



# THE SOUTH ASIA CONFERENCE ON ADOLESCENTS

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Country Support Team  
for Central and South Asia  
Kathmandu



# **THE SOUTH ASIA CONFERENCE ON ADOLESCENTS**

21-23 July 1998  
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UNFPA Country Support Team  
for Central and South Asia  
Kathmandu

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## CHAPTER 1

# INTRODUCTION



The 1994 Cairo International Conference on Population and Development (ICPD) recognized for the first time the individual health needs of women and men of all ages – children, adolescents and adults – as *human rights*. The conference drew special attention to the health and well-being of adolescents which had been largely ignored up until the present. It recognized adolescents and youths as “...the most important resource for future development” and made several recommendations to meet the multi-dimensional needs of adolescents.

As a follow-up to the implementation of the ICPD Programme of Action (POA), UNFPA launched the five-year Post Cairo review process, known as ICPD+5 Initiatives. As part of the review process, UNFPA Headquarters (in collaboration with the UNFPA Field Office, India, and UNFPA Country Support Team for Central and South Asia (CASA)) organized a three-day *South Asia Conference on Adolescents* in New Delhi, on 21-23 July 1998. Conference

participants reviewed and assessed progress made, lessons learnt and constraints encountered in the implementation of the ICPD Programme of Action for adolescents in countries of the SAARC region (Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka). The deliberations of the conference provided valuable inputs for the identification of issues concerning adolescents, and the formulation of policies and programmes on adolescents in the SAARC countries.

The conference was attended by official representatives of the seven SAARC governments, selected adolescents from each of the SAARC countries, national, regional and international NGOs, and UN and other international agencies based in Delhi. In particular, the active participation of approximately thirty male and female adolescents from all of the SAARC countries enriched the conference proceedings. H. E. Dalit Ezhilmalai, Minister of State for Health and Family Welfare, Government of India, inaugu-

rated the conference, and Dr. Nafis Sadik, Executive Director, UNFPA, presented the key note address in which she emphasized the importance of involving young people in the development of programmes that address adolescent concerns. Ms. Imelda Henkin, Director, Asia and the Pacific Division, UNFPA Headquarters; Ms. Brenda Gael McSweeney, United Nations Coordinator in India and Mr. Saad Raheem Sheikh, Director, UNFPA CST for CASA, also addressed the conference (see Annex I: List of participants).

The conference was organized around three major themes:

- (i) ***Responsible Sexual and Reproductive Health Behaviour of Adolescents;***
- (ii) ***Literacy and Education of Adolescents; and,***
- (iii) ***Exploitation of, and Violence against, Adolescents.***

Conference deliberations took place in seven sessions (see Annex II for details of each session) and centered on three thematic papers mentioned above, seven country background papers (one from each country), and one background paper on the situation analysis of adolescents entitled “Socioeconomic, Demographic and Reproductive Health Profiles of Adolescents in SAARC Countries”.

Country papers assessed the country specific situation of adolescents – their

needs and concerns related to sexual and reproductive health, violence, and education – and reviewed the programme of action adopted by each country to address these concerns. The thematic papers, prepared by specialists, provided a critical analysis of the issues related to adolescents’ sexual and reproductive health attitude and behaviour; access to education, and the future trends and directions of education; and exploitation of and violence against adolescents from a regional perspective. The thematic papers also assessed the implications of these issues for formulating and implementing policies and programmes for adolescents. The background paper, prepared by CST/CASA, portrayed a regional situation analysis of adolescents, based on existing surveys and studies.

Groups, consisting of (a) adolescent and adult, and (b) exclusively adolescent participants, were formed to deliberate in depth on each of the thematic areas and draw policy and programme recommendations. The adolescents’ needs and concerns, and future programme strategies for adolescents which emanated from the papers and deliberations of the conference, are summarised and presented in the following four chapters: Situation of Adolescents in South Asia (Chapter Two); Country Perspectives on Priority Needs and Concerns of Adolescents (Chapter Three); Voices of Adolescents (Chapter Four); and, Conclusions, Strategies and Recommendations (Chapter Five).



## CHAPTER 2

# SITUATION OF ADOLESCENTS IN SOUTH ASIA

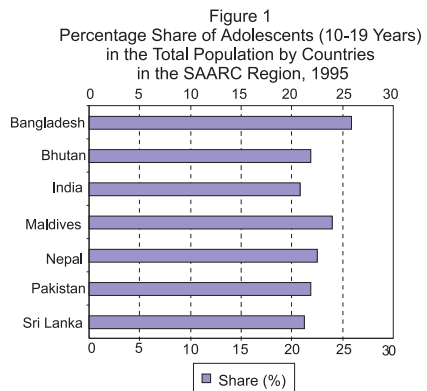
## Introduction

This chapter examines the multi-dimensional needs and concerns of adolescents from a regional perspective. An analysis of the background paper, three thematic papers and the seven country specific papers presented at the conference, and evidence from existing surveys and studies, reveal the following major demographic, socio-economic and reproductive health characteristics defining the situation of adolescents in South-Asian countries: (i) large and rapidly growing adolescent populations; (ii) improved levels of literacy; (iii) low levels of educational achievement; (iv) persistence of gender disparity in school enrolment; (v) high labour force participation and unemployment rates; (vi) gender disparity in labour force participation rates; (vii) persistence of early marriage; (viii) persistence of early childbearing; (ix) high and increasing adolescent fertility; (x) shorter birth intervals and unplanned births; (xi) poor nutrition and unsatisfactory antenatal care; (xii) higher risk of infant and mater-

nal mortality; (xiii) low use of contraceptives and high unmet demand for family planning; (xiv) inadequate efforts to promote RH and family planning; (xv) early onset of pre-marital sex and induced abortion; (xvi) lack of information and services; (xvii) lack of protection against sexual abuse and violence; (xviii) large number of missing women; and (xix) lack of policies on adolescents.

## 2.1 Demographic Situation

2.1.1 Large and rapidly growing population: Adolescents (10-19 years) account for at least one-fifth of the total population of each of the SAARC coun-



tries, ranging from highest 26 percent (Bangladesh) to lowest 21 percent (Sri Lanka and India) (see Figure 1).

*2.1.2 Adolescents constitute a sizeable proportion of the total population in the SAARC region, and the adolescent population will continue to grow rapidly over the next 30 years: Due to the population momentum effect, particularly for countries which have failed to reduce their fertility rates appreciably during recent decades, adolescent populations in many SAARC countries will continue to grow. Conversely, adolescent population growth will be lower, and even decline in some instances, for countries which have experienced substantial fertility decline during recent decades. The higher the decline in fertility rate in recent decades, the lower the growth of the adolescent population.*

*2.1.3 The adolescent population in the region as a whole will increase by 18 percent, from 263 million in 1995 to 311 million in 2020: During the same 25-year period, the number of adolescents is projected to increase by 108 percent in Maldives, 83 percent in Bhutan, 73 percent in Pakistan, 65 percent in Nepal, 11 percent in India and 6 percent in*

Bangladesh but will decline by 9 percent in Sri Lanka (see Figure 2). The decline of the adolescent population in Sri Lanka is attributed to the sharp fall in fertility during recent decades.

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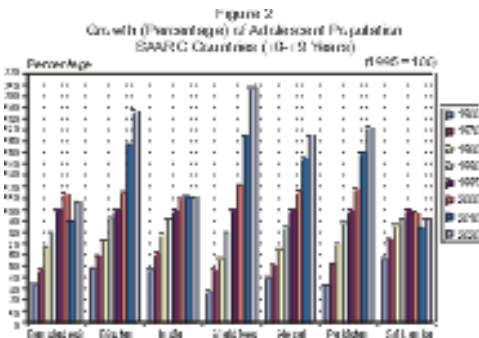
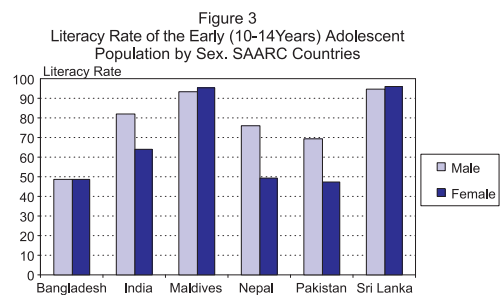
*Adolescents constitute over one-fifth of the total population in the SAARC region, and the adolescent population will continue to grow, particularly for the countries which have failed to reduce fertility appreciably during recent decades.*

---

## 2.2 Education and Labour Force Participation

### 2.2.1 Education

*Although levels of literacy have improved, there is still much to be done to achieve universal education: There has been a significant improvement in education-*



al opportunities in recent years in the region, as indicated by higher rates of literacy among the adolescent population, as compared to the general population in each of the SAARC countries (see Table 3). In most South Asian countries, the majority of both the early (10-

14 years) and late (15-19 years) adolescents groups are literate (see Table 1). The literacy rate for early adolescents ranges from 49 percent (Bangladesh) to 95 percent (Sri Lanka). The corresponding literacy rate for late adolescents ranges from 55 percent (Nepal) to 98 percent (Maldives).

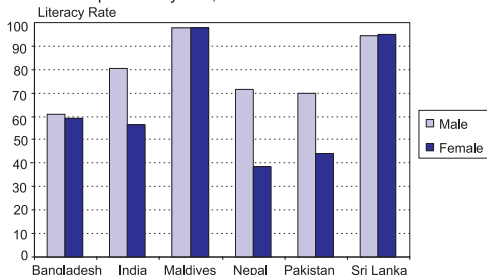
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*In spite of significant improvement in educational opportunities in recent decades, a sizeable proportion of the adolescent population, particularly females, have received no formal education.*

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*Although there has been a significant improvement in educational opportunities in recent decades, a sizeable proportion of adolescents, particularly females still remain illiterate except in Sri Lanka and the Maldives. In most countries of the region, 33-60 percent of early adolescent girls, as compared with 20-50 percent of early adolescent boys, are illiterate. The situation is even worse among the older cohorts in which about 40-60 percent of late adolescent girls, as compared with 20-40 percent of late ado-*

Figure 4  
Literacy Rate of the Late (15-19 Years) Adolescent Population by Sex, SAARC Countries



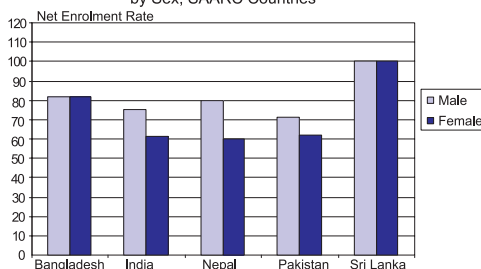
lescent boys, are illiterate except in Sri Lanka and the Maldives. *Nearly one hundred percent of adolescent boys and girls are literate in Sri Lanka and the Maldives (see Table 1 and Figures 3 and 4).*

## 2.2.2 Unsatisfactory School Enrolment

### (a) Enrolment at Primary School

*School enrolment is far from satisfactory:* Most countries of the region, except Sri Lanka, failed to achieve one hundred percent enrolment at primary level. To achieve the same level of enrolment as that of Sri Lanka, other countries in the region will require additional enrolment for 18-30 percent of primary school-age male children, and 18-40 percent of primary school-age female children (see Table 2 and Figure 5).

Figure 5  
Net Enrolment at Primary Level by Sex, SAARC Countries



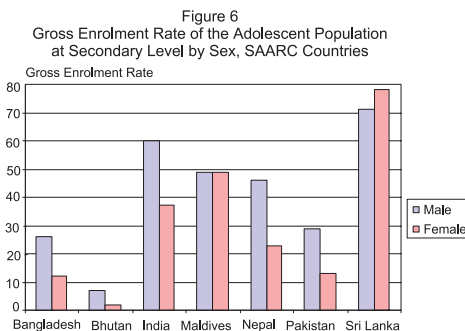

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*Most countries of the region except Sri Lanka are still far from enrolling all primary school age children in school. The situation is worse for female than male children*

---

## (b) Enrolment at Secondary School

*The school enrolment rate declines drastically from primary to secondary level, indicating relatively few adolescents tend to attend school beyond the primary level:* In most countries of the region, an absolute majority of secondary school-age children do not attend secondary school. The situation is worse for female than male children. For example, 40-74 percent of adolescent boys, compared to 51-88 percent of adolescent girls, in almost all countries of the region do not attend secondary school. Bhutan and Sri Lanka have the lowest and highest enrolment ratio at the secondary level respectively. Over 70 percent of adolescent boys and girls in Sri Lanka, compared to only 7 and 2 percent of adolescent boys and girls in Bhutan respectively, attend secondary schools (see Table 3 and Figure 6).



*An absolute majority of the secondary school-age children are outside the education system. The situation is worse for female than male children.*

## 2.2.3 Low Level of Educational Achievement

*Not only is the enrolment at the primary level far from satisfactory, the completion rate at the primary level also falls short of expectations:* A considerable proportion of children enrolled at the primary level, ranging between 38 percent to 53 percent, fail to reach grade 5 in almost all countries of the region. Only the Maldives and Sri Lanka have achieved nearly one hundred percent completion rates for primary school-going children through grade 5. Gross enrolment rates for both boys and girls are also well over 100 in these two countries. (see Table 2).

*A large proportion of primary school-going children fail to complete primary level education.*

## 2.2.4 Persistence of Gender Disparity in School Enrolment

*A wide gender gap exists in enrolment at both the primary and secondary level, particularly the latter:* The gender disparity in enrolment at the primary level is highest in Bhutan followed by Pakistan, Nepal and India. The female gross enrolment rate, as a percentage of the male enrolment rate, constitutes about 60–67 percent in Bhutan, Nepal and Pakistan, and 80 percent in India. Sri Lanka, Maldives and Bangladesh have

achieved gender parity in enrolment at the primary level (see Table 2 and Figure 5). The female to male enrolment ratio at the secondary level ranges from 29 percent in Bhutan to 110 percent in Sri Lanka, and 45-60 percent for rest of the countries in the region (see Table 3 and Figure 6). Bhutan and Sri Lanka reflect the highest gender disparities in enrolment at the secondary level in favour of males and females respectively.

---

*A wide gender gap exists in enrolment at both the primary and secondary levels, particularly the latter.*

---

### 2.2.5 Lack of Quality Education

*Although there has been a significant improvement in school enrolment over the years, the quality of education still remains poor in most countries of the region:* The existing education system is inadequate to meet the needs of adolescents and to prepare them for adult roles in all aspects of life, including reproductive health and sexuality. This is attributed, among other factors, to: (a) lack of proper training of teachers to address the academic, emotional and psychological needs of adolescents; (b) overburdened and outdated school curricula to meet the current needs of adolescents and prepare them to meet the challenge of the next millennium; (c) poor physical facilities, both within and outside of

the classroom; (d) a lack of community and parental involvement in education; and, (e) a lack of student commitment to learning.

### 2.2.6 Limited Emphasis on Life Skills in Education Curricula

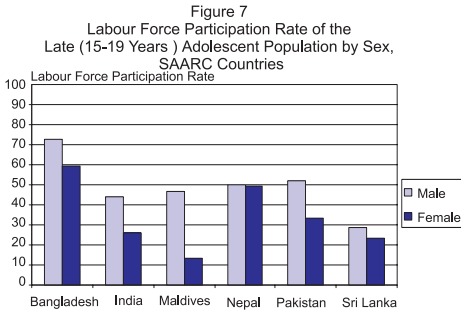
*The education programme, both formal and non-formal, in most countries of the region is overly academic and theoretical:* Little attention is given to life skills in the curricula such as vocational education, family life education, income generating skills and decision-making skills. Life skills make education more meaningful and relevant for adolescents.

### 2.2.7 Limited Coverage of Education Programme

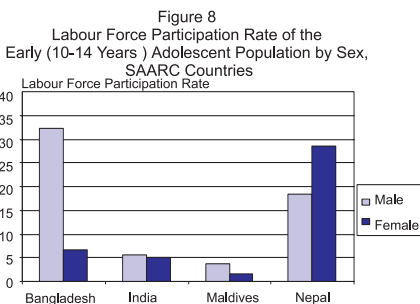
*Existing education programmes are beyond the reach of adolescents from marginalized groups (e.g., disabled adolescents, adolescent prostitutes and children of prostitutes, school dropouts and children who have never been to school, child labourers and street children and adolescents belonging to ethnic minorities) and are insensitive to the needs of these marginalized groups.*

### 2.2.8 High Labour Force Participation and Unemployment Rate

*A large proportion of adolescents, partic-*



ularly the late adolescent population (15-19 years), is engaged in productive activities in most countries of the region, particularly in those countries which have lower enrolment ratios at the secondary level: The labour participation rate for the late adolescent population ranges from 18 percent (Sri Lanka), to 49 percent (Nepal), to 67 percent (Bangladesh), averaging 30-36 percent for the rest of the countries in the region (see Table 4 and Figure 7). A large proportion of the early adolescent population (10-14) is also engaged in economic activities in some countries of the region, particularly Bangladesh and Nepal (see Table 4 and Figure 8). The unemployment rate among late adolescents is also reported to be high in the majority of the SAARC countries, with the highest in Sri Lanka followed by Nepal, Pakistan and India (see Table 5).



*A large proportion of adolescents participate in productive activities. The labour force participation rate, in general, is higher in countries which have lower enrolment rates at the secondary level. The higher the school enrolment rate, the lower the labour force participation rate. The unemployment rate among the late adolescent population is also reported to be very high in some countries of the region.*

### 2.2.9 Gender Disparity in Labour Force

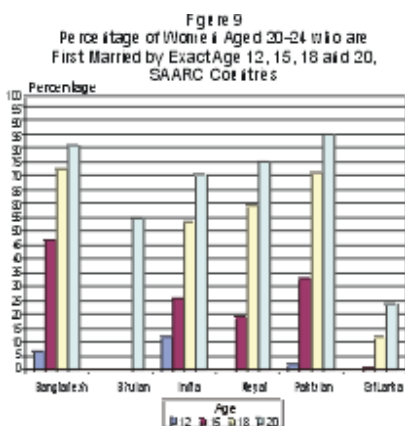
*The labour force participation rate is higher for male adolescents, than female adolescents, in every SAARC country. However, the gender disparity in labour force participation rate is more glaring in Pakistan and Maldives than other countries in the region. The unemployment rate is usually higher for females than males (see Tables 4 and 5 and Figure 8).*

## 2.3 Reproductive Health Behaviour

### 2.3.1 Persistence of Early Marriage

*Early marriage continues to be the norm, particularly for girls, in most countries of the region, despite laws prohibiting marriage before age 18 for girls, and 21-24 years for boys: Although girls are*

slowly marrying later, in general, South Asian girls still marry early. Spouse age gender gaps at marriage reflect patriarchal structures of the societies which are reinforced by the legal systems of respective countries. In most countries of the region, except Sri Lanka, nearly 60 percent of women ages 20-24 were married by the age of 18, with one-quarter marrying by the age of 15 (see Table 6 and Figure 9). The proportion of women ages 20-24 married by the time they were 18 and 15 were lowest for Sri Lanka, and highest for Bangladesh, followed by Pakistan, Nepal



and India. At least 70 percent of women ages 20-24 in Bangladesh and Pakistan were married by the age of 18, declining to 60 percent for Nepal, 55 percent for India and 12 percent for Sri Lanka. The proportion of women ages 20-24 who were married by the age of 15 is as follows: Bangladesh (35 percent), India (25 percent), Nepal (20 percent), and Sri Lanka (1 percent).

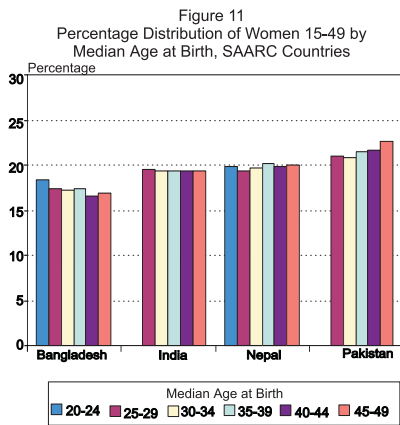
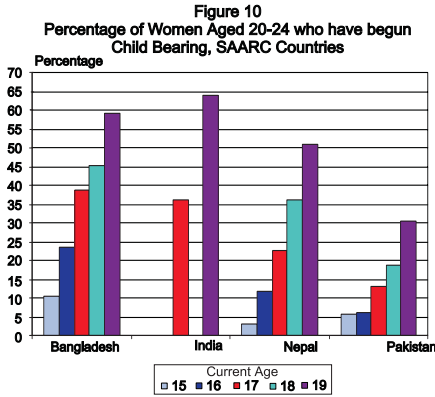
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*Early marriage has been and continues to be the practice, particularly for girls. In most countries of the region, nearly 60 percent of all girls were married by the age of 18, with one-quarter marrying by the age of 15.*

---

### 2.3.2 Persistence of Early Childbearing

*Early childbearing, despite a greater risk to the health of both the mother and child, has been and continues to be the norm in the region:* A large majority of girls become mothers on or before they reach the age of 20. At least one-in-two adolescent girls begin childbearing by the age of 19 in all countries of the region for which data are available, except Pakistan. In Pakistan, about one-third of adolescent girls begin childbearing by age 19. Twenty-five to thirty-five percent of adolescent girls of Bangladesh, India and Nepal, and only ten percent of adolescent girls of Pakistan, begin childbearing as early as 17 (see Table 7 and Figure 10). The age at which women have their first child has shown little or no increase in almost all countries of the region (see Figure 11). *These findings may signal a plateau in the trend towards later maternal age at first birth, particularly for countries which have achieved a median age at first birth of 19 or above.*



*Early childbearing is the cultural practice in the region. A large majority of women become mothers on or before the age of 20. Data also signal a plateau in the trend towards later age at first birth.*

### 2.3.3 High Adolescent Fertility

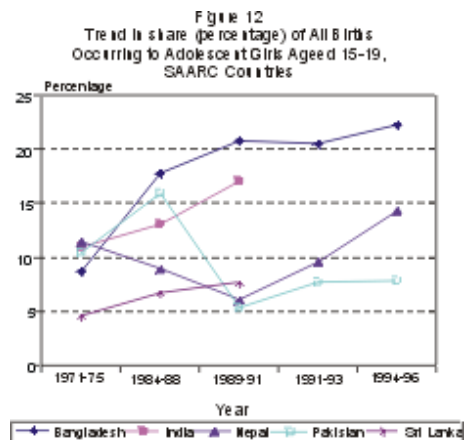
Consistent with the practice of early motherhood, it is observed that a significant proportion of all births in any given year occur to adolescent girls between the ages of 15-19: The share of all births occurring to adolescent girls ranges from 22 percent in Bangladesh, to 17 percent in In-

dia, 14 percent in Nepal, 11 percent in Bhutan, 8 percent each in the Maldives, Pakistan and Sri Lanka respectively (see Table 8). By the time a girl reaches the age of 20, she has had two children on average in almost all countries of the region, except Sri Lanka where she gives birth on average to one child.

*Adolescent girls contribute a significant proportion of total births in a given year.*

### 2.3.4 Increasing Adolescent Fertility

A progressively larger share of all births is occurring to adolescent girls between the ages of 15-19: This overall trend holds, in general, for all countries of the region (see Table 9 and Figure 12). A large proportion of these births could have been avoided if timely and adequate services were available, since many of these births were unplanned. Ten to thirty percent of all births among adolescents are reported to be unplanned



in Bangladesh, India, Pakistan and Sri Lanka (see Table 10). Most unplanned births among adolescents in the region occur to married adolescent girls. *Increasingly high fertility among adolescent girls in most countries of the region is a matter of great concern. The early child-bearing will expose adolescent girls and their infants to higher risk of mortality and morbidity.*

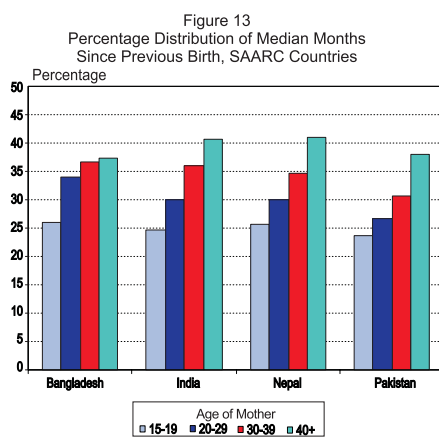
### 2.3.5 Shorter Birth Intervals

*Adolescent girls have shorter spacing intervals between births than older women in all countries of the region adding to already high fertility rates among adolescent girls:* The median birth interval for adolescent girls aged 15-19 ranges between 24 to 26 months, compared to 38-41 months for women over age 40 (see Figure 13). *Closely spaced births increase the risks of maternal and infant mortality.*

---

*Adolescent girls have shorter birth intervals.*

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### 2.3.6 Early Onset of Pre-marital Sex and Induced Abortion

#### (a) Pre-marital Sex

*Although sex outside marriage is considered unethical and widely frowned upon in the socio-cultural milieu of the region, pre-marital sex is increasingly taking place with a prolonged pre-marital period, due to later marrying ages and increased schooling:* Data on pre-marital sex is very limited. However, a few studies conducted in Bangladesh and India reveal a high degree of prevalence of pre-marital sex among adolescents. In Bangladesh, over 60 percent of unmarried urban adolescent boys, and ten percent of unmarried urban girls, younger than 16 are reported to have had sexual experiences. In India, 20-25 percent of unmarried adolescent boys are reported to have engaged in sexual relations. The incidence of pre-marital sex is higher in urban than in rural areas, higher among boys than girls, and positively associated with age. Pre-marital sex often leads to illegitimate births. In Sri Lanka, 11 percent of births to late adolescent girls were reported to be illegitimate.

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*Studies, although limited, reveal a high degree of pre-marital sex among adolescents.*

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#### (b) Induced Abortion

*Pre-marital pregnancies, which are mostly unwanted, are terminated largely as in-*

*duced abortions under clandestine and unsafe conditions by untrained providers, increasing the risk of death:* Data on induced abortion, although limited, shows a large proportion of adolescent pregnancies are terminated through induced abortions in many countries of the region. For example, 6 percent of all induced abortions in Nepal are reported to occur to adolescent girls under the age of 20. A similar trend is also observed in India. A high rate of abortion is also reported among married and unmarried late adolescent girls in Sri Lanka. As many as 750 abortion cases a day are reported to be occurring to adolescent girls between the ages of 15-19 in Sri Lanka. Among unmarried adolescent abortion clients, a large proportion seek abortion during the second trimester when adverse consequences can be particularly critical.

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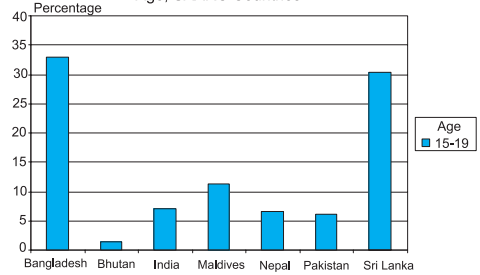
*Available evidence, although limited, portrays a disturbing picture of adolescent abortion seekers.*

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### 2.3.7 Universal Knowledge of Contraceptive Methods But Low Use of Contraception

*Although knowledge of traditional and modern methods of contraception among currently married late (15-19 years) adolescent girls is nearly universal, only a limited number of them practice contraception in most countries of the region.* The proportion of late adolescent girls practising contraception does not account for

Figure 14  
Percentage of Currently Married Women (15-19 years) who are Currently Practising Contraception by Age, SAARC Countries



more than 11 percent of the late adolescent population in any SAARC country, except in Bangladesh and Sri Lanka. In these two countries, nearly one-third of currently married late adolescent girls practice contraception (see Figure 14).

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*Only a limited number of adolescent girls practice contraceptive methods although knowledge of contraceptive methods is widespread among the adolescent population.*

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### 2.3.8 High Unmet Demand for Family Planning

*Although the use of contraceptive methods is limited, there exists a large unmet demand for contraception among currently married late adolescent girls.* At least one-in-four girls (married; 15-19 years) would like to limit or postpone births for some time but are not practicing contraception. The unmet demand for family planning varies among countries in the region. It is highest in Nepal, followed by India, and lowest in Bangladesh (see Table 11). The unmet demand for contraception is largely

concentrated among those who use contraception to space rather than to limit births, indicating that promotion and wider availability of spacing methods could lead to greater use of contraception. Efforts to promote family planning among currently married adolescent girls need to be aggressively pursued.

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*There is a large unmet demand for family planning among currently married late adolescent girls. This group has received little information about family planning.*

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### 2.3.9 Inadequate Effort to Promote Family Planning

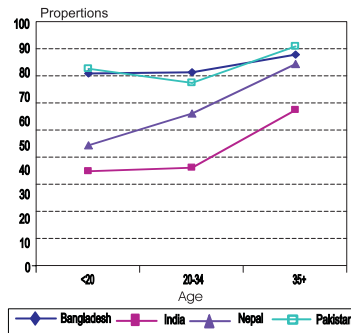
*Despite substantial demand for contraception among currently married late adolescent girls, and an acceptance of family planning by the girls and their husbands (see Table 12), the majority were not approached by family planning and health workers about family planning services, as data from some countries in the region show.*

### 2.3.10 Poor Nutrition and Unsatisfactory Antenatal Care

*The nutritional status of currently married late (15-19) adolescent girls is unsatisfactory (see Tables 13 and 14): A sizeable proportion of late adolescent girls are acutely malnourished [measured in terms of Mean Body Mass Index (BMI)], fail*

to meet calorie requirements, and are short-statured, [(i.e., shorter than the cut-off point of 145 cm)]. This will increase the risk of difficult child birth. *Approximately 19-50 percent of girls in Bangladesh, and 13-31 percent of girls in Nepal, are short-statured and acutely malnourished.* Adolescent girls also suffer from iron deficiency. Approximately 40 percent of adolescent girls ages 11-19

Figure 15  
Proportion of Mothers who do not Seek Antenatal Care in Selected SAARC Countries

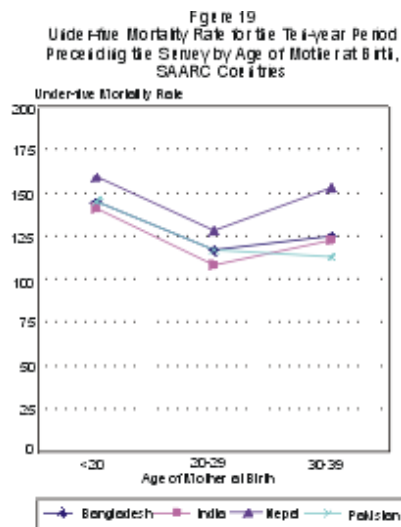
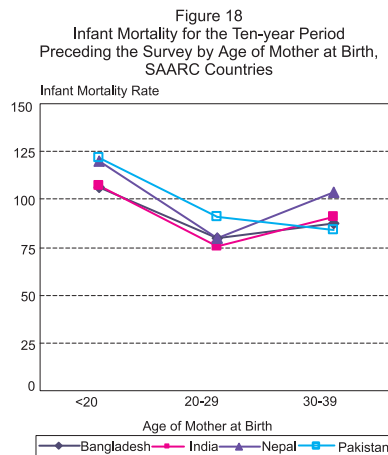
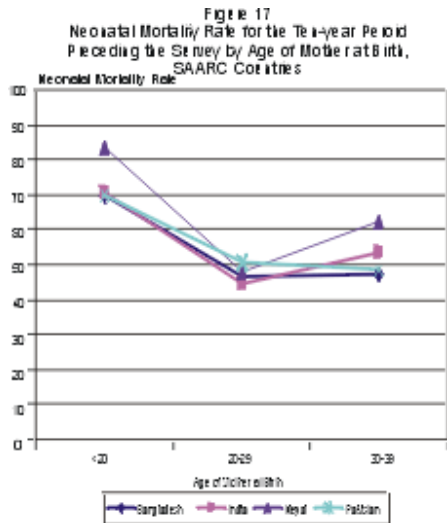
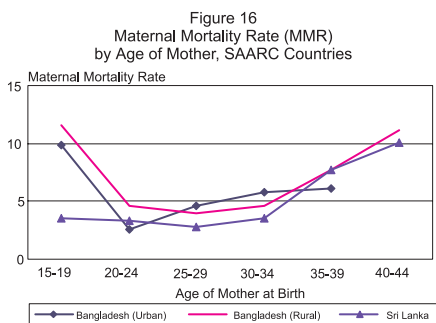


were reported to be suffering from iron deficiency in Sri Lanka. Malnutrition among adolescents is a matter of great concern as it increases the risk of maternal and perinatal mortality and morbidity. Antenatal care among adolescent mothers is also inadequate (Table 15 and Figure 15). A majority of pregnant adolescent girls do not seek antenatal care, except for tetanus toxoid shots (Table 16), particularly in Nepal and Pakistan. Only a small proportion of births to adolescent girls are assisted by trained birth attendants, accounting for 5 to 11 percent of births in Bangladesh, Nepal and Pakistan, and 25 percent of births in India (Table 17).

*A sizeable proportion of adolescent mothers are malnourished and also short-statured which increases the risk of difficult child birth. Antenatal care among adolescent girls is also not satisfactory. A large proportion of adolescent births still remain unattended by trained health workers.*

### 2.3.11 Higher Risk of Infant and Maternal Mortality and Morbidity

*Rising fertility rates, closely spaced births, poor nutrition and a lack of antenatal care exposes adolescent girls, and their infants, to higher risks of mortality and morbidity:* This increased risk to adolescent mothers and their infants is confirmed by data from various countries in the region. For example, the risk of maternal death is about three times higher among late (15-19 years) adolescent girls, compared to their immediate older cohorts (20-24 years) (see Figure 16). The neo-natal, infant and under-five mortality rates among the live births of adolescent girls are at least 38, 34 and 24 percent higher, respectively, as compared to live births to women ages 20-



29 (see Table 18 and Figures 17, 18, 19). Adolescents also have a higher propensity to experience adverse pregnancy outcomes than older women. About 7 to 12 percent of all pregnancies of adolescent girls are terminated by miscarriages and/or still births ( i.e., foetal wastage), compared to 6 to 8 percent of all pregnancies among slightly older girls/women ages 20-24.

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*Children born to adolescent mothers have a higher risk of death. The risk of maternal mortality is also higher among adolescents. They are also likely to experience higher foetal wastage than older women.*

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### 2.3.12 Increased Risk of Sexually Transmitted Diseases

Data on the prevalence of Sexually Transmitted Diseases (STDs), including HIV/AIDS, are not available for all SAARC countries and are also limited in scope. *However, the limited information that is available, reveals a high level of prevalence of Reproductive Tract Infection (RTIs) and STDs among both married and unmarried adolescent girls and boys:* For example, in Bangladesh over 40 percent of unmarried and married adolescent girls, and twenty percent of unmarried adolescent boys, are reported to have had symptoms of RTIs and STDs, respectively. In Sri Lanka, about 7 percent of adolescents are reported to have had STDs. The incidence of HIV/AIDS

among adolescents is limited but increasing, particularly among girls. For example, in Nepal, adolescents constitute about 16 percent of the HIV/AIDS cases, with adolescent girls representing 72% of the cases. Knowledge of HIV/AIDS is limited among adolescents. For example, only 19-24 percent of married adolescent girls are reported to have ever heard of HIV/AIDS in Bangladesh and Nepal (see Table 19).

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*Data, although limited, reveal a high level of prevalence of Sexually Transmitted Diseases (STDs) and increasing exposure to HIV/AIDS among adolescents, particularly girls. Knowledge of HIV/AIDS among adolescents is poor.*

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### 2.3.13 Lack of Information and Services

*Adolescent boys and girls, particularly those who are unmarried, lack access to reproductive health information and services, including family planning services.* Existing reproductive health care facilities are adolescent unfriendly and cater largely to the needs of married women and couple. Parents play a minor role in educating children on reproductive health and sexuality as cultural inhibitions limit discussions on private matters with their children. Parents also lack knowledge of reproductive health. Formal and non-formal education programmes do not include lessons on reproductive health and sexuality in most countries of the region.

The finding that a majority of currently married adolescent women in almost all countries of the region are not familiar with condoms as a modern contraceptive method bears ample testimony to their lack of access to information on family planning services (see Table 20). Adolescents also lack accurate information about their physiology, sexuality and reproductive health as data from selected countries in the region suggest. For example, only 3 percent and 25 percent of late adolescent girls in Pakistan and Sri Lanka, respectively, could correctly mention the number of fertile days in the menstrual cycle. In Sri Lanka, only 37 percent of late adolescent girls have adequate knowledge of hymen, and only 39 percent of unmarried adolescent girls of Bangladesh are reported to have had prior knowledge of menstruation before they experienced it.

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*Adolescents lack access to reproductive health information and services, including family planning. Knowledge of reproductive biology is also inadequate among adolescents.*

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## 2.4 Exploitation of and Violence against Adolescents

*Adolescents, particularly girls, are subject to many types of exploitation (i.e., an act of violence that involves the use of victims for profit, discrimination, and unequal treatment - social or economic), and vio-*

*lence (i.e., an act carried out with an intention or perceived intention of physical abuse/harm):*

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*Adolescents, particularly girls, are being subjected to increasing levels of exploitation and violence of all types. Existing laws and regulations against violence are either inadequate and/or not enforced with full force.*

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### 2.4.1 Exploitation

Among the most common exploitations prevailing in the region, particular mention may be made of:

- (i) **Sexual exploitation** (i.e., trafficking of girls, both within and inter-country, for the purpose of commercial sex and prostitution). For example, according to one estimate prepared by human rights activists and agencies, 200-400 young women are smuggled from Bangladesh to neighbouring and other countries each month. According to another source, 20,000 women from Bangladesh were trafficked to middle-eastern countries over the last 20 years. In 1996, a Nepalese NGO reported that the number of Nepalese girls trafficked to neighboring countries ranged from 100,000 to 200,000. The victims of trafficking are subject to sexual, physical and emotional abuse by all parties, including abuse by law enforcement officials;
- (ii) **Domestic exploitation** (i.e., gender

disparity in favour of males within the family) in (a) unequal distribution of food and nutrition results in excessive deaths of female children in SAARC countries.... For example, in Pakistan, 12 percent more girls than boys die in the age group 1-4 years. In Bangladesh and India, females receive only 88 percent of the required nutritional intake as compared to boys; (b) unequal education and economic opportunities.... For example, late adolescent girls constitute only 29 to 50 percent of male enrolment in secondary school in most countries of the region (see Table 3); (c) unreasonable expectations from parents to perform academically and to follow certain career paths; and, (d) demands by parents to perform a variety of domestic chores.

- (iii) **Social exploitation** i.e., dowry system, social acceptance of child labour and child sexual/drug trafficking, "ragging" of students in colleges and universities which may include sexual harassment and molestation, forced early marriage for young girls, exploitation of girls in the name of religion such as *Badi* (girls sacrificed to temple) system in Nepal and *Devadasi* (girls sacrificed to temple) system in India; and
- (iv) **Economic exploitation** (e.g., use of children from poor families for domestic help, industrial labor, and including all types of coerced child labour such as organized begging and prostitution rackets, sexual trafficking and brothels.... For example,

in a sex worker survey conducted in six urban centers in India in 1991, 15 percent of the sex-workers were found to be children. An estimated 7,000 new children are being trafficked from Nepal to India for child prostitution every year.

## 2.4.2 Violence

The most common types of violence that are meted out against adolescents, particularly girls, include:

- (i) **Domestic violence** (i.e., wife beating, dowry deaths, acid throwing).... For example, in a study conducted in 1993, nearly one-in-four (22 percent) of 107 women of child-bearing age surveyed in three villages of southern Karnataka (India), were reported to have been physically assaulted by their husbands, with an average of three beatings per month. The widespread incidence of wife beating is also reported elsewhere in India and other SAARC countries among different social classes. In Delhi, two women die of burns per day. In both urban Maharashtra and greater Bombay, one of every five deaths among women age 15 to 44 is due to "accidental burns." For the younger age groups 15 to 24, the proportion is one of four;
- (ii) **Sexual abuse** (i.e., incest or sexual abuse by relatives in the family, sexual abuse of domestic help, particularly female helpers, and rape of

adolescent girls).... For example in Bangladesh, around 1,000 rapes per year in 1995 and 1996 were reported, of which around 20% were of minors. However, this may be considered as the tip of the iceberg. The incidence of rape remains mostly unreported because this is linked to shame in the socio-cultural milieu of Bangladesh and other SAARC countries;

- (iii) **Political violence against adolescents** (i.e., political violence in which student wings of different political parties are involved in clashes leading to injuries and sometimes death; violence due to armed conflicts, terrorism and insurgencies, ethnic and communal conflicts; and trafficking of girls and children across the border to other countries). Most countries in the region have taken minimal legislative measures to control or eliminate violence against women and children. However, existing laws are either inadequate to deal with all aspects and specific types of violence and exploitation, and/or are not enforced.

### 2.4.3 Missing Girls and Women

*The exploitation and neglect of girls and women in South Asia has led to excess female deaths over male deaths, resulting in an adverse sex ratio of 94 females to 100 males in South Asia, compared to a global ratio of 106 to 100.*

Applying the global female/male ratio, about 74 million girls and women are missing in South Asia.

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*An estimated 74 million girls and women are missing in South Asia.*

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## 2.5 Policy on Adolescents

*There are no comprehensive national policies and programmes addressing all the multi-dimensional needs of adolescents including not just reproductive health and sexuality needs and problems but also education, employment, empowerment, food security and nutrition.*

Existing national programmes are limited in size and scope, addressing only some aspects of reproductive health. They are mostly isolated in nature, (i.e., stand-alone, not inter-related) and targeted at youth (i.e. 20-30 year-olds). Interventions targeted specifically at adolescents (ages 10-19 years), including both married and unmarried adolescents, are few. Also, adolescent interventions have focussed on easy-to-reach in-school adolescents neglecting urban poor, unemployed and rural adolescents. The heterogeneity in any adolescent population requires multi-dimensional policies which can address the different population groups within the adolescent population as a whole. The role of adolescents is hardly recognized in the formulation, monitoring

and evaluation of national programmes. Many governments in the region during the post-ICPD period have begun planning and implementing adolescent health programmes as part of the overall reproductive health package. However, these programmes are of recent origin and cannot be assessed as yet. There are also health programmes implemented by NGOs but they are limited in scope and coverage.

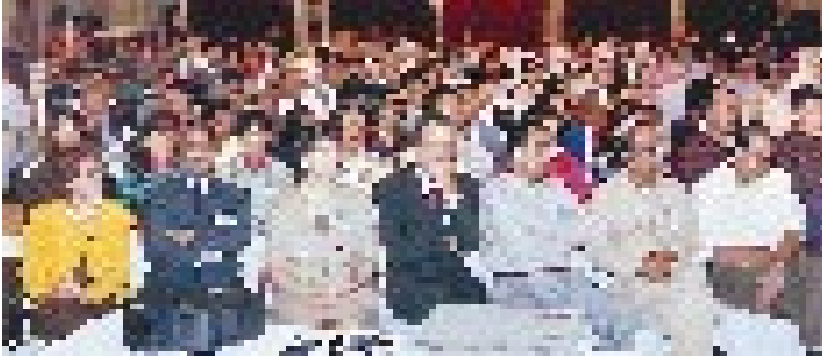
## 2.6 Data on Adolescents

*There is a paucity of data, both quantitative and qualitative, on adolescents in general and reproductive health and sexuality needs, in particular. This lack of data and knowledge is a great impediment to the formulation of comprehensive health policies and programmes.*

## CHAPTER 3

# COUNTRY PERSPECTIVES ON ADOLESCENTS' PRIORITY NEEDS AND CONCERNS





## Introduction

This chapter presents country-specific perspectives on the key issues of reproductive health, education and exploitation/violence facing adolescents among SAARC countries. The chapter also highlights country-specific policies and programmes for adolescents, including UNFPA-supported programmes. The country papers reveal country-specific adolescent situations, as well as commonalities in the region. The country perspectives are summarized below and presented within the three theme areas of the conference: a) adolescent sexual and reproductive health; b) literacy and education; and, c) exploitation of, and violence against, adolescents.

### 3.1 Bangladesh

Over the last two decades, Bangladesh has undergone a major demographic

transition, including a decline in the TFR from 6.3 to 3.4. Despite this impressive demographic achievement, adolescents still constitute over one-fifth (26 percent) of the total population which is the highest level in the SAARC region. The adolescent population will continue to grow in the near future at



a higher rate than the overall population growth. Adolescent population growth poses a major challenge to the government to try to meet the increasing reproductive health, educational and economic needs of adolescents. Specific issues pertaining to adolescents in Bangladesh are as follows:

### 3.1.1 Adolescent Sexual and Reproductive Health (ASRH)

- Despite a dramatic decline in TFR, and a fall in age-specific fertility for all age groups of women, the fertility rate for adolescents (15-19) has increased. The government needs to pay attention to the specific needs of this age group in order to meet its demographic and reproductive health goals.
- The key underlying issue for adolescent sexual and reproductive health is the social stigma attached to sex and sexuality, particularly for the young and those communities observing *Purdah*. Sexual taboos are compounded by a lower mean age of marriage for girls compared to boys (18 years versus 27 years - which is still lower in the rural areas), a large spouse age differential (9 years), early pregnancy, and low birth spacing. The maternal mortality rate, and infant and child mortality rates, are high for adolescent mothers. Approximately 50 percent of adolescent mothers are acutely malnourished (with BMI < 18.5).
- Conflicting new trends are emerging among adolescents: (i) increasing rate of pre-marital sex (38 percent and 6 percent for boys and girls, respectively, in rural areas); (ii) rapid rise in the proportion of teenage mothers among all mothers; and, (iii) increasing number of adolescent females entering the labor market in an environment where women have

been traditionally excluded from market employment (garment sector alone employs 77 percent of female labour, most of whom are young unmarried women).

### 3.1.2 Literacy and Education

*Although much improved over the last 20 years, literacy and education levels are still among the lowest in the sub-region. Severe gender disparities persist, particularly at higher levels of educational attainment.*

- The majority of the adolescent population (over 50 percent) is illiterate. Although 87 percent of adolescents were enrolled in primary education, only half of them reach the final grade. Few students go on to secondary and higher education.
- Wide gender disparity exists at higher levels of educational attainment. Only 23 percent of late adolescent women (15-19) have seven years of schooling. Enrolment of boys is over twice that for girls at the secondary level. Gender disparity increases at the higher education level.

### 3.1.3 Exploitation of, and Violence against, Adolescents

Gender-based violence occurs throughout the life cycle of women from pre-birth to infancy, to puberty and adolescence, throughout the reproductive years and into old age.

- Violence against adolescents is on the rise ranging from date rape to courtship violence (acid throwing), economically-coerced sexual abuse, rape, harassment, forced prostitution and trafficking of teenage girls and murder. The trafficking of girls across the border was discussed as an urgent regional issue requiring a regional solution.
- One study revealed that 6 percent of maternal deaths are due to homicide or suicide motivated by such factors as the stigma of rape and illegitimate pregnancy. Beating and dowry-related abuse and murders are increasingly being reported. Young women are the most vulnerable to health risks.
- Adolescent participants at the conference expressed concern about rising exploitation and the use of students (particularly boys) by political leaders for political violence and protests. Politics jeopardizes adolescents' career opportunities and exposes them to injury and sometimes death.

### 3.1.4 Policies/Programmes for Adolescents

*“Adolescent Health” is a new idea that had not been sufficiently addressed in the existing national policies and programmes on population and health. Recently, ASRH issues and problems have been placed on the national agenda.*

- Currently, ASRH is generally cov-

ered under the catchall of the “Health for All” strategy.

- Population education activities targeted for adolescents are carried out under IEC and Advocacy programmes.
- Bangladesh’s *Fifth Health and Population Programme* (HPP-V, 1998-2002) gives greater attention to the health needs of adolescents than past programmes. The Programme outlines specific ASRH services.
- Under the Country Programme, UNFPA/Bangladesh supports specific adolescent reproductive initiatives such as the incorporation of Family Life Education (FLE) into the school system, non-formal education to reach out-of-school adolescents, skill training for adolescent girls and youth, and RH/FP information and services for newly-wed young couples.

## 3.2 Bhutan

Although Bhutan is gradually adopting a market economy and modernization, it has retained its unique traditional heritage. Buddhist tradition accords equality between women and men in social, marital and economic relationships that is unique in the region. However, the country’s accelerating population growth (3.1), its growing adolescent population (22 percent of the total population), urbanization and consequent pressure on land resources, all have important implications for the future of adolescents in Bhutan. The

relative freedom and equality enjoyed by Bhutanese girls and women could be threatened with demographic changes and the present lack of adequate reproductive health information



and services. Some of the consequences of changing sexual and marital relations are already surfacing. Emerging adolescent reproductive health, education and exploitation issues particular to Bhutan are as follows.

### 3.2.1 Adolescent Sexual and Reproductive Health

- Bhutan has a total fertility rate of 5.6. A significant proportion of all births occurs to adolescent girls (11 per cent). The high teen-age fertility rates will increase the adolescent population at a faster growth rate than the general population growth rate.
- Men and women have considerable freedom of choice of sex partners. Divorce and remarriage are common. Social attitudes towards sex and sexuality are fairly tolerant, and premarital sex is not stigmatized. Daughters are valued and considered a source of support for old age.
- Bhutanese girls and boys become sexually active at an early age and also marry early (16 years for girls, and 18 for boys). The legal age at marriage has now been raised to 18 years for girls. Although reliable statistics are not available, premarital sex is quite prevalent.
- A relatively egalitarian attitude towards girls and women has not resulted in a corresponding equality in health status due to adverse conditions for pregnancy and childbirth. Women are often malnourished, and experience a high maternal mortality rate, particularly among adolescent mothers.

### 3.2.2 Literacy and Education

- Bhutan's literacy rate ranks is one of the lowest among SAARC countries (54 percent). Although adolescent literacy levels have improved, girls lag far behind with a literacy level of less than 10 percent. Girls are over five times less likely than boys to be literate.
- School enrolment ratios are still modest, despite remarkable progress made over the last thirty years. The gross primary school enrolment rate is 72 percent and much lower in secondary and higher education. Enrolment is significantly lower for girls at all levels (overall 38 percent).
- At 37 percent, the dropout rate is high, particularly for girls between classes 6 and 8 at the secondary level.

### 3.2.3 Exploitation of, and Violence against, Adolescents

The general belief is that gender-based violence does not exist in Bhutanese society. However, as the country opens up slowly to outside influences, new trends are emerging:

- The incidence of STDs is increasing, particularly gonorrhoea, and is equally dispersed among adolescent girls and boys.
- HIV/AIDs cases are emerging and will expose the adolescent population to greater risks.
- Alcohol abuse, drug abuse, tobacco use, juvenile delinquency and rape are all on the rise.

### 3.2.4 Policies/Programmes for Adolescents

Bhutan does not have explicit policies or programmes for adolescents. However, recently, the government of Bhutan has shown concern about emerging adolescent health issues.

- In the 8th Five Year Plan of the Royal Bhutanese Government, adolescents are treated as a specific target group within the framework of reproductive health, eligible for family planning, STD/HIV/AIDs prevention services, and school health services.
- Particular emphasis is given to universal education with a focus on girls' education.
- UNFPA/Bhutan's Third Country

Programme commits substantial financial support to improve access to quality reproductive health services for men, women and adolescents.

- In the population education (PE) sector, UNFPA supports knowledge-attitude-practice surveys (KAP), the introduction of PE in teacher training for college and high schools, and PE activities for school drop-outs, particularly girls.

## 3.3 India

India is experiencing a dramatic decline in fertility rates, from 5.3 to 3.6 with wide regional variations ranging from 4.8 in Uttar Pradesh to 1.9 in Kerala. Even though the fertility rate is declining, the adolescent population is large (22 percent of the total population) and will continue to grow rapidly in the near future. A further decline in fertility rates will hinge on the enhancement



of women's status as well as overcoming deeply ingrained social preferences for male children. India has some of the region's most severe forms of female neglect and infanticide. The country faces a major challenge in its attempts to overcome social biases and

prejudices against girls and women, and to meet adolescents' growing needs for education, health care, and social and economic opportunities.

### 3.3.1 Adolescent Sexual and Reproductive Health

- The female/male ratio in India's population has been declining since the turn of the century with a current adverse sex ratio of 107. The country's strong male child preference leads directly to subtle and sometimes severe neglect of girls, especially in poor and conservative families. The large deficit of women is attributed, among others factors, to nutritional neglect, sex-selected abortion and infanticide. It indicates high female mortality, low status of women, inferior medical and health care, lack of adequate nutritional intake and opportunities for girls.
- Girls still marry at a young age although the mean age at marriage has risen to 20 years, as compared to 24 years for boys/men. Fifty percent of adolescent girls aged 15-19 are already married resulting in early conception and high risks of maternal mortality.
- There is a wide disparity between the ages of spouses at marriage with girls marrying at much younger ages than boys. Gender disparity in marrying ages varies widely between regions, states, classes and castes.
- Recent data shows increasing evidence of pre-marital sexual activity

among educated adolescents. Some studies show an increasing incidence of illegal abortion and maternal deaths associated with pre-marital sex and early marriage. Around 12 percent of the spontaneous abortions were reported among adolescents 13-14 years, and 9 percent among adolescents 15-19 years, including induced abortion.

- Increasingly, adolescents are exposed to non-pregnancy related reproductive health disorders such as STDs and RTIs. Girls are disproportionately infected.
- WHO estimates as many as 2.5 million Indians are infected with the HIV virus as of 1994, with 800,000 reported cases of AIDS. It is suspected that many Indians acquired the virus during adolescence.

### 3.3.2 Literacy and Education

- Although adolescent literacy in India has increased to 56 percent; there are large discrepancies in literacy rates between states, regions and by gender. Overall, a 20 percent gap in literacy exists between boys and girls in the 10-19 age group.
- The school enrolment ratio declines sharply from the primary to the high school level (104 to 33) for both boys and girls, indicating relatively few adolescents tend to go on to school beyond the primary level. Wide regional and gender discrepancies exist at every level of educational attainment.

- In the state of Kerala, there is a near universal adolescent literacy rate (98 percent) characterized by gender equality. Yet, in the most populous states such as Uttar Pradesh, Madhya Pradesh, Bihar and Rajasthan only 20 percent of girls, and just over 50 percent of boys, are literate.
- School drop-out rates for girls are significantly higher than drop-out rates for boys due to girls assuming domestic and sibling care responsibility from a young age.

### 3.3.3 Exploitation of, and Violence against, Adolescents

- Approximately five million children, many of them girls below 14 years of age, continue to be involved in hazardous and non-remunerative occupations or work for unequal wages in both rural and urban settings.
- The incidence of adolescent rape (between 10-16 years of age) increased by 26 percent between 1991 and 1995. Alcohol abuse, in both domestic and non-domestic settings, appears to be the main cause of adolescent rape.
- Several studies show an insidious spread of drug abuse and addiction among those in the 12 to 23 age group regardless of literacy status.
- Dowry killing is a particular form of violence reported to be more common in India than elsewhere in the region. Over 5,000 brides are re-

ported to be killed per year. Young brides are the most vulnerable due to their age disadvantage.

- Commercial sexual exploitation of children and young girls, including forced prostitution and trafficking, is a serious and growing problem. More documentation of commercial sexual exploitation is needed.

### 3.3.4 Policy/Programme on adolescents

Since the 1994 ICPD, the Government of India has taken steps to address the special needs of adolescents, particularly girls.

- The national Reproductive and Child Health programme (RCH) is a major comprehensive package on maternal and child health care services. Adolescents, particularly girls, form an important segment of targeted beneficiaries with an emphasis on counselling and reproductive health services.
- The RCH programme supports special projects for adolescents from urban slums, tribal and disadvantaged groups. The programme includes improved family health care services. Integrated child development schemes (ICDS) have been designed for out-of-school girls. Other health activities indirectly promote girls' education.
- UNFPA/India, in its Fifth Country Programme (1997-2001), accorded special attention to information and counseling about reproductive

health services in all its programme components and initiatives.

- Specific initiatives for adolescents supported by UNFPA include: the *Harayana Integrated Women's Empowerment and Development Project*; the *Lok Jumbish Project* in Rajasthan to enhance access to education to all children up to 14 years of age; and the *Gujrat Bicycle Scheme* for 16- and 17-year-old girls.
- UNFPA has supported Population Education projects since 1980. *The Family Life Education for Adolescents Out-of-School Project* has been introduced recently in response to the needs of adolescents in India.

### 3.4 Maldives

Although small in size and composed of scattered tiny islands, the Maldives presents a unique socioeconomic and demographic situation. The country's economic performance (with a GDP growth rate of 6-8 percent) is compara-



ble to that of industrialized countries of the north and also Southeast Asia. The Maldives has achieved near universal literacy and reports comparatively low infant, child and overall

mortality rates. Women and girls enjoy considerable freedom in marriage, divorce and remarriage. However, despite strong economic growth and good



social indicators, there has not been a corresponding increase in employment and reproductive health status for adolescents. The population of approximately 250,000 is one of the fastest growing (2.8) in the region with a high TFR. of 6.4. Adolescents (10-19 years) constitute 24 percent of the total population, and the adolescent population is expected to grow at a rapid rate for the near future. The effects of population momentum on the socioeconomic fabric and health status of the population is expected to be adverse, particularly for the young. The Maldives needs to balance economic growth with meeting the specific socio-economic and reproductive health needs of adolescents. Key issues related to ASRH in the Maldives are as follows.

#### 3.4.1 Adolescent Sexual and Reproductive Health

- Late adolescents (15-19) contribute thirty percent of the TFR (with an age-specific fertility rate of 1.5). Most girls and women conceive and bear children within the first year of marriage.
- There is considerable sexual and marital freedom for both sexes.

Divorce and remarriage are frequent. The average age at marriage is around 16 years. The majority of adolescent girls are already married by the age of 20. The divorce rate is among the highest in the world.

- Early marriage and closely-spaced pregnancies lead to high rates of maternal mortality (indicated by higher deaths in the reproductive years for women compared to men) and reproductive health complications. Malnutrition and anemia are common problems among girls and women of reproductive age (15-49 years).
- Approximately 40 percent of children are malnourished. Thirty to sixty percent of women are anemic, of whom 20 to 25 percent are chronically malnourished.
- Although the maternal mortality rate has declined in the Maldives, this decline has not been matched by an improvement in the nutritional status of children and women, particularly among the adolescent population.
- There is growing evidence of pre- and extra-marital sexual activity among adolescents. In 1995, 280 persons were sentenced for offences related to extra-marital sex, most of whom were adolescents.
- Outside influences and unsafe sexual relations/practices among adolescents exposes them to STD/HIV/AIDS and unwanted pregnancies indicated by a rising number of female adolescents seeking abortion abroad. There have been reports of complications, including deaths.

However, accurate information is not available.

### 3.4.2 Literacy and Education

*Although primary education is universal with equal numbers of boys and girls completing primary school, gender disparities begin to appear in secondary and higher levels of education.*

- Drop-out rates for girls are higher in secondary and post-secondary levels.
- There is a virtual absence of girls in vocational and technical training schools.
- Population education has been integrated into the curricula at the primary and middle school levels and into the *Dhivehi* (local language) curriculum as well.

### 3.4.3 Exploitation of, and Violence against, Adolescents

*Nearly half of the children and adolescents (40 percent) in the Maldives experience their parents' separation and divorce. There is a growing recognition that much of the violence and exploitation against adolescents is linked to this form of social instability.*

- In 1996, a total of 249 cases of child abuse, of both a physical and sexual nature, were reported.
- Substance abuse is on the rise with a marked increase in abuse by youth and adolescents.

### 3.4.4 Programmes/Strategies on Adolescents

*Maternal, child and family planning services are provided within the traditional framework of health services. More recently, health initiatives targeted for adolescents have started up.*

- The Health Master Plan for 1996-2005 identifies goals and strategies to address adolescent health needs, including the empowerment of women and adolescents. The Plan gives due attention to quality health care services to be supported by advocacy tools and IEC campaigns.
- UNFPA/Maldives supports interventions in three areas: (1) population, development and environmental courses in schools; (2) reproductive health information and services for adolescents; and, (3) dissemination of population education and reproductive health information through Island Women's Committees.

## 3.5 Nepal

Although small in size, Nepal is a country of great diversity with quite varied topography, cultures, and religions. There are over 200 ethnic and linguistic groups. All of these factors – physical accessibility, different social and cultural beliefs, varying health practices and health seeking behavior – influence adolescents' reproductive health. Despite the decline in Nepal's population growth (2.6 to 2.1), and a

visible drop in the TFR (from 6.33 to 4.6), adolescents constitute a sizable proportion of the total population (23 percent) which will fuel future population growth. The proportion and rate of growth of the adolescent population vary substantially between urban and rural settings, ecological regions and



ethnic groups. The effects of the adolescent population growth rate, and the ecological and cultural diversity within the adolescent population, will pose a serious challenge for the government to meet the educational and health needs of adolescents. The main issues confronting ASRH are as follows:

### 3.5.1 Adolescent Sexual and Reproductive Health

- The adolescent fertility rate (1.31) contributes significantly to Nepal's TFR (28 percent). In addition, age-specific fertility rates (ASFR) show a shift in fertility peaks to the younger age groups (15-19 and 20-24 years). This trend indicates that family planning and reproductive health services should be targeted to younger, as well as older, adolescents.
- The adverse sex ratio (108) among

the young adolescent population in the rural areas (112) indicates a lower status of girls and women in rural areas as compared to urban areas (with an overall sex ratio of 99.5).

- The mean age of marriage is 18. An estimated 60 percent of marriages take place to girls younger than 18 years.
- Child marriages, a traditional feature of the predominantly Hindu culture, are reportedly on the rise again after leveling off for a number of years.
- Evidence suggests that the age at menarche is decreasing, particularly in urban areas.
- There is evidence that polygamy is also increasing.
- Pre-marital sex appears to be increasing among adolescents. The mean age of first sexual contact is reported to be 18 years.
- Maternal mortality is among the highest in the sub-region at 539 per 100,000. For adolescent girls (15-19 years), it is 864 per 100,000. Discussions revealed that adolescent girls 15-19 years represent the largest percentage of reproductive age deaths (19 percent). Adolescent girls from conservative and low cast communities are particularly at risk.
- Although abortion is legally restricted in Nepal, studies reveal that Nepalese women do resort to induced abortions (11 percent of all abortions) for various reasons such as unwanted and out-of-wedlock pregnancies. Nearly 7 percent of all abortion cases were attributed to adolescents younger than 20 years of age. In addition, a recent study by

the Department of Health Services, of 1,178 hospital admissions of women of reproductive age in three districts of Nepal, found that the leading cause of morbidity was due to complications from abortion.

- The incidence of STDs and HIV/AIDS is increasing at an alarming rate. Among adolescent boys, 10 percent reported their first sexual contact was with commercial sex workers. Fifty percent of female adolescent STD patients are reportedly involved in the commercial sex trade. Just under one-in-five of these patients (16-19 years) were found infected by the HIV virus.

### 3.5.2 Literacy and Education

The adolescent literacy rate is low. Less than 40 percent of adolescents are literate. The school drop-out rate is high, especially among girls. There are wide gender disparities in educational attainment that increase over time.

### 3.5.3 Exploitation of, and Violence against, Adolescents

Child labour and sexual slavery – including prostitution, domestic abuse, incest, rape and the international trafficking of girls – are the most common forms of exploitation and violence against adolescents.

- The most prevalent form of exploitation is child labour which is exten-

sively practiced in almost all sectors of the primarily rural economy. In urban areas, some 200,000 children and youth may be employed as domestic servants, construction labourers, carpet weavers, restaurant workers, tea pickers, transportation workers and porters.

- There are an estimated 6,000 bonded labourers indentured under the *Kamaiya* system.
- There may be as many as 300,000 street children (small children and adolescents), most of whom are boys.
- Girl trafficking and forced prostitution are increasing. Some estimates are that as many as 200,000 Nepali women and girls work as CSWs in India. Parents and relatives often act in collusion in the sex trade. Poverty and the low status of girls and women are the responsible factors.
- Drug abuse among adolescents is increasingly emerging as an issue and threat. There are an estimated 50,000 drug dependant persons in Nepal. It is roughly estimated that between 75 to 80 percent of the drug dependent persons are youth (20-29 years).

### 3.5.4 Policies/Programme for Adolescents

*For His Majesty's Government, the issue of adolescent reproductive health is a new and highly sensitive area. Since the ICPD (Cairo) conference in 1994, HMG/N has taken some steps to recognize and address adolescent issues:*

- The national reproductive health policy recognizes adolescents' rights to services.
- A national NGO, the Family Planning Association of Nepal, has been appointed by the government to oversee health services and counseling for adolescents.
- Laws enacted several decades ago, that prohibit child marriage and establish a minimum age for legal marriage, are being more strictly enforced.
- Efforts are being made to increase the enrolment of adolescents, particularly girls, in public schools and to promote Family Life Education (FLE) through formal and non-formal sectors.
- UNFPA/Nepal has incorporated adolescent health activities in its Fourth Country Program (1997-2001), including the regional EC RH initiative.
- Surveys of adolescents' reproductive health knowledge, attitudes, and practices; advocacy efforts and population education programs; IEC campaigns, including radio and TV programs targeted for adolescents, have been developed and implemented with UNFPA support.

## 3.6 Pakistan

Adolescents' sexual development and reproductive health needs remain an undefined area within Pakistan's traditionally conservative society. Cultural and social mores and very strict, and

there is a general preference for first cousin marriages. Pakistan has the second largest and fastest growing population in the region (with a population growth rate of 2.9). Adolescents comprise 22 percent of the total population. This population sub-group is expected to grow at a rapid rate for sometime.



### 3.6.1 Reproductive and Sexual Health of Adolescents

- A large share of all births occur to girls between 15-19 years of age in part due to closely spaced pregnancies. Most married adolescent girls (90 percent) prefer early pregnancy as an insurance against rejection, isolation and the threat of the 'second wife'. These social and cultural fears have serious implications on adolescents' sexual and fertility behaviour.
- A significant proportion of Pakistani women marry by the age of 17 although the average age of marriage is 21 years. There is a wide differential between the age of spouses at marriage reflecting the patriarchal values and structure of the society.
- The tradition of furnishing a dowry (*watta satta or walwar* - bride price) is widely practiced necessitating a

strict control of girls' property and choice of partner.

- Reproductive mortality among adolescent mothers is high, i.e., 341 per 100,000 live births.
- Given early deficient nutritional status, 90 percent of adolescent mothers suffer from malnutrition and anemia.
- Thirty percent of infants born to adolescent mothers are underweight.
- An estimated 40 percent of maternal deaths are attributable to unsafe abortion practices associated with unwanted and pre-marital pregnancies.
- There are an estimated 50,000-80,000 cases of HIV/AIDS nationwide which will impact heavily on the adolescent population.

### 3.6.2 Literacy and Education

Overall, 40 percent of the Pakistani population is literate, with a higher rate of literacy among the adolescent population. However, wide gender disparities exist in literacy and educational attainment.

- Mean years of schooling for adolescent boys are 2.9 years, compared to 0.7 years for girls. Gender disparity in educational attainment is even higher in the rural areas.
- Gross enrolment rates for boys and girls at the primary school level are 85 percent and 58 percent, respectively. Subsequently, fewer boys and girls go on to higher levels of second-

ary school and beyond. Gender disparities increase with each level of educational attainment.

- The drop-out rate at the secondary level is over 50 percent. The school drop-out rate is highest for girls at the lower secondary level.
- Adolescent girls have fewer educational opportunities at all levels compared to their male counterparts. Schools are highly sex segregated. For instance, there are fewer educational and training institutes available for girls compared to institutes for their male counterparts (only nine professional colleges for female as compared to 101 professional colleges for boys).

### 3.6.3 Exploitation of, and Violence against, Adolescents

The Government of Pakistan now recognizes the widespread practice of different forms of exploitation and violence against adolescents.

- An estimated 2.5 million girls and boys are reported to work at various forms of manual labor, such as brick-making.
- Young Pakistanis are increasingly vulnerable to substance abuse.
- Child prostitution, specifically sexual exploitation of young boys, is reported to be a hidden problem.
- Custodial rape in police stations has reached serious proportions.
- Violence against women ranges from domestic beating and killing often

associated with unmet dowry demands to sexual harassment, including rape. Eighty percent of Pakistani women reported being beaten in one survey. Another study of female mortality in two hospitals, over a six-month period, identified 89 deaths due to “accidental burning” or “chula” homicide.

- Gender- and age-related Islamic laws – including the Hudood Ordinances, the Blasphemy Law, and the Laws of Qisas and Diyat, reinforce biases.

### 3.6.4 Policies/Programmes on Adolescents

Although the Government of Pakistan recognizes the particular problems of ASRH, national policies specific to adolescents have not yet been adopted. Reproductive health and family planning needs are covered only under the broad framework of the Family Welfare Programme (MCH/FP). Family life and adolescents educational needs are not yet directly featured in school curricula or in any government policy document. Islamic moral parameters, characterized by fundamentalism, continue to form the basis of official discourse. Some NGOs, however, have exhibited flexibility in implementing some female literacy training and population education initiatives for adolescents.

Since 1994, UNFPA/Pakistan has supported projects to develop population education curricula in the formal school system.

### 3.7 Sri Lanka

Over the last three decades, socioeconomic and demographic changes have greatly altered the structure of the population in Sri Lanka, with the proportion of adolescents shrinking to 21 percent of the total population. Sri Lanka has achieved fertility transition. The



mean age of marriage is now 26, and population growth is at replacement level. In terms of human development, Sri Lanka has achieved a comparatively high quality of life as indicated by a HDI of 90. However, demographic and social changes have not led to corresponding changes in societal beliefs and biases against adolescent sexuality and reproductive health. Adolescent sexuality still remains taboo in many segments of the Sri Lankan society. Although the 1993 Demographic and Health Survey revealed a high demand for family planning knowledge among youth and adolescents, there are still no formal family planning programmes for adolescents and unmarried people. Adolescents' sexual and reproductive health issues need to be addressed in

the specific cultural and socioeconomic context of Sri Lanka.

#### 3.7.1 Reproductive and Sexual Health of Adolescents

- The decline in age at menarche and the rise in the age at marriage have prolonged adolescence. Few studies exist on the reproductive health and sexual development needs of adolescents.
- There is no scientific data on the prevalence of premarital sex although it is thought to be rising.
- Abortion is widely practiced with as many as 750 abortion cases per day occurring to adolescents (15-19).
- Adolescents account for up to 11 percent of all illegitimate births.
- Available studies show low levels of communication between adolescents and their parents on matters pertaining to sexuality.
- Studies show that students lack comprehensive knowledge about their reproductive physiology and sexual health and are widely ignorant about risks associated with unprotected sex.
- Maternal mortality is higher among young mothers compared to those who are older.
- The increasing incidence of suicide among the young population is an emerging problem in Sri Lanka.

### 3.7.2 Literacy and Education

*The combined literacy rate is about 90 percent and the gap between male and female levels of literacy is only 5 percentage points. Population education and Family Life Education activities are now part of the standard curricula of all secondary schools.*

- Girls outnumber boys in enrolment at secondary and higher secondary levels.
- School drop-out rates are higher for boys
- Family planning and sex education courses have not been included in school curricula as the issue of adolescent sex and sexuality is still a culturally sensitive topic.

### 3.7.3 Exploitation of, and Violence against, Adolescents

Although there is limited information and data on exploitation and violence against adolescents, incidents seem to be increasing both in number and in kind.

- There are an estimated 3,000 to 10,000 street children.
- An estimated 30,000 adolescents are trapped in some form of commercial exploitation.
- Approximately 100,000 to 500,000 children, youth and adolescents are involved in child labour.
- Suicide rates among young females are rising, reportedly, due to “unde-

sirable adolescent subculture”, family conflicts arising from generation gap.

- Sexual exploitation and violence against children and adolescents in work places (such as domiciles or factories) seem to be on the rise which increases their exposure to the risk of acquiring an STD, or contracting the HIV virus.
- Sri Lanka's ongoing ethnic conflict with the Tamils has led to increased conscription of children, youth and adolescents into the military of both factions.

### 3.7.4 Policies/Programme on Adolescents

After ICPD, the Government of Sri Lanka initiated a collaborative effort to develop a national policy on adolescent reproductive health issues. The government formed a Task Force consisting of government officials, NGOs, CBOs and the private sector. However, the national reproductive health and family planning programme still do not directly cater to the growing number of unmarried population due to cultural ramifications.

- A network of youth counseling centers, involving NGOs and vocational training centers, was established.
- Premarital counseling on sexual and reproductive health issues (including STDs and HIV/AIDS) are being regularly provided in most NGO ini-

tiated education programmes as well as in some of the government counseling programmes.

- FLE and gender concerns have been built into the curriculum in the formal school system.
- Advocacy initiatives are being initiated to create a supportive environment for adolescent reproductive health among parents, community and religious leaders.
- The UNFPA/Sri Lanka country programme supports government and NGO initiatives to address the reproductive health needs of adolescents. UNFPA supports reproductive health clinics in the Free Trade Zone where many adolescents are employed. In addition, UNFPA is collaborating with the Family Planning Association of Sri Lanka to establish reproductive health centers for in-school and out-of-school adolescents and youth.

## CHAPTER 4

# VOICES OF ADOLESCENTS





**S**exuality and reproductive health are not the only concerns for adolescents. Equally important, and interrelated, are issues related to career opportunities, lack of employment opportunities, competition, parental expectations and the lack of choices and decisions to be made by adolescents, irrelevant educational curricula, exploitation and violence, and adolescent rights.

The identification of adolescents' needs and concerns, by adolescents themselves, represented the conference's greatest achievement. Adolescents voiced their concerns during "role play" sessions with selected adult participants (see Annex III), and during group discussions with their peers. Adolescents' views and experiences provided a practical perspective of the real life situation of their myriad problems and needs. Their major concerns expressed at the conference are summarised as follows: (i) increasing erosion of moral values, and vulnerability to self-abuse resulting from frequent exposure to pornography, blue films, sex shops, obscene cinema advertisement, etc.; (ii) undue high expectations from parents to follow parents' goals and aspirations; (iii) little opportunity to make independent choices and decisions; (iv) widespread perception of adolescents as immature; (v) discriminating practices against female children in almost

"Save us from 'self-abuse' resulting from frequent exposure to pornography, blue films, sex shops, and obscene cinema advertisements."

"There are high expectations from parents... parents want to be successful through their child's success. Parents impose their thoughts and dreams on their children... adolescents don't have the opportunity to make choices..."

"Involve us in the process of developing programmes that are meant for us."

"Our biggest dilemma - Why are girls discriminated against? Do something!"

".... We need affectionate and happy parents because much of the moral teachings come from parents of happy and united families...."

"..... Political leaders use adolescent boys to fulfill their selfish goals. They use them to create violence in the campus.... We need to negotiate with honorable politicians from all our different countries..... against the involvement of students in politics."

all aspects of life; (vi) persisting high levels of illiteracy and gender gaps in education; (vii) increasing use of students, particularly boys, in partisan politics; (viii) increasing violence committed by adolescents against each other; (ix) high prevalence of child abuse, child labour, and continued violence and exploitation against adolescents within and outside the family and at work places; (x) early marriage and teenage pregnancy; (xi) poor knowledge of sexuality and reproduction; (xii) lack of access to sexual and reproductive health services; (xiii) lack of access to professional and confidential counselling services on sexual and reproductive health issues; (xiv) increasing exposure to health risks caused by abortion, STDs, HIV/AIDS; (xv) diminishing job opportunities and increasing competition; (xvi) lack of access to counselling and career guidance opportunity; (xvii) lack of rehabilitation centres for drug addicts and sexually abused adolescents; (xviii) poor enforcement of laws against violence; (xix) increasing cost of education; (xx) out-dated school curricula with little emphasis on life skills, and extra-curricula activities such as physical education; (xxi) poor quality educational instruction and few marketable skills; (xxii) lack of sex education in formal and non-formal education programmes, and (xxiii) out-dated examination systems which give undue emphasis to memorizing, rather than real learning.

“Information is lacking in every area. We want to know. Give us correct and relevant information, give us information we can use in our lives. Help us make informed choices. When we do not know....., we try to experiment and land ourselves in trouble.”

“Make primary education compulsory for every child. We have witnessed adolescents in rural areas who could not even sign their own names to obtain documents. This is indeed a sad situation.”

“..... financial constraints related to education, like the phenomenon of donations to schools as entry fees, make good education inaccessible. There are very few people who can afford to pay these donations. And the cost of education is also increasing continuously. Just by opening a large number of schools or colleges, you can't expect a good quality of education.”

*The voices of adolescents expressed here may not necessarily represent the voices of adolescents of all walks of life and residential background as these are based on the experiences of selected school-going urban adolescents.*

## VOICES OF THE ADOLESCENTS OF SOUTH ASIA

### Delhi Declaration

#### PREAMBLE

We adolescents are not only conscious of our rights but we also feel responsible for moving away from the “me” decade in which we are living, to a decade where adolescents will prove to be an important human resource for the betterment of the region. We pledge to make this a reality.

#### OUR PERSPECTIVES

- We feel neglected, and so we need more attention, care and support from all.
- We feel we do not have the right to make our own choices, even after learning about all the alternatives and choices related to our careers, friends, movements and life partners.
- We greatly lack proper and correct information and guidance, especially related to our bodies’ physiological and psychological changes.
- We are not allowed to express our emotions and our thoughts.
- We are treated as immature persons. We would like to share responsibilities and prove ourselves.
- We are not given ample opportunities to ascertain our individuality.  
We do not want our parents’ dreams and aspirations imposed on us.
- We feel increasingly ‘self-abused’ through frequent exposure to pornography, blue films, sex shops and obscene advertisements.
- We feel moral values eroding.

## PARENTS – CAN YOU HEAR US?

- We need you to listen to us to our dreams, our experiences, our EXPLANATIONS,
- Our insecurities and our achievements.
- Give us your time-you gave us life, now we want your time.
- Be our friends.
- Understand us.
- Don't hide things from us, especially when they are related to us.
- Give us the privacy and the space to grow.
- We prefer openness and encouragement to pressures and threats.
- Guide us, don't drive us.
- Share your problems, even financial ones, we are part of you.
- Correct and explain, don't reprimand us in public.
- We want to fight life's battles together, and not as opponents.
- So what if we are boys or girls, we're yours after all !
- We need affectionate, happy and understanding parents.
- Give us the opportunity to make our own choices in all aspects of life, including career choices.
- Do not impose your wishes and goals upon us.

- Give us freedom of thought and expression.
- Show respect for our values, wishes and opinions.

## GOVERNMENTS AND SOCIETY - DO OUR VOICES REACH YOU?

- Our biggest dilemma - why are girls discriminated against ? Do something.
- We are human, aren't we ? Don't abuse us.
- Review the education system - especially the way you evaluate us.
- Don't experiment with us and change curricula frequently.
- Make education more relevant and interesting.
- Include co-curricular and recreational facilities in the education programme and give us time for them.
- Don't just make laws, enforce them.
- Require law enforcement agencies to be more sensitive towards physical abuse cases.
- Provide more counselling and career guidance centres.
- Provide non-formal education programmes for adolescents who can't go to school.
- Let us support you and join

hands to fight the menace of drugs.

- Set up rehabilitation centres for drug addicts and sexually abused youth.
- Give us access to reproductive health services, including family planning services ensuring confidentiality.
- Provide adolescents with professional and confidential counselling services on sexual and reproductive health issues.
- Remove gender disparity in school enrolment.
- Make primary education compulsory.
- Eliminate child labour, child abuse and all types of violence against adolescents including trafficking.
- Take legal action against immoral acts such as pornography, blue films, sex shops, and obscene advertisements.
- Generate job opportunities and establish career counselling and guidance centers for adolescents.
- Include lessons on life skills and

sex education in formal and non-formal education programmes.

- Do not involve us in partisan politics. We are too young for politics.
- Give more emphasis to learning and understanding, and less emphasis to memorizing.
- Involve us in decision-making, particularly on matters directly related to us.
- Inculcate religious and moral values through education programmes.
- Discourage, and take necessary steps against, early marriage and teenage pregnancy.

*Our declaration ends here but not our desire to do something for the millions of adolescents we represent. You have given us your support these last three days, you have given us your time and lent a patient ear. Continue to do so, PLEASE !*

**PARENTS, we love you. Please understand us.... All of us.....**

## CHAPTER 5

# CONCLUSIONS, STRATEGIES AND RECOMMENDATIONS





## 5.1 Conclusions

**B**ased on the conference presentations and proceedings, the following conclusions were drawn:

- (i) Adolescents constitute a sizeable proportion of the total population in the SAARC region, and the adolescent population will continue to grow rapidly in the near future.
- (ii) Many adolescents are deprived of a quality education, the opportunity to acquire marketable skills, employment, and vital sexual and reproductive health information and services. They are also subject to all types of exploitation and violence, and vulnerable to increasing exposure to STDs/HIV/AIDS. Among adolescents, girls are the most disadvantaged group.
- (iii) SAARC countries are starting to recognize the particular sexual and reproductive health needs of adolescents. This is a marked shift in attitude on the subject from pre- to post-Cairo era.
- (iv) Sexual and reproductive health needs are not adolescents' only concerns. Equally important to them are issues related to career opportunities, competition and high parental expectations.
- (v) Sexual and reproductive health needs must be viewed from a holistic developmental and integrated programme approach, rather than from a narrow biomedical approach, in order to address the multi-dimensional needs of adolescents.
- (vi) Adolescents' own views and experiences provide a broader and better perspective of their real life problems and needs than regional and national perspectives and studies by "experts". This underscores the need for a perspective change in formulating policies and programmes for adolescents (i.e., a participatory approach in planning, formulation and implementation).
- (vii) A greater degree of regional and national level cooperation between governments, adolescents,

NGOs and donor partners will be required to address adolescent concerns from a holistic perspective.

- (viii) Improved and more realistic ARH indicators are needed to reflect the multi-dimensionality of adolescents' needs and concerns.
- (ix) Existing data are inadequate to assess all aspects of the multi-dimensional needs of adolescents in general, and socio-cultural aspects of adolescent reproductive health behavior in particular.
- (x) Adolescents can and should be more pro-active in articulating and promoting their concerns. For this task, adolescents will require necessary skills, information and services and support from all concerned.

## 5.2 Strategies and Recommendations

The conference concluded with a set of strategies and recommendations to meet the sexual and reproductive health and education needs of adolescents, and to eliminate exploitation and violence against them. These strategies are summarized under the three broad thematic areas of the conference:

- sexual and reproductive health;
- literacy and education; and
- exploitation and violence.

Some recommendations and strategies cut across all three thematic areas. The

latter are grouped under the category of Overall Strategic Recommendations.

### 5.2.1 Overall Strategic Recommendations

- ***Adopt a SAARC Declaration on the Rights of Adolescents***, guaranteeing their rights to protect themselves against violence and sexual abuse; to access education information and reproductive health information and services, including family planning services, in line with the ICPD POA, by all countries of South Asia, under the auspices of the South Asian Association for Regional Cooperation (SAARC).
- ***Strengthen national capacity in the collection, compilation, updating and analysis of qualitative and quantitative data*** on all aspects of socio-cultural, economic, demographic, sexual and reproductive health, education, employment, food and nutrition issues affecting the situation of adolescents, including information on violence against adolescents by gender. Establish a data bank on adolescents at the country level.
- ***Sensitize politicians, policy makers, parents, teachers and members of the press*** on the needs and problems of adolescents. Mobilize their support to meet the special needs of adolescents.
- ***Formulate a comprehensive national strategy and programme of action*** to address adolescents' multi-

dimensional needs (such as employment, education, empowerment, food security and nutrition, and sexual and reproductive health taking into account the country/culture-specific context under which adolescents live). Recognize the needs of adolescents from all walks of life and backgrounds (rich and poor, urban and rural, married and unmarried) while formulating policies and programmes for adolescents. Involve adolescents in all stages of health programme planning, management and implementation of national strategies and programmes related to adolescents.

- ***Incorporate adolescent concerns into existing development programmes for adolescents*** such as linking family life education programmes with the formal school system, youth development programmes with adolescents' sexual and reproductive health education and services, and credit programmes with vocational training.
- ***Establish a Centre of Excellence for Adolescents*** in the region to promote a holistic approach in dealing with all aspects of the needs of adolescents. Catalogue and disseminate each country's 'best practices' in adolescent programmes and policies to allow SAARC countries to learn from each other's experiences and successes.
- ***Foster inter-ministerial collaboration to address adolescent*** needs from a holistic point of view.
- ***Hold country level conferences on***

***adolescents***, as a follow-up to the *South Asia Conference on Adolescents*, with the participation of all concerned stakeholders – particularly adolescents from rural and remote areas and marginalized groups.

- ***Form a network of adolescent groups***, both at the national and regional level, to articulate the voices of adolescents in a more coordinated manner and establish forums for adolescents to articulate their grievances in a participatory manner.
- ***Establish counselling and career guidance centers*** for adolescents.
- ***Ban the involvement of students in partisan politics.***
- ***Eliminate discriminating practices against female children***, including adolescent girls.

## 5.2.2 Strategic Recommendations: Sexual and Reproductive Health

The major sexual and reproductive health concerns of adolescents were identified as follows: (i) lack of appropriate policies and programmes addressing adolescents' sexual and reproductive health needs; (ii) lack of data to assess the sexual and reproductive health needs of adolescents; (iii) lack of access to reproductive health information and services; (iv) poor sexual and reproductive health knowledge. Various strategies were identified to address the sexual and reproductive health needs of adolescents as follows:

- Sensitize politicians, policy makers, community leaders, parents and teachers to the uniqueness of adolescents' sexual and reproductive health needs. Create a national consensus on the importance of formulating special strategies and programmes to address adolescents' sexual and reproductive health needs.
- Collect, analyse and disseminate data on all aspects of adolescents' sexual and reproductive health on a regular and systematic basis. Data collection and dissemination will ensure the formulation of need and information based policies and programmes.
- Formulate country specific comprehensive *Adolescents' Sexual and Reproductive Health Programmes* (ASRH), based on an assessment of adolescents' actual needs. Conduct pilot tests of the ASRH programmes. Recognize heterogeneity (differences in social class, gender, marital status, place of residence, ethnic groups) in the composition of adolescents and their different sexual and reproductive health needs. Ensure the inclusion of these different needs and backgrounds in the policies and programmes addressing adolescents' reproductive health. In addition, involve all concerned stakeholders, particularly adolescents, in all stages of the formulation, implementation, monitoring and evaluation of sexual and reproductive health programmes related to them.
- Formulate and implement specific sexual and reproductive health strategies for married and unmarried, sexually active and non-active adolescents, and those in remote and rural and urban areas, and in- and out-of-schools.
- Implement ASRH programmes in phases and in selected areas, with *priority given to unmarried adolescents in remote and rural areas. Adolescents' Sexual and Reproductive Health Programmes* (ASRH) should be multi-dimensional in approach. All ASRH programmes should be related to each other.
- Develop appropriate mechanisms for the coordination and monitoring of progress in the implementation of the ASRH programmes.
- Improve the sexual and reproductive health knowledge of in- and out-of-school adolescents, especially unmarried girls by providing them accurate information on physiology, sexuality, reproduction and the consequences of unsafe sex, through formal and non-formal education programmes.
- Ensure the accessibility and quality of reproductive health services for all, including family planning services: (i) establish referral networks for special services such as youth centers, population clubs and peer group networks; (ii) establish more outreach programme centers; (iii) provide contraceptive services in schools while respecting students' right to confidentiality; (iv) expand current contraceptive services to in-

clude RTI and STD services; (v) provide quality guidance and counselling on sexual and reproductive health issues by professional counsellors, teachers, parents and peers; (vi) establish telephone 24 hour hotlines operated by experts to respond confidentially to questions on Adolescents' Sexual and Reproductive Health (ASRH) issues and crisis situations; (vii) make existing health services more adolescent friendly by (a) *maintaining flexible service hours*; (b) *ensuring privacy and confidentiality*; (c) *providing training to the service providers on the sexual and reproductive health needs of adolescent*; and, (viii) coordinating with NGO service providers.

- Improve the sexual and reproductive health knowledge of parents to facilitate better communication between parents and children on ASRH issues.
- Use mass media and the internet for the promotion of responsible sexual behaviour and for awareness of reproductive health issues.
- Take legal action against immoral activities such as pornography, blue films, sex shops and obscene cinema advertisement.
- Lobby for increasing the legal age of marriage, with no gender disparity between boys and girls. Discourage, and take necessary steps against, early marriage and teenage pregnancy.
- Incorporate adolescents' sexual and reproductive health (ASRH) concerns into existing development pro-

grammes such as linking youth development programmes with ASRH education and services, and family life education with formal and non-formal education programmes.

### 5.2.3 Strategic Recommendations: Education

The major education concerns of adolescents were identified as follows: (i) poor quality of education; (ii) social class/gender disparity in access to education; (iii) lack of relevance of educational programmes to the needs of adolescents; (iv) lack of involvement by adolescents in the planning and implementation of education programmes; (v) lack of extra-curricular activities, and (vi) inadequate lessons on sexual and reproductive health issues in school curricula.

Strategies suggested to meet these concerns are as follows:

- Make primary education compulsory for all primary school age children.
- Enhance the quality of education through (a) arranging proper training of teachers to address the academic, emotional, psychological and physiological needs of adolescents; (b) updating curricula to meet the current needs of adolescents and prepare them to meet the challenge of the next millennium; (c) involving adolescents in the planning and

implementing of educational programmes including curricula planning; (d) improving the school environment, i.e., physical facilities; (e) promoting positive attitude of students towards school and increasing their commitment to learning; and (f) increasing community and parental participation in education programmes.

- Update the existing programmes on ASRH education on a continuing basis in light of the new research findings and best practices.
- Inculcate moral and religious values through education programmes. Education curricula should be designed and developed with due consideration given to local values on sex and sexuality. Not all modern or western values on sex and sexuality are good. Similarly, all traditional values on sex and sexuality are not bad. All traditional values should not be discarded in favour of so-called modern or western values. Values are changing and dynamic. However, one needs to be very discreet and judicious in adopting and disseminating values on sex and sexuality.
- Revise education curricula to address adolescents' needs. Curricula should include lessons on negotiating skills needed in daily life situations, such as how to avoid premarital sex, particularly unsafe sex and taking drugs. Life skills such as family life education, lessons on sexuality and reproductive health, vocational education, income gener-

ating skills, decision-making skills etc., should be introduced into formal and non-formal education programmes. Extra-curricular activities, such as sports, debates and physical exercises, should be incorporated into education programmes to improve the physical and mental health of school children.

- Efforts should be made to provide education for all. In this vein, remove the existing disparity in access to education by bringing adolescent boys and girls from marginalised groups (e.g., disabled adolescents, adolescent prostitutes and children of prostitutes, school dropouts, children who have never been to school, child labourers and street children and adolescents belonging to ethnic and religious minority groups.) into the formal and non-formal education programmes run by governments and NGOs. Programmes should be innovative and flexible. In addition, remove gender gaps in school enrolment and completion rate through innovative and flexible programmes, and develop appropriate strategies to reduce drop-outs and increase enrolments at primary and secondary level for both girls and boys.
- Develop a holistic education plan for out-of-school adolescents that will give them functional literacy and income generation skills.
- Develop appropriate educational materials to orient parents and teachers on reproductive health needs of adolescents.

- Increase the allocation of government budget to education.
- Increase the participation and role of NGOs and the private sector in education.

#### 5.2.4 Strategic Recommendations: Violence Against Adolescents

Adolescents, particularly girls, are subject to exploitation and violence of all types: domestic, sexual, social and economic. Various strategies were suggested at the national and regional level to combat violence against adolescents.

##### (a) Strategies at the National Level

The strategies suggested to eliminate violence against adolescents at the national level are as follows:

- Sensitize all law enforcement personnel, politicians, policy makers, parents, teachers, and members of the press on the needs and problems of adolescents, including the pervasiveness of violence and exploitation against adolescents. Mobilize widespread support to redress adolescents' problems
- Formulate a comprehensive national strategy and programme of action to address social, economic and domestic exploitation of, and violence against, adolescents through a national consensus process with all concerned stakeholders.

Involve adolescents at every stage of the formulation, implementation, monitoring and evaluation of national strategies and programmes to eliminate all types of exploitation and violence against adolescents.

- Establish a national coordination council, consisting of representatives of all parties concerned (i.e., government, NGOs, private organisations, social action groups, and international organisations) to strengthen and coordinate intra-country efforts to eliminate all types of exploitation of, and violence against, adolescents.
- Review existing laws and identify gaps and take necessary corrective legal steps. Existing laws should be amended where needed and new laws formulated as necessary to ensure stringent legal measures against all types of violence and exploitation against adolescents. Identify bottlenecks in the implementation of existing laws against the repression and abuse of women and children. Develop appropriate strategies for monitoring and implementing such laws.
- Identify factors inhibiting the rehabilitation of sexually abused/exploited girls in societies and develop appropriate strategies and programmes of action for their rehabilitation. Set up rehabilitation centers for drug addicts and sexually abused adolescents, both boys and girls.

**(b) Strategies at the Regional Level**

Among the strategies suggested to eliminate exploitation, of and violence against, adolescents at regional level are the following:

- Adopt a declaration by SAARC countries on the rights of adolescents, guaranteeing their rights to protect themselves against all types of violence and exploitation.
- Formulate a comprehensive regional strategy and programme of action to address all types of violence and exploitation against adolescents, including drug trafficking and trafficking of girls. Convene a regional (SAARC) summit on violence and exploitation of adolescents, with the participation of all concerned stakeholders.
- Establish a regional cooperation network, consisting of all parties concerned (governments, NGOs, private organizations, social action groups and international organisations) to strengthen and coordinate inter-country efforts to eliminate all types of exploitation and violence against adolescents.



## List of Tables

**Table 1: Literacy Rate of the Early (10-14 Years) and Late Adolescent (15-19 Years) Population by Sex, SAARC Countries**

Country	Year	Literacy Rate by Age/Sex								Overall Literacy Rate for the Population 6 Years and Above		
		10-14				15-19				Male	Female	Total
		Male	Female	Total	F/M Ratio	Male	Female	Total	F/M Ratio			
Bangladesh	1995	48.5a/	48.6a/	48.5a/	100	61.1a/	59.1a/	60.2a/	97	38.9b/	25.5b/	32.4b/
Bhutan	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
India	92/93	82.1	64.1	73.4	78	80.5	56.2	68.1	70	68.8	43.3	56.3
Maldives	1990	93.3	95.2	94.2	102	97.6	98.0	97.8	100	90.0	91.0	90.5
Nepal	1991	76.0	49.3	63.2	65	71.5	38.6	54.7	54	54.5	25.0	39.6
Pakistan	91/92	69.2	47.3	58.4	68	69.8	44.1	57.5	63	52.8	26.3	39.9
Sri Lanka	1994	94.8	95.7	95.3	101	94.4	95.1	94.8	100	92.5	87.9	90.1

NA = Not Available.

**Sources:** 1. **Bangladesh:**

a/ Bangladesh Bureau of Statistics. *Survey on Household and Population Characteristics*, 1995.

b/ Bangladesh Bureau of Statistics. *Population and Housing Census*, 1991.

2. **India:** *National Family Health Survey 1992-93*, 1995

3. **Maldives:** *Population and Housing Census*, 1990.

4. **Nepal:** *Population and Housing Census*, 1991.

5. **Pakistan:** *Women and Men in Pakistan*, 1995.

6. **Sri Lanka:** *Demographic Survey*, 1994.

**Table 2: Gross and Net Enrolment Ratio of the Adolescent Population at Primary Level by Sex and Proportion First Graders Reaching Final Grade of Primary School, SAARC Countries**

Country	Year	Gross/Net Enrolment Rate at Primary Level by Sex						% of Grade 1 Enrolment Reaching Final Grade of Primary School
		Gross Enrolment			Net Enrolment (1993-97) b/			
		Male	Female	F/M Ratio	Male	Female	F/M Ratio	
Bangladesh a/	1993	128	105	82	82	82	100	47
Bhutan b/	90-95	31	19	61	-	-	-	82
India a/	1993	113	91	81	75	61	81	62
Maldives b/	90-95	136	133	98	-	-	-	93
Nepal a/	1993	129	87	67	80	60	75	52
Pakistan a/	1993	80	49	61	71	62	87	48
Sri Lanka b/	90-95	105	105	100	100	100	100	98

**Source:** a/ Jones, Gavin. 'Population Dynamics and Their Impact on Adolescents in the ESCAP Region', *Asia-Pacific Population Journal*, Vol. 12, No. 3, 1997.

b/ UNICEF. *The State of World's Children*, 1998.

**Table 3: Gross Enrolment Rate of the Adolescent Population at Secondary Level by Sex, SAARC Countries**

Country	Year	Gross Enrolment Rate		
		Male	Female	Female/Male Ratio
Bangladesh	1993 a/	26	12	46
Bhutan	1990-95 b/	7	2	29
India	1993 a/	60	37	62
Maldives	1990-95 b/	49	49	100
Nepal	1993 a/	46	23	50
Pakistan	1993 a/	29	13	45
Sri Lanka	1990-95 b/	71	78	110

**Source:** a/ Same as in 'a' of Table 2.  
b/ Same as in 'b' of Table 2.

**Table 4: Labour Force Participation Rate of the Early and Late Adolescent Population by Sex, SAARC Countries**

Country	Year	Labour Force Participation Rate by Age					
		10-14			15-19		
		Male	Female	Total	Male	Female	Total
Bangladesh a/	1990/91	32.3 d/	6.6 d/	20.3 d/	72.8	59.5	66.8
Bhutan	-	-	-	-	-	-	-
India b/	1991	5.66 (5-19)	5.07 (5-19)	5.38 (5-19)	43.8	26.2	35.6
Maldives a/	1990	3.8	1.6	-	46.8	13.6	30.1
Nepal c/	1991	18.4	28.5	23.3	50.0	49.3	49.4
Pakistan a/	1993/94	-	-	-	52.3	33.4	33.4
Sri Lanka a/	1995	-	-	-	28.5	23.5	18.2

**Source:** a/ Jones, Gavin. 'Population Dynamics and Their Impact on Adolescents in the ESCAP Region', *Asia-pacific Population Journal*, Vol. 12, No. 3, 1997.  
b/ Computed by Professor Ashish Bose from Table B.1 Economic Table, *Population Census of India*, 1991.  
c/ Central Bureau of Statistics. *Population and Housing Census of Nepal*, 1991.  
d/ Bangladesh Bureau of Statistics. *Population and Housing Census*, 1991.

**Table 5: Unemployment Rate Among the Late Adolescent Population (15-19 Years) by Sex, SAARC Countries**

Country	Unemployment Rates	
	Female	Male
Bangladesh (1989)	3.2 *	3.3 *
Bhutan	-	-
India (1981)	5.6	13.9
Maldives (1990)	3.6 *	1.9 *
Nepal	10.0	21.2
Pakistan (1994)	11.9	8.4
Sri Lanka (1995)	58.3	41.0

**Note:** \* The age group is 10-19 (under 20 years).

**Source:** **India, Pakistan and Sri Lanka:** Jones, Gavin. "Population Dynamics and Their Impact on Adolescents in ESCAP Region", *Asia-Pacific Population Journal*, Vol. 12, No. 3, 1997.

**Bangladesh:** UN, *Women of Bangladesh, A Country Profile*, 1995.

**Maldives:** Ministry of Planning, Human Resources and Environment, *Analytical Report on the 1985 & 1990 Population and Housing*, 1996.

**Nepal:** Central Department of Population Studies, *Employment Survey*, Tribhuvan University, Nepal, 1995.

**Table 6: Percentage of Women 20-24 who were First Married by Exact Age 12, 15, 18, 20; and Median Age at First Marriage Among Women 20-49 Age, SAARC Countries**

Country	Percentage of Women who were First Married by Exact Age				Median Age at First Marriage		
	12	15	18	20	20-24	20-49	25-49
Bangladesh (1993-94)	7	47.2	73.3	82.1	15.3	14.4	14.1
Bhutan	NA	NA	NA	55.4	NA	NA	NA
India (1992-93)	11.8	26.1	54.2	71.4	17.4	16.4	16.1
Maldives (1990)	NA	NA	NA	NA	NA	NA	NA
Nepal (1996)	NA	19.1	60.3	75.7	17.1	16.4	16.2
Pakistan (1994-95)	2.2	33.4	71.9	86.3	16.9	NA	17.3
Sri Lanka (1993)	NA	1	12	24	NA	NA	22.4

**Source:** **Bangladesh:** *Bangladesh Demographic and Health Survey 1993-1994*, 1994.

**Bhutan:** Health Division, *Report on National Health Survey*, June 1994, Thimphu, Bhutan, January 1996.

**India:** *National Family Health Survey 1992-93*, August 1995.

**Nepal:** *Nepal Family Health Survey 1996*, March 1997.

**Pakistan:** *Pakistan Contraceptive Prevalence Survey 1994-95*, Final Report, 1998.

**Sri Lanka:** Singh, S. et.al. 'Early Marriage Among Women in Developing Countries', *International Family Planning Perspective*, 22, 148-157, 1996.

**Table 7: Percentage of Women 15-19 who are Mothers or Pregnant with their First Child According to Current Age, SAARC Countries**

Country/ Current Age	Percentage Who Are:		Percentage Who Have Begun Child Bearing	Number of Women
	Mothers	Pregnant with First Child		
<b>Bangladesh</b>				
15	6.8	3.8	10.6	615
16	17.1	6.2	23.4	566
17	32.1	6.5	38.7	463
18	38.5	6.5	45.1	539
19	54.4	4.7	59.2	382
Total	27.4	5.6	33.0	2566
<b>India*</b>				
13-16	24.5	11.7	36.1	2170
17-19	52.4	11.7	64.1	7277
Total	46.0	11.7*	57.7	9447
<b>Nepal</b>				
15	1.1	2.1	3.2	485
16	6.4	5.4	11.8	469
17	15.0	7.8	22.8	428
18	31.2	4.8	36.0	449
19	44.1	6.6	50.7	399
Total	18.7	5.3	23.9	2229
<b>Pakistan</b>				
15	3.0	2.5	5.5	173
16	3.7	2.5	6.1	381
17	7.6	5.4	13.0	260
18	15.1	3.8	18.9	630
19	27.4	3.3	30.6	276
Total	12.2	3.5	15.7	1720

\* refers to ever married women age 13-19.

**Source:** Same as in Table 8.

**Table 8: Age-specific Fertility Rates, SAARC Countries**

Age	Age-specific Fertility Rates						
	Bangladesh (1996/97)	Bhutan (1994)	India (1992/93)	Maldives (1990)	Nepal (1996)	Pakistan (1996/97)	Sri Lanka (1993)
15-19	0.147	0.120	0.116	0.106	0.132	0.082	0.035
20-24	0.192	0.267	0.231	0.286	0.266	0.245	0.109
25-29	0.150	0.242	0.170	0.303	0.237	0.275	0.134
30-34	0.096	0.195	0.097	0.270	0.154	0.212	0.104
35-39	0.044	0.174	0.044	0.199	0.087	0.145	0.054
40-44	0.018	0.095	0.015	0.096	0.031	0.071	0.014
45-49	0.006	0.024	0.005	0.023	0.012	0.023	0.002
Total 15-49	0.653	1.117	0.678	1.283	0.919	1.053	0.452
TFR	3.27	5.58	3.39	6.42	4.60	5.26	2.26

**Source:** Bangladesh: *Demographic and Health Survey 1996/97, 1997.*

Bhutan: *Report on National Health Survey 1992-93, 1995.*

India: *National Family Health Survey 1992/93, 1995*

Maldives: Ministry of Planning and Environment, *Population and Housing Census of Maldives 1990, 1991.*

Nepal: *Family Health Survey 1996, 1997.*

Pakistan: *Pakistan Fertility and Family Planning Survey 1996/97, 1998.*

Sri Lanka: *Demographic and Health Survey, 1993.*

**Table 9: Trend in Share (Percentage) of All Births Occurring to Adolescent Girls Aged 15-19, SAARC Countries**

Year	Percentage of All Births Occurring to Adolescent Girls				
	Bangladesh	India	Nepal	Pakistan	Sri Lanka
1971-75	8.65	1971 = 11	1976 = 11.45	1975 = 10.39	1976 = 4.63
1984-88	17.84	1981 = 13	1981 = 8.91	1979/80 = 15.91	1982-87 = 6.74
1989-91	20.81	1993/94 = 17	1986 = 6.04	1984/85 = 5.33	1988-93 = 7.74
1991-93	20.58		1991 = 9.62	1990-91 = 7.77	
1994-96	22.27		1996 = 14.34	1994-95 = 3.90 1994-96 = 7.80	

**Source:** Various Demographic and Health Surveys (same as in Table 8).

**Table 10: Percentage of Adolescent Births that are Unplanned, SAARC Countries**

Country	Reference Year	% of Unplanned Births 1/
Bangladesh	1993/94	21
India	1992/93	16
Pakistan	1990/91	11
Sri Lanka	1987*	30

Source: Same as in Table 8.

\* Allan Guttmacher Institute, *Into a New World, Young Women's Sexual and Reproductive Lives*, 1998.

1/ Those who wanted no more births and/or wanted to have at a later date.

**Table 11: Percentage of Currently Married Adolescent Girls with Unmet Need for Family Planning, and the Total Demand for Family Planning Services, SAARC Countries**

Country/ Age	Unmet Need for Family Planning 1/			Met Need for Family Planning	Total Demand for Family Planning	Percentage of Demand Satisfied	
	For Spacing	For Limiting	Total	Total			
Bangladesh	10-14	21.3	0.8	22.1	15.6	37.7	41.4
	15-19	17.8	0.9	18.7	32.9	51.6	63.8
India	10-14	29.6	3.6	33.2	4.7	37.9	12.4
	15-19	28.2	2.3	30.4	7.1	37.5	18.9
Nepal	10-14	-	-	-	-	-	-
	15-19	38.9	1.6	40.5	6.5	47.0	13.8
Pakistan	10-14	-	-	-	-	-	-
	15-19	-	-	21.7*	6.2*	27.9*	22.2*

Note: 1/ Unmet need for spacing includes women who are not using any method of family planning but say they want to wait two or more years for their next birth. While unmet need for limiting refers to women who are neither pregnant nor amenorrhic, and who are not using any method of family planning but want no more children.

\* Pakistan Contraceptive Prevalence Survey 1994-95.

Source: Same as in Table 8.

**Table 12: Attitudes of Couples Towards Family Planning (FP), SAARC Countries Percent Distribution of Non-sterilised Currently Married Women who know of a Contraceptive Method by Wife's Attitude Toward Family Planning and Wife's Perception of her Husband's Attitude Toward Family Planning, According to Respondent's Age Group, SAARC Countries**

Country/ Age Group	Attitudes Towards Family Planning									
	Respondent Approves			Respondent Disapproves			Respondent Unsure	Total	Number of Respondents	
	Both Approve	Husband Dis-approves	Husband's Attitude Unknown	Husband Approves	Husband's Attitude Unknown	Both Disapproves				
India	10-14*	56.4	7.0	11.6	1.3	9.3	11.5	1.0	100.0	55036
	15-19	42.0	3.7	24.2	2.2	16.9	8.8	2.2	100.0	273
		56.5	5.6	16.9	1.2	10.0	8.9	0.8	100.0	7927
Nepal	10-14	68.8	10.2	11.1	0.7	1.6	4.6	3.0	100.0	6462
	15-19	-	-	-	-	-	-	-	-	273
		63.2	6.5	21.7	0.4	1.3	3.8	3.0	100.0	930
Pakistan	10-14	34.1	12.5	15.0	2.1	13.4	22.4	0.5	100.0	4729
	15-19	-	-	-	-	-	-	-	-	277
		33.3	10.5	13.9	2.6	19.6	15.3	1.2	100.0	

**Note:** (\*) refers to 13-14 age group.

**Source:** Same as in Table 8

**Table 13: Among Mothers (15-19 Years) of Children Under Five Years, Mean Height and Percentage of Women Shorter than 145 Centimetres, Mean Body Mass Index (BMI) and the Percentage of Women whose BMI is Less than 18.5 (kg/m<sup>2</sup>), by Age of Mother: Nepal and Bangladesh**

Country	Age	Height			BMI		
		Mean	Percentage <145 cm	Number of Women	Mean	Percentage <18.5 (kg/m <sup>2</sup> )	Number of Women
Nepal (1996)*	15-19	150.1	13.3	393	19.7	30.6	336
	20-24	150.9	13.3	1,192	19.8	29.8	981
Bangladesh (1996-97)	15-19	149.9	18.7	762	18.6	50.1	654
	20-24	150.2	18.3	1,314	18.7	53.6	1,155

**Note:** (\*) refers to women who had a birth in the three years preceding the survey.

**Source:** Nepal: Nepal Family Health Survey 1996, 1997.  
Bangladesh: Demographic Health Survey 1996-97.

**Table 14: Energy and Protein Intake by Males and Females of Different Age Groups: India and Pakistan**

Country	Age Group	Energy, kcal/d				Protein, g/d			
		RDA		% of RDA Fulfilled		RDA		% of RDA Fulfilled	
		Female	Male	Female	Male	Female	Male	Female	Male
India (1975-80)	Adolescents								
	10-12	1950	2150	76.1	72.1	62	59	66.1	72.7
	13-15	2050	2400	79.0	73.9	65.4	76	65.6	64.6
	16-18	2050	2600	84.0	74.5	66	81	72.3	72.3
	Adults	1800	2350	99.4	92.3	50	60	100.8	100.3
Pakistan (1985-87)	6-15	2100	2200	86.4	86.8	45	45	117.8	122.2
	Adult	2100	2900	106.5	87.0	61	72	104.9	101.4
	Pregnant	2500	-	86.6	-	70	-	88.6	-
	Lactating	3100	-	74.1	-	82	-	84.1	-

**Note:** RDA = Recommended Daily Allowance.

**Source:** India: UNICEF. *Children and Women in India - A Situation Analysis*, 1990.

Pakistan: Federal Bureau of Statistics. *Women and Men in Pakistan*, 1995.

**Table 15: Percent Distribution of Live Births in the Five Years Preceding the Survey by Source of Antenatal Care during Pregnancy according to Mother's Age at Birth: Selected SAARC Countries**

Country	Mother's age at birth	Antenatal care provider*						Total	Number of Births
		Doctor	Trained nurse/ Midwife**	Traditional birth attendant	Other	No one	Don't know/missing		
Bangladesh (1996-97)	< 20	20.4	6.8	0.2	1.9	70.7	-	100	1997
	20-34	19.8	6.7	0.3	2.1	71.1	-	100	3890
	35+	12.4	7.4	0.0	2.2	78.0	-	100	343
India (1992-93)	< 20	40.8	9.8	0.4	13.3	34.6	1.1	100	11,514
	20-34	40.8	9.4	0.3	12.6	36.0	0.9	100	35,258
	35+	22.5	5.9	0.3	13.1	57.2	1.1	100	2,597
Nepal (1996)	< 20	16.5	33.2	0.7	2.5	44.3	2.7	100	817
	20-34	12.6	26.3	0.8	1.7	56.1	2.4	100	3,136
	35+	6.1	15.9	0.8	1.5	74.2	1.5	100	422
Pakistan (1990-91)	< 20	20.3	3.8	2.7	0.1	72.6	0.5	100	746
	20-34	24.4	4.2	2.6	-	67.2	1.5	100	4843
	35+	13.6	4	1.3	-	80.8	0.3	100	818

**Note:** \* If the respondent mentioned more than one provider, only the most qualified provider is considered.

\*\* For Pakistan it includes lady health worker and trained birth attendant; for Nepal, it includes VHW, MCH worker and other health professionals (health assistant and health post staff)

**Source :** Same as in Table 8.

**Table 16: Percent Distribution of Births in the Five Years Preceding the Survey by Number of Tetanus Toxoid Injections during Pregnancy according to Mother's Age at Birth: Selected SAARC Countries**

Country	Mother's age at birth	Number of Tetanus Toxoid injections					Number of Births
		None	One dose	Two doses or more	Don't know/missing	Total	
<b>Bangladesh (1996-97)</b>							
	< 20	20.7	12.7	66.4	0.2	100.0	1,997
	20-34	25.4	16.9	57.4	0.3	100.0	3,890
	35+	45.9	12.3	41.6	0.2	100.0	343
<b>India (1992-93)*</b>							
	< 20	37.0	7.7	55.1	0.1	100.0	11,514
	20-34	37.8	6.9	55.1	0.2	100.0	35,258
	35+	62.8	6.8	30.3	0.1	100.0	2,597
<b>Nepal (1996)**</b>							
	< 20	44.0	15.0	40.7	0.4	100.0	817
	20-34	53.5	13.6	32.6	0.3	100.0	3,136
	35+	73.6	9.7	16.7	0.0	100.0	422
<b>Pakistan (1990-91)</b>							
	< 20	71.3	7.2	21.5	-	100.0	746
	20-34	68.7	6.5	24.6	0.2	100.0	4,843
	35+	76.5	5.7	17.3	0.5	100.0	818

**Note:** (\*) For India, refers to live births during the four years preceding the survey.

(\*\*) For Nepal, refers to live births during the three years preceding the survey.

**Source:** Same as in Table 8.

**Table 17: Percent Distribution of Live Births in the Five Years Preceding the Survey by Place of Delivery and Type of Assistance during Delivery according to Mother's Age at Birth, Selected SAARC Countries**

Country/ Mother's age at birth	Place of delivery		Assistance during delivery								Number of Births
	Health facility	At home	Doctor	Trained nurse/ Midwife**	Trained TBA	Traditional birth attendant	Friends/ Relatives/ Other	No one	Don't know/ missing	Total	
<b>Bangladesh (1996-97)</b>											
< 20	3.4	95.4	4.8	2.6	7.0	56.7	23.0	0.6	0.2	100	1997
20-34	4.5	94.6	5.6	2.9	7.3	57.2	24.8	1.5	0.2	100	3890
35+	3.3	96.6	3.8	3.1	5.8	60.1	23.3	3.9	0.0	100	343
<b>India (1992-93) 1/</b>											
< 20	24.0	74.8	20.8	13.5	-	35.1	29.7	0.4	0.5	100	11,514
20-34	27.0	72.1	22.6	12.6	-	34.8	28.8	0.6	0.5	100	35,258
35+	12.5	86.1	10.3	8.8	-	41.3	37.6	1.0	1.0	100	2,597
<b>Nepal (1996) 2/</b>											
< 20	8.8	90.7	6.9	6.8	-	29.2	52.4	4.6	0.1	100	817
20-34	7.6	91.6	5.7	3.9	-	21.4	57.6	11.3	0.0	100	3,136
35+	4.3	93.9	4.0	2.6	-	17.8	55.5	19.4	0.8	100	422
<b>Pakistan (1990-91)</b>											
< 20	11.0	88.5	10.3	6.8	13.7	55.4	11.1	1.9	0.9	100	746
20-34	14.6	83.7	13.4	6.6	16.8	50.6	3.3	1.4	1.7	100	4543
35+	6.1	91.4	8.5	4.8	18.5	57.7	8.1	2.3	0.6	100	818

**Note:** 1/ refers to live births during four years preceding the survey; 2/ refers to live births during three years preceding the survey.

If the respondent mentioned more than one provider, only the most qualified provider is considered.

\*\* For Pakistan it includes lady health worker. For Nepal, it includes VHW, MCH worker and other health professionals (health assistant and health post staff).

**Source:** Same as in Table 8

**Table 18: Neonatal, Infant and Child Mortality Rates for the Ten-year Period Preceding the Survey, by Age of Mother at Birth, SAARC Countries**

Country	Age of Mother at Birth 1/	Neonatal Mortality (NN)	Infant Mortality (1q0)	Under-five Mortality (5q0)
Bangladesh*	<20	70.2	106.1	145.0
	20-29	46.6	79.3	117.2
	30-39	47.3	87.2	124.7
India	<20	70.8	107.3	140.9
	20-29	44.8	75.8	107.8
	30-39	53.7	91.1	122.3
Nepal	<20	83.4	120.1	158.9
	20-29	48.0	79.5	127.7
	30-39	62.3	103.9	152.8
Pakistan	<20	70.1	121.3	144.8
	20-29	50.9	90.8	116.7
	30-39	48.5	83.9	113.0

**Note: 1/** Rates for age group 40-49 are not shown for other countries because they are based on fewer than 250 exposed persons. (\*) For Bangladesh, age of mother at birth 30-39 refers to age group 30-49.

**Source: Bangladesh:** *Demographic and Health Survey 1996-97, 1997*

**India:** *National Family Health Survey 1992-93, 1995.*

**Nepal:** *Nepal Family Health Survey 1996, 1997.*

**Pakistan:** DHS. *Pakistan Demographic and Health Survey 1990-91, 1992.*

**Source:** Same as in Table 8.

**Table 19: Percentage distribution of ever-married women who have ever heard of AIDS, percentage who received information about AIDS from specific sources and mean number of sources of information about AIDS by age, SAARC countries**

Age/sex	Percentage who have heard of AIDS	Number of women	Source of knowledge among those who have heard of AIDS								Mean No. of sources
			Radio	TV	News Paper	Pamphlets	Health worker	Friends/Relatives	Other Sources	No. of women who know of AIDS	
<b>Bangladesh</b>	<b>18.7</b>	<b>9127</b>	<b>8.0</b>	<b>13.0</b>	<b>4.3</b>	<b>1.1</b>	<b>0.6</b>	<b>7.2</b>	<b>2.3</b>	<b>1707</b>	<b>2.0</b>
15-19	17.2	1446	7.6	11.7	2.6	0.6	0.4	6.8	1.7	249	1.8
20-24	19.7	1727	8.8	14.4	3.8	1.6	0.6	7.6	2.7	340	2.0
25-29	20.2	1905	9.2	14.5	5.7	1.2	0.6	6.6	2.5	385	2.0
30-39	19.1	2530	7.3	13.0	4.8	0.7	0.9	7.9	2.1	483	1.9
40-49	16.5	1518	7.1	10.8	3.7	1.4	0.2	6.8	2.7	250	2.0
<b>Nepal</b>	<b>26.8</b>	<b>8429</b>	<b>78.7</b>	<b>30.4</b>	<b>17.7</b>	<b>10.8</b>	<b>9.0</b>	<b>45.3</b>	<b>14.6</b>	<b>2263</b>	<b>2.0</b>
15-19	24.3	982	79.0	22.9	16.9	9.2	7.9	42.7	19.2	238	1.9
20-24	32.9	1626	80.8	26.8	25.9	12.3	8.6	44.1	11.9	535	2.0
25-29	29.0	1594	78.2	35.1	16.8	12.2	8.9	44.4	17.7	463	2.0
30-39	27.2	2480	79.4	32.3	14.7	10.1	10.0	47.9	12.5	674	2.0
40-49	20.2	1747	74.7	31.3	7.9	8.9	8.6	45.0	15.7	353	1.8

Source: Nepal: Nepal Family Health Survey, 1996.

Bangladesh: Bangladesh Demographic and Health Survey, 1996-97.

**Table 20: Contraceptive Knowledge Among Adolescents (15-19 years) in Selected SAARC Countries**

Country and Survey Year	Contraceptive Use			
	% Women 15-19 Who Know			
	Fertile Days in the Menstrual Cycle	About the Pill, Injectable, IUD or Implant	About the Condom	Where to obtain a Modern Method
Bangladesh (1993-94)	-	99	85	70
India (1992-93)	-	63	47	80
Pakistan (1990-91)	3	59	18	32
Sri Lanka (1987)	25	85	48	90

**Source:** The Allan Gattmacher Institute. *Into a New World: Young Women's Sexual and Reproductive Lives*, 1997.



# Annex I

List of Participants to the South Asia Conference on Adolescents, New Delhi, 21-23 July, 1998

S.N.	Name	Designation	Organization	Country
1.	Mr. Aftab Uddin Khan	Joint Secretary	Ministry of Health & Family Welfare	Bangladesh
2.	Ms. O.N. Siddika Khanam	Senior Assistant Secretary	Ministry of Education	Bangladesh
3.	Ms. Masuda Binte Kader	Executive Director	Jatiya Mahila Sangstha	Bangladesh
4.	Ms. Firoza Begum	Deputy Director	Dept. of Youth Development, Ministry of Youth and Sports	Bangladesh
5.	Dr. Morshedul Karim Chowdhury	Medical Officer (MCH)	Directorate of Family Planning, Ministry of Health & Family Welfare	Bangladesh
6.	Mr. M. Ali Siddiqui	Thana Family Planning Officer	Directorate of Family Planning, Ministry of Health & Family Welfare	Bangladesh
7.	Mr. Rajib Iqbal	Adolescent (College Student)	Ministry of Health & Family Welfare	Bangladesh
8.	Ms. Susmita Nazreen	Adolescent (College Student)	Ministry of Health & Family Welfare	Bangladesh
9.	Dr. Rinchen Chopel	Programme Director (Team Leader)	Information, Education & Communication for Health Ministry of Health and Education	Bhutan
10.	Mr. Aum Yandey Penjore	Planning Officer	Education Division	Bhutan
11.	Mr. Nado Rinchen	Programme Officer	Youth Guidance and Career Counselling Section	Bhutan
12.	Mr. Mencha Wangdi	(Representative of NGO)	Royal Society for Protection of Nature	Bhutan
13.	Ms. Sonam Wangmo	Programme Officer, STD/AIDS	Health Division Ministry of Health and Education	Bhutan
14.	Ms. Pem Dem	Scoutmaster	Changangkha Junior High School	Bhutan
15.	Ms. Yuden	Scoutmaster	Dechencholing Junior High School	Bhutan
16.	Mr. Ugyen Dhendup	Adolescent (Class XII Arts)	Yangchenphug High School	Bhutan
17.	Ms. Sonam Pema	Adolescent (Class XII Commerce)	Yangchenphug High School	Bhutan
18.	Ms. RazeenaThuthu Didi,	Director Welfare Services	Ministry of Women's Affairs & Social Welfare	Maldives
19.	Ms. Mairmoona Aboobakuru	Information Officer	Department of Public Health	Maldives
20.	Ms. Jameela Ali	Deputy Principle	Aminiya School	Maldives
21.	Ms. Aishath Rasheed	Youth Officer	Ministry of Youth & Sports	Maldives
22.	Mr. Hussain Rasheed	Member	Society for Health Education	Maldives
23.	Ms. Aminath Mufeed	Member	FASHAN	Maldives
24.	Mr. Nishwan Abbas	Adolescent (Grade 10)	Majeediyaa School	Maldives
25.	Ms. Aashiyath Mohamed	Adolescent (Grade 10)	Southern Secondary School	Maldives
26.	Ms. Fathimath Nasheeda Mohamed	Planning Officer	Ministry of Health	Maldives
27.	Ms. Maryam Jeeza	Senior Secretary	Institute of Health Sciences	Maldives
28.	Mr. Deepak Subedi	Section Officer	Ministry of Youth, Sports and Culture	Nepal
29.	Mr. Prem B. Ghale	Section Officer	Ministry of Youth, Sports and Culture	Nepal
30.	Ms. Mukta Dhakal	Section Officer	Ministry of Women and Social Welfare	Nepal
31.	Mr. Gajendra Lal Pradhan	Section Officer	Ministry of Education	Nepal
32.	Mrs. Bunu Shrestha	Coordinator	Pop.Ed. Project, Ministry of Education	Nepal
33.	Dr. L.R. Pathak	Director	Family Health Division, Ministry of Health	Nepal
34.	Dr. Sudha Sharma	Gynaecologist	Maternity Hospital, Ministry of Health	Nepal
35.	Dr. T.N. Jha	Director	Ministry of Health	Nepal

S.N.	Name	Designation	Organization	Country
36.	Mr. Nava Raj Marahatta	Adolescent	Ministry of Women and Social Welfare	Nepal
37.	Ms.Indira Adhikari	Adolescent	Ministry of Women and Social Welfare	Nepal
38.	Mr. J.P. Aryal	Under Secretary	Ministry of Foreign Affairs	Nepal
39.	Mr. Hari P. Khanal	Dy. Director	Family Planning Association of Nepal	Nepal
40.	Ms.Nayantara Kakshapti	Adolescent ('O' Level)	Shuva Tara School	Nepal
41.	Ms. Mehtab Rashidi	Secretary	Women's Development Department, Government of Sindh, Karachi	Pakistan
42.	Mr. Saad Subhani	Director (SMC)	MoPW, Islamabad	Pakistan
43.	Ms. Naseem Shahid	Additional Secretary	PWD, Karachi	Pakistan
44.	Dr. Altaf Hussain Bosan	Epidemiologist	National AIDS Programme National Institute of Health, Islamabad	Pakistan
45.	Dr. Saqib Ali Khan	Deputy Educational Adviser	Ministry of Education, Islamabad	Pakistan
46.	Mr. Daud Saqlain	Assistant Director	Women, Youth & Environment Section, Family Planning Association of Pakistan, Lahore	Pakistan
47.	Ms. Salma Amina Bashir	Programme Co-ordinator	PDP/SAP & SWM, Youth Commission for Human Rights, Lahore	Pakistan
48.	Mr. Naveed Iqbal	Adolescent & Member	Pakistan Boy Scouts Association, Government High School Machan, Pishin, Baluchistan	Pakistan
49.	Ms. Huma Rasheed	Adolescent (Class 10) Member	Youth Commission for Human Rights Lahore	Pakistan
50.	Ms. Mudaffra Munir	Adolescent		Pakistan
51.	Mr. Saifur Rehman	Adolescent		Pakistan
52.	Dr. (Ms.) Deepthi Perera	Director/Youth	Elderly Disabled and Displaced	Sri Lanka
53.	Dr. S.W. Pathinayake	DPDHS	Matara	Sri Lanka
54.	Dr.((Ms.)Lanka Obeysekera	Regional Epidemiologist	Galle	Sri Lanka
55.	Dr.(Ms.) U. Jathun Arachchi	Divisional Director of Health Services	Angunakolapelossa	Sri Lanka
56.	Mr. Viraj Abeysinghe	Adolescent		Sri Lanka
57.	Mr. S. A. Dissanayake	Project Officer	National Institute of Education, Ministry of Education	Sri Lanka
58.	Ms.Chandra Senaratne	Assistant Director	National Youth Services Council	Sri Lanka
59.	Mrs. Kanthi Wijetunge	Director	Women's Bureau	Sri Lanka
60.	Ms. N.T. Vaidyaratne	Adolescent (Island's First)	Visaka Vidyalaya Colombo	Sri Lanka
61.	Mr. L.S. Jayasinghe	Adolescent (Islands 6th and District First)	Bandarawela Mahavidyalaya	Sri Lanka
62.	Mrs. Rosie Senanayake	Goodwill Ambassador	UNFPA	Sri Lanka
63.	Mr. Gautam Basu	Joint Secretary	Ministry of Health and Family Welfare, Government of India Nirman Bhavan, New Delhi	India
64.	Dr. Sethumadhav Rao	Joint Education Adviser	Dept. of Education, Ministry of Human Resource Development, Shastri Bhavan, New Delhi	India
65.	Ms. Neelam Kapoor	Deputy Director	National AIDS Control Organisation, Nirman Bhavan, New Delhi 110011	India
66.	Ms. Asha Das	Secretary	Department of Women & Child Development, Ministry of Human Resource, Shastri Bhavan, New Delhi	India
67.	Dr. Anubha Ghosh	Assistant Commissioner	(MH), Department of Family Welfare, Ministry of Health & Family Welfare, Nirman Bhavan, New Delhi - 110011	India
68.	Mr. N.N. Sinha	Deputy Secretary	Department of Family Welfare Ministry of Health and Family Welfare, Nirman Bhavan, New Delhi 110011	India

S.N.	Name	Designation	Organization	Country
69.	Dr. K. Pappu	Acting Director	Child in Need Institute (CINI), Village Daulatpur, P.O. Pailan, Via Joka 743512 West Bengal, Calcutta	India
70.	Master Matiur Rahamana Molla	Adolescent	c/o CINI	India
71.	Maser Rajibul Naskar	Adolescent	c/o CINI	India
72.	Dr. Sunil Mehra	Executive Director	Mamta Health Institute (Mother & Child), House No. 33A, Saidulajab, Opp. 'D' Block Saket Road, New Delhi 110017	India
73.	Ms. Sauda Saifi	Adolescent	Janta Jeevan Camp, Tigri, Khanpur, New Delhi	India
74.	Ms. Rajjo Rani Thakur	Adolescent (Class 10)	A-457, Janta Jeevan Camp, Tigri, Khanpur, New Delhi	India
75.	Dr. Ramneek Sharma	Director & Programme Co-ordinator	SWACH Sector 16 Panchkula 134109, Haryana	India
76.	Dr. Tripta Bhasin	Director	Central Health Education Bureau Ministry of Health, Kotla Road, Opp. Mata Sundari College, New Delhi 110002	India
77.	Dr. Sudha Tiwari	Managing Director	Pariwar Sewa Sansthan Defence Colony Market, New Delhi 110024	India
78.	Dr. M.P. Gupta	Deputy Director (Programme)	Nehru Yuvak Kendra Sangathan East Plaza, Indira Gandhi, Indoor Stadium New Delhi 110002	India
79.	Ms. Renuka Motihar	Consultant	CEDPA, Shantiniketan, New Delhi 110021	India
80.	Ms. Vinita Nathani	Executive Director	Prerana, Sarita Vihar (DDA SFS Flats) New Delhi 110044	India
81.	Ms. Rami Chhabra	Independent Consultant	Safdarjung Enclave, New Delhi	India
82.	Ms. Sagri Singh	Project Director	(Adolescent Girls Programme) Population Council, New Delhi	India
83.	Dr. Saramma Mathai	Independent Consultant	1 Underhill Road, Civil Lines, Delhi	India
84.	Ms. Violet Scott	Department for International Development (DFID)	Anand Niketan, New Delhi 110021	India
85.	Ms. Rekha Maslani	Chief of Health Services Division	USAID Qutab Institutional Area New Delhi 110016	India
86.	Ms. Poonam Muthreja	Country Coordinator	MacArthur Foundation Core C, Zone 5-A, India Habitat Centre, Lodhi Estate, New Delhi 110003	India
87.	Ms. Padma Seth	Adviser	National Commission for Women Deen Dayal Upadhyaya Marg New Delhi 110002	India
88.	Dr. Kirti Iyengar		Action Research & Training for Health (ARTH), Adinath Nagar Fatehpura, Udaipur 313004	India
89.	Mr. Dhruv K. Dey		Manjulika Foundation for Human Concerns, Pardi Road, Kadma, Jamshedpur 831005	India
90.	Mr. Suman Mukhuty	Adolescent (Class XI)	Jamshedpur, Bihar	India
91.	Ms. Puja Kumari	Adolescent (Class 9)	Jamshedpur, Bihar	India
92.	Mr. Maxwell Chettri	Adolescent (Class 10)	Jamshedpur, Bihar	India
93.	Ms. P. Smitha	Adolescent (Class 9th)	Jamshedpur, Bihar	India
94.	Mrs. Veena Nayyar	President	Women's Political Watch Hauz Khas Enclave, New Delhi 110016	India
95.	Ms. Mina Das	Secretary	Nishtha, Centre for the Development of Women & Child Village Subuddhipur, Depara, P.O. Baruipur, Dist. 24 Parganas (S) West Bengal 743302	India

S.N.	Name	Designation	Organization	Country
96.	Ms. Swati Bhattacharjee	The Telegraph	Prafulla Sirkar Street, Calcutta 700001	India
97.	Ms. B. Bhamathi	Independent Consultant	Type V-3 Lodhi Road Complex New Delhi 110003	India
98.	Dr. Rabia Mathai	Regional Health Advisor	International Federation of Red Cross and Red Crescent Societies, F-25A Hauz Khas Enclave New Delhi 110016	India
99.	Dr. D. Anand	President	Centre for Information Education & Communication, Defence Colony New Delhi 110024	India
100.	Dr. Raj Brahmabhatt		Family Planning Association of India, Bajaj Bhawan, Nariman Point Bombay 4000021	India
101.	Mr. Ashraf Ahmed	Director	Samajik Nav Chetan Samiti Kurmotola, Azamgarh 276001	India
102.	Mrs. Nandita Mathur	Consultant	New Delhi	India

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103.	Ms. Anju Sharma	Community Development Officer	Sansad Marg, New Delhi 110001	India
104.	Mrs. Pushpa Nadkarni	Joint Director (Guide) Bharat Scouts & Guides	Lakshmi Mazumdar Bhawan Marg, I.P. Marg, Post Box 7043, New Delhi 110003	India
105.	Ms. Nanda Krairiksh	Chief	Human Resources Development Section, Social Development Division ESCAP, Bangkok	Thailand
106.	Prof. Moegiadi	Director	UNESCO, Poorvi Marg, Vasant Vihar, New Delhi 110057	India
107.	Mr. Tarun Roy	Consultant	UNESCO, Poorvi Marg, Vasant Vihar, New Delhi 110057	India
108.	Dr. Suniti Acharya	Regional Adviser on Maternal & Child Health	World Health Organisation World Health House, New Delhi 110002	India
109.	Dr. Bhardwaj	Consultant Specialist in Maternal & Child Health	The World Bank Lodhi Estate, New Delhi 110003	India
110.	Ms. Chandni Joshi	Regional Programme Advisor	United Nations Development Fund for Women, Lodhi Estate, New Delhi 110003	India
111.	Ms. Jayashree Jayanand		UNHCR, 14 Jor Bagh, New Delhi 110003	India
112.	Dr. L.N. Balaji	Chief of Planning	UNICEF, Lodhi Estate, New Delhi 110003	India
113.	Dr. Sanjiv Kumar	Project Officer (Health)	UNICEF, Lodhi Estate, New Delhi 110003	India
114.	Dr. K. Suresh	Project Officer	UNICEF	India
115.	Ms. Alka Narang	UNDP	New Delhi	India
116.	Mr. Abdul Latif	Regional Representative	UNDCP India International Centre Bldg 2nd Floor, 40 Max Mueller Marg Lodhi Estate, New Delhi 110003	India

#### UNFPA HQ

117.	Ms. Imelda Henkin	Director	Asia and Pacific Division UNFPA	New York
118.	Ms. Nerina Perea	Deputy to the Director and Chief	South & West Asia Branch Asia and Pacific Division UNFPA	New York
119.	Ms. Elena Pozdorovkina	Program Officer	Asia and Pacific Division UNFPA	New York
120.	Ms. Delia Barcelona	Senior Technical Officer	Technical and Policy Division UNFPA	New York

S.N.	Name	Designation	Organization	Country
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#### UNFPA COUNTRY SUPPORT TEAM FOR CENTRAL AND SOUTH ASIA (CST), KATHMANDU

121.	Mr. Saad Raheem Sheikh	Director	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
122.	Mr. Rafiqul H. Chaudhury	Adviser, Population Policies/Development Strategies	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
123.	Dr. D. M. de Rebello	Adviser, Population Education	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
124.	Ms. Malicca Ratne Castelli	Adviser, IEC for RH/FP	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
125.	Ms. B. Pradhan	Adviser, Socio-Cultural and Operations Research	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
126.	Ms. Neera Shrestha	Management Officer	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal
127.	Ms. Toko Kato	Research Assistant	UNFPA Country Support Team for Central and South Asia (CST), Kathmandu	Nepal

#### UNFPA SOUTH ASIA OFFICES

128.	Ms. Choeki Ongmo	National Programme Officer	UNFPA Country Office	Bhutan
129.	Mr. Wasim Zaman	UNFPA Representative for India & Country Director for Bhutan	UNFPA Country Office	India
130.	Mr. Deepak Gupta	Consultant	UNFPA Country Office, New Delhi	India
131.	Mrs. Farah Usmani	Member, TSU	UNFPA Country Office, New Delhi	India
132.	Mrs. Firoza Mehrotra	GPD Programme Specialist	UNFPA Country Office, New Delhi	India
133.	Mrs. Mridula Seth	Member, TSU, Population Education	UNFPA Country Office, New Delhi	India
134.	Mrs. Shachi Grover	National Programme Assistant	UNFPA Country Office, New Delhi	India
135.	Mr. S.K. Alok, Nepal	UNFPA Representative	UNFPA Country Office	Nepal
136.	Mr. Francois Farah	UNFPA Representative	UNFPA Country Office	Pakistan
137.	Ms. Suneeta Mukherjee	UNFPA Representative for Sri Lanka & Country Director for Maldives	UNFPA Country Office	Sri Lanka

#### RESOURCE PERSONS

138.	Ms. Kushi Kabir	President	Nijera Kori	Bangladesh
139.	Dr. Saroj Pachauri	Asia Regional Director	Population Council of India, India Habitat Centre, New Delhi 110003	India
140.	Prof. Jay Satia	Executive Director	ICOMP	Malaysia
141.	Mr. Thirtha Bahadur Manandhar	Education Specialist	Administrative Staff College Kathmandu	Nepal
142.	Dr. Zeba Ayesha Sathar		Population Council	Pakistan
143.	Mr. Suman Mehta	Adviser on RH/FP Training	UNFPA CST, Bangkok	Thailand



# Annex II

United Nations Population Fund (UNFPA)  
South Asia Conference on Adolescents  
New Delhi, India, 21-23 July 1998

**Dates and Time** **Activities** **Resource Persons**

## Monday, 20 July 1998: Pre Conference Programme for Adolescent Consultations

*The Purpose is to: (a) orient adolescent girls and boys coming from the seven South Asian Countries, about UNFPA, ICPD, and the conference, b) provide a forum for discussion, interaction and contemplation on priority concerns of adolescents, as perceived by them, (c) to assist and encourage adolescents to articulate their concerns and perceptions, (d) identify about 4 adolescents (at least half of whom should be girls) to represent the adolescents and present their concerns and perceptions, through a report, during the plenary session-5 at the main conference, and (e) initiate a process of networking amongst participating adolescents.*

Dates and Time	Activities	Resource Persons
<b>Monday, 20 July 1998: Pre Conference Programme for Adolescent Consultations</b>		
<p><b>08:00 - 11:00</b>  <b>11:30 - 13:00</b>  <b>14:30-17:00</b>            14:30-14:45            14:45-15:00            15:00-15:20            15:20-16:10            16:10-16:30            16:30-17:00  <b>19:00-21:00</b></p>	<p><b>Visit to important monuments in New Delhi</b>  <b>Introductory and orientation session</b>  <b>Working sessions:</b>            a) UNFPA &amp; ICPD - The special focus on Adolescents            b) "Faces of the future" - A film on adolescents            c) Why a South Asia Conference on Adolescents?            d) Adolescents speak out on priority issues of concern to them            e) The Role of Adolescents in the Conference            f) Consolidation exercise  <b>Building Bridges Through Cultural Exchange</b></p>	<p>UNFPA &amp; CST             CST Team</p>
<b>Tuesday, 21 July 1998</b>		
<p><b>08:30 - 10:00</b>  <b>10:00 - 11:10</b>            10:00 - 10:05             10:05 - 10:20             10:20 - 10:30             10:30-10:40            10:40-10:50            10:50-11:00            11:00-11:10   <b>11:30-13:30</b>             11:30 - 12:10            12:10 - 12:50            12:50 - 13:30   <b>14:30 - 15:50</b>             14:30 - 15:10            15:10 - 15:50   <b>16:15 - 17:35</b>             16:15 - 16:55            16:55 - 17:35</p>	<p><b>Registration</b>  <b>Inaugural Session</b>            Welcome Statement             Keynote Address             Inaugural Address             "UN Systems Collaborative Efforts in the Social Sector"            Conference Statement            Faces of the Future: A film on the Adolescents in South Asia            Vote of Thanks   <b>Plenary Session 1: Country Papers</b>  <i>In this session the country delegation will review the situation of adolescents in their respective country, along with presentation by UNFPA Representatives to share UNFPA experiences and achievements; followed by discussions.</i>   <b>Presentation of Country Papers</b>            Bangladesh Country Paper: Adolescents' Health and Development – Issues and Strategies            Bhutan Country Paper            Maldives Country Paper   <b>Plenary Session 1 (Continued)</b>  <b>Presentation of Country Papers</b>            Nepal Country Paper: Adolescents' Reproductive Health in Nepal            India Country Paper   <b>Plenary Session 1 (Continued)</b>  <b>Presentation of Country Papers</b>            Pakistan Country Paper            Sri Lanka Country Paper</p>	<p>Ms. Imelda Henkin            UNFPA New York            Dr. Nafis Sadik            UNFPA New York            (Chief Guest: H.E.Mr. Dalit Ezhilmalai, Minister of State for Health and Family Welfare, GOI, New Delhi)            Ms. Brenda Gael McSweeney            Mr. Saad Raheem Sheikh            UNFPA            Mr. Wasim Zaman   <u>CHAIRPERSON:</u>            Dr. Deepthi Perena  <u>RAPPORTEUR:</u>            Dr. S.W. Pathinayake   <u>CHAIRPERSON:</u>            Dr. Rinchen Chopel  <u>RAPPORTEUR:</u>            Ms. Jameela Ali   <u>CHAIRPERSON:</u>            Dr. L. R. Pathak  <u>RAPPORTEUR:</u>            Mr. Hari Khanal</p>

Wednesday, 22 July 1998		
09:00-10:15	<p><b>Plenary Session 2 : Adolescent Reproductive Health Behaviour</b></p> <p><i>The session's presentation will be a critical analysis of the issues related to sexual and reproductive health of the adolescents from a regional perspective.</i></p>	<p><u>CHAIRPERSON:</u> Dr. Sudha Sharma</p> <p><u>RAPPORTEUR:</u> Dr. K. Pappu</p>
09:00-09:30	<p><b>Presentation of Theme Paper 1</b></p> <p><i>Responsible Sexual and Reproductive Health Behaviour Among Adolescents</i></p>	<p><u>PAPER PRESENTER:</u> Dr. Suman Mehta</p> <p><u>DISCUSSANT:</u> Dr. Saroj Pachauri</p>
09:30-10:15	<p><b>Discussions</b></p>	
10:30-11:45	<p><b>Plenary Session 3: Education and Adolescents</b></p> <p><i>A critical analysis of the relationship between education and reproductive health will be presented in this session</i></p>	<p><u>CHAIRPERSON:</u> Ms. Razeena Thuthu Didi</p> <p><u>RAPPORTEUR:</u> Ms. Sonam Wangmo</p>
10:30-11:00	<p><b>Presentation of Theme Paper 2</b></p> <p><i>Education and Adolescents</i></p>	<p><u>PAPER PRESENTER:</u> Mr. Thirtha B. Manandhar</p> <p><u>DISCUSSANT:</u> Ms. Daphne M de Rebello</p>
11:00-11:45	<p><b>Discussions</b></p>	
11:45-13:00	<p><b>Plenary Session 4: Exploitation of, and Violence Against, Adolescents</b></p> <p><i>This session will highlight issues related to violence against adolescents including trafficking and violence within and outside families. The session will focus on the experiences in countries of the region.</i></p>	<p><u>CHAIRPERSON:</u> Dr. Aftab Uddin Khan</p> <p><u>RAPPORTEUR:</u> Dr. Ambha Ghosh</p>
11:45-12:15	<p><b>Presentation of Theme Paper 3</b></p> <p><i>Exploitation of, and Violence Against, Adolescents</i></p>	<p><u>PAPER PRESENTER:</u> Ms. Kushi Kabir</p> <p><u>DISCUSSANT:</u> Dr. Zeba Sathar</p>
12:15-13:00	<p><b>Discussions</b></p>	
14:00-15:15	<p><b>Plenary Session 5: Perspectives of Adolescents</b></p> <p><i>In this session, representatives of adolescent participants will make a presentation on their views and experiences concerning the three themes of the conference and suggestions on the kinds of programme that would best meet their needs.</i></p>	<p><u>CHAIRPERSON:</u> Ms. Mehtab Rashidi</p> <p><u>RAPPORTEUR:</u> Dr. Saqib Ali Khan</p>
15:30-18:00	<p><b>Working Group Session</b></p> <p>Participants will be formed into 3 Groups: Group A: Sexual and Reproductive Health of Adolescents Group B: Education and Adolescents Group C: Exploitation of and Violence against Adolescents</p> <p><i>Based on the presentation and discussions during the plenary sessions and the background papers, each working group will identify and prioritise issues and suggest strategies and programmes for attention by Governments and NGOs.</i></p>	

Thursday, 23 July 1998		
<b>09:00-13:00</b>	<b>Final Plenary</b> <i>Recommendation and Closing Sessions</i>	<b>CHAIRPERSON:</b> Mr. Gautam Basu <b>RAPPORTEUR:</b> Dr. Saramma Mathai
<b>09:00-10:30</b>	<b>Presentation of Recommendations of the Working Groups</b>	Dr. Sudha Sharma
09:00-09:15	Group A Presentation	
09:15-09:30	Discussion	
09:30-09:45	Group B Presentation	Dr. D. Anand
09:45-10:00	Discussions	
10:00-10:15	Group C Presentation	Ms. Kushi Kabir
10:15-10:30	Discussions	
<b>11:00-12:00</b>	<b><u>Presentation: Strategies to Operationize Innovative Programmes to Address Adolescent Concerns</u></b>  <i>The main objective of this session is to link the three theme papers, the country experiences and synthesise recommendations from the Working Groups.</i>	<b>PAPER PRESENTER:</b> Prof. Jay Satia
<b>12:00-13:00</b>	<b><u>Closing Session</u></b>  <i>Declaration by Adolescent Participants</i>  <i>Concluding remarks</i>  <i>A few words on behalf of the participants</i>  <i>Vote of Thanks</i>	Dr. Nafis Sadik  Mrs. Rosie Senanayake  Dr. Wasim Zaman



# Annex III

## VOICES OF ADOLESCENTS: COMMUNICATING WITH ADULTS

Session V was for the adolescents to present their views and perspectives. It started with a set of questions addressed to adult participants for them to reflect and react - a role play exercise to help adults to relive their adolescence, before they plan for adolescents. Little slips of paper were distributed randomly to the adults at the conference. Each one who received the slip was to read it out aloud and then act/react to the question. Following are the questions and reactions.

- Question:* You are a girl, living in a male dominated society where there are no proper opportunities to go to school. What would you do?
- Reaction:* Very sportingly, donning a dupata (veil), she first pleaded with her parents to send her to school and ended by saying very forcefully to everyone - DO SOMETHING !
- Question:* You want to make friends with the opposite sex, but your parents won't allow it. What would you do?
- Reaction:* He would first try to explain and reason with his parents and if they still did not respond favourably, he would still go ahead and make friends.
- Question:* You are an average student, but your parents want you to perform beyond your capacity and are constantly pressurising you to excel.
- Reaction:* "I will try to explain to my parents and suggest that they don't force me.....we really can't talk to our parents - we're confused." said the participant actor.
- Question:* You have heard about a condom, but want to know more about it and how to use it. What would you do?
- Reaction:* Since he can not ask his parents or the Government or an NGO, he will go to a friend, who may not always be acceptable to society.
- Question:* You are in love with a girl and want to marry her but your parents are not agreeing to the marriage. What would you do?
- Reaction:* I will try and reason with and explain to my parents but if they still do not agree, I would go ahead and get married.
- Question:* Your friends want you to smoke just one "puff". Your parents have forbidden you to smoke. What would you do?
- Reaction:* I'd think it over for a while - procrastinate not being able to decide but finally I'd take a puff. But after that I'd smoke only when and if I like it.
- Question:* Both your parents are doctors and they want you to become one too but you hate the sight of blood. You want to be an artist. What would you do?
- Reaction:* I'd try and convince them to let me do what I want and not what they want. I may also take the medical entrance exam and purposely fail.
- Question:* You are curious and want to know how to use a condom. What would you do?
- Reaction:* The participant who reacted to this described very graphically how one friend would ring and ask the other about using a condom and they would ask yet another who claims to know all about life. The climax was when they realised that neither of them really knew how to use a condom.
- Question:* You want to go to prostitute but you have heard of AIDS and so you want to use a condom. However you don't know where to get one. What would you do?

*Reaction:* I'd try making inquiries from friends none of whom will really know. I'd finally try to procure one from a condom vending machine but it would not be working. I'd simply go home.

*Question:* You are a young 16 year old girl. Your parents want to explain the facts of life to you but you already know it all. How would you behave?

*Reaction:* Three delegates actually acted out a short scene on this reaction. While both parents were a bit uncomfortable and hesitant, the adolescent girl was most unconcerned and dismissed the whole incident by saying she knew it all.

The above clearly conveyed the kinds of concerns the adolescents have.



Adolescents Drafting Delhi Declaration