CHAPTER - 1
INTRODUCTION

1.1 Introduction

The much neglected ‘adolescent’ is in the centre stage today. Adolescent ‘health and wellbeing’ is a buzz word in the health and development talks world around. Looking at it from the developmental perspective, adolescence mirror a promising future for any nation and at the same time is in increasing demand to meet their developmental needs. Thus one can name it as an age of opportunities and challenges. The positive youth development frame work that focuses equally on the strengths of the individual and the context or environment in which the individual operates offers a promising approach in comprehensive service delivery to the adolescents. The current project is one such attempt to operationalise the positive youth development frame work in the Indian context.

Adolescent population around the globe has reached 1.2 billion (UNICEF, 2011), the largest generation of adolescents in history (UNFPA, n.d). India is home to 20% of the total adolescent population in the world i.e. around 243 million. (UNICEF, 2010). Adolescents represent a tremendous source of positive energy, and have enormous potential to contribute to the betterment of their societies (Larson, Wilson, & Mortimer, 2002). The future of any society depends on their success in providing pathways, where by young people develop and prepare themselves to be contributing adults to their societies.
The term adolescent means ‘to emerge’ or ‘achieve identity’ (Planning commission, Government of India, 2001). Adolescence typically is defined as beginning at puberty, a physiological transformation that gives boys and girls adult bodies and alters how they are perceived and treated by others, as well as how they view themselves. Adolescence is also a time for first experiences of various kinds: being out of the direct control of parents and guardians, living away from home, first sexual experience, and the transition from the role of cared for to caregiver. In the process of taking these developmental steps towards independence, adolescents make decisions, and develop habits with lifelong implications for their health and well-being. (Kathleen, Aylin, Karen, Vonnie, Anne, & Michele, 2002).

1.2 Adolescents sidelined in the past

Adolescence is considered to be one of the healthiest life stages in an individual’s life when compared with the many other stages of life, in terms of the morbidity and mortality criterion. The ‘storm and stress’ of becoming a fully mature adult (Ingersoll, 1989) has been considered as the normal developmental task of adolescence. It is also noteworthy that even in the phase of severe stress and strain, majority of adolescents show high resilience and only a small number of them develop significant deviance or mental health problems. Family, as the primary agent of socialisation has the responsibility of guiding its adolescent members in their maturation process. In the family any small deviances were handled with much tolerance. Because of all these reasons the adolescent age group never received the needed attention in the human resource development agenda till recently.
1.3 Awakening in adolescent care

In the last two decades both empirical and practice fields showed ever increasing attention being paid to the adolescent age group. In the international and national arena, adolescent issues are getting due importance as far as policy discussions and programme planning are concerned. This is evident from the various UN conventions and conferences have been discussing adolescent issues in their main agenda recently. (Eg: Convention on the Rights of the Child (CRC) -1989, International Conference on Population and Development (ICPD) -1994 which stressed the reproductive and sexual health needs of all including the adolescents). In line with these developments, at the national level also, increasing attention is being paid to adolescent issues and various policies like National population policy (2000), National AIDS policy(2000), National youth policy (2003), and The National curriculum framework (2005) for school education etc have highlighted the need to address adolescent issues.

1.4 Necessity of investing on adolescents

There are certain reasons why this kind of shift in focus is happening world around, as far as adolescent issues are concerned. Most important in this, is the growing awareness about the need to view this period, as a critical developmental period for acquisition of health enhancing behaviours. In developed and, increasingly in developing countries, behaviour and mental health are becoming the most important factors in adolescents’ current and future wellbeing. There is an ever increasing thrust for preventive programmes especially in the field of mental health services for the adolescents.
The very essence of the rights perspective as described in the Convention on the Rights of the Child (CRC) entail adolescents all rights and opportunities for growth and development. Investing on adolescents has been described as the most effective way, to consolidate and maintain the global gains achieved through early childhood care since 1990 as proposed by UNICEF (2011). This is the last chance to rectify the developmental deficits of childhood (E. g. Nutritional deficit). So also this has been projected as the best way to accelerate the fight against poverty, inequity and gender discrimination (UNICEF, 2011). Having seen the socio political context of shift in adolescent care let us now examine in detail why the adolescent age group needs special attention.

1.5 Developmental demands of adolescence

Normative developmental tasks of adolescence itself demands additional inputs for the healthy maturation process in the changing socio economic scenario. The very fact that adolescence is characterised by many developmental changes (biological, psychological, cognitive &social)which are rapid and overwhelming for any individual, to cope with, differentiates this stage from all other life transitions.

In the biological development spear he/she has to learn to adjust with the changing body image that occurs, due to the rapid growth spurt and development of secondary sexual characteristics (Tanner, 1962). Gender differences in physiological changes, timing of maturation, simultaneous life changes, gender role expectations, and parental reactions create different challenges for girls than boys in early adolescence (Corina, & Laura, 2002). Physical maturation occurs at an early age in recent years (Mizrahi & Davis,
Early physical maturation has a positive effect on boys where as it will have a negative impact on girls (Simmons & Blyth, 1987). Similarly studies have shown that negative body image can lead to eating disorders. (Cash & Lavellee, 1997).

**Psychological development** during adolescence has been explained by 1) psychosexual theorists (eg; Freud) who explained the storm and stress of adolescents, as the manifestation of the conflict between the id and the ego, as the individual develop his or her own personal identity (Gold and Douvan, 1969). 2) Psychosocial theorists (Eg; Erikson) considered it to be the result of an “identity crisis” (i.e. developing own view of the self, of the world, and of his or her place in that world (Steinberg, 1989). 3) Social learning theorists describe adolescents as a period of development that for the majority of individuals, proceeds from childhood with great continuity in behaviour, interpersonal relationships and self evaluation (Garrod, Smulyan, Power and Kilkenny, 1992).

Adolescence has long been characterized as a time when individuals begin to explore and examine the psychological characteristics of the self in order to discover who they really are, and how they fit in the social world in which they live (Laurence, & Amanda, 2001).

**Cognitive development** during adolescence is a progression from concrete operational thinking to ‘formal operational thought’ process (Piaget, 1972) which is characterised by hypothetico deductive reasoning. Adolescents’ ‘egocentrism’ results in the creation of an ‘imaginary audience’ which explains their “feeling of self-consciousness” and they tend to view their own thoughts and feelings as unique. “Feeling of invulnerability” often
accompanies this and they tend to indulge in ‘risk taking behaviours’ (Elkind, 1967).

*Moral development* in adolescence has been explained by various theorists in different ways. Attainment of formal operational thinking, helps adolescents to recognise the difference in perspectives, and they ‘tend to question the rigid law and order morality’ of the adult world. Hoffman (1980) proposed the ‘development of empathy’ and its transformation during cognitive development as the basis for moral development.

The most important research findings in the *social development* realm includes, shift in the intimacy with persons of the same sex during preadolescence to the appearance of ‘lust dynamism’ when they reach middle adolescence, which later on get stabilised to form a picture of ones preferred sexual relationship when they reach late adolescence as proposed by Sullivan(Mizrahi & Davis, 2008). Attachment theorists (Bowlby, Anisworth etc) say that the relationship skills and competence learned from parents form the basis for the relationship with friends (Coleman, 1974). Researches have also shown that during middle adolescence, girls show more anxiety in friendship relations (Coleman, 1980).

Klaus, & Matthias (2006) proposed that the pressure exerted by the problems confronting youth can be directed outward, towards the social environment of the family, school, workplace, circle of friends, and the public (externalising variant). The pressure exerted by problems can also be directed inward to one’s psyche and body (internalising variant). In the social realm, this variant is expressed by withdrawal and isolation, a lack of interest in public events, and a lack of engagement; in terms of health it can manifest
itself in psychosomatic disorders and depressive moods, including suicide attempts. The handling of problems can take a third direction that is neither outward nor inward (evasive variant). This “getting out of the way” is expressed in the social realm by nonconformist types of behaviour and fickle, capricious social relationship patterns. In terms of health-related consequences, it often appears as addictive behaviour, such as the use of legal and illegal drugs, eating disorders, compulsive consumption, or gambling. Studies have shown that the prevalence of depression is higher in adolescent girls than boys, conduct disturbances are more common in adolescent boys than girls. (Corina, & Laura, 2002).

1.6 Present day challenges

The adolescent age group needs special attention not just because of the specific developmental challenges of that particular life stage but because of the fact, that they need to adjust, to the growing complexities of the present day society, in order to become productive and contributing members.

Adolescence –as a distinct stage of preparation for adulthood-is facing newer challenges world around. Larson et al (2002) describes these challenges as follows Expanding in the length of the adolescent time period in virtually all parts of the world, as a product of earlier puberty, later age of marriage, longer schooling, and more engagement in the peer world. The developmental demands placed on adolescents are increasing. Eg: The greater diversity and complexity of the adult world demands that youth develop more versatile interpersonal skills. The greater complexity of the occupational world require youth to develop more advanced job skills, including literacy, numeracy and information and computer skills.
Middle and upper class youth throughout the world are gaining access to newer resources to prepare themselves for adulthood, including more varied social experiences, longer education, access to health care, and use of information and communication technology, and other new technologies. Poor youth, especially those from poor nations are locked out of these opportunities.

Differences in opportunities persist for girls and boys. Even though more and more women are entering the paid work force, double standards and discriminations based on gender remains strong. In some parts of the world girls are denied equal rights, opportunities, freedom and access to education.

A great majority of teenagers experience close and functional relationship with their parents. Many adolescents are living in much diverse and fluid family situations of single –parent and divorced families. With the erosion in family structure, its function as the primary agent of socialization has been taken over by other institutions like school, community etc with dire consequences in the character formation of the younger generation.

Increasing peer relationships are an important part of the adolescent experience. This has the potential to improve their skills in cooperation and horizontal relationships. At the same time in the absence of positive adult influence, more youth may be exposed to negative peer dynamics and develop substance abuse and such harmful behaviour. The adolescent’s involvement in romantic relationships and non marital sexuality is increasing in many regions. Across settings, there is the dire need for adolescents to develop skills for the healthy management of these relationships. Infectious diseases (like HIV/AIDS), under nutrition and starvation continue to increase in poorer
countries. Violence is a frequent experience for adolescents in many parts of the world. Disadvantaged youth both in poor and affluent nations experience more dangerous neighbourhood, greater exposure to negative behaviour models and fewer life choices that may endanger their health and wellbeing.

Having analysed the reasons why the adolescent age group need special attention from the developmental and societal point of view, let us now have a look at the adolescents in the Indian context.

1.7 Adolescents in the Indian context

Even though the Indian adolescents are somewhat protected from such deviances seen across the world due to its relatively conservative family environment (Hackett & Hackett, 1993) they are still at risk. Rapid industrialisation, and globalisation, break up of joint families, increasing competition in the academic and career front, along with high illiteracy and unemployment and exposure of the youth to global mass media etc (Bharath & Kumar, 1999) are all putting newer challenges for the Indian adolescents. The population’s economic, social, cultural, and geographic disparities contribute to wide variations in nutritional and reproductive health, sexually transmitted disease infection, smoking behaviours, and problems related to mental and physical stress. (Mano, & Anura, 2004).

1.8 Situational analysis

Today in India we have about 243 million adolescents in the age group of 10-19 years, the largest ever cohort of young people to make a transition to adulthood. Adolescents demand special attention by this sheer number. (UNICEF, 2010). The situation being this, it is interesting to note that this age
group of 10-19 years is not considered as a distinct age group in the official statistics of India. Hence data sets that can facilitate planning and programming for adolescents in the age group of 10-19 years is lacking in the country. (Adolescents In India A profile, 2003 December).

India has the world's largest number of sexually abused children, with a child below 16 years raped every 155th minute, a child below 10 every 13th hour and one in every 10 children sexually abused at any point of time. [Ministry of Women and Child Development, Government of India (MWCD, GOI), 2007]. Crimes against adolescents take many shapes and forms, ranging from eve teasing and abduction to rape, incest, prostitution, battering, sexual harassment etc. The study on child abuse in India report says that 53.22% children reported having faced one or more forms of sexual abuse. 21.90% child respondents reported facing severe forms of sexual abuse and 50.76% other forms of sexual abuse. Out of the child respondents, 5.69% reported being sexually assaulted. 50% abuses are by persons known to the child or in a position of trust and responsibility. Most children did not report the matter to anyone.

Gender discrimination prevails across all sections of society; girls and women have less access to opportunities and resources and have an inferior status. The ratio of females to males, according to the 2001 Census is 933:1000 - a disturbing indicator of gender discrimination. Again teenage pregnancy, abuse of the girl child and sexual exploitation of young women are all expressions of this discrimination. (Bharath & Kumar, 1999). State of the Worlds’ Children a report published by UNICEF in 2011 states that 43% of women in India are married before the legal minimum age of 18. Female
mortality is significantly greater than male mortality as female adolescents begin to experience problems of early pregnancy, malnutrition and anaemia.

A study done at Tamilnadu, one of the southern states in India found that people recognise the importance of the girl child in the family. However, more than one girl in the family is often considered as an economic and social burden. This is because of the socio cultural practice of giving priority to marriage over education, once a girl attains puberty. This compromise on her education puts her at a disadvantaged position socially (Shanthi & Nalini, 2002).

In India, there is a considerable rise in the age of marriage due to rapid urbanisation, population growth, need for economic independence and career competition. The ultimate result of this is increase in premarital sexual activity, teenage pregnancy and sexually transmitted diseases. (Rajesh, Anupam, Agarwal, & Manmeet, 2000). Increasing penetration of the international mass media is changing social values and shifting the standard of societal behaviour from conservatism to liberal interactions between both sexes. Adolescents find themselves sandwiched between a glamorous western influence, which arouses their curiosity and instincts, and a stern conservatism at home, which strictly forbids discussion on sex. This dichotomy aggravates the confusion in adolescents (Saroj, Rajesh, Indrajit, & Arun, 2005).

General morbidity such as low Body Mass Index [BMI] and anaemia especially among girls are a major public health problem in India. (Joshi, Chauhan, Donde, Tryambake, Gaikwad, Bhadoria, 2006). There is an increase in obesity among affluent family adolescent children in India which predisposes them to many non-communicable diseases like hyper lipidaemia,
hypertension, coronary artery disease, atherosclerosis and osteoarthritis. (Singh, Pathak, & Kapil, 2003). This shows a mixed picture of the health status of adolescents in the rural and urban areas of India.

Adolescents, irrespective of their academic performance tend to aspire for white-collar jobs. Thus almost 90% of the adolescent population are therefore perceived as ‘unemployables’ instead of being an asset to the country. Adolescents are often led or driven into vocations and careers unrelated to their aptitude and suitability often under parental and societal pressure, especially with regard to traditional careers like engineering, medicine, teaching etc. It is paradoxical that on the one hand, there is growing unemployment and lack of awareness about career options and on the other hand, there are many new avenues and areas for employment (Planning Commission, GOI, 2001).

Changes in the family structure and relationship patterns have resulted in decreasing family ties producing dire consequence on behaviour and character formation of adolescents. Evidence of this is the increasing rate of substance abuse and crimes committed by youth. More and more youth are misdirected to deviant paths under the influence of peers. Adolescents in India are vulnerable and at risk of unwanted pregnancies due to ignorance and lack of access to contraceptives during early teens. Other reproductive health related problems such as STDS, HIV/AIDS and RTIs are also on the rise amongst adolescents in the age group 15-19 years. Trafficking of adolescents and use of illicit drugs are all on an increase among adolescents in recent years (Adolescents in India -A profile 2003 December).
1.9 Adolescents in Kerala

Kerala has been appreciated much for its achievements in life expectancy, literacy and health care. However the following reports give a dismal picture of Kerala in crime rate, suicide rate, violence against women, and in the incidence of noncommunicable diseases etc.

2005 Annual Report of the National Crime Records Bureau reported 386 cases of crimes against children, including 45 murder cases, 140 rape cases, 45 abduction cases, among others in Kerala during 2005. According to Kerala government's Police Department figures, as many as 361 children became victims of crime in the State in 2004. Of this, 102 children were murdered, 159 raped and 74 reported kidnapped or abducted. (Indian Human rights report, 2006). Gender based violence is reported to be above 30%. (Vijayan, 2007 November).

In Kerala the % of children facing severe forms of sexual abuse is 17.70 and the % of children facing one or more other forms of abuse is 44.80. Among adolescents, Mizoram (57.89%) and Kerala (54.29%) were the states where children reported high percentage of forcible kissing. It is important to note that the percentage of children in the 15-18 age group was constantly high in Kerala in all severe forms of sexual abuse and the same trend is seen even in the other forms of sexual abuse. Majority of children (31%) were subjected to sexual assault by their uncles or neighbours followed by 29% by friends and class fellows, 10% by their cousins and 9% by their employers. (72.1%) of children subjected to sexual assault kept quiet and did not report the matter to anyone. Among those who reported, the majority of children shared the incident with their parents followed by brother and sister (6.7%).
Only 3.4% children reported the matter to police. (Child Abuse Report, Ministry of women and child Development, GOI, 2007). In the state there is an all time increase in the rate of sexual exploitation of minors by the sex mafia as per news paper reports (Krishnakumar, 2002).

For the past decade, the state of Kerala in South India has had the highest suicide rate in India. (John, n. d). As per the reports of the Department of Health Government of Kerala (2000) the suicide rate is 31 per 100,000 population.

Kerala is facing newer health challenges like return of infectious diseases, increase in accidents and injuries, increasing geriatric population and their problems, high level of suicide, diseases due to environmental degradation, and newer diseases like Dengue, Chikungunia and HIV/AIDS. (National Rural Health Mission [NRHM] Kerala, January 2008-09).

During the first anniversary of the passing of the Protection of Women From Domestic Violence Act 2005 (PWDVA), the Lawyers Collective Women’s Rights Initiative released the one year monitoring and evaluation report of the PWDVA. The report states that 7,913 cases totally were filed under the Act in 2005 (in the one year since its enactment) As per this report Kerala ranked second highest(with 1,028 cases) in the number of cases registered under the act. (Vijayan A, 2007).

About 30 percent of girls in the districts of Malappuram, Kozhikode, Kannur and Kasargode are getting married before 18 years. Early marriages lead to high fertility, high infant mortality, pregnancy and delivery
Increasing suicide rates and crime rates are indicative of a diseased mental status of Kerala society. Rapidly growing consumerism and materialistic culture is pushing Kerala to an individualistic societal order, as we see in many of the developed countries. High rate of migration to foreign countries, increasing involvement of the women folk in employment out side home etc has changed the family environment in such a way that the emotional need of the children are left unattended many a times. This has dire consequences on the parent child relationship with the resultant problems in the behaviour of the young. Life style of Keralites has changed in such a way that young ones prefer sedentary work more than physical labour. The ever increasing number of unemployed youth who are willing to do only white collar jobs is slowly becoming a big burden to the state. It is high time that policies and programmes targeting the youth, to tackle these menaces be developed, with out which the next generation is going to suffer more from the consequences of it all. Having seen the situation of the adolescents around the globe, in India and in Kerala, it is worthwhile to look at the interventions for the adolescents.

1.10 Interventions for the adolescents

In the western societies from the middle of the 20th century itself, adolescence has been recognized as a special period that requires support for healthy maturation. From the second half of the 20th century, specific interventions started focusing on adolescents with problem behaviors like delinquency, school failure etc, which got expanded to include other problems
like teenage pregnancy, substance abuse etc in the last three decades. Earlier prevention interventions had a single problem behavior in focus. Many of them had no theoretical basis and hence failed to prove its efficacy under controlled trials. Thus a second generation of prevention efforts started focusing on the predictors of problem behavior. Later on programmes that focus on single problem behavior came under increasing criticism and investigators started giving more stress on factors that promote positive youth development. These factors include promoting bonding, social, cognitive, behavioral, emotional and moral competence, fostering resilience, self determination, self efficacy, clear and positive identity development and personal norms etc. (Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004). Currently more and more empirical studies are in progress in this area.

1.11 National initiatives on adolescent development

India has signed and ratified all the major conferences and conventions, and the most important among them which has been instrumental in increasing policies and programmes for adolescents include The International Conference on Population and Development (ICPD) (1994), Cairo, The Fourth World Conference on Women (FWCW)(1995), Beijing and The Convention on the Rights of the Child (CRC)(1989). (Planning Commission, GOI, 2001).

When we look at the five year plans, we see that from the ninth five year plan onwards, adolescent age group as a specific group started getting the attention of policy makers. The Ninth plan envisaged to universalise nutrition and supplementary feeding, expand the adolescent girls’ scheme, and to assess health needs in Reproductive Child Health [RCH] programme. During the
Ninth Plan, health care needs of adolescents were being addressed under the RCH Programme. The Department of Women and Child Development initiated the Kishori Shakti Yojana, a (comprehensive intervention aimed at improving the nutritional and health status of adolescent girls) in selected blocks.

A working group on adolescence (which was the first of its kind in India) was set up to provide inputs to the Tenth plan. The concept of the holistic approach with need based programmes, to be implemented through active participation of the adolescent was emphasised in the Tenth plan. The Tenth plan highlighted the need for catering to the sexual and reproductive health needs of the adolescent. Reproductive child health (RCH) services started including Adolescent Reproductive and Sexual Health (ARSH) programme in its ambit. During this period The Adolescent Girls’ Scheme (KSY) of ICDS was expanded 6118 projects. The Eleventh plan which is to be completed in 2012 has revamped the erstwhile Kishori Shakti Yojana clubbing the Nutritional Programme for Adolescent Girls (NPAG) also and renamed it as SABLA (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls) which got started in the year 2010. (Ministry of Women and Child Development, 2010 December 14).

At the policy level, the National Nutrition Policy 1993 considered adolescents as a vulnerable group and talked specifically about the need to redress the nutritional problems of adolescent girls. The National Education Policy 1986 modified in 1992 aimed at eradicating illiteracy in the age group of 15-35 years, and stressed the importance of including vocational courses in the higher secondary level. The National Plan of Action on Children 1992 and SAARC Decade of the girl child (1991-2000) etc had also mentioned the
adolescent issues to some extent. The National Policy for The Empowerment of Women 2001 talked about the elimination of all kinds of discriminations against girls, and protection against trafficking and prostitution. The National Population Policy 2000 included adolescents as a category of underserved population.

National AIDS Policy 2000 outlined interventions for the age group of 18-40 years. The National Youth Policy 2003 recognised 13-19 years as a distinct age group who is to be covered in programmes of all sectors. This policy provided a comprehensive overview of youth issues and concerns. It stressed the intersectoral approach in service delivery, nutritional requirements and the educational needs of the adolescents. The National curriculum framework 2005 for school education highlighted the need for integrating age appropriate adolescent reproductive and sexual health messages in the school curriculum.

The Government of Kerala has prepared and started implementing a State Plan of Action for Child in Kerala (SPAC) 2004 (Department of Social Welfare, GOK, 2004) in which one chapter is exclusively on adolescence. The major thrust areas under SPAC are 1) Highlight adolescent issues to create adolescent friendly initiatives 2) Commitment to health and development issues 3)Strengthening adolescent girls programme in ICDS 4) Promoting Government, professional and NGO collaboration. 5) Promoting adolescent health care services.
1.12 Programmes for the adolescents

There is still a paucity of programmes that directly target adolescents. Although all departments and ministries are in some manner administrating programmes that affect adolescents, only 3 departments ie Department of Youth and Sports affairs, Department of Women And Child Development and Department of Family Welfare are actively involved in adolescent related programmes. Of these the explicit mention of adolescents is in the Integrated Child Development Services Scheme(ICDS) run by the Ministry Of Women And Child Development and to a certain extent the adolescent component of the RCH programme of the Ministry of Health and Family Welfare. The various government initiatives though are still quite unsatisfactory. They can be divided into areas of health, economic development, education and employment etc. Many commendable efforts are happening in the NGO sector and various international agencies are actively involved in planning and implementing programmes for the adolescent.

In the state of Kerala, specific programmes targeting the adolescent population got shape after the formulation of the State Plan of Action for the Child in Kerala (SPAC) 2004. Programmes implemented by the Social Welfare Department through ICDS and RCH programmes of the Health Department are the two programmes currently focusing on adolescents. Since 2008 a special service by the name of ‘Psycho social counselling services for the adolescent girls in schools’ is being offered by the Department of Social Welfare which is an innovative attempt to provide counselling service to school children.
1.13 Critical appraisal of the national initiatives

Even though there are no policies specifically for adolescents, their unique and special needs are mentioned in some of the policies like the Population Policy 2000 and the National Youth Policy 2003 etc. None of the policies however take an integrated and holistic view of adolescents. The rights approach to adolescent care seems to be missing in all the policies. Except for the National Youth Policy, none of the other policies, seem to have taken the adolescent’s perceptions or participation into account.

Comprehensive programmes or schemes addressing all the needs of adolescents are lacking in India. A number of Government departments have interventions that impact the lives of adolescents. Some of these schemes and programmes are generic in nature and so affect adolescents as well and some have been designed especially for adolescents like the Adolescent Girls Scheme of ICDS. However all these are vertical programmes and do not take an integrated view of the adolescent issue.

Sporadic efforts to address adolescent issues from a preventive and developmental point are in progress in the NGO sector. Many of them have life skill development curriculum designed to address the sexual and reproductive health needs of adolescents as its prime focus. The only problem with these efforts is that there is small coverage of beneficiaries and micro level projects operating, in restricted geographical areas. (Adolescents in India –A Profile, 2003 December).

‘A guide to family health and life skill education to teachers and students’ prepared by NCERT (2000) (National Council of Education Research and Training) needs special mention in this context. However
efforts to introduce the Family Life Education course at the school level was not acceptable to many and it still continues to be a debatable issue.

The National Service Scheme (NSS) activities of college students are a good example on how we can engage our youth in pro-social behaviour, that promote positive development in them. More and more youth in the rural areas can be engaged in such kind of activities through the Nehru Yuva Kendra (NYK) programmes also.

1.14 Integrated Child Development Services Scheme (ICDS) and adolescents

In pursuance of the National policy for children, Government of India sanctioned Integrated Child Development Services Scheme (ICDS) on an experimental basis on 2nd October 1975. Over the last 35 years, ICDS with its commendable service delivery to preschool children, expectant and nursing mothers, and women in the age group of 15-45 years has created massive changes in the nutrition and health status of children and women in the country. The uniqueness of the scheme is its wide coverage of services to the beneficiary category and its public acceptance. (See Appendix-4 for details of ICDS scheme). The scheme underwent lots of changes since its inception and one of the most important change was the introduction of the ‘Adolescent Girls Scheme’ in selected projects (507 projects) on a pilot basis in the year 1990-91 which was later on extended to more projects. (Ministry of Women and Child Development, 2011 January).

1.15 Adolescent Girls’ Scheme

In order to meet the constitutional obligations under the five year plans the Central and State governments tried to bring in positive changes in the lives of adolescent girl children, especially in the last two decades.
Declaring the nineties as the SAARC Decade of the Girl Child acted as an impetus to start a special programme for the adolescents. The Government of India thus launched the Adolescent Girls’ Scheme (AG scheme) in the year 1991 in connection with the existing ICDS infrastructure. The scheme envisaged to focus on school drop out girls in the age group of 11-18 years, to meet their need for self development, nutrition, health, education, literacy, recreation and skill formation. The Department Of Women And Child Development under which the ICDS scheme is functioning thus decided to lounge 2 programmes under the Adolescent Girls’ Scheme.

1.16 Programmes under AG Scheme

*Scheme I- Girl To Girl Approach*-which aimed to address issues of the 11-15 year age group girls from poor families. Among an average of 18 such girls in an anganwadi area, 3 girls each were to be identified and placed in respective anganwadi centres to get hands on experience in the functioning of the centre, which in turn would benefit them to acquire knowledge in health hygiene nutrition, and family life education.

*Scheme II-Balika Mandals*-selected anganwadi centres (10% of the total anganwadies in the project) with active mahila mandals had to form balikamandals which has all the girls in the age group of 11-18 years. They were to be given education sessions on health and nutrition along with skill development sessions with the support of local resource persons and also with the support of experts in health, the food and nutrition board etc for a period of six months. On an average, 20 such girls were expected to benefit in the six months period as per this scheme. An anganwadi worker is expected to be a regular honorary instructor for the balikamandal.
The Government of India issued revised guidelines for implementation of the AG scheme in the year 2000 (Ministry of Human Resource Development, ICDS, A Compendium of Guidelines, 2000) and renamed it as the Kishori Sakthi Yojana. As per this order instead of following a tailor made programme throughout the country, as it is mentioned in the earlier paragraph a list of programme options were given from which the State/Union territory could selectively plan programmes based on their local requirements. However, it also proposed to continue the earlier programmes (for those who wish to continue) along with trying region specific innovations as per the revised guideline. The Central Government allocation every year for implementation was decided to be Rs 1.10 lakh per ICDS project. KSY is implemented in 6118 ICDS projects across the nation as per the annual report of the Ministry of Women and Child Development 2007-08.

1.17 Services for adolescent girls

Under the AG Scheme I selected adolescent girls (3 from one anganwadi area) are offered training and hands on experience of working at the anganwadi centre. These girls are provided with supplementary nutrition in the same quantity as was provided to pregnant and lactating women. Those girls registered under the AG Scheme II are given training on various vocational skills, home care, child care, personal hygiene, literacy and numeracy skill etc along with nutrition health education. Supplementary nutrition is given to these girls also. Enrolment of these girls is for a period of 6 months. Apart from this, health check ups and referral services and IFA supplementation etc are also included in the service package which are to be delivered with the support of the health department. Some innovations like the introduction of iron supplementation to control anaemia were tried in the
state of Rajasthan. Tamilnadu tried to introduce life skill education programme as part of innovative effort. (Implementation report-World bank ICDS III project-borrowers evaluation report, 2006 December).

1.18 Adolescent Girls’ Scheme in Kerala

Like all the other states in India the KSY scheme got introduced and is being implemented in all the ICDS projects of Kerala also. In the first phase the adolescent girls’ scheme was introduced in 13 blocks in the state. It was extended to all the projects in the year 2005 under the name Kishori Shakhti Yojana. (Govt of India letter regarding KSY, 2005 August 18).

Though the scheme got operational in all the ICDS projects from 2005 onwards only, services for adolescent girls were given through all the anganwadi centres in the state even before that. There were certain modifications in the scheme implementation in Kerala. Unlike the original scheme guidelines, adolescent girl clubs were formed in all the anganwadi centres in the state. Each AG club consisted of not less than ten members and their selected representatives who formed leaders of the clubs. Meetings of the club were to be convened twice in a month.

In each anganwadi centre, supplementary nutrition was provided to selected adolescent girl beneficiaries, as it was provided to pregnant and lactating women (criteria for beneficiary selection was present). Financial requirements for this was met by the local self government (LSG) bodies. Iron and folic acid supplements were given to the adolescent girls with the assistance of the Health Department in some of the projects. In majority of these centres, nutrition health education (NHED) activities were conducted once in a month, though it is expected to be done fortnightly. Under the
ICDS projects in Kerala as per the official reports of the director of social welfare, 24421 adolescent girl clubs were functioning and about 3, 66, 315 girls were enrolled as members. (Proceedings of the Director of Social Welfare 2006, September 27).

Central assistance for the implementation of the AG scheme from the year 2003 to 2006 was not utilised by the state government. From 2006 onwards State specific programmes have been planned and implemented under the KSY scheme in Kerala. Programmes planned under AG Scheme varied each year up till 2008. From 2008 till now the KSY scheme is implemented in schools as psycho social counselling for adolescent girls in schools. Professionally trained counsellors are appointed at selected schools in each project area for giving counselling service to the adolescents in that school, primarily. The programme was extended to include more schools (200 in addition to the initial 163) with state government funds, also along with the KSY fund allotted by the central government. (Department of Social Welfare, Govt of Kerala, 2009). Preparations for starting the new SABLA scheme in selected districts as per the revised guidelines issued by the central government in 2010 is in progress in the state.

1.19 AG Scheme implementation during 2000-2006

The Adolescent girls’ scheme implementation during this period was mostly centred on the supply of supplementary nutrition to the selected beneficiaries and conducting the monthly meetings (which was mostly happening in paper at majority of the centres). Workers were given a list of topics on which they used to conduct classes and organise activities. At times,
supervisors and health department staff would be present to conduct classes for the adolescents.

The researcher while working in the ICDS could observe the following problems in the implementation of the KSY scheme during this period. The Adolescent girls’ scheme implementation was very weak at that point of time in the state in terms of the service utilisation by the beneficiaries and the motivation level of the anganwadi workers to implement the scheme. This was evident from the infrequent club meetings and low participation of adolescents in club activities. Many a times project officers and supervisors had to force the workers to convene club meetings monthly.

Even though help from locally available resource person to lead educative and skill training sessions is mentioned in the scheme, this very rarely happened. The reason being lack of financial resources to conduct such sessions and the lack of availability of interested and qualified manpower from the locality to conduct such training sessions. Since the anganwadi workers themselves are not properly oriented on adolescent problems and issues very often those sessions that were handled by the workers became monotonous, poor in the quality of information that is shared and unattractive due to wrong teaching methodologies.

Apart from this the workers had difficulty in organising club meetings since the adolescent girls would often be busy with their academic activities and parents of the adolescents were not very keen on sending the girls for the Ag club activities. Children had to attend special tutorial sessions on holidays also which were meant to help them learn their school lessons better. Parents were keener to send them for these tuition classes than sending them to the
anganwadi for club meetings. All these further complicated the implementation of the AG scheme.

However, it is worth mentioning that even in such circumstances few very motivated workers used to conduct activities of the AG clubs as and when possible. They used to organise cultural and sports competitions. In some of the centres the AGs used to help the workers in preschool education during vacation time. These workers used to give them nutrition and health education whenever possible. In some of the projects under the initiative of the project officers certain innovative activities also happened. Funds from local self governments were utilised for such programmes. Various programmes that were organised include residential camps for the personality development of the beneficiaries, preparation of manuscripts (compilation of creative writings and other works of these girls into a book form) by the adolescents, making kitchen vegetable gardens at the anganwadi, forming thrift and credit units for the Adolescent girls etc. are the few such efforts worth mentioning. However these were sporadic attempts.

1.20 KSY implementation since 2006

Plan of action for KSY implementation was chalked out for the first time with central assistance in the year 2006-07. Various innovative programmes have been tried every year since then. 1.10 lakhs per annum is the central allocation for each project for KSY implementation in the state. In the period from 2006-2008 yearly plans were made and implemented. These were primarily one or two training programmes conducted at the project level. Most of the time these programmes were organised during the summer vacations and many of these programmes reached a limited number of
beneficiaries only. From 2008 onwards psycho social counselling services through the schools started. With this the whole focus of the scheme got shifted to schools and the activities of the AG clubs at the anganwadi level has slackened since then

1.21 Background of the present study

When we look at the above facts on AG scheme implementation in the state, it becomes clear that the Adolescent girls’ clubs’ activities through the anganwadi centres need to be strengthened. Routine monthly meeting of the AGs at the anganwadi level form the central platform for service delivery of the non-nutritional component of the scheme. There is immense scope for providing quality service to all adolescent girl beneficiaries in an anganwadi area using this. To achieve this one needs to ensure that the adolescents are provided with various developmental opportunities through the activities organised in the monthly meetings. This may range from good training and skill building sessions to providing them with opportunities for getting engaged in pro-social behaviour etc.

To achieve this apart from making use of the expertise of the resource persons from other line departments, skill building of the ICDS functionaries also need to be done. Some of the studies done on KSY scheme implementation across the nation showed weakness in the training input for the functionaries and this has reportedly affected the service delivery of the scheme (NIPCCD, 2002; Solidarity among women on AG scheme implementation in Kerala, 1997; Formative Research and Development Services, 2009; NIPCCD, 2006; and Sen, 2009).
The present study aims at evaluating the adolescent girls’ scheme, more specifically its non nutritional component to see how best it can be modified to make it more beneficiary oriented. To achieve this objective the study aims to look at the ICDS functionaries need perception for a capacity building training programme for them on the subject of adolescent development. It also attempts to experiment a model of training anganwadi functionaries on adolescent development. A training programme on various essential adolescent development issues (which are relevant in the current social condition of Kerala and also based on ICDS requirements) was prepared as part of this project. Using anganwadi functionaries as master trainers, it was attempted to see how best adolescent development education programmes could be implemented. Since anganwadi functionaries are the ones involved in the field level implementation on a continuous basis, it is essential that they have the basic minimal information on various adolescent issues and skills to handle training sessions for them in an interesting way. It is expected that this would indirectly benefit to boost the functionaries’ self confidence and motivation level to do programmes for the adolescent girl beneficiaries in their respective anganwadi centres.

Training programme of this kind can be done cost effectively, if the existing training infrastructure of the ICDS scheme is properly utilised. Such a programme would be more sustainable and at the same time it would ensure wider beneficiary coverage under the non-nutritional component implementation. The proposed adolescent development education programme focuses on 4 core areas which are

1) Healthy Living –which focuses on lifestyle related risk factors on health and nutrition
2) Developing a positive self image through analysis of ones own strengths and weaknesses, identifying personal goals, learning to prioritise ones needs based on values and by developing a gender related positive self image.

3) Enhancing good interpersonal relationships through analysis of the relationship network and the skills, fostering good relationships with parents, peers and by teaching them how to identify situations of exploitation.

4) Lastly giving them accurate information on essential sexual and reproductive health matters.

1.22 Aim of the study

The present study aims to develop an adolescent development education programme for anganwadi centres.

As a first step of this project a field study and secondary data analysis was done to know how the non nutrition component of the Kishori Sakthi Yojana Scheme is running currently. After analysing the field situation, depending upon the requirements of the functionaries a practical and easy to use manual on adolescent development was developed and field tested for its efficacy and feasibility.

1.23 Objectives of the study

This research work attempted to fulfil the following objectives

1) To evaluate the implementation of the non nutritional component of the adolescent girls’ scheme of ICDS.
2) To understand the functionaries need perception for a capacity building training programme on adolescent development.

3) To develop and implement a feasible training programme on adolescent development for the anganwadi centres

4) To assess the utility of the training programme on adolescent development.

5) To check the feasibility of the training programme on adolescent development.

6) To suggest suitable measures to improve the service delivery of anganwadi centres to adolescent girl beneficiaries.

Detailed outline and design of the study is presented in the methodology chapter.

Adolescents in rural area are in a more disadvantaged position compared to their urban counterparts as far as access to resources and growth opportunities are concerned. As Gandhiji rightly pointed out ‘the soul of India rests in its rural villages’, any efforts to develop and empower the budding generation of women folk in villages would strengthen the developmental efforts for a healthy nation. The wide rural outreach of ICDS offers a good opportunity to achieve this provided its potentials are properly utilised. It is expected that the current research project would throw some light in this direction.
Adolescents got recognition, as a distinct age group who require special attention in the human resource development agenda only recently. Policies and programme interventions targeting this age group initially were focused on ameliorating the problems as and when they arose. Later on the attention started getting shifted to prevention of these problems. Of late the focus has again been shifted to include a developmental perspective in adolescent care. More emphasis is now being given to improving the global competencies of the young, through positive youth development programmes. Before proceeding in to the different research studies related to the current work, conceptual frame work of the study is presented first.

2.1 Conceptual Frame Work

The present study has used a positive youth development frame work which primarily applies a strength based approach to promote competence of the adolescents to be contributing adults in the future. Basic premises under which the positive youth development programmes function is the Pittman’s proposition(as sited in Catalano, Berglund, Ryan, Lonczak, & Hawkins, 2004) that ‘problem-free does not mean fully prepared’. Young people in today's society need help in understanding life's challenges and responsibilities and to developing the necessary skills to succeed as adults.

Catalano, Berglund, Ryan, Lonczak, & Hawkins, (2004) define positive youth development programmes as approaches that seek to achieve one or more of the following objectives: 1) Promotes bonding, 2) Fosters
resilience 3) Promotes social competence 4) Promotes emotional competence
5) Promotes cognitive competence 6) Promotes behavioural competence
7) Promotes moral competence 8) Fosters self-determination 9) Fosters spirituality
10) Fosters self-efficacy 11) Fosters clear and positive identity
12) Fosters belief in the future 13) Provides recognition for positive behaviour
14) Provides opportunities for pro-social involvement 15) Fosters pro-social norms.

In the opinion of Whitlock and Hamilton (as cited by Small and Memmo, 2004) positive youth development can be conceptualised in three ways: (a) to describe the natural process of development in children and adolescents; (b) as a category of programmes and organizations that provide activities to promote youth development; and (c) as a unifying philosophy characterized by a positive, asset-building orientation, that builds on strengths rather than categorizing youth according to their deficits. It is the second conceptualisation that formed the basis for the present intervention programme.

A positive youth development approach is based on the following assumptions: 1) helping youth achieve their full potential is the best way to prevent them from experiencing problems. 2) youth need to experience a set of supports and opportunities to succeed. 3) communities need to mobilize and build capacity to support the positive development of youth. 4) youth should not be viewed as problems to be fixed, but as partners to be engaged and developed. The positive youth development approach has relevance for all youth, rather than just a certain targeted group. (Dotterweic, n.d).