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Adolescents in Asia: Issues and Challenges

Introduction

ONE-fifth of the world population is between 10 and 19 years of age. Half the world's people are under age 25. The generation entering the adolescent years now is the largest generation in human history (Rockefeller Foundation, 1997). In Asia, about a third of the population are 10 to 24 years old. Although youth across Asia have several common concerns, there is tremendous diversity in this region, especially between South Asia and Southeast Asia. Significant social and cultural differences between these regions make generalizations regarding policy and programme interventions tenuous if not impossible. The lack of data on youth further compounds the problem of making a comprehensive analysis of the challenges faced by youth across Asia and the nature and scope of efforts required to address them.

Defining Adolescence

All cultures recognize and mark the transition from child to adult (WHO, 1977). The concept of this transition as a life stage did not exist in developed countries until the late 1800s and early 1900s (Harari and Vinovskis, 1993; Juster and Vinovskis, 1987). In many developing countries the concept did not exist as recently as 20 years ago and in some regions the idea is new even today.

Sri Lanka was one of the first Asian societies where adolescence began to emerge, especially as girls' marriage age increased, averaging 18 years by the end of the nineteenth century. The growth of the non-farming occupational sector together with the Buddhist belief in enlightenment, fanned by the nineteenth century Buddhist reform movement which extolled the virtues of schooling, led to a rapid spread of schooling for both boys and girls. Nowprimary schooling is universal and most Sri Lankans enjoy substantial secondary education, equalling that in some Western countries (Caldwell and Caldwell, 1997).

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In Bangladesh, on the one hand, female adolescence is a recent development: The Bangladesh Fertility Survey found that even as late as 1974, the average age of marriage among girls was 14 years. Since then it appears to have climbed about four years as this agrarian society has been increasingly penetrated by the market economy and as the proportion of teenage girls in school has trebled. Male adolescence has also been transformed and to a large extent it too has come into existence (Caldwell and Caldwell, 1997).

The World Health Organization defines adolescence as the:

- progression from appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity;
- development of adult mental processes and adult identity; and
- transition from total socio-economic dependence to relative independence (WHO, 1975).

Many reports place adolescence in the 10 to 19 age group, while others cover 15 to 24, but neither range is intended to mark a universal beginning and ending, either socially or biologically. Puberty marks thebiological beginning of adolescence, butmarkers of its completion are varied and ill-defined. Thus age and puberty are important defining criteria for adolescence. However, does age plus puberty equal adolescence cross-culturally? Can a young, married woman who bears her first child at the age of 17 still be considered an adolescent or a married 21 years old an adult? The only universal definition of adolescence appears to be that, although no longer considered a child, the young person is not yet considered an adult.

The meaning of adolescence, as a social construct varies across cultures. An appreciation of this variation and complexity could provide a clearer understanding of fertility intentions and information needs of young people. During adolescence many young adults experience critical and defining life events—first marriage, first sexual intercourse and parenthood. Earlier these life events were considered inseparable, but this no longer holds true for many young people. Age atpuberty is falling while age at marriage is rising. Since time between puberty and first marriage has increased, first sexual experience and childbearing may take place for many in a different personal and social context (Population Reports, 1995).

Boys and girls now experience puberty at younger ages than previous generations. In general, girls enter puberty between ages 8 and 13 while boys enter puberty between ages 9 and 14 (Senanayake, 1990; Winter, 1982). The reasons for earlier menarche in girls are not well understood. Most of the change is attributed to better health and nutrition (Forrest, 1993; Gyepi-Garbrah *et al.,* 1985; and Winter, 1982). In North America age at menarche decreased by three to four months each decade after 1850; in 1988, the median age at menarche was 12.5 years for girls (Forrest, 1993; Winter, 1982). In some developing countries age at menarche appears to be decreasing even faster. For example, in Kenya average age at menarche fell from 14.4 in the late 1970s to 12.9 in the 1980s (Gyepi-Garbrah *et al.,* 1985). Studies conducted during 1972 to 1989 indicate that mean age at marriage for girls in India is 12.6 years (Aggarwal *et al.,* 1992).

These changes in age at menarche can have profound consequences for reproductive and sexual health of adolescents. But adolescence cannot be defined discretely by age, puberty, sexual intercourse or marriage. Rather, all these events must be viewed within the context of

gender relations, age hierarchies and social class, to understand the real meaning of adolescence in different cultures in order to define the challenge of addressing the needs of young people.

Defining the Challenge

Recognition of the changes and challenges that are faced by young people has led to the development of several recent policy statements and initiatives for youth. In the last few years, the international community in particular has affirmed the importance of youth to every aspect of social development and their rights within it. The following are some of the most significant policy statements endorsed internationally:

Convention of the Rights of the Child, 1990 Defines Childhood upto and Including 18 Years of Age and Affirmed these Persons' :

- right to life, survival and development;
- right to freedom of expression, thought, conscience and religion;
- right to highest attainable standard of health and to treatment and rehabilitation of health;
- right to education, with a view towards equal opportunity;
- right to protection from all forms of physical or mental abuse and violence;
- right to protection from economic exploitation; and
- right to protection from sexual exploitation and abuse.

International Conference on Population and Development, 1994 Affirmed the Need to :

- protect youth from disease, malnutrition and other effects of poverty;
- ensure equal opportunities for boys and girls;
- address the neglect and exploitation of young people, including sexual exploitation;
- enact and enforce laws prohibiting abuse of children;
- enact and enforce laws banning child marriage;
- eliminate discrimination against pregnant young women;
- protect children harmed by armed conflict or disaster;
- ensure the future of youth by providing education, training, employment, housing and health care;
- support organizations that assist young people;
- involve youth in activities that affect their lives; and
- protect the reproductive and sexual health of young people by providing access to information and confidential services (UNFPA, 1994).

"To meet the special needs of adolescents and youth, especially young women, with due regard for their own creative capabilities, for social, family and community support, employment opportunities, participation in the political process and access to education, health, counselling and high quality reproductive health services" (UNFPA, 1994)

United Nations International Conference on Women, 1995 Reaffirmed:

- the importance of meeting the health needs of youth, especially young women;
- that young people be given better access to health care information, especially information about reproductive health care, taking into account the responsibilities of parents and legal guardians; and
- girls are especially vulnerable to early marriage and pregnancy, genital mutilation, sexual abuse, violence, and prostitution, they have a greater need for reproductive health care (UN, 1995).

Some common international recommendations include enhancement of education and employment opportunities, especially for girls and right to information and services, especially sexual and reproductive health services. The gender dimension in determining social and health policies is underscored in all these statements.

Addressing the Challenge

Adolescents and youth have multiple needs—needs for education, employment -.nd reproductive and sexual health. There are crucial linkages between these. However, there are differences in the way these needs are met for boys and girls from different socio-economic strata of society, as well as for those living in urban and rural areas. Young people form one of the largest groups with unmet needs for reproductive health services. They should be able to protect themselves from unwanted sex, sexually transmitted infections (STIs), unplanned pregnancy, early childbearing and unsafe abortion.

Unfortunately, young people often face these risks on their own. In many parts of the world, traditional family and community support systems are either no longer available or are unable to cope with rapidly changing realities. Organized community health and social policies and programmes have not yet filled the gap although they are beginning in someplaces, despite controversy. While the revolution in family planning helped to meet the reproductive needs of many older, married women and couples, young people have been largely left out (Population Reports, 1995).

Too often, when adults discuss young people, the most common words used is "problem" —the pregnancy problem, problems with STIs, behaviour problems, the problem of educating young people, the problem of irresponsibility. Meeting the reproductive health needs of adolescents requires more than solving problems. It requires investing in their potential and helping them to prevent and solve problems for themselves (Population Reports, 1995).

There is now growing awareness of the needs of adolescents. However, programmirig for this group is still in its infancy in Asia, struggling to find a niche within national programmes -often within environments that are politically and culturally hostile to changing existing norms. On the other hand, there is an overwhelming tide of social change in Asia, as in other parts of the globe. Societal change has been ongoing but is now occurring at a much more rapid pace. Values, zealously preserved in traditional cultures, will inevitably have to be relinquished (Pachauri, 1997). Asian societies are in transition and each society must look within itself to find its own answers. Adolescence as experienced in the West is not a universal phenomena.

There is clearly no universal model that Asia can emulate. Western models may not be applicable or acceptable in Asian cultures.

However, there are lessons to be learnt from societies that have made the transition. Where social attitudes have changed and adults are willing to face the issues, fertility, STI and abortion rates among young people are low. A study of 3 7 developed countries found that these rates were lowest in the northern European countries that provide young people with good access to contraceptive information and services (Friedman, 1994; Persson, 1993; and Sondergaard, 1993).

Societies in Asia must necessarily design their own responses to the reproductive health needs of adolescents because ignoring these problems will not make them disappear. In fact, rates of sexually transmitted infections have risen and pregnancies among young women are increasingly occurring outside marriage in many countries despite public concern and condemnation of these trends. Reproductive health programmes can help communities start addressing the various needs of adolescents.

One of the earlier efforts to reach young people was by providing population education in schools. The first national programmes on population education in schools in India, the Philippines, and South Korea in the late 1960s and early 1970s, did not cover sexuality or contraception. These programmes have now been broadened to provide family life education. But they are often controversial and even where governments have endorsed them, they have not always been effectively implemented. Most programmes have not been evaluated or even described in detail and so little is known about their impact. More recently, some of these programmes are being redesigned in light of the ICPD recommendations (UNFPA, 1996).

An Adolescent Study Group, supported by WHO, UNICEF and UNFPA, that has a mandate to accelerate programming for adolescent health states that the overall aim of adolescent health programming is:

> "to have informed, skilled youth who are motivated to make healthy choices and an environment that facilitates these choices and provides key services, opportunities and interpersonal support. The objectives of adolescent health programming are to promote healthy development, to prevent health problems and to provide care when needed" (WHO, 1997).

Young people's greatest need is for accurate information - about their bodies, about handling relationships, about sexuality and reproduction. This need is shared by all young people, rich and poor, sexually active and inactive, married and unmarried, male and female. They prefer to get information about sexuality from caring adults, but often learn about sex from their peers. Unfortunately, much of this information is either inaccurate or insufficient (Hughes and McCauley, 1997).

Social norms also shape the attitudes of young people about appropriate sexual behaviour. When young people act upon negative social norms and gender stereotypes, they may unknowingly endanger their health. For example, in Thailand both young men and women expect males to have multiple partners (Childhopeef *al.*, 1997; Praditwong, 1990). Thus, social norms can condone and even force young people into unhealthy behaviour.

At present there is a poor fit between reproductive health programmes and the needs of adolescents. As a result, few young people are adequately prepared to take responsibility for protecting their health. For programming in sexual and reproductive health, the most fundamental distinction should be made around young peoples' levels of sexual activity. Strategies should be designed to address the distinct needs of sub-groups of adolescents: The first group includes those who have not yet begun sexual intercourse. These adolescents are almost invisible and their needs are usually not addressed but there is an opportunity to change their behaviours. The second group includes those who have engaged in sexual intercourse but with no unhealthy consequences such as unwanted pregnancy, unsafe abortion, STIs, RTIs, HIV or abusive or violent sex. They need information, skill-building, counselling and services. And a third group of adolescents, who contribute a substantial share of adverse health consequences and are also the group that those delivering services have in mind, require a different set of interventions (Hughes and McCauley, 1997).

The Gender Dimension

As sexual activity is an important defining factor in the lives of young people, adolescent fertility has been seen as problem that needs redressal. Those in the field of family planning have specially highlighted the issue of adolescent fertility as they are *concerned about population momentum that will fuel population growth.* A key question asked is: How can policy-makers manage the problem of adolescent fertility? Policy prescriptions that are offered within the population momentum framework focus on delaying childbearing by raising age at marriage. Although the average age of marriage has risen across Asia, especially in the past decade, marriage still occurs at very young ages, particularly in South Asia. In Bangladesh and Nepal, nearly 50 per cent of 15 to 19 years old girls are married. In Bangladesh, where girls as young as 13 years old are married, 80 per cent have had a birth by age 20. In Pakistan, nearly 50 per cent of all births occur to women under 20.

Unfortunately, there are no 'technology bullets' to raise age at marriage and delay childbirth i.e., to solve the problem if it is viewed solely within the population momentum framework. It is, therefore, important to examine the social and cultural context in which this 'problem' is embedded. When examined from this perspective, then it becomes clear that the 'problem' is not adolescent fertility, rather the social processes that make it a mandatory experience in these cultures. In most of South Asia, the majority of adolescent sexual activity is within marriage. Early marriage is not a choice when wife and mother are the only socially valued and economically secure roles for women (Bruce and Haberland, 1997).

When examined within this framework, a different set of policies could be recommended. Policy prescriptions would require challenging social norms that devalue girls. The answers lie in finding routes to economic and social survival for girls and providing information that is honest, timely and recognizes the power differentials in relationships that perpetuate the problem and prevent information and services from reaching youth. It must be recognized that although all young people are vulnerable, some are more marginalized. Adolescents do not constitute ahomogenous entity. There are significant social, economic and gender differences. For example, girls do not have the same education and employment opportunities as boys and

they face family and societal pressures for early marriage and early childbearing. In many parts of South Asia a girl must prove her fertility soon after marriage. Sexual coercion within and outside marriage is the norm. There are strong pressures for women to marry young, to have children early and to go on having children till they have had the number of sons that the family desires.

These biases reflect broader social norms regarding the roles of women and men whose culturally ascribed positions directly influence their patterns of sexual behaviour, contraceptive use and the balance of responsibility for child-rearing. Male and female gender roles typically create an imbalance in negotiating positions between partners. Such imbalances are exacerbated for younger people since they are more vulnerable.

Therefore, the first step is to understand how biological and culturally-constructed gender roles relate to sexual behaviour. Sexuality, a subject of obvious relevance to reproductive health, has been largely ignored in the family planning and health fields because it is a sensitive issue-politically and culturally (Pachauri, 1996). Sexuality is also complex. But this complexity is beginning to uhfold as we listen, in non-judgmental ways, to what young people have to say about their own sexual realities. This information can guide us in learning how to offer services and information in ways that enhance equality between sexual partners, support partner communication and address gender inequality that underlies reproductive ill health.

Research on HIV/AIDS among adolescents in developing countries, undertaken by the International Center for Research on Women, vividly illustrates the problem. This research shows that:

- economic gain and sexual coercion underly many young women' s sexual experiences;
- the social expectation of virginity does not necessarily protect young women from STIs and HIV/AIDS;
- and social and sexual inequalities promulgated for males during childhood and adolescence increase vulnerability to HIV/AIDS of their sexual partners who cannot negotiate safe sexual behaviours as equals in their relationships (Weiss *etal.,* 1996).

These studies underscore the need to increase investment in girls' education; enhance their negotiating power within the family, among their peers and sexual partners; promote greater male responsibility; and foster women's livelihood (Weiss *et al.,* 1996).

Margaret Greene, who examined the situation of the adolescent girl in India states:

> "Families' reluctance to invest in young girls is echoed in the policy silence surrounding adolescent girls. This policy silence reflects and supports the social and physical invisibility of girls in their communities."
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> "A final element of resistance to the notion of femaleadolescence especially in India has to do with the connotation of sexuality that the term "adolescent" carries. This contrasts sharply with the term most often used in India, the "girl child"—it is no coincidence that the "girl child" disappears at marriage, whatever her age, because by activating her sexuality, marriage finalizes her transfer from her family of origin to her in-laws' home and signals the cessation in investment in her as an individual." (Greene, 1997).

A recent review in India by Shireen Jej eebhoy has underscored the paucity of information on adolescents even though they constitute one-fifth of the country's population. Adolescent fertility occurs mainly within the context of marriage. Because girls marry early, about half are sexually active by the time they are 18; and almost one in five by the time they are 15. Well over half of 15-19 years old girls have experienced a pregnancy or a birth. There is sparse information regarding other aspects of reproductive health although adolescents face several reproductive health problems beyond early marriage and childbearing. This review shows that between 20 and 30 per cent of boys and up to 10 per cent of girls are sexually active during adolescence before marriage. Social attitudes clearly favour cultural norms of premarital chastity but there are double standards for unmarried boys and girls. Both unmarried and married girls are vulnerable to pregnancy and STIs but do not have the decision-making power in their sexual relationships (Jejeebhoy, 1996).

Reproductive Health Risks

Reproductive health risks are especially pronounced in the younger age groups. Both biologic and behavioural factors make them susceptible to higher rates of infections, morbidity and mortality. Social and political factors further exacerbate the problem by denying crucial health services to adolescents. Across the region, low enrolment and attendance levels in schools, high drop-outrates and poor quality of education further compromise adolescents by restricting opportunities and options.

Very early marriage is not as prevalent in Southeast Asia as in South Asia. Later marriage has led to a longer period of adolescence in Southeast Asian countries where levels of premarital sexual activity seem to be high, but in many cases this activity is a prelude to marriage. Demographic and Health Survey data show that 4 per cent of Thai women who were 20-24 at the time of the survey had a pre-marital conception leading to a live birth in their teenage years; the proportions were 11.5 per cent for Indonesia and 8.5 per cent for Sri Lanka (DHS 1987 Thailand, DHS 1987 Sri Lanka, DHS 1994 Indonesia).

In general rates of adolescent pregnancy have been falling alongside overall fertility rates, but not as fast, so the share of births to teenage mothers has actually increased in some areas. Adolescent pregnancy, whether wanted or unwanted, can be dangerous for both mother and infant. Complications of childbirth and unsafe abortion are among the main causes of death for women under age 20 (PRB and CPO, 1994; Senanayake and Ladjali, 1994; Stewart and Cuervo, 1994). Even under optimal conditions, young women, especially those under age 17, are more likely than women in their 20s to suffer pregnancy-related complications and to die in childbirth (Miller, 1992; Senanayake, 1990; UN, 1989; and WHO, 1989). For example, a retrospective hospital study of nearly 11,000 pregnancies over a 5-year period in India showed that maternal mortality was almost four-fold higher and perinatal mortality seven-fold higher among women below 20 years than among those over 30 years of age (Mishra and Dawn, 1986).

In some countries, contraceptive use is reasonably well established and available to adolescents. According to studies in the late 1980s, 43 per cent of 15-19 years old girls in Thailand, 24 per cent in Indonesia, 20 per cent in Sri Lanka and 18 per cent in the Philippines

were using some form of family planning, including traditional methods (PRB, 1996). However, few countries offer special services for adolescents.

Unintended pregnancies are not rare even where early marriage and childbearing are the norm. In Pakistan 34 per cent of current pregnancies among ever-married young women were unintended. In India among ever-married young women, 16 per cent of current pregnancies and births in the preceding four years were unintended (UPS, 1995). Yet among the 35 Asian countries only three offer abortion on request and in 15 it is illegal or there are very strict conditions. In Bangladesh, menstrual regulation has been available since the 1970s, but is not easily accessible for younger women and unsafe abortion is common (IPPF, 1994).

Adolescents and young adults are a prime target for the burden of STIs. These infections in adolescent girls can cause major long-term morbidity including pelvic inflammatory disease, tubal infertility, adverse outcomes of pregnancy and reproductive tract cancer. Where data on STI levels are available, the highest rates occur in 15-19 and 20-24 years olds. Half the STI cases in a Mumbai clinic dealing with 1,200 men a day are 15-25 years of age (IPPF, 1994). STIs are also co-factors in the synergistic transmission of HIV. In many developing countries, recent data indicate that up to 60 per cent of all new HIV infections are among 15-24 years olds, with female outnumbering males by a ratio of two is to one (Weiss *et al.*, 1996). One study in Bangkok found that 17 out of 18 sex workers 14-18 years old had HIV years infection (IPPF, 1994).

Rapidly changing conditions, especially urbanization, have brought additional problems for Asian adolescents, including drug, alcohol and the spread of STIs. Sexual violence is also emerging as a major problem among youth, although data on the prevalence and severity of the problem are rare (Sood, 1990; and Deraniyagala, 1990). Official statistics in Vietnam and India suggest that 30 and 25 per cent respectively of rape victims are adolescent girls, though these statistics are generally held to be underestimates (Hong, 1994; Greene 1997). The growth of sex tourism in South and East Asia has led to an increased demand for young people in the sex industry and to higher levels of STIs. Trafficking of young girls and boys for profit is a lucrative practice in a number of Asian countries. The Government of India estimated that 30 per cent of all sex workers in six major cities were below the age of 20 and that almost 40 per cent of them entered the profession before they were 18 years of age (Young and Chernikoff,1996).

Concluding Comments

In the long run, reproductive health programmes for adolescents will face a lonely challenge until the community decides to guide young people to learn about sexuality. No health or education programme will ever have the resources to make a great difference to young people's lives if it must always work against social norms. Therefore, programmes for adolescents should include not only specific strategic approaches but also provide a balance of enabling approaches to help change this situation.

Making this change requires advocacy on behalf of adolescents—advocacy for a new understanding, by the community, of the world in which young people live; the pressures and decisions that they face; and the biological and social process of becoming sexually active. Advocacy for more responsible adult behaviour is essential to improve young people's lives

—advocacy for an end to the double standards concerning sexual behaviour that adults often apply to boys and girls; advocacy for prevention of sexual abuse; and advocacy for responsible, rather than irresponsible, depiction and discussion of sex and sexuality in the mass media. There is clearly a need to work with parents, community leaders and organizations such as schools and other service groups to build mutual confidence and understanding so that programmes for adolescents become a respected voice of the community, speaking with authority on behalf of young people (Population Reports, 1995).

Today, there is a growing discourse in several Asian countries on how to address the needs of adolescents among governments and NGOs working in the field of health and education, as well as among other stake-holders and gate-keepers, including parents and teachers. There is an increasing appreciation of the need to provide information and a growing understanding of how to reach adolescents with services. The question that is being asked is no longer whether such programmes should be implemented but how they should be implemented. Early efforts are underway to search for ways of effectively reaching young people with information and services. For the design of effective programmes, however, there is an urgent need to analyze the experience of innovative programmes and document best practices. There is a need to learn lessons from ongoing efforts by government and non-government organizations and to build partnerships between them. While a range of different organizations must necessarily work on policy, advocacy, implementation and research initiatives, depending on their particular skills and capacities, there is a need for creating a common vision so that there is a synergy of effort by all to improve young people's lives.

Discussions in Asian countries are now beginning to focus on how unmet needs of adolescents should be addressed. Questions on the design and implementation of policies and programmes are being raised. Should special programmes be designed for adolescents or should sexual and reproductive health services be mainstreamed within existing primary health care programmes? What strategies should be implemented to reach adolescents in school and out of school? How should programmes target boys and girls? What strategies can most effectively engage the involvement of parents, teachers, religious leaders and communities? Thus, Asia is on the threshold of change where many concerned constituencies are moving forward to address the problems confronting adolescents—an important target group that has, so far, been virtually bypassed by all programmes.

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