Adolescent Sexual And Reproductive Health And Rights In India

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CREATING RESOURCES FOR EMPOWERMENT IN ACTION (CREA)

is a non-profit organisation based in New Delhi, India. CREA empowers women to articulate, demand and access their human rights by enhancing women's leadership and focusing on issues of sexuality, sexual and reproductive rights, violence against women, and women's rights.

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Contents

List of Abbreviations

AIDS	:	Acquired Immuno Deficiency Syndrome
BSS	:	Behaviour Sentinel Survey
CRC	:	Convention on the Rights of the Child
GOI	:	Government of India
HIV	:	Human Immunodeficiency Virus
ICDS	:	Integrated Child Development Services
ICPD	:	International Conference on Population and Development
MCH	:	Maternal and Child Health
MSM	:	Men who have Sex with Men
NACO	:	National AIDS Control Organization
NFHS	:	National Family Health Survey
NGO	:	Non-governmental Organisation
NPP	:	National Population Policy
RCH	:	Reproductive and Child Health
RTIs	:	Reproductive Tract Infections
SRH	:	Sexual and Reproductive Health
STDs	:	Sexually Transmitted Diseases
STIs	:	Sexually Transmitted Infections
WHO	:	World Health Organization

Introduction

The notion of adolescence inspires conflicting emotions and ideas. To parents, educationists, social scientists, public health specialists and perhaps to adolescents themselves, this period is an intriguing mix of vulnerability, and of agency. Of a body that can respond and behave in ways that are thought of as 'adult', and a mind and heart that may still be as sensitive as a 'child's'.

In India, however, this is a curious situation, for the words 'child' and 'adult' are laden with deep-rooted cultural connotations. Traditionally, the body and being of a child is the preserve of the family, a prospect for greater wealth, greater security, and greater honour. Children are seen as a gift from God, yet as in any hierarchical society, their place is clearly at the very bottom. Age implies wisdom and power, and befits respect. Biology is considered the greatest predictor of behaviour, so puberty means that marriage is not far away, especially for young girls. The creation and propagation of the family is of utmost importance, so there is little thought given to the needs and desires of the adolescent.

Marriage and parenthood are the most common rites of passage into adulthood, out of the embrace of natal protection and security. But, does a 19 year old boy become responsible because he is married?[1] Is a 16 year old girl capable of raising a child? Traditional ways of relating to and within the family may not be relevant today when the structures of livelihoods and families have changed, where human migration is commonplace, and resources are meagre. In a society where a shared/collective identity is paramount, how does a young person claim an individual destiny?

These shifting layers of self, body, and identity lie at the centre of much confusion about the understanding and position of adolescents in society, and based on that, their entitlements. So within this cultural framework it is a struggle to award adolescents the right to space, identity, and respect. It was perhaps first through the eyes of science and public health that adolescents' experiences were seen in terms of the threats posed to their health and well-being. What this has meant is that their health needs are viewed in terms of disease control and prevention. This has become the central feature of the programmatic and policy lens that is focused on adolescents as a marginalised group of people.

> "Adolescence is a period of change and, consequently, one of stress, characterized by uncertainties in regard to identity and position in the peer group, in society at large and in the context of one's own responsibilities as an adult. The compulsions of parental approval often encounter the emerging aspirations of independence. Adolescents exhibit mood-swings and might even indulge in self-destructive activities, such as use of alcohol, drugs and violence…"[2]

Not surprisingly, this definition does not mention the sexual evolution of adolescents. Advocating for the rights of adolescents so they can have improved sexual and reproductive health is a delicate issue, one that raises strong emotional responses from adults in general. It is the most intimate relationships within which the vulnerability of young people can be exploited, as well as, paradoxically, be the source of pleasure and self-discovery. By providing adolescents with information about sex and sexuality there is an implication that they are capable of self-determining actions and thoughts with regard to their own sexuality.

[1] According to the Hindu marriage act, 1955, Chapter II section 5, for a marriage to be solemnised the bridegroom has to attain the age of twenty one years. Yet in practice many get married earlier.
[2] Government of India, 2003. National Youth Policy.

However, sexual and reproductive self-determination is threatening to many societies unless in the context of violations, disease or family planning. The socio-cultural milieu prohibits public discourse on sexuality using arguments of culture and tradition, thereby denying young people access to basic information that would benefit them. It is perhaps a larger discomfort with sexuality outside of the framework of marriage that raises complex questions for professionals working in the fields of public health, social sciences and policy, who are concerned with creating greater equity and opportunity for young people, especially those who lack resources and opportunities.

Adolescents who are poor and inadequately educated often have to bear the physical and psychological strain of adulthood before they are fully equipped. Pregnancy and motherhood for a body that has not been adequately nourished or allowed to develop, due to lack of resources and support, can have fatal consequences. Unwanted pregnancies can be damaging to a young woman's mind and body.

In the absence of adequate information, adolescents exercise decisions without being able to consider all the aspects and impacts of these decisions. Ignorance, misinformation, and misconceptions abound among the vast majority of adolescents in India concerning issues of sexuality and health. However, cultural norms that censure adolescents' access to information and sexual expression have not stopped them from being sexually active. This results in a situation where adolescents make uninformed choices that could affect their lives and health in a serious and irreversible way.

In addition, it means that sexual behaviour is cloaked in shame and guilt and largely ignores the important aspects of trust, sharing and intimacy with partners and the concepts of mutual respect, consensual relations and the receiving and giving of pleasure. For adolescents whose sexual orientation does not conform to the heterosexual normative framework, there are even fewer spaces for self-exploration.

This paper attempts to understand the complexities of advocating for the rights of young people, most of which arise from their very state of transition. It begins with problems in defining this group for some of the reasons mentioned earlier. Some current research on adolescent sexual and reproductive health in India throws light on the risks they face, which are unique to their age and socio-economic situations. As a disclaimer, it is important to state that the research cited cannot be said to hold true for the entire country, considering the size and diversity of India. Research often occurs in community based and local settings and the issue of representation may be raised. The intention of including research from around the country is more to present an overview of the reproductive and sexual health situations of young people, rather than to critique the research itself.

Research also tends to focus on the risks and threats to young people's physical and mental health that keep them trapped within the stereotypes of vulnerability, recklessness, and danger. There is little inquiry into the positive potential of adolescents as emotional, sexual, and creative beings.

Defining Problems

Laws, policies, and social actions in India have used the words 'children', 'minors', and 'adolescents' interchangeably. According to the Convention on the Rights of the Child (CRC), a child is "a human being below the age of 18 years unless under the law applicable to the child majority has been achieved earlier"[3]. Laws in India, as in many other parts of the world, have tended towards a paternalistic approach, based on an idea that persons below a certain age are unable to make their own decisions.

Internationally there has been considerable progress in the notion of what youth and adolescence imply, and the difference between a child and an adolescent. It is perhaps the especially unique nature of adolescents' lives, in that stereotypical grey zone between childhood and adulthood, that has resulted in the development of specific problems in definition and therefore the scope and range of programmes and policies.

According to the World Health Organization's (WHO) definition, youth is the period between the ages of 10 and 24 years. Adolescence is the period between the ages of 10 and 19 years, which is generally when puberty occurs.

It is estimated that the adolescent group constitutes about one fifth of India's population. There are almost 200 million adolescents in India and it is estimated that this age group will grow to over 214 million by 2020.[4] However, estimating numbers is rendered more complicated by the fact that there is no clear consensus on the exact age group that comprises adolescence. Therefore, programmes and organisations use differing categories depending on their specific target groups.

For instance, the National Youth Policy (2003)[5] defines 'adolescents' as those aged between 13 and 19 years, and 'youth' includes those between the ages of 20 and 35. And it recognises that these are not homogenous groups. The Government of India Reproductive and Child Health programme declares 10-19 year olds as adolescents. To complicate the issue further, the Government's Integrated Child Development Services (ICDS) state that adolescent girls are between 11 and 18 years old and the Constitution and labour laws of the country consider all people below the age of 14 to be children. The Government of India's (GOI) tenth Five Year Plan Report adheres to the WHO definition as stated above.

Interestingly, culture and language play a role in confounding these discussions further, and particularly in community based research and programmes. For instance, a married girl aged 18 or 19 is not considered an adolescent either by herself or her parents, and the Hindi word for adolescent/youth is 'kishor(i)', which implies that one is unmarried.

Young Women in India

- **Close to 189 million women in India still lack the basic capability to read and write.[6]**
- **The dropout rates of girls have not just been high, but are higher than that of boys at the primary (41.9%), upper primary (57.7%), and secondary (71.5%) levels.[7]**
- **By the age of 18 years, 54% women are married.[8]**
- **25-35% of adolescent girls of India begin child bearing as early as 17 years.[9]**

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[3] Article 1, 1989.
[4] Gupta, 2003.
[5] Government of India.
[6] Provisional population totals. Census of India, 2001.
[7] Department of Education, Ministry of Human Resource Development website www.education.nic.in
[8] IIPS, 2000.
[9] United Nations Population Fund CST for CASA, 1999.

These overlaps and contradictions in definitions of ‘child’, ‘adolescent’ and ‘youth’ mean that there is little or no coordination between the various actors who design and implement programmes to support the needs of young people - the State, donor agencies, educationists, and NGOs - unless there is a concerted effort to plan and programme together. By making artificial categorisations based on age and culture, rather than experience, these definitions reflect unrealistic notions of what adolescents experience. Adolescents’ needs thus tend to be constructed within the framework of reproductive health rather than sexuality. So existing programmes talk of married adolescents, mainly young women, and their needs for contraception and spacing methods, safe childbirth, antenatal care, and other reproductive health issues. Despite the shifting definitions based on age, there is still perhaps a blind spot about adolescent experiences; somewhere they are still seen as children, and therefore there is a resistance to acknowledging the range of adolescents’ sexual experiences and the resulting needs for information and services.

Sexual and Reproductive Rights

Today sexual and reproductive health may be spoken of in the same breath, but this has not always been the case. Maternal and child health (MCH) have for long been the primary focus of development and policy. It was with the influence of the women's movement, the struggle for gay and lesbian rights, and more recently the HIV/AIDS epidemic that the term sexuality has found its way onto development and policy agendas. There continue to be debates about their relationship, however it is clear that reproductive health cannot be discussed without an understanding of sexuality.[10] One outcome of this acceptance of the sexuality connection in reproductive health discourses is that it has remained just that - a connection. There is often a conflation of the terms 'sexuality' and 'reproduction', leading to the subsuming of the former under the latter.

A critical review of sexuality and sexual behaviour research in India in the last decade including academic research and writing, NGO reports, and conference papers,[11] reveals the myths and biases related to sexuality issues of young people. Sexual health discourses and interventions are still within the framework of reproductive health. The age group addressed in research and interventions is the reproductive age group thereby implying the strong influence of fertility control and population stabilisation. Sexuality is seen as worth studying because of its links with disease, particularly HIV/AIDS, reproductive tract infections and sexually transmitted diseases.

In the context of adolescents these debates become even more fractious as there is often a discomfort with recognising the sexual nature of their lives.

> "Sexuality is influenced by different factors including socio-cultural and psychological factors as well as biological capacity and political ideologies and systems. It is a personal and intimate part of life and is also interwoven with myth, taboo and morals. It encompasses eroticism, sexual behaviour, social and gender roles and identity, relationship and the personal, social and cultural meanings that each of these might have."[12]

Sexual and reproductive rights are based on certain ethical principles of bodily integrity, personhood, equality and diversity[13]. They encompass a broad range of internationally and nationally recognised civil, political, economic, social, and cultural rights. Broadly speaking, they encompass two key principles: that all persons have the right to reproductive and sexual health care, and secondly, they have the right to make their own decisions about their sexual and reproductive lives.

The concept of sexual rights widens the scope and dialogue on sexuality because it deals with the topic as independent of reproduction and includes the consideration of the affirmative right to pleasure. Sexual rights include the right to choose with whom we have sex and how we express our sexuality, and also the right to information for people of all ages.[14]

[10] Dixon-Mueller, 1993.
[11] Chandiramani, Kapadia, Khanna, and Misra, 2000.
[12] Ibid.: pg. 8.
[13] Correa and Petchesky, 1994.
[14] Miller, 2000.

Sexual and Reproductive Rights

Sexual Rights[15]	Reproductive Rights[16]
The right to sexual pleasure without fear of infection, disease, unwanted pregnancy or harm The right to sexual expression and to make sexual decisions that are consistent with one's personal, ethical, and social values The right to sexual and reproductive health care, information, education, and services The right to bodily integrity and the right to choose if, when, how and with whom to be sexually active and engage in sexual relations with full consent The right to enter relationships, including marriage, with full and free consent and without coercion The right to privacy and confidentiality in seeking sexual and reproductive health care services The right to express one's sexuality without discrimination and independent of reproduction	The right to the highest attainable standard of health The right to life and survival The right to liberty and security of the person The right to health, reproductive health and family planning The right to decide the number and spacing of children and to have the information and means to do so The right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free from coercion, discrimination, and violence The same right of men and women to marry only with their free and full consent The right to privacy The right to education The right to participation The right of access to information The right to be free from discrimination on specified grounds The right to be free from practices that harm women and girls The right to not be subjected to torture or other cruel, inhuman, or degrading treatment or punishment The right to be free from sexual violence The right to enjoy scientific progress and to consent to experimentation The right to reproductive health care

[15] Health, Empowerment, Rights and Accountability (HERA).
[16] TARSHI, 2001.

According to the International Conference on Population and Development (ICPD) Programme of Action:

> "...reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility…and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant."[17]

This definition emphasises that reproductive rights extend to all human beings but it is particularly essential for women's exercise of their right to health, and includes the right to comprehensive, good quality reproductive health services that ensure privacy, complete information and free consent, confidentiality and respect.

The ICPD document also focuses on reproductive health and rights of youth and suggests that States have an obligation "…to address adolescent sexual and reproductive health issues including unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behaviour, specifically suitable for that age group…"[18]

An ambiguity in this definition comes through in the last few words: "the promotion of responsible and healthy reproductive and sexual behaviour, specifically suitable for that age group". In a rights based approach, States have to be given the space to develop culturally specific interventions based on social, economic and political conditions. But this also gives States the leverage to maintain a cultural status quo in policy, or even silently condone harmful cultural practices.

A rights based approach to the issue of adolescent sexuality would mean that adolescents have a right to information that has a direct bearing on their health and well-being. It would also affirm that sexuality is a rich and positive area of life and adolescents have a right to grow up understanding their bodies and being able to make informed and consensual choices about sex including the choice of sexual preference.

Denial of sexual health information, or an abstinence-only approach to sexuality education interferes with fundamental rights including the right to "seek, receive, and impart information and ideas of all kinds"[19] and the right to the highest attainable standard of health,[20] which can have dire consequences on the right to life. Sexual health information is key to the right to life.[21] The failure to provide accurate information about the prevention of HIV transmission, for example, puts young people at risk. However, the obscenity and censorship laws in India[22] often restrict this right on the grounds of preserving public decency and morality. The end result often is that the right to information is compromised in the name of protecting an arbitrary notion of Indian culture and morality. These laws have been used to bring within their ambit the instruction of sexual health information, the distribution of literature on sexual health information and tools such as condoms. Courts in other countries have recognised the pressing need of adolescents for sexual health information (including condoms) to prevent the spread of HIV/AIDS.[23]

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[17] Paragraph 7.2, 1994.
[18] Ibid. Paragraph 7.44.
[19] Access to information is also essential to secure the highest attainable standard of health. See United Nations, 2000: Paragraph 12.
[20] United Nations, 1989: Article 24(2)(e); United Nations, 2003: Paragraph 38(h); United Nations, 2000: Paragraphs 12(b) and 16.
[21] United Nations, 2000: Paragraphs 12(b), 16 and 34.
[22] Sections 292, 293 and 294, Indian Penal Code. These sections criminalise the sale of obscene books/objects and performance of obscene acts. 'Obscenity' is again widely defined and has been interpreted with moral overtones by courts in the past.
[23] Quoted in Lawyers Collective, 2003: pg.60.

The Status of Adolescent Sexual and Reproductive Health in India

There is a consensus in literature that adolescents in developing countries are particularly vulnerable to sexual and reproductive health risks due to factors such as "their young age, their ignorance of matters related to sexuality and reproductive health, their lack of factual knowledge about contraception and their inability or unwillingness to use most family planning and health services".[24] Gender and sexual violence, sexually transmitted diseases, reproductive tract infections and HIV/AIDS are some of the risks associated with sexual activity under these circumstances. Adolescent girls, across the board, are a particularly disadvantaged group in relation to sexual and reproductive health due to cultural norms mandating early marriage and early childbirth. Although present laws in India prohibit early marriage, mandating the legal minimum age as 18 for girls and 21 for boys, marriage below these ages is still fairly common.

This section focuses almost exclusively on adolescent girls and young women up to the age of 24 years. There is a serious paucity of information on young men's and boys' reproductive and sexual health needs and conditions, but it has been included wherever possible.

- **The average age of menarche is 13.4 years and 50% of rural and urban girls have no information or understanding of this basic biological process.**
- **India has more than 10 million pregnant adolescents and adolescent mothers.**
- **One in six girls begins childbearing between the ages of 13 and 19 years.**
- **One source suggests that 44.7% of girls between the ages of 15 and 19 years in rural areas are married.**
- **Approximately 56% of adolescent girls are anaemic.**
- **Only 7.4% of married girls between the ages of 15 and 19 years use contraception.**
- **68.7% of mothers under the age of 20 receive prenatal care from a skilled health worker and 41.6% give birth with the assistance of a skilled birth attendant.**
- **Unsafe abortions account for half of all maternal deaths of girls between 15 and 19 years.**
  (Data from CEDPA, 2001)

Adolescents' Information Levels

One of the first steps towards ensuring adequate reproductive and sexual health care for adolescents is to provide them with information about their bodies, puberty, relationships, sex and sexuality. There is no State mandated sex education in schools in India, and not all adolescents are fortunate enough to get text books or magazines from which they might glean some information about their changing bodies and relationships. A great deal of adolescents' knowledge however comes from informal communications with their peers and select family members.

Some studies on girls in India have found that they are generally told nothing of menstruation until their first personal experience of it.[25] In a study of 800 girls from Tamil Nadu[26] a little less than a third of the girls had any information about menstruation before it occurred, and not all had access to accurate sources of information.

[24] Mamdani, 1999: pg.11.
[25] for example, George, 1997.
[26] Narayan, Srinivasa, Pelto and Veeramal, 2001.

The Population Council's FRONTIERS in Reproductive Health Programme and Policy Research Division, in collaboration with CARE India, is conducting an operations research study. The subject is an intervention designed to improve the lives and prospects of young women in several slum areas of Allahabad in the populous North Indian state of Uttar Pradesh. A baseline study from this of 1518 young men's and 1683 women's reproductive health knowledge indicated that:[27]

- **39% of boys and 97% of girls are familiar with the menstrual cycle.**
- **88% of boys and 42% of girls know about sexual intercourse and the process of conception.**
- **6% of boys and 2% of girls know the peak fertility period in a woman's cycle.**
- **87% of boys and 86% of girls know the period of gestation.**
- **87% of boys and 67% of girls can name at least one STD.**
- **93% of boys and 80% of girls have heard of HIV/AIDS (when prompted).**
- **44% of boys and 55% of girls know that a married woman can get HIV from her husband.**
- **94% of boys and 91% of girls have heard of at least one contraceptive method.**
- **84% of boys and 32% of girls know that using a condom can prevent the spread of HIV/AIDS.**

In an action research undertaken by the Brihanmumbai Municipal Corporation (Public Health Department) and UNICEF Mumbai, 80 girls between the ages of 13 and 19 years participated in focused group discussions, and 399 girls filled in questionnaires revealing that:[28]

- **57.6% of girls were informed of menstruation by their mothers. However only 16.2% of girls had correct biomedical knowledge about the menstruation process.**
- **31.8% reported to know about conception. Of them a majority clearly stated that a woman conceived when sperm from a man's penis entered the vagina.**
- **Only 14.2% could give the correct answer that a baby was delivered through the vagina.**

In a study of 500 adolescent boys and girls in rural Maharashtra state in Western India, the results showed that:[29]

- **25% thought that menstrual blood was located in the uterus.**
- **56% of married and 71% of unmarried male adolescents reported that there is a common opening for urine and menstrual blood.**
- **51% of unmarried girls did not know that a baby is delivered through the vagina.**
- **Only 15% of married male adolescents and 8% of unmarried male adolescents had information about sexually transmitted diseases.**
- **44% of married males thought HIV/AIDS was a curable condition.**
- **For adolescent males, married or otherwise, the prime source of information on sexual intercourse, menstruation, and pregnancy has been the peer group.**

Urban Indian youth usually have far greater access to diverse sources of information; some might even have school based sex education. But like their rural peers, there is still lack of opportunities to learn about sex and sexuality openly and confidently. This could lead to inconsistencies in their actual recall and understanding of issues as noticed in some of the data presented here. The peer group remains the primary source of information, in addition to books, movies and magazines with sexual content (for adolescent males), TV, and specific family members such as mothers and elder siblings (especially for adolescent girls). A qualitative reading of research

[27] Population Council and CARE India, 2002.
[28] Ubale, Gadgil and Roy, 1997.
[29] Apte, 1997.

indicates that each of these sources of information have widely varying styles of presentation, and of information packaged either in the language of 'science' or as 'morality' (usually in the form of warnings to stay away from sexual activity), or of the two reinforcing each other. It is important to note that there is far more data available for rural youth than urban youth because of the large number of intervention programs conducted by non government organisations for the former. The studies of adolescent reproductive and sexual health awareness cited here are diverse and cannot be used to compare different samples of adolescents. What they do reveal consistently is that there is always a slew of unanswered questions and confusions.

Sexual Activity

Designing useful interventions for adolescents has been hindered by the fact that there is a dearth of reliable research on the sexual behaviour of adolescents. This forms a major obstacle to designing programmes and interventions that could assist adolescents in terms of the sexual choices they are making and inform them as to the potential consequences of these choices. Accurate data on the sexual behaviour of unmarried girls is very hard to gather for concerns of confidentiality, and the general taboo against premarital sex, or at least talking about it. In studies of 500 adolescents in rural Maharashtra[30] significant gender differentials were found. Girls did not report premarital sexual activity whereas 10 percent of unmarried boys and 30 percent of married boys reported premarital sexual activity. Much of what does exist has been derived from hospital or clinic records of abortions for unmarried and rural girls.

Generally, research on sexuality with adolescents has tended to focus more on sexual acts and activity per se, rather than provide a conceptual framework for understanding the contexts and socio-psychological dynamics of these. This means that self-report questionnaires form the core of the research methodology because they are anonymous and 'safe'. The findings of these are usually followed up with qualitative methods such as focused group discussions or in-depth interviews. There are few intervention-based studies, or action research studies that might actually follow up baseline surveys with specific inputs such as further information or services or a supportive space.

In a study conducted in the city of Mumbai, Abraham surveyed the nature of heterosexual relationships in over 1000 youth in the urban context to find:[31]

- There are three types of heterosexual relationships amongst youth - 'brother-sister', 'time-pass', and 'true love'.
- The 'brother-sister' relationship is usually platonic but it is a fluid category that allows boys and girls to initiate friendships that have the potential to become 'true-love' relationships.
- 'Time-pass' is a transitory relationship characterised by sexual intimacy that could lead to sexual intercourse. These were more popular amongst older adolescent boys rather than their female peers.
- Girls tended to see their relationships in terms of 'true-love' whereas boys see it as 'time-pass'. In other words, boys' perceptions are more likely to be directed towards casual sexual behaviour where as girls focus on the emotional involvement.

The working paper of MAMTA, a NGO, on 'Sexual Behaviour Among Adolescents and Young People in India' suggests that there is a rising incidence of premarital sex (up to 28 percent) among male and female teenagers in India.[32] Yet the document states that many of these teenagers are not aware of their own sexuality or the risks they are taking. In recent workshops conducted by the organisation at an affluent New Delhi school, 16 year olds

[30] Mutatkar and Apte, 1999.
[31] 2001.
[32] 2002.

displayed knowledge of sexual terms and positions as well as of books, movies and magazines of a sexual nature, but had little idea how girls got pregnant or how to protect themselves from sexually transmitted diseases.[33] Hugging, kissing and petting are prevalent among adolescents even if they are not engaging in sexual intercourse.

The study also revealed that 60-70 percent of girls felt that a girl would lose respect if she engaged in a pre-marital sexual relationship whereas it would have no impact on boys.[34] Marriage is the only perceived option for girls, and their sexual role within this is to satisfy their husbands so as to keep them from straying. Young men are also under pressure to perform and prove their virility. Although adolescent attitudes and lifestyles are changing, especially within the large cities, most adolescent girls still have little decision-making power about or within their marriage. Their low status within society and the family, along with their lack of access to information and services, renders them even more powerless when it comes to choices to do with their sexual life and their reproductive freedom.

The emphasis on the procreative role of relationships within the Indian family and the immense taboo on homosexuality within society means that very little information exists about homosexual and lesbian behaviour. In some cases homosexual encounters during adolescence could be part of experimentation or learning about sex. However, the lack of recognition within society and the tremendous pressure to be heterosexual and eventually married often result in adolescents suppressing their sexuality and eventually marrying but continuing to have same sex extra-marital relationships.

Pregnancy and Fertility

Early pregnancy in India, almost all of which takes place within marriage, is the major cause of poor reproductive health among female adolescents. Girls under 18 are 2-5 times more likely to die during pregnancy or childbirth. Adolescent pregnant mothers, who are often already poorly nourished before becoming pregnant, run a high obstetric risk for premature delivery, giving birth to a low birth weight baby, prolonged and obstructed labour, and severe intrapartum and postpartum haemorrhage.[35] [36]

The NFHS-2 (National Family Health Survey) showed that over one third of married girls aged between 15 and 19 had given birth to their first child and another one-tenth to their second child.[37], Although the national average age of women at the birth of their first child was found to be 19.2 years, there are many regions and states in India such as in Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar, Maharashtra, Karnataka and Andhra Pradesh where the age of the mother is below the national average at the time of birth of her first child.[38]

Post-ICPD there has been more focus on men's roles in women's reproductive health care. Adolescents however have been largely overlooked. In a study of young couples in rural Maharashtra a census of 1866 married women in 22 villages was conducted and 972 of their young husbands were followed up. The mean age at marriage for men was 23 years and 16 years for women. These young couples face enormous pressure from the joint family and peers to bear children soon after marriage. Consequently, childbearing occurs early and 86 percent of the women have at least one pregnancy by the age of 22 years. Some findings from this study:

- Young women have limited mobility and depend on husbands or other family members to take them to a

[33] Majid (n.d.).
[34] MAMTA, 2002: pg.7.
[35] Jejeebhoy, 2000a.
[36] Verma and Das, 1997.
[37] NFHS provides a comprehensive portrait of population and health conditions in India. The NFHS-2 surveyed more than 90,000 women in 1998 and 1999. The first NFHS was conducted in 1992-93 and proved to be a major landmark in the development of a comprehensive demographic and health database for India. The second NFHS further expands the database, providing information on trends over time and meeting emerging needs of population and health.
[38] Foundation for Research in Health Systems and International Centre for Research on Women, 2001.

health centre. Husbands do not take the time to accompany their wives unless they perceive it as absolutely necessary. However, given the high value placed on proving fertility early in the marriage, prenatal care is sought relatively promptly especially for the first child.

- Fewer husbands accompany their wives for routine care; husbands are more likely to be present for problem situations.
- Belief that maternity is a 'women's issue' is one of the contributing factors to this.

Abortion

Another risk to the reproductive health of female adolescents comes from induced abortions. Unsafe abortion is a leading cause of death among women in South Asia. The region accounts for one-third of the world's unsafe abortions and the largest annual number of abortion-related deaths worldwide. An estimated 29,000 women die every year in the region from unsafe abortion.[39] This translates into approximately three deaths per hour.

An estimated six million induced abortions are performed in India a year, and anecdotal evidence suggests that a fairly large proportion of them are performed for adolescent mothers and unmarried teenage girls. While data is limited, the enormity of the problem may be judged by the fact that 8-10 percent of those who seek medical terminations of pregnancy are teenage mothers and unmarried girls. The real percentage may be far larger. While induced abortion was legalised in India under the Medical Termination of Pregnancy (MTP) Act, a major proportion (approximately 80 percent) of all induced abortions are still performed illegally by private and untrained persons in unhygienic conditions.[40] Induced abortions account for more than 11 percent of maternal deaths and significantly influence women's reproductive health.[41] [42] [43]

In India, up to half of all maternal deaths among adolescents aged 15-19 is reportedly due to unsafe abortion. Adolescents are generally more exposed to the danger of unsafe abortion than older women because of their relatively greater lack of information about and access to health services, and higher risk of unplanned pregnancy, particularly among married adolescents.

Community based research has revealed that girls are often forced to resort to unsafe abortions performed by untrained people in unhygienic conditions simply because of a lack of appropriate, accessible and affordable facilities.[44] The social stigma attached to premarital sex also means that girls who are unmarried and afraid that services may not be confidential would seek backstreet practitioners to perform the procedure. In a study conducted in the North Indian city of Rohtak,[45] 83 adolescent girls in the 10-19 years age group who visited five unrecognised abortion clinics and nine recognised ones were interviewed. It was found that unqualified personnel carried out 56 percent of the abortions in unrecognised centres. Confidentiality and the cost of the procedure were considered more important factors than the safety of the procedure. This points to the need for empathetic doctors and paramedical staff at all centres providing abortion services. Youth-friendly sexual and reproductive health services are thus essential in such a context. And it goes without saying that young women face untold risks in having abortions performed by unqualified personnel.

The high demand for abortions indicates a disturbing level of unwanted pregnancies among adolescents and NFHS-2 revealed that only 8 percent of married adolescents were currently using a method of contraception to avoid pregnancy. The NFHS data showed that 86 percent of adolescents had never used contraceptives and only 7 percent

[39] Center for Reproductive Rights, 2004.
[40] Chhabra and Nuna, 1997.
[41] Registrar General, India, 1993.
[42] Jejeebhoy, 2000b.
[43] Gupta, 2003.
[44] Mamdani, 1999.
[45] Trikha, 2001.

used contraceptives before having any children. The use of contraceptives was lower in rural areas than urban areas, at 7.7 percent and 9.9 percent respectively. Also, 27.1 percent of married adolescents stated an unmet need for family planning services in order to be able to space out the births of their children. A study conducted in rural Uttar Pradesh[46] underscores that the restriction of family size and the need for spacing between children are two of the main reasons for abortion. Obviously, the availability of contraceptives is limited, as is their usage and negotiation.

One reason for low use of contraceptives is that the Government of India's family planning programme has been focused on population control and has targeted older women to encourage permanent methods of contraception. Barrier methods that can be controlled by women and girls have not been widely available, and condoms have yet to be properly utilised by young men. These methods would be more appropriate for younger women who aim to continue having children but wish to space them out.

Reproductive Tract Infections (RTIs)

The extent to which young women experience reproductive tract infections is unknown but often underestimated. Most information on RTIs in general is from hospital or clinic based studies rather than community based studies and indicates that treatment seeking is low. Very few studies focus on adolescents or young women despite indications that young women may be even less likely than older women to seek care due to their low status in the household, less knowledge about available services, and greater reluctance to discuss symptoms with those involved in the decision to seek care.[47] Results from a baseline study conducted by the International Centre for Research on Women and CMC Hospital Vellore in South India with 616 young married women on RTIs found that:[48]

- **87% identified at least one symptom that could indicate the presence of RTI. Nearly 40% correctly identified three or more RTI symptoms. The most commonly identified symptom was vaginal discharge followed by painful urination and genital itch.**
- **In this sample nearly 24% reported that they currently experienced a symptom suggestive of an RTI with 8% reporting multiple symptoms. Another 19% had experienced an RTI symptom in the last year with vaginal discharge being the most common.**
- **In most cases women sought treatment for symptoms experienced in the last year (75%) than for symptoms they currently experienced (57%).**

This study finds that young women are more likely to seek treatment for symptoms that are seen as 'abnormal' such as genital ulcers. The patterns of treatment seeking for symptoms in the last year rather than current symptoms reflect a delay in assessing if the current symptoms require treatment, or in convincing family decision makers of that need, or in accessing services. Sometimes young women are reluctant to seek treatment unless the symptoms persist over time.

[46] Social and Rural Research Institute, 1999.
[47] International Centre for Research on Women and CMC Vellore, 2003.
[48] Ibid.
[49] NACO and UNAIDS, 2004.

Sexually Transmitted Diseases including HIV/AIDS

The lack of access to information on health and sexuality, and existing rates of sexual activity, implies that most young people are very susceptible to STDs and HIV/AIDS.

According to the National AIDS Control Organization (NACO), the number of Indians living with HIV increased by 500,000 in 2003 to 5.1 million.[49] HIV/AIDS primarily affects the socially and economically productive age group of 15-24 years with 34 percent of infections occurring in this age group. Within this group, young women and adolescent girls are being increasingly infected due to their vulnerable social and economic status within society.[50] Studies reveal that most women still lack basic information about HIV/AIDS.

Behaviour Sentinel Survey (BSS) figures for 2001 indicate that 15-24 year olds in India have information about HIV/AIDS but this has not resulted in the adoption of safer sexual behaviour.

Parameters	Urban	Rural	Male	Female	Total
Know at least two modes of HIV/AIDS transmission correctly	90.6%	76.2%	88.7%	78.1%	83.4%
Know two correct modes of prevention	59.4%	50.1%	58.6%	51.0%	54.8%
Know STI patients have a higher risk of HIV infection	21.8%	17.4%	21%	18.2%	19.6%
Heard of condoms	88.4%	77.0%	90.2%	75.2%	82.7%
Reported casual sex in a year's recall	6.6%	7.2%	11.8%	2.0%	7.0%
Reported using a condom in last casual sex episode	60.8%	43.9%	52.6%	48.8%	52.0%
Self-reported STI prevalence	3.2%	4.1%	2.72%	4.6%	3.6%
Know there is no cure	57.5%	58.4%	57.9%	58%	57.9%
Willing to share food with infected persons	46%	34.5%	41.1%	40.3%	40.7%

The spread of HIV/AIDS in India is an important health issue for young people but it also, crucially, exposes the unequal power relations between men and women. Young men engaging in unprotected sex with multiple partners, including sex workers, put women at risk since they do not have the power to say no to unwanted sex. Young women are also vulnerable to sexual abuse and rape by older family members. Approximately 25 percent survivors of rape are estimated to be young adolescent women below the age of sixteen.[51] Marriage does not improve the situation. Young women, married off during their adolescence have little decision-making power or ability to negotiate regarding their sexual or reproductive selves. There is no concept of marital rape in India and cultural norms support the notion that a wife cannot refuse to have sex with her husband. Men who are not monogamous within their marriage run the risk of infecting their wives who are certainly unable to insist on condom usage to protect themselves.

[50] United Nations, 2001: pg.8.
[51] Mamdani: pg.18.

The vulnerability of adolescents to HIV/AIDS is also exacerbated by the denial of access to information as mentioned in an earlier section of this paper. In addition, NACO states in its guidelines, that minors who want to be tested for HIV, should first obtain consent from their parents. The fact that minors might be dissuaded from taking the test if it is conditional upon their parents' knowledge does not seem to have an impact upon policies. This reflects the prevailing belief that adolescents are not sexually active and therefore do not require information on issues of safe sex let alone confidential or anonymous HIV testing.

Violence and Coercion

(This section is adapted from Jeejebhoy and Bott's *Non-consensual sexual experiences of young people: A review of the evidence from developing countries.*)

Sexual coercion has been defined in various ways, such as the:

> "…act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against her/his will…a wide range of behaviours from violent forcible rape to more contested areas that require young women to marry and sexually service men not of their choosing. The touchstone of coercion is an individual woman's lack of choice to pursue other options without severe social and physical consequence."[52]

The socio-cultural context in India enforces heterosexuality and marriage on young people, thereby almost endorsing sexual coercion and violence within relationships. Although there is increasing evidence of risky consensual sex among young people in developing countries, non-consensual sexual experiences among them have rarely been studied and few interventions have been designed to protect them from the risks of such experiences. However, what is available suggests that coercion and uninvited sexual advances may play a considerable role in the sexual relations of young people - girls and young women as well as boys and young men. The implications of non-consensual sexual experiences for young people's rights, their health and development, and the risks they pose in the transition to adulthood are enormous.

The consequences of sexual coercion are formidable: they are short and long term; and have physical, psychological and social effects. Sexual health manifestations range from unintended pregnancy, abortion and infection to risk taking behaviours, including early onset of consensual sex, multiple partner relations and non-use of condoms. Academic performance can also be affected. Psychological outcomes of sexual coercion could range from symptoms of anxiety and depression to suicide attempts.

A number of obstacles inhibit adolescents from protecting themselves from non-consensual sexual relations and from taking action against a perpetrator or to withdraw from a coercive relationship. Gender double standards and expectations of women and men in the sexual arena dominate these obstacles. Communication and negotiation on sexual matters tend to be difficult. The lack of a supportive environment and trusted adults and peers to consult on sexual health matters may also enhance young people's (and particularly young women's) vulnerability to coercive sexual relations. And finally, institutional indifference - at the community, school, law enforcement and health sector levels - can inhibit help seeking.

[52] Heise, Moore and Toubia, 1995.

A small body of research has begun to look at the circumstances surrounding the sexual experiences within marriage of girls who marry as young adolescents. Some of these studies highlight the extent to which marital sexual initiation is often characterised by force, fear and pain. For example, several studies from India, some reporting the retrospective experiences of adult women, reveal that early marital sexual experiences were typically traumatic, distasteful and painful, and often involved the use of physical force.[53] Excerpts from narratives of women from a study in a low-income urban setting in Delhi and among abortion-seekers in rural Uttar Pradesh support this evidence.

One respondent described her sister's wedding night thus:
"…she did not want to celebrate [the] first night but her husband was annoyed... he didn't agree and did it forcefully. She was having a lot of pain so her bhabhi [sister-in-law] took her to the dispensary the next morning."[54] (18 year old girl)

Recounting her first sexual experience with her husband at age 13, one woman said:
"It was a terrifying experience; when I tried to resist, he pinned my arms above my head. It must have been so painful and suffocating that I fainted."[55] (32 year old woman)

The narratives of young males in these settings corroborate this sense of entitlement:
"At night, I asked her to take off her clothes. She refused. When I asked her two-three times, she started crying. I made her keep quiet, and after that I took her clothes off and did my work."[56] (19 year old painter)

Older women in this setting told girls to accept this situation as normal. According to one girl, they were told, "if you won't give him [sex] then he would force [it] and you will have pain."[57]

As many as 77 per cent of street boys in a study by Murthi and Karrott (2003) reported pleasure from "raping a girl"; and some 44 per cent mentioned forcing sex on drunk women sleeping on the street as pleasurable - indeed, raping a girl ranked second only to engaging in consensual relations with a girl as a pleasurable sexual activity.[58]

A few qualitative studies have investigated forced sexual relations among young males. In-depth interviews in a low-income setting in Delhi revealed instances where older boys forced 12 and 13 year old boys to have anal sex.[59]

For example:
"… older boys used to ask me for [anal sex]... At that time, we used to feel very bad, but after some time, we also started asking boys our age for anal sex." (16 year old male)
"... when we were young, we used to have anal sex with large numbers of boys... We all together used to go to the latrines. Whosoever we would see there, we used to snatch his container and f— him. We couldn't put it inside but used to touch it on the skin only." (19 year old married male)

Young males are both victims and perpetrators of sexual coercion. A study of street boys in Bangalore reveals that large proportions of boys were initiated into sex at an early age, between 10 and 12 years, and most of these relationships were likely to have been non-consensual.[60]

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[53] George and Jaswal, 1995 for Mumbai; Khan, Barge and Phillip, 1996 for Uttar Pradesh; Sodhi and Verma, 2003 for New Delhi.
[54] Sodhi and Verma, 2003.
[55] Khan, Barge, and Philip, 1996.
[56] Sodhi and Verma, 2003.
[57] Ibid.
[58] Murthy and Karott, 2003.
[59] Sodhi and Verma, 2003.
[60] Ramakrishna, Karott and Murthy, 2003.

Case studies of unmarried adolescent abortion-seekers in rural Maharashtra reveal that of the 12 who reported that pregnancy had resulted from non-consensual sex, four named a family member as the perpetrator.[61]

Young people, especially girls and young women, perceive that their parents, families and communities are, by and large, neither supportive nor non-judgmental with regard to their sexual experiences - whether consensual or non-consensual. These perceptions can clearly deprive young people of the supportive environment necessary to navigate healthy and wanted sexual outcomes. Evidence indicates that sexual violence and harassment are common events even in settings in which parents strictly limit girls' interaction with the opposite sex.[62]

In fact, anecdotal evidence suggests that the taboo against intermingling of the sexes and the resulting perceptions of an unsupportive environment may actually compound risk factors. For example, boys and men in these settings have been observed to use the threat of ruining a girl's reputation as a way to pressure a girl to have sex or keep quiet about an incident of abuse or harassment.[63] In most settings, but particularly those in which gender double standards are widely prevalent, while parents strictly limit the autonomy and mobility of their daughters, yet they often tolerate and excuse abusive or sexually active behaviour of boys and young men, reinforcing in them a sense of entitlement to sex, and a recognition that they will suffer few consequences of harassment or abuse of young women.

At the same time, the taboo against discussing sexual issues between adolescents and parents makes it unlikely that a girl will turn to her parents for help if she feels threatened or needs help in resolving ongoing harassment or abuse. Young girls refrain from discussing sexual matters and issues of coercion with their parents because they perceive that their parents will be unsupportive or will accuse them of having incited the coercive incident.

The Case of Young Men

"*A real man should be able to produce children and particularly male children.*" - Young man in Mumbai.

Programmes and research on adolescent sexual and reproductive rights have tended to focus on young women rather than young men. Women's lower status in the family, their poorer levels of health, nutrition, and lack of education visit numerous risks upon them. Early marriage and early childbearing, precarious pregnancies and childbirth, unsafe abortions, the greater risks for RTIs/ STDs/ HIV/ AIDS, and limited access to information and health care have made girls and women the focus of attention. Much of this, however, has painted the male partner as a shadowy figure, difficult to access and whose power and social privilege exposes women and girls to health risks. The sexual and reproductive health and needs of men and boys have not been widely discussed in research or policy. However, this is changing, thanks in large part to the ICPD that expressly recognised the importance of drawing men and boys into the discussion on sexuality and reproductive health. Men's role in ensuring better health and survival of women, girls, and the whole family has previously been underscored.

The reproductive and sexual health of young men is important, and an engagement with their experiences of gender and sexuality are essential because:

- In a patriarchal country like India, it is assumed that young men will one day be the leaders and decision makers within the family, community, and society. This is partly due to the socio-cultural restraints put on women that restrict their mobility and access to resources. Working with men means that the effects will be felt by men themselves, and much more widely.

[61] Ganatra and Hirve, 2002.
[62] see, for example, Mehra, Savithri and Coutinho, 2002a.
[63] see Sodhi and Verma, 2003.

- The power accorded to young men accords them more control over sex than young women. Educating or working with female partners alone will be ineffective and expose women to coercion and violence, and infections like STDs and HIV/AIDS.
- Men's violence, whether real or threatened, has a powerful effect on controlling women and the choices they make in their lives, including their sexual lives.
- Young men are raised with as many expectations as women are. Cultural ideals of masculinity - to be providers, to take risks, to be virile and constantly sexually ready - can be a burden for some men. Not only does this lead them to act in ways that might be harmful to themselves, but these ideals can also be frustrating and burdensome.

It is perhaps in the last decade and within research on HIV/AIDS that male sexuality has been more extensively researched in India. But this research has typically tended to be either baseline surveys of boys' information and awareness levels, or in the context of male-to-male sexual activity, or with truckers who are believed to exhibit 'high risk behaviour' for HIV infection.

Such research tends to focus on a counting exercise of specific sexual activities and situations that are considered to be high risk, and on the rate of STDs and HIV/AIDS. Some research has looked at the gender and sexual constructs amongst indigenous male sexual sub-groups and communities such as Kothis and Hijras in India.[64] This research is exploratory work that tries to establish the diversity of Indian masculinities and sexual behaviour. However, this research does not focus on the socio-psychological development within adolescence; males are seen in terms of gender/sexual experience in a rather narrow sense rather than in the holistic terms of their adolescence.

A recent study by the Population Council and the Committee for Resource Organization (CORO)[65] gives rich insights into the social construction of gender identity in young men aged 16-24 years and its impact on risky sexual behaviour. This study was linked to the ongoing community based activities on literacy and livelihoods in a large Mumbai slum.

- Masculinity is the closest term in English for the Hindi/Urdu words 'Mardangi' and 'Purushtva'. A real man or 'asli mard' is dominant, aggressive, sexually powerful and potent and controls women. Good physical looks, a muscular body and substantial penis size are seen as crucial physical attributes of an 'asli mard'.
- A man who displays feminine characteristics is 'namard' (non-masculine) and this implies an inability to produce a male child or to fight back when provoked.
- Real women or 'asli aurat' are submissive both sexually and otherwise and take care of the home, children and rest of the family.
- Real men should be able to prove their manliness. Such proof amounts to behaviours that are risky, highly gender insensitive, and comprise of physical and verbal aggression. Violence was mentioned as domestic violence, gang fighting, use of weapons and self-inflicted harm, the latter as an expression of frustration in individual life.
- Anxieties about sexual health included concerns about early ejaculation, penis size, and semen quality.
- Masturbation and semen loss emerged as major causes for worry leading to sexual weakness and other sexual problems. These are all thought to have a significant impact on their masculinity and the quality of sexual relationships.
- Sex with sex workers is justified as proof of sexual vigour and health.
- Coercive sexual behaviour and sexual control are seen as expressions of mardangi. Such activities are used to demonstrate sexual power usually with no intention of engaging in a love affair or relationship

[64] Naz Foundation International, 2001.
[65] 2004.

and are primarily aimed at women and feminine men. These include verbal comments, whistling, touching, jostling and harassing in public areas as well as sexual acts such as forced kissing and forced intercourse. However, there is a distinction made between girls who 'deserve' teasing and coercion, and those who are 'good girls' or who are suitable for marriage.

- While most young men ridiculed homosexual men, some narrated their own homosexual experience, which often constituted their sexual debut. They perceived their homosexual behaviour as an expression of masculinity because they penetrated the other rather than receiving penetration.
- Sources of information about sexuality included peers, sexually explicit materials, and 'khillazadi', which is learning about sex by watching/peering at others having sex and narrating sexual acts to friends afterwards.
- Knowledge of HIV/AIDS was built on information from books and publications, the media, community programmes, doctors, and the corporation-run sex education in Class 9. In the perceptions of young men, women, sex workers, and those with multiple partners were seen as the main transmitters of the virus. Respondents talked about using condoms with sex workers but they were never mentioned in male-to-male sex, and were not seen as appropriate for use with a girlfriend unless the girl was thought to be promiscuous.

Such research is a useful starting point both for programmatic interventions at the community level, as well as policy directives on HIV/AIDS and risky sexual behaviour in adolescents. Moreover, it gives an important insight into the construction of health and sexuality in young men.

Assessing Adolescents' Access to Sexual and Reproductive Rights in India

A multiplicity of definitions around the words 'youth' and 'adolescence' has significant implications in terms of programming and interventions for this segment of the population. There are policies, drafts, and five-year plan documents that acknowledge that their health needs are unique and significant. They include mention of vital issues such as specific health care and education services for adolescents. For example, policy makers focus on adolescent reproductive health care needs, yet they do not specify the mechanisms or earmark funds or processes to ensure these.

A sectoral approach has been common so that population programmes may focus on married adolescents in terms of providing contraception but broad-based programmes focusing specifically on adolescent needs outside of the family planning framework have been conspicuous by their absence. Indeed, "while national strategies and programmes have focused on children and pregnant women, neither services nor research has focused on adolescents and their unique health and information needs."[66] Sexual health concerns of adolescents are given even less attention within the socio-cultural context of societies that stigmatise sex outside of marriage and treat the issue as taboo even for those who have tied the proverbial knot.

Below is a review of intentions enshrined in relevant policy documents:

- **The Tenth Five Year Plan** includes provisions that address certain aspects of adolescents' reproductive health. The Tenth Five Year Plan specifically recognises that the process of empowering women necessitates a "life cycle approach" and that "every stage of women's lives counts as a priority in the planning process." One of the plan's main objectives is to eliminate discrimination and all forms of violence against women and the girl child, recognising the increasing violence against these groups and the persistent discrimination against the girl child are critical areas of concern requiring government action.

- **The National Population Policy (NPP)** acknowledges that the needs of adolescents have not been specifically addressed in previous policies. It calls for programmes to encourage delayed marriage and childbearing and to educate adolescents about the risks of unprotected sex. It highlights the needs of adolescents in rural areas where early marriage and pregnancy are widespread and calls for information, counselling, education on population, affordable contraceptive services, food supplements, and nutritional services. It also advocates for the enforcement of the Child Marriage Restraint Act. The action plan of the NPP includes the creation of a health package for adolescents. It asserts the need for community outreach to adolescents about the availability of safe abortion services and the dangers of unsafe abortions. This policy also outlines the need for separate strategies, which account for the differing needs of boys and girls especially in rural areas.

- **The National Youth Policy 2003** takes a broad look at youth in terms of their overall emotional, physical and psycho-social development, and their potential as citizens of the country. It does not, however, specifically address the wide range of reproductive and sexual health issues and situations that adolescents experience. It recognises adolescence as a time of upheaval, and that necessitates the understanding and support of adults, but does not regard adolescents as sexual and reproductive beings in a complete sense.

[66] Jeejebhoy, 2000a.

The National Youth Policy provides a detailed description of how it envisages gender justice for youth. Section 5.2 states

> "The Policy recognises the prevailing gender bias to be the main factor responsible for the poor status of health and economic well-being of women in our society and that any discrimination on grounds of sex violates the basic rights of the individual concerned and it, therefore, stands for the elimination of gender discrimination in every sphere. The Policy enunciates that:
>
> (a) Every girl child and young woman will have access to education and would also be a primary target of efforts to spread literacy.
> (b) Women will have access to adequate health services (including reproductive health programmes) and will have full say in defining the size of the family.
> (c) Domestic violence will be viewed not only as violation of women's freedom but also as that of their human rights.
> (d) All necessary steps should be taken for women's access to decision-making processes, to professional positions and to productive resources and economic opportunities.
> (e) Young men, particularly the male adolescents shall be properly oriented, through education and counselling to respect the status and rights of women.

The Policy further goes on to say in section 5.2.1 that

> (a) Action would be pursued to eliminate all forms of discrimination in respect of the girl child, negative cultural attitudes and practices against women, discrimination against women in education, skill development and training, and the socio-economic exploitation of women, particularly young women.
> (b) Concerted efforts will be made to promote a family value system that nurtures a closer bond between men and women, and ensures equality, mutual respect and sharing of responsibility between the sexes.

While in spirit this policy has all the right intentions, there is no mention of how various state programmes, functionaries, and partners might work together to bring the benefits of gender justice to young people. These seem to be lofty ideals rather than actionable points.

What is usually problematic with a notion of gender and sexual rights is that their reach often does not extend into the home. In a rights based approach, the responsibility to fulfil rights lies with the State. But the power of the State does not cross the threshold of the household. As a result, gender and sexuality are issues that confound the discourse on rights. Thus it is not easy to influence the power dynamics that operate in families and in intimate relationships. This does not mean that the State can be absolved of its responsibilities to respect, protect and fulfil the rights of all people. There has to be clear indication from the State of the recourse to justice in the case of discrimination based on gender or sex. It also has to ensure that the organisations working on the rights of young people adhere to the basic tenets of the policies and frameworks laid out by them.

The Impact of International Law and Policy in India

India has ratified certain key international documents, which are relevant to this discussion, including the ICPD Programme of Action and the CRC, as well as the Declaration arising out of the Fourth World Conference on Women, 1995. These international commitments have necessitated changes in policies on adolescent reproductive and sexual health and have affected programme interventions not only by the State but also by NGOs.

The ICPD resulted in the consensus definition that marked the global recognition of reproductive health needs. It postulated the need for affirmative action towards ensuring that women's health needs in particular, which had long been neglected, were better met. The ICPD also marked a shift from traditional population programmes, which aimed at reducing population through fertility control and provision of family planning services, to a more holistic approach and a broader definition of reproductive health.

India's commitment to the reproductive health approach put forward at the ICPD has resulted in a welcome shift in policy towards adolescents. Until then, the reproductive health needs of adolescents were subsumed within programmes dealing with population control, family planning services and child health services, catering to the well being of children and women. The primary aim of the Government of India in this regard over the last fifty years has been to reduce infant mortality, and ensure population control and safe motherhood. The minimal attention given to adolescents did not reflect the considerable size of the country's adolescent population or any recognition of the specific challenges facing them. However, after the ICPD, the family welfare programme has been reshaped into a broad-based Reproductive and Child Health (RCH) Services Programme. This programme is supposed to explicitly recognise that the adolescent population group has specific health and developmental needs.

Reflections on the State of Policy on Adolescent Sexual and Reproductive Health and Rights

Despite ambitious planning to ensure a coordinated public policy effort through a nodal agency (Ministry of Youth and Sports Affairs) and the framing of various policy documents, which ostensibly aim to provide adequate services and to ensure improvement in the reproductive and sexual health status of adolescents, problems still remain.

1. Explicit references have been made to adolescents being a 'vulnerable group' but this has not been extended to address vulnerability regarding reproductive and sexual health needs. The Reproductive and Child Health Programme of India, post ICPD, committed itself to a holistic programme addressing the needs of all age groups. This was the life cycle approach within which adolescents' reproductive and sexual health needs would be addressed within the scope of the programme. However, as Ramchandran mentions, the concept of sexuality is conspicuous by its absence.[67] Instead the RCH programme introduces 'family life education' (instead of the earlier population education) for adolescents. This translates into education for the future mother. The focus, therefore, remains on reproduction, conception, menstrual, and genital hygiene.
2. Since the government does not officially recognise adolescent sexuality and its attendant issues, problems such as sexual abuse of young people, child prostitution and sexual violence are brushed under the carpet or seen as aberrations. Teenage pregnancies and other critical needs of unmarried girls are also ignored.
3. The denial of the fact that adolescents are increasingly sexually active outside of marriage hinders any attempts to include youth as an active partner in formulating programmes, policies and services that

[67] 1999.

would address their needs. Sexual pleasure is ignored and a disease control model that focuses on motherhood persists. There is also an emphasis placed on heteronormative behaviour, which in turn invisibilises behaviours that do not fit into this norm. This ostrich-like attitude also hampers the opportunity to build knowledge and awareness and change attitudes through sexuality education.

4. On the issue of young men, the policy merely states that they need to be properly oriented towards the rights and status of women, rather than seeing them in need of health and education for their own situations.
5. The 2003 National Youth Policy presents a limited articulation of youth health and SRH. Youth sexuality is discussed only in reference to HIV/AIDS, STDs and reproduction. The Policy demonstrates the GOI's lack of trust in young people's abilities to make healthy decisions, referring to them as "highly impressionable and, therefore, prone to high-risk behaviour".[68]
6. The National AIDS Control Policy has not considered adolescents as a particularly vulnerable group, and not recognised the different vulnerabilities of migrant youth, school dropouts, and sex workers within this.
7. The Ministry of Youth Affairs and Sports has failed to spearhead public policy implementation through coordinating agencies such as the Department of Women and Child Development and the Ministry of Health. With various ministries (health, education, youth affairs, and women and child development) working on disparate approaches and States implementing conflicting policies, empowerment of the adolescent through holistic and participatory programming sometimes seems little more than a worthy illusion.

Civil Society Interventions

The ICPD document states that government and civil society organisations should work in collaboration and partnership with each other towards a better and healthier life for adolescents. "Governments in collaboration with non-governmental organisations are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs."[69]

In recent years, NGOs have been attempting to implement programmes that are reflective of needs of adolescents as identified by them. Two distinct models of implementation exist; one focusing on unmarried adolescents and the provision of information on puberty/reproductive and sexual health and the other consisting of information and awareness programmes on general health and linked to literacy and skills training programmes.

In a rural context, Mamdani points out that programmes aiming to provide information on sexuality for adolescents use community health workers at the grassroots level to build confidence and interact with young people. The women's group meetings (mahila mandals) are used to discuss issues and provide an effective way to draw the adolescent girls out of the house. Most programmes address adolescent girls but there are a few that reach out to boys as well. However, one crucial limitation of these initiatives is that "family life education projects have generally ignored sexuality and gender relations, promoting instead norms of responsible parenthood within marriage and abstinence outside it".[70] Thus these programmes fail to address or challenge existing gender inequities, and prevailing attitudes about sexuality. However, as Mamdani points out, these programmes are at a nascent stage and function within the context of powerful social and cultural taboos. Thus "their very ability to provide adolescents with information on sexuality and reproductive health, however basic, should be viewed as an achievement."[71]

A great deal more research is needed on civil society interventions, their scope and their impact. However, certain critical aspects should be noted for the design of future interventions:

[68] Paragraph 8.4.11.
[69] United Nations, 1995. Paragraph 7.47.
[70] Mamdani, 1999: pg.23.
[71] Ibid.

- Programmes need to be aware that adolescents are not a homogeneous group but a very diverse one with needs that differ according to age, region, socio-economic status and gender.
- The identification of various needs should be done using a participatory approach and must reflect the views of adolescents themselves.
- Programmes must promote consensual and respectful sexual behaviour in both boys and girls while advising them on health risks and consequences of unprotected sex.
- The differing needs of boys and girls should be addressed.
- Programmes should promote accurate and easily comprehensible information in order to enable adolescents to make informed decisions and choices.
- There has to be an acknowledgement of different sexual behaviours, thereby preventing the creation of a false hierarchy of heterosexuality over homosexuality in young people's minds.
- Programmes must provide information free from values, morality and judgement, thereby enabling young people to make choices based on their own decisions.
- Programmes must promote understanding of gender and sexual diversity and equality.

Conclusion

In a cultural milieu where parents and teachers cannot be relied upon to provide adequate information and support on reproductive health and sexuality, the State and community based organisations must step in to fill this gap. Yet, as we have seen, the Government of India policy on adolescents has until recently reflected a blinkered focus limited to addressing reproductive health concerns. The discomfort with the realities of adolescent sexual behaviour in India has sharply constrained India's ability to address the sexual and reproductive health needs of young people. Accurate information on sexuality is scarce, and health care of any kind is hard to come by for young people in India, who are seen as essentially healthy and not in need of services.

Factors contributing to this limited approach include:

- Lack of recognition of the specific needs of adolescents.
- Confusion over the critical age at which to build awareness on issues or provide information to the young.
- Discomfort of parents and elders in talking about reproductive and sexual health issues although they are considered to be important stakeholders in creating awareness among adolescents.
- Lack of acceptance of a framework of sexual rights, which could enable the conversations on issues of adolescent sexual and reproductive health to take place.
- No recognition of adolescents as young adults who require information and are capable of making decisions regarding their own bodies and sexuality.
- The linking of sexuality and sexual health only to disease control and reproductive behaviour.

In order to award adolescents the right to know how to lead healthy and fulfilling lives there are perhaps five key ingredients. These components serve to encompass adolescents' needs and truly move towards an achievement of sexual and reproductive rights:

- Information about sexual and reproductive processes and the interpersonal skills to implement and use this information.
- A family, peer, and community environment that supports such information and life skills.
- A supportive media and cultural environment that meets the information and education needs of adolescents.
- Recognition of adolescent needs in policy and in the design of programmatic interventions.
- Adolescent friendly health services where adolescents can access sexual and reproductive health care without the fear of judgment and in total confidentiality.

Recognising the sexual and reproductive realities of young people is not an easy journey for adult caregivers and caretakers in most societies. To wrench anything out of its accustomed course takes energy and effort. However, the effects of denial, as evident today in countries around the world, are more devastating than the difficulties of change. If we want adolescents in India to grow into adults that make informed decisions, we have to recognise and affirm their rights as young people. Before we can admonish the decisions that they make and decide what is best for them, we have to recognise their decision making capacity and make them part of the solution, rather than the problem.

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