Editorial

Adolescent Sexual and Reproductive Health

Improving literacy rate and available visual and print media facilitate adolescents' access to information, but not necessarily so on Adolescent Sexual and Reproductive Health (ASRH). It is now being recognized that in order to reduce risky sexual behavior and empowering adolescents to make informed decisions for facing the challenges of life. they need to develop the necessary life skills. Thus, the focus of interventions with adolescents has to shift from information given, to building life skills. While life skills are built through experiential learning, these skills can be enhanced in the context of ASRH and through client friendly service delivery system.

High rates of adolescent childbearing found in South and South-West Asia are obviously related with early age at marriage. Bangladesh has one of the highest levels of adolescent childbearing, followed by Nepal and India; all these countries are characterized by early age at marriage for females. It is interesting to note that in Bangladesh about 15 per cent of women aged 20-24 had had a child before they reached 15. By the time they were 18 years of age about 47% had had a child and over three fifths (63.3%) had had a child before age 20. Similarly, over half'the women aged 20-24 in Nepal and almost half the women in this age group in India have had a child before reaching age 20.

A higher level of knowledge about contraception, however, does not always translate into a higher level of contraceptive use. For example, in India and Nepal, knowledge of contraception among adolescents was more than 90%. Despite this high percentage, less than 10% of adolescent girls were found to be using any form of contraceptive in these two countries. There is a considerable difference in the use of contraceptives among adolescents across countries. Less than 10% of adolescents were found to be using any form of contraceptive in India, the Lao Peoples Democratic Republic, Nepal and Pakistan, while contraceptive use among adolescents was fairly high (at least 30%) in such countries as Bangladesh, Indonesia, Kazakhstan, Sri Lanka, Thailand and Turkey. It should also be noted that the use of contraceptives among adolescents is remarkably lower than among women aged 20-24 and among women aged 15-49 in general. The difference is especially striking in Mongolia, the Philippines, Sri Lanka, Turkey, Uzbekistan and Vietnam.

In India, although traditional norms oppose premarital sex, some studies indicate a growing trend towards premarital sexual activities among adolescents(1). Data from Bangladesh revealed a very high incidence of premarital sex: 61% of males as compared with 24 per cent of females had had premarital sexual activity among adolescents, and this percentage was much higher in urban than in rural areas (2). Results from a 1991 study conducted in nine districts of Nepal also found that 20 per cent of young people were engaged in premarital sex(3).

According to studies commissioned by UNESCO, Sexually Transmitted Disease (STD) is a major health problem among youth in much of Asia. For example, in Bangladesh

two thirds of all reported STDs occur among people under 25 years of age and the incidence is much higher among women aged 15-19 than among men of the same age(1). Half of the HIV/AIDS-infected persons in Vietnam were adolescents and youth(4). In China, 8.7% of the HIV carrier and AIDS patients belong to the age group 16-19(5).

According to a literature review by Ramasubban (1995), as many as 25% of patients attending government STI clinics in India are younger than 18 years old. Epidemiologists speculate that India may soon have the largest HIV-infected population in the world(6,7). An intervention study conducted among Lucknow slum boys have shown that approximately 15-17% of youths reported intercourse outside of marriage, including about 3% who reported intercourse with a prostitute and 3% who reported oral or anal sex with another male. After the intervention, awareness that STIs including HIV/AIDS could be acquired from women other than prostitutes increased significantly from 50% to 76% in the intervention group. However, young men's awareness that they were personally at risk of acquiring STIs changed little during the intervention. Population-based data about STI risk did not translate into increased recognition that their immediate environment rendered them vulnerable to STIs. Although the cultural and social mores of India complicate forthright discussion of sexual activity, particularly among the young and unmarried, rising rates of STls, including HIV/AIDS, demand that young people be educated about the dangers of unsafe sex and STI symptoms, as well as prevention and treatment of STIs(8).

The surprising and encouraging findings of a Nepal study were that parents are very supportive of sexual and reproductive health issues being taught in school (over 94% in urban and over 83% in rural areas). Support for the availability and access of family planning services to unmarried adolescents was also surprisingly strong (ranging from 38% to 85%). Parental support for services to married adolescents is almost universal (above 95%)(9).

A CDC-Unicef study of Adolescent girls' morbidity in a Panchayath revealed that the mean calorie intake of the girls was 1355 K Cal/day for early teenagers (13-15 years) and 1292 KCal/day for late teenagers (16-18 years) which is much less than that recommended for the age groups. The major medical problems were Headache-60%, Dysmenorrhea-48%, Curdy white vaginal discharge-10%, *etc*. 85% of teenage girls justified someone committing suicide if there was adequate reasons like unwed pregnancy, to prove innocence, to defeat parents, extreme financial loss and failed love affair(10).

The Assumptions to be made

We are yet not sure as to what are the needs of adolescents and the relative ranking of their sexual and reproductive health needs. ASRH is not the immediate felt need of the parents and hence awareness creation is a must for parents, teachers, community workers and adolescents themselves. Although school is the best opportunity for targeting the major chunk of adolescents, as sexual and reproductive health education program done exclusively by their own teachers may not be acceptable and hence the need for bringing in outside faculty. Out of school adolescents are a disparate group and hence need a multi prong strategy to access the majority of them. More than the knowledge, life skill development through peer group social interaction is vital and hence a forum for the same -Teen clubs - is essential. Availability of adolescent friendly reproductive health clinic services at Taluk level with facilities for STI and HIV testing is a

must for success of any ASRH program and hence the need for ASRH clinics at Taluk hospitals. In the Indian context ASRH clinics are more likely to be utilized by those adolescents with obvious reproductive problems only and hence the need for Adolescent Care, Counseling, Empowerment and Support Service (ACCESS) units. Poverty and lack of an income source are the major stumbling block for empowerment of adolescent girls and hence the need for a self-employment training in any ASRH program. Co-ordinated activities of many governmental agencies ably supervised by respective officers are a must for sustenance of any successful ASRH program in the long run and hence a district would be an effective unit for implementation. Experience of adolescent pilot programs has highlighted the need for inter-sectoral approach and addressing their diverse needs through comprehensive programming. Services for adolescents, especially the unmarried adolescents, have not been addressed adequately. Some of the questions that need to be addressed when designing interventions for adolescents are:

(*i*) What kind of services do adolescents need?

(*ii*) What is the mechanism of making these services accessible to them?

(*iii*) What do we understand by "Adolescent friendly services"?

(*iv*) How can convergence take place between the health sector and the other sectors like education, youth development, women and child development, vocational training, *etc*. in working with adolescents?

Intervention Strategies - Steps

Assessing Data on ASRH needs of Adolescents in the country

An agency with adequate experience and exposure to adolescent issues like the IAP Taskforce on Adolescence should be entrusted with the responsibility of assessing data on ASRH needs of adolescents in the country through review of studies and existing program reports; mapping of services available and preparing a directory of resource persons and materials.

Review and Preparation of Family Life Education Module

The FLE module to be prepared would focus not only on the subject content, but much more on social acceptance and appropriateness of language used. The following are the components of Family Life Education program:

(*i*) Adolescent nutrition -needs, issues and relation to obesity.

(*ii*) Personal hygiene - relation to urinary/reproductive tract infections.

(*iii*) Identity crisis - body image, psycho-social competence

(*iv*) Life skill development - capacity to say "NO" to peer pressure.

(*v*) Avoiding alcohol, cigarettes, drug abuse and sexual abuse.

(*vi* STIs and HIV/AIDS awareness, responsible sexual behavior.

Increasing Knowledge and Life skills (FLE) of Plus-2 School Adolescents

Family Life Education as against sex education is a more appropriate and acceptable term for the Indian parents. Abolition of the Pre-medical course in the colleges and starting of Plus-2 system in the school have benefited the students alright, but at the same time have created possibility of negative influences for the lower class students and hence the need for Family Life Education for Plus-2 students. Although school teachers are the easy faculty

available to give FLE class, pilot experiences have shown that teachers do have problems talking to their own children and that at least in the initial stages availability of an external faculty is advantageous. Presence of a Doctor and a Counselor make it a much more academic session and hence more effective.

> Family Life Education program for adolescent high school girls have revealed that there is an increase in knowledge observed after a gap of six months about adolescent health issues, family planning methods, and STIs and AIDS awareness was 20% and about infancy immunization was 40%. However, it is not yet clear if the sustained increase in knowledge would result in less risk taking behavior.

Increasing knowledge and life skills of Out of School Adolescents through National Literacy Mission

National Literacy Mission is a community linked agency of the government to promote neoliterates, a good number of them being out of school adolescents and youth. Nodal Continuing Education centersare mannewd by Preraks and supported by key resource persons. Hence, it is only appropriate that we utilize the existing community infrastructure to impart FLE for the out of school adolescents.

Formation of Anganwadi based Teen Clubs for out of school girls

Although the NYKs have Mahila Mandals for the out of school adolescent girls, it was thought more appropriate to organize teen clubs under the anganwadis, because of excellent community rapport, especially so because of monthly mothers' meeting at anganwadis.

Formation of NYKS - Youth Clubs based Teen Clubs for out of school boys

Nehru Yuva Kendra Sangathan (NYKS), a Government of India agency with a national network of Youth Co-ordinators at District level, National Service Volunteers at block level and affiliated Youth Clubs at panchyath level would be the ideal agency to form teen club as a downward extension of youth clubs, especially so because the Government of India have included adolescents also under the Ministry of Youth Affairs. The activities of Teen Clubs are as follows:

(*i*) Awareness classes for parents members of Panchayth and media;

(*ii*) Need Assessment study of Adolescents;

(*iii*) Formation of Teen Clubs, Teen club meetings;

(*iv*) Family Life Education (FLE) Classes;

(v) Medical check-up for Adolescents/ Mothers;

(*vi*) Personality/Skill Development Sessions;

(*vii*) Career Guidance sessions;

(viii) Low Cost Toy Making sessions;

(*ix*) Counselling Programs - Group and Individual;

(*x*) Pre-marital counseling for above 18 year olds;

(*xi*) Teen Fest, Sports and Athletic Meet, Painting competitions,

(*xii*) Networking with all agencies operating locally;

(*xiii*) Anganwadi based mothers meetings;

(*xiv*) Vocational Rehabilitation for Teen Club Members.

Establishing Adolescent Development Center (ADC) at NYK affiliated Youth Development Centers

ADCs are envisaged to be the nodal centers for continued supervision and sustenance and co-ordination of teen club activities especially Life Skill training for

enhancing leadership qualities, organizational skill and communication skills. The activities of ADCs are as follows:

(*i*) *Life Skill training program:* The components of a Life Skill training program would be, self awareness, empathy, interpersonal relations, communications, critical thinking, creative thinking, decision making, problem solving, coping with emotions and coping with stress.

(*ii*) *Skill Training for non-student youths:* Skill based training for the adolescents will be very enjoyable for them as it reveals their hidden talents, creativity and imagination. Training for improving the skill can be conducted according to the needs and feasibility of the adolescents. Skill based training may be imparted in the following areas, tailoring and garment making, mechanical and electrical work, low cost toy making, painting and sculpture.

(*iii*) *Leadership and Career Development Program:* Life Skill training program for augmenting the following; personality development, creative thinking and career guidance.

(*iv*) *Physical Fitness:* Martial Arts and Yoga training to promote the concept of physical fitness by reviving traditional culturally appropriate village activities.

(*v*) *Health check-up:* ADC also would have monthly once adolescent clinic with the help of a Pediatrician and Counselor.

Self Employment for below poverty line adolescent girls through Kudumbasree

Kudumbasree, the National Poverty Eradication program have made a real difference for the rural women and adolescents at the grass root level, in terms of community organization (Community Development Societies-CDS). Hence this vast infrastructure could be effectively utilized for imparting self-employment training for poor adolescent girls at CDS small-scale production units *e.g.*, Pickle making, soap manufacturing, candle making, sandal stick making, *etc*.

Adolescent Clinic at PHCs and Small Private Clinics

The Health Services Department is in a unique position to establish Adolescent Clinics allover India on all Saturdays, to begin with in selected PHCs where the service of a Lady Medical Officer is available. We have the experience of conducting Under Five Clinics at PHCs in a period when childhood malnutrition was a major concern. Activities of the clinic would be as follows:

(*i*) Assessment and measures for maintaining adequate nutritional status; keeping in mind that a minimum of 45 Kg weight and 145 cm height are needed to reduce the LBW rate.

(*ii*) Screening and advice regarding Rubella Vaccine to adolescent future mothers.

(*iii*) Treatment for medical problems and follow-up on Saturdays.

(*iv*) Gynecological services by a Lady Medical Officer.

(*v*) Blood grouping services for the adolescent population.

(*vi*) Psychosocial guidance to tackle the teenage identity-crisis, depression, emotional instability as well as counseling on dealing with educational and social problems.

(*vii*) Referral services to various speciality departments, including Psychiatry, Internal Medicine, Endocrinology, Dermatology and Obstetrics & Gynecology.

(*viii*) Family Life Education sessions to adolescents, using FLE modules.

ACCESS Units at Taluk & Small Private Hospitals

Adolescents do not prefer to go to any health facility especially so, to a reproductive health clinic except may be for serious diseases and unavoidable medical emergencies. Hence we need a twin approach of making the reproductive health facility adolescent friendly and by organizing a campaign through Junior Public Health Nurses (JPHNs) in the government sector and Nursing students in the private sector. Conducting a weekly once clinic preferably on a Saturday under the banner of Adolescent Care, Counseling, Empowerment and Support Services (ACCESS) units at Taluk hospitals and small private hospitals with the support of a Counselor would be a useful strategy to attract adolescents to a health facility.

ASRH Clinics at District Hospitals & Major Private Hospitals

District Hospital may be selected for organizing ASRH Clinics because of the linkage with a network of PHCs in each Panchayath, JPHNs services available for community mobilization, reasonably good laboratory support services, referral facility to the district hospital, presence of a Pediatrician & Gynecologist at all District hospitals. The ASRH Clinic must try to provide the following services:

(*i*) Gynecological check-up - Reproductive Tract Infections.

(*ii*) Screening for STls and also HIV when indicated.

(*iii*) Contraceptive services.

(*iv*) Abortion services

Policy Advocacy

This five year district Adolescent ASRH model project envisaged in a step-wise fashion would be evaluated by an external agency and a comprehensive report would be prepared highlighting how many of the objectively verifiable indicators have been achieved and if not why so? Now is the time for wider dissemination of the lessons learned at the state level first and may be at national and international, in an effort to bring in policy changes at a wider level.

At international level, remarkable improvement have been observed over the last few years with regard to adolescent sexual and reproductive health rights and adolescent friendly services. However, in India we have only made feeble attempts under the reproductive Child Health (RCH)-I project and it is important that we do not miss the opportunity of RCH-II, which should contain policies and programs emphasizing the following:

(*i*) Reproductive Rights of adolescents as part of.Human Rights.

(*ii*) Participation of young people in their own affairs as a matter of right.

(*iii*) Effective legal support system enabling girls to enjoy their reproductive rights.

(*iv*) Ensuring access to youth friendly reproductive health services.

(*v*) Promoting responsible sexual behavior of young boys and girls.

(*vi*) Access to contraceptive services to prevent pregnancies and STIs.

(*vii*) Providing high quality abortion services for married / unmarried girls

(*viii*) STI treatment services syndromic approach at community & ASRH clinics.

(*ix*) FLE / Premarital counseling / Newly married couple's education services.

(*x*) Development of cost effective sustainable, ASRH program models.

Fifty years ago, when we started planning health of the community through a strategy of setting up Primary Health Centers (PHCs) allover India we hoped to achieve definite targets. We have achieved a lot, but no one would claim that we have achieved enough. Policies and programs have come and gone but some of the fundamental issues are still unanswered and many of the national health indices are still very unsatisfactory. It is natural that we think of newer programs and better implementation strategies. However. is it not the time we thought of unconventional strategies. In the last 50 years we have not seriously looked at the possibility of "empowering the adolescents - future parents of India". This would involve a bold long-term strategy of using adolescents as "change agents". The l0th five year plan should see Adolescent Care as the priority area, and rightly so. It is in this context that the Indian Academy of Pediatrics (IAP) has committed itself, to providing Care & Counseling for Adolescents up to 18 years.

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