

Adolescent and Young People's issues and concerns in South Asia : Challenges Ahead

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Introduction

Adolescents and young people represent a significant proportion of the South Asian population. While adolescents between the ages of 10-19 years comprise over one fifth of South Asia's large population, young people between the ages of 10-24 years, constitute 31% of the total population of South Asian Region. South Asia is home to about 350 million young people aged 12-24 years, nearly 30% of all youth in developing countries. The sheer large numbers of young population and the socio-economic and cultural context of South Asia, which perpetuates gender stereotypes leading to discriminatory practices in nutrition and overall behaviour towards girls, early marriage and early pregnancy being a cultural norm, poor access to reproductive and sexual health services and information, increasing trend in violence and sexual abuse pose a tremendous challenge for addressing their development and health concerns especially reproductive and sexual health.

In addition a large proportion of South Asian population live in rural remote areas and below the poverty line. This compels most families to view children/ adolescents and young people as a work force augmenting family income. The South Asian adolescents and young people are therefore a working population contributing significantly to the economic growth. However, due to lack of opportunities for education and professional skills, majority of them end up working in the unorganised sector as unskilled labourers and receive low wages.

For many adolescents, this reality of life also makes them extremely vulnerable to various forms of exploitation and expose them to occupational and health hazards. "Comodification of adolescents and young people" is a common phenomenon in many resource poor families in South Asian countries. This manifests itself in the form of trafficking, flesh trade, sexual abuse, rape and incest among the young population. The growing rates of HIV/AIDS in the young population are a pointer in this direction.

Majority of South Asian countries particularly India, Pakistan, Bangladesh and Nepal are male dominated societies. Strong son preference is widespread. The neglect of the women starts from the womb. Sex selective elimination of the girl child in the womb is a reality of countries like India and Pakistan. Neglect of the young girls in nutrition and timely health care services are observed in India, Pakistan, Nepal and Bangladesh. Dowry deaths and high prevalence of violence against young girls, adolescents and women is a regional reality. Stories of beating and murder for dowry, are often published in print media. Suicides of women are often attributed to inhumane treatment by family members. Legal aid is often not sought despite adequate provision in all the South Asian countries In addition a strong culture of silence prevails around such issues. This results in the harsh reality that South Asia is the only region in the world where men outnumber women.

Culturally, marriages in South Asia takes place at a very early age, well before the age of 18 years. Since the girls are groomed to accommodate male-domination they grow up with low self esteem and enter a relationship with poor communication, negotiation and decision making skills. As a consequence, they continue to be suppressed and exploited in every sphere of their life. The high incidence of unsafe abortions among young girls, teenage pregnancy and childbirth continue to contribute to the high levels of maternal mortality among young women.

At the global level, the Programme of Action of the International Conference on Population and Development,(ICPD) held in Cairo in 1994, placed great emphasis on the concerns and needs of adolescents.

As recommended by the Cairo Programme of Action, it is important to "address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group." (ICPD-POA,1994). In particular, the Programme of Action calls for a substantial reduction of adolescent pregnancy. Young people in the Asian region are no exception to these global-level concerns.

Recent policy and programme initiatives by the “state” indicate a growing attention to this young population. The increasing participation of young people at the decision-making levels, growing media focus indicate the gradual shift in attention to the young population.

The Adolescent policy released by Nepal (2000) and the National Youth policy released by India (2003) and several other programmatic initiatives taken by Bangladesh and Pakistan are a welcome step. The challenge is to work towards effective implementation of these initiatives and devise “culture” and “context” specific strategies to empower adolescents and young people in South Asia.

The present paper is an effort to highlight the issues of concerns of South Asian adolescents. Evidences around the issues of adolescent reproductive and sexual health are reviewed and compiled. They are nutrition, early marriage and early pregnancy maternal mortality, violence and sexual abuse, prevalence of sexually transmitted disease, use of contraceptives, unplanned birth and abortion, knowledge among adolescents about reproductive and sexual health. Based on the review, the challenges ahead and recommendations are culled out.

Demographic Profile:

Defining Young People

- Adolescents: 10-19 years of age
- Youth 15-24 years of age
- Young People: 10-24 years of age

According to the United Nations, adolescence is defined as the stage of life during which individuals reach sexual maturity; it is the period of transition from puberty to maturity. (United Nations, *World Population Monitoring 1996*)

Young people between 10-24 years constitute approximately 1.8 billion and represent 27% of the world population. More than half of the world's young people - some 850 million between the ages of 10 and 24 - live in Asia and the Pacific (UNFPA 2005). In the South Asian region it constitutes 31% of the total population (PRB Data 2006).

Adolescents aged 10-19 comprise over one-fifth of South Asia's population. Within the region, Bangladesh and Pakistan have the greatest proportion of adolescents, while India has the greatest absolute number. (Sarah Bott and Shireen J. Jejeebhoy 2000). Adolescent age 10-19 years consists of 21% Bangladesh, 23% India, 21 % Nepal, 23 % Pakistan and 19% Sri Lanka of the total population. (UN 2001) The biggest demographic challenge and opportunity of the region is its enormous population of youth.

Table: 1 Demographic profile of Young People in South Asian Region

Country	Young People Age 10-24 (2006)		Young People Age 10-24 (2025)	
	Million	% of Total Population	Million	% of Total Population
World	1773	27	1845	23
Bangladesh	45.7	32	52.2	27
Bhutan	0.7	33	0.9	29
India	331.1	30	349.2	25
Nepal	9	33	11	28
Pakistan	54.2	34	64.8	28
Sri Lanka	5.4	26	4.7	20
South Asia	446.1	31	482.8	26

Source: PRB The World Youth 2006 Data Sheet

By the year 2025, there will be 1845 million of young people worldwide, which constitute 23% of the total population. However, during the same period, the South Asian region will witness an increase of 36 million young people, which constitute of 26% of the total population.

Under nutrition and anemia among Adolescents

Adolescence is a time of rapid growth and change leading to an increased need especially of energy and iron. Physical changes including growth, the onset of menarche for girls, and increases in fat and muscle mass place these extra nutritional requirements on adolescent boys.

Evidence from micro studies reveals that prevalence of anemia among the adolescents is disproportionately high in South Asian countries and other developing countries. Poverty is a main reason in adolescent malnutrition and anemia but usually it is accelerated by many discriminatory cultural practices towards adolescent girls. In South Asian countries, girls receive less food and lower quality food. The field observation of CHETNA team in rural India says that girl's food consumption is controlled due to the fear that they will grow too rapidly which leads to a tremendous pressure on parents to arrange an early marriage and also to accumulate a dowry. A study conducted in one of the districts of Gujarat State, India brings forward the reality that more than 70% adolescents girls both in rural and urban area were anaemic (Kotecha and et.al.2000).

Anemia is of particular concern for girls because during pregnancy, anemia is associated with premature births, low birth weight, and perinatal and maternal mortality. In South Asian region large number of pregnancies occur among adolescents and young people and anemia is the most common indirect cause of "maternal death". Anemia is one of the primary contributors to maternal mortality (20-25%) and is significantly associated with a compromised pubertal growth spurt and cognitive development among girls aged 10-19 years in South Asia. Overall, 60% of South Asian women of childbearing age are underweight, and malnourished (Bott S et al 2000)

Early Marriage and High Fertility ... A South Asian reality

Age at marriage and high fertility rates among the South Asian countries are the two issues of concern due to their implication on the reproductive and sexual health of the adolescents and young people. International attention on adolescent sexual activity usually focuses on premarital sex. Whereas in South Asia, the first sexual experience for adolescent girls usually occurs largely within marriage. Despite legal age at marriage for women being 18 years and for men 21 years in most South Asian countries. The majority of women marry as adolescents' especially in Bangladesh, India and Nepal with a mean age at marriage less than 20 years. Over 70 per cent of women in these countries have already been married by age 20.

Table3: Mean Age at Marriage and percentage of ever married among females aged 15-19 and 20-24

Country	Mean age at marriage		Percentage ever married among women aged	
	Men	Women	15-19 age group	20-24 age group
Bangladesh	24.9	18.1	51.3	89.5
India	23.9	19.3	35.7	83.0
Nepal	22.0	18.8	41.6	85.9
Pakistan	26.3	21.6	21.9	60.6

Source: United Nations, World Marriage Patterns 2000.

Table 4: Marriage and fertility related data of South Asian Countries

Country	% Ever Married Ages 15-19		% Women giving birth by age 18	% of women Ages 15-19 giving birth in one year	Lifetime births per woman (TFR)
	F	M			
World	14	3	-	6	2.7
Bangladesh	48	3	46	14	3
Bhutan	27	8	-	4	4.7
India	34	6	28	11	3
Nepal	42	12	26	11	3.7
Pakistan	21	6	-	7	4.8
Sri Lanka	7	-	-	3	2

Source: The World's Youth 2006 Data sheet- Population Reference Bureau

Almost half of the females aged 15-19 in Bangladesh were ever married and more than one third of females aged 15-19 in India and Nepal were ever married by age of 18 years. More than 45% adolescents in Bangladesh and more than 25% among Nepal and India give birth to the first child. Adolescent childbearing has emerged as an issue of great concern for some countries in the South Asian region. The adverse health consequences of adolescent fertility have been widely documented.

Social perspective of Early Marriage

It is an established fact that within the patriarchal family structure existing in majority of the South Asian countries, young, newly married women are particularly powerless. The adolescent girls usually have no say in the decision about whom or when to marry, whether or not to have sexual relations, and when to bear children. On the contrary, married adolescents face tremendous social pressure to prove fertility immediately after marriage, and in many settings, bearing sons is the only means by which young women can establish social acceptance and economic security in their marital homes. Lack of autonomy within their marital homes often means that married girls have limited alternative life choices and are constrained by non-egalitarian gender norms and expectations. They have limited mobility, decision-making power and control over their own reproductive and sexual rights.

Qualitative micro studies done in the region bring forward range of opinions of the adolescents about the "ideal" age for marriage, however there was consensus that girls and boys needed to be older at marriage than they typically were. They were also of the opinion that young girls and women within marriage are often powerless to make reproductive decisions. (Thapa S, Davey J, Waszak C -2000 P. Patel, I Capoor, U Joshi, 2000). If a woman does not feel like having sex, she has to do it anyhow if the man feels like it. Similarly, if the husband or the in-laws want a son, the woman has to keep giving birth until she has one. The decision depends entirely upon the family. - Woman from Nepal (Thapa S et al. 2000)

Focus group discussion (FGD) results from Nepal narrated here reflects a similar reality in other South Asian Countries. The FGD results reveal that many parents experienced anxiety about getting their daughters married. In some cases, parents believed that they would fulfill their religious duties (dharma kamaiencha) by marrying their daughters early (kanyadaan). Others worried that if girls delayed marriage, it would become "hard to find a suitable bridegroom". In addition, much pressure for early marriage came from concern over a girl's 'character'. The longer girls remained unmarried, the more chances there were of ruining their character and of reducing their chances of marriage. As one respondent described, many "parents fear that she might run away with a man or have a love marriage, which will lead to their dishonour in the society." There is a proverb about why daughters should marry early: Chori lai dherai rakhnu bhaneko dhoka ma pani bharnu jastai ho. Spilled water on the doorstep is very dangerous: anything can happen. Likewise, keeping daughters at home too long is very risky and dangerous. (Young woman from Kapilbastu -Nepal) (Thapa S et al 2000)

Maternal Mortality a Health Consequence of early marriage and early pregnancy

Early pregnancy and childbearing can have adverse health consequences for young mothers. Pregnancy during adolescent phase is risky and younger the girls the higher the risk. Pregnancy is a leading cause of death for young women aged 15-19 worldwide. Girls aged 15-19 are twice as likely to die in child birth as those in their twenties. Many of those who survive days of obstructed labour end up with fistula. (State of world children 2006-UNICEF) Early childbearing has resulted in adverse health consequences, including damage to the reproductive tract, maternal mortality, pregnancy complications, peri natal and neonatal mortality and low birth weight (Kulkarni S., Bott S 2003) More adolescent girls die from pregnancy-related causes than from any other cause Population Research Bureau (PRB 2006).

Violence and Sexual Abuse:

Violence and Sexual abuse is common among all the age groups and cultural and socio-economic strata's of society. It occurs in homes, schools, the workplace and other public places by family members, neighbors, teachers, supervisors, schoolmates and, on occasion, strangers. As a taboo subject, sexual violence is rarely reported or studied. Hence it is difficult to estimate how many adolescents and young people suffer from sexual abuse, violence, coercion, incest, rape or sexual trafficking. Nevertheless, evidence suggests that a disturbingly large number of adolescent girls and boys are subjected to coercion in South Asia. The data presented here may not necessarily be only of adolescents but they highlight the gravity of the problem of violence against women in the region.

Pakistan

In Pakistan, 80 per cent of women experience violence within their homes. Despite the fact that many incidents of 'honour killing' are not reported in 2002, more than 450 Pakistani women or girls were killed by relatives for so-called 'honour killings', and at least as many were raped. (Human Rights Commission of Pakistan Report 2002)

Honour Killing

The official figure of Human Rights Commission of Pakistan says that on an average 1000 Pakistani women die due to honour killing. Called by different names – karo kari, siah kari, kala kali swara – 'honour' killing is common in both rural and urban areas. This is because feudal, tribal and patriarchal value systems pervade the society and women are treated as male property (like other productive assets).

Research concluded over the past years shows that in the historical and cultural context, the practice of honour killing was bound to women's sexual conduct. Today, however, 'honour' killings take place for economic, political and social reasons as well.

A father could kill his daughter if she wants to marry a man of her choice or wishes to seek employment outside the home. A daughter, sister or wife could also be framed for having illicit relations and killed to settle scores with a man who might be a political opponent, a difficult business partner or one who might have publicly ridiculed the family patriarch. 'Honour' killings, thus, offer social and cultural approval to kill women. On President Pervez Musharraf's insistence for fresh legislation, the Law and Justice Commission of Pakistan recently endorsed that killing in the name of 'honour' would be treated as intentional murder.

But will this stem the tide of killings? It remains to be seen. The harder challenge lies in changing public attitudes about a crime rooted in custom and tradition and reinforced through modern day politics and economics.

Source-www.wecanendvaw.org-We can Regional Campaign Secretariat-Oxfam Trust India

India

Every six hours, somewhere in India, a young married woman is burned alive, beaten to death, or driven to commit suicide. It is estimated that more than 15,000 women suffer from dowry-related violence every year. In a nation-wide survey in India nearly 50 per cent of women reported at least one incident of physical or psychological violence in their lifetime' (ICRW) (2000), 'Domestic Violence in India)

Increasingly, young girls between the ages of 10-14 are trafficked to different parts of India from within India as well as Nepal and Bangladesh. Ironically, young girls and Women are often trafficked by close friends and family.

Mathura was a young girl from a Dalit community of India. She ran away from home and married her boyfriend. Her family threatened her and her husband. When she went to the police station to make a complaint, she was gang raped by the policemen. Her case so scandalized India, that the Parliament passed an amendment to the Penal Code making special provisions to protect the rights of victims who are subject to rape in state custodial institutions.

Cited in a paper: The varied contours of violence against Women In South Asia By Radhika Coomaraswamy For the Fifth South Asia regional ministerial conference, Islamabad, Pakistan, 3- 5 May 2005

Bangladesh

Forty seven per cent of Bangladeshi women experience some physical violence at the hands of their intimate partners.¹⁰ If psychological violence were included; the figure would be much higher. Every week, more than ten women in Bangladesh suffer from an acid attack that leaves them brutally disfigured, and often blind and disabled.(Acid Survivors Foundation, Bangladesh)A study in Bangladesh shows that 32 per cent of women working outside their homes experience disruption of their work due to incidents of domestic violence' (UNFPA 2003- Violence against Women in South Asia)

Sri Lanka

The Ministry of Child Development and Women's Empowerment 2006 reports that 60 per cent of women throughout Sri Lanka are victimized by domestic violence and 44 per cent of pregnant women are also subjected to harassment. On an average, over 100 cases of domestic violence per month are reported in the national media while many more go unreported and unrecorded: (We can Regional Campaign -Oxfam Trust India)

Nepal

There is no accurate figure of the scale of sex trafficking of women and girls from Nepal. Despite published figures suggesting that between 5,000 to 7,000 Nepali women and girls are trafficked for sex work each year, and that 200,000 Nepali women and girls are working in the sex industry in India (Human Rights Watch 1995:6), the actual magnitude of women and girls who are trafficked from Nepal is unknown: (M. Henninkand P. Simkhada 2004)

Domestic violence is a widespread but unreported problem in Nepal. Records of the Central Women Police Cell register 3,505 cases on domestic violence between 1998 and 2004.

Research in 2000 by a non-government organization SAATHI from Nepal revealed 66 per cent of the women in the country endure verbal abuse, 33 per cent emotional abuse, and 77 per cent of the perpetrators of violence to be family members. Fifty eight percent of women who suffered domestic violence confirmed daily abuse. (www.wecanendvaw.org)-We can Regional Campaign Secretariat-Oxfam Trust India)

Chamoli was sixteen years old and living with her father and step mother in Nepal. Her stepmother did not like her very much and used to often beat her. One day a young man came from outside to the village. Chamoli fell in love with him and he promised to marry her. She eloped with him to India. He then took her to a big house and he saw money exchange between her new lover and the madam of the house. After that her lover disappeared and she found she was in a brothel. She was literally tortured into submission. She had to service about ten customers a day and was living in a cubicle the size of a bed. Finally Maiti Nepal a Nepalese NGO came to her brothel and "rescued her" She then spent seven months in an Indian "protection home" before she was sent back to Nepal When she got there doctors at Maiti Nepal discovered that she was suffering from AIDS. Chamoli refuses to return to her family because of the shame and because of the fear of her stepmother.

Cited in a paper: The Varied Contours of violence against Women In south Asia By Radhika Coomaraswamy For the Fifth south Asia regional ministerial conference, Islamabad, Pakistan, 3- 5 May 2005

The acute consequences of sexual abuse especially female victims include physical injury, sexually transmitted infections (STIs), and psychological trauma. There is the added danger of unwanted pregnancy, injury, and the chronic complications of STI-related vaginal discharge, dysmenorrhea and pelvic pain. Adolescent girls who have been abused often have difficulty differentiating between sexual and affectionate behaviors, and have a higher incidence of teenage pregnancy and STI/HIV infection than in their non-abused peers.

It is an established fact that sexual abuse has long-term effects on the sexual and reproductive health of adolescents and young people. Victims of sexual abuse are often incapable of undertaking self-protective behaviour, because the personal skills needed to prevent STIs and unintended pregnancy are exactly those life skills stunted by sexual abuse. They may be unable or unwilling to make and follow through on decisions that will reduce abuse or remove them from harmful situations. Sexual abuse can also result in low self-esteem, causing victims to seek acceptance through sex.

Sexual behaviour

Early marriage being a reality of the South Asian region sexual activities start at very early age. The Indian data supporting this reality indicates that in India, one-half of all young women are thought to be sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15. (S. D. Gupta, Policy project document, January 2003) here are approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. This reality results in adolescents facing high risk of acquiring STDs. In past few years studies are done on the sexual behavior of adolescents and young people in the region. The studies reveal that pre-marital sex is also not uncommon. It is higher among males than females and higher in urban than in rural areas.

A study conducted in 1997 of boys and girls from the selected colleges of Mumbai India revealed that a large percentage of boys and girls reported engaging in non-penetrative sexual experiences (e.g., kissing, hugging, touching sexual organs), but only 26 percent of boys and 3 percent of girls reported that they had experienced sexual intercourse. (Leena Abraham 2001.). A study in 2000 in Madras India found that 13 percent of male school-going adolescents and 10 percent of female school-going adolescents clearly approved of premarital sex, 14 percent of the students, both boys and girls, stated that premarital sex is allowable for males only. (Sirur, Rajni R. 2000.)

A study done in Bangladesh during the same period Haider et al. (1997) found that by age 19, approximately 88% of urban adolescent males reported premarital sexual intercourse whereas 44% of their rural counterparts did. Differences in experimentation were even greater for girls. 47% of under 19 year old urban girls reported they had already experienced sexual intercourse, but only 5% of their rural counterparts had experienced.

Prevalence of Sexually Transmitted Diseases:

There are an estimated 333 million new cases of sexually transmitted diseases (STDs) every year. Worldwide, the disease burden of STDs in women is more than five times that of men. STDs are most frequent in young people aged 15-24 followed by 15-19 year-olds (WHO 1995). One in 20 young people is believed to contract a curable STI each year, excluding HIV and other viral infections (WHO, 1986).

As discussed sizable numbers of adolescents are sexually active either within or outside of marriage. Young age at first intercourse is a strong risk factor for STDs. Their immature reproductive and immune systems make adolescents more vulnerable to infection by various STD agents. Adolescents, especially young girls, are less able to refuse sex and/or less able to insist on adequate protection. Sometimes sexual activity involves abuse or coercion, which, in turn, is linked to young age at first intercourse and to more than one sexual partner—both STD risk factors.

Young adults are particularly vulnerable to STDs as most know very little about them. It is a reality of the South Asian region that millions of adolescents live or work on the streets; many turn to selling sex to make a living. Young women especially may be forced into sex or have little power to negotiate condom use with older sexual partners. Young people may be more reluctant to seek help from health services, because they do not know they have a disease, because they are embarrassed or ashamed, or because they cannot afford services.

Evidences on the sexual health and reproductive health status of adolescents and young people are available mostly from micro studies. A community-based study of RTI prevalence among 451 married women aged 16-22 in rural Tamil Nadu India underscores the extent to which infections go unnoticed in this outwardly "low-risk" population. Forty-nine per cent of women in the study reported suffering RTI symptoms while clinical and laboratory examination diagnosed 18 percent with an STI, including chlamydia, trichomoniasis and syphilis. Findings suggest that in many cases, husbands may transmit infections to their wives, which is a matter of concern given that many infected women are asymptomatic and are unlikely to seek care even when symptoms appear. (Joseph, Prasad and Abraham 2003).

A study in Bangladesh found that 40% of adolescent girls (including both married and unmarried) and 20% of unmarried adolescent boys reported symptoms of RTIs and STIs (United Nations Population Fund, 1998). A study in Sri Lanka found that 7% of adolescent boys had an STI (United Nations Population Fund, 1998).

Due to the fact that fewer adolescents seek the health services the problem of STDs becomes worst. It increases the likelihood of negative pregnancy outcomes for both the adolescent mother and her infant. STDs such as syphilis, hepatitis B, and HIV can be transmitted to newborns. Bacterial vaginosis and trichomoniasis are related to pre-term delivery and low birth-weight.

HIV/AIDS

50 per cent of HIV infected people are among people in this age group; many of the sufferers contracted the disease before they were 20. In all countries, young women are the group facing the highest risk of HIV infection through heterosexual contact. More than 5.5 million people are infected with HIV in South Asia, with the epidemic increasingly driven by the region's flourishing sex industry and injecting drug use. However, 99.6% of South Asians are uninfected. (AIDS in South Asia: 2006) The dominant mode of HIV transmission is heterosexual and this accounts for about two-thirds of the infections in South Asia. Globally, nearly 45 per cent of all new HIV infections (about 2.4 million per year) occur among 15-24 – years – olds, and in several settings, the rate is equal to or more than that estimated among adults (UNICEF, UNAIDS and WHO 2002)

Some of the estimated figures by USAIDS (Website: www.usaids.org) as of the end of 2005 are narrated here to present a grave situation of prevalence of HIV/AIDS. Though there is no age specific data available it is an established fact that more and more adolescents and young people are becoming infected with HIV/AIDS. Data reveals that the infection of Sexual Transmitted Infection is in increasing among adolescents and young people.

Pakistan

About 85,000 people, or 0.1 percent of the adult population in Pakistan, are infected with HIV. Officially reported cases are, however, much lower. As of September 2004, only some 300 cases AIDS and 2,300 cases of HIV infection were reported to the National AIDS Control Program. As in many countries, underreporting is due mainly to the social stigma attached to the infection, limited surveillance and voluntary counselling and testing systems, as well as the lack of knowledge among the general population and health practitioners. Although overall HIV prevalence is low in Pakistan, there is growing evidence of substantial high-risk groups, which could contribute to local concentrated epidemics.

India

As many as 5.7 million Indians could have been living with HIV at the end of 2005. India's highly heterogeneous epidemic is largely concentrated in seven states with over one percent antenatal prevalence (Tamil Nadu, Karnataka, Andhra Pradesh, Maharashtra, Goa, Manipur and Nagaland). Although some states appear to be experiencing stabilization in HIV prevalence, (Tamil Nadu, Andhra Pradesh, Karnataka, and Maharashtra) prevalence is increasing in at-risk populations in other states. The Indian epidemic continues to be concentrated in populations showing high risk behavior characterized by unprotected sexual intercourse with multiple partners, anal sex, and injecting drug use with non-sterile injecting equipment. Several high risk groups have high HIV prevalence, and sexual networks are wide and inter-digitating.

Bangladesh

Approximately 11,000 Bangladeshi adults and children could be living with HIV. Bangladesh's sixth round of sentinel surveillance (2004-2005) showed an overall prevalence of 0.6%. The sixth round was carried out in five groups: injection drug users (IDUs), female sex workers (FSW), men who have sex with men (MSM), male sex workers (MSW) and bridge population groups (mobile men including rickshaw drivers, truckers and dockworkers). Significant underreporting of cases occurs due to the country's limited voluntary testing and counseling capacity, and the social stigma attached to HIV and AIDS.

Sri Lanka

Sri Lanka has a relatively small number of people living with HIV—about 5,000 adults. Since 1986, only 712 cases have been officially reported, with underreporting mainly due to limited availability of counselling and testing, fear associated with seeking services and the stigma and discrimination associated with being identified as HIV positive. Of the total number of HIV cases reported from 1987 to 2000 in which the mode of transmission is known, 98% were sexually transmitted. Only a few cases of HIV transmission from mother to child and through blood transfusions have been reported and transmission through intravenous drug use has not yet been reported

Nepal

The first case of AIDS in Nepal was reported in 1988. Since then, the numbers have risen among the country's 27 million people. By early 2005, more than 800 cases of AIDS and over 4,700 cases of HIV infection were officially reported, with three times as many men reported to be infected as women. However, given the limitations of Nepal's public health surveillance system, the actual number of infections is expected to be much higher. It is estimated that 75,000 people were living with HIV at the end of 2005.

Adolescents and Use of Contraceptives¹ (S. Pachauri 2002)

Considering the large and growing proportion of many Asian populations; thus, their use of contraceptives have major implications for both public health and population growth. Data from Demographic and Health Surveys, other national surveys and studies conducted to examine the contraceptive behaviours of Asian adolescents including Bangladesh, India, Nepal, Pakistan and Sri Lanka in South Asia, revealed that, although awareness of contraception is almost universal among married adolescents, knowledge of specific methods and sources of supplies is limited. Use of modern methods varies considerably among countries, from 2% of adolescents in Pakistan to 44% in Indonesia. Although there has been a substantial increase in contraceptive use among adolescents, unmet need remains as high as 41% in Nepal. The vast majority of unmarried, sexually active adolescents either do not use any contraceptives or use traditional methods.

In almost all of the countries studied, the proportion of currently married adolescent women knowing of at least one traditional or modern contraceptive method exceeded 90%; it was as high as 99.9% in Bangladesh. However, this proportion was much lower in Pakistan, where only 76% of currently married adolescents knew of at least one method. The condom deserves special attention because it is the only method that can protect against both unwanted pregnancy and STIs.

Overall, contraceptive use was much lower in South Asia except for Bangladesh and Sri Lanka. Fewer than one in 10 married adolescent women reported using a traditional or modern contraceptive method in Pakistan (6%), Nepal (7%) and India (8%). Although there has been a significant increase in contraceptive use among adolescents in all countries of the region there remains a large unmet contraceptive need.

Unplanned births and induced abortion among adolescents² (Sarah Bott and S. J. Jeejeebhoy- 2000.)

Data on abortion are unreliable and difficult to obtain. The available figures are likely to be significantly underestimated because abortion is illegal and/or severely restricted in all South Asian countries except

¹ Saroj Pachauri and K G Santhya 2002 International Family Planning Perspectives, Volume 28, Number 4, Reproductive Choice for Asian Adolescents A Focus on Contraceptive Behavior

² Sarah Bott and Shireen J. Jeejeebhoy-2000. Adolescent sexual and reproductive health in South Asia: an overview of findings from the Mumbai conference

India. Therefore, the majority of abortions in the region are clandestine; are usually performed under unsafe conditions; and are not reported.

As the data from various studies indicates many adolescents have sex without protection (both in and out of marriage), the proportion of births that are unplanned, unwanted to the adolescents and young people is relatively high.

Worldwide, many unplanned births end in induced abortion, often under unsafe conditions. Data on the numbers of adolescent abortions are scarce. Adolescents particularly unmarried adolescents are more likely to seek abortions from untrained providers, to undergo second trimester abortions and to suffer complications. Fear, shame and lack of access to both services and resources inhibit adolescents from seeking safe and early abortions on the one hand, and from seeking care in case of complications on the other. (Bott S 2000, Puri CP 2000)

The abortion scenario varies considerably within South Asia. In India, abortion has been legal since 1972, but limited availability and poor service quality keep safe abortion beyond the reach of most poor women, particularly adolescents and young women. In Bangladesh, abortion has been available since 1999 for up to 12 weeks of gestational age in the form of “menstrual regulation”, and large proportions of women use these services. In Sri Lanka, abortion is legally restricted, but available, and women have access to relatively safe services. In Pakistan, it remains severely restricted and women who undergo an abortion are liable to prosecution.

Few studies have explored the context of abortion among young women in South Asia. The majority of these studies have been hospital-based rather community-based, urban rather than rural, and among married women rather than all women.

Review of various studies from Bangladesh reveals that because abortion services are available only up to 12th week of pregnancy, women who want such services must recognize their pregnancy as early possible. This poses a major obstacle for girls who may not recognize their or find the resources to access services in time. While adolescents constitute 9% of women who received services “menstrual regulation” clinics, they constituted 15% of those rejected by the clinics; presumably their pregnancies were too far along. As a result, many adolescent girls are hospitalized for complications of induced abortion after an abortion by traditional birth attendants or after attempting to self-induce.

About half of these girls resorted to unsafe methods such as inserting a solid stick or rubber catheter, or ingesting medicines. Researchers observed life threatening complications such as severe infection, mechanical injury to the cervix or vagina, and evidence of a foreign body having been inserted into the vagina, cervix or uterus. Awareness and prior practice of contraception were found to be limited among young women in the study.

A community based study of abortion in a rural Indian setting reveals that young women age 15–24 constituted over half of all abortion-seekers in the area. About 14% of married women who had recently experienced an induced abortion were younger than age 20, and another 40% were aged 21–24. Although abortion among unmarried women in India is a highly sensitive topic, researchers were able to identify 43 unmarried adolescents who admitted to having had an induced abortion. Their results suggest a number of important differences between married adolescent and adult abortion seekers. First, adolescents reported considerably less decision-making authority than older abortion seekers.

They were less likely to have been allowed a major role in the decision, more likely to have been coerced into an abortion, and conversely, more likely to have faced opposition from their families. As in Bangladesh, young women’s knowledge about and use of contraception were limited, yet their need to space births was a leading reason for seeking abortion. Finally, providers were more likely to insist on spousal consent from younger abortion-seekers than from adult women, even though such consent is not legally required.

The study found several important differences between married and unmarried adolescent abortion-seekers. While no evidence indicated that married adolescents delayed seeking services compared to older married women, it was clear that unmarried adolescents sought abortions further along in their pregnancy than their married counterparts. While married adolescents preferred the private sector, unmarried adolescent abortion seekers reported higher use of traditional providers as a result of less family support, less money, and concerns about confidentiality and provider attitudes.

Adolescents tended to believe that abortion services were not legally available to unmarried women. Researchers also found that some providers charged unmarried women a higher price for their services. Regardless of marital status, however, almost three-quarters of adolescent abortion-seekers reported post-abortion morbidity. The evidences from different studies indicates that deaths related to abortions and unwanted pregnancies account for a significantly larger proportion of pregnancy-related deaths among adolescents than among older women.

Knowledge about reproductive and sexual health among the adolescents

Providing information and education on reproductive health will help young people explore their own attitudes, values and options, as well as increase their knowledge and understanding of reproductive health issues. Although there exist great variations between different cultures, studies have shown that adolescents in the South Asian countries rarely discuss sexual matters (e.g. sexual intercourse, sexuality and sexual preferences, menstruation) explicitly with their parents or with adults older than themselves. Most information on these subjects comes either from their peers, who may be equally uninformed or misinformed and are likely to be relatively inexperienced themselves, or from the media, which tend to represent either sexual and gender stereotypes or extremes. Due to such a situation the adolescents are not prepared mentally or psychologically to cope with these changes. (Suman Mehta et al 1998)

People who are working in the area of AIDS awareness across the South Asian region come across various questions the adolescents usually ask. These questions indicate that there is a dearth of information among the adolescents. Some of questions asked by the adolescents boys and girls are:

- Could one get AIDS from kissing, sharing a cigarette, or mosquito bites?
- Does AIDS always end in death?
- Does man get STD if he has sex with woman who is menstruating or had discharge?
- Does someone develop STIs from too much sex?
- Is masturbation a sickness or addiction?
- Does masturbation alter the size of one's penis or cause it to hang to one side?
- Does masturbation affect one's virility or ability to impregnate one's wife later in life?
- Does masturbation result in weakness of the body?
- How do we know whether the girl had a sex before marriage or not?

A nation wide adolescents' knowledge, attitude and practices (KAP) study (UNFPA 1999) on sexual and reproductive health in Nepal covered 2,025 adolescents aged 15 to 19 from seven districts across Nepal says Before their first sexual intercourse, about 53.1 per cent of males and 23.2 per cent of females claimed to know about sex mostly from friends.

Only 30.0 per cent of adolescents heard of reproductive tract infections (RTIs). More than three quarters (77.0 per cent) heard of sexually transmitted diseases (STDs), particularly HIV/AIDS. They cited multiple sex partners (78.4 per cent) and commercial sex workers (52.7 per cent) as sources of STDs.

A study from Sri Lanka also shows similar results. According to them only 35 per cent of the respondents correctly named the parts of the female reproductive system. Only 15 per cent of the respondents were able to identify the parts of the male reproductive system. Less than a tenth of the students were able to identify two or more STDs. Majority of the students (64 per cent) were only able to name one. Despite the extensive information campaign on AIDS, less than half were able to name the AIDS virus. Out of all students, 63 per cent were unable to state even one mode of AIDS transmission. An alarming level of 76 per cent could not name even one preventive action against HIV/AIDS. A little over half of the students

agreed that the spread of AIDS could be checked by legally keeping the patients out of society. (Attanayake, C 1999) Nugegoda 1999)

A study from UP India reiterates the similar results. It highlight that only 13.5 per cent of Adolescents (15-22 Years old) had heard about sexually transmitted diseases (STDs) while 19.6 per cent heard of AIDS. (Singh, M. et al 1998) A study conducted in Madhya Pradesh of India points out that less than half of students were able to correctly define puberty, wet dreams and ages of secondary growth changes. Only 38 per cent understood why menstruation occurs. Some rural students even simply took it as a curse from god. Only a quarter (25.5 per cent) knew that AIDS could spread through non-sexual contact as well. Only 39.6 per cent of the students know what the acronym STD stands for. Less than this percentage could name STDs other than AIDS. (Pathak, R et al 2001)

A similar study done in Bangladesh among the boys and girls of 15-19 years reveals that between a quarter and one third of all boys had heard of STDs. Girls, particularly from small municipalities, were less knowledgeable. A smaller proportion of older adolescent girls reported knowledge of STDs. As perceived by adolescents, 46% adolescents boys and 53% adolescent girls were still not aware that HIV is transmitted through sexual activity. (Islam 2000)

Limited Access to Sexual and Reproductive Health Services

Providing specialized reproductive health information, counselling and treatment services for reproductive and sexual health services are a post ICPD phenomenon in the South Asian countries. In most South Asian countries efforts are being made in this area however access of adolescent to these services is still a major concern. Adolescents often avoid to reach to these services is usually because of lack of privacy and confidentiality. To fulfil the need of the access to health care services the concept of youth friendly services has come to existence in very recently and yet not fully implemented in South Asian countries.

Various studies have revealed a list of reasons for the adolescents not access the services. Some of them are mentioned here:

- They are often embarrassed at being seen at a reproductive health facility with a fear that their parents and relatives might find out about their visit
- Many are afraid of medical procedures, especially pelvic exams and may be afraid of the fact that society will come to know that they have experienced coercive or abusive sex.
- It is a hard fact that adolescents in South Asian countries are not well aware of their entitlements of health services and also may not be aware where reproductive health services are located.

On the other hand less attention and efforts are being made by the State to reach out to adolescents. Data on STI / RTI service provision and its access to adolescents are not easily available. The general observation of people working in the area of prevention and treatment of HIV/AIDS claims that sexual health programmes mainly serve older and married young people.

Challenges and Recommendations:

Ensure Coherence in Understanding of Adolescent Reproductive and Sexual Health

Today in the South Asian region the term adolescent reproductive and sexual health is being used in majority of the health programmes of the government and non-government organizations. However there is a wide range of understanding of the reproductive, sexual health and rights concepts among the stakeholders and advocates, which limits formulation of policy, strategies to address the reproductive and sexual health need of adolescents. Also it limits to demand their reproductive and sexual health entitlement of adolescents as describe in ICPD platform for Action.

It is recommended to sensitize range of stakeholders to develop a common understanding on the issues of adolescent reproductive and sexual health and work towards it to achieve it. The definition developed

during the ICPD need to be taken as a reference point. Government in collaboration with NGOs and academic institutes can take a lead to sensitize the bureaucrats, policy makers, programme designers and implementers of different departments concern to adolescent health and development. NGOs can take lead in sensitizing the advocates and the community including the parents to sensitize them about the meaning of adolescent reproductive and sexual health.

Ensure and promote Participation of adolescents

It has been observed that if adolescents and young people are not involved in the development of the laws, policies and programmes that affect them, even well-intentioned actions on the part of adults will often fail to protect their best interests. Because their voices are not heard and the impact of public policy on their lives is not discussed in decision-making forums, their concerns never reach the top of the political agenda. Young people have a body of experience unique to their situation, and they have views and ideas that derive from this experience. They know their needs the best.

It is therefore recommended that all programmes planned and implemented by government and non government organizations are designed keeping the socio-cultural perspective and the need of the adolescents in view. This can be achieved only if the participation of the adolescents and young people is ensured in planning, designing, implementation of the programmes to address their needs. Also the programmes should be flexible to ensure that they can respond to the changing needs of adolescents.

The adolescents and young people can be involved at various levels. There are possibilities to involve them in research by providing them training as researchers and later undertaking independent investigations focusing on issues of direct concern to them, incorporating their views and experiences in programme design, implementation, monitoring and evaluation, serve as advocates, working with adult institutions to lobby for greater respect for their rights, involving adolescents in reviewing existing legislation and policies from the perspective of their own experience.

Such opportunities of participation will be empowering for young people to take action to influence or change aspects of their lives for the better. There are efforts done in this direction in the region however they need to be made more popular and structured with a financial support.

Some suggestive mechanisms to include the voices of adolescents are:

- Initiate youth organizations and networks ensuring leadership of young people who are committed to sexual and reproductive health and rights issues. Donor agencies and Government funded programmes can take lead in this direction.
- With in the NGOs and GOs set up committees of youth or at least have two youth representatives on all committees or boards

In India, an initiative of conducting live mock 'Youth parliament session' on the issue of HIV /AIDS was a historical event since it was organized for the first time in the world. Extensive groundwork was done for the successful completion of the event. Selected young people representing from all states of India were trained for five days on the issues of HIV/AIDS and also on the parliamentary proceedings. Resource persons were inducted to educate and sensitize young people coming from all over the country on the various dynamics of HIV/AIDS and then select 20 from each state to form members of the parliament. In all 543 young people were selected to participate in the parliamentary session conducted on 7, November 2005 which proved to be a rich experience of youth participation and involvement.

Another experience from Bangladesh Youth Forum (BYF), which is an initiative by the youth for the youth and in it Bangladeshi Youth voices can be heard crying aloud for alleviation of poverty, an end to social and armed conflict, clear policies dealing with the HIV/AIDS pandemic and a call for responsible leadership and good governance" The BYF is a network of young leaders, peace builders and social

activists from all over the countries working in promoting and advocating for youthful solutions to Bangladesh's developmental challenges. (Projects.takingitglobal.org 2005)

BYF promotes community empowerment through youth participation in the development process, supports skills development and capacity building programs, advocates for the rights of Bangladeshi youth and their communities and environments, and supports young people's on grassroots initiatives to achieve social justice, sustainable development and a culture of peace.

There are a number of challenges in ensuring participation of adolescents and young people. They include the need for extra training and supervision, a high turnover rate resulting in the constant need for training, difficulty with reliable participation due to competing interests and demands in their lives. These problems demand careful selection of participants and by providing good training, supervision, incentives, and rewards. However there is a need to have more scientific studies and research to learn the effectiveness of the programmes planned and led by adolescents and young people.

Inclusion of Life skills education and sexual and reproductive health awareness programme in formal and non-formal educational programmes/vocation training programmes and livelihoods programmes

Various studies conducted on knowledge, attitude and practice in the region reveal that the adolescents and young people are looking forward to receive the correct and scientific knowledge about their reproductive and sexual health. At the same time, the patriarchal norms of the region leads to low self esteem and poor life skills which has direct effect on the reproductive and sexual health of adolescents specifically the adolescent girls.

Keeping in view this reality efforts are being made in the region to create awareness among the adolescent under the heading of life useful education. However it majorly focuses on the reproductive health and very little attention given to the sexual health and sexuality education. Life skills education focusing on negotiation skills, decision-making skills, assertive communication etc is extremely rare.

It is recommended to review existing efforts of the region by ensuring the participation of adolescents followed by integration of recommendations in the existing programmes and up scaling the successful efforts. Adolescent being a dynamic group, fresh innovative initiatives in life skill education and reproductive and sexual health education in formal and non formal education system need to become a regular feature in programme planning. These initiatives need to be planned through active involvement of adolescents so as to ensure the process of adolescent empowerment.

In Nepal, UNICEF has created a communications initiative for young people that has three interlinked ways of reaching young people: a combination of education and entertainment on radio and television, communication materials and interpersonal discussions. The radio program "Chatting with My Best Friend" is produced and hosted by and for youth. It focuses on common problems such as drug abuse, sex, relationships, and peer pressure. The TV program "Catmandu," acted and directed by and for young people is a drama series that improvises stories from issues raised in the radio program and the letters from listeners. It helps demonstrate life skills such as creative and critical thinking, problem solving, and making difficult decisions. (Wendy Santis et al 2006)

Another effective small-scale initiative of CHETNA, India in partnership with Interact WorldWide (IWW), UK and International Council on Management of Population Programs(ICOMP) Malaysia demonstrated an approach of providing opportunity to adolescents to develop as young leaders to plan and implement grassroot level educational intervention to improve the reproductive and sexual health of adolescents and young people. Five adolescents between 17-20 were provided an opportunity to develop understanding on the issues like reproductive and sexual health concerns, HIV/AIDS, gender discrimination and life skills education etc. With a structured capacity building input on developing the grass roots level interventions these five young adolescent developed an educational interventions on the local geographical specific

issue of their concerns. With nominal financial support and continuous support from the organisation they are working with and CHETNA implemented the project in their field area. The experience was very successful in developing young leaders. It provided young people with the opportunity to develop and sustain leadership skills, which in turn would bring them out as reflective, analytical and progressive young leaders in the long run.(CHETNA June-2006 Breaking Barriers)

Improving Access to Adolescent Reproductive and Sexual Health Services

Under the Reproductive and Child Health programme in the South Asian countries there is a provision of adolescent and young peoples reproductive and sexual health services including, treatment for RTI/STDs, access to contraceptives, counseling, and awareness building. These components need to be strengthened along with effective Behaviour Change Communication (BCC) with necessary budgetary requirements.

It is recommended to

- As a part of existing Reproductive and Child Health Programme of the South Asian countries and other programmes for adolescents and young people development being implement by various government departments like education, sports and culture etc and non government organizations BCC strategies can be created and implemented to promote a wider choice of contraceptives, to address adolescent fertility and reproductive and sexual health issues and gender equality. If necessary separate funds need to be allocated for the same in the programme budget.
- As a part of awareness building component of Reproductive and Sexual health programme make effort to create demand for adolescent reproductive and sexual health (ARSH) information and services to help increase ARSH service utilization and lastly
- Involve men and boys to improve women's/girls' status and utilization of ARSH information and services by sensitizing them regarding the issues concerns to adolescents girls like gender discrimination resulting in their venerability towards reproductive and sexual infections, role and responsibility of men to bring the gender equality in the society, refusing to early marriage, involving their wives in any decisions related to reproduction etc.
- Non-government organizations can implement advocacy and BCC activities to attain support from politicians, decision-makers, religious leaders, and community leaders for enhanced utilization of ARSH information and services.
- Government can take a lead to sensitize and train the health care providers to implement the youth friendly health services. Budgetary and resource allocation for capacity building is critical to enable this.

Ensure Comprehensiveness in the Adolescent Health and development Programmes:

It is a well-established fact that the reproductive and sexual health concerns of the adolescents are complex and interlocked. They are influenced by socio-cultural, religious and economic environment. Any concern of adolescents addressed in isolation will not bring forward desirable results. The programmes being implemented in the region to a large extent lacks comprehensiveness and gender and empowerment perspective. They are also being addressed through vertical programmes. For example while anemia, maternal health and prevalence of STI/RTI are interrelated issues of adolescents, still they are being addressed in isolation in all the countries of South Asia. It is recommended that a convergence is forged between the Ministry of Health and Family Welfare, Women and Child Development, Youth Affairs, Employment and Education to design and implement programmes for the comprehensive development of the Adolescents. Adolescents must also be an integral part of the design, implementation and monitoring of programmes.

Formulation of Adolescent Health Policy

In South Asian countries very recently adolescents have received focus at the policy level. Various socio-cultural, economic and political factors influence the societal attitudes and legitimacy to address adolescent reproductive health issues. Without a clear cut policy at the country level on adolescent reproductive and sexual health it is difficult to plan a comprehensive reproductive and sexual health programme at the country. Recently in India the National Youth Policy gave a special attention of adolescents reproductive and sexual health. There is still no separate policy for adolescents in the region, except in Nepal. The region need to develop a country wise adolescent Policy, which need to integrate the human right perspective by active involvement of adolescents and civil society.

The National Alliance of 'Young people towards healthy future', India (CHETNA Ahmedabad-Gujarat is a secretariat of the alliance) organized a series of consultations which provided young people an opportunity to voice their recommendations to be included in the formations of the programmes after the National Youth Policy was declared in 2003. Similar efforts are made at state levels in different part of the country to frame State youth policies too during 2005-2006 (CHETNA -Report 2006)

Under the Women's Health Rights and Advocacy Programme-(WHRAP) being implemented in Pakistan, India, Nepal and Bangladesh and coordinated by ARROW Malaysia a regional policy dialogue was organized during 2006. As an outcome a regional task force was setup which includes elected representatives, government officials, researchers and media persons from Nepal, India, Pakistan, and Bangladesh. The task force will lead the advocacy efforts for the priority issues of the region to achieve the ICPD goal of universal access to sexual and reproductive health and rights by 2015. There is a need to support and strengthen such advocacy and networking initiatives in the region.(CHETNA News- 2006)

Conclusion

The information provided here is an attempt to bring forward the reproductive and sexual health situation and concerns of adolescents in the South Asian region. The results of the studies reviewed, the observations of the people actively working on the issue of the adolescent health and development and the voices of the adolescents reconfirms that even after more than a decade of adolescents continue to face considerable risk of unsafe or unwanted sexual activity resulting in increasing trend of RTIs and STDs including HIV/AIDS, unwanted pregnancy and abortion. The patriarchal socio cultural scenario of the region to a large extent contributes to this situation as early marriage and early pregnancy are still a grim reality of the region and the culture of silence does not allow adolescents to openly share their concerns and inhibits them to access health services. In addition lack of life skills and power imbalance between the girls and boys are still an unsolved issue (agenda) and major threat for the adolescent girls reproductive and sexual health.

Though adolescent health has come to the national agenda for all the countries of the South Asian region in post ICPD era, a lot more needs to be done to make access to information and reproductive and sexual health services more accessible to the adolescents of the region. To some extent, the region has initiated the process of involving adolescents at various levels of programme implementation and policy formation. Few but promising evidences exist, but much more still remains to be done. The voices of young people reconfirm the fact that they are ready to receive the information and services related to reproductive and sexual health if privacy and confidentiality is maintained. There is also an urgent call for the adults to take a few steps forward to understand the perspective of the adolescents and take them along while designing programmes for them.

The recommendations related to programme planning and implementation and policy formation articulated here are based on the ground reality which needs to be taken as a reference point for the policy-makers, programme implementers, researchers and service providers to plan their future action which will surely contribute towards improving the health of the adolescents in the region. Finally as an

end note, we would like to firmly state that if the health programmes fails to seriously integrate the concept to gender equality and empowerment; the region will fail to show any significant improvement in the adolescent reproductive and sexual health scenario of the South Asian region.

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