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Young people's sexual and reproductive health in India: Policies, programmes and realities

K.G. Santhya
Population Council

Shireen J. Jejeebhoy
Population Council

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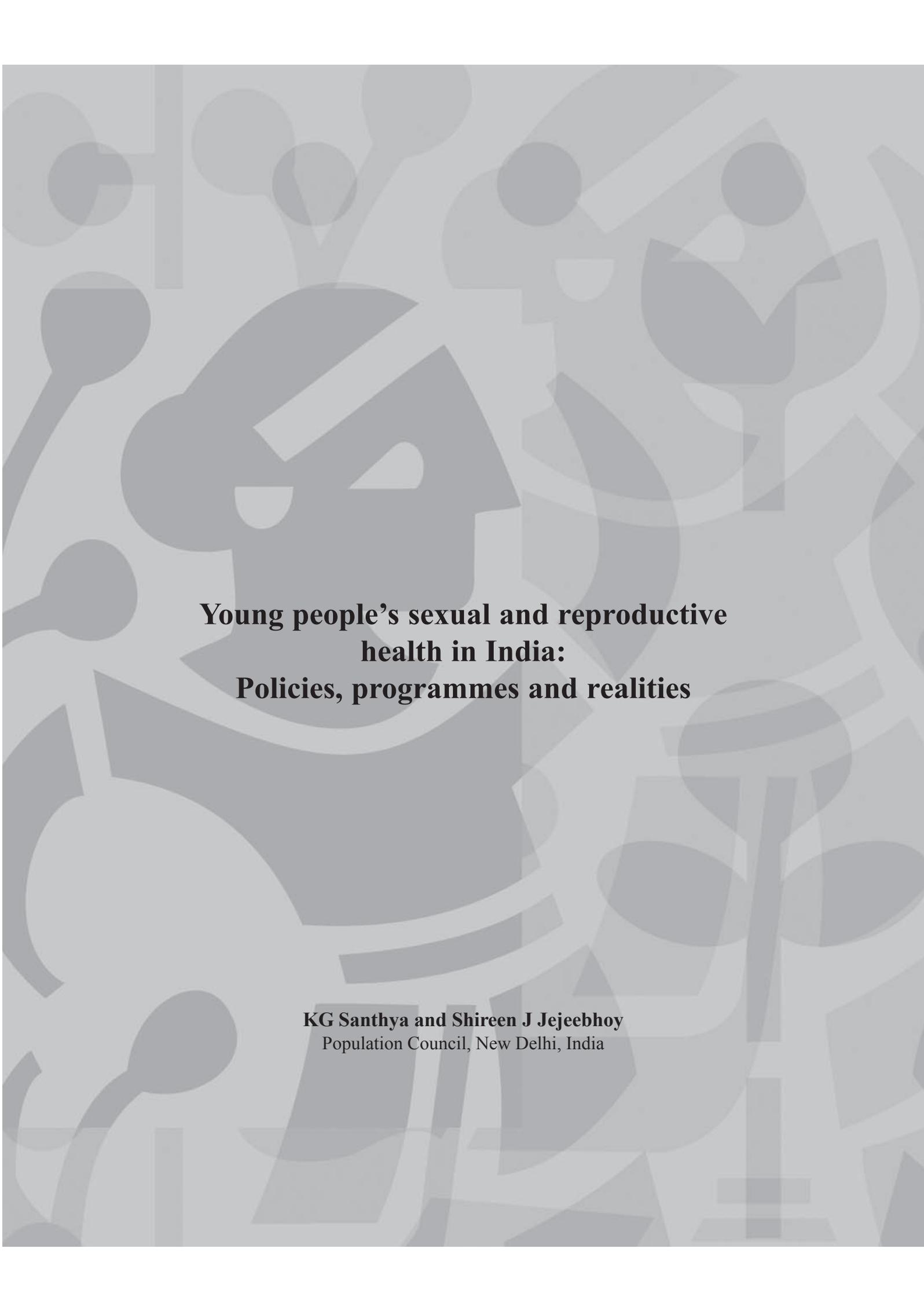
South & East Asia

Young people's sexual
and reproductive health
in India: Policies,
programmes and
realities

KG Santhya

Shireen J Jejeebhoy

 **Population Council**
New Delhi, India



**Young people's sexual and reproductive
health in India:
Policies, programmes and realities**

KG Santhya and Shireen J Jejeebhoy
Population Council, New Delhi, India

**Population Council
Regional Office for South and East Asia
Ground Floor, Zone 5A, India Habitat Centre
Lodi Road, New Delhi - 110 003, India**

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Abstract

This paper presents an overview of key policies and government programmes intended to reduce HIV vulnerability and improve sexual and reproductive health among young people in India, and identifies the extent to which these policies and programmes have addressed the gamut of unique sexual and reproductive needs of young women and men. It also explores the extent to which programmes have been adapted to accommodate state-level differences in the sexual and reproductive vulnerability of youth; the review takes the examples of two states, namely, Andhra Pradesh, characterised by both early marriage and high HIV prevalence, and Madhya Pradesh, characterised by early marriage and low rates of HIV. The review focuses on four programme dimensions: awareness building, service provision, reducing gender disparities and developing a supportive environment.

Findings suggest that significant strides have been made in articulating a commitment to addressing many of the sexual and reproductive health needs of adolescents and youth. However, there remains a considerable schism between the commitments made in policies and programmes, the implementation of these commitments and the reality of young people's lives in India. At the state level too, the implementation of programmes to meet these commitments varies considerably.

While several national and state-specific programmes have been implemented to raise awareness about sexual and reproductive health among young people, our review suggests that on balance, communication programmes appear to stress HIV and safe sex over other aspects of sexual and reproductive health. Moreover, the focus of awareness raising programmes has been somewhat skewed in terms of sub-populations covered; married young women for example, are least likely to be reached. With regard to the provision of services, although policies and programmes have underscored the right of adolescents and youth to sexual and reproductive health counselling and services, service delivery has not been youth-friendly or responsive to their unique needs, and there is considerable ambiguity in the extent of service delivery; the unmarried for example, remain under-served. Programmes intended to reduce gender disparities and enhance the status of girls and young women tend to be limited in their reach and variable in their content; efforts thus far have focused more on improving the nutritional status of adolescent girls than on changing gender inequalitarian attitudes, sensitising youth and their gatekeepers about the sexual and reproductive rights of women and men, or changing the perceptions of young men. Similarly, efforts to build a

supportive environment to meet young people's needs have yet to be undertaken in a sustained way and among all gatekeepers, particularly parents. Evaluations of programmes that have been implemented have not always been systematic or rigorous.

Policies and programmes have recognised the importance of improving sexual and reproductive health and choice among young people and the importance of healthy youth in shaping India's future. Efforts have been initiated to translate this commitment into practice; what is needed is a similar level of commitment to ensuring that programmes do indeed reach young people, that the scope and content of programmes are expanded, and promising lessons are assimilated and scaled up.

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Caveat

Information is, happily, in a state of fluidity. Since writing the original draft of this paper, new information and data have been published and have shed new light on the situation of young people, and policy and programmatic efforts to address young people's sexual and reproductive health needs in India. As far as possible we have tried to update the paper, but recognise that there will always be gaps, and perhaps whole areas of importance, that have not been addressed. We would be grateful for any further relevant information that anyone reading this Working Paper is able to provide us with, and we will try to incorporate it into our next publication.



1 Introduction

About 315 million people in India—nearly one-third of the country’s population—are young people aged 10–24 (RGI 2001). Compared to earlier generations, the situation of young people in India has considerably improved; they are healthier, more urbanised and better educated than ever before. Nonetheless, the majority continue to experience major constraints in making informed life choices. It is generally acknowledged that significant proportions of young people experience risky or unwanted sexual activity, do not receive prompt or appropriate care, and experience adverse reproductive health outcomes. Indeed, youth constitute a large proportion of the HIV-positive population; it is estimated that over 35 percent of all reported HIV infections in India occur among young people 15–24 years of age (www.unaids.org.in). Clearly, the extent to which the current cohort of young people engages in risky or safe behaviour will determine the trajectory of the epidemic in the coming decades.

India has articulated its commitment to promoting and protecting the sexual and reproductive rights of adolescents and youth through its policies and in several forums. The National Population Policy 2000, the National AIDS Prevention and Control Policy 2002, the National Youth Policy 2003 and the Reproductive and Child Health (RCH) Programmes (I and II) 1997; 2005 are key examples of the recognition that the sexual and reproductive rights of adolescents require urgent attention. This commitment has been reinforced at various international forums. India has, for example, endorsed the International Conference on Population and Development (ICPD) and the ICPD+5 Programme of Action, and made a commitment to “protect and promote the right of adolescents to the enjoyment of the highest attainable standard of health” (UN 1999). India was one of the first countries to ratify, in 1992, the Convention on the Rights of the Child. India has also signed the Convention on the Elimination of All Forms of Discrimination Against Women that reinforces the rights of adolescent and young females. It is also evident that the realisation and sustainability of the Millennium Development Goals rests, to a considerable extent, on the sexual and reproductive situation of young people.

In this paper, we present an overview of key policies and government programmes intended to reduce HIV vulnerability and improve sexual and reproductive health among young people, and

identify the extent to which these policies and programmes have addressed the gamut of unique sexual and reproductive health needs of young women and men. A secondary objective is to explore the extent to which programmes have been adapted to accommodate state-level differences in the sexual and reproductive vulnerability of youth; therefore our review draws contrasts between the situation in two states, namely, Andhra Pradesh, characterised by both early marriage and high HIV prevalence, and Madhya Pradesh, characterised by early marriage and low rates of HIV.

We begin with a summary of what is known about the sexual and reproductive health situation of young people. We then present a synthesis of the salient features of policies and programmes, and explore the extent to which these have responded to the diverse needs of youth; we focus specifically on four thrust areas, namely, raising awareness about sexual and reproductive health issues, facilitating access to sexual and reproductive health counselling and services, addressing gender disparity, and building a supportive environment to address the sexual and reproductive health needs of young people. The section also highlights state-level programmes implemented in Andhra Pradesh and Madhya Pradesh. Finally, we summarise the extent to which policies and programmes will have to traverse to make improved sexual and reproductive health a reality for young people in India.

Methodology

In preparing this paper, we reviewed national and state-level policies and vision documents pertaining to population, youth, health, HIV/AIDS prevention and control, women's empowerment and education. At the national level, the policy documents reviewed were the National Youth Policy 2003, the National Health Policy 2002, the National AIDS Prevention and Control Policy 2002, the National Policy for the Empowerment of Women 2001, the National Population Policy 2000 and the National Policy on Education 1986 (as modified in 1992). At the state level, the following policies were reviewed: the Andhra Pradesh State Population Policy 1997, the Andhra Pradesh Vision 2020 and the Madhya Pradesh State Population Policy 2000. We also reviewed national and state-specific programme documents, including national and state Programme Implementation Plans (PIPs) of the RCH Programme II, and the annual reports of various ministries, including Health and Family Welfare, Youth Affairs and Sports, Human Resource Development, Women and Child Development and AIDS Control Organisation/Societies, if any.

We start by acknowledging the limitations of this paper. First, though youth programming has a long history in India, our discussion mainly focuses on the policies and programmes initiated in the



1990s and after. Second, while the focus of this paper is on programmes initiated by the government, we recognise that NGOs have played a significant role in articulating the sexual and reproductive health needs and rights of adolescents and young people, and in designing programmes that respond to young people's diverse needs. Third, while our intention is to assess programmes intended to meet the needs of married and unmarried young people separately, we acknowledge that programmes have rarely distinguished between the married and the unmarried, or between married youth and adults. Fourth, the selection of states for comparison was based entirely on two indicators, namely early age at marriage and HIV prevalence rates; their experiences should not be taken as representative of youth programming across states. Finally, the lack of data on the reach of most programmes has hampered our discussion on the extent to which these programmes have succeeded in meeting the sexual and reproductive health needs of young people.

The situation of young people

Evidence on the sexual and reproductive health situation of young people in India suggests that this group continues to have a wide array of unmet needs (see Table 1). First, marriage and childbearing continue to take place in adolescence for significant proportions of young women: while the age at marriage for women has undergone a secular increase, the reality is that more than two-fifths of all women aged 20–24 were married by 18 years and 16 percent of all girls aged 15–19 have already experienced pregnancy or motherhood. Second, the use of sexual and reproductive health services by young people is far from universal. Indeed, even among the married, who are clearly included in policies and programmes, access to services is limited; neither contraceptive services nor pregnancy-related care are accessed by significant proportions of married young women. Third, young people remain poorly informed on issues of sexual and reproductive health, and those who report awareness tend to harbour misperceptions or have only superficial information about these issues. For example, only 50 and 75 percent of married young women and men had heard of HIV; of those who had heard of HIV, only 23 and 40 percent of married young women and men respectively were aware that correct and consistent condom use can reduce the chances of getting HIV. Among the married, communication between women and their husbands about sexual and reproductive matters tends to be limited; in 1999–2000, for example, only some 22 percent of married young women aged 15–24 had discussed family planning matters with their husbands (IIPS and ORC Macro 2000). While evidence on sexual risk-taking is not available at the national level, a synthesis of small and admittedly unrepresentative studies undertaken in different geographical settings and among different sub-populations of youth suggests that 15–30 percent of young men and fewer than 10 percent of young



women have experienced premarital sexual relations, mostly unprotected (Jejeebhoy and Sebastian 2004).

Comparable state-level data on young people are not available on all indicators, hence Table 2 provides the most recent available data on the sexual and reproductive health situation of young people in Andhra Pradesh and Madhya Pradesh, and the overall fertility and HIV prevalence rates more generally in each state. What is available reiterates that while both states are characterised by

Table 1: Sexual and reproductive health profile of young people in India

Indicator	India
Marriage (2005–6) % Females aged 20–24 married by age 18 ¹ % Males aged 25–29 married by age 21 ¹	44.5 29.3
Pregnancy and childbirth (2005–6) % Girls aged 15–19 who were already mothers or pregnant ¹ Median age at first birth for women aged 25–49 ¹ Total fertility rate ^{1*}	16.0 19.8 1.79
Contraceptive use (2002–4) % Married young women aged 15–24 currently practising contraception by self or husband ² % Married young women aged 15–24 currently practising modern contraception by self or husband ² % Married young women aged 15–24 expressing an unmet need for contraception ²	24.5 19.2 25.3
Maternal health seeking (2002–4) % Married young women aged 15–24 who received any antenatal check-up ² % Married young women aged 15–24 who delivered at a health facility ²	77.5 42.0
Awareness of HIV/AIDS (2002–4) % Married young women aged 15–24 who have heard of HIV/AIDS ² % Married young men aged 15–24 who have heard of HIV/AIDS ² % Married young women aged 15–24 who know that consistent condom use can reduce the chance of getting HIV (among those who have heard of HIV) ² % Married young men aged 15–24 who know that consistent condom use can reduce the chance of getting HIV (among those who have heard of HIV) ²	49.9 75.3 23.3 40.3
HIV prevalence among women seeking antenatal care (2005)^{3*}	0.88

Sources: ¹IIPS 2007; ²IIPS 2006; ³NACO 2006.

*refers to women in general and not just young people.



early marriage and early initiation of childbearing, they differ widely on other sexual and reproductive health indicators. For example, antenatal care and institutional delivery are far more likely to be experienced by young women in Andhra Pradesh than Madhya Pradesh; awareness of HIV is, likewise, considerably higher, and unmet need for contraception somewhat lower. Clearly, these kinds of differences call for different programme thrusts in each state.

Table 2: Sexual and reproductive health profile of young people in Andhra Pradesh and Madhya Pradesh

Indicator	Andhra Pradesh	Madhya Pradesh
Marriage (2005–6)		
% Females aged 20–24 married by age 18 ¹	54.7	53.0
% Males aged 25–29 married by age 21 ¹	34.8	54.0
Pregnancy and childbirth (2005–6)		
% Girls aged 15–19 who were already mothers or pregnant ¹	18.1	13.6
Median age at first birth for women aged 25–49 ¹	18.8	19.4
Total fertility rate ^{1*}	1.79	3.12
Contraceptive use (1998–99)		
% Married young women aged 15–24 currently practising contraception by self or husband ²	28.8	13.5
% Married young women aged 15–24 currently practising modern contraception by self or husband ²	28.5	12.5
% Married young women aged 15–24 expressing an unmet need for contraception ²	16.8	24.4
Maternal health seeking (1998–99)		
% Married young women aged below 20 who received any antenatal check-up ²	94.4	61.3
% Married young women aged below 20 who delivered at a health facility ²	47.6	17.9
Awareness of HIV/AIDS (1998–99)		
% Married young women aged 15–24 who have heard of HIV/AIDS ²	57.2	17.2
% Married young women aged 15–24 who know that consistent condom use can reduce the chance of getting HIV (among those who have heard of HIV) ²	16.4	25.7
HIV prevalence among women seeking antenatal care (2005)^{3*}	2.00	0.25

Sources: ¹IIPS 2007; ²IIPS and ORC Macro 2001a; 2001b; ³NACO 2006.

*refers to women in general and not just young people.



2 Policy initiatives to address young people's needs

The importance of investing in young people has been recognised in India since the time of the framing of the Constitution. One of the Directive Principles of State Policy for example, states that “children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment” (Article 39f) (www.lawmin.nic.in). In this chapter, we discuss national and state-level policies that seek to address young people's needs.

National policies: Key strategies

A number of policies reaffirming a commitment to young people were formulated in the 1970s and 1980s, including the National Policy for Children 1974 and the National Youth Policy 1985. However, these initiatives paid only superficial attention to the health needs and concerns of adolescents and young people. For example, the National Youth Policy 1985 limited itself to such matters as sports, education and vocational training (www.yas.nic.in), and made no reference to the health needs of young people.

The significant shift in the way population and reproductive health problems were conceptualised during the 1990s brought about greater attention to the health concerns of adolescent and young people as well. This attention is clearly reflected in several policies adopted since the 1990s. Notable among national policies that address young people's sexual and reproductive health needs and rights are those concerning the population, AIDS and youth.

The National Population Policy 2000 recognised, for the first time, that adolescents constitute an under-served group with special sexual and reproductive health needs, and advocates special programmatic attention to addressing this population (MOHFW 2000). It recommends the need to ensure for adolescents access to sexual and reproductive health information, and counselling and services that are affordable and accessible. It also underscores the need to “strengthen primary health centres and sub-centres to provide counselling, both to adolescents and also to newly-weds”.



The Policy also advocates special programmatic attention to delay age at marriage and to enforce the Child Marriage Restraint Act 1976.

The growth of the HIV/AIDS epidemic in India and the recognition of its spread among young people have resulted in a greater openness in addressing issues relating to sex among young people. Recognising the special vulnerability of youth, the National AIDS Prevention and Control Policy 2002 notes the need to promote a better understanding of HIV infection and safer sex practices among youth (NACO 2002). Indeed, one of the stated objectives of the Policy is to spread information among “students, youth and other sexually active sections to generate greater awareness about the nature of its transmission and to adopt safe behavioural practices for prevention” through programmes especially designed to meet their needs. The Policy stresses a variety of measures to prevent risky behaviour among these groups, including awareness building, condom promotion, creation of an enabling environment and reinforcing traditional Indian moral values. The Policy advocates the provision of HIV/AIDS education in schools and colleges through curricular and extra-curricular activities, as well as through youth organisations for those outside of educational institutions.

The National Youth Policy 2003 addresses the needs of those aged 13–35, but recognises adolescents (aged 13–19) as a special group requiring different strategies from those appropriate for young adults (aged 20–35) (Ministry of Youth Affairs and Sports 2003). With regard to health issues, the Youth Policy outlines a number of the recommendations articulated in the National Population Policy and the National AIDS Prevention and Control Policy, and highlights several new strategies as well. For example, like the National Population Policy, it recognises the vulnerability of youth in the sexual and reproductive health arena, and recommends the provision of counselling, services and information to enhance safe behaviours and to raise age at marriage. It also advocates the provision of free state-sponsored counselling services for youth, the establishment of “adolescent clinics” to provide appropriate counselling and treatment, and the establishment of Youth Health Associations at the grassroots level to provide family welfare and counselling services. As with the National Population Policy, the Youth Policy also reiterates the commitment to redress gender imbalances among young people in terms of age at marriage, nutritional status and life skills building. It discusses, in addition, the need for a multi-sectoral focus on youth empowerment and gender justice.

Several other policies, such as the National Policy on Education 1986 (MOHRD 1998), the National Policy for the Empowerment of Women 2001 (MOWCD 2001) and the National Health Policy



2002 (MOHFW 2002) also acknowledge the need to pay special attention to young people. The National Policy on Education emphasises that educational programmes should actively motivate and inform youth about family planning and responsible parenthood. It also stresses the need to reduce gender imbalances in school attendance and completion (MOHRD 1998). The National Policy for the Empowerment of Women identifies adolescent girls as a vulnerable group and highlights the need to address their education and nutrition needs; at the same time it recognises the need to raise age at marriage and address gender-based violence (MOWCD 2001). The National Health Policy also recognises the need to address nutritional deficiencies in women and girls, and to raise awareness among school and college students about health promoting behaviour (MOHFW 2002).

Also notable is the commitment to addressing the needs of adolescents and young people articulated in the Five-year Plans, particularly the Tenth and Eleventh Plans, and the National Adolescent Reproductive and Sexual Health Strategy that provides the framework for the adolescent sexual and reproductive health services proposed in the RCH Programme II. The action plan laid out in the Tenth Plan document clearly recognised adolescents as a group with special and distinct needs and underscored the importance of investing in adolescents. It proposed launching a new scheme aimed at sensitising adolescents about an array of issues including safe motherhood, reproductive health rights, sexuality and sexual responsibility, age at marriage and first pregnancy, hygiene, immunisation, HIV/AIDS prevention and the importance of education, particularly of girls, as well as providing some legal literacy and information about vocational opportunities and career planning. Additionally, it proposed to implement nutrition and health interventions for adolescent girls (Planning Commission 2002). In accordance with the importance placed on addressing adolescent and youth issues, a steering committee on youth affairs and sports has been established in connection with the preparation of the Eleventh Five-year Plan. While the recommendations of the committee are not yet available in the public domain, we note that the Eleventh Plan Approach Paper recognises that adolescent girls remain marginalised, and seeks to focus on reducing the incidence of anaemia and malnutrition among adolescent girls to break the cycle of ill-health and maternal and infant mortality. The Approach Paper also seeks to promote awareness about gender issues among youth using the Panchayat Yuva Shakthi Abhiyan (Planning Commission 2006).

Probably the most comprehensive and wide-ranging in terms of addressing young people's sexual and reproductive health needs is the National Adolescent Reproductive and Sexual Health Strategy. This strategy has recognised, for the first time, the heterogeneity of young people, including young men and the unmarried. It calls on the health sector to provide friendly, confidential and non-judgemental services for youth, proposes detailed training of various providers to enhance their



ability to serve youth needs, and advocates a wider range of services for youth than has been the case thus far (MOHFW 2005).

State-level policies: Key strategies

A number of state-specific health and population policies and vision statements were announced in the late 1990s and in early 2000, including those of Andhra Pradesh and Madhya Pradesh. These have reiterated the need to establish programmes that raise age at marriage and at first birth, encourage school continuation among adolescent girls, introduce family life education through schools and non-formal education channels, and/or provide counselling and/or health services for adolescents.

The Andhra Pradesh Population Policy 1997, for example, articulates a number of goals to improve the situation of adolescents, particularly girls. In the area of health, it aims to promote family planning among newly-married couples by providing counselling on birth spacing, and raising awareness about such issues as delaying first birth, increasing birth spacing and increasing male responsibility in reproductive behaviour. One of the stated objectives of the Policy is to increase age at marriage of females; the Policy contains a number of recommendations to achieve this objective, including IEC efforts to highlight the adverse effects of early marriage and pregnancy, introduction of the girl child scheme to delay marriage at young ages, involvement of political and community leadership, involvement of women's groups and NGOs in promoting attitudinal changes among young men, parents and communities, and the promotion of education for the girl child through awards and incentives for panchayats/ nagarpalikas/ districts that achieve full enrolment and retention of girl children in schools (Government of Andhra Pradesh 1997).

The Vision 2020 document of Andhra Pradesh also reaffirms this commitment. In line with the Population Policy, the Vision 2020 also aims to promote family planning among newly-married couples by providing counselling on birth spacing, encouraging male involvement in contraception, and improving maternal health by encouraging adolescents to delay pregnancy until age 21. It seeks to address such health problems of adolescent girls as chronic anaemia through the establishment of nutrition programmes for adolescent girls at *anganwadi* centres. As in the population policy, the document also discusses the need to ensure the enrolment and retention of girls in school, and proposes to expand the number of *anganwadi* centres to provide crèche services so as to enable older girls to attend schools; provide "Back to School" bridge courses to help girl drop-outs return



to school; and equip girls with vocational skills to make them self-reliant. The Vision document also underscores the need to involve communities in building awareness about the adverse effects of early marriage (www.aponline.gov.in). Similarly, the Madhya Pradesh State Population Policy describes measures to enact compulsory registration of marriages and conduct campaigns intended to draw attention to the importance of delaying marriage; encourage at least 30 percent of girls aged 14–15 to complete elementary education; provide vocational training to girls who have completed elementary education; provide family life education to those aged 18–25; and form groups of newly-wed couples and create awareness of about reproductive health issues in these groups. The Policy also notes the importance of sensitising parents about the need for family life education for adolescents (Government of Madhya Pradesh 2000).

Gaps

As can be noted, several policies formulated at the national and state levels in the recent past clearly articulate a commitment to meeting the sexual and reproductive health needs of adolescents and young people. However, with the exception of the recent National Adolescent Reproductive and Sexual Health Strategy, most policies have overlooked the fact that young people are not a homogenous group. For example, the National Population Policy has neglected to discuss whether it is advocating services for all adolescents or exclusively for married adolescents. While it does not specifically indicate that unmarried adolescents are ineligible to access services, such statements as “reproductive health services for adolescent girls and boys are especially significant in rural India, where adolescent marriage and pregnancy are widely prevalent” suggest a certain ambivalence with regard to the extent to which services will be made available to meet the sexual and reproductive health needs of the unmarried. Likewise, the National Youth Policy remains ambiguous about the extent to which services will be made available to the unmarried or to girls. On the other hand, the focus of the National AIDS Prevention and Control Policy 2002 is largely on unmarried young people (students in school and college) and to a certain extent, married young men. Even though the Policy advocates reaching out-of-school youth, who obviously include both the unmarried and married, through networks of youth organisations, sports clubs, the National Service Scheme and Nehru Yuvak Kendras, the fact that most of these networks largely cater to young males suggests that unmarried out-of-school and married adolescent girls and young women are unlikely to be reached by the proposed programmes.



While almost all policies underscore the need to raise awareness about sexual and reproductive health issues among young people, many do not recognise young people's need for sexual and reproductive health services. For example, the National AIDS Prevention and Control Policy is notably silent about the delivery of any specially packaged services for young people. Similarly, the National Health Policy does not contain any reference to young people's need for sexual and reproductive health services or counselling. Further, policies that have recognised such needs are somewhat ambiguous about the nature of services to be made available to young people. For example, the focus of the National Population Policy is clearly on the less controversial aspects of sexual and reproductive health—counselling and dissemination of information—but not quite as clearly on the provision of services to unmarried adolescents. In this Policy, adolescents are included as a target audience for community-level education campaigns about the availability of safe abortion services and the dangers of unsafe abortion, but they are not included as a target group for safe and legal abortion services. Also, while nutritional services (because of their link with subsequent safe pregnancy) and pregnancy-related care are recommended, other key services are not mentioned. Similarly, the National Youth Policy leaves ambiguous the kinds of services that the recommended adolescent clinics and programmes will provide and the extent to which services will be available to the unmarried or to girls.

Also of concern is the phased approach advocated in the RCH Programme II National PIP in which only selected districts, depending on fertility and other indicators, will implement the full range of adolescent sexual and reproductive health interventions. While this guarded approach is understandable given the lack of tested models for integrating adolescent sexual and reproductive health services within the framework of the existing public health system and the variable capacity of the health system at the grassroots level to deliver these services, it overlooks the fact that large proportions of young people continue to face significant sexual and reproductive vulnerabilities that need also to be addressed.

Further, the National Population Policy and the National Youth Policy do not adequately recognise the barriers that young people face in accessing sexual and reproductive health services. For example, affordability and accessibility are issues that are merely cited but not discussed in the National Population Policy, and issues of confidentiality are neither mentioned nor discussed. Similarly, while the National Youth Policy mentions these issues, it does not discuss how confidentiality or quality of care will be addressed. This gap has however been recognised, and the National Adolescent Reproductive and Sexual Health Strategy clearly notes both the need for confidentiality and youth-friendly care (MOHFW 2005).



Given the lack of recognition at policy level of young people's need for sexual and reproductive health services, it is not surprising that the need for orienting health care providers about young people's service needs have not been discussed in most policies, including the National Population Policy, the National Youth Policy and the National AIDS Prevention and Control Policy. Again, the National Adolescent Reproductive and Sexual Health Strategy is an exception, emphasising the need for provider orientation and training and even training guides for different levels of the health care system (MOHFW 2005).

Most of the national and state-level policies reviewed in this paper have made a commitment to address the gender disparities underlying the poor sexual and reproductive health situation of young people. However, the policy documents are vague about how these commitments are to be operationalised. Further, while reference is made to the need to create a safe environment to address young people's needs, the measures to be taken to do so are rarely described in national-level policy documents. However, some state-level policy documents of Andhra Pradesh and Madhya Pradesh do suggest strategies for creating a supportive environment to address youth needs.



3 Programme initiatives to address young people's needs

Several programmes to translate policy prescriptions for young people into reality were initiated in the 1980s, and a few programmes even earlier.¹ Since the 1990s programmatic efforts in the area of sexual and reproductive health have been considerably enhanced. These initiatives include, for example, the revamping of the National Population Education Programme, the launching of the Adolescent Girls Scheme (now known as the Kishori Shakti Yojana), the introduction of national and state-specific investment schemes for the girl child and the launching of the RCH Programme I and II. Generally, national and state-level programmes have focused on addressing young people's sexual and reproductive health and related needs in four broad areas: raising awareness about reproductive and sexual health matters, facilitating access to reproductive and sexual health counselling and services, addressing gender disparity, and building a supportive environment.

In the following sections we review government programmes and their implementation in each of these four broad areas. Evidence on many of these issues is admittedly sparse and we have relied on a small number of case studies, largely unrepresentative of youth in India as a whole. While we have presented a comparative analysis of programmes in two states—Andhra Pradesh and Madhya Pradesh—data are sparse and most information available is on awareness building initiatives in these two states.

Programmes to raise awareness about reproductive and sexual health issues

A number of national and state-specific programmes have been implemented to raise awareness about sexual and reproductive health among young people. While some of these programmes have targeted young people in school, others have focused on those out of school. Some programmes have targeted the population more generally, but have acknowledged young people as a group requiring special attention. While efforts to raise awareness have been made by both the RCH Programme (I and II) and HIV/AIDS control programmes, our review suggests that on balance, communication programmes appear to stress HIV and safe sex over other aspects of sexual and reproductive health, and that information delivery mechanisms are far more numerous with regard to HIV, safe sex and condom promotion than other aspects of sexual and reproductive health.



Programmes for school- and college-going youth

Programmes to build awareness on sexual and reproductive health matters tend to focus on school- and college-going youth rather than those out of school. Under the broad heading Adolescent Education Programmes fall two key programmes, namely the National Population Education Programme and the School AIDS Education Programme (MOHRD, NACO and UNICEF 2005). The earliest and most well known programme to be initiated in the country was the National Population Education Programme, currently known as the Population and Development Education Programme. Launched in the early 1980s and implemented through schools, colleges and non-formal adult education centres, the National Population Education Programme originally aimed to sensitise young people with regard to population and development issues. With the paradigm shift in the 1990s, the National Population Education Programme shifted its focus from demographic issues to reproductive and sexual health and gender issues (Chakrabarti 2003). To further national efforts to promote family life and population education among adolescents, the National Centre for Educational Research and Training, which is responsible for developing national curriculum standards, has incorporated sex education with information on the growth and development of adolescents, life skills and HIV/AIDS into the national curriculum since the mid-1990s.

With the emergence of the HIV epidemic, the Ministry of Human Resource Development, Department of Education and the National AIDS Control Organisation have launched a number of HIV/AIDS education programmes in schools and colleges. The School AIDS Education Programme for example has been established for students of Classes IX–XII. As part of the programme, a generic toolkit has been prepared for implementation at the state level, which includes a *Learning for Life* module as well as training and advocacy materials, teachers' workbooks and flip charts, reference books, booklets on *Frequently Asked Questions* for students and a 40-hour life skills programme. Sessions are generally conducted in the biology or science class, and include such topics as human anatomy and modes of HIV transmission, prevention and testing. By 2005, the programme covered some 60,000 higher secondary institutions out of a total of 150,000 institutions in the country, and was expected to cover 123,810 schools nationally by 2006 (see Table 3) (MOHRD, NACO and UNICEF 2005). Likewise, the University Talk AIDS Programme has been initiated for college students to spread awareness of HIV and safe sex; since its inception in 1991, this programme has reached over seven million young people in the country (NACO 2004). Additionally, the "Youth Unite for Victory on AIDS" campaign, launched in June 2006 by the Ministry of Youth Affairs and Sports and NACO in collaboration with seven National Youth Organisations, also intends to



strengthen ongoing efforts to raise sexual and reproductive health awareness among school- and college-going students (www.yuva.nic.in).

The RCH Implementation Guide for State and District Programme Managers prepared by the Ministry of Health and Family Welfare also proposes to strengthen health education activities in schools for adolescents as part of the RCH Programme II. Auxiliary nurse midwives (ANMs) and male health workers are expected to conduct monthly group communication activities in schools, and occasionally attend health education sessions in schools and provide appropriate inputs. Additionally, medical officers from primary health centres are expected to conduct health check-ups once in six months in schools and inform adolescents about the availability of services (MOHFW 2006a). PIPs associated with the RCH Programme II in various states also discuss ways of conducting school-based activities. For example, the Andhra Pradesh PIP proposes to conduct workshops on health for adolescent boys and girls annually at the high school level (Government of Andhra Pradesh 2006a). Similarly in Madhya Pradesh, plans are outlined for the provision of life skills education at the school level, and for training 250 school principals, 500 school teachers and 2,000 student peer leaders in 10 districts selected for the implementation of youth activities under the RCH Programme II (Government of Madhya Pradesh 2006).

At the state level, significant efforts have been made to build awareness among youth about safe sex. In Andhra Pradesh, the School AIDS Education Programme has been implemented for students of Class IX and Class X since 2002. The programme has been conducted in a phased manner and has involved training 15–20 resource persons in each district, who would then facilitate the training of nodal teachers, including two nodal teachers from each secondary school in every district; providing 16-hour classroom sessions for students of Class IX and Class X; training four students from each class as peer educators; and organising parent-teacher meetings to sensitise parents about the importance of the programme (Government of Andhra Pradesh 2004). The programme is considered to be one of the most promising and was one of the first programmes to have been scaled up to state level. As of 2005, the programme had been implemented in over 12,000 secondary schools (nearly 80% of secondary schools in the state; see Table 2) (MOHRD, NACO and UNICEF 2005). To raise awareness among adolescents, the state Education Department has also incorporated a chapter on HIV/AIDS in its biology textbook for students of Class IX and Class X. Similarly, with the support of the Andhra Pradesh State AIDS Control Society (APSACS), the Colleges Talk AIDS Programme has been implemented in 5,000 colleges in the state, covering about 1.2 million students (APSACS 2005). Village AIDS awareness clubs have also been initiated in some districts, starting with youth in junior colleges. Strategies have involved training youth to act as peer counsellors, supporting



groups to meet regularly, and involving counsellors from the Indian Red Cross Society to make regular visits to youth clubs, to respond to anonymous questions posed through a question box and to provide one-on-one and group counselling (Prabhakar, personal communication, 2007).

In Madhya Pradesh too, awareness raising activities have been taken up in schools under the School AIDS Education Programme. The programme is designed to cover higher secondary schools to target students between ages 15–19 years (www.mpsacsb.org). Not surprisingly, activities have not been as intensive or widespread as in Andhra Pradesh. As of 2005, the Adolescent Education Programme had been implemented in only 43 percent of the schools in Madhya Pradesh (MOHRD, NACO and UNICEF 2005). With regard to programmes for college-going youth, seven universities in the state have established red ribbon clubs intended to involve students in promoting HIV and safe sex related information (Bose, personal communication, 2006). The University Talk AIDS Programme has also been described as an IEC strategy for youth; however, data are not available on the extent to which this programme has been implemented in the state.

Programmes for out-of-school youth

Fewer activities to raise awareness about sexual and reproductive health among young people have been conducted among out-of-school youth till relatively recently. However, with the spread of HIV/AIDS, a number of programmes have been initiated for out-of-school youth. For example, the Village Talk AIDS Programme, currently implemented through Nehru Yuvak Kendras and other

Table 3: Coverage of the Adolescent Education Programme, 2005–6

	India	Andhra Pradesh	Madhya Pradesh
Number of secondary schools	144,409	15,232	8,075
Percentage of schools implementing the Adolescent Education Programme (up to 2005) ¹	41.9 (60,533)	78.8 (12,000)	43.3 (3,500)
Planned coverage: Percentage of schools to be covered (2005–6) ^{1*}	85.7 (123,810)	94.2 (14,342)	99.6 (8,041)

Source: MOHRD, NACO and UNICEF 2005.

¹Figures in brackets indicate number of schools.

*More recent data not available.



youth clubs in 385 districts in the country, has been initiated to reach rural youth to provide information on sexuality and HIV/AIDS (NACO 2004). The Nehru Yuvak Kendra Sangathan, with eight million rural youth volunteers in more than 200,000 youth clubs, has undertaken other reproductive health and HIV-related activities for youth as well; for example, a large programme to combat trafficking and HIV/AIDS has been launched in 10 states including Andhra Pradesh and Madhya Pradesh. The Nehru Yuvak Kendra Sangathan also actively participates in mobilising youth in all the states through which the Red Ribbon Express, a train that passes through some 180 locations in India imparting information on HIV/AIDS, operates (NYKS 2006).

The “Youth Unite for Victory on AIDS” campaign aims to reach adolescents and youth across the country and to ensure that by 2010 all young people have accurate information, in a conducive, safe and supportive environment. The campaign intends to reach rural youth through youth clubs and youth development centres, and to reach migrant and mobile youth workers on priority. As part of the campaign, all active youth volunteers will be oriented to function as peer educators (www.yuva.nic.in).

The RCH Programme II also recognises that out-of-school youth have special information needs. Several strategies have been proposed in the Implementation Guide for State and District Programme Managers to meet the information needs of unmarried and married adolescent boys and girls. For example, awareness raising activities for youth are to be implemented at least once a month by ANMs, *anganwadi* workers, ASHAs (Accredited Social Health Activists; discussed in detail in the next section), youth group coordinators and male health workers. Themes covered will range from the importance of delaying marriage and first pregnancy to sexual risk reduction strategies, gender relations and the role of men (MOHFW 2006a). State-level PIPs also discuss programmes to reach those out of school. For example, activities for out-of-school young people are to be implemented in 20 villages of each of the 10 districts of Madhya Pradesh in which youth activities are to be conducted (Government of Madhya Pradesh 2006). In Andhra Pradesh, plans for conducting village-level workshops for adolescents are proposed (Government of Andhra Pradesh 2006a).

As with awareness raising programmes for school- and college-going youth, programmes for out-of-school young people are more widespread in Andhra Pradesh than in Madhya Pradesh. For example, under the Andhra Pradesh State AIDS Control Society (APSACS) supported youth programme, a total of 210,000 youth group members in rural Andhra Pradesh have been trained to impart information on HIV/AIDS issues to other young people in the state (APSACS 2004). The



state government proposes to expand this programme by collaborating with youth groups formed under the Rajiv Yuva Sakthi Scheme (a scheme to empower young people through self-employment) (APSACS 2005). Similarly, to reach out-of-school adolescent girls and young women, APSACS, in collaboration with the state Women Development and Child Welfare Department, has trained 17,000 *anganwadi* workers to be resource persons at the village level, and has raised awareness among 928,000 adolescent girls on modes of HIV prevention (APSACS 2005). Other programmes have also been initiated that do not specifically focus on youth, but whose activities do address youth. For example, the state government has launched the AIDS Awareness and Sustained Holistic Action (AASHA) campaign to promote 100 percent awareness about HIV/AIDS. The second round of the AASHA campaign, implemented in May 2006, aimed to deliver HIV/AIDS-related messages to every home through a community member. As part of the campaign, IEC materials with HIV-related messages were displayed at locations frequently visited by young people in urban areas. In rural areas, awareness raising sessions were organised at youth group meetings at least twice in the campaign month (Government of Andhra Pradesh and Centre for Good Governance 2006). Further, the recent "Be Bold" campaign has sought to sensitise the population more generally to be more confident in such matters as talking about AIDS, getting themselves tested for HIV/AIDS and changing risky lifestyles, displaying empathy towards HIV-positive people, supporting HIV-positive family members and so on. The campaign, initiated from 1 December 2006, circulates a catchy questionnaire asking people to explore whether they "know themselves". The intention is to raise awareness that not only high-risk groups are vulnerable to HIV. The questionnaire includes a number of general and specific questions relating to sexual and reproductive health. Those responding "yes" to selected questions suggestive of sexual risk behaviours are then asked to seek further information or services. To meet respondents' needs, APSACS provides a directory of services along with the questionnaire, and encourages readers to visit specified locations/centres for HIV testing, services and care (Prabhakar, personal communication, 2007).

In Madhya Pradesh, programmes to reach out-of-school young people have been largely mass-media-based so far. For example, a dedicated radio programme for youth has been developed by a multidisciplinary group, including representatives from the state Education Department, NGOs, psychologists and doctors, and has been aired by 14 stations. Entitled "Jara Sochiye", the programme discusses safe behaviours, healthy relationships and a variety of issues pertinent to youth, from child abuse to marriage and married life. Another programme entitled "Hello Zindagi" was aired on the national television channel, Doordarshan; it focused on de-stigmatising the issue of HIV and shared the stories of positive people and those who provided them services and support. Finally, a live phone-in programme on HIV/youth issues was also presented (Bose, personal communication, 2006).



Gaps

From this overview it is evident that various approaches have been adopted to raise awareness about sexual and reproductive health among young people, and that programmes have been implemented for several sub-populations.

While these programmatic initiatives are commendable, many are poorly implemented; moreover, their impact has not been properly evaluated and assessments of coverage and quality or effectiveness differ. For example, as of 2005, the Adolescent Education Programme has been implemented in only slightly more than two-fifths of secondary schools nationally (MOHRD, NACO and UNICEF 2005). Further, while it has been reported that feedback from students who attended the programme was generally positive and the opportunity to explore sexual matters in a safe space appreciated by both girls and boys, it is evident that youth are interested in receiving more explicit information, for example, how to use a condom (MOHRD, NACO and UNICEF 2005; Prabhakar, personal communication, 2007). Similarly, even though components of sex education have been integrated into the school curriculum framework, several states including Madhya Pradesh have not incorporated these components into the textbooks for Classes VIII–X (MOHRD, NACO and UNICEF 2005). Further, a review of the textbooks in states where the topics of HIV/AIDS and life skills have been incorporated, for instance Andhra Pradesh, highlights a reluctance to discuss sexuality-related topics openly. For example, while the chapter on HIV/AIDS in the Biology textbook for Class IX in Andhra Pradesh has acknowledged the increasing spread of HIV among 15–29 year-olds in India, the discussion on modes of transmission tends to be technical and is explained as follows: “the concentration level of HIV is more in blood, semen and secretion of uterus [*sic*]; direct contact with these transmits HIV” (Government of Andhra Pradesh 2006b). This explanation shies away from discussing the sexual transmission of HIV.

Moreover, the focus of awareness raising programmes has been somewhat skewed both in terms of sub-populations covered and their content. In terms of coverage, for example, school- and college-based programmes are clearly more likely to reach the unmarried than the married, and more likely to reach young men than young women, the majority of whom tend to discontinue school before they reach Class IX. Indeed, data on gross enrolment ratio show that as on 2003, only 34 percent of girls and 43 percent of boys were enrolled in Classes IX–XII nationally; 39 and 49 percent, respectively in Andhra Pradesh and 27 and 41 percent, respectively in Madhya Pradesh (MOHRD



2006). Of the range of programmes intended for the out-of-school, for example, it is clear that programmes imparted through the Nehru Yuvak Kendras and youth clubs will reach more males than females, and probably more unmarried than married males. Likewise, access to information through television programmes, telephone helplines and to a lesser extent radio programmes is likely to be limited among young women, particularly the married, who typically have limited freedom of movement or decision-making authority within the home. Finally, the recently initiated information provision activities to be conducted under the RCH Programme II by ANMs and male workers are expected to be held on a monthly basis in schools, among youth groups, in villages and urban areas, and among recently-married couples, but again, it is unlikely that recently-married women will have the mobility or decision-making authority to attend group meetings in most settings.

With regard to the content of programmes, the themes addressed are generic and are rarely tailored to suit the unique needs of different groups of youth. For example, the various programmes relating to HIV/AIDS tend to focus on the nature of the disease, and the modes of transmission and prevention, including the role of condoms. Those relating to reproductive health address more generally contraception and pregnancy-related care; typically topics that are particularly suitable to the young such as opposite or same-sex relationships and sex, how condoms are to be used and appropriate contraceptive methods for young people (for example, emergency contraception and condoms) are not covered. While HIV and condom use are stressed, programmes make little effort to raise awareness of other sexually transmitted infections (STIs). Similarly, misconceptions, such as the belief that marriage ensures safety from infection or that one cannot become pregnant at first sex, are generally not addressed; nor are such central issues as gender inequities, sexual and reproductive rights and the importance of partner communication. In addition, even where sex education is conducted, for example at the school level, what is emphasised tends to be technical (for example, human anatomy or modes of HIV transmission) and such key issues as sexuality, sexual behaviour and gender relations are not explicitly covered. Finally, little attention has been paid to tailoring the language of messages to accommodate out-of-school and low-literate youth; indeed, messages are rarely conveyed in the local dialect, and colloquial terms for sexual matters used by youth are rarely incorporated, making it difficult for rural youth to absorb the nuances of the message. Moreover, messaging has not always taken into consideration the fact that out-of-school youth may have discontinued schooling at an early age and may be better served by pictorial messages and simple language.



Programmes that facilitate access to sexual and reproductive health counselling and services

Although policies and programmes in India have underscored the right of adolescents and youth to sexual and reproductive health counselling and services, service delivery has not been youth-friendly or responsive to their unique needs. Compared to awareness raising programmes, sexual and reproductive health counselling and services are provided overwhelmingly through the RCH Programme; AIDS control programmes play a smaller role in providing services to young people.

The RCH Programme II represents a major departure from earlier programmes in that it is more inclusive, addressing the needs of different groups of young people. The National PIP has outlined a two-pronged strategy by which to meet youth needs: first, incorporating specific activities to reach adolescents within sexual and reproductive health services intended for adults more generally; and second, providing services specifically intended for adolescents at the primary health centre level on dedicated days and at dedicated times. These special services are to be initiated in certain districts, to be selected on the basis of such indicators as low age at marriage and high prevalence of adolescent pregnancy (MOHFW 2005). Elaborating on these strategies, the Implementation Guide for State and District Programme Managers notes that “friendly services are to be made available for all adolescents, married and unmarried, girls and boys” (MOHFW 2006a). Steps are to be taken to ensure improved counselling and service delivery for adolescents and youth during routine sub-centre visits and through once a week youth clinics to be held on fixed days and timings at the primary health centre or community health centre level. Wide-ranging services are to be provided, including contraceptive supplies, pregnancy-related care, management of symptoms of infection, as well as counselling for a range of sexual and reproductive matters including nutrition and menstrual hygiene.

State PIPs have also outlined plans for providing sexual and reproductive health services to young people. However, the content and coverage vary among states. For example, the Andhra Pradesh PIP recommends that village-level counsellors provide counselling services to adolescents but makes no specific reference to the provision of sexual and reproductive health services to young people either as part of routine services in the public health sector or as part of special clinics meant for young people (Government of Andhra Pradesh 2006a). On the other hand, the Madhya Pradesh PIP states that adolescent-friendly health services will be provided through primary health centres and community health centres selected for providing basic and comprehensive emergency obstetric and



newborn care (BEmONC and CEmONC) in 10 selected districts in the state (Government of Madhya Pradesh 2006).

The proposed strategy for adolescents in the RCH Programme II includes initiatives to orient both medical officers as well as ANMs and lady health visitors (LHVs) on the provision of sexual and reproductive health services. Orientation programmes underscore the need to address both the married and the unmarried, as well as adolescent girls and boys. They also highlight the significant obstacles that youth may face in seeking information and counselling, including young married women's lack of autonomy, perceptions of poor quality of care and judgemental services at health centres, and young people's own reluctance to discuss sexual matters (MOHFW 2006b; 2006c).

Two new schemes have recently been launched (2005) under the National Rural Health Mission that may have the potential to address the sexual and reproductive health of youth, and young women in particular. The first is the establishment of ASHAs (Accredited Social Health Activists). These voluntary workers, appointed with community involvement in villages with populations of over 1,000, will act as a link between the local community, the *anganwadi* and the health system. They are not paid a salary but are compensated on the basis of the tasks they perform; they will be provided a kit containing essential drugs to treat common illnesses. ASHAs' tasks include providing counselling on sexual and reproductive health, assisting women in accessing pregnancy-related care, accompanying women availing of institutional delivery, and providing contraceptive and nutritional services. It is commendable that one of the themes included in the training package for ASHAs is adolescent health; modules make efforts to orient ASHAs about pregnancy risks that very young mothers may suffer, the vulnerability of adolescent girls to HIV/AIDS and so on (www.mohfw.nic.in). The scheme, launched in 10 states with poor health indicators (including Madhya Pradesh but not Andhra Pradesh), started with 250,000 ASHAs but will be expanded to one million by the end of the Mission period (2012) (Jalaja 2005; MOHFW 2006d). The second scheme is the Janani Suraksha Yojana (a modification of the National Maternity Benefit Scheme), launched in 2005, that aims to provide cash assistance to poor women who undergo institutional deliveries as well as to the ASHAs who are responsible for linking women to available health care facilities (MOHFW 2006d).



Gaps

Despite the government's commitment to addressing the sexual and reproductive health service needs of youth, there remains ambiguity in service delivery. For example, while the RCH Programme II has stated that services will be extended to the unmarried, the implications of this expanded coverage are not clearly addressed in terms of the precise services to which different categories of youth are entitled. Moreover, while all categories of young people (unmarried and married, females and males) constitute the target group for services provided through routine sub-centre clinics, only unmarried females and males are mentioned as the target group for services provided through weekly youth clinics at primary health centres (see Table 4, which reproduces the matrix on service provision at various levels of care from the National PIP). Similarly, the logical framework presented in the National PIP suggests that the focus of the programme is more likely to be on the needs of "married or out-of-school adolescents" rather than all categories of young people. Indeed, there remains considerable ambiguity with regard to the expansion of these services in state-level PIPs as well. For example, the Madhya Pradesh PIP does not specifically mention that services will be made available to all adolescents irrespective of marital status; rather, it only indicates that "friendly" services will be implemented in 10 selected districts (Government of Madhya Pradesh 2006). Likewise, the Andhra Pradesh PIP does not specify whether the counselling services provided by village-level counsellors will be available to all adolescents, irrespective of marital status (see for example, Government of Andhra Pradesh 2006a).

Moreover, as discussed above, the reach of the adolescent programme remains limited as it is to be implemented in only selected districts of each state. For example, in Madhya Pradesh, adolescent-friendly services are to be provided initially only in primary health centres and community health centres selected to provide basic and comprehensive emergency obstetric and newborn care in 10 of 48 districts of the state (Government of Madhya Pradesh, 2006). The content of sexual and reproductive health services to be provided to young people also tends to be limited. For example in Andhra Pradesh, the PIP does not include a plan to provide dedicated sexual and reproductive health services to young people through the public health sector other than counselling provided by village-level counsellors (Government of Andhra Pradesh 2006a). Likewise, the content of counselling remains unclear; indeed, while there is considerable evidence that young couples do not communicate with each other on contraception or other intimate matters, neither the national nor state-level PIPs highlight the need for counselling that enables young couples to overcome obstacles to inter-spousal communication on sexual and reproductive matters.



Table 4: Proposed provision of adolescent sexual and reproductive health services at each level of care in the RCH Programme II

Level of care	Service provider	Target group	Flow of service delivery activities	Services
Sub-centre	Health worker (Female)	Unmarried females Married females Unmarried males Married males	During routine sub-centre clinics	Enrol newly-married couples Provision of spacing methods Routine antenatal care and institutional delivery Referrals for early and safe abortion STI/HIV/AIDS prevention education Nutrition counselling, including anaemia prevention
PHC/CHC	Health assistant (Female)/LHV Medical officer	Unmarried male and female	Once a week, teen clinic organised at PHCs for two hours	Contraceptives Management of menstrual disorders RTI/STI preventive education and management Counselling and services for pregnancy termination Nutritional counselling Counselling for sexual problems

Source: MOHFW 2005.

Although the RCH Programme II National PIP has recognised the need to sensitise various categories of health care providers to the needs of adolescents, providers have not been oriented to issues relating to the delivery of these expanded services. Notably, the extent to and ways in which the programme is expected to address the contraceptive service needs of the unmarried has been conspicuously overlooked (MOHFW 2005). Similarly, there is a tendency to overlook the fact that newly-married women may not have the mobility, decision-making ability or access to resources in their marital homes to seek information, counselling or care on their own, and therefore would require more concerted provider contact within the context of the home than older women (IIPS and ORC Macro 2000). More importantly, the orientation guides make little effort to change the attitudes of providers or convey to them the right of all adolescents to sexual and reproductive services. While the guides suggest that adolescent-friendly services must be non-threatening, non-judgemental and understanding of young clients, they do little to change provider attitudes to, for



example, sexual activity among the unmarried and experience of symptoms of infection (MOHFW 2006b; 2006c). Finally, while the particular situation and needs of adolescent boys is recognised, the strategy does not describe the ways in which this will be incorporated into reproductive and child health services.

While the two newly launched schemes—the establishment of ASHAs (Accredited Social Health Activists) and the Janani Suraksha Yojana—have considerable potential for enhancing the reproductive health and choice of youth, this potential has not thus far been adequately tapped. As suggested earlier, ASHAs can play a positive role in accessing newly-wed women who may not be permitted to access health centres or *anganwadis*; counselling young couples about delaying the first birth, pregnancy-related care, safe sex practices and the importance of obtaining an institutional delivery; as well as providing contraceptive supplies and escorting young women to appropriate health facilities. Guidelines for ASHAs do highlight in general terms the vulnerability of young women and especially pregnant young women; there remains a need however to provide more specific information on possible strategies through which to deliver services to this group. Likewise, while the Janani Suraksha Yojana focuses on the first two births, paradoxically, it is expected to focus on women aged 19 and above, thereby excluding the vast number of women who become pregnant at younger ages and are particularly vulnerable.

Other programmes have, likewise, failed to address the special vulnerabilities of youth. For example, service provision under HIV/AIDS programming tends to be generic, and delivery mechanisms for married and unmarried young women and men are identical to those available to the adult population. Similarly, efforts have not been made to orient and sensitise providers to the special needs of youth.

In short, while impressive steps have been taken in the RCH Programme II to meet the service needs of youth, it is unclear whether youth clinics and other services intended for young people have actually been put in place, and if so the extent to which these services are being used by married and unmarried young women and men. Although the RCH Programme II has brought married and unmarried young men within its purview, it continues, in reality, to be a largely female-centred programme. Moreover, it has continued, in reality, to exclude unmarried young women and has made no special effort to provide reproductive health counselling and services to married young women, especially the newly married; indeed it has tended to neglect married adolescent girls and young women until they have proven their fertility. At the same time, HIV-related programmes, while technically available to all, have not made any special effort to address the service delivery needs of different groups of young people.



Programmes that address gender disparity

Almost every policy has articulated a commitment to reduce gender disparities among youth. Correspondingly, programmes have advocated a range of measures to reduce gender imbalances among young people; for example, those under the Ministry of Health and Family Welfare (such as the National Rural Health Mission and the RCH Programme I/II), as well as those advocated by the Department of Education (such as the Kasturba Gandhi Balika Vidyalaya, Mahila Samakhya and the National Programme for Education of Girls at the Elementary Level) and the Ministry of Women and Child Development (such as the Kishori Shakti Yojana, Nutrition Programme for Adolescent Girls and the Balika Samridhi Yojana).

Among the programmes for adolescent and young women, possibly the most extensive set of activities designed to enhance the status of young women has been undertaken by the Ministry of Women and Child Development. For example, the Kishori Shakti Yojana (formerly the Adolescent Girls Scheme), was initiated in 2000–1 in 2,000 Integrated Child Development Services (ICDS) blocks. This programme seeks to enhance young girls' capabilities in addressing nutrition and health issues as well as building literacy, numeracy and vocational skills among young girls through training camps, hands-on learning and sharing of experiences (www.wcd.nic.in). Compared to the previous Adolescent Girls Scheme, the Kishori Shakti Yojana has a stronger training component, particularly in vocational skills, intended to empower adolescent girls and enhance their self-perception. The scheme has nation-wide coverage, and was expected to be expanded to all 6,108 ICDS blocks in the country by 2005–6. Also being implemented is the Nutrition Programme for Adolescent Girls, now underway in 51 districts (including Alidabad and Mehboob Nagar in Andhra Pradesh and Sagar and Damoh in Madhya Pradesh). The programme is intended to provide free food grains to supplement the diet of poor adolescent girls aged 11–19 who are underweight (under 35 kg) (MOWCD 2006). Finally, a programme with national coverage is the Balika Samridhi Yojana, an investment scheme launched in 1997 to improve the status of the girl child by providing monetary incentives for completing schooling and postponing marriage till the age of 18 years.² Several state governments have also launched specific investment schemes to encourage schooling for girls, delay their marriage, and change family and community attitudes towards girls. Some examples are the Apna Beti Apna Dhan scheme in Haryana,³ the Girl Child Protection Schemes in Andhra Pradesh⁴ and Tamil Nadu,⁵ and the Kanya Jagriti Jyoti scheme in Punjab.⁶



Mahila Samakhya, launched in the late 1980s and funded by the central government but implemented only in certain states, is another programme that aims to address gender disparities by increasing educational opportunities for girls and adult women. Under this project, adolescent girls are imparted non-formal education in the form of functional literacy, leadership and life skills training through Mahila Shikshana Kendras. Centres function in 63 districts in nine states, namely, Andhra Pradesh, Assam, Bihar, Gujarat, Jharkhand, Karnataka, Kerala, Uttar Pradesh and Uttarakhand (the programme was discontinued in 2001 in Madhya Pradesh) (www.education.nic.in).

At the state level too, a range of initiatives have been undertaken. For example in Andhra Pradesh, under Chaitanya Kishoram, a scheme implemented by the state Women Development and Child Welfare Department through the ICDS in 21 districts, 15 girls from each district have been trained in imparting information on reproductive health and sex education to their peers. Once trained, these girls are expected to hold sessions at *anganwadi* centres to inform adolescent girls in their villages about sexual and reproductive health matters (Government of Andhra Pradesh 2006a). In Madhya Pradesh, the state Women and Child Development Department has made a commitment to provide, by 2007, books free of cost to girls up to Class VIII, address the nutritional needs of adolescent girls, and ensure safe water and toilet facilities in all areas in which girls reside and study (Government of Madhya Pradesh 2003).

Gaps

Few of these programmes have been systematically evaluated and their impact on girls' educational attainment, skill acquisition, gender role attitudes, age at marriage and other positive outcomes has not been assessed. However, an evaluation of the Adolescent Girls Scheme, the predecessor of the current Kishori Shakti Yojana, reported that the coverage was too limited to have resulted in any significant change; the evaluation also indicated that the programme should focus more explicitly on the information needs of adolescents in vital areas of reproductive health, behaviour change and the adoption of healthy life styles, as well as the provision of vocational skills (Lal and Paul 2003).

Even fewer programmes have taken on the challenging task of changing gender inequalitarian attitudes or sensitising youth and their gatekeepers about the sexual and reproductive rights of young women and men. Indeed, the School AIDS Education Programme, the University Talk AIDS Programme, plans formulated by the Ministry of Women and Child Development and activities conducted under the Nehru Yuvak Kendra Sangathan and other programmes for out-of-school youth do recognise



the rights of women and gender imbalances. Unfortunately, not much is known about the content, regularity or effectiveness of activities conducted to address gender inequities.

Gender sensitisation messages can well be incorporated into awareness building initiatives in the area of reproductive and child health and HIV/AIDS, described earlier. In fact, the RCH Programme II National PIP recommends that gender issues, roles and rights are incorporated into communication packages for adolescents (MOHFW 2005). However, the extent to which these messages are disseminated or the ways in which they are disseminated is not clear. While orientation guides for various levels of providers do attempt to raise awareness among providers that parents and other gatekeepers may not treat girls and boys equally, training manuals do not stress gender imbalances and their health consequences, or young people's sexual and reproductive rights (MOHFW 2006b; 2006c). Indeed, not a single document describes initiatives intended to apprise young people of their rights or programmes intended to build egalitarian relationships among young couples; measures that would clearly have implications for care seeking and sexual and reproductive health.

Programmes that build a supportive environment

In order to build a supportive environment to enable youth to obtain information, seek counselling and services, and adopt safe practices, it is critical that communities in general, and young people's gatekeepers in particular, are sensitised to the unique needs of young people. Key gatekeepers include parents and parents-in-law, health care providers, teachers and other community-level functionaries, for example *anganwadi* workers and organisers of self-help groups.

Efforts on the ground to sensitise different gatekeepers have been limited. The National PIP of the RCH Programme II proposes activities to reach a broad range of gatekeepers, including district officials, and members of panchayats, women's groups and civil society, with appropriate messages (MOHFW 2005). Similarly, the Madhya Pradesh PIP discusses plans for training health care providers to deliver gender-sensitive, confidential and quality adolescent sexual and reproductive health services, and sensitising teachers from selected schools to advocate the importance of addressing adolescent issues (Government of Madhya Pradesh 2006).



Gaps

While the Implementation Guide for State and District Programme Managers has included parents in the target audience, the guide contains no discussion of the specific measures to be taken to involve parents or the special messages to be imparted to them (MOHFW 2006a). The state PIPs are also ambiguous in this respect.

While there have been many more efforts to sensitise teachers, evaluations of population and sex education programmes highlight significant weaknesses. For example, an evaluation of the National Population Education Programme reports that a supportive environment has not yet been created to incorporate sexual and reproductive health in adolescent education programmes. Similarly, in-depth efforts that focus on training and building the aptitude of nodal teachers and helping them overcome their embarrassment and hesitation in discussing sexuality and reproductive health issues are missing (UNFPA 2003). Moreover, with respect to the sex education curriculum developed by the National Centre for Educational Research and Training, it has been observed that messages unacceptable to state officials⁷ are diluted and teachers omit certain topics out of discomfort (Greene et al. 2002). Likewise, there is evidence that teachers are embarrassed about discussing sexual matters with adolescents, typically skip chapters relating to reproduction and at best discuss these issues in such technical terms that key areas of concern to youth remain unaddressed (Chakrabarti 2003).

In short, the environment cannot be described as supportive of young people's needs; and efforts to build a supportive environment and specifically to engage young people's multiple gatekeepers to play a supportive role in young people's lives have yet to be undertaken in a sustained manner and among all gatekeepers.



4 Looking forward

This overview has explored the major policies and programmes related to the sexual and reproductive health of adolescents and youth in India, and assessed the extent to which these efforts have responded to young people's needs. Findings suggest that although significant strides have been made in articulating a commitment to addressing many of the sexual and reproductive rights of adolescents and youth, there remains a considerable schism between the commitments made in the policies and programmes, the implementation of these commitments and the reality of young people's lives in India. At the state level too, as our comparison of programmes in Andhra Pradesh and Madhya Pradesh reveal, the implementation of programmes to meet these commitments varies considerably.

Our review has focused on four major programme thrust areas. The first was efforts to build awareness of sexual and reproductive health issues among young people. Our review shows that several programmes have been undertaken that attempt to reach a number of sub-populations both through the RCH Programme II and through HIV awareness building activities. While these programmatic initiatives are commendable, our review suggests that many remain poorly implemented, may not reach all groups of adolescents and youth, and little is known about their impact or quality. Of particular concern is the finding that out-of-school and married females may not be reached as they are unlikely to be members of clubs or *mandals*, or to have access to television programmes or telephone hotlines, and may not have the mobility or decision-making authority to attend group meetings in most settings. Themes addressed in awareness raising programmes moreover tend to be generic, somewhat technical, do not integrate messages on HIV and other aspects of sexual and reproductive health, and do not address the misconceptions that young people harbour. State-level disparities are wide; HIV-related messages are considerably more likely to be imparted to youth in Andhra Pradesh than in Madhya Pradesh, perhaps as a consequence of the advanced HIV epidemic in Andhra Pradesh.

When we turn to our second thrust area, namely, delivery of and access to appropriate counselling and services, findings suggest that the reality falls far short of stated goals. There is considerable ambiguity in the extent of service delivery; for example, the unmarried—both females and males—have thus far effectively remained out of the purview of contraceptive services from the public



sector at the community level, and no special efforts have been made to reach young people with voluntary counselling and testing and condom promotion services. Indeed, the RCH Programme II National PIP and related orientation guides are inconsistent in describing the reach and content of the expanded services proposed; state-level programme documents of both Andhra Pradesh and Madhya Pradesh are silent about the youth populations to be served and the content of programmes for youth. Moreover, the reach of the new activities, where implemented, remains limited to a few selected districts of each state. Likewise, service provision under HIV/AIDS programmes tends to be generic, and delivery mechanisms for married and unmarried young women and men are identical to those available to the adult population. Although the need for provider reorientation and training is recognised and manuals have been prepared, few providers of all categories have been trained or oriented about the special service delivery needs of youth. In this thrust area, state-level disparities are relatively narrow: while both Andhra Pradesh and Madhya Pradesh, as India more generally, display a commitment to reaching all youth, programmes have not been adequately revamped to make this commitment a reality.

Over the next decade, huge strides will need to be made to integrate young people's diverse concerns more directly into programmes. While the expansion of the scope of the RCH Programme II and the responsibilities of health workers to include provision of sexual and reproductive health services, including contraceptives, to the unmarried is a significant step forward, the extent to which services have indeed been expanded in reality is not yet clear. Efforts must be made to ensure that providers at health and voluntary counselling and testing facilities deliver sensitive, non-judgmental, private and confidential services to young people. The roles and responsibilities of male health workers must be redefined to include sexual and reproductive health counselling and the provision of services to young men. Special efforts—home visits in particular—must be made to enable those newly-married young women and their husbands who wish to delay the first or subsequent pregnancies to access appropriate contraceptive supplies and, should pregnancy occur, to seek appropriate care. The establishment of regular adolescent health clinics at the primary health centre and community health centre level, highlighted in the RCH Programme II, is a positive move but needs to be urgently implemented and its ability to attract young people carefully monitored.

The third thrust area relates to programmes intended to reduce gender disparities and enhance the status of girls and young women. Our review suggests that while there are a number of programmes that address these issues, their reach is limited and their content is variable. Efforts thus far have focused on improving the nutritional status of adolescent girls and less so on changing gender



inegalitarian attitudes, sensitising youth and their gatekeepers about the sexual and reproductive rights of women and men, or changing the perceptions of young men. Moreover, among the few programmes that have attempted to address these issues, little is known about the extent to which they have stressed sexual and reproductive rights or ways of building egalitarian relations among young couples, measures that would clearly have implications for sexual and reproductive health and care seeking. Programmes have not been systematically assessed in terms of their impact on reducing gender disparities. Different states, moreover, have adopted different programmes intended to reduce gender imbalances: while in Madhya Pradesh, attention has largely been on efforts to prevent girls from discontinuing their education, in Andhra Pradesh, programmes have also focused on building women's groups and providing investment schemes to discourage early marriage.

The fourth thrust area of policies and programmes has been on creating a supportive environment for young people. Despite the fact that programmes have noted the importance of sensitising gatekeepers, efforts in this regard have been limited in terms of the number of activities undertaken, the kinds of gatekeepers addressed and the extent to which programme content is intended to orient gatekeepers to young people's needs or to enable gatekeepers to overcome their own discomfort and misconceptions about addressing sexual and reproductive matters among youth. Parents are rarely included in gatekeeper programmes, although the importance of parent-child communication has been frequently stressed. Teacher training has not succeeded in enabling teachers to overcome their own embarrassment in dealing with these issues. At the state level too, activities are limited; neither in Andhra Pradesh nor in Madhya Pradesh are programmes to sensitise and involve gatekeepers clearly described, and in neither state are efforts made to address parents. In short, efforts to build a supportive environment to meet young people's needs have yet to be undertaken in a sustained way and among all gatekeepers.

In conclusion, our review clearly shows that many key features of programmes remain unimplemented, the unique sexual and reproductive health needs of young women and men remain unmet, and evaluations of programmes that have been implemented have not always been systematic or rigorous. Of note however is that the policy environment has begun to shed its earlier ambivalence on the need to address the sexual and reproductive health needs of young people. Policies and programmes—be they related to women and child development, youth, health and family welfare or HIV/AIDS—have all recognised the importance of improving sexual and reproductive health and choice among young people, and the importance of healthy youth in shaping India's future. Efforts have been initiated to translate this commitment into practice, as evident from recently



introduced strategies to enhance the sexual and reproductive health of young people; what is needed is a similar level of commitment to ensuring that programmes do indeed reach young people, that the scope and content of programmes are expanded, and promising lessons are assimilated and scaled up.

Notes

- 1 These include the National Service Scheme targeted at university students; the Nehru Yuvak Kendra Sangathan catering to the needs of 15–35 year-old out-of-school rural youth; a population and family life education programme for school and college students; the Training of Youth for Self-Employment scheme for 18–35 year-old rural youth; and Mahila Shikshana Kendras for adolescent girls.
- 2 Under the scheme, the central government deposits Rs 500 in a bank/ post office in the name of the girl child, which is withdrawn to pay the insurance premium and incremental graded scholarship to the girl child as she graduates from different grades.
- 3 Under the scheme, the Haryana government provides a total financial package of Rs 3,000 to the family on the birth of a girl child (Rs 500 to the mother of the girl child in cash within 15 days of the birth of the girl child and Rs 2,500 invested for the girl child for 18 years, provided she remains unmarried till then).
- 4 The scheme provides a fixed deposit of Rs 5,000 in the name of the girl child on the condition that she does not marry till the age of 18 and continues her studies up to this age. From high school onwards, the girl student receives Rs 1,000 a year and then Rs 20,000 at marriage.
- 5 The Tamil Nadu government deposits Rs 22,200 in the name of the girl child born in families with only one girl child and no other children, and if either of the parents has undergone sterilisation. The interest accrued from the deposit is used to provide a monthly payment of a minimum of Rs 150 throughout the period of the child's school education, from Class I to Class X; the terminal benefit from the deposit with accrued interest will be given to the girl at the end of 20 years. For families with two girl children and no male child, the government deposits Rs 15,200.
- 6 The Punjab government invests Rs 5,000 for each girl child with the Life Insurance Corporation. Previously only one girl child was eligible; recently, the government has decided to extend the benefit of the scheme to scheduled caste families with two girl children.
- 7 The states are responsible for final decisions on the curriculum.



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South & East Asia-Regional Office
Zone 5-A, Ground Floor, India Habitat Centre
Lodi Road, New Delhi 110 003, India