

SEA/MCH/212

**Strategies for Adolescent Health  
and Development**  
***South-East Asia Region***

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New Delhi, 26–29 May 1998*

*Organized by WHO  
in collaboration with UNICEF, UNFPA, UNESCO and UNAIDS*

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We sincerely appreciate and acknowledge everyone's contribution in the meeting.



## 1. INTRODUCTION

Adolescence, the second decade of life (10-19 years), is a period of rapid development, when young people acquire new capacities and are faced with many new situations that create not only opportunities for progress, but also risks to health and wellbeing. It is a time when growth is accelerated, major physical changes take place and differences between boys and girls are accentuated.

The rapid growth that occurs in adolescence demands extra nutritional requirements. During this period, more than twenty per cent of total growth in stature and up to fifty per cent of adult bone mass are achieved. Adolescent girls also need additional requirements of iron, up to fifteen per cent, to compensate for physiological blood loss. Anaemia is also a problem for adolescent boys due to rapid growth and development of muscle mass. The nutritional status of young girls, prior to pregnancy, is important and impacts on the course and outcome of their pregnancy. Entering motherhood in a deficient nutritional state places both the mother and the newborn at risk of an adverse outcome. Foundations of adequate growth and development are laid during childhood and adolescence.

Adolescence is also a time of mental and psychological adjustment; a situation of being no longer a child, but not yet an adult either. The main change is the development of an integrated and internalized sense of identity. This means, to some degree, drawing away from other members of the family and developing more intense relationships with peers. Involvement with groups of the same sex, to mixed groups and sexual pairing may take place. In traditional societies, the earlier maturation of girls has been acknowledged by early marriage. However, the mean age of marriage is rising while the age of puberty in both sexes appears to be falling, creating a longer period during which premarital sexual relationships may occur. Adolescence is also a time to explore new interests and influences which can mould their thinking, ideas and actions. Adolescent behaviour during these years could range from exploring sexual relationships to alcohol, tobacco and substance abuse. Young people may be tempted to emulate their role model characters in TV or in cinema, often with disastrous consequences. Peer pressure may lead to risk-taking behaviour. And inadequate access to services and lack of a supportive environment may affect their health and development. Therefore, the support and understanding from family members during this phase is crucial in enabling them to meet these challenges.

While a holistic approach to adolescent health is advocated, with every effort being made towards a functionally integrated approach across sectors and disciplines, the Health Ministry in every country has to take a leading role. They must seek out and encourage multi-sectoral partnerships and ensure that they design specific need-based programmes to address the problems of youth.

Most UN agencies give high priority to the adolescent health programme. In the 1980s, the World Health Assembly passed resolutions urging Members States to promote adolescent health. In 1989, UNICEF and UNFPA joined WHO and issued a joint statement on the reproductive health of adolescents. The 1994 International Conference on Population and Development (ICPD), Cairo, Egypt, also re-emphasized and highlighted the needs of adolescents. The young people of today are the adults of tomorrow. While today's world offers remarkable opportunities for adolescents it also threatens their health. Therefore, it is of paramount importance that an environment be created in which adolescents can realize their full potential and grow to healthy and responsible adulthood.

## **2. PROCEEDINGS OF THE MEETING**

The Intercountry Consultation on Development of Strategies for Adolescent Health for South-East Asia Region of WHO was held from 26-29 May 1998 in WHO's South-East Asia Regional Office (SEARO), New Delhi, India.

The meeting was participated by representatives of countries from the health, education, youth, women and NGO sectors as well as by UN agencies and observers. (The List of Participants is at Annex 1).

## **3. INAUGURATION**

The Regional Director, Dr Uton Muchtar Rafei, inaugurated the meeting. He welcomed the participants. In his inaugural address,

he mentioned that despite the biological and social significance of this phase of life, adolescent health has not received adequate attention, until recently, in the South-East Asia Region. He also highlighted on several problems affecting adolescents in this Region. He mentioned that the adolescents in SEAR countries face problems from early marriage and child-bearing. This puts the life and health of both the child and the mother at risk. At the same time, unprotected sexual relations in unmarried adolescents have increased in countries where the age at marriage is high. This increases the danger of unwanted pregnancy and abortions, often in hazardous conditions, as well as sexually transmitted diseases, including HIV/AIDS. Other behaviours which put adolescent health and development at risk include smoking, alcohol use, substance abuse and violence.

Dr Uton also stated that research on the underlying factors contributing to the development of these problems reveal that they are inter-related. Poverty, violence against adolescents, sexual exploitation of adolescent girls, family conflict, and school drop-outs are often associated with substance abuse and adolescent pregnancies. Gender bias against girls, malnutrition and forced prostitution are other problems which affect the normal development of adolescent girls.

Further, negative community norms and environment, such as smoking by elders; peer examples of problem behaviour; low sense of family or community attachment, and inadequate laws for controlling drug abuse and crime, often spur negative behaviours. However, there also are positive environments which protect the youth from negative influences. These include: family cohesion and harmony; sense of belonging and caring; involvement and achievement in school;

improved socioeconomic status of the family, and employment opportunities for young people. Other positive environments include opportunities to: contribute to the community through involvement in community and civic organizations; to adequate schooling, and to ensure economic security.

In SEAR countries, there are already some programmes which focus on specific conditions of adolescents, i.e. substance abuse, street adolescents, HIV/AIDS, school health and, in a few instances, counselling on reproductive health.

The Regional Director acknowledged that these programmes have trained a large number of trainers, including peer educators, and have generated awareness. In many instances, they have been successful, to some extent, in changing the negative behaviours. Experiences have been gathered about what approaches work, which ones do not work and what kind of local innovations are needed. Based on these successes, the time has come for countries in this Region to now develop adolescent health programmes on a larger scale.

Dr Uton also highlighted the studies which have been conducted in countries of other regions which have carried out large-scale programmes focusing on specific problems affecting adolescents. These have shown that programmes which focus on a single health issue do not have adequate capacity to change the lives of adolescents. This was because they were dominated by a problem-and-risk- behaviour approach and did not intervene until the conditions reached the level of becoming problems. These programmes failed to address adolescents holistically and to include

their families, their environment, and the overall context in which these behaviours occur. He also stated that while developing adolescent health (ADH) programmes in this Region, it is necessary to learn from the experiences of other countries.

He further mentioned that adolescent health and adolescent development are positive concepts. Adolescent health comprises physical, mental and social well-being and adolescent development is closely related to adolescent behaviour. This period for young people is both a time of risks as well as opportunities. It is necessary to recognize these factors and strive for a holistic approach aimed at overall health and development of adolescents.

The Regional Director also emphasized the need for advocacy at the country level so that governments, communities and families, all recognize the needs, vulnerability and potential of adolescents and also the fact that failure to meet the needs of young people sets the stage for self-destructive behaviours and behaviours harmful to others. Whereas, a relevant response to their needs will contribute to their healthy development and growth, to responsible adulthood and a positive contribution to the society. Therefore, it is extremely important that their health and development should be an integral component of health and development plans and policies of our countries.

In the end, Dr Uton reminded the participants that their common goal should be to create an environment where young persons, both males and females, can enjoy trusting relationships within their families as well as with the adults in the community. They should not grow up as ignorant, abused, sexually exploited or violent

individuals. The aim should be to create an environment where adolescents can grow up, physically and mentally, healthy and strong, so that they can take on their role as confident and balanced individuals and productive citizens.

The Regional Director was happy to note that representatives of the health, education, youth and sports sectors of Member Countries, NGOs, major UN agencies as well as young people themselves were participating in this very important meeting.

He hoped that the interactions during the meeting would enable the participants to have a better understanding about each other's programmes and to develop strategies which are suited to the socio-cultural environment of SEAR countries. He was optimistic that with a multi-sectoral approach, and with networking and effective partnership among the relevant institutions and agencies at regional and country levels, it shall be possible to achieve the goal of attaining healthy development of adolescents in the Region.

Concluding, Dr Uton wished every success for the deliberations. (The full text of the Regional Director's inaugural speech is included in Annex 2).

The inaugural session was followed by the technical session. Dr Usha Nayar, India was nominated as the Chairperson; Dr Suwarna Warakamin, Thailand as the Co-chairperson, and Dr Rafiqus Sultan, Bangladesh, as the Rapporteur.

## 4. OBJECTIVES AND RATIONALE

**D**r Rita Thapa, Director, Family Health and Research, WHO/SEARO, presented the rationale and objectives of the meeting. The objectives of the meeting were:

- (1) To review the health situation and issues related to adolescents in South-East Asia;
- (2) To develop strategies for health and development of adolescents involving stake-holders from relevant sectors, and
- (3) To plan for follow-up actions.

Regarding the rationale, she reiterated the fact that adolescence is a period with the optimal mix of physical, psychological and behavioural potential, and thus the opportune time for laying the foundations for a healthy, responsible, and productive life ahead. Healthy habits adopted during adolescence remain for life. They contribute in preventing premature deaths during and after the adolescence phase, among others. Similarly, it is recognized that adolescence is also a time of self-assertion, experimentation including initiation of certain health-damaging risk behaviours. Complications of health problems in adolescents can last for life and they can even extend to the next generation. A well thought-out and socio-culturally sensitive health strategy on adolescent health could, thus, effectively contribute to preventing the transmission of these health problems to the next phases of people's lives and that of their babies. For promoting adolescent

health, it is necessary to build and operationalize partnerships among individuals, communities, institutions, government, intergovernmental organizations, NGOs and private sectors at all levels. Accordingly, the meeting was an attempt to practise partnerships. It intended to develop a practical strategy for promoting adolescent health in the Region, by mobilizing the respective expertise and mechanisms and other resources.

## 5. METHODOLOGY OF WORK

Dr Suniti Acharya, Regional Adviser, WHO/SEARO and Dr Bruce Dick, Senior Adviser, Youth Health, UNICEF, New York, explained the methodology. The meeting was intended to be highly interactive and participatory. The proceedings included plenary sessions and group work. (The detailed programme is included in Annex 3).

Most of the sessions were reviewed and evaluated. Key issues and ideas for the development of strategies were generated by using cards after most of the presentations.

## 6. PARTICIPANTS' EXPECTATIONS

The Regional Office had set some objectives of the meeting. However, the organizers were prepared to accommodate participants' expectations. The participants' expectations from the meeting were gathered by the participatory method. The expectations could be grouped as follows:

- (1) Development of strategies for adolescent health;

- (2) Sharing of innovative approaches, and
- (3) Prioritization of actions.

It was noted that participants' expectations were similar to the objectives set by the organizers and, therefore, the proceedings could be carried as planned.

## **7. HEALTH SITUATION: PROGRAMMES AND PRIORITIES IN SOUTH-EAST ASIA REGION**

**D**r Suniti Acharya, Regional Adviser, MCH/SEARO, presented a working paper on the subject which included status of ADH programmes in countries of the Region, WHO actions to support ADH as well as issues on ADH and the need for strategies for health and development of adolescents. The text is included here.

### **7.1 Status of ADH Programmes in Countries of the SEA Region**

The adolescent period is characterized by relatively low mortality and morbidity and, as a consequence, the overall well-being of adolescents has not been on the agenda for discussion until recently among the planners and policy-makers in SEAR countries. During the past decade, interest in adolescent issues and problems has been taken by many disciplines. Many studies, though on a small scale, on several aspects of adolescence have been conducted. These researches have documented the problems that adolescents encounter during this phase of their life, some of which relate to dropping out of school, child labour, several aspects of reproductive health behaviour and reproductive health problems including early

pregnancies, abortions, and STD, etc. These studies, though done on a small scale, have brought the ADH issue into focus. As a result, adolescent health problems are getting increasing attention.

In earlier years, problems such as substance abuse in adolescents were addressed primarily as NGO efforts in many countries. Later on, HIV/AIDS in adolescents was taken up by NGOs and by several government programmes also. And lately, reproductive health concerns of adolescents have gained momentum in countries of the South-East Asia Region of WHO especially through collection of information as well as through advocacy specially focusing on female adolescents.

Presently in most SEAR countries, not much systematically collected information on adolescents is available, encompassing health and demographic situation, availability of services and legal provisions, etc., at the national scale. Most of the countries do not as yet have well-defined policies and strategies on health and development of adolescents and young people. However, countries are sensitized on ADH issues through advocacy efforts from many quarters. A better understanding of the specific problems facing adolescents has taken place in these countries. Therefore, it is felt that this is the opportune time to develop well-defined strategies for adolescent health and development.

## **7.2 WHO Actions to Support ADH**

A technical consultation on adolescent health was organized in SEARO in 1995 involving WHO/HQ, other regional offices and Member Countries. This consultation developed protocols for a multicentric study on situation analysis, as well as protocols for the development of models of intervention.

Situation analyses using SEAR funds have been conducted in Indonesia, Thailand, Myanmar and Bangladesh. And intervention studies have been ongoing in Indonesia, Thailand and Myanmar. The intervention studies aim to develop- models of health intervention which increase the access of adolescents to health services.

Increasingly, countries in the Region are recognizing the importance of adolescent health. Adolescent health has been included as one of the priority components in the essential reproductive health care package developed as part of The Regional Reproductive Health Strategy for SEAR. Many countries have adapted the regional strategies and have included adolescent reproductive health as one of the priority components of the essential reproductive health care package at the country level.

During the 1996-1997 biennium, the WHO regional budget funds were provided to Indonesia, Myanmar, Sri Lanka, Thailand, India and Bangladesh for conducting advocacy meetings, seminars, operational research and development of manuals on counselling.

WHO/SEARO has developed an advocacy and information booklet which has been disseminated widely. Various units in SEARO: STD/AIDS, Nutrition, Health Promotion, Primary Health Care and Reproductive Health, contributed to it. A joint meeting was organized by the MCH and Nutrition units in SEARO on the nutritional status of adolescent girls and pregnant women.

The World Health Assembly passed resolutions in the 1980s urging Member States to promote adolescent health. During the last decade, WHO has developed several manuals and guidelines on

counselling techniques and research, which are being utilized widely by the SEAR countries.

In addition, the impetus and direction for increased action for adolescent health also come from many other sources. The basic rights and obligations related to the promotion and protection of the health of adolescents are articulated in the United Nations Convention on the Rights of the Child, as well as the earlier Convention on the Elimination of All Forms of Discrimination against Women. Further elaboration and support come from recent international conferences and statements such as the 1994 International Conference on Population and Development, the 1995 Fourth World Conference on Women and the United Nations World Programme of Action for Youth to the Year 2000 and Beyond. These international actions have played great advocacy role in SEAR countries. The countries of this Region are beginning to recognize the importance of ADH programmes.

### **7.3 Issues in Adolescent Health**

Adolescence represents crossroads in the process of development in life. Failure to meet the needs of young people can lead to self-destructive behaviours and behaviours harmful to others. A relevant response to their needs - equipping them with the knowledge, skills, values, support and opportunities for self-advancement in an equitable manner for both sexes - can set the stage for their healthy development and growth towards responsible adulthood and a positive contribution to society.

The following are some of the key issues in SEAR countries:

- ⑩ How to promote a greater understanding of young people's health needs among policy-making adults and a recognition that they are people, not problems, with an exceptional capacity for responsible behaviour when they are adequately informed about it. This is a relatively new area. Much more advocacy effort is needed.
- ⑩ How to engender positive and healthy relationships between young persons and other members of society including family members, school teachers, and community workers, leading to positive actions within the existing cultural context.
- ⑩ How to provide the knowledge, skills and education to young persons, and how to handle the cultural sensitivity involved in empowering adolescents with information and services on sexuality, safe sex and other reproductive health issues.
- ⑩ How to preserve the prevailing cultural values, yet make adolescents able to cope with peer pressure and media explosion which often promote values contradictory to the existing social norms in our countries.
- ⑩ How can a participatory and mutually-supportive environment, built on gender equity and respect between young people and adults, be nurtured in our society. Such environment will eventually protect them from engaging in negative behaviours.
- ⑩ How best can young persons themselves be involved in designing youth-friendly health programmes including reproductive health (RH) within the broader context of

primary health care (PHC) in improving their health and development.

- ⑧ How can UN and its agencies motivate governments to recognize adolescents as a specific target group for intervention and formulate effective policies for their health and development.
- ⑧ What are the operational research needs and priorities which can provide input for strengthening programmes.
- ⑧ How can service providers, where they may be available, be equipped or trained to deal with adolescent development, particularly interpersonal skills.
- ⑧ What kind of training and orientation are needed to enable health workers to provide the youth or adolescents with friendly services.
- ⑧ In some countries, there is difficulty in getting age-specific data for the 10-19 years age group. The information on adolescents is included in the data for young people (10-24 years) which group includes adolescents. How can information system on adolescents be strengthened.
- ⑧ What are the feasible indicators which can monitor the adolescent health status as well as the progress in adolescent health services.

#### **7.4 The Need for Adolescent Health and Development Strategy**

In the South-East Asia Region, many studies have been conducted, though on a small scale, which give insight into the problems facing

adolescents. Many actions have been initiated by governments, NGOs and international agencies dealing with adolescent issues. Now, there is need to systematize these efforts and develop culturally appropriate and feasible strategies for health and development including the psychosocial and behavioural aspects of adolescent health and development. The regional strategy developed during this consultation is expected to serve as a framework for national-level adaptation and for development of country-specific approaches.

For operationalization of the strategy, it will be necessary to adapt it at the national level, as well as identify actions in supportive areas, such as advocacy, training, development of information system, and operational research. As this programme is a relatively new programme, incremental approach will be needed. It will also not be possible to address all the identified issues. Therefore, it will be necessary to prioritize the interventions, and equally necessary, to develop coordination mechanisms. Coordination mechanisms should be developed between NGOs and government; and among NGOs, the private sector, government and NGOs for social marketing of some drugs and contraceptives, as well as for the development of mechanisms for the regulation on sales of harmful substances. It will be equally necessary to develop coordination and collaborative mechanisms between UN agencies and governments so that resources and efforts are complimentary to each other's programmes at regional and country levels.

## 8. WHO/UNICEF/UNFPA FRAMEWORK FOR PROGRAMMING

Dr Bruce Dick, Senior Adviser, Youth Health, UNICEF, New York, introduced the WHO/UNICEF/UNFPA framework for country programming and the common agenda for action. He explained that WHO, UNICEF and UNFPA convened a study group in ADH in December 1995 to bring together the best information available in order to strengthen the platform for systematic action in ADH. The said study group consolidated all the information on effective programming. Dr Bruce Dick presented the following concepts and approaches based on the ADH Study Group, recommendations:

Adolescent health policies and strategies should be guided by some important concepts which have emerged from some successful programmes. These include the concepts that adolescent development underlines the prevention of health problems and the influence of social environment on adolescent health and that the problems have common roots and are inter-related. Adolescence is a time for opportunity and risk as well.

The study group developed a framework for programming for adolescent health (Annex 4).

Programming as referred to in the framework was to, on the one hand, promote healthy development to meet the needs (such as safety, belonging, self-esteem, etc.) and build competencies, namely physical, psychological, social and vocational, and on the other, to prevent and respond to health problems arising from unprotected sex, substance abuse, nutrition and violence, etc. In order to achieve

this, five key interventions were identified, namely: providing information; building skills; providing counselling; improving health services, and creating a safe and supportive environment for young people. It was emphasized that these interventions were also not just needs alone, but rights for the health and development of adolescents as defined in the Convention of the Rights of Child.

Intervention settings could be the home, school, health centres, workplace, street, community organizations, etc. The framework also identified certain guiding concepts, such as “adolescence is a time of opportunity and risk”; “not all youth are equally vulnerable”, and “gender considerations are fundamental”, etc. The framework also identified certain keys to success, namely: put youth at the centre; address multiple health problems; build on and link the existing interventions in various settings, such as home, school, workplace and the street so as to ensure adequate coverage to adolescents in different circumstances; combine interventions to generate respect for cultural diversity; strengthen programme management and encourage positive adult attitudes and behaviour. The need to work with a group of interventions and to be committed to the task was strongly emphasized. Areas in which challenges would need to be met are: building political commitment; monitoring and evaluation; maintaining implementation, and identifying priorities for action.

## **9. COUNTRY PRESENTATIONS**

### **9.1 Bangladesh**

In Bangladesh, 34% of the population comprises those in the age group: 10-24 years. This group, having survived the hazards of infancy and early childhood, is considered to be healthy, resulting in a low priority being given to adolescent health issues. The available data indicates that a majority of adolescents do not have access to education and fall victims to early marriage. Sixty per cent of Bangladeshi girls are married by the time they are 15 years of age. Currently, 27% of teenage girls are mothers and another 6% are pregnant with their first child. Family pressures, lack of knowledge and lack of access to contraceptives puts adolescents at a high risk of unplanned pregnancy. Information on sexuality is limited and a recent study has identified high rates of premarital sex among adolescents, particularly so in the urban areas. Health surveys have also revealed a significant proportion of undernutrition among adolescents, in addition to high levels of anaemia and other micronutrient deficiencies. The situation is further compounded in that adolescents appear reluctant to utilize the government health services.

Though the government sector has not been actively associated with adolescent health concerns, the NGO sector (particularly BRAC) has initiated adolescent health activities since 1991, in the form of non-formal primary education and school health programmes. In this context, the post-ICPD environment and the Plan of Action of the ICPD has helped to focus on the special health needs of the adolescent and catalyse the design of appropriate health and development programmes for this group. As part of the future policy in Bangladesh, the delivery of adolescent health services as a sub-component of Reproductive Health Care (RHC) will be addressed in Health and Population Sector Strategy (HPSS) (1998-2005) under the umbrella of the Essential Services Package (ESP). It

is envisaged that the desired change would be effected through an effective information, education and communication programme, focusing on adolescents both in schools as well as in the community. Intersectoral coordination among relevant government agencies will be strengthened and close involvement of the private and NGO sectors will be encouraged in promoting the health of the youth.

## **9.2 India**

In India, it is estimated that adolescents (10-19 years) constitute 21.8% of the population, i.e. 207 million in number. Married adolescents comprise 20 per 1000 population. The data for 1992-1993 reveals that 6% of urban and 21% of rural women aged 15-19 years married before the age of 15 years. There has been considerable improvement in the number of adolescents marrying before the age of 13 years, as shown by a reduction from 27% in 1961 to 7% in 1992-1993. Adolescent fertility is estimated at 17% and contraceptive practice is very low in this age group.

Nutritional inadequacies during the critical period of growth and development have been reported, particularly anaemia which is estimated at 40-60%, as well as iodine deficiency. With regard to reproductive tract infections and STDs, disaggregated data for adolescents is not available. HIV surveillance focuses on high-risk groups but does not provide information on adolescents. Other issues related to adolescents include sexual abuse, prostitution, street children, violence, suicide, tobacco use, alcoholism and substance abuse. It has been found that in the six major cities of India, 15% of prostitutes are below 15 years of age and 24% are in the age group of 16-18 years.

The existing primary health care infrastructure also serves adolescents and consists of a well-organized network of primary health care services that extends from national and state to village levels. Of special significance to adolescents is the launching of India's National Reproductive and Child Health (RCH) programme in October 1997 which provides for a prioritized adolescent health component in order to effectively address the special needs of adolescents. The provision of adolescent health and development services necessitates an effective process of intersectoral coordination and collaboration. Towards this end, three ministries are closely involved, namely: (i) the Ministry of Health and Family Welfare; (ii) the Ministry of Human Resource Development with its two departments: the Department of Women and Child Development responsible for the ICDS programme, and adolescent girl schemes, etc. and the Department of Education with specific reference to the National Literacy Mission for total literacy, and (iii) the Ministry of Welfare which is responsible for development schemes for women and children in rural areas.

The overall plan for adolescent health and development envisages the extensive involvement of NGOs towards providing adolescent-friendly reproductive health services, that are accessible and which will also provide information, education and counselling services. The programme will also seek the active involvement of adolescents, their parents, important sections of the community such as school teachers and *panchayats*, and other relevant agencies as a means to effectively reach the adolescents and motivate them to utilize the available services.

### 9.3 Indonesia

In Indonesia, adolescents (10-19 years) comprise 22% of the total population. Among the 15-19 year age group, those attending junior high school in urban and rural areas are 87.5% and 69.2%, respectively (CBS-1996). There are 1.8 million children aged 10-14 years employed in the rural areas. Studies conducted in some parts of the country reveal the presence of chronic energy deficiency (CED) and anaemia among adolescents. The age at first marriage among ever married Indonesian women is relatively low as revealed by the National Economic Survey of 1996 (10-16 years: 20%;, 17-18 years: 28.2%). A study among young people in Jakarta revealed that almost half of the males (46.4%) between 15-19 years have had their first sexual intercourse, the corresponding figure for females being 37.1% and is largely a reflection of early marriage. An almost similar picture is seen in Yogyakarta. An Indonesian Household Survey in 1992 revealed that of the pregnant women studied, 56.1% were between 10-24 years, with more than half in the adolescent period.

No national data on STD are available. A study conducted in Bali in 1990 reports that two-thirds of 702 women with signs of reproductive tract infection were unmarried and less than 25 years of age. Up to April 1998, the Ministry of Health had reported 631 cases of HIV/AIDS of which 5.2% were in the age group: 15-19 years. Other important health problems include smoking, substance use, sexual abuse, accidents, violence, suicides and street adolescents. A study in West Java reported that in the age group: 13-19 years, 24.5% of males and 3.8% of females were smokers. The data from hospitals in Jakarta for drug addicts from 1985-1989 revealed that the majority started using drugs at the age of 13-17 years. With regard to sexual abuse and violence, 32.5% were between 6-14 years and 26.5% between 15-17 years. A review of

suicides from 13 hospitals in Jakarta between 1982-1983 reported 1337 cases of which 63.3% were women. About one-third (35.2%) were between 16-20 years. According to a recent study of 800 street children in Bandung, more than half were smokers and a quarter were stated as using alcohol and narcotics.

Adolescents have been found to usually go to private clinics, or to indigenous or traditional healers for their health needs with very limited use of public health services. The Centre for Health Education has launched a programme for the promotion of healthy lifestyle which has a national coverage. In addition to health personnel, high school teachers also are trained for adolescent counselling. Adolescent health is one of the priority concerns in the country covered by national policy. The adolescents in school are reached through the school health education programme of the MoH, while the out-of-school adolescents are covered by the Ministry of Social Welfare. Street children/adolescents and those in remote areas who are economically disadvantaged receive little or no attention.

Support for adolescent health has been received from WHO, UNFPA and the World Bank. The coordination mechanism between concerned sectors has been effective. Training and research have been actively pursued as well as advocacy through meetings and workshops. The establishment of an effective national task force for adolescent health is thought to be an important means of strengthening coordination and promoting adolescent health and development.

#### 9.4 Maldives

In Maldives, adolescents constitute about 19% of the population. Although less vulnerable to disease than the very young and the very old, they are still at risk of having to cope with social and psychological problems, accidents, substance abuse, sexually transmitted diseases and teenage pregnancies. Urbanization and inter-atoll migration have become more common, thereby exposing young people to the adverse effects of tourism and the mass media. Early marriage and early child-bearing puts both the mother and the infant at risk. The average age of marriage is 16 years, resulting in many adolescent parents. There is a growing recognition in the country that substance abuse among adolescents is on the increase, with smoking emerging as a serious problem, despite the prohibition on smoking by school-children. Programmes for adolescents are provided through all available PHC services. The Health Master Plan (1996-2005) has the stated goal of “ensuring the health and well-being of adolescents and women”. The Master Plan also has clearly defined specific objectives, namely: all adolescents in school will be provided with health information to protect themselves; reduction in the number of adolescents who take up to smoking; reduction in the number of adolescents who take up substance abuse; reduction in adolescent marriages before the age of 20 years; identifying and providing for adolescents infected with HIV through sexual transmission; reduction in the incidence of accidents among adolescents, and reduction in the incidence of reproductive health problems among adolescents and women.

Four main strategies have been developed to achieve these objectives: (i) the empowerment of adolescents and women, particularly through opportunities to participate in planning,

implementation and evaluation of projects and programmes; (ii) IEC for adolescents by way of easy access to information in the areas of STD, smoking, substance abuse, nutrition, reproductive health, exercise, thalassaemia and responsible parenthood; (iii) accessibility to health services that would be attractive and sensitive to adolescent needs including counselling, (iv) and advocacy for improving the well-being of adolescents.

The current achievements include expansion of the RH/FP services including a well-organized IEC programme, a special drug rehabilitation programme, banning smoking in government offices and public places as well as other incentives to quit smoking, various social programmes with the active participation of adolescents, incorporation of relevant issues and concerns in the secondary and tertiary school curricula, nutrition education at atoll and island levels and legal deterrents for pregnancy outside of marriage.

Though the adolescent health programmes are integrated into all PHC activities, there is need for a more focused approach as well as for more financial resources. Multisectoral efforts also need to be strengthened for the promotion of adolescent health and development.

## 9.5 Myanmar

In Myanmar, the adolescent population (10-19 years) is estimated at 9.3 million which comprises 20.5% of the total population. Among the student population of 8.25 million, adolescents account for 25.7%. However, only 23% of adolescents attend school, with the

school drop-out rate being the highest in the 10-14 age group (44.5%). The labour force participation in the age group: 15-19 years is 68.10% for males and 57.8% for females. With regard to nutrition, the calorie intake reported was 80% and the protein intake 86% of the required amounts, respectively. Among adolescent girls, anaemia was found in 26.4% cases. In the capital city of Yangon, adolescent pregnancies in 1998 were reported to be 8.9% of the total deliveries. The peak prevalence of STD in the 15-24 age group was reported to be 32%.

The sentinel surveillance data for the 15 - 19 age group revealed that HIV infection was the highest among the intravenous drug users (59%). A workshop utilizing the GRID methodology identified the major categories of problems to be sexual maturation and behaviour, pregnancy and child birth, induced abortion, STD, HIV/AIDS, alcohol, smoking and drug abuse. A baseline behavioural assessment study among adolescents (15-19 years) revealed that smoking and alcohol use were significantly more among male students. It was also found that 12.4% of male students and 5.4% of female students had experimented with drugs. The incidence of unprotected sex was quite low among male and female students but considerably higher in new military recruits (17.4%).

With regard to health services, the adolescents in the formal education sector are served by school health teams, in the major towns and cities, while the others are catered for through the routine health services system. Emphasis has been given to institutional strengthening particularly in respect of STD, both in the government and private sectors, as part of a collaborative effort of the Department of Health, the Medical Association and UNICEF. Training for health staff in HIV/AIDS prevention and control, birth-spacing

and life-saving skills has been supported by UN agencies as well as national and international NGOs. Community education programmes at all administrative levels are also much in evidence with the support of many different organizations.

Although certain intervention programmes for adolescents have been initiated in the country, the adolescent population and the basic health staff are largely unaware of the importance and availability of such services. In contrast, however, the programme, "Motivation of Adolescent Health through Sports and Physical Education", implemented by the Department of Sports and Physical Education and supported through WHO's collaborative programme is widely known and well accepted. The aim is to protect and promote physical fitness and promote healthy life styles and behaviour in adolescents.

## 9.6 Nepal

In Nepal, the adolescent population is increasing rapidly reflecting the young age structure of the population. The available data suggests that the proportion of females getting married at an early age is slowly decreasing. In 1971 and 1981, the proportions of ever married females aged 10-14 years was 13% and 14% respectively. This has decreased to 8% in 1991. Similarly, the proportion of married females aged 15-19 has declined from 61% in 1971 to 47% in 1991. In Nepal, abortion is illegal though, it is practised clandestinely. The Ministry of Health data reveal that about 5.3% of all pregnancies end in abortion and the female population aged 15-24 years contributes more than 50%. These data do not represent

unmarried women. Furthermore, the complete facts are likely to be under-reported.

Owing to the practice of early marriage, nearly 50% of the married adolescents enter into sexual union which increases to about 90% by 24 years of age. With respect to exploited young girls, who become commercial sex workers, their sexual experience starts very early, usually around 14-15 years, and in almost all cases before they are 20 years. In such a milieu, the risk of STD/HIV-AIDS is increasingly high. The Department of Health Services has reported that about 23% of all HIV-infected cases belong to the adolescent age group (MoH - 1997). Adolescents and youth of both sexes are generally poorly informed about how to protect themselves from unwanted pregnancy and sexually transmitted diseases including HIV/AIDS.

In Nepal, substance abuse and alcohol use are also major health problems among adolescents and youth, particularly in males. Smoking is a universal problem, among both males and females, particularly in the rural areas. Young people are not aware of their right to information and education, in order to protect themselves against anti-social and risk-taking behaviour.

The National Reproductive Health Strategy (MoH - 1996) has identified adolescents as a major group needing intervention. The NGO sector has been assigned to try out some models to address sexual and reproductive health problem of adolescents, that could be replicated. In addition, the Nepal reproductive health, family planning, information education and communication strategy (1997-2001) clearly specifies the adolescent group and has a plan to address this group through IEC efforts. Furthermore, NGOs like

the Family Planning Association of Nepal have already taken the initiative (in an area that is culturally sensitive) to develop prototype programmes for meeting the sexual and reproductive health needs of adolescents.

## 9.7 Sri Lanka

In Sri Lanka, the term adolescents refers to those in the age group: 10-24 years (young people) with a focus on the age group: 15-24 years. This category between 15-24 years comprises 19% of the population and is likely to remain at this level till the year 2001. The identified adolescent problems include: suicide; alcohol use, smoking and substance abuse; problems related to sexuality; nutritional problems; aggression, and stress usually from high expectation in educational performance.

Iodine deficiency among adolescents was found to be high in certain districts (18.8% for girls and 14% in boys). Universal iodination of salt has been introduced as an intervention. Suicides in Sri Lanka are unacceptably high particularly among the youth. In the age group: 15-24 years, suicide is now the commonest cause of death. The main reasons are stress, depression, lack of coping skills and lack of support when under stress. Ingestion and pesticides are the commonest means of committing suicide. Drug use in Sri Lanka is predominantly a male behaviour with cannabis as the most commonly used drug. The group most exposed to substance abuse appear to be the one comprising youth who have dropped out of school. As regards smoking, a survey conducted in schools indicates that a small minority of school-children (11-18 years) appears to be smoking – 7.2% urban and 4.2% rural. Only a small minority of

students in the higher grades in school and in the universities either smoke or drink, indicating a protective effect with higher education. Surveys and focus group discussions have revealed a lack of accurate information about sexuality. The mean age at marriage in Sri Lanka is 25.5 years for females and 27.9 years for males. Though data on pre-marital sex are not available, this provides the environment for an increase in pre-marital sexual relationships. There is a great debate as to how, where and who should give adolescents and youth this information. Data reported from STD clinics show that the highest percentage of STDs is among males: 25-29 years (40.5%) and among females in the age group: 20-24 years (45%).

Improving adolescent health and development is now a part of national health policy. Many NGOs are also actively associated with providing services to youths. Two presidential task forces of particular relevance to adolescents that have been set up are: the Task Force on Reproductive Health Policy, and the Task Force on Alcohol and Substance Abuse (including tobacco). Under the Ministry of Health, an Adolescent Health Steering Committee is also in operation, to develop action-oriented programmes for adolescents, support the development of IEC strategies and direct relevant research in areas where data is lacking. The work of this Committee is supported by WHO and UNFPA. The creation of a new post of Director, Adolescent Health in the Ministry of Health emphasizes the priority being given to this subject.

Adolescent health and development are also supported by many NGOs among which the Family Planning Association (FPA) of Sri Lanka, Sarvodaya, and World View Organization, to name a few, have been in the forefront. The FPA in particular has a very effective

reproductive health education programme addressed to school-children in the higher grades, which takes in about 150,000 children each year. Training school teachers in counselling has also been a priority activity.

## 9.8 Thailand

In Thailand, young people aged 10-24 years, which include both adolescents (10-19) and youth (15-24) comprise 27% of the total population. The health of young people, particularly adolescents has become a critical issue. With regard to nutrition, it was found that in 1997, iron deficiency, anaemia among school-children was 13.8% and iodine deficiency disorders 5.6% (1996). In Thailand, the number of adolescent AIDS patients (10-24 years) increased from zero cases in 1984 to 2 278 cases in 1997, which is about 12% of the total AIDS cases. The accumulated number of AIDS patients aged 10-24 years was 11 690 as at end March 1998. The AIDS incidence is relatively higher in males than females but in patients aged 15-19 years, females predominate over males. Sexual relations and intravenous drug use were the two major causes of HIV infection. Statistics revealed that STD cases in those under 25 years are on the decrease – a change from 53% of the total cases in 1993 to 34% in 1997. The incidence of STD cases is higher among females than males.

In Thailand, the average age at first marriage is 20.5 years and the average age of women at first childbirth 23 years. However, it was found that the pregnancy rate among women younger than 20 years of age was 11.2%. Due to the increased age at first marriage in both urban and rural areas, there is a corresponding increase in

premarital sex which results in unwanted pregnancies and illegal abortions. The problem of substance abuse is very severe among youth (15-24 years) as reflected by an increase in those seeking treatment. At the same time, the number of students seeking detoxification has increased greatly. Smoking is predominantly a male activity with 9.3% of 15-year olds and 39.2% of 22-year olds being regular smokers.

In Thailand, the formal interventions to promote healthy behaviour among adolescents can be categorized broadly into (i) school-based programmes that include: school health services – providing medical inspection, immunization, growth monitoring and development etc. school health education, and environmental health in schools, and (ii) community-based and family-based programmes which cater for those out of the school system.

A special initiative has been the pilot project on sexual health for adolescents and youth which commenced in 1984 and focused on the adolescents in universities and colleges. This project was an experimental service model undertaken by the Ministry of Public Health, the prime objective being to create awareness about sexual health in adolescents enrolled in educational institutions. Five years later, this programme was modified and developed for use at all levels of health services, in some experimental areas. The project did not achieve its objectives in that there were problems relating to its integration into the existing health services. However, it was possible to add sexual health (later called lifeskills) to the school health programme. This new development model is planned for implementation in the big cities in keeping with their own specific requirements. The programme will be closely monitored to avoid

problems as experienced in the past. Multisectoral cooperation and networking need to be developed for implementing a more complete model, as well as for programme sustainability.

**Discussions and synthesis of country presentations:  
why focus on adolescents**

The discussions on country presentations came out with the conclusion that there is a need to focus on adolescent health and development in SEAR. It was identified that investments in adolescents are an investment for the future. Adolescents constitute a large section of the population. They are the population at risk and are generally underserved. There is need to address the issue of both married and unmarried adolescents.

## 10. AN ADOLESCENT'S PERSPECTIVE

**M**r Kabir Singh from India represented "adolescents" in the meeting. A summary of his presentation is included here:

He made some observations which he believed to have a bearing on healthy adolescent development.

### (1) *Curiosity*

From the time children enter adolescence, they are consumed by curiosity: curiosity about their bodies and the changes taking place

in them. Curiosity about the opposite sex. Curiosity about the reproductive process. Curiosity about adulthood. Curiosity about the world around them. This curiosity must be satisfied if adolescents are to grow up into healthy and balanced adults. This translates into providing authentic information to them, clarifying their doubts, addressing their problems, and, most importantly, listening to them.

**(2) Sex**

When children are growing up into adolescents, they feel very guilty and abnormal because they think about sex so often. Also, when they need some information, they are not allowed to have it. From the questions that frequently come up on the telephone help-line, and over radio programmes, it is also known that adolescents are bothered most about issues that are considered taboo by society - like masturbation, homosexuality, and abortion. They want authentic information and do not often know who to turn to or where to seek it.

Information is empowerment, and the most important component of adolescent health.

**(3) Energy**

During these years, young persons have boundless energy that needs to be channeled along a productive path. In this context, it is important to remind ourselves of the cultural and socioeconomic environment in which most adolescents are forced to live, in many countries of the South-East Asia Region. Except for a privileged few, adolescents grow up in crowded family quarters, without any privacy. Their family's financial conditions may not allow them the

luxury of indulging in activities involving sports and the use of gymnasium etc. which require big investments in equipment. They may not have the money to buy trendy clothing like their peers or role models in the cinema. They may have restricted opportunities for entertainment. Some ways have to be found to channelise adolescent energy into creative activities.

#### **(4) Relationships**

Adolescence is also a period of forming relationships and breaking others. Many adolescents do not wish to acknowledge their parents and families, and parents should not wonder why they are seeking other company – it is a temporary phase and a natural part of growing up to seek relationships among peer groups. The traditional and conservative societies among which adolescents grow up may frown upon interactions, or close relationships, with members of the opposite sex. At the same time, they are being increasingly exposed to the freedom enjoyed by their counterparts in affluent societies. All this can lead to extreme frustration, unless community centres or other outlets like clubs can provide harmless activities and opportunities to keep them occupied. Frustration can lead them to seek undesirable company, to pursue dangerous activities, and to adopt harmful behaviour such as indulging in substance abuse.

#### **(5) Peer Pressure**

Adolescence is a very gauche and vulnerable age. It is a transition from childhood to adulthood. Young persons respond well to sensitive interactions. They do not like to be ridiculed, to be talked down to, or be mocked at. They like to be trusted. They like to feel

confident, not diffident. They want to feel they can cope with their changing bodies, their vacillating emotions, their need to explore and experiment, their need for space. Most of all, adolescents are most vulnerable to peer pressure. The herd instinct is strongest during these years. But, if the need to be accepted is strong, so also is the need to be respected. While this peer pressure can lead them to dangerous, harmful behaviour, it can just as easily be a resource to be exploited for promoting desirable behaviour. Thus, young people can easily be influenced to smoke, take drugs, drive dangerously, have unsafe sex, and commit crimes. Equally, adolescents can be influenced by the behaviour of their peer groups – especially sportsmen, film stars, teenage video jockeys, youth leaders and the like – to adopt safe, desired behaviour.

**(6) *Pressure to Perform and Conform***

Of serious concern to most adolescents is the intense pressure to perform and to conform. From the time they are in middle school parents and families express their expectations for them to excel in academics. The threat is always held out to them: “Unless you do exceptionally well in today’s competitive world, you will have no real future”. Some adolescents are under such intense pressure that they may become disturbed, suffer from acute depression and sometimes may even become more desperate.

**(7) *Opportunity***

It is imperative for society to provide young developing minds with stimulating opportunities. They should have options to pursue higher studies; they should be assured of employment thereafter, they should be given counselling to enable them to decide on their

future. Insecurity can lead to frustration and disappointment, comparison with more fortunate young people can put great pressure on less fortunate ones. Governments, NGOs and civil societies and private sectors should take initiative to provide opportunities to adolescents.

**(8) *Adult Concerns/Cares***

Adolescence should be a time without adult concerns and serious responsibilities. But for many adolescents in the developing countries, children are catapulted from childhood straight into adulthood. How often have we seen the face of an old woman on the body of a young child. When daily cares can so stunt the body of a child, how can we expect the child's mind not to be stunted? We all know that many thousands, nay millions, of children in the Region are being exploited – as domestics, as shoeshiners, as carpet weavers. They spend long days in tea stalls, stitching shoes or footballs, fetching water, doing heavy household chores, or being forced into prostitution, when they should be at school or on the playgrounds. They get inadequate nutrition, little health care or security. Is it surprising then that they grow up wanting to give back to society what society gave to them? They turn to crime, to anti-social behaviour, to deception and lies, to begging, imbibing alcohol and taking drugs.

Unless we can address these critical issues, it is not possible to promote the health of adolescents in the Region. The answer appears to lie in universal education, improved quality of life, equitable opportunities, access to health care, confidential counselling and information services but above all, understanding and supportive parents.

## 11. TECHNICAL PRESENTATIONS

The health status and health problems of adolescents in the countries of WHO's South-East Asia Region were presented by Regional Advisers dealing with specific adolescent health issues from the WHO Regional Office.

### 11.1 Nutrition

Dr Sultana Khanum, Regional Adviser, Nutrition, WHO/SEARO, deliberated on the nutrition issues related to adolescents. Adolescence is a period where significant growth changes occur necessitating optimum nutritional requirement. During adolescence, 20% of their adult height is attained and 50% of their adult bone mass gained. The main nutritional problems affecting adolescent populations include: undernutrition; stunting; iron deficiency and anaemia; iodine deficiency; vitamin A deficiency; calcium deficiency, other specific deficiencies like zinc and folate, and obesity. She expressed great concern that although 19% (1100 million) of the world population was constituted by adolescents, both the data regarding their nutritional status and programmes to improve their health status, were far from satisfactory. Limited data available worldwide shows poor nutritional status which has serious implications for adolescent girls both in terms of their own health and poor pregnancy outcomes for their infants such as low birth weight and neonatal mortality. The prevalence of stunting in adolescents varies from 32% in India to 47% in Nepal. Iron deficiency anaemia (IDA) is one of the major nutritional problems affecting adolescents. Anaemia is substantial in the adolescent age group with a 27% prevalence in developing countries and 6% in developed countries. A

study in Sri Lanka indicated that 59% of school girls aged 14-18 years have low iron stores. In Indonesia, it is stated that the prevalence of anaemia among female adolescents is 21% and 2.5% in males. The consequences of IDA in adolescents include increased maternal and infant mortality and morbidity. Iron deficiency anaemia also impairs cognitive development and behaviour resulting in reduced school performance. It reduces physical performance resulting in reduced work capacity and productivity and thus has economic implications. Iodine deficiency disorders (IDD) are also common among adolescents. The effects of IDD on foetus and infants born to iodine-deficient mothers are well documented, such as neonatal hypothyroidism, mental deficiency, deaf mutism, and cretinism, etc. Desegregated data on IDD for 10-19 years old are not available as such. However, the total goitre rate for 6-12 years old is available, which is high (30-50%) in some SEAR countries, having serious implications on school performance and intelligence quotients (IQs). Measures for reduction and sustainable elimination of IDD in all age groups are well in place in the Region with Universal Salt Iodization as a long-term, and use of iodine capsules and injectable forms where applicable as short-term measures.

## 11.2 Reproductive Health

Dr Suniti Acharya, Regional Adviser, MCH, WHO/SEARO, made a presentation on Reproductive Health of Adolescents in South-East Asia Region.

Adolescence (10-19 years) is a period of dynamic transition in which many interrelated changes of body, mind and social relationships take place. The adolescent's body develops in size,

strength, stamina and reproductive capacity and becomes more sexually defined; psychologically, adolescents begin to become more capable of abstract thinking, foresight, empathy and internal control; and new relationships develop with individuals not only of their own age but in the adult world too.

Of all the changes that occur none arouses more interest and anxiety than those surrounding sexuality. Sexuality is a fundamental quality of human life, important for health, happiness, individual development and indeed the preservation of the human race. It is a part of health which WHO defines as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. While the sexual response system is present throughout life, puberty brings with it an intensification of response and the beginnings of sexual behaviours which for most will eventually lead to sexual intercourse and the possibility of procreation. The beginning of sexual behaviour also leads to its sexual and reproductive health problems, some with grave consequences.

In addition to these, there are some health problems which are a consequence of childhood or other factors affecting the health status of growing children and adolescents. Other problems originate during adolescence itself and may have lifelong consequences (WHO-1993). These can be grouped into two categories:

**(1) *Problems originating in childhood and affecting adolescent health***

Foetal malnutrition causes health problems throughout the reproductive years and beyond. It can result in stunted growth,

obstructed labour and anaemia during pregnancy. Differential access to food and care in infancy, child marriage, sexual abuse by adults or child prostitution can seriously affect the physical, mental and social well-being of adolescents.

**(2) *Problems originating in adolescence and having lifelong health consequences***

The often lower status of women and their relative lack of physical, social and economic power makes them more vulnerable, among others, to (a) physical violence, (b) economically-coerced sex, (c) sexual harassment, (d) abuse at the workplace, and (e) forced prostitution (IPPF 1992). This can be severely detrimental to physical and mental health. Unprotected sexual relations can often cause young people to contract sexually transmitted diseases, some of which can have serious consequences during adulthood and in later life. Some STDs like HIV/AIDS can prove fatal. They are the most common causes of unwanted pregnancies, and may also lead to abortion often in hazardous condition, with grave consequences: often untimely health.

The problems which arise from too early marriage and child bearing in adolescence (which still predominate in SEAR countries) put the life and health of both the child and the mother at risk. Early marriage is also one of the major reasons which puts an end to a girl's education in South-Asia. Many studies have demonstrated a high correlation between the age at which women marry and their level of education. significant proportion of births is attributed to adolescent girls in the age group: 15-19, especially in South Asia, exposing them as well as their infants to a high risk of mortality.

Every pregnancy faces risk. However, it is known that adolescent pregnancies pose higher risk for the mother and the child.

There is little information on the differentials in maternal mortality, by age, of the woman. However, studies done in Matlab, Bangladesh (FHE Database), and West Bengal, India (Misra and Dawn, 1996), showed that the level of maternal mortality, per delivery among adolescent women was nearly double that of women aged 20-34. In addition, however, unprotected sexual relations in unmarried adolescents have increased in countries where the age at marriage is high. This brings with it the dangers of too early or unwanted pregnancy and induced abortion, often in hazardous conditions (Chabra, 1992, Solapunkar and Sangam, 1985).

The Regional Reproductive Health Strategy developed for South-East Asia Region has recognized this issue and has included adolescent reproductive health as one of the components of the essential reproductive health care package. However, the information and access to safe reproductive health services are still extremely limited. Cultural context, taboos and policy and legislation affect the utilization of existing reproductive health services by adolescents. Advocacy is necessary at all levels, and so is the involvement of adolescents in planning of adolescent-friendly reproductive health services.

### **11.3 STD/HIV-AIDS**

The subject of HIV/AIDS in adolescents was presented by Dr J.P. Narain, Regional Adviser, STD/AIDS, WHO/SEARO. A summary is presented here:

The acquired immunodeficiency syndrome (AIDS) was first recognized in 1981. The human immunodeficiency virus (HIV), the cause of AIDS, was isolated in 1983, and tests to detect HIV became available in 1985. By 1985, HIV had spread throughout the world. Precisely when and where this pandemic originated is not known, but such details are not important to prevention efforts. It is estimated that about four million persons have acquired HIV/AIDS in the South-East Asia Region; the majority of new infections occur in the age group: 15-24 years. Given the incubation period of 7-10 years, it is expected that majority of persons with AIDS in the age group of 20-29 may have been infected during adolescence. So far, 67394 AIDS cases have been reported in South-East Asia. The national average of HIV infection rates among pregnant women in Asia is still relatively low but is increasing rapidly in many areas. While the rates are below 1% in most countries, these are relatively high in some areas. For example, it varies from 8% in Chiang Mai to 3 - 7% in parts of Myanmar and up to 5% in parts of Maharashtra, India. Though the age breakdown is not possible, given the high prevalence of adolescent pregnancies in South-East Asia, it can be assumed that HIV among pregnant adolescents is a growing concern. Studies show that the peak HIV prevalence among girls occurs at a younger age than among boys; indicating that adolescent girls are getting infected at a younger age.

It is accepted that the major risk behaviours for the spread of HIV include unprotected sexual activities, high prevalence of sexually transmitted diseases and sharing drug injecting equipment. These risk behaviours are present to varying degrees in all countries. No ethnic/racial susceptibility or resistance to HIV/AIDS exists. With limited access to anti-retroviral drugs in the Region, the majority of HIV-infected persons will ultimately develop AIDS.

The HIV/AIDS prevention package in SEAR consists of promoting safer sex behaviour through education, condom promotion/provision, STD diagnosis and treatment, safe blood transfusion, and safe injecting behaviour. Interventions for adolescents consists of AIDS education at school and out-of-school youth and at workplaces. It has been found that contrary to earlier belief, AIDS education in schools does not increase promiscuity; specifically, it does not lead to earlier or increased sexual activity in young people, even when contraceptive are made available and leads to the delay of the initiation of sexual activities. For those adolescents who are already active, it may assist in the reduction of the number of sexual partners and increase the use of safer practices.

A number of successful examples now exist in the Region which show that interpersonal approaches, particularly through peer education, can lead to behaviour change among young adults and adolescents. These include 100% condom programme in Thailand; Sonagachi sex worker intervention in Calcutta, "University Talk AIDS" in India and peer education in schools in Maldives. Some of the key elements of successful interventions gathered from these projects include the following:

- (1) Selection of appropriate educators (peers, natural leaders);
- (2) Involving the population in design, message development, implementation and monitoring;
- (3) Availability of condoms; and
- (4) Attending to population's real-life concerns (e.g. violence, child care).

HIV/AIDS among adolescents and young adults remains a major challenge in the South-East Asia Region, needing a comprehensive and broad-based response and action. Some of the major opportunities and challenges for AIDS prevention and control in adolescents include mobilizing/sustaining political commitment and resources, mounting multisectoral response, expanding programme activities to community level, assigning priority to both prevention and care and countering discrimination against people living with HIV/AIDS and their families.

#### **11.4 Gender Issues in Adolescents**

Dr Sally Ann Bisch, Regional Adviser, Women Health and Development, WHO/SEARO, deliberated on gender issues. The presentation began with an overview of the development of the gender approach to health. It actually evolved from the women in development (WID) approach which aimed to integrate women in development by targeting efforts specifically to women. This usually meant “women’s only” projects designed, for example, to provide education and skills training for women. While the WID approach resulted in immediate improvements in women’s lives, it did not help to change their basic position in society or reduce the inequities that continued to adversely affect them.

The gender approach, on the other hand, places the focus of attention not on “women only” but on the political, economic and sociocultural context of their lives, in particular the inequitable social divisions between men and women that often put women in disadvantaged positions vis-à-vis men. Strategies in the gender approach are directed at correcting the imbalance between the

position of men and women in terms of access to benefits and resources that are needed to promote health and development. The approach is applied to both men and women but does not preclude a special focus on women in order to improve their disadvantaged position. Nor is it blind to a focus on men when they are at a disadvantage or at risk. The ultimate aim is to involve men along with women in the process of bringing about change that will benefit everyone.

Gender, as a concept, is used to describe those characteristics of men and women, which are socially constructed in contrast to those, which are biologically determined. People are born female and male but learn to be women and men. It is this learned behaviour which makes up gender identity and determines gender roles. Since this behaviour is learned, it can be changed. A gender approach to health would require examining the different roles of men and women and the consequences of the differences and disparities on their lives and health. It is all-encompassing because it requires an assessment of the implications for women and men of any planned action in any area at all levels.

Thus, a gender approach places emphasis on the role of social factors in health. In the case of adolescents, it is clearly evident that social factors influence their views on health and sexuality, their behaviour and relationships with others, and their access to information and health services. Some of the gender issues that need to be taken into account in adolescent health and development are the perpetuation of gender stereotyping or conditioning that, for example, socialize girls into household roles and boys into public roles of work and politics. Gender biases such as son preference in many societies means that girls receive less food and less care when

they are sick and have less access to education and training that would enable them to improve their situation. Social factors also result in gender differentials in health risks. For example, adolescent girls are socially more vulnerable to STDs and HIV infection. Their subordinate roles in relationships with men often means that they are not in a position to demand safe sex practices that would protect them from contracting the infections.

In conclusion, using a gender approach means focusing on the same situation but looking at it differently. It requires data and information to be disaggregated by gender and other relevant factors in order to identify where the differences and disparities exist. It requires identifying both biologic and social determinants of health problems, particularly attitudes, beliefs, feelings and behavioural aspects as the basis for planning and carrying out interventions. Lastly, health services must be planned and provided so that they are responsive to the identified and different needs of adolescent males and females.

### **11.5 Smoking/Alcohol**

The paper on consumption of tobacco and alcohol among adolescents was presented by Ms Martha Osei, Regional Adviser, Health Promotion and Education, WHO/SEARO. While data on consumption of tobacco and alcohol among adolescents is limited, anecdotal studies from some countries indicate that alcohol and tobacco use are on the increase among both boys and girls and among the poor sections of the populations. Consumption is starting earlier than ever before. Tobacco and alcohol consumption are influenced by a various factors ranging from pressure from

friends, and smoking by relatives, to boredom and frustration. The non-existence of social support for the prevention of consumption and for those who want to quit is also an important factor. Health, social and economic outcomes of tobacco and alcohol use either by the adolescents themselves or by family members impact seriously on the psycho-social and physical development of adolescents.

Studies have shown that cough is much more common in those who smoke regularly, at least one cigarette a week. There was evidence of ventilatory impairment in those who smoked, which improved rapidly on giving up smoking. Such children also demonstrated shortness of breath on exertion. Young smokers are found to be not as physically fit as their non-smoking peers. They are more likely to develop tobacco-related body odour which could irritate friends. Adolescents are more likely to become addicted to tobacco as they start the use early which can lead to premature deaths.

There is a direct and an indirect impact of alcohol use on adolescents. The direct impact includes drunk driving, public drunkenness, convictions for alcohol and narcotics-related offences and involvement in crime. Road accidents involving adolescents are also found to be related to alcohol use.

WHO, in its advocacy efforts, has carried out the following activities towards the control of tobacco and alcohol consumption at the global and regional levels:

- ® Since 1970, the World Health Assembly (WHA) has adopted over 14 resolutions (Five-year PoA on Tobacco or Health – 1990-1995, 1996-2001). The recommendations of the 1997

South-East Asian Regional Consultation on Tobacco and Alcohol stipulate protection of minors. WHO has supported the Member Countries in celebration of No-Tobacco Days which include education, seminars, workshops and mass media programmes, both for and with adolescents.

- ® WHO has provided technical and financial support to community-based tobacco and alcohol prevention programmes and collaborated with institutions and NGOs in the organization of problem definition and strategy development activities.
- ® Tobacco and alcohol prevention have been identified as critical entry points for health promotion in all countries of the Region.
- ® At the country level, some islands and districts have been designated as non-smoking areas, and public education of adolescents has taken place in all countries.
- ® The subject of tobacco and alcohol prevention have been incorporated in the curricula of educational institutions of some countries, e.g. India, Indonesia and Thailand.
- ® Non-smoking public places and non-smoking flights have been designated. Crop substitution has been adopted by Bangladesh. NGOs have been very active in conducting drives against tobacco in all countries.

Creating a supportive environment for demand reduction should include measures such as: integrating tobacco and alcohol prevention into formal and non-formal education programmes; strengthening societal and family norms against tobacco and alcohol use creating and providing social support systems which prevent tobacco and alcohol use, and maximizing the potential of the youth by promoting

the value of health as a means of self-actualization. Research to quantify the magnitude of alcohol and tobacco among adolescents, identify the pathways of smoking and alcohol use and the meaning of alcohol use among adolescents is critical to prevention interventions. Reducing the access and supply through several fiscal and educational measures is also necessary.

### **11.6 Behavioural Issues in Adolescence**

This topic was presented by Dr Helmut Sell, Regional Adviser, Health and Behaviour, WHO/SEARO.

In traditional communities, the transition from childhood to adulthood tends to be brief and smooth, often taking the form of initiation rites and rites de passage. However, with urbanization, industrialization, and prolonged periods of higher education, adolescence tends to become a period of vulnerability or puberty, a period of self-identification as adolescents, as different from adults. This self-identification manifests itself in various and varying ways, in “fashions” of behaving, dressing, leisure preferences, political affiliations, etc. Such behaviours are often perceived as provocative, rebellious and confrontational by adults, parents, and agents of law enforcement.

Such adolescent “sub-cultures” can take the form of street gangs and drug sub-cultures, or extremist students’ movements. The social dynamics of such “fashions” are not well understood. However, it is clear that an excess of confrontation by parents or the police as well as a lack of clear rules of conduct can both lead to lasting harm to adolescents like teenage pregnancies, drug dependence, and injuries from violence and inebriated accidents.

Such harmful outcomes are not normally the result of “abnormal risk taking” behaviour. Adolescents do not generally engage in behaviour they perceive as involving a high risk, but prefer behaviours they perceive as “scary but safe”. If a behaviour does in fact incur a risk of injury, for example in a fight between street gangs, members very often drug themselves or take alcohol to overcome their fear. This has been well documented for members of street gangs in Jakarta.

Another important finding from ethnographic research with adolescents is the fact that they do not tend to accept to be taught in the form of a one-way instruction, as younger children do. Adolescents are more amenable to learning as a participatory process.

In order to develop more effective interventions for behaviour change in adolescents, much more qualitative research into their motivational patterns, their perceptions and the meaning certain things have for them is necessary.

#### **Discussions and Key Issues from Technical Presentations**

The main problems identified were: inadequate educational skills and opportunities; gender bias against female adolescents; malnutrition, especially micro-nutrient and energy deficiencies; lack of information and skills and services to protect them from adolescent pregnancies; unwanted pregnancies and abortions, and STD/AIDS. Psycho-social and behaviour problems which lead to substance abuse and alcohol, tobacco consumption, violent behaviour and accidents were also

highlighted. Cultural and behavioural problems are still not well understood; the need for more ethnographic research was highlighted.

## 12. IDENTIFICATION OF GAPS

After reviewing the country and technical presentations, as well as the adolescents' perspective, the gaps in the existing services were identified. At the policy level, it was found that there was a general lack of supportive policies and even where some did exist, they were not coordinated among the relevant sectors. Reliable data was lacking and very few adolescent age-specific surveys were done on a larger scale.

The rights of individuals, particularly adolescents, were not recognized and significant gender disparity existed, with particular disadvantage to female adolescents. Lack of appropriate IEC materials and counselling services were identified as major gaps. Existing health services were unfriendly to adolescents. The services were difficult to access and, where accessible, they did not provide adequate and correct information. The access to reproductive health information services, particularly of unmarried adolescents was identified as a major problem.

Regarding training, adolescents themselves did not get training in appropriate skills development. At the same time, service providers did not have appropriate skills to deal with adolescents. The other important barriers identified were sociocultural barriers preventing parent and adolescent interaction, especially on reproductive health issues, as well as lack of parent and community

involvement. And lastly, it was recognized that conventionally, all services were designed by the service providers without involvement of beneficiaries. Therefore, the importance of involving adolescents in designing youth-friendly services was not fully understood and accordingly, there were very few instances where adolescents participated in assessment and planning.

## **13. STRATEGY FOR ADOLESCENT HEALTH AND DEVELOPMENT**

### **13.1 A Common Vision for Adolescents in SEAR for 21st Century**

A collective vision for adolescents in South-East Asia for the 21st century, as identified by the participants is as follows:

***“Adolescents in the WHO South-East Asia Region should be healthy, educated, socially responsible, have freedom of expression and live in a safe and supportive environment.”***

### **13.2 What will be the Adolescent Health Situation in the next ten years in SEAR Countries?**

The participants deliberated various aspects and came out with projections for the ADH situation in the next 10 years. The projections and their implications are as follows:

- (1) **Adolescents will be a defined force in countries:** There will be more adolescents in the Region. There will be a greater recognition of their identifying as a group with equal opportunities for both males and females.

- (2) **Improvement in adolescent health and development status:** Literacy and educational levels will increase. There will be greater gender sensitivity and equality. The age at marriage will increase and fertility will be reduced. There will be lesser proportion of adolescents who are working and not attending school. Adolescents will be able to practise safe sexual behaviours and will be able to prevent unwanted pregnancy.
- (3) **Empowerment of adolescents to handle pressures:** During the coming 10 years, there will be greater media pressure. There will be increased expectation as well as frustration. The programmes should empower adolescents and prevent them from indulging in substance abuse as well as to succumb to exploitation.
- (4) **Challenges faced by the education, health and employment systems:** There will be an increase in the number of adolescents in the next 10 years. The increased number will cause pressure for existing health and educational services. These services, therefore, should be projected and planned accordingly.
- (5) There will be better networking and multisectoral coordination for dealing with ADH issues.
- (6) There will be improved awareness among adolescents, adults and policy-makers on health issues and improved adolescent-friendly health services designed and implemented with participation of adolescents.
- (7) There will be supportive policies and legislation, as well as supportive environment and increased resource allocation.

### 13.3 How can the vision be translated into reality?

In order to translate the vision into reality, the following *overall objectives, approaches and interventions* were identified. These are as follows:

#### (1) **Objectives**

- ® To work towards the establishment of a national programme for adolescent health and development in all SEAR countries by 2003 AD.
- ® To provide accurate, culturally-acceptable, gender-sensitive information for the promotion of adolescent health and development utilizing all channels of communication.
- ® To provide life-skills training that is age-appropriate and culturally-acceptable, enabling adolescents to cope with their health and development including reproductive health.
- ® To identify and address the needs of adolescents in disadvantaged circumstances, such as those with disabilities, street children/adolescents and displaced population groups.

#### (2) **Approaches**

A holistic and developmental approach is proposed.

- ® A focus on both development and the health problems confronting adolescents in the Region.
- ® The active participation of adolescents and youths in all phases of programming, assessment, analysis and action.

- ® The development and support of partnerships between different sectors and organizations and in close collaboration with WHO, UNICEF, UNFPA, UNESCO, UNAIDS and other UN agencies.
- ® Special emphasis be given to adolescents in disadvantaged circumstances.

### **(3) Interventions**

All SEAR countries will focus on the following *categories of priority interventions* for accelerated action:

- (a) Information and skills
- (b) Providing safe and supportive environment through:
  - Policy and legislation
  - Family and community-level actions
  - Use of the media and entertainment
- (c) Health services and counselling

For each category of interventions, specific objectives, strategies and action have been identified. They are as follows:

#### **(a) Information and Skills**

##### **Specific Objective**

- ® To strengthen the provision of information and skills to service providers, communities, families and adolescents themselves in order to achieve an optimal level of health and development in adolescents.

##### **Strategies**

- ⑥ All channels of communication including the mass media, inter-personal communication, schools and relevant institutions be utilized for dissemination of information on adolescent health and development. Information could be provided through advocacy initiatives, training, use of IEC materials, partnerships and exchange of information through networking between institutions and agencies.

### **Actions**

- ⑥ An information package be developed consisting of information on growth and development, nutrition, sexual maturation, positive behaviour including safe sex, gender equity, substance abuse, rights and responsibilities and services for adolescents, to be targeted at adolescents, service providers, parents, teachers, decision-makers and the community at large.
- ⑥ Support adolescents by providing them with communication skills, negotiation skills, skills to develop self-esteem as well as skills for management of emotions and stress and other relevant skills as are necessary.
- ⑥ Provide skills training to service providers to deal with adolescent health and development problems. This includes skills to create empathy, listening skills and inter-personal communication, as well as management skills.

### ***(b) Providing Safe and Supportive Environment***

#### **Policy and Legislation**

#### **Specific Objectives**

- ® To reorient the existing policies and legislation in Member Countries which will contribute to providing a safe and supportive environment for adolescents.
- ® Utilizing the media, NGOs and international agencies for advocacy in relation to policies and legislation for adolescent health and development.

**Strategies**

- ® To establish or strengthen multisectoral national committees/task forces to support policy development and legislative actions in respect of adolescent health and development.
- ® To strengthen the collaborative efforts between governments and NGOs for implementation of policy decisions and legislation.

**Actions**

- ® At the national level, review the existing legislations and their enforcement. Strengthen or enact new legislation where necessary.
- ® Review the existing database for data on age-specific prevalence of particular behaviours, morbidity from endemic diseases, mortality from all causes, enrolment in schools and workforce, and participation in community organization; and take appropriate steps to generate new data, where needed, which could form the basis for future programme development.
- ® Generate awareness among adolescents, policy-makers and parents about the existing laws and rights relating to education and social services as relevant to adolescents.

- ® Sensitization of politicians and decision-makers at all levels on adolescent health and development issues.
- ® Advocacy efforts of international agencies should be strengthened to emphasize the need for countries to support the already-agreed-to international conventions and commitments.

## **Family and Community**

### **Specific Objectives**

- ® To encourage families and communities to promote and protect the adolescents' need for a safe and supportive environment as outlined in the Convention of the Rights of the Child.
- ® To mobilize family and community resources for adolescent health concerns and development programmes, together with the active participation of adolescents themselves.
- ® To intensify advocacy and IEC efforts for improvement of health and education services for adolescents in all SEAR countries by 2003 AD.

### **Strategies**

- ® Promote closer dialogue between adolescents and parents, as well as strengthen connections between adolescents and family members, within the context of a mutually-trusting relationship.
- ® Utilize local-level NGOs for advocacy, and for initiating service models, as well as for supporting and sustaining community actions.

- ® Encourage local-level adolescent clubs to plan, implement and coordinate adolescent programmes, as well as to form peer groups.
- ® Promote the acceptance of the “otherness” of adolescents.

**Actions**

- ® Establish better communication between adolescents and parents so that the gaps in perception and understanding could be reduced.
- ® Both parents should be educated/informed together on adolescent health and development issues.
- ® Utilize community resources for implementing adolescent health programmes.
- ® Encourage community groups to exert pressure at national level and advocate the cause of adolescents.

The overall objective, approaches, priority interventions along with specific objectives, strategies and actions should be reviewed and adapted at the national level while developing national strategies.

**Media and Entertainment**

**Specific Objectives**

- ® To utilize the media to promote positive societal values and norms that contribute to adolescent health and development.

- ® To reduce the exploitation of adolescents by the media and sensitize the media on the significance of adolescent health.

### **Strategies**

- ® Formulate and use specifically targeted, clear, consistent messages to promote health and development of adolescents.
- ® Use all available communication channels including the private media, radio, television and films to influence the social norms which shape adolescent behaviour such as those discouraging tobacco use, respectful sexual behaviour and gender relations.

### **Actions**

- ® Information on issues such as smoking and alcohol use; interactive programming with specific time slots in national radio and television.
- ® Use celebrity endorsements and role models to reduce resentment towards the “preaching by adult” effect.
- ® Particularly in rural areas, use outdoor activities such as street theatre with adolescent participation, concerts and local festivals to promote adolescent health.
- ® Make use of ‘chat sites’ on internet for those who have access to it.

## ***(c) Health Services and Counselling***

### **Specific Objectives**

- ® To reorient the existing primary health care services to be adolescent- friendly. These services to include reproductive

health services as outlined in the ICPD Plan of Action and the WHO South-East Asia Regional Reproductive Health Strategy, as well as services for the prevention and control of STD/HIV-AIDS, substance abuse/smoking and alcohol use, nutrition and control of endemic disease such as tuberculosis.

- ® To identify and address the health needs of adolescents in disadvantaged circumstances, such as those with disabilities, street children/adolescents and displaced population groups.
- ® To establish counselling services which would encompass adolescent health and development concerns.
- ® To improve the nutritional status of adolescents with particular emphasis on meeting the energy requirements and micronutrient, needs especially that of iron and iodine.

### **Strategies**

- ® Countries should develop innovative models for health services including counselling services that are adolescent-friendly and replicable. Such experiences in the Region be synthesized in order to identify effective approaches that can be taken on some reasonable scale.
- ® To involve youth clubs, NGOs and the private sector to complement government efforts at increasing the access to adolescents for counselling and health services.

### **Actions**

- ® Training programmes should be developed on ADH issues, especially related to counselling and service provision.

- ⑥ Monitoring and evaluation should form an integral component of adolescent health programmes. It should comprise of evaluation of the access, service quality, as well as cost-effectiveness.
- ⑥ Operations research be undertaken to specially focus on human resource development in support of adolescent health, NGO involvement and adolescent participation. Results of such research be utilized to improve the services.

### **13.4 Priority Actions at Country and Regional Levels**

#### **(1) *Country-level actions***

- ⑥ Member Countries should advocate the need for adolescent health and development policies and programmes on the basis of the public health and economic benefits which accrue from investing in the health and development of adolescents.
- ⑥ Countries should develop national strategies and plans of action and forge strategic partnerships with donors and interested organizations including the private sector for their implementation. The plans of action should address the critical issues and gaps identified during the review of technical and country presentations. The plans of action should include priority interventions identified for action, e.g. providing safe and supportive environment through policy and legislation, media and entertainment, family and community actions, information and skills, health services and counselling.
- ⑥ Countries should allocate adequate resources for adolescent health and development programmes.

- ⑥ Countries should co-sponsor situation assessment, analysis and planning activities with the meaningful involvement of adolescents, such as creating multisectoral and inter-sectoral national, regional and district task forces or convening national, regional and district workshops.
- ⑥ Collaborative training, field visits, experience exchange and sensitization of adolescents and government officials, participating organizations and institutions, NGOs and agencies should be initiated in order to improve and sustain the programming for adolescent health.
- ⑥ Support those approaches which have the potential to be taken up in cost-effective and sustainable ways. In order to study the lessons learned, carry out joint programme reviews, complementary to programming processes.
- ⑥ Introduce and intensify the means of sharing information and knowledge within the country that focus on the health and development status of adolescents, as well as information on successful programming experiences, ensuring appropriate language translations and adaptations.
- ⑥ Support the monitoring, evaluation and operations research of programmes, including the use of appropriate indicators. Use this information to orient the community that would lead to improvement in the accessibility, quality and coverage of programmes.
- ⑥ Involve adolescents at all stages of planning, implementation, monitoring and evaluation.
- ⑥ Support the implementation of country action plans and/or other clearly focused activities, mobilizing political commitment

including local resources and building on existing infrastructure within the public, NGO and private sectors. Enhance the social role of media in influencing positive norms and values that promote adolescent health and development.

**(2) *Regional-level actions to support and reinforce country efforts***

- ⑥ Co-sponsor and support regional programmes and networks for training, exchanging ideas and information, documentation and evaluation through regional, electronic and other networks on adolescent health and development. Consider the establishment of a specific electronic network devoted to adolescent health and development.
- ⑥ Organize meetings involving representatives from governments, NGOs and other relevant agencies and intergovernmental networks such as SAARC and ASEAN, to inform, extend consensus, identify priorities for action within and between agencies, and facilitate access to regional resource persons.
- ⑥ Organize and facilitate study visits of policy-makers, programme managers, young people and religious leaders to successful programmes, especially those that demonstrate the meaningful involvement of adolescents. Develop programming guidelines, increase the dissemination and availability of successful programme resource material and provide ongoing support for their adaptations.
- ⑥ Collect and analyse information on the health status of adolescents and country efforts in programming for adolescent health and development. Support operations research on programming to distill best practice. Support the establishment

of an appropriate management and information system for adolescent health and development programmes.

## 14. CONCLUSIONS AND RECOMMENDATIONS

The following are the main conclusions and recommendations of the meeting:

### 14.1 At Country Level

- (1) Make and strengthen the case for adolescent health and development;
- (2) Develop national strategies and action plans which addresses the identified issues and gaps, which aim at attaining the “Common Vision for Adolescents”;
- (3) Identify needs, forge partnerships and generate commitment at national, regional and district levels for ADH programmes;
- (4) Build and strengthen national capacity through appropriate training and information;
- (5) Demonstrate the feasibility through successful approaches that could be taken to scale for providing information, counseling and service to adolescents;
- (6) Share information and knowledge and use them for action to promote ADH programmes;
- (7) Monitor, evaluate and conduct operations research for programme improvement and community action. Promote

qualitative research on adolescent behaviours and motivational patterns;

- (8) Involve adolescents at all stages of the programme development and implementation, and
- (9) Generate political commitment including resources at country level to develop and sustain the programme.

## **14.2 At Regional Level**

The UN and other international and donor agencies working at regional level are urged to undertake the following actions to support and reinforce country efforts:

- (1) Co-sponsor and support regional programmes and networks.
- (2) Build advocacy and strengthen commitment.
- (3) Share knowledge and information, and use them for action.
- (4) Support operations research, development of a management information system and dissemination of information.

## Annex 1

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## Strategies for Adolescent Health and Development in SEA Region

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## **Annex 2**

### **INAUGURAL ADDRESS BY DR UTON MUCHTAR RAFEI REGIONAL DIRECTOR, WHO, SOUTH-EAST ASIA REGION**

Distinguished participants, ladies and gentlemen:

Adolescence is a period of transition from childhood to adulthood. These are formative years when maximum amount of physical, psychological and behavioural changes takes place. These years are also time of preparation for undertaking greater responsibilities, a time of exploration and widening horizons, and a time to ensure healthy all round development. There are approximately 1.5 billion young people including adolescents (10-24 years) worldwide. In the South-East Asian countries, the proportion of young people varies between 28 to 34% of the population. Despite the biological and social significance of this phase of life, adolescent health has not received adequate attention, until recently in many developing countries, including those of South-East Asia Region. It is obvious that neither maternal and child health programmes nor school health services adequately address the special needs of adolescents.

For over 20 years, WHO has been advocating and promoting the cause of adolescence. Now, our sister agencies – UNICEF and UNFPA, many NGOs, professional bodies and youth organizations are increasingly taking interest in the subject. I am happy to say that

finally momentum has gathered in this Region and, for the past few years, governments have been focusing on adolescent issues.

The adolescents in SEAR countries face problems from early marriage and child-bearing. This puts the life and health of both the child and the mother at risk. At the same time, unprotected sexual relations in unmarried adolescents have increased in countries where the age at marriage is high. This increases the danger of unwanted pregnancy and abortions, often in hazardous conditions, as well as sexually transmitted diseases, including HIV/AIDS. Other at-risk behaviours among adolescents include smoking, alcohol use, substance abuse and violence.

Research on the underlying factors contributing to the development of these problems reveal that they are inter-related. Poverty, violence against adolescents, sexual exploitation of adolescent girls, family conflict, and school drop-outs are often associated with substance abuse and teenage pregnancies. Gender bias against girls, malnutrition and forced prostitution are other problems which affect the normal development of adolescent girls.

Further, negative community norms and environment such as smoking by elders, peer examples of problem behaviour, low sense of family or community attachment, and inadequate laws for controlling drug abuse and crime often spurs negative behaviours. However, there are also positive environment which protect the youth from negative influences. These include family cohesion and harmony, sense of belonging and caring, involvement and achievement in school, improved socioeconomic status of the family and employment opportunities for young people.

In SEAR countries, there are already some programmes which focus on specific conditions of adolescents, i.e., substance abuse, street adolescents, HIV/AIDS, school health and, in a few instances, counselling on reproductive health.

These programmes have trained a large number of trainers, including peer educators, and have generated awareness. In many instances, they have been successful, to some extent, in changing the negative behaviours. Experience have been gathered about what approaches work, which ones do not work and what kind of local innovations are needed. Based on these successes, the time has come for countries in our Region to now develop adolescent health programmes on a larger scale. However, as most of these programmes are run on a small scale, it is not possible to estimate their impact.

Studies have been conducted in the countries of other regions which have carried out large-scale programmes focusing on specific problems affecting Adolescents. These have shown that single focus programmes do not have adequate capacity to change the lives of adolescents. This was because they were dominated by a problem-and-risk- behaviour approach and did not intervene until the conditions reached the level of becoming problems.

These programmes failed to address adolescents holistically and to include their families, their environment, and the overall context in which these behaviours occur. As we develop ADH programmes in our Region, we must learn from the experiences of other countries.

Adolescent health and adolescent development are positive concepts. Adolescent health comprises physical, mental and social

well-being and adolescent development is closely related to adolescent behaviour. This period for young people is both a time of risks as well as opportunities. We must recognize these factors and strive for a holistic approach aimed at overall health and development of adolescents.

At the implementation level, WHO and other UN Agencies, such as UNICEF, UNFPA, UNAIDS and UNDCP, are increasingly advocating focus on this crucial period of human development and are allocating resources in our country and intercountry programmes. There are also many NGOs who direct their efforts towards specific issues in adolescence, e.g., substance abuse, HIV, reproductive health problems, etc. Some programmes in the government sectors also address adolescent issues. These are all positive developments.

However, much more advocacy is needed at the country level so that governments, communities and families, all recognize the needs, vulnerability and potential of adolescents. Failure to meet the needs of young people sets the stage for self-destructive behaviours and behaviours harmful to others. We have to emphasize that a relevant response to their needs will contribute to their healthy development and growth, to responsible adulthood and a positive contribution to the society.

By their needs, we mean basic needs, such as equipping them with knowledge, skills, values, youth-friendly health services, education and social support and opportunities for self-advancement in an equitable manner to both sexes. We have to advocate that adolescents are at life's cross roads. Therefore, it is extremely important that their health and development should be an integral

component of health and development plans and policies of our countries.

Our common goal should be to create an environment where young persons can enjoy trusting relationships within their families as well as with the adults in the community. They should not grow up as ignorant, abused, violent individuals. Our aim should be to create an environment where adolescents can grow up, physically and mentally, healthy and strong, so that they can take on their role as confident and balanced individuals and productive citizens. It is important to have a long- range vision and strategic planning if we are to reach this goal.

It is within this context that we are convening this meeting where we can collectively crystallize our vision and develop strategies. It is important that these are relevant to the social, economic and cultural context of the countries of our Region.

I am, therefore, happy to note that representatives of health, education, youth and sports sectors of Member Countries, NGOs, major UN Agencies as well as young people themselves are participating in this very important meeting. I am confident that with the presence of such vast expertise in various aspects of adolescence, we can develop a comprehensive, yet feasible, strategy for health and development of adolescents and young people for our Region.

I hope that the interactions during the meeting will enable us to have better understanding about each others programmes. I am optimistic that with multi-sectoral approach, networking and effective partnership among the relevant institutions and agencies at

regional and country levels, we shall be able to achieve our goal of attaining healthy development of adolescents in our Region.

I wish your deliberations every success.

## Annex 3

### PROVISIONAL AGENDA

**Tuesday, 26 May 1998**

0830 – 0900 Registration of Participants

0900 – 0930 Inaugural Session

1000 – 1230 **Scientific Session**

Adoption of Agenda

Rationale of the Workshop

– Dr Rita Thapa, FHR/SEARO

WHO/UNICEF/UNFPA Framework for ADH programmes

– Dr Bruce Dick, Senior Adviser, Youth Health/UNICEF/HQ, New York

Adolescent Health Situation: Programmes and Priorities in the Region

– Dr Suniti Acharya, RA MCH/SEARO

**Country Presentations**

1330 – 1345 Bangladesh

1345 – 1400 Bhutan

- 1415 – 1430 India
- 1430 – 1445 Indonesia
- 1445 – 1500 Maldives
- 1500 – 1515 Myanmar
- 1515 – 1530 Nepal
- 1530 – 1545 Sri Lanka
- 1545 – 1600 Thailand

**Wednesday, 27 May 1998**

0900 – 0930 **Presentations on ADH issues in the Region**

- Adolescence: General Issues (Dr H.L. Sell,  
RA H&B/SEARO)
- Nutrition (Dr Sultana Khanum,  
RA NUT/SEARO)
- Smoking/Alcohol (Ms Martha R. Osei,  
RA HPE/SEARO)
- STD/AIDS (Dr Jai P. Narain,  
RA STD, AIDS/SEARO)
- Gender Issues in ADH Dr Sally A. Bisch,  
RA WHD/SEARO)
- Reproductive Health (Dr Suniti Acharya,  
RA MCH/SEARO)

0930 – 1000 Adolescent Perspective

1000 – 1045 Discussions on country Presentations

1045 – 1100 **Group Work**

Introduction to Group Work

- Dr Suniti Acharya
- Ms Jane Ferguson

**1100 – 1530 Group Work –Session I**

- Identification of Gaps
- Development of common vision for adolescents

**1530 – 1630 Group Work –Session II**

What will be adolescent health situation in the next 10 years in SEAR countries.

**Thursday, 28 May 1998**

**0900 – 1530 Group Work –Session III**

Review of Previous days work

How can the vision be translated into reality

- Objectives
- Approaches
- Intervention

**1530 – 1630 Group Work –Session IV**

- Priority action at regional level
- Priority action at country level

**Friday, 29 May 1998**

**0900 – 1035 Plenary Session**

Review of previous days presentation

1030 – 1430 **Group Work –Session V**

Drafting of Recommendations

1430 – 1530 Plenary –Presentation of Recommendations and  
Closure of the Meeting.

**VIPP METHOD WILL BE USED IN THE MEETING**

## Annex 4

### WHO/UNICEF/UNFPA

### A FRAMEWORK FOR COUNTRY PROGRAMMING FOR ADH

