An assessment of vulnerable and at-risk adolescents (13-18 years) in Bhutan:

Exploring social & health risk behaviours

Department of Youth and Sports,
Ministry of Education

In collaboration with:

The Nossal Institute for Global Health,
University of Melbourne

Centre for Research Institute Thimpu,
Bhutan

Supported by:

UNICEF Bhutan

CONTENTS PAGE

CONTENTS PAGE **2**

LIST OF TABLES **3**

LIST OF FIGURES **4**

ACRONYMS **5**

KEY TERMS & DEFINITIONS **6**

EXECUTIVE SUMMARY **8**

INTRODUCTION **15**

CONTEXT **20**
- Education 21
- Employment 23
- Gender, family and marriage 24
- Sexuality and sexual practice 25
- Tobacco, alcohol and drug use 28
- Vulnerability, risk and HIV 29

METHODOLOGY **32**
- Study design 32
- Ethics: consent, confidentiality, and protection of participants 37

FINDINGS **39**
- Section 1: Socio-demographic profile of at-risk adolescents 39
- Section 2: Sexuality and sexual practice 40
- Section 3: Tobacco, alcohol and drugs 51
- Section 4: Bullying and violence 58
- Section 5: Mental health and well-being 61
- Section 6: Information, services and programs 62

DISCUSSION & RECOMMENDATIONS **66**
- Section 1: Socio-demographic profile of at-risk adolescents 66
- Section 2: Sexuality and sexual practice 72
- Section 3: Tobacco, alcohol and drugs 79
- Section 4: Bullying and violence 82
- Section 5: Mental health and well-being 83

SUMMARY OF SECTOR RESPONSIBILITY AND PRIORITY ACTION **85**

REFERENCES **87**

ACKNOWLEDGMENTS **90**

LIST OF TABLES

Table 1: Categories of at risk and vulnerable adolescents covered during the assessment ... 33
Table 2: Locations/settings to access at-risk and vulnerable adolescents ... 33
Table 3: Regions, districts and total number of sample population by urban, rural ... 35
Table 4: Participant characteristics, by gender ... 39
Table 5: Ever had sexual intercourse, by key characteristics ... 40
Table 6: Ever had sexual intercourse, by gender ... 41
Table 7: Had sex during the past 12 months, among those with a history of sexual intercourse ... 42
Table 8: Number and type of sexual partners during the past 12 months* ... 43
Table 9: Use of contraception, by gender ... 44
Table 10: Sexually attracted to other males ... 45
Table 11: Risky sexual contacts, by gender ... 47
Table 12: Proportion of respondents who had heard of STIs, by key characteristics ... 48
Table 13: Proportion of respondents who had heard of HIV, by key characteristics ... 49
Table 14: Proportion agreeing with various true and false statements about HIV transmission, by education level ... 50
Table 15: Tobacco consumption behaviour, by gender ... 51
Table 16: Ever smoked, by key characteristics ... 52
Table 17: Alcohol consumption, source of alcohol and reason for drinking ... 53
Table 18: Ever consumed alcohol, by key characteristics ... 54
Table 19: History of trying particular drugs, by gender ... 54
Table 20: Ever smoked marijuana, by key characteristics ... 55
Table 21: Frequency of smoking marijuana ... 56
Table 22: Ever used inhalants, by key characteristics ... 56
Table 23: Frequency of using inhalants ... 57
Table 24: History of being bullied, by key characteristics ... 58
Table 25: History of physical fights in the last six months, by key characteristics ... 60
Table 26: Sources of information ... 64
Table 27: Contrasting results on ever had sex with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances ... 67
Table 28: Contrasting at-risk adolescent results on daily tobacco with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances ... 68
Table 29: Contrasting results on daily alcohol use of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances ... 69

LIST OF FIGURES

Figure 1: South Asian map highlighting Bhutan 20
Figure 2: Map of Bhutan highlighting the main cities, including Phuntsholing 28
Figure 3: Districts selected as study sites 34
Figure 4: Contrasting results on ever had sex with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances 68
Figure 5: Contrasting results on daily tobacco of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances . 69
Figure 6: Contrasting results on daily alcohol use of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances . 70

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BHU	Basic Health Units
BNCA	Bhutan Narcotic Control Agency
CRC	Convention on the Rights of the Child
DYS	Department of Youth and Sports
EVA	Especially Vulnerable Adolescents
FGD	Focus Group Discussion
GNH	Gross National Happiness
GPS	General Population Survey
HISC	Health Information Service Centers
HIV	Human Immunodeficiency Virus
IDI	In-depth interview
MARA	Most-At-Risk Adolescents
MDG	Millennium Development Goals
MSM	Men who have Sex with Men
NFE	Non Formal Education
NGO	Non-Government Organisation
Nu	Ngultrum
RENEW	Respect, Educate, Nurture and Empower Women
RGOB	Royal Government of Bhutan
STI	Sexually Transmitted Infection
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
WHO	World Health Organisation
YDF	Youth Development Fund

KEY TERMS & DEFINITIONS

Adolescence, youth and young people	*(Adolescence)* *Adolescence* is defined by the World Health Organisation as the period from age 10-19. Adolescence essentially marks the transition from childhood to adulthood and is a time of rapid physical, psychological and social development that offers opportunities yet similarly poses challenges. Adolescents can be categorised as early or younger adolescents aged (10-14) and those aged 15-19 as late or older adolescents. This assessment included only adolescents aged 13-18 and therefore for the purpose of this assessment, when the term *younger adolescents* is used, it is refers to the 13-15 age group, and when the term *older adolescents* is used, it refers to those aged 18.
	(Youth) *Youth* refers to those aged 15-24, and the term *young people* is often used to refer to the combination of the two groups of adolescents and youth (ages 10-24). The Convention on the Rights of the Child (CRC) defines children from birth through until their 18th birthday. While alignment of multiple definitions may be helpful, recognising adolescence as an important developmental life phase, as distinct from children and adults is the intention of an adolescent definition. The recently developed *Bhutan National Youth Policy 2010,* includes all adolescents and youth aged 13-24. In Bhutan the legal age for maturity for males and females is 18 years.
Drayang	A draying is a legal entertainment establishment (bar) where alcohol is sold and where adolescent females are known to dance and sing karaoke. Drayangs have a strong association with transactional sex and therefore are identified as risk settings for young people, particularly adolescent females.
Girl/boy	There are times when the term *girl* is used specifically in reference to *drayangs*, to respect the language used in focus group discussions. In this instance, "girls" also means "vulnerable and at-risk female adolescents". Similarly the word "boy" is used to respect the type of language used in focus group discussions in relation to gangs, peers or other adolescent males. "Boy/s" usually refers to vulnerable and at-risk male adolescent but in context may refer to adolescent males in the general community.
Inhalants	Substances and or drugs that are sniffed breathed as vapor often through inhaling the fumes. Substances indicated in the survey questions included dendrite, petrol and correction fluid.
Night hunting	"Night hunting" has been described as traditional courtship known to be practiced in the past, mostly in Bhutan's rural eastern and central regions. It is described as the rural equivalent of urban dates (blind or pre-fixed dates) and involves young men going out at night with the aim of sneaking into girls' houses to engage in sexual activities. The practice is reported to be not as popular as it once was because of changes to legislation and related penalty of impregnating a girl.

Not enough to eat as proxy for poverty and poorest adolescents	The survey asked at-risk adolescents if they had enough to eat. 50% of the adolescents responded that "often" or "sometimes" they did not have enough to eat. In the report this information has been used as a proxy for poverty and where the term *the poorest adolescents* or the demographic category of poor is used it is referring to that group who reported not having enough to eat. Sometimes the term not enough to eat may also appear.
Seeds	*Seeds* are individuals who are identified by research parthers as engaged in at-risk behaviours or working in risky settings. These individuals then identify other potential participants who are also involved in at-risk behaviours. This is a similar method to snow-balling, a more common method in participant recruitment, however it relies on local knowledge of people involved in high-risk behaviours who would be otherwise hard to identify.
Vulnerable and at-risk	The adolescents in the assessment are those considered "vulnerable and at-risk". For convenience the term "vulnerable and at-risk adolescents" is shortened to "at-risk adolescents" – this includes those adolescents who are "vulnerable" and those who are "at-risk".

EXECUTIVE SUMMARY

The overall aim of the assessment was to gather strategic information about the behaviours and needs of vulnerable and at-risk adolescents in Bhutan aged 13-18 years. The focus of the assessment was on specific behaviours and settings that make this important, yet sometimes forgotten, group of adolescents susceptible to negative social and health outcomes including: tobacco use, alcohol and drug misuse; early school leaving; pregnancy; sexually transmitted infections, including HIV; and violence.

HIV prevalence is currently low in Bhutan however understanding the context for sexual behaviour, violence, and drug use is important for planning future adolescent related policies and programmes - not just for HIV prevention but also to foster healthy sexuality and positive relationships; tobacco, alcohol and drug education; prevention of gender based violence and promotion of mental health.

While small in scope, the assessment provides an important perspective about vulnerable and at-risk adolescents including those with limited economic security, low or no education, unemployed and marginalised through remoteness. There are many factors and determinants that impact on the health and well-being of adolescents including family, peers, service providers, community leaders, social values and policies. The multi-level environments in which adolescents live are interconnected and shape how they act and interact and can be both a source of risk or protection.

Understanding the role of vulnerabilities in influencing health, education and well-being outcomes is challenging. In this assessment "vulnerability" refers to unequal opportunities, including early school-leaving, disability, unemployment and other social, cultural, political and economic factors that make adolescents more susceptible to risk behaviour.

This research provides comparative data that confirms that adolescents in Bhutan are not equally at-risk or equally vulnerable and highlights that significant inequalities and gaps exist within and between different groups of adolescents in Bhutan.

In this assessment, obtaining a random sample was not feasible or practical given the aim of obtaining a sample of vulnerable and at-risk adolescents from known hard-to-reach populations. Therefore, the sampling approach was necessarily based on a purposive sample and these findings do not represent the general experience of all at-risk and vulnerable adolescents across Bhutan. Importantly these findings do not represent the experiences and or behaviours of the majority of adolescents aged 13-18 in Bhutan many whom are still in-school, living with family and considered to be in the mainstream.

Through the use of mixed methods and triangulation, the research team has attempted to generate a robust set of findings. These findings provide an illustration of the vulnerabilities, risk behaviours and risk settings affecting this important sub-set of at-risk adolescents, thus providing evidence-based direction for programming and policy.

Socio-demographic profile of at-risk adolescents

The purposive sampling of vulnerable and at-risk adolescents[1] has resulted in disproportionate representation of adolescents from backgrounds of economic and social disadvantage.

- 50 percent of the sample reported they regularly did not have enough food indicating a high rate of poverty
- 17 percent of the sample had never been to school
- 10 percent of the sample only had reached higher secondary education, with at-risk adolescent males more likely to complete higher secondary school than at-risk adolescent females

Gender emerged as a significant issue. The impact and consequence of sexual risk behaviours and risky settings are much more severe for at-risk adolescent females than for the at-risk adolescent males. For example rates of sexual harassment, sexual violence and general violence is much higher among at-risk adolescent females than at-risk adolescent males. For the females, the reasons for leaving school include: marriage, pregnancy, forced employment.

Sexuality and Sexual Practice

This assessment found that 36 percent of the total sample of vulnerable and at-risk adolescents reported to be sexually active.[2] However this masks the 61 percent of 18 year old males in the group reporting to be sexually active and the zero percent of the younger female adolescents aged 13-15 years reporting to be sexually active. Being sexually active was associated with being male, being older and not being in school.

Comparing the sexual activity levels of at-risk adolescents aged 18 in this study with adolescents aged 18 still-in-school found significantly higher percentages of sexual activity in the at-risk adolescent group (males: 61 percent; females: 44 percent) compared with in school (males: 41 percent; females: 1 percent).

Regular sex with multiple partners, male-to-male sex, transactional sex and night hunting, while varied in frequency, were all reported. Adolescent males were more likely to report condom use at last sex (69 percent) compared to adolescent females (59%) however the females response was *at last sex with a non-regular partner*. 56 percent of the at-risk adolescent sample who reported having had a one night stand reported using condoms at least sometimes on these occasions.

---

[1] The adolescents in the assessment are those considered "vulnerable and at-risk". For convenience, the term "vulnerable and at-risk adolescents" is shortened to "at-risk adolescents" – this includes those adolescents who are "vulnerable" and those who are "at-risk". There are times when the term "girls" is used specifically in reference to *drayangs*, to respect the language used in focus group discussions. In this instance, "girls" also means "vulnerable and at-risk adolescents"

[2] Sexually active is defined as ever had sexual intercourse

Unprotected sexual activity is a common behavior of both at-risk adolescent males and females which poses a threat for STI's which are high in Bhutan and should be of concern in the context of the emerging risk of HIV. Alcohol use by respondents featured strongly in the sexual experiences and behaviour of the adolescents in this sample.

For at-risk adolescent males, 42 percent reported to be sexually active (associated with being older and being poor), while 27 percent reported to be currently sexually active.[3]

Of the sexually active adolescent males:

- The average age of sexual debut was 15 years of age
- 44 percent reported one regular partner in the prior 12 months and 33 percent reported two regular partners during prior 12 months.
- 28 percent of those currently sexually active reported to have paid for sex at least once
- 31 percent reported no condom use at last sex (with regular partner and casual partner)
- 38 percent of those currently sexually active reported night hunting (with the male respondent as the night hunter).
- 11 percent reported to having been sexually attracted to another male
- 7 percent reported having had a sexually transmitted infection
- Just fewer than 5 percent of all males in the sample reported forced sexual intercourse.

For at-risk adolescent females, 31 percent reported to be sexually active while 24 percent reported to be currently sexually active. Being sexually active was associated with being older, having no education, working and being poor.

Of the sexually active females:

- The average age of sexual debut was 16 years of age
- 90 percent of those currently sexually active adolescent females reported one regular partner with only 1 female reporting 2 regular partners. Just under 5 percent of adolescent females reported having a married man as a sexual partner in the prior 12 months and another 5 percent of females reported having 2 plus married men as sexual partners in the prior 12 months.
- 12 percent of those currently sexually active reported to have had sex in exchange for money
- 47 percent of the sexually active at-risk adolescent females reported a pregnancy
- 7 percent reported having had a sexually transmitted infection
- 7 percent of all females in the sample reported being forced into sexual intercourse. The sources of the forced sexual intercourse in order were; friends, strangers and relatives.

[3] Currently sexually active is defined as having had sexual intercourse in the last 12 months

Tobacco, alcohol and drug use

This assessment found the use of tobacco and alcohol among peer and friendship networks to be common among participants living in urban centres. Despite the ban on the sale of tobacco, 22 percent of the sample reported to smoke daily which was associated with being male, being older and living in an urban area. Daily tobacco use was twice as common among at-risk adolescent males (30 percent) compared to at-risk adolescent females (16 percent).

Again, although alcohol use by adolescents under 18 is illegal around 20% of the assessment sample reported to drink with higher levels of drinking reported by older at-risk male adolescents and female adolescents working in *drayangs*. For girls working in *drayangs,* negotiation power is undermined by heavy alcohol consumption or intoxication and for at-risk adolescent males heavy alcohol use is often linked with violence.

Only 21 percent of the adolescents in the survey reported to have ever consumed alcohol. Alcohol consumption was almost three times as common among at-risk male adolescents (33 percent) compared to at-risk female adolescents (12 percent).

22% of the adolescent males reported drinking at least once a week with 10% of the older adolescent males (18 years old) reporting drinking every day. Alcohol consumption was associated with being older, living in an urban area and having a mother-tongue other than *dzongka*, the national language.

18 percent of the adolescent male sample reported smoking marijuana and 16 percent reported using inhalants. Smoking marijuana and using inhalants was rarely reported among at-risk adolescent females. Marijuana, prescription medication and inhalants were widely discussed in FGD predominantly by males and a few females.

It is very clear from this assessment that tobacco, alcohol and drug use is associated with a number of different risk behaviours. There is a very strong association between alcohol and violence; and between alcohol and sexual activity.

Bullying and violence

A total of 52 percent of survey respondents reported that they had been bullied, with a slightly higher proportion of males (57 percent) than females (47 percent). School was reported as the place where most bullying occurred followed by in the street (gangs) for males and the workplace for females. At-risk adolescent males were more likely to be hit (20 percent) than at-risk adolescent females (9 percent) and females were more likely to be subjects of gossip and victims of bullying than males. Overwhelmingly, fellow students and peers were reported to be the perpetrators of bullying.

A total of 16 percent of all at-risk adolescents in the survey sample reported that they had been involved in physical fights. Twice as many adolescent males (24 percent) had been involved in physical fights compared to adolescent females (11 percent). Being involved in physical fights appears to be more common among urban at-risk adolescents

neither working nor going to school.

Fear of violence resulting from peers acting under the influence of alcohol and drugs was a very strong theme emerging from the assessment. There was a very strong association between gang violence and drug use, with the majority of participants highlighting issues of safety as a priority concern. Several participants identified the community policing as a positive or protective action.

At-risk adolescent females working in *drayangs* reported feeling very unsafe and experiencing different forms of sexual and physical abuse.

Mental health and wellbeing

For the poorest adolescents in the assessment, the feelings of self-esteem and wellbeing relied heavily on basic needs including food and clothing being met. 17 percent of the at-risk adolescents in the survey had not completed formal education and this was often reported as an underlying factor leading to feelings of worthlessness.

While FGD shared stories of stress, sadness and self-reported depression some at-risk adolescents reported coping strategies including talking with friends, and working hard. Of interest were some adolescents resilience to continue through tough times talking of dreams for a positive future and a life where they were welcome back in their community or family

Recommendations and priority actions

Comprehensive Youth Policy

- Review and if necessary revise new National Youth Policy Bhutan 2010 to ensure specific recommendations for at-risk and out-of-school adolescents and youth are included.
- Ensure policy focus is cross-sectoral and integrated involving health workers, teachers, police, social workers focusing on vulnerable and at-risk adolescents.

Keeping adolescents in school

- Early warning system for school-drop outs.
- Economic scholarship support for low income families.
- Easy access and flexibility for continuing equivalency education and non formal education.

Job opportunities for out-of-school adolescents and young people

- Increase the flexibility of current vocational training systems and establish new approaches which provide training and opportunities that match at-risk adolescents with employment market needs.

Comprehensive life skills program for out-of-school adolescents and young people

- Revise and consolidate existing out-of-school curriculum to include HIV; sexual reproductive health; rights; gender; sexuality and sexual identity; decision-making; critical thinking, as part of educating for Gross National Happiness.
- Expand settings for out-of-school implementation of non-formal education, continuing education, vocational training, Drop in Centres and selected *drayangs.*

Youth friendly sexual reproductive health services for at-risk adolescents

- Ensure current youth health services are appropriately targeted to at-risk, out-of-school adolescents.
- Ensure sexual reproductive health services are comprehensive and inclusive of adolescents (married and unmarried) and include: STI testing; treatment and management; HIV voluntary and confidential counseling and testing; pregnancy tests and contraception counseling. Protocols for unprotected sex and unplanned pregnancy should be available.
- Condom distribution and condom use promotion through peer education and outreach services (with referral links to health services): employment information services, vocational schools, youth clubs, and known clinics, *drayangs*, bars and hotspots.
- Continue to support health care providers (and relevant services) with capacity-development opportunities.

Tobacco, alcohol and drug support services

- Review current adolescent-specific tobacco, alcohol and drug education curriculum to ensure consistent messaging.
- Build consensus and commitment for the philosophy of “middle way” (harm reduction) messaging within a broader community tobacco, alcohol and drug strategy.
- Appropriate tobacco, alcohol and drug services targeted to at-risk adolescents includes: counselling for behaviour change; support to reduce consumption; facilitated detoxification and recovery; coordinated referrals for continuing education or vocational training.
- Consider the links between alcohol and unprotected sex and ensure alcohol and drug services include referral links to sexual reproductive health services.
- Engage retailers and venders in the alcohol and drug response.

Protection and safety

- Strengthen the process for identifying underage adolescents working in the *drayangs* and other hazardous work environments and provide a coordinated response that includes prevention, counselling on vocational options and support for continuing education.
- Review existing “hotline” services and referral links for victims of violence and abuse and ensure they are accessible to those at-risk adolescents, including girls working in *drayangs* and domestic workers. The “hotline” services need to have clear referral

links to programs, including refuge shelters.
- Strengthen the "positive community policing" programs, particularly the at-risk adolescent-police partnerships initiative to promote community safety and supportive environments.

Peer support and adolescent involvement

- Strengthen the peer education and the peer support network for at-risk groups of adolescents to create community connection and protection.
- Provide meaningful opportunities for youth participation with special consideration for the inclusion and participation of at-risk and out-of-school adolescents.
- Seek partnerships with emerging civil society organisations and encourage inclusion of vulnerable and at-risk adolescents.

INTRODUCTION

In late 2008, the Department of Youth and Sports (DYS) in Bhutan supported by UNICEF commissioned a study to better understand the vulnerable and at-risk adolescents in Bhutan aged 13-18 years. The focus of the assessment was on specific behaviours and settings that make this important group of adolescents susceptible to negative social and health outcomes including: tobacco, alcohol and drug misuse; pregnancy; sexually transmitted infections, including HIV; and violence. The research was motivated, in part, by the Commission on AIDS in Asia's[4] call to strongly consider the needs of most-at-risk adolescents and question the large investments in schools for low-risk adolescents.

The research consultants worked with a project steering committee and with local research counterparts, as well as a local survey team. The assessment work began in 2009.

HIV prevalence is currently very low in Bhutan, estimated at less than 0.02 percent.[5] However understanding the context for sexual behaviour and drug use is important for planning future adolescent-related programmes and services - not just for HIV prevention but also to provide information for sexuality; relationships; tobacco, alcohol and drug use; gender based violence and mental health. The study was designed to collect data about adolescents living in Bhutan who are marginalised or not easily accessed through formal systems and structures as their needs, experiences and aspirations have often been ignored.

While small in scope, the assessment provides an important perspective about the experiences and needs of vulnerable and at-risk adolescents and provides ideas about possible prevention and service interventions for this group who are easily forgotten and sometimes ignored. The findings show a strong association between risk or unsupportive physical environments and involvement in risk or health harming behaviours.

This research presents comparative data between mainstream in-school adolescents 13-18 and the at-risk adolescent group surveyed and interviewed for this assessment. Findings confirm that adolescents are not all equally engaging in risk behaviours nor are they equally exposed to risky situations or unsafe environments. The study confirms that significant differences exist between the behaviours, experiences and access to resources for adolescents and clear inequalities are evident between different groups of adolescents.

The following tasks were undertaken as part of the assessment:

---

[4] Independent Commission on AIDS in Asia (2008), *REDEFINING AIDS IN ASIA Crafting an Effective Response,* India, Oxford University Press (Presented to the United Nations Secretary-General Ban Ki-Moon on 26 March 2008 in New York).

[5] UNAIDS (2009) *Bhutan HIV and AIDS Estimates 2009,* Geneva, UNAIDS, *http://www.unaids.org/en/regionscountries/countries/bhutan/*

- A review of prior literature and research findings around adolescent behaviour and program interventions, focusing specifically on sub-populations involved in high risk behaviours and/or living in especially vulnerable circumstances.
- The development, piloting and implementation of data collection tools, which included a survey questionnaire, focus group discussions (FGD) and in-depth interviews (IDI).

This Report presents details about research methods, discussion of context for the study, seven substantive sections presenting assessment findings and analysis; discussion and comparisons with other relevant adolescent surveys, and recommendations for future programming and research.

Age range of assessment participants

'Adolescence' has been defined as the period from age 10-19, 'youth' refers to those aged 15-24, and the term 'young people' is often used to refer to the combination of the two groups (ages 10-24). The Convention on the Rights of the Child (CRC) defines children as 0 – 18th birthday. Therefore there is often cross-over in the use of terminology. In Bhutan, while adolescence is considered an important developmental phase, rigid age limits do not apply. Although 18 years is the legal age of maturity for adolescent males and females, judgements of maturity are made based on physical capability rather than age as in developed-country frameworks.[6] However the recently developed *Bhutan National Youth Policy 2010,* includes all adolescents and youth aged 13-24.[7] The specific age range of the sample as determined by the assessment terms of reference was 13-18 years old.

The adolescents in the assessment are those considered "vulnerable and at-risk". For convenience the term "vulnerable and at-risk adolescents" is shortened to "at-risk adolescents" – this includes those adolescents who are "vulnerable" and those who are "at-risk". There are times when the term "girls" is used specifically in reference to *drayangs*, to respect the language used in focus group discussions. In this instance, "girls" also means "vulnerable and at-risk adolescents"

Understanding key terminology: "at-risk" and "vulnerable"

Adolescence essentially marks the transition from childhood to adulthood and is a time of rapid physical, psychological and social development. Many characteristics of young people need to be taken into consideration when designing and delivering programs and policy. These characteristics include their age and sex, whether or not they are attending school, marital status, economic dependence, their family relationships (and support), where they live (in urban or rural environments)[8]. During the second decade of life, adolescents make important transitions which often include sexual initiation, leaving school and entering the labour market, forming partnerships and having children. It is also a period of curiosity, risk-taking and first-time experimentation with many things including alcohol.

[6] WHO Regional Office for South-East Asia (2007), *Adolescent Health at A Glance in South-East Asia Region (Country Profile – Bhutan)*, New Delhi, WHO SEARO
[7] Ministry of Education, RGoB (2010), *Bhutan National Youth Policy Final Draft for submission to Parliament 2010*, Timphu, Department of Youth and Sport, Ministry of Education
[8] Juarez F et al. (2008), Introduction to special issue on adolescent sexual reproductive health in Sub-Saharan Africa, *Studies in Family Planning* 39 (4) 239-244

There are many factors and determinants that have an impact on the health and well-being of young people including family, peers, service providers, community leaders, social values and policies. The multi-level environments in which adolescents live are interconnected and shape how they act and interact and can be a source of risk or protection. Studies from more than 50 countries have identified a number of common determinants that could either increase the risk of negative behaviours (risk factors) or protect against them (protective factors).[9]

Understanding the role of vulnerabilities in influencing health and well-being outcomes is complicated and the definition of *vulnerable young people* varies and is often used interchangeably with other terms such as *at-risk*. In this assessment "vulnerability" refers to unequal opportunities, social stigma, unemployment and other social, cultural, political and economic factors that make adolescents more susceptible to *at-risk behaviour*, such as substance use; early sexual debut; criminal behaviour and early school-leaving.

The following factors relating to adolescent risk need to be considered[10]:

- Adolescent risk behavior is often less fixed than adults' behaviour. Sexual practice and drug use are sometimes experimental and might not continue
- They are less likely to identify as a member of a high risk, at-risk group
- They are more easily exploited and abused
- They have less experience coping with marginalisation and illegality
- They might be less willing to seek out services because of concerns about the illegality of the behaviour and informed consent
- They are often less oriented toward long-term planning and thus might not think through the consequences of the risks that are related to the choices they make
- Some adolescents engage in multiple and overlapping risk behaviours

The factors underlying vulnerability may reduce the ability of individuals or communities to avoid risk and may be outside the direct control of individuals. These factors may include: lack of knowledge and skills required to protect oneself and others; accessibility, quality and coverage of services (including education, employment and health services); and societal factors such as human rights violations or social and cultural norms.

Literature suggests that adolescents become more vulnerable if their health and development needs are not met i.e. if they do not have access to education, economic security, information and services; do not live in safe and supportive environments and do not have opportunities to participate in the communities in which they live or the decisions that affect their lives[11].

The following factors relating to adolescent vulnerability need to be considered:

- They might not have access to information and services
- They might be living without parental guidance and support

---

[9] Blum R & Mmari KN (2004), *Risk and Protective Factors Affecting Adolescent Health in Developing Countries.* Geneva, WHO

[10] Interagency Youth Working Group, et al. (2010). *Young People Most at Risk of HIV.* North Carolina, FHI

[11] Blum R, & Mmari KN (2004)

- They might have been trafficked or exposed to physical or sexual violence and exploitation
- They might live in societies where laws or social values force adolescents to behave in certain ways that place them at-risk

Risk and vulnerability within the context of HIV

Two behaviours of greatest risk for the transmission of HIV are: penetrative sex (vaginal or anal) with multiple partners without using condoms, and sharing used needles and syringes to inject drugs. Unprotected vaginal sex is a risk not only for HIV transmission but also other sexually transmitted infections and unplanned pregnancy.[12] It is important to note that while recent most-at-risk terminology often refers to HIV transmission; it can also relate to other harmful and negative outcomes.

Some groups of adolescents and young people are considered *most-at-risk* because they adopt, or are forced to adopt certain behaviours, which, if practiced unsafely, might put them at increased risk of HIV infection: young men who have sex with men; young people who buy and sell sex; young people who inject drugs.

A recent United Nations report on HIV and AIDS explains that *most-at-risk* refers to specific behaviours while *vulnerability* refers to the circumstances and conditions that make risk behaviours more likely.[13]

Many of these conditions are beyond individual control and are often referred to as *structural factors* or the *HIV risk environment.*[14] Adolescents are more vulnerable to taking risks and being involved in risk behaviour if the social factors reduce their ability to avoid or control risky situations.

The term *especially vulnerable adolescents* refers to those whose living conditions are particularly likely to lead them to adopt most-at-risk behaviours. Those conditions include living: on the street or as an orphan; in a correctional facility; in a family or community where drug use is common; in a family or community where there is physical or sexual violence; in extreme poverty; in areas where human trafficking is common; in displacement or migration; in war or conflict situations; with disability.

Definitions used in this report: at-risk adolescents and young people

HIV prevalence is very low in Bhutan. While there is great interest in the specific behaviours that put adolescents *most-at-risk* of HIV transmission, only focusing on unprotected sex in the context of transactional sex, unprotected sex in the context of male sex and unsafe injection of drugs remains narrow and challenging. For low prevalence countries, there is increasing opportunity to explore the broader dimensions

---

[12] UNICEF Regional Office for South Asia (ROSA) (2009), *Guidance Note: HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia. Kathmandu, UNICEF*
[13] UNAIDS (2007), *UNAIDS Practical Guidelines for Intensifying HIV Prevention, Towards Universal Access.* Geneva, UNAIDS
[14] Gupta G R et al. (2008), Structural approaches to HIV prevention, *The Lancet*, 372 (9640), 764-75

of adolescent risk and vulnerability. Adolescents and young people who are *most-at-risk* of HIV are also at-risk of a range of other negative health outcomes including unplanned pregnancy; alcohol and drug misuse; violence; poor mental health and diminished opportunity for meaningful employment.

The overall aim of the assessment was to gather strategic information about the behaviours and needs of vulnerable and at-risk adolescents in Bhutan aged 13-18 years to better understand the range of broad risks and vulnerabilities faced by them and thereby better understand their service and programming needs. The focus of the assessment was on specific behaviours and settings that make this important, yet sometimes forgotten, group of adolescents susceptible to negative social and health outcomes including including those young people considered *most-at-risk* and *especially vulnerable* to HIV.

This assessment provides an illustration of the vulnerabilities, risk behaviours and risk settings affecting this important sub-set of at-risk adolescents, thus providing evidence-based direction for programming and policy. It is important to interpret the findings with some caution. In this assessment, obtaining a random sample was not feasible or practically possible given the aims of obtaining a sample of adolescents from hard-to-reach populations. Therefore, the sampling approach was necessarily based on a purposive sample and these findings do not represent the general experience of risk and vulnerability for all vulnerable and at-risk adolescents in Bhutan nor do they represent the broader experiences of risk for all adolescents in Bhutan.

CONTEXT

Bhutan is a land-locked country bordered by India and China (Map 1). Approximately 40 percent of the population lives in Indian border districts of Bhutan where movement across these porous borders is common.

The 2005 census indicates the total population of Bhutan was 672,425, with an overall sex ratio of 110 males per 100 females. Only 31 percent of people live in urban areas with the majority residing in rural areas.[15] Bhutan has a very young population with 60 percent of the population below the age of 25 years[16].

Figure 1: South Asian map highlighting Bhutan

Source: UNICEF Bhutan Country Profile

The first national election held in 2008 marks the transition of Bhutan from Buddhist monarchy to parliamentary democracy under constitutional monarchy. In addition to recent shifts in the political and administrative structures, Bhutan has also experienced growing trade with neighboring countries such as India, Nepal and Bangladesh which has resulted in greater movement of people across borders and within the country. While two-thirds of Bhutanese rely on subsistence farming as livelihood, the recent transition from traditional systems of labour mobilisation and increased rural to urban migration has highlighted new challenges for the majority.

In contrast to their parents, young people in Bhutan today grow up in a different and complex world in terms of globalisation and the spread of mass communication, global economic and political crisis, global violence and conflict and increasing access to drugs and alcohol. Adolescence is often characterised as a difficult and/or problematic time for young people as they explore their independence, cope with physical and emotional changes and experiment with a range of new experiences that can include risk behaviors.

---

[15] Office of the Census Commissioner, RGoB (2005) Results of Population & Housing Census of Bhutan 2005, Thimphu, RGoB

[16] Ibid.

Adolescents who do not conform to expected social, cultural, sexual or gender norms can face peer pressure, bullying and social stigma. Media coverage of adolescents in countries in the region have tended to label young people as prone to risky behaviours, and highly vulnerable to exposure to various risks, especially those related to sex, reproduction, substance use and juvenile delinquency[17].

While most adolescents make the transition from child to adult intact, the connection and support provided by families, schools, community and government significantly influences the opportunities, skills and resilience of the adult that emerges[18].

Bhutan has a very young population with 60 percent of the population below the age of 25 years[19]. This "youth bulge" phenomenon is new for Bhutan and presents a unique development challenge and opportunity, particularly in health and education. The RGoB has recognised the significance of and investment in healthy youth development, not only to reduce risk behaviour and vulnerability but also to harness national development opportunities[20]. This youth bulge is predicted to continue for the next decade with currently large numbers of children under ten years of age. For this reason investing in adolescence now is not only good for the current generation but can reap significant benefits for years to come.

Despite almost one in five Bhutanese aged between 15 and 25 years old, Bhutan's policy and program agendas have, until recently, neglected the adolescent and youth age group concentrating more on improving the survival and development of under-fives and elementary school-age children. As a result, Bhutan's adolescents until recently have been inadequately prepared for important life challenges and responsibilities in regard to sexuality and reproductive health.

Education

The socio-economic changes have had an impact on school enrolment, particularly during the period 1961 to 2004. The shift in interest from the traditional monastic education to the modern system was evidenced by an increase in the number of students from less than 400 in the late 1960s to around 170,405 in 2010 with an estimated gross primary school enrolment rate of 118 percent in 2010.[21] ♦

Bhutan is on track towards achieving the Millennium Development Goal number two of ensuring universal primary education. Net enrolment has scaled up to 88 percent in 2008 with enrolment ratio at par (83 percent) for both boys and girls.[22] The challenge ahead is in addressing those 12 percent of children unreachable by the educational system and re-engaging those children who disengage from education including the adolescents who drop out between ages of 10-15, particularly adolescent girls.

---

[17] Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB
[18] Blum R, & Mmari KN (2004)
[19] Office of the census commissioner, RGoB (2005)
[20] World Bank Group (2007) *World Development Report 2007: Development and the next generation,* Washington, World Bank
[21] Ministry of Education, RGoB (2010) Ministry of Education, *Annual Education Statistics 2010,* Thimphu, RGoB
♦ These figures include students, trainees and learners enrolled in 547 schools, 27 institutions and 714 non-formal education centres facilitated by 7,067 teachers.
[22] UNICEF (2009) *Equity in School. Water and sanitation: Overcoming exclusion and discrimination in South Asia, Bhutan Country Report,* Kathmandu, UNICEF ROSA

It is concerning that gender disparities in secondary school remain significant with fewer adolescent females attending secondary school than their male counterparts (81 females for every 100 males). The disparity is reported to be much higher in college with only 48 females for every 100 males. This trend is predicted to have considerable consequences for the economic future of women in Bhutan.[23]

For adolescent females, marriage and pregnancy are important factors in early school-leaving with economic and family pressure more likely to affect females than males. In 2005, 11 percent of all births were among 15 to 19 year olds and 10.2 percent of all 15 to 19 year olds reported having at least one child.[24]

The reasons reported for leaving school include: unplanned pregnancy, needing to work for family, gaining employment including domestic work (especially for adolescent females), failure at school and distance from school. Completion of education for pregnant adolescents has not been an option with most schools not supportive of pregnant adolescents. Adolescent females engaged as domestic workers by families in urban centres are also reportedly unable to participate in formal education.[25] [26] [27]

While significant advances in the provision of schooling across the country have resulted in higher education levels generally, these improvements have not resulted in secondary school education for all students and Government secondary schools award places on academic merit for the last two years of high school.[28] [29]

The competition for secondary school education can lead to feelings of exclusivity, failure and lack of opportunity, especially children from lower socioeconomic families who do not qualify for government schools. Often these families are unable to afford private education and therefore have no access to further formal education.

For some students, school education offers few incentives in terms of employment given the competition for jobs and limited number of vocational institutes. Some parents also express reservations in supporting education because they believe education lures their children from the village to towns.[30]

Education and vocational training remain the foundation for enhancing employability of youth. The policy document *Education Sector Strategy: Realising the Vision 2020* highlights the need for the education system to respond more effectively to the job market needs of adolescents, including increasing access to secondary education[31].

---

[23] Gross National Happiness Commission, National Commission for Women and Children & RGoB (2008) *National Plan of Action for Gender 2008-2013,* Thimphu, Gross National Happiness Commission, National Commission for Women and Children & RGoB

[24] UNICEF (2005) *Plus 5 "World fit for children" Review for the Kingdom of Bhutan 2006: Country progress Report,* New York, UNICEF

[25] Ministry of Education, RGoB (2008), *The Situation of Bhutanese youth 2005-2006,* Thimphu, RGoB

[26] Dorji L & Kinga, S (2005) *Youth in Bhutan – Education, Employment and Development*, Thimphu, Centre for Bhutan Studies

[27] Ministry of Education, RGoB (2006)

[28] Dorji & Kinga (2005)

[29] Ministry of Education, RGoB (2006)

[30] Dorji & Kinga (2005)

[31] Ministry of Health and Education, RGoB (2009), *Education Sector Strategy: Realising Vision 2020 Policy and Strategy*, Thimphu, RGoB

Recent UN reports have focused on the importance of the "adolescent girl" and refer to *"the girl effect"* providing evidence that educating and employing adolescent females can have a more significant impact on poverty reduction than investing in adolescent males[32].

Employment

Unemployment in Bhutan disproportionately affects adolescents and young people, with young women being more likely to be unemployed than young males. The youth unemployment rate has increased from 9.9 percent in 2007 to 12.9 percent in 2009.[33] In urban centres it is estimated that approximately 19 percent of young people are unemployed and those who are engaged in work remain concentrated in low-skilled, low-paid jobs with low prospects in career advancement.[34]

There are many factors affecting youth employment, unemployment and under-employment including: youth bulge, significant growth of school enrolment, limited employment absorption capacity in the public sector, underdevelopment of the private sector, rural-urban migration and young people leaving school without necessary skills and high salary expectations of educated youth entering the economy. [35]

The marked increase in adolescent domestic workers is due to a variety of factors including: a rising trend of rural-urban migration of adolescents in search of employment; increasing numbers of early school-leavers; growing affluence of the urban population enabling the hire of domestic workers and a growing private sector.[36] The Bhutan Labour Study (2009) found that 20 percent of domestic workers were under the age of 18 years[37]. In Bhutan, domestic work is a gendered phenomenon where young women work in poor conditions. In one study domestic workers reported being overworked and being subjected to sexual and physical abuse.[38]

Crime in Bhutan is relatively low compared to neighboring countries but is increasingly described as an "urban youth problem". In 2003, in Thimphu, more than a third of all juvenile crimes were committed by those unemployed. Rural-urban migration, unemployment and inadequate income have been cited as reasons leading to criminal behaviour in youth.[39]

Juvenile crime data for Thimphu reflects a 17 percent increase in the frequency of drug-related crime between 1989 and 2003. Unemployed and underemployed youth accounted for more than half of all drug-related offences in this period. The frequency and prominence of drug use and links to unemployment among young people is a growing and concerning issue.[40]

---

[32] UNFPA (2007) *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy,* New York, UNFPA
[33] Ministry of Education, RGoB (2008), *Bhutan National Human Development Report 2005: The challenge of youth employment*, Thimphu, RGoB
[34] RGoB, Ministry of Health (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB
[35] Ministry of Education, RGoB (2008)
[36] Pathak, N & Yonten, K (2004), *Assessment of the protection factors for vulnerable children in Bhutan,* Thimphu, RGoB & UNICEF
[37] Dorji, T (2009) Child labour study UNICEF [need complete reference]
[38] RGoB & UNICEF (2004)
[39] Dorji & Kinga (2005)
[40] Ibid.

Gender, family and marriage

Bhutan has generally high levels of gender equality in comparison to neighbouring countries, more subtle and indirect forms of gender bias still exist particularly in education, national economy and political participation.[41]

Unlike most other South Asian countries, Bhutanese Society is essentially matriarchal where woman enjoy a fair amount of independence in their personal, social, economic and political spheres. Matrilineal inheritance systems grant women access to land and ownership. An estimated 60 percent of rural women have land registered in their own name. Men and women have the same legal rights and access to property other than land.[42]

However, socio-cultural perceptions of both men and women indicate that women are seen as less capable and confident than men, especially in the areas of governance and men dominate the major decisions of the family.[43] For example, some rural women strongly believe that men are "higher" than women by nine "noble" births. Almost all rural women in a study on the status of women said they would have preferred to be born male.[44] In Bhutan as in many other Asian countries, reproductive health responsibilities, pregnancy and delivery, childrearing and family care appear to be women's duties.

Traditional practices of arranged marriage were replaced with "love marriages" based on mutual affection in the 20th century. [45] The Marriage Act (1980) was amended in 1996 to increase the legal age for marriage for girls from sixteen to eighteen. [46] While adolescent early marriage was historically important for families, particularly in rural areas the amended Marriage Act saw adolescent marriage reduced by 40 percent. [47] Traditional rural families in western and central Bhutan still favour the practice of early marriage due to economic and social benefits.[48]

The Marriage Act also stipulates that the man responsible for impregnating the woman must pay for all medical expenses and provide 20 percent of his monthly income as child-support allowance until the child is 9 years of age.[49]

Male sexual behaviour outside marriage is generally more "accepted" than that of females.[50] The practice of polygamy is permissible by law but dependent on consent of the first spouse. The practice is accepted in the south, some parts of western and central Bhutan as well as among some nomadic communities in the north.

---

[41] Planning Commission and Central Statistical Office (CSO), RGoB et al. (2001), *Gender Pilot Study Report,* Thimphu, CSO

[42] UNESCO (2009) Bhutan Country Profile, Country Specific ARSH Information, Ch. 5, Bangkok, UNESCO

[43] Department of Planning, Ministry of Finance, RGoB (2005), *Millennium Development Goals Progress Report 2005*: Bhutan, RGoB, Thimphu

[44] Kinga, S (1999) *The Status of Women in Traditional and Modern Bhutan*, Thimphu, Centre for Bhutan Studies

[45] Savada, A M (ed.) (1991) *Bhutan: A Country Study*. Washington, GPO for the Library of Congress

[46] UNOHCHR, Universal Human Rights Index of United Nations Documents, 'Rights Related to Marriage and Family', Geneva, UNOHCHR

[47] Ministry of Health, RGoB (1994), *National Health Survey,* Thinphu, RGoB

[48] Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB

[49] RGoB (1980) *Bhutan Marriage Act,* Thimphu, RGoB

[50] OECD Development Centre, Social Institutions and gender index: Gender Equality and Social Institutions in Bhutan, Paris, OECD

The current family planning policy provides universal access to family planning information and services and does not exclude young people.[51] Contraceptives are available free from all hospitals and health centres. Condoms and the oral contraceptive pill are also available for purchase from pharmacies, though pharmacies are limited to urban areas.[52]

Previous studies have found that young people's knowledge of family planning is high (94 percent), however contraceptive use is low (2 percent).[53] Embarrassment and shyness, lack of confidentiality or privacy and judgmental attitudes of health care providers may affect utilisation of sexual health services. This is in contrast to numerous studies and anecdotal reports that Bhutanese, adults and the young, can talk openly about sex.

A contemporary Bhutanese sociologist explains this apparent contradiction as a normal embarrassment linked to the generation divide that precludes open or explicit talk between parents and their children about sex. However peer-to-peer discussion across ages including genders is reported as acceptable and easier. A small study on youth perspectives regarding teenage sex, pregnancy and early marriage indicated lack of knowledge and awareness in rural areas as one of the main reasons for early adolescent pregnancy.[54]

While recent data on attitudes towards condoms reveals that most people felt they had easy access, this was less common for females (69 percent as opposed to 83 percent for men) and a substantial number of both males and females worried that people would think badly if an unmarried person buys condoms (33 percent for males and 59 percent for females).[55]

Given the strong adherence to Buddhist beliefs, and societal acceptance of children born out of marriage, the incidence of induced abortion is assumed to be relatively low. However, reports reveal a growing number of young Bhutanese women seeking abortions in neighbouring India.[56] Until 1999, abortion was illegal. In 1999, the RGoB legalised medical termination of pregnancy if two doctors certify that *"the pregnancy is a risk to the life of the woman, or is likely to cause grave injury to her physical or mental health, or is likely to resulting the birth of a child suffering from serious physical or mental abnormalities".*[57] Termination of pregnancy caused by rape is also permitted.

Sexuality and sexual practice

Bhutan society has a relatively open approach to sex and sexuality with less stringent practices and views about sexuality for both men and women than other South Asian countries. Premarital sex is not taboo in many rural communities.[58] Despite social

[51] WHO (2004) Regional Office for South-East Asia. *Reproductive Health Profile.* New Delhi, WHO.
[52] Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB
[53] WHO (2004) Regional Office for South-East Asia (2004) *Reproductive Health Profile,* New Delhi,
[54] YGCD
[55] Ministry of Health, RGoB (2008) HIV/AIDS General Population Survey Bhutan – 2006, Thimphu, Bhutan
[56] Ministry of Education, RGoB (2008), *The Situation of Bhutanese youth 2005-2006,* Thimphu, Bhutan
[57] Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, Bhutan
[58] Ibid.

tolerance of sex, it is not common for young people to discuss sexual concerns with parents or adults.

Although school health programs promote sexual reproductive health awareness through a number of life skills programs, supported by an intensive advocacy campaign lead by Her Majesty the Queen Mother Ashi Sangay Choden Wangchuck, young people's knowledge and skills remain vague and fragmented. [59]
A local study that focused on early pregnancy revealed sexual initiation among some girls and boys at 13-years old with 10 percent having had their first sexual experience by the age of 14.[60] However, results must be interpreted with caution as the sampling framework for this study is unknown.

More recently the HIV and AIDS General Population Survey (GPS) conducted in 2006 found that among those who had pre-marital sex, the average age for males' first sex was 16-17 years and for females 18-19 years.[61] The National AIDS Control Program rapid assessment on sexual behaviours and networks in Thimpu supports these findings, also reporting average age at first sex as 18.5 years of age with a greater proportion of men than women reporting first sex when they were under 15 (22 percent compared with 10 percent).[62] The Bhutan Narcotics Control Agency National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009 reports very small proportions of school students who are sexually active (1 percent of 18 year old girls) which is significantly lower than other countries in the region and local anecdotal evidence.[63]

The under reported sexual activity experience by adolescent girls could be explained in part by the legal age of consent defined as 18 years and issues of enforcement of this legislation against adolescent males even when adolescent females maybe consenting. Current moves are underway within the Bhutan parliament to repeal the age of sexual consent to 16.

Child pornography, child prostitution, rape and other forms of child sexual abuse are all Penal Offences under the Penal Code of Bhutan 2004. Section-183 of the Penal Code identifies sex with anyone below 18 years as rape and punishable by a minimum of 5 years imprisonment.[64]

Traditional courtship known as "night hunting" has been practiced in the past, mostly in Bhutan's rural eastern and central regions. It is described as the rural equivalent of urban dates (blind or pre-fixed dates) and involves young men going out at night with the aim of sneaking into girls' houses to engage in sexual activities. It used to be custom that a "night hunter" discovered in the morning by the parents would become the husband.[65]

---

[59] WHO (2004) Regional Office for South-East Asia. *Reproductive Health Profile.* New Delhi, WHO
[60] Studies reported were the Department of Youth Culture and Sports, Ministry of Education, RGoB (2000) *Teenage pregnancy and early marriage; Result of Youth Awareness Survey,* Thimphu, RGoB; and Ministry of Health RGoB and UNICEF (2004) *Exploratory Study on HIV/AIDS Issues affecting Out-of School Youth in Bhutan*, Thimphu, RGoB
[61] Ministry of health, RGoB (2008) *HIV/AIDS General Population Survey Bhutan – 2006*, Thimphu, Bhutan p. 44
[62] Ministry of Health, RGoB (2010) *Sexual behaviours and networks in Thimpu, Bhutan: A rapid assessment*, Thimphu, RGoB
[63] Bhutan Narcotic Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009,* Thimphu, Bhutan
[64] RGoB (2004). *Penal Code of Bhutan,* Thimphu, RGoB
[65] Carpenter, R (2002) *The Blessings of Bhutan*, Hawaii, Natural World Press

The practice is reported to be not as popular as it once was because of changes to legislation and because the penalty of impregnating a girl is as high as 20 percent of the salary (or 20 percent of father's salary if unemployed). The National Commission for Women and Children continues to address this issue.[66]
The HIV/AIDS General Population Survey 2006 survey reported that both are in urban areas reported same sex activities in the past year.[67]

There is very little information on male to male sex in Bhutan and little is known about social and sexual networks of men having sex with men (MSM). While some reports indicate that same sex relations might exist among monks[68], there is no published data to describe or support this.

Transactional sex

There is very limited data on sex work, transactional sex and sexual networks in Bhutan. While sex work does not appear to be an organised industry, there are differences between the transactions of sex in the rural border towns compared with urban centres.

Several reports indicate that women, including adolescent girls, are migrating from Nepal to Bhutan for sex work and crossing the border at Jaigon-Phuntsholing.[69] Small studies indicate that clients of sex workers in Phuntsholing consist mainly of uniformed services (army and police), business men, truck drivers, students from Delhi and Kanglung, Indian tourists from Darjeeling and Kalimpong and occasionally expatriate workers. Sex work in these border towns is described as a direct transaction of sex for money in small guesthouses known as paid sex establishments. The average number of clients in Phuntsholing range from 3 – 4 daily, increasing to 7-8 daily during the winter months.[70]

Compared with the border towns, sex work in urban centres is reported to be covert and indirect.[71] While the situation is hard to assess, three levels of sex work have been identified: street based (the estimated number was 50); call girls; and sex work which takes place in the workplace. [72] There are some studies that refer to socioeconomic "classes" of sex work. The low-end workers appear to pick-up clients by hanging out in numerous bars in the city centre, the Hong Kong market and a few smaller bars and tea-stalls in the vegetable market area. The high-level or "upmarket" girls are said to be educated office girls and divorcees.[73]

The majority of transactional sex in urban centres appears to take place in the workplace. The National AIDS Control Program rapid assessment on sexual behaviours and networks in Thimpu reports that there is a substantial presence of commercial

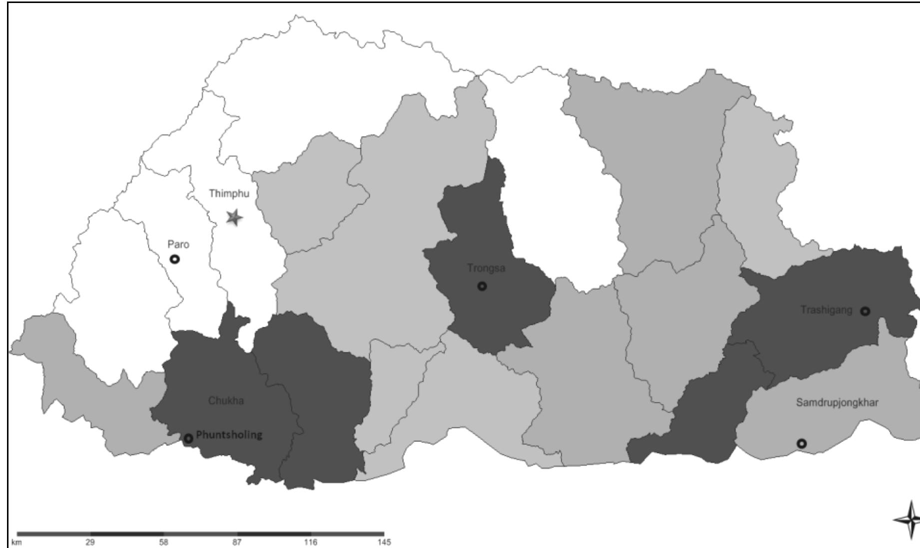
[66] RGoB (1980) *Bhutan Marriage Act,* Thimphu, Bhutan
[67] Ministry of Health, RGoB (2008) *HIV/AIDS General Population Survey Bhutan 2006*, Thimphu, RGoB
[68] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, Bhutan. Note that this was confirmed by young monk participants in one focus group conducted for this assessment in July 2009
[69] The World Bank (2008) *HIV/AIDS in Bhutan*. Washington, World Bank
[70] Ministry of Health, RGoB (2007)
[71] Ministry of Health, RGoB (2010) *Sexual behaviours and networks in Thimpu, Bhutan: A rapid assessment*, Thimphu, Bhutan
[72] Gampo, D (2007) Sexual Net Work, Sex Work and Sex Workers in Thimphu. April May 2007
[73] Ministry of Health, RGoB (2007)

sexual networking in the city. Within a random sample of 485 patrons to *drayangs*, 35 percent of the males and 11 percent of the females reported that they had ever paid or received payment for sex.

There appears to be strong correlation between young girls working in *drayangs*, sexual networking with older men and the forced consumption of alcohol. It was consistently and frequently reported that men found intoxicated women, especially young girls, to be more accessible or susceptible to their sexual advances.[74]

There is very little information about pathways to sex work. One report describes a group of young girls who entered Bhutan from Jaigon on the understanding of working as orange packers and on arrival were forced to sell sex. Some small bars and food shops along the Gedu highway (between Thimpu and Phuntsholing) have also been suspected of dealing in the sex trade through the recruitment of young women.[75] More research is needed to fully understand the dimensions of sex work in Bhutan, particularly the unique risk and vulnerabilities associated with being young.

Figure 2: Map of Bhutan highlighting the main cities, including Phuntsholing



Source: UNICEF Bhutan Country Office

Tobacco, alcohol and drug use

The consumption of alcohol is widely prevalent in Bhutan and a significant part of Bhutanese life. In many rural communities, drinking is a part of everyday life and while there are some differences in consumption patterns between regions, alcohol is easily available as both a locally brewed and a commercial product.[76] A 2004 study on alcohol reports that there are 10 bottles of beer and 10 bottles of spirits consumed per year for every man, woman and child of Bhutan.[77]

The adverse social impacts of alcohol affect young people both directly and indirectly. Apart from the physical health consequences, the social impact on family life and

---

[74] Ministry of Health, RGoB (2010)

[75] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu,

[76] Ministry of Health, RGoB (2008) *Adolescent Health and Development – A country profile,* Thimphu, Bhutan

[77] Dorji, C (2004) The Myth behind alcohol and happiness, presented at the *First International Conference on Gross National Happiness*, Centre for Bhutan Studies, Thimphu, Bhutan, April 2004

individual psychology is significant. Young people who drink are highly vulnerable to risky behaviors such as unsafe sex, sex with multiple partners and physical injury.[78] A study conducted by the NGO RENEW in 2008 found that that 77 percent of respondents (women) suffered physical abuse, 54 percent emotional torment and 23 percent had experienced forced sex. Alcohol was found to be the common factor that triggered the violence. [79]

Approximately 40 percent of the people of Bhutan live in border *dzongkhags* (districts) in Bhutan and their movement across borders is not difficult. In the 1990s, some of the *dzongkhags* bordering India witnessed a shift in psychotropic substance use among youth from traditional (alcohol, cannabis, opium and areca nut) to non-traditional forms (brown sugar[*] and pharmaceuticals).[80]

While alcohol and marijuana are most commonly used, other drugs reported to be used or accessed by young people include: solvents, inhalants, prescription tablets. Substances injected include heroin and combination of crushed tablets N-10 nitrazapam, relipin, buprenorphine, spasmo-proxyvon and syrup phensidryl mixed with alcohol.[81]

Apart from alcohol, substance use is a hidden activity and while the situation is very difficult to assess, a key informant in one study reports more than 200 young people who use soft, prescription drugs and about 30 people who inject drugs. Of those injecting, most had shared injection equipment at some point when supplies were difficult to get.[82]

Alcohol and marijuana are widely available but all other substances are brought into Bhutan from India (Jaigon) and Phuntsholing (the border town). Many drug users travel from Thimphu to Phuntsholing to purchase their own supplies to save costs and then sell to their drug-dependent friends for a small profit. All types of drugs and needles and syringes are available from across the border.[83]

Vulnerability, risk and HIV

Bhutan is a low HIV prevalence country (0.01 percent), with 160 total cases officially reported among Bhutan's population as of 2008.[84] The most common route of transmission is heterosexual (88.9 percent), followed by mother-to-child transmission (9 percent) and injecting drug use (1.4 percent).[85]

[78] Dorji, C (2004) The Myth behind alcohol and happiness, presented at the *First International Conference on Gross National Happiness*, Centre for Bhutan Studies, Thimphu, Bhutan, April 2004
[79] RENEW (2008) Research Study On Violence Against Women (VAW), Thimphu, Bhutan

[80] UNODC, *Drug use in northeastern states of India 2006*, New Delhi, UNODC
[81] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, RGoB
[82] Ibid.
[83] Bhutan Narcotic Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009,* Thimphu, RGoB
[84] Ministry of Health, RGoB, *STI/AHIV Reports of the Country*, Thimphu, RGoB
[85] Ministry of Health, RGoB (2008) *National Strategic Plan for Prevention and Control of STIs and HIV/AIDS*, Thimphu, RGoB, p.5

Although the total number of cases is small, the RGoB is concerned about the current situation and specific risks and vulnerabilities that face young people.[86] Data on key populations at higher risk are not representative and thus prevalence data should be interpreted cautiously.[87]

Awareness of HIV and STIs appears to be very high with one study reporting 97 percent awareness among secondary school students[88] but misconceptions about transmission exist and perception of risk and vulnerability is varied.[89] The association of STIs with "bad characters" and the desire to have people living with HIV be public about there HIV status is concerning.[90] A study conducted among candidates enrolled in the National Graduate Orientation Program (2005) found that 22.6 percent felt that the status of a person with HIV should be made known to everyone or they should be segregated for the sake of prevention. [91]

There are few reports on perception of risk and vulnerability to STIs and HIV. Sex workers appear to be the group most aware of their vulnerability to STIs and HIV although some reports indicate that younger sex worker's knowledge and perception of risk is much lower than their older counterparts. Little data exists on young people's perception of vulnerability and risk.[92]

Rural women, particularly rural adolescent females, are less informed about disease prevention and less able to effectively negotiate safe decision-making, including condom use. Village girls selling farm produce, doing seasonal work or living near highways, domestic workers, girls hired to sing in music bars and girls hired as temporary support in project offices are also considered especially vulnerable. [93]

Unemployed youth are also considered especially vulnerable. While unemployed male youth are more prone to substance use and more likely to be involved in crime, several studies indicate that unemployed adolescent girls are vulnerable to be forced to sell sex.[94] Risk behaviour among the educated youth is reported to be now heavily influenced by new trends based on modern western lifestyles and the emerging nightlife including music bars, discos, nightclubs and pool-rooms in urban centres.[95]

Underlying factors influencing the transmission of HIV in Bhutan include[96]:

- High rates of STI. Approximately 2000 STI cases are reported annually in Bhutan the most prevalent being syphilis and gonorrhoea. Sentinel surveillance revealed an overall rate of 1.4 percent among the population groups tested. While awareness and knowledge is quite high among sex workers, condom use was reported to be

[86] Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB
[87] The World Bank (2008) *HIV/AIDS in Bhutan*. Washington, World Bank
[88] UNODC and Bhutan Narcotics Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan*, Thimphu, RGoB
[89] Ministry of Education, RGoB (2007) *Life skills and Adolescent Reproductive Health Education Program*, Thimphu, RGoB
[90] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, RGoB
[91] Survey report of the KABP on HIV/AIDS among University Graduates of 2005
[92] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, RGoB
[93] Ibid.
[94] Ministry of Education, RGoB (2008) *The Situation of Bhutanese youth 2005-2006,* Thimphu, Bhutan
[95] Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, RGoB
[96] UNICEF Bhutan (2006) *HIV and AIDS Country Profile (fact sheet)*, Thimphu, UNICEF

low and inconsistent. This was largely attributed to poor negotiation skills with clients.[97]

- Migration and mobility within the country;
- Porous borders with neighbouring India (and particularly states of India reporting high HIV prevalence);
- Spread of sex work to new areas;
- Liberal attitude to sex;
- Low condom use;
- Increasing trends of substance use among youth.

In many countries in the region, HIV has spread from key populations at higher risk, including sex workers, injecting drug users and MSM, however there is little information on the behaviour of these groups, particularly adolescents who sell sex, young men who have sex with men and young people who inject drugs.[98]

[97] RGoB (2008) *National Strategic plan for Prevention and Control of STIs HIV/AIDS*, Thimphu, RGoB
[98] The World Bank (2008) *HIV/AIDS in Bhutan*. Washington, World Bank

METHODOLOGY

Study design

The aim of this study was to better understand the range of risks and vulnerabilities faced by at-risk Bhutanese adolescents aged 13-18 years, including those behaviours and situations and settings that put young people at-risk of negative social and health outcomes.

To achieve this aim a mixed-methods study design using quantitative and qualitative research methods was adopted:

1) Qualitative methods - focus-groups discussions (FGDs) and in-depth interviews (IDIs)[99] [100]
2) Quantitative methods - cross-sectional survey collecting behavioural data via an interviewer-administered questionnaire

The assessment was conducted in three phases as follows:

- Phase one: Literature review and consultation with adolescent advisory group
- Phase two: Design of the mixed-methods study using qualitative and quantitative research methods including development of sampling frame
- Phase three: Data Collection and data analysis

Phase One:

Phase one of the assessment focused on the comprehensive review of existing literature and discussion with the adolescent advisory group.

An adolescent advisory group was formed consisting of at risk, vulnerable and in-school adolescents from various categories such as drop in centres, drayangs, an adolescent working as waitress, disabled children from draktsho vocational institute, school children from Mothithang Higher Secondary School and Changangkha Lower Secondary School.

In discussion with the adolescent advisory group and in consultation with the Department of Youth and Sports (DYS) and UNICEF a rapid assessment was conducted during the youth festival in Thimphu to identify and obtain categories of at risk and vulnerable adolescents and their locations. However some categories of at risk and vulnerable adolescents could not be reached during the assessment due to time constraint and accessibility as indicated in Table 1. The assessment covered the locations of at risk and vulnerable adolescents such as, drayang, discotheque etc, as indicated in Table 2.

[99] FGD - A group of participants brought together for the specific purpose of discussing issues, or responding to ideas or materials of interest.

[100] IDI - Interviews conducted on one to one basis, designed to gather detailed information from individual participants about their views and experiences

Table 1: Categories of at risk and vulnerable adolescents covered during the assessment

Sub sets of adolescents identified by literature review and consultation adolescent advisory group	Groups of adolescents included in the actual assessment
At Risk	
Drug users, injecting smoking and illicit use of prescription medications	Yes
Alcohol users-Youth in pool halls	Yes
Drayang Girls	Yes
Sex workers	No
Children in conflict with the law	No
Vulnerable	
Out of School Adolescents	Yes
Unemployed/underemployed adolescents	Yes
Nuns	Yes
Monks	Yes
Girls working as weavers in urban settings.	Yes
Disabled children	Yes
Youth in industries, e.g. conductors for trucks, hotel workers	No
Domestic workers/servants	No

Table 2: Locations/settings to access at-risk and vulnerable adolescents

Locations identified by rapid assessment	Locations Covered in the Actual Assessment
Drayangs, discos, Karaoke venues	Yes
Pool halls	Yes
Addiction and recovery services	Yes
Boarding schools (male)	Yes
Juvenile justice centers	No
Job-seeker, vocational training sites	No
Rural weaver villages	Yes

Phase Two:

Phase two included the designing of the mixed-methods using qualitative and quantitative research methods as well as sampling.

Method Design

1. Qualitative Methods: Focus Groups Discussions (FGDs) and In-depth Interviews (IDIs)

A general discussion guide was developed to structure the FGDs around four themes; 1) health concerns 2) vulnerability and risk 3) health services/support and 4) health information needs and sources. The discussion guide was adapted from a previously developed rapid assessment tool administered during the youth festival to obtain the categories of at risk and vulnerable adolescents. The general discussion guide was then adapted for specific FGDs with adolescents who use drugs and those who sell or

exchange sex limited to only drayang girls. The discussion guide was pilot tested and necessary adjustments were made to validate its' integrity for data collection.

In-depth interviews (IDIs) were conducted to provide additional insight into the issues and themes which emerged from the focus groups discussion.

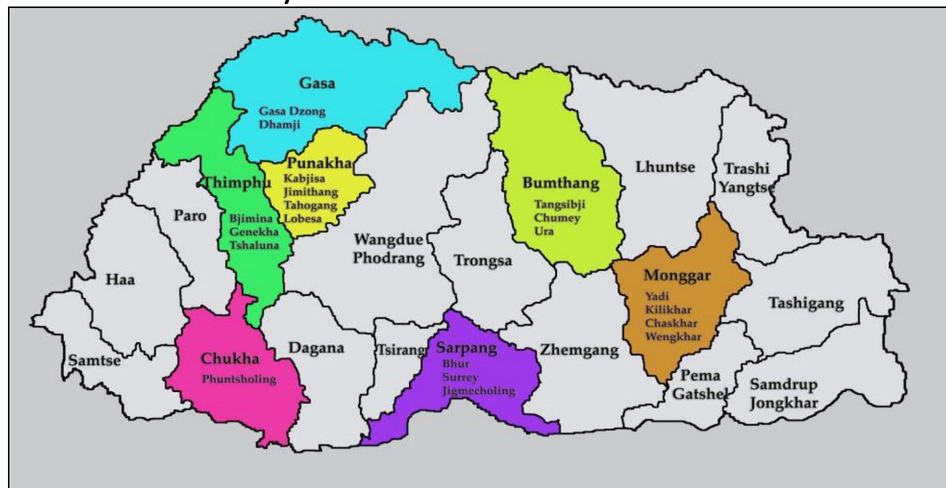
2. Quantitative Methods: Cross-sectional survey collecting behavioural data via an interviewer-administered questionnaire

A draft questionnaire was developed on the basis of themes identified during the literature review phase and in consultation with experts with local knowledge. Reference was also made to existing questionnaires used in research on adolescents and/or drug use and questionnaires used previously in Bhutan. The core themes covered in the questionnaire were; background demographics, tobacco use, alcohol use, illicit drug use, STIs and HIV, sexual behaviour and sexuality, bullying and violence, mental health and wellbeing, sources of information, and use of services and programs. The questionnaire underwent extensive revision and was further refined following a pilot testing phase. The questionnaire was piloted in Thimphu with 26 adolescents (12 Female and 14 male).

Sampling Design

In absence of mapping and information of the size of at-risk and vulnerable adolescents, the assessment was set in three regions; Western, Central, and Eastern. Based on distance and concentration of urban population in the region, different numbers of districts in each region were selected. Three districts from the western region (Thimphu, Chhukha and Punakha), one from the eastern region (Mongar) and two from central region (Bumthang and Sarpang) were selected based on the highest out of school adolescents in the respective regions as indicated in the Table 3 below. The district of Gasa was purposively selected based on limited information of adolescents from the existing studies and assessments due to its isolation. The assessment targeted only out of school adolescents since the Bhutan Narcotic Control Authority (BNCA) had carried out "The 'National Baseline Assessment' (NBA) on drugs and controlled substance use in school children in the same year.

Figure 3: Districts selected as study sites



1. Focus Group Discussion (FGD)

Nineteen focus groups were held with various categories of adolescents. In total the

focus groups comprised 86 participants between the ages of 13-18 years (46 boys and 43 girls). Participants were recruited from the following groups:

- Urban out-of-school adolescents
- Rural out-of-school adolescents
- Adolescents who use drugs and alcohol
- Drayang girls
- Monks
- Nuns
- Girls working as weavers in urban settings

The FGD took place in eight districts namely Thimphu, Punakha, Mongar, Sarpang, Bumthang, Chhukha, Gasa and Paro. Key informants from Paro and Thimphu were consulted to validate the findings from FGDs. Key informants from Paro included the gup of Dopshari, the gup of Lango, the principal and vice principal of the Drukryel higher secondary school, principal and school manager of the Kuenga private school, and an owner of pool hall. Similarly key informants from Thimphu included owners of six pool halls and monastic teachers of the central monastic body and Dechen Phodrang monastic school.

2. In-depth Interview (IDIs)

Seven IDIs were conducted. The seven interviewees were from different at risk groups and vulnerable adolescents such as drayang girls, substance abusers, out of school adolescents. The IDIs were conducted in all the seven districts.

3. Cross-Sectional Survey

Due to a lack of existing estimates for the populations of at-risks or vulnerable adolescents in Bhutan, probability random sampling was not feasible for this survey. Purposive sampling method was applied with the target of a sample size of 400. This sample size was determined based on the sample size of 300 set for the survey on Situation of the Bhutanese Youth (2005-2006). The 400 sample was at the higher estimate than the earlier survey ensuring an adequate sample size.

The total sample of 400 was distributed to seven selected districts in proportion to the size of out of school adolescents. Rural and urban areas were selected with a ratio of 30 to 70 percent of the sample size as indicated in Table 3.

Table 3: Regions, districts and total number of sample population by urban, rural

Region	District	Urban/Town	Number	Rural	Number
Western	Thimphu	Thimphu City	**75**	**Genekha, Jigmina**	**20**
	Chhukha	Phuntsholing	**75**		
	Punakha	Kuruthang	**20**		
	Gasa	Gasa town	**40**		
Central	Bumthang	Chamkhar	**25**	**Chumey, Ura**	**25**
	Sarpang	Gelephu	**30**	**Surrey, Bhur**	**30**
Eastern	Mongar	Gyelposhing	**20**	**Wengkhar, Chaskhar**	**30**
Total urban, rural			**285** **70%**		**115** **30%**
Total Sample size					**400**

The target sample size for each category of at-risk and vulnerable adolescents was determined by the team supervisors in the field. Targets were flexible and were adjusted to reflect and represent as far as possible the population size of groups in the locations sampled. The key contacts (or seeds) of different categories of at risk and vulnerable adolescents in each district were pre-identified by the District Education Officer (DEO) and the District Medical Officer (DMO). The key contact people (seeds) then used their network to identify and locate more respondents from the relevant at-risk and vulnerable categories. Following these targets, 392 questionnaires were completed, resulting in a total sample size of 392 participants.

Phase Three:
Phase three involved data collection and analysis.

1. **Data Collection**

The enumerators (data collectors) were selected based on a number of criteria including: age, previous experience, and ability to relate to at-risk young people. Prior to the data collection the enumerators were given two days training in July 2009 including practical experience in recruiting adolescent interviewees from the sample categories. This was done to ensure that the enumerators were able to find and access appropriate at-risk interviewees keeping in mind the accessibility and nature of the assessment itself.

The data collection period lasted for three weeks in August 2009. Two teams were formed with each team having one supervisor, four enumerators and one data entrant. Team A covered the districts of Thimphu, Punakha and Gasa. Team B covered districts of Mongar, Bumthang, Sarpang and Chhukha.

Nineteen FGDs, seven IDIs, and 392 survey for were completed.

2. **Data/Statistical Analysis**

Transcriptions from FGDs and IDIs were analysed to identify themes arising within the broad categories described in the discussion guides. The preliminary analysis of the first round of focus groups in Thimphu and Paro was conducted and shared, and the findings were presented to the survey team for verification. The qualitative findings were further analyzed and combined with the analysis of the quantitative data obtained from the cross sectional survey questionnaire to provide in-depth analysis.

Quantitative data from the cross-sectional questionnaire was entered in EpiInfo (version 6). The data set was then transferred into STATA 10 for analysis. Where the sample size allowed, Pearson's chi square tests were conducted to determine the statistical significance of associations between variables in the sample. Checks were made on the observed and expected counts in each cell to ensure the validity of using the Person's chi square test and only p-values below 0.05 were deemed to be statistically significant.

All percentages are calculated by first excluding missing cases for the relevant variable. Missing cases are common with survey questionnaires; that is, in the data we do not always have a response to each question from each respondent. This can be due to interviewer-error, an error of data entry, or simply that the respondent didn't answer

the question. The tables present the numbers and percentages of respondents for each category of each variable, and the total number and percentage among the entire sample is presented for the key risk variables.

Ethics: consent, confidentiality, and protection of participants

Measures were put in place to ensure that no harm was done as a consequence of the assessment for the adolescents involved. Investigators and stakeholders were provided with appropriate support and resources to ensure they could undertake their roles. Procedures to protect the confidentiality of the participants included:

- Keeping named records separate from all other detailed records (coded with a study number)
- Training young researchers to understand the critical importance of confidentiality
- Limiting access to identifiable data to appropriate team members
- Providing secure storage for interview transcripts

Strengths and Limitations of the Assessment

Strengths

1. *Adolescents Advisory Group*: An adolescent advisory group was formed to hold consultations and participate throughout the assessment process. This participatory approach through the involvement of the adolescents' advisory group allowed active participation of the target group and provided a rich insight to the lives. The involvement of adolescents through an advisory group set a precedent and followed good practice re actively engaging adolescent participates in the research. The AAG helped to identify categories of at risks and vulnerable adolescents and their locations as well as to verify the assessment results.

2. *Mixed Methodology*: The study has attempted to generate a robust set of findings, especially through the use of mixed methods of both qualitative and quantitative and verification with key informants at risks and vulnerable adolescents in Bhutan. The findings thus provide an illustration of behaviours of at risks and vulnerable adolescents and as well as provide evidence-informed direction for programming and policy.

Limitations

1. The sampling approach was necessarily based on a purposive sampling and therefore these findings do not represent general experience of risk and vulnerability for adolescents in Bhutan.

2. Due to time constraint all the categories of at risk and vulnerable adolescents identified initially could not be covered during the assessment such as at risks and vulnerable adolescents with disabilities, domestic workers, rural adolescents

who tend livestock and adolescents in closed settings (detention centres, youth development and rehabilitation centres).

3. Data collection occurred primarily in district centres (i.e. close to roads, close to police stations etc) which again may influence the size of samples of different categories, and it is likely that many of the more remote sites may have been missed. Further research would be necessary to establish the factors which influence the risk protective environments of these groups.

4. The key themes identified as problematic during the piloting phase were mental health and male to male sexual attraction. These concepts were difficult to translate both linguistically and culturally. Subtleties of meaning and cultural factors may have influenced the results and it is possible that some questions were not interpreted as intended.

5. For some survey questions, the response rate was low. Therefore caution should be used when interpreting some of the findings. All tables indicate the total number of respondents. Results were calculated based on the number of respondents who answered the question.

FINDINGS

Section 1: Socio-demographic profile of at-risk adolescents

A total number of 392 vulnerable and at-risk adolescents aged 13-18 took part in the quantitative survey. The balance between male and female respondents was slightly higher for the adolescent females with 220 (56 percent) and 172 adolescent males (44 percent). The survey included a higher number of older adolescents with just over half, 51 percent, being 18 years old. The younger age range 13-15 year olds made up 21 percent of the sample while those aged 16 - 17 comprising 28 percent of the sample.

Table 4: Participant characteristics, by gender

		Female		Male		Total	
		n	%	n	%	n	%
AGE	*13-15*	44	20%	40	23%	84	21%
	16-17	61	28%	47	27%	108	28%
	18	115	52%	85	49%	200	51%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
EDUC-ATION*	*No education*	60	27%	38	22%	98	25%
	Primary	58	26%	74	43%	132	34%
	Secondary	102	46%	60	35%	162	41%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
MOTHER TONGUE	*Dzongkha*	68	31%	61	35%	129	33%
	Nepali	58	26%	45	26%	103	26%
	Sharcho	52	24%	37	22%	89	23%
	Other	42	19%	29	17%	71	18%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
RELIGION	*Buddhist*	203	92%	154	90%	457	91%
	Hindu	17	7.7%	17	9.9%	34	8.7%
	Christian	0	0%	1	10.6%	1	0.3%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
LOCA-TION	*Urban*	108	49%	84	49%	192	49%
	Rural	112	51%	88	51%	200	51%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
MAINLY DOING NOW	*Working*	154	70%	98	57%	252	64%
	Attending school / training	39	18%	32	19%	71	18%
	Not working and not in school	27	12%	42	24%	69	18%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
LIVES WITH	*Mother*	92	42%	88	51%	180	46%
	Father	70	32%	76	44%	146	37%
	Spouse	17	7.7%	2	1.2%	19	4.8%
	Grandparents	44	20%	41	24%	85	22%
	Own children	11	5.0%	2	1.2%	13	3.3%
	Lives alone	4	1.8%	7	4%	11	2.8%
	Workplace	11	5.0%	9	5%	20	5.1%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**
EVER DON"T HAVE ENOUGH FOOD**	*Always*	11	5.0%	18	11%	29	7.4%
	Sometimes	86	39%	72	41%	158	40%
	Never	123	56%	82	48%	205	52%
	Total	**220**	**100%**	**172**	**100%**	**392**	**100%**

*The "no education" category includes 7 respondents who had received Monastic education

**Used as a proxy for poverty

Section 2: Sexuality and sexual practice

Questions regarding sexuality and sexual practice were examined by analysing self-reported responses by different key characteristics. The survey respondents were asked if they had ever had sexual (vaginal or anal) intercourse, analysed by key characteristics (Table 5) and analysed by gender (Table 6) Results from the FGDs also indicate that heterosexual activity among peers is common.

2.1 Sexual activity

Table 5: Ever had sexual intercourse, by key characteristics

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	250	64%	138	36%	388	100%	
Gender							0.021
Male	100	58%	72	42%	172	100%	
Female	150	69%	66	31%	216	100%	
Total	**250**	**64%**	**138**	**36%**	**388**	**100%**	
Age							<0.001
13-15	76	92%	7	8.4%	83	100%	
16-17	78	72%	30	28%	108	100%	
18	96	49%	101	51%	197	100%	
Total	**250**	**64%**	**138**	**36%**	**388**	**100%**	
Mother tongue							0.052
Dzongkha	95	74%	34	26%	129	100%	
Nepali	64	62%	39	38%	103	100%	
Sharcho	52	60%	35	40%	87	100%	
Other	39	57%	30	43%	69	100%	
Total	**250**	**64%**	**138**	**36%**	**388**	**100%**	
Mainly doing							<0.001
Working	152	61%	96	39%	248	100%	
School	61	86%	10	14%	71	100%	
Other	37	54%	32	46%	69	100%	
Total	**250**	**64%**	**138**	**36%**	**388**	**100%**	
Ever feel you don't have enough food (poverty proxy)							0.001
Always	14	48%	15	52%	29	100%	
Sometimes	88	56%	68	44%	156	100%	
Never	148	73%	55	27%	203	100%	
Total	**250**	**64%**	**138**	**36%**	**388**	**100%**	

Percentages were calculated excluding any missing cases.

- 36 percent (n=138) reported having had sexual intercourse, and this was associated with being male, being older, and NOT being engaged in schooling activities.
- 42 percent of males (n=72) reported having had sexual intercourse compared to 31 percent (n=66) of females.
- The mean age of first sexual intercourse was 15 (range: 8-18) for males and 16 (range: 13-18) for females.
- Among the younger adolescents (13-15 years of age), seven respondents reported having had sexual intercourse. All seven were adolescent males out of which six were 15 years of age and one was 14 years of age.
- The mother tongue of the respondents closely approached statistical significance. The direction of the relationship indicated that those whose mother tongue is

Dzongkha[♦] were less likely to report having ever had sexual intercourse.

- Education and location (urban / rural) were not associated with having heard of STIs and are not included in the table.

Table 6: Ever had sexual intercourse, by gender

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	250	64%	138	36%	388	100%	
Males							
All male respondents	100	58%	72	42%	172	100%	
Age							<0.001
13-15	33	83%	7	18%	40	100%	
16-17	34	72%	13	28%	47	100%	
18	33	39%	52	61%	85	100%	
Total	**100**	**58%**	**72**	**42%**	**172**	**100%**	
Ever feel you don't have enough food (poverty proxy)							0.001
Always	11	61%	7	39%	18	100%	
Sometimes	34	47%	38	53%	72	100%	
Never	55	67%	27	33%	82	100%	
Total	**100**	**58%**	**72**	**42%**	**172**	**100%**	
Females							
All female respondents	150	69%	66	31%	216	100%	
Age							<0.001
13-15	43	100%	0	0%	43	100%	
16-17	44	72%	17	28%	61	100%	
18	63	56%	49	44%	112	100%	
Total	**150**	**69%**	**66**	**31%**	**216**	**100%**	
Education							0.012
No education	34	59%	24	41%	58	100%	
Primary	47	84%	9	16%	56	100%	
Secondary	69	68%	33	32%	102	100%	
Total	**150**	**69%**	**66**	**31%**	**216**	**100%**	
Mainly doing							<0.001
Working	99	66%	51	34%	150	100%	
School	37	95%	2	5.1%	39	100%	
Other	14	52%	13	48%	27	100%	
Total	**150**	**69%**	**66**	**31%**	**216**	**100%**	
Ever feel you don't have enough food (poverty proxy)							0.043
Always	3	27%	8	73%	11	100%	
Sometimes	54	64%	30	36%	84	100%	
Never	93	77%	28	23%	121	100%	
Total	**150**	**69%**	**66**	**31%**	**216**	**100%**	

Note: Percentages were calculated excluding four missing cases among the female respondents.

- 42 percent (n=72) of all males reported having ever had sexual intercourse, and this was associated with being older and with poverty[101].

[♦] *Dzohngkha* is the national language of Bhutan spoken by the western Bhutanese

[101] The question in the survey "ever feel you don't have enough to eat" has been used as a proxy for poverty with "always" and "sometimes" defining poverty.

- The relationship between "mainly doing now" and "ever had sex" was approaching statistical significance for males, indicating that male out-of-school adolescents were more likely to have ever had sexual intercourse
- Education, location, mother tongue, and mainly doing now were not associated with ever having sex among males and are not included in the table.
- 31 percent (n=66) of all adolescent females reported having ever had sexual intercourse, and this was associated with being older, having no education, working and being poor.
- Location (urban / rural) and mother tongue were not associated with ever having sex among females and are not included in the table.
- Variables associated with being sexually active for adolescent females include poverty, never attending school and working.

Current sexual behaviour was further explored by analysing self-reported responses relating to penetrative sex in the past 12 months (Table 7).

Table 7: Had sex during the past 12 months, among those with a history of sexual intercourse

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	39	29%	97	71%	136	100%	
Gender							0.078
Male	25	35%	46	65%	71	100%	
Female	14	22%	51	79%	65	100%	
Total	**39**	**29%**	**97**	**71%**	**136**	**100%**	
Age							0.003
13-15	6	86%	1	14%	7	100%	
16-17	7	24%	22	76%	29	100%	
18	26	26%	74	75%	100	100%	
Total	**39**	**29%**	**97**	**71%**	**136**	**100%**	

Note: Percentages were calculated excluding two missing cases

- Of all respondents who reported to have ever had sex, 35 percent (n=25) of adolescent males and 22 percent of adolescent females reported that they did not have sex within the last 12 months.

2.2 Sexual Partners

Table 8 presents the findings about at-risk adolescents sexual activity related to the number and category of sexual partners reported.

Table 8: Number and type of sexual partners during the past 12 months*

	0 partners		1 partner		2+ partners		Total	
	n	%	n	%	n	%	n	%
Females								
Regular partner	4	8.2%	44	90%	1	2.0%	49	100%
Non-regular, non-paid	40	93%	1	2.4%	2	4.6%	43	100%
Married men	39	91%	2	4.7%	2	4.7%	43	100%
Exchange for money	38	88%	2	4.7%	3	6.9%	43	100%
Night hunted	37	86%	5	12%	1	2.3%	43	100%
Males								
Regular partner	10	23%	19	44%	14	33%	43	100%
Non-regular, non-paid	18	45%	13	33%	9	23%	40	100%
Exchange for money	27	73%	5	14%	6	14%	38	100%
Night hunter	25	63%	6	15%	9	23%	40	100%

* These numbers are based on those 51 female and 46 male respondents who reported having had sexual intercourse during the past 12 months. Each respondent was allowed to name more than one type of partner.
Note: Missing cases were frequent in each category of sexual partner so caution should be applied when interpreting this data. Percentages were calculated excluding any missing cases.

Among adolescents who reported having had sex in the last 12 months (i.e. currently sexually active), the following was found:

- Almost all females (90 percent) reported only one regular partner during the past 12 months. 77 percent of males identified a regular partner as one of their sexual partners while 33 percent reported more than one regular partner
- 28 percent of males reported having sexual intercourse with at least 1 person in exchange for money (males paying) compared with 12 percent of females (females receiving).
- 38 percent of males reported having sexual intercourse as part of night hunting with at least 1 person whom they identify as being night hunted (males hunting) compared with 14 percent of females (females hunted).
- 56 percent of males reported at least one non-regular, non-paid partner compared to 7 percent of females.

A number of FGDs and interviews explored sexual practice. Themes emerged about multiple partnerships, particularly for adolescent males. The adolescent males revealed that they often used "*lies of love*" and deception to convince girls to have sex with them, often promising marriage. The adolescent males in the FGDs and interviews described divorced women as being *"easy"* and village vegetable sellers with low education as being *"more vulnerable because they have no home and accept our lies in love for marriage".*

Many of the adolescent females in the FGDs and interviews explained that while most *drayangs* girls had a *"steady partner"* these girls knew that many of the men were already married. Despite this, they explained that there were benefits such as money, gifts, security and intimacy that came with this type of relationship. These benefits were

some of the reasons why they remained in the relationship.

> *"All girls have boyfriends… however some boyfriends are already married and are willing to pay more than 30,000 (Nu) per month without the knowledge of their wife." (17 year old female, FGD, Jakar)*

Some of the adolescent females working in *drayangs* described sexual relationships that were mostly transactional. There were strong themes that connected *drayangs* to *"easy sex"*. Girls who worked in *drayangs* were described as *"sex workers or very available for sex"* also highlighting that *"outsiders, mainly Indian men"* were common clients who would pay high rates for a night of sex. Selling sex was also reported to be common in specific hotels in border towns however young people were less likely to work or go there because these places were *"scary and dirty"*.

> *"All relations are money induced and not out of love …Those who have money are the older elite men and they openly say that they are married and want to have girlfriend for a night or two." (18 year old female, FGD drayang, Thimpu)*

2.3 Contraception and Condoms

Contraception use was explored by analysing self-reported responses relating to penetrative sex in the past 12 months with the (Table 9).

Table 9: Use of contraception, by gender

	Yes		No		Total	
	n	%	n	%	n	%
Female						
With spouse	38	64%	21	36%	59	100%
*With non-regular partner(s)**	13	59%	9	41%	22	100%
Male						
At last sexual intercourse	46	69%	21	31%	67	100%

* Only 22 of the 66 females with a history of sexual intercourse responded to this question so caution should be applied when interpreting this data, however, some confidence can be had given that the percentage obtained fits closely to the other results.
Note: Different questions were asked of males to those asked of females. Percentages were calculated excluding any missing cases.

- Approximately 60-70 percent of the sexually active adolescent males and females surveyed reported using contraception with adolescent males reporting more condom use at last sex (69 percent) compared to adolescent females (59%) at last sex with a non-regular partner.
- Almost all respondents identified condoms as the contraceptive being used. A very small numbers (i.e. < 5) of respondents identified using other contraceptive options including birth control pills, the withdrawal method, or an injection (DPMA).

In addition to contraception use, contraception preference was further examined through the FGDs and interviews. While condoms were cited as the contraception of choice and respondents appeared to understand the link between condoms and prevention of infection, many males maintained that condoms reduced pleasure. Myths

associated with condoms, virginity and safety were explored and gender-norms examined.

Adolescent males from one FGD from Gelephu explained that *"they only used condoms if they were suspicious about the girl being sexually active. However, if the girl was thought to be a virgin and safe, then they did not use condoms".*

While knowledge of sexual health and contraceptives was very high, young people explained that condom use was *"not easy"* within a regular relationship because condoms were used mainly to prevent disease and therefore was an indication of *"distrust".* Several males in FGDs explained that their girlfriends did not want to use condoms.

"*I use condom when I have sex with unknown peoples. I don't use this with my girlfriend but with the fear of getting pregnant I let my girlfriend to consume pills." (17 years old male, interview, Monggar)*

Despite high knowledge and condoms being available free from the government, there were several barriers to consistent use of condoms. Some people described situations where they were *"not prepared for sex",* that it was *"the boys responsibility to carry the condom"* and that *"it was embarrassing"* to get condoms from the health centre or to buy them from the medical shops. Many male respondents also explained that condoms reduced pleasure and *"marginalised the ecstasy of love-making"*

2.4 Same sex attraction

Same sex attraction was examined through self-reported responses in the survey and through focus group discussions. Male respondents were asked about same sex attraction (Table 10) and specifically about penetrative sex with other men.

Table 10: Sexually attracted to other males

	n	%
No	149	87%
Yes	18	11%
No response	2	1.2%
Don't know	1	0.6%
Total	**170**	**100%**

Note: Percentages were calculated excluding two missing cases.

- 11 percent (n=18) of the male respondents reported to having been sexually attracted to another man.
- 2 males reported having been receptive to anal intercourse, and 2 reported having been in the penetrative position.

Caution is needed interpreting these results as some misunderstanding of the question may have occurred. One of the respondents who reported male sex, also reported he had sex as a both a penetrative and receptive partner. Both these males reported 2

male partners in the last 6 months, that they had never used a condom with these partners and that the sex was in exchange for money or payment in-kind.

Through FGDs, monks explained that sex between boys in the monastery was "*common"* and that emotional relationships between the boys developed. Monks reported sex between boys as *"thigh sex"* that is a non-penetrative form of sex.

While survey respondents were not asked about their attitudes to same sex attraction, males from several focus groups said they thought male sex was *"unnatural"* and a *"foreigner thing"*, explaining that *"some Indian labourers do it".*
One FGD with out-of-school adolescents in Paro reported that they knew of male and female adolescents involved in same sex activity but were unable to provide details of same sex social and/or sexual networks. It was explained that if this activity was happening, it would be in private.

2.5 Pregnancy

Pregnancy and abortion questions were examined by analysing self-reported responses.

- 47 percent (n=31) of adolescent females who have had sexual intercourse reported having been pregnant. Of those, only 2 reported having had a termination.
- These figures are mysterious given that; only 11 women reported that they were currently living in a household with a child.

Students in a FGD admitted that they knew of some girls who had become pregnant and had to leave school. They reported that they thought this was because the school authorities would not allow the girls to remain in the school while they were pregnant and because the girls themselves were *"shy"* and "*embarrassed"* and did not want to remain in school. Despite liberal attitudes to sex, there is stigma attached to being pregnant without being married with several participants claiming it was *"risky to the girl's mental health".*

> *"Getting pregnant without getting married is a shame in this society." (16 year old female, FGD students, Kuenga)*

The FGDs revealed very high and detailed knowledge on sexual reproductive health, including emergency contraception and abortion. Emergency contraception *"i-pills"* was reported to be very easy to access.

> *"Today there are many methods of getting abortion. I hear most girls consuming I-pills to get rid of pregnancy. Some do abortion by undergoing surgery in Jaigon. They are more scared of getting blamed than the danger of surgery so no matter the difficulty they try managing to get rid of the pregnancy." (17 year old female, FGD, Phuntsholing)*

In some instances, participants talked of family members looking after babies for several reasons including the mother being *"too young"*, *"unmarried"* or *"unable to look after* [the baby]*"*.

> *"My baby is with my parents in Thimphu. My parents kept her since I went to jail over a year ago." (20 year old female, recovering addict released from jail)*

2.6 Risky sexual contacts

Risky sexual contacts were examined by analysing self-reported responses Table 11). There are a number of vulnerable situations that can increase the chance of risky sex. One night stands, sexual harassment and forced sex are three situations of interest that were examined. The relationship between alcohol and sex will be explored later.

Table 11: Risky sexual contacts, by gender

	Female		Male		All respondents	
	n	%	n	%	n	%
Ever had a one night stand*						
No	57	88%	47	66%	104	77%
Yes	8	12%	24	24%	32	24%
Total	65	100%	71	100%	136	100%
Ever been sexually harassed**						
No	158	72%	--	--	--	--
Yes	62	28%	--	--	--	--
Total	220	100%	--	--	--	--
Ever been forced into sexual intercourse+						
No	193	93%	157	95%	350	94%
Yes	15	7.2%	8	4.8%	23	6%
Total	208	100%	165	100%	373	100%

* Question on one-night stand was only asked of those respondents who reported having had sexual intercourse. Percentages were calculated excluding two missing cases.
** Question on sexual harassment was only asked of females.
+ Question on forced sexual intercourse was asked of all respondents. Percentages were calculated excluding 19 missing cases.

- 56 percent of those who have had a one night stand on at least one occasion reported using condoms at least sometimes on these occasions.
- The sources of sexual harassment of adolescent girls were: friends (79 percent, n=49), strangers (27 percent, n=17) and relatives (16 percent, n=10).
- 7.2 percent (n=15) of females and 4.8 percent (n=8) of males reported having been forced into sexual intercourse. The sources of the forced sexual intercourse were; friends (35 percent, n=8), strangers (48 percent, n=11) and relatives (13 percent, n=3)
- Of those 23 respondents who had been forced into sexual intercourse, 43.5 percent (n=10) reported that this had occurred on more than one occasion.
- There was not a strong relationship between women who report sexual experiences through night hunting and adolescent females who report forced sex.

Drayangs emerged as significantly risky settings for adolescent girls. The participants in the FGDs and interviews commonly described the girls who worked in the *drayangs* as *"seen to be bad and easily accessible for sex"*. The girls who work in *drayangs* gave

detailed examples of how their work environment was not safe, explaining that they were often harassed and *"tortured"* by males. Some *drayang* girls choose to live together to offer protection for each other.

These girls appear to be at high risk of abuse and violence. Although the legal age to work in the *drayang* is 18 years of age, many knew of girls as young as 16 years who lie because they need the money. The *drayang* owners are known to *"go out and find the unemployed girls".*

Adolescent female participants gave numerous examples of *"eve teasing"*, where groups of males would tease girls and make sexual jokes. They explained that they did not feel safe, especially in the evenings. Several girls mentioned that they *"prayed for it [rape] not to happen".* While some girls talked of their distrust of the police who they had seen harass and sexually tease young girls, others talked favourably and explained that police presence at night made them feel safe and protected from the teasing boys.

> *"Rape and violent sex happened because of fewer defences from young girls… they feel insecure and are worried about rape and don't go out in the evening. They said that this can happen any time of the day and are not secure even with the presence of the police." (16 years old female, FGD weavers, remote village)*

2.7 Sexually transmitted infections and HIV

Knowledge of STIs and HIV were examined by analysing self-reported responses to the survey and through focus group discussions (Table 12, Table 13 and Table 14).

Knowledge of HIV and STIs was further explored through FGDs and interviews. The majority of participants demonstrated very high and detailed understanding of transmission and the majority of participants could name HIV, syphilis and gonorrhoea as STIs and understood that *"condoms protect against disease".* Some of the younger participants had incomplete or incorrect knowledge of some symptoms, particularly around HIV transmission, explaining that *"HIV could be transmitted by sharing a towel".*

Table 12: Proportion of respondents who had heard of STIs, by key characteristics

	No		Yes		Total		p-value
	n	%	N	%	n	%	
All respondents	57	15%	335	86%	392	100%	
Gender							0.566
Male	27	16%	145	84%	172	100%	
Female	30	14%	190	86%	220	100%	
Total	**57**	**15%**	**335**	**86%**	**392**	**100%**	
Age							<0.001
13-15	25	30%	59	70%	84	100%	
16-17	14	13%	94	87%	108	100%	
18	18	9.0%	182	91%	200	100%	
Total	**57**	**15%**	**335**	**86%**	**392**	**100%**	
Education							<0.001
No education	25	26%	73	75%	98	100%	
Primary	25	19%	107	81%	132	100%	
Secondary	7	4.3%	155	96%	162	100%	

Total	**57**	**15%**	**335**	**86%**	**392**	**100%**	
Ever had sex							
Yes	14	10%	124	90%	138	100%	0.06
No	43	17%	207	83%	250	100%	
Total	**57**	**17%**	**331**	**85%**	**388**	**100%**	

Note: Percentages were calculated excluding any missing cases

- The vast majority (86 percent, n=335) of respondents had heard of STIs. There were no statistically significant differences based on gender or mother tongue, but significant differences based on age, education and sexual history.
- 7.0 percent (n=12) of males and 7.0 percent (n=15) of females reported having had an STI
- Of those 335 respondents who had heard of STIs, 79 percent (n=264) reported that they could name a specific STI. There was no association between responses to this variable and age, education, gender, mother tongue or history of sexual intercourse.
- Gender, mother tongue and poverty were not associated with having heard of STIs and are not included in the table.

Table 13: Proportion of respondents who had heard of HIV, by key characteristics

	No		**Yes**		**Total**		**p-value**
	n	**%**	**n**	**%**	**n**	**%**	
All respondents	24	6.1%	368	94%	392	100%	
Gender							0.822
Male	10	5.8%	162	94%	172	100%	
Female	14	6.4%	206	94%	220	100%	
Total	**24**	**6.1%**	**368**	**94%**	**392**	**100%**	
Age							0.003
13-15	11	13%	73	87%	84	100%	
16-17	8	7.4%	100	93%	108	100%	
18	5	2.5%	195	98%	200	100%	
Total	**24**	**6.1%**	**368**	**94%**	**392**	**100%**	
Education							0.001
No education	10	10%	88	90%	98	100%	
Primary	13	9.8%	119	90%	132	100%	
Secondary	1	0.6%	161	99%	162	100%	
Total	**24**	**6.1%**	**368**	**94%**	**392**	**100%**	
Mother tongue							0.098
Dzongkha	13	10%	116	90%	129	100%	
Nepali	6	5.8%	97	94%	103	100%	
Sharcho	2	2.2%	87	98%	89	100%	
Other	3	4.2%	68	96%	71	100%	
Total	**24**	**6.1%**	**368**	**94%**	**392**	**100%**	
Ever had sex							0.015
Yes	3	2.2%	135	98%	138	100%	
No	21	8.4%	229	92%	250	100%	
Total	**24**	**6.2%**	**364**	**94%**	**388**	**100%**	

Note: Percentages were calculated excluding any missing cases

- The vast majority (94 percent, n=368) of respondents had heard of HIV. There were no statistically significant differences based on gender or mother tongue, but there

were small (and statistically significant) differences between the categories of age, education and sexual history.

- 13 percent (n=50) of respondents reported having had an HIV test. This was higher among people with a history of sexual intercourse (24 percent, n=33) compared to those who were not sexually active (7 percent, n=17).
- Being poor was not associated with having heard of HIV.

Table 14: Proportion agreeing with various true and false statements about HIV transmission, by education level

True statements	True			False statements	True		
	n	%	p-value		n	%	p-value
By using a needle / syringe that has already been used by someone else			<0.001	From a mosquito that has bitten an HIV infected person			0.805
No education	28	29%		*No education*	68	69%	
Primary	51	39%		*Primary*	88	67%	
Secondary	126	78%		*Secondary*	106	65%	
Total	**205**	**52%**		***Total***	**262**	**67%**	
By having sex just once without a condom			0.007	By sharing food or drinks with an HIV infected person			<0.001
No education	69	70%		*No education*	33	34%	
Primary	96	74%		*Primary*	41	31%	
Secondary	138	85%		*Secondary*	24	15%	
Total	**303**	**77%**		***Total***	**98**	**25%**	
Through HIV infected blood products			<0.001	Kissing an HIV infected person			0.018
No education	29	30%		*No education*	46	47%	
Primary	55	42%		*Primary*	46	35%	
Secondary	111	69%		*Secondary*	48	30%	
Total	**195**	**50%**		***Total***	**140**	**36%**	
From an HIV infected mother to her child during pregnancy, child birth or breastfeeding			<0.001	Wearing the clothes of an HIV infected person			0.015
No education	14	14%		*No education*	33	34%	
Primary	25	19%		*Primary*	34	26%	
Secondary	67	41%		*Secondary*	29	18%	
Total	**106**	**27%**		***Total***	**96**	**25%**	

Note: Percentages were calculated excluding any missing cases

- Only 29 percent of respondents with no education knew that HIV can be transmitted through sharing needles / syringes.
- Respondents living in urban centres have higher levels of accurate knowledge of HIV transmission, especially in regard to transmission through needles and syringes; through having unprotected sex and through infected blood products.
- Only 27 percent of the sample knew that HIV could be passed from a mother to her child during pregnancy and this was as low as 14 percent in those with no education.

Section 3: Tobacco, alcohol and drugs

Tobacco, alcohol and drug use was explored by analysing self-reported responses to the survey and through FGDs. The use of tobacco, alcohol and drugs among peer and friendship networks was reported by all FGDs, the exceptions being monks and nuns. Use of tobacco, alcohol and illicit drugs was found to be significantly higher among respondents (FGD and survey) living in urban towns than among those living in villages.

It is interesting that FGD participants estimated the use of tobacco, alcohol and drugs to be higher than reported by survey respondents. FGD participants between the ages of 15-18 years of age estimated that between 40 - 65 percent of young people they knew used illicit drugs; 30-70 percent used alcohol and between 65 - 70 percent were cigarette smokers. In contrast, the survey found that only 8 percent had ever smoked marijuana, about 21 percent had used alcohol during the last four weeks and 30 percent had ever used tobacco. This discrepancy requires further research.

The FGD and interviews explored the reasons why at-risk adolescents use drugs and alcohol. While most of the adolescent females working in *drayangs* use alcohol and smoke tobacco, drugs and alcohol were mainly used by adolescent males. The FGDs and interviews explained that different people use different drugs for different reasons and that the choice of the drug depended on the situation or context.

> *"For me there is a vast difference between consumption of alcohol and drugs. After smoking marijuana, I want to sleep and go to bed. But when I consume alcohol, I get aggressive and get involved in fights and create problems." (17 year old male, FGD, Thimpu)*

3.1 Tobacco

The survey found that just under a quarter of respondents smoked every day and having ever smoked tobacco was associated with being male, being older and living in an urban area (Table 15 and Table 16).

Table 15: Tobacco consumption behaviour, by gender

	Female		Male		Total	
	n	**%**	**n**	**%**	**n**	**%**
Frequency of smoking (over last 4 weeks)						
Have never smoked tobacco	178	81%	95	55%	273	70%
Less than once a week	0	0.0%	2	1.2%	2	0.5%
At least once a week	6	2.7%	23	13%	29	7.4%
Everyday	36	16%	52	30%	88	22%
Total	220	100%	172	100%	392	100%
Source of tobacco*						
Shops	35	83%	66	86%	101	85%
Friends	21	50%	53	69%	74	62%
Other	0	0.0%	4	5.2%	4	3.4%

* Multiple responses allowed. Percentages were calculated based on the 119 respondents who reported having consumed tobacco (42 females and 77 males)

Note: Percentages were calculated excluding any missing cases.

- The mean age at first cigarette was 15 years of age (16 years of age for females and 14 years of age for males).
- Respondents who smoked *at least once a week* or *everyday* were more likely to know people who also smoked. The inverse was also true with those reporting not smoking, less likely to have friends who smoked.
- Participants in the focus group discussions reported very high rates of smoking among their peers.

Table 16: Ever smoked, by key characteristics

	Never smoked		Smoked		Total		p-value
	n	%	n	%	n	%	
All respondents	273	70%	119	30%	392	100%	
Gender							<0.001
Male	95	55%	77	45%	172	100%	
Female	178	81%	42	19%	220	100%	
Total	**273**	**70%**	**119**	**30%**	**392**	**100%**	
Age							<0.001
13-15	75	89%	9	11%	84	100%	
16-17	75	69%	33	31%	108	100%	
18	123	62%	77	39%	200	100%	
Total	**273**	**70%**	**119**	**30%**	**392**	**100%**	
Education							0.099
No education	75	77%	23	24%	98	100%	
Primary	94	71%	38	29%	132	100%	
Secondary	104	64%	58	26%	162	100%	
Total	**273**	**70%**	**119**	**30%**	**392**	**100%**	
Location							<0.001
Urban	108	56%	84	44%	192	100%	
Rural	165	83%	35	18%	200	100%	
Total	**273**	**70%**	**119**	**30%**	**392**	**100%**	

Percentages were calculated excluding any missing cases.

- Having ever smoked tobacco was associated with being male, being older, and living in an urban area. While as many as 45 percent of the adolescent males had ever smoked tobacco only 19 percent of the adolescent females had ever smoked tobacco.
- There was no significant association between being aware of the dangers of smoking and having ever smoked (p=0.854).
- Mother tongue was not associated with having ever smoked and is not included in the table.

3.2 Alcohol

Alcohol use was examined by analysing self-reported responses to questions asking how often respondents had consumed alcohol in the last 4 weeks (Table 17).

Relatively low levels of alcohol consumption were reported across both sexes, with higher levels of drinking reported among male participants. This is in contrast to the levels of alcohol use reported by male FGD participants among their peers in the 15-18 year age range. When asked how many of their friends and peers used alcohol on a regular (at least once a week) basis estimates among the male focus group participants ranged between 30-70 percent, with proportions increasing with older male adolescents. One school-based focused group reported that some students, mostly boys, bring *Ara* (a local alcohol) to school in water bottles and get drunk.

Table 17: Alcohol consumption, source of alcohol and reason for drinking

	Female		Male		All respondents	
	n	%	n	%	n	%
Frequency of alcohol consumption						
Never consumed alcohol	193	88%	115	67%	308	79%
Less than once a week	10	4.5%	7	4.1%	17	4.3%
At least once a week	14	6.4%	38	22%	52	13%
Everyday	3	1.4%	12	7.0%	15	3.8%
Total	220	100%	172	100%	392	100%
Source of alcohol**						
Bar	16	59%	45	54%	61	73%
Friends	11	41%	26	46%	37	44%
Shop	4	15%	29	51%	33	39%
Family	9	33%	15	26%	24	29%
Reason for drinking**						
Makes me happy	16	59%	40	70%	56	67%
Makes me brave	10	37%	34	60%	44	52%
To lose control	7	26%	19	33%	26	31%

* Multiple responses allowed. Percentages are based on the 84 respondents who reported having ever consumed alcohol (27 women and 57 men)

- The large majority of at-risk adolescent females (88 percent, n=193) report never consuming alcohol while (67, n=115) percent of the at-risk adolescent males sample also report never consuming alcohol.
- The mean age at first alcohol drink was 15 years of age (14 years of age for males and 15 years of age for females)
- 22 percent of the at-risk adolescent males and 6.4 percent of the at-risk adolescent females reported to drink at least once a week
- Of those reporting to drink they do so with friends and access alcohol mainly from bars 59 percent of females and 54 percent of males. 44 percent of adolescent drinkers reported accessing alcohol from friends.
- Of the older male adolescents drinkers (aged 18) ten percent reported to drink every day compared with only one per cent of the at-risk adolescent female sample.
- The most commonly reported reason for drinking by adolescent males and females was to make themselves happy (males 70 percent, females 59 percent). 60 percent of males also reported that drinking "*makes them brave*" while 30 percent of adolescent females reported drinking "*makes them brave*"

Associations between participant characteristics and alcohol consumption were further explored (Table 18).

Table 18: Ever consumed alcohol, by key characteristics

Characteristic	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	308	79%	84	21%	392	100%	
Gender							<0.001
Male	115	67%	57	33%	172	100%	
Female	193	88%	27	12%	220	100%	
Total	**308**	**79%**	**84**	**21%**	**392**	**100%**	
Age							<0.001
13-15	79	94%	5	6.0%	84	100%	
16-17	79	73%	29	27%	108	100%	
18	150	75%	50	25%	200	100%	
Total	**308**	**79%**	**84**	**21%**	**392**	**100%**	
Location							0.002
Urban	138	72%	54	28%	192	100%	
Rural	170	85%	30	15%	200	100%	
Total	**308**	**79%**	**84**	**21%**	**392**	**100%**	
Mother tongue							<0.001
Dzongkha	114	88%	15	12%	129	100%	
Nepali	87	85%	16	17%	103	100%	
Sharchop	59	66%	30	34%	90	100%	
Other	48	68%	23	32%	70	100%	
Total	**308**	**79%**	**84**	**21%**	**392**	**100%**	

Note: Percentages were calculated excluding any missing cases.

- Having ever consumed alcohol was associated with being male, being above 15 years, living in an urban area, and having a mother-tongue other than *dzongka*, the national language.
- There was no significant association between awareness of the dangers of alcohol and reported drinking behaviour (p=0.528).
- Education was not associated with having ever consumed alcohol and was not included in the table.

3.3 Drugs

History of drug use and patterns of consumption were examined by analysing self-reported responses to questions. Marijuana use and using inhalants was further examined through self-reported responses and analysed by key characteristics (Table 20 and Table 22).

Table 19: History of trying particular drugs, by gender

	Female		Male		All respondents	
	n	%	n	%	n	%

Marijuana	1	0.5%	31	18%	32	8.2%
Used inhalants*	1	0.5%	27	16%	28	7.1%
Prescription drugs	3	1.4%	12	7.0%	15	3.8%
Ever injected drugs**	5	2.3%	3	1.7%	8	2.0%
Heroin brown sugar	0	0.0%	3	1.7%	3	0.8%

* Substances indicated to respondents included dendrite, petrol or correction fluid

** Drugs injected for non-medical purposes

Note: This is a multiple response question. Percentages for each category of drug are calculated based on the total sample of 392 respondents (220 female and 172 male)

- Very few adolescent female survey respondents reported having tried marijuana, inhalants or prescription drugs
- 18 percent (n=31) of males have smoked marijuana and 16 percent (n=27) have used inhalants and 7 percent (n=12)
- Of note is that 5 adolescent females (2.3 percent) reported to have injected drugs compared to only 3, or 1.7 percent of adolescent males reporting to have done so.

3.3.1 Marijuana

Table 20: Ever smoked marijuana, by key characteristics

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	360	92%	32	8%	392	100%	
Gender							<0.001
Male	141	82%	31	18%	172	100%	
Female	219	99%	1	0.5%	220	100%	
Total	360	92%	32	8%	392	100%	
Age							0.074
13-15	82	98%	2	2.4%	84	100%	
16-17	99	92%	9	8.3%	108	100%	
18	179	90%	21	11%	200	100%	
Total	360	92%	32	8%	392	100%	
Education							0.013
No education	96	98%	2	2.0%	98	100%	
Primary	122	92%	10	7.6%	132	100%	
Secondary	142	88%	20	12%	162	100%	
Total	360	92%	32	8%	392	100%	
Location							0.002
Urban	168	88%	24	13%	192	100%	
Rural	192	96%	8	4.0%	200	100%	
Total	360	92%	32	8%	392	100%	
Mainly doing							<0.001
Working	241	96%	11	4.4%	252	100%	
School	68	96%	3	4.2%	71	100%	
Other	51	74%	18	26%	69	100%	
Total	360	92%	32	8%	392	100%	

Note: Percentages were calculated excluding any missing cases.

- Having ever smoked marijuana was associated with being male, being older, having higher levels of education (however this could be more related to age), living in an urban area, and being engaged in neither work nor school.
- 74 percent (n=163) of female respondents reported that none of their friends smoke marijuana, compared to 45 percent (n=77) of male respondents.
- Of those 32 people who had used marijuana, 94 percent (n=30) reported being introduced to it by friends, and 28 percent (n=9) reported using marijuana because it was cheaper than tobacco / cigarettes.
- 3.3 percent (n=12) of all respondents reported that a parent or guardian smokes marijuana.
- Mother tongue was not associated with having ever smoked marijuana and is not included in the table.

Table 21: Frequency of smoking marijuana

	n	%
How often do you smoke marijuana		
Everyday	12	38%
At least once a week	17	53%
At least once a month	1	3.1%
Once a year	2	6.3%
Total	**32**	**100%**

Note: Percentages were calculated excluding any missing cases.

- Of those 32 adolescents who have smoked marijuana, 91 percent (n=29) reported smoking regularly (i.e. at least once a week or every day).
- The mean age of first smoking marijuana was 15 years of age (range: 10-18).

3.3.2 Inhalants

Table 22: Ever used inhalants, by key characteristics

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	364	93%	28	7.1%	392	100%	
Gender							<0.001
Male	145	84%	27	16%	172	100%	
Female	219	99%	1	0.5%	220	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	
Age							0.046
13-15	83	99%	1	1.2%	84	100%	
16-17	100	93%	8	7.4%	108	100%	
18	181	91%	19	9.5%	200	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	
Education							0.003
No education	96	98%	2	2.0%	98	100%	
Primary	126	96%	6	4.5%	132	100%	
Secondary	142	88%	20	12%	162	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	
Location							0.014

Urban	172	90%	20	10%	192	100%	
Rural	192	96%	8	4.0%	200	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	
Mainly doing							<0.001
Working	242	96%	10	4.0%	252	100%	
School	68	96%	3	4.2%	71	100%	
Other	54	78%	15	22%	69	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	
Ever used marijuana							<0.001
Yes	8	25%	24	75%	32	100%	
No	356	99%	4	1.1%	360	100%	
Total	**364**	**93%**	**28**	**7.1%**	**392**	**100%**	

Note: Percentages were calculated excluding any missing cases.

- Having ever sniffed substances like dendrite, petrol of correction fluid was associated with being male, being older, having higher levels of education (however this could be more related to age), living in an urban area, and being engaged in neither work nor school.
- There was also a strong association between having ever smoked marijuana and having ever used inhalants. 75 percent (n=24) of people who have smoked marijuana have also used inhalants.
- 17 percent (n=68) of respondents reported that their friends used inhalants like dendrite, petrol or correction fluid.
- Mother tongue was not associated with having ever used inhalants and is not included in the table.

Table 23: Frequency of using inhalants

How often did you use inhalants during the past 4 weeks		
4 or more times per day	1	3.6%
2-3 times per day	1	3.6%
2-3 times per week	7	25%
About once a week	5	18%
Never	14	50%
Total	**28**	**100%**

Note: Percentages were calculated excluding any missing cases.

- Of those 28 adolescents who have used inhalants, 50 percent (n=14) had not inhaled such substances during the past 4 weeks.

3.3.3 Injecting drug use

The survey identified 2 percent (n=8) respondents who reported ever injecting drugs (males: 1.7 percent, females: 2.3 percent) (Table 21). Focus groups with recovering drug users reported knowing of people who injected heroin in Thimpu.

Over one third of survey respondents were not aware of the dangers of injecting drug use. Of the eight respondents reporting ever injecting drugs using a needle and syringe for non-medical purposes, the average length of time was three years. When respondents who reported ever injecting were asked about how often, in the past month they had injected with a needle that no one else had ever used, one adolescent male and one adolescent female reported they did not know and two adolescent males and three adolescent females reported never. When asked about the reasons why they initiated injecting drugs, five females and one male reported they had been introduced by friends, three females reported curiosity, and one female and one male reported not knowing why.

Alcohol and drug use were further explored through FGDs, particularly exploring pathways to drug use with many participants describing peer influence, family stress, boredom and loneliness as vulnerability factors. Some participants from rural areas described using alcohol as a way of *"relaxing after chasing yaks all day and to keep warm".*

"Students go on drugs because of their friends through influence and through family problems and stress at home. Dropouts go on drugs because they have nothing to do. They are bored at home." (16 year old male, FGD, Thimpu)

Knowledge of the risks of drugs and alcohol was very high and participants were able to explain the negative health outcomes in great detail. Those participants who admitted to heavy use of alcohol and other drugs explained that they *"had no motivating factor to stop drugs"* because it was "*difficult to get a job"* and *"people look down on us".*

Section 4: Bullying and violence

4.1 Bullying

Bullying was examined by analysing self-reported responses to questions (Table 24). Themes of violence and safety (in the context of bullying) were further explored through focus group discussions. Violence and bullying in schools was a common theme explored through FGDs.

Table 24: History of being bullied, by key characteristics

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	189	49%	201	52%	390	100%	
Gender							0.044
Male	73	43%	98	57%	171	100%	
Female	116	53%	103	47%	219	100%	
Total	**189**	**49%**	**201**	**52%**	**390**	**100%**	
Age							0.124
13-15	49	58%	35	42%	82	100%	

16-17	49	46%	58	54%	108	100%	
18	91	46%	108	54%	200	100%	
Total	**189**	**49%**	**201**	**52%**	**390**	**100%**	
Education							0.012
No education	57	58%	41	42%	98	100%	
Primary	68	52%	64	49%	131	100%	
Secondary	64	40%	96	60%	161	100%	
Total	**189**	**49%**	**201**	**52%**	**390**	**100%**	
Location							0.019
Urban	81	42%	110	58%	191	100%	
Rural	108	54%	91	46%	199	100%	
Total	**189**	**49%**	**201**	**52%**	**390**	**100%**	
Mother tongue							0.020
Dzongkha	76	59%	53	41%	128	100%	
Nepali	39	39%	62	61%	103	100%	
Sharcho	41	46%	48	54%	89	100%	
Other	33	47%	38	54%	70	100%	
Total	**189**	**49%**	**201**	**52%**	**390**	**100%**	

Note: Percentages were calculated excluding any missing cases.

- A total of 52 percent of survey respondents reported that they had been bullied, with a slightly higher proportion of adolescent males (57 percent) than adolescent females (47 percent). Bullying appears to be more common among adolescents above 15 years of age, among Nepali speaking and in urban areas.
- School is reported as the place where most bullying occurred followed by in the street (gangs) for males and the workplace for females.
- Adolescent males were more likely to be hit (20 percent) than adolescent females (9 percent) and females were more likely to experience gossip as bullying than males.
- Mainly doing now (occupation) was not associated with having a history of being bullied and is not included in the table.

Beating of school students by teachers was mentioned as common by the male participants and by young monks who reported they where occasional beatings from their teachers (using a leather strap) when they were caught breaking the rules or not studying hard enough. One FGD of monks reported that some monks run away from the monastery when they feel they have been beaten too many times and on their return they are beaten for running away. Monks of Trashichhodzong talked about how bullying and beatings had been common in the past but was now very reduced.

Overwhelmingly fellow students and peers where reported to be the perpetrators of bullying. A FGD of school-based 13 and 14 year old adolescent females reported that they all typically experienced harassment from boys, even those younger than themselves. They noted that this form of behaviour was learned from the older male students.

4.2 Violence

Violence was examined by analysing self-reported responses to questions (Table 25). Themes of violence and safety (in the context of physical fights) were further explored through FGDs.

Table 25: History of physical fights in the last six months, by key characteristics

	No		Yes		Total		p-value
	n	%	n	%	n	%	
All respondents	326	84%	64	16%	390	100%	
Gender							<0.001
Male	130	76%	41	24%	171	100%	
Female	196	90%	23	11%	219	100%	
Total	**326**	**84%**	**64**	**16%**	**390**	**100%**	
Age							0.412
13-15	66	81%	16	20%	82	100%	
16-17	88	82%	20	19%	108	100%	
18	172	86%	28	14%	200	100%	
Total	**326**	**84%**	**64**	**16%**	**390**	**100%**	
Location							0.004
Urban	149	78%	42	22%	191	100%	
Rural	177	89%	22	11%	199	100%	
Total	**326**	**84%**	**64**	**16%**	**390**	**100%**	
Mainly doing							0.023
Working	217	86%	35	14%	252	100%	
School	59	86%	10	15%	69	100%	
Other	50	73%	19	28%	69	100%	
Total	**326**	**84%**	**64**	**16%**	**390**	**100%**	

* Education and mother tongue were not associated with a history of being in a physical fight in the last six months and are not included in the table.

Note: Percentages were calculated excluding any missing cases.

A total of 16 percent of all at-risk adolescents in the survey reported that they had been involved in physical fights in the last six months. Double the percent of adolescent males (24 percent) had been involved in physical fights compared to adolescent females (11 percent). Being involved in physical fights appears to be more common among urban at-risk adolescents and those neither in work nor school.

All FGDs reported fear of violence resulting from peers acting under the influence of alcohol and drugs. There appeared to be little difference among the groups on this issue. Carrying of weapons was reported by a number of participants and the acceptance of carrying and using weapons especially by young men suggests a community risk.

> *"Youth carry knife especially Rambo knife, various types of knuckles, sticks and chains. Some carry these weapons to use it in a fight and hurt the opponent. Some carry it to protect themselves if someone attacks them. When there are fights in the pool and snooker halls, cue-sticks are used. Bottles are also used in bars. Foster's bottle is most commonly used as it is easy to break." (16 year old male, FGD, Paro)*

Gangs were more typically all male but one FGD of all female school students reported that "*in the area of their school there were several all girl gangs and that gang membership was most common among girls in classes 9-12. "* Participants and interviewees were also aware that levels of gang and street violence were significantly reduced when there was a police presence.

> *"Exchange of some words with those boys creates more problems. They are afraid but feel safe due to presence of police patrolling." (16 year old female, FGD darayang, Thimpu)*

Section 5: Mental health and well-being

For the poorest adolescents in the sample the feelings of self-esteem and well-being relied on basic needs being met. The following quote is taken from an interview with a 13 year old boy who has never attended school and works in the fields attending non-formal education (NFE) in the evening.

> *"When parents bring home food to eat and clothes for us to wear and when the families have enough to sustain us we become happy." (13 year old male, interview, Monggar)*

Gangs were discussed during many of the FGDs and while discussions were often framed around the negative effects of violence, for many males, gang membership provides a sense of "*belonging to a community"*, missing for many who are living away from the parents and families of origin.

Many of the participants in FGDs (out-of-school adolescents; drug users and young women working in the *drayangs*) reported not having completed formal education as the underlying factor leading to feelings of low self-esteem and "*worthlessness"*. The majority of girls working in the *drayang* explained that they wanted to finish their education but were unable to attend non formal education (NFE) evening classes

because of the conflict with work. They explained that there wasn't much motivation in their lives.

> *"Most are de-motivated. They did not bother about the drugs and sex and all related stuff because they said at least one day they have to die." (18 year old female, FGD drayang, Thimpu)*

The discussions elicited a number of common concerns among adolescents, these included:

- Family arguments and tension, particularly with parents
- Difficulties in romantic relationships, particularly when relationships break-up
- Lack of money and status
- Lack of food and shelter
- Boredom and a sense of failure for those who have dropped out of school
- Lack of jobs and opportunities
- Job insecurity
- Prospects for the future

Section 6: Information, services and programs

Programs and services were examined by analysing self-reported responses. 30 percent of survey respondents identified education/school as services they considered to be most important, followed by the hospital (20 percent) and the Basic Health Units (10 percent). Approximately 12 percent of the sample did not know what services were available. Despite schools being identified as the most important and trusted source of information on adolescent health issues, respondents reported that they received most information from their peers.

Focus group participants reported variable access to services and information. Several groups did report a lack of access to support and information, highlighting important gaps in current services and suggesting important areas for youth and related policy and service development. These included:

- For adolescents working in *drayangs,* bars and snooker halls more flexible hours for continuing education
- Access to English language classes for school drop outs, and expanded access for other groups, for example monks
- Better and expanded access to internet facilities
- Sports facilities and sports institutes where they could pursue sports as a career.

Adolescent females working in the *drayang*s spoke about their frustration at not being able to access confidential and supportive information regarding their rights at work.

They spoke about being fearful of requesting changes and amendments to current employment practices from their employers because of fear of being sacked. They work long hours and receive little time off; they are given minimal information about sexual and reproductive health and some report being abused by clients.

"I did not face any problems when I was in school. I was happy then. Although I was interested in studying, I was not intelligent … I had to drop school under compulsion." (17 year old female, FGD Drayang, Thimpu)

The majority of adolescent females working in the *drayangs* explained that they wanted to finish their education but were unable to attend NFE evening classes because of the conflict with work. They valued education but without being able to access NFE, there wasn't much motivation in their lives.

Privacy and fear of lack of confidentiality from service providers was also a theme frequently raised in the FGDs. The perception that youth services, specifically sexual reproductive health services, may not respect confidentiality was identified as a barrier restricting access.

At-risk female adolescents discussed the stigma and shame of going to the health service for sexual health matters, saying it was *"embarrassing"* and people *"look at you".* Some participants explained that they preferred to purchase condoms from the medical shops because they were *"better quality".*

"I only use condoms. Sometimes I use the ones available from the hospital but most of the times I prefer purchasing it from the medical shops. I have the taste for the banana flavoured and the dotted ones because these are better quality than from the hospital. I am ashamed to take the ones from the box in the hospital when there are people around." (*18 year old female, Phuntsholing)*

6.1 Sources of information

Sources of information and services were examined through self-reported responses in the survey and through FGDs.

Table 26: Sources of information

		Female		Male		Total	
		n	%	n	%	n	%
Sexual Health	Television	115	52%	69	40%	184	47%
	Radio	76	35%	65	38%	141	36%
	School	77	35%	48	28%	125	32%
	Youth group	7	3.2%	7	4.1%	14	3.6%
	Friends	81	37%	48	28%	129	33%
	Health centre	0					
	Parents/guardians	67	31%	14	8.1%	81	21%
	Internet	8	3.6%	11	6.4%	19	4.8%
	Other						
		Female		Male		Total	
		n	%	n	%	n	%
Tobacco	Television	127	58%	94	55%	221	56%
	Radio	98	45%	78	45%	176	45%
	School	88	40%	73	42%	161	41%
	Youth group	18	8.2%	26	15%	44	11%
	Friends						
	Health centre						
	Parents/guardians						
	Internet	6	2.7%	15	8.7%	21	5.4%
	Other	83	48%	73	33%	156	40%
		Female		Male		Total	
		n	%	n	%	n	%
Alcohol	Television	102	46%	81	47%	183	47%
	Radio	84	38%	63	37%	147	38%
	School	72	33%	60	35%	132	33.7%
	Youth group	13	5.9%	18	11%	31	7.9%
	Friends						
	Health centre						
	Parents/guardians						
	Internet	10	5.8%	4	1.8%	14	3.6%
	Other	71	32%	69	40%	140	35.7%
		Female		Male		Total	
		n	%	n	%	n	%
Marijuana	Television	99	45%	64	37%	163	42%
	Radio	82	37%	51	30%	133	34%
	School	64	29%	47	27%	111	28%
	Youth group	19	8.6%	26	15%	45	12%
	Friends						
	Health centre						
	Parents/guardians						
	Internet	5	2.3%	9	5.2%	14	3.6%
	Other	43	20%	49	29%	92	24%
		Female		Male		Total	
		n	%	n	%	n	%
Inhalants	Television	84	38%	54	31%	138	35%
	Radio	70	32%	45	26%	115	29%
	School	62	28%	50	29%	112	29%
	Youth group	23	11%	22	13%	45	12%
	Friends						
	Health centre						
	Parents/guardians						
	Internet	2	0.9%	11	6.4%	13	3.3%%
	Other	37	17%	53	31%	90	23%

*** Respondents could answer more than one source**

Note: Percentages were calculated based on the total sample size of 392 (220 females, 172 males).

Table 26 illustrates where participants get their information from about a number of things including sexual health, alcohol and other drugs. Information on sexual health was found to come from a variety of sources (Table 26). While only one third of respondents reported to have a television in the household where they live, the main sources of information on sexual health were television (47 percent), closely followed by radio (36 percent), friends (33 percent), and school (32 percent). Parents were a common source of sexual health information for females (31 percent) but not for males (8.1 percent). Of note, very few only 4.8 percent respondents reported getting any sexual health information from the internet

FGD further explored themes of information and access to information about sexual health. When asked about health centres as a possible source of information, many focus groups participants reported that they *"would not go to the health centre for information on sexual health……..only those with problems go to those centres. Just by asking for information, people would see you as having a problem".*

Respondents most commonly identified television (56 percent, n=221), radio (45 percent, n=147) and school (41 percent, n=161) as a source of information on the dangers of smoking tobacco. Parents/guardians and health centres were rarely reported as sources of information.

Similarly, with regards to the dangers or drinking alcohol, respondents identified television (47 percent, n=183) and radio (38 percent, n=147) as the most common sources of information.

Participants identified television (42 percent, n=163), radio (34 percent, n=133) and school (28 percent, n=111) as the main source of information on the dangers of smoking marijuana. 60 percent (n=235) of respondents reported being aware of the dangers of smoking marijuana; 65 percent (n=142) of females and 55 percent (n=93) of males.

Participants identified TV (35 percent, n=138), radio (29 percent, n=115) and school (29 percent, n=112) as the main source of information on the dangers of using inhalants.

DISCUSSION & RECOMMENDATIONS

Section 1: Socio-demographic profile of at-risk adolescents

The survey questionnaire and FGDs were not intended to measure income levels; rather they were aimed at determining in a broad sense the level to which basic needs of food and shelter were met among the sample.

The purposive sampling of vulnerable and at-risk adolescents has resulted in a deliberate disproportionate representation of adolescents from backgrounds of economic and social disadvantage. For example, 50 percent of the survey respondents report that they regularly do not have enough food to eat. This is regarded as a proxy for poverty in the discussion. Poverty is the major source or underlying factor of vulnerability and risk for at-risk adolescents in Bhutan and is indicated as a key factor in restricting access to education.

Ethnic groups other than *Dzongka*, using mother-tongue as a proxy, are disproportionately represented in the sample (67 percent) compared to national population demographics. There were significantly higher rates of alcohol use observed among *Sharcop* and other ethnic language groups and the mother-tongue of the respondents closely approached significance for sexual intercourse, indicating that those whose mother-tongue is *Dzongka* were less likely to report having ever had sexual intercourse and less likely to report regular consumption of alcohol.

For this sample of adolescents access to education was generally seen as the gateway to enhanced life prospects. 25 percent of the survey sample had never been to school, (note that this figure includes those who received non-formal education and monastic education). 41 percent were enrolled in secondary education, with at-risk adolescent females more likely to be enrolled in secondary education than at-risk adolescent males. For many young people who took part in the assessment, failure in education was perceived as a very significant barrier to future meaningful employment.

In comparison with prior adolescent and youth studies in Bhutan this sample of 13-18 year olds reported more risk behaviours. This is not surprising given the study focus was to explore risk behaviours of adolescents who lived, worked or socialised in risk settings. The data suggests that this study has reached adolescents practicing risk behaviors and many of them with multiple risk behaviours. The qualitative data reinforced previous findings that risk behaviors often occur within especially vulnerable settings that contribute to continued health risk behaviors.

When contrasting the results of this small assessment with the National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009[102], it appears that education is protective for adolescents, particularly adolescent females with regard to sexual activity (Table 27; Figure 4).

The in-school survey component of the National Assessment[103] demonstrates very small proportions of school students who reported to be sexually active (1 percent of 18 year old adolescent females ♠) compared with almost 44 percent of the at-risk survey sample of adolescent females. The majority of these at-risk adolescent females had very low levels of education. In this instance, education is a significant protective factor however some out-of-school settings are considerably risky. This is especially the case for at-risk adolescent females working in *drayangs.*

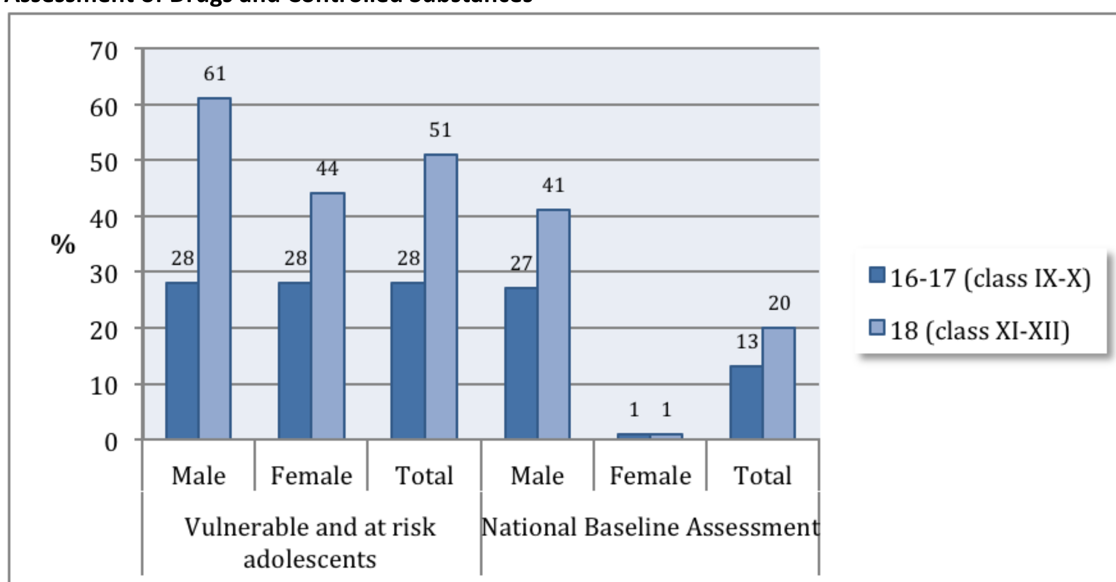
Table 27: Contrasting results on ever had sex with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances

	Vulnerable and at-risk adolescents (current assessment)						In-school sample from the National Baseline Assessment					
	Male		Female		All respondents		Male		Female		All respondents	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (class*)												
13-15 (class VII-VII)	40	23%	44	20%	84	21%	3441	34%	3870	36%	7311	35%
16-17(class IX-X)	47	27%	61	28%	108	28%	3328	33%	3620	34%	6948	34%
18 (class XI-XII)	85	50%	115	52%	200	51%	3292	33%	3206	30%	6498	31%
Total	**172**	**100%**	**220**	**100%**	**392**	**100%**	**10,061**	**100%**	**10,696**	**100%**	**20,757**	**100%**
Ever had sex												
13-15 (class VII-VII)	7	18%	0	0.0%	7	8.4%	--	--	--	--	--	--
16-17(class IX-X)	13	28%	17	28%	30	28%	901	27%	30	1.0%	931	13%
18 (class XI-XII)	52	61%	49	44%	101	51%	1358	41%	34	1.0%	1392	20%
Total	**72**	**42%**	**66**	**31%**	**138**	**36%**	**--**	**--**	**--**	**--**	**--**	**--**

* School classes may have older adolescents and may not be absolutely comparable. These data should be interpreted with caution.
-- Data unavailable
Note: Percentages were calculated excluding any missing cases

[102] This nationally representative 2009 study of over 20,000 school students focused on tobacco, alcohol and drug use and sexual behaviours. This study has been used as a baseline for mainstream, in-school adolescents.
[103] Bhutan Narcotic Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009,* Thimphu, RGoB
♠ These data should be interpreted with some caution because the reported proportions are significantly lower than other countries in the region and local evidence. The under reported sexual activity experience could be explained in part by the legal age of consent defined as 18 years and strictly enforced.

Figure 4: Contrasting results on ever had sex with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances



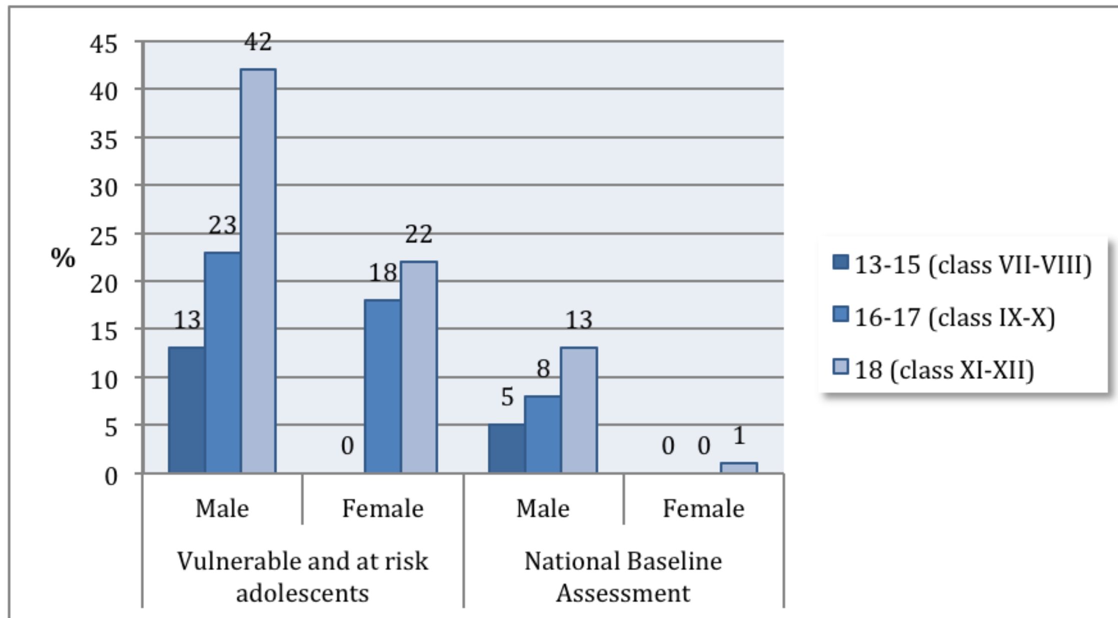
Education and being in-school is also a protective factor against tobacco use (Table 28; Figure 5) with adolescents in-school less likely to smoke tobacco (almost 13 percent of 18 year old adolescent males) than the at-risk survey sample of adolescent males (almost 43 percent of 18 year old males). The differences are also striking for adolescent females and interesting in light of tobacco control laws in Bhutan which strictly regulates the consumption of tobacco.

Table 28: Contrasting at-risk adolescent results on daily tobacco with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances

	Vulnerable and at-risk adolescents (current assessment)						In-school sample from the National Baseline Assessment					
	Male		Female		All respondents**		Male		Female		All respondents**	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (class*)												
13-15 (class VII-VII)	40	23%	44	20%	84	21%	3441	34%	3870	36%	7311	35%
16-17(class IX-X)	47	27%	61	28%	108	28%	3328	33%	3620	34%	6948	34%
18 (class XI-XII)	85	50%	115	52%	200	51%	3292	33%	3206	30%	6498	31%
Total	**172**	**100%**	**220**	**100%**	**392**	**100%**	**10,061**	**100%**	**10,696**	**100%**	**20,757**	**100%**
Daily tobacco												
13-15 (class VII-VII)	5	13%	0	0.0%	5	6.0%	--	5.0%	--	>1.0%	--	--
16-17(class IX-X)	11	23%	11	18%	22	20%	--	8.0%	--	>1.0%	--	--
18 (class XI-XII)	36	42%	25	22%	61	31%	--	13%	--	1.0%	--	--
Total	**52**	**30%**	**36**	**16%**	**88**	**22%**	**--**	**--**	**--**	**--**	**--**	**--**

* School classes may have older adolescents and may not be absolutely comparable. These data should be interpreted with caution.
-- Data unavailable
Note: Percentages were calculated excluding any missing cases

Figure 5: Contrasting results on daily tobacco of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances



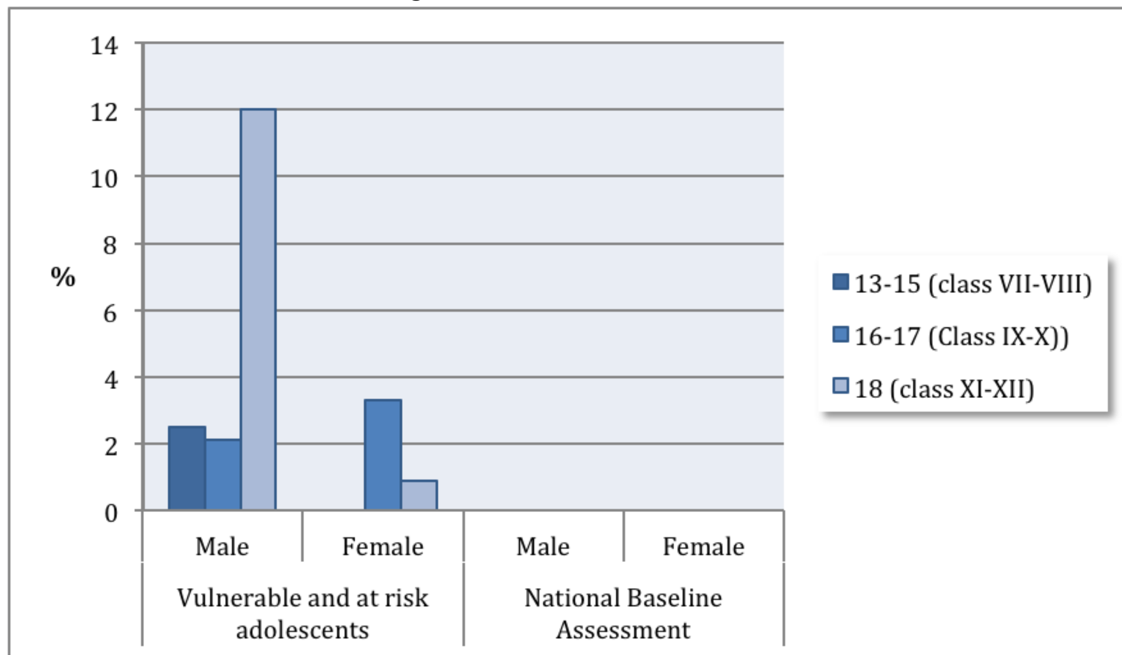
Education and being in-school is also a protective factor for alcohol use (Table 29; Figure 6) with at-risk adolescent males almost 12 times more likely to drink alcohol than their in-school counterparts: 12 percent of at-risk 18 year old males compared to just 1 percent of in-school 18 year old males.

Table 29: Contrasting results on daily alcohol use of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances

	Vulnerable and at-risk adolescents (current assessment)						In-school sample from National Baseline Assessment					
	Male		Female		Total**		Male		Female		All respondents**	
	n	%	n	%	n	%	n	%	n	%	n	%
Age (class*)												
13-15 (class VII-VII)	40	23%	44	20%	84	21%	3441	34%	3870	36%	7311	35%
16-17(class IX-X)	47	27%	61	28%	108	28%	3328	33%	3620	34%	6948	34%
18 (class XI-XII)	85	50%	115	52%	200	51%	3292	33%	3206	30%	6498	31%
Total	**172**	**100%**	**220**	**100%**	**392**	**100%**	**10,061**	**100%**	**10,696**	**100%**	**20,757**	**100%**
Daily alcohol												
13-15 (class VII-VII)	1	2.5%	0	0.0%	1	1.2%	--	>1.0%	--	>1.0%	--	--
16-17(class IX-X)	1	2.1%	2	3.3%	3	2.8%	--	>1.0%	--	>1.0%	--	--
18 (class XI-XII)	10	12%	1	0.9%	11	5.5%	--	1.0%	--	>1.0%	--	--
Total	**12**	**7%**	**3**	**1.4%**	**15**	**3.8%**	**--**	**--**	**--**	**--**	**--**	**--**

* School classes may have older adolescents and may not be absolutely comparable. These data should be interpreted with caution.
-- Data unavailable
Note: Percentages were calculated excluding any missing cases

Figure 6: Contrasting results on daily alcohol use of at-risk sample with the in-school sample from the National Baseline Assessment of Drugs and Controlled Substances



The assessment identified a number of reasons why adolescents do not complete and succeed at school. Of primary concern is the barrier created by financial costs. For adolescent females, marriage and pregnancy are important factors in early school-leaving with economic and family pressure more likely to affect females more than males.

Education has again been confirmed as a significant protective factor for adolescents, particularly in the context of health risk behaviour. This finding is strongly aligned with global literature, including literature in Asia, which identifies connection to school and education levels as essential protective factors for adolescents.[104]

There is a growing body of research that suggests that greater improvements for adolescents can be achieved by focusing not only on those factors that predispose risk ("risk factors") but also on those factors that protective young people from harm ("protective factors"). To optimise outcomes for adolescents, both those factors that predispose risk and those that are protective need to be identified. This assessment highlights that education is overwhelmingly protective. In a country like Bhutan, where enrolment levels are high and education is valued, early-school leaving for adolescents has very serious, long-lasting negative impacts.

Education is also highly valued by adolescents who see the completion of secondary school education as the foundation for enhancing employability. Special policy and programming consideration should be given to the provision of universal and equitable access for all children and adolescents.

[104] Mmari, K & Blum, R (2009) Risk and Protective Factors that Affect Adolescent Reproductive Health in Developing Countries: A Structured Review, *Global Public Health* 4(4) 350-66

Under and unemployment among adolescents is a continuing problem and is reflected in the findings of the survey. Many vulnerable and at-risk adolescents in this assessment report feelings of frustration regarding employment prospects. The larger levers of public policy will need to be engaged to address the structural problems at the root of unemployment. However discussions among stakeholders show some support for measures designed to provide adolescents and young people with meaningful work and training in preparation for entering work in a more vibrant employment market.

Gender emerged as a significant issue. The impact and consequences of risk behaviours and risky work settings appear to be much more severe for adolescent females than for their male counterparts. For example, rates of sexual harassment, sexual violence and general violence among adolescent girls are much higher than for adolescent males. For adolescent females, the reasons reported for leaving school include: marriage, pregnancy and the need to earn money. Until recently, completion of education for pregnant adolescents has not been an option. In support of the United Nations Joint Statement on Accelerating Efforts to Advance the Rights of Adolescent Girls, increased investments are required to ensure adolescent females are educated, healthy and skilled to build a better future, advance social justice, support economic development and combat poverty.

While the focus of this assessment has been on the specific age group 13-18 year olds, the recently developed National Youth Policy of Bhutan 2010 (draft)[105] considers policy and programs for adolescents with flexible age bands to include young people, acknowledging the important transitions from adolescence to young adulthood. These recommendations fit within this context.

Recommendations

- An important area for policy consideration, particularly for poorer families is the need to consider an 'early warning system' which will allow schools to identify students in danger of dropping out of school.

- Economic support to low income families to allow children to complete their education through the use of scholarships and boarding facilities. Special consideration should be given to at-risk adolescents to ensure easy access to continuing education programs.

- Increased flexibility should be given to continuing education to ensure adolescents and young people who are facing particularly difficult circumstances are able to access continuing education. For example, girls working in the *drayangs* need to access continuing education during the day because they work at night.

[105] Ministry of Education, RGoB (2010), *Bhutan National Youth Policy Final Draft for submission to Parliament 2010*, Timphu, Department of Youth and Sport, Ministry of Education

- Consideration should be given to reviewing education policy on student expulsion for first time drug misdemeanors and linking the review to the Gross National Happiness philosophy implemented in schools. Punitive measures towards drug using students should be replaced with a participatory motivating intervention.

- There is a need to strengthen implementation of the policy which supports pregnant adolescents to continue their education.

- Increase the flexibility of current vocational training systems and establish new approaches which provide training and opportunities that match at-risk adolescents with employment market needs.

- There are opportunities to sensitise Bhutanese media (television, radio, print) to gender to help address and challenge some of the broader gender issues. There should be specific focus on masculinity, gender based violence and gender roles with opportunities to promote positive, equitable relationships between men and women and to address the role of young men and masculinity in sexual violence against women and adolescent females.

Section 2: Sexuality and sexual practice

2.1 Sexual activity by key characteristics and gender

This assessment found that 36 percent of the total sample of vulnerable and at-risk adolescents reported to be sexually active (i.e. having ever had sex) while approximately one fourth were currently sexually active (i.e. having sex during the last 12 months). However this masks the 61 percent of 18 year old males in the group reporting to be sexually active. None of the 13-15 year old females reported to be sexually active.

The average ages of sexual debut was 15 for males and 16 for females, which is lower than that found by the GPS conducted in 2006 especially for girls (16-17 years for males and 18-19 years for females) and significantly lower than the National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009. This is not surprising given the purposive sampling framework for vulnerable and at-risk adolescents but does highlight the differences between defined groups of at-risk adolescents and the mainstream, in-school adolescents.

Some caution is advised when interpreting the low adolescent female reporting of sexual activity. The strong enforcement of the Law relating to age of consent (18 years) and the high profile media coverage at the time of the assessment may have influenced under-reporting of sexual activity. The 18 year old female in-school sample reported only 1 percent sexual activity which is significantly lower than India, Nepal and other countries in Asia.[106]

[106] UNFPA, *Adolescents and Youth,* New York, UNFPA

2.2 Sexual Partners

Regular sex with multiple partners, including male-to male sex, transactional sex and night hunting were reported amongst this sample. Alcohol featured strongly in the sexual experiences and behaviour of the adolescents in this sample.

2.3 Contraception

Despite 60-70 percent of both sexually active at-risk adolescent males and females reporting to use contraception and nominating condoms as the preferred option, limited skills to use condoms and beliefs about the effectiveness of condoms plus issues of trust within regular partnerships were all identified as a barrier to consistent condom use.

2.4 Same Sex Attraction

The survey data suggest that 10 percent of the at-risk adolescent male sample is attracted to other males and that a higher proportion is attracted to both males and females. In addition, 1 percent of the survey sample (males) reported having had sex with another male. This finding is similar to findings reported in the GPS survey in 2006 among older males.

There is little or no information or support available to same sex attracted adolescents. Given the limited discussion on same sex attraction in Bhutan this issue will need to be approached sensitively. The assessment found that participants in FGDs generally had negative views towards same sex attracted young people, describing same sex attraction as, *'un-natural'* or against the cultural values of Bhutan. This suggests that the low levels of awareness and discussion regarding same sex attraction are accompanied by stigmatising views. The apparent openness to talk about HIV and address prevention early in the HIV issue does offer an opportunity to discuss sexual preference but again caution in how same sex attraction and MSM issues are dealt with are certainly required

2.5 Pregnancy

This small-scale assessment provides some information on unprotected sex. 7 percent of at-risk adolescent males and 7 percent of at-risk adolescent females in the survey reported to have had an STI. 47 percent of vulnerable and at-risk adolescent females report to have been pregnant. Although the data on pregnancy is inconclusive (high proportions of adolescent girls reported being pregnant yet only 11 report to be currently living with a child), the trends are concerning.

The data from the survey revealed only two adolescent females reported having had an abortion. Yet very high proportions of adolescent females reported to have been pregnant and FGD revealed very detailed knowledge on abortion and emergency contraception (*i-pills)*. It is clear from the assessment that it is socially unacceptable to

be pregnant and unmarried. Like elsewhere in the region, it is difficult for unmarried adolescent females to access safe abortion services. The adolescents in this assessment reported using self-prescribed over-the-counter medications to induce abortion or travelling to clandestine abortion sites.

The issue of pregnancy remains significant, particularly for adolescent females being forced to leave school as a result of becoming pregnant. This implies that the policy shift of the Ministry of Education in support of young mothers returning to school has not yet been strongly felt at the level of practice.

In this context of heightened sexual risk and high rates of pregnancy, comprehensive sexual and reproductive health information, education and accessible services for adolescents and young people are all critical, particularly for those vulnerable, at-risk and out-of-school adolescents.

Recommendations

- An important area for policy and programming consideration is how to effectively provide comprehensive information, education and skill-development (life skills) for at-risk, out-of-school adolescents. With significant numbers of adolescents leaving school early, consideration must be given to effective ways of delivering information and education to out-of-school and/or employed adolescents.

- While assessing the content, quality and coverage of sex and sexuality in-school curriculum is critical, it is equally important in light of these results, to ensure out-of-school adolescents engaging in risk behaviours have access to a minimum package of sexual reproductive health and drug education prevention and treatment services. There is a need to revise the current life skills curriculum and ensure implementation in out-of-school settings including: drop in centres; NFE; *drayangs*; employment centres; vocational training.

- There are opportunities to revise, consolidate and ensure the current national curricula on life skills includes topics of HIV; sexuality; contraception; drug use and abuse; gender and addresses issues of discrimination including respect and tolerance for sexual identity and decision-making.

- There is a need to ensure current youth health services are appropriately targeted to at-risk, out-of-school adolescents. Current programs report that the majority of adolescents accessing services are school students. Provision of information and commodities through peer delivered outreach services and linked to fixed but friendly settings is an effective model to engage at-risk adolescents. Peer education and outreach services connected to health services, information services, vocational schools, youth clubs, and known clinics are effective mechanisms to consider for the distribution of condoms and other commodities.

- There is a need to ensure adolescent sexual reproductive health services are comprehensive and include: STI testing, treatment and management; HIV voluntary counseling testing; pregnancy tests and contraception counseling; Protocols for unprotected sex and unplanned pregnancy should be available. Continuing to support health care providers with capacity-building opportunities is important.

- There is an opportunity to expand the choices and availability of contraceptives, emergency contraception and, if necessary, safe abortion or safe motherhood.

- It is important to engage and encourage youth-friendly approaches for medical shops to include information (posters, brochures) on emergency contraception (i-pills), STI symptoms, treatment and management.

- Stretching the age bands to include adolescents and those under 18 in existing interventions and services has been a successful strategy in other countries in Asia. Services and initiatives that target young adults can also reach adolescents without having to establish new or special programmes or services.

- As this assessment was small, some emerging themes warrant further exploration. It is important to better understand sexual and social networks of young people; adolescent pregnancy and abortion; same sex attraction.

2.6 Risky sexual contacts

Of all respondents, 5.9 percent reported having been forced to have sex against their will. This was slightly higher among at-risk adolescent females (7.2 percent) than among at-risk adolescent males (4.8 percent). There was evidence that for these adolescents the threat was from peers rather than from family or strangers. The FGDs with vulnerable and at-risk adolescent females reported quite a high level of fear regarding their vulnerability to sexual violence, including being afraid to go out alone at night and having little faith in the police to protect them.

While the practice of night hunting is described in the literature as being on the decline and not extensively practiced, this assessment demonstrates that night hunting still retains a place in the sexual behavior of vulnerable and at-risk adolescents. Among currently sexually active adolescent males, a high proportion (38 percent) reported having night hunted and thus having affects for a number of young females. This assessment was unable to establish a link between the at-risk adolescent females who reported sex as a result of night hunting and those reporting sexual violence, despite some of the literature framing night hunting as coerced or forced sex.

Consideration should be given to a more focused study on the practice of night hunting, including investigating any association with sexual violence and the role night hunting plays in traditional gender belief systems.

In contrast with previous studies, this assessment found some evidence of a networked sex work industry and certainly identified *drayangs* as risk settings for transactional sex. 12 percent of currently sexually active at-risk adolescent females reported having partners whom they had sex with in exchange for money or payment in-kind and 28 percent of currently sexually active at-risk adolescent males reported having sexual partners whom they gave money to or payment in-kind for sex.

There are some at-risk adolescents in this assessment who, according to technical definitions and based on the behaviours they report, are considered most-at-risk of HIV. This includes a number of at-risk adolescent females who work in *drayangs* and report unprotected sex with clients; at-risk adolescent males who report penetrative anal sex; at-risk adolescent males who report having multiple partners in the past 12 months and did not use condoms consistently every time.

Adolescent girls who work in *drayangs* are particularly vulnerable to risky behaviour for a number of reasons. The qualitative data suggests there are various gender, age and power relationships which shape and reinforce adolescent female's vulnerability to HIV infection. For example, many of the girls who worked in the *drayangs* knew about the protective benefits of condoms. However, many were unable to effectively negotiate condom usage given their economic dependence and, for some, a sense of powerlessness triggered by the need for jog security. Negotiation power is further undermined by heavy alcohol consumption or intoxication.

The data from this assessment clearly indicates that out-of-school adolescent females in particular are involved in more risk taking behaviors than their counterparts who are still in school. Again this is to be anticipated given the extensive literature about the cumulative protective effect of school. This highlights the need for diversity in approaches and close attention to development and delivery of programmes that respond to multiple risk behaviors simultaneously.

Recommendations

- Free condom distribution for *drayangs*, discos and other known hotspot areas through targeted peer outreach and fixed sites, for example a box of condoms for easy access for adolescent females working in *drayangs* to ensure condom saturation to reduce STIs, HIV and unplanned pregnancy.

- It is important to strengthen the process for identifying underage girls working in the *drayangs* and provide a coordinated response that includes prevention, counselling on vocational options and support for continuing education.

- Review existing "hotline" services and referral links for victims of violence and abuse. Marketing of "hotline" services for crime, violence and labour issues then needs to be strengthened and targeted so they are accessible to those at-risk adolescents, including adolescent females working in *drayangs* and domestic

workers. The “hotline” services needs to have clear referral links to programs, including refuge shelters.

- Strengthening the “positive community policing” programs, particularly the at-risk adolescent-police partnerships as this could be a promising initiative to promote community safety and a more supportive environment.

- As this assessment was small, some emerging themes warrant further exploration. It is important to better understand sexual and social networks of adolescents and young people, including the practice of night hunting and understanding adolescent vulnerability and risk pathways, particularly pathways to sex work.

2.7 STIs and HIV

Bhutan is a low HIV prevalence country (0.01 percent). This assessment demonstrates that there are a number of factors that influence the transmission of HIV and STIs among vulnerable and at-risk adolescents:

- Early sexual debut (15 years for males; 16 years for females)
- Vaginal sex without consistent use of condoms
- Anal sex without consistent use of condoms
- Multiple partners as reported by over half of the currently sexually active adolescent males
- 7 percent of all survey respondents reported having been treated for an STI. Although the survey sample is not representative, a 7 percent rate of STIs is of concern, particularly where there are a number of factors which influence the transmission of STIs, including HIV
- Sexual intercourse in the context of transactional sex and night hunting, a practice reported by 38 percent of the currently sexually active males
- Limited information and resources on sexual reproductive health: relying on media (television and radio) as the primary source of information

In relation to identifying transmission modes of HIV, the assessment found varying levels of correct knowledge among the survey sample. This reflects the availability of HIV and STI information in the school setting, confirmed in focus groups with school students. The survey assessment also confirmed the continuing existence of a number of misconceptions regarding HIV transmission among groups with no or little education. The majority of respondents in the survey thought that HIV can be transmitted via mosquito.

These findings strongly suggest the need for STI and HIV information to be more widely available to out-of-school adolescents, including monks. While HIV prevalence is currently low (0.01 percent), the most common route of transmission is heterosexual (88.9 percent) which is also supported by the findings in this assessment. There is a strong rationale for integrating HIV into STI and sexual reproductive health.

Although the legal age to work in the *drayang* is 18 years of age, many adolescent females are much younger. Targeted programs for *drayangs* will be essential to reducing HIV, STI and unplanned pregnancy. The involvement of young people as outreach agents and providers of advice and commodities is critical.

Recommendations

- There is an urgent need to strengthen and coordinate engagement with out-of-school adolescents, particularly those working in vulnerable and risky settings (discos, karaoke and *drayangs*) to help revise and design appropriate models of services to ensure access to information, education, skill development and health services. There is a need to focus on condom distribution through assertive peer outreach.

- Peer education models could be further explored and are particularly effective if linked to a health centre providing youth-friendly sexual reproductive health services. There is an opportunity to explore peer support and peer education programs specifically for girls working in *drayangs*. This assertive outreach model has been effective in other countries in the region and has been a successful way to ensure condom distribution for at-risk adolescents who are less likely to access health services or purchase condoms from medical shops.

- It is important to strengthen the process for identifying underage girls working in the *drayangs* and provide a coordinated response that includes prevention, counselling on vocational options and support for continuing education. It will be important to formalise these networks to ensure clear coordination and accountability.

- For a low-prevalence country like Bhutan, there are advantages in considering HIV prevention integration models to ensure: improved access and uptake of key HIV and SRH services; reduction of stigma and discrimination; improved coverage for vulnerable populations, particularly adolescents engaged in risky behaviour; greater support for dual protection; improved quality of care; decreased duplication of efforts and competition for resources; better understanding and protection of individual rights; mutually reinforcing complementarities in legal and policy frameworks; enhanced programme effectiveness and efficiency.

- There are several recognised models of integration. Selection of appropriate models will depend on the specific context and can be re-oriented so they are youth-friendly and youth responsive. The models comprise:[107]
    - Antenatal Care Clinics *adding HIV services*
    - HIV counseling and testing centres *adding SRH services*
    - Family Planning Clinics *adding HIV services*
    - HIV Clinics *adding SRH services*

[107] WHO, UNFPA, International Planned Parenthood Federation, UNAIDS & University of California San Francisco (2009) *Sexual and reproductive health and HIV linkages: evidence review and recommendations*, Geneva, WHO

  - STI clinics *adding HIV services*
  - Primary Health Care Clinics *adding HIV and/or STI services*

- As this assessment was small, some emerging themes warrant further exploration. It is important to better understand migration, cross border issues, with a focus on injecting drug use patterns on the border with high prevalence states of India; students studying abroad; trafficking across borders (including domestic workers); transitions to sex work and transitions to injecting drug use.

Section 3: Tobacco, alcohol and drugs

Use of tobacco, alcohol and drugs among peer and friendship networks was reported by all FGDs except for the FGDs with monks and nuns. Use of tobacco, alcohol, and illicit drugs was found to be significantly higher among FGD participants and survey respondents being male, older and living in urban centres.

It is very clear from this assessment that tobacco, alcohol and drug use is associated with a number of different risk behaviours, particularly poly drug use, violence and sexual activity.

FGD participants discussed the relationships between gangs, violence and alcohol explaining that the people in gangs use drugs and alcohol daily and some drugs make people more aggressive and violent. There is a very strong association between alcohol and violence; and between alcohol and sexual activity. Understanding substance use as a determinant for violence and unprotected sex can help inform integrated programming.

3.1 Tobacco

Despite the ban on the sale of tobacco products, 22 percent of the survey respondents and a significant proportion of FGD participants reported smoking at least once a day compared with 13 percent of high school students (National Baseline Assessment of Drugs and Controlled Substances). Twice as many at-risk adolescent males (30 percent) smoked everyday compared to at-risk female adolescents (16 percent). In this assessment, adolescents report to choose marijuana instead of tobacco because it is affordable.

3.2 Alcohol

Of surprise to some readers may be the fact that 88 percent of females and 67 percent of the males in the survey reported never to have consumed alcohol. While this is in-line with the literature, these low levels contrasts with the levels of alcohol use reported by male FGD participant.

While alcohol use in Bhutan seems well accepted by adults alcohol purchase and consumption by adolescents under 18 is generally not permitted by law. This may

explain this result however when breaking down the findings 33 percent of at-risk male adolescents drink compared with only 12 percent of adolescent females. Of the older adolescent males aged 18 who are drinkers, one in ten of them reported to drink every day.

When asked how many of their friends and peers in the 15-18 year age range used alcohol at least once a week, estimates among the adolescent male FGD participants ranged between 30-70 percent, with proportions increasing with older males. It is concerning to note that some FGDs estimated that up to 40 percent of young people they know regularly drink alcohol until they are drunk. In line with prior studies drinking can be functional in relieving the pain experienced by at-risk adolescents who often face multiple challenges and problems including poverty, violence, lack of family support and a sense of helplessness. If drinking relieves some of this stress and pain and momentarily makes these adolescents happy (as reported as a main reason for drinking) then it serves a function. Focusing not only on at-risk adolescents but on the underlying causes of that drinking will be important in addressing some of the issues around alcohol and drug abuse found in this assessment.

Much of the drinking reported in FGD suggests that the context and settings where adolescents drink, like bars and drayangs can be controlled with public policing if there is a community interest for that to occur. The study demonstrates an acceptance of adolescent's drinking by some adults and therefore at-risk adolescent drinking must be seen in the broader context of the drinking culture in Bhutan with all its associated risks and consequences.

3.3 Drugs

3.3.1 Marijuana

Smoking marijuana is a gendered phenomenon, with the overwhelming majority of respondents being male. 18 percent of males reported ever smoking marijuana. Smoking marijuana is associated with being male, being older, living in an urban area and being engaged in neither work nor school, again highlighting that education and/or (safe) employment is protective for young people. Ease of access to marijuana and prescription drugs in Bhutan is clearly an enabling factor for use.

3.3.2 Inhalant use

Like marijuana, inhalant-use is a gendered phenomenon. 16 percent of males reported ever using inhalants. Smoking marijuana and using inhalants is also associated with being older, living in an urban area and not being engaged in work or school. Prevention initiatives will need to consider interventions to control access to specific substances.

3.3.3 Injecting Drug Use

Although low, the incidence of injecting drug use (IDU) among young people is a concern and an indication that IDU exists in the adult community. Given the potential for HIV infection through IDU, reported lack of knowledge about the dangers of IDU and

evidence of high level use on border areas, this is an area that needs to be given attention.

Recommendations

- While addressing the issue of pre-marital sex, Bhutan takes a “middle ground” or harm reduction approach. This is not the case with alcohol and controlled substances. Abstinence-based model dominate and while they certainly have a place in addiction and recovery services abstinence messages for at-risk adolescents already using drugs and alcohol may be ineffective. Experts leading the alcohol and drug education directions need to ensure they are informed by available evidence and build consensus and commitment for the philosophy of “middle way”. Reviewing drug education curriculum to ensure consistent messaging is critical.

- Special consideration must be given to effective ways of delivering information and education to out-of-school and/or employed adolescents to ensure implementation in out-of-school settings including: drop in centres; NFE; *drayangs*; employment centres; vocational training.

- Messages focusing on reducing use, responsible use, rethinking use, rather than abstaining have been shown to be more effective from a disease prevention perspective. When abstinence may not be a realistic goal as mentioned in a few FGD, a “safer use” message may be more effective.

- Appropriate alcohol and drug services that are responsive and adolescent and youth friendly must be available and targeted to at-risk adolescents. This includes: counselling for drug use behaviour change; support to reduce consumption; facilitated detoxification (alcohol and other drugs) and recovery; and coordinated referrals for continuing education or vocational training. Considering the links between alcohol and unprotected sex, it is important that alcohol and drug services also provide prevention information (and condoms) and referral links to sexual reproductive health services including screening for STI including HIV.

- With considerable numbers of parents and guardians also drinking and smoking (both tobacco and marijuana), it is also important that adults understand the impact of drugs on adolescent development. Tobacco, alcohol and drug programs designed for adolescents and young people must sit within a broader community alcohol and drug strategy.

- Engaging retailers and venders in the tobacco, alcohol and drug response is strongly advised. Current urban-based educational campaigns with retailers and venders selling commonly inhaled substances and over-the-counter drugs in Thimphu should be evaluated for impact and the results should inform the scale up and expansion of improved approaches to other urban districts.

Section 4: Bullying and violence

4.1 Bullying

A total of 52 percent of survey respondents reported that they had been bullied, with a slightly higher proportion of adolescent males (57 percent) than adolescent females (47 percent). School is reported as the place where most bullying occurred followed by in the street (gangs) for males and the workplace for females. Males were more likely to be hit (20 percent) than females (9 percent) and females were more likely to experience gossip as bullying than males. Overwhelming, fellow students and peers were reported to be the perpetrators of bullying. There was a strong association between bullying (victim and perpetrator) and the use of tobacco, alcohol, marijuana and inhalants. It is important to note that this only an association and not a predictor of behaviour.

4.2 Violence

A total of 16 percent of all at-risk adolescents in the survey reported that they had been involved in physical fights. Twice as high a proportion of at-risk adolescent males (24 percent) had been involved in physical fights compared to at-risk adolescent females (11 percent). Being involved in physical fights appears to be more common among urban adolescents and adolescent neither in work or school.

All FGD participants reported fear of violence resulting from peers acting under the influence of alcohol and drugs. There was a very strong association between gang violence and drug use, with the majority of FGDs and interviews highlighting issues of safety as a priority concern. Several participants identified the community policing as a positive action.

Gender based violence and the threat of sexual violence was also discussed among the adolescent female members of FGDs and many adolescent females were fearful of being out alone at night. Again, several participants indicated that the community policing made them feel more secure.

Adolescent females working in *drayangs* reported feeling very unsafe and experiencing different forms of abuse, including sexual and physical abuse. This, again, confirms the *drayangs* as a risky setting for adolescent girls and highlights the need for policy and programming priority.

Recommendations

- There is a need for a sustained and consistent approach to educating adolescents about violence and bullying. There are opportunities to approach these issues within a comprehensive life skills education program and build protective factors between peers. Special consideration must be given to implement programs in out-of-school

settings to reach at-risk adolescents. This out-of-school approach is critical to help combat violent, gang-related crime.

- Positive community policing has been recognised as a promising initiative to develop constructive relationships with young people and build community connection. The new initiative to build partnerships between police and out-of-school (gang) youth should be supported and evaluated for success, with results informing possible expansion of the program to more districts.

- Strengthening the peer support network for adolescent females working in *drayangs* is important to create community connection and protection from violence and abuse. There are opportunities to strengthen the peer support network within a larger health-promoting settings-based programme with special consideration given to targeted outreach for condom distribution, referral to essential health services, access to continuing education and vocational training opportunities.

Section 5: Mental health and well-being

The vulnerable and at-risk adolescents who took part in the assessment are experiencing the normal emotional changes which accompany adolescence. However, for many of the sample, economic and social disadvantage add considerably to these pressures. Dealing with the emotional mental pressures these issues exert can lead to depression and anxiety and this can lead to increased risk taking behavior. The use of some psychotropic drugs, including marijuana, can also lead to short term and long term mental health problems.

Gangs were explored during many of the FGDs and while discussions were often framed around the negative effects of violence, for many adolescent males, gang membership provides a sense of "*belonging to a community"*, missing for many who are living away from the parents and families of origin.

17 percent of the participants had not completed formal education and this was often reported as the underlying factor leading to feelings of low self esteem and "*worthlessness"*.

The majority of girls working in the *drayangs* explained that they wanted to finish their education but were unable to attend continuing education evening classes because of the conflict with work. They explained that because of this there wasn't much motivation in their lives.

Understanding the broader social determinants of mental health and well-being helps direct programming priorities. This assessment identifies poverty, education and employment as significant determinants of adolescent mental health and well-being.

Recommendations

- Special consideration should be given to numerous mechanisms designed to keep adolescents in school including: early warning systems to identify students in danger of dropping out; economic scholarship support for low income families; easy access and flexibility for continuing education and NFE.

- Increase the flexibility of current vocational training systems and establish new approaches which provide training and opportunities that match at-risk adolescents with employment market needs.

- There is a need for programmes and interventions that result in increasing community connection and decreasing social isolation. Peer support networks for at-risk adolescents can help to build individual and community protective factors.

- Access to trained youth counsellors who are skilled in dealing with adolescent mental health issues is required. While there may not be a need for stand-alone services, integrating mental health into sexual reproductive health and alcohol and drug recovery programs will be important.

- For out-of-school and unemployed adolescents, access to subsidised leisure and arts opportunities can provide structure, community connection and decreases isolation.

SUMMARY OF SECTOR RESPONSIBILITY AND PRIORITY ACTION

Recommendation	Lead coordinating department	Support departments	Priority Actions
Comprehensive Youth Policy	DYS	Health (HIV), Labour, Police, Women and Children	▪ Review draft policy of Bhutan National Youth Policy 2010 to ensure specific recommendations for at-risk and out-of-school adolescents and youth
Keeping adolescents in school	Education	NFE, DYS	▪ Early warning system for school-drop outs ▪ Economic scholarship support for low income families ▪ Easy access and flexibility for continuing education and NFE
Job opportunities for out-of-school adolescents and young people	Labour	DYS	▪ Increase the flexibility of current vocational training systems and establish new approaches which provide training and opportunities that match at-risk adolescents with employment market needs.
Comprehensive life skills program for out-of-school adolescents and young people	Education (DYS)	Labour, NFE, Health (HIV, SRH)	▪ Revise and consolidate existing curriculum to include HIV, sexual reproductive health, rights, gender, sexuality and sexual identity, decision-making, critical thinking, GNH. ▪ Determine out-of-school settings for implementation (NFE, continuing education, vocational training, Drop In Centre, selected *drayangs*)
Youth friendly sexual reproductive health services for at-risk adolescents	Health (HIV)	DYS, MTSP	▪ Ensure current adolescent and youth health services are appropriately targeted to at-risk, out-of-school adolescents and explore innovative outreach methods to deliver services needed by at-risk adolescents. ▪ Ensure youth sexual reproductive health services are comprehensive and include: STI testing, treatment and management, HIV voluntary counseling testing, pregnancy tests and contraception counseling. Protocols for unprotected sex and unplanned pregnancy should be available. ▪ Condom distribution through peer education and outreach services (with referral links to health services): employment information services, vocational schools, youth clubs, and known clinics, *drayangs*, bars and hotspots ▪ Continue to support health care providers with capacity-building opportunities
Alcohol and drug support	DYS (curriculum	MTSP	▪ Review current youth-specific drug education curriculum to ensure consistent messaging

services	and prevention) Health (broader alcohol and drug strategy) BNC, YDF (services)		▪ Build consensus and commitment for the philosophy of "middle way" (harm reduction) messaging within a broader community alcohol and drug strategy ▪ Appropriate alcohol and drug services targeted to at-risk adolescents includes: counselling for behaviour change; support to reduce consumption; facilitated detoxification and recovery; coordinated referrals for continuing education or vocational training. ▪ Consider the links between alcohol and unprotected sex and ensure alcohol and drug services include referral links to sexual reproductive health services. ▪ Engage retailers and venders in the alcohol and drug response
Protection and safety	Women and Children's Commission	Home Affairs (police), specialist agencies (RENEW)	▪ Strengthen the process for identifying underage adolescents working in the *drayangs* and other hazardous work environments and provide a coordinated response that includes prevention, counselling on vocational options and support for continuing education. ▪ Review existing "hotline" services and referral links for victims of violence and abuse and ensure they are accessible to those at-risk adolescents, including girls working in *drayangs* and domestic workers. The "hotline" services need to have clear referral links to programs, including refuge shelters. ▪ Strengthen the "positive community policing" programs, particularly the at-risk adolescent-police partnerships initiative to promote community safety and supportive environments
Peer support and youth involvement	DYS	Specialist agencies (YDF, BNCA, HISC – Health, youth networks e.g. Youth Champions, Kuzoo FM)	▪ Strengthen the peer support network for at-risk groups of adolescents to create community connection and protection ▪ Provide meaningful opportunities for youth participation with special consideration for the inclusion and participation of at-risk and out-of-school adolescents

REFERENCES

Bhutan Narcotic Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan 2009,* Thimphu, Bhutan

Carpenter, R (2002) *The Blessings of Bhutan*, Hawaii, Natural World Press

Department of Planning, Ministry of Finance, RGoB (2005), *Millennium Development Goals Progress Report 2005*: Bhutan, RGoB, Thimphu

Dorji, C (2004) The Myth behind alcohol and happiness, presented at the *First International Conference on Gross National Happiness*, Centre for Bhutan Studies, Thimphu, Bhutan, April 2004, available online at: http://www.gpiatlantic.org/conference/papers/dorji.pdf (accessed August 2009)

Dorji L & Kinga, S (2005) *Youth in Bhutan – Education, Employment and Development*, Thimphu, Centre for Bhutan Studies

Dorji, T (2009) Child labour study UNICEF [need complete reference]

Gampo, D (2007) Sexual Net Work, Sex Work and Sex Workers in Thimphu. April May 2007

Gross National Happiness Commission, National Commission for Women and Children & RGoB (2008) *National Plan of Action for Gender 2008-2013,* Thimphu, Gross National Happiness Commission, National Commission for Women and Children & RGoB, available online at http://www.undp.org.bt/assets/files/gender/NPAG.pdf (Accessed May 2011)

Gupta G R, Parkhurst, J O, Ogden, J A, Aggleton, P & Mahal, A (2008) Structural approaches to HIV prevention, *The Lancet*, 372 (9640), 764-75

Independent Commission on AIDS in Asia (2008) *REDEFINING AIDS IN ASIA Crafting an Effective Response,* India, Oxford University Press

Interagency Youth Working Group, U.S. Agency for International Development, UNAIDS, Inter-Agency Task Team on HIV and Young People, and FHI (2010) *Young People Most at Risk of HIV,* North Carolina, FHI

Juarez F, LeGrand T, Lloyd C B, Singh, S. (2008) Introduction to special issue on adolescent sexual reproductive health in Sub-Saharan Africa, *Studies in Family Planning* 39 (4) 239-244

Kinga, S (1999) *The Status of Women in Traditional and Modern Bhutan*, Thimphu, Centre for Bhutan Studies

Ministry of Education, RGoB (2000) *Teenage pregnancy and early marriage; Result of Youth Awareness Survey,* Thimphu, RGoB

Ministry of Education, RGoB (2004) *Annual Statistical Report 2004,* Thimphu, RGoB

Ministry of Education, RGoB (2007) *Life skills and Adolescent Reproductive Health Education Program*, Thimphu, RGoB

Ministry of Education, RGoB (2008), *Bhutan National Human Development Report 2005: The challenge of youth employment*, Thimphu, RGoB

Ministry of Education, RGoB (2008), *The Situation of Bhutanese youth 2005-2006,* Thimphu, RGoB

Ministry of Education, RGoB (2010), *Bhutan National Youth Policy Final Draft for submission to Parliament 2010*, Timphu, RGoB

Ministry of Education, RGoB (2010) Ministry of Education, *Annual Education Statistics 2010,* Thimphu, RGoB

Ministry of Health, RGoB (1994), *National Health Survey,* Thinphu, RGoB

RGoB (1980) *Bhutan Marriage Act,* Thimphu, RGoB

Ministry of Health, RGoB (2007) *Assessment of risk and vulnerability to STIs and HIV/AIDS in Bhutan*, Thimphu, Bhutan

Ministry of Health, RGoB (2008), *Adolescent Health and Development – A country profile,* Thimphu, RGoB, available online at: http://www.whobhutan.org/LinkFiles/Publications_country_profile.pdf (Accessed May 2011)

Ministry of Health, RGoB (2008) HIV/AIDS General Population Survey Bhutan – 2006, Thimphu, Bhutan

Ministry of Health, RGoB (2008) *National Strategic Plan for Prevention and Control of STIs and HIV/AIDS*, Thimphu, RGoB, p.5

Ministry of Health, RGoB (2010) *Sexual behaviours and networks in Thimpu, Bhutan: A rapid assessment*, Thimphu, Bhutan

Ministry of Health, RGoB (2010) *STI/AHIV Reports of the Country*, Thimphu, RGoB, available online at: http://www.health.gov.bt/hivStatistics.php (accessed May 2011)

Ministry of Health, RGoB and UNICEF (2004) *Exploratory Study on HIV/AIDS Issues affecting Out-of School Youth in Bhutan*, Thimphu, RGoB

Mmari, K & Blum, R (2009) Risk and Protective Factors that Affect Adolescent Reproductive Health in Developing Countries: A Structured Review, *Global Public Health* 4(4) 350-66

OECD Development Centre, Social Institutions and gender index: Gender Equality and Social Institutions in Bhutan, Paris, OECD, http://genderindex.org/country/bhutan (accessed August 2009)

Office of the census commissioner, RGoB (2005) Results of Population & Housing Census of Bhutan 2005, Thimphu, RGoB

Pathak, N & Yonten, K (2004), *Assessment of the protection factors for vulnerable children in Bhutan,* Thimphu, RGoB & UNICEF

Planning Commission and Central Statistical Office (CSO), RGoB, UNDP, UNICEF, WFP & UNIFEM (2001), *Gender Pilot Study Report,* Thimphu, CSO, available online at: http://www.rnrstat.bt/csbhutan/documents/gsr2001.pdf (Accessed May 2011)

RENEW (2008) Research Study On Violence Against Women (VAW), Thimphu, Bhutan

RGoB (1980) *Bhutan Marriage Act,* Thimphu, RGoB

RGoB (2004). *Penal Code of Bhutan,* Thimphu, RGoB

RGoB (2010) *Bhutan National Youth Policy*, Thimphu, RGoB

Savada, A M (ed.) (1991) *Bhutan: A Country Study*. Washington, GPO for the Library of Congress, available onlint at: http://countrystudies.us/bhutan/ (accessed May 2011)

The World Bank (2008) *HIV/AIDS in Bhutan*. Washington, World Bank, available at: http://siteresources.worldbank.org/SOUTHASIAEXT/Resources/223546-1192413140459/4281804-1231540815570/5730961-1235157256443/HIVAIDSbriefBT.pdf (accessed May 2011)

UNAIDS (2007) *UNAIDS Practical Guidelines for Intensifying HIV Prevention, Towards Universal Access,* Geneva, UNAIDS

UNAIDS (2009) *Bhutan HIV and AIDS Estimates 2009,* Geneva, UNAIDS, *http://www.unaids.org/en/regionscountries/countries/bhutan/* (accessed May 2011)

UNESCO (2009) Bhutan Country Profile, Country Specific ARSH Information, Bangkok, UNESCO, www.unescobkk.org (accessed August 2009)

UNFPA, *Adolescents and Youth,* New York, UNFPA, available online at: http://www.unfpa.org/public/adolescents/dhs_adolescent_guides.html (accessed May 2011)

UNFPA (2007) *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy,* New York, UNFPA

UNICEF (2006) *Plus 5 "World fit for children" Review for the Kingdom of Bhutan 2006: Country progress Report,* New York, UNICEF, available online at: http://www.unicef.org/worldfitforchildren/files/

Bhutan_WFFC5_Report.pdf (Accessed September 2009)

UNICEF (2009) *Equity in School. Water and sanitation: Overcoming exclusion and*
(ROSA) (2009) *Guidance Note: HIV prevention among most at risk and especially vulnerable adolescents and young people in South Asia. Kathmandu, UNICEF*

UNODC, *Drug use in northeastern states of India 2006*, New Delhi, UNODC, available online at: http://www.unodc.org/india/drug_use_in_ne.html (accessed May 2011)

UNODC and Bhutan Narcotics Control Agency, RGoB (2009) *National Baseline Assessment of Drugs and Controlled Substance Use in Bhutan*, Thimphu, RGoB

UNOHCHR, Universal Human Rights Index of United Nations Documents, 'Rights Related to Marriage and Family', Geneva, UNOHCHR, available online at: http://www.universalhumanrightsindex.org/hrsearch/search.do?lang=en&accessType=category&categories=24&orderBy=country&clusterCategory=category (accessed May 2011)

discrimination in South Asia, Bhutan Country Report, Kathmandu, UNICEF ROSA

UNICEF Regional Office for South Asia

WHO (2004) Regional Office for South-East Asia. *Reproductive Health Profile.* New Delhi, WHO

WHO Regional Office for South-East Asia (2007) *Adolescent Health at A Glance in South-East Asia Region (Country Profile – Bhutan)*, New Delhi, WHO SEARO

WHO, UNFPA, International Planned Parenthood Federation, UNAIDS & University of California San Francisco (2009) *Sexual and reproductive health and HIV linkages: evidence review and recommendations*, Geneva, WHO, available online at: http://www.ippf.org/en/Resources/Reportsreviews/Linkages+Evidence+Review+and+Recommendations.htm (accessed May 2011)

World Bank Group (2007) *World Development Report 2007: Development and the next generation,* Washington, World Bank

ACKNOWLEDGMENTS

This publication is a joint project between DYS The Nossal Institute for Global Health at The University of Melbourne, CRI and UNICEF.

The primary authors are Emma Brathwaite from the Nossal Institute and Margaret Sheehan from UNICEF, Dr. Tandi (association) and Dr. David Stephens (formally Nossal, currently Research Triangle Institute)

We would also like to thanks Dr. Rob Moodie, Greg Armstrong and Alex Devine from the Nossal Institute.

Thanks must go to the DoYS staff Madame Rinzen and …

The UNICEF Office in Bhutan has done a huge amount to support the quality of this research under the close guidance of the Representative Gepke, with ……………… for their assistance.

The authors extend special thanks to the young people of Bhutan.