SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ADOLESCENTS AND YOUTH

A NARRATIVE REVIEW OF CHALLENGES AND
OPPORTUNITIES FOR ACHIEVING SRHR GOALS FOR
ADOLESCENTS AND YOUTH

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CONTENTS

ACKNOWLEDGEMENTS

ACRONYMS AND ABBREVIATIONS

CoP	- Community of Practice
CRPD	- Convention on the Rights of Persons with Disabilities
CSE	- Comprehensive Sexuality Education
FGD	- Focus Group Discussion
FGM	- Female Genital Mutilation
GBV	- Gender Based Violence
iCoP	- International Community of Practice
ICPD	- International Conference on Population and Development
ICT	- Information and Communications Technologies
LGBTQI	- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex
NGO	- Non-Governmental Organization
SRHR	- Sexual and Reproductive Health and Rights
UHC	- Universal Health Care
UNFPA	- United Nations Population Fund
UNICEF	- United Nations International Children's Emergency Fund
WHO	- World Health Organization

EXECUTIVE SUMMARY

The narrative review is commissioned by the Share-Net International as part of its second annual International Sexual and Reproductive Health and Rights (SRHR) Co-creation Conference, "Engaging in Knowledge Translation Together". The aim of this narrative review is to present the state-of-the-art knowledge and evidence around the theme "SRHR for adolescents and youth." The theme focuses on empowering local organizations and users to improve access to SRHR services and information for adolescents and youth in their own country.

A combination of methods i.e., a literature review, key experts' interviews, focus group discussions (FGD) was used for this narrative review. The literature review was conducted in order to present the existing knowledge, identify knowledge gaps, review which interventions have worked (or not), assess the lessons learned and provide insights into the main challenges to be addressed. Key expert interviews were conducted with key and recognized experts in the field of sexual and reproductive health as well as experts and practitioners working with adolescents and youth. The key experts represented government offices, academia, global institutions, NGOs, and youth-led organizations, from different regions in the world. Focus group discussions (FGDs) were conducted with the members of the CoPs on SRHR for adolescents and youth from the country hubs of Share-Net International- Share-Net Burundi, Share-Net Bangladesh, Share-Net Jordan and Share-Net Netherlands. FGDs were formatted to conduct deliberative dialogues with the participants and the members of the CoPs were asked to share their experiences and perspectives, the main gaps and the good practices and interventions in the field of SRHR for the adolescents and youth.

According to UNICEF, adolescents are making up 24% of the world population. While adolescents and young people have the same right to control over their bodies as adults, and need to receive information, counseling and access to the full range of modern contraceptive options, this group consistently lacks access to sexual and reproductive health information and services. Hence, it is important to integrate adolescents and youth in the SRHR programmes in a participatory way so that they are able to take decisions and act accordingly having the right information. Thinking "SRHR for adolescents and youth" a broad topic, four sub-themes were identified to work with. The sub-themes are "sustainable meaningful youth participation," "reaching the more vulnerable or hard to reach adolescents and youth," "impact of social norms, values and ideologies on SRHR for adolescents and youth" and "evidence-based advocacy."

The narrative review identified a number of persistent and new challenges that directly affect the security, agency, opportunities, and aspirations of adolescents worldwide. For instance, in most countries, unmarried adolescents are not recognized as sexual beings while both the girls

and boys start to have sexuality related lessons according to the social norms. Such a situation worsens for LGBTQI groups where they are even criminalized for their sexual orientation. Their sexual wellbeing and sexual relationships are strictly controlled or ignored. Many countries offer sexuality education safeguarding the cultural and ideological norms. Issues like knowledge of contraception, safe sex, LGBT rights etc. are not included in the curriculum So the programmes lack of comprehensive as par the UNESCO guidelines. Due to the existing unequal gender norms, most of the SRHR programmes target girls and women while boys and men remain out of the discussion. Thus, on one side, boys' reproductive health rights were left unattended. Along with sexuality, adolescent and youth's agency is overlooked. Even though meaningful youth participation is encouraged to apply widely, tokenism and underrepresentation are two key challenges that keep behind the sustainability of meaningful youth participation. Existing social norms, values and ideologies are one of the big challenges to SRHR achievement.

Additionally, existing SRH programmes and interventions fail to reach the most vulnerable groups of adolescents. Adolescents from ultra-poor families, in some contexts adolescents from lower caste, intellectually disabled- all these group's sexuality remains largely invisible. In fact, it is also a political agenda (national, international) that hinders the progress of sexual and reproductive health schemes. For instance, funding for particular programmes or rights, or donating to an organization is dependent on the priority agenda that is in most of the cases determined by the political agenda.

Keeping in mind there is no simple solution or no single approach to overcome the challenges, the narrative review has come up with some recommendations for mitigating the existing problems i.e., ensuring rights-based comprehensive sexuality education, advocating for the place of SRHR for adolescent and youth specifically, mainstreaming the vulnerable groups for breaking taboo, emphasizing on creating and using evidence-based data, designing and implementing community based approach, using mass media, using digital platforms and creating innovative and alternate products. Finally, the review suggests to rethink working with the "adolescent and youth" differently. Because, the age range (generally 10 – 24 while in some countries it is up to 35) of adolescent and youth is an incredibly broad to work with. While adolescents and youth are from two different age groups; however, the programmes and policies are often overlapping for addressing the SRHR issues of the young people.

1.
INTRODUCTION

1.1. BACKGROUND

Share-Net International is organizing its second annual International Sexual and Reproductive Health and Rights (SRHR) Co-creation Conference, **"Engaging in Knowledge Translation Together".** The conference will start on 25th January 2021 and end on the 28th January 2021. The conference is hosted by the Share-Net Bangladesh and Share-Net International. This year, all the events of the conference will be held online giving people all around the world the opportunity to join.

This conference will be a working conference during which participants will develop concrete knowledge products that will be used for influencing policy and practice at country level. All participants, including researchers, practitioners and policy makers will engage in dialogues and are part of the creation process of these knowledge products.

This narrative review is one element of the expected outcomes of the process, which aims to present state of the art knowledge and evidence around the theme **"SRHR for adolescents and youth."** The theme will focus on empowering local organizations and users to improve access to SRHR services and information for adolescents and youth in their own country. At the inception stage of the narrative review, four sub-themes were identified to work with, as the conference theme covers a broad topic. The sub-themes are **"sustainable meaningful youth participation," "reaching the more vulnerable or hard to reach adolescents and youth," "impact of social norms, values and ideologies on SRHR for adolescents and youth"** and **"evidence-based advocacy."**

Adolescents and young people consistently lack access to sexual and reproductive health information and services (Engel et al., 2019). Adolescents and young people have the same right

to control over their bodies as adults, and need to receive information, counseling and access to the full range of modern contraceptive options. The adolescent SRH challenges are currently recognized through Sustainable Development Goals (SDGs) number 3, which aims to eradicate HIV infections and provide universal access to sexual and reproductive health services as well as incorporating such services into national strategies.

According to UNICEF, the number of adolescents in the world today is 1.2 billion, making up 16% of the world population [a]. It is important to integrate adolescents and youth in the SRHR programmes in a participatory way so that they are able to take decisions and act accordingly having the right information. According to UNICEF, globally around 21% of young women were married before their 18th birthday [b]. Adolescents and youth friendly SRHR services and information therefore are essential conditions to reduce teenage pregnancies and related maternal mortality also to prevent risky sexual behaviour of adolescents, correct information about SRHR through social media, adolescents clubs, youth clubs, child marriage, sexual orientation, equal opportunities, menstrual health management (MHM), use of media for communication, helpdesks could be the underlying issues of this track.

Therefore, the topic is framed around **"SRHR for young people [c]: challenges and opportunities"**. A broad community of interested parties was interviewed and people's concrete experiences with challenges and best practices were solicited. In addition to that, a critical assessment of partnerships between international and local organizations, with a focus on bridging the public-private nexus was done.

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a   https://www.unicef.org/media/58171/file

b   https://data.unicef.org/topic/child-protection/child-marriage/

c   WHO defines young people as: 10-24 years age, adolescents: 10-19, youth: 15 to 24.

1.2. METHODOLOGY

A combination of methods was used for this narrative review. A literature review was combined with key experts' interviews and focus group discussions (FGD).

The literature review was conducted in order to present the state-of-the-art knowledge, identify knowledge gaps, review which interventions have worked (or not), assess the lessons learned and provide insights into the main challenges to be addressed. Peer reviewed articles based on qualitative studies and quantitative studies have been included in the review and a snowballing method was followed to identify relevant literature from the references in the reviewed articles. In addition to the peer reviewed articles, published documents such as, policy briefs, annual reports and research updates of various organizations that work with SRHR as well as with young people were reviewed.

Key experts shared their experiences and knowledge about the state of the art of issues pertaining to access to quality SRHR for adolescents and youth. During the interviews, suggestions were sought for relevant documents and reports. And, further targeted searches were followed in order to validate the inputs given by key experts.

In preparation of the conference, an international Community of Practice (iCoP) was formed with international experts and Share-Net International members, including members of the national Community of Practice (CoP) working in each country hub of the Share-net International. The members of the iCoP were actively involved in shaping and validating the focus of the conference theme and raised key issues related to SRHR for adolescents and youth.

The iCoP members and the members of Share-Net Bangladesh CoP gave input at different phases of the preparation process of the narrative review. Furthermore, the CoP members of each country participated in focus group discussions or key informant interviews. Members of the Conference Coordination Committee (CCCom) oversaw the process of narrative review and provided valuable suggestions and input at different phases of the process.

1.2.1. DATABASE SEARCH

A broad search of the literature was done to identify the scope of the review and the current evidence around the subject using the databases ScienceDirect, Scopus and Google Scholar. The reports and publications of national and international organizations working with SRHR as well as with young people were searched through the organizational websites and various online knowledge platforms. A more targeted search was done to accommodate the input from the key experts and FGD participants. We searched for literature and other resources when new topics and publications were mentioned in the key experts' interviews and FGDs.

1.2.2. SUPPLEMENTAL RESEARCH

In order to ensure an all-encompassing research strategy and optimize SRHR related findings, online search engines and social media platforms were consulted. Search engines such as Google and Google Scholar were consulted to complement the database research; and social media platforms including Facebook, LinkedIn and Twitter were also used to follow the relevant events and posts of SRHR for adolescents and youth, meaningful youth participation, and other youth related issues. We used the search terms such as, but not limited to, 'opportunities and challenges for SRHR for adolescents and youth', 'meaningful youth participation for SRHR,' 'intersectionality in SRHR,'

and 'improving SRHR for young people.' We found interesting information from NGOs, newspapers, blogs, and academic sources through these supplemental research attempts.

The websites of the Share-Net international and Share-Net Bangladesh were consulted on a regular basis as these websites were updating with news, reports, policy briefs, blogs, publications, events and other activities of their partner organizations regarding SRHR.

1.2.3. KEY EXPERT INTERVIEWS AND FOCUS GROUP DISCUSSIONS WITH COPS

Key expert interviews were conducted with 12 key and recognized experts in the field of sexual and reproductive health as well as experts and practitioners working with adolescents and youth. The key experts represented government offices, academia, global institutions, NGOs, and youth-led organizations, from different regions in the world. The interviews used a semi-structured questionnaire, which was developed by the consultants and then consulted with and approved by the members of the iCoP and the Conference Coordination Committee (CCCom). All the interviews were conducted online using Zoom.

FGDs were conducted with the members of the CoPs on SRHR for adolescents and youth from the country hubs of Share-Net International: Share-Net Burundi, Share-Net Bangladesh, Share-Net Jordan and Share-Net Netherlands. During the FGDs, the members of the CoPs were asked to share their experiences and perspectives, the main gaps and the good practices and interventions in the field of SRHR for the adolescents and youth. An FGD-guideline was developed and used to conduct these discussions. Both the consultants were present during the FGDs playing the role of moderator and notetaker alternatively.

The interview questionnaire included questions around the main four sub-themes identified by the iCoP. FGD participants were from the partner organizations of Share-Net International. In all four FGDs, participants were asked three key questions pertaining their experience, the main gaps and the good examples of interventions in the field of SRHR for adolescents and youth.

1.2.4. LIMITATIONS

Sexual and Reproductive Health and Rights issues are extremely broad. Moreover, Sexual and Reproductive Health and Rights for adolescent and youth is an incredibly broad theme to work with. While adolescents and youth are from two different age group; however, the programmes and policies are often overlapping for addressing the SRHR issues of the young people. It has not been possible within the time available for this study to ensure that all factors for these two groups have been given robust attention, and this review mostly discussed them together. Besides this, the key factors and concerns raised by the key experts and the members of international and national CoPs have been a driving factor for determining the focus of this review. Key experts may have 'organisational' or 'professional' agendas and priorities, which could determine their input in the interviews and this may be contributing to some bias. Another limitation is that we could not interview adolescents due to the limited time and scope of the research conducted for this narrative review. However, we interviewed a number of key experts that work with adolescents. They represented the voices of the adolescents they work with and informed us about adolescents' SRHR needs and the challenges adolescents face.

2.
SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ADOLESCENT AND YOUTH: AN OVERVIEW

2.1. INTRODUCTION TO SRHR

Sexual and reproductive health and rights, in short SRHR, is a human right concept and a major health issue concerning sexuality and reproduction. According to UNFPA, good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system (UNFPA, n.d.). Therefore, having a safe, satisfying sexual life is a basic right of every person. Reproductive and child bearing rights are also basic human rights; and every person must have their own authority on whether or not they will exercise that right (Chandra-Mouli et al., 2019; Mahmood, T., & Bitzer, J. 2020).

As a concept, SRHR is comparatively new, as it did not get recognition up until the 1990s. Before that, reproductive rights and reproductive health programs were mainly confined into family planning, a means for government's population control initiative. Reproductive rights were

first officially recognized at the International Conference on Population and Development (ICPD) in Cairo in 1994 (European Humanist Federation, 2015). Agreed by 179 countries, it was the first and most comprehensive international document to embody concepts of reproductive health and rights and sexual health. However, the Millennium Development Goals, adopted in 2000, completely omitted reproductive health and it took a sustained campaign by SRHR advocates to add a reproductive health target in 2007. Following this, the Sustainable Development Goals (SDGs) call for comprehensive access to SRHR (Targets 3.7 and 5.6).

A new, comprehensive definition of sexual and reproductive health and rights highlighted in 2018 Guttmacher–Lancet Commission. It proposes, "….Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability"(Starrs et al., 2018: 2642).

2.2. SRHR FOR ADOLESCENTS AND YOUTH

Adolescents and youths (aged 10-24 years) make up 24 percent of the world's population. That's around 1.8 billion young people, 90 percent of whom live in developing countries (UNFPA, n.d.). According to World Health Organization, individuals of the age group 10-19 years are defined as 'Adolescents' and individuals of the age group of 15-24 years are defined as 'Youth' (WHO, n.d.). However, in some countries the age for youth population goes up to 30 or 35 years. For instance, the age range for youth in the Netherlands goes up to 30 years. The United Nations secretariat recognizes different definitions of youth since several UN entities, instruments and regional organizations have differences in definitions. The following table summarizes these differences:

SDG TARGETS RELEVANT TO SRHR FOR ADOLESCENTS AND YOUTH

TARGET 3.7
By 2030 ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into na-tional strategies and programs

TARGET 5.2
Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation

TARGET 5.3
Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

TARGET 5.6
Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the ICPD and the Beijing Platform for Action and the outcome documents of their review conferences.

Adolescence is generally defined as being the time between puberty and reaching adult independence (Curtis, 2015), and puberty is considered a key element in human development into adulthood (Peterson, 1988; Steinberg & Morris, 2001), yet this marker of physical maturity is occurring at earlier ages in many settings, accompanied by an earlier onset of sexual attention, sexual thoughts, and experimentation (Tulloch & Kaufman, 2013).

In the context of SRHR, adolescents and youth have health care needs that are distinct from those of adults. Young people's SRHR refers to their physical and emotional wellbeing and

Entity/Instrument/ Organization	Age	Reference
UN Secretariat/UNESCO/ILO	Youth: 15-24	UN Instruments, Statistics
UN Habitat (Youth Fund)	Youth 15-32	Agenda 21[7]
UNICEF/WHO/UNFPA	Adolescent: 10-19, Young People: 10-24, Youth: 15-24	UNFPA[8]
UNICEF /The Convention on Rights of the Child	Child until 18	UNICEF[9]
The African Youth Charter	Youth: 15-35	African Union, 2006[10]

Source: https://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf

includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/ AIDS), and all forms of sexual violence and coercion. While these needs concern adults as well, young people's inexperience and their physical and emotional state at the transitional period make these needs acute. Sexual relationship is one of the important concerns of young people's SRHR. In particular, young people need to know how they can maintain healthy personal relationships. A common misconception prevails that young people should not be sexual beings, with the exception of marriage or of a certain age (Braeken & Rondinelli, 2012).

Overlooking these health care needs brings some crucial problems such as, unwanted pregnancies, early marriages, sexually transmitted infections, and sexual violence that jeopardize the process of human development. Neglecting SRHR for adolescents and youth may cause a painful or damaging transition to adulthood, which can result in a lifetime of ill effects. For adolescent and young women, "early pregnancy/motherhood can be physically risky and can compromise educational achievement and economic potential" (Morris & Rushwan, 2015:5). World Health Organization reported that adolescent mothers (ages 10–19 years) are more prone to pregnancy related diseases compared to women aged 20 to 24 years (WHO, 2014). Adolescent mothers face a much

higher risks of puerperal endometritis, eclampsia, and systemic infections and their babies face higher risks of low birth weight, preterm delivery and severe neonatal conditions.

Adolescent boys and girls face increased risk of exposure to HIV and sexually transmitted infections (STIs), and adolescent girls- in particular, face risks of sexual coercion, exploitation, and gender based violence (GBV). These risks have huge impacts not only on an individual's physical and mental health, but also cause long-term implications for them, their families, and their communities.

A review article summarizing the achievements of the ICPD after 25 years shows that, many aspects of adolescent SRHR have substantially improved in these 25 years. The impact of ICPD made changes in delaying first marriage, first sex, and first birth for adolescent girls; and they are more likely to use contraceptives now than 25 years ago. Both child marriage and female genital mutilation (FGM) rates have declined; however, these gains vary between countries and, in some locations, are offset by population growth and leave more girls affected.

However, around the world, conservative forces keep holding the progress back on this issue. Conservative forces as gender stereotypes, detrimental social norms, inimical religious belief,

gender and economic inequalities make it hard, in some cases almost impossible for young people to access information and services regarding SRHR. These forces keep the adolescents and youth back in almost all countries however, the young people in LMICs face these most acutely.

2.2.1. KEY GAPS IN SRHR FOR ADOLESCENTS AND YOUTH

There are gaps and needs with regard to data on adolescent SRHR. In the 25 years since ICPD, program implementers, researchers, and policymakers have greatly expanded the available public knowledge concerning adolescents, their needs and concerns, and how to help them overcome barriers to their sexual and reproductive health and well-being and to support them in fulfilling their aspirations. However, disaggregation of data across different age groups (early and late adolescence and young adulthood) and marital status is not carried out consistently in many national and international datasets, which may hide important discrepancies (Liang, et al, 2019).

The World Health Organization reports that, approximately 12 million girls aged 15–19 years and at least 777,000 girls under 15 years give birth each year in developing regions (WHO, n.d.). At least 10 million unintended pregnancies occur each year among adolescent girls aged 15–19 years in the developing world (ibid). And complications during pregnancy and childbirth are the leading cause of death for 15–19 year old girls globally. And what's scarier is that, an overwhelming number of those girls don't get the required SRHR services. Millions of girls are coerced into unwanted sex or marriage, putting them at risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV, and dangerous childbirth [d].

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d   https://www.unfpa.org/resources/adolescent-sexual-and-reproductive-health

Early and forced marriages exacerbate inequality and lack of opportunity for adolescents and youth in many countries. Early marriage also underscores the need to access SRHR services such as maternal care, abortion care, contraception, etc. Although countries such as India, Pakistan, Bangladesh have laws in order to prohibit child marriage, those laws have little or no implementations in the rural areas as well as in urban lowincome settings. According to a children's right NGO CRY's study, there are 17.26 million married children and adolescents within the age group of 10-19 years in India (The New Indian Express, 2020).

In Bangladesh, the minimum age for a girl's marriage is 18; however, it has the highest rate of child marriage in Asia, with 59% of girls (more than 4.3 million) getting married before turning 18 (Girls not Brides, 2020.). For decades, the Bangladesh government and civil society organizations have been working to address this issue. Contradictory to those efforts, section 19 of the Child Marriage Restraint Act 2017, approved by the Bangladesh parliament permits girls under age 18 to marry under "special circumstances," with permission from their parents and a court. Now, there is no minimum age for these marriages (Human Rights Watch, 2017).

Many countries worldwide do not address the need of young people to get safe abortion care. Of the estimated 5.6 million abortions that occur each year among adolescent girls aged 15–19 years, 3.9 million are unsafe, contributing to maternal mortality, morbidity and lasting health problems (WHO, n.d.). Yet exercising their rights to SRHR care, which includes abortion care, is still out of reach for many adolescents and youth around the world. In China and India, where world's most adolescents are, the abortion laws strict for the adolescents. An adolescent does not have the right to terminate the fetus unless she has legal consent from her parents.

In most African countries, abortion is restricted by

law. Even in the African countries where abortion rights are provided to adolescents (on request or for social reasons), most of them do not get safe and accessible abortion care. Two reasons are identified for that a) the majority of women cannot get safe abortion services, because of factors such as distance, cost of services, or lack of awareness about the location of facilities, and b) government officials and other key stakeholders are largely unaware of the abortion law, which means that abortion care remain administratively inaccessible to women (Ipas Africa Alliance, 2014). A lot of advocacy work is still needed to make policy makers understand that SRHR is an integral part of Human Rights conventions that States have ratified according to the UN OHCHR [e].

Europe's abortion laws are mixed. In three EU Member States (Cyprus, Ireland and Malta), abortion is generally considered illegal, with some exceptions. In nine Member States, abortion is only allowed without parental consent from the age of 18 years (Bulgaria, Denmark, Greece, Hungary, Italy, Luxembourg, Poland, Slovakia and Spain). In the other Member States, girls can access abortion services only under specific medical circumstances, depending on the maturity of the pregnant child and on the doctor's assessment. Under a certain age, parental consent might also be needed. Abortion is only possible within a certain timeframe, which is also the case for adult women (European Union Agency for Fundamental Rights, 2017).

United States' abortion rights are preserved to individual states. And most states don't permit girls having abortion without their parents' consent or court order. Though most adolescents do get the consent of their parents, this extra barrier sometimes puts their health and safety at jeopardy.

In recent years, menstrual health has emerged as an important yet neglected entry point to discuss puberty, gender, reproductive health,

and sexuality issues with young women. Globally, knowledge and understanding of menstruation are highly variable and often low among adolescent girls (Tangcharoensathien et al., 2015). Lack of understanding coincides with stigma around menstruation and a cultural perception of menstruation as dirty and taboo (Kangudie et al., 2019; Tangcharoensathien et al., 2015). Comprehensive sexuality education can help to enhance understanding of menstruation and dispel such beliefs and practices, reducing stigma and giving girls greater freedom.

Interventions and programmes on SRHR for adolescents and youth have almost overwhelmingly focused on girls and young women (Saewyc, 2012). The majority of studies on adolescents and youth SRHR is focused only on girls and young women in comparison to fewer studies that include both genders. Only a handful of studies in sexual and reproductive health focus exclusively on boys and young men. While adolescent girls and young women are more vulnerable to experience gender based violence in many contexts, boys may face challenges of different sort. If SRHR research are focused only on girls we can miss important information regarding young men's SRHR needs and challenges.

SRHR needs of sexual and gender minorities are not properly addressed in many countries due to criminalization and stigmatization of nonheterosexual orientation and non-binary gender identity. In the countries, sexual and gender minorities are legally and socially marginalized, LGBTQI adolescents and youth experience double-marginalization due to their age and sexual and/or gender minority identity, and that they are routinely excluded from existing SRHR services (Müller, et al., 2018).

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e   https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.aspx

3.
COMPREHENSIVE SEXUALITY EDUCATION

Comprehensive sexuality education (CSE) is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality (UNESCO, 2018). It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to realize their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives (UNESCO, 2018). Although Comprehensive sexuality education was started in response to the HIV epidemic, later it was promoted from a transnational SRHR framework supported by international organizations like UNFPA, WHO UNESCO and IPPF and now-a-days, its relevance is recognized worldwide. After the 2015 ICPD, resolutions repeatedly call on governments to provide CSE both in schools and at

the community level (Haberland & Rogow 2015). However, interventions in many countries fail to make sexuality education comprehensive as par the UNESCO guidelines.

In many developing countries, sexuality education is mainly promoted from a knowledge building awareness approach. In the Sub-Saharan Africa, the main focus was to prevent HIV infections awareness creating to avoid potential dangers of sex. Similarly, in some South Asian countries, sexuality education is approached to avoid gender-based violence, to disseminate reproductive knowledge. In both contexts, the sexuality education curricula follows 'abstinence' approach. In such situations, issues like knowledge of contraception, safe sex, LGBT rights etc. are not included in the curriculum.

In some countries, public policies do not even allow to include the term 'sexuality' in the curricula. An expert working in the South Asian context explained, *'the government of Bangladesh and Sri Lanka used the term, 'life skills education'.'* She further said, *'even the Sri Lankan ministry of education does not use the name of sexual organs i.e. breasts, penis, vagina etc. instead these are termed as 'hidden body parts'.'* Same examples were given by the members of Burundi CoP during the focus group discussion. Burundi government also named sexuality education to life skill education. Identifying the challenge in this process, a participant in the Jordan FGD said, *'[d]on't implement SRH program for the sake of implementing. To make it effective everything should on based on culture'.* However, another participant in the same FGD said, *'this is up to the development workers to be creative about how this approach can be included'.*

A youth development worker upheld the importance of cultural context mentioning that,

'[w]hat comprehensive sexual education deals with is a taboo topic in existing cultural norms, so it needs to be a long-term operation. Therefore, the design of the curriculum and deliver of the content should be in such a way that won't hurt peoples' emotion. So, don't rush. Speak from their point of view on their language.'

The interactions between SRH and education are associated both with an interconnection of effects and with processes, intrinsic to each, where the one draws on the other. Demographic and Health Surveys data in many countries show correlation between the uptake of primary education (as measured by enrolment, attendance, and completion) and uptake of SRHR services, leading to better outcomes, particularly reduced maternal mortality, better neonatal survival, better sexual health outcomes, greater women's autonomy over decision-making regarding health, and possibly household economics and family redistribution of esteem and influence for women. Thus, through this connection with sexual and reproductive health, we can see a link between girls' schooling and some gender and women's rights goals, as articulated in the Beijing Declaration, the SDGs, and other similar international declarations and agreements.

Research show that, despite all the interventions running for school-based sexual health education globally adolescents continue to make unsafe sexual health decisions than their adult counterparts (Lucero, et al., 2020). Adolescents receive sexual health education developed largely by adults without any input from adolescents. It is very important role of the educator, researcher, and policy maker to listen to the adolescents' perceptions in order to modify and create programs that could potentially improve sexual health outcomes for adolescents (Corcoran et al., 2020).
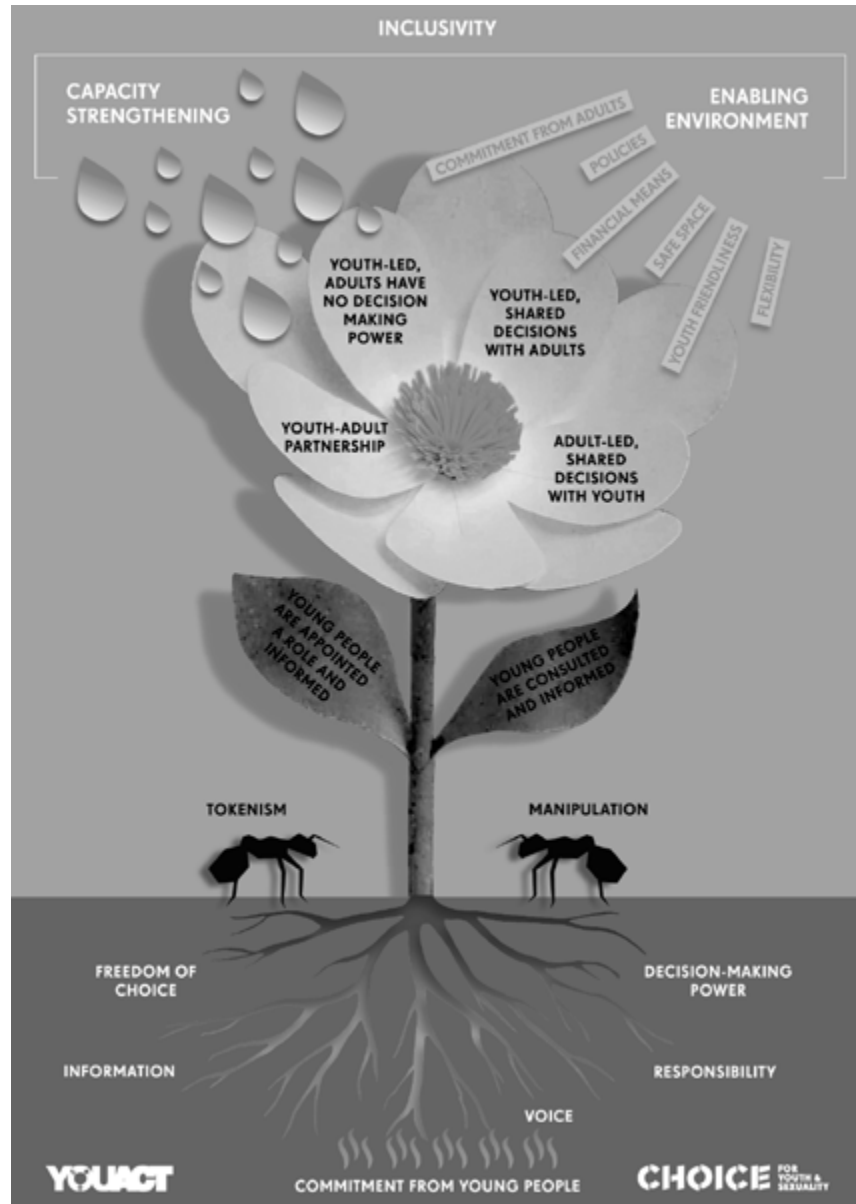
4.
SUSTAINABLE MEANINGFUL YOUTH PARTICIPATION IN SRHR

To successfully achieve the goals of SRHR for adolescents and youth it is important to ensure sustainable meaningful youth participation (MYP). A rights-based approach that sees young people as active social agents is vital in SRHR programmes. Through this approach, SRHR programmes should reflect young people's capacity to critically reflect on factors that underpin the SRHR issues they want to change and provide them with the opportunities to address these factors and contribute to change.

Meaningful youth participation (MYP) refers to active, informed and effective involvement of youth in the decision-making process within and outside of a group or organization. Yet, MYP can be perceived differently due to the differences among societies and cultures. In fact, the core term "youth" of MYP is not a homogeneous entity rather it has diversity with complex, changing and varied desires. Hence, MYP's definition, use and objectives vary.

In the context of SRHR for adolescents and youth MYP is essential to create spaces where young people have access to accurate information about their SRHR, as well as youth-friendly services that help them to make free and responsible decisions about their sexuality. It is important to have young

Source: https://www.youthdoit.org/themes/meaningful-youth-participation/flower-of-participation/

people involved in every step of the decision-making process. That way, their needs will be met more effectively, and the projects and programmes will thus have better chances of being sustainable for the youth and the organizations working with/for them (YouAct, 2019).

Key experts working on the issues of SRHR and young people across the world stressed on the significance of youth participation in different phases of SRHR programs designed for the young people. One key expert, who is involved in various research projects and programmes on adolescent development, says, *'it's absolutely vital to include the youth in the programmes from the very beginning. No program should begin until the programme beneficiaries are involved in the different phases of a programme and this is especially important for the youth to participate actively in the SRHR programmes for them.'*

Another key expert, who is a policy maker at the govt. level, commented that *'we should inspire and promote to form youth groups based*

at school, community, as well as in different locations where we can involve out of school children so that we can bring them together and enhance their bonding and belongingness. This will result good outcome for our SRHR programmes.'

The discussion around the importance of MYP is already on the floor, yet these youth strategies have not translated into action due to two major challenges – tokenism and underrepresentation. Tokenism refers to the process when young people's participation is superficially accomplished. It means in projects, programs, activities and processes where young people are not thoroughly involved in all the aspects of the decision-making process from a presumption that young people don't have the maturity to express an opinion, their voices are not listened or respected by the other nonyouth members of the organizations, and in the end their ideas are not reflected and a real impact is not visible. To present the nature of tokenism one young key expert explained,

if you have a panel and you have just said 'oh you are a young person we need you to talk about this but they haven't been involved in designing what they are talking about, implementation or any decision-making that's tokenism. Because yes, they are young people but they have no idea what has happened from the inception of the content. So that is just a complete tokenism and not meaningful at all.

According to Share-Net Netherlands, only 10% of their community of practices are youth-led, which means there is still a huge number of young people excluded (Share-Net and Choice for Youth and Sexuality, 2020; Young, 2018). A youth expert said during a key expert interview, *'due to tokenism it becomes pitiful representation not meaningful representation'.*

Another challenge is underrepresentation. Having a stereotypical assumption that young people are a homogeneous group, minority groups who are already underrepresented in mainstream development practices, are also underrepresented in MYP practices. '*Excluding a section of young people from the decision-making process we cannot expect to build a sustainable youth participation',* opine the Youth Ambassador, 2020. Therefore, in order to ensure meaningful youth participation, the most marginalized and 'invisible' youth must also have a safe space to participate and to contribute to the decision-making processes - this indicates genuine inclusion in MYP.

Low budgeting also hampers the sustainability of meaningful youth participation. As most of the youths are students and they had to skip their studies to participate in the projects or programs. If they are not paid sufficiently, their guardians will not allow it for long. Further, being students, young people do not have skills and training compared to not-young professionals. This situation hence turns into an unfair and unsustainable relationship between the organization and the youth keeping the youth in a disadvantaged position. The Share-net Netherlands CoP recommended for meaningful youth participation to be institutionalized to make it really meaningful and sustainable.

A young leader and key expert from a youth-led organization emphasized on the partnership and knowledge exchange between youth and the adults. In their words, *'youth wants to be engaged and to make MYP sustainable, the conversation of youth participation should constantly be on the floor. And, adult experts are like treasure boxes, they have firsthand experience and knowledge while the Youth can borrow that knowledge.'*

5.
REACHING THE MORE VULNERABLE OR LESS HEARD ADOLESCENTS AND YOUTH

SRHR interventions and programmes often overlook the needs of the populations with vulnerabilities, such as adolescents and youth with a disability, Lesbian, Gay, Bisexual, Transsexual, Queer and Intersex (LGBTQI), indigenous population, geographical remoteness, all of which are often hard to reach. Persons or groups can be affected by multiple disadvantages and have different experiences of power, as people have overlapping identities and experiences. Race,

nationality, disability, socio-economic status, sexual orientation, gender identity immigration status, livelihood, and being members of indigenous peoples or ethnic, religious or linguistic groups are examples of identity markers that can be sources of marginalization (Logie et al., 2019). It is important to recognize the diverse identities and different contexts of young people for effectively strategizing responsive implementation to the right target groups in certain topics.

5.1. YOUNG PEOPLE WITH DISABILITIES

An estimated 15% of the world's population live with a disability, and one-fifth of the estimated global total, or between 110 million and 190 million people, experience significant disabilities [f]. Persons with disabilities have the same sexual and reproductive health (SRH) needs as other people. Yet they often face barriers to information and services. The ignorance and attitudes of society and individuals, including health-care providers, raise most of these barriers – not the disabilities themselves (WHO/UNFPA, 2009).

At the 4th Women's World Conference, held in Beijing, SRHR's significant impact on almost every aspect of development and life improvement was thoroughly defined, where women with disabilities also were granted a part. It came on the back of the first legal recognition of women's reproductive rights at ICPD's 1994 conference. From then on, the SRHR of people with disabilities started to get attention worldwide. Many developed countries started to recognize the SRHR of these marginalized people, and on some occasions, it started to show up in their policies. Internationally, the UN Convention on the Rights of Persons with Disabilities (CRPD) is the most significant policy paper. It was adopted at the 61st UN general assembly, which entered into force on 3 May 2008 (UNFPA, 2018).

Despite the international conventions addressing these issues and putting forward policies, the results on the ground are not that positive, especially in the low and middle-income countries (LMICs). There are ample barriers that hold back these marginalized people from enjoying their SRHR i.e. stigma and stereotypes, self-stigmatization, access to information and services, harmful and forced practices and gender-based violence. Nonetheless, evidence based data on disabled population are scarce almost all over the world.

Persons with disabilities are up to three times more likely than non-disabled persons to be victims of physical and sexual abuse and rape. Persons with intellectual and mental disabilities are the most vulnerable (UNFPA, 2018). The fact that these people who need more medical and societal care ends up getting abused, in some cases, just for their disabilities is sickening.

This abuse and neglect sometimes come from the sole institutions that are supposed to help them. Like specialized shelter homes, hospitals, families, and sometimes states. There are places in the world where people believe that persons with disabilities are by default asexual, thus their SRHR are ignored.

SRHR programmes and interventions worldwide fail to address the fact that young people with disabilities need special programmes and interventions. All the key experts, who were interviewed for this narrative review, agreed to the fact that the young people with disabilities are a hugely underserved population. As one key informant explained the gap,

'[w]e just assume that just because you have a disability, whether it's a physical disability or a mental disability, your sexuality or sexual wellbeing is not necessarily as important. Having said that, it's even more important. Right? It's specific, it's exactly because they have disability in some other sphere, we need to make sure that their sexual reproductive health is addressed but it's often overlooked.'

There is more and more recognition in mainstreaming disability issues worldwide but the actual focus on sexual reproductive health of the young people with disabilities is almost non-existent. Pointing to the major focus in the programmes for the young people with disabilities, one key expert said, *'we focus on education, we focus on child protection, we focus on WASH, so making toilets disability-friendly and then also health and nutrition. So, in terms of making sure that they have the health necessary equipment that's needed, or the nutrition that's needed.'*

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f   *https://www.worldbank.org/en/topic/disability*

All young people with disabilities need comprehensive SRHR information and services, yet it is more crucial for the youth with cognitive disabilities. Specialized curricula and programmes should be designed for young people with intellectual disabilities. The narrative review of Share-Net Netherlands recommended that, youth with disabilities must be engaged in CSE as they are not asexual beings. They need to be well-informed about SRHR by ensuring access to information and the creation of peer support groups. Sensitizing their rights to a wider audience is also critical so they can self-advocate and be an active part of the youth for the SRHR movement (Share-Net Netherlands, 2020).

5.2. YOUNG PEOPLE WITH DIVERSE GENDER IDENTITY AND SEXUAL ORIENTATION

Youth LGBTQI is another group who are not only hard to be reached but also one of the most vulnerable groups in the context of SRHR. Most SRHR programmes and interventions for adolescents are influenced by the dominant heteronormative viewpoint, where most adolescents are thought to be a heterosexual homogenous group. Hence, as Muller and colleagues argued, "their identity as lesbian, gay or bisexual (sexual minority adolescents) or as transgender or gender non-conforming (gender minority adolescents) identity are often not recognized in SRH interventions, nor are their specific needs addressed" (Muller et al., 2018:3). Moreover, existing SRH projects mostly deal with the adult LGBTQI population while issues regarding safety, sexual identity and health rights are the same or worse for the young population. Even the CSE curricula in many countries does not address the issue.

The past decade has seen progress in rights and academic scholarship for lesbian, gay, bisexual transgender, queer or questioning (LGBTQI) persons, which is promising. However, homosexuality and transgender identity remains illegal or highly stigmatized in many countries (Amnesty International, n.d.; Mehta and Seeley, 2020), and children and adolescents who are LGBTQI face substantial discrimination, harassment, and violence (UNICEF, 2014). Promoting human rights to condemn abuses related to sexual orientation or gender identity and to protect and provide supportive services for LGBTQI youth are a priority (UNICEF, 2014). However, pointing the limitations of SRHR services and information provision for LGBTQI youth and the violation of their rights, one key expert said,

'It is much easier to say that the child has the right to education because everyone will accept this, I suppose saying an adolescent has a right to decide who they want to have sexual relations with whether having girls having sex with a girl or a girl having sex with a boy, that is so much more difficult. If you say okay to certain rights and not to others you are going against those human rights based principles. Because they say all rights can be enabled. So you can't give more value to one right over the other but we all do that. If you ask anyone what is more important, the right to education or the right to choose a sexual partner people will of course more often say – right to education.'

Notably, data are limited on how best to develop and implement practices and policies that support LGBTQI youth, and the limited data that available are mostly originated in North America or Europe, and underrepresenting the countries with the greatest stigma (Saewyc, 2011). While the health research for adolescents is already challenging, these challenges can be amplified by: difficulty measuring sexual orientation, identity, attraction, and behavior along developmental trajectories (Saewyc, 2011), inadvertent risk of "outing" to parents, peers, or community (Heck, Poteat, & Goodenow, 2016), and increased sensitivity and stigmatization of LGBTQI research (Fisher & Mustanski, 2014).

In many countries, the expressions of sexuality and gender other than the heteronormative one is illegal. It is often impossible or extremely challenging to work with the LGBTQI youth for

their SRHR needs in countries that do not legally recognize them. The United Nations work within the legal framework of the country they are in because every UN body has been invited by the host government to work in that country, so the organizations have to work within that context. A key expert with experience working in the UN organizations said that,

'same sex relation is illegal in the two countries I worked, it is a punishable act there, one can be imprisoned. So, we don't work with the government, we don't directly advocate but we work with NGOs where they support the rights of individuals who prefer LGBTQ rights. Through them we kind of support their work and help them advocate the things.'

It is important to bring the changes and help the vulnerable groups, and to achieve that much effort should be put to make things easier for those through.

While the situation is much better for the LGBTQI youth in some developed countries, challenges exit. The Share-Net Netherlands team provided an example of such a challenge in their report developed for the CCC. The Dutch education minister had recently defended the right of Christian schools to require parents to sign covenants rejecting homosexuality and this practice has been the source of a continuous political debate. The Netherlands has numerous fundamentalist Christian schools that oppose homosexuality- in total 34 out of 170 had a document online making their position clear (Share-Net Netherlands, 2020). The authors recommended that 'it is vital to reach out to youth from Christian schools to give them a safe space to access SRHR information, as well as to freely express their gender and sexuality' (Share-Net Netherlands, 2020: 4).

5.3. REFUGEES OR DISPLACED YOUTH

Global reports show that the number of refugees and displaced population has increased significantly in the last few years. In 2019, 14% of global migrant population were below the age of 20 years, equivalent to 38 million international migrants (United Nations D of E and SAPD, 2019). SRHR in crisis settings is often not given priority as it is not seen as immediately lifesaving and, as one of the interviewed experts highlighted, *'it is often seen as predominantly a women's issue.'* Comprehensive SRHR services are hardly available in most contexts of displacement. A key expert said, *'the first thing that is always addressed in a humanitarian crisis situation is to ensure shelter, food, and medicine and gender policy is seen as a soft issue.'*

A key expert who worked in the Rohingya refugee context in Bangladesh expressed their view saying, *Their lives are at stake, right? They have just escaped absolute violence…In the midst of all of that for us to then go and talk about comprehensive sexuality education would be laughed at. Because people prioritize certain things, they prioritize their life and being absent from violence. They are not going to prioritize their sexual health unless it's linked to violence like rape or sexual harassment in a context when those other needs are much more severe.*

In the immediate aftermath when the Rohingya came in, we obviously set up health facilities but in terms of young people all that we did we gave them hygiene kits. In that kits, we had a menstrual pad. It was health and nutrition and WASH - things like essential services. So, we gave this kit which had things like a shawl, dress, sanitary pads, panties, slippers, toothpaste, and toothbrushes - things like that. Because it was about meeting the immediate need

which was you know some of them left without anything. So, we were making sure that they have something else to wear, to cover their body. Because that's also part of their sexual health, being and feeling comfortable.

Another key expert conducting research with Syrian refugee adolescents in Jordan told us that they are facing a lot of challenges to include SRHR related questions to the survey questionnaire because these topics are not aligning with the local cultural and religious norms. A key expert working in Ethiopia with the internal displaced population reported, *'IDPs in Ethiopia face discrimination to get any kind of health services and SRH services are specially lacking there.'* In the conflict situations, young people- mostly girls experience a lot of sexual harassment and in many cases services- medical, mental, justice- are not available.

To deal with these challenges one key expert suggested that, *'a very good entry point is to talk about health risks and safety, sexuality and family honor, a shift in usage of services, contraception. Talking about the rights of girls does not get an audience, talking about health consequences does.'*

It is critical to push the boundaries and to make sure that the health programmes for refugee and displaced youth are much broader and wider than what is during the emergency phase. While it is important to make a balance in the emergency phase, it is crucial to include sexual reproductive health services in the health service provision in the protracted situations.

Working children, young sex workers, indigenous population, religious minority, – these are some other important groups that are excluded from the mainstream SRHR interventions. Indigenous population are deprived of their basic human rights including sexuality and reproductive health care services. Maternal mortality rate, gender-based violence, poorer access to health services and increased vulnerability to contract HIV and AIDS are some major problems indigenous people are facing. Research shows, compared to non-indigenous counterparts, the rate of teenage pregnancies and STIs of indigenous adolescents are much higher in Australia; in Latin America, indigenous adolescents and youth experience early sexual initiation; in Africa, discriminatory practices based on gender and HIV status are extreme. Although there are interventions targeting sex workers, young sex workers are excluded. It is obvious that, demands of young sex workers will be different from adult sex workers, but they are hardly addressed as a distinct group.

Reaching out to the most vulnerable youth groups would address the human rights approach of SRHR and strengthen the programme to be more inclusive and effective.

6.
IMPACT OF SOCIAL NORMS, VALUES AND IDEOLOGIES ON SRHR FOR ADOLESCENTS AND YOUTH

Social norms, values and ideologies in any society impacts SRHR programmes and services deeply. Sexuality and reproduction are intrinsic parts of any culture; however, sexuality is a delicate subject as it is not only related to intimacy, belonging and reproduction but also to morality, taboo and stigma. Sociocultural norms and values strongly influence the way people relate to each other intimately (Nagel, 2003). Religion is an important governing factor in the delineation and implementation of sexual norms and values (Cornwall, Corrêa & Jolly, 2008). Many religious

dogmas as well as other 'traditional' cultural values related to gender and sexuality are, in many more or less subtle ways, at odds with the idea of sexual rights for all and complicate efforts to improve sexual and reproductive health (Altman, 2001; Bijlmakers et al., 2018; Bradley, 2010; Corrêa et al., 2008, 2014; Harcourt, 2009; Kuhar & Paternotte, 2017; Vanwesenbeeck, 2011).

The rights-based agenda of SRHR often collides with the traditional cultural, religious values and convictions in different contexts. For example, in

sub-Saharan African contexts, 'traditional values and norms' (e.g. resistance to open discussion about sex) are often identified as one of the most significant barriers to 'complete adoptions' of comprehensive sexuality education (CSE), in that teachers skip or modify content, or the teaching of CSE might be banned outright (Mukoro, 2017; Vanwesenbeeck et al., 2019) where CSE is considered one of the basic aspect of SRHR for youth.

In order to avoid this collision, strategies are taken to make CSE curricula as 'culturally relevant.' It is a kind of middle-ground, where 'essential aspects' such as rights-based perspectives can be combined with localized understandings of sexuality. One of the members of Jordan CoP commented that, *'we do need CSE, we need to provide information of SRHR to the young people, but we need to make sure that those are culturally sensitive.'* Another key expert narrated their experience while working with the policy makers in Bangladesh for designing the curricula for CSE,

The Ministry of Education do not want to use the term sexual organs, instead they changed it to hidden body parts. They would not use the terms for the sexual organs - your breast, your penis your vagina - while teaching children about their "own body." They call it hidden body parts and people will understand what they are talking about. But they will not use the word sexual or sexual secondary organs.

Thus, international organizations are to negotiate with the policy makers in order to meet their requirement for cultural sensitivity. The development workers come up with innovative ideas while making these negotiations. One key expert form an international NGO said, '*they [local policy makers] do take contents but it's up to development workers to be creative about how this content can be included. The students and children actually enjoy the games and interactive*

material much more than the curriculum.' As part of the CSE programme in Bangladesh, some board games were created for teaching SRHR components to secondary school children and that was a big success. A key expert involved in the implementation process said that,

whenever we came back and ask them how we can improve on this work that we have done. Their first response is always, "give us more games give us more interactive materials". Because they found it fun. They are 16 years old and they don't want to listen to a teacher telling you things. They would rather want to play with their friends and find out whats going on.

Sexuality and reproduction are considered as a private matter, yet it is very political at the same time. A variety of legal systems are at work in order to regulate sexuality and reproduction, and privilege heterosexuality in the state systems (Lewis, 2004). These legal systems are, in many states, based on heteronormativity and male dominance. Women, and girls are disproportionately sexualized and objectified; their sexualities, as well as the sexualities of nonheterosexuals and young (unmarried) people, are looked upon with great ambivalence and in most cases normatively and/or legally, restricted. In many developing countries, it is not allowed to provide information and services related to sexual relationship, contraception and/or safe abortion to the unmarried young people even if there is data on prevalent unwanted pregnancies and unsafe abortion practices. A key expert from Burundi told us that, *'talking about sexuality is a taboo, we have lot of unintended pregnancies and high rate of HIV, but we cannot talk to the young people about their sexuality.'* Another key expert from Nepal said, *'young people are sexual beings and whether you like it or not some of them engage in sexual relations and is far better for us to assume that with knowledge people will behave in a way which is more responsible.'*

A number of key experts claimed that convincing the bureaucracy on the importance of providing SRHR information and services to the young unmarried people is the biggest challenge. One key expert said,

it's almost an expectation if you are 18/19 and you are married then you obviously have an access to the services. You go to the government facilities or even go to private facilities, no one is going to question you because you now have that within court socially approved status of being eligible for sexual and reproductive health information and services. For unmarried I think it's a different story all together and think one of the biggest challenges and this is just not in Bangladesh, this is everywhere.

Even in the context of working with the bureaucracy key experts face different challenges within the bureaucracy. For example one key expert said, *'working with the ministry of health officials were not as difficult because they were open and were of course of health background so they were open to address the sexual health of young people regardless of their marital status, not all but majority. The ministry of education was not that. They were much more conservative.'*

All the key experts agreed to the fact that healthy relationship and healthy attitudes to sex are important for development and for engaging in society but it's not seen as something to be critically addressed and it has lot to with cultural context. It is a taboo to talk about sexuality or sexual pleasure especially for young people and women. A key expert commented that, *'sexual pleasure for women is a taboo for almost every culture. So, those cultural nuisances create even more of a barrier to be able to address these issues.'*

Global conventions and programmes on SRHR promotes a rights-based position on gender and sexuality emphasizing that all people regardless of their gender and sexual orientation should be free to make sexual and reproductive choices, respecting the rights of others, in supportive societies. Stakeholders who work with that vision engage with the mission to empower people through education and improved access to information and services and strengthen professionals, organizations and societies. Notably, Roodsaz (2018) observes in their research that rights-based framings of agency and subjectivity are not essential or universal, but rather are specific to Western secularism, making culturally-sensitive CSE paradoxical and exclusionary in non-Western contexts- "[t]he concept of 'rights', as opposed to 'health', appears to be highly loaded. While health issues were seen as a more culturally acceptable way of presenting their work, the idea of 'sexual rights' was often seen as culturally insensitive" (Roodsaz, 2018:115).

7.
EVIDENCE BASED ADVOCACY

Although a significant amount of data is available, it is essential to look at the areas where data and evidence are currently lacking. Keeping in mind the comprehensive ICPD definition of sexual and reproductive health, we note that the focus of past and current research is still largely on physical health outcomes, starting from a public health perspective and predominantly using a risk reduction approach. Mental and social wellbeing, including body image, self-esteem, and equal romantic and sexual relationships, which are intrinsic parts of sexual and reproductive health, receive far less attention and are often measured only in small-scale cross-sectional studies, making it difficult to detect trends.

The continuing influence of social taboos on adolescent sexuality also affects the availability of data. This is not only reflected in the choice of indicators but may also influence the reliability of data because of underreporting of socially less accepted behaviors such as sexual activity or induced abortion. The scale of such underreporting is not easy to estimate.

Although adolescence is, in general, a crucial transitionary period, characteristics of specific subgroups of adolescents intersect to heighten this vulnerability. In particular, adolescents of diverse sexual orientation and gender identity, adolescents in humanitarian contexts, and adolescents from

child headed households are under researched groups, but emerging evidence suggests the importance of these circumstances for adolescent SRHR. With underrepresentation in mainstream SRHR interventions, there is less research and little data on LGBTQI adolescents that in turn negatively effect on further inclusion of the group in SRHR projects.

Future research in developing sexual health programmes should review adolescents' perceptions of the current programmes to inform the development of new programmes. Programmes focused on educator training in content and in delivering unbiased content could improve the adolescents' perceptions of sexual health education. Destigmatization of adolescent sexual behaviors is vitally important to improving sexual health education programmes and intended outcomes of preventing STIs and pregnancy. Future research should focus on how educators can destigmatize content, improve the delivery of relevant content, and create a safe environment for adolescents.

Generating and disseminating evidence to understand multiple adolescent SRH outcomes simultaneously with regard to the shared ecosystem in which risks occur can optimize development of more effective and multiple purpose interventions. Some of the barriers to generating socioecological system data include siloing of disciplines, coordination of policy and funding across multiple sectors, and the common emphasis on single level or single exposure studies (Gilbert, et al., 2015). Simultaneously addressing multiple levels of the socioecological sphere may lead to more effective and sustainable interventions (DiClemente et al., 2005; Bagliacca et al., 2020), and can even be incorporated in study processes to improve recruitment and retention (Salihu et al., 2015), supporting more successful scaling.

Conducting adolescent and youth SRHR research is challenging, as there are complex ethical considerations for protecting confidentiality and privacy, obtaining informed consent, and addressing vulnerabilities (Knopf et al., 2020; Singh et al., 2019; Shirmohammadi et al., 2018). Adolescent and youth SRHR may also face political challenges and limited funding opportunities (Mechielsen et al., 2016). As a result, adolescent SRHR research can be limited in scope, scale, methodological rigor, and explanatory power, with resultant limitations for generalizability, reproducibility, and dissemination. Despite this, research done under these limitations may still have merit, but it may be modest and fail to find an audience or contribute to progress in the field of SRHR.

While greater investment in adolescent and youth SRHR research is needed, in the current context, we encourage high quality and innovative studies—as well as research which yields negative/unexpected results, pilot studies, hypotheses, and concepts—to accelerate discovery in SRHR for adolescents and youth. Given the many gaps and challenges in understanding determinants and barriers of adolescent SRHR and how to optimize translation of existing knowledge, innovation is a critical component of the Global Strategy for generating evidence, prioritizing local needs and capacities, and supporting active engagement across sectors to improve adolescent health outcomes (WHO, 2015).

8.
IMPACT OF COVID-19 ON SRHR FOR ADOLESCENTS AND YOUTH

SRHR services and programmes have been affected so much by the Covid-19 pandemic. Key experts across the context identified that there is much more to do now because in the field of youth SRHR as the impacts of the pandemic is huge. SRHR service system has faced adverse effects from both the service side and the demand side. Health worker shortages (due to movement restrictions, illness, family demands or inability to work remotely), supply chains stock out (supply of products has been disrupted globally and locally due to manufacturing shutdowns, restrictions in transportation and import delays) are only a few examples of the adverse effects at the service side. On the other hand, many young people could not get necessary SRH services because the services were not part of essential services. Movement and travel restriction during lock down, financial shocks (cash flow shortage because of reduced banking availability, drops in income that affect people's ability to pay for the services, redirecting budgeted resources to buy personal protective equipment, or for related maintenance), as well as policy level restrictions or lack of regulatory approval on telemedicine (i.e. in cases where abortion, injectable contraception is illegal) created huge barriers to people for accessing necessary SRH services. Due to decrease in family income women and girls are to sacrifice using better hygiene and sanitary materials.

In fact, women and girls are severely at risk in COVID-19 pandemic. In low- and middle-income countries (LMIC) women, particularly rural, uneducated and women with low socioeconomic status, face several health hazards. These women and girls face increased maternal mortality due to unsafe abortion, infection, postpartum hemorrhage, malnutrition, heart disease and so on. This rate will further increase by the lack of decreasing health care during the pandemic. Expert from youth led organization said anxiously,

I predicted that 6 months lock down would create 7 million unintended pregnancies for young people. It means that the cases of child marriage are increasing because adolescents are kept at home and there are more cases of female genital mutilation and cutting cases. Because of Covid, LGBT people are stuck in their homes with family and their family might not know about their sexuality. So, it does create quite a dangerous situation for young people. This is something that we have been seeing across the board in all the countries we work in. And specially if these sensitive issues are criminalized or socially forbidden because of Covid it will be dangerous.

A youth key expert think Covid-19 situation especially affected the processes of meaningful youth participation. They identified the problem with events happening online cannot make room for the youth voices to be heard. They also added, *'decision making around SRHR is also much more exclusive because of Covid-19, much more private. There are decisions being made about young people without their input at all; and not just on end level but on any level too.'* However, another key expert from South America identified the opportunities created by the pandemic mentioning that shifting to online forums and formats has also improved the ability to reach more and diverse groups of young people that due to limited resources were not able to participate in some of the events in-person.

Another big challenge is seen in the context of comprehensive sexuality education. In a lot of countries CSE is not seen as a priority. Since the school sessions are down, young people cannot

carry on with comprehensive sexuality education. Parents would want kids and teenagers to be learning about the proper subjects and not CSE because it's not considered necessary. One key expert working in advocacy for youth SRHR said,

…when you have a pandemic and everyone is at home, doing home office or learning from home they have to have access to the internet. They require laptops, mobile or any other devices from where they can access. But if you are coming from a family who doesn't have that kind of money then you cannot access comprehensive sexuality education, youth friendly health services or about contraceptives, you can't access a doctor if you need to. So, having safe abortion becomes harder for young people as well. Young people lag behind in acquiring knowledge on SRHR and access to it. As a result, the young generation is missing out on so much that is required to form a healthy sexual relationship, healthy ideas about their bodies, gender identity, and sexuality. It's something that is also dangerous because it's often seen as a soft SRHR.

Another key expert said, '*sexuality, healthy relationships are seen as soft topics since they are not about safety necessarily, they are about people and social manners or social relationships so they are addressed as soft issues because they are safe.'* And, Covid-19 makes this evident that these issues do not get policy attention in the crisis situations like pandemic.

However, some key experts think that the epidemic creates an opportunity to rethink SRHR services. Responding to the epidemic, some countries have already innovated some systems to their service delivery model. For instance, Physical distancing policies – introducing appointment systems in clinic (to prevent infection), telemedicine (to provide medical abortion at home), use of mega phones, mobile phones, community radio messages, social media – Facebook, WhatsApp (to deliver SRH messages), involving pharmacies as contact and counseling centers so that people particularly girls and women will easily access the service.

9.
OPPORTUNITIES AND KEY CHALLENGES IN SRHR FOR ADOLESCENTS AND YOUTH

9.1. OPPORTUNITIES

Despite our research identified prevailing challenges in the field of SRHR for adolescents and youth, we would like to highlight some timely and emerging opportunities to advance SRHR for the young population. Inclusion in the SDG targets placed SRHR and adolescent health on numerous global, regional, and national agendas (Chandra-Mouli et al., 2019). In 2016, the special needs of adolescents were recognized in both the SDGs and in the Global Strategy for Women's, Children's, and Adolescents' Health to fulfill the mission of "leaving no one behind" (Kuruvilla, et al., 2016). This context makes it possible for SRHR for young people to get priority in numerous global and regional partnerships, initiatives, and commitments (e.g., Family Planning, 2020, Girls Not Brides, the African Coalition for Menstrual Health Management, the Eastern and Southern African Commitment, the Montevideo Consensus, and the Ouagadougou Partnership), which in turn "have created strong impetus for learning and action through their advocacy and convening power" (Plesons, et al., 2019: S52-53).

Countries are also signaling their attention to SRHR for adolescents and youth through commitments and through new and/or updated national laws, policies, and strategies (Chandra-Mouli et al., 2019; Commitment Makers | Family Planning 2020, n.d.). In the FGD, members of Jordan CoP informed that, when the reproductive health strategy was initiated in 2003, sexual health was not included. However, new components including comprehensive sexuality education and family planning have been included as an impact of SDGs. Similarly, in Bangladesh, Adolescent Reproductive Health (ARH) strategy [g] was introduced in 2006 without sexual health. Then in National Adolescent Health Strategy (2017 t0 2030) was introduced with a focus in SRHR, Nutrition, Violence Against Women and Mental Health [h].

Because of the above-mentioned inclusion on global, regional, and national agendas there is more funding available for SRHR for young people, particularly for specific issues (e.g., ending child marriage, preventing and treating HIV, and—increasingly—improving adolescents' access to and use of contraception) (Chandra-Mouli et al., 2019). Yet certain areas of ASRHR (e.g., violence against women and girls; menstrual hygiene and health) still remain underfunded (Plesons, et al., 2019). In recent years, more than 90 million USD from a range of funders have been mobilized in support of efforts to end child marriage (Candid, n.d.; DevTracker Project GB-1-204496, n.d.; UN-FPA-UNICEF Global Programme to End Child Marriage, n.d.). Nevertheless, two key experts men-tioned during the interviews that US funding for SRHR was completely cut off during the Trump government and they are now hoping that the upcoming government will reenact funding for SRHR. The Global Fund to Fight AIDS, Tuberculosis and

g   https://www.dgfpbd.org

h   http://etoolkits.dghs.gov.bd/national-strategy-
      adolescent-health-2017-2030

Malaria 55 million USD matching fund was used to leverage an additional 140 million USD from 2017 to 2019 country grants in 13 countries to reduce HIV violence, and unintended pregnancies among adolescent girls and young women in 2017 (The Global Fund, n.d.).

Many countries are complementing external funding with their own domestic resource. India, for example, now funds almost the entirety of *Rashtriya Kishor Swasthya Karyakram*, its National Adolescent Health Programme, with domestic resources (Krishnan, 2014). Similarly, South Africa now funds about 80% of its own HIV response, which includes prevention, care, and treatment for adolescents (UNAIDS, n.d.). Similarly, In some countries, control over financing is becoming decentralized. If this process is closely managed to mitigate risks of misalignment between national and local goals and commitments, it has the potential to amplify impact by bringing decision-making closer to communities.

Youth-led organizations and young leaders are increasingly getting involved in dialog around Universal Health Care (UHC), which is a critical step toward increasing attention to adolescents and ASRHR within the UHC agenda (Musili, 2019). Meaningful youth participation can bring significant progress to meet the goals and objectives of youth SRHR.

Another significant matter that created opportunities for adolescent SRHR is that a greater proportion of adolescents—especially girls—are in school than ever before, and efforts are underway to improve the quality, equity, and relevance of education (OECD, 2014). Given that school is protective for many aspects of adolescent health, this bodes well as a step toward addressing some of the social determinants of ASRHR (Patton, et al., 2016). Similarly, there are tremendous

opportunities for education and health sectors to work together to leverage the potential of schools as a platform to reach large numbers of adolescents with comprehensive sexuality education (CSE), as well as school-based and school-linked health and social services (Bundy, et al., 2017). Meanwhile, there is also recognition that many of the most vulnerable adolescents are still not in school, and that they require targeted responses to meet their health, social, and developmental needs.

Finally, technological advancement and access to Internet, and other communication technologies have tremendous impact on SRHR for the young population. These technologies are profoundly shifting the ways that adolescents interact with their peers, family, and the world at large, including how they learn, communicate, make decisions, form relationships, explore their sexuality, and manage their health (UNICEF, 2017; Livingstone, et al., 2017). Online interventions are enabling adolescents to independently seek ASRHR information on their own terms, as in the case of text lines, online counseling, chatbots, and informational Web sites (UNICEF, 2017). Biomedical and technological innovations are increasingly providing new opportunities for adolescents to exercise self-efficacy and autonomy in obtaining health services, as in the case of self-care (e.g., HIV self-testing kits and self-injection of subcutaneous DMPA) (UNICEF, 2017). Smartphones, apps, and social media are supporting adolescents to expand their social networks, meet romantic partners, and engage with peer-led social activism, as in the case of numerous youth-led movements now pushing for change around the world (WHO, 2019). All the key experts and stakeholders that we interviewed emphasized on utilizing internet technologies for reaching the young population and providing youth-friendly and safe resources for SRHR information and services.

These advanced technologies are embraced by the adolescent health community and the health community more broadly to implement lots of digital interventions. Digital health interventions have been lauded as an opportunity to partner with young people for designing interventions that are more attractive and relevant to adolescents' and youth's needs and preferences. Such innovations hold great promise in improving SRHR for the young people, as long as careful attention is paid to identifying and mitigating risks, such as data privacy, cyberbullying, state surveillance, commercial exploitation, and exposure to unreliable information (e.g., fake news) and non–age-appropriate content—the latter is particularly important in the case of very young adolescents. Similarly, although technological innovations have the potential to improve adolescents' ability to independently access information and services, we must apply them in a way that mitigates rather than exacerbates existing inequities, such as those related to wealth and gender (Livingstone, et al., 2017).

9.2. KEY CHALLENGES AND GAPS IN SRHR FOR ADOLESCENTS AND YOUTH

Although we have several opportunities for improving SRHR for young people, a number of persistent and new challenges directly affect the security, agency, opportunities, and aspirations of adolescents worldwide.

It is not culturally or social acceptable to discuss sexuality of unmarried adolescents in most countries. Unmarried adolescents are not recognized as sexual being while both the girls and boys start to have sexuality related lessons according to the social norms. Their sexual wellbeing and sexual relationships are strictly controlled or ignored. Such situation worsens for LGBT groups where they are even criminalized for their sexual orientation. This situation negatively affects their access to sexual health related

services. For instance, in developing countries unmarried adolescents are not allowed to have contraception. While for married young couple, the situation is different. Being devoid by the service system adolescents tend to collect information from alternate sources, i.e., peers, porn, neighbors etc. That might be misleading and might cause long term harm to their sexuality. Adolescents often suffer from psychosocial distress when they cannot trust anyone to share their problems and concerns regarding sexuality, mentioned by several SRHR experts from developing countries.

Along with sexuality, adolescent and youth's agency is overlooked. It is not only in the SRHR field, everywhere. A key expert opines,

It is important to acknowledge the agency that the adolescents have. They have agency as human beings, and we do acknowledge that their contributions, their perspectives, their experiences matter. When planning then signing, implementing, monitoring and evaluating programmes, policies, interventions, projects we should acknowledge their agency.

Existing gender inequality and harmful gender norms are one of the big challenges to SRHR achievement. Unequal gender norms teach boys to behave like a boy (aggressive sexually and physically) and girls to be womanly (calm & quiet, vulnerable and asexual) in a heteronormative ground. Due to such gender norms, most of the SRHR programmes target girls and women while boys and men remain out of the discussion. Thus, in one side, boys' reproductive health rights left unattended, on the contrary, girls had to bear most of the burden. WHO identifies, how gendered norms intersect with other social variables-

The World Health Organization reported that, *"[t]hese gendered expectations intersect with other inequalities such as poverty, education, employment, and access to information and services for an amplified negative impact on adolescents'* lives. These consequences particularly

manifest in gendered differences in the levels and causes of adolescent mortality and morbidity, including those related to SRH" (WHO, 2014). Discriminatory gender norms result in high rate of adolescent pregnancy that again turn into abortion risk, gender-based violence, drug and smoking addiction, high levels of HIV infections.

While it is a conscious choice to avoid unmarried adolescents' sexual rights for the sake of social values and gendered norms, existing programmes and interventions fail to reach the most vulnerable groups of adolescents. Adolescents from ultrapoor family, in some context adolescents from lower caste, intellectually disabled- all these group's sexuality remains largely invisible. On the other side, in most of the cases, SRH interventions are prepared under the broader development framework based on national interest. Therefore, so long the interest of vulnerable groups is not recognized (even if it is recognized, sometimes it is not implemented according to the policy due to the lack of government's interest) in the mainstream development policy, it becomes unattended.

In fact, policy making and programme designing often impacted by stereotypes of cultural norms rather than based on evidence. For instance, LGBTQI rights. In Sub-Saharan Africa LGBTQI rights is not legal, so the LGBTQI groups remain unreachable. Some sexual rights are also violated by the government's political or stigmatized approach e.g., safe abortion rights. Key expert from South America stated the reason why government does not recognize the safe abortion right for (un-married) adolescents, '*no government will go against social norms because government are afraid of social chaos that might have an effect on their power.'*

Therefore, it is also political agenda (national, international) that hinders the progress of sexual and reproductive health schemes. For instance, funding for particular programmes or rights, or donating to an organization is dependent on

the priority agenda that is in most of the cases determined by the political agenda. In the case of meaningful youth participation, the importance is already acknowledged, but the fund budgeting is not enough. From the Latin America and Caribbean perspective, one of the key informants raised the challenge,

We recognized compensating young people for their time and expertise. But reality is that we are struggling with the current funding landscape. Compensating young people for their time is our priority and sometimes we do that. But unfortunately, we are not able to do that every single time, we can dream of.

Similarly, tokenism and underrepresentation are other two challenges that kept behind the sustainability of meaningful youth participation. A study on MYP illustrated this challenge this way: "[i]ntentional efforts to include adolescents in political and programmatic processes and to ensure they have the real power to hold decision makers accountable remain limited and under resourced" (Villa Torres in Plesons et al., 2019). When adolescents and young people are given opportunities to contribute, it is most often older, urban, educated, and well-connected young people that are selected, and their engagement remains largely tokenistic and their responsibilities menial.

A government officer working at a health ministry told us that there are many programmes and interventions are at work to meet the needs of adolescents and youth in regard to their sexual and reproductive health. However, different programmes are run by different ministries and different partners. And, the key challenge to the success of those programmes is that there is a lack of coordination amongst the different partners and stakeholders. Discordant public-private partnership, weak systems and limited integration and coordination across different sectors can hinder the progress of SRHR interventions for the adolescents and youth.

It is notable that the structures of family and society have changed globally. Families now have fewer children and more adolescents and youth are living in single-unit families or in home with one or no parents. Large, extended family structures are becoming more and more uncommon worldwide. Urbanization such as the migration of one or more parent—or the adolescents themselves—to cities for education or work; and crises such as those related to conflict or climate change are changing the dynamics of families and societies. This change created challenges for SRHR needs for adolescents and youth as these issues had been dealt within the extended family structures historically. There is convincing evidence that adolescents who grow up without the stability and support of their families are at a much greater risk for numerous health and social problems, including some related to ASRHR (Plesons et al., 2019).

10.
CONCLUSION

We conclude this review with some recommendations based on our research. The key challenges and gaps identified by the key experts and stakeholders in the field of sexual and reproductive health and rights push us to come up with more innovative, sustainable and more coordinated solutions to the existing problems that the young people are now facing regarding their sexual and reproductive health and rights.

10.1. RECOMMENDATIONS

While in the era of 21st century, several opportunities have observed in sexual and reproductive health rights for adolescents and youth, there remains some major challenges in the achievement of goals. This is not only because of the complex, transitional and diversified nature of this demographic group but also contextual barriers rigorously hamper the progress. Every context is different and there is no simple solution to address these barriers while there is no single approach to overcome the challenges. Considering all these aspects in grounds recommendations came from (interviewed) key experts, policy makers, development workers and youth leaders are clustered as follows:

RIGHTS–BASED COMPREHENSIVE SEXUALITY EDUCATION

- Move sexuality education beyond biology and reproduction and focus on matters that are relevant in their actual lives, such as dating, online behavior, sexual pleasure, relationships, and sexual coercion.

- Integrate and normalize sexual diversity in all sexuality education content, instead of treated as a separate issue.

- Teach sexuality education in a safe class atmosphere, which requires a teacher who is knowledgeable and sensitive enough to know which questions can be answered publicly, and which cannot, and who takes young people seriously and encourages them to form their own judgments.

- Move towards a participatory, learner-centered approach rather than teacher-as-expert approach and create more interactive teaching materials.

- Ensure that the content of sexuality education is more relevant to young peoples' lives and provide more opportunities to develop their sexual agency.

COORDINATED AND INTEGRATED APPROACH TO SRHR FOR ADOLESCENT AND YOUTH

- Utilize political and social support for SRHR policies and programmes for adolescents and youth by creating more links between adolescent and youth-focused programs across sectors (i.e. health, education, sports, well-being, etc.).

- Continue to advocate for the place of SRHR, and SRHR for youth specifically, on global agendas (e.g., in the context of the Global Financing Facility or UHC). At the national level, there is now strong political and social support in many countries to implement national SRHR policies and programme for the young people that did not exist at the time of the ICPD.

- Ensure ongoing attention to strengthen human and system capacity and facilitate efficient technical support to design/strengthen SRHR programmes, ensure their integration and sustainability within the health system and beyond; and track progress.

- Global funding organizations need to work together for addressing crucial and under-funded issues of adolescents and youth SRHR.

COMMUNITY BASED APPROACH

- Community and people are in the center of SRHR interventions. It is necessary to start from the local level targeting all key areas of the community so that every adolescent and youth can be reached including the most marginalized groups.

- Create safe shared space for all stakeholders (different groups of adolescents and youth, service providers, caregivers, teachers etc.) to meet and share information related to SRHR. These safe shared spaces can be school, community clubs, sports clubs, as well as adolescents' working place.

- Identify less communicated individuals/groups and enable the environment to ensure their participation.

- Provide with counseling services if needed and include parents, care givers, community leaders, religious leaders, teachers, service providers (to address working adolescents and youth).

- Ensure inclusion of both girls' and boys' SRHR needs and from gender norms perspectives.

SUSTAINABLE MYP

- Institutionalize youth participation to make it meaningful and sustainable.

- Make youth participation valuable by formalizing and incentivizing their activities.

- Avoid tokenism by ensuring the participation of the young people in every phase (from design to implementation) of the programmes taken for the adolescents and youth.

USE OF DIGITAL PLATFORM

- Make use of digital platforms to moderate the challenging situation of the youth by providing safe space alternatives as well as informative support on how to seek help or to report potentially harmful conditions.

- Make the digital space available for adolescents and youth in educational institutions, workplace, clubs.

- Address the probable consequences and challenges of digital space. Provide counselling for proper use of digital platforms. Information found in search engines are not always accurate, so young users should learn to identify authentic and fake sources as well as would prevent themselves from mishandling the opportunity.

- Provide safe space for marginalized communities by ensuring privacy and data protection. Primarily, privacy and data protection are vital to ensure digital spaces can be safe for marginalized communities due to the sensitive issues and discussions shared. It needs to be ensured that no one can tap into the conversations, including families and governments.

- Governments need to be able to protect its citizens' digital rights and enact relevant and strong laws on data protection and privacy, anti-online harassment and violence, and abolish minor pornography.

- Provide equal access, services and support to young people for using digital platform regarding SRHR. Identify all the challenges and reframe them as the opportunity to engage more young people in the decision-making process, particularly as they are no longer limited by geographical distance.

USE OF MASS MEDIA

- Use all types of mainstream media i.e., cinema, television, radio and newspaper to circulate SRHR related news. Also use the critical ability of the media to explain the broader objective.

- Discuss with the government to be less regulative. Strict regulation restricts and distorts messages between service providers and targeted population.

- Choose the right media depending on the content and target group. Prepare the message based on the media platform. If the content is prepared for the marginalized poor people, it is better to use broadcast media instead of print media. Because, in most of the cases poverty and marginalization has a negative relation with literacy.

- Support to increase media literacy. Because mass media is the public domain that addresses mass people. Thus, to ensure the access of the public and to be evaluated by the public properly, an enabling environment is necessary.

MAINSTREAMING THE VULNERABLE GROUPS TO BREAK TABOO

- Address the legal framework that creates discrimination and violates human rights of vulnerable groups. Without amendment of restrictive laws, no organization can ensure equal rights to all people.

- Allocate specific funding for vulnerable groups. Funding plays an important role to decide the target people and in the mainstreaming process.

- Increase visibility of marginalized groups and publish continuous promotional messages to subvert negative depictions of marginalized groups.

- Lack of information creates misrepresentation. There is very little data available on marginalized groups. Therefore, needs to promote more research on vulnerable, excluded groups to have enough data. Evidence based data is essential while launching new programs.

INNOVATIVE SERVICES

- Create innovative and alternate products such as podcast, offline video game, toys, mobile apps; and ensure accessibility by making those cheap, and available to all young people.

- Engage adolescents and youth meaningfully to codesign new programs and approaches in order to increase access to quality and accessible services.

- Design the product according to local demand, contextualize it and concentrate on youth-friendly approach.

- Keep the programmes up-to-date with new ideas, approaches and tools so that they are timely and prepare the young group for new messages.

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