Advocacy Kit on Adolescence Education Programme (AEP)

Advocacy kit has been proposed in two parts:

1. Main kit - **Challenges of Adolescence: Lets empower them with information and Skills**
2. Supplementary - **Ready Reckoner –For Advocacy on AEP**

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)
8. Voices of Young People

Ready Reckoner contains detailed information on corresponding topics discussed in the kit. The advocate can use detailed information for her/his understanding on specific topics. 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 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. Adolescence Education Programme (AEP), 2005

Adolescence Education Programme (AEP) is a joint initiative by Ministry of Human Resource Development (MHRD) and National AIDS Control Organisation (NACO), Government of India, to equip every adolescent (child between 10-19 years) with scientific information, knowledge and life-skills to protect themselves from HIV infection and manage their concerns pertaining to reproductive and sexual health. AEP is an umbrella programme to cover all the secondary and senior secondary schools of the country. Presently it is being proposed for transaction by nodal teachers in classes 9th and 11th for minimum of 16 hours in an academic year. The methodology adapted for AEP is interactive, participatory and based on life-skills.

KEY ELEMENTS OF AEP:

I. Process of Growing-up necessitate understanding of:
II. Adolescent Reproductive and Sexual Health entail:
III. Mental Health and Substance Abuse:
IV. HIV and AIDS

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.

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

Objectives of AEP:

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.

BENEFITS OF AEP:

A. An 'Adolescent' will have

- enhanced perception about oneself; self-confidence and self-esteem
- strong skills to think rationally and critically, negotiate, assert, and make informed decisions at crossroads of life
- knowledge on physical, mental and emotional changes
- understanding on importance of abstinence till physical and mental maturity is attained
- knowledge on HIV and other sexually transmitted infections
- better understanding on the risks involved in substance abuse
- enhanced level of confidence and communication skills to voice ones' concern; to seek protection and freedom from exploitation of any kind

B. A Parent will have

- better understanding on needs and concerns of their adolescent child especially with regard to Adolescent Reproductive and Sexual Health (ARSH)
- better comfort level to initiate a dialogue with child on matters pertaining to ARSH
- a supportive environment to discuss and workout solutions for specific concern related to their child

C. A Teacher and Educator will have

- a structured content to talk on ARSH with comfort and confidence
- opportunities to enhance understanding and professional skills to deal with inappropriate behaviour by students (that is usual upshot of adolescence) at times
- opportunities to enhance understanding and skills to effectively address the adolescents in special needs.

2. Appreciating the Need of Adolescence Education Programme (AEP)

More than 22 percent of India's population is between the age group of 10-19, representing a vibrant human resource. Adolescence is a period of formative and dynamic transitions. What happens in the future depends, to a large extent, on the decisions taken by adolescents as they enter their reproductive years. At the same time, the process of commercialization and globalization is influencing the social mores world over including India. Hence it is of utmost importance to strengthen efforts and formulate innovative strategies to channelize adolescents' energies in a constructive direction. AEP is one such effort, keeping pace with the challenges of the new generation.

NEGATIVE HEALTH OUTCOMES INFLUENCE OVERALL DEVELOPMENT

- Affect education of adolescent and may prevent further education;
- Influence the overall development of an individual
- Result into lesser job opportunities
- Affect the economic status of the family while investment on health concerns increase substantially
- Affect the overall progress of the family- socially and economically
- Will have serious impact on the economy and development of nation as a whole

REACHING YOUNG PEOPLE EARLY IS MORE EFFECTIVE

- Health behaviors that will last long into adulthood can be strongly influenced
- Gender norms and roles, notions about responsible sexual behaviors, and awareness of such issues can be shaped
- Positive life style can be encouraged
- Education does not have adverse impact, it always enriches human beings

ADOLESCENCE EDUCATION CAN MAKE THE DIFFERENCE

- To avoid harmful behaviour like drug use and irresponsible sexual practices
- Help adopt self-control as a best option to lead a healthy life
- Prevent early marriages and pregnancy
- Preserve resources invested on negative health outcomes

'Increasing investment in improving the lives of adolescents will also have an impact on achieving several of the Millennium Development Goals (MDGs) that includes gender equality, education, maternal and child health and reversing the trend of HIV epidemic'

ADOLESCENTS ARE MORE VULNERABLE THAN THE OLDER ADOLESCENTS

- They are different cognitively and emotionally.
- They may lack the ability to use abstract thought to project their actions
- They have unclear understanding of consequences of their behaviour.
- Younger adolescents may not readily associate emotional issues with puberty and are often unable to express their feelings

YOUNGER ADOLESCENTS OFTEN HAVE DIFFERENT CONCERNS ABOUT SRH

- Mostly concerned about issues of puberty and body image and developing interest in relationship with opposite sex
- Some may be especially concerned with masturbation.
- Myths regarding body growth and physiological change adolescents' rate of development in relation to their peers

ADOLESCENTS MAY BE MORE VULNERABLE TO SEXUAL COERCION

- Lack of knowledge prevent children clearly differentiate between love; care and abuse and often they don't know how to express their discomfort.
- They have lower level of confidence and communication skills to voice their concern and seek protection
- Abusers being known and or from within the family add to their inhibitions

- **53.2 % of children have reported facing one or more forms of sexual abuse**
- In 50% of cases, the abusers were either known or in the position of trust and responsibility and most children do not report the matter to anyone
- Adolescent boys are equally at risk

Source: National study on child abuse-2007, Department of Women and Child, DWCD

- Young girls are more likely to regret first sex, suggesting that they may have been coerced.
- In many regions, trafficking of girls is an increasing concern.
- Evidence suggests that older boys and men intentionally seek younger partners whom they think they are not HIV positive.
- Sexual abuse in both boys and girls is linked to increased chances of multiple sexual partners and non-use of contraception during adolescence.

3. Understanding Adolescence

We as adults often tend to see adolescents either as children or young adults. The transitory but crucial phase of passage from childhood to adulthood goes unrecognized. Adolescent population is a positive and vibrant force to nurture and preserve and this necessitates a better understanding on 'growing-up' concerns.

ADOLESCENTS

- **Adolescents are persons between the age group of 10-19 years**
- **Growth phases can be demarcated as early adolescence (10-13 years), middle adolescence (14-16 years) and late adolescence (17-19 years)**

ADOLESCENCE IS MARKED BY

- Rapid physical, psychological and social maturation
- A need to extend relationships beyond the immediate family
- A sense of idealism, curiosity and adventure
- Willingness to take greater risks and experiment

CONCERNS OF ADOLESCENTS

A. Psychological Concerns

1. Developing an identity

- Self – awareness helps adolescents understand themselves and establish their personal identity. Lack of information and skills prevent them from effectively exploring their potential and establishing a positive image.
- Adolescent girls are brought up with several stereotype gender roles. Boys build their 'egos' to assume masculine roles. " Suffering in silence" is seen as a virtue among women and girls.

2. Managing Emotions

- Adolescents have frequent mood changes reflecting feelings of anger, sadness, happiness, fear, shame, guilt, and love. Very often, they are unable to understand the emotional turmoil.
- Sex hormones secreted during puberty affect changes in sexual and emotional behaviour. Lack of knowledge regarding bodily and emotional change cause stress.
- They do not have a supportive environment in order to share their concerns with others. Counseling facilities are not available.

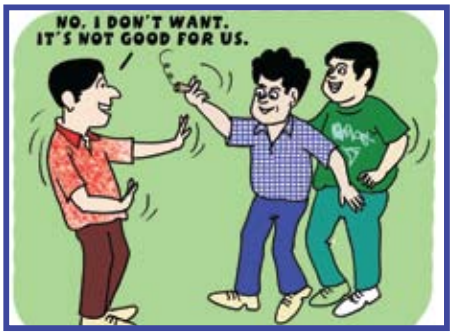
3. Building Relationships

- As a part of growing up, adolescents redefine their relationships with parents, peers and members of the opposite sex. Adults have high expectations from them and do not understand their feelings.

- Adults do not respect their right to choose with dignity and participate in decision- making processes.
- Adolescents need social skills for building positive and healthy relationships with others including peer of opposite sex. They need to understand the importance of mutual respect and socially defined boundaries of every relationship

4. Resisting Peer Pressure

- Adolescents find it difficult to resist peer pressure. Some of them may yield to these pressures and take on to experimentation at greater risk.
- Aggressive self conduct; Unsafe sexual behaviour and Drug use involve greater risks with regard to physical and mental health
- The experiment with smoking and milder drugs often leads to switching over to hard drugs and addiction in later stage.
- The risk of contracting HIV and getting involved in anti-social behaviour are serious consequences of drug abuse.



B. Health Concerns

1. Understanding the process of growing up

- Body image and rate of growth in relation to peers is a major concern of young adolescents
- Misconceptions about menstruation, masturbation and nocturnal emissions cause stress.
- Social norms and inability to share their concerns with others make it even more stressful.

2. Acquiring Information, Education and Services on Reproductive and Sexual Health

- Exposure to media and mixed messages from the fast changing world have left adolescents with many unanswered questions
- The widening gap in communication between adolescents and parents especially on ARSH is a matter of great concern
- Teachers still feel inhibited to discuss issues frankly, sensitively and interestingly
- Services providers are judgmental and do not ensure confidentiality
- Adolescents seek information from their peer group who are also ill informed and some fall prey to quakes
- Fear and hesitation prevent them from seeking knowledge on preventive methods and medical help if suffering with RTIs and STIs.

3. Communicating and Negotiating safer sexual practices

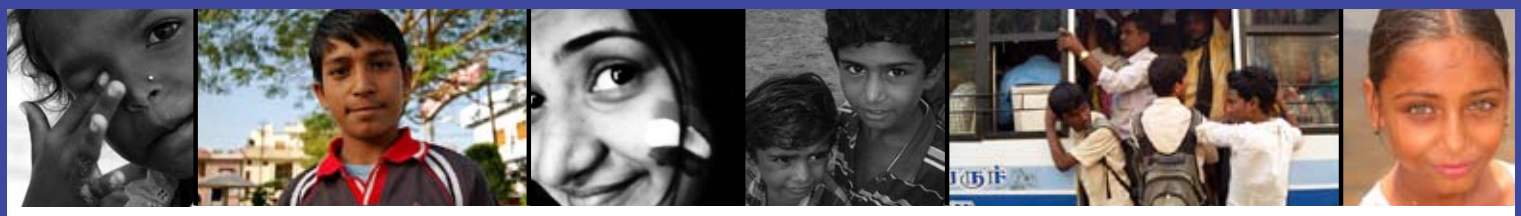
- Sexually active adolescents face greater health risks
- Their knowledge of contraceptive and use of condom to prevent sexually transmitted infections (STIs) is limited
- They have poor access to contraceptives and condom
- They have poor skills to communicate, negotiate and assert
- These increase vulnerability to STIs / HIV infection
- The power relation in a sexual relationship makes it difficult for female adolescents to negotiate for condom use.
- Adolescent female are more susceptible to such infections due to biological structure; lower status within gender relationship; lack of financial power
- Girls may also face mental and emotional problems related to too early sexual initiation
- For unmarried mothers, there is social stigma, leading to horrifying consequences.

4. Poor health

Nutritional intake among adolescents especially girls is still a matter of concern. Several families do not yet recognize food intake needs of a girl. Girls are not served adequate/ nutritious food incomparision to male members/ siblings in the family etc. Besides, over nutrition and other lifestyle diseases like obesity; diabetes are emerging fast as major health problems among adolescents. mental health

C. Social practices: Avoiding Early Marriage and Early Pregnancy

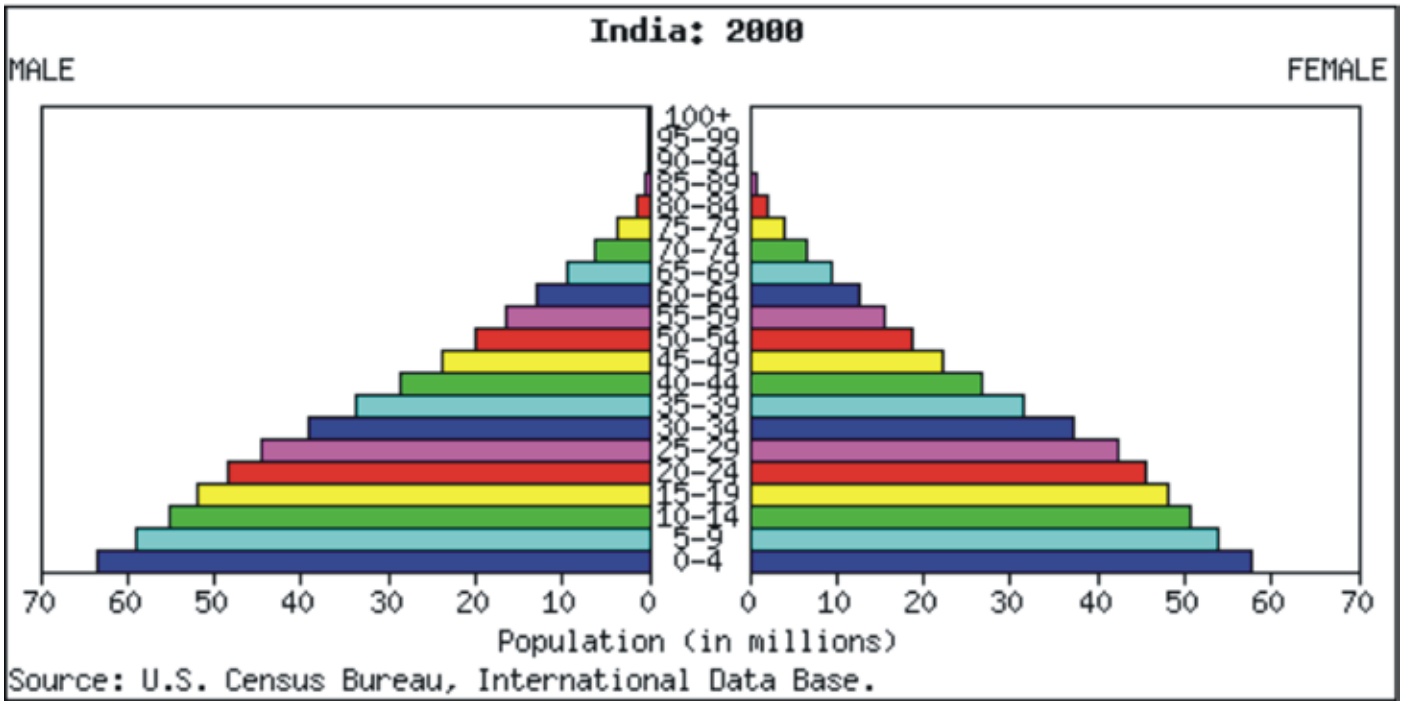
- Adolescents, both girls and boys are forced into early marriage and have very little say in selecting their marriage partners.
- Early marriage has far reaching consequences in terms of their development, fertility rate and reproductive health.
- Marriage curtails education and alters their choice of careers.
- Cultural norms may encourage early child bearing, posing risks to both infants and mother. If girls who are not fully developed become pregnant, they can experience damage to their reproductive tracts, delayed or obstructed labour, ruptures in the birth canal and increased risks of maternal mortality.
- Teenage parents lack experience, skills and resources needed to raise their children



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 needs and 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.

Young and Vibrant India



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 literate [1] Today young people are 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.

SOME HARD FACTS IN CONTEXT OF ADOLESCENT (15-19 AGE GROUP)

I. Population

- Adolescents (10-19yrs) comprise nearly one-fifth of the total population in the country (21.8 %)[2] Female adolescents comprise 47 % and male adolescents 53 % of the total population [3]
- Adolescents in 15-19 age group constitute approx. 45% of total adolescent population.[4]
- 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[5]

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.

II. Poor Education

- Gender Disparity Index (GPI) that measures progress towards gender equity in education (on a scale of 0 to 1), reflects increasing disparity with increasing level of education (class wise).[6]

1-V - 0.95% → I-VIII- 0.93 % → IX to XII 0.79

**When GDI is 1 at any level of education, it shows that the learning opportunities are available for girls equally to that of boys.*

- Gross Enrolment for 14-18 years (for IX-XII classes) is only 44.26% for boys and 35.05 % for girls.[7]
- The Drop-out rate for Boys for I-VIII is 50.49 % and for I-X is 60.41 %; while for Girls it is 1-VIII is 57.28 % and for I-X is 63.88 %.[8]

III. Early Marriage and Early Pregnancy

- More than 49 lakhs of adolescents under the age of 18 years are married. [9]
- Approximately 21% of boys and 28% of girls still get married below the legal age of marriage.[10] Nearly 20 percent of the 1.5 million girls married under the age of 15 years are already mothers.[11]
- Maternal mortality and morbidity of teenage mothers is a cause for concern. Mortality in female adolescents of 15-19 is higher than adolescents 10-14 years.
- In case there is sexual relationship, it takes place by the age of 16, especially in case of girls. These sexual contacts are usually without condoms and for some adolescents, such relationship is a result of force.[12]
- In India,11 million abortions take place annually and around 20,000 women die every year due to abortion related complications.
- At least one half of unmarried women seeking abortions at facilities are adolescents, many of who are below 15 years of age.[13]

2 Census 2001
3 Census 2001
4 Census 2001
5 Census 2001
6 Selected Educational Statistics 20004-5, Department of Education, MHRD
7 Selected Educational Statistics 20004-5, Department of Education, MHRD
8 Selected Educational Statistics 20004-5, Department of Education, MHRD
9 Census 2001
10 NFHS-III
11 Census 2001
12 (IIPS and Population Council 2007, Youth in India, Situation and Needs 2006-2007: Fact Sheets Maharshtra, Tamil Nadu, Jharkhand , IIPS Mumbai)
13 Jeejebhoy, S. 2000 "Adolescent Sexual and Reproductive Behaviour: A review of Evidence from India."

IV. Unmet need of Contraception

- 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.[14]
- Some 15 % births to adolescents' aged 15 to 19 in India have been reported to be unplanned.[15]
- Adolescent mothers in the age group of 15-19 years constitute age specific fertility rate (ASFR) of 0.090.[16]
- Adolescent mothers in the age group of 15-19 years contribute to TFR by 19%.[17]

V. Child Labour

- Nearly one out of three adolescents in 15-19 years is working – 21 percent as main workers and twelve percent as marginal workers.[18]

VI. Malnourishment

- More than 70 percent girls in the age group of 10-19 years suffer from severe or moderate anaemia.[19]
- Increasing number of adolescents especially in the towns and cities are falling prey to lifestyle diseases like obesity, diabetes, etc.

VII. Mental Health and Substance abuse

- Young people have a high rate of self-harm and suicide is a leading cause of death in young people.
- In adolescents (15-19 years) 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.[20]

VIII Crime

- 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-outs.[21]
- 53.2 % of children have reported facing one or more forms of sexual abuse.[22]
- In 50% of cases, the abusers were either known or in the position of trust and responsibility and most children do not report the matter to anyone [23]
- Adolescent boys are equally at risk[24]
- 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 [25]
- Unfortunately, social taboos prevent these crimes from being registered. Even when registered, prosecution rarely takes place. Incase of sexual abuse of boys (12-17 years), they are mainly victims of homosexual abuse.

IX. Misconceptions about transmission of STI and HIV

- 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.

14 NFHS-III
15 Pachauri, S. and K.G. Santhya (2003). "Contraceptive behaviour of adolescents in Asia : Issues and Challenges."
16 NFHS-III
17 NFHS-III
18 Census 2001
19 DLHS-RCH 2004
20 IIPS and Marco International, 2007. NFHS-3, 2005-06: India: Volume I, Mumbai: IIPS
21 NCRB 2003
22 DWCD, MHRD-2007
23 DWCD, MHRD-2007
24 DWCD, MHRD-2007
25 National Crime Record Bureau, 2001

- Among 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.
- 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 %).
- 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%).
- 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%). [26]

26 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)

State Specific Fact Sheet

Rajasthan is the largest state in the country according to land area and has population of 56 million according to 2001 Census.

I. Population:

- Total Population : 56 Million
- 15-19 years: 43 % of total adolescent population in the State

II. Literacy Rate:

- 75.5% of adolescents between 15-19 are literate. Of this 88.2% are male and 60.3% are female.
- Gender Disparity Index (GPI) that measures progress towards gender equity in education (on a scale of 0 to 1), reflects increasing disparity with increasing level of education (class wise). [1]

1-V - 0.93% → I-VIII- 0.85 % → IX to XII 0.48

**When GDI is 1 at any level of education, it shows that the learning opportunities are available for girls equally to that of boys.*

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

- Gross Enrolment for 14-18 years (for IX-XII classes) is only 44 % approximately for boys and 21 % for girls approx.[2]
- The Drop-out rate for Boys for I-VIII is approx. 61% and for I-X is approx. 70 %; while for Girls it is 1-VIII is 71% and for I-X is 81% .[3]

III. Early marriage

Mean age at marriage is 16.6 years for girls and 19.9 years for boys according to Census 2001. This is below the legal permissible age, in-spite of legal enactments on right age at marriage the traditional norm of child marriage perpetuates.

IV. Maternal mortality ratio and Infant Mortality rate

Maternal mortality ratio in women is 445 per hundred thousand live births [4]. Infant mortality rate for the state of Rajasthan is 65.3 as compared to the National average of 57. This clearly indicates towards more infant deaths in the state as compared to National figures.[5]

V. Fertility rate

Age specific fertility rate of young people aged between 15 to 19 years in Rajasthan state is 0.098 as compared to 0.090 for India. Similarly in the age group of 20-24 years the specific t\fertility rate has been 0.245 in Rajasthan compared to 0.209 in India The total fertility rate of women aged 15 to 49 is 3.21 in the state as compared to a National average of 2.06 [6]. Due to the early age at marriage leading to early sexual debut the fertility span of the married young woman is prolonged hence creating the probability for more children.

VI. Child Sex Ratio

Most of the North Indian states have demonstrated a son preference this has resulted in skewed child sex ration due to sex selective abortion and female infanticide. Rajasthan records a decline from State average of 916 in the year 1991 to 909 in the year 2001 [7].

VII. Unmet need for contraceptives

The unmet need for contraceptives amongst young people aged 15 to 19 years in the state of Rajasthan is 26.8 as compared to the National average of 27.1 and reduces marginally for young people aged 22.8 but National average in this age group indicating only 21.1[8] .

This unmet need for family planning therefore explains the fertility rate in young people in the state.

VIII. Misconceptions about HIV/AIDS are widespread

With the epidemic of HIV looming large on reproductive and sexual health implications of youth and society at large it is imperative to understand knowledge on HIV transmission. In the state of Rajasthan only 23.2% of women and 42% of men in the age group of 15-19 years know about the misconceptions of HIV and also know how to prevent HIV. The percentile increases marginally within the age group of 20-24years of women (27.5) and men (44.5) .

IX. 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 state shares long porous border with Pakistan. The nexus is so strong and its execution flawless and above all the stigma attached to sex trade most of the cases go unreported. However in the recent past inter-state trafficking case was highlighted from some of the tribal districts of Rajasthan to Gujarat .

Indicators pertaining to education and health have been taken primarily because of its co-relate to Adolescent Education Program and its need in the country.

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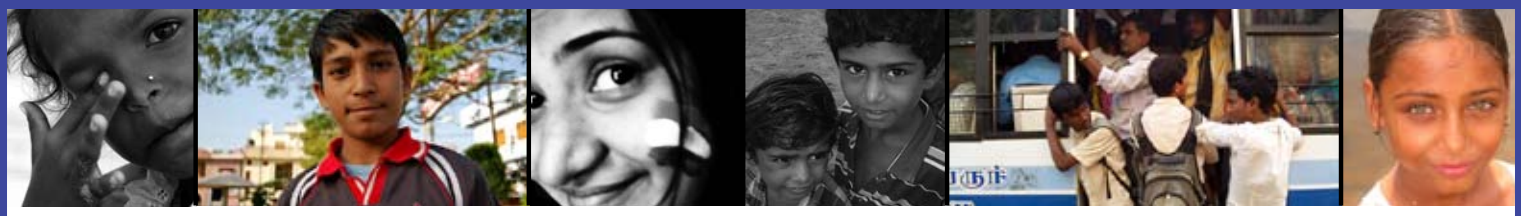
2 Selected Educational Statistics 20004-5, Department of Education, MHRD
3 Selected Educational Statistics 20004-5, Department of Education, MHRD
4 Maternal Mortality in India: 1997-2003 trends, causes and risk actors, Registrar General, India, NewDelhi in collaboration with Centre for Global Health Research University of Toronto, Canada, October, 2006
5 International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-2006. India. Mumbai: IIPS
6 Source: NFHS – III
7 Missing...Mapping the adverse child sex ratio in India UNFPA, June 2003
8 Source: Raw Data, International Institute for Population Sciences (IIPS) and Macro International. 2007. National Family Health Survey (NFHS-3), 2005-2006. India, MEASURE DHS, Macro International Inc., 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA



6. Initiatives by the Government of India

"AIDS is now becoming a major national problem and we need to tackle this on a war footing. We need to have a mass movement to ensure that this disease is rapidly checked and its growth arrested."

Dr. Manmohan Singh
Prime Minister of India
15th August 2005

India has ratified International Conference on Population and Development (ICPD), held at Cairo in 1994 and its Program of Action, the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), all highlighting the need for addressing the sexual and reproductive health concerns of young people. The commitment to such declarations has been a guiding principle for translating some of the consensus related to adolescent health in the policies and programmes in the country.

The key policies and Programmes that have emphasized the need of information, education, counselling and health services to address adolescents' needs and concerns are given below.

The National Polulation Policy 2000 addresses adolescent group as an underserved group. The policy acknowledge that the needs of adolescents, including protection from unwanted pregnancies and sexually transmitted diseases (STD), have not been specifically addressed in the past. Thus, it emphasizes on programmes for adolescents promoting access to information, counselling, education on risks of unprotected sex, right age for marriage and child bearing and improving access to contraceptive services with special attention to the needs of adolescents in rural India.

The National Health Policy, 2002 states, "It is widely accepted that school and college students are one of the most impressionable targets for imparting information relating to basic principles of preventive health care. The policy will attempt to target this group to improve the general level of awareness in regard to 'health promoting behaviour".

The National Youth Policy (NYP) was the first policy ever by the Government of India to recognise youth as a vital and vibrant human resource that had both right and an obligation to participate actively in shaping national development. The policy covers all youth in the country in the age group of 13-35 years. The youth belonging to the age group 13-19 years is regarded as a separate constituency. Adolescent especially female adolescent have been referred as priority target group.

National Youth Policy 2003 strongly recommends introduction of health education in the curricula of regular / formal education in higher classes of schools and colleges, in non-formal education centres and in every other organised interaction with the youth. Policy also acknowledge that adolescents exhibit mood-swings and might even

indulge in self-destructive activities, such as use of alcohol, drugs and violence; they need, therefore, to be treated with openness, understanding and sympathy and offered creative channels to harness their energies.

With regard to increasing vulnerability of young people especially adolescents to substance abuse, STI/HIV, policy states that adolescents being highly impressionable, and, therefore, prone to high risk behaviour, they require proper education and awareness about reproductive health issues, including safe sexual behaviour. The Policy, therefore, advocates a two-pronged approach of education and awareness for prevention and proper treatment and counselling for cure and rehabilitation. It further enjoins that information in respect of the reproductive health system should form part of the educational curriculum. The Policy also stresses the need for establishment of adolescent clinics in large hospitals and similar projects in rural areas to address the health needs of the young adults.

Last but not least policy recognizes that a growing population is a serious national problem that has negated many of our achievements in the field of development. The youth have an important role to play in this sphere and can create greater awareness in this regard through community programmes. Responsible sexual behaviour can be promoted through education in family-life issues and control of population. Therefore, adolescent age group has to be sensitized with regard to the correct age for marriage and for the first pregnancy, sufficient spacing between births and limiting the size of the family.

Youth empowerment and gender justice are recognised as the major thrust areas of the policy

Adolescent Reproductive and Sexual Health Programme (ARSH) under RCH-II (2005) reflects Government's unceasing commitment to international declarations towards promoting and protecting adolescent health and development. The RCH–II programme state that addressing adolescents in the program framework will yield dividends in terms of delaying the age at marriage, reducing the incidence of teenage pregnancy, the prevention and management of obstetric complications including access to early and safe abortion services and the reduction of unsafe sexual behavior. The two-pronged strategy under the Adolescent Reproductive and Sexual Health (ARSH) programme calls for integration of adolescent issues in all communication materials, and specific activities to address stakeholders at all levels and delivery of SRH services to adolescents through OPD on a dedicated day and time at PHC/CHC.

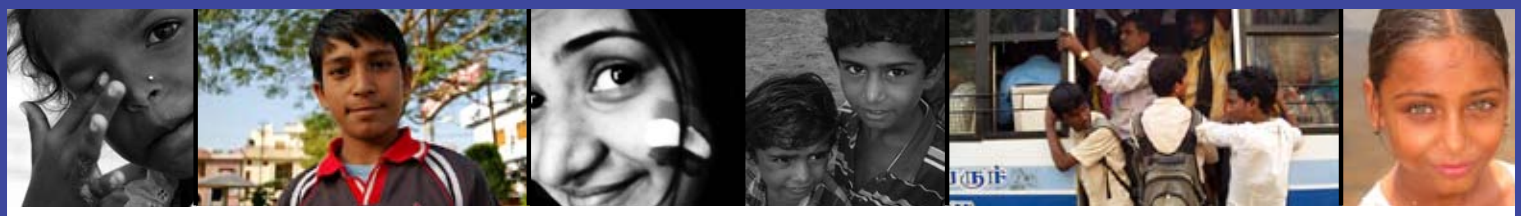
The third phase of National AIDS Control Programme (NACP-III- 2005), calls for a comprehensive approach to reach young people especially highly vulnerable groups. The overall focus of this five-year plan is on AIDS education, condom promotion, and the establishment of an improved blood transfusion system, among other areas. The Adolescent Education Programme, University Talks AIDS, Villages Talk AIDS, Red Ribbon Clubs and Link workers scheme are a few initiatives that have been specifically designed for adolescents, young people and women who otherwise are often missed out in the HIV education drive.

Kishori Shakti Yojana (KSY- 200) aims at empowerment and enhanced self-perception of adolescent girls is one of the significant programmes being run by Department of Woman and Child (MHRD). The **Integrated Child Development Services (ICDS)** Programme by the department is the world's largest early childhood intervention programme. Nutrition and health education for women in the age group of 15-45 is a major component of ICDS programme. Besides, Food and Nutrition Board (FNB) and National Nutrition Mission complement the education on nutrition. Department had been instrumental in amendment of crucial acts like Immoral Traffic (Preventions) Act (ITPA) to combat trafficking; Child Marriage Restraints Act 2005 to prevent early marriages and initiating Protection of Women from Domestic Violence Bill, 2005.

The National Population Education Programme (NPEP) was introduced in India in 1980 with the aim of institutionalizing population education in the existing education system of the country. Adolescent Reproductive Health is one of the six basic themes of NPEP, focusing on critical population education and development issues. The NPEP has now been institutionalized as part of the GOI's Tenth Five Year Plan.

National Adolescence Education Programme, a collaborative effort by MHRD and NACO is aimed at providing adolescents with authentic knowledge about process of growing up during adolescence, HIV/AIDS and substance abuse, helping them inculcate positive attitude towards these issues and developing in them life skills, so that they are capable to manage risky situations and challenges of life.

Besides, several ministries and departments of the government have schemes, services and plans that impact different aspects of the lives of adolescents. Ministry of social justice; Information and Broadcasting, Rural Development, Urban Affairs, Tourism and Culture, Environment and Labour and Employment are too doing their bit to streamline health and development of adolescents in a holistic way.



7. Working Together to Protect the Health and Well-being of Adolescents

No amount of research would be sufficient enough to address the growing needs and concerns of adolescents. In view of the dynamics of Adolescent behaviour especially during early adolescence, and the rapidly changing socio-economic environment, the issue of reaching this group becomes a complex process. Research on adolescents under the age of 16 or even 18 years is not easy because of deep-rooted social beliefs and taboo attached to the issue of reproductive and sexual health.

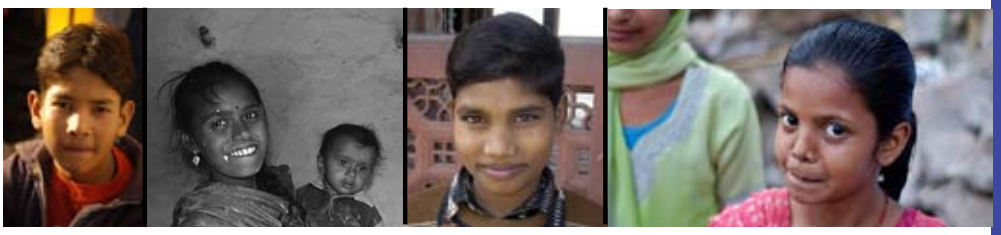
At the same time, increasing vulnerability of adolescents to a range of conventional and modern days practices is not unknown. The need to reach them with information and skills is now being widely recognised. Therefore, the endeavour to make the AEP program, culturally and developmentally appropriate continues.

Thank you for your valuable feedback that helped agencies to revisit the program strategy and contents with a new perspective. We are confident that together we partners in adolescent health and development can come out with the best possible methods to empower young people to make rational decisions in life.

At the Macro level we can contribute in:

- *Building positive relationships with adolescents;*
- *Opening channels of communication (two-way) with adolescents on their needs and concerns especially with regard to difficult subjects like Reproductive and Sexual Health*
- *Ensuring proper implementation of AEP and ARSH Programmes; and*
- *Strengthening linkages with other systems and enable concerted effort for adolescent development.*

Lets weave a safety net for our adolescents to flourish without fear and discrimination



7 a. Parents

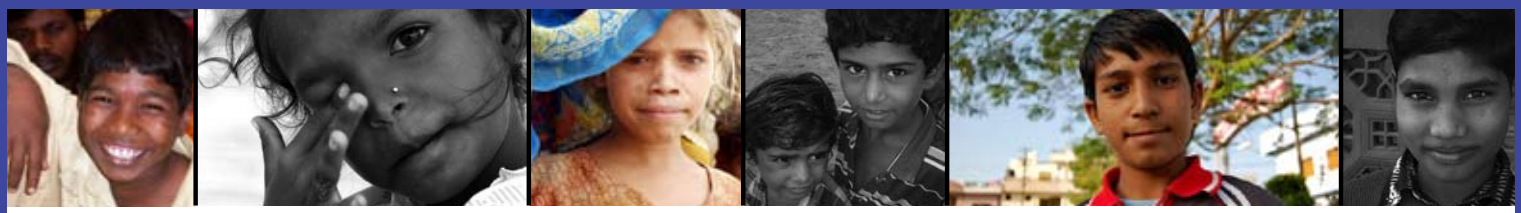
The ability to effectively navigate the unpredictable passage from childhood to adolescence is highly dependent on the presence of relations—positive relationships with peers, adults, and institutions that provide a safety net to support healthy development. These relations serve as a foundation upon which young people enter adulthood. Families that provide love, nurture and care equally to their children ensure healthier development for all children.

WE AS 'RESPONSIBLE PARENTS' CAN...

- appreciate the significance of the period of adolescence, its problems and challenges
- express our respect, love and care equally to all children irrespective of their gender and sexuality
- help them learn basic values to live by
- encourage decision-making skills among adolescents by providing them with age-appropriate opportunities.
- find out about their friends and help them identify and make friends with those who have a positive influence on them.
- refrain from thrusting goals on them; rather help them to channelise their energies in constructive ways.
- talk to them on their sexual and reproductive health needs and concerns;
- be aware of and understand childrens' inquisitiveness about love, life and relationships
- offer correct, age-appropriate and scientific information and counselling in a comfortable setting as and when required: it is important to communicate the importance of emotional and physical changes that they are experiencing; relationships; sexual abstinence; marriage; spacing of children; accessing healthcare.
- it is important to understand that parents own behaviour has determining impact on adolescent children. For parents teaching is same as living.

With regard to Adolescence Education Programme (AEP) and Adolescent Reproductive and Sexual Health Programme (ARSH), Parents should –

- keep track of teachings and activities at school. (Find out what is being taught about sexuality and reproductive health, who is teaching it, and what your children think about it.)
- help children to find reading material that offer accurate information on sexuality and reproductive health issues
- contact the right person (either school counsellor/ AEP teacher/ or a doctor) to talk to the child if it is uncomfortable for you to handle communication with the child on matters pertaining to growing up
- facilitate health services to adolescents in case of requirement



7b. Teachers

Teachers are the most important determinant of success of Adolescence Education Programme. Teachers/ educationists can help in creating an enabling environment for integration of AEP in school system and implementation in a proper way. Besides, teachers have are also responsible for explaining the content of AEP effectively and sensitively.

WE AS 'TEACHERS' CAN…

- Express our respect, and value for adolescents. Let them know that teachers trust them
- Never be judgmental and refrain from forcing personal values while interacting with adolescents (preaching proves counter productive)
- Create a supportive school environment: the human factor is personified in the teacher.
- Work towards integrating gender and rights perspective in the school system
- Contribute to development of their self-esteem and positive body image.
- Help adolescents to become sexually responsible adults by changing negative attitudes and perceptions.
- Promote sexual and reproductive health seeking behaviour; breaking down the taboo attached with it.
- Protect them from sexual exploitation or sexual abuse.

With regard to AEP and ARSH…

- Be convinced about the need and urgency of education about Adolescent Reproductive and sexual health (ARSH)
- Equip ourselves well for engaging students in educational activities on ARSH
- Encourage students to identify their personal, family, community, and religious values on sexual health and respect values that differ from their own.
- Discuss issues and concerns in the context of socio-cultural settings, reinforcing positive social values and clarifying negative social values in the context of changing situations.
- Influence a student's ability to question gender stereotypes and prevailing myths on reproductive health and sexuality
- Organize public events. Invite guest speakers to your school. Organize inter-school debates to open dialogue on the subject.
- Facilitate opportunities for adolescents to voice their concerns

7c. Opinion leaders / Community Leaders

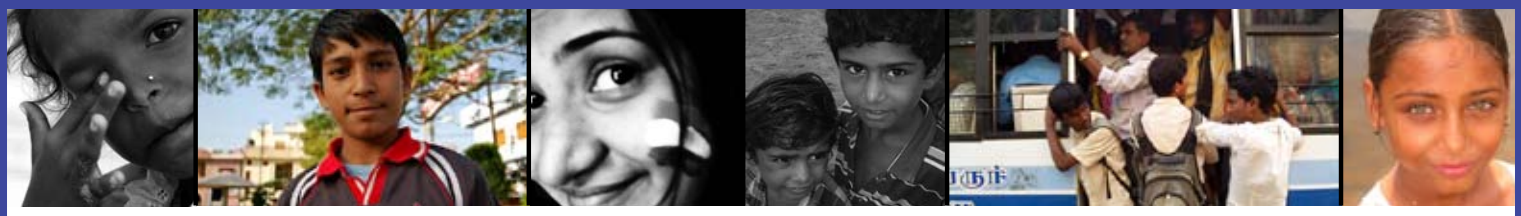
Opinion/community leaders have a important role in changing people's attitude and opinion. They are natural advocates for reproductive and sexual health (ARSH) concerns of adolescents. These leaders can nurture a supportive community environment for adolescent sexual and reproductive health and rights. Their endorsement to ARSH is a big support to individuals and agencies working for adolescent health.

WE AS A 'OPINION/ COMMUNITY LEADERS' CAN …

- Endorse the cause of adolescent health at any every available opportunity/opportunity
- Initiate a positive dialogue on adolescent concerns and Rights
- Represent the cause of adolescent to elected representatives of our area and other relevant authorities especially health and education authorities
- Provide protection to adolescents from unlawful punishments
- Provide space and opportunities to adolescents to present their concerns to elders without fear and hesitation.
- Help government and civil societies to organize IEC camps and interactive sessions on adolescent health; social evils like early marriages in the area
- Support media to produce in-depth news stories, articles and features on issues for adolescents particularly on days like the World AIDS Day, International Youth Day and Women's Day.

With regard to Adolescence Education Programme (AEP) and Adolescent Reproductive and Sexual Health Programme (ARSH), Opinion /Community leaders can

- Talk about the importance of AEP at public gatherings/meetings
- Create a demand for AEP in schools as well as for adolescents in out-of- school environment
- Create a demand for adolescent friendly health services
- Facilitate the work of AEP team and NGO workers
- Facilitate smooth implementation of adolescent health intervention programmes at the community level



7 d. Government Officials

Government Officials are the backbone for designing and implementation of development Policies and Programmes at all levels ranging from Central to State and Districts. They are the major stakeholder in breaking myths and barriers pertaining to ARSH and adolescent education in the society.

WE AS GOVERNMENT OFFICIALS/ CIVIL SERVANTS CAN:

- Enhance and push for positive policy changes and decisions on matters pertaining to adolescents
- Integrate Gender and Rights perspective in all policies and programmes
- Help in bringing and maintaining Adolescent Reproductive and Sexual Health center-stage
- Sensitize decision makers and elected representatives for pro adolescent /pro-youth approach keeping in tune with globalisation and changing perceptions and expected demands by young people as they take on electoral responsibilities in near future

With regard to Adolescence Education Programme (AEP) and Adolescent Reproductive and Sexual Health Programme (ARSH), Government servants and Bureaucrats can –

- Help in breaking barriers by talking on AEP and ARSH at conferences, seminars and other occasions
- Advocate for the integration of AEP in education system at national, State and district levels.
- Ensure speedy implementation of AEP and ARSH

7e. Service Providers

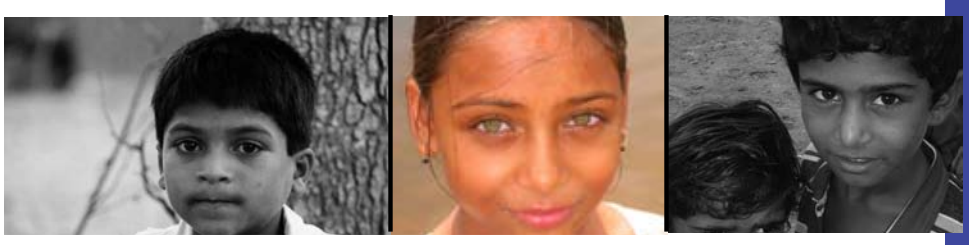
Service providers can bring about measurable improvement in the health status of the adolescents. They are considered most knowledgeable person and trusted source of information with regard to reproductive and sexual health matters. They can help immensely in reducing the barriers in utilization of RSH services by adolescents.

AS A SERVICE PROVIDER WE CAN …

- Make reproductive and sexual health services adolescent friendly
- Involve local adolescents/young people in planning to encourage ownership
- Promote and disseminate information on available services for adolescents at the CHC/PHC/district hospital
- Make procedures easier and designate days and timings suitable to adolescents
- Be non-judgmental
- Be conscious of our language and conduct to avoid biasness with regard to sex, gender, caste/religion
- Assure trust and confidentiality
- Maintain a record of adolescents seeking Information and services
- Make available range of services- preventive, curative and counselling
- Provide necessary support to those complaining sexual abuse and harassment
- Mobilize community leaders and parents to reach information, education and counselling to every adolescent in the area
- responsibilities in near future

With regard to Adolescence Education Programme (AEP) service providers can –

- Establish linkages with the schools to complement the educational work
- Offer help for counselling if required by the school system in some special cases
- Take help of school system to organize adolescent health camps
- Be available for teachers and parents for extra support in communicating with adolescents.



7 f. Elected Representative

With several progressive policies and programmes for adolescents and young people in place, there are still opportunities to streamline the strategies to effect implementation at each level of system. Adolescents representing 22% of India's population today is going to decide country's future course of progress and development.

AS 'PEOPLES' REPRESENTATIVE' IN THE GOVERNMENT, WE CAN...

- Continue efforts towards effective policy program dialogue and legislations
- Endorse adolescent needs and concerns publicly
- Play a positive role in breaking social taboos
- Address traditional practices that are harmful for adolescent growth and development like early marriages, female feticide, dowry, child labour etc.
- Promote need to bring about change in peoples' attitude to empower young people by providing equal opportunities for education and recreation irrespective of age, sex, gender and class
- Take proactive role in providing protection to adolescents from community/family punishments and facilitate counselling/ medico-legal assistance to adolescents in need. Your supportive action will send the message fast and clear.
- Raise adolescent health issues in public forum and encourage positive discussions and debate on the issue
- Incorporate Gender and Rights perspective in our addresses/speeches
- Ensure adolescent health concerns are incorporated into educational and health programmes and projects
- Advocate for additional resources to take up issues on adolescent health in Education/ Health budgets

With regard to Adolescence Education Programme (AEP) and Adolescent Reproductive and Sexual Health Programme (ARSH), elected representatives can –

- Help in breaking barriers by talking on AEP and ARSH
- Advocate and Facilitate integration of AEP at school system.
- Oversee speedy implementation of adolescent education programme and ARSH at the National/State/ District/ Panchayat levels

7 g. Media

Media has always been instrumental in positioning debates on development issues and voicing concerns of people especially those of social, economic and legal justice. Media commands respect from all sections of society for being credible and just. With people's exposure to at least one medium – T.V, Radio or Print; media has a major role to play with regard to adolescent reproductive and sexual health (ARSH) and need of appropriate education and services. However, media also being a major stakeholder in commercialization and globalization, wherein children and adolescents are exposed to varied messages on sexuality; media has the responsibility to impart correct information and dispel misconceptions.

AS A 'MEDIA REPRESENTATIVE' WE CAN…

- play a constructive role in breaking myths and prejudices that are prevalent in the society on adolescent sexual and reproductive health
- Integrate Gender and Rights perspective in all programmes that involve adolescent and young people
- Promote Sexual and Reproductive health Rights of adolescents and children
- Mould peoples' attitude and perceptions with regard to adolescents and their needs
- Encourage positive and meaningful discussions on ARSH
- Dedicate specific time/space for adolescent issues
- Provide space and opportunity for adolescents to voice their concern
- Partner in carrying public service campaigns on adolescent sexual and reproductive health in media

With regard to Adolescence Education Programme (AEP) and Adolescent Reproductive and Sexual Health Programme (ARSH), Media can –

- Help in breaking barriers on discussion of topic related to sexuality
- Advocate for the need of adolescent education on SRH through special programmes aimed at various stakeholders including elected representatives, teachers, service providers, parents etc.
- Communicate rationale for addressing needs and concerns of adolescents on reproductive and sexual health
- Keep track of integration and implementation of AEP in schools
- Complement efforts by teachers and parents by columns/programmes dedicated to address adolescent concerns
- Establish linkages with Schools/Teachers and organize talk shows on adolescent reproductive and sexual health
- Provide common platform for all stakeholders to discuss adolescent reproductive and sexual health needs and concerns face to face.

Voices of Young People

Recollection of adolescent years by some young people living with HIV who are also young advocates for Adolescent Reproductive and Sexual Health and Rights

"I have HIV since I was very small. My parents say I was very sick and some doctor by mistake gave me injection with used syringe. My parents don't know much, I tell them all these that I learn from the network… they are not like me, HIV positive. But you know they are happy to see me when I act like a teacher…I am also their teacher."

Rahul, student of class 7th

When we approach schools to conduct positive speaking session, the authorities ask so many questions. They are more interested in me rather than my work. They will ask how did I get HIV, make me feel miserable, as being a positive you do not have credibility to talk about prevention and values. I just tell them, look I got positive when I was 15, how… that is not important. I do not want these young people to face what I had. So, it is important for me to talk to them. I think teachers need training and sensitisation as well.

Mangesh, age 19

'16 years ago I left home due to bad company. That time I was only 14 years old. I have two sisters and three brothers. I left home because I did a mischief. On the eve of my sister's marriage, my father kept some money, which he wanted to spend for my sister's marriage. I stole all the money and left home and since then I have not gone back to meet my parents. Today I feel very sad about it and I realise my guilt. My parents tried to trace me out but when I saw them from far away, I hid myself and ran away from them. Many a times I feel like going home but I do not have the courage to go there'.

(from positive voices, SM05-22)

I was doing a part time job as an electrician in a shop. One day, people from an NGO came and asked few of us to help them with some interviews with other men working like us. After some days the officer from the organisation spoke to my boss and said we all should go for HIV test. We didn't have any issues as it looked like any other health programs conducted by such organisations and government. But…I was tested positive…I haven't told my family…no one as yet knows about my status…the organisation has given me so much of support…now I work with them on carrying out HIV prevention work among MSM groups.

Dilshad, 19

"I used to live in Delhi with my family. I was in class 9th. Then one day, one of our close relative came with a marriage proposal and told my parents if you delay then you might not get a good match later. Also the boy was of same kul/ gotra in Brahmin caste. My parents agreed and I was married off at the age of 16. I had to move to my in-laws village while my husband had to take up a job with diamond work at Surat. He was not keeping well. I was concerned and wanted to be with him but my in laws used to say, "Shahar ki ladki nahi lani chahiye, who kya kabhi gaon ghar mein rahegi." After few months when he visited us, he looked very weak, but we all thought it was because of exertion and also when you are living alone, you don't get proper food and care. So, this time my in-laws sent me to Surat with him. But his health was not improving at all rather he was very sick. We brought him back and admitted him in a hospital in Ghaziabad. He had to go through all the tests and one of them was for HIV. I was asked to collect the report, and I almost fainted when doctors asked me too to get tested. Both of us were found positive. We were completely shattered. His condition was deteriorating fast, he was not responding to medicines. I didn't have guts to tell my father and bhaiya about our HIV status but I had to, as I wanted to shift him to bigger hospital in Delhi and more than that to get doctors to attend my husband.

Rashmi Tiwari, age 24