

**Review Article**

## **ADOLESCENTS – GROWING THROUGH TROUBLES AND TRIBULATIONS**

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### **ABSTRACT**

Adolescent is the future of any country. It is a challenging crossroads between childhood and the adult world characterized by search for new interests, talents, and social identities but not without undergoing a lot of troubles and tribulations. Various issues like physical, cognitive emotional changes, sexual health problems, risk taking behavior, substance use, bullying and violence go hand in hand with adolescence. Adolescent girls particularly face many other challenges like gender disparities in education and nutrition, early marriage and discrimination anemia, RTI/STI menstrual irregularities. This article highlights various health problems faced by adolescents, their remedies and strategies for the betterment and empowerment of youth.

**Keywords:** *Adolescents, Health Problems, ARSH, Empowerment*

### **INTRODUCTION**

Adolescent is derived from the Latin word *adolescere* meaning to grow up. WHO defines adolescence as the second decade of life, between the ages of 10 and 19 years whereas youth refers to period between 15-24 years age group (UNICEF, 2011). The Government of India, however, in the National Youth Policy defines adolescents as 13-19 years and youth as the 15-35 age-groups.

Today, 1.2 billion adolescents stand at the challenging crossroads between childhood and the adult world. Nine out of ten of these people live in the developing world and face especially profound challenges, from obtaining an education to simply staying alive – challenges that are even more magnified for girls and young women. India is home to more than 243 million adolescents, who account for almost 20 per cent of the country's population (UNICEF, 2011). In absolute numbers, more adolescents live in India than any other country. It is followed by China, with around 200 million adolescents (UNICEF, 2012). This sheer number itself is a big challenge in itself.

#### ***Health Problems Affecting Adolescents***

Adolescents are the citizens and working force of tomorrow. But they are mostly overlooked in most health programmes as they are basically considered a healthy group those children who have reached adolescence after coping with the years of greatest mortality risk.

Estimating the true extent of problems and issues among adolescents is a difficult task as there is a complete lack of data on the 10-14 years age group. Additionally, there is no consistency in the age group divisions between NFHS-1, 2 and 3. While in NFHS-1 the age group starts at 13 years, for NFHS-2 and 3 it is 15 years. Also, the NFHS does not provide information on several crucial domains related to health and development of adolescents / young people, like, indicators on mental health, substance abuse, accidents and injuries. Also, these surveys do not capture data on the causes of death and disability (MoHFW, 2009).

India's youthful population, particularly girls, face many challenges like gender disparities in education and nutrition, early marriage and discrimination, especially against those belonging to socially excluded castes and tribes. Poor nutrition, lack of immunization, adoption of unhealthy eating habits and addictions form foundation of morbidity and early mortality in adulthood. Iron deficiency anaemia is the most common nutritional disorder among adolescents which reduces the mental and physical ability of the

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individual. There are 56% females and 25% males who are anaemic amongst youth. Adolescent girls face a greater risk of nutritional problems than adolescent boys, including anaemia and underweight. Underweight prevalence among adolescent girls aged 15–19 is 47 per cent in India, the world's highest. In addition, over half of girls aged 15–19 (56 per cent) are anaemic (UNICEF, 2011). According to NFHS-3, the prevalence of mild, moderate and severe anaemia among adolescent girls was 39.1%, 14.9% and 1.7%, respectively (MoHFW, 2009). This has serious implications, since many young women marry before age 20 and being anaemic or underweight increases their risks during pregnancy. Anaemia is the main indirect cause of maternal mortality. Such nutritional deprivations continue throughout the life cycle and are often passed on to the next generation (UNICEF, 2011).

Reproductive and sexual health problems are again a major area of concern due to inadequate awareness and knowledge among adolescents. In India, although traditional norms oppose premarital sex, some studies indicate a growing trend towards premarital sexual activities among adolescents (Nair, 2004). Most sexual activities begin in adolescence - 3% of adolescent males and 8% of adolescent females had sex before age 15, 1% female and 63% males aged 15–19 had higher risk sex with a non-marital, non-cohabitating partner and 31% adolescent males and 20% adolescent females used a condom at last higher risk sex (USAID, 2012). This population is vulnerable for contracting sexually transmitted infections (STI) including HIV and unsafe abortion. Younger men and women (15-19 years) reported more high risk sexual activity and low condom use compared to those in the 20-24 years age group (MoHFW, 2009).

As was reported in DLHS-3, 2007-08, only 30 percent of unmarried women aged 15 to 24 heard about RTI/STI (USAID, 2012). According to National Family Health Survey-III (NFHS-III) almost 11% of females and 7% of males in age 15-24 had a history of STI in the preceding one year of the survey (Parasuraman, 2011). The HIV prevalence among youth (15-24 years) was 0.1 percent - 0.09% among men and 0.11% among women (NFHS-3) it was found to be higher in urban areas (0.14%) as compared to rural (0.09%) and higher among women. Even among young women HIV prevalence is higher for those whose first sexual partner was more than 10 years older. Early marriage, early sexual activity, lack of knowledge and exposure to HIV related information and limited access to health care services and condoms, make young women more vulnerable to HIV risk (MoHFW, 2009). As per UNICEF: Progress for Children – A report card on adolescents – 2012, 35% adolescent males and 19% adolescent females have comprehensive knowledge of HIV in India; 49000 adolescent males and 46000 adolescent females live with HIV in India (UNICEF, 2012).

The fertility pattern and contraceptive use among adolescents help us to understand the implications for adolescent reproductive health in a society. Knowledge of contraception among adolescents was more than 90% in NFHS-3; despite this high percentage, only a little more than 10% of adolescent girls were found to be using any form of contraceptive (MoHFW, 2009). Many of these married women may choose not to use contraception because they wish to have a child. Others do not wish to have a child and among these, fully one quarter have an unmet need for family planning (United Nations, 2011).

An important aspect of neglected adolescent girls is that, although the legal age for marriage is 18, majority of Indian women are married off as adolescents and have their first child in their teens. Recent data show that 30 per cent of girls aged 15–19 are currently married or in union, compared to only 5 per cent of boys of the same age. The figure is the eighth highest in the world and Pakistan fares much better with just 25 per cent of girls getting married before the age of 18 years. Also, 3 in 5 women aged 20–49 were married as adolescents, compared to 1 in 5 men. While the prevalence of child marriage among urban girls is around 29 per cent, it is 56 per cent for their rural counterparts (UNICEF, 2011).

Bangladesh, India and Nigeria alone account for one in every three of the world's adolescent births (UNICEF, 2012). NFHS-3 shows that 12% of all women (married and unmarried) aged 15-19 years and 44% of currently married women in the same age group have begun childbearing (MoHFW, 2009). Adolescent girls who are suffering from malnutrition, anaemia and stunted growth usually deliver low birth weight babies. Young women in the poorest households are seven times more likely to give birth before age 18 than young women from the richest households in India (UNICEF, 2012). Along with prevailing illiteracy, ignorance and poverty; these adolescent mothers are neither able to take care of

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themselves nor their child. This vicious cycle goes on and the result is high maternal and infant mortality, chronic ill-health and increased burden of disease in the country.

Educated youth is the backbone of a country's infrastructure. While India has made significant progress towards gender parity in primary education enrolment, which stands at 0.96, gender parity in secondary school enrolment remains low at 0.83. India ranked 119 out of 169 country rankings in the United Nations Development Programme's gender inequality index (GII) in 2010 (UNICEF, 2011). "Certainly, now 74 per cent of adolescents are in school. Most of them are getting primary education. But there is a high-drop-out rate afterwards, both in male and females. It is still an area of concern," Karin Hulshof, country representative for UNICEF said (Deccan Herald, 2012).

It has also been reported that about one-third of adolescents suffer physical abuse and about one-third of adolescents suffer from sexual abuse (Deccan Herald, 2012). While younger children are more likely to experience physical abuse, older children and adolescents are more vulnerable to sexual violence. Boys are at greater risk of physical and armed violence, girls of neglect, sexual abuse and exploitation (UNICEF, 2010).

Despite constitutional and legal provisions (Child Labour Act, 1986), children continue to be employed and occupied in work. According to the 2011 census estimates, 11% of the workforce of India is child labour. One in every 10 workers in India is a child, Street child and orphans form a particularly vulnerable group. A comparative study of working children and school children in India showed that working children's health was considerably inferior to nonworking school children (Deccan Herald, 2012).

Other emerging major problems, affecting mainly the higher class of the society, are menstrual irregularities, obesity and hirsutism - due to defective lifestyle and increasingly prevalent insulin resistance and concomitant increase of polycystic ovarian disease among females and diabetes among both sexes. More than half had experienced dysmenorrhoea and around 40% reported passing of clots during menstruation. However, of the adolescent girls who experienced menstrual problems, only 26% sought consultation (Acharya, 2011).

Adolescents start to identify themselves with an ideal hero, whom they obey and follow. As the preoccupation with slim figure supersedes a desire to be healthy and teenagers often resort to desperate or even dangerous methods of weight control. In extreme cases eating disorders such as bulimia and anorexia can permanently damage physical and mental health causing poor health and early death. Some adolescents have a 'yeh dil maange more' life style. They want more of everything - dietary fat, tobacco and alcohol, sedentary jobs but they never want more of vegetables and fruits. As a result prevalence of non-communicable diseases like obesity, diabetes and hypertension are increasing at an alarming rate among the adolescents. Tobacco use including cigarette smoking and oral tobacco mostly starts during adolescence which impacts health and can have disastrous consequences in later life.

Adolescents and youth, with their penchant for experimentation and exploration of new ideas and activities are especially vulnerable to drug abuse. In India, it is estimated that most drug users are between the age group of 16-35, with a bulk of them in the 18-25 age group. Though the actual age of first use of drugs varies, studies reveal that a considerable number begin taking drugs below the age of 18, and sometimes as young as 5, 6 or 7 years. Lifetime habits are formed during this age, and can lead to gradual increases in the intensity of drug use and addiction from alcohol or cannabis to 'hard' drugs (UNFPA, 2003).

Today's youth faces an increasingly uncertain world where climate change, rapid urbanization, the economic recession and rising unemployment pose unprecedented challenges. In any given year, about 20% of adolescents experience a mental health problem, most commonly depression or anxiety. The risk is increased by experiences of violence, humiliation, devaluation and poverty, and suicide is one of the leading causes of death in young people (WHO, 2011). 85% of teenage girls justified someone committing suicide if there were adequate reasons like unwed pregnancy, to prove innocence, to defeat parents, extreme financial loss and failed love affair (Nair, 2001).

A recent systematic analysis on 'global burden of disease in adolescent's reports that the total number of incident Disability Adjusted Life Years (DALYs) worldwide in the age group 10-24 years is 230 million

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which constitutes 15.5% of total DALYs. The three main causes of Years Lived with Disability (YLD) for 10 - 24 years worldwide are neuropsychiatric disorders (45%), unintentional injuries (12%) and infectious and parasitic diseases (10%) (Gore, 2011).

### **Role of Parents and Teachers**

Adolescents are vulnerable to psychological problems owing to pressure of expectations of parents, friends, teachers and their own selves and this drives them to premarital sex, substance abuse, risk-taking behaviour and other self-destructive tendencies. Socrates characterized youth as inclined to "contradict their parents" and "tyrannize their teachers" (Arnett, 1999).

Parents are unaware about their role in improving adolescent health. Every single day's influence of parents helps in shaping up the adolescent's life. The World Health Organization (WHO, 2007) states five dimensions which have an important bearing on adolescent health. They are:

- connection – 'love'
- behaviour control – 'limit'
- respect for individuality – 'respect'
- modeling of appropriate behaviour – 'model'
- provision and protection – 'provide'

The adolescents spend a major proportion of their time in their schools. Teachers can play an influential role in shaping up the adolescent's health by screening for common disorders, providing nutritional counseling, reproductive and sex education, life-skill education, etc. In one of the articles on school-based policies and programmes, Kolbe (Kolbe, 2006) writes "Today, more than ever, school health programs could become one of the most efficient means available to improve the health of our children and their educational achievement". Early diagnosis of preventable and treatable conditions/illnesses can be made through school health services, supported by the Government.

Neither young children nor adults, but adolescents lack the services that respond to their distinctive needs. Interventions for children very often focus on the younger ages; adolescents 'age out' of paediatric health care, for example, and they are often unreached by programmes for adults. Many adolescents are excluded from services that would reduce their risk of HIV and sexually transmitted infections, or that would help them prevent pregnancies, because of laws that limit their access to these services without parental consent. Adolescents who live on their own, either by choice or by circumstance, may no longer have the protection of their families.

### **Government of India Initiatives**

In India, adolescent health is the domain of the Ministry of Health and Family Welfare and the Departments of Health and Family Welfare of the states. The Ministry of Women and Child Development is significantly involved with the issues of nutrition and development of children, particularly girl children.

Promoting healthy practices during adolescence, and taking steps to better protect young people from health risks is critical to the future of countries' health and to the prevention of health problems in adulthood. The National Rural Health Mission (NRHM) recognizes this and underscores adolescent reproductive and sexual health (ARSH) as a top development priority in its Reproductive and Child Health (RCH-II) program (USAID, 2012).

The ARSH Strategy focuses meeting the service needs of adolescents by re-organization of public health infrastructure. The Medical Officers of both the Primary and Community Health Centres (PHCs and CHCs) and grass-root level health workers are required to ensure preventive, promotive, curative and counseling service delivery at sub-centres and PHCs at fixed day and timings (MoHFW, 2006). Haryana was one of the first states in the country to have launched a distinct Adolescent Reproductive and Sexual Health (ARSH) programme providing 'adolescent friendly health services' at government health facilities (TOI, 2007).

However, NFHS-3 shows adolescents (26%) are less likely to visit public health facility or camps as compared to women of older age groups (MoHFW, 2009). It was found that private sector utilization was

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more prevalent especially in the urban areas. Therefore, it is all the more pertinent to raise the question “why adolescents shy away from accessing the health services”? We need to identify the barriers in accessing health services by the adolescents and the young people. These may be lack of confidentiality, privacy, odd hours of the clinics, feeling isolated among adults in the waiting line, stigmatization of visiting a clinic, non-availability of health provider especially the female health provider, and/or drugs at the health facility etc. (MoHFW, 2009).

### **Scope for Betterment**

Although, Government of India has launched several programmes for adolescent population like ‘Kishore Shakti Yojana’, ‘12x12 initiative’, ‘Balika Samridhi Yojana’, ‘Mahila Samakhya programme’, ‘SABLA’, ‘School AIDS Education’, etc. If we look closely, we will find that some things are missing. Where is the emphasis on boys? Because when you are going to develop model, you will be talking about peer educator and so on. So there is no comprehensive programme for adolescents.

Prevention of adolescent health problems needs to have a multidimensional approach. Many stakeholders like the schools, the parents, the community, and the politicians and most importantly the “Health care providers” play an important role in providing health care services. Adolescent friendly health services need to be established which provide services to the adolescents at a separate timing to ensure confidentiality, where a gynaecologist, pediatrician/physician, psychologist, counselor, dietician are available to cater to all needs of the ‘adolescent’. These adolescents are the “future” of our country, therefore, the opportunity should be utilized not only to treat any medical problem but to counsel them regarding diet, lifestyle, and positive health practices. Proper psychological environment can prevent risk-taking behaviour, substance abuse, unsafe sex & spread of STIs and HIV. Awareness about harmful effects of early marriage and childbearing in society and knowledge of family planning can help a lot in reducing maternal and infant mortality rates.

The challenges in providing services for adolescent health is not providing newer technologies or interventions as they would not bring the adolescents in purview of health care but to make the ‘adolescent friendly health services more accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient (WHO, 2002). Using media to dissolve the barrier of shyness and hesitation in discussing problems of adolescents can also help. Moreover, strong political will and commitment is necessary to boost up the adolescent health.

“We must reach them. For adolescence is not only a pivotal time in the life of a child – the gateway to adulthood – it is also a critical opening in which we can make progress for all children,” said UNICEF Executive Director Anthony Lake.

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