CHAPTER I: REPRODUCTIVE AND SEXUAL HEALTH IN ADOLESCENT POPULATION

1.1 INTRODUCTION

"This world demands the qualities of youth: not a time of life but a state of mind, a temper of the will, a quality of imagination, a predominance of courage over timidity, of the appetite for adventure over the love of ease." - Robert Kennedy

Adolescence is a time of opportunity and change. It is all about growing up. The rationale of this is located in the decision making process that exists between the parents and the child. The major concern during this period is adolescent health. Adolescent health involves professional perspectives and is of high public health concern, particularly reproductive and sexual health. Programs that can provide information, ensure access to services, and develop life skills are crucial to the future of the adolescents.

In the past (and still in some cultures) there were ceremonies that celebrated adulthood, typically occurring during adolescence. For example, In Jewish tradition the transition is celebrated in the Bar Mitzvah for the boys or the Bat Mitzvah for girls. Adolescents have also been an important factor in many movements for the positive social change around the world. Adolescent can if effectively harnessed, contribute towards the promotion of nation building. In order to build a healthy and strong nation, special attention has to be paid to the youth in terms of health, education, employment of youth, fight against substance abuse by the group, bringing HIV AND AIDS awareness among the adolescents and conflict transformation so as to enable them to participate fully in the process of nation building. Especially since ICPD in 1994, many

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1 For Jewish people, these rituals are called bar mitzvah and bat mitzvah. Bar mitzvah is the Hebrew phrase meaning "son of the commandment" and bat mitzvah means "daughter of the commandment". Becoming a bar or bat mitzvah means that a boy or girl has become an adult, and is fully responsible for his or her morals and religious duties. It also means that he or she has become a full-fledged member of the Jewish community, and must follow the rules of Jewish life and the commandments (http://www.jewfaq.org/barmitz.htm)
innovative methods and media have been used to deliver health messages tailored to various audiences. These include drama and folk communications, mass media, sports events, and individual counseling, as well as formal and informal education. Telephone hotlines, radio call-in shows and the Internet are also popular and cost-effective ways to offer information and counseling to adolescent who seek anonymity. School, workplaces and community, vocational or recreational centres are other possible entry points for referrals, counseling or information. Using several of these channels, a campaign can reach different segments of the population and reinforce key messages. Increasingly, many organizations the world over is involved in programmes that address adolescent's need for employment or skills that can help them generate income.

Adolescence is also a time of heightened vulnerabilities. During adolescence an intense sexual drive develops and adolescents typically start exploring relationships with the opposite sex. Adolescents start defining social relationships outside the family (Naseem, 2004). Their behavior is guided by an intense desire for independence and identity. Sexual development is a normal part of adolescence. Most adolescents go through these changes. Nonetheless, all adolescents need support and care during this transition to adulthood. The lives of millions of adolescents worldwide are at risk because they do not have the information, skills, health services and support they need to go through sexual development during adolescence and postpone sex until they are physically and socially mature, and able to make well-informed, responsible decisions.

Since adolescents have limited access to vital information and services pertaining to sexual and reproductive health for many adolescents, sex may be linked with coercion, violence and abuse – sometimes even by family members or adults with privileged relations. In many societies, women are conditioned to be submissive to men, and they find it difficult or impossible to refuse early marriage, to space births, or to refuse to have unprotected sex with an unfaithful
spouse or partner. The social environment is critical to healthy adolescent development. Healthy in terms their emotional, physical, mental and spiritual development. There are key aspects of this environment, which can prevent adolescents from engaging in unsafe/unwanted sexual behaviour, for example, a strong relationship with parents, a connection to school and open communication with sexual partners. It would not be wrong to mention that adolescents are poorly informed about sexuality and reproduction. Often policy makers, public opinion leaders and parents believe that withholding information about sexuality and reproduction from the adolescents' will dissuade them from becoming sexually active. Adolescents need life skills in order to face the challenges of adulthood.

Most adolescent boys and girls, married and unmarried become sexually active before the age of 20, but generally lack access to family planning services (including appropriate contraceptives), prevention and care of sexually transmitted diseases, or pregnancy care. Cultural taboos surrounding communication about sexual matters persist in the parent–child relationship, and adolescent have few opportunities outside their peer group to talk about their feelings and anxieties.

Providing adolescent reproductive health as a separate service is not feasible in conservative societies as many health care facilities require the consent of parents or spouses. For many adolescent, the opening times or location of services make them inaccessible, or the care is too expensive. In addition, the judgmental attitudes of many health care professionals often discourage adolescents from seeking advice and treatment related to sexual and reproductive health. However, when provided within the umbrella of general health services, the adolescent reproductive health services are readily acceptable by the parents and the society at large. Hence, it is important to consider adolescence as a phase having needs and desires rather than a fixed age group, with physical, psychological, social and cultural dimensions, perceived differently by different cultures. As a group, adolescents include nearly 1.2 billion people; about 85% of who live in developing countries.
(United Nations, 1999) therefore providing the adolescent with the reproductive health services now will prevent them from indulging in high-risk activities. The needs of adolescents remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviors during adolescence have far reaching consequences for people's lives as they develop into adulthood.

Leading a healthy and productive life given the challenges that many adolescent face, require access to appropriate information, counseling and services in the health and other sector as well as the development of a broad range of decision-making and interpersonal skills.

1.1.1 Background of the Study

Adolescents' are not a homogeneous group, and programmes need to consider economic, social, cultural and religious differences. Cultural sensitivity is essential, and for this reason, no single programme can work for all India. Also in the absence of other information and services, quacks have taken advantage of adolescents' sexual concerns throughout India. On every street corner, such people advertise services for sexual problems. Adolescents' need services and counseling that do not perpetuate misconceptions. Programmes designed for the adolescents' need to go beyond limited kinds of "sex education" that focus primarily on anatomy, to "sexuality education" which addresses broader dimensions. In India, in recent times the attention of the government bodies and other agencies has seen a shift towards the adolescent needs. In the late 1960s, Family Planning Association of India (FPAI) began educating the adolescents' in schools, colleges and non-formal educational institutions on issues related to population and family life. These programmes provide an orientation for the adolescents' regarding sexuality, reproductive health, the prevention of unplanned pregnancies and sexually transmitted infections (STIs). In 1978, FPAI established Sexuality Education Counseling Research Therapy/Training (SECRT) centres, which provided sexuality education and counseling. Today 37 SECRT centres have reached over 120 000 young people. SECRT centres
offer counseling services to both married and unmarried adults and adolescents, on a range of topics, including premarital counseling, family planning, and marital and infertility counseling (FPAI, 1990). In 1999, FPAI implemented a project on “Enhancing Sexual and Reproductive Health of Young Persons”. This project aimed to extend information and counseling on issues related to human sexuality, preparation for marriage, responsible parenthood, gender issues, contraception and prevention of STIs/HIV AND AIDS.

Most adolescents’ in different part of the country tend to marry early, and experience high fertility rates, low levels of contraceptive use, high abortion rates, and high levels of violence and sexual coercion (IIPS, 2000). To address these issues, Family Health International (FHI), the World Association of Girl Guides and Girls Scouts (WAGGGS) and the Bharat Scouts and Guides Association (BSG), the largest youth organization in India, have collaborated on a two-year project called the Healthy Adolescent Project in India (HAPI), with funding from the David and Lucile Packard Foundation. The purpose of HAPI is to address gaps in reproductive health knowledge and services for adolescents and young adults by enhancing adolescent’s knowledge and skills, using a life-skills approach. The World Health Organization (WHO) Meeting on Pilot Approaches in Adolescent Reproductive Health, held in Lisbon on 8 and 9 April 1999, targeted the broader societal framework of the public health action in the field of adolescent reproductive health needs and emphasized upon the need to take account of the wider social and political contexts which affect the adolescents’ and also identified the lessons learnt in Europe in specific areas important for adolescent sexual and reproductive health: peer education, intersectoral action and building partnerships among different organizations at different levels of policy-making.

Another way to ensure the possible level of reproductive health among adolescent include sound public policies, supportive environment, community action and the availability of health services, but the most important aspect is
the direct involvement of the adolescents' in the promotion of their own sexual health. In brief we can mention that the adolescents needs to be considered a special group because challenges to adolescent health and development are numerous, and often underestimated. Adolescence is a period of evolution; it provides an opportunity for laying the foundations for a healthy, responsible and productive life ahead. Habits and behaviors picked up during adolescence have life long impact but gender discrimination has adverse effects on the health and development of adolescent especially girls who are also the future mothers. Due to early marriage adolescent fertility and reproductive health has a major impact on demographic indicators. Also, sexual relations in adolescents occur before they acquire skills and experience in self-protection therefore, it cannot be ruled out that adolescence have unmet needs regarding nutrition, reproductive health, mental health and require appropriate skills. They require a safe and supportive environment for development.

1.1.2 Defining Adolescents

The word adolescent is derived from the Latin verb *adolescere* meaning 'to grow up'. The term 'adolescence' has been associated with the transition from childhood to adulthood, encompassing the interval between puberty and marriage, and it has been evolved into a distinct period of biological clock. Adolescent refers to the period of life after the development of secondary sex characteristics, usually between childhood and adulthood representing the period of time during which a person is biologically adult but emotionally not at full maturity. The ages, which are considered to be part of adolescence, vary by culture.

According to UNFPA, people in 15-24 year age group are considered ‘youth’. Those aged 10-19 years are referred to as adolescents (WHO 1989). UNICEF however, refers to all age 5-19 years as “children”. WHO also emphasized that ‘adolescence is neither merely a social classification nor merely a specific age limitation, rather the combination of the two’ (WHO, 1989)
Pachuri (1998, p.118-119) states 'puberty marks the biological beginning of adolescence, but of its completion is varied and ill defined. Thus, age and puberty are important defining criteria for adolescence...the only universal definition of adolescence appears to be that, although no longer considered a child, the young person is not yet considered an adult.' Thus, defining adolescence within a social construct is not possible as it varies across cultures. Adolescence therefore, cannot be defined only by age, puberty, sexual intercourse or marriage so, to have a clear understanding of the meaning of adolescents across cultures, events need to be viewed within the context of gender relations, age hierarchies and social class as well.

'Variation in social and cultural settings between countries and biological differences concerning age of physical maturation render different connotations to the meaning of adolescence in different settings. In India, traditionally the transition from childhood to adulthood among females has tended to be sudden' (Jejeebhoy, 1996)

At the World Health Organization (WHO) meeting on 'Pregnancy and Abortion in Adolescence' in 1974, adolescence was described as 'the period of sexual development from the initial appearance of secondary sex characteristics to sexual maturity, psychological development from child to adult identification, and socio-economic development from dependence to relative independence' (WHO, 1989). In any country adolescents represent major potential human resources for the overall development of a nation. The International Conference on Population and Development (ICPD) held in Cairo in September 1994 recommended among other things, focusing on all issues concerning the adolescent in their entirety, and has suggested development of an integrated approach to their health, education and social needs. Adolescents include a wide gamut of categories like the school going and out of school/drop-outs, sexually exploited children, working adolescents (both paid and unpaid), and the married adolescent. Adolescence is often seen as a stage of both opportunity and risks since their behavior including sexual and reproductive have
generational and intergenerational consequences. Emotionally, adolescent move
toward independence from their parents or elders and establish new interests
and relationships. As adolescents become adults, they consider sexual relations,
marrige and parenthood as signs of maturity. They seek information and clues
about sexual life from a variety of sources; parents, peers, religious leaders,
health providers, teachers, magazines, books and mass media as adolescent
have few opportunities outside their peer group to talk about their feelings and
anxieties. For many adolescent, the opening times or location of services make
them inaccessible, or the care is too expensive. Many health care facilities
require the consent of parents or spouses. In addition, the judgmental attitudes
of many health care professionals often discourage adolescents from seeking
advice and treatment. The needs of the adolescent remain poorly understood or
served in much of the world. Neglect of this population may have major
implications for the future. Encouraging the full participation of adolescents in
the development and promotion of health-related programmes and policies
would enable them to become agents of change in their communities and
positively affect their lives and those of their peers. Adolescents who do not
have a nurturing family environment or for whom the family is the setting for
abuse or neglect should be especially targeted.

Adolescents have the right to and require information, intervention or services
about the basic information regarding growth and development, about physical,
psychological, emotional and social changes. They should also be provided
with an opportunity to share and explore information about the role needs each
sex plays in a relationship, family life and society. Be informed accurately
about reproductive health and quality services. Introduce Life skills and
integrate it with their curriculum and day-to-day activities. Be made aware
about the risks to their health from behaviors such as early and unprotected sex,
use of tobacco, abuse of alcohol and other drugs and also be provided with
information about opportunities and available services related to health,
education and vocational and recreation. It is more so important to provide
adequate information to the adolescents because the adolescents cannot be
taken in isolation, they are a part of the population and hence their needs should
also be understood. However, the reproductive health needs of the adolescents
also vary depending on the individual situation. There may be some adolescent
who are shy and require the skills and motivation to help them postpone as well
as say ‘NO’ to unsafe sexual practices.

1.1.3 Profile of Adolescents in India
Adolescence is a critical period of biological and psychological changes for
both boys and girls. For almost all of them, it brings a drastic change in social
environment as well. The three stages of adolescence development have been
described below: (nipccd.nic.in/indore/design2.doc, accessed on 30th May, 2008)

a) Early adolescence (9-13 years) - characterized by a spurt of growth and
   the development of secondary sexual characters.

b) Mid-adolescence (14-15 years) - where adolescence develops separate
   identity from parents, new relationship with peer groups and opposite
   sex and of experimentation.

c) Late adolescence (16-19 years) - at this stage, adolescents has fully
   developed physical characters and has formed a distinct identity and has
   well formed opinions and ideas.

Approximately one-third of the world's population is between 10-24 years of
age, and four out of five young people live in developing countries, a figure
which is expected to increase to 87% by the year 2020 (Friedman, 1993). Globally, 5 out of every 10 unemployed are adolescent; in some developing
countries it is 8 out of 10. In the least developed countries, only 13% of the girls
and 22% of the boys enroll for secondary education (www.who.int/inf-pr-
and injury between the ages of 10-24 represents 15% of the global burden. In
India adolescents constitute nearly a fifth of total population. National Family
Health Survey (1998-99) data reveals that over 50% of girls marry below 18, the minimum legal age of marriage for women set by Child Marriage Restraint Act, 1976. This has resulted in a typical reproductive pattern of “too early and too many” (NFHS-2). 15-19 age groups contribute 19% of total fertility in India. Adolescents thus, become the largest group with highest unmet needs for contraception (populationcommission.nic.in/unmet-contraception.htm, last accessed 30th May, 2008). Since the age level of premarital sex among male and adolescent girls varies the median age of initiation of sexual activity is 15-16 years.

In India, traditionally, the transition from childhood to adulthood has tended to be sudden. As a result of the poor nutritional status of the average Indian adolescent, menarche occurs later than in other region of the world, therefore the biological onset of adolescence at least among females, may be later in India than elsewhere. (Jejeebhoy, 1996) On the other hand, marriage and consequently the onset of sexual activity and fertility, occur far earlier in India than in other regions of the world, thrusting adolescent girls early into adulthood, frequently soon after regular menstruation is established and before physical maturity is attained. (Jejeebhoy, 2000) Little information is available on this significant section of the population and that adolescent is rarely considered a distinct group with special needs apart from those of adults and children. Health programmes generally make provisions for adults and young children, but adolescents have largely been overlooked. There are an estimated 300 million young people in India today; representing almost one-third (31 per cent) of the population. Specifically, 22 per cent of the population falls into the adolescent age group (aged 10-19) (IIPS, 2000). Such a large group represents a major human resource that can and must contribute to the overall development of the country. Addressing their needs will contribute not only to social and economic development, but also to social harmony, gender parity, population stabilization and improved quality of life. In spite of adolescents being a huge segment of the population, policies and programs in India have
focused very little effort on the adolescent group. The situation of adolescents varies widely by gender and region in terms of not only educational attainment and economic activity but also in terms of sexual and reproductive risk behavior.

Although literacy and educational attainment among adolescents have been increasing, in the 1990s, about 30 per cent of all adolescents continue to be illiterate. Gender differences persist, with about four in five boys aged between 10-19 years considered literate compared to about three in five girls (IIPS, 1995). As far as educational attainment is concerned, school attendance among younger adolescents is in favor of boys, with 76 per cent of all boys and 55 per cent of all girls aged between 11-14 years in school (Jejeebhoy, 2000). Adolescent labor force participation rates are relatively high. About one third of adolescents aged between 15-19 years were reported to be working in 1981 (MoHFW, 1993) Rural girls are both more likely to work and work for longer durations than rural boys. However, since girls are typically constrained from activities requiring much contact with the outside world, they are less likely than boys to work in wage activities (Bhende, 1995). Within the gender stratified social structure in India, adolescent girls are especially disadvantaged in terms of food intake, access to health care, and growth pattern, they are worse off than their brothers.

1.1.4 Understanding Reproductive and Sexual Health

"Reproductive health, 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 rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning and the right of access to appropriate health care services that will enable the women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant". (ICPD Programme of Action, 1994)
The origin of the reproductive health often lie in human behavior-the practices in which individuals are engaged, the choices they make and can make, their awareness of healthy practices, and their perceptions of what constitutes acceptable behavior for women or men-that determine the extent to which women and men can attain 'a state of complete physical, mental and social well-being'. Adolescents' needs for reproductive health services are often misunderstood, unrecognized or underestimated. This may be because the information about the adolescent health services is not available or the attentions of the health care provider have not seen a shift towards adolescent health care. Inspite of the lackadaisical approach towards the adolescents reproductive health needs it is important to focus on them because:

- Adolescents have a right to quality reproductive health services.
- Adolescents need reproductive health services.

"Sexual health is a state of physical, emotional, mental and social well being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (WHO, 2002). Further WHO have mentioned that there should be a positive and respectful approach to sexuality and sexual relationship along with pleasurable and safe sexual experiences free from any kind of discrimination or ill treatment. In order to attain as well as maintain sexual health, it is important to respect the sexual rights of every individual in terms of its protection and fulfillment. A whole range of factors influences every individual sexual health and it is not isolated from the problems of HIV, RTI or STIs. Sexual health also encompasses the problem of unwanted pregnancy, which results in abortion. Thus, there is an evident need to address sexual health needs at all the levels of the health system starting from the individual to the health care institutions. Thus, sexuality can be understood as-

'Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientations, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, roles and relationships. While sexuality can include all of these...
dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors. (WHO, 2002) Unfortunately, the overall lack of acceptance of adolescent’s sexuality translates into a lack of information and services in this realm. Not only does this make adolescent vulnerable to infection, it also restricts their capacities to make decision around sexuality. The causation in most of the health problems of adolescents is multifactorial in nature. Information leads to better and more responsible choices among the adolescents however, this information is more or less denied. In a situation where sex and sexuality are never directly talked about, adolescent grow up with a host of misconceptions. There is a gender-based expectation that boys are supposed to know more about sex than girls. They are expected to conform to the norms of heterosexuality, but male sexual behavior is often naturalized for e.g. boys will be boys while female sexual behavior is socially constructed for e.g. girls will have to be girls (CREA, 2002). However, the ‘norms of heterosexuality’ are slowly breaking down in most society due to the information provided around sexuality in a number of ways by organizations working in the specific fields. Even when information around sexuality is provided, it is often garbed as ‘Family Life Education’ (FLE) rather than a sex education. This may be due to the fact that FLE is a label that is more acceptable to the society. FLE is softer than sex education as a term. Sex education for adolescents is a controversial issue in India. The controversy, however, is slowly shifting from whether sex education should be there or not to the topics to be covered in such education, and whether the emphasis should be on anatomic and physiologic facts or on norms and morality. In many cases the name itself is unacceptable and a more sanitized name of Family Life Education is being used (Narayan et al, 2000). At schools, sex education is all too often taught by embarrassed teachers who rarely mention homosexuality or condoms. It is indeed a strange paradox because it is everywhere in the media but no one wants to talk about it. Sex education for adolescents started in the west many decades ago, but in India it
was unimaginable till a few years ago. Had it not been for the onset of AIDS and the special vulnerability of adolescents and young people, it would never have been even considered. Nevertheless, the Supreme Court on 16 November 2005 decided that sex education in schools cannot be brought under the ambit of fundamental rights by making it a part of the right to education (www.indiatogether.org/2005/dec/edu-notaboo.htm). Dangerously enough, there is no consensus in India over introducing sex and reproductive health education in the school and college syllabus. Meanwhile, the reality is that a large population of adolescent is in the age group 12-24, and studies are showing their growing preference for pre-marital sex. In a survey in 2002 by The Week magazine, of unmarried young Indians, 69 per cent of men admitted to pre-marital sex compared to 38 per cent of women. In the 16-19 group, forty-five per cent had pre-marital sex, while 27 per cent were 15 years or under and 28 per cent were 20 years or older. At present, information regarding sexuality education is gaining prominence not only in the schools but also in the society, among family or within the workplace. Safdarjung Hospital Adolescent Health Network (SHAHN) operational in New Delhi since 2nd August 2001 undertook a study regarding the needs of adolescent who are between the age group of 15-19 years, in Delhi in the year 2002. The findings are as below:

Table 1 (a): NEEDS OF ADOLESCENTS

<table>
<thead>
<tr>
<th>Problems</th>
<th>1st priority (%)</th>
<th>2nd priority (%)</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Height/weight issues</td>
<td>27.3</td>
<td>6.5</td>
<td>33.8%</td>
</tr>
<tr>
<td>Sexual health</td>
<td>19.9</td>
<td>20.1</td>
<td>40%</td>
</tr>
<tr>
<td>Academic matters</td>
<td>14.1</td>
<td>14.5</td>
<td>28.6%</td>
</tr>
<tr>
<td>Career</td>
<td>13.3</td>
<td>16.5</td>
<td>29.8%</td>
</tr>
<tr>
<td>BF/GF issues</td>
<td>5.9</td>
<td>12.5</td>
<td>18.4%</td>
</tr>
<tr>
<td>Conflict with parents</td>
<td>5.5</td>
<td>10.1</td>
<td>15.6%</td>
</tr>
<tr>
<td>General health</td>
<td>5.1</td>
<td>10.1</td>
<td>15.2%</td>
</tr>
</tbody>
</table>

Source: SHAHNS- Safdarjung Hospital, 2002.
The table indicates that while 33% of the adolescent have height/weight as first and second priority, 40% of them have sexual health as first and second priority.

1.2 REVIEW OF LITERATURE

1.2.1 Reproductive and Sexual Health Concerns: Global Scenario

The International Conference on Population and Development (ICPD) was held in Cairo, Egypt, in the year 1994. In CHAPTER VII part A and E of the ICPD Programme of Action Summary Report the expert group recommended that full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meet the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality

All the 180 countries including India which participated in the conference were called upon to strive to make reproductive health accessible through the primary health-care system to all individuals of appropriate age as soon as possible and no later than 2105 (ICPD Programme of Action Summary Report, 1995). The expert also recommended that such care should include, interalia: family planning counseling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counseling on human sexuality, reproductive health and responsible parenthood. It was also emphasized that the Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and

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2 ICPD Programme of Action Summary Report, 1995
evaluation of services. Innovative programmes must be developed to make information, counseling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STDs.

PART E of the report addressed the adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion (as defined by the World Health Organization), and STDs and HIV AND AIDS, it further stated that this can be achieved through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counseling specifically suitable for that age group (ICPD Programme of Action Summary Report, 1995). A substantial reduction in all adolescent pregnancies is also sought. The text stresses that countries must ensure that programmes and attitudes of health-care providers do not restrict adolescents' access to the services and information they need. The services must at all cost safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents. Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care, and greatly reduce the number of adolescent pregnancies. Governments are urged, in collaboration with NGOs, to establish appropriate mechanisms to respond to the special needs of adolescents.

1.2.2 Reproductive and Sexual Health Concerns: Regional Scenario

Changing social and economic conditions have brought risks as well as opportunities for the adolescents. While early marriage and some harmful traditional practices are diminishing, measures to prevent unwanted pregnancy and sexually transmitted diseases (STDs) among adolescents remain inadequate. In addition to these reproductive health issues, which are beginning
to be better documented, there remain areas of special concern which need more research and policy consideration. It is a fact that adolescents around the world engage in sexual activity and that the levels of sexual activity and the age at which they become sexually active do not vary considerably across comparable developed countries, such as Canada, Great Britain, France, Sweden and the United States (www.guttmacher.org/pubs/fb_teens.html, accessed on 27th May, 2008) In the United States, the teen pregnancy rate is more than nine times higher than that in the Netherlands, nearly four times higher than the rate in France, and nearly five times higher than that in Germany (Singh and Darroch, 2000). In the United States, the teen birth rate is nearly 11 times higher than that of the Netherlands, nearly five times higher than the rate in France, and nearly four times higher than that in Germany (Martin et al, 2001) and the teen abortion rate is nearly eight times higher than the rate in Germany, nearly seven times higher than that in the Netherlands, and nearly three times higher than the rate in France (Rademakers, 2001). The primary reasons why U.S. adolescents have the highest rates of pregnancy, childbearing and abortion among developed countries is the less overall contraceptive use and less use of the pill or other long-acting reversible hormonal methods, which have the highest use-effectiveness rates (www.guttmacher.org/pubs/fb_teens.html, accessed on 27th May, 2008).

The situation of the adolescents is not so different in the South or Southeast Asia. The only differences may be in terms of taboo attached to sexual activity. The countries of South and Southeast Asia encompass a richly layered mix of cultures, religions, languages, racial and ethnic groups, and economic and political systems. Although South and Southeast Asia are very different settings with regard to many aspects of adolescent sexual and reproductive health, there are also important commonalities. Most young adolescents throughout the region have little if any accurate information about their bodies and their sexual and reproductive health (Bott et al, 2003). In South Asia, 26% of all Bangladeshi girls ages 15 – 19 were married at age 14 or younger compared
with 14% in India, 9% in Nepal, and 7% in Pakistan. Arranged marriages of girls before age 15 do appear to be declining in these countries (Lloyd, 2005).

In Southeast Asia, very few girls ages 15 – 19 were married or say they had intercourse before age 15—from 3% in Indonesia to virtually none in Vietnam and almost no girls had babies this young. In a survey of unmarried adolescents ages 15 – 19 throughout Vietnam, only 19% of girls report ever having a girlfriend or boyfriend. Norms of sexual purity remain strong, resulting in very low reported levels of premarital sex before age 18 and virtually none before age 15 (Mensch, 2003). In a metropolitan region of the Philippines, adolescents begin dating in groups at ages 13 – 16. Romantic relationships and physical intimacy are postponed to later adolescence: at ages 17 – 19, 30% of boys and 20% of girls report having intercourse, and higher proportions report engaging in kissing, petting, and other intimacies (Upadhyay et al, 2006)

Adolescent health involves different professional perspectives and is of high public health importance, particularly reproductive health. More coordinated action in this field is required internationally, nationally; sub nationally and at other levels of government. In the 1990s, a series of global conferences of governments organized by the United Nations has produced an agenda designed to promote social equality and sustainable development for the twenty-first century. These conferences including the Fourth World Conference on Women (Beijing, 1995), the World Summit for Social Development (Copenhagen, 1995), the International Conference on Population and Development (Cairo, 1994), and the World Conference on Human Rights (Vienna, 1993) have resulted in an ambitious agenda for social equality, justice, development, and peace. Among the recommendations of these conferences was a governmental commitment to expanding adolescents' access to reproductive health information and services and promoting their well-being also, the World Health Organization (WHO) Meeting on Pilot Approaches in Adolescent Reproductive Health, held in Lisbon on 8 and 9 April 1999, targeted the broader societal framework in specific areas important for adolescent sexual and reproductive
health such as peer education, intersectoral action and building partnerships among different organizations at different levels of policy-making. Member States during the meeting have (increasingly) recognized that adolescent reproductive health is a public health issue of high priority, but few international and national guidelines exist for the planning, implementing and monitoring of programmes in this area. Over the past 10 years or so, the United Kingdom has seen an increase in initiatives to reduce barriers to sexual and reproductive health services for young people, and a decrease in adolescent pregnancy rates. The European Commission has a long tradition of supporting Reproductive Health Initiatives for Youth and Adolescents (RHIYA). Building on the successful model of RHIYA, the EU and UNFPA collaborate on a Reproductive Health Initiative for Youth in the South Caucasus. At country level, the EU and UNFPA support comprehensive youth-friendly sexual and reproductive health services in Zimbabwe, the scaling up of HIV and reproductive health services for young people in Malawi, and the establishment of comprehensive social services for young drug users in Ukraine.

1.2.3 Reproductive and Sexual Health Concerns: National Scenario

The commitment of the national government to the reproductive health approach forged at the International Conference on Population and Development (ICPD) in 1994 has reshaped the family welfare program into a broad-based Reproductive and Child Health (RCH) Services Program in India. Over the past 50 years, the population has grown at a rapid pace and so, has the adolescent population, despite a formal and a well-organized family planning program in India. Until quite recently, the approach of the family planning program has focused on achieving demographic goals by increasing contraceptive use. Policymakers and planners have now realized that the adolescent population group has specific health and developmental needs. There is a growing understanding that adolescence is a bridge between childhood and adulthood. The newer focus on RCH also has been invigorated
by the continuing realization of the importance of women’s health; it is now widely accepted that if the health of women is to be improved, the health of adolescents must be given high priority in Indian policy and program development and implementation. Unfortunately, the special needs of adolescents are rarely addressed by the educational, health, and family welfare programs in India.

In 1996, India included Adolescent Health in Reproductive and Child Health Programme. This Task-Force Study was planned to test the awareness level of adolescents regarding various reproductive health issues and to identify lacunae in knowledge, particularly in legal minimum age of marriage, number of children, male preference, contraceptive practices, about STIs/AIDS etc. Similarly, in the last five years, interest in the health of adolescents has begun to grow in developing countries and the concern about the adolescents sexual and reproductive health is great, in part because of real or perceived increases in their sexual activity and rates of pregnancy outside marriage, and in part because of high rates of HIV infection among adolescents. Despite the near-universal adult discomfort with the subject, consensus has begun to build in many countries that adolescent need expanded information, skills, and services concerning sexual and reproductive health. Adolescents' overall health and development are shaped by many factors. These factors range from the social, economic, cultural, and political conditions of the wider society to those that characterize the living situation of an individual adolescent, including family, education and income level. Improving health programs for adolescent can be only a partial solution to addressing the issues that concern their health. The concept of providing “friendly services” for the adolescents is gaining ground globally.

With an estimated 1 billion adolescents alive today, the world is experiencing the largest adolescent population in history. As a result, adolescent reproductive health is an increasingly important component of global health. Although adolescent reproductive and sexual health education is a new programme area
when taken under the context of the ICPD POA framework, not a few efforts had been ventured though by a number of forward-looking countries in the region to implement educational, advocacy and communication activities in the areas of human sexuality, HIV AND AIDS, and family life/population education, and of course more recently, adolescent reproductive health. Without doubt, these programmes and activities are characterized by weaknesses and gaps as planners and implementers are usually held back from trying out innovative approaches by opposition and objections from concerned quarters. However, there is also not a dearth of successful innovative strategies and approaches which can be documented and shared for others to learn from and even replicate. Sexuality and reproductive health education is an area that generates misconceptions, confusion, fear and unwarranted caution, to say the least. These can be ascribed by many factors. First, policy makers, community members, parents and teachers are reluctant to confront issues of sexual and reproductive health. Teen-agers often get their information from their peers who may be ignorant of the topic or the mass media which may provide sensational and inaccurate information.

In many programmes, curriculum and textbooks continue to limit their focus on biological, demographic, population and development and family life education issues. Sometimes, in spite of a well-designed curriculum, an ill-prepared or uncomfortable teacher can render a programme ineffective. Teaching methods used are often not suited to the sensitive nature of sexual and reproductive health education issues. However, the developments in this field have not been held back by a few conservatives and traditionalists. Many organizations, especially the non-governmental and voluntary organizations as well as bold government agencies have taken steps to undertake innovative strategies to introduce reproductive and sexual health messages into their programmes to reach the adolescents and influence them into taking responsible decisions regarding their sexual and health behaviors.
1.2.4 Reproductive and Sexual Health: Some Specific Issues

A common theme among literature reviews of adolescent sexual behaviour and reproductive health interventions is the poor methodological quality of much of the formative research, intervention development, and evaluation (Jejeebhoy, 2000). This has been attributed both to lack of cooperation between health promotion practitioners and researchers in terms of developing theoretically sound interventions, and to the suspicion with which many social scientists, educationalists, health promotion practitioners, and policy makers regard experimental research. Many educationalists regard access to sex education as a right in the same way as they regard access to learning to read and are therefore not interested in whether or not it changes some specific behavioral or biomedical outcome measures in an experimental study. This view contrasts sharply with that of some parents and religious groups, who are suspicious of sex education on the basis that it promotes sexual activity. Policy makers are not sure of the relative cost effectiveness of different educational approaches with different resource implications. Possibly as a result of this uncertainty, studies from around the world show that sex education is often poorly implemented and that high rate of HIV, STI, and unplanned pregnancy among adolescents continue to occur. Many women lack proper knowledge regarding sexual and reproductive health. This is an irony when in most countries of the SAARC region; nearly 60 percent of all girls are married by the age of 18 years with one fourth marrying by the age of 15 years. Till recently in India, an adolescent girl in the age group of 15-19 years is married. Mean age at marriage among adolescent girls is 14.7 years and the mean age at cohabitation slightly higher, 15.5 years (Narayan et al, 2000) this highlights the fact that sexual activity commences at an early age for the majority of Indian women. According to NFHS- (1) nearly 58 percent of adolescents have commenced childbearing. Only 7 percent adolescent girls use contraception (Narayan et al, 2000). Fertility in the age group of 15-19 years accounts for 19 percent of total fertility in India. About 23 percent of married adolescent girls’ age 15-19 years has second order of birth (Roy et al, 2000). A major concern about teenage
pregnancy is its impact on the overall health and well-being of the mother and the child. Social and economic changes, including urbanization, industrialization, and education, have eliminated many of the traditional restraints on early sexual activity outside marriage and have exposed many adolescents, especially adolescent girls, to the risks of unwanted pregnancy and abortion, which, in turn, increase the risks to their reproductive health and well-being (Dixon-Mueller, 1993; Cho, 1995). Presumably, rates of pre-marital sex are on the rise. Even though age at marriage is increasing, age at intercourse is clearly declining, both among males and females. Nutritional deprivation, increased demand for her growth, excessive menstrual losses and superadded pregnancy, all conspire to aggravate anemia, and its ill effects (Bhatia and Chandra, 1993). Lack of knowledge, skills, and access to contraception and vulnerability to sexual abuse put adolescents at highest risk of unwanted pregnancy, early childbirth, unsafe abortion and RTI including HIV and AIDS. More than half of all new HIV infections, reported globally are from the age group of 15-24 years (WHO, 2002). In many developing countries, data indicate that up to 60 per cent of all new HIV infections are among 15-24 year olds (UNAIDS/WHO, 1998). Infection among females outnumbers infection among males by a ratio of 2 to 1 (UNAIDS/WHO, 1998; ICRW, 1996). According to WHO, 333 million new cases of STIs occur worldwide each year, and at least 111 million of these cases occur to people under the age of 25 years (WHO/UNFPA/UNICEF, 1999). Adolescents are at high risks of STIs and HIV for a variety of reasons, such as lack of knowledge about STIs, including HIV; not perceiving themselves to be at risk of exposure; lack of access to or inconsistent use of condoms; increased number of sexual partners leading to increased risk of exposure; biological factors (a woman’s cervical epithelium is more susceptible to infections); economic factors (adolescent may live or work on the street and participate in ‘survival sex’ or ‘transactional sex’); and social factors (such as being forced into sexual relationship, lacking the skills or power to negotiate condom use, and encountering gender norms, double standards, or cultural/religious norms regarding sexuality and fertility) (McCauley and Salter
Adolescents may be reluctant or unable to seek treatment for STIs or HIV because they fear the disapproval of family or the community, are afraid to get tested, or do not know how to recognize the symptoms. In some instances attitude and behavior of the service providers may discourage adolescent girls to seek antenatal and postnatal care which is vital to their reproductive health and the health of new born (Williams et al., 1994; De Silva, 1997).

Substance abuse usually begins during adolescence. Few people begin tobacco misuse after the age of 18. Half of regular smokers who start in adolescence and smoke all their lives will eventually be killed by tobacco. Alcohol is the commonest factor in substance related deaths among the adolescents. Thus, drug addiction among adolescent is another malady. Drug abuse among adolescent would affect their physical, psychological, social and future family life. Risk-taking behavior is heavily concentrated during adolescence, and when adolescents take one risk, they also tend to take other risks; alcohol or drug use often takes place in combination with unsafe sexual activities. (Saloucou et al, 2003). The dramatic rise in the frequency of unprotected sex when moving across the marital boundary is driven by not only the implication of infidelity or distrust associated with certain forms of contraception, such as condoms, but also often by a strong desire to become pregnant (Gardner et al, 1999).

Similarly, the health problems need special attention in the context of tribal communities of India. The tribal population in India represents a unique form of society, which is distinct in several respects from the general population. As per the 1991 Census, the Scheduled Tribes account for 67.76 million representing 8.08 percent of the country’s population. Despite the difficulties which stood in the way of identification of tribes, there has been a complete awareness about the extreme social, educational and economic backwardness of the tribal communities among the policy makers, planners and administrators of the country. The tribal community development has come into focus recently due to the economic progress being made in the country and the issues raised in its wake. Though a lot of funding has been allocated to their development, not
much difference has made to their lives due to the problems of implementation as acknowledged by the government from time to time. Tribal populations have distinctive problems, not because they have a special kind of health, but because of placement in difficult area and circumstances in which they live. 'To fulfill the goal of Health for All, it is high time that sorting of the problems of difficult areas, specific groups of populations and of need based health problems at large should be done on priority basis' (Bali, 1988). The health and nutrition problems of the vast tribal population of India are as varied as the tribal groups themselves which present a bewildering diversity and variety in their socio-economic, socio-cultural and ecological settings. Tribal groups of India have specific problems, some of these are built-in problems and some are imposed upon them, which jeopardize their overall development and progress inclusive of their health. Therefore the health care delivery system should be such designed for each specific group that it caters to their specific needs and problems by bringing their personal involvement. Very little scientific information is available on the health status of the tribal adolescent especially girls due to lack of systematic and comprehensive research investigations. Data on reproductive health among the tribal population is meager. Collection of this sensitive information was found to be difficult in tribal situation, and mostly the information was underreported.

'The National Health Policy (1982) as well as the new revised 20 point programmes of the Government of India stressed the need for improving the health status and quality of life of the underprivileged population. Under these programmes, extension of existing health system to remote and difficult tribal areas is being made with the earnest hope that this will improve the deplorable health conditions of the tribal people' (Basu, 1993:272).

Thus, we can list out some important problems specific to adolescence regardless of any boundaries, these include:

- Early pregnancy
- Abortion
- STDs including HIV AND AIDS
• Substance abuse (including abuse of alcohol and tobacco with or without addiction)
• Risk-taking, impulsive behavior leasing o accidents, suicides, and homicides
• School dropout or truancy and unemployment
• Juvenile delinquency
• Prostitution

In conclusion it would not be wrong to mention that adolescents have only recently been recognized as a separate group with different needs than adults or other children. In India, adolescent reproductive and sexual health (ARSH) programming is therefore still at its nascent stages, though there has been a welcome increase in community-based programs for adolescents. Like many countries India’s general policies related to adolescent reproductive health can aims to improve the reproductive health status, including sexual health, of adolescent through education, counseling and provision of reproductive and sexual health care services. Though the effort has begun the more important need is to sustain the effort.