THEME PAPER

Responsible Sexual and Reproductive Health Behaviour Among Adolescents*

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1. Introduction

1.1 ICPD Consensus

At the ICPD, the international community formally acknowledged that adolescent reproductive and sexual health involves a specific set of needs that are distinct from adult needs. With a growing realization of the importance of including adolescents in population and reproductive health programmes worldwide, ICPD highlighted adolescents' reproductive health as a priority concern. The *ICPD-Programme of Action* specifically emphasizes the need to address the rights of adolescents to reproductive health information and services and that the needs of adolescent reproductive health should be addressed programmatically.

> *"Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs"* (POA, para 7.47) (UNFPA 1996).

> *"Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies"* (POA, para 7.46) (UNFPA 1996)

The ICPD calls for recognizing the rights of adolescents within the broader context of reproductive rights. While recognizing the rights of all adolescents, the ICPD specifically highlighted the rights of adolescent women with regard to issues of gender inequality, their greater vulnerability to unprotected sexual activities, and stressed the rights of young women to reproductive health information and services.

For many years, the needs of adolescents have largely been neglected in population and reproductive health programmes, partly because issues relating to adolescent sexuality and reproductive health are extremely sensitive. The countries in South Asia, especially following the ICPD, have, however, increasingly become aware of the importance of adolescent reproductive health. In several countries, especially youth organizations and NGOs, in particular, are developing culturally appropriate, broad-based adolescent reproductive health programmes with activities related to advocacy, IEC and services.

1.2 Adolescence

Adolescence is a distinct and dynamic phase of development in the life of an individual. It is a period of transition from childhood to adulthood and is characterized by spurts of physical, mental, emotional and social development. WHO considers "adolescence" as the period between 10 and 19 years of age which generally encompasses the time from the onset of puberty to the legal age of majority. For the purpose of the International Youth Year, the

United Nations has defined "youth" as encompassing the age range 15-24, overlapping with mid-adolescence as in WHO's definition.

While the onset of adolescence is usually associated with the commencement of puberty and the appearance of secondary sex characteristics, the end of adolescence is less well defined. It varies greatly from culture to culture as far as the attainment of adult independence is concerned. It is a time when influences outside the family take on greater significance. Adolescents find themselves facing new opportunities and are eager to assume new responsibilities. It is also a formative stage in terms of sexual and reproductive maturity. During this phase of transition from childhood, adolescents are often confused with the physical and emotional changes in their bodies and feel hesitant and embarrassed to discuss them with anyone. In most parts of the world, many individuals begin sexual relations during their adolescence. Therefore, adolescence is a critical period which influences one's reproductive health and well-being throughout life. Adolescent girls are especially vulnerable to the biological and social changes taking place during this time and their effects, due to the existing inequity between the sexes.

1.3. Changing Issues and Needs

According to recent statistics, more than 50 percent of the world's population are below the age of 25 and about one fifth of the world's population are adolescents (WHO 1995). The adolescents comprise about one-fifth of the total population, and when added to the 20-24 year old cohort, form about 29 percent of the population (Jones 1997). As this is a large percentage of the population, any change in the pattern of education, behaviour, age at marriage and life style of adolescents would have a significant impact on the societies in which they live.

Despite the importance of this period, not much is known about knowledge, attitude, reproductive health related behaviour and health and social support needs of adolescents in the region. Adolescence in general is a complex period and often not very well understood by both adolescents themselves as well as by adults. This is particularly true in relation to sexuality and reproductive health. A number of factors has affected sexual behaviour and reproductive health related risks in recent years. They include an apparent trend of declining age at menarche, an increase in age at marriage, improved levels of literacy, changes in cultural values brought about by rapid socio-economic changes such as globalization, urbanization, widespread availability and use of communication technologies, high migration rates, and decline in the prevalence of the extended family system. As a result, the period between sexual maturity and marriage has increased in most of the countries in the region. In addition, traditional customs which often discourage pre-marital sex have started to erode. These changes have also affected the sexual behaviour of boys and girls. Pre-marital sex for women has been unacceptable behaviour in most countries in the region, although it has usually been condoned for men, or may even be encouraged in some societies as part of

"becoming a man". But this too is changing, and sexual activity among unmarried teenagers (both boys and girls) is on the rise.

Although information is difficult to obtain, some broad patterns of sexual and reproductive behaviour can be noticed. In most countries in South Asia, compared to other developing countries, pre-marital sexual activity is uncommon - as is pregnancy and childbirth out-of-wedlock - but given the early mean age at marriage, adolescent pregnancy rates are high. Studies reveal that a substantial proportion of young people in many countries are, however, engaged in largely unprotected pre-marital sex (De Silva 1997). As a consequence, the risk of unwanted pregnancy and sexually transmitted diseases, including HIV/AIDS, has significantly increased for the adolescents and youth. Regardless of whether the pregnancy takes place in or outside marriage, there are serious biomedical hazards, especially for adolescents living in poor conditions with limited access to health services. Furthermore, since a large proportion of pregnancies are unwanted, they are more likely to end up as induced abortions, often under unsafe conditions with high risk of serious and long-term complications and even death. Adolescents are especially vulnerable to STDs including HIV/AIDS because of higher risk-taking behaviour, less knowledge of preventive methods, greater biological susceptibility to the infections and their sequelae, and limited access to health facilities for treatment. Although adolescents of both sexes face these risks, these are especially paramount for girls, who physically and emotionally suffer the adverse reproductive health consequences of sexual abuse, unsafe sexual behaviour and lack of social and physical access to reproductive health services, including access to information and supply of contraceptives.

2. Socio-demographic Profile of Adolescents in South Asia

The Asia-Pacific region accounts for about 60 percent of the world population of which one-fifth are adolescents. In South Asia, adolescents form 20-23 percent of the population. The countries are experiencing rapid demographic, social and economic changes which affect both the proportion of adolescents in the population and their roles, behaviour and needs in society. The sub-regions are distinctly different in terms of socio-demographic and fertility patterns with East Asia being more advanced in demographic transition than the countries in South Asia.

2.1 Growth of adolescent population

As can be seen from Table 1, there are significant variations among sub-regions in Asia in the projected growth of the adolescent population. Overall, the number of adolescents in the region will register an increase for the next 10-15 years, before starting to decline. However, the rate of increase (0.6 percent per annum between 1990 and 2000) has been slower than the growth over the past few decades. East Asia is more advanced and is already experiencing

a decline in the absolute number of adolescents, growth is relatively slow in South-East Asia. In South Asia is rapid. This differential pattern of growth reflects the fertility decline which has been very pronounced in East Asia and in parts of South-East Asia. Delayed onset of fertility decline is the main reason why the adolescent population is continuing to grow rapidly in South Asia. Within the broad sub-regions, there is considerable variation as well. For example, during 1995-2020, the growth is projected to be 85 percent in Pakistan but only 24 percent in neighbouring India. Similarly, in the neighboring subregion, during the same period while the number of adolescents are projected to increase by 18 percent in the Philippines and one percent in Indonesia, the numbers will decline by seven percent in Thailand and 10 percent in China (Jones 1997).

Even though, the proportion of adolescents in the population and their growth rate will begin to decelerate as a result of increase in elderly population and fertility decline, the next 10-15 years will especially be a challenging period for adolescent health in view of the rapidly changing economic and social environment of the countries in the Asian region, including in the South Asian countries.

Table 1 : Number (in thousand) of persons in age group 10-19 and their percentage in total population by subregion, 1995-2020

Sub-regions	1995	2000	2010	2020
East and North-East Asia	227,178 **(16.0)**	243,473 **(16.4)**	224,452 **(14.2)**	204,664 **(12.3)**
South-East Asia	103,156 **(21.4)**	107,669 **(20.7)**	111,433 **(18.8)**	108,074 **(16.4)**
South and South-West Asia	296,435 **(21.6)**	327,730 **(21.8)**	341,730 **(19.4)**	358,048 **(17.9)**
North and Central Asia	36,097 **(16.9)**	38,449 **(17.9)**	29,408 **(13.4)**	29,604 **(13.3)**
Pacific	4,418 **(15.6)**	4,658 **(15.4)**	5,186 **(15.1)**	5,521 **(14.3)**
ESCAP	667,284 **(19.0)**	721,839 **(19.2)**	712,209 **(17.0)**	705,911 **(15.4)**

Note: *Percentage is in parentheses*
Source: *World Population Prospects 1996 (United Nations)*

2.2 Age at marriage

In all societies, marriage marks an important transition in a person's life. As marriage determines largely the onset of sexual activity - at least for women - in most of the countries in South Asia, age at marriage has been considered important in this respect. Nonetheless, whom a woman marries and when she does so are decisions over which she may have little control. In most South Asian countries, the age at marriage for women is 3-6 years lower in comparison with the age at marriage for men. As shown in Table 2, in Bangladesh about 50 percent of women aged 20-24 were married by age 15 and 82 percent by age 20. Similarly, India and Nepal also shows a high rate of adolescent marriages with 71 percent and 76 percent women aged 20-24 married by age 20, respectively. Sri Lanka is the only South Asian country where 76 percent women marry in their twenties. Bangladesh shows the most dramatic difference with 8 percent of boys compared to 76 percent girls married in the age group 15-19 (De Silva 1997).

Most countries in South Asia have shown a trend towards increasing age at marriage of both sexes, i.e. marriage before age 18 is less common than it was one generation ago. Compared to what they were a generation ago, levels of early marriage have decreased by one quarter in Bangladesh and India (The Alan Guttmacher Institute 1998). Similarly, in Nepal, the mean age at marriage has increased from 15.4 years in 1961 to 18.1 years in 1991 with proportion married at ages 10-14 declining from 25 to 7.6 percent during the same period (Nepal 1998). The age at marriage has increased more for women than for men, leading to narrowing of age difference between spouses. In Bangladesh, teenage marriage, though still prevalent, has declined from 75 percent in 1974 to 51 percent in 1991.

Table 2: Percentage of women 20-24 married by age 15, 18, 20; and median age at first marriage in selected countries in Asia.

	Age 15	Age 18	Age 20	Median age at first marriage
Bangladesh (1993-4)	47	73	82	14.1
India (1992-3)	26	54	71	16.1
Indonesia (1994)	9	31	48	17.7
Japan (1992)	0	0	2	26.4
Nepal (1996)	19	60	76	16.4
Philippines (1993)	2	14	29	21.4
Sri Lanka (1993)	1	12	24	22.4
Thailand (1987)	2	20	37	20.5
Vietnam (1998)	1	9	31	-

Source: De Silva 1997, Singh 1996

Socio-economic development, such as improved education, increased urbanization, more employment opportunities and greater access to communication technologies have a potential influence on age at marriage. This pattern is observed in India, where among rural women aged 20-24, a higher incidence of marriage before age 20 (80%) or in early adolescence - age 10-14 (about 30%) - takes place compared to their counterparts in urban areas (about 50% and 11% for marriage before the age of 20 and early adolescence respectively) (International Institute of Population Sciences 1995).

The implications of the changing marriage pattern for young men and women are significant with adolescence becoming an extended period before marriage, raising issues about pre-marital sexuality and relationships with the opposite sex. A smaller age difference between spouses, improved opportunities for education and employment has usually positive implications as it tends to increase gender equality.

2.3 Education

In all regions of the world, getting a education has become key to hopeful future. Though Governments have clearly taken strides towards making basic education more widely available, young people in many parts of the world are not always able to attend school, because of their gender or economic status of the family or because they live in remote or underserved communities.

In some countries, educational disparities between urban and rural areas are noteworthy. In Pakistan, for instance, 56% of urban girls have at least seven years of schooling, while in rural areas the proportion who have attended school for seven years is only nine percent. The comparative figures for urban and rural areas are 60 and 35 percent for India, and 40 and 21 percent for Bangladesh. Drop-out rate within primary education is also quite significant. For example, less than 50 percent reach grade 4 in Bangladesh (World Bank 1994 and 1997). There is a wide difference in school attendance between boys and girls, with the school enrollment rate being significantly lower for girls in most countries. Enrollment rates for girls are significantly lower in Bangladesh, India, Nepal and Pakistan, although an impressive improvement has been witnessed in these countries between 1980 and 1993 (World Bank 1994 and 1997).

Table 3: Education status among adolescents in selected countries in South Asia

Country	Secondary school enrollment		women 15-19 with 7 years or more of schooling	
	Males	Females	Urban	Rural
Bangladesh, 1993-1994	25	13	40	21
India, 1992,1993	59	38	60	35
Pakistan, 1990-1991	28	13	56	9
Sri Lanka, 1987	71	78	u	u

Note: -u- unavailable
data indicated as percentage

Source: UNESCO, 1995

At secondary level, gender differences in enrollment and drop-out rates are substantial between the countries, as well as between socio-economic groups within countries (Table 3). Though the rates have increased in most countries, especially for girls, substantial gender differences remain. The gender gap is wide in all South Asian countries, with the exception of Sri Lanka, where secondary school enrollment rate is higher for girls (78% compared to 71% for boys). Educational disparities between urban and rural areas are larger than gender differences. In Pakistan, for instance, 56% of urban girls have at least 7 years of schooling, while in rural areas this proportion is only 9 percent. This situation reflects the lower value attached to girls and the need for educating them, and the traditional roles assigned to men and women with regard to their expected economic contribution (by men) and early marriage (of women). Although it appears that the gender gap in primary and secondary level education is narrowing in most countries, concerted efforts are called for in order to improve the situation in all South Asian countries except Sri Lanka.

2.4 Fertility patterns

To have a child before age 15 is rare throughout much of the world with less than 3 % women in developing countries giving birth by this age. Fertility outside marriage, is extremely rare in South Asian countries compared to other developing countries. However, given an early age at marriage in most South Asian countries, fertility at young ages tends to be high. Newly married couples often find themselves under pressure by the elders in the family to begin childbearing following the wedding. In most Asian countries, less than 20% of women have their first birth before age 18, with exception of Bangladesh and India (30% and 50% - The Alan Guttmacher Institute 1998). Age-specific fertility rates are highest in

South Asia ranging from 71-119 births per 1000 women compared to East Asia where fertility levels range from 4-5 births per 1000 women aged 15-19 (Jones 1997).

Table 4. Adolescent Childbearing in Selected countries in South Asia

Country	women 20-24 who gave birth by age 20	women 40-44 who gave birth by age 20	women 20-24 who gave birth by age 18		
			All	If had fewer than 7 years of schooling	If had 7 or more years of schooling
Bangladesh, 1993-1994	66	85	47	54	19
India, 1992,1993	14	22	2	3	1
Pakistan, 1990-1991	31	38	17	21	2
Sri-Lanka, 1987	16	31	5	u	u

Note: data indicated as percentage; Source: The Allan Guttmacher Institute 1998

The age-specific fertility in most South Asian countries has declined over the years. Young women are less likely than women of their mother's generation to have their first child during adolescence. For example, in Bangladesh, India and Pakistan, levels of adolescent childbearing among women aged 20-24 are about 80% of those found among women aged 40-44, while in Sri Lanka the levels are one-half those of the previous generation (Table 4). However, it is questionable whether the risk of teenage pregnancies, which is a better indicator of the fertility status, has decreased. It is difficult to collect data on a systematic basis on teenage pregnancy. With the decline in the TFR and the increase in contraceptive use among older women of reproductive age, fertility tends to be concentrated among the adolescent group. For example, in India, the proportion of all births to adolescents between 15-19 increased from 11 percent in 1971 to 13 percent in 1989 and 17 percent in 1992-93 (International Institute of Population Sciences 1995). The health and social consequences of adolescent pregnancy are discussed in subsequent sections of the paper.

Urban women may delay the birth of their first child because they have better access to education and employment opportunities than do rural women. In every region of the world, including South Asia, women who have completed their basic education are far more likely to have their first baby after their adolescent years than women without basic education. Data from India, Bangladesh, India and Pakistan indicate that percentage of women 20-24 who gave birth by age 18 are up to 4 times higher when they have fewer than 7 years of schooling (Table 4).

2.5 Sexual Attitudes and Behaviour

With the decline in average age at menarche and the trend of increased age at marriage, the length of time that adolescents may experience pre-marital sexual activities also increases. Recent socio-economic developments have influenced the cultural values that makes pre-marital sexual activities more appealing and acceptable to adolescents. Even though, relatively limited information is available on sexuality patterns of unmarried adolescents, some recent surveys provide useful insights as to now sexual attitudes and behaviour are rapidly changing with serious short and long-term implications for reproductive health. These studies include information on the prevalence of sexual activity, age at first encounter, and source of knowledge about sexuality issues.

Sexual activity begins in early adolescence for many men and women in Asia. However, unlike other sub-regions, the onset of sexual activity in South Asia occurs largely within the context of marriage, where age at marriage is relatively low for both men and women. National surveys in many countries, including in South Asia, do not collect data on sexuality patterns of unmarried women. Young men are often not included in surveys of reproductive behaviour, so much less information is available about them. However, given the increase in age at marriage, information on issues related to unmarried adolescents become important for planning and delivery of reproductive health services. Results of special studies conducted in some South Asian countries and data available from other countries in Asia suggest that:

(a) Rates of sexual activity among unmarried adolescent women are low, but under-reporting of nonmarital relationships because of strong social disapproval cannot be ruled out. For example, in a rapid assessment study conducted in three districts in Nepal, the prevalence of premarital sexual activity is reported to be 19.2 percent (Nepal 1998). In a survey conducted in Philippines indicates that never-married women aged 15-19 years reported a lower pre-marital sexual activity than those who were married at the time of the interview (0.4% and 13% for never and ever-married women aged 15-19)(National Statistical Office, Philippines 1994).

(b) Men are more likely to become sexually active and they do so at a younger age than do their female peers. A multicenter study from India carried out among 15-29 years old, reports that pre-marital sex is relatively more acceptable to men (18%) than to girls (4.2%). These data reflect the differential attitudes and standards for men and women, tolerating sexual behaviour among unmarried men, while restricting or condemning it among unmarried women. As in other age groups, a higher percentage of men aged 15-19 (16%) than women (3%) reported to be sexually active. The average age at their first sexual encounter was 16 years for men and 18 for women. It was noted that the average age at first encounter was declining with time (Family Planning Association of India 1995).

(c) Parents appear to play a minor role in informing their children about issues related to sexuality. When in need, adolescents (and young people) seek advice from peers and friends, who may be equally uninformed or incorrectly informed, rather than from their parents for fear of being punished or not being understood (Department of Health, MOPH, Thailand 1997).

(d) Commercial sex workers serve as the partners for first time sexual encounters which often take place without contraceptive protection. For example a study conducted in Thailand reported that for about 14 percent of the urban youth and 22 percent of the rural youth commercial sex workers are the first sexual partners. The first sexual experience for many men and women (56 percent for rural males and 75 percent for urban women) was reported to be without any contraceptive protection (Podhista and Pattaravanish 1995).

3. Adolescent Reproductive Health Issues and Concerns

The socio-cultural and health consequences of unprotected adolescent sexual behaviour are more severe for adolescent girls than for boys and are mainly associated with unwanted pregnancy, adolescent childbearing, STD including HIV/AIDS and the related social repercussions for women such as the forced termination of education, lower economic opportunities and the social condemnation by the community. These risks are largely avoidable by developing and implementing broad-based preventive interventions aimed not only at adolescents but also at parents and elders in the community and national policy makers and programme managers.

In comparison with the health status of children and adults, adolescent health has largely been ignored. One of the reasons often put forward is that adolescents, as a group, are generally healthier than others, despite the low health status of young girls is observed in various countries. This understanding about adolescents might be correct when comparing the morbidity and mortality patterns of adolescents with those of younger and older cohorts in a given country. However, particular behaviour acquired during adolescence frequently has long-term reproductive health consequences. Given the enormous public health and social implications - including the cost involved to manage the disease(s) that manifest many years later - makes strong arguments for making investments in adolescent reproductive health.

3.1 Unwanted pregnancy

Given the social restrictions on adolescent sexuality and cultural unacceptability of pre-marital pregnancy in most countries, abortion is a likely outcome of a unwanted pregnancy. Adolescents, perhaps initially, unaware of a pregnancy, or fearing the social consequences,

are more likely to hide the pregnancy and tend to seek abortion relatively late during pregnancy. Due to socio-cultural factors, as well as financial constraints, abortion is more likely to be performed under clandestine and unsafe conditions by untrained providers. Adolescents are therefore seriously at risk of serious complications (hemorrhage, septicemia, injuries and infertility) and even death from procedures performed during the second trimester of the pregnancy, often under unhygienic conditions by untrained providers.

The abortion tends to be kept secret by most adolescents. A study from Vietnam indicates that only one quarter of women aged 15-24 who underwent an abortion shared the experience with a friend and only 13 percent with a family member. Family members are informed only when the pregnancy is late and difficult to hide or when a parent's authorization is required for the procedure (Institute of Sociology 1996). The situation is likely to be similar in South Asia. Data on the prevalence and safety of abortions, especially for illegally performed procedures, is difficult to collect. It is estimated that 1 to 4.4 million abortions per year take place among adolescents in developing countries (Center for Population Options 1992). In some countries in Africa, adolescents account for 74 percent of all induced abortions, 60 percent of all gynecological admissions to hospitals, and 80 percent of patients with abortion related complications are women under 19 (Adetoro, et al 1991). In Thailand, the cost of managing complications of unwanted pregnancy to the health system, as in the African countries, is substantial and 25 percent of women admitted to hospitals for such complications are students (Koetsawang 1993). In India, 30 percent of all hospital abortions are performed on women under 20. Although, as in other countries, most abortions in India are carried out in the first trimester, among teenagers most procedures are performed in the second trimester (Solapurkar and Sangam 1985).

Unwanted pregnancy and induced abortion can be avoided through use of effective contraceptive methods. Many factors influence whether an adolescent woman uses a contraceptive method. Her marital status, and her desire to have a child are important determinants, although in many countries, societal norms and expectations have even greater influence. Thus access to information and services to prevent unwanted and too-early pregnancies is the exception rather than the rule in most countries in the world, including those in South Asia. There are often legal as well as social restrictions to the provision of contraceptive services to unmarried adolescents. Data on contraceptive use is usually available for married adolescents only. As shown in Table 5, recent data from DHS and other surveys on ever-married women indicate that although many adolescents have a knowledge of contraceptive methods, current use among adolescents compared to older women is low. Contraceptive use among adolescents varies markedly, from 3 percent in Pakistan to 30 percent in Sri Lanka. Such variation is less marked among women aged 20-24 (De Silva 1997, The Alan Guttermacher Institute 1998). Knowledge regarding contraceptive method does not mean that the young person knows how to use the method properly. For example, in a survey of secondary school students in Kenya, only one in three male students and one in four females knew that contraceptive pills were for use by women and not men,

and even fewer knew that the pill had to be taken daily rather than prior to the intercourse (Kiragu et al 1995). These findings highlight the magnitude of the unmet need for family planning for married and sexually active unmarried adolescents since pregnancy among adolescents is associated with high risk of mortality and morbidity.

Table 5: Contraceptive knowledge and current use among women 15-19 and 20-24 in the selected countries in South Asia

Country	Knowledge				Current Use (Any method)	
	Any method		Three or more			
	15-19	20-24	15-19	20-24	15-19	20-24
Bangladesh (1993-4)	99.5	99.8	98.0	98.9	24.7	48.2
India (1992-93)	90.4	96.5	65.5	77.3	7.1	44.7
Pakistan (1990-91)	59.0	-	-	-	3.0	-
Sri Lanka (1993)	96.3	98.9	-	-	30.3	53.6

Source: De Silva 1997, The Allan Guttmacher Institute 1998

As regards unmet need of unmarried adolescents for information and means to prevent unwanted pregnancy is concerned, the ICPD- POA (para 7.12) clearly states:

> *"The aim of family-planning programmes must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods.... Informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities...."* (UNFPA 1996).

Countries now face the challenge of translating the Cairo consensus into action.

3.2 Adolescent childbearing

Childbearing always carries potential health risks for all women. However, the risks are increased, and new hazards emerge, when a young adolescent regardless of whether she is married or not becomes pregnant. Young adolescents are up to four times as likely as women older than 20 to die from pregnancy related causes (McCauley et al 1995). There are serious

health consequences especially for adolescent girls living in poor conditions and where access to health services is limited. Young age is a risk factor for maternal mortality in all countries, but in developing countries, where the risk of death in pregnancy and childbirth may be as much as 100 times higher and where pregnancy at young ages is common, maternal mortality makes a significant contribution to the total number of deaths during this period of life. Young women who are younger than 17 years, have often not reached complete physical maturity, and as such their pelvis may not be wide enough to accommodate baby's head. In such circumstances, prolonged and obstructed delivery is common and these difficult deliveries can result in hemorrhage and death of both the mother and the child.

It has been shown that in several countries including Bangladesh, Indonesia and Egypt, a large proportion (26-37%) of deaths among female adolescents can be attributed to maternal causes (WHO 1995). A study in Bangladesh showed that girls aged 10-14 and 15-19 were five and two times more likely to die from maternal causes compared to women aged 20-24 (Chen, et al 1974). In Bangladesh, the excess of female deaths over that of men in the age group 15-24 can be attributed to maternal mortality (Fauveau, et al 1989). In addition to the risk of deaths, adolescents also face a high risk of serious complications, some of which have long-term consequences. In contrast, in Sri Lanka, as is the pattern in the developed countries of low fertility and maternal mortality levels, death rates are lower among women than men (UN 1991).

The causes of higher levels of maternal mortality and morbidity among adolescents are due to:

- **Medical factors**: Adolescents are more prone to develop some specific complications compared to older women. A study from Bangladesh shows that deaths from hypertensive disorders of pregnancy and abortion are twice as high among teenagers as among women aged 20-34 (Fauveau, et al 1988). Similarly, as mentioned above, the adolescents are more likely to suffer from prolonged and obstructed labour, and therefore require special care, including for surgical interventions, in hospital settings. When such care is not available, the risk of death and long term serious sequelae such as obstetric fistula is high.

- **Service-related factors**: Because adolescents are less likely to avail of antenatal or delivery care for a variety of reasons, they are at an increased risk of death. Many of the pregnancy related complications such as hypertension and anemia can be prevented or recognized early and managed through timely provision of antenatal care. However, adolescents often do not seek or lack access to such services due to economic and social reasons. Consequently, the treatable conditions progress to life threatening levels. In Bangladesh, less than 40 percent of all pregnant women obtain any antenatal care. Even though skilled care is needed for assistance during delivery,

in India no more than 25 percent adolescent mothers give birth a health facility; in Bangladesh the proportion is only 3 percent (The Alan Guttmacher Institute 1998).

- **Reproductive risk factors**: Age and parity which are risk factors for maternal mortality and exert independent effect, place adolescents at a higher risk.

- **Social factors**: Since adolescents are more likely than older women to be unmarried and lack social support, they are at substantially increased risk of mortality. For example, in Bangladesh deaths from violence (including suicide, homicide, complications of induced abortion) were four times higher among 15-19 year old adolescents than among women aged 20-34 (Fauveau, et al 1988).

3.3 Sexually Transmitted Diseases (STDs) including HIV/AIDs

STDs were until recently a widely ignored aspect of health. However, with the advent of the HIV/AIDS pandemic, the attention of the world community has focussed on other STDs as well. Young people have been recognized as a high risk group, both for high risk behaviour and, possibly for young women, for susceptibility of STD infections. It is estimated that about 50 percent of HIV infection is among people aged 15-24 and that many of the sufferers contract the infection before they are 20 years of age (UNFPA 1997). Young people who become sexually active early, are more likely to change sexual partners, and risk greater exposure to STDs. Young women are particularly at risk due to biological factors and greater vulnerability to abuse and forced sex. In Asia, a large number of adolescents girls are working in prostitution. In Thailand, it is estimated that there are 800,000 sex workers under 20 years of age, of which 200,000 are below the age of 14. Many of them were forced into prostitution, live and work in slavery conditions, have little power to negotiate condom use with their clients, are usually uninformed and ignorant of basic RH issues, and have little access to services. Even if the services would be available and they have freedom of movement, they are more reluctant to seek help from health services for financial and social reasons in fear of being turned away or looked down upon by health providers (IPPF 1992). Since many STDs are asymptomatic, adolescent women may not even realize that they have an infection. As the cervical mucus of young women is different than that of their older counterparts, this makes them more susceptible to certain types of STDs. Moreover, individuals infected with an STD will increase their risk of contracting or transmitting HIV/AIDS. Long term health effects of untreated STDs are also noteworthy. Untreated gonorrhea, for example, can lead to sterility in men and to ectopic pregnancy, tubal infertility and chronic pelvic pain in women. Infection with human papilloma virus is associated with cervical cancer.

While it is recognized that STDs including HIV/AIDS is an emerging issue of great magnitude, knowledge about the epidemiology of STDs by the public in the region is limited. There are no surveys to indicate the prevalence of different STDs among different sub-

populations or how the pattern is changing over time. Of the total number of STDs reported in Sri Lanka, approximately 6.5 percent were in the age group 15-19 with syphilis and gonorrhea being among the common STDs in this age group. In another study, it was observed that while awareness among 15-19 is high about HIV/AIDS (88-97 percent), the knowledge was low regarding the protective role of condoms (Sri Lanka 1998). There is a common misconception that STDs can affect only a small proportion of the population, usually commercial sex workers. Since it is a sensitive issue and was considered a taboo until very recently, accurate data are lacking in most countries. Prompted by the efforts to understand and address the spread of HIV/AIDS, the few studies that have been undertaken make it clear that the risk of STDs extends to other groups as well, and not only commercial sex workers. In a study conducted in 1992 among 450 sex workers in Calcutta, it was found that only one percent used condoms on regular basis. Laboratory tests confirmed that HIV and STD prevalence in this group was one percent and 80 percent, respectively (All India Institute of Hygiene and Public Health 1992). Data on HIV prevalence tends to be better documented though information on distribution of the disease by age is not systematically collected. In spite of the lack of data on age and specific sub-groups, it is clear that the issues of STDs and AIDS cannot be separated. Comprehensive strategies are needed which reinforce the inter-linkages between STDs and HIV/AIDS.

4. Special gender considerations

Although gender issues have been addressed throughout the paper, this section focuses on some specific gender consideration that deserve special attention.

In order to improve adolescent reproductive health (ARH), it is imperative to include a gender perspective into all such programmes and policies. Whereas "sex" refers to the *biologically* determined universal differences between men and women, "gender" refers to the *social* differences between men and women, that are learned, changeable over time and have wide variations both within and between cultures. The gender roles in a given society condition which activities, tasks, and responsibilities are perceived as *male* and which as *female*. This has major implications for the reproductive health status and needs of adolescents. Prevalent socio-cultural views affect the way adolescents approach sexuality and reproduction, the way adolescents' sexuality is perceived, whether they have access to information and services and are able to protect themselves from unwanted pregnancies and STDs.

As children grow up, boys and girls receive different attention and different messages from their social surrounding about how to behave and what to do. Some behaviours are expected from boys but not accepted from girls. Especially in the area of sexuality, major differences exist in gender roles between men and women. In the South Asian context, the double standard in attitudes and behaviour related to sexuality is one of those expressions. Men, or

boys for that matter, have much more freedom to experience and express their sexuality, while for women and young girls, such expressions are not considered appropriate and their sexuality is often under the control of men. The promotion of gender equality in reproductive rights is one of the areas which appears to have been neglected in the government and the international community programmes and it commands major attention in the future.

In South Asia, many cultures place a higher value on males than females which results in girls receiving substantially less food and education than boys while growing up, and less medical attention when sick. Existing gender norms may place girls at higher risks for sexual abuse and violence. Because women and girls often lack the ability to control when they have sex and with whom, there is an urgent need to incorporate gender sensitivity and empowerment of girls into all ARH programmes (Network 1997). Boys need to be involved in these programmes in order to make them more gender sensitive and responsible. Health care providers need to be aware of the different gender values placed on boys and girls and the different options each of them have with regard to access to information and services and control over their own sexuality and fertility.

The way in which different societies may make a woman suffer for her reproductive role has been described as follows:

> *"As a menstruating girl, she may be set aside as unclean, polluting, and made to feel dirty and ashamed. As a teenager, she may be married to someone she does not know, and made pregnant before her own body is fully grown. As a woman unable to bear children, she may be abused and abandoned, even though it may be the husband who is infertile, or even if her infertility is caused by a sexually transmitted disease originally contracted by her partner. As a pregnant woman, she may be denied the basic consideration, the rest and the food and the antenatal care, to which she is entitled. As a woman in labour, she will run the risk of dying from the lack of obstetric care, and of sustaining injuries and disabilities for which she will not receive treatment. As a woman enduring a prolonged childbirth, she may be left to die alone and in agony. ..... As a woman suffering from a childbirth injury.....she may die because her husband will not allow her to be seen by a male doctor. As the mother of a baby girl, she may be blamed and beaten despite the fact that it is the chromosomes of the male that determine the sex of the baby. As a wife, she may be forced to submit to sex within a few days of giving birth, or subjected to violence if she refuses. As a new mother, she may be expected to become pregnant again before her body has recovered. And finally, even if she has sustained an injury or infection that is serious and treatable, and even in those rare cases when health worker seek her out knowing that she will not come to them, she may still not be allowed to go into hospital because there will be no one to cook the meals"* (UNICEF 1996).

The major reason for levels of child malnutrition - which is markedly higher in South Asia than anywhere else in the world - is the poor care that is afforded to girls and women by their husbands and by elders, due to the lower value placed on women in society (UNICEF 1996).

The vulnerability of young girls to sexual abuse and exploitation is another area which needs urgent attention in the region. Dr. Nafis Sadik, Executive Director UNFPA, in her recent correspondence to all staff, drew attention again to the recommendations of the ICPD-POA regarding the elimination of violence against women and the girl child by reiterating UNFPA's and its United Nations partners' commitment to the elimination of gender-based violence. She reiterated that UNFPA will develop a conceptual framework and plan special activities linking gender-based violence with reproductive health in order to further strengthen UNFPA's support on these issues. (UNFPA HQ 1998).

Underreporting of gender-based violence in the region, especially against young girls, is widely acknowledged. (De Silva 1997; UNFPA/CST Kathmandu 1998; United Nations Division for the Advancement of Women 1997). Adolescent girls are in need of special protection and an enabling environment should be created for the realization of human rights and empowerment of adolescent girls while adolescent boys should be educated in order to become more gender-sensitive, and inculcate a positive image of women. UNFPA Pakistan recommends the strengthening of the legal framework for dealing with cases of domestic violence, rape and prostitution among adolescent girls, and the increase of legal Aid Centers throughout the country (Rafiq 1997).

The last few decades, a dramatic increase in the commercial sex trade (including trafficking) of women and children has taken place in various countries in the region. According to the 1996 Report of the UN Special Rapporteur on the Sale of Children, Child Prostitution and Child Pornography, about 1 million children in Asia are currently victims of the sex trade (Calcetas-Santos 1996). The ILO/IPEC Report prepared for the World Congress on Commercial Sexual Exploitation of Children (Stockholm 1996) notes that trafficking of children, especially of young girls among the neighbouring countries of Thailand, is on the rise. Girls from Cambodia, China, Laos, Myanmar and Viet Nam are reported to be sold to brothels in Thailand. In South Asia the problem is becoming more visible in countries such as Bangladesh, India, Nepal and Sri Lanka, where NGOs and governments have reported that extensive trafficking of girls takes place across national borders, such as young girls from Nepal who are being lured and forced to work in brothels in major cities of India (ILO/IPEC 1996). The UNFPA State of the World Population 1997 reports the estimate of 300,000 Nepalese women having been sent to brothels in India. UNFPA Sri Lanka reports of the "alarming sexual exploitation of youth, especially in the vicinity of the Western and Southern coastal belt. It is estimated that there are approximately 30,000 child prostitutes." (UNFPA Field Office, Colombo 1998). The ILO/IPEC report states that commercial sexual exploitation is one of the most brutal forms of violence against children as it results in life-long, and in many cases, life threatening consequences for the future development of children

as they are at risk of early pregnancy, maternal mortality and STDs, including HIV/AIDS. References are made to case studies and testimonies of child victims which reflect traumas so deep that the children are often unable to re-enter or return to a normal way of life, while many children are reported to die before they reach adulthood (ILO/IPEC 1996).

The ICPD-POA (para 4.23) on the girl child urges governments to:

> *"..take the necessary measures to prevent infanticide, prenatal sex selection, trafficking in girls and the use of the girl child in prostitution and pornography."*

(para 6.10) states:
"Countries should take effective steps to address the neglect, as well as all types of exploitation and abuse, of children, adolescents and youth, such as abduction, rape and incest, pornography, trafficking, abandonment and prostitution. In particular, countries should take appropriate action to eliminate sexual abuse of children both within and outside their borders" (UNFPA 1996).

5. Challenges and Constraints in Meeting Adolescent Reproductive Health Needs

The countries in South Asia have been aware of adolescent reproductive health needs long before the 1994 ICPD and have responded in various ways to meet those needs mainly through IEC, population education, family life education programmes, and out-of-school interventions. The overriding emphasis of those programmes and interventions during the 1970s and 1980s was the relationships between population and development, the dominant theme that ran through the various educational and training curricula. The programmes paid little attention to the needs of the youth and skirted addressing the issues of reproductive health and human sexuality which were beginning to emerge (particularly in the 1990s) as a result of the economic and social changes taking place.

The concern of most countries during the 1970s of the population and family planning programme was filling in the knowledge gaps among the youth. It was thought that knowledge of impact of rapid population growth would translate into individual RH behavioural change. Learning was however passive; the youth including the adolescents were not taught how and where to seek information and services. Because of perceived cultural sensitivity on the matter, this knowledge change was not supported with the appropriate programmes and services tailored to the needs of the young. Rather, this gap left the adolescents to seek RH information from peers whose knowledge on RH matters might be inadequate or even inaccurate.

The population and family planning programmes during the 1970s and 1980s reinforced this emphasis by focusing exclusive attention on married couples of reproductive age, thus indirectly ignoring the health needs of the unmarried youth. Fortunately, however, this imbalance had been recognized by many countries in the 1990s with the result that the needs of the youth, including adolescents, have received special attention in the ICPD-POA. These needs are now a major concern of many countries worldwide, including South Asia.

5.1 Lack of Data and Information on Adolescents

As mentioned earlier in the paper, the lack of information (qualitative and quantitative) on actual adolescents' behaviour, knowledge, views, needs and problems in most of the countries in the region poses serious problems for any programme or activity to be developed in the field of ARH. In view of the major differences in behaviour and needs of various sub-groups within the adolescent population, such as young adolescents (10-14) and older adolescents (15-19), between boys and girls, rural and urban adolescents, married and unmarried youth, and various ethnic groups, adolescents should not be addressed as if they form one homogenous group.

There are many reasons for the scarcity of information on adolescents - particularly unmarried adolescents:

- Young people, as a group with its own identity and needs, are not considered relevant or important, or addressed as a special target group in current RH programmes. As they are in-between childhood and adulthood and have a limited power base, adolescents are generally not represented and reflected in the usual national statistics, policies and programmes. Their RH health needs have been seriously neglected.

- Lack of fora for interactions between youths and adults (teachers, parents, etc); and limited "positive" attention for adolescents in the media.

- Unmarried adolescent are not expected to be sexually active; if they are, it is frowned upon and in case of a girl may result in serious repercussions by the social environment. Pre-marital sex is still a taboo and to be avoided at any time. Research undertaken in this field remains highly sensitive, and under-reporting of sexual experiences of unmarried youth poses also serious problems.

- The concept of adolescence and ARH is relatively new for most countries in the region. Lack of information and understanding inhibits the formulation of effective policies and appropriate programmes, including undertaking of research.

- Major socio-economic changes are taking place in the region, which also have an impact on the lives and views of many groups of adolescents (increased education,

later age of marriage, AIDS, labour migration, urbanization, sexual exploitation).

5.2 Misconceptions

Throughout the Asian region, where information on adolescents reproductive health and sexuality is virtually non-existent and many taboos continue to prevail about discussing sexuality, adults share the strong believe that providing family life or sexuality education[1] in schools leads to earlier or increased sexual activity by young people. A recent review of 35 studies shows that sex education was found to lead to an increase in the adoption of safer sexual practices by sexually active youth, and that young people delayed starting sexual activity or decreased their overall sexual activity. It was also found that sex education was most effective when given *before* a young person became sexually active, and those which promoted a choice of options - including postponement of sex and protected sex - were better received and more effective than those which promoted abstinence. As not all adolescents are "in school" at that period in life, particularly girls, "out-of-school" education approaches need to be developed (IPPF 1994).

The knowledge of adolescents - whether married or unmarried - of a variety of reproductive health issues, including sexuality, reproductive functions, contraceptives, safe sex, etc., appears to be limited.

The earlier sections have shown the increase of sexual activities among unmarried adolescents in almost all countries in the region. De Silva states therefore:

> *"Marriage in the Asia-Pacific region countries has long been used by researchers as a determinant of exposure to sexual relations. The age at entry into first marriage is often viewed as the age of initiation into sexual intercourse. More recent information collected from many surveys indicates that this assumption is no longer valid in Asian societies. The increase in age at marriage tends to increase pre-marital activities and use of contraceptives."* (De Silva 1997).

The differences in sexual behaviour between boys and girls is, however, very obvious and as mentioned earlier, is partly the result of the existing double standards which condone pre-

[1] Many different terms exist for education for young people on population, reproductive health issues. Sexuality education does not teach young people how to have sex, but explores the wide area of human sexuality, including subjects such as: reproductive system, anatomy, conception and the prevention of conception, STDs, friendship and relationships, communication and decision making, responsibilities, gender aspects of sexuality, violence, etc. Family life education usually refers to a broader programme and can cover a wide array of socio-cultural, socio-medical topics but might in reality totally avoid the subject of sexual and reproductive health, including conception, contraceptives and STDs.

marital sex for boys but condemns it for girls.

In addition, the rapid increase in STDs and HIV/AIDS in most of the countries in the region has made the need for effective ARH programmes even more urgent, especially in view of the limited knowledge of effective protection among teenagers.

5.3 Inadequacy or Lack of Appropriate Information and Services

In order to be effective, information and education on sexual health must be linked with service delivery. Providing education and counselling alone without access to RH services, including contraceptive services, could be considered as an infringement of the rights of young people to take care of their own sexual health. Similarly, providing services without information and education ignore the factors that determine usage.

Access to information: Providing RH information and education is necessary to help young people explore their own attitudes, values and options, as well as increase their knowledge and understanding of RH issues. Although there exist great variations between different cultures, studies have shown that adolescents in many developing countries rarely discuss sexual matters (e.g. sexual intercourse, sexuality and sexual preferences, menstruation) explicitly with their parents or with adults older than themselves. Most information on these subjects comes either from their peers, who may be equally uninformed or incorrectly informed and are likely to be relatively inexperienced themselves, or from the media which tends to represent either sexual and gender stereotypes or extremes.

Young people are often not ignorant of how their bodies function in terms of sex and reproduction, and frequently they express a strong desire for the opportunity to discuss such issues with an *informed, nonjudgmental* adult. Unmarried adolescents often have no knowledge of, or access to, family planning services and are at risk of an unwanted pregnancy or acquiring a sexual transmitted disease, including HIV/AIDS. Providing young people with information on sexuality and reproductive health is a delicate subject in all countries of the region. Adults do not like to discuss sex, and too often do not want to face the fact that adolescents might be sexually active. Many take the position that only abstinence before marriage is acceptable, even though this contradicts what is actually happening among a growing number of adolescents.

Most young people in the region simply do not have access to RH education and training as this does not form part of their school curriculum or because they leave school at an early age. Experience with adolescent education so far has shown that in addition to the normal school curriculum, what they need are *life skills* to empower them. Adolescents need clear *information,* in non-medical terms about: sexual development; reproductive health and family planning; gender issues and the need for gender equality; and STDs and HIV/AIDS, as early as possible. They need *skills* to learn to handle social and peer pressure, ambivalence,

assertiveness and reproductive protection. They need *help in developing skills* for responsible behaviour, gender equality, the ability to anticipate, analyze, plan, make decisions, learn how to communicate with others and to share. These skills can be taught to adolescents within school, out-of-school and in the workplace through teachers, parents, peers, the community and the media. Especially out-of-school adolescents comprise a varied and, frequently hard-to-reach group and are at a much higher risk for becoming pregnant or acquiring an STD. Each sub-group of adolescents has its special needs for which different approaches are necessary. However, a recent evaluation of seventy UNFPA supported ARH projects throughout the world found that most projects focus, on the easy-to-reach in-school-youth while the poor, unemployed and rural youth are almost completely neglected and seriously underserved. In Asia, a strong bias was found towards addressing elderly youth, well above twenty or university-based, while the actual adolescents were overlooked (UNFPA 1997).

The population/family life education which currently forms part of the school curriculum in only few countries in the region is usually not designed to prepare adolescents for the future roles and demands. It does not correspond with adolescents' experience of sexuality, and seldom includes subjects such as contraceptives, STDs/HIV/AIDS, sexuality, sexual violence and abuse, etc. but mainly focuses on macro-demographic issues. The present education system teaches mainly cognitive skills but pays little attention to developing the life skills of adolescents. The majority of adolescents are, however, out-of-school and simply receive no basic RH information during those years at all. Teachers are seldom trained in ARH issues, or feel uncomfortable to talk about it, or try to avoid the subject altogether. If some form of family life education is provided it tends to focus on girls, although important subjects such as sexual violence and abuse, and sexual harassment are notably absent. Boys are left out and do not receive any information to make them more responsible and gender sensitive. Gender stereo-typing is the usual pattern in the educational materials used which further discriminates against girls while gender empowerment is lacking (UNFPA 1997).

Access to services: Many countries are increasingly becoming aware of the importance of adolescent reproductive health and have taken action to address the concerned issues. However, most of the action is limited to (i) collection of data/information by conducting quantitative and qualitative research on knowledge, attitude and behaviour patterns among adolescents, and (ii) as mentioned above, to some extent addressing the information and education needs. As regards service delivery, little if any action is evident at country level. As the existing RH services/clinics in the countries of the region focus on married women/couples, managed by the government or religious organizations (for example in Indonesia), it is not surprising that adolescents are very hesitant to seek professional services or information at these centers.

NGOs throughout the region have usually been first to offer ARH information and often also to deliver services. These interventions are, in most instances, on project basis, covering a small number of individuals.

The provision of *appropriate and accessible RH information and services* is needed in order to prevent the use of non-effective or harmful/unsafe remedies to which adolescents might turn to when in need. The essential components of RH services include: (i) family planning; (ii) STD and HIV prevention, testing and care; and (iii) pregnancy-related care. In order to effectively address the RH needs of adolescents, service providers, both in the public and private sectors, need special training/skills in order to be sensitive to the needs of adolescents, to respond to their questions and doubts and to provide necessary 'counseling' advice and treatment, including making appropriate referrals.

The role of the private sector in RH service delivery is of major importance in the field of ARH as it enhances access to contraceptives. In some countries, the pharmacists, retailers and private doctors form the only access for unmarried adolescents to contraceptives. Existing social marketing programmes are often aimed at increasing access by offering contraceptives at subsidized costs, using innovative, straightforward approaches, and having unmarried adolescents as one of their target groups.

Undoubtedly, there is a strong need for high quality, accessible, and adolescent-friendly services which meets their health needs in general, and reproductive health needs in particular. Such services need to be made available within the framework of "quality of care" and need to involve training of RH care providers who are not only technically skilled, but are also nonjudgmental in their attitude towards adolescents seeking RH related preventive and curative RH care.

The active participation of youth during the design of ARH programmes is one of the basic requirements of any ARH intervention. Most existing ARH projects and programmes have however seldom involved adolescents/youth and this seriously affects the appropriateness and effectiveness of the approaches.

6. Conclusions and Recommendations

The needs of adolescents, until recently, have largely been neglected in population and reproductive health programmes, partly because issues relating to adolescent sexuality and reproductive health are extremely sensitive. Although information on knowledge, attitude, reproductive health related behaviour and health and social support needs of adolescents in South Asia is difficult to obtain, some broad and distinct patterns can be noticed.

Socio-economic development, such as improved education, increased urbanization, greater employment opportunities and increasing age at marriage for both boys and girls have significant programmatic implications. A smaller age difference between spouses, improved opportunities for education and employment have a potential for positive implications, as it tends to increase gender equity. However, declining age at menarche and increasing age at

marriage are equally significant raising issues about premarital sexuality and relationships with opposite sex.

In order to adequately address the reproductive health needs of adolescents, concerted efforts are needed not only at policy and programme level but more importantly at the community level. The common misperception that provision of information on sexuality in schools leads to increased sexual activity by young people needs to be corrected, as also the need to address the gender inequality. These are major challenges that can no longer be ignored by the countries.

Provision of reproductive health information and services to adolescents is often constrained by lack of policies. Intensive advocacy efforts are needed to begin with, aimed at the influential persons including policy makers, to sensitize them about issues related to adolescent reproductive health and to promote positive societal attitudes towards the adolescents. Such efforts would result in the formulation and enactment of legislation and subsequently in the development and implementation of policies and programmes.

Some of the policy issues which are extremely relevant for the adolescents include: legislation related to age at marriage; access to RH information and services (contraceptive and pregnancy related); and universal education at primary and secondary level. The policies and legislations should reflect the gender differences in a specific countries and adequately address them. Advocacy efforts would also be needed to target programme managers, such as teachers, community leaders, and health care providers, as well as parents and elders in the community. It is hoped that these efforts would take into account the prevailing culture and country-specific gender concerns and ultimately contribute not only to the growth and development of adolescents and increased gender equality, but also towards their participation in national development efforts as responsible citizens.

Issues of concern for adolescents involve many aspects of sexual and reproductive health such as increased risk of unwanted pregnancy and unsafe abortion, maternal mortality and serious maternal morbidity, STDs including HIV/AIDS, and issues of sexual relationships. If services and educational programmes are to be effective they must operate within the realities of adolescent sexual behaviour. However, it is also essential that the programme strategies are designed within the socio-cultural context of a given country in which they must operate. As mentioned in earlier sections of the paper, inadequate understanding of the needs of the adolescents, the influence of the socio-cultural factors inhibiting access and adversely affecting their RH status are the underlying causes which have led to inadequate responsiveness on the part of the policy makers, and service providers.

Many different strategies for addressing needs of various groups of adolescents, not just one or two models for replication, are required to be developed. Programmes should be flexible in the development of strategies to ensure that they can respond to changing needs of

adolescents as well as address the heterogeneous group that adolescents comprise. For example, needs will vary for younger and older adolescent groups, those living in urban and rural areas and for the in-school and out-of-school adolescents, while special care should be given to distinguish the different needs of adolescent men and women. Similarly strategies need to vary for the married and the unmarried adolescents, although health risks are equally high, irrespective of marital status.

The health sector (public and private) is directly responsible for the provision of appropriate constellation of services for prevention and management of (i) unwanted pregnancy, (ii) STDs including HIV/AIDS, and (iii) antenatal and delivery care. In order to deliver adolescent-friendly services, due consideration should be given to ensure that service providers have the necessary communication and technical skills, while respecting confidentiality. The education and social sectors have the main responsibility to reach out to adolescent population in- and out-of-school with appropriate information and counseling on RH issues. It is however recognized that existing strategies and programmes in these sectors need to closely collaborate with the health sector to ensure that uniformity and accuracy of the technical content of information provided. Since NGOs have relatively more experience and success in working with adolescents, their active participation should be encouraged.

Active participation by all levels of the various groups of adolescents in programme development and implementation is the most effective way to assure relevance, commitment, and gender sensitivity and responsiveness of the programme. This could be done through the active involvement of young people as partners in the process of development of policies, programmes and strategies. This is in line with the ICPD-POA and fits well with the quality of care framework, recommending a client-centered-approach.

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