and discrimination that young people with diverse SOGI/E experience. Non-conformity with rigid, conservative gender and sexual norms, as well as cultural and religious beliefs and taboos, mean that these young people are faced with the double stigma associated with both premarital sexual activity and engaging in behaviours that may be highly taboo or criminalised. Across the region, the experience of stigma is associated with higher prevalence of risks for HIV and low use of SRH services, and contributes to social isolation and exclusion, including from formal education.[121,141,153,154] The major determinants of poor SRH risks and outcomes are summarised in figure 31.

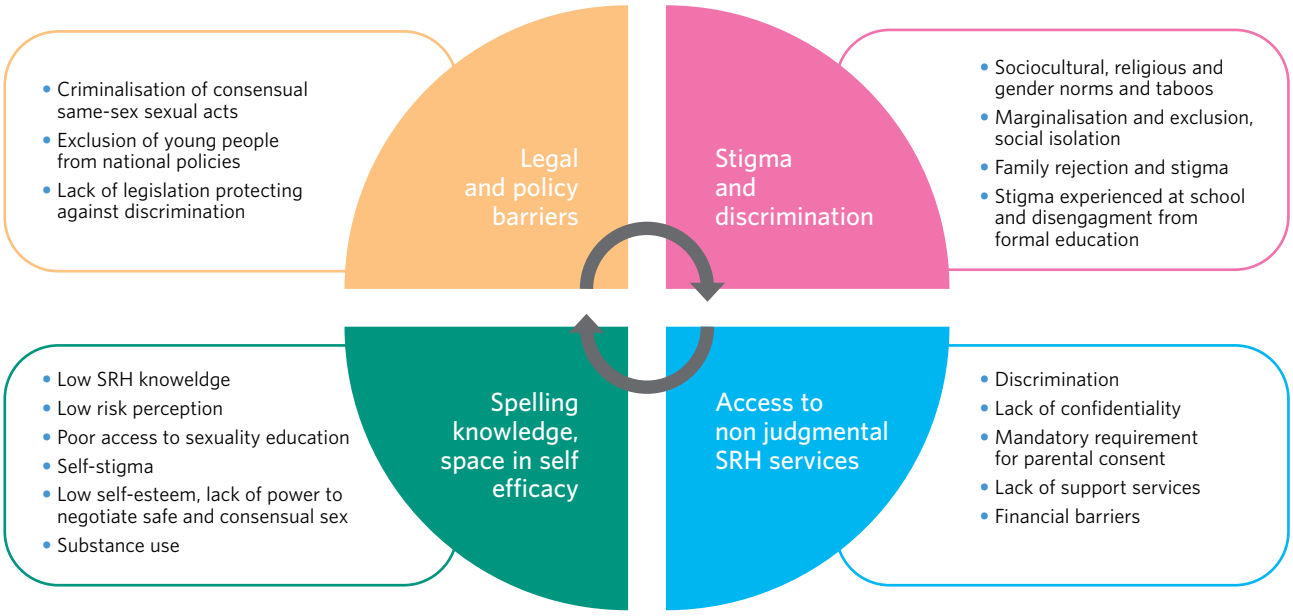
FIGURE 30. CRIMINALISATION OF SAME-SEX SEXUAL ACTS AND TRANSGENDER PEOPLE

Subregion	Country	Same-sex sexual acts: men	Same-sex sexual acts: women	Transgender people
South Asia	Afghanistan	Criminalised	Criminalised	Decriminalised/no punitive law
	Bangladesh	Criminalised	Criminalised	Decriminalised/no punitive law
	Bhutan	Criminalised	Criminalised	
	India	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Iran			
	Maldives	Criminalised	Criminalised	
	Nepal	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Pakistan	Criminalised	Criminalised	Decriminalised/no punitive law
	Sri Lanka	Criminalised	Criminalised	Decriminalised/no punitive law
East Asia	China	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	DPR Korea	Decriminalised/no punitive law	Decriminalised/no punitive law	
	Mongolia	Decriminalised/no punitive law	Decriminalised/no punitive law	
Southeast Asia	Cambodia	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Indonesia	Decriminalised/no punitive law	Decriminalised/no punitive law	
	Lao PDR	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Malaysia	Criminalised	Criminalised	Criminalised
	Myanmar	Criminalised	Decriminalised/no punitive law	Decriminalised/no punitive law
	Philippines	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Thailand	Decriminalised/no punitive law	Decriminalised/no punitive law	
	Timor-Leste	Decriminalised/no punitive law	Decriminalised/no punitive law	
	Viet Nam	Decriminalised/no punitive law	Decriminalised/no punitive law	
Pacific	Fiji	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Kiribati	Criminalised	Decriminalised/no punitive law	Criminalised
	Marshall Islands	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Micronesia	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Nauru	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law
	Papua New Guinea	Criminalised	Decriminalised/no punitive law	Decriminalised/no punitive law
	Samoa	Criminalised	Decriminalised/no punitive law	Decriminalised/no punitive law
	Solomon Islands	Criminalised	Criminalised	
	Tonga	Criminalised	Decriminalised/no punitive law	Criminalised
	Tuvalu	Criminalised	Criminalised	Decriminalised/no punitive law
	Vanuatu	Decriminalised/no punitive law	Decriminalised/no punitive law	Decriminalised/no punitive law

Criminalised
Decriminalised/no punitive law

Source: ILGA 2019

FIGURE 31. COMMON DETERMINANTS OF POOR SRH AMONG YOUNG PEOPLE WITH DIVERSE SOGI/E

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RESPONDING TO THE NEEDS OF YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION

Much of the evidence for addressing SRH needs of young people with diverse SOGI/E comes from HIV research, with very little published research from this region addressing other SRH needs and outcomes. A summary of key WHO strategies,[155] regional initiatives,[114] and global evidence[156] of effective approaches to address HIV is provided in box 8.

Several recent studies from this region have suggested that peer-led approaches to provide education and counselling have the potential to increase knowledge, improve condom use, and increase uptake of HIV testing among young men who have sex with men and transgender women, particularly when these approaches are linked with health services.[117, 157-159] There is also the significant potential of digital media to provide accurate, tailored and anonymous sexuality information, education and counselling, particularly for those young people with very poor access to comprehensive sexuality education.[160, 161] However, some studies have identified the need to combine other approaches (such as face-to-face counselling) with online platforms to promote life-skills.[162] There is also potential of using mobile phone apps to enable young people with diverse SOGI/E to identify health services that provide non-judgmental care.[163]

Other studies have highlighted the need for comprehensive 'one-stop' services that address multiple health needs and risks, and also link to community-based organisations to improve access to social and other supports.[151, 164] Lay / peer provider testing for HIV, or self-testing, has also been reported to be preferred by some young people due to convenience, confidentiality and less stigma.[165-167] Vouchers for targeted HIV prevention, testing and care may improve linkages to SRH and HIV services in some settings.[168] Pre-exposure prophylaxis for HIV (PrEP) has been demonstrated to be highly effective at reducing HIV transmission, across age groups. While there is currently limited evidence of its use in adolescents, in 2014 WHO recommended PrEP for all men who have sex with men, with recent technical guidance provided on the implementation of PrEP for adolescents and young adults.[155] Low adherence has been reported among some adolescent populations most vulnerable to HIV, suggesting that young people may require additional support and monitoring to ensure adherence. Careful consideration of policies and procedures in relation to consent and confidentiality are also required. Limited studies from this region have reported low awareness and willingness to use PrEP among young men who have sex with men and transgender women, and 2015 regional guidelines for Asia and the Pacific have emphasised the need to develop clear communication strategies to support PrEP implementation.[114, 169, 170]

While the current evidence base in this region has some limitations, what is evident is that a multi-component, multisectoral approach that fully engages young people with diverse SOGI/E in design, implementation and evaluation is required to address the complex determinants and multiple vulnerabilities that contribute to poor health outcomes.

BOX 9. KEY STRATEGIES TO ADDRESS SRH OF YOUNG PEOPLE WITH DIVERSE SOGI/E

- **Create an enabling environment:**
  - Inclusion of young people with diverse SOGI/E in national policy and strategic plans related to adolescent health, SRH, and HIV
  - Remove regulatory and legislative barriers that limit access to SRH services, including HIV testing (such as requirements for parental consent)
  - Remove discriminatory laws that criminalise consensual same-sex sexual acts and transgender behaviour
  - Introduce legislation that protects young people with diverse SOGI/E from discrimination
  - Introduce and enforce legislation to protect young people from violence and sexual exploitation
  - Improve linkages with community-based organisation and other social supports to address multiple risk factors
  - Mass media and other community-engagement strategies to address stigma and discrimination
- **Scale-up high-impact, effective interventions:**
  - Consistent condom use (including community-distribution of free condoms and lubricant through peer-led and outreach approaches)
  - Access to testing and counselling for HIV and STIs (improved point-of-care and rapid testing)
  - Improve continuity of care and adolescent-friendly delivery of HIV care and treatment
  - PrEP to prevent HIV infection (develop communication strategies, screening tools, delivery approaches, support and monitoring)
- **Empower and engage young people with diverse SOGI/E**
  - Engage young people with diverse SOGI/E in policy, programme design, delivery and evaluation to ensure approaches are responsive, inclusive and acceptable
  - Advocacy with youth networks to address social norms and include young people in decision-making
  - Peer support and peer empowerment
- **Improve engagement with formal education and access to comprehensive sexuality education**
  - Address stigma and safety in schools
  - Improve access to and quality of school-based sexuality education to better address SOGI/E, diversity, stigma
  - Improve school-based and out-of-school sexuality education to better address the needs and realities of young people with diverse SOGI/E (self-stigma, life-skills, risk perception)
  - Multiple channels to reach young people (peer-led, outreach, digital media)
- **Increase access to and quality of SRH services, including HIV testing**
  - Improve health provider training and supportive supervision
  - Ensure confidentiality and remove requirements for parental consent
  - Mobile outreach services
  - 'One-stop' health centres to provide comprehensive, non-judgmental services that extend beyond HIV testing to address other SRH needs and risks
  - Linkages with other clinical services and supports (violence, substance use, mental health)
  - Remove financial barriers
- **Strengthen data and research to inform policies and programmes**

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SEXUAL AND REPRODUCTIVE HEALTH IN A DIGITAL AGE

Digital media are increasingly influencing the lives of young people. Around the world, adolescents are using digital media as a platform to learn, experience, and communicate. Across Asia, and increasingly in the Pacific, young people use smartphones, tablets and computers to engage in diverse online activities, such as social networking, instant messaging/texting, and browsing websites/ search engines.[171] Mobile phone ownership among 15-19 year olds is high in several South Asian and Southeast Asian countries, and a notable proportion regularly use the Internet (figure 32 and 33). There remain gender disparities in access to digital media: in most countries with available data, boys have greater access to these technologies, particularly in South Asia.

FIGURE 32. PROPORTION OF 15-19 YEAR OLDS WHO OWN A MOBILE PHONE

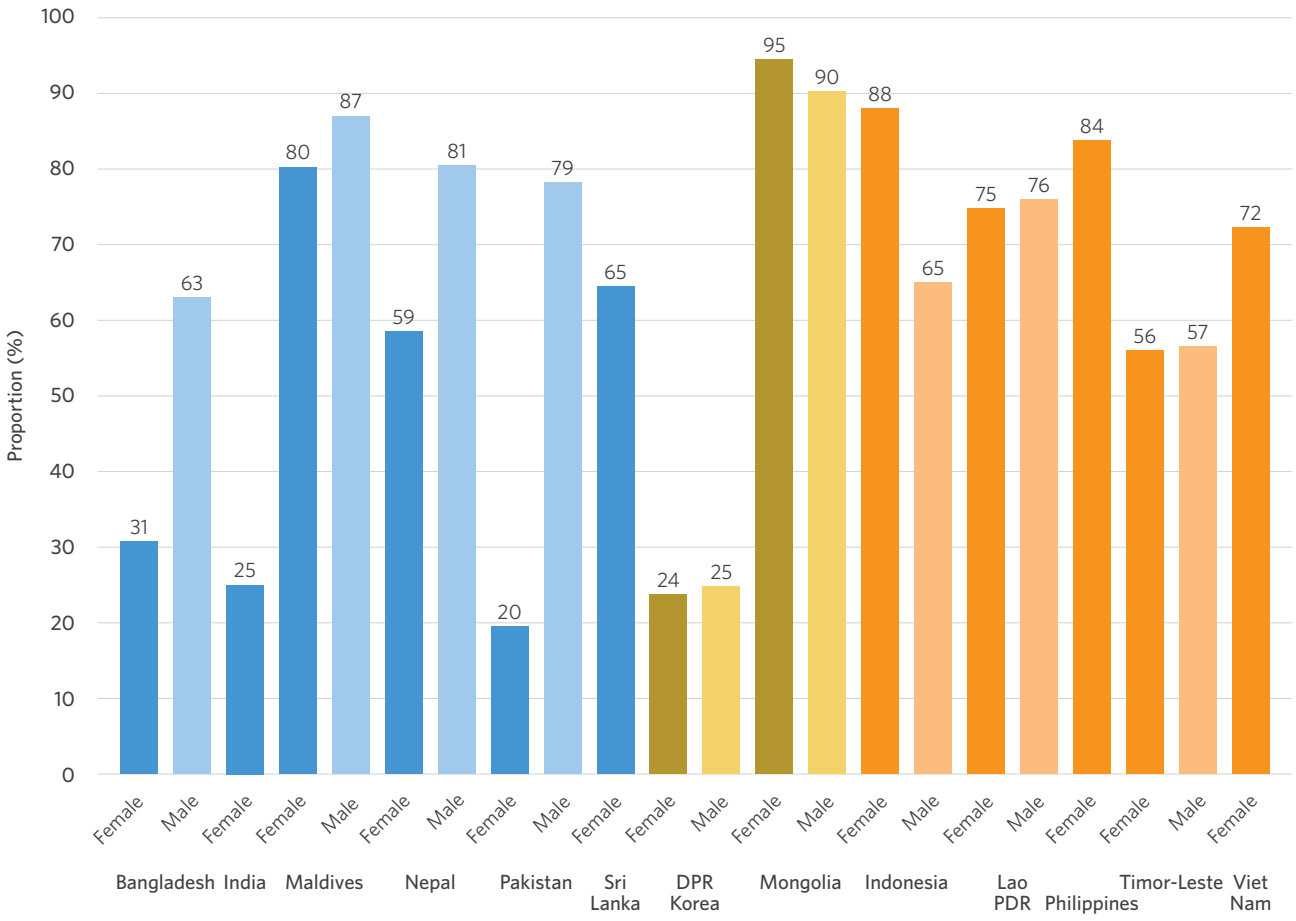
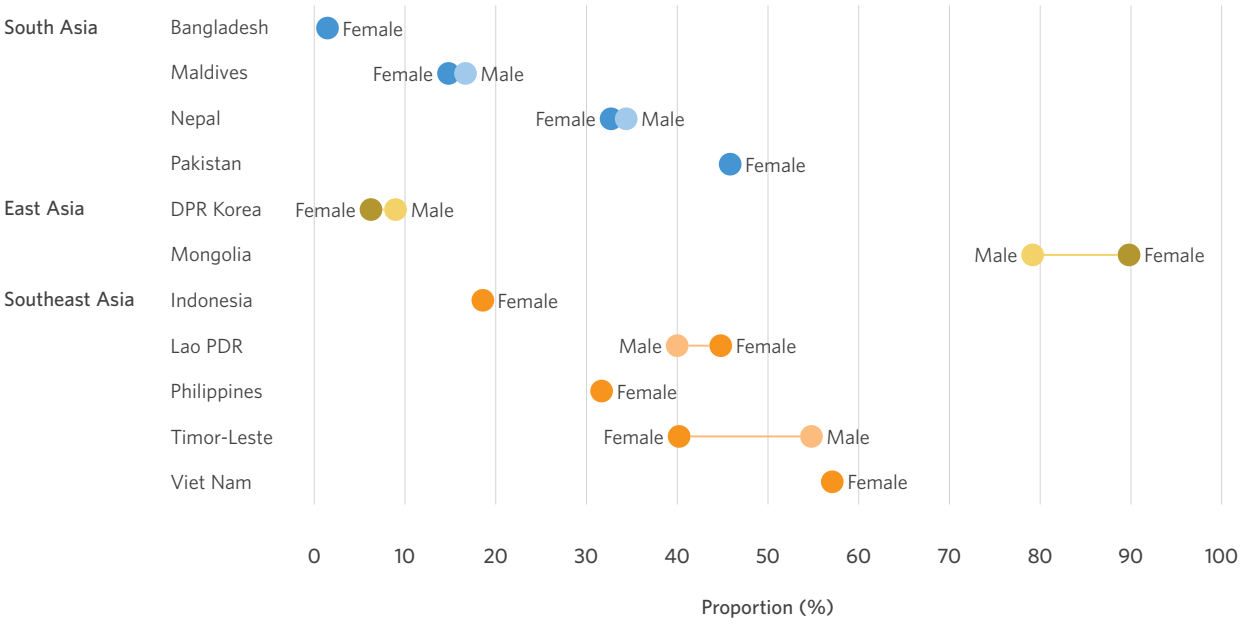


FIGURE 33. PROPORTION OF 15-19 YEAR OLDS WHO USED THE INTERNET AT LEAST ONCE PER WEEK IN THE LAST MONTH



Source: DHS and MICS (country estimates provided in appendix)

USES OF DIGITAL MEDIA IN RELATION TO SRH

There are several new ways in which the Internet has changed the way that young people communicate, learn and experience SRH (figure 34). In particular, the Internet offers increased access to information, people, and communities, and increased **anonymity**.[172] These features offer important opportunities for young people's SRH.

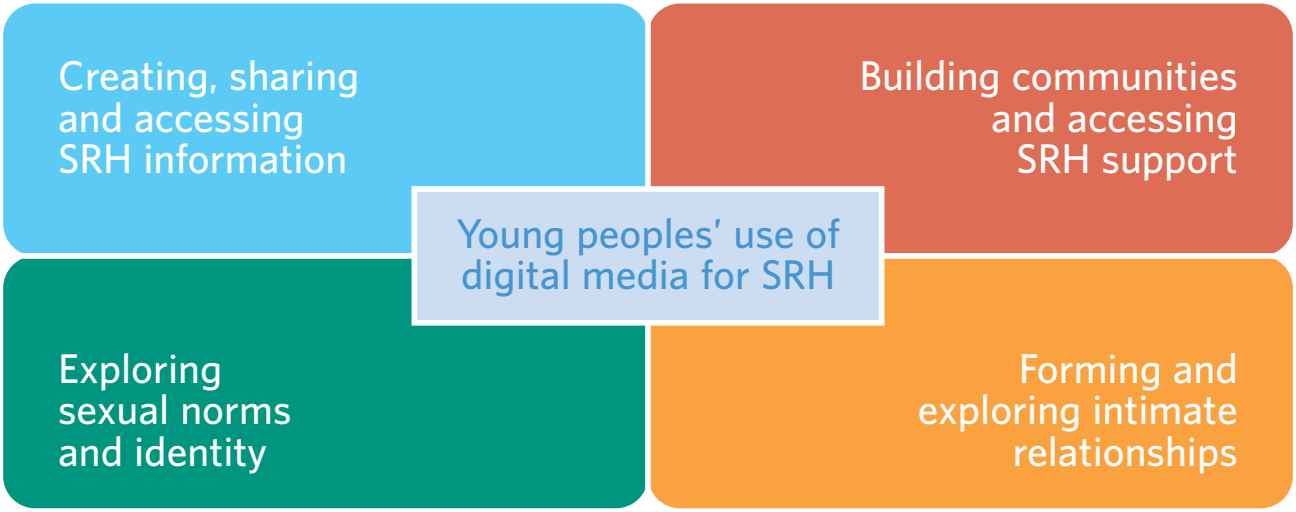
Creating, sharing and accessing SRH information

In the context of poor access to comprehensive sexuality education in the region, young people have turned to the Internet and social media to learn about sexuality and SRH.[171] A survey of 1,432 15-24 year olds from across Asia and the Pacific conducted in 2019 by UNFPA found that the Internet (55% of respondents) and peers (56%) were the most important sources of information about sex, compared to schools (39%) (figure 35).[173] Of note, however, this electronic survey sampled young people who had digital access (biased) and may not be representative of the preferences of all young people.

Around half of young people identify the
Internet/social media
as one of most important sources of information about sex.

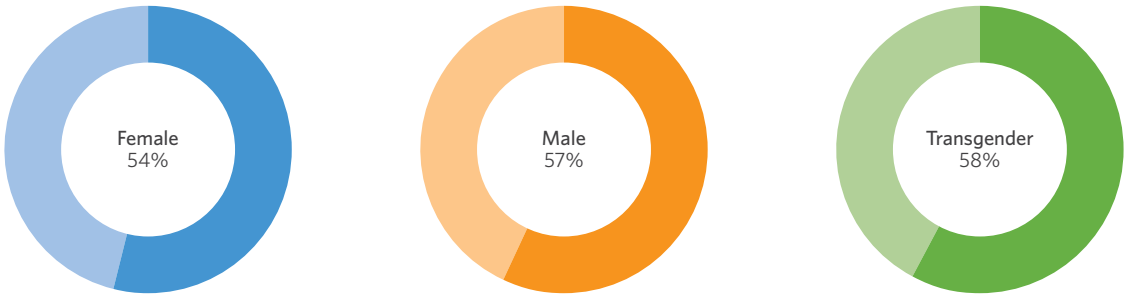
> **"I don't want to talk or ask the teacher. Usually I find the information through the internet. I fear that the teacher can spread our story, and [that] scares us."**
>
> (Young person, Indonesia)

FIGURE 34. YOUNG PEOPLE'S USE OF DIGITAL MEDIA FOR SRH



Source: UNFPA 2019[173]

FIGURE 35. PROPORTION OF 15-24 YEAR OLDS WHO STATE THAT THE INTERNET / SOCIAL MEDIA IS ONE OF THE MOST IMPORTANT SOURCES OF SRH INFORMATION



Source: UNFPA 2019[173]

The Internet offers unprecedented access to information from a wide range of sources and from all around the world. Anonymity also allows adolescents to seek information about SRH that they may otherwise feel too shy to obtain.[172] Conservative sociocultural and religious norms often prevent families and communities from discussing sex and SRH openly.[171, 174] As a result, online sources information are particularly popular among young people because they can be reached privately, free from sociocultural restrictions and taboos, and with less stigma and discrimination.[171]

There are many different ways in which young people interact with SRH information online. Social media, such as YouTube and Instagram, have become popular places for sex educators and young people to share information in the form of photos, audio, text and videos.[172] In this region, many websites (Love Matters, Sobat ASK, and Love9) are also present on social media, with dedicated Facebook pages and YouTube channels. For example, Youth Chhlat is a platform developed for Cambodia, where young people can access SRH information through their website, app, YouTube info-cartoons, mobile podcast, and question-answer services.[9, 171]

These platforms also offer Q&A forums, or "Chat Bots," where adolescents can ask a range of SRH questions that they may normally feel too embarrassed to ask.[171] For example, Love Matters has a discussion page, called "Let's Talk," where users can either post their own questions anonymously, send questions privately to the website's moderator, or read the questions posted by other users and the answers provided by the website's moderators.[11]

> **"I went through YouTube videos for entertainment and came across HIV prevention, so I took a look..... I used Facebook to see how to use a condom to prevent infection."**
>
> (Young person, Thailand)

Building communities and accessing SRH support beyond regional boundaries

Social media, like Facebook, allow users to build online communities and stay connected with friends, peers and family, as well as finding and interacting with people that they may not have normally met offline. This can allow young people to find support from peers with similar experiences and questions regarding their SRH. For example, for young people with diverse SOGI/E, online networks can provide a source of support.[175] Through online groups, young people are able to receive support and connect with SOGI/E communities that they may not be able to access in their offline world, particularly in settings where same-sex behaviour is criminalised or highly stigmatised. Through these networks, young people with diverse SOGI/E are able to discuss problems and concerns, openly acknowledge their sexual orientation and identity, and seek information and advice about SRH and other related issues from peers.[172]

Supporting healthy adolescent development by exploring sexual norms and sexual identity

Adolescence is a period of intense social and emotional development during which sexuality, sexual identity, and gender roles are consolidated.[3] It is also when young people acquire sexual values and norms, through their interactions with their peers and sociocultural contexts.[176] Potential harms are discussed below, but digital media can also be a very useful tool for adolescents to develop their sexuality, and explore norms, values and identities, particularly in conservative settings where open discussion of sexuality is restricted.

'Sexting' is used to describe the sending, receiving and/or sharing of sexually explicit text messages, photos and video.

The 2019 UNFPA online youth survey found that **31% of girls** and **51% of boys** aged 15-24 years in this region had engaged in sexting.

Research from other regions indicates that young people are increasingly using social media to develop their sense of sexual identity.[177] This can include posting sexually suggestive photos to receive positive feedback from peers, in order to reduce uncertainties that are a normal part of puberty and adolescent development.[178] Although the use of social media in this form has sparked intense concern amongst parents, teachers, researchers and policymakers, it is important to consider how these activities (when done safely) can fit within the healthy sexual development of adolescents. A growing body of research has pointed to the ways in which consensual sexting can potentially fit within the healthy sexual development of older adolescents, by helping young people evaluate their own sexual feelings and actions.[176,179] Sexting may be used to seek positive feedback on body image from peers, and therefore help to improve self-esteem and sense of identity. Greater self-esteem and a positive understanding of sexual identity may, in turn, improve young people's assertiveness in relationships and reduce risk-taking.[180] It is important to note, however, that the existing evidence related to sexting is limited to North America and European contexts, with a significant gap in knowledge for this region.

> **Some health facilities use the internet and social media. One example has Facebook and Instagram accounts. Some of them have a hotline you can directly consult through WhatsApp."**
>
> (Young person, Indonesia)

> **"I think people who use the same dating app or an app that is mostly for sharing sexual issues can really get along and feel more comfortable sharing secrets."**
>
> (Young person, Thailand)

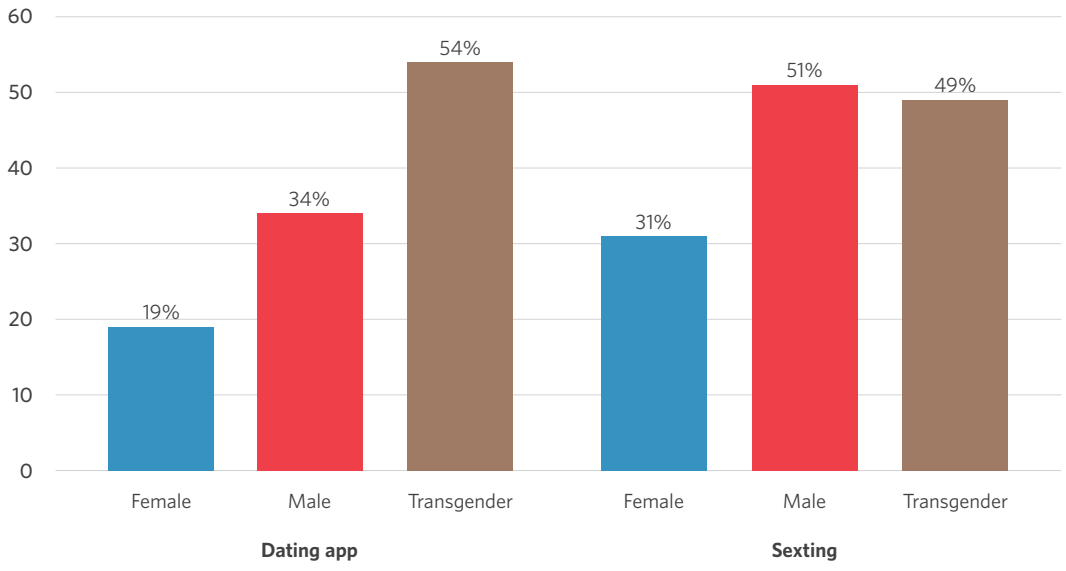
Forming and exploring intimate relationships

Experimenting with relationships, within a safe environment, is a normal part of adolescent development. For many young people, this experimentation and aspects of intimate relationships are increasingly conducted using digital platforms.

Like other courtship practices such as dating or flirting, sexting can be part of normal sexual behaviour. For many young people, sexting may be a first expression of sexuality during adolescence.[180] This is particularly true for young people with diverse SOGI/E, for whom sexting may allow private exploration of sexuality and intimacy.[181,182] Sexting also has the potential to be beneficial as a way of sustaining intimate relationships,[183,184] and is often conducted in the context of a romantic relationship to demonstrate love, trust and commitment.[185,186] In this way, consensual sexting can have a positive role when done in a safe and mutually respectful context.

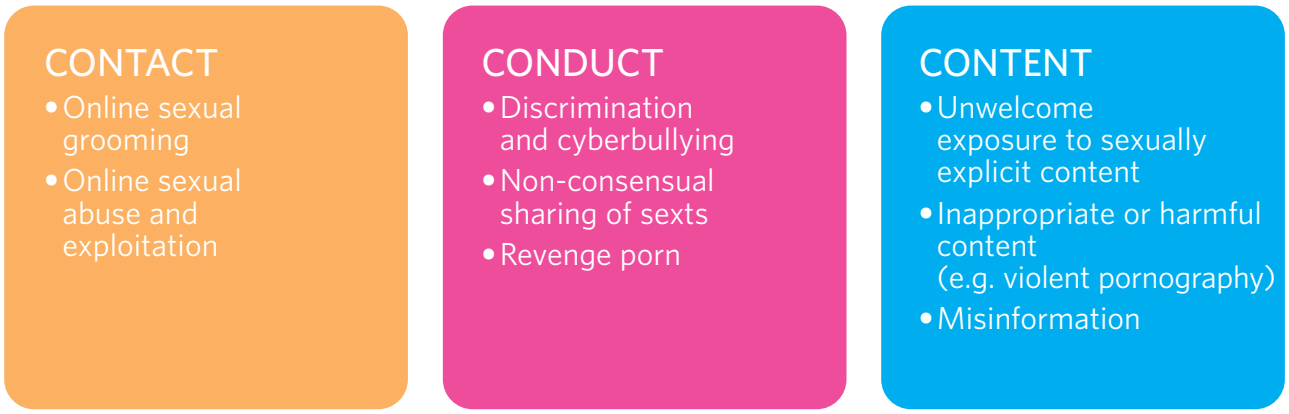
Sexting can be a safer alternative to other sexual behaviours, particularly for adolescents who are forming their first romantic relationships but do not feel 'ready' to engage in other sexual activities with a partner.[174,176,185,187] Through sexting, young people can explore sexual thoughts and feelings, that are common during adolescence, while potentially avoiding the risk of pregnancy and STIs. Sexting can also be combined with other behaviours, such as masturbation, that may help young people become more familiar with their bodies and their likes and dislikes.[188] While research in this region is limited, the 2019 UNFPA online youth survey found that almost a third of girls, and half of boys and transgender young people had engaged in sexting (figure 36).[173]

FIGURE 36. PROPORTION OF 15-24 YEAR OLDS WHO HAVE USED DIGITAL MEDIA FOR SEXTING OR DATING APPS



Source: UNFPA 2019[173]

FIGURE 37. POTENTIAL SRH-RELATED HARMS OF DIGITAL MEDIA



POTENTIAL HARMS AND CONSIDERATIONS

Unfortunately, the very features of the Internet that facilitate new opportunities also create new risks for young people's SRH. Common harms have been organised in the following categories: contact, conduct and content (figure 37).

CONTACT

Harmful contact refers to instances where a young person participates in risky communication with another person, particularly where there is a power difference- such as an adult. Within the context of SRH, risky communication often comes in the form of an adult seeking inappropriate online or offline contact with a young person for sexual purposes.

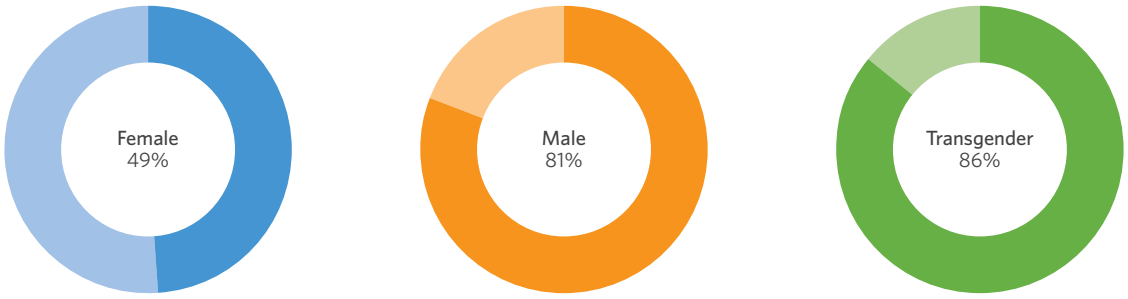
While the increased accessibility of social media can provide important connections with like-minded people, it can also facilitate easier connections between young people and potential predators.[172] As young people are increasingly developing online profiles on these platforms, it has become easier for adults seeking inappropriate contact to connect with potential victims. By having much more access to communication networks, traffickers are also able to more effectively exploit young people.[189] These contact risks include online grooming where they may solicit an adolescent for sexual purposes, or try to encourage sexual risk-taking.[171,190] Young adolescents are particularly vulnerable to these risks as they are more likely to see stranger contact as an opportunity to make new friends.[191] Following initial grooming, young people are vulnerable to sexual exploitation and online abuse. The online world has created new forms of child sexual abuse.[191] Labelled as 'live streaming,' 'pay-per-view', 'on-demand child sexual abuse,' or 'child sexual abuse to order,' perpetrators sexually exploit children by asking them to perform sexual activities via webcam for money.[192] There are examples of this in the Philippines, where older men pay for online sexual activities of girls aged 13 to 17 years old.[192]

CONDUCT

There are various ways in which young people engage in conduct online that is potentially harmful to themselves and/or others. While these platforms can be used to provide peer support that reinforces self-esteem, they can also be used to do the opposite. Like the offline world, discrimination based on gender, sexuality, race, and disability are common on online platforms. In fact, due to the anonymity of online communication, online discrimination and cyberbullying can often be enhanced compared to the non-digital world. For example, girls commonly report experiencing increased surveillance and shaming if they post a sexually revealing image online.[193] Young people with diverse SOGI/E report higher levels of cyberbullying through social networks in comparison to their heterosexual peers.[194]

Another form of harmful conduct is the non-consensual distribution of sexts. This can come in the form of forwarding a privately sent image/video to others, posting it on social media, or showing it in-person to others without consent. Non-consensual sharing of sexts is significantly gendered: girls are at greater risk of having their sexts shared without their consent and consequently report experiencing far greater negative outcomes when their sexts are shared without their consent.[183,187,195]

FIGURE 38. PROPORTION OF 15-24 YEAR OLDS WHO HAVE USED DIGITAL MEDIA TO ACCESS PORNOGRAPHY



Source: UNFPA 2019[173]

A potentially more harmful outcome of sexting is the risk of 'revenge porn' or non-consensual pornography. 'Revenge porn' refers to the online distribution of private sexually explicit content of an individual by their partner on a social media site or pornography site.[39] Often, this occurs following a relationship breakdown, with a partner using photos or videos that were taken consensually during their relationship to share online in an act of vengeance and demonstration of power over the victim. These activities can have damaging impacts for victims of revenge porn, such as humiliation, poor mental health, and offline harassment.[196]

CONTENT

Content risks refer to instances where a young person is exposed to unwelcome, inappropriate or potentially harmful online content. This can take various different forms, including pornographic content, discriminatory content, and misinformation. Increased accessibility of the Internet has facilitated the dissemination of harmful content to young people. Strict anti-pornography laws exist in many countries in the region, however, a significant proportion of young people are exposed to pornography online, either by accident or deliberately seeking it out.[171] In this region, around half of girls aged 15-24 years, and more than 80% of boys and transgender young people have used digital media to access pornography (figure 38).[118] A study in Indonesia found pornography to be as readily and widely consumed as in less conservative countries.[197] Significant gender differences were also observed, with men consuming more often, for longer periods, and at an earlier age than women.

There is good evidence that young people's attitudes, values and norms about sex are affected by exposure to pornography, particularly in the absence of access to comprehensive sexuality education.[171]

Sexual activity portrayed in online pornography is often not safe, with limited content including the use of condoms or addressing issues such as consent. Of particular concern is the increasing accessibility and normalisation of violent pornography, and/or content that perpetuates harmful gender norms that underpin gender-based and sexual violence. Studies from other regions have indicated that boys experience greater exposure to more violent and abusive content and at a young age, and those exposed to violent pornography are 2-3 times more likely to perpetrate dating violence.[198]

Another potentially harmful aspect of digital content is misinformation. While there are many comprehensive, reputable and high quality online SRH resources, there are also many websites and other platforms that provide unreliable, incorrect, or misinformation.

> **"Considering the truthfulness of the information on the internet, it is complicated to distinguish between a genuine and an unreliable source..... this has resulted in many misunderstandings."**
>
> (Young person, Viet Nam)

DESPITE THESE CHALLENGES AND CONCERNS, DIGITAL PLATFORMS PRESENT AN IMPORTANT OPPORTUNITY TO BETTER UNDERSTAND AND ADDRESS YOUNG PEOPLE'S SRH

However, there remains a considerable knowledge gap in Asia and the Pacific, particularly research to understand the influence of digital media on young people's knowledge, attitudes, behaviours and health outcomes, and the effectiveness of using these platforms to improve SRH.

Although there has been an increase in digital tools adapted for Asia and the Pacific, they are still lacking in terms of reach, independent access, targeted content, and/or age appropriateness and appeal.[171] Key to developing more effective and acceptable approaches is ensuring young people are engaged in the development and implementation of these platforms. These efforts can also support youth-led entrepreneurial activities, and include young people in dialogues about untested, creative alternatives to traditional websites, apps, and other digital media. By including the voices of young people, there is potential for the development of culturally sensitive, age-appropriate and innovative digital tools that reduce the risk of harm and support SRH.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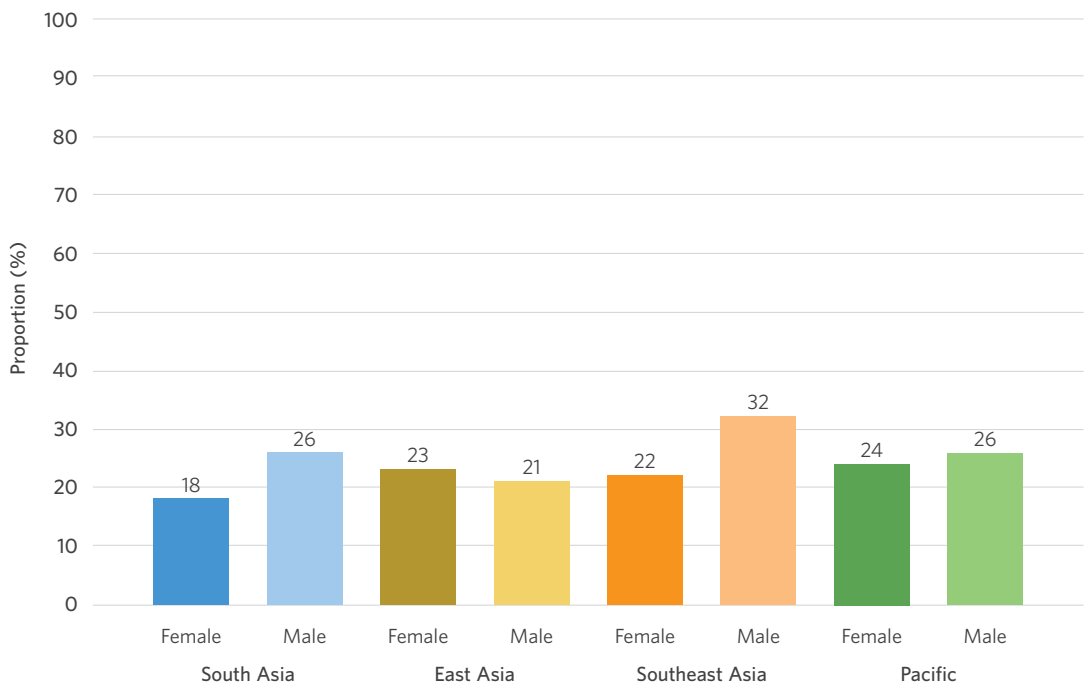
COMPREHENSIVE SEXUALITY EDUCATION

Sexuality is a fundamental part of human life. Every young person will have to make decisions that impact on their SRH and wellbeing, however, many lack the comprehensive knowledge, supportive attitudes and life-skills they need to make these decisions safely and responsibly.

Across the region, less than a third of young people have comprehensive knowledge of HIV (figure 39). In Afghanistan, Pakistan and Samoa fewer than 1 in 10 young people have comprehensive HIV knowledge, and in the majority of countries, girls have poorer knowledge than boys. Young people living in rural areas, from the poorest households, and with no or only primary-level education have the lowest level of knowledge. Among sexually active young people, the majority know that using a condom can prevent HIV (figure 40). However, less than half of young people have this knowledge in Afghanistan, Pakistan and Timor-Leste, and there are considerable disparities between boys and girls in many countries.

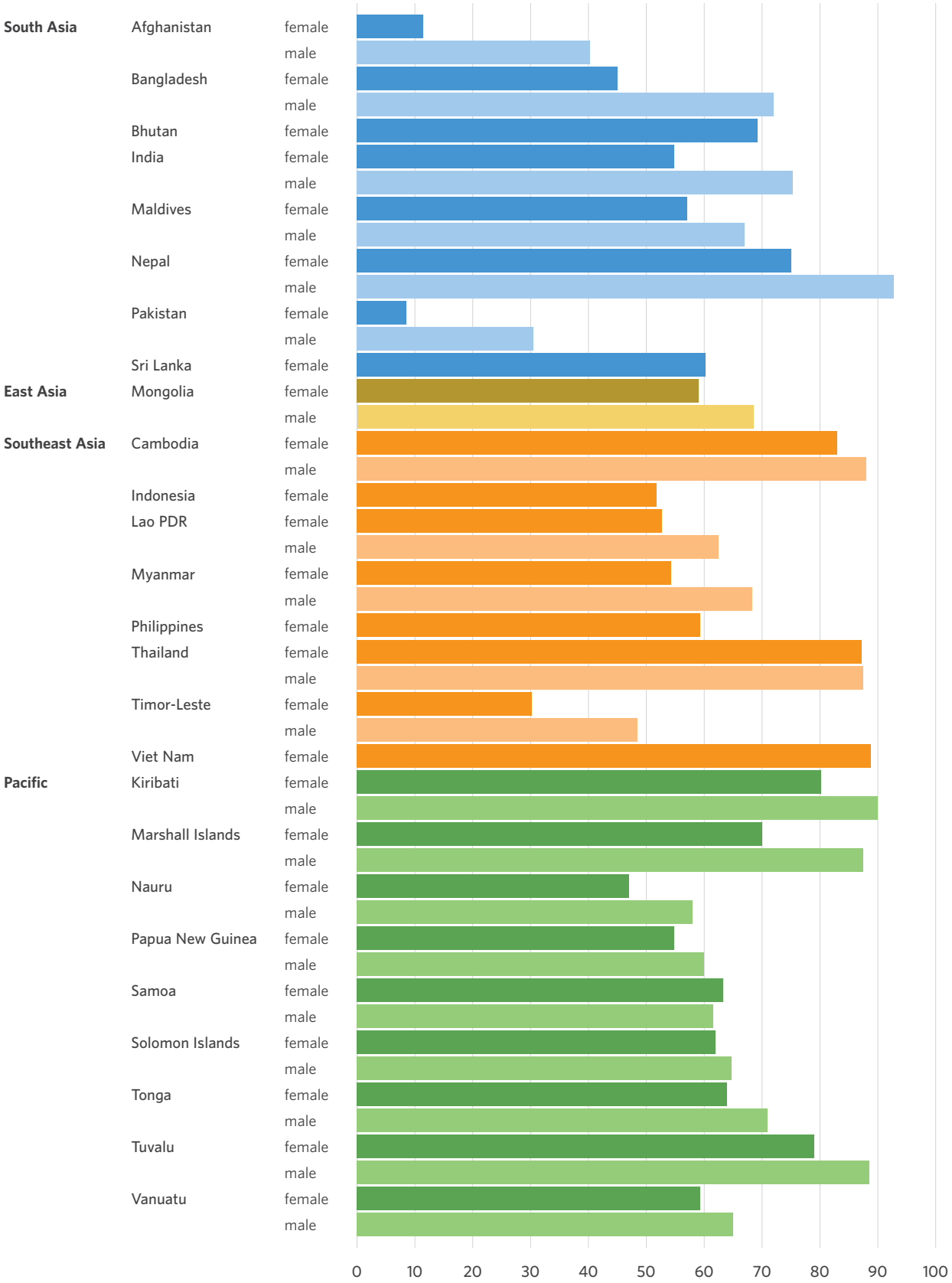
> **"I knew a little bit about how a baby is made, but not much. I had no education about this at school, no lessons at all related to this topic. Nothing."**
>
> (19-year-old mother, Timor-Leste)

FIGURE 39. COMPREHENSIVE KNOWLEDGE OF HIV AMONG 15-24 YEAR OLDS



Note: East Asia estimate includes Mongolia only
Source: DHS and MICS

FIGURE 40. PROPORTION OF SEXUALLY ACTIVE 15-24 YEAR OLDS WHO KNOW THAT A CONDOM CAN PREVENT HIV

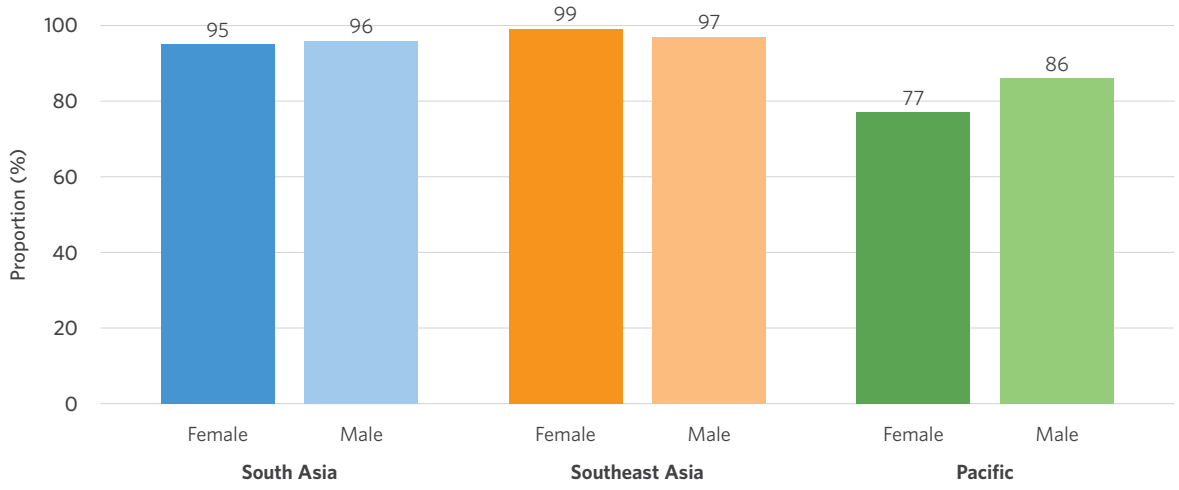


Source: DHS and MICS (country estimates provided in appendix)

While the majority of married young people can name at least one method of modern contraception (figure 41), poor understanding of different methods (including emergency contraception), lack of knowledge about sources of contraception, and myths and misconceptions are common.[199,200] There is limited national-level data describing contraceptive knowledge among unmarried girls and boys.

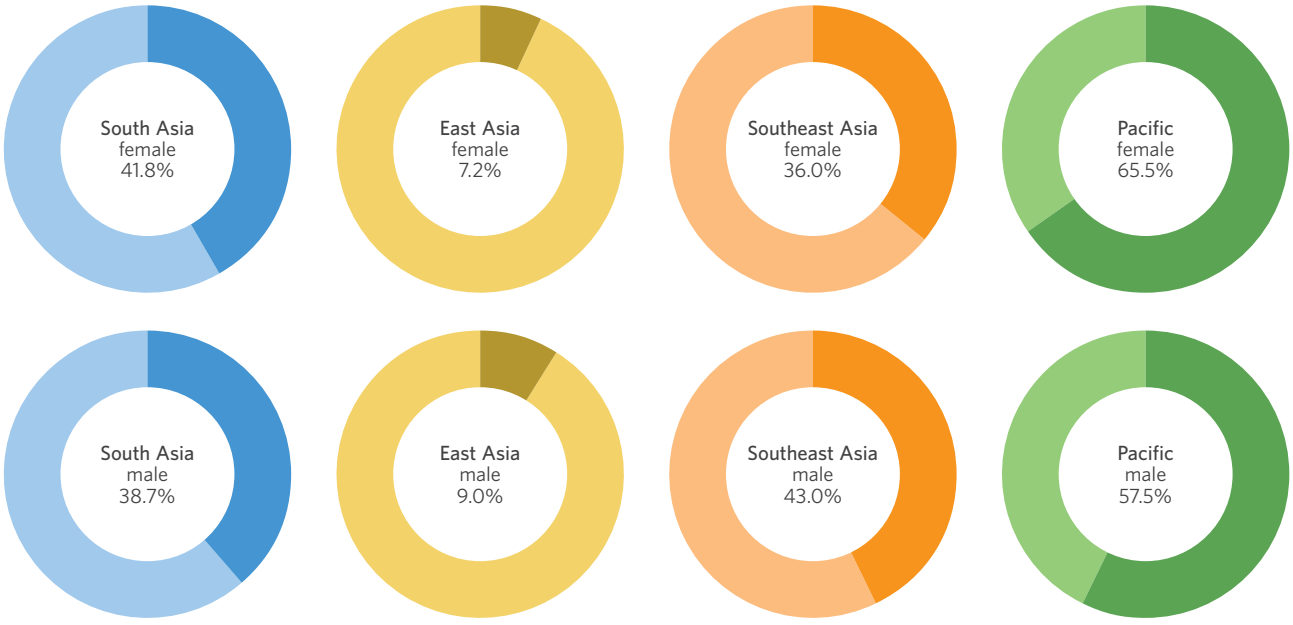
A significant proportion of adolescents in the region also report attitudes that reflect the acceptance of intimate partner violence, most notably in the Pacific where two thirds of girls and 58% of boys agree that physical violence is justified for at least one reason (figure 42). Global studies have demonstrated that gender norms and attitudes are formed during childhood and early adolescence, highlighting the importance of providing comprehensive sexuality education from an early age.[201]

FIGURE 41. PROPORTION OF MARRIED 15-24 YEAR OLDS WHO HAVE HEARD OF AT LEAST ONE MODERN METHOD OF CONTRACEPTION



Source: DHS and MICS

FIGURE 42. PROPORTION OF 15-19 YEAR OLDS WHO STATE THAT A HUSBAND IS JUSTIFIED IN HITTING OR BEATING HIS WIFE FOR AT LEAST ONE REASON



Source: DHS and MICS

COMPREHENSIVE SEXUALITY EDUCATION (CSE) IS A RIGHTS-BASED APPROACH TO EMPOWERING YOUNG PEOPLE WITH KNOWLEDGE AND SKILLS TO PROTECT THEIR HEALTH, WELLBEING AND DIGNITY

In addition to providing accurate and comprehensive information about SRH, CSE is also grounded in gender equality and human rights. It goes beyond simply providing education about reproduction, risks and diseases, to address positive sexuality and relationships, and the broader sociocultural and gender influences on SRH, with an emphasis on developing life-skills (box 9). International technical guidance is that age-appropriate CSE should be started early (at least from age 5 years).[202]

UN's International technical guidance on sexuality education: an evidence-informed approach 2018 outlines eight key concepts central to effective CSE (figure 43).[202]

There is good evidence of the effectiveness of CSE that includes these core components. Reviews of studies conducted in a broad range of countries and contexts (including countries from this region) have found that curriculum-based CSE has a positive impact not only on knowledge and attitudes, but also contributes to:[202]

- Delayed onset of first sex
- Decreased frequency of sex
- Decreased number of sexual partners
- Reduced risk behaviours
- Increased use of condoms and contraception

BOX 10. DEFINITION OF COMPREHENSIVE SEXUALITY EDUCATION

CSE is a curriculum-based approach to teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip young people with knowledge, attitudes, skills and values that empower them to: realise their health, wellbeing and dignity; develop respectful social and sexual relationships; consider how their choices affect their own wellbeing and that of others; and understand and ensure the protection of their rights throughout their lives.

CSE programmes are:

- Scientifically accurate
- Incremental (starting from an early age, before puberty and sexual debut)
- Age and developmentally appropriate
- Curriculum based
- Comprehensive
- Based on a human-rights approach
- Based on gender equality
- Culturally relevant and context appropriate
- Transformative
- Designed to develop life-skills

Source: UNESCO 2018[202]

FIGURE 43. UNESCO INTERNATIONAL TECHNICAL GUIDANCE: CORE CSE CONCEPTS

Key concept 1: Relationship

Topics:

1.1 Families

1.2 Friendship, love and romantic relationship

1.3 Tolerence, inclusion and respect

1.4 Long-term commitments and parenting

Key concept 2: Values, rights, culture and sexuality

Topics:

2.1 Values and sexuality

2.2 Human rights and sexuality

2.3 Culture, society and sexuality

Key concept 3: Understanding gender

Topics:

3.1 The social construction of gender and gender norms

3.2 Gender equality, stereotypes and bias

3.3 Gender-based violence

Key concept 4: Violence and staying safe

Topics:

4.1 Violence

4.2 Consent, privacy and bodily integrity

4.3 Safe use of information and communication technologies (ICTs)

Key concept 5: Skills for health and well-being

Topics:

5.1 Norms and peer influence on sexual behaviour

5.2 Decision-making

5.3 Communication, refusal and negotiation skills

5.4 Media literacy and sexuality

5.5 Finding help and support

Key concept 6: The human body and development

Topics:

6.1 Sexual and reproductive anatomy and physiology

6.2 Reproduction

6.3 Puberty

6.4 Body image

Key concept 7: Sexuality and sexual behaviour

Topics:

7.1 Sex, sexuality and the sexual life cycle

7.2 Sexual behaviour and sexual response

Key concept 8: Sexual and reproductive health

Topics:

8.1 Pregnancy and pregnancy prevention

8.2 HIV and AIDS stigma, care treatment and support

8.3 Understanding recognizing and reducing the risk of STIs, including HIV

Source: UNESCO 2018[202]

CSE programmes are most effective if they incorporate a rights-based approach, are gender-transformative (that is, challenge gender norms and promote gender-equitable relationships), and are complemented by community-based interventions such as condom distribution and improved linkages with adolescent-friendly health services. Programmes that address gender are five times more likely to be effective at reducing STIs and pregnancy than programme that do not.[202,203] CSE can also play an important role in preventing gender-based violence by promoting respectful, equal and non-violent relationships.

There is no evidence that sexuality education programmes lead to early sexual debut, increased sexual activity, or risk-taking behaviour.

However, approaches that focus only on abstinence have been found to be ineffective at delaying the onset of sexual activity and reducing risk behaviours. Additionally, young people in the region identify topics related to positive sexuality, violence, consent, safe sex and contraception, diversity and gender as areas that are of particular importance and relevance to their lives.[173]

CSE programmes that address gender are **five times** more likely to be effective at reducing pregnancy and STIs.

FIGURE 44. NATIONAL LAW AND SEXUALITY EDUCATION CURRICULUM

Source: UNFPA 2020[288]

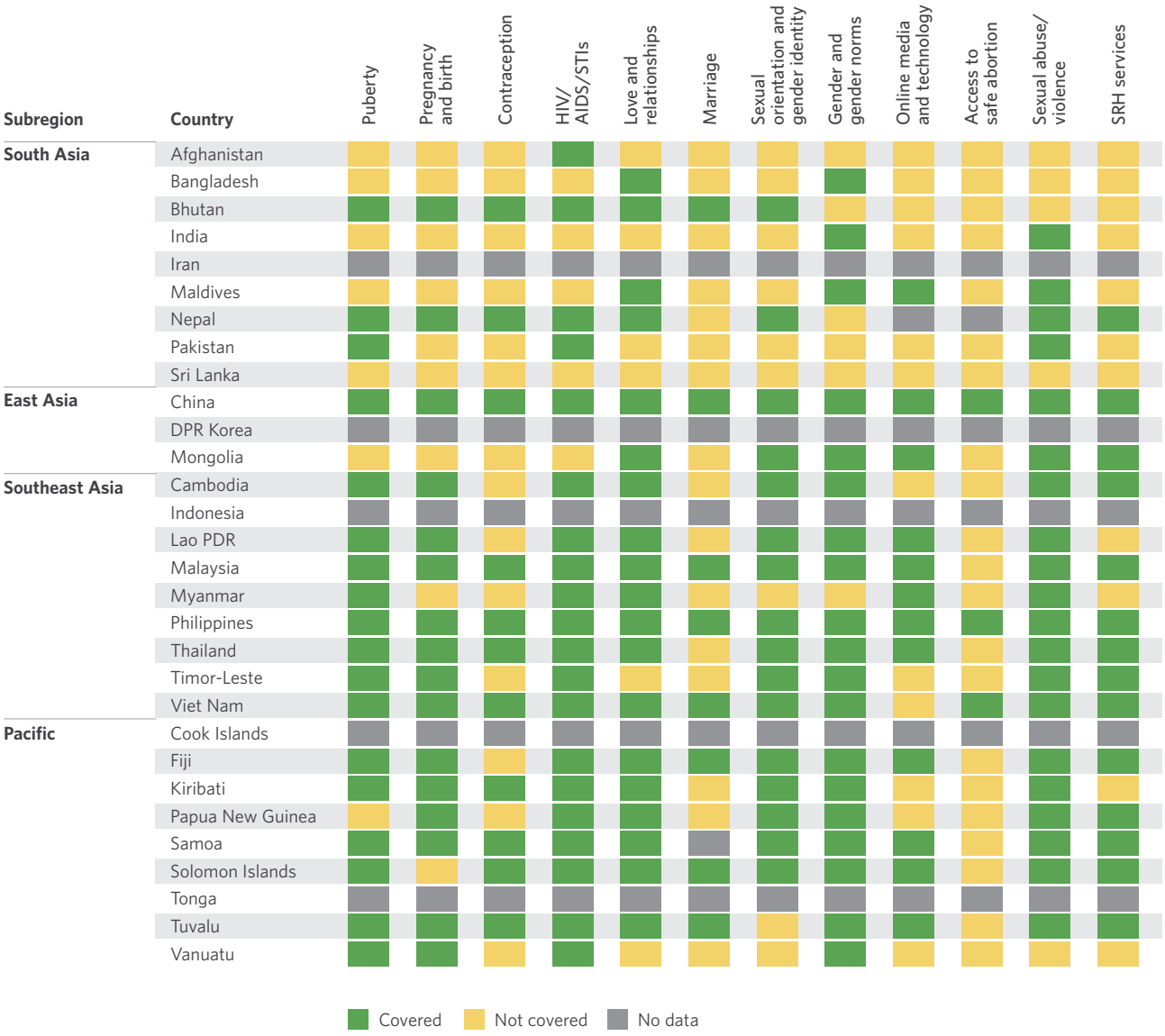
COVERAGE OF SEXUALITY EDUCATION CURRICULA AND CONTENT

Recent data on coverage of CSE are available for 30 countries from a recent UNFPA, UNESCO and IPPF report.[288] This report demonstrates considerable progress in many countries in the region to have national law and national sexuality education curricula (figure 44). Twenty-seven countries have at least one national law, policy or strategy in place referring to the provision of sexuality education for young people (figure 44). This report also suggests that over half of the countries have mandated sexuality education at primary level (16 countries) and secondary level (15 countries). It was also reported that nearly two-thirds of countries (22 countries) reported that training for teachers in sexuality education is required before teaching the subject (figure 44). While this report does not contain data on Technical and Vocational Education and Training (TVET), sexuality education is delivered as a part of TVET in some countries.

Among countries with national curricula, sexuality education topics covered in the curriculum, and how extensively they are dealt with, varied by country. The topics commonly reported as being covered in the curriculum at the primary level included puberty, HIV & AIDS / STIs, love and relationships, gender and gender norms, and sexual abuse/violence (figure 45)***. Topics less commonly covered at primary level included contraception, marriage and access to safe abortion in the frame of national law (figure 45).

*** Primary-level curriculum recently released in India shows that "puberty", "love and relationships", and "online media and technology are also taught. While CSE is not delivered in Iran, puberty is taught in primary education according to UNFPA Iran.

FIGURE 45. COVERAGE OF CORE CSE TOPICS AT PRIMARY LEVEL



Source: UNFPA 2020[288]

Compared to the primary level curricula, topics covered in the secondary curriculum are more diverse and are reportedly taught more extensively. While puberty, HIV & AIDS / STIs, and sexual abuse/violence continue to be taught from primary through to the secondary level, there is an increase in the number of countries that introduce other topics at the secondary level, including pregnancy and birth, contraception and marriage (figure 46).[†††] Overall, however, contraception, along with sexual orientation and gender identity, online media and technology, access to safe abortion in the frame of the national law, and services for sexual and reproductive health, are the least commonly covered topics in sexuality education curricula.

The 2019 UNFPA online (non-representative sampling) youth survey reported that "Human body, sexual and reproductive anatomy" was the most frequently reported topic 15-24 year olds learned at school (81%), followed by HIV/AIDS and STIs (71%), puberty (68%), and pregnancy and birth (65%) (figure 47). School was identified as an important source of information about sex by only 39% of young people.[173]

[†††] Secondary-level curriculum recently released in India includes "love and relationship".

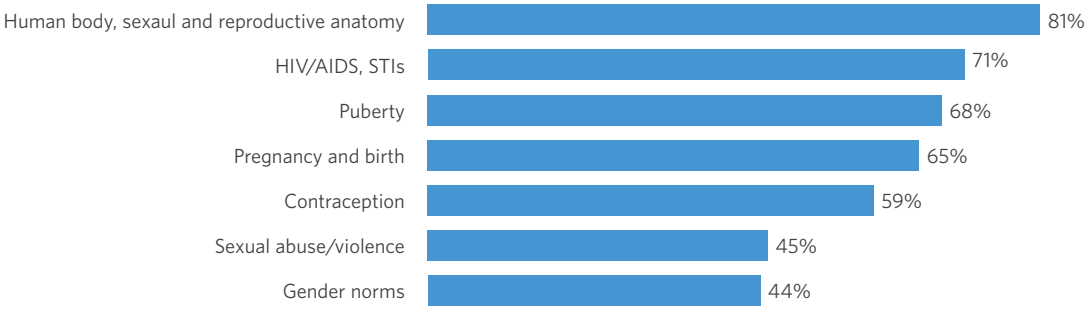
FIGURE 46. COVERAGE OF CORE CSE TOPICS AT SECONDARY LEVEL

Subregion	Country	Puberty	Pregnancy and birth	Contraception	HIV/ AIDS/STIs	Love and relationships	Marriage	Sexual orientation and gender identity	Gender and gender norms	Online media and technology	Access to safe abortion	Sexual abuse/ violence	SRH services
South Asia	Afghanistan	Covered	Covered	Not covered	Covered	Not covered	Covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Bangladesh	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered	Covered	Covered
	Bhutan	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Not covered	Covered	Covered	Covered
	India	Covered	Covered	Not covered	Covered	Not covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Iran	No data	Covered	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Maldives	Covered	Covered	Not covered	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered	Covered	Not covered
	Nepal	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Pakistan	Covered	Covered	Covered	Covered	Not covered	Covered	Not covered	Covered	Covered	Not covered	Covered	Not covered
	Sri Lanka	Covered	Covered	Not covered	Covered	Covered	Not covered	Covered	Covered	Not covered	Not covered	Covered	Covered
East Asia	China	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	DPR Korea	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Mongolia	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Southeast Asia	Cambodia	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Indonesia	Covered	No data	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	No data
	Lao PDR	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Malaysia	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Myanmar	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Philippines	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Thailand	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Timor-Leste	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Viet Nam	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered	Covered
Pacific	Cook Islands	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data	No data
	Fiji	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Kiribati	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered	Not covered	Not covered	Covered	Not covered
	Papua New Guinea	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
	Samoa	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Solomon Islands	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Tonga	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Tuvalu	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Not covered	Covered	Covered
	Vanuatu	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered	No data	Not covered	Covered	Covered

Covered · Not covered · No data

Source: UNFPA 2020[288]

FIGURE 47. SRH INFORMATION RECEIVED AT SCHOOL



Source: UNFPA 2019[173]

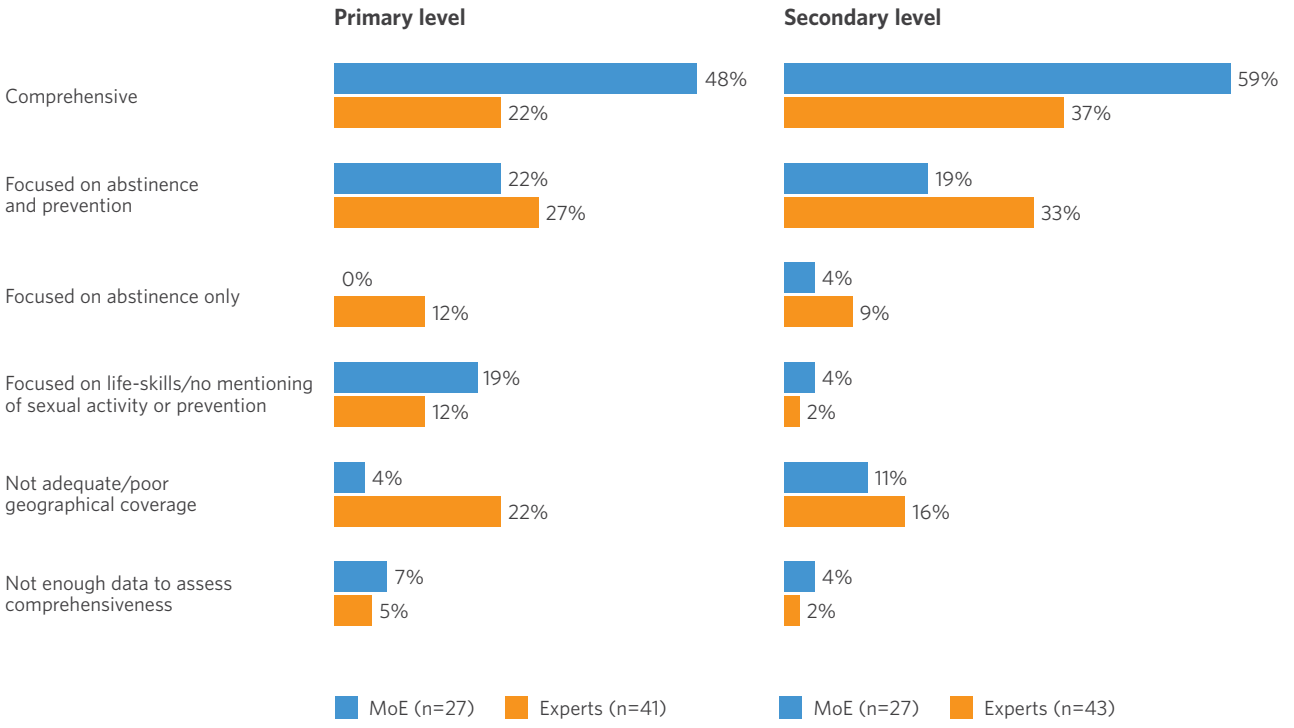
SCHOOL-BASED COMPREHENSIVE SEXUALITY EDUCATION

School-based CSE is an effective means of reaching a large population of young people, particularly where rates of school participation are high. When sexuality education is optional, only taught informally outside of schools or as an extra-curricular subject, a significant number of young people miss the opportunity to access sexuality information.[287] Having a mandatory sexuality education curriculum through schools is therefore imperative to ensure a wider reach of the youth population. Sixteen out of 28 countries reported that sexuality education is mandatory for primary-level students, and 15 out of 28 reported the same for secondary-level students.[288]

Sexuality education should be comprehensive in its content.[287] In the 2020 UNFPA, UNESCO and IPPF report, 48% of the countries (n=13) reported that their primary level curriculum was "comprehensive" and 59% (n=16) reported this at the secondary level (see figure 48). However, what constitutes "comprehensiveness' appears to be dependent on individual perspectives or country standards and the rating was not necessarily a reflection of the standards outlined in the ITGSE. China reported "very comprehensive" at both the primary and secondary level, but stated that only 3-8 hours a year of sexuality education are taught in the highest grade level. Bhutan also reported "very comprehensive" for both levels, however only teach puberty "extensively" at both the primary and secondary level, and several other topics related to pregnancy, STIs and relationships "briefly".

No country in the region provides a comprehensive sexuality education curriculum that meets international standards, with limited inclusion of rights, diversity, positive sexuality and life-skills.

FIGURE 48. COMPREHENSIVENESS OF SEXUALITY EDUCATION CURRICULA AT PRIMARY AND SECONDARY LEVEL



Source: UNFPA 2020[288]

In fact, a survey conducted with 43 experts that consisted of UNFPA, UNESCO, IPPF, CSO staff and independent consultants revealed different perspectives from country surveys. Twenty-two % of them (n=9) perceived that the primary level curriculum of the country they are assessing to be "comprehensive, while 37% of them (n=16) reported this at the secondary level.[288]

There appears to be limited education provided to or that addresses vulnerable populations of young people, including young LGBTI people, young people with disabilities, or young people out-of-school).[288]

An earlier UNESCO report also notes that the majority of curricula do not adequately address diversity in gender identity or sexual orientation. Most curricula assume that young people are heterosexual and not sexually active, with references to same-sex relationships only framed in the context of HIV risk, if at all. The extent to which current programmes address the needs of young people who are same-sex attracted or transgender remains unclear.[206]

Additionally, many national curricula focus on theory, relying on traditional lecture-based teaching methods, with limited inclusion of participatory approaches to address behaviour change and develop life-skills. While some countries include content on communication skills and assertiveness, few address other key skills that reflect the reality of young people's lives, such as skills related to social media and pornography.[206]

Timing

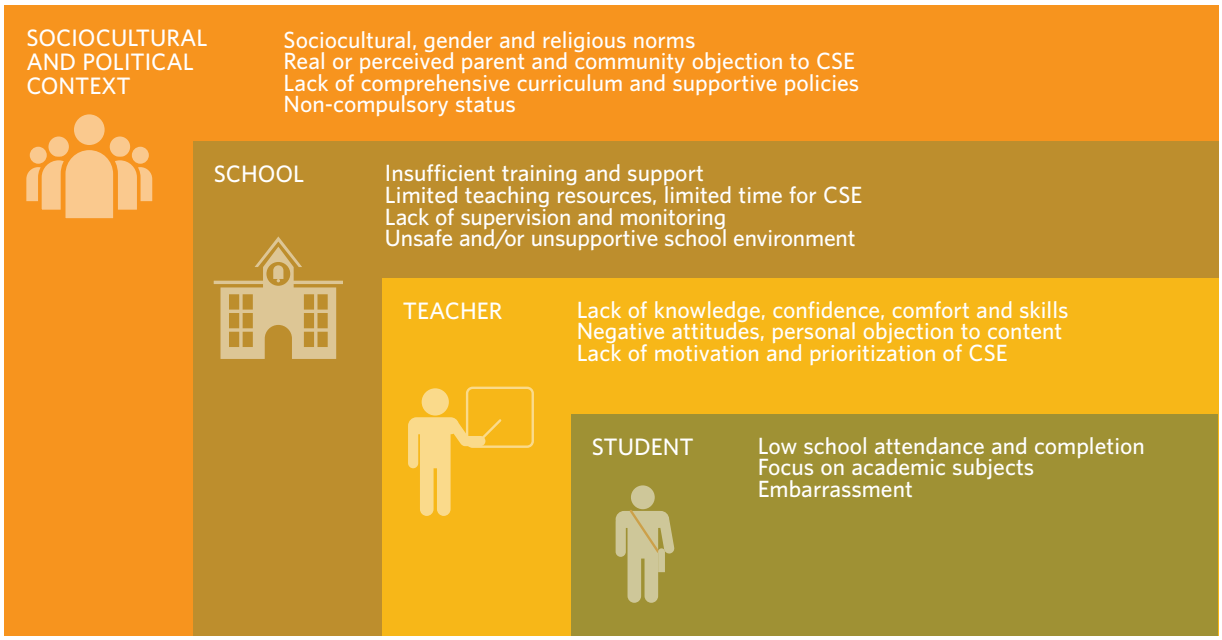
International guidelines recommend that sexuality education be introduced as early as possible and that it continue to be provided in schools with age-appropriate content as students grow older.[202] In approximately half of the countries surveyed in the 2020 UNFPA, UNESCO, and IPPF study, aspects of sexuality education are introduced in the first grade of primary school education or earlier (five years and below). In some countries, sexuality education is not introduced until Grade 6 or above.[288]

Approaches to school-based delivery of CSE in the region vary, although most programmes are integrated into existing mainstream subjects, rather than delivered as stand-alone CSE subjects.[207,288] Of the countries surveyed in the 2020 UNFPA, UNESCO and IPPF report, sexuality education is integrated with other subjects in 16 countries in primary-level education and in 19 countries in secondary-level education. Integration with other subjects can have the advantage of linking CSE to other key topics (such as life-skills), pooling or sharing resources across subjects, and enabling the inclusion of CSE into already 'full' education programmes (rather than relying on non-compulsory activities delivered outside regular school hours).[202] However, this approach has some important limitations. CSE is often integrated into science, health education subjects, with emphasis on the biomedical aspects of SRH, which can come at the expense of content related to gender, rights, relationships and positive sexuality. In some settings, aspects of CSE are incorporated into religious studies, where a focus on religious norms, laws and morality may severely limit the inclusion of some CSE topics. When taught as a standalone subject, more time can be focused on sexuality education and it is easier to monitor and evaluate effectiveness.[287] However, as this requires more time and resources to develop and implement, it may be vulnerable to being discontinued or overlooked compared to other school curricula.[287]Available data suggests that most teachers rely on lecture-based delivery of CSE, with little opportunity for students to ask questions or for the inclusion of activity-based methods to build skills.[207,210,211]

The capacity and training of teachers is a critical determinant of the coverage and quality of school-based CSE. Trained and supported teachers are more likely to cover broad CSE topics and to include participatory teaching methods than those who have not received training.[210,212] Two-thirds (22) of the countries reported providing sexuality education pre- and/or in-service training for teachers.[288] However, findings from the literature review indicate that this may be inadequate and several barriers may prevent effective delivery. An earlier study also reveals that many programmes rely on limited in-service training focusing on knowledge only, without adequately addressing attitudes, participatory teaching methodologies, and confidence. As a result, many teachers lack the skills and confidence to deliver CSE effectively. A review in Viet Nam found that less than 5% of teachers had the competency required to teach CSE, and data from Papua New Guinea found that almost a third of teachers skip CSE content that they feel is too sensitive or explicit.[206] In Thailand, a recent review found that half of secondary school teachers had not received CSE training, and for those that had the majority of training had focused on lecture-based delivery of content.[210]

> **People think it's too early to give children sex education. But I think it's important because it's the reality they will face in their life. Menstruation is something girls will face, and they should know what is actually going on with their bodies. Instead of just leaving them confused.**
>
> (21-year-old woman, Indonesia)

FIGURE 49. COMMON CHALLENGES IMPACTING ON SCHOOL-BASED CSE IMPLEMENTATION



In addition to insufficient teacher training and support, several other **challenges** contribute to limited and inconsistent implementation of CSE in the region (figure 49).[206,207,213,214]

Many programmes fail to acknowledge the sensitive nature of some CSE topics, for both teachers and students. While most age-appropriate content focuses on less sensitive topics such as communication, relationships, decision-making, human development and biology, some content areas important for older age groups may be sensitive in the context of conservative sociocultural norms and taboos. Recent studies from India and Iran have highlighted that while students find sexuality education (or reproductive health education) important and feel it addresses many of their needs, many feel uncomfortable or embarrassed during these classes. CSE subjects (stand-alone or integrated) are frequently taught like any other school subject without acknowledging the potential for embarrassment, or adapting teaching approaches to more effectively deliver sensitive content.[215,216]

> **Even though some sexuality education is there in schools, often the teacher is not confident to deliver the information.... They tell me when they get to this topic, they rip the pages of the textbook out.**
>
> (NGO worker, Timor-Leste)

> **At first I thought, how are they talking about these things, why aren't they shy? During the first lesson I couldn't even look at the teacher's face. [But] we found out that this is all natural, so I thought why should we be shy about it?**
>
> (Young student, Nepal)

There are examples of pilots or smaller-scale approaches delivered in school settings to overcome some of these challenges. Many have combined teacher-led sexuality education with extra-curricular or co-curricular activities, often delivered by non-government organisations or through school health programmes / health providers, with greater attention to participatory-based methods and skills development.[217,218] Other programmes have incorporated peer-led activities (such as group discussions, role play) and digital media (social media groups, game simulations) to complement content taught in standard teacher-led sexuality education subjects. Recent studies in Thailand and China found that such approaches are acceptable to young people and may improve knowledge, attitudes and skills, and reduce some risk behaviours.[219,220]

Many documented and evaluated programmes in the region are implemented as pilot-projects that are non-compulsory and rely on extra-curricular delivery. Rigorous evidence from the region demonstrating how to effectively, and sustainably, scale-up school-based CSE is limited. Much of the available data is also focused on secondary students, with very little evidence about the best approaches to deliver age-appropriate CSE in primary schools.

REACHING OUT-OF-SCHOOL YOUNG PEOPLE

Young people not engaged in formal education, due to early marriage, early pregnancy, poverty, migration, displacement, or marginalisation, are at particular risk of poor SRH and are therefore a critical target for CSE programmes. Non-formal settings such as community centres, sports clubs, health facilities, workplaces, and digital media are important platforms to reach young people with CSE who are not engaged in formal education. As with school-based CSE, effective sexuality education delivered in these settings needs to be age-appropriate, evidence and curriculum-based, and comprehensive to ensure young people acquire the knowledge, values, attitudes and skills they need to protect their health and wellbeing.[202]

25 million adolescents are not enrolled in lower secondary school. In many countries, CSE is not introduced until secondary level, and therefore a considerable number of adolescents miss out on essential knowledge and skills to support SRH.

Twenty-three countries in the region include sexuality education programmes for informal or out-of-school settings. However, there is very limited information about the scope, populations included, and coverage of these approaches.[206] Most examples of approaches to reach out-of-school young people come from small-scale studies and pilot projects, and many are delivered by non-government organisations with a focus on young married couples, young people who sell sex, young people with diverse sexual orientation and gender identity, migrants, and street-based young people. These programmes typically combine **peer-led education**, distribution of condoms and contraception, and individual SRH counselling and services provided by outreach workers, with limited data demonstrating that such approaches can increase SRH knowledge and reduce risk behaviours.[8]

Parents have an important role as health educators, and also have an important influence on young people's attitudes and behaviours.[221,222] Parents are an uncommon source of SRH information for young people in the region, with

parents' own lack of knowledge, discomfort and sociocultural taboos among the reasons given for little parent-adolescent communication.[223-225] However, many young people report that they would like to be able to discuss SRH issues with their parents.[226,227] Curriculum-based education targeting parents and adolescents can increase SRH knowledge, improve attitudes, and promote communication between parents and adolescents. The Creating Connections programme, which has been evaluated in Viet Nam and translated for use in Bangladesh, China, Cambodia, Myanmar, Lao PDR, the Philippines and Indonesia, includes up to 13 participatory education workshops for parents and adolescents, with an emphasis on improving communication and life-skills, in addition to increasing SRH knowledge of parents and young people.[228,229] **Engaging parents is also critical for building support for school-based CSE**.

Digital media offers great potential to reach young people in and out of school with SRH information. In this region, traditional mass media (including programmes delivered by radio and television), youth-focused SRH hotlines, mobile phone-based interventions, and social media have been able to reach large numbers of young people and contribute to improved knowledge and attitudes, although rigorous evaluation of these interventions is limited.[8,214,215] For young people not engaged in formal education, and/or those who are marginalised and not adequately reached with school-based CSE, digital platforms have the potential to deliver tailored information, support and education.[214]

There is very little documented concerning the provision of CSE to young people living with disability in school, institutional or community settings, despite recognition of the high need for relevant education and life-skills.[230]

EFFECTIVE APPROACHES AND CONSIDERATIONS FOR SCALE-UP

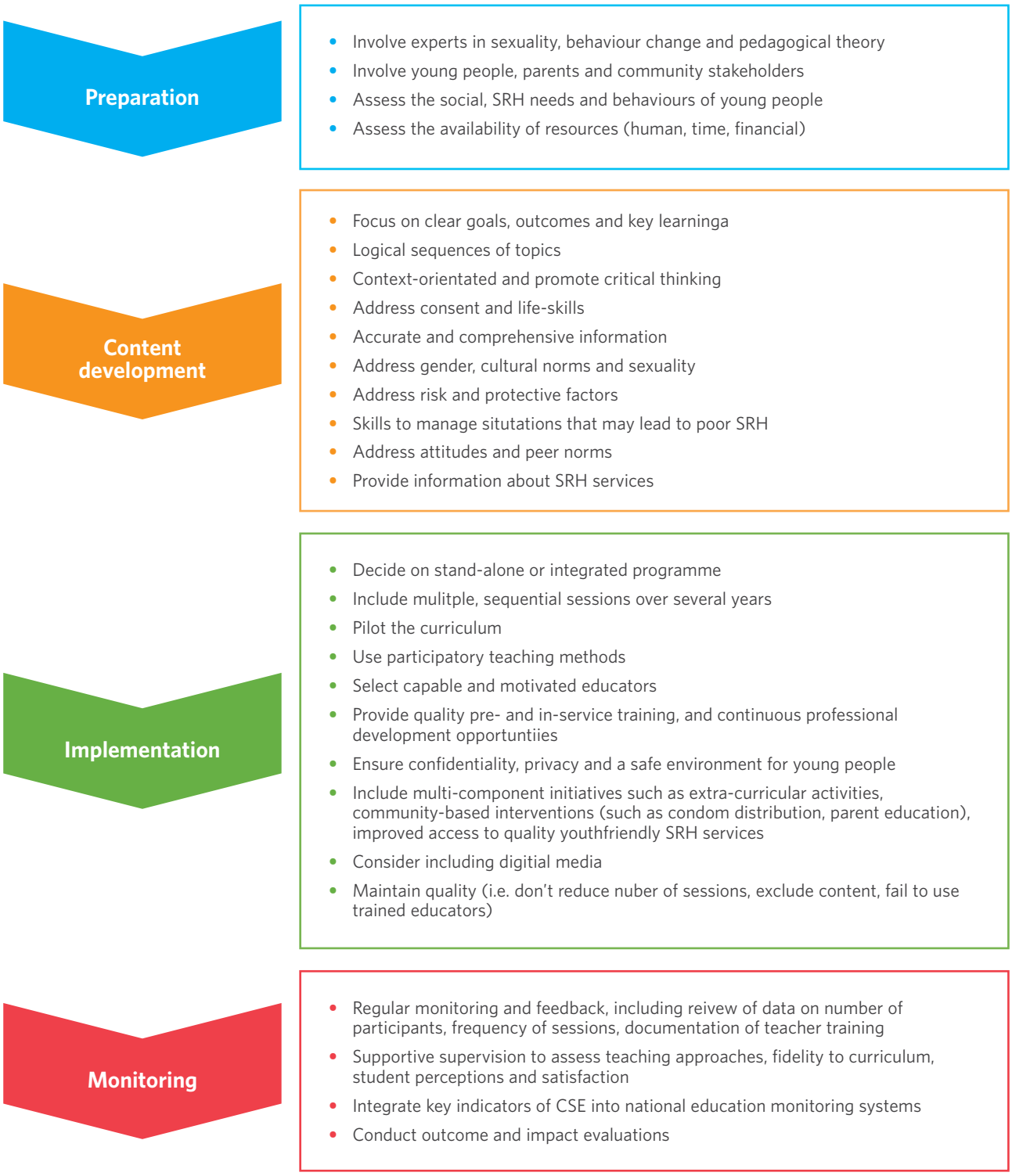
Considerable progress has been made in the region, particularly in relation to the inclusion and integration of sexuality education into secondary schools. However, several areas require greater attention to improve the quality and coverage of CSE:[206]

- Develop curricula and implement CSE from early primary school in line with international guidelines. It is critical to provide age-appropriate education during early childhood, before norms and attitudes are crystallised, before puberty, and before the onset of sexual activity
- Develop comprehensive curricula that meet international standards, in particular rights-based approaches that include content related to gender, relationships, positive sexuality, violence, and diversity
- Address the over-reliance on lecture-based teaching methods and supporting participatory teaching approaches to enhance life-skills
- Reduce missed opportunities to reach children and young adolescents by including CSE in primary school.
- Strengthen curriculum-based CSE for young people not engaged in formal education, as these young people may be at greatest most significant risk of poor SRH
- Improve implementation, including teacher training and support, monitoring and evaluation
- Increase the engagement of young people in programme design, planning and evaluation

Real or perceived parent and community objection to CSE, sociocultural norms that limit open discussion of sexuality and SRH, and misconceptions that sexuality education encourages sexual activity are common barriers to effective CSE delivery in the region. Successful CSE approaches in the region have included careful engagement and consultation with stakeholders (parents, community and religious leaders, young people, school officials) to build support for CSE, address sensitivities without compromising curriculum fidelity, and provide feedback on positive outcomes.[231]

There has been limited implementation research published from this region to describe effective approaches to delivering CSE at scale. However, the characteristics of effective CSE programmes based on global best practice are summarised in figure 50.[202] Important considerations to support scale-up include identifying approaches that can be implemented in existing systems, piloting programmes to identify effective implementation approaches, identifying and allocating sufficient resources, and recognising the importance of leadership.[202]

FIGURE 50. CHARACTERISTICS OF EFFECTIVE CSE PROGRAMMES



Source: UNESCO 2018

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UNIVERSAL HEALTH COVERAGE AND ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

Health services play an important role in reducing preventable poor health and supporting young people to make a healthy transition into adulthood. In addition to essential curative care, health services are also a crucial source of preventive services for a range of adolescent health needs, including SRH. Many young people come into contact with health services for common health complaints, therefore, health facilities are an important entry point to reach young people with a range of SRH interventions (box 10).

While many countries in Asia and the Pacific have made considerable progress towards effective coverage, and to some extent equitable coverage, of SRH services, progress has not been realised for adolescents. Many national universal health coverage programmes exclude SRH services of particular priority for adolescents (such as contraception, HPV immunisation, care for violence, comprehensive abortion services), and provide insufficient financial risk protection for young people.[232] Across the region young people continue to have a high unmet need for essential SRH services and coverage is particularly low among rural, less educated, poorer, and marginalised young people.[233,234]

BOX 11. SRH SERVICES FOR ADOLESCENTS

- SRH information, education and counselling
- Contraception counselling and commodities
- Antenatal, safe delivery, and postnatal care
- Prevention of unsafe abortion, safe abortion (to the fullest extent of the law), post-abortion care
- Menstrual health care
- Prevention, care and treatment of STIs and HIV (including provision of condoms)
- Human Papillomavirus (HPV) immunisation to prevent cervical cancer
- Prevention, surveillance and care for sexual and gender-based violence
- Action to eliminate harmful practices (forced child marriage, female genital mutilation)
- Address associated risk factors (substance use, mental health, nutrition)

BARRIERS THAT IMPACT ON ACCESS TO SRH SERVICES

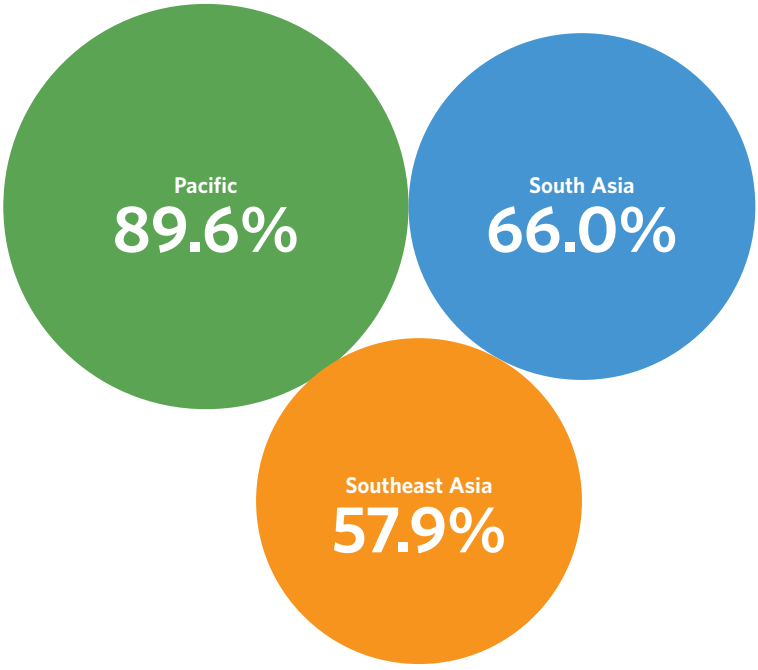
Despite the incentives to provide SRH services to young people, many face considerable barriers to accessing quality SRH services, and services for adolescents are generally uneven in quality, poorly coordinated, and fail to comprehensively address young people's needs. The majority of adolescent girls report at least one serious barrier to accessing health care (figure 51), including financial barriers, lack of female health providers, barriers related to distance and transport, and needing to seek permission.

Common barriers reported by young people across the region are summarised in figure 52. These include young people's low knowledge of their own SRH needs, awareness of SRH services, and health literacy; embarrassment, fear, shame and stigma, in part driven by community disapproval and sociocultural norms; and lack of decision-making autonomy, particularly with respect to married adolescent girls.[235-240]

On the supply-side, judgmental attitudes of health providers and lack of appropriate skills (including communication and counselling skills), as well as insufficient privacy and confidentiality, are major reasons why young people do not seek care or report poor quality care.[236, 241, 242] Laws or policies that require parental or spousal consent, or that prohibit access to some services, also contribute to low uptake of SRH services and poorer health outcomes.[243,244] In addition, lack of data describing young people's SRH needs and preferences with respect to service delivery is a key barrier to informing more responsive policy and approaches.[245]

> **"People only go to the dentist when their teeth hurt. It's the same with reproductive health."**
>
> (17-year-old woman, Indonesia)

FIGURE 51. PROPORTION OF 15-19-YEAR-OLD GIRLS REPORTING AT LEAST ONE SERIOUS PROBLEM ACCESSING HEALTH CARE



Source: DHS and MICS

FIGURE 52. BARRIERS THAT LIMIT ACCESS TO SRH SERVICES

Demand-side barriers	Health system barriers	Policy, regulatory and legal barriers
• Low SRH knowledge • Low health literacy • Lack of decision-making autonomy (particularly girls) • Embarrassment, shame, stigma • Socio-cultural norms	• Judgmental health providers • Poor communication and counselling skills • Lack of privacy and confidentiality • Unwelcoming environment • Discrimination • Cost of services/commodities • Poor quality of care • Inconvenient opening hours	• Exclusion of young people and SRH services from UHC • Mandatory requirement for parent, guardian or spouse consent • Policies that restrict access to services on the basis of marital status, age, migrant status

> **"As a person with a mental disability, it's difficult for me to get services.... When I go there to see someone they don't allow me, and they don't take me seriously."**
>
> (Young person, Fiji)

Many of these barriers are substantial for unmarried young people, young people living with disability, young people with diverse SOGI/E, young key populations, and marginalised adolescents. Young people living with disability in particular can face considerable stigma, discrimination, and violation of their right to privacy and autonomy when seeking SRH services.[246] Importantly, socio-cultural norms that prohibit sex outside of marriage are a strong disincentive to seek care if young people are afraid of disclosing sexual activity, particularly if confidentiality is not guaranteed. This often results in young people delaying seeking care, or turning to private clinics, pharmacies, unskilled providers, or self-treatment rather than public facilities.[247, 248]

ADOLESCENT-RESPONSIVE HEALTH SYSTEMS

The particular health needs of young people, their rapidly evolving emotional and cognitive capacity, and the socio-cultural context in which they live have important implications for health systems and service delivery.[249] Health workers require additional knowledge and skills, including counselling skills, to deal sensitively and effectively with young people. Young people's increasing autonomy and need for privacy have implications for the facility environment and policies related to confidentiality and consent. Health financing mechanisms need to ensure inclusion of adolescents and their health needs.

Adolescent-responsive health systems are those that provide quality care addressing these factors, in a way that is accessible, appropriate and acceptable to young people. Key characteristics are summarised in box 11.[250, 249, 251] Where efforts have been made to incorporate these features into health services (with particular attention to improving health worker guidelines, protocols and training, improving facilities' physical environment, and engaging communities to increase support) use of services by young people has increased.[249, 252]

BOX 12. WHO GLOBAL STANDARDS FOR QUALITY SERVICES FOR ADOLESCENTS

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

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

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

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

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

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

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

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

Source: WHO 2014

National policies and standards

Nearly all countries refer to 'adolescent-friendly' health services (AFHS) in national reproductive health, HIV or youth policies. Most have also developed, or are developing, national standards or guidelines defining adolescent-responsive service delivery and supporting implementation (figure 53).

The available national and regional standards detail characteristics of adolescent-responsive health services that are consistent with the WHO global standards: emphasising non-judgmental care that respects young people's rights, privacy and confidentiality; skills and training of providers; attention to the facility environment and opening times; provision of information and education materials; and, linkages with activities to increase awareness and demand for services and generate community support.[253] Most also specify a package of services that should be available to young people, with a strong focus on SRH including information and counselling about puberty and SRH, provision of condoms and contraception, pregnancy-related care, management of STIs, and provision of, or referral for, HIV testing and care, and services for sexual violence. Some guidelines address other key adolescent health concerns (such as mental health and substance use) that are priority needs for young people and are also linked to SRH outcomes. However, these issues are often not comprehensively addressed.

There are important gaps: while many policies and guidelines highlight marginalised young people, young key populations, and those with diverse SOGI/E as facing particular barriers, few national standards provide specific guidance on actions required to meet the needs of these young people. Additionally, few policies and strategies provide clear guidance around adolescents' evolving capacity to consent to medical care, nor their rights and agency with respect to making decisions about their SRH, in line with the Convention on the Rights of the Child. Even where legislation exists that enables access to some services (such as HIV testing) to young people under the age of 18 as 'mature minors', there are few specific guidelines about how to assess a young person's capacity to provide consent effectively.

FIGURE 53. EXISTENCE OF NATIONAL AFHS POLICY AND STANDARDS

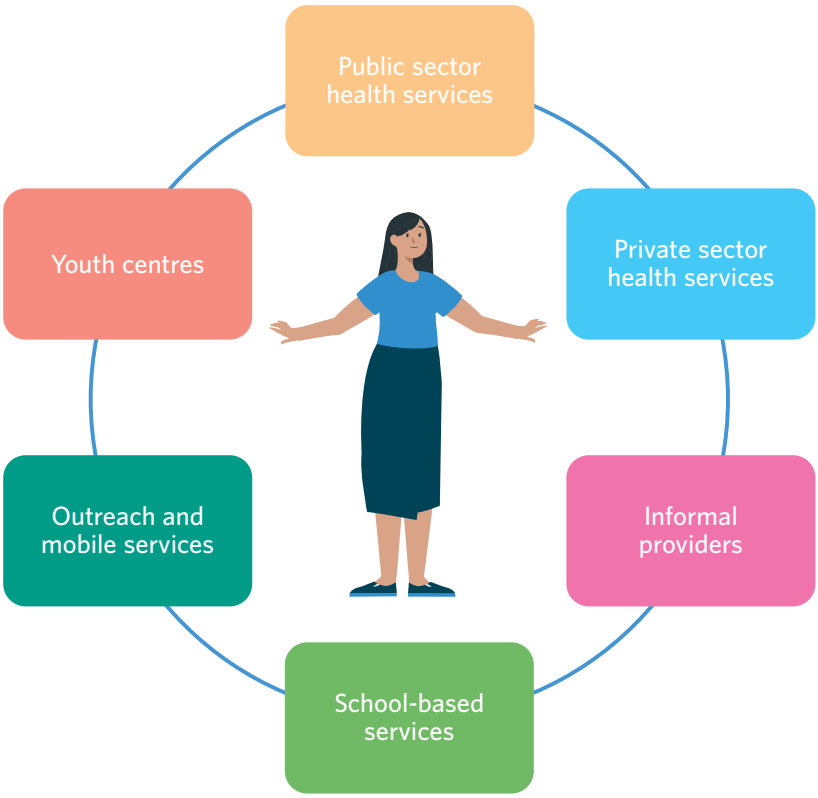
Source: Review of available national policies conducted by authors

Consideration also needs to be given to other policies and legislation that impact on young people's access to comprehensive SRH services. As discussed previously, policy or legal restriction on the access of unmarried young people to some services, legal requirements for parental or spousal consent, and criminalisation of some behaviours will continue to result in low coverage of effective care, even where 'youth-friendly' health services exist.[52]

Platforms for service delivery

There are several different platforms for reaching young people with SRH services in the region (figure 54), reflecting the diversity of young people's needs and preferences, and the diversity of approaches to overcome barriers to access. While each is likely to have an important role in improving young people's SRH, these multi-sectoral platforms are often poorly coordinated, leading to gaps in coverage and quality.

FIGURE 54. COMMON SERVICE DELIVERY PLATFORMS



Public sector health services

Many young people come into contact with public sector health services, so it is important that existing service delivery points are strengthened to provide quality care for adolescents. Most governments in the region have developed specific guidance to improve the quality and accessibility of public services (including those that provide SRH care) for adolescents, and there is some evidence that such efforts to standardise and improve government-run health facilities can improve quality and coverage.[254]

Smaller-scale projects, typically led by non-governmental organizations, have generally focused on: upgrading facilities to improve privacy and provide a separate waiting area for adolescents; health worker training; and community engagement to increase demand and support. Evaluations of these projects have reported improved quality and utilisation by young people.[255, 256] There are fewer documented and evaluated examples of large-scale or nation-wide implementation of AFHS in government facilities. Evaluations of large-scale government initiatives in Nepal and India have demonstrated that efforts to improve health provider training, provision of clear implementation guidelines and operational support (in addition to technical support), and use of formative research to inform approaches can improve quality and uptake of priority adolescent health services, although sustained non-government organisation technical support, improved monitoring and supportive supervision, and community engagement are required to maintain quality.[257, 258]

Youth-centres

Young people may be reluctant to access public health facilities because of concerns about privacy and confidentiality. Youth-only centres can have the advantage of providing young people with a greater degree of privacy in an environment that is welcoming and appealing. They may also have the advantage of being located in areas that young people already congregate, making them physically more accessible.[259] Youth-centres that provide SRH services often also provide an array of resources, activities and other supports, enabling young people to avoid the stigma associated with SRH services (such as family planning clinics, or STI/HIV clinics).

There are a number of examples of youth centres or youth-only clinics that provide SRH counselling and services, although many are small-scale or pilot projects. Most are run by, or in partnership with, non-government organisations. While often providing high quality services, youth-only facilities are generally only located in urban areas and so have limited coverage. The resources required to establish and maintain such facilities, and their sustainability, also remains unclear. A review of youth-friendly health services in five Pacific Island countries (Tonga, Solomon Islands, Vanuatu, Kiribati and Tuvalu) as part of the Adolescent Health and Development Programme found that non-government youth clinics were generally performing better than government facilities on all indicators, in large part due to greater resources and operational and management support. However, the review emphasised the need to prioritise investment in government facilities given their population coverage.[260] A global review of youth centres in low- and middle-income countries concluded that these approaches generally only reach a small proportion of young people, are mainly used by women and men outside the target age group, and are often accessed for non-SRH education or recreational activities.[259]

School-based services

Schools are potentially an important provider of SRH services, particularly in settings with high rates of school participation, although, there is currently limited quality research evaluating their impact on health behaviours and outcomes.[261, 262] Many young people report a preference for services to be delivered in schools, including SRH counselling and provision of commodities (such as condoms). Several countries have national school health or health-promoting schools programmes, with a focus on improving health education, life-skills, health literacy and linkages with health services and health providers.[263, 264] However, there is currently a paucity of documented examples or evaluations of approaches providing SRH services (beyond some aspects of sexuality education) in school settings, and both school and community objection to school-based SRH services have been noted as key barriers.[264] An increasing number of counties have introduced, or planning the introduction, of national HPV immunisation programmes, typically delivered in school settings. These programmes offer a potential opportunity to reach adolescents in schools with other SRH information and services, although careful community education and engagement is required to improve community support.[265, 266]

Outreach and mobile services

Not all young people will be able to access adolescent-responsive services, even if they exist. Young people in rural or remote areas, or poorly serviced urban settings, may have very little geographical access to services. Marginalised young people, including those with diverse SOGI/E, disability, young people who sell sex, young people who inject drugs, and street-based adolescents can face considerable barriers to accessing health facilities. While the strength of global evidence documenting the impact of outreach services on SRH outcomes is currently limited,[267] for some populations outreach services and mobile clinics may help overcome barriers accessing facilities, and can also provide an essential link between these young people and mainstream services. Mobile clinics and outreach services (often complemented by peer-based distribution of commodities) is a common approach for reaching young key populations in this region and may improve access to services and condom use.[268] In Lao PDR, mobile clinics have also been used in rural areas to reach underserved young people. The approach demonstrated an increase in knowledge of modern methods of contraception and an increase in the proportion of sexually active young people who had ever used contraception.[105]

Engaging the private sector

To overcome challenges accessing care from public health providers, adolescents seek a range of health services and advice from non-public sector providers, such as private clinics, pharmacies, non-government organisations, and informal providers (shops, unregistered drug sellers, traditional healers) who may offer less judgmental care, with greater privacy, more convenient locations and opening hours, and with less stigma than public-sector services.[8, 247, 248] While the need to engage the private sector in adolescent health programmes in the region is fairly well recognised in national policies, evidence of the role of the private sector in improving access to and quality of services for adolescents, and understanding of the opportunities and challenges to effective private sector engagement, is very limited.

There are some innovative examples of engaging pharmacies and private clinics to provide young people with better access to commodities such as condoms and contraceptives. This has included training pharmacy staff to increase their counselling skills and knowledge about young people's SRH, providing them with youth-friendly educational resources, providing branding and demand generation support. Evaluations of such approaches in Viet Nam demonstrated improved knowledge and quality of services provided by pharmacy staff, and contributed to an increase in contraceptive use at last sex by young people.[105]

Social franchising approaches have also been used to reach young people, although it has been noted that adolescents and unmarried young people may not access services that are potentially stigmatising (such as large community-based outreach clinics for contraception). Suggested strategies to overcome these concerns have included demand-side vouchers, linking services with youth-friendly hotlines and websites to provide advice and referral, and delivering services in locations such as schools, marketplaces, and workplaces.[107] Social marketing can also be an effective way of generating behaviour change, with some evidence from the region that social marketing of condoms specifically targeting young people may increase uptake. [104]

Adolescent-competent health workforce

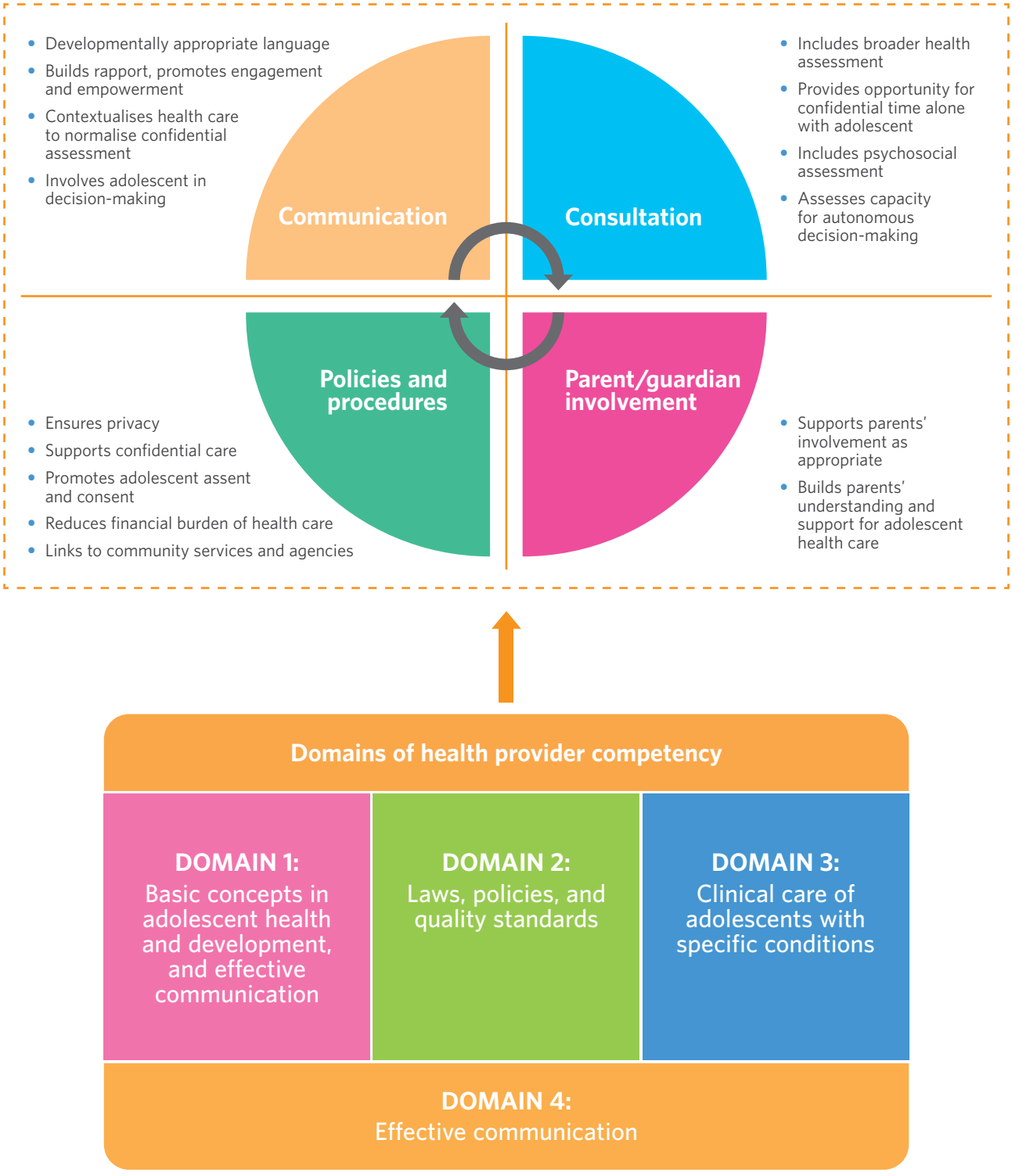
Assuring universal health coverage for adolescents requires renewed attention to the education, training and support of health providers.[269] **Health care staff are important gate-keepers to health care, and their knowledge, attitudes, and skills are major determinants of young people's access to quality services, including SRH services**. Improving providers' education in adolescent health and development improves clinical performance; however, many health providers lack access to quality education and training programmes that build required knowledge, attitudes and skills.[270]

Every health provider requires core competencies in adolescent health, including adolescent SRH. A recent review of the reproductive and maternal and child health workforce in the Pacific estimated that around 10% of health provider time was required to address adolescent health and development.[271] Core competencies for all providers include understanding of adolescent health and development, awareness and application of relevant laws and policies that affect service delivery (such as legal age of consent, national standards for quality adolescent care), effective communication and counselling skills, and clinical skills to address common adolescent health needs (figure 55). Particular attention is needed to provider attitudes to support non-judgmental, non-discriminatory, confidential care that respects the evolving capacity of young people, their agency, and right to self-determination.[269, 272, 273]

Pre-service (undergraduate) training in adolescent health in the region is limited, with many existing programmes focused on the knowledge delivered using traditional didactic teaching methods, rather than competency-based education.[274] There are some examples in the region of integration of adolescent health into university undergraduate curriculum: Sri Lanka's University of Kelaniya has integrated adolescent health into several subjects as part of the Bachelor of Medicine, Bachelor of Surgery degree;[269] and curriculum also been developed in India that can be integrated into undergraduate and postgraduate medical training.[273] Limited existence and/or involvement of specialist professional associations or leadership with expertise in adolescent health, as well as limited availability of competent teaching staff are noted challenges in many countries.[271, 274]

Much of the current approach to health provider education in adolescent SRH has focused on in-service training, typically as part of continuing education, and often one-off training programmes led or supported by non-government organisations and/or academic institutions. Some countries, such as Thailand have developed standard training materials and guidelines for health workers, but generally, there is little documented regarding the coverage and quality of training in adolescent health competencies in the region.[275] A key challenge is the lack of data to assess current adolescent health competency of providers, necessary to inform effective education and training programmes.[271] In addition to strengthening pre- and in-service training and education, health providers also need ongoing support through the provision of job aids, supportive supervision, and monitoring; however, these remain major gaps in many countries in the region.

FIGURE 55. CONSIDERATIONS FOR HEALTH CONSULTATIONS WITH ADOLESCENTS, AND SUPPORTING HEALTH PROVIDER COMPETENCIES (ADAPTED FROM WHO[269] AND SAWYER[272])



Health Financing

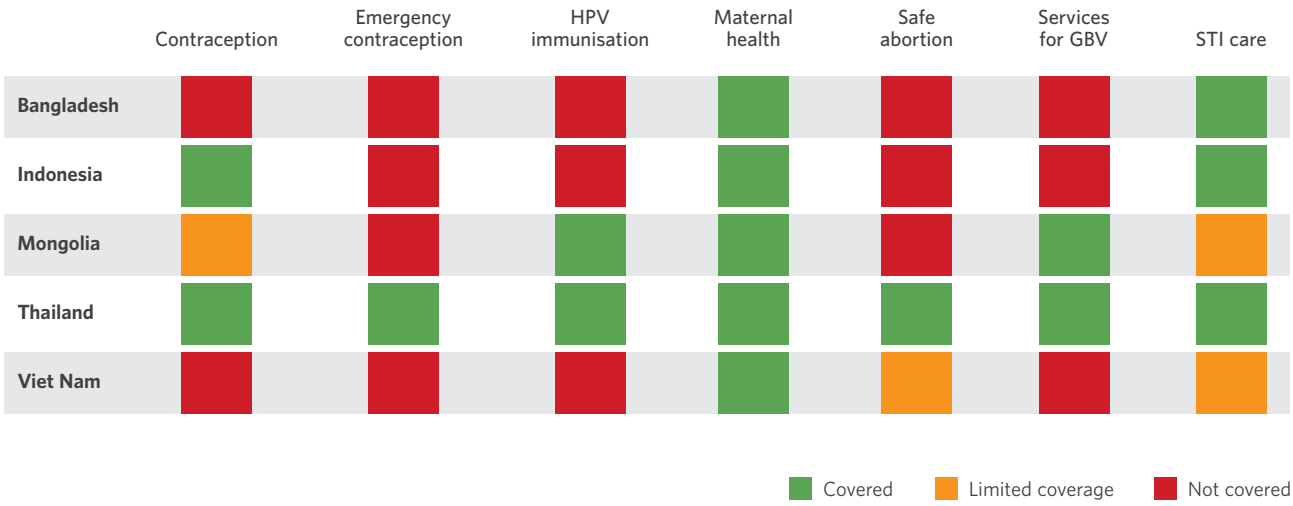
The cost of health services can be a significant barrier preventing young people from accessing quality SRH services. Globally, an estimated 100 million people are pushed below the poverty line each year as a result of out-of-pocket payments for health care.[276] **Despite the recognition that adequately financing the health care of young people is essential for achieving universal health coverage, there remains limited evidence on the impact of health financing on young people**.[277] Young people face unique challenges to accessing health care such as limited access to cash for user fees, and limited freedom to access services independently of their parents.[277] Free services are also identified by young people themselves as a key feature of youth-friendly services[278] although may not address other financial barriers related to transport costs or informal fees. Young people and their health needs may be overlooked in national health financing mechanisms due to competing health priorities and lack of visibility of their SRH needs in policy and national data.

Financial barriers faced by young people can potentially be addressed through a range of mechanisms, such as waiving fees for young people under a specified age, health insurance or pooled financing, and voucher schemes. A number of countries in the region have national policies that provide for free essential services, which include several SRH-specific services relevant for young people such as maternal health care, HIV-related testing, counselling and treatment, and in some cases contraceptive services.[279] However, adolescents may not always be included in such policies.

FIGURE 56. PROPORTION OF 15-19 YEAR OLDS COVERED BY ANY HEALTH INSURANCE

Source: DHS

FIGURE 57. GENERAL SRH SERVICES COVERED BY NATIONAL SOCIAL INSURANCE SCHEMES



Source: UNFPA 2017[232]

With the exception of Indonesia, fewer than **20%** of **15-19 year olds** are covered by any health insurance programme

Prepaid pooled financing arrangements such as taxes or insurance schemes can be effective in increasing coverage of health services. A number of countries in the region have adopted pooled financing for health care including Viet Nam, Indonesia, India, the Philippines and Thailand.[280] In many countries, young people are able to access health care services through family, employee or school-based insurance schemes.[281] Financial benefits for children through insurance or co-payments may cover young people up to a specific age, often 18 years.[277] Age-disaggregated data for this region are limited, but indicate that a substantial proportion of adolescents are not covered by any health insurance programme (figure 56). Additionally, pooled financing programmes may not always include services needed by young people, such as contraceptive services. A recent review of universal health coverage at a population level in six countries in the region revealed that SRH services of particular importance to adolescents are often not covered by social health insurance; these include contraception (particularly emergency contraception), abortion-related care, HPV immunisation, and services for gender-based violence (figure 57).[232]

Older adolescents and young adults, and those who are unemployed, out-of-school, marginalised or from low-income households are more likely to face financial barriers to accessing health services and may be excluded from national financing mechanisms.[241, 281] Other strategies that have shown potential to overcome financial barriers include the use of vouchers entitling young people to subsidised or free SRH services, often linked with other interventions to improve the quality of adolescent health services.[282] There are examples of voucher schemes for reproductive health in a number of countries in Asia, including Pakistan,[283] Bangladesh[284] and Cambodia[285] but these typically target married women with no published studies examining the effectiveness of such approaches for adolescents and unmarried young people in the region.[286]

CHALLENGES AND APPROACHES TO SUPPORT SUSTAINABLE ADOLESCENT-RESPONSIVE HEALTH SYSTEMS

Despite many smaller project examples, delivery of quality adolescent SRH care at large scale remains challenging and coverage is generally low.[105] Common challenges in the region include:

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

Despite these challenges, there are many opportunities to improve young people's access to SRH service and transition from small projects that provide adolescent-friendly services, to those approaches that build adolescent-responsive health systems. The few evaluated approaches in the region have highlighted important factors that would support this transition:

- Ensuring government engagement and ownership
- Building partnerships with non-government organisations to increase coverage and provide quality services where government facilities do not have capacity
- Undertaking advocacy and community sensitisation to increase support for service provision
- Conducting needs assessments to identify priorities for training and facility upgrade
- Providing ongoing training and supportive supervision to health workers
- Supporting health workers with clinical guidelines, education materials and job aids
- Integrating services with other initiatives to increase young people's awareness, demand and uptake
- Engaging young people in the design, implementation and evaluation of services, and using local research to define 'youth-friendly.'
- Monitoring and evaluation to ensure the quality and accessibility of services
- Beginning with pilot projects with gradual scale-up based on successful models

Recent WHO recommendations to improve the inclusion of adolescents in universal health coverage are summarised in figure 58.

FIGURE 58. RECOMMENDATIONS TO IMPROVE UNIVERSAL HEALTH COVERAGE FOR ADOLESCENTS[274]

CONCLUSIONS

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

A significant proportion of young people in the region are sexually active, and while for many the onset of sexual activity is associated with marriage, an increasing number are initiating sex before marriage. The available information indicates that most are under-prepared for this transition, having inadequate knowledge and life-skills to negotiate safe and consensual relationships, and facing considerable barriers to accessing quality services and commodities needed to avoid unsafe sex and its consequences. As a result, both married and unmarried young people are at risk of poor outcomes such as early and unintended pregnancy, unsafe abortion, and STIs.

Important progress has been made in some areas: the prevalence of traditional child marriage and adolescent childbearing has declined significantly in South Asia, and the demand for family planning satisfied by modern methods in married women is high in some countries. But significant challenges remain. Adolescent fertility rates have remained stagnant or are increasing in Southeast Asia and the Pacific, a substantial number of girls experience intimate partner or sexual violence, and almost 27 million young women were married before the age of 18 years. Young people with diverse SOGI/E, and young key populations, continue to face enormous stigma and discrimination, and experience a high burden of preventable poor SRH.

The majority of countries in the region have introduced legislation, policies and programmes to address key priorities such as child marriage, adolescent pregnancy, comprehensive sexuality education, and adolescent-responsive health care. However, implementation and quality assurance remain challenging in many settings. Weak systems and poor integration across sectors, entrenched gender inequality, and stigmatisation of adolescent sexuality outside of marriage continue to deny young people access to essential SRH information and services, and limits their agency with respect to their own SRH. Services need to be tailored for both rural and urban youth, with a particular focus on reaching marginalized young people. The full and meaningful participation of young people in the development, implementation and evaluation of policies and programmes is critical if SRH and rights are to be realised for all young people in Asia and the Pacific.

The data in this report reflects the status of SRH of young people in the region before COVID-19, and therefore can be used as a baseline to measure the pandemic's effect on the already limited access of young people to SRH services.

BOX 13. KEY ACTIONS TO ADVANCE YOUNG PEOPLE'S SRH AND RIGHTS IN ASIA AND THE PACIFIC

- **Ensure the full and meaningful participation of young people in the development, implementation and evaluation of SRH policies and programmes**
- **Supportive legislation:**
  - Prohibit forced marriage before the age of 18 years for girls and boys
  - Prohibit sexual violence, including within marriage
  - Prohibit child sexual abuse and exploitation
  - Decriminalise consensual same-sex sexual activity and transgender persons
  - Decriminalise consensual sex between young people close in age (<3 years)
  - Decriminalise premarital sex
  - Remove age, marital status, and mandatory parental consent requirements to access SRH services and commodities
  - Ensure legal protection against discrimination on the basis of gender identity, sexual orientation, disability
- **Strengthen the quality and coverage of comprehensive sexuality education:**
  - Develop comprehensive curricula that meet international standards, in particular rights-based approaches that include content related to gender, relationships, positive sexuality, violence, and diversity
  - Introduce CSE from early primary school
  - Improve teacher training and support
  - Strengthen the delivery and evaluation of approaches to reach out-of-school and marginalised adolescents
  - Monitor and evaluate the implementation of CSE
- **Strengthen adolescent-responsive SRH services**
  - Include a specific focus on adolescents and adolescent SRH in universal health coverage policy, plans and financing mechanisms
  - Remove policies and regulations that require minimum age, mandatory parental or spousal consent, and other regulatory barriers that limit access for unmarried, migrant, or displaced young people
  - Ensure provision of a comprehensive package of SRH services including contraception, maternity care, comprehensive abortion care (to the fullest extent of the law), prevention and management of STIs and HIV, prevention of cervical cancer, menstrual health, sexual and gender-based violence
  - Tailor services for rural and urban youth, with a particular focus on reaching marginalised adolescents and youth
  - Provide competency-based training of providers in non-judgmental counselling and services for adolescents, and improve supportive supervision
  - Monitor and evaluate national AFHS standards
- **Address community attitudes, norms and barriers:**
  - Educate and mobilise families, communities and leaders to address harmful cultural, religious and gender norms that promote non-consensual early marriage, gender-based violence, stigmatise adolescent sexuality, and stigmatise young people with diverse SOGI/E
  - Build community support for CSE and adolescent SRH services, including contraception
  - Engage parents to improve support for adolescent SRH and increase parent-adolescent communication
  - Engage boys and men to address harmful gender norms that limit girls' agency and contribute to sexual violence and coercion
- **Research to better understand the influence of digital media on young people's SRH, and effective approaches to improve SRH using these platforms**
- **Strengthen data and research to inform policies and programmes, including data for unmarried sexually active adolescents, young people with diverse SOGI/E, young key populations, young people with disability, and other marginalised adolescents**

APPENDIX: COUNTRY-LEVEL ESTIMATES

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Socio-demographics

Country	Population aged 10-24 years, thousands			Population of total population aged 10-24 years (%)			Mean years of educational attainment 20-24 years olds		Population of lower secondary aged children who are not enrolled in secondary school (%)			Population of 15-24 year olds not in education, employment or training (%)			Population of 15-24 year olds who have used the internet at least once a week in the last month (%)				Population of 15-24 year olds who own a mobile phon (%)			
	Female 10 to 24	Male 10 to 24	Total 10 to 24	Female 10 to 24	Male 10 to 24	Total 10 to 24	Female 20 to 24	Male 20 to 24	Female 12 to 15	Male 12 to 15	Total 12 to 15	Female 15 to 24	Male 15 to 24	Total 15 to 24	Female		Male		Female		Male	
															15 to 19	20 to 24	15 to 19	20 to 24	15 to 19	20 to 24	15 to 19	20 to 24
Afghanistan	6,544	6,888	13,432	35	35	35	3	6	55	25	39	66	18	42								
Bangladesh	22,576	23,489	46,065	28	28	28	8	7	12	22	17	45	10	27	1	2			31		63	
Bhutan	102	110	212	28	27	28	11	10	6	18	12	34	20	27								
Cambodia	2,281	2,347	4,628	27	29	28	8	8	14	12	13	15	10	13								
China	118,803	136,286	255,089	17	19	18	13	13				23	13	18								
DPR Korea	2,728	2,849	5,577	21	23	22			8	9	8	18	10	14	6	8	9	13	24	52	25	47
Fiji	111	117	228	25	26	26	12	12			4	30	11	20								
India	176,656	197,815	374,471	27	28	27	10	10	10	9	9	49	8	28					25	51		
Indonesia	33,407	35,315	68,722	25	26	25	11	11	14	19	16	28	15	22	19	15		69	88	92	65	89
Iran	8,479	8,778	17,257	21	21	21	12	12	6	3	5	48	22	34								
Kiribati	1	18	34	27	31	29						48	46	47								
Lao PDR	1,062	1,089	2,151	30	30	30	8	9	26	25	25	6	5	5	45	38	40	36	75	77	76	85
Malaysia	3,910	4,150	8,060	25	25	25	13	12	12	15	13	15	8	12								
Maldives	44	72	116	23	21	22	11	10	7	6	6	25	22	24	15	10	17	9	80	99	87	100
Marshall Islands	8	9	17	29	29	29	10	11	32	30	31											
Micronesia	18	18	36	32	31	32	11	11	10	15	13	29	18	24								
Mongolia	356	361	717	22	23	22	12	10	2	5	4	22	18	20	90	81	79	75	95	98	90	97
Myanmar	7,361	7,356	14,717	26	28	27	10	9	23	25	24	24	11	17								
Nauru	2	2	3	29	29	29			7	16	11	51	22	36								
Nepal	4,773	4,589	9,362	31	35	33	7	9	3	7	5	47	22	35	33	30	34	27	59	85	81	100
Pakistan	31,526	33,953	65,479	30	30	30	7	8	32	22	27	55	8	31	46	26		58	20	32	79	94
Papua New Guinea	1,314	1,395	2,709	31	31	31	6	7	19	10	14	29	26	28								
Philippines	15,198	16,072	31,270	28	30	29	12	11	4	6	5	26	14	20	32	26			84	92		
Samoa	28	31	59	29	30	30	12	11			0	42	35	38								
Solomon Islands	98	107	205	30	31	31	8	9				3	1	2								
Sri Lanka	2,436	2,425	4,861	22	24	23	13	12	2	1	1	35	18	27					65	77		
Thailand	6,584	6,900	13,484	18	20	19	13	12	11	11	11	19	11	15								
Timor-Leste	213	220	433	33	34	33	11	10	12	14	13	26	16	21	40	41	55	41	56	79	57	84
Tonga	16	17	33	31	33	32	12	11	4	6	5	29	11	19								
Tuvalu	2	2	3	29	29	29			23	23	23	37	22	29								
Vanuatu	44	47	91	30	31	30	9	8	4	2	3	32	20	26								
Viet Nam	9,930	10,666	20,596	21	22	21	11	11	7	7	7	12	8	10	57	53			72	89		

Sexual behaviour

Country	Proportion of 15-19 year olds who have ever had sex (%)		Proportion of 15-24 year olds who report first sex before the age of 15 (%)		Proportion of 20-24 year olds who report first sex before the age of 18 (%)		Proportion of never married 15-24 year olds who have ever had sex (%)		Proportion of 15-24 year olds who report sex with 2 or more partners in the last 12 months (%)						Proportion of 15-24 year olds who had sex in the last 12 months who report sex with partner 10 or more years older (%)			Proportion of 15-24 year old males who paid for sex in the last 12 months (%)	Among 15-24 year olds who report sex with two or more partners in the last 12 months, the proportion who report condom use during last sex (%)						Percentage of 15-24 year olds who have ever had sex, who report STI or STI symptoms in the past 12 months (%)	
	Female	Male	Female	Male	Female	Male	Female	Male	Female			Male			Female		Male	Male	Female			Male			Female	Male
	15 to 19	15 to 19	15 to 24	15 to 24	20 to 24	20 to 24	15 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	15 to 24	15 to 19	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 24	15 to 24
Afghanistan	17.00	3.10	4.00	0.30	31.10	6.00																			11.80	6.90
Bangladesh	45.00		17.90	0.30	56.00	6.10																			13.50	6.70
Bhutan	18.00		3.70				3.60				0.30					13.40										
Cambodia	17.10	7.50	1.50	0.30	17.40	4.40	1.10	11.30	0.00	0.40	0.30	2.70	4.50	4.30	14.10			2.00					43.40	46.20	11.80	2.70
India	16.90	8.20	2.40	0.90	21.70	5.90	3.00	11.00	1.00	0.40	0.50	9.80	6.00	6.60	10.60		1.20	1.20	35.30	25.10	28.70	29.90	27.60	28.20	10.30	11.10
Indonesia	13.80		2.00		16.80													0.70							16.80	
Kiribati	20.10	68.90	1.65	13.65	18.60	53.90	5.00	76.50														38.10	28.40	32.80		
Lao PDR	29.70	21.80	5.50	2.80			11.20	29.70			0.60			5.60		11.50			27.40	33.40	30.70	57.20	41.60	46.30		
Maldives	7.60	6.20	1.40	2.30	5.70	17.50	5.70	17.00										0.10							22.00	2.70
Marshall Islands	65.30	72.30	13.60	26.50	60.40	73.40	62.30	77.40																22.60	8.70	3.50
Mongolia	14.10	35.30	0.70	4.90			26.10	51.00			1.10			8.30		3.00				45.10	51.00	77.80	61.80	64.70		
Myanmar	13.60	7.50	1.10	0.30	14.00	5.60												1.70							8.90	7.30
Nauru	54.10	67.30	14.80	31.30	14.80	76.10	56.70	75.90													8.20		23.30	16.70	20.20	6.00
Nepal	27.70	23.80	5.10	3.00	38.40	26.80	0.60	25.40	0.10	0.10	0.10	11.60	10.90	11.10	9.40			1.20					60.00	62.00	15.40	3.80
Pakistan	13.60	2.60	2.20	0.20	16.60	3.80																			34.60	14.40
Papua New Guinea	25.60	26.30	5.10	4.00	33.90	32.50	21.10	39.70											10.20	8.30	12.00	26.80	22.80	24.00		
Philippines	12.20		2.00		20.70		8.30								14.70											
Samoa	15.50	26.70	1.00	2.60	17.00	22.70																				
Solomon Islands	44.40	44.10	11.00	11.20	19.70	54.00	47.80	58.30											20.50	20.50	20.50	28.60	22.50	24.50	5.20	6.40
Sri Lanka	6.00		0.63		10.10																				1.40	
Timor-Leste	8.80	12.20	2.00	2.00	16.10	15.20			0.60	0.60	0.60	9.40	13.70	12.60	21.10		2.20	2.90					17.10	25.00	8.60	13.40
Tonga	7.60	14.50	0.50	1.10	5.40	10.60																		17.40	7.30	9.80
Tuvalu	15.20	60.10	1.70	14.70	13.20	51.70	9.90	65.20																	7.30	3.20
Vanuatu	38.20	50.60	6.20	7.10	37.10	51.50	40.90	63.20																38.10	11.70	7.90
Viet Nam							1.50																			

Marriage, early union, and intimate partner violence

Country	Proportion of 15-24 year olds currently married or in union (%)						Proportion of females aged 20-24 years who were married by 15 (%)	Proportion of females aged 20-24 years who were married by 18 (%)	Proportion of currently married /in union females aged 15-19 years whose partner is 10+ years older (%)	Proportion of 15-19 year olds who state that a husband is justified in hitting or beating his wife for at least one reason (%)		Proportion of ever partnered women aged 15-24 years who have ever experienced physical or sexual violence committed by husband/ partner (%)			Proportion of women aged 15-24 years who have ever experienced sexual violence (%)			Percentage of married 15-24 year olds women who can say no to their husband if they do not want to have sex (%)		Percentage of married women aged 15-24 years who usually make decisions about their own health care either by themselves or jointly with their husband (%)		Percentage of married women aged 15-24 years who usually make decisions about visiting family or friends either by themselves or jointly with their husband (%)		Percentage of married women and girls aged 15-24, not using contraception, who are involved in decision-making about contraceptive use (%)	
	Female			Male			Female	Female	Female	Female	Male	Female			Female			Female		Female		Female		Female		
	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	20 to 24	20 to 24	15 to 19	15 to 19	15 to 19	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 19	20 to 24	15 to 19	20 to 24	15 to 19	20 to 24	15 to 19	20 to 24
Afghanistan	16.90	66.20	39.50	3.10	30.50	15.50	8.80	34.80	11.00	78.30	70.60	30.80	43.80	40.90	6.50	6.70	6.70			40.90	42.80	41.80	44.10				
Bangladesh	44.20	83.00	62.00	2.10	29.60	14.50	22.40	58.60	20.40	28.80		47.30	49.00	48.30	20.40	19.30	19.70			48.90	60.70	43.60	55.90				
Bhutan	11.10	47.40	29.51	3.90	27.30	16.22	6.00	26.00	11.90	70.10					4.46	7.07	5.79										
Cambodia	15.60	60.80	38.60	3.00	36.90	19.00	1.90	18.50		45.50	25.70	7.50	14.40	13.10	1.00	6.20	3.50			89.20	90.70	95.30	95.70				
China	3.00	32.40	18.27	2.00	19.90	11.21									15.76	21.13	18.55										
DPR Korea	0.20	16.10	8.25	0.00	1.10	0.56				7.20	9.00				11.08	14.76	12.94										
Fiji	6.30	34.10	20.00	2.20	14.60	8.32									6.65	9.49	8.05										
India	15.20	65.30	40.40	1.60	24.40	12.30	5.40	25.30		40.80	34.50	19.80	26.30	25.10	2.60	5.20	3.90			60.70	68.60	58.70	67.70				
Indonesia	9.30	49.40	28.30	6.00	30.30	17.88	2.00	16.30		40.30	48.40				1.96	2.68	2.32			83.40	86.50	81.80	83.30	87.60	85.50		
Iran	17.50	45.00	31.68	2.10	22.00	12.20	3.00	17.00							1.90	2.75	2.34										
Kiribati	15.70	56.30	36.00	4.80	37.30	22.53	2.80	20.30		76.80	64.70				9.77	13.88	11.82			45.80	66.30	35.40	60.60				
Lao PDR	18.50	51.00	34.68	5.90	31.70	18.67	7.10	32.70	11.30	30.40	17.10				3.04	3.72	3.38										
Malaysia	4.90	28.60	17.11	5.10	24.10	14.86									2.37	2.89	2.64										
Maldives	3.80	50.40	28.30	0.40	20.40	8.90	0.00	2.20		29.50	27.90	3.50	12.70	12.00	12.40	11.20	11.80	65.70	59.30	80.90	88.10	96.50	94.20	78.50	82.60		
Marshall Islands	21.20	65.00	42.01	5.40	51.10	27.04	5.50	26.30		47.40	71.40	38.60	26.50	29.70	12.80	11.40	12.013			64.80	61.20	60.80	47.40				
Micronesia	7.00	33.80	20.40												6.20	8.90	7.58										
Mongolia	3.70	38.40	21.82	1.10	33.20	17.98	0.90	12.00	0.00						1.63	1.99	1.82										
Myanmar	12.60	44.60	28.90	5.00	33.00	18.60	1.90	16.00		52.60	57.10	24.00	17.80	19.10	1.00	3.10	2.10			69.70	76.10	81.10	81.90				
Nauru	18.40	58.30	37.36	8.60	46.80	26.69	3.50	26.80		47.40	71.40																
Nepal	27.10	74.80	49.30	6.40	43.80	21.80	7.00	39.50	6.30	33.20	30.70	22.20	19.00	19.90	2.90	7.30	5.00	87.70	91.70	26.90	44.30	19.30	35.30	88.10	87.00		
Pakistan	13.50	48.60	29.80	2.60	23.50	11.50	3.60	18.30		50.70	58.10	23.50	17.60	18.80	7.10	4.80	5.30	41.30	49.90	23.60	36.80	18.80	31.80	77.50	76.70		
Papua New Guinea	13.70	57.80	36.97	1.40	31.50	16.50	8.00	27.30				42.80	58.60	55.27	3.40	4.20	3.78										
Philippines	8.50	41.10	23.50	1.40	23.50	12.20	2.20	16.50		12.40		13.50	16.20	15.60	2.70	4.20	3.40	83.90	86.20	95.10	94.50	92.10	91.30	91.70	93.40		
Samoa	7.80	48.60	23.14	1.40	19.70	10.60	0.70	10.80		34.10	27.60				5.01	7.29	6.08			85.50	91.20	82.10	89.20				
Solomon Islands	11.40	56.30	32.01	1.70	28.50	14.10	5.60	21.30		77.70	59.70				6.06	8.77	7.30			82.60	87.10	72.30	78.80				
Sri Lanka	10.60	41.80	25.49	2.30	18.50	9.97	0.90	9.80							2.60	3.19	2.88			80.10	83.80	81.90	84.30				
Thailand	10.00	31.60	21.29	6.80	20.10	13.71	4.00	23.00	7.50	9.10	8.50				3.19	3.89	3.56										
Timor-Leste	8.20	47.60	24.80	0.70	16.00	6.90	2.60	14.90		69.00	48.20	40.70	34.10	35.10	2.90	5.70	4.00	45.60	42.90	90.90	90.70	88.30	91.70	94.20	91.80		
Tonga	4.70	36.60	20.65	4.20	25.30	13.79	0.30	5.60		26.50	28.90			42.90	5.45	7.93	6.69			79.60	79.60	67.50	80.00				
Tuvalu	8.00	53.90	29.81	2.00	20.00	10.52	0.00	9.90		69.00	83.10		47.00	47.00		20.10	20.10				79.90		82.90				
Vanuatu	11.30	62.60	36.00	3.50	29.40	15.52	2.50	21.40	31.60	55.90	62.50	62.00	68.00	67.02	5.84	8.52	7.13			73.20	77.00	76.40	77.30				
Viet Nam	9.40	50.20	30.88	2.30	23.30	13.28	1.00	11.00	5.80	44.50					3.10	3.79	3.46										

Fertility, childbearing, and access to services

Country	Adolescent birth rate (births per 1,000 females aged 15-19 years)	Proportion of 20-24 year olds females who commenced childbearing by age 15 (%)	Proportion of 20-24 year olds females who commenced childbearing by age 18 (%)	Percentage of births to women age 15-24 in the 5 years preceding the surey, including current pregnancies, that were wanted later (mistimed) or not wanted at all (unwanted) (%)		Percentage of females <20 years with a brirth in the last 2 or 5 years who were attended at least once by a skilled antenatal care health provider for the most recent birth (%)	Percentage of live births to <20 year olds in the last 2 or 5 years attended by a skilled health provider (%)	Percentage of live births to <20 year olds in the last 2 or 5 years delivered in a health facility (%)	Percentage of females aged <20 years who had a live birth in the last 2 or 5 years, who received a postnatal check from a skilled health provider (%)	Percentage of females aged 15-24 years who report haveing at least one serious problem accessing health care for themselves (%)		Percentage of of population aged 15-24 years covered by any health insurance (%)					
	Female	Female	Female	Female		Female	Female	Female	Female	Female		Female			Male		
	15 to 19	20 to 24	20 to 24	15 to 19	20 to 24	15 to 19	15 to 19	15 to 19	15 to 19	15 to 19	20 to 24	15 to 19	15 to 24	20 to 24	15 to 19	15 to 24	20 to 24
Afghanistan	69.0	3.0	20.4	4.2	7.3	58.4	53.6	51.5	30.8	91.3	89.1	0.0	0.0	0.0	0.0	0.0	0.0
Bangladesh	83.0	8.3	35.7	21.5	23.8	64.4	41.8	36.1	33.9								
Bhutan	20.2		15.3			96.0	58.2	57.2									
Cambodia	50.2	0.4	7.0	10.3	12.6	95.7	91.4	85.9	82.0	78.7	71.8	13.3	13.7	14.1	9.2	9.4	9.7
China	7.6																
DPR Korea	0.3																
Fiji	49.4																
India	13.2	1.0	9.3	6.0	7.2	80.8	85.5	83.9	63.0	61.5	57.8	17.0	16.6	16.1	18.6	19.0	19.6
Indonesia	47.4	0.3	6.9	11.2	10.2	95.0	770	72.0	76.6	55.3	34.7	56.4	33.5	57.1	41.3	33.9	33.3
Iran	40.6																
Kiribati	16.2	0.0	8.7	13.5	14.0	91.5	78.1	70.8	49.2	87.0							
Lao PDR	65.4		18.4			74.7	56.4	57.0	37.9			8.7		10.9	7.5		9.0
Malaysia	13.4																
Maldives	7.8	0.0	0.8	29.5	19.4	99.1	100.0	96.8	89.5	65.4	58.1	3.5	6.8	9.8	1.6	6.6	13.4
Marshall Islands	138.0	1.7	21.4	62.2	47.7	95.7	93.5	82.8	62.8	86.0							
Micronesia	13.9																
Mongolia	31.0		4.2			100.0	100.0	100.0	90.9								
Myanmar	28.5	0.3	5.1	6.3	7.9	80.0	60.8	37.3	53.0	52.0	49.2	0.2	0.9	1.5	1.1	1.3	1.5
Nauru	69.0	0.7	21.5	56.5	54.0	95.5	90.6	95.7		97.3							
Nepal	65.1	1.1	16.1	20.0	16.5	88.0	68.7	68.1	52.7	86.6	81.9						
Pakistan	38.8	0.8	7.4	3.9	8.5	84.2	70.2	67.4	48.0	83.0	71.5	0.1	0.2	0.2	0.0	2.0	2.3
Papua New Guinea	52.7	2.8	16.6	26.6	28.8	81.4	61.1	60.6	47.1								
Philippines	54.2	0.4	10.5	29.1	28.6	90.5	85.9	79.2	83.5	63.6	51.8						
Samoa	23.9	0.4	5.8	18.0	11.9	94.5	86.4	85.6	61.4	87.4							
Solomon Islands	78.0	3.3	14.9	33.0	32.8	95.0	88.2	87.8	61.7	92.8		0.6		1.2	2.7		4.5
Sri Lanka	20.9	0.2	3.4			99.2	99.3	99.8	99.8								
Thailand	44.9		9.4			98.5	99.4	99.4	80.1								
Timor-Leste	33.8	0.3	7.4	4.9	3.9	79.6	57.8	44.5	30.3	68.5	68.1						
Tonga	14.7	0.0	2.3	37.3	17.8	92.3	99.0	100.0	89.9	63.4		1.3		6.1	0.5		2.7
Tuvalu	42.0	0.0	3.2	30.2	14.6		100.0	100.0		97.4							
Vanuatu	49.4	1.8	13.3	40.2	27.1	76.5	92.5	92.7	78.0	90.3		0.8		0.5	0.5		2.5
Viet Nam	30.9		4.7			90.7	86.9	85.8	82.6								

Contraception

Country	Proportion of 15-24 year olds who have heard of at least one modern method of contraception (%)						Proportion of women aged 15-24 years who are currently using a modern method of contraception (%)						Proportion of 15-24 year old females who have their need for family planning satisfied with modern contraceptive methods (%)							Proportion of 15-24 year old females whose need for family planning is NOT satisfied with modern contraceptive methods (%)
	Female			Male			Female			Female			Female							Female
	Married			Married			Married			Unmarried sexually active			All	Married			Unmarried sexually active			All
	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 19	20 to 24	15 to 24	15 to 24
Afghanistan	91.4	92.7	92.4	93.8	89.4	89.9	6.0	15.3	13.1				26.8	20.8	34.1	31.9				73.2
Bangladesh							46.7	54.5	51.5				144.3	68.4	73.8	71.8				26.3
Bhutan							30.2	56.5	103.3	0.2	2.5		55.5							44.5
Cambodia	98.8	99.8	99.6				20.2	34.4	31.6				109.3	45.8	55.9	54.4			45.8	45.0
China							46.8	60.4	59.3				84.8							15.2
DPR Korea								18.2	18.2				67.1							32.9
Fiji													79.2							20.8
India							10.0	23.6	21.0				96.7	26.9	46.0	43.3		76.2	57.2	46.9
Indonesia	98.4	99.5	99.3	94.8	97.8	97.3	43.8	55.4	57.0		13.3		168.8		80.6	86.2		29.0	15.0	16.8
Iran							26.4	50.3	43.9				70.9							29.1
Kiribati	87.0	94.1	92.6		98.8	98.8	0.0	15.4	12.0				52.6	0.0						47.4
Lao PDR							29.1	42.9	39.2	14.1	16.4		57.3	58.5	66.7	64.3	16.0	17.7		42.7
Malaysia							20.5	31.6	30.1				75.5							24.5
Maldives	98.2	98.2	98.2		99.1	99.1	4.7	9.5	9.2				87.4	9.5	18.5	47.8			1.5	28.3
Marshall Islands	96.5	98.3	97.8		100.0	100.0	23.7	24.9	24.6	12.7	26.8		65.8	40.0						34.2
Micronesia													69.2							30.8
Mongolia							35.5	35.8	36.3	33.3	34.0	33.9	65.0	52.5	55.3	55.0	35.4	45.6	43.1	35.0
Myanmar							53.2	59.3	58.0				158.7	73.0	81.3	79.5				20.7
Nauru			97.8			97.3		12.7	12.7						20.0	20.0				
Nepal							14.5	23.9	21.1				71.4	24.9	37.0	33.7				62.3
Pakistan	90.5	96.3	95.0	97.4	97.9	97.8	5.9	13.4	11.6				68.4	23.3	36.2	33.9				65.9
Papua New Guinea	65.2	77.4	74.8	86.4	84.6	84.8	16.5	24.9	23.1	13.1	15.2	14.4	45.2	32.6	39.3	37.9	16.0	17.8	17.0	54.8
Philippines	99.0	99.8	99.7				29.7	44.0	41.2	12.9	15.2		97.5	46.6	59.3	57.1	13.8	17.3	16.1	55.9
Samoa	73.7	91.2	88.2		88.7	88.7	6.0	19.7	17.4				55.0	11.0						45.0
Solomon Islands	92.3	93.0	92.9	100.0	98.0	98.1	7.1	19.0	16.7	5.0	8.1		71.5	12.7	27.0	24.4	5.2	8.5	6.9	47.6
Sri Lanka	96.4	99.3	98.7				37.5	47.8	45.6				75.0	57.8	71.1	69.2				25.0
Thailand							68.2	72.4	71.5	1.3	2.5		85.0	83.0						15.0
Timor-Leste	71.5	77.2	76.2		86.5	86.5	8.1	18.7	16.7				73.9	22.1	38.2	35.7				61.2
Tonga	97.9	94.9	95.2		100.0	100.0	8.6	17.1	16.1				66.7							33.3
Tuvalu		97.2	97.2					10.2	10.2											
Vanuatu	87.6	95.6	94.3		100.0	100.0	25.6	31.1	30.2	24.5	20.0		61.1							39.0
Viet Nam							29.4	43.8	41.7	0.0	0.3		67.2	59.9	64.9	64.1				32.8

HIV

	Percentage of 15-24 year olds with comprehensive knowledge of HIV (who correctly identify the two ways of preventing the sexual transmission of HIV , who know that a healthy-looking person can be HIV-positive and who reject the two most common misconceptions about HIV transmission)		Proportion of 15-24 year olds who know that using a condom every time can prevent HIV		Percentage of men who have sex with men <25 years living with HIV	Proportion of men who have sex with men <25 years who know their HIV status	Proportion of men who have sex with men aged <25 years who used a condom the last time they had anal sex with a male partner (%)	Proportion of men who have sex with men <25 years reporting having received a combined set of HIV prevention interventions (%)	Percentage of transgender people <25 years living with HIV	Proportion of transgender people <25 years who know their HIV status	Proportion of transgender people aged <25 years who used a condom at last sex or last anal sex (%)	Proportion of transgender people <25 years reporting having received a combined set of HIV prevention interventions (%)	Percentage of sex workers <25 years living with HIV	Proportion of sex workers <25 years who know their HIV status	Proportion of sex workers aged <25 years who used a condom with their most recent client (%)	Proportion of sex workers <25 years reporting having received a combined set of HIV prevention interventions (%)	Percentage of people who inject drugs <25 years living with HIV	Proportion of people who inject drugs <25 years who know their HIV status	Proportion of people who inject drugs aged <25 years who used a condom during last sexual intercourse (%)	Proportion of people who inject drugs <25 years reporting having received a combined set of HIV prevention interventions (%)
Country	Female	Male	Female	Male	Male	Male	Male	Male	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total	Total
Afghanistan	1.0	6.3	11.5	40.4	0.0		17.0						0.3		52.9		2.7		42.6	
Bangladesh	9.1	14.4	45.0	72.0	0.0	10.0	46.3	3.5	1.1	36.4	43.2	28.8	0.1	25.0	64.2	11.6	0.7	26.3	40.8	47.4
Bhutan	21.0		69.2																	
Cambodia	37.6	45.9	83.2	88.1	0.6	72.9	75.4	19.7		71.8	85.0	87.9	0.8			52.6				66.7
China					5.6	53.6	85.4						0.1	50.4	94.1		4.0	53.1	67.1	
Fiji													0.0		90.7					
India	21.7	31.5	54.7	75.2	3.4		84.0		5.9		81.4		1.2		91.4		7.6		80.7	
Indonesia	11.4		51.7		23.8		88.0		18.9				4.1		62.8		3.3		58.0	
Kiribati	44.4	48.6	80.4	90.1																
Lao PDR	19.3	22.2	52.8	62.6	2.1	8.3	25.2	8.0					1.3	94.9	91.3	49.6				
Malaysia					15.5	42.1	66.2	35.6	4.6	31.1	68.2	45.7	3.6	31.3	77.7	12.5	6.1	28.6	30.0	0.0
Maldives	29.3	26.4	56.9	67.0																
Marshall Islands	26.6	39.4	69.9	87.6																
Micronesia													0.0							
Mongolia	20.2	20.2	59.0	68.5	1.9	76.5	78.7	23.8					0.0	8.6	77.4					
Myanmar	16.2	17.8	54.2	68.2	5.5	30.6	55.0	26.0					4.5	40.6	78.8		28.3	25.6	26.6	24.7
Nauru	13.3	9.6	46.8	58.0																
Nepal	36.4	33.9	75.1	92.7	5.3	90.6	95.1		1.9	82.7	96.2			87.2			4.0	97.6	86.8	
Pakistan	4.2	5.2	8.6	30.5	3.6	44.7	83.3	1.8	6.2	24.2	26.9	0.8	3.8	45.0	58.8	0.6	17.5	15.4	21.9	2.3
Papua New Guinea	24.4	26.2	54.7	60.3		58.8	59.9						12.7		75.4					
Philippines	15.1		59.2		3.8	23.0	38.0	12.2	3.0	33.7	37.8	16.2	0.7	22.5	68.7		14.5	20.0	14.8	
Samoa	5.2	5.7	63.1	61.6	0.0	100.0	2.2	100.0	0.0	100.0	46.7	100.0		100.0	37.5					
Solomon Islands	28.8	33.6	62.0	64.6																
Sri Lanka	24.0		60.3		0.0		47.0						0.0		95.0				37.0	
Thailand	46.0	45.1	87.2	87.6	6.2	45.1	84.0	52.8	10.2	34.9	80.0	46.8	0.0	53.8	79.9		25.0		49.0	
Timor-Leste	12.2	19.7	30.3	48.3																
Tonga	12.1	14.0	64.0	71.0			66.7		0.0		77.8									
Tuvalu	39.4	60.7	79.0	88.4																
Vanuatu	18.1	18.9	59.2	64.9																
Viet Nam	49.3		88.7		10.6	72.7	64.9	28.4					2.0	62.4	90.1	27.5	1.6	50.3	44.9	16.3

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