Adolescents in India • Desk Review Report

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A desk review of existing evidence and behaviours, programmes and policies

Population Council
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November 2013

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Adolescents in India

A desk review of existing evidence and behaviours, programmes and policies
Acknowledgements

UNICEF India commissioned the Population Council, New Delhi to undertake this desk review.

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Foreword

It’s my pleasure to share this report on “ADOLESCENTS IN INDIA: A DESK REVIEW OF EXISTING EVIDENCE AND BEHAVIOURS, PROGRAMMES, AND POLICIES”. The report synthesizes key findings from various research studies conducted with adolescents in India. The review also highlights the existing national programmes and policies providing services to adolescents under various ministries of The Government of India.

Adolescence marks the developmental transition from childhood to adulthood. The nature and quality of young people’s future lives, as well as a country’s future social and economic development, depend largely on how well adolescents navigate this transition. There has been political commitment to meet the specific needs of the adolescent population which often varies depending on factors such as age, gender, marital status, place of residence and educational attainment. The review highlights gaps in existing evidence and makes policy recommendations emerging from the materials reviewed on sexual and reproductive health, education, nutrition, child labour, sexual abuse, substance abuse, agency and decision making ability and role of media. Adolescents today are healthier, better educated and more aware. The average age at marriage has increased and gender disparities in education attainment have declined. Despite this, they continue to be at a disadvantage and face barriers that restrict their access to resources, inhibit their ability to make informed choices about their life, limit young women’s agency, limit access to education, employment opportunities and access to reproductive health and care services.

UNICEF is committed towards helping create a better India for and with adolescents. UNICEF supports the government and civil society organisations in their efforts to develop evidence based policies, programmes and interventions for adolescents. This desk review is a step in that direction.

Louis-Georges Arsenault,
UNICEF Representative to India
Adolescents aged 10–19 years constitute about one-fourth of India’s population and young people aged 10–24 years about one-third of the population. This large cohort of young people represents a great demographic dividend with the potential to contribute to India’s economic growth and development. In order to realise this potential to the fullest, young people must be healthy, educated and equipped with information skills and confidence that would enable them to contribute to their communities and the country’s socio-economic growth.

The challenges facing adolescents are increasingly recognised and documented. This desk review examines published evidence reporting the vulnerabilities of adolescents aged 10–19 years in India. The review highlights the fact that adolescents are a heterogeneous group with diverse needs that vary depending on factors such as age, gender, marital status, place of residence and educational attainment. There has been a concerted effort on the part of the government to address the needs of young people through programmes and policies directed specifically at them. However, most legal policies, legislations and programmes define adolescents differently, often conflating them with children or young adults. Despite these efforts, adolescents continue to face a number of vulnerabilities and challenges, highlighting the gaps in the implementation of programmes and policies.

For this review we accessed scientific articles and reports, published during 2002–13, on adolescents in India. In total, 571 articles were reviewed and 171 of those have been included in this report. The search was based on keywords listed in the title or abstract of articles using PubMed, JSTOR, and Google Scholar. Government reports and policies were accessed through websites of the various ministries of the Government of India.

The literature review addresses key aspects of adolescents’ lives, including sexual and reproductive health, education, nutrition, and challenges they face such as child labour, physical and sexual abuse, substance misuse, trafficking, the lack of autonomy and decision making in important areas of their lives and impact of media on adolescent behaviour. These vulnerabilities impact adolescents’ health and well being and create obstacles to their growth and development. This overview also highlights government policies and programmes and gaps in implementation of select policies and programmes that have an impact on young people’s lives.

Adolescents face a number of challenges with regard to their sexual and reproductive health. The literature indicates that at the individual level, early marriage, early and unsafe initiation into sexual activities and consequently early childbearing, limited knowledge about and access to contraception, unwanted pregnancies and lack of access to safe abortion services, exposure to sexually transmitted infections, and lack of autonomy and gender- based power imbalances exacerbate young people’s vulnerabilities. At the family or household level, the barriers include lack of family support, unequal gender norms and limited communication between parents and adolescents on sexual and reproductive health related matters. The existing health system does not recognize the diverse needs of youth and is not conducive to or supportive of providing unbiased services to adolescents, particularly to those who are unmarried. Additionally, laws that aim to protect the young - like the prevention of early marriage, sexual harassment, rape, sex selection, prohibition of dowry - are not implemented to their fullest extent.
Primary school enrolment has increased significantly over the last decade and India is likely to meet target 3 of Millennium Development Goal (MDG) 2 ahead of 2015. However, young people continue to face many challenges with regard to completing their education. There is a steep dropout rate after completion of elementary education and subsequently at secondary and higher secondary levels, suggesting that gains at the elementary level have not had an impact on the school sector as a whole. Young women continue to have less education compared to their male counterparts. The literature indicates non-enrolment or withdrawal from school takes place for various reasons, including economic barriers, the need to undertake household chores, parental concerns about safety of the girls, and poor quality of teaching. Gender, religious and caste disparities are evident in both enrolment and completion of schooling. School-level barriers include the lack of an adequate number of secondary schools, limited geographic access, and absence of adequate water and toilet facilities within the school, especially separate toilets for girls. Poor quality of education and limited vocational training options further prevent young people from continuing their education. At the policy level, gaps exist between policy and implementation as education is overseen at the state level and policies and programmes launched centrally are not necessarily implemented by local governments. There is also a gap between budgetary allocations and utilisation, including the timely release of funds for implementing programmes at the local level.

The state of nutrition among young people continues to be of concern despite a number of national-level programmes. However, unlike sexual and reproductive health and education, evidence on the nutritional status of adolescents is limited to adolescent girls and their childbearing roles. The available evidence highlights the high prevalence of anaemia among the young, particularly among girls from marginalised communities. Small-scale studies show obesity as an emerging problem in India and an increase in irregular dietary habits among the young. At the systems level there are gaps in implementation of the programmes directed towards improving the nutritional status of the young people including the irregular flow of funds and a delay in allocation of food grains.

The young face vulnerabilities in many other areas of their lives. Child labour is a complex issue with multiple layers which need to be understood in-depth. Evidence suggests that there are a number of factors that push young people to work: conditions of extreme poverty and economic distress, a view that earning an income is more valuable than spending his/her time in school, and pressure to stay at home to complete household chores and take care of family members, especially for girls. Child labourers face multiple challenges – they are often made to work long hours, are often exposed to physical abuse at the workplace, subject to malnutrition, susceptible to infections and ailments, and not paid according to the laws.

Child and sexual abuse is prevalent in India in various forms. This subject is the least studied because of its sensitive nature but available evidence highlights a significant increase in the number of reported crimes against young people. Physical and sexual abuse among the young can occur at home, school, the workplace, or the streets and children and adolescents are exposed to a range of abuse – from rape and sodomy to fondling, forced kissing and sexual advances and exposure to pornographic materials among others. Most sexual abuse is perpetrated by family members or persons known to the family. There is a culture of silence that surrounds sexual abuse and those who have experienced any form of abuse are discouraged from talking about their experiences to protect family honour and for fear of bringing shame to the family. Trafficking for sex is another form of abuse that requires urgent attention and action by the government. Sex work in India takes different forms. Available evidence suggests that the majority of trafficked persons are young women or children who have been forced into sex work as a result of poverty, often before they were 18 years old. Sex tourism relates to the sexual exploitation of young boys and girls by national and international tourists; street children are particularly vulnerable to this type of exploitation.
Substance misuse is an area of growing concern. Tobacco consumption is widely prevalent among young people, with a direct impact on their health. Adolescence and early adulthood are the most susceptible periods for initiation of tobacco use and a majority start using tobacco before attaining 18 years of age. Some even start as young as 10 years of age. Factors like access to money, parents who use tobacco, and the perception that tobacco using girls/boys have more friends appear to be positively associated with smoking behaviour. Tobacco use appears to be the first step in the path to other addictions. Several studies document use of other addictive substances among adolescents in school, out of school and those living on the streets. Substance used range from use of inhalants such as petrol, glue, correction fluids and adhesives, the use of oral ingestion of non-prescription drugs such as pain killers and cough syrups to the injection of non-prescription drugs and opioids. Few studies examine alcohol use. Cocaine use is limited to higher socio economic groups. Curiosity, peer pressure, depression, to overcome shyness and being tricked by others are some of the factors pushing adolescents to use drugs, as reported in the literature.

Available evidence highlights the fact that while girls have limited agency compared to boys, young boys too have limited agency and decision making ability on matters affecting their lives. Girls continue to face issues related to limited decision making, mobility, access to resources as well as inegalitarian gender role attitudes; this is particularly evident with regard to purchase of personal items, visiting places outside their immediate neighbourhood, the timing of marriage and choice of partners and the pursuit of secondary school/higher education. Girls have limited access to resources and very few have a bank or post office account either in their name or jointly with someone else.

Both print and visual media are important sources of information on reproductive and sexual health matters and influence young people’s lives, particularly with respect to their interaction with the opposite sex. The majority of young people are exposed to television; evidence shows the negative impact especially for tobacco, alcohol consumption, aggression and violence on the society through films and advertisements. Media also serves as an important source of information on reproductive and sexual health and gender roles.

To conclude, the review reiterates the need for programming and policies that would address the specific needs of this heterogeneous group. More specifically, the review highlights gaps in existing evidence and policy recommendations emerging from the materials reviewed on sexual and reproductive health, education, nutrition, child labour, sexual abuse, substance abuse, agency and decision making ability and role of media. An overarching recommendation pertains to the need for a uniform definition of ‘adolescent’ as various government policies, legislations and programmes use differing age cut-offs, as do research studies, limiting the ability to use available evidence. Please see below for research gaps and recommendations emerging from this review.
Key research gaps

- Adolescents aged 10 to 14 years are understudied and a difficult age group to reach. It is important to acknowledge that their needs are distinct from those aged 15 to 19 years. There is no data available on the current status or levels of information or knowledge on different issues related to the sexual and reproductive health of 10 to 14 year olds.

- There is a need for a better understanding of the processes that underlie the formation of sexual relationships, consensual and non-consensual premarital sexual experiences and sexual violence among adolescents. Among married adolescents, there is a need for a better understanding of the negotiation of safe and wanted sex and desired reproductive health outcomes including the timing of childbearing. Factors underlying adolescents’ agency and autonomy and expression of unequal gender role attitudes need to be examined in greater detail.

- Although there is ample data on education of adolescents, certain areas have not been studied. For example, the specific needs of marginalised adolescents, including minorities and tribal youth, in order to better understand the extent of exclusion and the strategies that will work towards addressing these barriers, the functioning and content of non-formal and religious education systems to utilize their potential in addressing adolescent issues and the role of private schools by studying the populations they serve, the quality of education they provide and the impact of availability of private sector education on public sector facilities, particularly in tribal and rural areas.

- Most nutrition studies focus on children 0 to 6 years of age and older adolescents 15 to 19 year olds. There is no information on the nutritional needs of 10 to 14 year olds. The impact of malnourishment on the cognitive development and academic performance of adolescents needs more research, as does, the emerging health problem of obesity among adolescents.

- Research related to nutrition has largely focussed on girls; the nutritional needs of adolescent boys have been neglected. Large-scale studies are required to ascertain the nutritional status of boys, particularly their need for Calcium, Vitamin D and other nutrients to meet their growth requirements. Similarly, the sexual and reproductive health of adolescent boys is understudied—there is a need to explore the vulnerabilities faced by young adolescent boys, including unsafe premarital sex, early marital relationships and gender roles.

- There is limited information on sexual abuse in the adolescent population despite the increasing reporting of sexual abuse. There is a need to gather evidence on the extent and nature of abuse of adolescents and its long term impact on their lives. Qualitative studies to document stories of survivors of child abuse or trafficking would assist in understanding their context and design targeted programmes for them.

- Several studies document the existence of substance misuse. Intervention research is needed to evaluate strategies to prevent initiation, prevent transition from oral/inhalation drug use to injecting drug use and to promote safe injecting among active drug users.

- Media studies are needed to assess the impact of media and information technology in altering the social context of the young and examine how the media provides sexual and reproductive health-related messages that enable young people to make a safe transition to adult life in a rapidly changing milieu.
Key policy and programme recommendations

- Rigorous implementation of legislation that has been put in place to empower and protect adolescents, such as the Right to Education Act, Child Marriage Restraint Act, Dowry Prevention Act, Sexual Harassment Act and labour laws. Ensure effective implementation of schemes targeting adolescents, for example, the Kishori Shakti Yojna, Nutrition Programme for Adolescent Girls.

- Increase focus of programmes on young boys and men in order to develop equitable gender role attitudes. Programmes should include a component on gender socialization providing opportunities for boys and girls to interact and develop a culture of mutual respect.

- Ensure that programmes that provide appropriate information and health care services in a sensitive and non-threatening manner, including family planning and infection prevention, to young boys and girls, regardless of their marital status, are effectively implemented. For example the Adolescent Reproductive and Sexual Health (ARSH) programme and the Adolescent Education Programme (AEP).

- Implement Behaviour Change Communication (BCC) programmes at the community level to increase awareness among parents, adolescents, and other community members about existing laws that aim to protect the young, the availability of services for adolescents, the importance of nutrition, the importance of delaying marriage and child birth, including family planning.

- Ensure provision of universal, free and compulsory education to ensure that children do not go into employment before completing their education. Ensure that where needed the school timings are adjusted to suit the needs of the children, particularly when they are engaged in seasonal work at farms. Support vocational training to provide employability skills to the children while simultaneously encouraging them to complete their education. Involve parents and gatekeepers in programmes that aim at building agency. Programmes should encourage parents to accept more equal and egalitarian attitudes towards their children.

- Implement livelihood skills programmes for married and unmarried adolescents that are linked with employment or income-generating opportunities to ensure that the skills learnt are put into practice and that young people are able to generate income for themselves and their families. Identify safe spaces where young girls can meet and build a support network with their peers.

- Provide effective rehabilitation programmes and residential services for girls who have been rescued from trafficking. Establish de-addiction and rehabilitation centres that cater to the specific needs of adolescent drug users.

- Include adolescents in national surveys such as the NFHS and DLHS with the provision for disaggregated data facilitating detailed analysis for better policy formulation.
Introduction

Adolescence marks the developmental transition from childhood to adulthood, a time when many important social, economic, biological, and demographic events set the stage for adult life. The nature and quality of young people’s future lives, as well as a country’s future social and economic development, depend largely on how well adolescents navigate this transition. In India, myriad social, economic, and health factors may undermine the ability of adolescents to lead full and productive lives. This is of particular concern given the sheer number of young people in India—an estimated 31% (358 mn) of national population is aged between 10-24 years and almost 22% comprise of 10-19 year olds (242 mn) (Office of the Registrar General and Census Commissioner of India 2006). It is well recognized that India’s ability to achieve the Millennium Development Goals and to achieve its population stabilisation goals will depend on the investment made in its young people.

There has been political commitment by the government to meet the specific needs of the adolescent population. Policies have been put in place to ensure access to equitable education, reproductive health services and information targeted especially for adolescents; programmes initiated to provide nutrition to adolescents and laws enacted to protect the young from exploitation in the workplace or through trafficking. Adolescents today are healthier, better educated, and more aware; the average age at marriage has increased, and gender disparities in education attainment have declined. Despite these achievements, adolescents continue to be at a disadvantage and face barriers that restrict their access to resources, inhibit their ability to make informed choices about their life, limit young women’s agency, and limit access to education, employment opportunities, and access to reproductive health and care services.

A key challenge in addressing these issues is the lack of a universal definition for this population. At the global level, WHO and UNICEF define adolescents as those aged 10–19 years (WHO 2012; UNICEF 2005). While the Ministry of Health and Family Welfare, Government of India (GOI) has adopted the WHO definition, various agencies of the government continue to use different definitions and age groups. The lack of consensus on the age group and therefore, the lack of characterisation of the vulnerabilities of adolescents make it difficult to form policies; provide legal protection; and create health, education and social welfare services for the adolescent population. Additionally, adolescents are not a homogeneous group; their situations and needs vary by age, sex, socio-cultural context, including marital status, level of educational attainment, employment status, rural–urban residence, migration status, sexual activity, living arrangements, religion, and household economic status.

This desk review was undertaken to synthesise available evidence on programmes, policies, and research relating to the adolescent population in India. In this review the adolescent population has been defined as young persons between 10–19 years in conformance with the Ministry of Health and Family Welfare, WHO, and UNICEF guidelines. The objectives of this desk review were: (1) to synthesise existing evidence around adolescents in order to characterize their specific vulnerabilities, (2) to collate information around existing policies and programmes for adolescents and to identify gaps and challenges, and (3) to provide recommendations for future areas of research and evidence gathering.
Methodology

For this desk review, we accessed published articles and reports on adolescents in India. The review was limited to materials published from 2002–2013; legal policies were reviewed without a time limit. An effort was made to explore available literature through the lens of equity and inclusion, gender and empowerment of adolescents. The search was based on keywords listed in titles and abstracts using PubMed, JSTOR, and Google Scholar. Reports and policies were accessed through websites of relevant ministries of the Government of India. Search items were limited to the following focus areas:

- Sexual and reproductive health
- Education
- Nutrition
- Child labour
- Child sexual abuse
- Substance misuse
- Autonomy and decision-making
- Media and adolescent behaviour

The literature review was narrowed down in three stages. In the first stage all the abstracts were reviewed to shortlist relevant abstracts; articles were then downloaded and reviewed. Articles which had a robust research methodology and analysis were included in this report. Through this process we identified qualitative and quantitative research articles, intervention evaluation reports and Government of India reports. The following categories of documents were reviewed:

- Government of India reports and publications, including national reports, and documentation from government organizations working with the adolescent population.
- Large national and sub national surveys, including the National Family Health Survey (NFHS), National Sample Survey Organization, the India Human and Development Survey, Youth in India: Situation and Needs Assessment by IIPS and Population Council, and the Annual Status of Education Report (ASER).
- Scientific papers published in national and international peer reviewed journals using search engines through selected keywords.
- Laws addressing the protection of adolescents.

The first level of searches yielded 571 titles and abstracts. In the second round, prior to writing the chapters, each abstract was read and 248 relevant articles were accessed. In the third and final round, only those articles and reports that were relevant to the chapters were reviewed and included in the current report. A total of 171 articles have been included in this report.
Chapterization of the report

This report aims to provide a synopsis of the situation of adolescents in India and highlights their vulnerabilities and obstacles in accessing opportunities and services. The report is divided into nine chapters. Each chapter includes an overview of the situation of the adolescents (in the context studied) as reported by the government or UN reports, a brief description of government policies and programmes and evidence on existing situations and barriers and challenges identified in the published literature. Some of the studies also highlight successful interventions and recommendations to maximize the opportunities and reduce gaps in policy implementation. Key findings relevant to our topics of interest were synthesised to provide recommendations and directions for programmes and policy.

The first chapter highlights the current sexual and reproductive health situation of adolescents and the barriers they face at the individual, family/community, and health-system level. Chapters 2, 3 and 4 discuss education, nutrition and employment. Chapters 5 and 6 focus on the sensitive and key issues of child sexual abuse and substance misuse among adolescents. Chapter 7 discusses issues regarding the limited agency of adolescents. Chapter 8 focuses on the impact of media on adolescent behaviour. Finally, Chapter 9 provides conclusions and recommendations for future research on adolescents.

Study limitations

The desk review had certain limitations. The lack of a universal definition for this population meant that findings from various studies mentioned in this report are conflated with those from children younger than 10 years of age or youth over 19 years of age. There were very few studies focussed exclusively on adolescents 10-19 years of age. Additionally adolescents are not a homogeneous group; their situations and needs vary by age, sex and socio-cultural context, including marital status, level of educational attainment, employment status, rural–urban residence, migration status, sexual activity, living arrangements, religion and household economic status. Very limited evidence was available on adolescents in the age group of 10–14 years especially with regard to sexual and reproductive health. Also, NFHS has limited disaggregated data on 15–19 year-olds on reproductive and sexual health indicators. Only research studies and articles published in peer-reviewed journals and reports which were available in the public domain could be included in this report. Therefore, we may not have accessed all the research available in the country. And finally, India being such a diverse country with major regional, gender, religion and caste differences, this review may not have covered all the differences in all the chapters.
To realise the demographic dividend of its adolescent population, India must pay careful attention to the quality of transition that young people make into adult life. Over the past decades, there have been significant changes in the lives of adolescents. Adolescents marry later and have children later than previous generations, and they are more educated and healthier than before. At the same time with changing socio-cultural norms they are more exposed to sexual and reproductive health–related risks, including HIV but lack the autonomy to take decisions on important sexual and reproductive health–related matters. Adolescents must be acknowledged as a heterogeneous group with varied needs based on their age, gender, marital status, work status, class, and social context. Despite conscious efforts on the part of the government, there continue to be many obstacles which inhibit young adolescents from making informed choices impacting their lives, particularly sexual and reproductive health–related choices. Available research on sexual and reproductive health focuses mainly on pregnancy and reproduction among married youth; there are limited data on other issues like premarital sexual activity, non-consensual sexual relations, and reproductive tract and sexually transmitted infections.

Most available data on young people combines 15–24-year-olds and it is not always possible to disaggregate by age, for 15–19-year-olds. More importantly data on 10–14-year-olds is practically nonexistent. This is a major limitation for designing programmes targeting young adolescents as their needs differ from 15–19-year-olds.

Evidence suggests that adolescents continue to have a variety of unmet needs. Within sexual and reproductive rights–related issues, early marriage, early childbearing, initiation into sexual activity, and experiencing non-consensual sex continue to be matters of concern. Early marriage has been reported in many surveys at national as well as sub-national levels. According to NFHS-3, more than one fourth (27%) of women aged 20-49 years were married before age 15 and more than half (58%) were married before the legal minimum age of 18 years (IIPS and Macro International 2007). Among girls aged 15–19 years, 27% were currently married (15% urban women and 33% rural women). However, very few men in this age group were currently married (1% of urban men and 4% of rural men) (IIPS and Macro International 2007). Parasuraman et al. (2009) in their analysis of data from NFHS-1, -2, and -3 highlight that at the time of NFHS-3, half of the women and almost one in five men aged 15–24 were currently married. Further, 19% of women aged 15–17 and 7% of men aged 15–20 were married (Parasuraman, Kishor, Singh et al. 2009). Statewise differentials are notable. In Bihar, Jharkhand, Rajasthan, West Bengal, and Uttar Pradesh more than one-fifth of young women aged 15–17 years were married – with Bihar and Jharkhand being the highest, 38% and 36% respectively. Among men aged 15–20 years, more than one in five in Rajasthan were married, one in ten in Bihar, Jharkhand, Uttar Pradesh, and Madhya Pradesh (Parasuraman et al. 2009) were married. The strong correlation between early marriage and missing school needs to be noted here. The NFHS-3 data show that girls with higher/secondary education marry later than those with less education or no education. Only 13% of women who completed minimum of 10 years of education were married by 18 years, compared to more than 72% who had no education at all (IIPS and Macro International 2007).
As a consequence of early marriage, childbearing is also initiated early for many young women in this age group. They experience teenage pregnancy and motherhood resulting in health, social, and economic problems. Apart from the high risk of pregnancy complication because of physiological immaturity, inexperience associated with child care practices also influences child and maternal health. The risk of maternal death is about three times higher in girls aged 15–19 years and five times higher in those younger than 15 years compared to women in their 20s (Barua, Apte and Pradeep 2007). NFHS-3 data show that 12% of all women aged 15–19 years have already had a child and 4% are currently pregnant. In other words, one in six women aged 15–19 have begun childbearing. Rural–urban differences and differences based on levels of education need to be noted here. The proportion of women aged 15–19 years who have begun childbearing is more than twice as high in the rural areas as in urban areas (19% and 9% respectively); more than one-quarter of women in this age group with no education became mothers and almost one-third have begun childbearing (IIPS and Macro International 2007). There are also statewise differentials for the percentage of women aged 15–19 who have had a live birth or are currently pregnant, with Jharkhand being the highest (28%) followed by West Bengal and Bihar (25%), and Himachal Pradesh, Goa, and Jammu and Kashmir reporting less than 5% of teenage childbearing (IIPS and Macro International 2007).

Adolescents today are exposed to wide-ranging media and new technology and hence are exposed to new ideas about their roles and rights. At the same time, they continue to be exposed to traditional norms that do not permit formation of romantic relationships among the unmarried. While there is limited evidence available on the nature and formation of premarital relationships in India, there is a trend that despite strict norms, partnerships are formed with young men having more freedom than young women. There is growing evidence of sexual activity before marriage, particularly among men, though the studies are small-scale using different methodologies and focus on different age groups of adolescents. A sub national study in six states of India reports that 11% of young men and 5% of young women aged 15–24 years reported experiencing premarital sex before age 20. (IIPS and Population Council 2010). Another study undertaken in rural and urban settings in Pune, Maharashtra, among young men aged 15–24 years, 17%–24% reported having a romantic relationship, 20%–26% had engaged in some form of physical intimacy and 16%–18% had engaged in sexual activity; the proportions among young women were 5%–8%, 4%–6% and 1%–2% respectively (Alexander, Laila, Savita et al. 2007). In her report Sujay indicates that 5% of female students and 16% of male students from Ahmedabad, Vadodara and Anand in Gujarat reported engaging in sexual relations with the opposite sex (Sujay 2009). A school-based study in Patna, Bihar indicates that 10% of young boys in classes 9-11 reported sexual experience compared to just 1% among young women in same classes (Shekhar, Medha, Saswata et al. 2007).

Parasuraman et al.’s (2009) report based on NFHS-3 data indicates that among adolescents aged 15–24, 51% of young women and 27% of young men have ever had sexual intercourse. Sexual initiation by 15 years of age was reported by 10% of young women and 2% of young men. This could be attributed to age at marriage – with more girls than boys getting married before age 18. Among the never married, 12% of young men and 1% of young women reported having had sexual intercourse. Higher-risk sexual behaviour is of particular concern in this age group as it is associated with the risk of sexually transmitted infections, including HIV. The Youth Study findings indicate that among young men and women aged 15–19 years who reported experiencing premarital sex, 21% and 25% respectively, reported engaging in sex with more than one partner (IIPS and Population Council 2010).

Reporting about the number of partners with whom the respondents had sexual intercourse is low – just 7% of young men and less than 0.5% of young women reported having two or more partners in the 12 months preceding the NFHS 3 survey (Parasuraman, Kishor, Singh et al. 2009). Underreporting particularly for young girls is possibly due to the stigma attached to having premarital relationships. The proportion of never-married youth who report ever having had sex is higher in rural than in urban areas among both men and women. Although relatively low, there is a clear indication that high-risk sex and sex with multiple partners is taking place and a significant proportion of young people who experience sexual intercourse are not using condoms to protect against disease as well as unwanted pregnancy (Parasuraman, Kishor, Singh et al. 2009).
Recognising that adolescents have different and unique needs depending on their marital status, work status, place of residence, and gender, the government has initiated a number of adolescent-specific policies and programmes. These policies take into account recent shifts in addressing the needs of this special population and indicate a political commitment for meeting the sexual and reproductive needs of the adolescents. For the first time adolescents were acknowledged as an underserved group in the National Population Policy 2000 (Ministry of Health and Family Welfare 2000). The policy recognises that adolescents need access to sexual and reproductive health related–information, counselling, and services that are affordable and easily accessible. The National AIDS Prevention and Control Policy 2002 reiterates the need to provide information on HIV, including the source of infection, and to promote safe sex at school and college level through curricular and extracurricular activities (National AIDS Control Organisation 2002).

The National Health Policy 2002 which also highlights the special needs of adolescents and recognises the need for information dissemination among school and college going youth on issues related to sexual and reproductive health, contraception and safe sex (Ministry of Health and Family Welfare 2002).

The National Youth Policy 2003 includes 13–35-year-olds as youth but recognises adolescents aged 13–19 as a special group with special needs and advocates for specialised programmes for them which are different from those aimed at youth aged 20–25. The Policy reiterates the need for “adolescent friendly clinics” to provide counselling and treatment (Ministry of Youth Affairs and Sports 2003). The Exposure Draft National Youth Policy 2012, aims to change the age bracket to 16–30 years with specific subgroups as each group has a distinct need and all groups are not homogenous. The first subgroup is 16–21 years, second is between 21–25 years, and the third is 26–30 years (Ministry of Youth Affairs and Sports 2012). The Exposure Draft recognises the need for an integrated and collaborative approach to youth development programmes and the need to provide a distinct framework to all concerned ministries and departments (Ministry of Youth Affairs and Sports 2012).

Other laws and policies are also in place that address the issue of early marriage, and promote gender equity and empowerment. Special mention must be made of Child Marriage Restraint Act 1978; the Prohibition of Child Marriage Act 2006; the National Policy for Empowerment of Women 2001; and the National Plan of Action for Children 2005. Programmes under the Reproductive and Child Health Programme II (RCH II) recognise the need for specific services for adolescents and provide Adolescent Reproductive and Sexual Health (ARSH) services including outreach; information, counselling, and services related to sexual concerns, pregnancy, contraception, abortion, and menstrual problems; management of RTI/STI; and communication activities and mass media campaigns to promote utilisation of ARSH services to delay age at marriage and improve health outcomes (Ministry of Health and Family Welfare 2006). The Adolescence Education Programme (AEP) was launched as early as 1993 as an introduction to sex education and was repeated in the National Curriculum Framework in 2005 and subsequently launched in 2005 by the Ministry of Human Resource Development and the National AIDS Control Organisation. The programme is designed to provide accurate and age appropriate information on sexual and reproductive health–related issues to classes 9 and 11 (National AIDS Control Organisation 2002). The programme had received a lot of criticism resulting in its modification by the National AIDS Control Organisation in collaboration with the Ministry of Human Resource Development. Additionally, the National Council of Educational Research and Training (NCERT) with support from UNFPA has further revised the curriculum (NCERT 2011).

While there is a commitment from the government to address the special needs and concerns of adolescents, gaps remain. The challenges consist of barriers at the individual, family/ community, as well as the health-system levels. Discussed below is each of these barriers in detail.
Information and access to contraception services

The lack of information on contraceptives, its use and discontinuation characterise a significant proportion of sexual encounters, among both married as well as unmarried adolescents.

Knowledge of contraceptives has increased over the years, with 94% of 15–19-year-old respondents in NFHS-3 reporting knowledge about some method of contraception. The differentials by background characteristics are not significant although young adolescents from urban areas were likely to have more knowledge than those from rural areas and the knowledge increased with education and wealth index (Ministry of Health and Family Welfare 2009). Other studies indicate similar findings on knowledge of contraceptives but highlight the lack of specific information, especially on reversible methods which are most suitable for this group. Findings from the Youth Study show that, whereas overall 95% of young men and women aged 15–24 were aware of at least one method of contraception, 8% of all unmarried young women and 12% of rural unmarried young women were not aware of even one method of contraception (IIPS and Population Council 2010). Low awareness has been documented in small-scale studies indicating that while general awareness of contraceptives is there, in-depth understanding of methods is far from universal (Acharya, Kalyanwala, Jejeebhoy et al. 2009).

Almost 13% of currently married 15–19-year-old girls reported having ever used some method of contraception. The unmet need for contraception is also of concern – at 27% the unmet need among 15–19-year-old girls is unchanged since NFHS-2. There are stark regional and state wise differentials. Bihar, Jharkhand, Nagaland, and Meghalaya are the states with the lowest contraceptive use and the highest unmet need. It is clear that for many young mothers, high fertility is not by choice but rather a result of family planning programmes being unable to meet their needs. The programmes need a special focus on this group of adolescent married women (Ministry of Health and Family Welfare 2009).

Evidence on ever use of contraception by unmarried women is sparse. NFHS-3 highlights the low use of contraception among the unmarried women 15–19 years old – 18% of those who had experienced sex reported having used any form of contraception. The difference in ever use of contraception between the married and the unmarried highlights the limited accessibility to contraception for unmarried women (Ministry of Health and Family Welfare 2009). Sujay (2009), in her study of college-going youth (17-27 years) in Gujarat, notes that among those who reported any sexual experience, an overwhelming majority reported ever using contraception: 90% of female and 86% of male students. However, consistent contraception use was less reported – 72% of female and 49% of male students – mainly because of the spontaneous nature of the episode (Sujay 2009). A study undertaken among young men and women aged 15–24 years in urban and rural slum settings of Pune, Maharashtra highlights similar findings and reports limited and irregular condom use – 38% of rural and 44% of urban young men reported condom use at first sex; and 26–29% reported regular condom use with a romantic partner. Among women, both married and unmarried, condom use was reported by few and premarital condom use was rare – just 18% reported condom use at first sex and 6% reported regular use. The reasons for not using a condom as reported in this study are lack of awareness and unplanned and unexpected nature of first sex (Alexander, Laila, Savita et al. 2006). The Youth Study also reported limited contraception use – among unmarried respondents who reported premarital sex, 14% of females and 28% of males had used a condom at last sex (Santhya, Jejeebhoy, and Acharya 2011). Consistent condom use among those reporting premarital sex was even lower – just 8% and 3% among men and women aged 15–19 respectively. The study further highlights the correlates of condom use. Some of the reasons for non-use were discomfort in approaching anyone, including a
pharmacist, for obtaining contraceptives; lack of access to the product; perception of not being at risk; and sexual contact with romantic partner and a perception that this person is “safe” (Santhya, Jejeebhoy, and Acharya 2011). In a study in Mumbai, Maharashtra, men reported sex with girls in a variety of situations, often in a hurry or characterised by coercion or force and they did not think about condom use (Verma, Pulerwitz, Mahendra et al. 2006).

### Pregnancy and childbearing

Early childbearing results in adverse health consequences; while risks of pregnancy-related complications and adverse health outcomes exist for all women, the risks are significantly higher for adolescents who are yet to fully mature physiologically. Analysis of NFHS-3 data indicates that rural women were two times more likely than their urban counterparts to have their first birth by age 18. Women with less or no education, those belonging to Scheduled Castes/Scheduled Tribes (SC/ST), and those coming from poor households were again more likely to have had a birth before age 18 (Santhya and Jejeebhoy 2012). Add to this is the burden of multiple pregnancies among the young – one in eight women aged 20–24 had three or more live births (IIPS and Macro International 2007). Access to antenatal care, institutionalised deliveries and postnatal care are some of the issues that need to be addressed. Young women having a third or higher order birth are at a great disadvantage – not only have they had three or more births before they are 25 years, but they are also less likely to receive antenatal care services (Parasuraman, Kishor, Singh et al. 2009). The resulting maternal and neonatal mortality rates are higher for adolescents compared to older women – 45% of all maternal deaths are reported among 15-24 year-olds (Office of the Registrar General India 2011). Neonatal mortality among those aged 15–19 years is 54 per 1000 live births compared to 34 among those aged 20–29 and 38 for those aged 30–39 (IIPS and Macro International 2007). An analysis of rural data from NFHS 3 survey reiterates that 62% of rural women who had at least one live birth during the last five years preceding the survey had given birth by age 18. The report further analyses the determinants of access to antenatal care services and indicates that women’s education, husbands’ education, economic status, birth order, and interval, and place of residence are significant determinants of access to services (Singh, Rai, Alagarajan et al. 2012). A study in Jharkhand among married tribal adolescents aged 15–19 indicates that receiving antenatal services is positively associated with women’s autonomy, spousal communication, and perceptions about the importance of antenatal services (Rani, Ghosh and Sharan 2007).

### Reasons for abortion and access to safe abortion services

Young women, particularly adolescents, both married and unmarried, experience unplanned and unwanted pregnancies. A major factor delaying timely access to safe abortion services is the lack of awareness among the young about the legality of abortion as well as information on facilities providing safe and legal abortion or providers of legal abortion services. The Youth Study data highlights the limited awareness – just 7% of both young men and women aged 15-24 years were aware that it is legal for married and unmarried women to seek abortion, that it is illegal to seek abortion for pregnancies beyond 20 weeks, and that it is illegal to terminate a pregnancy because the fetus is a female and the couple wants a son. Knowledge of the legality of abortion was reported by 26% of young men and 23% of young women and 39% and 46% of men and women respectively were aware that an unmarried woman can terminate a pregnancy legally (IIPS and Population Council 2010).

Evidence on abortion is sparse and comes from facility-based studies or small studies. What is evident is that the young are most vulnerable – irrespective of their marital status – compared to older women. NFHS-3 data on 15–24 year olds shows that 17% of births to women in this age group in the five years preceding the survey were not planned and that the women either did not want this pregnancy or wanted it later (IIPS and Macro International 2007). In a study in rural Maharashtra among women aged 15–24 years, adolescents made up 13% of the married women included in the study who had had an induced abortion at least 18 months prior to the survey. The main reason most of the adolescents cited for abortion was a previous child being too young. A few mentioned wanting to delay the first birth as they were either working, studying in college, or doing a vocational training course (Ganatra and Hirve 2002). In the study mentioned above, unmarried adolescents usually sought informal providers and travelled a considerable distance out of their place of residence. These adolescents reported that they did so to keep the pregnancy a secret from the community; repeated visits and judgemental
attitude of providers in public hospitals were some of the factors guiding them in their choice of providers (Ganatra and Hirve 2002). A study by Sujay (2009) undertaken with college-going students in Gujarat (17-27 years) found that 9% of all sexually experienced young women reported having experienced an unintended pregnancy and 17% of sexually experienced young men reported that they had ever made a girl pregnant; 4% reported that they had done so more than once. The outcome of most of the pregnancies was abortion (Sujay 2009). The unmarried are particularly vulnerable and evidence suggests that they delay accessing safe abortion services. A facility-based study in Bihar and Jharkhand among 15-24-year-old unmarried adolescents seeking abortion services indicated that almost 25% of young girls delayed seeking abortion into the second trimester (Jejeebhoy, Kalyanwala, Zavier et al. 2010). The obstacles reported by the unmarried in accessing abortion services included delay in recognising pregnancy, unsuccessful previous attempts to terminate the pregnancy, the need for assured confidentiality in selecting the abortion facility, and a lack of partner support (Jejeebhoy, Kalyanwala, Zavier et al. 2010).

Decision-makers for abortion are often not the women themselves. The decision to terminate a pregnancy is a complex one involving not only the woman herself but also her husband/partner and family. In a facility-based study on adolescents seeking abortion services in Bihar and Jharkhand, 14% of the unmarried young women reported that their parents had made the decision on their own and 4% said that their partner had done so. Among the married, 12% said that their husband had made the decision and 5% reported that their parents or parents in law had made the decision (Jejeebhoy, Kalyanwala, Zavier et al. 2010).

Menstrual hygiene

The onset of menstruation is one of the most important physiological changes occurring among girls, with an impact on many aspects of their lives. The onset of menarche often means reduced mobility, possible withdrawal from school and a list of do’s and don’ts that the girls are required to follow (Garg, Goyal, and Gupta 2012). There is a culture of silence around menstruation and often the young girls are not prepared for their first menstrual cycle. Fear, trauma, and a belief that this is impure and dirty dominate the attitude of young girls towards menstruation. In a study conducted in Uttar Pradesh by UNICEF, 86% of girls reported that they were completely unprepared for their first menstrual period and 64% reported that they felt scared at menarche (UNICEF 2012). It is important to prepare young girls for the onset of menarche as well as inform them about the need to be vigilant and careful about hygiene to reduce the risk of reproductive tract infections (RTIs). Poor menstrual hygiene is one of the leading causes for high RTI prevalence contributing significantly to female morbidity (Garg, Goyal, and Gupta 2012). In the study in Uttar Pradesh mentioned above, a majority of the girls were unaware of how to maintain personal hygiene during menstruation and as many as 90% of girls did not know that washing used menstrual cloths with soap and water and drying them in the sun killed germs (UNICEF 2012). In the absence of sanitary napkins, most adolescent girls in the rural areas use old cloths or rags which, when not cleaned, makes them susceptible to RTIs (Garg, Goyal, and Gupta 2012).

Special needs of married and unmarried adolescents

Adolescents report limited knowledge on specific sexual and reproductive health related issues. The Youth Study findings indicate that while 91% of young men and 73% of young women reported that they had heard of HIV/AIDS, comprehensive awareness of HIV/AIDS was reported by more men than women – 45% vs. 28% (IIPS and Population Council 2010). The National Behavioural Surveillance Survey (BSS 2006) among youth aged 15–24 reiterates similar findings – among those aged 15–19 years, 92% of young men and 80% of young women had heard about either HIV or AIDS. More urban men (96%) and women (92%) compared to their rural counterparts had heard of HIV or AIDS – 88% and 75% among rural men and women respectively (National AIDS Control Organisation 2008). NFHS 3 reports that while 86% of adolescent boys aged 15–19 years have heard of HIV/AIDS, only 64% of adolescent girls in the same age group reported so (Ministry of Health and Family Welfare 2009). While not a direct reflection of the physical availability of facilities, awareness of an HIV testing facility in the neighbourhood was also very low. Among those aged 15–19, 42% young men and 30% of young women were aware of any HIV testing facility (National AIDS Control Organisation 2008).
HIV prevalence among the youth population is 0.11% or one youth per 1000 is HIV positive. Data indicate that age-specific HIV prevalence rates are similar among young men and women aged 15–24 years (0.09 and 0.11 respectively). Very few boys and girls aged 15–19 years (0.04%) are HIV positive compared to the older cohort aged 25–49 (0.38%) (Parasuraman, Kishor, Singh et al. 2009).

Knowledge about STIs is also low – just 19% of young men and 15% of young women had heard of STIs in the Youth Study referred above (IIPS and Population Council 2010). The BSS 2006, explored STI awareness – among those aged 15–19, similar proportions were aware of STIs in urban (34%) and rural areas (32%) (National AIDS Control Organisation, 2008).

Self-reported symptoms of STDs were recorded in BSS 2006. Among 15–19 year olds, there were few differences between rural and urban reporting – 4% and 3% respectively (National AIDS Control Organisation 2008). Data from the NFHS-3 indicate that irrespective of age, education, and place of residence, never-married men aged 15–24 were more likely than ever married men in the same age group to have reported an RTI/STI symptom – 12% and 7% respectively (Parasuraman, Kishor, Singh et al. 2009). This level of reporting could be attributed to some extent to the finding that at least 7% of never married males are sexually active and have reported having high-risk sexual encounters without using a condom (Parasuraman, Kishor, Singh et al. 2009). The Youth Study indicates that more young women than young men reported symptoms of genital infection in the three months preceding the survey – 17% vs. 5%. More married women compared to the unmarried reported experiencing a symptom of genital infection – 20% vs. 13% (IIPS and Population Council 2010).

As far as treatment for STIs and symptoms is concerned, among the respondents aged 15–19 years, the proportion that sought treatment from any health facility was higher in urban areas (46%) compared to rural areas (40%) (National AIDS Control Organisation 2008). Treatment-seeking for sexual and reproductive health problems is limited among young women – just two in five young women experiencing symptoms of genital infection reported accessing care (IIPS and Population Council 2010).

Limited knowledge about HIV/AIDS as well as RTI/STI highlights the need for specific interventions and awareness programmes for the young. Furthermore, fewer women than men seek care for sexual and reproductive health–related symptoms highlighting the fact that young women may let symptoms go untreated. In the context of the high-risk sexual behaviour of this age group, it is imperative to provide information and places/facilities that could be accessed for treatment.

**Lack of autonomy, gender role attitudes, gender imbalances**

The limited autonomy and decision-making among the young has been documented in various studies. The NFHS-3 data highlight the fact that currently married adolescent girls aged 15–19 have limited mobility and face many constraints in taking decisions about issues like health care, visiting friends and relatives, accessing money and making purchases. For example, 46% of adolescent girls (aged 15–19 years) reported that they were not involved in decision-making related to their health care, major family purchases, buying daily household needs, and visiting family and friends. Young girls’ lack of autonomy, especially in the marital home, is highlighted by the fact that just 40% of married adolescent girls aged 15–19 were involved in making decisions about their own health care. The situation of these married girls has not changed much since the NFHS-2; the inability to make decisions and access resources is a limitation on young people to access healthcare services or obtain required information on sexual and reproductive health–related issues (Ministry of Health and Family Welfare 2009). The Youth Study findings reiterate the limited agency of these young girls, both married and unmarried. The Study reports limited decision-making autonomy among girls aged 15–19 – only 23% reported exercising autonomy in making decisions (Santhya and Jejeebhoy 2012). The Youth Study also highlights the limited agency of young women in making choices about whom to marry and on engaging in safe sex. Findings from data on 15–24-year-olds indicate that compared to 11% of young men, one quarter (25%) of married young women reported not being involved in the decision of their marriage – either in the choice of partner or the timing of the marriage; rural youth were more likely than urban youth to so report (IIPS and Population Council 2010).
Limited autonomy is further highlighted by the fact that a significant proportion of young men and women reported meeting their spouse only on the day of the wedding – 64% and 68% respectively. They did not know what to expect out of marriage – (70% of young men and 78% of young women), and as many as 47% of young women and young men were either scared or unhappy about getting married. An overwhelming majority felt that young people do not get adequate information about married life before marriage – 72% of young men and 80% of young women (IIPS and Population Council 2010).

Traditional gender norms continue to influence adolescents and have an impact on girls' decision-making ability on sexual and reproductive health–related matters. A significant percentage of both young men and women aged 15-24 years agreed that a woman should obtain her husband’s permission for most things – 72% of men and 65% of women so reported. They also agreed with statements relating to feeling justified if a man beat his wife on different matters including not wanting to have sexual relations or disagreeing with husbands’ opinion or if the wife has been unfaithful or she goes out without telling her husband. Notably, 54% of young men and 58% of young women agreed with the statement that wife beating was justified in at least one of the above-mentioned situations (IIPS and Population Council 2010).

There is limited evidence available on masculinity and the vulnerabilities men face in decision-making in their lives. A few studies have explored the role young husbands’ play in sexual and reproductive health–related matters including delaying first pregnancy, use of contraceptives and so on. Findings from a study among adolescent tribal girls in Jharkhand indicates that adolescent girls who reported spousal communication on reproductive health matters were more likely to have received antenatal care and participated in decision-making on the place of delivery than those who reported no such communication (Rani, Ghosh, and Sharan 2007).

There is sparse evidence on the experience of non-consensual sex among unmarried young women and violence within marriage. However, available evidence suggests that young women who marry early are at higher risk of experiencing violence, both physical and sexual, in their marriage. Findings from these studies among young men and women reiterate that violence within marriage is initiated early. For example, as many as 44%–56% of young women from Andhra Pradesh and Madhya Pradesh reported experiencing forced sex within marriage and 17%–25% of those from Pune so reported. The men corroborated the high rates of violence – 23%–26% of young men from Pune District and 33%–41% from Andhra Pradesh and Madhya Pradesh reported perpetrating violence on their wife (Alexander, Laila, Savita et al. 2007; Santhya, Jejeebhoy, and Ghosh 2008). Data from the Youth Study indicate that experience of physical or sexual violence in the 12 months preceding the interview was reported by one third of the young women (33%). While men’s reports were similar to those of women as far as physical violence is concerned, it was very different for sexual violence – 19% reported perpetrating physical violence and only 6% reported that they had forced their wife to have sexual relations in the 12 months preceding the interview (IIPS and Population Council 2010).

Among the unmarried, evidence is very sparse. Sujay’s study among college-going young men and women finds that 14% of young women reported that the first sexual encounter was forced (Sujay 2009). Another study, undertaken by the Population Council in Andhra Pradesh and Madhya Pradesh, reports that first sex with a romantic partner was not always consensual – one-tenth of young women in Guntur in Andhra Pradesh and over one-fourth in Dhar and Guna in Madhya Pradesh reported that they were persuaded or forced into first sex. Condom use was virtually nonexistent thereby reiterating the need for sexuality education among the young (Santhya, Jejeebhoy, and Ghosh 2008). In a facility-based study of adolescents seeking abortion services in Bihar and Jharkhand, 18% of the unmarried and 2% of the married adolescents reported that the sexual relations resulting in the current pregnancy were non-consensual (Jejeebhoy, Kalyanwala, Zavier et al. 2010).

This section highlights the barriers young adolescents face. It is evident that unmarried adolescents are vulnerable as they lack the autonomy and the authority to make decisions, thereby limiting their ability to negotiate a number of sexual and reproductive health–related issues. They do not have adequate information about contraception, the legality of terminating a pregnancy, or HIV/AIDS and other sexually transmitted infections. Additionally, they do not know of or have access to facilities or service providers.
Barriers at the family/community level

Lack of family support

Newly married adolescent girls do not have the autonomy or the power to negotiate timing of first pregnancy or contraception, which is rarely used before the birth of the first child. The family elders and community expect the newlyweds to establish their fertility. For the men it implies demonstrating “manliness” and for the woman that she can fulfil her role of mother and can provide a son to carry on the family lineage (Sethuraman et al. 2007). Barua and Kurz (2001) report that young women do not have the autonomy to delay the first pregnancy as the family members do not want to delay the birth of a grandchild in the family. Limited autonomy within the marital home implies limited access to healthcare and contraception indicating that though a significant proportion of married adolescents want to delay their first pregnancy, they are unable to do so because of family pressure not to use any contraceptives for fear of their impact on future health and childbearing. The decision to access healthcare services is also vastly limited for young married women – more so for adolescents as the main decision-makers continue to be the husbands or mothers-in-law (Santhya and Jejeebhoy 2003).

Among the unmarried, gender norms continue to play a major role in determining access to reproductive health care services and information, though not as much as for their married counterparts.

Unequal gender norms and power imbalances are a significant part of a patriarchal and gender-stratified India. Young men in India grow up in a male dominated society and continue to uphold the belief that women are subordinate to men. Early marriage, coercive sexual relations, and risky sexual behaviour are some forms of expressing male virility and those who do not fulfil these expectations are often ridiculed (Verma, Pulerwitz, Mahendra et al. 2006). Verma et al. (2006) describe the link between traditional masculinity norms and gender-role attitudes on one hand and high-risk behaviour among men on the other (Verma, Pulerwitz, Mahendra et al. 2006). Masculinity is associated with toughness and dominance, and femininity with submissiveness, and this reiterates the notion that a woman must give in to her husband’s sexual demands (Verma, Pulerwitz, Mahendra et al. 2006). Unbalanced gender norms play a considerable role in increasing the vulnerability of married adolescents and young women to HIV. For example, premarital relations are acceptable for men but not for women (Santhya and Jejeebhoy 2007).

Communication barriers between adolescents and parents

There is a culture of silence between parents and their adolescents in talking about matters related to sexual and reproductive health. The young have limited communication with their parents, especially on sensitive topics like romantic relationships or reproduction. Findings from the Youth Study indicate that romantic relationships and reproductive processes were rarely discussed with parents – 0% – 2% of young men and 1%–6% of young women. Young women were more comfortable in talking to their mothers about menstruation (77%) and more urban women than their rural counterparts were likely to have discussed growing up matters with their mothers (IIPS and Population Council 2010).

A study in Maharashtra among 15–19-year-old married girls, reported that two-thirds of the girls who reported experiencing a gynaecological problem did not discuss it with anyone initially. A third of the girls talked to their mothers about burning urination and menstrual disorders. Mothers-in-law were almost never spoken to about any of these matters even though mothers-in-law in this study were open to talking to their daughters-in-law as they felt that gynaecological problems could be a threat to conceiving (Barua and Kurz 2001).

Baseline findings of an intervention evaluation undertaken by the Population Council in 2006 show that girls aged 13–17 years reported limited communication with their parents, specifically mothers about sexual and reproductive-health related matters. Only 33% reported discussing growing up issues with their mothers; 29% discussed adolescent body changes with their mothers, and far fewer (2%) discussed reproductive processes or contraception with their mothers (Acharya, Kalyanwala and Jejeebhoy 2009).
The Youth Study addressed parents’ perspectives on talking about sexual and reproductive health with their adolescents. Parents of youth aged 15–24 years expressed discomfort around talking about these issues and may not always provide correct information. Some of the reasons voiced by the parents included a perception that this was against the existing cultural norms, embarrassment both on the part of the parents as well as the adolescents in addressing these issues, and an apprehension that awareness or information on sexual issues may result in the adolescents engaging in sexual activity (Jejeebhoy and Santhya 2011).

Another study undertaken with parents of rural and urban young people in Jammu reiterates the same findings – mothers reported a reluctance to talk to the youths about sex education and avoided any mention of sex in their day to day interaction with their children. Additionally, parents themselves do not have correct and scientific information about sexual and reproductive health–related matters (Mahajan and Sharma 2005).

**Barriers at policy and programme level: Health-system level**

Limited information and access to healthcare services has been a major gap in ensuring that the adolescents maintain good sexual and reproductive health. The unmet need of sexual and reproductive health varies among married and unmarried adolescents and there are serious gaps and lacunae in the delivery of services for the young.

**Health-system limitations**

The existing health system is often not conducive to or supportive of providing unbiased services to the young, particularly the unmarried. Additionally, in a conservative society like India, where talking about sexual and reproductive health–related matters is taboo, easy access to help remains far from reality for this group. The needs of the young people also vary depending on marital status, age and gender. Despite the initiatives taken by the government and the implementation of various programmes to address the healthcare needs of the young, this group remains on the periphery of the healthcare system. Most of the reproductive healthcare services provided in the public sector cater to the needs of the married, but even these young people shy away from seeking services because of embarrassment at discussing sexual and reproductive health issues. The unmarried are at a greater disadvantage and may not access services because of lack of confidentiality, an inability to pay for the services, the need for parental approval, and negative and insensitive attitude and behaviour of the providers (Nath and Garg 2011). Other factors hindering access to services is the absence of health care providers at the facility and poor provider-client interaction on one hand and limited mobility and decision-making power of the adolescent on the other (Nath and Garg 2011). The unmet need for family planning among 15-19 year old is 26%. The reason could vary from supply or demand related hurdles or because family planning programmes are not catering to the special needs of young women. This clearly reflects that young married women need to be a key focus of family planning programmes (Parasuraman, Kishor, Singh et al. 2009).

**Poor implementation of programmes**

The government has committed to taking specific actions to raise adolescents’ awareness of sexual and reproductive health matters and has implemented a number of programmes to do so. However, the implementation of these programmes continues to be of concern. While there are many programmes in place, most of these cater to in-school adolescents, leaving out a large number of out-of-school adolescents, dropouts, the poor, or the socially excluded. The programmes that cater to the out-of-school population, moreover, are most likely to reach young men, not young women, as the latter do not have freedom of mobility (Santhya and Jejeebhoy 2012).

Recognising the need to provide sexuality education, the **Adolescence Education Programme (AEP)** was initiated as early as 1993 as an introduction to sex education. It was repeated in the National Curriculum Framework in 2005 and was subsequently launched in 2005 by the Ministry of Human Resource Development and the National AIDS Control Organisation. However, there has been no consensus in the state governments and a majority of them have not been willing to include sex
education as part of the curriculum. The curriculum for AEP has been revised, from mainly HIV to a broader framework to enable young people not only to gain information on sexual and reproductive health matters but also to understand the risks they face and ways to address these (Santhya and Jejeebhoy 2012).

The Adolescent Reproductive and Sexual Health (ARSH) strategy addresses the needs of adolescents under Reproductive and Child Health (RCH) II by setting up clinics, particularly in the existing public healthcare facilities. However, evaluations of the functioning of these programmes suggests that the strategy has not succeeded in either increasing services for the adolescents or in improving the quality of services received by them (Santhya and Jejeebhoy 2012). The Centre for Operations Research and Training (CORT) undertook an evaluation of ARSH in Gujarat in 2008. The findings highlight the fact that the young people do not access these services because of lack of confidentiality and privacy; providers’ insensitive attitudes; hesitation in accessing services located in public hospitals; and lack of awareness about these services (Centre for Operations Research and Training 2009). Even though under the ARSH strategy training has been offered for healthcare providers at different levels, not all cadres have been sensitised through this process. Furthermore, the training is not comprehensive; it does not combine information to be imparted and ways in which it could be imparted (Santhya and Jejeebhoy 2012).

Some of the other programmes like Kishori Shakti Yojna (KSY), the SABLA scheme, or the University Talk AIDS Programme have not yet been evaluated to assess their effectiveness in imparting information and their acceptability by the young (Santhya and Jejeebhoy 2012).

Young people also do not get an opportunity to participate in the programmes being implemented. For example, NACO, SACS, and other NGOs have implemented extensive mass media and interpersonal communication interventions on various aspects of STD/HIV/AIDS. Only 21% adolescents aged 15–19 reported having received interpersonal communication in the 12 months preceding the interview, with Chhattisgarh and Madhya Pradesh being the lowest at 6%. Participation in any campaign or meetings on STD/HIV/AIDS among 15–19 years was low – 8% at the national level. It was the lowest in Bihar (1%) and Madhya Pradesh (2%) (National AIDS Control Organization and National Institute of Medical Statistics 2008).

Lack of focus on boys and men

It has been noted that most of the programmes focus on young girls, neglecting the role of young boys in maintaining sexual and reproductive health for themselves and their partners. It is, nonetheless, essential to include boys in the group in order to develop equitable gender attitudes among them. It is also important to acknowledge the vulnerabilities faced by this group, be it substance misuse or experience of unsafe premarital sex (Santhya and Jejeebhoy 2012). Boys are at as much of a disadvantage as their female counterparts and it is important to provide access to information as well as healthcare services to them as a group.

Laws and their poor enforcement

Laws such as the Child Marriage Restraint Act, Dowry Prevention Act, Sexual Harassment Act, Pre-conception and Pre-natal Diagnostics Techniques Act, Sexual Harassment at Workplace Bill are in place to promote and ensure positive sexual and reproductive health outcomes among the young, but these laws are poorly implemented. A major challenge facing India is the gap between policy and laws and their implementation. For example, the Child Marriage Restraint Act has not been successfully implemented resulting in the continuation of marriages of girls and boys under age 18. There is limited evidence available on the levels of implementation of other Acts such as the Dowry Prevention Act or the Sexual Harassment at Workplace Bill. Young girls and women in our study age range as well as the community at large are not aware of the laws that protect them and promote the sexual and reproductive health of young people. Efforts have been made by the government agencies as well as NGOs to create community level-awareness of these laws, but these efforts are not enough and nor have these been documented or scaled up. Added to this is the problem of defining “child” as different laws have different definitions – the Child Marriage Restraint Act defines a child as men who are under 21 and women who are under 18 while the Immoral Traffic Prevention Act considers those below 16 years of age as a child, while the Juvenile Justice (Care and Protection of Children) Act considers any individual who is below 18 a child (Jejeebhoy and Santhya 2011).
The way forward

Young people face a number of barriers in ensuring positive sexual and reproductive health outcomes at the individual, family, and community level, as well as at health-systems level. These barriers need to be addressed urgently if India is to realise its demographic dividend and have a healthy young population.

There is a lack of evidence on the sexual and reproductive health needs of 10–14 year olds. This is a difficult age group to reach and one must acknowledge that their needs are distinct from those aged 15–19 years. However, there are no data available on their current status or levels of information/knowledge on different issues of sexual health.

While the onset of puberty marks a major shift in the status of young adolescent girls, and despite limited evidence available on the impact this shift has on their mobility, there is a need to obtain evidence on menstrual health and hygiene–related practices among 10–19 year olds.

Research needs to focus on the impact of the media and information technology in changing the social context of young people as well as in providing sexual and reproductive health–related messages. There is a need to understand how these influence the young and how adolescents make transitions to safe sexual lives in this changing context.

There is limited evidence available, but a lot more to understand about the processes of formation of sexual partnerships among the young and their premarital sexual experiences. One needs to address how safe these relationships are (disease and pregnancy-related concerns) and to what extent are these consensual.

Research is needed to understand how young people negotiate safe and wanted sex, particularly among young married girls, and how they negotiate wanted reproductive health outcomes, including timing of childbearing.

There is a need to evaluate existing intervention models by NGOs and assess the extent to which programmes have increased young people’s agency and levels of knowledge on sexual and reproductive health–related matters, as well as acceptance of integrated health and social interventions models.

Research is needed on exploring existing gender roles and addressing gender biases among parents and elders in the community, or the gatekeepers and their impact on young adolescents’ agency and autonomy. This is particularly needed for married girls given the restrictions they face in accessing sexual and reproductive health–related information or services, or in the timing of their pregnancy or actions taken in case of unwanted pregnancy.

Experience of sexual violence both within and outside marriage also needs to be documented.

Research should explore whether and how often young people access sexual and reproductive health services and programmes designed for them, and what the underlying factors are that prevent them from utilising these services.

Existing government programmes targeted at young people need to be evaluated, including, for example, Adolescent Reproductive and Sexual Health (ARSH) centres; the training of service providers, sensitisation processes, and quality of care provided in ARSH Centres should be reviewed.
References


• 2009. Reproductive and Sexual Health of Young People in India. New Delhi: MoHFW, Government of India.


Young people are spending more time in school than ever before. Recent growth rates on all indicators of school participation and grade attainment have been significant and the change has been there for girls as well as for boys. India has made marked progress in improving access to education; the mean number of years of schooling for the working population (15 years and above) has increased from 4.19 years in 2000 to 5.12 years in 2010 (Planning Commission, Twelfth Five Year Plan 2012–2017 Government of India). Enrolment of children at the primary education¹ stage has reached near universal levels (Planning Commission Twelfth Five Year Plan 2012–2017 Government of India) and India is likely to meet Target 3 of Millennium Development Goal (MDG) 2 ahead of 2015. Secondary school² enrolment has also increased from 4.3% per year during the 1990s to 6.27% per year in the decade ending 2009–10 (Planning Commission). Target 4 of MDG 3 aims to eliminate the gender disparity at all levels of education by 2015. Progress is also noticeable in reducing the gender gap in elementary education with the female–male ratio for years of education and literacy reaching over 90% in 2009–10 (Planning Commission, Twelfth Five Year Plan 2012–2017 Government of India). For males and females aged 15–24, the 21.59 percentage point gap recorded between male–female literacy in the 2001 Census has declined to 16.68 percentage points in 2011, mainly due to an increase in female literacy (Ministry of Statistics and Programme Implementation 2012).

Despite these achievements, there are many challenges that the young face in completing their education. The mean years of schooling at 5.12 years is well below other countries (for example China at 8.17 years, Brazil at 7.54 years, and the average for all developing countries at 7.09 years) (Planning Commission Twelfth Five Year Plan 2012–2017 Government of India). There continues to be a steep dropout rate after elementary² education, both at secondary² and higher secondary³ levels suggesting that gains at the elementary level have not had an impact on the school sector as a whole (Ramachandran and Jandhyala 2010). Women continue to be at a disadvantage with young men having substantially higher education attainment than young women. Data from the National Family Health Survey (NFHS)³ show that while 22% of girls aged 15–19 reported having no education just 7% of boys in the same age group did so. Further, 74% of adolescent girls aged 15–19 years reported that they could read and write compared to 89% of boys of the same age (IIPS and Macro International 2007). The gender gap widens further at the secondary level with more young girls dropping out of school – 18% of adolescent girls aged 15–19 years had completed 10+ years of education compared to 25% of young men in the same age group (IIPS and Macro International 2007). Regional and state level differentials also exist. For example, 4% of young girls aged 15–19 in Rajasthan, and 5% in Chhattisgarh reported completing 10+ years of education compared to 23% in Kerala and Himachal Pradesh. Among young men in this age group, 7% in Arunachal Pradesh and 9% in Madhya Pradesh reported completing 10+ years of education compared to 31% in Himachal Pradesh (IIPS and Macro International 2007).

¹ The definition of different levels of education varies in India. Primary education includes classes 1–5 or 1–6; Upper Primary includes classes 5–8 or 6–8. Recently, the government is pushing for a common terminology and is encouraging states to use Elementary to include classes 1–8; and secondary education includes classes 9–12. Some states further break up Secondary education into Secondary (classes 9–10) and Higher Secondary (classes 11–12).
Education

Religion and caste differences in accessing education remain a concern. A sub-national study among youths aged 15–24 years undertaken in six states of India (Youth Study 2010) showed that as many as 32% Muslim girls aged 15–24 had not received an education compared to 25% of Hindu girls and 21% of Muslim girls compared to 31% of Hindu girls had completed 10+ education. Similarly, 13% of Muslim young men versus 8% of Hindu young men had not received any education and 31% of Muslim boys had completed class 10 compared to 43% of Hindu young men (IIPS and Population Council 2010). Caste differences also exist, with SC/ST young people remaining on the fringes of education attainment. SC/ST young men and women were considerably less likely to have completed 10 years of education than general caste young men (27% vs. 54%) and women (18% vs. 45%) (IIPS and Population Council 2010). These differences are evident at younger ages as well. Findings from a survey undertaken by the Social and Rural Research Institute (SRI) and Indian Market Research Bureau (IMRB) in 2009 showed that 8.1 million (4.3%) children aged 6–13 years, out of an estimated 190 million, were out of school. Data from the same study indicates that more rural (5%) than urban (3%), more girls (6%) than boys (5%) aged 11–13 years, and a significant proportion of Muslims (8%), Scheduled Tribe (ST) and Scheduled Caste (SC) (6%), and Other Backward Caste (OBC) (3%) children were out of school (UNICEF 2012).

The government has put in place a number of programmes and policies aimed at increasing enrolment and retention in school, and providing technical and vocational education training for those who are unable to pursue secondary education. These programmes, implemented by the Ministry of Human Resource Development, the Directorate of Education and Ministry of Youth Affairs and Sports also reiterate the government’s commitment to reducing gender disparities in access to education among young people. A list of relevant government policies and programmes is available in Annex 1. The National Youth Policy, 1988 and revised in 2003 and 2012, emphasises the importance of providing education to the youth and reiterates the need to remove gender barriers by ensuring that all young girls and women have access to education; they are the primary target of efforts to spread literacy (Ministry of Youth Affairs and Sports). The National Education Policy, 1986 and revised in 1992, the Programme of Action towards Universalisation of Elementary Education of 1992, the Education Guarantee Scheme of 1997–98, the Sarv Shiksha Abhiyan (SSA) launched in 2001, the Rashtriya Madhyamik Shiksha Abhiyan (RMSA) launched in 2008-09, the 86th Amendment to the Constitution and the more recent Right of Children to Free and Compulsory Education (RTE) Act of 2010 (Ministry of Law and Justice 2009) are some examples of government initiatives to ensure education for all. In order to provide education to girls who drop out of school, the government has launched two programmes – namely, the National Programme for Girls’ Education at the Elementary Level (NPEGEL) and Kasturba Gandhi Balika Vidyalaya (KGBV) – which have made concerted efforts to improve girls’ participation at the upper primary level.

There is increasing recognition for education to be relevant to the needs of adolescents and to provide them with skills that make them employable and financially independent. The Government launched the National Skills Development Initiative in 2009 (Ministry of Labour and Employment 2009) that provides adolescents, women, and school dropouts with opportunities to acquire vocational skills. The Saakshar Bharat Scheme, 2009 (Ministry of Human Resource Development 2009) is yet another Government initiative geared towards providing functional literacy and numeracy for 15–35-year-olds who have never attended school, and to enable neo-literates to continue their learning, acquire education equivalent to formal education, and learn relevant skills that would create employment opportunities.
Gaps and challenges

The RTE Act of 2010 stipulates free and compulsory education for children aged 6–14 years and also emphasizes the role of local authorities to provide access to elementary schools within their neighbourhood. While the government has made a conscious effort to bridge the gaps in education access, and government figures indicate that Net Enrolment Rate (NER)² for primary level (6–10-year-olds) has gone up to 98% in 2010, a large number of children either do not attend school despite enrolment or drop out of school and do not complete their education. Available data show that currently fewer than 60% of children complete class eight (World Bank 2009). Barriers that impede access to and continuation of education are discussed below:

Family/community-level barriers

The family and the community play a critical role in decision-making for enrolment as well as continuation in school.

Although NER has gone up, a number of adolescents still do not go to school. A sub-national study among youth 15–24 years from six states (Youth Study 2010) examined the reasons for non enrolment in school; multiple responses were permitted. Economic reasons were cited most often; of those who were never enrolled, 60% of young men and 56% of young women were not enrolled as they were expected to work in the family farm or business, be a wage earner, and contribute to the family income. The second most frequently cited reason was household chores including the responsibility of sibling care, disproportionately more for young women (52%) than for young men (24%). Further, one-third of young people (34% females and 37% male) were not enrolled in school because of parental concerns about safety, negative attitudes about the importance of education, and a perception that the adolescent/youth was not interested in education. Furthermore, 8% of young men and 18% of young women reported school-related reasons including distance, lack of transport, and poor quality of school and teaching. Finally, 10%–13% youth indicated poor health as the reason for never enrolling in school (IIPS and Population Council 2010).

Using data from 61st round of the National Sample Survey (NSS) (Ministry of Statistics and Programme Implementation, 2006) Bandyopadhyay and Subramanian (2008) provide rural–urban and gender differences in reasons for non-enrolment among 5-14 and 10–14 year olds (Table 2.1). While the perception that education is not necessary and economic reasons are cited, other reasons seem most important but are not detailed. Similar evidence emerges from other smaller studies (Planning Commission and Indian Institute of Education 2006).

### TABLE 2.1 Distribution of children aged 5–14 who have never attended an educational institution: Gender, Location and Broad Reasons for non-attendance (2004–05) (per 1000)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Rural male (by age group)</th>
<th>Rural female (by age group)</th>
<th>Urban male (by age group)</th>
<th>Urban female (by age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10–14</td>
<td>5–14</td>
<td>10–14</td>
<td>5–14</td>
</tr>
<tr>
<td>School too far</td>
<td>37</td>
<td>55</td>
<td>26</td>
<td>43</td>
</tr>
<tr>
<td>Had to support household income</td>
<td>66</td>
<td>30</td>
<td>35</td>
<td>43</td>
</tr>
<tr>
<td>Education not considered necessary</td>
<td>156</td>
<td>124</td>
<td>184</td>
<td>172</td>
</tr>
<tr>
<td>Had to attend to domestic chores</td>
<td>22</td>
<td>12</td>
<td>73</td>
<td>44</td>
</tr>
<tr>
<td>Other</td>
<td>289</td>
<td>579</td>
<td>253</td>
<td>482</td>
</tr>
</tbody>
</table>

Source: Government of India 2006 (Bandyopadhyay and Subrahmanian 2008)

² Net Enrolment Rate (NER) The number of children of official primary school age who are enrolled in primary education as a percentage of the total children of the official school age population
Although the NER has gone up, a large number of young people discontinue education and the number who drop out of school increases progressively as the level of education increases. GOI statistics indicate that the Gross Enrolment Ratio (GER)\(^3\) of 100.46 for all students for classes 1–8 falls to 58.1 when they reach classes 9–10 and 32.83 in classes 11–12. For girls, the decline is sharper, falling from 98.33 to 53.18 to 29.53 for classes 1–8, 9–10, and 11–12 respectively (Ministry of Human Resource Development 2011). Several studies show economic reasons to be the most frequent for boys (40%-65%) and responsibility for household chores, including taking care of siblings, the most cited reason for girls(39%-42%). Lack of interest in continuing education, and the perception that education is not important for facilitating future employment for boys or finding a suitable groom for girls are other reasons for discontinuation of education (Rani 2011; IIPS and Population Council 2010; Pramanik 2010; Planning Commission and Indian Institute of Education 2006; Khokar, Borg, and Bhandi 2005). Using data from 61st round of the NSS, Bandyopadhyaya and Subrahmanian (2008) present reasons for dropping out of school among 5–14 and 10–14 year olds (Table 2.2). Around 23% of urban and 17% of rural young boys aged 10–14 dropped out of school because they were required to support household income. At the same time 11% of rural girls and 17% of urban girls aged 10–14 years dropped out to attend to household chores. Education was not considered important among 10% and 11% of urban girls and boys respectively and 7% and 9% of rural boys and girls. Wadiker and Das (2004) report that migration of adults also impacts the schooling; children and adolescents accompanying migrant parents are drawn into the labour market or become involved in the care of younger siblings. Small-scale studies also indicate that poor quality of teaching, lack of motivation for students, and insufficient educational aids also contribute to reasons for students dropping out before completion of their education (Planning Commission and Indian Institute of Education 2006).

### TABLE 2.2 Distribution of children aged 5-14 who have dropped out of school: Gender, location, and broad reasons for dropping out (2004–05) (per 1000)

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Rural Male (by age group)</th>
<th>Rural Female (by age group)</th>
<th>Urban Male (by age group)</th>
<th>Urban Female (by age group)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10–14</td>
<td>5-14</td>
<td>10–14</td>
<td>5-14</td>
<td>10–14</td>
</tr>
<tr>
<td>School too far</td>
<td>3</td>
<td>2</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Had to supplement household income</td>
<td>171</td>
<td>72</td>
<td>70</td>
<td>36</td>
</tr>
<tr>
<td>Education not considered necessary</td>
<td>73</td>
<td>33</td>
<td>92</td>
<td>53</td>
</tr>
<tr>
<td>Had to attend domestic chores</td>
<td>12</td>
<td>5</td>
<td>109</td>
<td>54</td>
</tr>
<tr>
<td>Other</td>
<td>170</td>
<td>89</td>
<td>142</td>
<td>88</td>
</tr>
</tbody>
</table>

Source: Government of India 2006 (Bandyopadhyay and Subrahmanian 2008)

As noted above, gender disparities are striking in both enrolment as well as completion of schooling. The reasons for discontinuation are similar to those cited above for non-enrolment, with one additional factor; that is, early transition into adulthood, namely marriage/engagement for young women and employment for young men. One in seven and one in four young women who discontinued their education in class 7–9 and 10–11 respectively reported the main reason for dropping out of school was to be marriage (IPS and Population Council 2010). Furthermore, several small-scale studies highlight the decisionmaking role parents play in making girls drop out of school and the limited autonomy of these girls in challenging this decision. As indicated earlier, the reasons for not continuing schooling for girls were mainly the requirement to look after household chores and care of siblings. A study undertaken by Sharma et al in Himachal Pradesh indicates that 58% of parents reported that they stopped their daughters from going to school because of household chores and 24% said that they felt that time was needed to train the girls to perform household chores (Sharma, Shubhangna, and Shipra 2007). There is also a perception among parents that if the girls were educated, it would be difficult to find a suitable match for them (Khokar, Garg, and Bharati 2005; Rani 2011; Sharma, Shubhangna, and Shipra 2007).

\(^{3}\) Gross Enrolment Ratio is the share of children of any age who are enrolled in primary school. This can exceed 100%.
There are regional differences in the gender parity index. For instance, in Bihar and Rajasthan girls are only half as likely to enrol in secondary school as boys. The situation is similar in Uttar Pradesh and Madhya Pradesh. On the other hand, Kerala and Tamil Nadu show pro-female secondary enrolment rates (Kingdon 2007). Recent data from Statistics of School Education for 2009–10, reveal that the gender parity index drops from 0.97 in classes 1–8 to 0.88 for classes 9–12 (Ministry of Human Resource Development 2011).

Religion and Caste disparities in access to education exist particularly for the marginalized, including Muslim, SC, ST, and OBC populations. Youth Study (2010) showed that 13% of Muslim boys and 32% of Muslim girls aged 15-24 had not received any education compared to 8% and 25% among Hindu boys and girls respectively (IIPS and Population Council 2010).

Data for Muslim girls are limited but available evidence highlights the disadvantage they face in accessing education. There is some evidence that they are far more likely to never be enrolled in school or to drop out of school upon completion of elementary school. In the absence of schools near the place of residence, unavailability of female teachers, and lack of a gender-friendly environment within the school, most Muslim girls around puberty are sent to religious schools for education (madrasas and makhtabs) (Jeffery, Jeffrey, and Jeffrey 2007). There is a declining trend in education of the Muslim community making the Muslim girl-child a most vulnerable group (Ramachandran and Jandhyala 2010).

Scheduled castes and scheduled tribes continue to remain at the fringe. Data for 2007–08 show that as many as 54% SC and 64% ST boys dropped out of school at the elementary level and 68% of SC and 76% of ST boys dropped out at the secondary level (Table 2.3) Similarly, 51% of SC and 63% of ST girls dropped out of elementary school while 69% of SC and 77% of ST girls did so at the secondary level.

**TABLE 2.3 Dropout rates by gender and social group**

<table>
<thead>
<tr>
<th>Year</th>
<th>PRIMARY (1-5) %</th>
<th></th>
<th></th>
<th>ELEMENTARY (1-8)%</th>
<th></th>
<th></th>
<th>SECONDARY (1-10)%</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All boys</td>
<td>SC boys</td>
<td>ST boys</td>
<td>All girls</td>
<td>SC girls</td>
<td>ST girls</td>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-91</td>
<td>40.1</td>
<td>46.3</td>
<td>60.3</td>
<td>46</td>
<td>54</td>
<td>66.1</td>
<td>42.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
<td>38.4</td>
<td>43.7</td>
<td>51</td>
<td>39.9</td>
<td>47.1</td>
<td>54.1</td>
<td>39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td>26.1</td>
<td>33.6</td>
<td>32</td>
<td>24.8</td>
<td>29.4</td>
<td>32.4</td>
<td>25.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SC Boys</td>
<td></td>
<td></td>
<td>ST Boys</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-91</td>
<td>59.1</td>
<td>64.3</td>
<td>75.7</td>
<td>65.1</td>
<td>73.2</td>
<td>82.2</td>
<td>60.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
<td>50.3</td>
<td>58.6</td>
<td>67.3</td>
<td>57.7</td>
<td>63.6</td>
<td>72.7</td>
<td>53.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td>44.2</td>
<td>53.9</td>
<td>63.5</td>
<td>41.4</td>
<td>50.9</td>
<td>63.1</td>
<td>43</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All Girls</td>
<td></td>
<td></td>
<td>ST Girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990-91</td>
<td>67.5</td>
<td>74.3</td>
<td>83.3</td>
<td>76.9</td>
<td>83.4</td>
<td>87.7</td>
<td>71.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001-02</td>
<td>64.2</td>
<td>71.1</td>
<td>79.9</td>
<td>68.6</td>
<td>74.9</td>
<td>82.9</td>
<td>66</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2007-08</td>
<td>56.4</td>
<td>67.7</td>
<td>75.8</td>
<td>57.2</td>
<td>68.5</td>
<td>77.3</td>
<td>56.8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Select Educational Statistics, GOI 2004 and 2010 (Ramachandran and Jandhyala 2010)
School-level barriers

There has been an unprecedented infrastructure development under the auspices of Sarv Shiksha Abhiyan, a comprehensive plan to provide free education to all children in the age group 6–14 years that was launched in 2001. The number of schools increased, facilities and infrastructure were provided in schools, and there was a reduction in the average student-teacher ratio from 39 in 2005–06 to 32 in 2009–10 (Planning Commission, Twelfth Five Year Plan 2012–2017 Government of India). The resulting increase in demand for secondary education has been a challenge for the government. Projections suggest an increase in absolute demand for secondary education between 2007–08 and 2017–18 of around 17 million students per year with total enrolment growing from 40 to 57 million students (World Bank 2009). At the secondary level, the number of institutions declines and a rural–urban divide is apparent. For example, there are only 84,370 secondary schools available to absorb students coming out of 250,975 upper primary schools in rural areas and 46,305 secondary schools to absorb children from 87,005 upper primary schools in urban areas (Ministry of Human Resource Development 2011). Around 27 percent of India’s districts have less than one secondary school for every 1000 youths aged 15–19 who have completed grade 8 (World Bank 2009).

The increase in demand for secondary education has led to a growth in the number of private aided and unaided schools in the last two decades and jointly these make up 60 percent of all secondary schools. While private aided schooling is subsidized in India, private schools are fee-charging institutions, often unaffordable by the poor and the marginalized, located in urban areas and catering to wealthier sections of society (World Bank 2009). There is some evidence to suggest that a large number of female and SC/ST adolescents attend government schools, while those from upper castes and boys are more likely to attend private school. Kumar et al. (2005) found government schools in West Bengal to cater mainly to underprivileged children, including SC/ST groups and girls. There is little documentation on the role private education plays in addressing unmet needs in elementary and secondary education, which segments of the population access it, how do families meet the costs, and how -the quality of teaching and learning in these schools compare with government schools.

Geographic access: The National Coalition for Education report (2011) finds that social status as well as difficult geographic conditions have a negative impact on access to schools; distance and lack of transport are important reasons for school dropout (National Coalition for Education 2011). In the absence of schools within walking distance or a lack of safe public transport, a number of students, particularly girls drop out upon completion of primary school (Bandyopadhyay and Subrahmanian 2008) Sexual harassment and violence are major constraining factors preventing parents from freely sending their girls to school. In her study, Rani (2011) reports that 9% of girls aged 6–14 years dropped out of school because there was no education facility in proximity to their village of residence (Rani 2011). While 99% of the rural population has access to a primary school within one kilometre, only 86% have an upper primary school within a range of three kilometres (Ministry of Human Resource Development 2011). Data from the NSSO education survey of 2007–08 highlights the disadvantage in accessing education facilities of people in rural areas compared to those in urban areas. Further, socially marginalized groups are at a greater disadvantage, and more so in case of access to upper primary and secondary schools. For instance, nearly 30% of ST households in rural areas do not have a secondary school within five kilometres of their residence (Bhog, Ghosh, and Mullick).

School environment: Physical infrastructure and school environment including the availability of toilets and drinking water are important contributing factors in retaining students, particularly girls, in school (Rani 2011). Several studies suggest that a large proportion of schools do not have buildings, drinking water, a library, playground, and toilets (National Coalition for Education 2011, Rani 2011, Bandyopadhyay and Subhramanian 2008). Although there has been substantial improvement in infrastructure in the past decade, not all schools have a pucca building or toilets or drinking water. Annual Status of Education Report (ASER) survey undertaken by Pratham tracks facilities and quality of education in elementary schools (classes 1–8). In 2012 only 73% of primary schools had drinking water facilities and 80% of the schools visited by ASER teams had separate toilets for girls; however,
only half of the schools visited had usable toilet facilities. The District Information System for Education (DISE) report for 2010–11 shows that only 60% of all elementary schools, including co-educational schools, had toilets for girls (National University of Educational Planning and Administration and DSEL 2012).

**Quality of education:** Poor quality of teaching and learning in the country continues to pose a challenge. The learning levels in elementary education in both scholastic and co-scholastic or non-cognitive areas are far below the corresponding levels in other countries (Planning Commission, Twelfth Five Year Plan 2012–2017 Government of India). The ASER survey focuses on learning achievements among 6–16-year-old school-going students. The 2011 report notes that teaching methods are outdated and the syllabus is not relevant to the children, particularly in the rural areas. Furthermore, regional differences in teaching systems bring in different standards and have an impact on learning. For example, learning levels are dropping gradually in most Northern and Eastern states while steadily improving in the Southern and Western states (ASER Rural Report 2011).

A study carried out by Education Initiatives Pvt. Ltd in 48 districts of 18 states and one Union Territory (Educational Initiative and Wipro Applying Thought in Schools 2011) noted similar findings. Few students could comprehend what they read and levels of learning of students in government schools in classes 4 and 8 were much lower than the international average. There are significant statewise differentials in performance. (Educational Initiative and Wipro Applying Thought in Schools 2011)

Not all students complete school education and not all go on to higher university education. Although the government has introduced vocational training as a distinct centrally sponsored stream at the plus-two stage, this action has failed to provide the necessary impetus to formalization of vocational training. The vocational education programme has a rigid and outdated centralized syllabus that is unsuitable for prevailing marketing conditions; has temporary and often inexperienced teachers, insufficient books and instructional materials, little or no infrastructure including laboratories and workshops to provide hands on training; and more importantly no linkages with industry (Majumdar 2005). This is of concern in the context of the rapidly changing economic scenario and to skill sets required by industry. Further vocational training is only available to those having completed Class 10 leaving school dropouts with no opportunities to obtain vocational skills.

The most recent 2011 ASER report highlights the lack of an adequate number of trained teachers and poor attendance by teachers, particularly in rural and tribal areas. The report also notes the lack of female teachers. ASER report has shown a steady decline since 2009 in teacher attendance at public elementary schools; in 2012, 15% teachers were absent on the day of the visit to the school (ASER 2012). A shortage of trained teachers, especially at the secondary and senior secondary levels hampers the education system. Only 88% of teachers were trained at the secondary level while 89% of teachers were trained at the senior secondary level. Further; there are 61 female teachers per 100 male teachers at the higher school level or post-basic school level and just 65 per 100 male teachers at the higher school or inter-college level (Ministry of Human Resource Development 2009). The quality of teacher training remains poor. The preservice teacher training course uses an outdated pedagogical approach, and has poor standards and inadequate supplies of basic teaching/learning materials (World Bank 2009).
Policy and system-level barriers

In India, education is a state subject and national policies and programmes launched at the centre have to be implemented by local state governments. Thus, gaps exist between policy and its implementation. For example, the RTE Act, launched in 2010, is yet to be implemented in 16 states which have not yet formulated the state level laws/regulations for implementation (National Coalition for Education 2011).

Further, gaps exist between budgetary allocations and utilization. The National Coalition of Education report (2011) shows that of the total funds allocated to the education sector between 2007–08 to 2010–11, University Grants Commission accounted for 46% of the expenditure and teachers’ training for 36%, leaving very little for school education (National Coalition for Education 2011). Further, funds are not always transferred on a regular basis and there is usually a rush to spend the funds in the last quarter of the financial year resulting in inefficient and insufficient expenditures (National Coalition for Education, 2011). A study undertaken by the World Bank (Sanker 2007) shows that while there was a significant increase in the per child revenue expenditure on elementary education between 1991 and 2004–05 – from Rs. 580 to Rs. 1275 (at comparable constant 1993–94 prices) – most of the funds came from the centre and the share of the states was minimal. Additionally, there were large state and regional differentials (National Coalition for Education 2011).

The way forward

Over the last few years there has been accelerated and increased focus on making education accessible and available for all at the primary, and more recently at the secondary levels. Most data on education for adolescents is available from government sources/reports; large-scale surveys such as NFHS, NSS, AIES, DISE; and a few peer-reviewed journal articles. Further, most published material pertains to elementary education which has been the focus of policies and programmes since the late 1980s; there is limited information related to secondary education. Additionally, reports and papers often present data by school levels (for example, primary, or upper primary) which overlap with younger children. Data on adolescents are available but require abstraction, including barriers and attitudes to education and retaining the young in school to enable them to complete their education.
Education is necessary to achieve the full potential of the nation’s human capital. The positive externalities of secondary education on health, gender equality, and living conditions are even stronger than those for primary education, however, several challenges exist. Retention in schools is a key challenge and several supply- and demand-side factors contribute to this. On the supply side geographical access, infrastructural facilities, and quality issues have been highlighted at both the elementary and secondary levels. On a broader level better enforcement of the RTE Act, the SSA, and the RMSA would address the gap between policies and programme implementation and would require government commitment at the state level, stronger governance, and better centre–state communication. Several reports (World Bank 2009, ASER 2012, Planning Commission and IIE 2006) provide detailed recommendations for the education system pertaining to physical access, infrastructure, quality, and financing. In this report we focus on gaps in available information.

For several years the focus of education policies and programmes was directed at expanding access to primary education. The focus shifted beyond primary education as recently at 2008 with the launch of the RMSA. Further the RTE Act (2010) has transformed the education scenario by legally mandating education for all and placing the onus on governments to deliver. National-level impact assessment studies are needed to evaluate these programmes to guide their further expansion. A system of monitoring that uses ‘data for decision-making and strategic planning is needed to provide feedback on the programme and facilitate successful implementation.

On the demand side economic issues and parental attitudes impede access. BCC efforts are needed at the community level to increase demand for education among parents and communities. Such efforts may shape gender-differentiated ideologies that impede access to education for girls, in particular the lack of the importance of education and early transition to adult roles, especially marriage. Studies with parents and community/religious leaders to examine their views of and attitudes about education in the context of RTE would be useful. There is limited evidence available on minorities and marginalized populations and on nonformal or religious education in the country. More research is needed in this area to provide information on the extent of exclusion and strategies to address these barriers. Similarly, there is limited evidence on what works for out-of-school adolescents, including those who are street based, and what innovative strategies could be used to bring them back to school. Rigorously evaluated innovative interventions are needed; for example, financial incentives or vouchers for poor, minority, or marginalized households. Successful and cost-effective interventions could then be scaled up.

There is limited information on teachers including the barriers they face and difficulties they encounter, for example working in remote areas. Qualitative studies would give an indication of the issues teachers face and provide guidance and suggestions for policy and future training needs. While there are ample data on the number of teachers and training levels, there is no assessment of their competency or a system of continuing education or in-service teacher refresher training. There is a need to address the capacity, motivation and accountability of teachers to deliver quality education which could, possibly, be measured periodically and assessed in terms of the learning outcomes of students.

Evidence from various sources suggests that the quality of education and learning is poor. To make the education system competitive internationally, a national system of standardized assessments comparing educational levels to international indicators/leagues are required. This would serve as a quality control mechanism for the education system to provide an impetus for improving quality. An essential requirement for such a mechanism would be to remove state-level and regional differences in education systems and bring them in line with a national standard.

The private sector is playing an increasingly larger role in delivering primary and secondary education in the country. It needs to be brought into the ambit of a national assessment for standards and quality. More research is needed to examine the populations the private sector serves, the quality of their education, their fee structure and the impact of availability of private sector education on public-sector facilities in rural areas.
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Nutrition constitutes the foundation for human development by reducing susceptibility to infections, reducing the related morbidity, disability and mortality burden and enhancing cumulative lifelong learning capacities and adult productivity (Planning Commission, Twelfth Five Year Plan 2012–2017 Government of India). The state of nutrition among young children, women, and men in India is of concern. Despite a number of national level programmes and policies, current nutrition status reflects the lack of progress over time. Nutritional status is based on specific indicators like height and weight, anaemia, iodization of household cooking salt, utilization of nutrition programmes, information on child feeding practices and vitamin A supplementation (Arnold et al. 2009). Deficiencies of micronutrients continue to impose a substantial health, economic, and social burden worldwide. Globally 60%–80% of adolescents suffer from micronutrient deficiencies. Fluctuations in the status of one or more micronutrients may reasonably be expected to alter the metabolism of the other, particularly in adolescents (Shashi et al. 2012). Additionally, India being in a state of nutritional transition is facing the dual burden of malnutrition along with emerging problems of overnutrition and obesity.

The government has put in place a number of programmes and policies aimed at improving nutritional status among adolescents, specifically the girls. Various programmes are implemented by the Ministry of Women and Child Development, Ministry of Health and Family Welfare, the Department of School Education and Literacy (under Ministry of Human Resource Development), and the Ministry of Youth Affairs and Sports. The National Nutrition Policy 1993 was instrumental in setting nutrition goals to control and prevent malnutrition in the country. The policy sought to create a balance between the short-term direct nutrition interventions and long-term institutional/structural changes to improve the nutritional status for all sections of the society. To give due importance to nutrition among adolescent girls, Kishori Shakti Yojana (KSY) – part of the Integrated Child Development Services (ICDS) programme – was rolled out in 2000. With a focus on girls who are school dropouts (11–18-year olds), KSY provides take-home rations, health package, and non formal education, along with home-based and vocational skills development (ICDS and Planning Commission 2011). In addition to KSY, the government of India started the Nutrition Programme for Adolescent Girls (NPAG) in 2002 in 51 districts for adolescent girls and pregnant/lactating women. All adolescent girls in the district were weighed once in three months to identify girls who weighed less than 35 kgs and provided free of cost 6 kg of food grains per month for the next three months. In 2010 the Ministry of Women and Child Development rolled out the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) – the SABLA programme to provide supplementary nutrition to adolescent girls (11–18 years). This scheme merged the KSY and NPAG in order to address the multidimensional needs of the adolescent girls. Out-of-school girls are also provided two adult Iron Folic Acid tablets per week along with nutrition and health education. (Implementation Guidelines for SABLA Programme, Ministry of Women and Child Development 2010).

The Mid-Day Meal Scheme, run by the Department of School Education and Literacy, started in 1995 and revised in 2001 provides young people (9–14-year-old from classes 1–8 in government and aided schools and Education Guarantee Scheme (EGS)/Alternative and Innovative Education (AIE) centres) a cooked mid-day meal where 300 calories and 8–12 grams of protein is provided.
Gender and nutrition

In India, 33% of adolescent girls between 11–18 years of age are undernourished. Their health and nutrition status is further compromised by early marriage and early childbearing (Planning Commission, Twelfth Five Year Plan 2012-17 Government of India). Women’s deprivation in terms of nutrition and health care rebounds on society as a whole in the form of ill health of their children- males and females alike – both as children and adults (Siddiq and Sen 2003). Young undernourished girls get married and make the transition from their natal homes to marital homes, where they have the least ability to negotiate or influence decisions to improve their own or their children’s health and nutrition status. This sociocultural dimension to nutrition among adolescent girls magnifies the complexity of the issue (Kavita and Duvvury 2007).

Gender bias in nutrition is apparent. Fifty-six per cent of adolescent girls aged 15–19 had reported any anaemia compared to only 30% of boys aged 15–19 (Parasuraman, Kishor, Singh et al. 2009). Similarly, girls aged 15–19 were more likely to have moderate to severe anaemia compared to boys in the same age group – 17% and 13% respectively. Also, gender differences are noticeable among urban residents – while 16% of young women residing in urban areas reported anaemia, just half of that percentage of young men living in urban areas so reported (8%). In a study done with adolescents in Pune, Mane et al. (2012) reported prevalence of anaemia in 51% of girls which was statistically highly significant compared to boys (13%) (Mane et al. 2012).

A study done by Mondala et al (2012) with 725 children aged 6–16 years in West Bengal showed that most socioeconomic variables, like father’s occupational status, per capita income, number of siblings, and number of living rooms, were significant predictors of undernutrition among girls but not boys. This discrepancy is indicative of gender discrimination against the female child resulting in them suffering from chronic undernutrition (Mondala, Biswasb, and Boseb 2012).

The findings from a three-site qualitative study (two study sites in Maharashtra and Rajasthan; one in Bangladesh) with unmarried and newly married adolescent girls by Sethuraman and Duvury(2007) suggest that nonnutrition interventions that address the gender inequality experienced by adolescent girls are necessary and possible for improved nutritional outcomes (Sethuraman and Duvury 2007).

Nutrition status of adolescents

During adolescence nutrient requirements are at a peak and in absolute terms are the highest than at any other stage of life. Malnutrition at this stage leads to stunting of growth, repeated infections, constraints on full physical and psychological development, and in girls compounds the risks associated with pregnancy – even if at the time of pregnancy adolescent girls have access to enough nutrients. There is a clear association of malnutrition with low birth weight of babies, more complications in pregnancy and at child birth, anaemia, more frequent abortions [Draft policy note on nutrition by NHSRC]. Nutritional anaemia remains a major public health concern in India. Anaemia in women results in increased risk of low birth weight or premature birth; perinatal and neonatal mortality; inadequate iron stores for the newborn; increased risk of maternal morbidity and mortality; lower physical activity, mental concentration, and productivity.

Issues like malnutrition and anaemia affect large sections of the Indian population, and are particularly high among adolescents. Findings from the National Family Health Survey 3 (NFHS-3) indicate that as many as 56% of females and 30% of males in the 15–19 age group are anaemic (IIPS and Macro International 2007). The high prevalence of anaemia among females in India is of great concern as it is directly associated with maternal and perinatal mortality. Parasuraman et al. highlight various background characteristics which play an important role in determining the prevalence of anaemia. Education appears to be an important factor in reducing anaemia – while 22% of adolescent girls aged 15–19 years and 16% of boys aged 15–19 had moderate to severe anaemia, it is less than half (12%) among girls who had completed 12 or more years of schooling and 5% among boys in the same age group. Similarly, poverty is another important factor in poor nutritional status and anaemia – 22% of young women and 18% of young men belonging to the poorest households, compared to 13% and 6% from the richest households were found to be anaemic. Anaemia among young women cuts across place of residence – 18% of rural women and 16% of urban women are anaemic (Parasuraman, Kishore, Singh et al. 2009).
Some groups of adolescents including girls and those belonging to marginalised communities face specific barriers like gender bias, poverty, socio-cultural norms etc. Low age and anaemic mothers are more prone to deliver low birth weight children, with significant morbidity and mortality associated for both mother and child. The prevalence of anaemia is higher in rural than in urban areas. Ever-married women in the age group 15–24 years are more likely to be anaemic than their never-married counterparts (IIPS and Macro International 2007).

The National Nutrition Monitoring Bureau (NNMB) conducted a multi-state study in 2003 which reported the overall prevalence of anaemia among 12–14 year old adolescent girls at 69% and among older adolescent girls 15–17 years at 71% (Table 3.1). The overall prevalence of moderate anaemia was 21% and severe anaemia was about 1%–2%. In this study, prevalence of anaemia and underweight were found to be positively associated. Among adolescent girls, the mean level of haemoglobin was 11.1–11.2 g/dl.

### TABLE 3.1 Prevalence of anaemia by religion and community

<table>
<thead>
<tr>
<th>Religion</th>
<th>N 12–14 yrs</th>
<th>N 15–17 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hindu</td>
<td>2907</td>
<td>2897</td>
</tr>
<tr>
<td>Muslim</td>
<td>281</td>
<td>302</td>
</tr>
<tr>
<td>Christian</td>
<td>97</td>
<td>112</td>
</tr>
<tr>
<td>Others</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community</th>
<th>N 12–14 yrs</th>
<th>N 15–17 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST</td>
<td>322</td>
<td>332</td>
</tr>
<tr>
<td>SC</td>
<td>693</td>
<td>669</td>
</tr>
<tr>
<td>OBC</td>
<td>1364</td>
<td>1368</td>
</tr>
<tr>
<td>Others</td>
<td>916</td>
<td>952</td>
</tr>
</tbody>
</table>


A number of other small studies across India have been conducted to examine anaemia among adolescent girls. Rao et al. (2011) reported a mean Haemoglobin level of 11.07g/dl in rural parts of Pune among women in the age group of 15–35. While age disaggregated data are not available, the study findings indicate that more than 75% of women were suffering from some form of anaemia. Multiple logistic regression analysis for risk of Iron Deficiency Anaemia (IDA) among the study population showed that factors like higher maternal parity (>=2), younger age at marriage (<19 years), and poor pre-pregnancy weight (<40 kgs) had significant odds ratio for IDA risk. Reasons for not consuming green leafy vegetables/milk/fruits included their preference for selling the products in the market, perishability, and that their husbands and children did not like them. Also, the purchase of these products from the market is in the domain of duties of the male members or the in-laws in the family and not young women and hence they do not have any control over the vegetables that are bought (Rao, Joshi, Bhide et al. 2011). A study done by Toteja et al. (2006) to study anaemia among adolescent girls across 16 districts in 11 states of India found a prevalence rate of 90.1% (Hb/dl <12g/dl) with almost 7% having severe anaemia (Toteja, Singh, and Dhillon 2006).

The National Nutrition Monitoring Bureau undertook a multi-state study in 2001 among the rural population in the states of Andhra Pradesh, Gujarat, Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, and West Bengal to assess the diet and nutritional status of individuals and the prevalence of morbidity in rural populations. The average daily intake of food and nutrients was assessed among 10-17-year-olds. The study found that the mean intake of cereals and millets and pulses was lower than Recommended Dietary Allowances (RDA) for Indians as suggested by the Indian Council of Medical Research (ICMR) expert committee (Table 3.2). The study mentioned that the nutrition education component is unsatisfactory, covering a mere 14% of the targeted beneficiaries.
TABLE 3.2 Average intake of foodstuffs (g/day)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Cereals</th>
<th>Millets</th>
<th>Pulses/legumes</th>
<th>Leafy vegetables</th>
<th>Other vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10–12 year boys</strong> (n=1227)</td>
<td>Mean</td>
<td>267</td>
<td>21</td>
<td>15</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>148</td>
<td>130</td>
<td>23</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>RDA*</td>
<td>420</td>
<td>45</td>
<td>50</td>
<td>52</td>
</tr>
<tr>
<td><strong>10–12 year girls</strong> (n=1218)</td>
<td>Mean</td>
<td>258</td>
<td>67</td>
<td>23</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>146</td>
<td>131</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>RDA</td>
<td>380</td>
<td>45</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td><strong>13–15 year boys</strong> (n=921)</td>
<td>Mean</td>
<td>319</td>
<td>83</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>184</td>
<td>174</td>
<td>26</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>RDA</td>
<td>302</td>
<td>67</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td><strong>13–15 year girls</strong> (n=921)</td>
<td>Mean</td>
<td>302</td>
<td>67</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>158</td>
<td>139</td>
<td>24</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>RDA</td>
<td>380</td>
<td>45</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td><strong>16–17 year boys</strong> (n=475)</td>
<td>Mean</td>
<td>379</td>
<td>93</td>
<td>29</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>219</td>
<td>201</td>
<td>39</td>
<td>48</td>
</tr>
<tr>
<td><strong>16–17 year girls</strong> (n=493)</td>
<td>Mean</td>
<td>332</td>
<td>70</td>
<td>25</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>173</td>
<td>156</td>
<td>28</td>
<td>42</td>
</tr>
</tbody>
</table>


* Recommended Dietary Allowance

Various small-scale studies highlight the high prevalence of micronutrient deficiencies among adolescents. Kapil and Bhavna (2002) in a cross-sectional study among 260 adolescent school adolescents (11–18 years) in Delhi, estimated the prevalence of zinc deficiency at 50.8% for boys and 48.2% for girls. The numbers are worrisome since zinc deficiency results in delayed sexual maturation, menstrual irregularities, decreased growth rate, and impaired mental development (Kapil and Bhavna 2002). Another study by Chiplonkar and Kawade (2012) with 630 (10–16-year-old) girls in Pune observed that the average zinc intake was low, around 40% of the Indian RDA. Similarly the average intake of calcium, iron, beta carotene, and vitamin C were 30%–60% of the respective RDAs, indicating dietary deficiencies of these minerals and vitamins in girls, and 27.2% of girls were anaemic (Chiplonkar and Kawade 2012).

Another small study with 223 adolescent girls in an urban slum area of Andhra Pradesh reported an overall prevalence of stunting at 28.3% (Indian standard), underweight at 22.9% and thinness at 20.6%. The paper highlighted the fact that an urban slum adolescent girl is subjected to more physical and mental challenges compared to a rural adolescent girl. (Prashant and Shaw 2009). A study on anaemia in pregnant adolescent mothers in Uttarakhand revealed that 46% were anaemic and had poor dietary intake of iron and retinol (Pathak, Singh, Kapil et al. 2003).
Overweight/Obesity and their correlates

Obesity in adolescents appears to increase the risk of subsequent morbidity, whether or not obesity persists into adulthood (Raj et al. 2007). Outcomes related to childhood obesity include hypertension, type-2 diabetes mellitus, dyslipidaemia, left ventricular hypertrophy, non-alcoholic steatohepatitis, obstructive sleep apnoea, and orthopaedic and psychosocial problems. WHO defines a BMI greater than or equal to 25 as overweight and a BMI greater than or equal to 30 as obesity.

NFHS 3-data state that overweight and obesity are emerging problems in India – 13% of women and 9% of men are overweight and obese (IIPS and Macro International 2007). In the age group 15–19, nearly half of the females (47%) and nearly three-fifth of the males (58%) are thin. At the same time, 2.4% of females and 2% of males in the age group 15–19 suffer from obesity reflecting the changes in dietary and lifestyle patterns among the young. Young people in rural areas are more likely than youth in urban areas to be abnormally thin and less likely to be overweight or obese. As expected, the likelihood of being abnormally thin generally declines with education and wealth and the likelihood of being overweight/obese increases with education(IIPS and Macro International 2007).

There are several medium-to-small–scale studies addressing the growing concern about obesity and overweight. A study conducted with 5664 school-going adolescents in the 12–18 year age group indicated that age-adjusted prevalence of overweight was higher among boys than girls – 14% among boys and 9% among girls – whereas obesity was 2.9% among boys and 1.5% among girls (Goyal, Shah, and Saboo 2010). The authors reported that the increase in the prevalence of overweight and obesity occurred at the age of 12 years and thereafter decreased with age. On the other hand, Deshmukh et al. (2006) found that the prevalence of thinness was significantly higher in early adolescence than in late adolescence in rural Wardha. They also reported the prevalence of thinness was significantly higher (69.8%) in girls than in boys (40.7%). (Deshmukh, Gupta, Bharambhe et al. 2006)

Kotian et al. (2010) reported a prevalence of overweight at 9.9% and obesity at 4.8% among adolescents aged 12–15 years in Mangalore city of South Karnataka. This prevalence was comparable to the prevalence in US females aged 15–17 years and Australia (Kotian, Kumar and Kotian 2010). A significant prevalence was also observed in affluent adolescent girls in Delhi – 5% were obese and 15% overweight which could be attributed to the affluent societies in India transitioning to Westernized lifestyles like in the United States (Mehta, Bhasin, Aggarwal et al. 2007).

Exploring the connection between overweight and socioeconomic status (SES), the study conducted by Goyal, Shah, and Saboo(2010) indicates that while adolescents in middle SES were more likely than those in the higher SES to be overweight, those from the higher SES were more likely to be obese compared to those from the middle SES. On the other hand, the prevalence of obesity and overweight in adolescents from the low SES was the lowest compared to other groups (Goyal, Shah, and Saboo 2010). A study in Ludhiana city in the 9–15 year age group compared the prevalence of obesity among boys and girls of the two school groups. The findings indicate that in the affluent school significantly more boys were overweight (25% vs. 16.6%, p=0.001) and obese (19.9% vs. 13.1%, p=0.003) compared to children in schools attended by middle and low socioeconomic families. Taking different socioeconomic classes, the prevalence of obesity was found to be directly proportional to the socioeconomic status. A plausible explanation may be that people are using their growing incomes to replace their traditional diets rich in fibre and grain with diets that include greater proportion of fats and caloric sweeteners. The study also found that more boys were obese and overweight compared to girls – 12.4% vs. 9.9%, 15.7% vs. 12.9% respectively. However, gender differences are not visible in obesity among adolescents from less privileged background. Among those from affluent families; significantly more boys were obese than girls (Chhatwal, Verma, and Riar 2004).

In a cohort of 24,000 children in the 5–16 age group years in Ernakulum district of Kerala the proportion of overweight children increased from 4.94% in 2003 to 6.57% in 2005. Notably, the increase was significant in both boys and girls, proportion of overweight was significantly higher in urban regions and in private schools, and the rising trend was limited to private schools. An interesting finding was the association of hypertension with overweight since 17.34% of overweight adolescents vs. 10.1% of the remaining students were found to be hypertensive (Raj, Sundaram, Paul et al. 2007) Another study of rural adolescents showed hypertension in 3.4% of the study population that was positively correlated to the BMI (Kumar, Deshmukh, and Garg 2012).
An interesting finding from a study which compares obesity among rural and urban adolescents (14–16 years) demonstrated an increase in the prevalence of obesity and overweight and a decrease in the prevalence of underweight in urban adolescents compared to their rural counterparts. A significant finding of the study was the independent association of urban male gender and high socio-economic status with the risk of being overweight and obese in childhood. Both these groups showed an increased prevalence and higher risk of being overweight and obese. Hormonal, cultural and social factors account for the observed gender differences. Compared to boys, post-pubertal girls are more conscious of their physical appearance and consequently take active steps to control obesity. Socio-economic status is another factor. Cultural beliefs in the region that being overweight is considered a sign of prosperity and good health may play a major role (Parekh, Parekh and Vadasmiya 2012).

One possible explanation for the differential relationship between socioeconomic status and overweight/obesity is the influence of SES on people’s lifestyle: diet, food consumption patterns and public services such as health care and transportation and physical activity may differ. Goyal, Shah, and Saboo (2010) reported that junk food, chocolate eating and restaurant visits per week were positively associated with BMI. Family history of diabetes and overweight were also found to be positively associated (Goyal, Shah, and Saboo 2010).

**Trends in dietary habits**

Irregular dietary habits have negative consequences not only on health but on academic performance, concentration, and memory. Adolescents need to spend considerable time on academics, prepare for various competitive examinations, and function at the highest level of concentration and achievement. A few available studies examine the impact of breakfast and regular meals on academic performance and physical activity levels and find that a regular habit of eating breakfast as opposed to skipping this meal had a beneficial impact on attention, concentration, memory and school achievement (Gajre, Fernandes, Balakrishna et al. 2008). A small study by Jaswal and Jaswal (2012) of students in the 13–16 year age group reported a negative association between adolescent obesity and academic performance. The reasons could be that poor academic performance causes higher body weight for adolescents who may choose to eat excessively as a psychological reaction for doing poorly in studies. Productive studying could be impeded due to adverse psychological and physiological effects of obesity (Jaswal and Jaswal 2012).

Arora et al. (2012) studied 1814 students (12–18 years old) in eight schools in Delhi and found that the overall prevalence of overweight and obesity among adolescents who consumed breakfast daily (14.6%) was lower than among those who only sometimes (15.2%) or never (22.9%) consumed breakfast. This relationship was found to be statistically significant among boys but not girls (Arora, Gaurang, Gupta et al 2012). Other studies have also reported that breakfast consumption is positively associated with academic achievement among students (Klienman, Hall, Green et al. 2012, Taras and Potts-Datema 2005, Gajre, Fernandes, Balakrishna. 2008).

A study in Delhi reported breakfast consumption was significantly lower among older students compared to younger students and higher among students attending government schools than private schools. There was no significant gender difference (Arora, Gaurang, Gupta et al. 2012). It was also found that breakfast consumption was positively associated with positive values and beliefs about healthy eating, body image satisfaction, and positive peer and parent influence.

Another study conducted with 550 adolescents (12–18 years) in Delhi to evaluate the prevalence of lifestyle-associated risk factors reported inappropriate dietary practices – about 33% admitted to eating fast food more than three times a week, only 40% had daily fruit consumption, low physical activity-54.4% boys and 63.9% girls admitted to not engaging in any sports activity either at home or school, and higher levels of experimentation with alcohol (30% boys and 26% girls). The study concluded that gender, BMI, extra table salt, obesity, and smoking contributed to systolic hypertension in the study population (Singh, Maheshwari, Sharma et al. 2006). Similar findings were reported by Mane et al. (2012) in their study done with 200 adolescents in Pune, where 6% of boys were found to have systolic hypertension. Also, they reported sedentary habits and family history of hypertension to have a positive correlation with systolic BP (Mane, Agarkhedkar, Karwa et al. 2012).
Chitra and Reddy studied the dietary pattern of 10–15-year-olds and demonstrated that only 42.8% of the adolescents ate breakfast regularly and the mean nutrient intakes were inadequate compared with the recommended values for energy and protein. The inadequate energy intake was reflected in a high incidence of malnutrition in both boys and girls; 40.3% of the boys and 32.1% of the girls studied were found to be underweight (Chitra and Reddy 2007).

Shrivastav and Thomas studied the snack consumption of adolescent girls studying in government schools in Delhi and revealed a high preference for snacks. The girls identified their parents and teachers as the most influential factors determining their food choices (Shrivastav and Thomas 2010).

Findings of intervention studies to address nutrition needs

Few researchers have explored intervention strategies and their impact on improving the nutrition status of the young. Chiplonkar and Kawade (2012) did a 10-week intervention trial with 180 girls (aged 10–16 years) in Pune city. Food supplementation with zinc and other micronutrient rich food decreased the prevalence of zinc deficiency and mild anaemia. This group showed 95% compliance since the supplements were not substitutes for their regular meals and the authors suggest that this can serve as an acceptable strategy for sustainable improvement of the micronutrient status of girls.

An analysis of the current dietary intake of adolescents belonging to poor income groups and reported deficiencies of several nutrients with associated clinical and functional consequences was done by Rao (2002). He suggested three broad strategies to overcome deficiencies in the diets of the population: provide micronutrient-rich supplementary food prepared at home from locally available sources; to fortify a universal vehicle like salt; and to fortify supplementary foods with minerals such as calcium, iron, zinc, and iodine (Rao 2002). Kameswararao and Bachu (2009) conducted a school-based intervention with 610 adolescents in the Karim Nagar district in Andhra Pradesh. Adolescents participated in weekly two hour sessions at school for six months. The intervention reported 0.33% reduction in obesity, 27.5% reduction in sweets, chocolates, and carbohydrate-rich food consumption, 17% reductions in sedentary activities, and 19% reduction in prolonged TV watching (Kameswararao and Bachu 2009).

Evidence is building that preventive supplementation coupled with nutrition education may be an effective strategy for combating iron deficiency and deficiencies of other micronutrients in growing children and adolescents (Ahluwalia 2002). Long term, effective approaches include fortification, dietary modification, and public health and disease control measures. Adherence and compliance could be improved with weekly rather than daily supplementation. It must also be integrated with community education activities such as child-to-child trust or focus groups with health workers, parents, or teachers. For supplementation programmes to be of maximum benefit, they need to include deworming efforts.

Policy and system-level barriers

The evaluation of KSY by the Programme Evaluation Organization (PEO) in 2011 highlights gaps in the implementation of the scheme. Findings suggest that effective coverage at the national level is only 10% and only 41.7% of the adolescent girls recorded in the delivery registers receive nutrition support in the country. These girls receive such support for only 6 days in a month on average against a stipulated norm of 25 days. Among those recorded in the delivery register, 54.9% reported not receiving support due to supply constraints, only 26.8% were aware of their quantitative entitlement of food support and 3.5% reported not receiving the support for demand-related reasons. State-level variations across all the indicators are quite significant (Evaluation of ICDS, Planning Commission 2011) (Table 3.3).
### TABLE 3.3 Status of effective coverage of supplementary nutrition programme for adolescent girls (11–18 years old)

<table>
<thead>
<tr>
<th>State</th>
<th>Receiving food</th>
<th>Effective coverage as % of those recorded in delivery register</th>
<th>Not receiving food due to constraints on Supply side</th>
<th>Awareness of food entitlement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>As % of those recorded in delivery register</td>
<td>Average number of days per month</td>
<td>as % of those recorded in delivery register</td>
<td>as % of those recorded in delivery register</td>
</tr>
<tr>
<td>Andhra Pradesh</td>
<td>44.5</td>
<td>3</td>
<td>5.3</td>
<td>53.7</td>
</tr>
<tr>
<td>Assam</td>
<td>42.8</td>
<td>3</td>
<td>5.1</td>
<td>49.8</td>
</tr>
<tr>
<td>Bihar</td>
<td>67.6</td>
<td>9</td>
<td>24.3</td>
<td>31.6</td>
</tr>
<tr>
<td>Chhattisgarh</td>
<td>26.3</td>
<td>3</td>
<td>3.2</td>
<td>68.6</td>
</tr>
<tr>
<td>Gujarat</td>
<td>91.9</td>
<td>17</td>
<td>62.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Haryana</td>
<td>17.0</td>
<td>3</td>
<td>2.0</td>
<td>83.0</td>
</tr>
<tr>
<td>Himachal Pradesh</td>
<td>87.2</td>
<td>17</td>
<td>59.3</td>
<td>12.8</td>
</tr>
<tr>
<td>J&amp;K</td>
<td>89.8</td>
<td>17</td>
<td>61.0</td>
<td>10.3</td>
</tr>
<tr>
<td>Jharkhand</td>
<td>86.7</td>
<td>18</td>
<td>62.5</td>
<td>13.3</td>
</tr>
<tr>
<td>Karnataka</td>
<td>81.2</td>
<td>10</td>
<td>32.5</td>
<td>14.5</td>
</tr>
<tr>
<td>Kerala</td>
<td>95.6</td>
<td>20</td>
<td>76.4</td>
<td>4.5</td>
</tr>
<tr>
<td>Madhya Pradesh</td>
<td>89.1</td>
<td>7</td>
<td>24.9</td>
<td>10.1</td>
</tr>
<tr>
<td>Maharashtra</td>
<td>70.9</td>
<td>13</td>
<td>36.9</td>
<td>25.8</td>
</tr>
<tr>
<td>Orissa</td>
<td>0.4</td>
<td>0</td>
<td>0.0</td>
<td>99.0</td>
</tr>
<tr>
<td>Punjab</td>
<td>91.9</td>
<td>15</td>
<td>55.1</td>
<td>4.3</td>
</tr>
<tr>
<td>Rajasthan</td>
<td>93.0</td>
<td>6</td>
<td>22.3</td>
<td>6.4</td>
</tr>
<tr>
<td>Tamil Nadu</td>
<td>0.8</td>
<td>0</td>
<td>0.0</td>
<td>91.3</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>82.6</td>
<td>15</td>
<td>49.5</td>
<td>17.3</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>79.0</td>
<td>9</td>
<td>28.4</td>
<td>21.0</td>
</tr>
<tr>
<td>West Bengal</td>
<td>46.4</td>
<td>7</td>
<td>13.0</td>
<td>53.6</td>
</tr>
<tr>
<td>All India</td>
<td>41.7</td>
<td>6</td>
<td>10.0</td>
<td>54.9</td>
</tr>
</tbody>
</table>

Note: Demand-side factors include: Anganwadi Center far away, food quality is not good, family does not allow, loss of work/no time, and not aware of services. Supply side factors include: Not distributed, most of the days the food is not available, and AWC often remain closed.

Source: Table 5.4 Evaluation Report on ICDS, Planning Commission 2011

An evaluation of the NPAG programme undertaken by the Nutrition Foundation of India in 2006 reported that the programme was disrupted by the irregular flow of funds, and delays in allocation of food grains were reported both at the central and rural levels. The report also highlighted that most states implemented the programme in the rural anganwadis, as the urban anganwadis were not well established and there were delays in allocation of food grains both at central and rural levels. Some households reportedly sold food grains during the school reopening period to get money for buying books or school uniform. Among the poorest sections of the population, women reported using the food grains to improve the household food security. A majority of younger adolescent girls were categorised as undernourished by using a single cut off weight and less than 10% of girls crossed the cutoff mark even after several months of supplements. Many educated family members questioned the feasibility of giving food grains to families of adolescent girls for several years continuously (NPAG Evaluation Report, Nutrition Foundation of India 2006).
The evaluations of both these schemes (NPAG and KSY) influenced the lives of adolescent girls to an extent but did not show the desired impact. Moreover, the extent of financial assistance and coverage under the programmes was limited and both offered similar interventions and catered to more or less similar target groups (Implementation Guidelines for SABLA Programme, Ministry of Women and Child Development 2010).

**The way forward**

Nutrition is a critical element for human development. Since Independence, India is constantly aiming for universal access and provision of nutrition to all citizens especially children. Despite a number of national-level programmes and policies, current nutrition status reflects the lack of progress over time. For adolescents, limited data are available from government reports on nutrition. Furthermore, most published material is from small and medium scale studies which make it difficult to generalize the study findings to a larger geographic area. The varying patterns of food consumption across India add to the complexity of the issue. In this report, we present the following gaps in available information:

The research studies on nutrition have largely focussed on adolescent girls considering their imminent childbearing roles. It is important to note that boys also have a growth spurt during their adolescent years and need calcium, vitamin D, and other nutrients to meet their body requirements. Therefore, it is important to have large-scale – national or subnational studies to ascertain the nutrition status of adolescent boys so that appropriate intervention can be tailored to meet their requirements.

The significance of micronutrients in determining sexual maturation, the physical work capacity, the cell-mediated immune response, cognitive functions, and growth is well established. Unfortunately, there is limited work which looks at malnourishment through the lens of cognitive development and academic performance.

Obesity is a new emerging problem in India. Currently, there are no national or subnational studies which look into the various correlates of overweight and obesity in the adolescent group. To plan effective and sustainable interventions which can address this issue it is important to evaluate the magnitude of this problem.

Gender differences in access to education, health services, and nutrition have been widely studied in India. For nutrition, these studies have focused on early infant feeding practices which have an impact on child survival (0–5 years). NFHS data and other studies highlight the higher prevalence of obesity among boys and higher prevalence of anaemia among girls but there is lack of evidence to understand the reasons for it, one of which could well be gender bias at home for food distribution.

There is a growing need to understand the role of the media in influencing the dietary habits of adolescents. This influence can be studied to explore the impact of endorsement of various fast food products by celebrities’ vis-à-vis parental advice on food intake.
References


- Draft policy note on nutrition by NHSRC. International Institute for Population Sciences (IIPS) and Macro International.2007.


India has the world’s largest population of children and the highest number of children engaged in work. Due to the invisible nature of children’s work, it is difficult to indicate the exact number but estimates range from 12.6 million (Government of India) to 44 million (ILO) to as high as 70-80 million (civil society estimates) (Save the Children 2009). Data from the National Family Health Survey 3 (NFHS-3) indicates that nearly one in every eight (12%) children aged 5–14 years either work for their own household or for someone else. Rates increase from 5% among boys aged 5–7 years to 15% among boys aged 12–14 years. Among girls, it ranges from 5% for those aged 5–7 years to 18% among those aged 12–14 years. Boys aged 12–14 are mainly engaged in paid work or family work while girls in this age group are responsible for household chores or family work (Ministry of Statistics and Programme Implementation 2012). Among children who work for others, 2% are engaged in paid work and 3% in unpaid work. Notably, at all ages, girls are more likely than boys to be engaged in household chores while boys are more likely than girls to be employed or working for someone else (Ministry of Statistics and Programme Implementation 2012). The problem of child labour is largely a rural one as a large number of children are concentrated in rural areas and these children are sent to urban areas for work in case of calamity or distress in rural areas. Data from 61st Round of NSSO (2004–05) indicate that out of 9.07 million child labourers aged 5–14, as many as 7.44 million were in rural areas and just 1.52 million were in urban areas. Caste and religious disparities are also evident from NSSO data. For example, children (aged 5–14 years) in scheduled tribes are twice as likely to be engaged in gainful employment as the ‘others’, mainly from upper caste. About 3% of children from scheduled castes are employed in some way compared to 2% of “other” castes. The data reflects the vulnerability of Scheduled Castes (SC), Scheduled Tribes (ST) and Other Backward Castes (OBC) (National Commission for Protection of Child Rights 2008). Work participation rates are higher among minority religious communities compared to Hindu groups. NSSO data indicates that almost 7% of Muslim adolescents in the age group 10–14 were employed compared to 5% of Hindu children (National Commission for Protection of Child Rights 2008). The incidence of child labour is also higher among households where the head of the household is illiterate.

There is a declining trend in child labour between the three rounds of the NSSO as indicated in the table below. However, the reduction in child labour shown in NSSO 61st round (2004–05) should be considered in the overall context of declining employment growth in the country (National Commission for Protection of Child Rights 2008) (Table 4.1).
The NSSO data documents a wide variation among different states; Uttar Pradesh accounts for almost one-fourth of the entire child work force in the country followed by Andhra Pradesh (13%). Maharashtra and West Bengal respectively account for 9% and 8% of child labour (National Commission for Protection of Child Rights).

Provisions in the Constitution of India impose on the state the main and primary responsibility of ensuring that all needs of children are met and that their basic human rights are protected. For example, Article 23 prohibits trafficking and forced labour, and Article 24 specifically prohibits child employment below the age of 14 years.

The Commission for the Protection of Child Rights Act was set up in 2005 and provides for national and state-level commissions to protect the rights of children, specifically by examining and reviewing legal safeguards, to initiate inquiries for any violations of child rights, to spread awareness about child rights, and to establish Children’s Courts for speedy trials of offences against children or violations of child rights (Ministry of Statistics and Programme Implementation 2012).

Additionally, there are a number of policies in place to protect the rights of children (Annex 1). The National Policy on Child Labour of 1987 spells out steps that need to be taken to deal with the problem of child labour. The National Child Labour Projects (NCLP) launched in 1988 include time-bound projects like establishment of special schools to provide nonformal education, vocational training, supplementary nutrition, stipends, health care, etc. to children withdrawn from employment. The National Plan of Action for Children 2005 aims to secure for all children legal and social protection from all kinds of abuse, exploitation, and neglect. Specific Acts have been put in place to ban child labour and to specify conditions under which they cannot be employed (Ministry of Statistics and Programme Implementation 2012).

The Child Labour Act 1986 prohibits employment of children below 14 years in specified hazardous occupations and has systems in place for regulating the working conditions of children in other places of employment. The Act levies penalties in the event that the conditions are violated. The Factories Act, Mines Act, and Plantations Labour Act all focus on reducing working hours for children, increasing minimum wages, and prohibiting employment of children in occupations and processes that may harm their health and development (CREA 2005).

Child labourers under the age of 14 face a number of challenges. They are often made to work long hours in poorly lighted, cramped and overcrowded work places, and in many cases with exposure to harmful chemicals or pollutants resulting in impaired vision, deformities, malnutrition, diseases such as TB, occupational respiratory diseases, and cancer from exposure to harmful chemicals. This is compounded by the fact that they are taken away from their families and deprived of education and training activities that could prepare them for a better and probably different future (Ministry of Statistics and Programme Implementation 2012). Child labour is a complex issue operating at multiple levels that requires a better understanding of the factors that push children to work and the various forms of work included in child labour.

### TABLE 4.1 Estimate of trends in India’s child labour by rural–urban residence, 1983–2004/05 (in millions)

<table>
<thead>
<tr>
<th>Year (Round)</th>
<th>5–9 years</th>
<th>10–14 years</th>
<th>5–14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993–94 (50th round)</td>
<td>1.13</td>
<td>11.03</td>
<td>12.16</td>
</tr>
<tr>
<td>1999–00 (55th round)</td>
<td>0.60</td>
<td>8.05</td>
<td>8.65</td>
</tr>
<tr>
<td>2004–05 (61st round)</td>
<td>0.26</td>
<td>7.18</td>
<td>7.44</td>
</tr>
<tr>
<td><strong>Urban</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993–94 (50th round)</td>
<td>0.12</td>
<td>1.52</td>
<td>1.64</td>
</tr>
<tr>
<td>1999–00 (55th round)</td>
<td>0.07</td>
<td>1.32</td>
<td>1.39</td>
</tr>
<tr>
<td>2004–05 (61st round)</td>
<td>0.08</td>
<td>1.44</td>
<td>1.52</td>
</tr>
<tr>
<td><strong>Combined</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993–94 (50th round)</td>
<td>1.27</td>
<td>12.59</td>
<td>13.86</td>
</tr>
<tr>
<td>1999–00 (55th round)</td>
<td>0.63</td>
<td>9.50</td>
<td>10.13</td>
</tr>
<tr>
<td>2004–05 (61st round)</td>
<td>0.35</td>
<td>8.72</td>
<td>9.07</td>
</tr>
</tbody>
</table>

Situations pushing children to work

It is essential to distinguish between child labour and bonded labour at the start of any discussion on factors pushing children to work. While economic distress drives child labour, in the case of bonded labour it is further compounded by social hierarchy and discrimination, and women and children are most affected (Srivastava 2005).

Children who live under conditions of extreme poverty and economic distress are often sent to work to contribute to the family income. These children have to forgo educational opportunities and take up jobs that are often underpaid and hazardous. Parents of these children consider education to be non-beneficial as neither the textbooks nor the curriculum is relevant to their life situation while hours spent at workplace generate income and support the family (National Human Rights Commission 2011). Many working children do not want to study and remain dependent on their families for the extended period of their school education. Further, children feel that starting to work early in life provides them with some degree of independence, gets them work experience and the possibility of higher wages in the future (National Human Rights Commission 2011). Employers prefer child labour because children are pliable and easily intimidated, have nimble fingers and hence are more suitable for certain industries such as carpet weaving, beedi rolling, embroidery and gem cutting, are more productive than adult workers and can be paid low wages (National Human Rights Commission 2011). The unregulated and rapid growth of market economies has further exacerbated the situation rendering many more children vulnerable to labour related exploitation - many of these children are classified as out of school but not in work. Sex and caste also play an important role in propagating child labour and defining the type of work. Girls are more likely to be expected to work while the boys go to school. Girls are invariably assigned domestic household chores and child care, either paid or unpaid, and in rural areas, they are also expected to work as casual labour on agricultural land (National Commission for Protection of Child Rights 2008). A segment of the civil society believes that while child labour per se is not bad, exploitative child labour in hazardous occupations needs to be abolished (National Commission for Protection of Child Rights 2008).

Forms of work

Most child labour is invisible. Children work within the household by caring for siblings, cooking and cleaning, thereby allowing adult family members to obtain paid work. They also work for household production, including family farms or businesses. Outside the home children are employed in agriculture, small industrial workshops, service establishments, restaurants and on the streets as ragpickers, porters, vendors, domestic workers among others. Although, exposure to hazardous chemicals occurs in certain industries, most employment puts children at risk for harm.
Children are employed in a wide range of agricultural activities and small scale industry. A 2008 report from the National Commission for the Protection of Child Rights highlights the challenges children face in the course of their employment. For example, Bt cotton requires manual cross-pollination over a period of 100 days during the season and children are most suited to do this intensive work. Young children, especially females aged 7–14 years, are engaged at lower wages than adults, during this period. Gujarat, Andhra Pradesh, and Tamil Nadu are the largest producers of Bt cotton employing mainly young girls who are either school dropouts or who do not attend school regularly. Beedi making is another sector where the children are often pledged by their parents against advance cash payment. While these children work for six hours or more per day, they are not counted as work force per the ILO definition. An example of the misuse of schemes for adolescent girls is the textile and knitwear industry in Tamil Nadu. The Sumangali Scheme (marriage assistance scheme) was introduced by spinning mills in Coimbatore to train young girls in the spinning industry and provide livelihood skills before marriage. Under this scheme, young girls 14 years or older are recruited to work in the spinning mills are initially engaged as trainees. However, within a few days they assume full time work but continue to be regarded as trainees - they are not entitled to any benefits and are not considered a part of the work force in the official statistics (National Commission for Protection of Child Rights 2008). There are about 815 spinning mills in Tamil Nadu accounting for 52% of all spinning mills in India and most of them are located in Coimbatore. In a petition filed by SOCO Trust before the National Human Rights Commission, the SOCO Trust mentions that most of these girls working in textile mills as camp coolies belong to dalit and backward communities. These girls are denied all statutory benefits, like minimum wages, ESI, PF, bonus, etc. and are also subject to sexual harassment and sexual torture (National Commission for Protection of Child Rights 2008).

A Human Rights study in 2003 focused on the silk industry as it had received little attention from the international community as compared to the carpet industry. Three states that are prominent in the silk industry are Uttar Pradesh, Tamil Nadu and Karnataka. Silk manufacturing is a hazardous occupation and the children employed either as labour or as bonded labour are exposed to a range of extreme conditions. A conservative estimate indicates that there are more than 350,000 children involved in producing silk thread and helping to weave saris. The children are involved at every stage of the production – from boiling cocoons to hauling baskets of mulberry leaves to embroidering saris. The children, who start as young as five years, face physical and verbal abuse, harsh working conditions, paltry payments, and injuries from machines and sharp threads. Furthermore, the vapour from boiling cocoons, smoke, diesel fumes from machines, poor ventilation and damp conditions often cause respiratory ailments (Human Rights Watch 2003).

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**TABLE 4.2 Child labour in hazardous occupations, 2001**

<table>
<thead>
<tr>
<th>Occupation</th>
<th>% of children engaged in child labour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pan, beedi, and cigarettes</td>
<td>21</td>
</tr>
<tr>
<td>Construction</td>
<td>17</td>
</tr>
<tr>
<td>Domestic workers</td>
<td>15</td>
</tr>
<tr>
<td>Spinning and weaving</td>
<td>11</td>
</tr>
<tr>
<td>Brick-kilns, tiles</td>
<td>7</td>
</tr>
<tr>
<td>Dhabas/restaurants/motels/hotels</td>
<td>6</td>
</tr>
<tr>
<td>Auto workshop, vehicle repair</td>
<td>4</td>
</tr>
<tr>
<td>Carpet making</td>
<td>3</td>
</tr>
<tr>
<td>Gem cutting, jewellery</td>
<td>3</td>
</tr>
<tr>
<td>Ceramics</td>
<td>2</td>
</tr>
<tr>
<td>Agarbatti, dhoop, and detergent making</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
</tbody>
</table>

The way forward

Child labour has been studied largely at the national level and thus most of the data is available from national reports such as the census, NHRC and NSSO and most evidence emanates from secondary analysis of national data sets. While child labour has been widely documented, there is little or no evidence on the impact of child employment in improving the economic situation of the family. Further research is also needed to evaluate the longer-term outcomes of children rescued from employers - their reintegration in the family, physical and mental health problems, their return to school or vocational training and further employment. NGO led interventions have demonstrated positive outcomes in getting children back to formal schooling, however, these programmes are small scale, exist in pockets and have not been rigorously documented or assessed. Evaluation and documentation of successful NGO led interventions is necessary for scale up.

All reports and studies on child labour recommend an investment in education as the key to addressing child labour and stress the need for a holistic approach using the rights framework. The need for policy advocacy and legislation to make education compulsory and accessible up to the secondary level has been suggested. Further, government support is required for stronger enforcement of protection policies and legislation (Human Rights Watch 2003). While universal, free and compulsory education would prevent children from being employed before completing school, for children who are already working there is a need for innovative strategies to keep them engaged in education. For example, flexible timing and calendars to coincide with part-time work or seasonal agricultural requirements have been suggested (Save the Children 2009). Provision of residential schools for children rescued from child labour would ensure that these children receive full-time formal education at least up to secondary level and availability of vocational training would provide skills for future employment.

References


Recognising the urgency for articulating the need to protect child rights, the UN Convention on the Rights of Child was formulated in 1989 and subsequently ratified in 1992 by several countries including India. Article 19 of the Convention relates to the protection of children against all forms of violence, abuse, neglect, and mistreatment by parents or any guardian and Article 34 stipulates that governments protect children from sexual abuse and exploitation (UNICEF 1989).

The National Commission for Protection of Child Rights (NCPCR) was established and the Offences against Children (Prevention) Bill formulated in 2009 to protect child rights. The NCPCR was set up in March 2007 under the Commission for Protection of Child Rights Act, 2005 with a mandate to ensure that all laws, policies, programmes, and administrative mechanisms are in consonance with Child Rights perspective as enshrined in the Constitution of India and also the UN Convention on the Rights of the Child. A ‘Child’ is defined as a person in the 0–18 year age group (Annex 1).

An analysis of records pertaining to trafficking or crime data shows that child abuse is prevalent in India in various forms and has increased steadily over the years. According to the National Crimes Records Bureau a total of 26,694 cases of crimes against children were reported in 2010, compared to 24,201 cases during 2009, an increase of 10.3%. Kidnapping and abduction were the most frequent (40%), followed by rape (20.5%), other crimes (31.5%), murder other than infanticide (5.3%), and exposure and abandonment (2.7%). Notably, Madhya Pradesh, Delhi, Maharashtra, and Uttar Pradesh account for 18.4%, 13.6%, 12.2% and 8.7% respectively of the total crimes against children at the national level (National Crimes Records Bureau 2010).

Studies on sexual abuse in the Indian context are almost nonexistent and available evidence is dated, except for one study commissioned by the Ministry of Women and Child Development in 2006-07. This national-level study was undertaken among 12,447 children in 13 states and assessed the extent and prevalence of sexual abuse in the country. The report dealt with various crimes against children including sale/transfer, sexual assault, sexual/physical/emotional abuse, commercial sexual exploitation, child pornography, grooming for sexual purpose, incest, corporal punishment, bullying and economic exploitation. Findings of this study indicate that the scale of abuse is far worse than expected. It reports that 69% of all Indian children are victims of physical, mental, or emotional abuse, and across all states the overall incidence of physical abuse was uniformly over 50%. Children from Assam and Mizoram (84.6%), Delhi (83.1%), and Uttar Pradesh (82.7%) reported very high prevalence of physical abuse. The findings highlight that family members frequently perpetrate the crime (89%) and that more boys face physical abuse (73%) than girls (65%). Overall, children were found to be exposed to a range of abuse and sexual crimes – from rape and sodomy to fondling, forcible kissing and sexual advances, and exposure to pornographic material, among others. As many as 21% of respondents acknowledged experiencing severe sexual abuse like rape, sodomy, fondling, or exposure to pornographic material. Additionally, most of the abused children belong to a lower socioeconomic group. Although the study did not collect data on reasons for abuse, it suggests that the high incidence of physical abuse could be a result of the patriarchal nature of society, poor parenting skills, dysfunctional families, existing domestic violence in families, vulnerability of children outside their home environment including on the street, at work or in educational institutions (Ministry of Women and Child Development 2007).
Similar findings were reported from other small and medium scale studies. In a study with 811 senior secondary students in Goa, Patel et al (2001) found that one-third (33%) of adolescents reported experiencing some form of sexual abuse, including physical and verbal violence, in the 12 months preceding the interview. Coercive sex was experienced by 6% of adolescents. Rural boys were more likely to have experienced coercive sexual intercourse than urban boys (10% and 3% respectively), and urban girls on the other hand were more likely to have experienced some form of sexual abuse compared to their rural counterparts (37% versus 25% respectively). In more than half the cases the perpetrators were older students or friends (53%), followed by parents or relatives (8%), and teachers (4%). The study also assessed the effect of these experiences on the students’ mental and physical health and the findings show that these adolescents had significantly poorer academic performance, poorer mental and physical health, greater substance abuse, poorer parental relationships, and a higher risk of consensual sexual behaviours (Andrew 2001). In another small study of runaway boys aged 10–16 years in Delhi, 14.6% of respondents reported sexual abuse and 38% reported physical abuse (Khurana, Sharma, Jena et al. 2004).

The available evidence highlights the culture of silence surrounding the discourse on sexual and reproductive health–related matters. There is little or no discussion on sexual abuse at the family or society level; however, in view of the findings from the large and small scale studies depicting pervasive and prevalent sexual abuse in the community, comparable among girls and boys, it is imperative for sexual abuse to be addressed urgently at the family, societal and state level (Ministry of Women and Child Development 2007). Protecting family honour and the sense of shame in discussing sexual abuse, rape or incest are reasons for denial and non-reporting of crimes against children and adolescents. In a study undertaken with students and teachers in higher secondary schools in Goa, 6% of the students reported sexual abuse - being forced to have sexual intercourse. In the same study, during focus group discussions, teachers rejected the finding that so many students had been sexually abused. Teachers attributed abuse to poor relationships with parents, lack of sex education and media exposure (Andrew 2001).

Sexual abuse can lead to one or more sexually transmitted infections like HIV. A study conducted with 554 street based children in Kolkata reported that 9% were sexually abused, 4% had STIs and 1% were HIV positive (Bal, Mitra, Mallick et al. 2010). Another study with young boys and girls less than 15 years of age showed that more boys than girls accessed STD services in Civil Hospital, Ahmedabad – 29 boys versus 8 girls (Burzin, Parmar and Rao, 2007). Dhawan et. al. (2010), in their study reviewing clinic data for STIs among children and adolescents, report the highest prevalence of STIs among adolescents 11–14 years of age. This finding points to the early onset of voluntary or consensual sexual activity occurring in this group. The study also reports that homosexual and bisexual behaviour further increase the chances of acquiring STDs including HIV at an early age (Dhawan, Gupta and Kumar. 2010). Thus, available evidence suggests that adolescent boys are at equal or greater risk of sexual abuse as adolescent girls, they experience homosexual practices and may have ‘more symptomatic’ STIs than adolescent girls.

Human trafficking for sexual exploitation is widespread in Asian countries including India. The Ministry of Women and Child Development reports that around 2.8 million people are trafficked for commercial sexual exploitation every year. The majority of trafficked persons are young girls or children who have been forced into sex work, often before the age of 18 years (Joffres et al. 2008). To curb trafficking for sex, the Government of India passed the Immoral Traffic Prevention Act, in 1986. The Act outlines the illegality of prostitution and the punishment for owning a brothel or a similar establishment, or for living off the earnings of prostitution. It also states that a person who procures, induces, or takes a child for the purpose of prostitution or is involved in the recruiting, transporting, transferring, harbouring, or receiving of persons for the purpose of prostitution is punishable under law.

Joffres et al (2008) describe the various forms of sex work in India. The most common form involves young women and girls from economically deprived and marginalized groups recruited by ‘brokers’ and sold off to pimps and brothel owners. Similarly, victims of ‘customary sex work’ (socially acceptable forms of prostitution like religious or tribal prostitution) are forced into sex work at a very young age (9–13 years) by family members who act as agents of the victims. They are generally pre-pubertal girls from scheduled castes who are offered to temple deities and later on sold or auctioned to traffickers. Another form of sexual exploitation includes ‘sex tourism’ where young boys and girls are sexually exploited by international as well as Indian tourists; street children are particularly vulnerable to sex tourism. Sex
tourism is generally facilitated by travel agencies, tour operators, hotels, and associated businesses. Adolescent girls/children, particularly children from families where abuse/neglect is prevalent or families in crisis (caused by war, civil unrest, or environmental catastrophes) are more vulnerable to trafficking for commercial sexual exploitation (Joffres, Mills, Joffres et al. 2008).

Wirth et al. (2013) report a strong association between sex trafficking and HIV prevalence. Women forcibly initiated into sex work were more likely to be HIV-infected than women who joined the industry voluntarily. They did not, however, find any association between age at entry into prostitution and HIV risk (Wirth, Tchetgen, Silverman, 2013). An earlier study conducted by Silverman et al. (2006) in Mumbai found that approximately one-quarter of trafficked individuals tested positive for HIV and the mean age at trafficking was marginally younger for girls infected with HIV (15.9 years) compared to those not infected (17.2 years). The study also found that girls trafficked as minors (<18 years) reported longer periods of confinement compared to those trafficked at older age (18.5 vs. 9.6 years). Longer duration in brothels was associated with greater likelihood of HIV infection; a 3%–4% increased risk for HIV was observed for each additional month of brothel captivity (Silverman, Decker, Gupta et al. 2006). Kamalesh et al. (2008) report similar findings from a study with 580 brothel-based sex workers in West Bengal. Forty-six per cent of participants started sex work between 16–20 years of age. Almost half of the girls under 20 years of age were victims of trafficking and faced more violence compared to the non trafficked sex workers. As reported by Silverman et. al., this study also found higher HIV prevalence among trafficked women as compared to those who joined the profession voluntarily (13% vs. 10%). Further, HIV was found to be associated with younger age (less than 20 years), trafficking and violence but not with negotiation for condom use (Kamalesh, Bal, Mukherjee et al. 2008).

Risk factors for contracting HIV among adolescents include life on the street, lack of adult supervision, care and support, extreme poverty, child trafficking, migrant population, and exploitation in terms of sex and labour. HIV-infected adolescents with long standing infections often face considerable physical challenges – delayed growth and development, late puberty, stunting, wasting and malnutrition (Mothi et al. 2012).
The way forward

There is an urgent need for a wider discourse on sexual abuse and incest in the community and in the family. The majority of sexual abuse occurs within the family and the perpetrator is often someone from the family or a person known to the family. Parents and guardians should be encouraged to educate adolescent boys and girls about possibility of sexual abuse and the ability to distinguish sexual abuse from affection. Adolescents should be encouraged to communicate with parents, guardians or other adults in the family to facilitate early reporting of suspicious or abusive behaviour. Communication interventions designed to assist parents, guardians and adolescents need to be evaluated. There is little or no evidence on how family members handle the abuse, the barriers they face in supporting the abused adolescent and in reporting the crime. Adolescents experiencing sexual abuse need counselling to deal with the psychological trauma resulting from the abuse and medical care for physical symptoms such as sexually transmitted infections, pregnancy or genital injuries. Several NGOs, address the needs of young people who have experienced sexual violation at the hands of close family members. There is a need to identify and rigorously evaluate successful intervention models for wider implementation and scale up. There is a need for information, education and communication initiatives to discuss sexual abuse in the community and in schools.

There is limited evidence available on the extent and nature of abuse of adolescents. Research is needed to explore the extent of violence and abuse and its long term impact on the mental and physical health of adolescents. Further, there are no studies from India that examine the profile of the abuser - more research is needed to characterise persons perpetrating sexual abuse to understand the reason for their behaviour and to design strategies to prevent them from doing so again. Although several NGOs and the police work to rescue and rehabilitate sex workers, there is little documentation of the long-term success of these rehabilitation efforts. More work is needed to understand the needs and expectations of trafficked individuals to navigate life outside a brothel or customary sex-work. Lastly, most evidence on trafficking for sex relates to girls - there is a need for more documentation on sexual abuse and trafficking of boys.
References

Adolescence is a critical period when the first initiation of substance use usually takes place. Substance use includes tobacco, alcohol, non-prescription pharmaceutical medications, narcotics and other addictive substances such as glue and adhesives. Encouragement by peer groups, the lure of popularity, and early availability of tobacco, alcohol and various other non prescription drugs make adolescents an easy prey.

There are currently an estimated 250 million tobacco users aged 10 years and above in India. As in other developing countries, the most susceptible time for initiation of tobacco use in India is during adolescence and early adulthood, i.e., in the age group of 15–24 years (Ministry of Health and Family Welfare 2004). The majority of users start using tobacco before the age of 18 years, while some even start as young as 10 years. The 2004 report on Tobacco Control in India, estimates that 5500 adolescents start using tobacco every day in India, joining the 4 million people under the age of 15 years who already use tobacco regularly (Ministry of Health and Family Welfare 2004). A more recent Global Youth Tobacco Survey (2009) conducted with 10,112 students aged 13–15 in India, found that 14.6% of 13–15-year-olds were current users of tobacco in any form and 4.4% were current smokers. Among never-smokers 15.5% are likely to initiate smoking next year (Ministry of Health and Family Welfare 2009).

The Youth Study (2010) conducted with 15–24 year olds across six states reported that a substantial proportion of young men and a small minority of women consumed tobacco – 30% of young men and 2% of young women had ever consumed tobacco products. Rural young men were more likely to report ever use of tobacco than urban men (32% vs. 26%). Fewer young people reported alcohol consumption – young girls (1%) and young men (18%). Statewise differences suggest that young men in Bihar, Jharkhand and Maharashtra were more likely than their counterparts from other states to have consumed tobacco products while young men from southern states were more likely to have consumed alcohol (IIPS and Population Council 2010) (Table 6.1).

<table>
<thead>
<tr>
<th>TABLE 6.1 Percentage of youth reporting lifetime substance use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ever used</td>
</tr>
<tr>
<td>Tobacco and its products</td>
</tr>
<tr>
<td>Alcohol</td>
</tr>
<tr>
<td>Drugs¹</td>
</tr>
</tbody>
</table>

¹ Includes ganja, charas, brown sugar, cocaine, bhang, etc. Source: Youth in India – Situation and Needs; Study by IIPS and Population Council 2010.
Many small- and medium-scale studies published highlight the high prevalence of tobacco use among young people across the country. A survey with 6th- and 8th-grade students in Delhi and Chennai reported 24.8% and 9.3% ever use of tobacco. Students attending government schools (of middle-lower socio economic status), boys, older students, and those in 6th grade were using more tobacco in this survey compared with students who were in private schools (of middle to high socio economic status), girls, younger, and in 8th grade (Stigler, Perry and Arora 2006).

Singh et al. (2005) reported a 5.1% prevalence of tobacco use among 1626 school students (10–12 years old) in Patna district; 16.6% reported ever use of tobacco. Current use was significantly associated with being male, not participating in sports, tobacco use among friends and unaware of harmful effects of tobacco (Singh, Sinha, Sarma et al. 2005). Similar findings were reported among 596 adolescents in school (class 9–11) in Delhi by Kotwal et al 2005. They reported that almost 42% of tobacco users started before the age of 12 years. Peer pressure, general stress, and media were important influencers (Kotwal, Thakur and Seth 2005). A 3.3% prevalence of cigarette smoking was reported among 2014 adolescents (13–15 years) in Punjab. The study found that factors such as receiving pocket money, having tobacco-using parents, the perception that tobacco-using boys/girls have more friends and that tobacco use is linked to weight loss were positively associated with smoking behaviour (Siziya Muula, and Rudatsikira 2008). Similar findings were reported by Mohan et al. (2005) who studied 1323 adolescents (12–19 years) and reported that current tobacco use was higher among boys securing poor (<40% marks) grades, those who received pocket money, older boys and whose fathers/friends used tobacco (Mohan, Sarma, and Thankapann 2005).

Prashant et. al. (2011) reported a high prevalence – 32.7% for substance use among 260 male adolescents (10–19-year-olds) in an urban slum. They reported an increase in substance use with age. The most commonly used substance was tobacco (60%), followed by alcohol (12.9%), and only one admitted the use of ganja. Out of 85 substance users, 30.6% had initiated use at 13–15 years of age, followed by (20%) at 10–12 years. The most important reasons for the initiation of substance use were peer pressure, sense of enjoyment, failure of love relationship, parental pressure, work stress, family problems, on festivals, and to relieve body pain (Prashant, Rao, and Jogdand 2011). Similar findings were reported by Sarangi et al. (2008) among adolescents living in urban slums of Sambalpur (Sarangi, Acharya, and Panigrahi 2008).

Sinha et al (2003) in a survey with 13–15 year olds in eight northeastern states reported highest percentage of ever use of tobacco in Mizoram (75.3%) and lowest in Assam (40.1%) (Singh, Gupta, and Pednekar 2003). In Tamil Nadu, 10% of students in this age group had ever consumed tobacco (Vendhan, Asma, and Warren 2004). Overall 44.2% prevalence of substance abuse was reported among 217 street based children staying in an observation home in Mumbai (Naik, Gokhe, Shinde et al. 2011). Exposure to tobacco advertisements and receptivity to tobacco marketing was found to be significantly related to increased tobacco use among students (Stigler, Arora and Reddy 2008).

Considering the early initiation and high rates of tobacco consumption, some school based interventions were rolled out. Project MYTRI (Mobilizing Youth for Tobacco-Related Initiatives in India) implemented a two-year, school-based, multiple-component tobacco prevention program in Delhi and Chennai. The overall goal of the programme was to reduce tobacco use among students in grades 6–9, including cigarette smoking, beedi smoking, and chewing tobacco (e.g., gutkha), which are common in this setting (Stügler, Perry and Arora 2006). The objectives of the programme were to change multiple intrapersonal factors (e.g., knowledge, meanings, skills) and social environmental factors (e.g., social norms) known to be related to tobacco use among urban Indian youth. Intervention strategies included classroom activities, school posters, parent postcards, and peer-led health activism. Another intervention, a School-based Teenage Education Programme (STEP) on HIV/AIDS and alcohol abuse was implemented in 23 schools in Himachal Pradesh with adolescents aged 13–16 years. The intervention had a greater impact on girls; girls demonstrated greater communication skills and a trend towards greater self-efficacy and reduced risk-taking behaviour (Chhabra 2010)
In addition to early initiation of tobacco use, an increasing trend of using non-prescriptive drugs early in life is also reported. A report by Childline Foundation (2008) documents that among children who accessed NGOs for drug abuse treatment, 63.6% were introduced to drugs before the age of 15. Among those involved in drug and substance abuse in India, 13.1% are below 20 years. Heroin, opium, alcohol, cannabis and dextro-propoxyphene were the five most common drugs used by children in India and among the alcohol, cannabis, and opium users 21%, 3%, and 0.1% respectively were under the age of 18.

A study with 220 adolescents (14–18 years) in Manipur reported the majority of respondents initiated drugs between 14 to 15 years of age. Curiosity, peer pressure, fun, depression, being tricked by others, easy availability and desire to overcome shyness were the reasons cited for drug abuse. Almost 30% of these adolescents, injected drugs because the method is less expensive and gives a better high (Childline 2008). Among, 1020 higher secondary school students in Manipur 14% and 12% reported the use of cannabis and opiates respectively (Ningombam, Hutin, and Murhekar 2011).

Pagare et. al. (2004) in their study with 115 street-based male children (6–16 years) in Delhi, showed that more than half had indulged in substance use before coming to the observation home. Most children (44.5%) had consumed nicotine, inhalants (24.3%), alcohol (21.8%) and cannabis (26.4%). Maltreatment of the child by family members was found to be a significant predictor of substance use in the study group (Pagare, Meena, Singh et al. 2004). Similarly, Basu et al. (2004) reported that inhalant users visiting their clinic were predominantly young males (10–18 years) from low socioeconomic strata. All of the patients reported using inhalants as an addictive substance because of their easy accessibility, cheap price, faster onset of action, and the regular ‘high’ that they provided. These are usually inexpensive compared to alternative illegal substances (Basu, Jhirwal, Singh et al. 2004).

Drug abuse has wider social and health implications. Malhotra (2007) in a qualitative study at an observation home in Delhi reported an association of drug abuse with criminal activities. Peer group and media were the most important influences for initiation of drug use. All kinds of drugs could be procured easily by children and there was a gradual progression from non-use to tobacco and alcohol use, to marijuana and ultimately other drugs. Knowledge about the bad medical and social effects of consuming drugs did not seem to affect either the consumption of drugs or the desire to leave this habit (Malhotra 2007). A Rapid Situation and Response Assessment (RSRA) of HIV/AIDS-related risk behaviours, adverse health consequences, knowledge, and attitudes relating to HIV/AIDS among drug users and their regular sex partners showed that 6.5% of participants from India were in the age group of 11–20 years (RSRA, UNODC 2007). The HIV Sentinel Surveillance (HSS) country report for 2006–07 and subsequently 2010-11 indicated that HIV prevalence decreased significantly in selected north eastern states (Manipur, Nagaland, and Mizoram). The decrease was particularly noted in younger intravenous drug users (15–24 years) where it declined from 15.1% in 2002 to 6.9% in 2004 and further to 5.7% in 2006, suggesting a reduction in new infections among IDUs (National AIDS Control Organisation 2006). At the same time HIV prevalence has increased in previously low prevalence states such as Delhi and Punjab.

Tobacco use is one of the major risk factors for noncommunicable diseases, with a profound impact on resource-poor low-income and middle-income countries such as India, where tobacco use is high and socioeconomic and health inequalities widespread (Reddy, Yadav, Arora et al. 2013). To halt the growing trend of tobacco consumption, the government of India rolled out the **Cable Television Network (Regulation) Amendment Bill** in 2000 that prohibits cigarette and alcohol advertisements on television. Further, since 2008, smoking in India is prohibited in public places under the **Prohibition of Smoking in Public Places Rules 2008** and **Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act 2003**. The sale of tobacco products within 100 yards of educational institutions has also been banned (Annex 1). To check drug abuse in India, the government passed the **Narcotics Drugs and Psychotropic Substances Act** in 1985 thereby making it illegal for a person to produce/manufacture/cultivate, possess, sell, purchase, transport, store, and/or consume any narcotic drug or psychotropic substance except for medical or scientific purposes and in accordance with the terms and conditions of any license, permit, or authorization given by the government. Despite this law, drug abuse continues to be a growing concern in urban pockets of the country. The Department of AIDS Control implements harm reduction services for injection drug users across the country through the Targetted Intervention (TI) Programme and Oral Substitution Therapy (OST), however, neither are designed to address the needs of adolescent injection drug users.
The way forward

Substance use among adolescents has been widely documented across the country. However, most studies focus on tobacco and drug use; there is limited evidence on the extent of alcohol use among adolescents. Further most research studies explore the existence and extent of drug use; there is very little implementation research evaluating and documenting strategies to prevent or mitigate substance use. Adolescents are, most often, new entrants into the world of substance use and studies show an escalatory path from tobacco to alcohol to hard drugs. This offers programmes the opportunity to intervene before young users transition to hard drugs and entrenched behaviours that are difficult to change. Research is needed to evaluate strategies preventing the transition from oral/inhalation drug use to injecting drug use among adolescents. Lastly, there is no evidence on the sexual exploitation of children in exchange for drugs.

At a programmatic level, most of the drug de-addiction and rehabilitation centres run by various NGOs and charitable trusts are tailored to adult drug users and hence, do not meet the needs of young drug users. Youth friendly centres with services for adolescents are needed. School-based interventions have been rolled out to prevent substance misuse among adolescents. Similar interventions are needed to address out-of-school, street-based and working adolescents.

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Agency has been defined as the capacity to make choices through the acquisition of a sense of self and a sense of personal competence (NRC and Institute of Medicine 2005). Available literature on empowerment of young adult women suggests that key elements of agency include young people’s decision-making ability, freedom of movement, a sense of self worth and access to resources (Malhotra, Schuler and Carol 2002). There is limited evidence available on agency and decision-making among young adolescents. Whatever little is available suggests that while adolescent girls have limited agency compared to boys, young boys themselves have limited agency and decision-making ability on important matters affecting their lives. Evidence on the key components of agency from selected studies are discussed below.
Decision-making

The ability of adolescents, both girls and boys, to make decisions about matters that affect their lives is a critical aspect of empowerment. Evidence suggests that while young adolescents do have the freedom to decide who their friends will be, the ability to decide on how to spend money or to purchase clothes for self is limited. For example, NFHS 3 data measured decision making for 15-49 year old currently married women on four primary indicators- own health care, major household purchases, daily household needs and visit to family members or relatives. For 15-19 year old married adolescent girls, 15% women participated in all the four decisions and 46% did not participate in any of the four decisions. Maximum participation (40%) was noted for own health care and minimum for major household purchases (25%). NFHS 3 also explored the attitude of men towards the participation of their wives in decision making on five different indicators - major household purchases, daily household needs, visit to her family/relatives, decision relating to the money the wife earns and number of children to have. Overall, 43% married adolescent boys (15-19 years) agreed to an equal or greater say of their wives when deciding about these five factors. 89% and 88% agreed to greater or equal say when deciding about the number of children to have and decision relating to the wife’s income (IIPS and Macro International 2007).

Other studies provide similar evidence. Acharya et al. (2009) indicate that although 88% of young girls aged 13–17 chose their own friends, fewer girls made independent decisions on how to spend their own money or on buying clothes for themselves (57% and 28% respectively) (Acharya, Kalyanwala and Jeejebhoy 2009). Another study undertaken with rural girls in Gujarat aged 13–19, indicates that while 61% of the girls agreed strongly that they had the freedom to choose their own friends, only 39% said that they could buy clothes for themselves (SEWA Academy and Kalyanwala 2006). The Youth Study undertaken by IIPS and Population Council reiterates these findings. Unmarried youth aged 15–24 overwhelmingly indicated that they could choose their own friends – 94% men and 91% women. However, fewer young people could decide on how to spend their own money and the differences were particularly visible for young women – 70% of young men indicated that they could decide on how to spend their own money compared to 52% of young women. Even fewer youths could make independent decisions on purchasing clothes for themselves – 62% of young men and 35% of young women so reported (IIPS and Population Council 2010) (Table 7.1).

Another study undertaken among youth aged 15-24 in urban and rural sites of Pune, Maharashtra examined three dimensions of decision-making namely, participation in decisions regarding family outings, household purchases such as a television, and seeking health care when sick. The study showed that young boys were more likely than their female counterparts to have taken decisions for themselves or taken part in family decisions. While differences were narrow, the decision-making index shows that young men were more likely than young women to make decisions in general (scores ranging from 0.70-0.72 for men and 0.65-0.67 for women) (Table 7.2) (Jejeebhoy et al 2010).
Freedom of movement

Freedom of movement is a key component of agency and is especially important to assess it among girls particularly after puberty. In the three studies mentioned above, mobility or freedom of movement was assessed by asking the girls a number of questions. While young girls in all three studies reported mobility, albeit limited, within the village or neighbourhood, there were more restrictions on their ability to move out of the village/neighbourhood. For example, the freedom to visit a shop or market within the village unescorted ranged from 53%–72% while visiting friends within the village or neighbourhood unescorted was reported by 42%–68% young women (IIPS and Population Council 2010, Acharya et al. 2009, SEWA Academy and Kalyanwala 2006). Notably, mobility outside the village or neighbourhood, unless escorted, was highly limited. In the study undertaken by Acharya et al. in rural areas of Uttar Pradesh, only 4% of girls reported that they could go unescorted to visit friends or relatives outside the village (Acharya et al. 2009). A slightly higher proportion of girls reported being permitted to go alone outside the village in Gujarat (14%) and among unmarried youth from the Youth Study (25%) (IIPS and Population Council 2010, SEWA Academy and Kalyanwala 2006). Access to health facility was even more restricted – just 5% of young girls in rural Gujarat, 8% in rural Uttar Pradesh, and 14% in the six states where Youth Study was undertaken (Bihar, Jharkhand, Rajasthan, Maharashtra, Andhra Pradesh, and Tamil Nadu) reported that they could access a health facility alone (IIPS and Population Council 2010, Acharya et al. 2009, SEWA Academy and Kalyanwala 2006). In the Pune study mentioned above, the mobility index included freedom to visit a range of places both within and outside the village alone, including a local shop, a friend’s house and a place of worship inside the village and visit to a friend or a fair outside the village. Findings reiterate the limited mobility of young women and vast gender differences. Just 2% - 9% of young men reported that they were required to be escorted to any of the places indicated. In contrast, as many as 15%-21% of young women were not permitted to go to a shop or visit a friend inside the village; between one third and two fifths were not permitted to visit a place of worship and about four in five were not allowed to go out of the village (Table 7.2) (Jejeebhoy et al. 2010). The NFHS 3 data for 15-19 year old adolescent girls also highlights their limited mobility (IIPS and Macro International 2007).

Access to money

The young have limited access to financial resources and therefore limited savings. Data from the NFHS 3 for 15-19 year adolescent girls showed that 35% had money they could use, 7% had a bank or an independent savings account and 31% knew of a micro credit program but less than 1% took a loan from it (IIPS and Macro International 2007).

Findings from the Youth Study indicate that more young women compared to young men have access to savings – 36% and 23% respectively. However, only 15% young men and 11% of young women aged 15–24 reported having a single or joint bank account (IIPS and Population Council 2010). Similarly, half of all girls in the Uttar Pradesh study reported that they had savings (50%) but just 10% had a single or joint bank account (Acharya, Kalyanwala and Jejeebhoy 2009). In Gujarat, fewer than half (42%) of all the girls reported savings and 25% held a bank account, usually jointly with an adult (SEWA Academy and Kalyanwala 2006). In India, minors (below 18 years of age) are not permitted to hold a single bank account; they can, however, hold joint accounts with an adult guardian, a possible reason for the small number of bank accounts held by adolescents.
Gender role attitudes

Egalitarian gender role attitudes are a distinct sign of empowerment for young adolescents. Evidence from studies is mixed. On the one hand girls continue to foster traditional beliefs and attitudes towards specific gender roles as defined by the society at large on issues such as decisions related to marriage or boys doing household chores, while on the other hand they appear to be more open to considering that education is equally important for girls or that they are as good as boys.

NFHS 3 data highlights that 52% adolescent girls (15-19 year) compared to 56% adolescent boys (same age group) agreed that a husband is justified in hitting his wife for one reason or the other. Almost 60% adolescent girls (15-19 years) agreed that a wife is justified in refusing sex with her husband while 65% adolescent boys (15-19 years) agreed with it. It was equally encouraging to see that 76% of young men (15-19 years) did not agree that husbands have a right to reprimand/ refuse financial support, have forceful sex or have sex with another woman if their wives refuse to have sex with them (IIPS and Macro International 2007).

Acharya et al. (2009) indicates that as many as 9 out of 10 girls reported a gender egalitarian attitude on questions related to whether educating boys is more important than educating girls and whether girls are as good as boys in studies. However, on questions related to whether girls should be allowed to decide the timing of their marriage and whether boys should do as much domestic work as girls elicited less gender egalitarian responses – 55% and 58% respectively (Acharya, Kalyanwala, Jejeebhoy 2009). The Youth Study reports similar findings (Table 7.1). Most gender egalitarian responses were on questions related to whether educating boys is more important than educating girls (63% of young men and 81% of young women agreed) and whether girls are as good as boys in their studies (78% of young men and 85% of young women agreed). While 77% of young women agreed that girls should be allowed to decide the timing of their marriage, fewer men agreed to this statement (59%). Further, the question of whether boys should do as much domestic work as girls elicited the least gender egalitarian response – 43% of young men and 49% of young women agreed with this idea. (IIPS and Population Council 2010) (Table 7.1)
### TABLE 7.1 Percent distribution of adolescents on participation in decisionmaking; extent of freedom to visit select locations; having savings and savings account in their own or joint name; gender role attitudes

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Took independent decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice of friends</td>
<td>94.1</td>
<td>91.0</td>
<td>88.4</td>
</tr>
<tr>
<td>Spending own money</td>
<td>70.1</td>
<td>51.5</td>
<td>56.5</td>
</tr>
<tr>
<td>Buying clothes for oneself</td>
<td>62.0</td>
<td>35.0</td>
<td>28.1</td>
</tr>
<tr>
<td>Mobility indicators</td>
<td>Freedom of movement within and outside village/ neighbourhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permitted to visit: shop/market within the village/neighbourhood alone</td>
<td>93.6</td>
<td>71.7</td>
<td>52.8</td>
</tr>
<tr>
<td>Permitted to visit: friend/relative within the village/neighbourhood alone</td>
<td>87.4</td>
<td>68.1</td>
<td>42.2</td>
</tr>
<tr>
<td>Permitted to visit: friend/relative outside the village/neighbourhood alone</td>
<td>77.5</td>
<td>24.7</td>
<td>3.6</td>
</tr>
<tr>
<td>Permitted to visit: nearby village/neighbourhood for entertainment alone</td>
<td>57.7</td>
<td>5.9</td>
<td>6.7</td>
</tr>
<tr>
<td>Permitted to visit: health facility alone</td>
<td>64.6</td>
<td>14.1</td>
<td>8.0</td>
</tr>
<tr>
<td>Savings indicators</td>
<td>Access to money</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has savings of any amount</td>
<td>21.0</td>
<td>37.0</td>
<td>49.9</td>
</tr>
<tr>
<td>Has an account in bank/post office either in own name or jointly with someone else</td>
<td>14.4</td>
<td>13.1</td>
<td>10.4</td>
</tr>
<tr>
<td>Egalitarian gender role</td>
<td>Gender role attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree that educating boys is more important than educating girls</td>
<td>62.7</td>
<td>80.6</td>
<td>88.5</td>
</tr>
<tr>
<td>Agree that girls should be allowed to decide about their own marriage</td>
<td>59.4</td>
<td>77.1</td>
<td>55.2</td>
</tr>
<tr>
<td>Agree that girls are usually as good as boys in studies</td>
<td>77.5</td>
<td>85.3</td>
<td>92.3</td>
</tr>
<tr>
<td>Agree that boys should do as much domestic work as girls</td>
<td>42.5</td>
<td>49.4</td>
<td>58.0</td>
</tr>
</tbody>
</table>

*Includes reference to only friend.
** Includes reference only to WHEN to marry.
Limited Agency and Decision-Making Ability

### TABLE 7.2 Dimensions of agency by residence and sex of respondent: Selected variables

<table>
<thead>
<tr>
<th>Decision Making</th>
<th>Urban</th>
<th>Rural</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Decision-making index (mean normalised score)</td>
<td>0.72</td>
<td>0.65</td>
<td>0.72</td>
<td>0.67</td>
</tr>
<tr>
<td>Takes part in decisions to buy TV etc</td>
<td>85.3</td>
<td>82.3</td>
<td>83.9</td>
<td>83.6</td>
</tr>
<tr>
<td>Decides/consulted about family outings</td>
<td>80.9</td>
<td>67.0</td>
<td>80.7</td>
<td>73.3</td>
</tr>
<tr>
<td>Decides what action to take when sick</td>
<td>64.2</td>
<td>65.7</td>
<td>61.5</td>
<td>63.4</td>
</tr>
<tr>
<td>Freedom of movement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility index (mean normalised score)</td>
<td>0.93</td>
<td>0.56</td>
<td>0.94</td>
<td>0.58</td>
</tr>
<tr>
<td>Can go alone to shop inside area</td>
<td>96.7</td>
<td>84.5</td>
<td>97.7</td>
<td>82.7</td>
</tr>
<tr>
<td>Can visit alone a friend inside area</td>
<td>96.6</td>
<td>78.7</td>
<td>97.7</td>
<td>83.6</td>
</tr>
<tr>
<td>Can go alone to nearby village for entertainment</td>
<td>94.7</td>
<td>18.9</td>
<td>95.4</td>
<td>17.1</td>
</tr>
<tr>
<td>Can go alone to a temple/mosque</td>
<td>98.0</td>
<td>62.6</td>
<td>97.5</td>
<td>65.8</td>
</tr>
<tr>
<td>Can visit friends outside village</td>
<td>90.7</td>
<td>17.8</td>
<td>89.9</td>
<td>22.5</td>
</tr>
</tbody>
</table>

Source: Select indicators from Jejeebhoy et al. 2010.

**Life-skills programmes**

Several programmes have been implemented that aim specifically to facilitate safe transitions into adulthood, especially for young girls. These range from provision of nonformal education, to development of livelihood skills, to increasing awareness about sexual and reproductive health–related issues. Life-skills education programmes have been considered an effective intervention strategy and most programmes include building negotiation and communication skills; raising awareness on sexual and reproductive health issues; and developing gender egalitarian attitudes and countering gender disparities. Some interventions also focus on provision of vocational skills training providing young girls opportunities to be wage earners.

A range of programmes is implemented by the government as well as NGOs. Among the programmes being implemented by the government, the Adolescence Education Programme (AEP), developed by the Ministry of Human Resource Development, Department of Education, and the National AIDS Control Organisation (NACO) for school-going adolescent boys and girls in Classes 9–11 seek to build adolescents’ skills in making important life decisions; improve interpersonal communication; foster egalitarian gender role attitudes; and raise awareness about growing up matters, as well as about HIV. The Kishori Shakti Yojana (and its 1990s predecessor, the Adolescent Girls Scheme) aims at training adolescent girls in vocational skills as a means of empowerment and building their self-esteem. Programmes being implemented through Mahila Shikshana Kendras under the auspices of the Mahila Samakhya programme provides girls with nonformal education and leadership training. The Rajiv Gandhi National Institute of Youth Development has, likewise, implemented life-skills programmes which aim to instil leadership qualities and broaden the personality of young female and male participants.

Programmes implemented by NGOs focus largely on life-skills building and include those developed and implemented by NGOs like the Center for Development and Population Activities (CEDPA), New Delhi; the Centre for Health Education, Training, and Nutrition Awareness, Ahmedabad (CHETNA); MAMTA, New Delhi; Sahayog, Mumbai; and Pathfinder International, New Delhi to name a few. The Self-Employed Women’s Association (SEWA) in Gujarat and the International Council for Research on Women (ICRW) in New Delhi, Maharashtra, Bihar, and Jharkhand have also implemented programmes that could be used as demonstrating models.
The way forward

Young girls continue to have limited decisionmaking ability and agency. There are several research gaps that would supplement the limited evidence on the impact of programmes for young girls.

Operations research needs to be undertaken to assess the impact of intervention programmes, including life-skills building programmes, over a longer period of time.

Livelihood skills programmes need to be linked with employment or income generating opportunities to ensure that the skills learned are put in practice and the young girls are able to generate income for themselves or for their families. These programmes should reach out to the most marginalized girls.

In programmes that aim at building agency, involvement of parents and gatekeepers is of great importance. Apart from informing the parents about the programme content prior to its initiation, it is important to inform the parents regularly about the progress of the participants. The parents should be encouraged to accept more equal and egalitarian attitudes towards their young. There is a need for programmes promoting gender sensitivity among adolescent boys. It is important to involve them in programmes that build more gender egalitarian roles and encourage them to be gender sensitive. These programmes should be designed to promote gender egalitarian attitudes and re-shape traditional masculine roles.

Community involvement and ownership are essential for programme sustainability and steps need to be taken to ensure that the programmes continue after donor support ends.

References

- Malhotra, Anju, Sidney Schuler, Carol Boender. 2002. Measuring women’s empowerment as a variable in International development on women”, Paper commissioned by the Gender and Development Group of the World Bank and by the World Bank’s Social Development Group
Although, young people are exposed to media more than ever before, there are few studies that explore the linkage between the media and the attitudes and behaviours of young people in India. Media, both print and visual, is an important source of information on reproductive and sexual health matters and influences young people’s lives, particularly with respect to their interaction with the opposite sex (Vasan 2010). Little is known about media preferences of the young, interpretation of the content, and what messages are finally picked up and applied in their lives.

Content analysis of films and advertisements shows the kind of negative messages that are delivered to the society. For example, the Burning Brain Society analysed films released in 2004–05 and found that 89% of the films showed smoking despite the fact that the Government banned direct and indirect forms of tobacco advertisement in 2004 (Goswami and Kashyap 2006). Analysis of Hindi films randomly selected from 1997–99 box office hits found that ‘moderate sexual violence is depicted as fun, enjoyable, and a normal expression of romantic love’ (Ramasubramanian and Oliver 2003). A similar analysis of nine popular Kannada films highlighted stereotypical depiction of men’s control over women and ideas of “good” and “bad” women (Maslekar, Hamsa, and Casan 2004).

Thus, stereotypical portrayal of men and women is not uncommon with films and advertisement portraying women as victims, caregivers/homemakers, and sex objects while men are usually the masters, intellectuals, and protectors (Vasan 2010).

In a study undertaken with male college-going students in Bangalore, Vasan (2004) reports that media – especially print and visual – is an important source of information for young people on reproductive and sexual health (Vasan 2004). In a study of school going adolescents in rural South Karnataka, boys and girls who indicated media as their main source of information obtained higher scores on sexual and reproductive health–related knowledge compared to those who received information primarily from their parents, older siblings, or peers (Kilaru 2004).

Studies have found that films and television are an important part of young people’s lives and a major source of information. Findings of the Behaviour Surveillance Survey (2006) undertaken among youth reported television viewing at least once a week in the month preceding the survey by 75% of the respondents. Rural–urban and gender differences exist. Among those aged 15–19 years, a higher proportion of youths from urban areas compared to their rural counterparts had access to television viewing (92% versus 68%) and more males than females had exposure to television (81% versus 69%) (National AIDS Control Organisation 2006).

Findings from a study undertaken with college-going young people (mean age for boys- 18.1 years, girls- 17.2 years) in a town in south Karnataka show that youths have considerable exposure to media, both films and television – with over two hours of television viewing and between 10–20 films viewed per month (Vasan 2010). The Youth Study highlights that a substantial proportion of young people are exposed to media, typically television, and the media was one of the leading sources of information on sexual matters. Findings indicate that 89% of unmarried men aged 15–24 and 76% of unmarried young women aged 15–24 were exposed to television (IIPS and Population Council 2010).
Few qualitative studies report the influence of visual media on sexual behaviour. A study undertaken in Pune with 300 schoolgirls found a strong correlation between the girls’ television watching and involvement with boys (Joshi 2004). Other studies show that scripts and songs from films are used as conversation/dialogues in heterosexual interaction (Belaku Trust 2004, Sodhi, Verma, and Schensul 2004; Vasan 2010).

The Youth Study explored exposure to pornographic material at length and findings indicate that more men compared to young women reported such exposure. Among young men, 35% reported watching a “blue” or pornographic films, 23% had either looked at or read pornographic books or magazines, and 37% of those who were exposed to the internet had accessed pornographic materials by that means. Among young women, just 3%–5% reported exposure to pornographic materials in films, books, magazine, or on the internet (IIPS and Population Council 2010). Urban–rural differences suggest that more urban than rural young men had watched a pornographic film (47% versus 30%), accessed pornographic book or magazine (27% versus 21%), or had used the internet to access pornographic materials (43% versus 28%). Among young women, the differences were negligible (IIPS and Population Council 2010).

Studies have found that films and television have an impact on young people’s behaviour and lifestyle. They serve as a medium through which the young are presented with new ideas about dress codes and behaviour that they may use in their daily lives. Further, the young also imitate the hairstyles, clothing, and accessories of their favourite actors in popular films (WHO 2003, Goswami and Kashyap 2006, Vasan 2010). A study undertaken by WHO with 16–18-year-olds in Delhi and Mumbai notes that films create ‘a yearning for romance’ and indicator of popularity among the young includes being a ‘boyfriend’ or ‘girlfriend.’ The study highlights that young people prefer movies with violence and aggression and the young use the film dialogues in conversations with friends. Using appropriate accessories, like a motorcycle along, with language from the films becomes an indicator of popular youth culture (WHO 2003). Vasan (2010) reports that young men in her study were significantly more likely than young women to report engaging in various behaviours, including dressing style and mannerisms, interactions with the opposite sex, smoking, and drinking (Vasan 2010).

Findings from the Youth Study highlight that a considerable proportion of youth aged 15–24 years felt that television and films influenced their friends’ behaviour, including the way they dressed and aggression. More than three-fifths (62%) of young men and over half (54%) of young women believed that television and films affected the way their friends dressed. Similarly, 62% of young men and 60% of young women felt that violence in television and films could make youth aggressive (IIPS and Population Council 2010).

There has been increasing concern over the growing use of tobacco by young adolescents. Evidence suggests that mainstream films have a great influence on young people and increase their openness to smoking or tobacco use (Goswami and Kashyap 2006, WHO 2003). A study with 13–15-year-olds in 23 states of India found a high correlation between tobacco advertisement and smoking behaviour (Shah, Pednekar, Gupta et al. 2008). A cross-sectional study on tobacco use among pre-university students in Bangalore city found that one out of five male students (18%) and one out of 20 female students (6%) indicated a desire to use tobacco after watching film or television stars on screen; combined with peer pressure, films and television appear to have a significant influence on smoking behaviours (Bhojani 2009).

**The way forward**

The media has a significant impact on young people’s behaviour and attitudes. There is a need for larger studies that explore media use patterns among young people including their media preferences, the context of media, their interpretation of media content, and finally what they use and act out in their daily lives.

Research that aims to understand how the media influences young people and how they negotiate these influences toward a safe adulthood is required.

It is important to better understand the gendered influences of media as they provide pointers for interventions to use media in creative ways to ensure healthy and responsible transition to adult life.
References


Conclusion and The Way Forward

This overview, based on recent available evidence, explores the social and health needs of and vulnerabilities faced by adolescents in India. The literature review addresses key aspects of adolescents’ lives, including sexual and reproductive health, education, and nutrition. It also considers other vulnerabilities resulting from child labour, child abuse including trafficking, substance misuse and its ramifications, and the lack of autonomy and decision making ability. These vulnerabilities impact adolescent health and well-being, create obstacles to their growth and development thereby impeding their contribution to the social and economic development of the country. This report also reviews government policies and programmes and highlights gaps in the implementation of select policies that impact young people’s lives.

Adolescents are a heterogeneous group with diverse needs that vary depending on age, gender, marital status, place of residence, educational attainment levels, parents’ education levels, and other socio-demographic factors. The government has made a concerted effort to address the varying needs of young people through programmes and policies targeted at them. However, adolescents continue to face a number of vulnerabilities and challenges, highlighting the gaps in implementation of these initiatives. They continue to face barriers in accessing services for health, education, and nutrition and continue to be exploited in several ways including child labour, physical and sexual abuse, and trafficking. Limited decisionmaking power further compounds the issues that affect their safe transition to adulthood.

Key areas for future research and programme and policy recommendations emerging from the materials reviewed for each theme: sexual and reproductive health, education, nutrition, child labour, sexual abuse, substance abuse, agency and decision making ability and media are delineated below. Two overarching issues emerge from the desk review. There is an urgent need for a uniform definition of an ‘adolescent’ person. Various government policies, legislations and programmes use different cut offs, as do researchers; thus, a lot of published material conflates evidence for adolescents with children or older adults and policies are not implemented effectively. Second, there is very little or no published research on the reproductive and sexual health, nutritional status, agency and empowerment among adolescents 10 to 14 years of age.

Conclusion and The Way Forward
### Sexual and Reproductive Health

Young people face a number of barriers at the individual, family, community and health-systems levels that prevent them from achieving positive sexual and reproductive health outcomes. These barriers need to be addressed if India is to realise its demographic dividend and have a healthy young population. Barriers faced at the individual level include, early marriage, early and unsafe initiation into sexual activities, early child bearing, limited knowledge about and access to contraception to name a few. The lack of autonomy and decision making and existing gender imbalances further exacerbate young people’s vulnerabilities. At the family level young people face lack of family support and unequal gender norms and have limited communication with parents on sexual and reproductive health related issues. There is a need for the health system to recognise the diverse needs of youth, (married and unmarried) and provide unbiased services that are targeted specifically to address their needs.

### Research gaps

- Most available evidence on the sexual and reproductive health of adolescents is focussed on those 15-19 years of age. Adolescents aged 10–14 years are understudied and a difficult age group to reach and there is a need to acknowledge that their needs are distinct from those aged 15–19 years. There is no data available on the current status or levels of information/knowledge on different issues related to sexual and reproductive health among younger adolescents 10-14 years.

- There is little evidence on the impact of media and information technology in changing the social context of the young, in providing sexual and reproductive health–related messages and in enabling young people to make safe sexual transitions in this changing context.

- Research is needed to understand the processes of formation of sexual relationships among the young, premarital sexual experiences, experiences of consensual and non-consensual sex including awareness of and the ability to navigate the risks of sexually transmitted infections including HIV and unplanned pregnancy. Early marriage among adolescent girls has been documented extensively. However, there is little evidence on the negotiation of safe and wanted sex, particularly among the married young girls, and wanted reproductive health outcomes including the timing of childbearing. Sexual violence both within and outside marriage has not been studied. More research is needed to examine the barriers faced by young girls, particularly married girls, in accessing sexual and reproductive health–related information and services, in deciding the timing of their pregnancy and the actions taken at the time of an unwanted pregnancy.

- There is a need to evaluate existing intervention programmes implemented to assess the extent to which participation in these programmes has increased young people’s agency and levels of knowledge of sexual and reproductive health–related matters and their ability to make informed choices for different issues impacting their lives such as education, marriage, childbearing and mobility. More evidence is needed to explore existing gender roles and biases among gatekeepers, including parents and elders in the community, and their impact on the young adolescents’ agency and autonomy.

- An evaluation of existing government programmes targeted at the young, including for example, Adolescent Reproductive and Sexual Health (ARSH) centres is necessary to assess the training of service providers, sensitisation processes, and quality of services and care provided at ARSH centres.

- Most research among adolescents has focussed on young girls. There is a need for more research to explore the vulnerabilities faced by young adolescent boys, including unsafe premarital sex, sexual and physical violence and abuse, trafficking, substance misuse, and gender attitudes.
Policy and programme recommendations

- Increase focus of programmes on young boys and men in order to develop equitable gender role attitudes.
- Ensure that programmes that provide appropriate information and health care services, including family planning and infection prevention services, to young boys and girls, regardless of their marital status, are effectively implemented. For example the Adolescent Reproductive and Sexual Health (ARSH) programme and the Adolescent Education Programme (AEP).
- Ensure the availability of health care service providers and train them to be sensitive to the distinct needs of this heterogeneous group.
- Rigorous implementation of acts that have been put in place to protect adolescents, such as the Child Marriage Restraint Act, Dowry Prevention Act, and Sexual Harassment Act.
- Behaviour Change Communication (BCC) programmes at the community level to increase awareness among parents, adolescents, and other community members about existing laws that aim to protect the young and availability of services including family planning.

Education

Although evidence suggests that enrolment in primary schools has increased, young people continue to face challenges in completing their education. For example, the gains in enrolment at the elementary school level are lost with high dropout rates at the secondary and senior secondary school level, particularly amongst girls. At the school level, poor infrastructure, poor quality of teaching and limited options for vocational training further prevent the young from completing their education. At the community level, economic barriers, undertaking household responsibilities and chores, concerns about girls’ safety and poor quality of teaching result in non-enrolment or drop out after completion of elementary school. While there are policies and programmes in place to ensure that the young are enrolled in school, there are gaps in implementation that need to be addressed.

Research gaps

- Access to education is particularly challenging for marginalized groups. There is a need to assess the specific needs of the marginalised, including girls, in order to better understand the extent and nature of exclusion and what strategies would work to address these barriers. Further, a large number of children remain outside the school system. More research is needed to understand the vulnerabilities faced by out-of-school children, including street children and those engaged in child labour. A review existing programmes for out-of-school children and those aimed at bringing the young back to school or provide alternate systems of learning, including vocational training, is warranted.

- Although, educational attainment for adolescents is dependent on the parents and gatekeepers, there is little understanding of the attitudes of parents and gatekeepers towards educating their young, particularly the girls, and barriers to enabling them to complete their education.

- The number of private schools is increasing across urban and rural India. There is a need to examine the role of private schools by studying the populations they serve, quality of education they provide, and the impact of availability of private sector education on public sector facilities, particularly in tribal and rural areas. Further, non-formal and religious education systems are widely available in the community. Research is needed to explore the functioning and content of non-formal and religious education systems.

- Lastly, more research is needed to explore the barriers teachers’ face, difficulties they encounter, and their training needs for working in remote areas. An assessment of the capacity, motivation, and accountability of teachers for delivering quality education is needed for programmes to implement strategies to improve educational outcomes for adolescents.
Policy and programme recommendations

- Ensure implementation of the Right to Education (RTE) Act in all states.

- Ensure geographic access to schools by the young and provide an adequate number of schools and required infrastructure, including availability of toilets and drinking water, to enable students to complete their schooling.

- Ensure that the funds allocated are utilized appropriately to include provision of infrastructure, teacher training, and in-service training for teachers. Take steps to improve quality of teaching in government schools to retain the young in school so that they complete their education.

- Prepare a curriculum that is appropriate and relevant to the young and include an increased focus on vocational training.

- Provide quality teacher training and ensure their accountability.

Nutrition

Nutritional requirements peak during adolescence and, in absolute terms, are higher than at any other stage of life. Malnutrition at this stage leads to stunting of growth, repeated infections and places constraints on full physical and psychological development. The current nutritional status of the population reflects the lack of progress over time, despite a number of national level programmes and policies. Only limited data on the nutritional status of adolescents is available from government reports. In addition, most published material is from small and medium scale studies which make it difficult to generalize the findings to a larger geographic area. Also, the research has largely focused on adolescent girls, considering their imminent childbearing roles, overlooking the nutritional requirements of adolescent boys. The role of gender in nutrition among adolescents is a critical area for future study.

Research gaps

- Most research on nutrition has focused on children 0-6 years or older adolescents 15-19 years of age. The nutritional status of adolescents aged 10-14 years is understudied. There is a need for more evidence on the nutritional status and gender disparities from this group, particularly as this period coincides with the start of the pubertal growth spurt.

- There is limited evidence on the nutritional status of adolescent boys as most research has focused on older adolescent girls. Large-scale studies to ascertain the nutritional status of boys, particularly their need for Calcium, Vitamin D, and other nutrients to meet their growth requirements are warranted.

- More research is needed to assess the long-term impact of malnourishment on cognitive development and academic performance of adolescents. Obesity is an emerging health problem among adolescents and research is needed to identify its determinants and strategies to prevent it. The influence of media on dietary habits of adolescents, particularly the impact of food products endorsement by celebrities, needs to be examined.

Policy and programme recommendations

- Ensure effective implementation of schemes geared to improve the nutrition status of girls e.g., Kishori Shakti Yojna, Nutrition Programme for Adolescent Girls.

- Information, Education and Communication and Behaviour Change Communications initiatives need to be implemented at the community-level to raise awareness about nutrition and related issues, including anaemia and obesity. Promoting diets that are specific to each region and taking advantage of local resources needs to be proposed.
**Child Labour**

Children who live under conditions of extreme poverty and economic distress are often sent to work so that they can contribute to the family income. Parents of these children consider education to be non-beneficial, as neither the textbooks nor the educational curriculum, are relevant to their lives. Working children have to forgo educational opportunities and take up jobs that are often underpaid and hazardous. Further, they often face physical and sexual violence and abuse. The unregulated and rapid growth of market economies, rising prices, lower agricultural growth and migration to cities for work, has further exacerbated the situation by increasing insecurity and poverty. In addition to parental attitudes and economics, gender and caste also play a key role in the employment of children. Child labour needs to be dealt with using a holistic approach based on a rights framework. Documented research has placed great stress on investment in education as being of utmost importance in this context.

**Research gaps**

- The government has several legislations and policies in place for the prevention of child labour. An evaluation of child labour programmes implemented by the government and NGOs is needed to assess the extent to which they have been successful in protecting the children from child labour and providing them with relevant education.

- Not all children or adolescents may be interested in education after having worked for some years. For these children the government is committed to providing vocational training. However, there is limited information on the availability and uptake of vocational training programmes. It is important to assess the success of rehabilitation programmes for children rescued from factories, farms, brothels and private homes. An assessment of the availability of vocational programmes and the employment opportunities made available through this route would contribute important evidence for the national programme.

**Policy and programme recommendations**

- Ensure effective implementation of laws that protect children.

- Ensure provision of universal, free, and compulsory education to prevent children from going into employment before completing their education.

- Ensure that where needed the school timings are adjusted to suit the needs of children, particularly when they are engaged in seasonal work at farms.

- Provide residential schools for children rescued from child labour to ensure that they receive formal education up to secondary level.

- Support vocational training that would provide employability skills to children while simultaneously encouraging them to complete their education.

**Child Sexual Abuse**

Shrouded by a culture of silence, child sexual abuse is pervasive and prevalent in Indian society. The high prevalence reported in a national study commissioned by the Ministry of Women and Child Development highlights the urgent need to focus on this issue at the family, societal and state level. Families often overlook abuse and in many instances family members are involved in forcing girls from the family to enter the sex trade at very young ages (9-13 years). Young boys also suffer sexual abuse; some studies suggest that more boys face sexual abuse than girls. Street children are particularly vulnerable and sex tourism also involves sexual exploitation of young boys and girls.

**Research gaps**

- Studies on child sexual abuse are very limited. More research is needed to gather evidence on the extent and nature of abuse of children and its impact on their lives. Qualitative studies with children or adolescents who have experienced abuse or trafficking could provide an understanding of the context and nature of sexual abuse and help to design programmes to address it.
Research is needed to assess the long-term impact of child abuse and rehabilitation. It is necessary to document the experiences of NGO-run programmes that provide services for survivors of sexual abuse and rape for possible replication and scale-up.

**Policy and programme recommendations**

- Ensure effective and strict implementation of laws against trafficking to ensure that young girls are not trafficked.
- Provide effective rehabilitation programmes and residential services for girls who have been rescued from trafficking. Provide sensitive outreach and support and counselling services that would address the trauma faced by a child who has been abused as well as provide medical services where required.
- Offer sexuality education programmes that encourage children to talk and communicate with adults. Behavior change communication (BCC) and community-level intervention programmes should aim at sensitising adults and the young about sexual abuse.
- Scale up and replicate efforts of NGOs working with survivors of sexual abuse and rape.

**Substance Misuse**

In many instances the initiation of substance misuse usually takes place during adolescence. Encouragement by peer groups, the lure of popularity, and early availability of many such substances make an adolescent an easy prey. Several studies document tobacco use among adolescents. Smoking or chewing tobacco is often the first step in the path to addiction followed by alcohol; however few studies examine the extent of alcohol use in this population. Some adolescents move on to the use of non-prescription drugs consumed orally or via inhalation and in some cases followed by a gradual transition to injecting drug use. Most of the drug de-addiction and rehabilitation centres run by the government are tailored to adult drug users and fail to address the needs of adolescents under the age of 18 years.

**Research gaps**

- Several studies document the early initiation of substance abuse among adolescents and most document tobacco use; there is limited reporting on alcohol consumption. Research is needed to explore the extent of alcohol use among adolescents. The specific vulnerabilities of young people and the context and reasons that lead them to substance misuse need further exploring to better inform interventions and programmes.
- More research is required on the use of non-prescription drugs and narcotics to better understand the transition from non-injecting (oral/inhalation) to injecting drug use. A review of the few small-scale-NGO-run programmes for adolescents is urgently needed to identify successful interventions that could be evaluated and considered for replication and scale-up. Further, more evidence is needed on the long-term success rates of detoxification and rehabilitation programmes for adolescents.

**Policy and programme recommendations**

- Establish de-addiction and rehabilitation centres that would cater to the specific needs of the adolescents instead of sending them to centres that are for adult drug users.
- Implement Behaviour Change Communication (BCC) Interventions for in-school and out-of-school children including street children to sensitise young people to the adverse effects of drugs and substance misuse.
- Implementation of the Adolescence Education Programme to increase awareness about different forms of substance misuse and provide information on de-addiction centres.
Limited Agency and Decision-Making

The ability of adolescents, both girls and boys, to make decisions about matters that affect their lives is a critical aspect of empowerment. Evidence suggests that while young adolescents do have the freedom to decide who their friends will be, the ability to decide on how to spend money or to purchase clothes for themselves is limited. They also have limited access to financial resources and hence limited savings. Adolescent girls have less agency compared to boys with regard to decision making, freedom of movement and access to money. There is some evidence to suggest the emergence of egalitarian gender role attitudes, a distinct sign of empowerment for young adolescents. More girls appear to be more open to considering education to be equally important for girls as for boys or considering themselves to be as good as boys.

Research gaps

- Evidence on adolescents’ agency and autonomy is limited to studies with young men and women aged 15-24 years. Further research is needed to examine factors underlying adolescents’ agency, autonomy and the expression of unequal gender role attitudes for adolescents 10-19 years of age. Operations research should be undertaken to assess the impact of ‘lifeskills building’ programmes to identify effective interventions suitable for scale-up. The impact of limited autonomy and decision-making on the age at marriage and long-term reproductive health outcomes, educational attainment, and access to employment among adolescents needs to be studied.
- Finally, there is a need for a better understanding of parent–child communication patterns including issues related to decision making on important life decisions such as marriage, educational attainment and employment.

Policy and programme recommendations

- Implement livelihood skills programmes for married and unmarried adolescents that are linked with employment or income-generating opportunities to ensure that the skills learnt are put into practice and that young people are able to generate income for themselves or for their families.
- Identify safe spaces where the young girls can meet and build a support network with their peers.
- Involve parents and gatekeepers in programmes that aim at building agency; programmes should encourage parents to accept more equal and egalitarian attitudes towards their children.
- Reach out to the most marginalised girls for intervention programmes.
- Develop programmes for young boys to address their roles and attitudes; build gender egalitarian roles, and encourage them to be gender sensitive; break the masculinity roles that the boys grow up with.
- Develop programmes for parents to encourage parent–child communication and sensitise them to the specific needs of their adolescent and identify comfort and discomfort levels with different topics to be discussed with the adolescents.

Media and Adolescent Behaviour

The media has a significant impact on young people’s behaviour and attitudes. While the young are more exposed to media than ever before, there are few studies that explore the linkage between the media and the attitudes and behaviours of young people in India. Media both print and visual, is an important source of information on reproductive and sexual health matters and influences young people’s lives, particularly with respect to their interaction with the opposite sex. Little is known about media preferences of the young, interpretation of the content, and what messages are finally picked up and applied in their lives.

Research gaps

- There is a need to explore media use patterns among adolescents aged 10-19 years including their media preferences, media context, their interpretation of media content, and to what extent what they view influences their daily interactions and behaviours. Intervention studies evaluating media communication strategies to change behaviours and guide adolescents to make a safe transition to adulthood are required.
Annex 1:

List of Government Policies and Programmes

- Adolescent Education Programme, Ministry Of Human Resource Development, Government of India
  http://mhrd.gov.in/adolescence_education

  http://wcd.nic.in/BSY.htm

- Child Labour (Prohibition and Regulation) Act of 1986, Ministry Of Labour and Employment, Government of India


- Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act 2003

- Factories Act of 1948, Ministry Of Labor and Employment, Government of India

- Integrated Child Development Scheme (ICDS), Ministry of Women and Child Development, Government of India, 1975
  http://wcd.nic.in/icds.htm

- Juvenile Justice (Care and Protection) of Children Act of 2000, Ministry of Women and Child Development, Government of India

- Mines Act of 1952, Ministry of Labor and Employment, Government of India

- Planning Commission 12th Five Year Plan Vol 1 and 3 -
  http://planningcommission.nic.in/plans/planrel/12thplan/pdf/vol_3.pdf

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- Implementation Guide for RCH II Adolescent Reproductive and Sexual Health Strategy, Ministry of Health and Family Welfare, 2006 -
List of Government Policies

- Implementation Guidelines for SABLA Programme, Ministry of Women and Child Development, Government of India, 2010 -
  http://wcd.nic.in/schemes/sabla.htm

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- National Health Policy (NHP), Ministry of Health and Family Welfare, Government of India 2002


- National Programme for Girls’ Education at the Elementary Level, Department of School Education and Literacy, Ministry of Human Resource and Development, Government of India
  http://ssa.nic.in/girls-education/npegel/npegel.pdf/view


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  http://yas.nic.in/writereaddata/mainlinkfile/File1046.pdf

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- Prohibition of Smoking in Public Places Rules 2008
- Rashtriya Madhyamik Shiksha Abhiyan, Department of School Education and Literacy, Ministry of Human Resource and Development, Government of India, 2009
  http://mhrd.gov.in/rashtriya_madhyamik_shiksha_abhiyan
  http://mhrd.gov.in/rte
- Sarva Shiksha Abhiyan, Department of School Education and Literacy, Ministry of Human Resource and Development, Government of India,
  http://www.ssa.nic.in/
- School health programme, Ministry Of Health and Family Welfare, Government of India,
  http://mohfw.nic.in/WriteReadData/i892s/2099676248file5.pdf
- National Charter for Children, Ministry of Women and Child Development, Government of India
  http://wcd.nic.in/nationalcharter2003.htm
  http://wcd.nic.in/napaug16a.pdf
- National Policy for Children 2012, Ministry of Women and Child Development, Government of India
  http://wcd.nic.in/empwomen.htm
  http://wcd.nic.in/cma2006.pdf
  http://www.nihfw.org/NDC/DocumentationServices/NationalHealthProgramme/REPRODUCTIVEANDCHILDHEALTH.html
- Sakshar Bharat Scheme, Ministry of Panchayati Raj, Government of India,2009
  http://www.panchayat.gov.in/home/-/asset_publisher/jSJtaEw0XxM/content/saakshar-bharat-programme