INTRODUCTION
Providing a service for young people in India can be a challenge. The vastness of the country that is more than half the size of Europe and ten times the size of Italy, with a population of more than one billion, with diverse cultures, languages, customs and beliefs, religions, habits, dietary preferences and dress, certainly presents a setting within which a prototype of young people could be difficult to define.

Orthodoxy and modernism co-exist as do poverty and wealth, illiteracy and advanced education presenting bewildering variations in attitudes, behaviour and mores. Family traditions and cultural attitudes cross-fertilize with new ideas, which the conservative adolescent is often unable to understand. Economic necessity, inadequate machinery for exercising compulsion in education and illiterate parents are among the main causes for the high dropout rate from schools. Dropping out of school at the crucial age when personal life style and knowledge on sexuality can be imparted is a handicap.

Daunting numbers
The sheer size of the numbers of young people is daunting. There are an estimated 300 million young people in India comprising almost one third (31.0%) of the country’s population, 22% are aged between 10-19 years. The very young adolescent 10-14 years of age, comprising 12% of population.

Young boys and girls who would be classified as adolescents are not only often married but also have become parents of one or more children.

Despite rising age at marriage and laws prohibiting early marriage, half of all women aged 20-24 years are married by age 18 and a quarter by 15 years. In the three highly populated states of Bihar, Madhya Pradesh and Uttar Pradesh, marriage continues to be at the early age of 15-16 years and child marriages still continue (Table 1).
TABLE 1
Percentage of young women married

<table>
<thead>
<tr>
<th>Women currently aged</th>
<th>15-19</th>
<th>20-24</th>
<th>25-29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage ever married</td>
<td>33.6</td>
<td>78.8</td>
<td>94.5</td>
</tr>
<tr>
<td>Percentage married by age 13</td>
<td>8.9</td>
<td>12.1</td>
<td></td>
</tr>
<tr>
<td>Percentage married by age 15</td>
<td>23.5</td>
<td>29.2</td>
<td></td>
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<tr>
<td>Percentage married by age 18</td>
<td>50.0</td>
<td>58.9</td>
<td></td>
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<tr>
<td>Percentage married by age 20</td>
<td>67.1</td>
<td>74.9</td>
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Health concerns of the adolescent

Although there is a commitment by the government to meet young people’s sexual and reproductive health (National Policy 2000), the health needs of the adolescent has not been implemented seriously by either the government or municipal authorities, or voluntary agencies as having any priority. Neither have doctors, nurses nor the teachers given much thought or attention to the health needs of the adolescent. The services being adult based, an adolescent is often confused as to whom to approach for reproductive health advice. What little information they receive on this subject is generally given by peers or a handful of doctors who are sensitive to their needs. A few voluntary agencies such as the Family Planning Association of India do provide sexuality education and counseling facilities; other than that there is a great void. Recently sexuality education focused on safer sex to avoid sexually transmitted infections, particularly HIV, has been introduced in many states.

The nutritional status of an adolescent is often very poor. Malnutrition is not necessarily caused by a lack of food but by non nutritious food habits. Anemia is particularly common among women and is the greatest killer during childbirth. A number of health problems directly concerned with fertility, for example, include illegal abortions, unmarried or unwanted pregnancies and sexually transmitted disease such as HIV infection, are increasing. There is evidence that the age of starting sexual experiences has decreased as has premarital sex increased (Table 2). There is a definite indication that group pressure and emotional insecurity has made an adolescents in urban areas, susceptible to the lure of alcoholism, excessive smoking drugs and sexual satisfaction from unhygienic sources. Personal hygiene in both, male and female adolescents is often neglected due to the myths and misconceptions that still persists and a lack of education.

As in other parts of the world early child bearing is a serious threat to the life and health of a young woman. Children born to a young mother, a common occurrence in India, have a high risk of morbidity, mortality and other

TABLE 2
Casual sex experience among adolescents aged 15-19, India, 2001

<table>
<thead>
<tr>
<th>India</th>
<th>Percentage of respondents reporting casual sex in a one-year recall period</th>
<th>Percentage of respondents reporting consistent condom use in casual sex partnerships in a one-year recall period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>10.1</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Source: NACO and UNICEF, 2002

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handicaps. Pregnancy out of marriage in the young mother can trigger social consequences that can be overwhelming. The young woman often faces permanent rejection and is regarded as an outcast. To avoid this stigma the girl may resort to a hazardous abortion or suicide. The child is generally abandoned, and may be picked up to grow in poorly equipped orphanages. Medical termination of pregnancy (MTP) is legally available but few young people are able to access the services, often due to the attitude of the providers.

The government, planners and politicians have yet to be convinced that every rupee spent on the health of youth, their behaviour and fertility pattern, would return manifold results that could avoid social problems. It is encouraging to note that young people are now on the National agenda for health and are being recognized as essential to make the programme a success. It is increasingly hoped they will adopt roles of articulating, designing, implementing and evaluating programmes.

The need for coordinated efforts

In order to bring about awareness, influential bodies and the government could get together and participate in tackling health problems such as alcoholism, drug addiction and sexually transmitted diseases. Relevant educational material made with the local situation in mind is an urgent necessity. Presently there is a lack of coordination, between government ministries, government and NGOs among NGOs themselves and only a core working committee consisting of members from the government and other agencies like the Family Planning Association of India (FPA India) who have associated themselves with youth and their problems could mobilize resources and talent.

There is also a lack of clear directive on sexual behaviour from persons that young people look up to and the double standards of parents and elders often bewilder them. Young people also have to be included in the strategy and implementation of programmes of them. The people in India continue to look up to the doctors and paramedicals not only for medical advice but also to solve many of the problems in the family. The parent, teacher and social worker are also consulted but their peers when consulted often give wrong advice. None of them have had any formal training to counsel the adolescent or to deal with adolescent health problems particularly, reproductive health. Agencies like the World Health Organisation (WHO), the International Planned Parenthood Federation (IPPF), the FPA India should plan a holistic strategy to train the trainer – be they adult or adolescent to impact healthy life style and relevant sexuality education.

No special facilities especially for the adolescents exist in India. The services for both adult and adolescent are: delivery and abortion services in various hospital, private nursing homes, family planning clinics etc. (integrated with adult services), isolated scanty counseling services by doctors and counselors, sex and family life educational programmes, rehabilitation programmes by different social welfare agencies, through teaching skills for employment, marriage, adoption etc.

Approaches to the problems of the young people

Creating awareness regarding the importance of adolescent behaviour, conduct fertility pattern and its impact on the nation has become an urgent task. Primarily the government should initiate interest in this area, particularly among health professionals. The government should allocate a special budget for establishing services especially for adolescents in the area of counseling and help them to locate suitable services. In the first instance an apex body of experts should be formed, which would include youth leaders, to give consideration to the manner in which phased action could be taken.

Educational institutions at all levels must accept the teaching of population and sex education. The government has introduced
population education (this does not include sex education) in the school curricula, although implementation is still not complete.

For the large majority of youth and young adults who are put of school and are possibly working or are in the rural areas, it is important to develop a core of peer group leaders from among them, as the present day youth is more involved in political activities. The selected leaders must be provided with suitable demonstration aids, not only to explain sex and family life, but also helps to deal with many of the problems that worry young people.

The preparation of sexuality and family life educational material is not an easy task, because no coordinated effort has been made to get the expert in family planning worker with media experts. At least there should be a concerted effort to choose what is best. A number of foreign assistance is available but lack local flavour.

Educating the teacher, health visitor, social workers and paramedicals to achieve a rapid multiplier effect is direly required. There is at present a shortage of skilled manpower. Voluntary bodies like the FPA India is perhaps one of the organizations to have included human sexuality among its programmes, can play an important role in training.

Services that the adolescent can easily identify and utilise needs urgent planning and implementation. These may be merged with school or college health programme and counselling services or with governmental, municipal and voluntary services providing total health care. In our country with so many health problems, providing separate services in hospitals and clinics is at this stage not practical, but certainly health personnel in these areas can be oriented to the special needs of the adolescent.

Changing the attitudes of the adolescent towards marriage or starting a family etc. is going to be a task. Youth can be constricted by cultural traditions, society, caste and creed and by a lack of opportunities, education and a lack of essentials to make the adolescent physically, nutritionally and emotionally fit to take correct decisions, particularly concerning reproductive health.

A holistic approach strategy should be designed collectively by government along with concerned NGOs and a core group jointly appointed to implement this. Education, knowledge and change of attitude of all concerned is imperative. The involvement of young people is important, if adolescents are to take an active part in the country's family planning programme. Briefly, the obstacles can be listed: (a) the difficulty of teaching the adolescent; especially if there is a high percentage of uneducated, unemployed youth, (b) the social attitudes and stigma attached to this type of knowledge and practice, (c) lack of scientific perspective not only by the general public but also by the medical professional and health providers, (d) lack of governmental awareness realization and support to the extent needed, (e) lack of sufficient and adequate service, (f) lack of properly trained staff and their attitude, (g) lack of funds, (h) lacunae in the law, and (i) religious beliefs.

**Organising family life, sex education & counselling programme in the RH clinic**

If reproductive and sexual health success means an attitudinal and social change in the people, then life skills education can be the major instrument to bring about this change. Sexuality education as a part of the training, builds feelings of need, benefit, hope, wanting to, and personal pleasure. But as it stands today, it is still a very sensitive subject, one beset with total misunderstanding of its aims and objects.

In such an environment, the health provider who decides to pioneer or enhance sexuality education must be totally committed and, must be prepared to face resistance both visible and invisible. Convincing other health providers of the value of introducing the sexuality approach
instead of sticking to their conventional ways is at times a frustrating job, but once achieved, provides completely satisfying results.

Journalists, politicians and, well meaning defenders of morals often will publicize the titillating aspects of sexuality. It is important to identify influential and sensible groups and have press conferences, introduce programmes explaining the importance of interpersonal relationships and positive feelings that sex education builds.

The environment that exists around the clinic and the country must be studied carefully. No person in the field of human sexuality can ignore custom, tradition, superstition and religious beliefs. At times it seems that the rapid in-roads of modernity especially in the urban areas are fast gaining ground, so the strategy and implementation will be a mix of the past and the realities of today. The sensitivity of the people must be given full consideration.

Should the subject be called human sexuality, sex education or family life education? Experience indicates that human sexuality or sexuality education is quite well accepted by professional groups whereas Family Life Education (FLE) is more acceptable to the public, educational authorities, parents, because some authorities believe that FLE is a more comprehensive one, including sexuality education and a gamut of family and interpersonal relationships which are important, especially in societies of developing countries. It is advisable when approaching resistant groups to speak of values, relationships, health and hygiene education rather than trying to convince them to introduce sexuality education.

The clinic/centre must identify the specific groups to whom sexuality education will be directed. The demographic picture of the country will help greatly in pin pointing the groups. In India and the South Asia regions the primary group from the demographic point of view will be in the age group 15 to 25 years – a group who has made a significant impact on reproductive and sexual health. Counseling clinic must be prepared for adolescent and premartial counseling. Population education in schools should include sexuality education in the young (10-14 years) and geriatric sexuality could be provided on demand basis.

Is there need to have an exclusive or special centre for the activity? It is preferable to have a separate center where young people can meet, relax and where services can be provided e.g. gynaecological, psychological testing, contraceptive counseling and other facilities. People still do not wish to be identified entering a special counseling clinic; therefore, wherever the centre is located it must provide strict confidentiality, have no complicated forms and be totally free from embarrassment and away from public gaze. If it is not possible, then the FLE Centre can be established as well in a hospital or family planning clinic or in a college or high school health clinic set up; it will have to draw on the speciality services of the other departments.

The centres will mainly be visited by young people, although newly married couples and those with marital problems will approach clinics. Many different types of activities can be undertaken according to the need and convenience. The centre should undertake both, outreach and clinic based programmes. The outreach programme include: (a) to school children of both sexes undergoing population education, (b) to adolescents; programmes include a discussion and advice in selecting a mate, responsible sexual behaviour, responsible parenthood, birth of a baby, the biology of the male and female, personal hygiene, gender and relevant aspects of sexuality, (c) to specialist groups: e.g. Medical Associations including Psychiatric and Obstetrics and Gynaecology and doctors of the Indian System of Medicine. The programme should concentrate on teaching simple counseling techniques, identifying prob-
lems and helping in filling the gaps on sexuality knowledge not provided at the medical college, (d) to educate out-of-school and uneducated youth at the work place at Industrial sites through their Welfare Officers at Slum Social Welfare Centres (e) to collaborate with special organizations like the physically handicapped.

**Within the Centre:** The Centre should concentrate on family planning counseling, marital problems and female sexual problems; investigative research; and preparation of suitable material for the various target groups; training post graduates, social work students and counselors. Through its sharpening skills programmes, family planning workers, social workers, peer groups, counselors and others should be oriented and trained to be better counselors and to use new approaches. Hold club meetings regularly, once in six weeks can yield good and consistent response; the intention is for like-minded people to share their thoughts and experiences and enhance their knowledge.

Although setting up of the centre is difficult, attracting the clientele is even more difficult. Surprisingly, persons live with their problems for years. For example, FPA India has had a client coming with a newspaper cutting more than a year old mentioning the Centre and married couples with unconsummated marriages for periods as long as ten years.

**Publicity:** How is the service of the centre to be made known? A website and an internet answering service has proved very popular so also has a telephonic helpline. An approach can be made through social organizations like the Rotary Club, the Lions Club and other social organisations who keenly invite experts to their meetings. Articles can be written for the press and personal interviews should be granted to the media. The centre can work in collaboration with industrial units and other a social organisations.

Programmes with medical profession generate interest and make the subject of human sexuality an ethical subject in their eyes. Above all its introduction has positively generated much greater interest in reproductive and sexual health including family planning and has increased attendance at the clinics.

**The staffing:** It is difficult even in urban areas to identify experts interested in FLE and sexuality counseling. The center/clinic could have consultants with different backgrounds, e.g. consultant on sexual medicines, psychologist, psychiatrist, dermatologist, gynaecologist, pediatrician, social worker, and even a housewife. To encourage such specialists to pay greater attention to sexuality orientation programmes should be held either alone or in collaboration with other agencies. Such meetings have created interest and many doctors, psychiatrists, social scientists have now turned their attention to family life and sexuality education and counseling. To sustain their interest, regular meetings between the experts of the centre to solve such problems as how to counsel men having sex with men will help to break the barrier of hesitation and embarrassment and personal sensitivity seen.

A full time counselor to help and coordinate the work of the visiting consultants and look after the special activities of the Centre would greatly enhance the work. To get a suitable person is difficult, even after selection it takes time to desensitize the person and correct prejudices, to get the correct perspective and to properly plan and record the work of the centre. Preference would be for a female counselor around 25 to 30 years of age, married with a qualified Master of Social Work (MSW) or a graduate in psychology with practical experience with a sympathetic and pleasant personality willing to learn sexuality counselling. Both males and females should relate well with her, particularly the adolescents.
CONCLUSION
In conclusion, while the government now recognizes sexual and reproductive health needs, successful implementation has yet to occur. Greater involvement of NGOs working with specific recommendation of forming a Core Committee of NGOs. Government, parents, teachers, young people religious and community leaders is strongly recommended. The voice of young people, actively involved at all level of policy, strategy and implementation is imperative.