

Guidelines to Use Ready Reckoner

The purpose of Ready Reckoner is to provide additional reading material on topics discussed in the advocacy kit. It is primarily meant for facilitators and teachers. It is suggested to read the ready reckoner and the content of advocacy kit before meeting any stakeholder for one to one interaction.

The Ready Reckoner has been divided broadly in 4 sections:

1. Advocating for Adolescence Education Programme (AEP)
2. About AEP
3. Appreciating the need of AEP
4. Detailed Profile of Adolescents in India

The Advocacy Kit has following sections/inserts:

1. About Adolescence Education Programme
2. Appreciating the need of AEP
3. Understanding Adolescents
4. Profile of Adolescents in India
5. Profile of Adolescents in Rajasthan (Sample state specific fact sheet)
6. Initiatives by Government
7. Role of Stakeholders (Parents, Teachers, Opinion / Community Leaders, Service Providers, Government Officials, Elected Representatives and Media)

The content of the advocacy kit and ready reckoner may be used to develop presentations (power point, hand-outs, etc.) in case of mass advocacy meetings like media and parents meet.

1. Advocating for Adolescence Reproductive and Sexual Health

Sustained advocacy by various stakeholders including international development organisations, civil societies, state and central government and UN agencies have resulted into number of progressive policies and programmes for health and development of adolescents and young people in the country. Efforts are still continuing to address adolescent development in a holistic manner. Now it is important for all to come together to facilitate effective implementation at every level overcoming obstacles to reach adolescents including those in the most difficult circumstances. Creating enabling environment for access to information and empowering adolescents with skills pertaining to ARSH is one of the many approaches that leads to the health and development of adolescents in India.

Adolescence Education Programme (AEP) too envisage a safe and reassuring environment for adolescents to seek information and empower themselves with necessary skills to cope up with challenges of passage to adulthood. However, AEP has met a backlash ever since the Ministry of Human Resources and Development and National AIDS Control Organisation, MOHFW jointly introduced it in the school system in the year 2005. Yet the criticism has helped implementing agencies immensely to revisit the programme to fine-tune the age and cultural appropriateness of the curriculum to be transacted in the 9th and 11th class. The need of AEP has been widely recognised and is evident from number of research on adolescent growth and development especially with regard to sexual and reproductive health. At this stage of programme implementation, it is necessary to meet people's apprehensions at every step/levels, carefully armed with strong evidences in support and required skills of a true advocate.

OBJECTIVES OF ADVOCACY PROGRAMME FOR AEP

1. To create a general understanding about AEP that is being implemented by MHRD and NCAO in the school system.
2. To create an enabling environment for smooth implementation and integration of AEP at the school level.
3. To support every individual as an advocate for AEP in their own capacity.

WHY ADVOCACY IS NEEDED?

Advocacy is a critical component at this stage to ensure that AEP is enacted, funded, implemented and sustained in school education system at every level.

WHAT IS ADVOCACY?

There are many definitions given for advocacy but the underlying concept in each remains same:

“Advocacy is a set of targeted actions directed at decision makers in support of a specific policy issue”.

“Advocacy is defined as the promotion of a cause or influencing the policy, funding streams or other politically determined activity.”

“Advocacy is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organisations with power, systems and structure at different levels for betterment of people affected by this issue.”

In simple words:

All advocacy involves is making a case in favor of a particular cause using skillful persuasion and/or strategic action. In other words, advocacy simply means actively supporting a cause, and trying to get others to support it as well.

WHO IS AN ADVOCATE? WHAT ARE THE QUALITIES TO BE A GOOD ADVOCATE?

An advocate is a person who influences others to support an idea, issue, organisation or programme.

The only qualification to being an advocate is being committed to the issue at hand. It’s a wrong perception that the responsibility of advocacy lies with the person in-charge for liaison or lobbying on behalf of the organisation. Persons with the first hand experience of educating, training, counselling and building life skills of adolescents have the required expertise to be a strong advocate for the cause. Everyone working with or for adolescents whether you are a school principal, teacher, (any stream - sports or literature) counsellor, doctor, social worker or even peer educator can be very articulate and compelling advocate for AEP as you are the ones in close association with adolescents and young people, knowing them the best.

Some of the skills that are helpful with the knowledge on the issue for advocacy are:

- Positive attitude and patience
- Thinking skills; social skills and negotiation skills
- Credibility of the person, like a role model

WHAT DOES ADVOCACY INVOLVE?

- Analyzing the environment
- Defining the agenda or cause
- Identifying the partners
- Lobbying the support of decision makers
- Forming allies and rallying support
- Establishing Networks

- Mobilising public opinion
- Enlisting the support of beneficiaries
- Addressing the concerns of adversaries

GENERAL TIPS FOR ADVOCACY?

The definitions given above speak about the step wise methods to make your advocacy effort successful. Given below are basic conduct expected from an advocate-

- **Be gracious** – Adolescence Education Programme has received a lot of criticism in past. Always be thankful to those who have agreed to listen and talk about it or have provided opportunity for advocacy.
- **Be professional** – Do not speak negative about individual or group with different opinion.
- **Be focused-** Be clear and direct about what support you want from the stakeholder you are meeting.
- **Do your homework** – It is important to know about the stakeholder, its opinion about the issue, and prepare yourself with information and rational arguments.
- **Consider yourself an information source:** The stakeholder you are meeting might not have all the information on the issue as you have. Your role is to respectfully fill the information gap.
- **Tell the truth** –False or misleading information, no matter how trivial it may be does a serious damage to the credibility of both, the advocate and the programme. It might give immediate results but those are short-lived, not the **change** in true sense.
- **Know who else is on your side:** Advocacy becomes stronger with more and more on your side. Be informed about other individuals and groups who share your thoughts/ support AEP. Maintain contact and exchange of information with them for a well co-ordinated advocacy effort.
- **Know the opposition:** As a good advocate you should have the ability to anticipate who will be opposition and likely criticism/ backward reasoning to your points in support.
- **Don't be afraid to admit if you don't know something-** You are an advocate; you should be well informed and updated but it is possible that at times you might not have certain information or you might not be sure about the answer. Politely tell them you will get back with the information and do so at the earliest.
- **Be specific in what you ask for:** Whether asking for their consent, their support in implementation; signature campaign; creating demand for Youth Friendly Health services; establishing linkages with service providers; be clear about what support you expect from the stakeholder you have approached. Support your expectation with relevant evidences and arguments.
- **Follow up** – It is the most important part of any advocacy exercise. Repeated and regular follow up is necessary in all cases – whether to continue the advocacy effort till you get a positive response or to remind them about their commitment or thank them for their initiative.
- **Stay informed-** keep yourself updated with the latest and all relevant information.

- **Don't burn bridges-** Its natural to get emotional about issues you strongly feel for but remember as an advocate you have to win other person with convincing arguments and evidences and let the channel of communication open for future.

2. ABOUT ADOLESCENT EDUCATION PROGRAMME, 2005

Many adults (teachers, educators, parents, social workers, and service providers) feel uncomfortable talking to adolescents about matters related to Sexuality. They are unable to provide important information on Sexual and Reproductive Health (SRH) to the adolescent age groups especially to those who are not married. Even those who work with older youth may not know or may be misinformed about what is appropriate for this younger age group. In order to escape the subject when confronted by queries and curiosities of an adolescent, adults tend to either react aggressively, or give value-laden messages that does not help adolescent in any way. Such attitude may prevent young adolescents from seeking SRH information and services from the right sources and unconsciously push them on a misleading pathway. It is important to talk to adolescents; therefore to bridge this information and communication gap, Adolescent Education Programme is being proposed for integration in the school education curriculum.

About Adolescent Education Programme (AEP), 2005

Adolescence Education Programme (AEP) was launched by the Ministry of Human Resource Development (MHRD) in collaboration with National AIDS Control Organisation (NACO), Government of India in the year 2005 as a follow up of the decisions taken in an Inter-Ministerial (Minister of Health & Family Welfare, Labour, Rural Development, Social Justice and Empowerment and Information & Broadcasting) held in October 2004. It was an initiative to upscale the ongoing three educational programmes: (i) *National Population Education Project (NPEP)* from 1980, (ii) *School AIDS Education Programme (SAEP)* from 1993-94 and (iii) the *Project on Adolescent Reproductive and Sexual Health (ARSH) in Schools*. Since these programmes had limited outreach, covering relatively smaller number of target groups. Adolescence Education Programme was, therefore, launched as an umbrella programme to cover all the **secondary and senior secondary schools** of the country¹.

Aims and Objectives of AEP

Aims:

1. Provide opportunities for the reinforcement of existing positive behavior and strengthening of life skills that enable young people to protect themselves from and to cope with risky situations they encounter in their lives.
2. Reinforce development of behaviour that will empower adolescents to make healthy choices.
3. Prevention of new infections of HIV among youth

¹ MHRD & NACO, "Key Outcomes and Next Steps for Action", *Adolescence Education: National Framework and State Action Plans (2005-06)*, NACO, July 2005, p. 3.

Objectives:

1. All schools integrate and provide accurate age appropriate life skills based adolescence education in a sustained manner in schools;
2. Structured education to enhance knowledge and skills of adolescents to deal with challenges of life.

Key Elements of AEP:

I. Process of Growing-up necessitate understanding of:

- **Adolescence;** and **ten core life-skills**
- **Physiological changes** and knowing effectiveness of life skills to cope with pubertal changes like managing body image concerns; and relationship with peers and adults.
- **Emotional and mental changes** and life-skills to accept these changes and enhance self-confidence; self-control and self-esteem

II. Adolescent Reproductive and Sexual Health entail:

- **Gender; gender roles;** influence of gender on the health and development of males and females and skills to foster gender relationship based on equality and mutual respect
- Male and female reproductive system; **reproduction;** consequences of adolescent pregnancy; life skills to adapt **responsible sexual behaviour** (practicing abstinence); protect oneself from risky situations and mutual respect and understanding in a relationship.

III. Mental Health and Substance Abuse:

- Consequences and impact of substance abuse
- Linkages between substance abuse and other high-risk behaviors
- Communicating assertively; Learning to say 'No', good listening skills; conflict resolution without violence
- Alternative ways to deal with Anger, Loss and Sadness and coping with Stress
- **Sexual abuse;** identifying and avoiding risky situations and skills to protect oneself and voice ones' concern to gain protection

IV. HIV and AIDS:

- Prevalence of HIV infection and AIDS in the country
- Socio-cultural reality and gender stereotypes in context of HIV epidemic
- Basic facts about HIV infection - modes of transmission; available voluntary counselling and testing (VCTC); ways for prevention

- Basic facts about sexually transmitted infections; vulnerability of adolescents and linkage between STIs and HIV infection
- Skills to identify and avoid risky situations; make informed decisions; and communicate empathy for people living with HIV and AIDS around us.

Basic Principles of AEP

- ✓ Interactive teaching- learning process
- ✓ Gender sensitization built into the content and process
- ✓ Use of culturally specific methods and materials
- ✓ Recognition of Rights of adolescents to health information and services.

Life- skills Approach

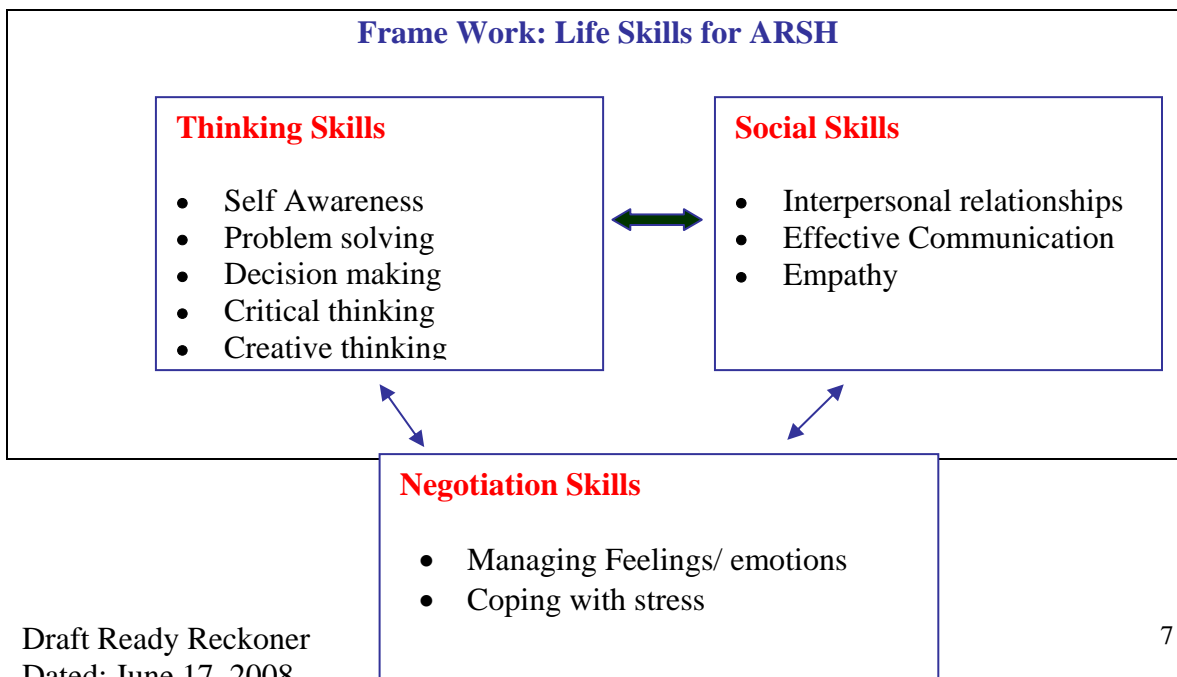
Life skill is defined as “the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life”. These abilities facilitate physical, mental and emotional well-being of an individual.

Life skills approach is an interactive educational methodology that not only focuses on transmitting knowledge but also aims to shape attitudes and develop interpersonal skills.

Life skills are essential possessions for any young person for inevitable turning points in life especially when one has to leave protected environment of school and home for varied reasons like job, higher studies, etc. This is the stage where one is exposed to peer groups and friends from diverse background and one demonstrate creativity, energy, weakness, and resilience.

Basic Principles

- ✓ Interactive teaching- learning process
- ✓ Gender sensitization built into the content and process
- ✓ Use of culturally specific methods and materials
- ✓ Recognition of Rights of adolescents to health information and services.



3. Appreciating the Need of Adolescent Education Programme (AEP)

The world now has the largest cohort of young people entering their reproductive ages. The majority of young people, 86 percent, live in developing countries (adolescents of 10-14yrs living in developing countries form 10 percent of world's population). In India adolescents in the age group of 10-19 years comprise 22 percent of the total population. Population Stabilization is one of the major development challenges for India today. What happens in the future depends, to a large extent, on the decisions taken by adolescents as they enter their reproductive years. Within this paradigm of population and development related issues, the role of adolescents cannot be overlooked.

Besides Adolescence is a period of formative and dynamic transitions, when young people take on new roles, responsibilities, and identities. It is a period of life full of fundamental changes and young people attempt to achieve autonomy from their parents/guardians. Adolescence also marks cultural transitions through traditions such as circumcision, marriage, and childbirth.

At the same time, the process of commercialization and globalization is influencing the social mores world over. India is no exception. In an era, that is flooded with attractive communications on fashion, lifestyle, diverse facets of relationships, and brand awareness, it is important to reinforce positive behaviour along with values through necessary life skills and information. Keeping pace with modern days challenges, AEP has been proposed for integration in the school education system.

Reaching young people early is more effective. Adolescence is a period when health behaviors that will last long into adulthood can be strongly influenced. Gender norms and roles, notions about appropriate sexual behaviors, and awareness of such issues are shaped during adolescence.

No evidence exist that adolescent education/ sex education encourage early sexual behaviour/initiation.

It has been extensively researched and established that; policies that encourage healthy behaviour among youth, by improving their productivity and health as adults, have ripple effects on the economy. Risky health behaviour during youth can deplete the economy of productive human capital for many years into the future. Safe behaviour on the contrary can encourage greater investment in productive human and physical capital¹.

A central element of health promotion is providing health education for a positive behaviour change and adoption of healthy behaviour. A few evaluated programs suggest that providing culturally appropriate teaching about health risks and increasing the

¹ Ch 5, Growing up Healthy, World Development Report 2007

capability of young people to practice healthy behaviour (including negotiating safe sex with partners) are more likely to change behaviour. The structured school environment is conducive to teaching young people about their bodies and about safe health behaviour.² A large majority of school based sex education and HIV education interventions reported, reduced risky sexual behaviours in developing countries.³

Evidence shows that there is strong relationship between education and health. Healthy decisions are promoted by education and economic growth. Education often called a “social vaccine” is considered by many to protect young people from engaging in risky behaviours.

Comprehensive education about sexuality is effective in delaying the onset of sexual intercourse, reducing the number of sexual partners and increasing contraception and condom use among teens. Unlike what is often thought comprehensive sexuality education does not increase the number of sexual partners among young people or increase any measure of sexual activity⁴.

Sex education Programs grounded in evidence-based approaches are a cornerstone in reducing adolescent sexual risk behaviours and promoting sexual health.⁵

The Alan Guttmacher Institute study, on Cross national comparisons to identify certain pervasive factors regarding ‘*Teenage Sexual and Reproductive behaviour in Sweden France Canada, Great Britain and United States (1998-2001)*’ wherein Teenage pregnancy rates and birth rates vary widely with lowest in Sweden and highest in U.S, reveals,

i. **Societal acceptance of sexual activity among young people combined with comprehensive balanced information about sexuality** and clear expectation about commitment and prevention of child bearing and STD’s within teenage relationship are hallmarks of countries (Sweden and France) with low levels of adolescent pregnancy, child bearing and STD’s.

ii. **Easy access to contraceptives and other reproductive health services** (Sweden, France, Canada and Great Britain) **contributes to better contraceptive use and therefore lower teenage pregnancy rates.** Easy access means that adolescents know

² Knowles and Behrman, 2005

³Sex and HIV education Programs; ‘The effectiveness of sex education and HIV education interventions in schools in developing countries’ Douglas Kirby, Angela Obasi & B.A. Laris 2006

⁴ Wellings K, Collumbien M Slaymaker E et al. sexual behaviour in context of Global perspective, Lancet 2006

⁵ World Population Foundation, Sexual Health and care everywhere, comprehensive sexuality education and life skills training http://www.planetwire.org/files.fcgi/6278_Compsexualitytraining.doc

⁵ World Population Foundation, Sexual Health and care everywhere, comprehensive sexuality education and life skills training http://www.planetwire.org/files.fcgi/6278_Compsexualitytraining.doc

where to obtain information and services, can reach a provider easily are assured of receiving confidential non judgmental care and can obtain services and contraceptive supplies at little or no cost.

iii. **Comprehensive sexuality education, not abstinence promotion with provision for comprehensive information about prevention of HIV and STD's**, pregnancy, contraceptives availability, accessibility and usage with respect and responsibility within relationships.

iv. **Media to promote positive sexual behaviour** is more likely to promote health and responsible behaviour among adolescents⁶.

v. **Strong social welfare systems committed to reducing economic disparity** within their population with **Government commitment to social welfare** and equality for all members of society provides greater support for individuals well – being especially **in the areas of health and social policy**.

There are other examples in Bangladesh wherein Adolescent reproductive Health Education Program (ARHE)⁷ implemented by Bangladesh Rural Advancement Committee (BRAC); with rural adolescents has triggered the discussion on right age of marriage, child bearing and power relationships in the community for decision making on Sexual Reproductive Health and Rights of young adolescents girls in the program intervention area.

People's Opinion on Family Life Education in India

The latest National Family Health Survey –III by Government of India presents opinion of people regarding Family Life Education.

“Contradictory but true. While anxious parents are protesting against family life education in schools, the National Family Health Survey-III (NFHS) has found that people are for it. And most men and women think that boys and

⁶ Mass media can inform youth and the community about health issues, in principle, shape attitudes, beliefs and behaviours. Mass media campaigns raise knowledge significantly. In addition to curriculum based health education and sex education program in schools efforts should be made to include youth development programs through youth center's and the use of mass media to influence the knowledge attitude and behaviour of young people. (Source: Ch 5, growing up Healthy, Pg 123 ; world Development Report 2007)

⁷ The ARHE curriculum includes physical and mental changes during adolescence, physiology, pregnancy and child bearing, guidance about age at marriage, sexually transmitted infections (STI's), family planning, substance abuse, gender issues, male and female roles in reproduction and violence against women and girls. In 1999, BRAC evaluated the ARHE program the article (wherefrom the extract sites example) explores perceptions of adolescents as they faced psychological and social changes, the program results of ARHE and the factors that influenced community acceptance of the programme. (Source: Providing Sex education to rural adolescents in Bangladesh: Experiences from BRAC, Gender and Development 2000)

girls should be informed not only about HIV/AIDS but also about sex and sexual behaviour.”

Source: Indian Express, Chennai, October 26, 2007

First ever study in India on Acceptability of Family Life Education in schools, by NFHS-III has following findings:

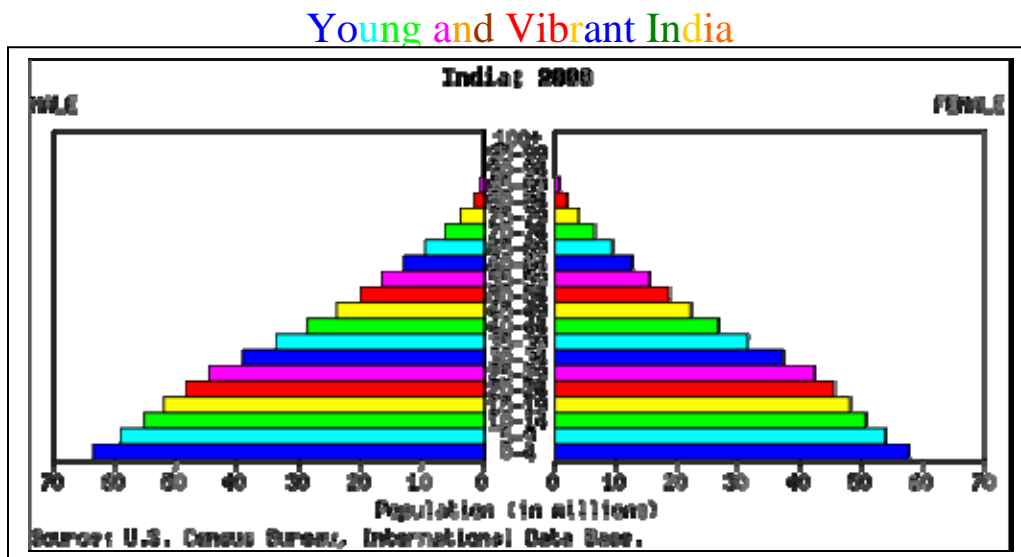
- Virtually all Indian adults agreed that Children should be taught moral values at schools”. And that is not all, most adults think
- Most adults think the young ones should know about the changes in their bodies during puberty too.
- The survey found that approval to topics related to HIV/AIDS- sex and sexual behaviour, condom use is lower but substantial

In many societies, young women have sexual relationships with men who are considerably older than them. Sexual relations with a significantly older partner may be consensual or may be forced or coerced. A culture of silence surrounding sexuality may result in young women not registering any formal or informal complaint when forced by a man to have sex. Recent studies (Kishore and Johnson, 2006; Watts and Zimmerman, 2002) have highlighted the dynamics of sexual violence, which includes lack of young women’s control over their own sexuality. In most cases of sexual violence against young women, the male perpetrators are older than the women, be they a family friend, a relative, or a stranger. Sex between young women and men who are significantly older than the women is theorized to be one of the contributing factors to the spread of HIV and other STIs, under the assumption that older men have been exposed to the risk of HIV and other STIs longer than have the younger women they have sex with, whether it is forced or consensual sex.

Accordingly, NFHS-3 asked all women age 15-24 who had sex in the 12 months prior to the survey to identify the age of their last sexual partner and, if they had more than one partner, the age of their next-to-last sexual partner. Women who could not state the exact age of their sexual partner were asked to estimate whether or not the partner was 10 or more years older than them. Overall, NFHS-3 found that 11 percent of women age 15-19 who had higher-risk sexual intercourse in the 12 months preceding the survey report having sex with a man who was 10 or more years older than themselves. However, the total number of young women age 15-19 who engaged in higher-risk sex in the 12-month period prior to the survey is too few to assess meaningful associations in age mixing by background characteristics. Accordingly, these data are not shown. (*NFHS_III*)

4. Socio-economic, Health and Demographic Profile of Adolescents in India

Many times, the resistance to Adolescence Education Programme is due to the lack of earnest appreciation for the concerns of adolescents and misplaced apprehensions among adults. To shed the veil of apprehensions with regard to Adolescent Education Programme and Adolescent Sexual and Reproductive Health Programmes, it is important to do a reality check vis-à-vis adolescents and their socialization and behaviour.



Total population of India: 1 Billion

Adolescent Population: 225 million in the age group of 10-19 years i.e., 22 % of the total population

- The broad-based population pyramid of India indicates that largest population group are that of children and adolescents
- 225 million adolescents will be added to the reproductive age group in the coming years, determining the future population growth in the country.
- Increase in children and young people especially girls' enrollment in schools.
- More than 80% of adolescents 15-19 age group are literate¹ Today young people in India have diverse career options.

¹ census 2001

- Increasingly women are joining the work force and are being encouraged for higher studies
- Age at marriage is increasing steadily and there is increased consciousness for restricting family size.

A sizeable population: Adolescents comprise nearly one-fifth of the total population in the country (21.8 %)²

Composition varies by age and sex: Of the total population, 12.1 % belong to 10-14 age group and 9.7 % are in the 15-19 age group. Female adolescents comprise 47 % and male adolescents 53 % of the total population³

Adverse Sex Ratio: The sex ratio among 10-19 years is 882 females for 1000 males, lower than the overall sex ratio of 933. It is 902 for younger adolescents aged 10-14 years and 858 for older adolescents aged 15-19 years (Census 2001). The present adverse sex ratio in 0-6 years (927 girls for 1000 boys), will affect the adolescent population in the coming years. This is fast leading to a situation where there will be more men and fewer women for marriage.⁴

Literacy: Census 2001 indicated that more than 80% (85.5% men and 75 % women) of 15-19 age group is literate. However details of state of education is not reflected. The **Gender Parity Index (GPI)** that measures progress towards gender equity in education, reflects increasing disparity with increasing level of education- **I-V (0.95); I-VIII- (0.93) and IX to XII (0.79)**. GPI value of 1 indicates equal learning opportunities being available for girls. Present GPI values indicate details that are of serious concern. Gross Enrolment for 14-18 years (for IX-XII classes) is 44.26% for boys and only 35.05 % for girls. Corresponding Dropout rate for Boys for I-VIII is 50.49 % and for I-X is 60.41 %; while for Girls it is I-VIII is 57.28 % and for I-X is 63.88 %.⁵

Early marriage: More than 49 lakhs under the age of 18 years are married.⁶ Approximately 21% of boys and 28% of girls get married below the legal age of marriage (NFHS-III). Mean age at marriage for females is 18 years and males 22.6 years. Fertility at age 15-19 accounts for 14 percent of total fertility in urban areas and 18 percent in rural areas.⁷

Higher Female Mortality Rates – A high risk of pregnancy and childbirth results in a high level of female mortality, in addition to high morbidity, in the reproductive age group. Maternal mortality and morbidity of teenage mothers is a cause for concern.

² census 2001

³ census 2001

⁴ census 2001

⁵ Selected Educational Statistics 20004-5, Department of Education, MHRD

⁶ census 2001

⁷ International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS)

Gender differentials in mortality rates exist during adolescence. Mortality in female adolescents of 15-19 is higher than adolescents 10-14 years. The pervasiveness of discrimination, lower nutritional status, early marriage and complications during pregnancy and childbirth among adolescents contribute to female mortality⁸

Premarital Sexual Relations are increasing – Increase in age at marriage, increased mobility and peer pressure makes the young people vulnerable to indulging in unsafe sexual behaviour.

More than one in five young women and men report that they have made or received an offer to become romantically involved with a number of opposite sex. About one in five males and about one in twenty females have engaged in sex before marriage and many more have experienced physical contacts with a romantic partner. In case there is sexual relationship, it takes place by the age of 16, especially in case of girls.⁹

The median age at first sex was reported to be 18 years in rural and urban areas as well as for male and female respondents. Eight percent of the youths in BSS 2006 against seven percent in BSS 2001 reported sex with non-regular partners during preceding 12 months. The proportion reporting sex with non-regular partners was significantly higher among males at 13 percent as compared to females (3%). Among the youth who had sex with a non-regular partner in the last 12 months, 62 percent reported condom usage during last sex with non-regular partner. There has been a significant increase in this respect since BSS 2001 (52%). Compared to 34 percent of the youth in BSS 2001, 47 percent in BSS 2006 reported consistent condom usage with non-regular sexual partner in last 12 months.¹⁰

These sexual contacts are usually without condoms and for some adolescents, such relationship is a result of force.¹¹

Unsafe abortions: In India, 11 million abortions take place annually and around 20,000 women die every year due to abortion related complications. Between 1 and 10 percent of abortion-seekers in India were adolescents.¹² Atleast one half of unmarried women seeking abortions at facilities are adolescents, many of who are below 15 years of age.¹³ The stigma attached to unmarried pregnancies and judgmental attitude of service providers prevent adolescent to seek abortion services in a legal set-up.

Economic compulsions force many to work – Nearly one out of three adolescents in 15-19 years is working – 21 percent as main workers and twelve percent as marginal workers¹⁴. Economic compulsions force adolescents to participate in the workforce

⁸ (CSO 2002, SRS 1999)

⁹ (Source: National AIDS Control Organisation, Ministry of Health and Family Welfare Government of India and National Institute of Medical Statistics, (Indian Council of Medical Research), New Delhi, 2008, Youth, National Behavioural Surveillance Survey (BSS), 2006)

¹¹ IIPS and Population Council 2007, Youth in India, Situation and Needs 2006-2007: Fact Sheets Maharashtra, Tamil Nadu, Jharkhand IIPS Mumbai

¹² Ganatra B. Abortion Research in India, 2000

¹³ Jeejebhoy, S. 2000 “Adolescent Sexual and Reproductive Behaviour: A review of Evidence from India.”

¹⁴ Census 2001

resulting in high dropout rate for education. Despite adult unemployment, employers like to engage children and adolescents because of cheap labour.

Malnutrition affects development – Intake of nutrients is less than the recommended daily allowances for adolescents below the age of 18 years both for boys and girls in rural India¹⁵. More than 70 percent girls in the age group of 10-19 years suffer from severe or moderate anaemia¹⁶. Two thirds suffer from Chronic Energy Deficiency of the third degree with Body Mass Index (BMI) below 16. Adolescent mothers are at higher risk of miscarriages, maternal mortality and giving birth to stillborn and underweight babies. Iodine Deficiency Disorders can lead to growth retardation and retard mental development. Only half of the households are using iodized salt for cooking in India¹⁷. Increasing number of adolescents especially in the towns and cities are falling prey to lifestyle diseases like obesity, diabetes, etc.

Mental Health and Substance Abuse: Youth is the stage in which most mental disorders have their onset. Young people have a high rate of self-harm and suicide is a leading cause of death in young people.

In adolescents of 15-19 age group, it has been reported that 3.5 % of girls chew; and 0.1 % smoke tobacco while in 28.6% of boys chew and 12.3% smoke tobacco. 11% of boys of the same age group drink alcohol.¹⁸

The subjects in the treatment centers reported that about 11 percent were introduced to cannabis before the age of 15 years, and about 26 percent between the age of 16 and 20 years¹⁹. Social factors such as illiteracy, economic background, unemployment and family disharmony increase vulnerability to drug abuse.

Delinquent behaviour is increasing- Incidences of vagrancy; delinquency, alcoholism, drug addiction, truancy and crime amongst adolescents have seen a sharp increase in the last few years. Boys outnumber girls and most of them are illiterate or have studied upto the primary stage (41 percent primary, 29 percent illiterates); a large number are school drop-outs²⁰.

Crimes against adolescents are on rise –Sexual abuse of both boys and girls cut across economic and social classes. Crimes against girls range from eve teasing to abduction, rape, prostitution and violence to sexual harassment. Most rape victims are in the age group of 14-18 years. In 82 percent of rape cases, the victims knew the offenders and 32 percent were neighbors.²¹ Unfortunately, social taboos prevent these crimes from being registered. Even when registered, prosecution rarely takes place. In case of sexual abuse of boys (12-17 years), they are mainly victims of homosexual abuse.

¹⁵ NNMB 2001

¹⁶ DLHS-RCH 2004

¹⁷ MICS 2000

¹⁸ IIPS and Marco International, 2007. NFHS-3, 2005-06: India: Volume I, Mumbai: IIPS

¹⁹ (UNODC and Ministry of Social Justice & Empowerment, 2004

²⁰ (NCRB 2003)

²¹ National Crime Record Bureau, 2001

Unmet need for contraceptives - While knowledge of family planning is being promoted, the availability and skill to use contraceptives is not well publicized. In addition, lack of choices and quality is a major constraint too. Even amongst currently married women there is an unmet need of contraception, being the highest in the age group 20-24 followed by 15-19 years. In 15-19 age group 25% have reported unmet need for limiting and 2 % for spacing.²² Some 15 % births to adolescents' aged 15 to 19 in India have been reported to be unplanned.²³

Misconceptions about HIV/AIDS are widespread – Youths (86%) in BSS 2006 were aware of either HIV or AIDS or both and there has not been any change in this respect since the BSS 2001. The awareness about HIV/AIDS was significantly higher in urban areas and within both urban and rural areas, higher proportion of males than females were aware of HIV/AIDS. Even among the youth aware about HIV/AIDS, only two-thirds reported that the disease can be prevented by consistent condom use and by having one faithful uninfected sex partner. Proportion of respondents with comprehensive correct knowledge of HIV/AIDS transmission and prevention has increased significantly from 22 percent in BSS 2001 to 28 percent in BSS 2006. In both the surveys, the corresponding percentage was significantly higher among males and in urban areas. This proportion was relatively higher for 20-24 age group (30%) compared to the 15-19 years age group (27%).²⁴

Among respondents aware of HIV/AIDS, 68 percent (urban 69%, rural 66%) reported that PLHA should be allowed to stay in the community/village. More than three-fifths of the respondents aware of HIV/AIDS reported that they are willing to share food with PLHA. This proportion was significantly higher for urban (69%) and male (64%) respondents. Overall, five percent of the respondents in BSS 2006 (4% in BSS 2001) reported any STD symptom (self-reported prevalence) in last 12 months. Higher proportion of females (6%) reported any STD symptom as compared to males (4%). Further, STD prevalence was observed to be marginally higher in rural areas (5 %) than urban areas (4 %).

Compared to the awareness of HIV/AIDS, the awareness regarding STDs was significantly lower among the youth. However, the awareness about STDs has significantly increased from 29 percent in BSS 2001 to 36 percent in BSS 2006. Nearly two-thirds of the youths aware of STDs, knew that there is a linkage between STDs and HIV/AIDS.

At the national level, 48 percent of the youth reporting STD prevalence in the last one year, visited any health institution during last episode of any STD symptom. The proportion was higher among male respondents at 55 percent as compared to females (43%).

²² NFHS-III.

²³ Pachauri, S. and K.G. Santhya (2003). "Contraceptive behaviour of adolescents in Asia : Issues and Challenges."

²⁴ BSS 2006

Only 22 percent (males 23%, females 20%) received interpersonal communication on STD/HIV/ AIDS in last one year preceding survey.

Among respondents aware of HIV/AIDS, only around one-third (males 39%, females 30%) reported to be aware of any HIV/AIDS testing facility in their area. The awareness was observed to be higher among respondents from urban areas (43%) than those from rural areas (31%).²⁵

Young People and HIV: A large percentage of HIV infected persons are between 20-40 years and had contacted the virus early in life indicating the importance of education during adolescence. Over 35 percent of all reported AIDS cases in India occur among young people in the age group of 15-24 years and more than 50 per cent of the new infections are being reported from young people²⁶.

However HIV prevalence is lower among young persons (age 15-24) than among persons in any other age group. Very few women (prevalence 0.03 %) or men (0.0) age 15-17 are HIV positive and HIV prevalence remains low at age 18-19 (0.12 % women, 0.02 % men). Among youth, HIV prevalence is highest for women age 20-22 (0.21 %) and for men age 23-24 (0.21%).²⁷

Trafficking and sex work has increased – Extreme poverty, low status of woman and complacency of law enforcing agencies has led to an increase in sex work. Expansion of trafficking and clandestine movement of young girls has also increased across national and international borders. The proportion of Human trafficking crimes committed towards total IPC crimes have shown mixed trend during last 5 years. A decrease of 55.0% has been observed in **Importation of Girls (Sec. 366-B IPC)** cases as 67 cases were reported during the year 2006 as compared to 149 cases in the previous year (2005). 231 cases were reported in the year 2006 under **Procurement of Minor Girls (Sec. 366A IPC)** as compared to 145 such cases in 2005, accounting for 59.3% increase over 2005. 123 cases of 'Selling of Girls for Prostitution' were reported in the country during 2006 against 50 such cases in 2005, thereby indicating an increase of 146 percent over 2005. 35 cases of 'Buying of Girls for Prostitution' were reported in the country during the year 2006. This indicates a 25 percent increase in the incidence over 2005 when 28 cases reported in the country. Cases under **Immoral Trafficking (Prevention) Act 1956** have registered an increase of 23.1 per cent (4,541) during the year as compared to the previous year (5,908). The cases reported under **Child Marriage Restraint Act, 1929** have declined by 18.9 per cent over the previous year (122)²⁸.

Disability in adolescents is being recognised – Disability was reported among 1.99 percent of the adolescents in the 10-19 age group. Among the disabled adolescents, 40 percent reported visual disability and nearly one third (33 percent) reported movement

²⁵ National AIDS Control Organisation, Ministry of Health and Family Welfare Government of India and National Institute of Medical Statistics, (Indian Council of Medical Research), New Delhi, 2008, Youth, National Behavioural Surveillance Survey (BSS), 2006

²⁶ (NACO, 2005)

²⁷ (International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005–06: India: Volume I. Mumbai: IIPS)

²⁸ <http://ncrb.nic.in/cii2006/cii-2006/CHAP6star.pdf>

disability. Males generally reported a higher percentage of the disability than the females.²⁹

²⁹ census 2001