

Adolescents and their issues in Gujarat:

A Desk Review of their status in Dahod
district, Gujarat



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Abbreviations

AFHC	Adolescent Friendly Health Clinics
AHC	Adolescent Health Clubs
AHD	Adolescent Health Day
ANMs	Auxiliary Nursing Midwifery
ARSH	Adolescent Reproductive and Sexual Health ()
AWWs	Anganwadi Workers
BMI	Body Mass Index
CRC	Convention on the Rights of the Child
DLHS	District Level Household & Facility Survey
GC20	The General Comment on Adolescents
GOG	Government of Gujarat
ICCPR	International Covenants on Civil and Political Rights
ICDS	Integrated Child Development Services
ICESCR	Economic, Social and Cultural Rights
IEC	Information Education and Communication
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate
MOHFW	Ministry of Health and Family Welfare
MWCD	Ministry of Women and Child Development
NFHS	National Family Health Survey
NGO	Non-Government Organization
NRHM	National Rural Health Mission
PURNA	Prevention of Under-Nutrition & Reduction of Nutritional Anemia among Adolescents
RMNCH+A	Reproductive Maternal New-born Child and Adolescent Health
ROSC	Rapid Survey on Children
ST	Schedule Tribes
SAARC	South Asian Association for Regional Cooperation
SC	Schedule Caste
SH-RBSK	Rashtriya Bal Swasthya Karyakram
TFR	Total Fertility Rate
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRC	UN Convention on the Rights of the Child
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VHSNCs	Village Health Sanitation and Nutrition Committees
WHO	World health Organisation

Section 1 ADOLESCENTS: NURTURING THE FUTURE

Adolescents share a big number in the overall population of the country. Owing to their transition stage to adulthood their say in decision making processes, opinions on issues affecting their lives and spaces/opportunities to acquire and share knowledge, are limited, due to various reasons. This is also a group experiencing changes due to biological and physical developments. There is thus a need to look at them with sensitivity and support them, including them in the process to solve their issues.

Adolescents as a category, are most often subsumed with youth, children or with young adults. Different policies and programmes define the adolescents age group differently. For example, adolescents in the draft

The term adolescent means 'to emerge' or 'achieve identity.' Adolescence is defined as a phase of life characterized by rapid physical growth and development, physical, social and psychological changes and maturity, sexual maturity, experimentation, development of adult mental processes and a move from the earlier childhood socio-economic dependence towards relative independence. This is also the period of psychological transition from a child who has to live in a family to an adult who has to live in a society. Adolescents have very special and distinct needs, which can no longer be overlooked. It is also essential to invest in adolescents, as they are the future of the country.

Youth Policy have been defined as the age group between 13-19 years; under ICDS adolescent girls are considered to be between 11-18 years; the Constitution of India and labour laws of the country consider people up to the age of 14 as children: whereas the Reproductive and Child Health programme mentions adolescents as being between 10-19 years of age. Internationally and as is with most UN agencies like WHO, UNICEF, UNFPA etc. the age group of 10-19 years is considered to be the age of adolescents. It is observed that the age limits of adolescents have been fixed differently under different programmes keeping in view the objectives of that policy/programme. However, the most common and appropriate is to consider adolescence as the age between 10-19 years, Youth as the age between 15-24 years and Young People as the age group between 10-24 years.¹

In India National Youth Policy 2003 states, "This Policy will cover all the youths in the country in the age group of 13 to 35 years. It is acknowledged that since all the persons within this age group are unlikely to be one homogenous group, but rather a conglomeration of sub-groups with differing social roles and requirements, the age group may, therefore, be divided into two broad sub-groups viz. 13-19 years and 20-35 years. The youths belonging to the age group 13-19, which is a major part of the adolescent age group, will be regarded as a separate constituency"²

¹ Based on international standards contained in the Convention on the Rights of the Child and Conventions No. 138 and No. 182 (Worst forms), as well as legislation current in our country

² National Youth Policy 2003

The 2030 SDG declaration mentions adolescents or youth in several instances as a vulnerable population. Goal 2 of Zero Hunger has a target that by 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under five years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women and older persons. Many other targets include a few specific targets for youth, mostly on employment, but several targets that, if met, will substantially improve adolescent health. In addition to disease specific interventions, such as increasing access to male circumcision and HPV vaccination, structural, environmental and social changes are required. These include infrastructure changes to improve road safety, greater alcohol and tobacco taxation, and increased access to education. In addition, actions to create adolescent-responsive

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- *The 2030 Agenda includes 17 Global Goals addressing the social, economic and environmental dimensions of sustainable development.*
 - *Attached to the Goals are 169 concrete targets measured by 232 specific indicators. 35 of these indicators are directly related to children.*
 - *Most countries have insufficient data to assess whether they are on track to achieve the SDG targets for children.*
 - *Available data show an alarming number of countries needing to speed up progress to reach global targets.*
 - *Within countries, particular groups of children are at greater risk of being left behind such as children from poorer households, those living in rural areas, or – often – adolescent girls.*
 - *UNICEF, as the global leader of data for children, is the custodian for 7 global SDG indicators and co-custodian for a further 10 indicators.*

UNICEF data

health systems are necessary, such as facilitation of the adoption of health promoting and protecting policies that prevent exposure to harm and enable adolescents to adopt healthy lifestyles and strengthening of the capacity of primary and referral-level facilities to deliver adolescent responsive services.³

India ranks 125 out of 159 countries in the Gender Inequality Index as per the Human Development Report. (UNDP 2016) An adverse sex ratio (940 females to 1000 males) is indicative of gender discrimination in the country. (Census 2011) Poor nutrition, food insecurity and gender discrimination has a negative impact on growth and development of adolescents. In India 41.9% adolescent girls and 44.8% adolescent boys, in the 15 to 19 age group, are

-
- ***72% of the total adolescents in India resides in rural areas (181 million)***
 - ***In case of youth population, 68% live in rural areas***
-

³ https://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter4_snapshot_adolescent_health.pdf

underweight with a body mass index less than 18.5 kg /m². (NFHS 4)

1.1 ABOUT THE DESK REVIEW AND METHODOLOGY

This document reviews the existing status of adolescent on following aspects in Gujarat with focus on Dahod district.

- Education
- Health and nutrition
- Age at marriage
- Violence faced by them including child labor and child sexual abuse
- Skill building opportunities at hand

The information has been presented for each of these issues and following categories of documents have been reviewed

- Government of India report and publications
- Large national and sub national surveys
- Scientific papers published in national and international peer reviewed journals using search engines through selected keywords
- Current policy and strategy documents pertaining to protection of adolescents implemented by various departments of the Government of India such as the Ministry of Health and Family Welfare, National Commission for Protection of Child Rights, Ministry of Human Resource Development, Ministry of Women and Child Development, Ministry of Youth Affairs and Sports, Ministry of Labour and Employment and Ministry of Social Justice and Empowerment.
- Laws addressing the protection of adolescents
- Documents shared by Utthan team regarding its work with UNICEF in Dahod, Gujarat

Limitations of the Review

Wherever possible data from NFHS-4 (2015-16) has been used for state and district level indicators as information for DLHS-4 (2012-14) for Gujarat is not available on public domain. The data and its availability across same time period has also been one of the key limitations in presenting the information. District level data for Dahod is not available for many indicators that have been presented, therefore state level data was used to present the scenario.

1.2 ROLE PLAYED BY STATE AND CENTRAL GOVERNMENTS

In India, the Reproductive and Child Health (RCH) program was launched by the Government of India (GOI) in 1997 for reducing infant, child and maternal mortality. The rights of adolescents to protect themselves from HIV and AIDS and other illnesses were recognized by World Health Organization (WHO) in the year 2000. Subsequently, a global consultation on adolescent friendly health services was organized by WHO which suggested each country to develop health programs addressing the multiple health needs of adolescents. The National Rural Health Mission (NRHM) was launched in 2005 by the Ministry of Health and Family Welfare, (GOI) to provide equitable and quality health services to the rural population. Reproductive Maternal New-born Child and Adolescent Health (RMNCH+A), is an important component of NRHM. Recognizing the increasing needs of adolescents, the national and state governments initiated various programs under RCH

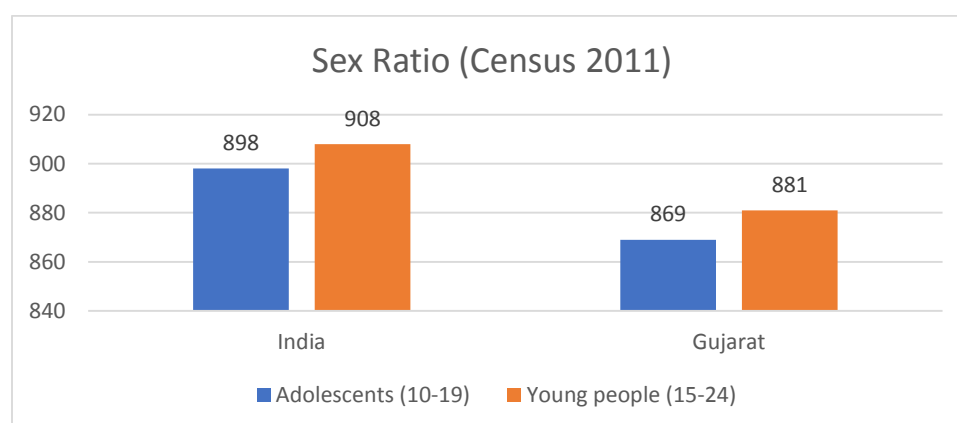
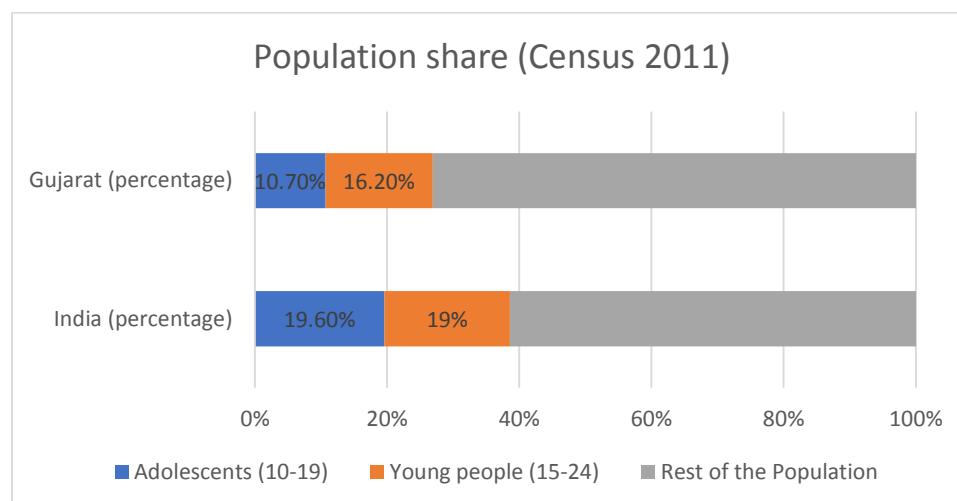
and RMNCH+A at different time periods. Adolescent Reproductive and Sexual Health (ARSH) is an important component of GOIs RCH-II programme which aims to reduce Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and Total Fertility Rate (TFR). The ARSH program aims to address health needs of adolescents, delay age at marriage, and reduce teenage pregnancy and unsafe sexual behaviour. It also aims to provide menstrual hygiene promotion, counselling and access to SRH services through Adolescent Friendly Health Clinics (AFHCs). The Government of Gujarat (GOG) is implementing many health programs for the adolescent such as

- SABLA- Rajiv Gandhi Scheme for Empowerment of Adolescent Girls
- Scheme for Adolescent Girls
- Prevention of Under-Nutrition and Reduction of Nutritional Anemia among Adolescents (PURNA), GOG
- Adolescent Friendly Health Clinics, Peer Education Programme, Weekly Iron Folic Acid Supplementation, Menstrual Hygiene Scheme
- Rashtriya Kishor Swasthya Karyakram
- Mamta Taruni Programme
Rashtriya Bal Swasthya Karyakram (SH-RBSK)- School Health

All these schemes are initiated by Ministry of Women and Child Development (MWCD) and Ministry of Health and Family Welfare (MOHFW) and the village level activation takes place through the Anganwadis (ICDS centres).

Section 2 ADOLESCENT STATISTICS

Gujarat has an adolescent population contributing to 10.7% of the total state population of 60, 439, and 62 as per census 2011 which is lower than the national figure of 19.6%. The sex ratio in adolescents is 869 which much lower than the country figure of 898.



The sex ratio of adolescents in Gujarat is lower than the corresponding figure for youth and both these ratios are much lower when compared to national figures of 898 for adolescents and 908 for youth. ST adolescent population of Gujarat is 15.7% of the total adolescent population of the state and corresponding figure for youth is 13.9%. Although a large number of programs are being implemented for adolescents, their coverage is limited and the impact has not been carefully evaluated. While the government has often emphasized on convergence, the programs have largely continued to function in silos, with dilution of results compared to what could have been achieved if synergies accruing from their operations had been realized. This has resulted in increasing discussions on need for demonstrating comprehensive health program that improves health and empowers adolescents and young people. Gaps in service delivery can also be inferred from the NFHS 4 India and Gujarat data on adolescent and young people as given in the table below⁴.

⁴ <http://iiphg.edu.in/images/pdfs/2019/Monograph-MacArthur.pdf>

S.No.	Indicator for the population %	
1	Women 20-24 years who were married before 18 years	24.9
2	Men 25-29 years who were married before 21 years	28.4
3	Women 15-19 years who were already mothers or pregnant with first child at the time of the survey	7.0
4	Women 15-19 years who use contraceptives	14.0
5	Married women 15-19 years with unmet need for family planning	32.5
6	Women 15-19 years whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m ²)	49.6
7	Women 15-19 years who were overweight or obese (BMI ≥ 25.0 kg/m ²)	5.2
8	Men aged 15-19 years whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m ²)	52.5
9	Men 15-19 years who were overweight or obese (BMI ≥ 25.0 kg/m ²)	6.4
10	Women 15-19 years who were anemic (<12.0 g/dl)	56.5
11	Men 15-19 years who were anemic (<13.0 g/dl)	31.9
12	Women 15-24 years who have comprehensive knowledge of HIV/ AIDS	20.0
	Men 15-24 years who have comprehensive knowledge of HIV/ AIDS	31.5
13	Women 15-24 years who use hygienic methods of protection during menstrual period	60.3

Table 1: NFHS 4, Gujarat data on adolescent and young people:

Challenges faced by Health Programs for Adolescents and Young People Programs⁵ that are implemented for improving adolescent health face many challenges such as:

- Increasing access, coverage, outreach and utilization of services;
- Promoting community involvement to improve outreach;
- Creating linkages with other programs to increase scope of services;
- Developing effective IEC (Information Education and Communication) strategy and materials;
- Increasing access to health products such as sanitary pads and contraceptives;
- Addressing issues such as anaemia, substance abuse (tobacco and alcohol), counselling and life skills; and
- Enhancing sustainability of programs.

⁵ Satia J, Saxena D. (2018). Improving Adolescent Health: Learnings from Gujarat. Indian Institute of Public Health Gandhinagar, Gujarat, India

2.1 DAHOD: DISTRICT PROFILE

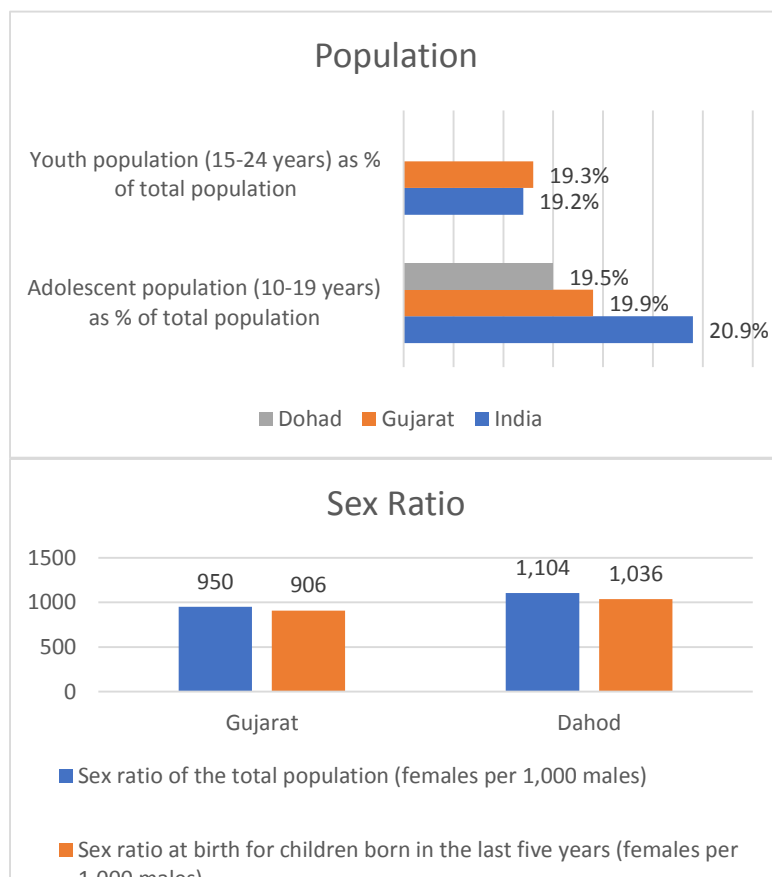
Dahod district is situated in the east part of the Gujarat State. The Dahod district is well-known as “Adivasi region” in Gujarat. The area covered by this district is 3,642.0 sq. km i.e. it covers 1.86 % of total geographical area of Gujarat and 584 population per sq.km and the rank of this district is 18th in comparison to other districts of the State. The population of the district is mostly rural and a majority of the district residents are Tribals, mostly Bhils. Dahod. The district has 91% rural population and therefore figures for rural population present a very fair figure of the overall scenario of the district.

The total Scheduled Tribes population of the district works out to 74.32 percent of the total population. District also has the second largest population of Dawoodi Bohra Samaj people in India. For administrative convenience, the district has been divided into 7 talukas, 522 gram Panchayats with total 692 villages and 6 towns. Agriculture is the main source of livelihood for the rural people of district.

Dahod is a newly created district of 2001 Census. According to 2011 Census, the total population of Dahod district is 2,127,086 persons comprising 1,068,651 males and 1,058,435 females. Dahod has 3.5 per cent of total state population and it ranks 12th in population among all the 26 districts of Gujarat. As high as 91.0 per cent of district population lives in rural areas while only 9.0 per cent lives in urban areas.

Dahod's poor socio economic indicators brings it to the list of 117 aspirational districts⁶ of India. Dahod is home to the economically poor and socially excluded *Adivasi*, other backward castes (OBC) and minority population with high poverty and rate of migration, poor levels of literacy, extremely low health status esp. of women and children and instances of violence against women. 64.8 % of the households in this district fall in the BPL category and is ranked 2nd among the districts in Gujarat as per this marker⁷.

Poor livelihood situation leads to large out Migration which has a negative impact on health and education of young population. Dahod is listed as one of the aspirational districts of government



⁶ <https://niti.gov.in/about-aspirational-districts-programme>

⁷ Estimates of BPL-households in Rural Gujarat: Measurement, Spatial Pattern and Policy Imperatives by Amita Shah and Jignasu Yagnik, published by GIDR in August 2007, Working Paper No. 176. The figures are for the period 2003-04

under the Transformation of Aspirational Districts programme. The figure below shows the information on the dashboard of the website specifically dedicate to monitor the progress⁸.

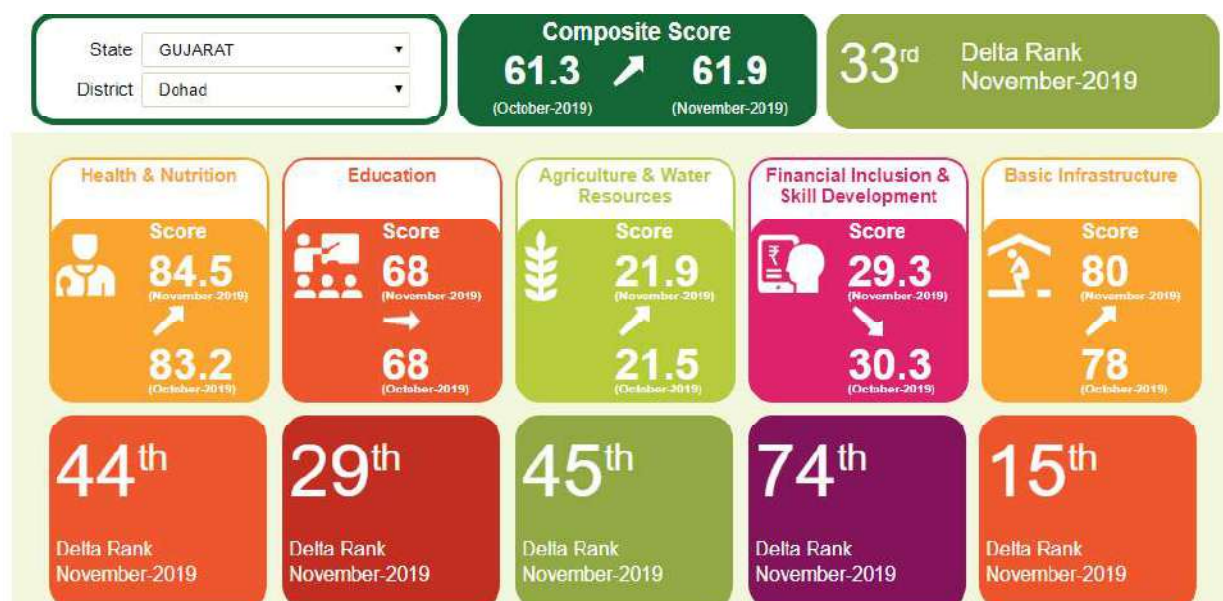


Figure 1: Dashboard of Transformation of Aspirational districts programme- Dahod

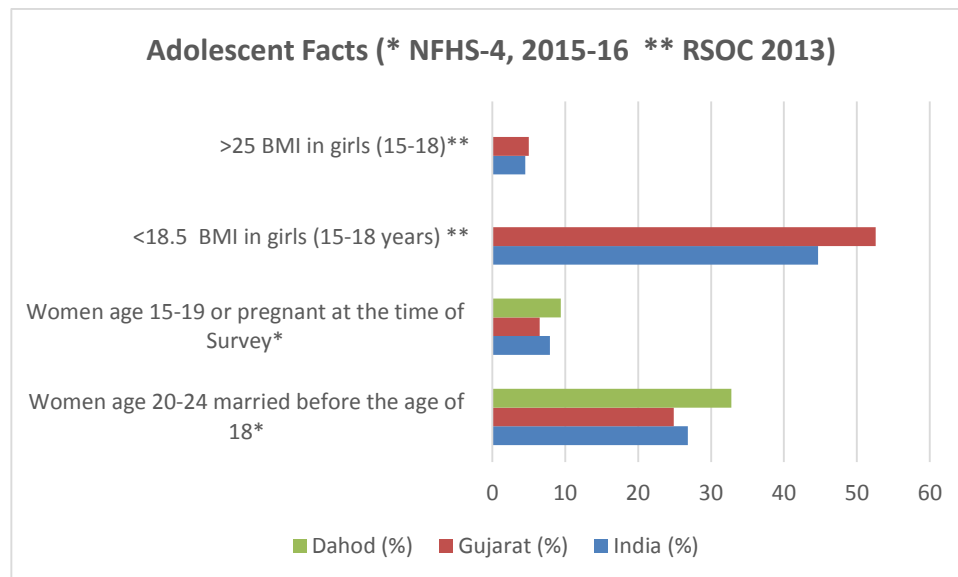


Figure 2: Adolescent Facts India, Gujarat and Dahod (* NFHS-4, 2015-16 ** RSOC 2013)

⁸ www.championsofchange.gov.in

Section 3 EDUCATION

Primary school enrolment has increased significantly over the last decade and India is likely to meet target 3 of Millennium Development Goal (MDG) 2 ahead of 2015. However, young people continue to face many challenges with regard to completing their education. There is a steep dropout rate after completion of elementary education and subsequently at secondary and higher secondary levels, suggesting that gains at the elementary level have not had an impact on the school sector as a whole.

Young women continue to have less education compared to their male counterparts. The adolescents and youth have a special place in the social composition of our society and their knowledge and well-being today act as a catalyst for a better future. Providing them with a wholesome education which develops their literacy, life skills, personality, mind and body should be seen as important development agenda specifically for this age group. The adolescent and youth population in India

being around 364.6 million in 2011 and constituting about 30 per cent of the total population, the literacy status of this important section would be a major determinant of the nation's future.

The graph below show the progress country has made in terms of reducing illiteracy in the adolescent and youth group from 2001 to 2011⁹.

While education is the strongest determinant of the age at marriage for females, the effect of middle schooling, within the levels of schooling, is more pronounced than that of secondary and higher schooling. Thus, the point in an adolescent girl's life when she is at most risk for early marriage, or the critical transition point, is likely to be around middle school years. If a girl manages to stay in school to complete middle school, there is a strong possibility that she will stay on to complete her entire schooling and study beyond, and effectively postpone marriage until or after the age of 18 years. Primary schooling, on the other hand, does not seem to have a similar marriage-postponement effect and, in this respect, is likely to be no different from illiteracy and having less than one year of schooling in its impact on female age at marriage.

⁹ (https://india.unfpa.org/sites/default/files/pub-pdf/4-A-A%26YProfile_StateofLiteracy.pdf)
https://india.unfpa.org/sites/default/files/pub-pdf/AProfileofAdolescentsandYouthinIndia_0.pdf

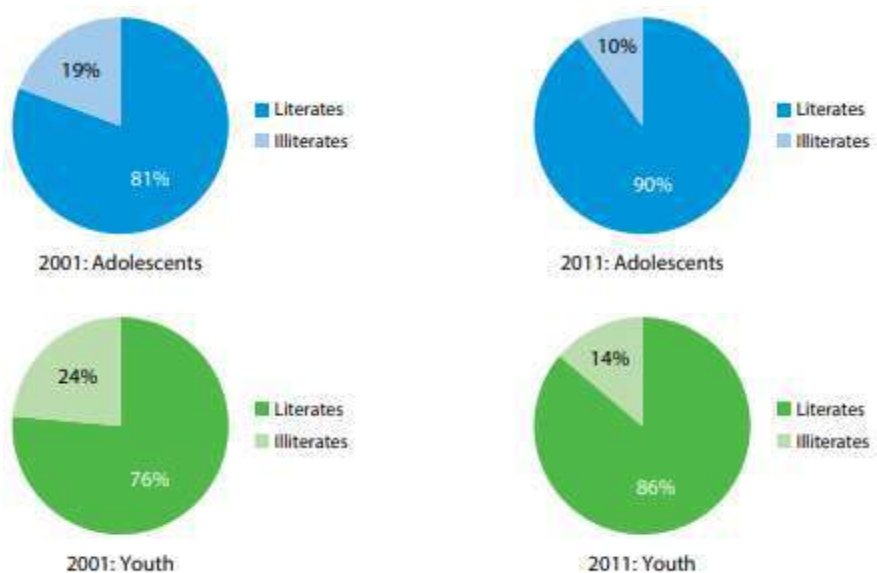


Figure 3: % of Literates and Illiterates among Adolescents and Youth in India, 2001-2011

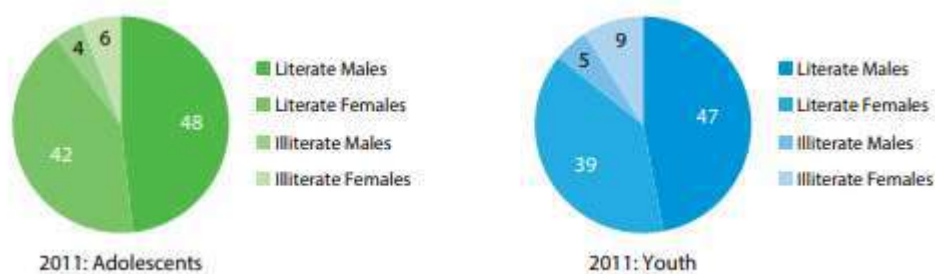


Figure 4: Share of Literates and Illiterates among Adolescents and Youth in India, 2001-2011

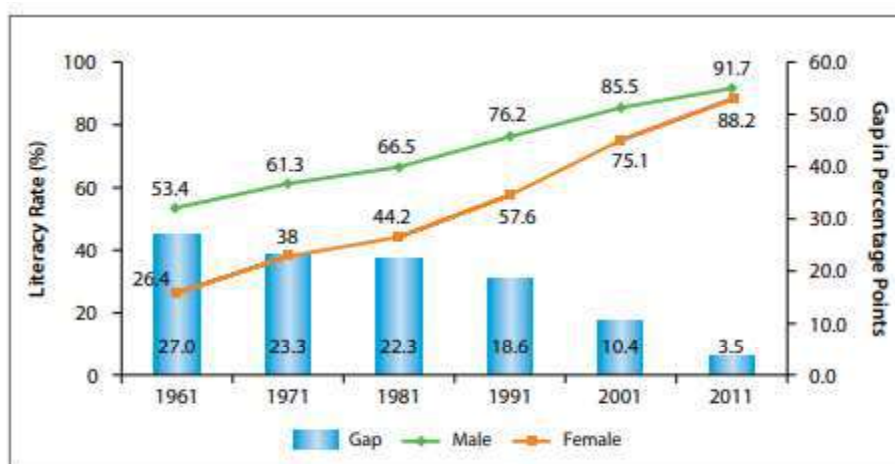


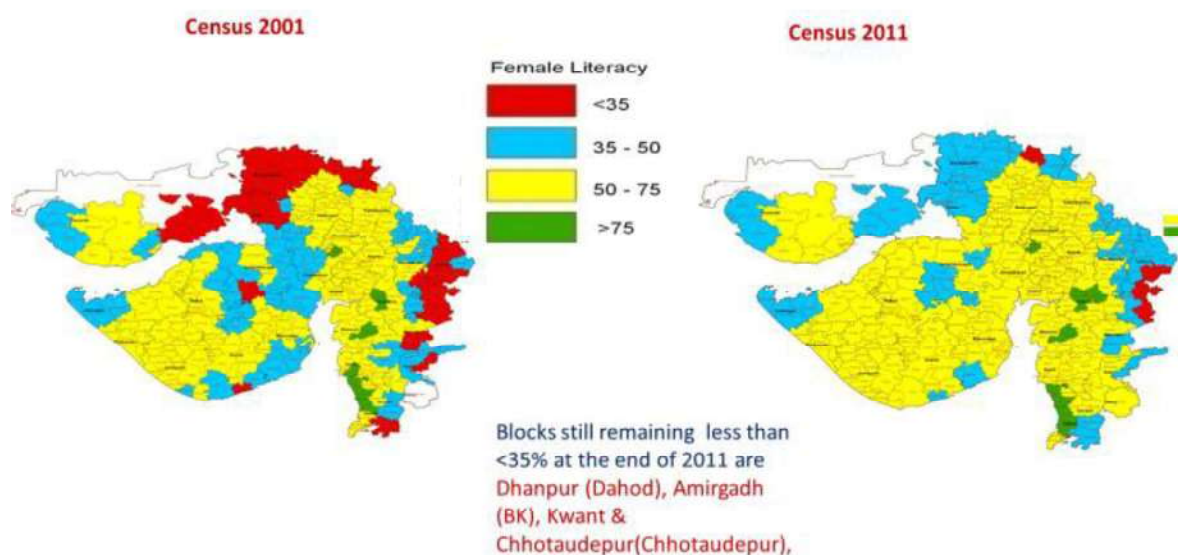
Figure 5: Trends in Literacy Rate among Adolescents in India by Sex and Gender Gap, 1961-2011

Gujarat has been slower compared to national figures when it comes to % decadal change in literates from 2001-2011. The figure for Adolescent population is at 20.9% compared to 25.7% for the country. Similarly, the figure for Youth population is at 21% compared to 37.6% for the country.

The Report, Children in India 2018 released by the Ministry of Statistics and Programme implementation shows that in the bottom 10 States in gross enrolment ratio at various stages. 58% girls compared to 68% boys (15-17 years) attend school in Gujarat, whereas 23% females and 8% males have never been to school. Gujarat is 7th from the bottom. The report reveals that by the time the students enrolled in Class I reach class VI, 1.5% of them leave school, and only 74% of them get themselves enrolled in class VIII. After class VIII, the dropout rate rises sharply, particular. The Gender Gap in Literacy Rate in Gujarat has been at 3.7 for adolescents compared to national figure of 3.5 and 7.8 for adolescents compared to national figure of 8.2. by States and Union Territories, 2011

As per 2011 Census Dahod district reported 1,007,171 literates indicating literacy rate of 58.8 percent. The district ranks 26th in literacy rate in all 26 districts of Gujarat State. Gap in male and female literacy rates is 22 percent with male literacy at 70.01 and female literacy at 47.65.

There are total 36 primary schools, 17 secondary schools and 10 senior secondary schools per 10,000 population in the district. In terms of average there are 6 primary school, 3 secondary school and 2 senior secondary school available per 10,000 population in district. In any towns of the district, there is no college facility available per 10,000 population.



The map above shows the poor progress made by Gujarat and Dahod during 2001-2011. Many blocks still have less than 35% of literacy rate. The Gender Parity Index¹⁰ of Upper Primary in Dahod is 0.92 compared to 0.84 for Gujarat.

¹⁰ The Gender Parity Index (GPI) is a socioeconomic index usually designed to measure the relative access to education of males and females

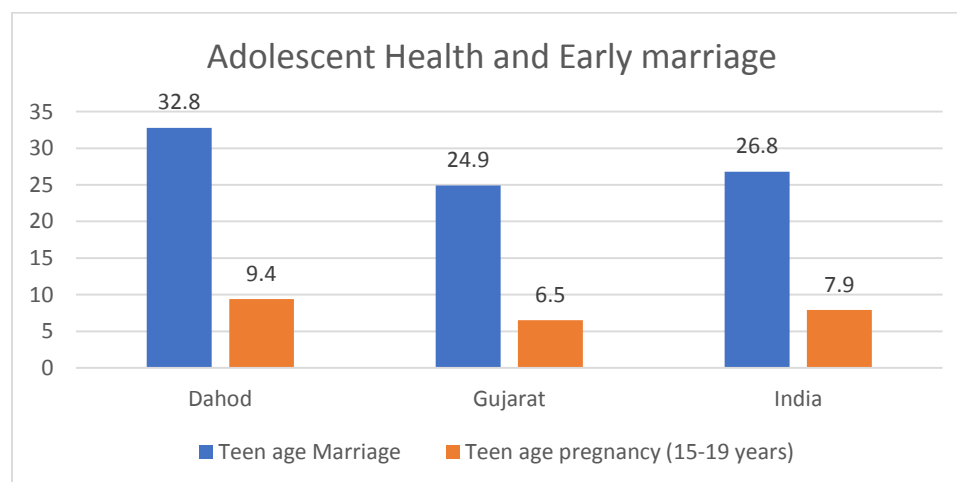
Section 4 HEALTH AND NUTRITION

The emphasis to the specific needs of adolescents and youth started with issues related to health and gradually now the government is acknowledging the need to include other issues affecting overall development. Addressing health and nutrition aspects has been government's agenda since 1997 with the launch of Reproductive and Child Health (RCH) program for reducing infant, child and maternal mortality and the launch of National Rural Health Mission (NRHM) in 2005.

Later Rashtriya Kishor Swasthya Karyakram (RKSK) was launched in 2014 to reach out to 253 million adolescents - male and female, rural and urban, married and unmarried, in and out-of-school adolescents with special focus on marginalized and undeserved groups. **The programme expanded the scope of adolescent health programming in India - from being limited to sexual and reproductive health, it now includes in its ambit nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health and substance misuse.**

Despite all these programs, evidence suggests large unmet need for promotive, preventive and curative health services for adolescents. Although government programs recognise the importance of convergent action and seek to adopt a convergence approach, the programs often work in silos resulting in limited outreach.

A 2015 Study¹¹, shows that despite Gujarat's significant socioeconomic growth in the last 10-15 years, the state continues to experience moderately high levels of under-18 marriage among females. Dahod district falls in one of the two clusters (Dahod, Kheda & Vadodara) of districts with relatively high child marriage prevalence easily identifiable in the state. Related to this is the issue of teen age pregnancies and high maternal mortality.



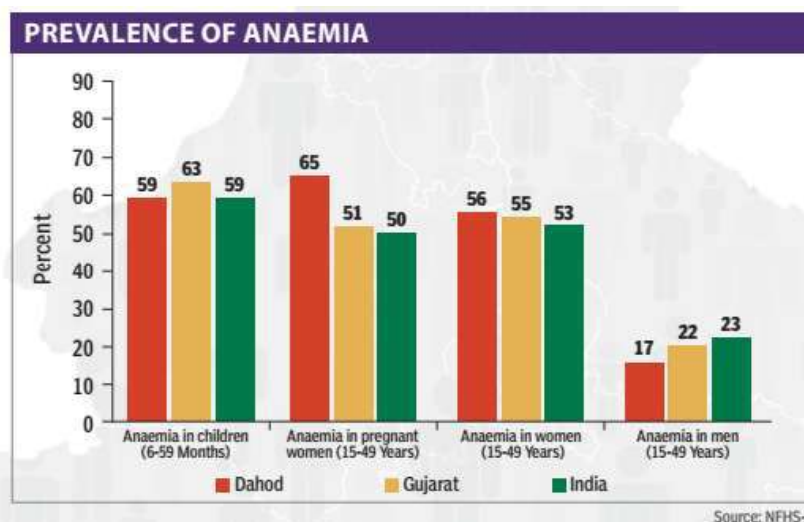
Anemia during adolescence also affects growth and development, and increases risk of infections. 54% adolescent girls and 29.2% adolescent boys in the 15 to 19 years age group are anemic. (NFHS 4) Anemia in adolescent girls also increases the risk of complications in pregnancy, low birth weight children, maternal and infant mortality¹².

¹¹ Srinivasan, Padmavathi; Khan, Nizamuddin; Verma, Ravi; Giusti, Dora; Theis, Joachim & Chakraborty, Supriti. (2015). District-level study on child marriage in India: What do we know about the prevalence, trends and patterns? New Delhi, India: International Center for Research on Women.

¹² <http://iiphg.edu.in/images/pdfs/2019/Monograph-MacArthur.pdf>

Further, as per NFHS 4 data 27% women of 20 to 24 age group are married before 18 years of age. Teenage marriage may result in dropping out of school, early age of pregnancy, and complications during pregnancy and child birth. Among adolescent girls aged 15 to 19 years, 8% had begun child bearing, 5% had live-birth and 3% were pregnant with first child (NFHS 4). Use of contraception is low as NFHS 4 data shows that 22% married women (15 to 24 years) have unmet needs for family planning.

Dahod shows high anemia amount young women esp. pregnant women and men as well. 65% women (15-49 years) were found anemic in Dahod as per NFHS 4 compared to 50% in Gujarat state.



In Gujarat 49.6% adolescent girls and 52.5% adolescents in 15 -19 age group are underweight with a body mass index less than normal i.e.18.5 kg/m² (NFHS 4).

Menstrual hygiene management is important for adolescent girls to stay in school and promote good health. Around 60.3% adolescent girls and women in Gujarat aged 15 to 24 years use hygienic method for menstrual protection. (NFHS 4). The similar figure for Dohad was not available.

There is limited data on sexual behaviours of adolescent boys and girls in India. However there is increasing evidence from studies conducted in various parts of the country that some adolescents engage in pre-marital sex. Lack of information and limited access to contraceptives are some of the reasons for low contraceptive use among adolescents. HIV prevalence in adults in India is at 0.26 percent. 87.4 percent of the HIV cases in India are transmitted through unsafe sexual practices. (MoHFW, NACO 2015) HIV prevalence among young people is 0.1%, and only around 18.5% adolescent girls and 28.2% adolescent boys aged 15 to 19 years have comprehensive knowledge of HIV and AIDS. (NFHS 4)

Experimenting high risk behaviours such as tobacco and alcohol use also occurs during adolescence. The Global Youth Tobacco Survey 2009 reported 14.6% prevalence of tobacco use among 13 to 15 years adolescents in India. Peer influence is one of the factors that contribute to initiation of tobacco use and alcohol consumption among adolescents.18.5% adolescent boys and 1.6% adolescent girls aged 15 to 19 years use tobacco, and 0.5% adolescent girls and 8.9% adolescent boys aged 15 to 19 years consume alcohol. (NFHS 4)

Adolescents are also vulnerable to developing mental health problems. Early identification and intervention is important for addressing mental health problems. Poverty and unemployment are some of the risk factors for developing mental health problems. Stigma towards mental health problems, and limited information and services, contribute to limited access. The

prevalence of mental health disorders among 13 to 17 years adolescents is 7.3% as per the National Mental Health Survey 2015-2016.

The tables below gives district-wise health care infrastructure in Gujarat and Dahod.

	As on 31 st March 2018 ¹³				
	Number of				
	Sub Centres	Primary Health Centres	Community Health Centres	Sub Divisional Hospital	District Hospital
Gujarat	9153	1474	363	37	22
Dahod	637	97	21	1	1

Table 2: District wise Healthcare Infrastructure in Gujarat and Dahod

District	Taluka	CHC	Sanctioned	Filled
Dahod	Dahod	DH- Dahod	1	1
	Dahod	Katvara	1	1
	Garbada	Garbada	1	0
	Limkheda	Limkheda	1	1
	Jhalod	Jhalod	1	1
	Jhalod	Limdi	1	1
	Limkheda	Singvad	1	1
	Fatepura	Fatepura	1	1
	Jhalod	Pethapur	1	1

Table 3: Adolescent Counsellor Details (Shared by RKSK, Dahod)

No	AFHC	Functional since	No	AFHC	Functional since
1	Katwara CHC	2016	16	Dasa PHC	2015
2	Boradi PHC	2015	17	Bandibar PHC	2015
3	Jekot PHC	2015	18	Rai PHC	2015
4	Dahod DH	2015	19	Handi PHC	2015
5	Garbada	2014	20	Sanjeli CHC	2016
6	Pachwada PHC	2015	21	Mandali PHC	2016
7	Gangardi PHC	2015	22	Vasiya PHC	2016

¹³[https://nrhm-mis.nic.in/RURAL%20HEALTH%20STATISTICS/\(A\)RHS%20-%202016/District-wise%20Health%20Care%20Infrastruture.pdf](https://nrhm-mis.nic.in/RURAL%20HEALTH%20STATISTICS/(A)RHS%20-%202016/District-wise%20Health%20Care%20Infrastruture.pdf)

8	Zalod CHC	2014	23	Piplod CHC	2016
9	Limdi CHC	2014	24	Bhathwada PHC	2016
10	Pethapur PHC	2014	25	Guna PHC	2016
11	Rupakheda PHC	2014	26	Dhanpur CHC	2014
12	Bilwani PHC	2014			
13	Gamdi PHC	2015			
14	Limkheda CHC	2015			
15	Singhwad CHC	2015			

Table 4: AFHC Clinic details (Total: 31): Shared by RKSK, Dahod

	PHCs	CHCs	DH	Total
Girls registered in AFHC	3865	5101	947	9913
Boys registered in AFHC	3157	4471	523	8151
Out of registered, Girls received clinical services	2645	4898	486	8029
Out of registered, Boys received clinical services	2899	4173	289	7361
Out of registered, Girls received counselling	2335	5024	790	8149
Out of registered, Boys received counselling	2390	3927	455	6772

A study report prepared for MoHFW by Population Research Centre, Baroda carried out quality monitoring and process evaluation of Programme Implementation Plan (PIP) 2013-14 for the state of Gujarat¹. The study, carried out in Dahod district, brought to light certain important points:

- 1. Adolescent health cell has been established in the district, ADHO at district appointed to look after adolescent health programme including SHP.*
- 2. ARSH programme has been initiated in the district.*
- 3. Menstrual Hygiene Scheme has not been initiated.*
- 4. Adolescent friendly health services are available at District Hospital, Sub District Hospital and one Community Health Centre-First Referral Units*

*A 2018 Study by SAHAJ on Status Of Rashtriya Kishore Swasthya Karyakram(RKSK) in two pilot Primary Health Centers (Dahod and Mahisagar districts – Gujarat) brings out that the Awareness on roles and responsibilities of the implementing staff was low in both districts (below 50 % in both the districts), **but relatively lower in Dahod.***

Only 18 % ASHAs (respondents) were aware about their roles in Dahod and responsibilities as compared to 40 % in Mahisagar. Around 25 % Peer Educators (respondents) were aware about their roles and responsibilities in Dahod as compared to 40 % in Mahisagar. The Peer Education strategy has not yielded expected results in Dahod. The Study recommends the involvement of an NGO to maximise results and strengthen implementation.

Selection process of Peer Educators and facilitation of their sessions as educators was not satisfactory. 20 % Peer Educators (respondents) shared of forming adolescent groups in Dahod. Only 10 % Peer Educators (respondents) in Dahod shared they conducted sessions with their groups. None of the respondents have shared of participating in any other village level activity.

Awareness regarding Adolescent Health Day (AHD), Adolescent Friendly Health Clinics (AFHCs) and Adolescent Health Clubs (AHC) was completely lacking amongst Peer Educators (respondents) in Dahod.

The agency also noted that majority of the respondents could not differentiate between the activities of the SABLA programme and the RKSK programme. The concept around AFHC seems to not have percolated in the community as none of the Peer Educators (respondents) or ASHAs / ANMs knew about the clinic and the services provided by the AFHC

With five years after rolling out the RKSK programme in these pilot districts of Gujarat, the degree of awareness and programme implementation is not uniform at all levels. It reduces from higher level to grass root level stake holders

There are several reasons for the poor development performance in the district, but the most common running thread is the lack of awareness, concerted and integrated efforts and skills amongst responsible stakeholders in promoting behavioural change to achieve improved indicators and practices.

4.1 SUBSTANCE ABUSE

Adolescence is a critical period when the first initiation of substance use usually takes place. Substance use includes tobacco, alcohol, non-prescription pharmaceutical medications, narcotics and other addictive substances such as glue and adhesives. Encouragement by peer groups, the

lure of popularity, and early availability of tobacco, alcohol and various other non prescription drugs make adolescents an easy prey.

As per a study on Adolescents in India by UNICEF, there are currently an estimated 250 million tobacco users aged 10 years and above in India. As in other developing countries, the most susceptible time for initiation of tobacco use in India is during adolescence and early adulthood, i.e., in the age group of 15–24 years (Ministry of Health and Family Welfare 2004). The Department of AIDS Control implements harm reduction services for injection drug users across the country through the Targeted Intervention (TI) Programme and Oral Substitution Therapy (OST), however, neither are designed to address the needs of adolescent injection drug users.

At a programmatic level, most of the drug de-addiction and rehabilitation centres run by various NGOs and charitable trusts are tailored to adult drug users and hence, do not meet the needs of young drug users. Youth friendly centres with services for adolescents are needed. School-based interventions have been rolled out to prevent substance misuse among adolescents. Similar interventions are needed to address out-of-school, street-based and working adolescents.

At district level substance abuse data could not be found although it is one important issue affecting the wellbeing of the adolescents.

Section 5 EARLY MARRIAGE

Exact data on child marriage is difficult to obtain, because of weak administrative systems and poor record keeping in countries where child marriage is widely practiced. Frequently, births are not recorded, so a bride's exact age is unknown. Marriage certificates are not systematically issued in many countries – particularly when the bride is under the age of 18. But the statistics that are available indicate a slight decrease in the number of child brides. In the developing countries, 48 per cent of women between the ages of 45 and 49 married before they were 18. The percentage drops to 35 for women between the ages of 20 and 24.¹⁰ Even though it is dropping, these are still very high numbers of girls affected by child marriage.

“Child Marriage is a practice that robs millions of girls of their childhood, their rights and their dignity.”

– Archbishop Desmond Tutu

Child marriage has been linked to a number of negative health consequences for the child bride and for the bride's children¹⁴:

- Child brides face a higher rate of contracting HIV and other sexually transmitted infections because of their biological vulnerability and social inequality;
- Child marriage increases the likelihood that a girl will give birth at a young age and that childbearing will continue uninterrupted throughout reproductive age;
- Girls under the age of 15 are five times more likely to die in childbirth than women in their 20s;
- Girls aged 15-19 are twice as likely to die in childbirth than women in their 20s;
- Girls under 18 face a higher risk of pregnancy-related injuries such as fistula;
- A child born to an adolescent mother is twice as likely to die before the age of one, compared to the child of a woman in her 20s.

Although there has been a significant decline in child marriage for females throughout the country, a significant percentage of Indian females continue to marry between the ages of 15 and 17 years. Child marriage among females customarily leads to early pregnancy and motherhood. Data from the Indian Census 2011 confirm this: around 30% females ages 15-19 years who are ever married are already mothers and 10% have had at least two children. Maternal mortality risks are high. According to NFHS 4 (2015-16), 25% women and 28% men in Gujarat marry before their legal age. The India figure is 27% women and 20% men marrying before their legal age. A Study notes that districts that have seen significant catching up of female literacy rate with that of males in the last 10 years have seen appreciable declines in the prevalence of female child marriage¹⁵.

Gujarat has seen significant growth in industrialization and modernization, and vast improvements in its socioeconomic conditions in the last 10-15 years. Yet, the state continues to

¹⁴ A note on child marriage, World Day of Prayer and Action for Children Secretariat New York, Working Document July 2012

¹⁵ District Level Study on Child Marriage in India: What do we know about the prevalence, trends and patterns? (ICRW and UNICEF)

experience moderately high levels of under-18 marriage among females (35 percent of women aged 20-24 years married before reaching the age of 18) and substantial percentage of marriages (28 percent) among females occur between the ages of 15 and 17 years.

In **Gujarat** the number of convictions of those charged with committing child marriage is very small. Since the passing of the Prohibition of Child Marriage Act 2006, the total number of applications received reporting Child marriage in **Gujarat** is 1831. But only in 391 cases these kinds of marriage were prevented and just in 21 cases punishment or penalty has been issued. Due to lack of evidence 1064 applications have been rejected and 107 cases are under court hearing and 228 cases are still pending.

Child marriages are not limited to the poor, the uneducated and backward castes but it prevails across all classes and castes in **Gujarat**. The younger daughters in the family are married into family along with the elder girl to save expenditure.

The year 2018 saw a 21% jump in reporting of child marriages. Against 143 marriages reported in 2017, the last year report 174 or three child marriages per week.

When age-proof documents were checked it was found 14 of the the 18 marriage candidates were underage.

The instances of child marriages, as per this data, is higher among Scheduled Tribes where 25,508 persons in the 10-14 year age group are married (9,878 Males and 15,630 females). Among them 1009 are widowed, 526 are separated and 285 are divorced.

Meanwhile, the Census figures also reveal that among the Scheduled Castes in Gujarat, there are 9,930 married persons (3,945 males and 5,985 females) in the age group of 10-14 years. Of these, 469 are widowed, 197 are separated and 104 divorced.

Surprisingly, there are more number of married SC teenagers (5,523) in the urban areas compared to the rural (4,407), while child marriages seem to be more prevalent among SCs like Bhambi, Valmiki and Vankar.

There are over 37,000 married males among the ST population, while there are over 10,000 SC married males in the age group of 15-19 years.

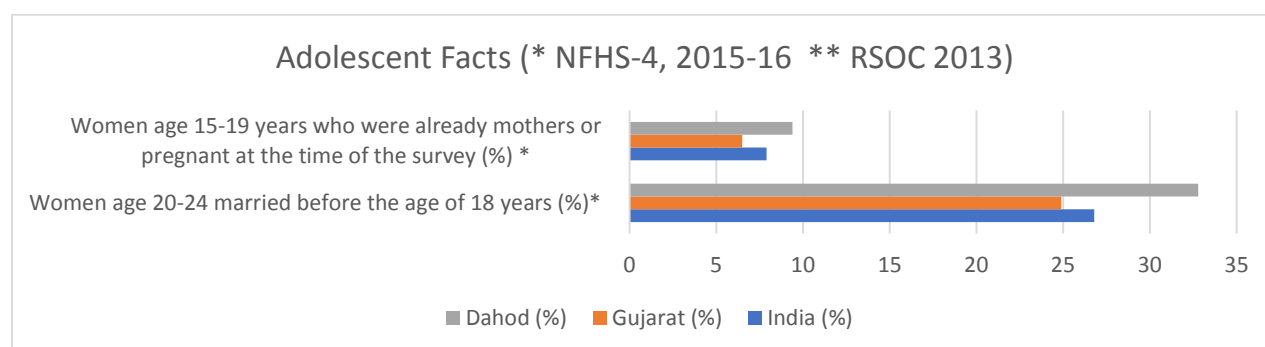


Figure 6: Early marriage (NFHS-4, 2015-16, RSOC 2013)

As per NFHS-4 and RSOC 2013, 9.4% women of age 15-19 years were already mothers or pregnant at the time of the survey in Dahod as against 6.5% in Gujarat. Similarly 32.8% women got married before the age of 18 years in Dahod as against 24.9% in Gujarat.

Section 6 VIOLENCE AGAINST ADOLESCENTS AND THEIR RIGHTS

Recognising the urgency for articulating the need to protect child rights, the UN Convention on the Rights of Child was formulated in 1989 and subsequently ratified in 1992 by several countries including India. Article 19 of the Convention relates to the protection of children against all forms of violence, abuse, neglect, and mistreatment by parents or any guardian and Article 34 stipulates that governments protect children from sexual abuse and exploitation (UNICEF 1989).¹⁶

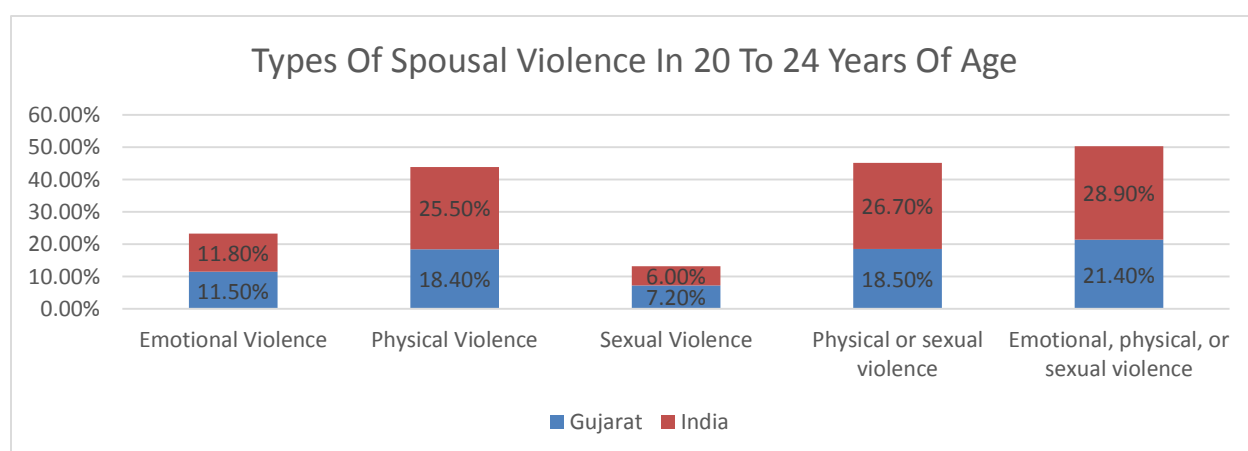
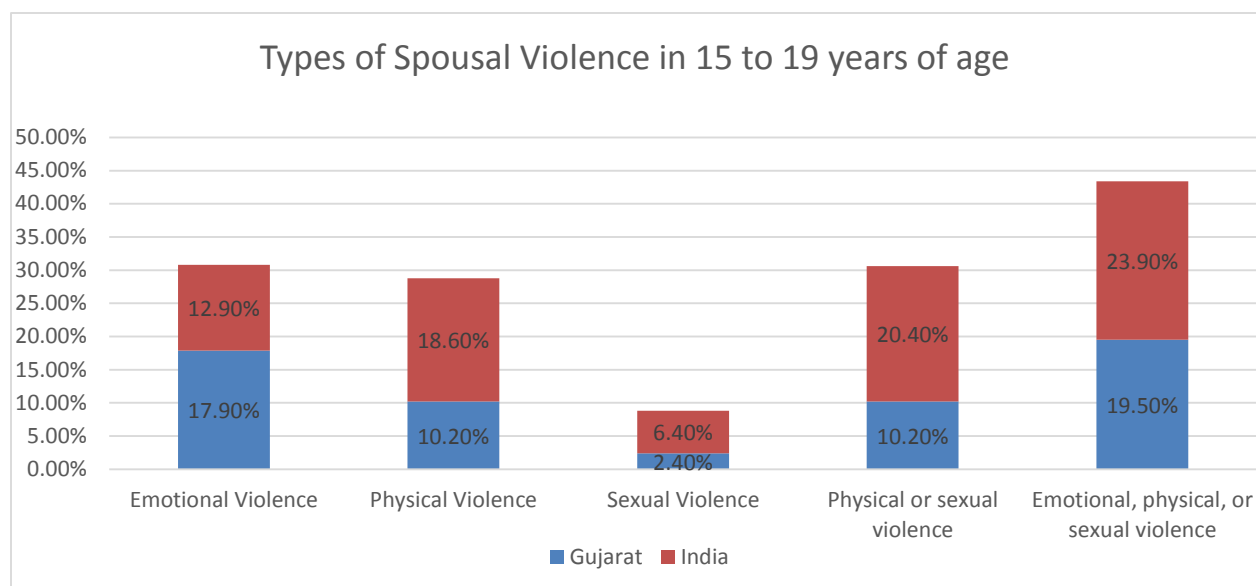
Teenage marriages, low economic status and poverty increase the vulnerability of adolescent girls to violence. Violence and sexual abuse of adolescent girls increases their risk of unwanted pregnancy and HIV. 2.8% adolescent girls aged 15 to 19 years and 4.6% women aged 20 to 24 years had experienced sexual violence. Further, 17% adolescent girls aged 15 to 19 years and 24.8% women aged 20 to 24 years had ever experienced physical violence since 15 years of age. (NFHS 4)

Experience of violence during pregnancy ¹⁷				
	Gujarat		India	
Background characteristic	Percentage who experienced violence during pregnancy	Number of women who have ever been pregnant	Percentage who experienced violence during pregnancy	Number of women who have ever been pregnant
Age				
15-19	3.0	56	5.2	1,205
20-24	1.1	357	3.8	7,821
Residence				
Urban	0.4	1,206	3.4	20,056
Rural	3.0	1,539	4.1	37,786
Caste/ tribe				
SC	2.1	307	5.7	11,195
ST	5.1	414	4.8	5,294
Other backward class	1.1	1,194	3.5	25,575

In India, 5.2% of adolescents (15-19 years) and 3.8% of women (20-24 years) experienced violence during pregnancy. Similarly in Gujarat 3.0% of adolescents (15-19 years) and 1.1% of women (20-24 years) experienced violence during pregnancy.

¹⁶ Adolescents in India: A desk review of existing evidence and behaviours, programmes and policies." 2013. New Delhi: Population Council & UNICEF

¹⁷ Factsheet on Adolescent issues, Sahaj



As we can see from the figures above, highest kind of violence amongst 15-19 years is physical violence and lowest is sexual violence. In 20-24 years age group highest is physical violence and lowest is sexual violence. Similarly, for Gujarat highest kind of violence amongst 15-19 years is emotional violence and lowest is sexual violence. In 20-24 years the trend for Gujarat is same as the national trend.

The violence is also experienced by adolescents who work as child labor living under conditions of extreme poverty and economic distress and are often sent to work so that they can contribute to the family income. Working children have to forgo educational opportunities and take up jobs that are often underpaid and hazardous. Further, they often face physical and sexual violence and abuse.

6.1 RIGHTS OF ADOLESCENTS

The launch of the General Comment on Adolescents in Geneva and Brussels is the most important articulation of adolescent rights since the UN Convention on the Rights of the Child in 1989. A General Comment is an “interpretation of the provisions of its respective human rights treaty” – in this case the UN Convention on the Rights of the Child (UNCRC). The UNCRC sets out the rights of all children and is “the most rapidly and widely ratified international human rights treaty in history.” The General Comment on Adolescents (GC20) was finalised in September 2016.

The GC20 attempts to bring visibility to the age of adolescence – still a contentious and undefined life stage – which remains a squeezed period of life; not child, not youth, and rarely considered in either national policies. Except in one domain: when it comes to juvenile justice, adolescents feature prominently given that this life stage spans the period when children become criminally responsible. Within UNICEF, adolescence has become an emerging issue as part of their focus on the “second decade”. While UNICEF is traditionally known for their work on early childhood, their logic with this shift is clear: there is no point in keeping children alive until they are 10 years, only to abandon them in their adolescence¹⁸.

Adolescent girls in India face intersecting forms of discrimination on the basis of gender, age, class, caste, race, ethnicity, socio-economic status, and other factors that create specific obstacles that prevent them from experiencing their civil, political, social, economic, and cultural rights to the fullest. These obstacles must be addressed by legislators and policymakers, separately and equitably, with a full understanding of how laws, policies programmes, plans, budgets and schemes intended to empower women and girls translate to ground realities. This understanding must be gender-responsive and rights based, to assess the effectiveness of national-level measures to promote gender equality.¹⁹

India is also obligated to ensure that its country-level initiatives abide by its obligations under international law, including the United Nations core human rights treaties, especially the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the International Bill of Rights, which consists of the Universal Declaration of Human Rights (UDHR), and the two International Covenants on Civil and Political Rights (ICCPR), and Economic, Social and Cultural Rights (ICESCR). Other relevant international treaties include those by the International Labour Organization, especially the core labour Conventions and the Fundamental Principles and Rights at Work. India is also obligated under regional standards created by organizations of which it is a member such as the South Asian Association for Regional Cooperation (SAARC), such as the SAARC Convention against Trafficking in Women and Children (2002). These international and regional standards form a framework of complementary and mutually protections that uphold the rights of India’s girls.²⁰

¹⁸ <https://www.youthpolicy.org/blog/youth-childrens-rights/the-rights-of-adolescents-the-most-important-articulation-of-adolescent-rights-since-1989/>

¹⁹ Rights of Adolescent Girls in India: A Critical Look at Laws and Policies, by Saumya Uma with an Introduction by Dr. Vibhuti Patel

²⁰ <https://www.childwatch.uio.no/news/2013/vacha-s-new-publication-details.pdf>

Section 7 WORK OPPORTUNITIES AND SKILL BUILDING

The adolescent and the youth population in a society constitute a critical segment as the future demographic, social, economic and political developments of the entire population depend on them. Imparting education and enhancing the technical skills of this segment of the population has far reaching implications on economic prosperity. Transition of young people from schools and training institutions into the labour market is a phase marking a critical period in their life cycle.

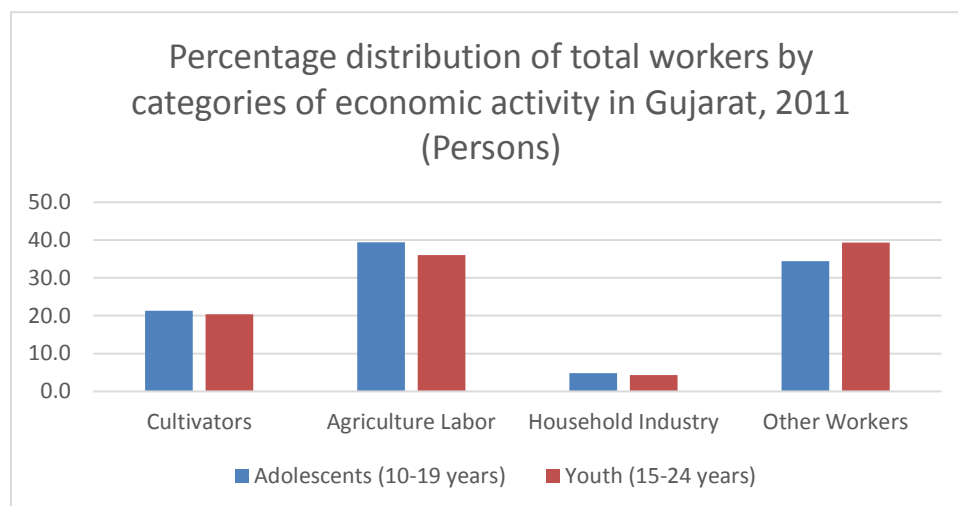
Several programmes have been implemented that aim specifically to facilitate safe transitions into adulthood, especially for young girls. These range from provision of nonformal education, to development of livelihood skills, to increasing awareness about sexual and reproductive health-related issues. Life-skills education programmes have been considered an effective intervention strategy and most programmes include building negotiation and communication skills; raising awareness on sexual and reproductive health issues; and developing gender egalitarian attitudes and countering gender disparities. Some interventions also focus on provision of vocational skills training providing young girls opportunities to be wage earners.

A range of programmes is implemented by the government as well as NGOs. Among the programmes being implemented by the government, the Adolescence Education Programme (AEP), developed by the Ministry of Human Resource Development, Department of Education, and the National AIDS Control Organisation (NACO) for school-going adolescent boys and girls in Classes 9–11 seek to build adolescents' skills in making important life decisions; improve interpersonal communication; foster egalitarian gender role attitudes; and raise awareness about growing up matters, as well as about HIV. The Kishori Shakti Yojana (and its 1990s predecessor, the Adolescent Girls Scheme) aims at training adolescent girls in vocational skills as a means of empowerment and building their self-esteem. Programmes being implemented through Mahila Shikshana Kendras under the auspices of the Mahila Samakhya programme provides girls with nonformal education and leadership training. The Rajiv Gandhi National Institute of Youth Development has, likewise, implemented life-skills programmes which aim to instil leadership qualities and broaden the personality of young female and male participants.

Programmes implemented by NGOs focus largely on life-skills building and include those developed and implemented by NGOs like the Center for Development and Population Activities (CEDPA), New Delhi; the Centre for Health Education, Training, and Nutrition Awareness, Ahmedabad (CHETNA); MAMTA, New Delhi; Sahayog, Mumbai; and Pathfinder International, New Delhi to name a few. The Self-Employed Women's Association (SEWA) in Gujarat and the

International Council for Research on Women (ICRW) in New Delhi, Maharashtra, Bihar, and Jharkhand have also implemented programmes that could be used as demonstrating models.

The work participation rate of adolescents in India is 14.9 and in Gujarat 13.2. Similarly, for youth the corresponding country figure is 36.9 and for Gujarat it is 42.3.



Section 8 WAY AHEAD

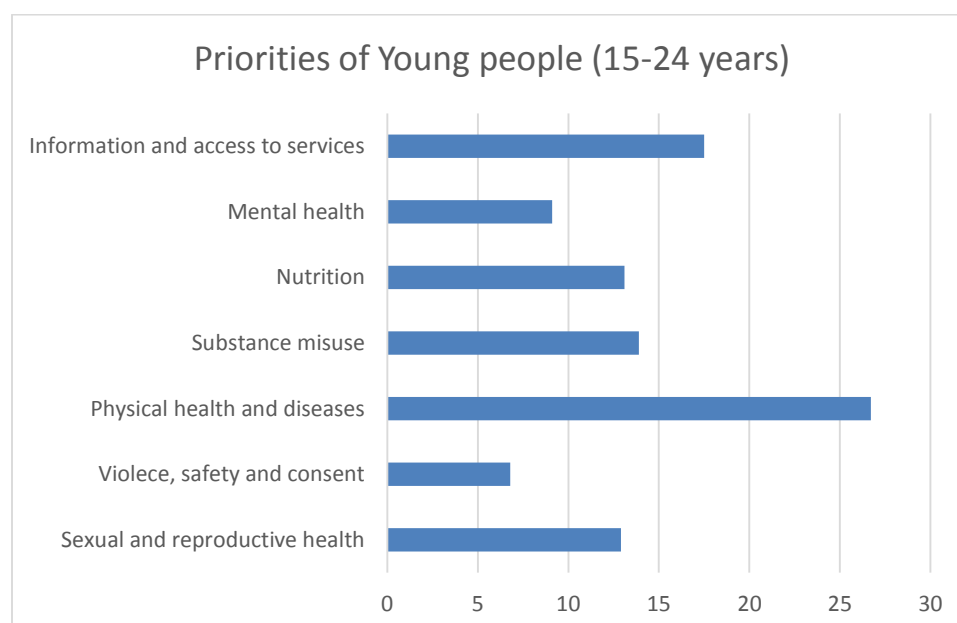


Figure 7: Data from a survey led by SAHAJ and partners in 8 districts of Gujarat, including Dahod

SAHAJ was the nodal organisation in Gujarat, part of a Study spearheaded by Centre for Catalysing Change UNDER 'Youth Bol', a national campaign, aimed to reach 1 lakh youth of the country supported by MoHFW to enable young people (10-24 years) to articulate their top priorities about healthcare services.

Key questions which we could delve into

- How effective is our Convergence between departments?
- What better strategies can our AFHCs use to attract youth?
- Are we effectively engaging with Influencers (Parents, teachers, ASHAs, AWWs, VHSNCs, Panchayat, traditional leaders)
- Are we promoting gender equality? – discrimination is the core of practices like discontinuing girl child education, child marriage, teen pregnancies, violence against women and girls?
- Are our strategies attuned to literacy levels in Dahod?
- Do our trainings with front line workers look at gender sensitive behavioural change? Are we periodically mentoring these workers?

Can we reflect & learn collectively?

- SAHAJ & Sarthi's experience: Involvement of local NGO, ensuring following of RKSK protocols (2018-19)
- CHETNA & IIPHG's experience: Demonstration of Convergence of Health Programmes in Sabarkantha with concerned District authorities (model Adolescent health day, convergence mechanism) over 2013-15

- Utthan's experience: Involving Local influencers like Parents, traditional leaders, those whom youth look up to
- Integrate gender equality messaging in outreach with girls and boys
- Ensure regular trainings & mentoring of front line workers – protocols, gender sensitive behavioural change tools, use of local folk media tailored to different audiences

Section 9 REFERENCES

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