



Advocating for the Rights of Children Worldwide Trust

Adolescent Girls in India



**A report prepared by
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Cover Photo:

Adolescent girls in the state of Rajasthan, India make their way to school through the crowded streets
NATASHA TASSELL/INDIA/MAY 2007

Acknowledgements

The adolescent is a complex individual crying out for attention and demanding understanding. While a lot of research has recently been done focusing on adolescents, the need for a holistic approach in policies is essential. I am grateful to Natasha Tassell and Susan Bolitho of the A.R.C. Worldwide Trust for giving me an opportunity to showcase the dilemmas, traumas and special needs of the Indian Adolescent Girl, especially where policy formulation is concerned. The A.R.C. Worldwide Trust firmly believes the children and adolescents of today are the future of tomorrow, and require crucial focus to reach their full potential as human beings. I am grateful to the organisations and institutions mentioned in this report, and from whom I sourced various information and data.

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Executive Summary

Adolescence (between the ages of 10-19 years) is a transition period in life, when an individual is no longer a child, but not yet an adult. It is important to note adolescents are not a homogeneous group - their needs vary according to gender, stage of development, life circumstances and socio-economic conditions.

A general lack of understanding about the particular needs of Indian adolescents, specifically adolescent girls, persists in India and the wider global community. The Indian context calls for a focus on adolescent girls due to their general vulnerability, inaccessibility to basic health care and education, unmet sexual and reproductive health needs and rights, and age old traditions and misconceptions that have seen this cohort marginalised.

The gender ratio in India is adverse, with males outnumbering females in every age group. The present gender ratio of 0-6 year olds is 927 girls for every 1000 boys, will affect the adolescent population in coming years. Indeed, a variety of developmental indicators already reflect a wide gender disparity. Malnutrition, high workforce participation, low enrolment figures in school, human trafficking, victimisation by being forced into non-consensual sex, and a lack of awareness, information and education are high among girls. This report provides an overview of these issues.

India is committed to promoting and protecting adolescent rights because it has recognised that investing in adolescents will lead to a “demographic bonus”. India has endorsed the International Conference of Population and Development, which was held in Cairo in 1994. In 1992, it was one of the first countries to ratify the Convention on the Rights of the Child. It has also signed the Convention on the Elimination of All Forms of Discrimination against Women, and has initiated policies and programmes for the realisation and sustainability of the Millennium Development Goals.

This report also overviews key policies and government programmes in India, the salient features of which are to address the gamut of unique adolescent needs. While India may

be committed to the development of the adolescent cohort, there remains a considerable schism between policy formulation and grassroot implementation. Nonetheless, programmes continue to be initiated with expansion in scope and content.

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Glossary of Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ARSH	Adolescent Reproductive and Sexual Health
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
HIV	Human Immuno Virus
ICMR	Indian Council of Medical Research
ICPD	International Conference on Population Development
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development
MoHRD	Ministry of Human Resource Development
NACO	National AIDS Control Organisation
NCRB	National Crime Records Bureau
NFHS	National Family Health Survey
RDA	Recommended Dietary Allowance
RTI	Reproductive Tract Infection
STI	Sexually Transmitted Infection
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organisation



Adolescents

1.0 Adolescents

Gender discrimination or bias starts as early as conception, when stereotyping of roles, ideologies and behavioural traits are inculcated by the family or community. It takes an extreme form when it is manifested in practices like sex-selective abortions, infanticide, malnutrition, neglect, and sexual, physical and emotional exploitation. There is a growing realisation that gender inequality lowers productivity and efficiency of labour, and intensifies unequal distribution of resources.

Genuine human development can be achieved by prioritising the development of women, with a particular focus on the adolescent. Human progress will come about when institutional and cultural discrimination is rectified and cultural traditions perpetuating social exclusion are challenged. There is recognition that the ultimate responsibility for enhancing development and reducing poverty must be borne by the whole of societies. Indeed, every adolescent girl holds a place in the future of a society, and thus it is the responsibility of present society to ensure her adequate growth and development. Neglect of this population, will have major implications for the future development and growth of communities.

Social systems can only be sustained when they provide solutions to the disparities and inequalities that have arisen from disharmonious development. Euphony in a social system creates a world that is fit for children. Gender equality benefits all, and empowering adolescent females would enable the maximisation of their capabilities and potentialities, which would have the subsequent effect of empowering families, communities and nations. In this respect, gender equality is not only morally right - it is pivotal to human progress.

1.1 Understanding Adolescents

According to World Health Organisation (2003a), an adolescent is any person between the ages of 10 and 19 years. It is a developmental period during which a person is no longer a child, but not yet an adult. This is the phase of life when important changes occur in different dimensions of life, such as physical, biological and emotional growth

and maturity. A time of rapid growth, adolescence is an extremely sensitive period, as it is the stage when an adolescent becomes inquisitive, attempts to explore their individuality and independence, and thinks critically about themselves and the world around them. During this time, transformation of body contours, the onset of puberty, unusual mood swings, and emotional and hormonal changes occur. The young individual undergoes rapid behavioural variations - anxiousness, apprehension, curiosity, and defiance. Cognitive development, involving the maturation of the mind, perceiving abstract phenomena and articulating an argument logically and maturely, also takes shape (UNICEF, 2002).

1.2 Significance of Adolescence

Every adolescent is confronted with a host of changes and challenges. In every society, social, economic and political forces are rapidly changing, and unfortunately the needs of younger populations are often overlooked. Physiological, emotional and social changes complemented with the huge uncultivated potentials of adolescents, often prove to be an antithesis towards holistic development. Crucial developments during this stage are the expression of sexual urges, appearance of secondary sex characteristics, sexual and reproductive maturity, and the transition from total socio-economic and emotional dependence on primary caregivers, to relative independence.

A wide range of obstacles can prevent an adolescent from evolving and navigating the various challenges associated with these developments. There is a clear need to understand that the main problems that adolescents face arise from their vulnerability to risky behaviour. As such, a reason for a crucial focus on the development of adolescents is to ensure the mental, emotional and physical health of future generations, in addition to population stabilisation.

Adolescents are not a homogeneous group. Their needs vary according to their sex, stage of development, and socio-economic and environmental conditions. There are nearly 1.5 billion young people aged between 10-25 years worldwide today (UNFPA, 2007) – a significant proportion of which are adolescents. Table 1 shows the regional distribution of the global adolescent population under the age of 18 years, in 2005. As shown, the

most recent data suggest children and adolescents below the age of 18 years account for one-third of the world's population

Table 1. *Distribution of Global Adolescent Population under the Age of 18 Years, in 2005*

Region	Total Population (000)	Adolescent Population (000)	Adolescent Population (as a % of total popn.)
Sub-Saharan Africa	713 457	361 301	51
Middle East and North Africa	378 532	154 130	41
South Asia	1 483 358	587 319	40
East Asia and the Pacific	1 952 656	572 465	29
Latin America and the Caribbean	555 853	199 284	36
Industrialized Countries	961 191	204 366	21
World Total	6 449 371	2 183 143	34

Source: UNICEF (2007a)

Education, health, diseases, employment, and poverty are indicators reflecting the situation of adolescents. Adolescents in developing countries have fewer opportunities for education than their counterparts in developed countries. Gender disparity appears to be prevalent worldwide, with girls having fewer opportunities for education than boys, particularly in less developed nations (Tassell, 2007).

Education should aim at developing the skills and abilities of adolescents, which enable them to deal effectively with the demands and challenges of every day life, in positive and beneficial ways. Life skill education is particularly essential for adolescents, and involves the development of *thinking skills* - to initiate self and social awareness, *social skills* - ability to take responsibility and cope with stress, and *negotiation skills* - to be enabled to say “no” to required situations (UNICEF, 2007b). However, because adolescents often do not get incorporated into the realm of education in a large number of developing countries, such crucial life skills are rarely imparted.

A substantial population of adolescents work in the informal and casual sectors of the employment market. Worldwide, many millions of adolescents are homeless and live and work on streets, which make them vulnerable to sexual and/or substance abuse and random or targeted violence. Due to a rapid growth in the number of economically deprived adolescents in many developing countries, it is estimated that in the 5-17 years age bracket, 126 million adolescents work in conditions detrimental to their health (UNICEF, 2006). Lack of education and forced employment due to adverse circumstances, complemented by poverty, brings risks to the health, well-being and development of the young person.

The health problems experienced during adolescence generally relate to sexual and reproductive health, which can include unsafe sex, unwanted pregnancies, abortion, HIV/AIDS, STI and RTI. An alarming 13% of all births worldwide are to girls between 15-19 years of age, and unsafe abortions are estimated at 20 million a year (WHO, 2003b). Of the estimated 38 million people living with HIV/AIDS, 11.8 million are young people, of which an estimated 2 million are in the 0-14 years age group (UNICEF, 2007a, 2007b). These recent statistics reveal it is adolescents at the centre of the pandemic, and their vulnerability increases due to a lack of accessibility to HIV information and prevention services.

Another health problem experienced during adolescence is substance abuse, which increases the likelihood of early sexual initiation. Mood disorders, depression, and other psychotic problems also contribute to the mental ill health of adolescents. While suicide is not a common problem among all adolescents, rates have increased substantially over the past few decades, and adolescent/youth suicide is reported to be the second or third leading cause of death in both the 13-19 years and 15-24 years age groups in a number of countries (Lewinsohn, Rhode, & Seeley, 1996; WHO, 2007a). Alarming, the mean suicide rate is reported as 7.4 for every 100 000 of the 15-19 years age group (Wasserman, Cheng, & Jiang, 2005).

Some other conditions that adversely affect adolescent development are chronic diseases, communicable and non-communicable diseases, intentional injuries such as date violence and rape, and unintentional injuries such as road traffic injuries. It is estimated 1 192 000

people are killed every year in traffic accidents worldwide, of which 73% are males (WHO, 2004). In 2000, road traffic injuries were the leading cause of death for the 15-19 years old age group, with 67 634 males and 22 960 females dying as a result of road traffic injuries (WHO, 2007b). Thus, a focus on adolescent health and development will reduce the burden on morbidity and mortality for this cohort, and enhance the quality of adult life.

With the aforementioned factors in mind, particular areas of adolescent development requiring investment are:

- (i) Human rights – it is a fundamental human right for all adolescents to achieve the highest attainable level of health and well-being
- (ii) Health benefits - adolescent deaths equate to a waste of earlier investments, and preventive and curative strategies would avoid future problems
- (iii) Economic benefits - healthy and empowered adolescents increase the productivity of societies, and can go some way to ensuring sustainable development.

1.3 Adolescent Rights

Empowering adolescents is fundamental to the social and economic development of a nation, and a key component of an equitable society. The well-being of adolescents can be achieved by strengthening their capabilities, enlarging their access to opportunities, and providing them with a safe and supportive environment. The United Nations Convention on the Rights of Child (CRC) raises concerns in Articles 6 and 24 that adequate attention has not been given to adolescents as right holders, and specific strategies or policies formulated for their health and development have not been adequately addressed.

Article 12 states “that it is the duty of the state to ensure that the views of the child are respected which would enhance their decision making and participative capacity”. In the context of the rights of adolescents to health and development, minimum age for sexual consent, marriage, medical treatment without parental consent, right to privacy (Article 16) and protection from all forms of abuse, neglect, violence and exploitation (Article 19, 32, 36 and 38) have been laid down. In Articles 13 and 17, access to proper information

and material, cost effective interventions in family planning, prevention of female genital mutilation, prevention of substance, tobacco and alcohol abuse, and the social, spiritual, physical, moral and mental health development of adolescents, have been emphasised.

Thus, the CRC encompasses adolescents of every background. Adolescents with a mental disorder or disability, married adolescents, school dropouts, those employed in the formal or informal sector, child soldiers and juveniles, all have the right to live in a safe and supportive environment, as well as the right to information and privacy. It is essential for every state and community to construct a strategy based on adolescent needs, which would enable them to combat social exclusion and develop life skills for capacity building. This would not only empower adolescents, but also the communities and economies within which they reside.



Adolescent Girls in India

2.0 Adolescent Girls in India

2.1 India: At a Glance

The population of India comprises approximately one-sixth of the world's population. Data from the 2001 census was the first to count more than one billion Indians, with the country's total population estimated at 1 027 015 247, which is an increase of 21.34% since 1991. The population growth rate was 1.606%, while birth and death rates were 22.69 and 6.58 per 1000 of the population, respectively (National Commission on Population, 2007). Clearly then, India's population is set to continually increase over the coming years. Table 2 shows the projected growth of the country's population.

Table 2. *Estimated Population Projection of India (in millions)*

Year	Under 15	15-59	60+	Total
2001	340	600	85	1 012
2006	330	690	90	1 094
2011	330	750	99	1 179
2016	340	800	101	1 264

Source: National Commission on Population (2007)

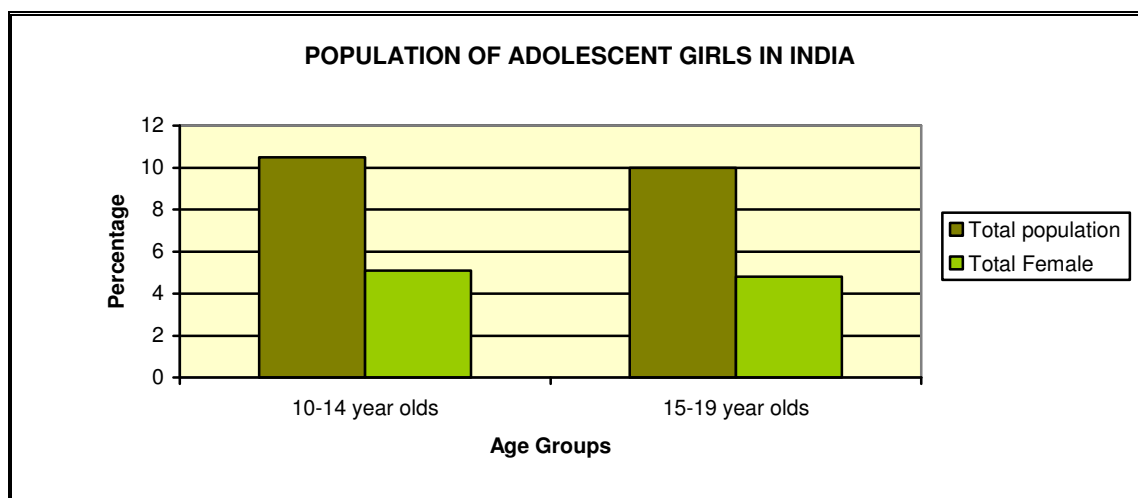
One third (30%) of all Indians are younger than 15 years of age (UNESCO, 2005), of which a total of 120 011 000 are below the age of five years. Girls account for only 927 for every 1000 boys (Bakshi, 2005), leaving the country with a growing disparity in the gender ratio. Save A Girl Child (2007) - an Indian NGO, has revealed several startling facts, which may account for this imbalance between the sexes:

- i. India accounts for the termination of some 10 million foetuses over the past 20 years
- ii. An estimated 2.7 million children die annually in India, of which more than half are girls
- iii. In more than half of all districts in India (i.e., 224 of 402), female mortality is highest

- iv. 8% of girls born in India will die during the first year of life - often due to poverty, being caught in the vicious cycle of early motherhood, and an ingrained obsessive mentality to have, care and nurture a male child.

2.2 Population of Adolescent Girls

India's population of young people is approximately 327 million, which comprises 30% of the population of the country, with the number of adolescents projected to continue growing over the coming years (National Commission on Population, 2007; UNESCO, 2005). Males outnumber females in every age group (Bakshi, 2005), and this phenomenon may be attributed to a general cultural preference for raising a male child. This then manifests in the form of sex selective abortions, infanticide, exploitation, and lack of accessibility to health care services, nutrition and hygiene. Figure 1 highlights the demographic details of adolescent girls in the 10-14 years and 15-19 years age groups.



Source: WHO (2007c)

Figure 1. Adolescent girls as a percentage of the total adolescent population in India, according to age group.

2.3 Educational Status

There has been a steady and gradual increase in the literacy rates of both boys and girls in India. However, females remain disadvantaged in terms of literacy, and the educational disparity between boys and girls living in rural and urban areas is still considerable. Gender disparities are also prevalent with regard to enrolment at schools. For example,

UNFPA (2005) reported only 43.8% of girls are enrolled in primary education (6-11 years), as opposed to 61.7% of boys. Other data clearly indicate a higher percentage of males have completed primary, secondary and tertiary education, in comparison to their female counterparts (WHO, 2007c). Table 3 highlights educational attainments according to gender over 1998-99.

Table 3. *Comparison of Educational Attainment between Adolescent Boys and Girls*

Age	Primary incomplete (%)		Primary completed (%)		Secondary Completed (%)	
	Male	Female	Male	Female	Male	Female
10-14 years	37.0	31.7	40.3	35.1	0.3	0.3
15-19 years	8.0	7.4	21.4	18.2	18.6	14.6

Source: WHO (2007c)

Despite literacy rates increasing and the gender gap narrowing, India still has an enormous population (approximately 44 million) who are illiterate. The main reasons for an adolescent girl not going to school have been attributed to poverty, an inherited lack of interest in studies, education not being a priority, a need to work at home, and taking care of younger siblings (WHO, 2007c). A report by UNFPA (2005) reported level of education, residence and gender per 1 000 adolescents in 1999-2000, with the data clearly indicating a gender bias and residential constraints on the level of education of girls and boys. Table 4 provides an overview of such data.

Table 4. *Distribution of Adolescents by Level of Education, Residence and Gender*

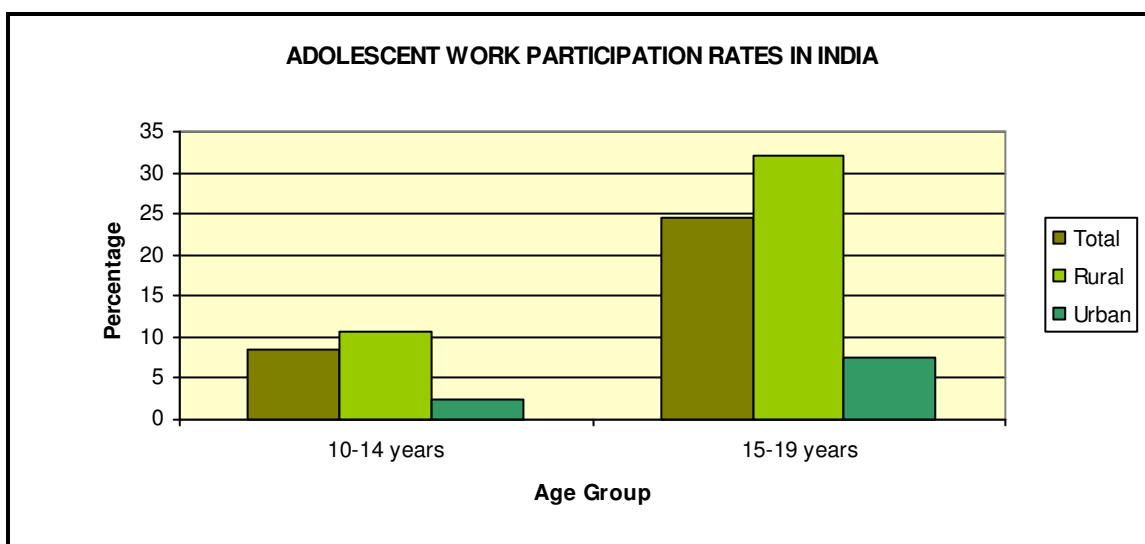
Age Group	Not Literate	Pre-Primary	Primary	Middle	Secondary	Higher Secondary	Graduate
Rural India							
10-14 (M)	152	351	347	139	10	0	0
10-14 (F)	267	296	305	123	9	0	0
15-19(M)	185	101	161	320	176	55	3
15-19 (F)	343	101	144	237	133	40	1
Urban India							
10-14 (M)	77	268	401	234	20	0	0
10-14 (F)	108	249	382	239	22	0	0
15-19(M)	89	68	122	303	262	145	12
15-19 (F)	114	67	114	277	254	160	14

Source: UNFPA (2005)

2.4 Employment Status

The legal minimum age for employment in India is 14 years, and 18 years for government jobs (WHO, 2007c). However, labour force participation rates are high for both older and younger adolescents, with a reported 12 million children involved in some form of employment (Global March Against Child Labour & International Centre on Child Labour and Education, 2006).

Rural adolescent girls are more likely to work and shoulder household responsibility than their urban counterparts, and labour participation in family farms and businesses is often without remuneration. In these cases, the girl's contributions to household labour and economic input are underestimated and largely unreported. UNFPA (2005) stated the activity rate amongst rural adolescent girls in the 10-14 years age group was 10.64%, while it was 2.32% amongst urban adolescent girls. In the 15-19 years age group the labour participation rate between rural and urban residents was astoundingly wide, at 7.55% for urban girls and 32.02% for rural girls. This difference is largely attributed to the urbanisation and education of girls in urban areas. Figure 2 highlights age specific work participation rate in rural and urban India.



Source: UNFPA (2005)

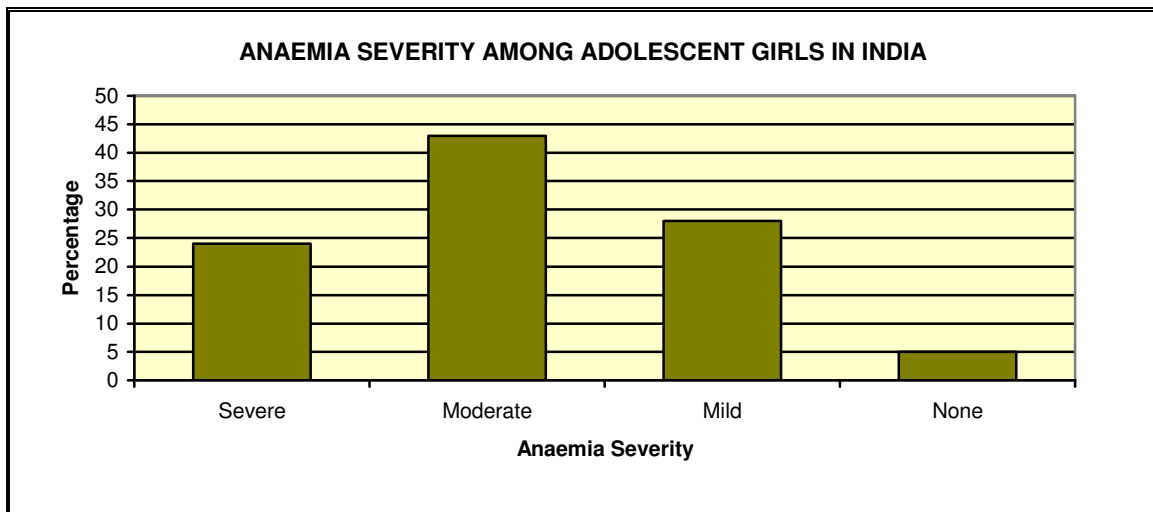
Figure 2. Age specific work participation rates in 2001.

Across India, the magnitude of child labour is vast and closely associated with poverty, illiteracy and large families. Although the Indian Government has taken proactive measures to address child labour (up to age 14 years) under the Child Labour Prohibition and Regulation Act 1986 (Amended), National Child Labour Policy 1987, and the Bonded Labour System (Abolition) Act 1976, a concerted effort is required from all sections of the society to address this socio-economic problem. Despite legislation on protecting children from harmful labour, adolescent girls continue to participate in the work force due to economic and familial compulsions. Indeed, a reported 35% are economically active in the age group of 15-19 years, although there has been a decline in previous years (Population Reference Bureau, 2006).

2.5 Nutritional Status

Imbalances in mortality rate, inaccessibility to education, low level of gainful employment, adverse sex ratio, and early marriage are not the only challenges faced by adolescent girls in India. Low nutritional status is also a major hindrance for their growth, with anaemia and vitamin A deficiency being highly prevalent. In 2002, UNICEF reported 55% of adolescent girls in India were anaemic. According to the National Family Health Survey (NFHS-3) for the 2005-2006 period, there was a high prevalence of anaemia (56%) amongst ever married women aged 15 years and above, which

represented an overall increase of 5% from the 1998-1999 period. Figure 3 indicates anaemia severity among adolescent girls (between ages 10-19 years) in India.



Source: WHO (2007c)

Figure 3. The prevalence of anaemia among adolescent girls in India.

Research suggests across both genders, the median intake of nutrients is less than the Recommended Dietary Allowance (RDA), and the average diet of adolescent girls is grossly deficient in micronutrients, iron and calcium (Toteja & Singh, 2002). In this respect, it appears the qualitative aspect of their diet is more of a problem than the quantitative aspect.

2.6 Marriage

In the South Asia region which includes India, sexual debut among adolescent girls occurs largely within marriage, as opposed to the worldwide concern for premarital adolescent sexual activity. There are many social connotations to early marriage and childbearing, with the most important factor being a young girl's chastity. The underlying rationale for Indian parents insisting on marrying-off their daughters at a young age, is premised on the general mentality that a girl's virginity is a gift to her husband. The irrational fear that a young girl can get raped or indulge in premarital sex, which would be regarded as ruinous to her family's status and reputation, is another reason for early marriage. An average adolescent girl usually has little, if any, input into the decision of her own marriage, sexual initiation and child bearing.

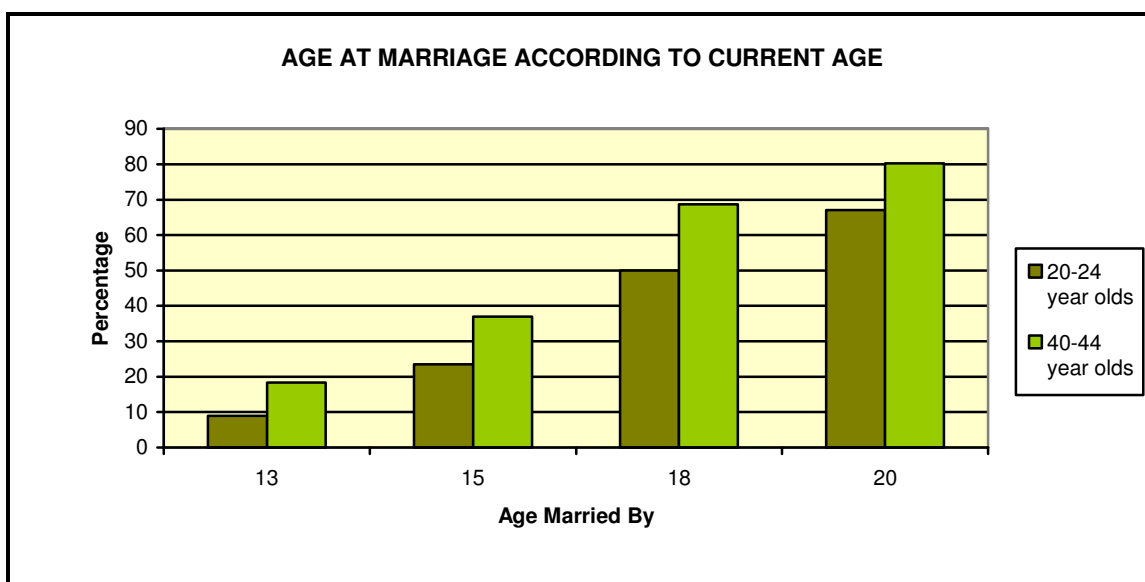
Immediately after marriage, there are strong familial and communal pressures to prove her fertility, which often results in early child bearing. Again, bearing sons is considered the only means to establish social acceptance and economic security. Thus, child bearing (the fertility period of a woman) starts as early as 15-16 years, and often continues until 35-38 years. Consequently, early marriage and pregnancy, limited nutritional food intake, disproportionate workload, limited access to timely health care, and absolutely no participation in decisions involving her own health and future, all contribute to the vulnerability and oppression of adolescent girls in India. The practice of *very early* marriage (before age of 13 years) has disappeared in urban areas and is becoming uncommon in rural areas too. The median age of first marriage for women aged 20-24 years is 18 years. Table 5 shows illustrates the realities pertaining to early marriage over the 2005-2006 period.

Table 5. *Marriage Figures for 2005-2006*

Median age at first marriage for girls	18 years
Women aged 20-24 who were married by 18 years	45%

Sources: International Institute for Population Sciences (2006), Population Reference Bureau (2005)

Figure 4 reflects the percentage of girls/women married by 13-20 years, who are in the age group of 20-24 years. A comparison has been given with women in the 40-44 years age group. As shown, there has been a steady rise in the age of first marriage for adolescent girls, which may be attributable to the law stipulating a minimum marriageable age for girls. However, the median age for marriage for 20-24 year olds, is a youthful 18 years.



Source: WHO (2007c)

Figure 4. Marriage ages of adolescent girls in India.

Level of education also has some impact on the age of first marriage for adolescent girls. For example, the average age of marriage for educationally disadvantaged females is 15 years, while it is seven years older (22 years) for women who have completed some form of schooling (UNICEF, 2005).

2.7 Pregnancy and Child Bearing

Indian adolescent girl's have high rates of fertility, with 19% of total fertility rates accounted for by women in the 15-19 years age group (WHO, 2007c). Table 6 gives child bearing figures for young Indian women, during 2005-2006.

Table 6. Child Bearing Figures for 2005-2006

Women aged 15-19 years already pregnant or mothers	16%
Median age at first birth	19 years
Fertility rates per 1000 women aged 15-20	72
Total fertility rate for all women	2.7

Sources: International Institute for Population Sciences (2006), Population Reference Bureau (2005)

Early marriage and subsequent pregnancies can have adverse effects on both mother and child. Adolescent mothers receive less prenatal, antenatal and postpartum care, with only 41.6 % of births by adolescent girl being attended by trained personnel (WHO, 2007c). There is a considerable high incidence of low birth weight newborns to adolescent mothers and high rates of neonatal, under five and infant mortality. The main postpartum complications an adolescent girl faces are massive vaginal bleeding and high fever (India Institute of Population Studies, 2000).

India suffers a higher rate of obstetric morbidity among adolescents than among adult women. According to the Indian Council of Medical Research (ICMR), maternal mortality rates among 15-19 year olds were 645 per one lakh¹ live births, compared to 342 per one lakh among adult women aged 20-34 years.

Unplanned pregnancy due to rape or non-consensual sexual activity or unsafe sexual debut has significantly risen in recent years, and has resulted in a disturbing proportion of adolescent abortion seekers. Although data relating to induced abortion by unmarried adolescents is difficult to measure, it is estimated that up to 10% of abortion seekers are adolescents (Ganatra, 2000).

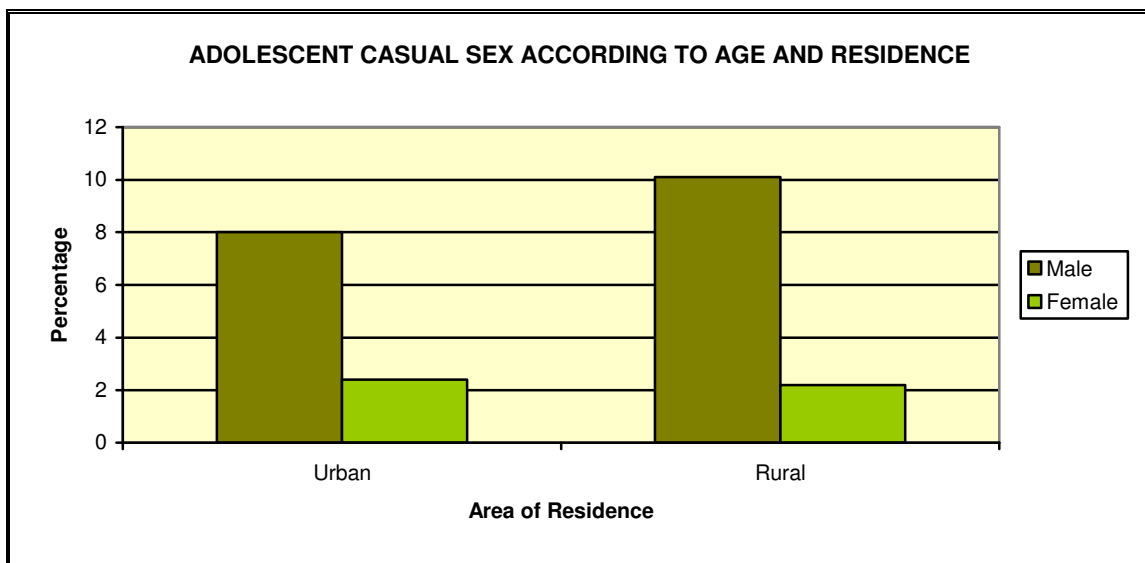
This can be corroborated with a study by Trikha (2003), which highlights the scenario of abortions amongst adolescent girls in Rohtak City of Haryana, India. Using a sample of 83 girls aged 15-19 years, the study revealed 75 (90%) were unmarried, 11% were undergoing abortion for a second or third time, and only 21% could persuade their partners to use a condom. Such findings highlight the vulnerability and lack of negotiation skills of adolescent girls, in the context of premarital and unsafe sexual practices.

2.8 Sexual Debut and Sexual Crime

Risky sexual behaviour by adolescent girls is under-reported, due to highly conservative attitudes about sex in India. Sexual initiation occurs earlier than parents, community leaders, health providers, and policy makers assume, and it is often unplanned and unprotected. A cross-sectional study of 2000 adolescent boys and girls aged 10-19 years

¹ 1 lakh = 100 000

conducted in three districts of the state of Rajasthan, revealed as many as 15% of the adolescents (both boys and girls) had experienced sexual intercourse at the time of the survey. The mean age of sexual intercourse was found to be 14.1 years, the girls being 3.5 years younger than boys (Jain, Gupta, & Singh, 2002). The National Behavioral Surveillance Survey (2001) findings show the percentage of adolescents in the 15-19 years age group reporting casual sex over a one year period, is higher for males than females. Figure 5 shows a comparison of rural and urban adolescents (15-19 years) who reported casual sex with multiple partners over a period of one year.



Source: WHO (2007c)

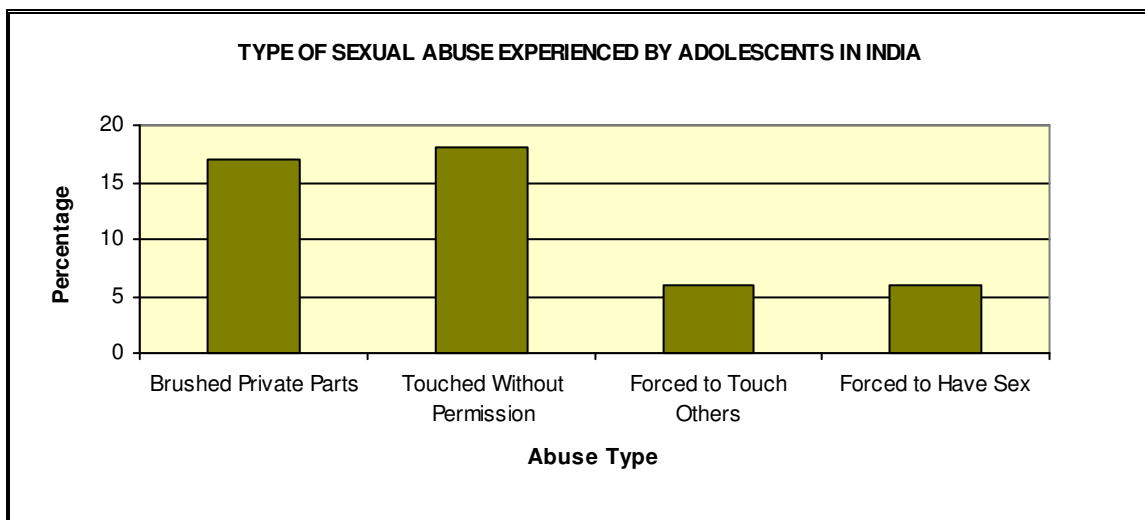
Figure 5. Adolescents (between 15-19 years) reporting casual sex during a 12 month period.

Non-consensual sexual activity and sexual coercion also often go unreported. As such, it is extremely difficult to measure or estimate the number of adolescent girls who suffer from sexual abuse, violence, coercion, incest, rape or sexual trafficking. Sexual coercion is pervasive because it occurs as rape within marriage, date rape, and under threats of disclosure by the perpetrator. The perpetrator can be an uncle, sibling or cousin, and is typically someone with accessibility to the family. Sexual coercion has considerable health consequences such as unsafe abortions, adverse emotional and psychological impact (such as guilt), stress, anxiety, suicidal tendencies, fear of social stigma, and STI/RTI and/or HIV/AIDS. In effect, early sexual initiation or sexual coercion exposes

adolescent girls to high-risk partners or multiple partners, and often results in serious mental, physical and social health issues.

Collecting data on sexual coercion is difficult in any homogeneous group of adolescents, as disclosure of involvement in such activities can have serious repercussions. However, certain studies do provide some insight into the severity of the problem. For example, interstate variations in the incidence of rape are apparent, with Madhya Pradesh and Maharashtra accounting for 44% of all child rape cases in the country. In these cases, 82% of victims knew the offender well (National Crime Record Bureau, 2000).

Additionally, a cross-sectional survey in schools in Goa revealed about 266 out of a sample of 811 adolescent boys and girls had experienced sexual abuse of some form or other, in the past twelve months. In this study, as many as one third of all students reported having experienced some form of coercion and 6% reported forced sexual intercourse (Patel, Andrews, Pierre, & Kamut, 2001). Nearly half of all adolescents who experienced coercion reported more than one such experience. The perpetrators in this study were older students or friends, parents, relatives, teachers or neighbours. Figure 6 reveals the percentage of adolescent girls (aged 16-17 years) who reported some form of sexual abuse over a 12 month period.



Source: Patel, Andrews, Pierre & Kamut (2001)

Figure 6. Percentage of adolescent girls who had experienced sexual abuse over a 12 month period, according to abuse type.

Since schools, homes and social institutions do not provide a safe and supportive environment and societal norms perpetuate violence by condoning harassment and blaming victims, it is not surprising the study found strong associations between sexual coercion and adverse consequences like poor school performance, emotional stress, high levels of anxiousness, and subsequent consensual sexual relations. Parental relationships were also poorer among girls who had undergone any form of sexual abuse. These young victims tend to suffer in silence, and there was no evidence of any legal action being taken against the perpetrators. Thus, the shocking phenomenon of sexual coercion is rampant, with the culprits continuing to live around their victims, freely and unpunished.

2.9 Trafficking

The trafficking of adolescents across India is difficult to ascertain with any certainty. However, India is the main transit point for human traffickers in the entire South Asia region, and the illegal trafficking of minors, including girl children and adolescent girls, is thought to be rampant. Trafficking of adolescent girls is not solely for prostitution, but also to cater for other markets such as adoption, entertainment, forced wedlock, labour, commercialised begging and the organ trade (WHO, 2007c).

Table 7 shows trafficking and abduction rates of adolescent girls in 2003 for various purposes such as illicit sexual intercourse, prostitution, sale or forced marriage. The number of reported cases of trafficking adolescent girls aged 15-18 years, was more than double that of girls aged 10-15 years.

Table 7. *Trafficking and Abduction of Adolescent Girls in 2003*

Purpose	10-15 years	15-18 years
Adoption	1	9
Illicit Intercourse	163	209
Forced Marriage	343	995
Prostitution	15	42
Ransom	6	4
Revenge	4	5
Sale	1	3
Slavery	2	0
Unlawful activity	20	29
Others	111	233
Total	666	1529

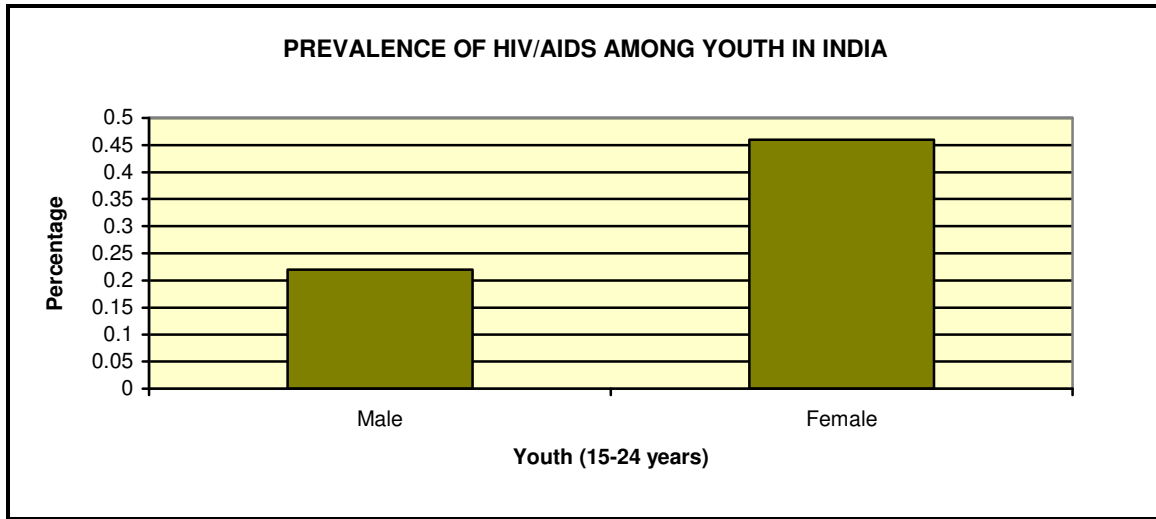
Source: WHO (2007c)

Of the 2 million sex workers in India, UNAIDS (2001) estimates 20% are under the age of 15 years, while the Department of Women and Child Development (2005) estimates one quarter are below 18 years of age. Of this, 25% are believed to have entered prostitution between the ages of 15-18 years, while an alarming 15% enter before age 15 years. Girl prostitutes are categorized according to various 'roles', such as common prostitute, bar girl (dancer/singer), and Devdasis. Devdasis are sanctified prostitutes dedicated to the goddess Yellama. As a girl child, this dedication is in the form of singing, dancing and ceremonial activities, while upon the attainment of puberty her virginity is auctioned to the highest bidder in the form of a 'touching ceremony' (Misha, 1987).

2.10 HIV/AIDS

In their global review, McCauley and Salter (1995) discussed the physiological, behavioural and social risk factors surrounding STI/HIV among adolescents. They stated adolescents are vulnerable to STI/HIV, but girls are more at risk. Gender power imbalances, societal norms, poverty, economic dependence, and high workforce participation in detrimental circumstances, all contribute to this risk. Young adolescent girls lack control over the choice of their marital and sexual partners, and the nature of sexual activity they have to indulge in, hence falling prey to non-consensual sex. Additionally, they lack information about condom use or are unaware of the risks of not

using them. Thus, the observation that “Asia and the Pacific hold the key to the global future of the HIV/AIDS epidemic” (Piot, 2001) holds true for India, as 35% of reported AIDS cases occur among youth between the ages of 15-24 years. According to WHO health indicators, HIV prevalence was 0.46% for females aged between 15-24 years, while it was 0.22% their male counterparts. Figure 7 shows HIV prevalence among Indian youth in 2001.



Source: WHO (2005)

Figure 7. HIV prevalence among youth aged between 15-24 years in 2001.

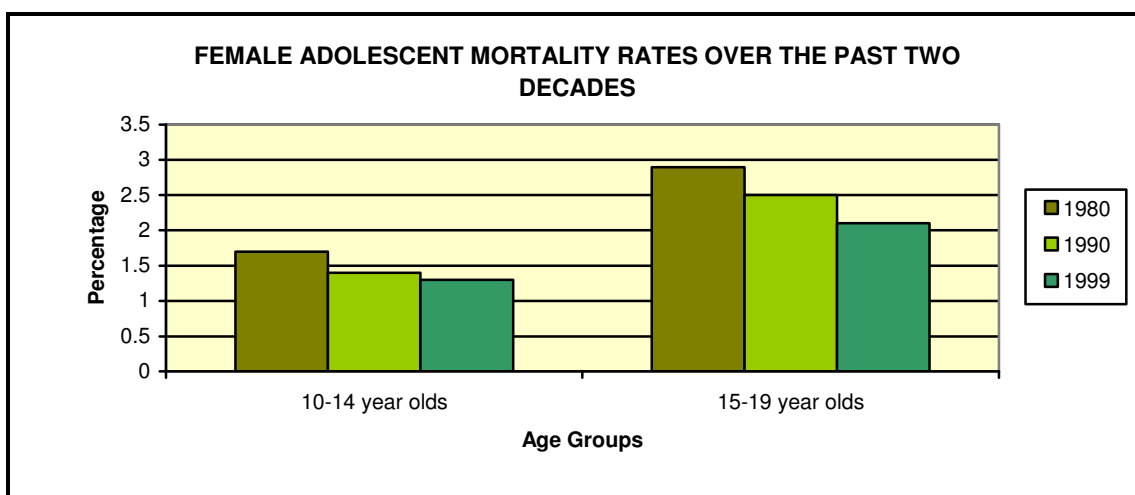
Women in India run a high risk of contracting HIV, and one in every four AIDS cases reported in the country, is a woman. Gender inequalities leave adolescent girls socially, economically and educationally disadvantaged, which increases their vulnerability to risky activities that can expose them to HIV/AIDS. Early marriage of an adolescent girl results in the commencement of sexual activity at a time when they are physiologically vulnerable to reproductive tract infections, due to the under-development of their reproductive tracts. Forced sex within or outside marriage, considerable age gaps between spouse, risky sexual behaviours of partners/spouses, a culture of silence surrounding sexual issues, lack of sexual negotiation skills, and limited access to HIV information and prevention services, has resulted in a higher rate of HIV cases among females, compared to males.

Of the 2 million sex workers in India, one quarter are below 18 years of age (The Department of Women and Child Development, 2005; UNAIDS, 2001). HIV Surveillance of 2005 revealed 13% of female sex workers were in Andhra Pradesh, 18% in Karnataka, 23% in Maharashtra, and an increase in this trend has been witnessed in Nagaland, West Bengal, Rajasthan and Bihar. In India, the overall rate of HIV cases among female sex workers was estimated to be 8.44% in 2005. According to the National Behavioural Surveillance Survey (2001), young brothel-based female sex workers were more vulnerable to HIV infection compared to their non-brothel-based peers. The survey revealed these sex workers were less literate, exposed to sex very early in life, entertained 1.5 times more clients, and were exposed to a higher probability of sexual initiation before they attained the age of 15 years.

As the rate of HIV/AIDs infections gradually increase, several initiatives by the government in alliance with non-governmental organizations and social institutions have been initiated. Preventive interventions with capacity building and strong outreach programmes are being implemented, but a lot remains to be achieved. Focusing only on HIV/AIDs amongst young adolescent girls (10-19 years) would not resolve the pandemic. Rather an integrated approach could assist to contain the problem.

2.11 Mortality Rates

High mortality rates amongst adolescent girls are prevalent, in comparison to boys of the same age group (i.e., 10-19 years) (WHO, 2007c). This may be due, in part, to gender disparities, which see girls experience insufficient food intake, inadequate access to health care, and gender discrimination based on stereotypes. These are compounded by long hours of domestic work, high priority given to the preservation of chastity resulting in early marriage, early pregnancy, and seclusion after attaining puberty, which serve to limit access to health care and nutrition. Figure 8 reflects the trends in age specific mortality rates, 1980-1999.



Source: WHO (2007c)

Figure 8. Age-specific mortality rates of female adolescents over the past two decades.

Data reveals a predominance of female deaths due to psychological disorders, with a large proportion occurring during pregnancy and child birth. Table 8 gives an overview of the highest causes of death among girl children in both the 5-14 years and 15-24 years age groups.

Table 8. Causes of Highest Deaths among Girl Child and Young Girls in 1999

Major Causes	Age groups	
	5-14	15-24
Pregnancy and Childbirth	1.1	34.3
Mental and Psychological disorders	0.9	11.4
Infections diseases	7.8	13.9

Source: WHO (2007c)

Disturbingly, adolescent suicide rates have been increasing by 5-10% every year (Gururaj & Isaac, 2001). Indeed, around one quarter of suicide deaths in India occur in the 15-19 years age group, and a recent study of autopsy records in a Delhi hospital revealed 55.4% of suicide fatalities were by girls aged 15-18 years (Lalwani, Sharma, Kabra, Girdhar, Dogra, 2004; WHO, 2007c).

A group of young women, likely students, are standing in a line. They are wearing white tops and pink bottoms. The background shows a building with posters and a sign that says 'MEMBER'.

Adolescent-Oriented Programmes, Policies and Legislation

3.0 Adolescent-Oriented Programmes, Policies and Legislation

Due to gender discrimination and rigid cultural norms, Indian girls do not have adequate access to formal education and health services, which limit options in relation to making decisions about important aspects of their life and development. Young adolescent girls adopt risky behaviour or fall victim to it, as they are poorly informed about their physical and sexual well-being, and are not adequately equipped with life skills which could ensure they are not coerced into difficult situations. Thus, lack of access to correct information and gender discrimination further impedes preventative measures.

In a study by Barua and Kurz (2001) on reproductive health service-seeking behaviours of married adolescent girls in Maharashtra, it was reported over 97% of girls suffering from cough, cold, fever and headaches sought treatment, but only half suffering from gynaecological or reproductive health problems sought any treatment.

Although no national data on health-seeking behaviour of young adolescents are available, data from NFHS-2 reported 45% of ever-married adolescents (15-19 years) are not exposed to any mass media on health services or behaviours. The Behavioural Surveillance Survey (2001) revealed awareness among rural adolescent girls was extremely low in the states of Jharkhand, Gujarat, Chattisgarh, Uttar Pradesh and West Bengal.

Data from region specific studies on the impact of mass media, reveals television is the most common source of information, followed by radio and newspapers. However, what is most needed by adolescent girls is uninhibited communication, reassurance, life skills development, and confidentiality. Confidentiality as a result of interpersonal communication with family and members of the community is currently woefully lacking for most girls in this cohort.

3.1 Programmes

Realising the necessity for adolescent-friendly integrated holistic programmes, developmental organisations and the national government have been adopting an approach to respond to their unique needs. The approach essentially focuses on advocacy,

life skills, sexual and reproductive health counselling, improvements in nutritional standards, sensitising youth on gender discrimination, and the combating of HIV/AIDS. All these encompass the specific issues of adolescent reproductive and sexual health, and adolescent health development.

Several programmes in the area of adolescent development have been initiated to translate policy decisions into grassroots initiatives. Programmes to raise awareness about reproductive and sexual health issues have been implemented for school and college attending youth, and for out-of-school youth. The Ministry of Human Resource Development (MoHRD), National Aids Control Organization (NACO) and UNICEF have focused on programmes to build awareness, incorporate sex education into growth and development initiatives in school curriculum, and have launched a number of HIV/AIDS education programmes. Programmes like “Youth Unite for Victory on AIDS” and the School AIDS Programme, have been implemented to strengthen ongoing efforts to raise sexual and reproductive health awareness and capacity building. Table 9 shows the coverage of Adolescent Education Programmes in secondary schools in India, during the 2005-2006 period.

Table 9. *Coverage of Adolescent Education Programmes During 2005-2006*

Number of Senior Secondary School	Percentage of school AEP up to 2005 implementing	Planned Coverage: Percentage of school to be covered
144,409	41.9 (60,533)	85.7 (123,810)

Source: MOHRD, NACO, UNICEF (2005)

As India has a large population of school dropouts, programmes for out-of-school youth have been initiated to ensure by 2010, youth across the country have accurate information, which is provided in a conducive and supportive environment. To reach rural youth in India, the Village Talk AIDS Programme has been undertaken to combat human trafficking and create awareness on HIV/AIDS. Every district in the 28 states of India are implementing the Reproductive and Child Health Programme, which covers topics on the importance of delayed marriage and pregnancy, gender relations, importance of male involvement, HIV/AIDS, STI and RTI. An interesting and innovative strategy is the Red

Ribbon Express, a train which passes through 180 locations in India, imparting information on HIV/AIDS.

Schemes have been launched which emphasise “friendly services to be made available for all adolescents, married and unmarried, girls and boys” (MoHFW, 2006). Steps to ensure counselling, routine check-up, management of systems of infection, nutrition and menstrual hygiene have been facilitated at health sub-centres. The National Rural Health Mission² addresses the issue of sexual health of rural girls and encourages institutional deliveries.

There are several other programmes that address gender disparity, being undertaken by the Ministry of Women and Child Development (MoWCD), MoHFW, and the Department of Education, which seek to empower young girls. Several states have launched innovative schemes to encourage schooling, delay marriage and to bring about change in the attitude towards a young girl. Advocacy and behaviour change programmes have also been undertaken to build a supportive environment. To fulfil this, the caregivers, health care providers, teachers, and community level functionaries are trained to be gender sensitive, understand the unique needs of young people, and ensure confidentiality.

3.2 Policies and Legislation

As a member state of the UN, India has made a commitment “to protect and promote the rights of adolescents to the enjoyment of the highest attainable standard of health” (UN, 1999), and was one of the first countries to ratify the Convention on the Rights of Child in 1992. India has also signed the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), endorsed the International Conference on Population Development (ICPD), and has articulated and promoted programmes on the achievement of the Millennium Development Goals (MDGs).

After Independence in 1947, while framing the Constitution of India, Article 39f of Directive Principles of State Policy stated “Children are given opportunities and facilities

² Launched on April 2005, it aims at providing accessible and affordable quality health care through out the country with focus on eight empowered action group states. The aim is to reduce MMR, IMR and TFR within a time frame of seven years. It focuses on adolescent reproductive and sexual health.

to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and mental abandonment”. A number of policies emphasising children and youth were formulated before ICPD 1994, while post-ICPD policies were conceptualised to address health and development needs.

The laws promulgated in the pre-ICPD period impacting adolescents are as follows:

- National Policy for Children 1974
- The Child Marriage Restrain Act 1978
- Medical Termination of Pregnancy Act 1972
- The Child Labour (Prohibition and Regulation Act) 1986
- Immoral Traffic (Prevention) Act 1986
- The Narcotic Drug and Psychotropic Substances (NDPS) Act 1985
- National Youth Policy 1985

(see Table 10 below for more details of each law)

During the post-ICPD period, India has integrated the Reproductive and Child Health Programme into the Family Welfare Programme. It is the National Population Policy 2000, which stated “adolescents are an underserved group with special sexual and reproductive health needs”. It emphasises adolescent’s accessibility to health information and strengthens the need for interventions to be provided at health centres and sub-centres³.

The National AIDS Prevention and Control Policy 2002 recognises the vulnerability of youth, and the need to promote a better understanding of HIV infection and safer sex practices. The objectives of the policy are to provide a variety of measures to prevent risky behaviour, build awareness, condom-use promotion, the creation of an enabling environment, and the reinforcement of traditional Indian values. The policy advocates

³ The seventh Five-Year Plan of India emphasized rural health care delivery systems. For this purpose, health sub centres have been established for a population of five thousand in plains, and three thousand in tribal and hilly areas. There is one female and one male multipurpose health worker per sub centre. The services provided are enrolment of newly married couples, routine ante-natal care, and institutional delivery, and RTI/STI/HIV/AIDS prevention education, referrals for early and safe abortion, counseling on nutrition, menstrual hygiene, anaemia prevention and immunisation for pregnant mothers.

adopting safe behavioural practices, by providing HIV/AIDS education in schools and colleges.

The National Youth Policy 2003 addresses the needs of 13-35 year olds, but recognises adolescents (13-19 years) as a special group. It realises the vulnerability of youth to risky behaviours, and thus advocates for free state-sponsored adolescent counselling and treatment clinics. This policy emphasises redressing gender discrimination in terms of marriage, nutritional standards and life skills building. It focuses on youth empowerment and gender justice through multi-sectoral capacity building strategies.

Other comprehensive wide-ranging policies addressing the needs of adolescents are as follows:

- National Policy on Education 1998
- National Policy for Empowerment of Women 2001
- 10th and 11th Five-Year Plans
- National Adolescent Reproductive and Sexual Health Strategy 2005.

(see Table 10 below for more details of each legislation)

Table 10. *Adolescent-Oriented Policies, Acts, Plans, Strategies and Laws of India*

Policy/Act	Year	Description
National Policy for Children	1974	Outlines measures for how the UN Declaration of the Rights of the Child can be met
The Child Marriage Restrain Act	1978	This Act prescribes the marriageable age as 18 for girls and 21 for boys
Medical Termination of Pregnancy Act	1972	Allows for the termination of certain pregnancies by registered medical practitioners
The Child Labour (Prohibition and Regulation Act)	1986	Regulates 14 years as minimum legal age limit for employment of children and prohibits engagement of children in certain employment
Immoral Traffic (Prevention) Act	1986	Prohibits trafficking in children
The Narcotic Drug and Psychotropic Substances (NDPS Act)	1985	Outlines measures under which India may meet its obligations under the Single Convention on Narcotic Drugs, Convention on Psychotropic Substances, and United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances
National Youth Policy	1985	Emphasizes sports, education and vocational training
National Policy on Education	1998	Reduce gender imbalances in school attendance
National Policy for Empowerment of Women	2001	Address nutritional deficiencies promote health awareness
10 th and 11 th Five year Plans		Focuses on marginalization of adolescent girls, need to reduce anemia, sensitize on safe motherhood, sexuality and sexual responsibilities, provision of vocational opportunities
National Adolescent Reproductive and Sexual Health Strategy	2005	Recognizes the heterogeneity of young people, addresses sexual and reproductive health needs, proposed training for service providers

2.3 Gaps and Realities

Like every developing nation that tends to face teething problems during the execution of any policy, similarly India, a country with wide regional and cultural variations, also has its own difficulties and obstacles that surface when translating policies into grassroot initiatives. India is perhaps the best example of democratic governance, where not only programmes or interventions are formulated and executed at district and state levels, but

also policies specific to the socio-cultural milieu and needs of the states are formulated at those levels.

Although India's adolescent policies articulate a commitment to meet adolescent development and also focus on adolescent girls, a lot is yet to be achieved. Until the National Adolescent Reproductive and Sexual Health Strategy 2005, most policies considered adolescents as a homogeneous group. In view of the fact the needs of every adolescent are determined by age, sex, economic background, social setup and environmental conditions, taking them as one homogeneous group grossly neglected the particular needs of many adolescents.

Secondly, all policies underlined the need to raise awareness about sexual and reproductive health issues, but did not at all recognise the need for health services and imparting life skills for empowerment. Unfortunately, due to the ambiguity of these policies, adolescents are included as part of the target audience for community level educational campaigns about the availability of safe abortion services and the dangers of unsafe abortion, but are not included as a target group for safe and legal abortion services.

There are also gaps between policies, legislation and practices which govern issues of adolescent confidentiality and privacy. Unfortunately, service providers are not oriented to deal with the needs of adolescents and respond to the local social milieu, while maintaining reasonable standards of human rights. Undergoing medical examination without parental consent, enhanced quality of care, and sensitivity towards adolescents' needs and vulnerabilities, are some issues not cited or addressed in earlier policies.

With regard to programmes initiated to address young people's need, the main problem is the themes and content are generic, and critical issues like sexuality, sexual behaviour, and gender relations are explicitly covered. The emphasis of education is technical (i.e., human anatomy, modes of HIV/AIDS transmission and prevention), and specific aspects like emergency contraception and need for usage of condoms, are not included. These exclusions are due to reluctance and inhibition on the part of service providers and teachers. Incomplete education can be confusing to adolescents, and can overlook

significant sexual and reproductive vulnerabilities that need to be addressed, if such programmes are to achieve the objectives they seek to attain.

In India, where age-old socio-cultural beliefs, myths and misconceptions are still deep rooted in the psyche of the people, interventions for the adolescent cohort have to be persistent and continuous, and yet still be sensitive to the rich moral traditions of the country. These gaps and realities will need to be bridged and adolescent needs must be addressed, in order to enhance the potentialities and capabilities of present and future members of this population group.



**Adolescent Girls –
Shaping Tomorrow**

4.0 Shaping Tomorrow

Being neither a girl child nor a woman, adolescent girls are physiologically, socially and culturally vulnerable. Irrespective of the social or cultural circumstances, the period of 10-19 years involves very complex changes and issues for the individual. An adolescent girl requires special attention, as it is primarily a girl child or young woman who lives through a complex life affected by gender, race, ethnicity, class and sexual orientation.

With focus shifting from demographic issues to integrated holistic reproductive health approaches, several projects, programmes and advocacy strategies are concentrating on gender equality, adolescent girls' empowerment, reproductive health and rights, sexual behaviour, health education, family life education and imparting awareness on HIV/AIDS. Investing in adolescent girls will enhance human development, economic and social standards, and facilitate sustainable development for the community, and hence the country.

In conclusion, building self sufficiency among adolescent girls is essential. Interventions in the form of life skills education, behaviour change communication, and health care services are being adopted to enable adolescent girls to raise their self-awareness and self-esteem. It is necessary to uphold democratic governance, community participation, peer leadership based on community-led innovative schemes, and health development projects. Additionally, having a peer education approach while focusing on life skills options in conformity with regional, social, environmental and cultural milieu, is necessary to achieve a safe and nurturing environment for the productive development of adolescents, particularly adolescent girls.





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