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The Sexual & Reproductive Health Status of Young People in India

Challenges and opportunities for healthy outcomes

Adolescent Health Days

Quarterly meetings conducted at the village level to provide preventive and promotive health services and increase awareness among adolescents, their families and other key stakeholders about issues and needs related to adolescent health.

Adolescent Friendly Health Centres (AFHCs)

Health clinics established by the government to provide preventive, promotive, curative and referral services to young people

Ante- and post-natal care

Ante-natal care is the care provided by skilled healthcare workers to pregnant women and adolescent girls in order to ensure better health conditions for both mother and baby during pregnancy. Post-natal care is healthcare provided to women and their newborns for the first few months following childbirth.

Hygienic methods of menstrual protection

Locally prepared napkins, sanitary napkins, tampons or menstrual cups.

Menstrual Hygiene Management (MHM)

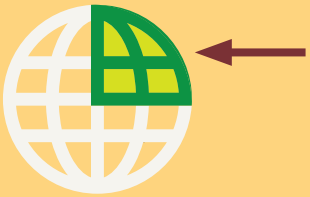
Access to menstrual hygiene products during menstruation, privacy to change the materials, and access to facilities to dispose of used menstrual management materials.

Modern contraceptive prevalence rate

Percentage of women who use any modern contraceptive method.

Young people and their unique sexual and reproductive health (SRH) needs

'Young people' are collectively defined as those in the age-group of 10 to 24 years[1]



Young people comprise nearly a quarter of the world's population[2]

India has an estimated 370 million young people – its largest number ever[3]

Sexual and reproductive health (SRH) is an important component of young people's overall health and development, encompassing physical, emotional, mental and social well-being[4]. This is the period of life with the most significant physical, intellectual and emotional changes, also characterised by the onset of puberty, and sexual awareness and maturation. Inequitable social norms and gendered attitudes differentially impact the SRH outcomes for boys and girls.

Girls encounter conflicting messages about SRH, fertility and womanhood, and many face stigma and taboos related to menstruation. Due to prevailing gender norms, many girls are expected to take on household responsibilities in preparation for marriage, and often miss or drop out of school. For boys on the other hand, puberty is seen as the onset of masculinity, with increased exposure to risk-taking practices such as substance use, violence and unsafe sex. They also begin to engage in paid work, with the expectation of becoming breadwinners as adults[5],[6]. As gender socialisation and formation of habits begin in early adolescence, this time in life is critical for shaping positive attitudes, behaviours, and SRH outcomes[7].

SRH needs of young people range from age-appropriate information and awareness about physical changes, sexual health and well-being, puberty and menstrual health in early adolescence (10 – 14 years), to knowledge and counselling on contraceptive methods and use, safe sexual practices and prevention of sexually transmitted infections (STIs), and access to quality SRH services including family planning for delaying and spacing births among older adolescents and young married people (15 – 24 years).

Modern methods of contraception

Male and female sterilization, injectables, intrauterine devices (IUCDs/PPIUCDs), contraceptive pills, emergency contraceptive pills, implants, female and male condoms, diaphragm, foam/ jelly, standard days method (a calendar-based method of avoiding sexual intercourse on fixed days to prevent pregnancy), and lactational amenorrhoea method (LAM – temporary infertility after giving birth, when a woman is not menstruating and is fully breastfeeding).

Modern reversible methods of contraception

Pill, intrauterine devices, injectables, male condom, female condom, emergency contraception, lactational amenorrhoea method (LAM).

Peer educators

Adolescents from the community selected and trained to sensitise and inform peers about their health and well-being.

Unmet need

Proportion of women in the reproductive age (15 to 49 years) who want to stop or delay childbearing, but are not using any method of contraception.

NFHS

The National Family Health Survey (NFHS) is a large-scale, multi-round survey conducted since 1992-93 in a representative sample of households, women and men throughout India. The survey provides district, state and national information on fertility, infant and child mortality, family planning, maternal and child health, reproductive health, nutrition, anaemia, utilisation and quality of health and family planning services.

What is the status, knowledge and access to SRH services among adolescents and youth in India?

India's large segment of young people will drive the country's trajectory of population growth for the next two to three decades[8]. Many of them have or will soon join the reproductive age group (15 to 49 years). Fulfilment of their SRH needs will have a significant and long-term impact, not only on population growth, but also overall economic and development outcomes.

Recognising the needs of this group and the health risks it is exposed to in the course of transition to adulthood, the Government of India adopted the Adolescent Reproductive and Sexual Health Strategy in 2005, and the subsequent *Rashtriya Kishor Swasthya Karyakram* (RKSK) or national adolescent health programme in 2014. In addition, the National Population Policy (2000), the National Youth Policy (2014), *Rashtriya Yuva Sashaktikaran Karyakram* (RYSK – 2016), the National Health Policy (2017), the School Health & Wellness Programme (2020), and several other policy commitments as well as programme initiatives address the needs of adolescents and youth.

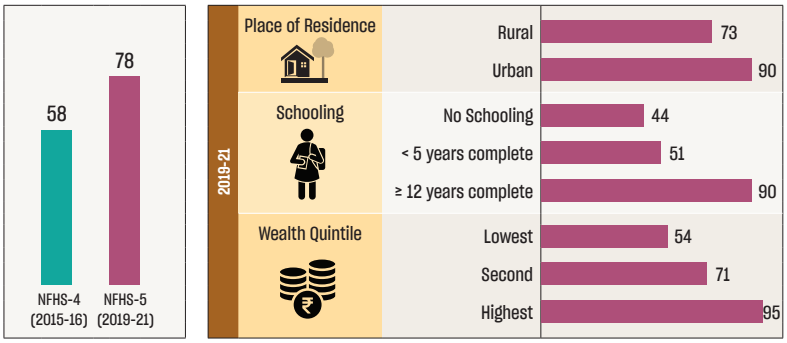
Menstrual health

One of the most significant physical manifestations of puberty for girls is the onset of menstruation. The government has addressed menstrual hygiene management for adolescent girls through outreach under RKSK, awareness generation, and distribution of sanitary napkins at subsidised rates under the Menstrual Hygiene Scheme, through *Pradhan Mantri Bhartiya Janaushadhi Pariyojana* (PMBJP) stores, and several state government schemes.

NFHS data shows that the use of hygienic methods[9] of menstrual health management by 15 to 24 year-old women increased by 20 percentage points between 2015-16 and 2019-21 (***Figure 1***). However, there are significant variations in menstrual health management (MHM)

Figure 1

Percentage of women using hygienic method of protection* during menstrual period, 2019-21



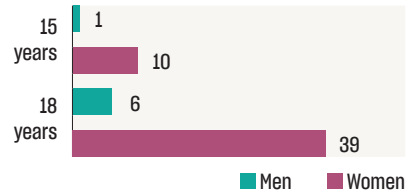
*Locally prepared napkins, sanitary napkins, tampons, and menstrual cups

For women in the age-group of 15 to 24 years who ever menstruated; Source: NFHS Rounds 4 & 5

Nine of 10 young women in urban areas use hygienic methods, as against a little over seven of 10 in rural areas. Those with 12 or more years of schooling are twice as likely to use hygienic methods compared to those with no schooling. Young women in the lowest wealth quintile are 40 percentage points less likely to use hygienic methods compared to those in the highest wealth quintile.

Figure 2a

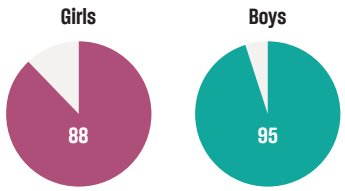
Age at first sexual intercourse (percentage of women & men)



For women & men 25 – 49 years old; Source NFHS-5

Figure 2b

Knowledge of modern reversible methods, by percentage of adolescents



For women & men 15 – 19 years old; Source NFHS-5

that of young women across regions, and based on the place of residence, education and household income. Analysis of NFHS-5 data shows that adolescent girls with higher levels of education were 85 percent more likely to use a hygienic method of protection than those with no education (OR=1.0 vs OR=0.15). Girls from the highest wealth quintile were 90 percent more likely to use hygienic methods as compared to those from the lowest quintile (OR=1.0 vs OR=0.09)[10].

Young girls also continue to face social barriers due to myths and taboos related to menstruation. Their movement often gets restricted, in some cases as a result of the social stigma, and in others due to the unavailability of adequate water, sanitation and hygiene facilities. Increase in school absenteeism or dropouts are seen among adolescent girls with the onset of menstruation[11,12]. Health emergencies such as the COVID-19 pandemic that necessitate shifting of public health priorities exacerbate the challenges faced by young girls, especially from marginalised segments, in managing their menstruation[13].

Sexual initiation and knowledge

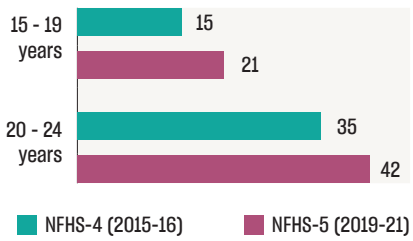
The National Family Health Survey (NFHS) found that on an average, women reported their first sexual intercourse at a younger age than men as they marry much earlier than men (***Figure 2a***). Despite early sexual debut among women, their knowledge and information on contraception was lower than that of men. Although overall knowledge of contraceptive methods among older adolescents (15 to 19 years) and youth (20 to 24 years) was found to be nearly universal, older adolescent girls had lower knowledge of modern reversible methods[14] as compared to older adolescent boys (***Figure 2b***).

Contact with health care workers and facilities

Family life education in school and through community outreach with frontline health workers and peer educators, and counselling as well as health care at Adolescent Friendly Health Centres (AFHCs)[15] are important programme components for the health and well-being of young people. NFHS-5 data shows that contact of older adolescent girls (15 to 19 years old) and young women (20 to 24 years old) with health workers in three months preceding the survey increased between 2015-16 and 2019-21 (***Figure 3***). However, the share of adolescent girls who had contact with a health worker was half

Figure 3

Percentage of women who had contact with any health worker* by age, 2019-21



*Auxiliary nurse midwife (ANM), lady health visitor (LHV), Anganwadi worker (AWW), Accredited Social Health Activist (ASHA), multipurpose worker (MPW), or other community health worker

For women who had any contact with a health worker in three months preceding the survey; Source: NFHS Rounds 4 & 5

A study among adolescents and youth found low exposure to family life education, and a negligible percentage who had heard of AFHCs[16]. A rapid programme review carried out by the World Health Organization in 2016 found that although resources were allocated for adolescent health, young people continued to face geographical barriers in accessing health centres. In addition, there were gaps in training of counsellors and monitoring of community outreach initiatives such as Adolescent Health Days and Peer Educators, and interdepartmental convergence for programme implementation was poor[17].

Reproductive health practices among young women and their socio-economic determinants

As adolescent girls grow older, critical events such as marriage and childbearing change their life course, over which they often have limited decision-making autonomy[18],[19]. The transition depends on many interrelated factors, including prevailing gender norms, their educational and socio-economic status, place of residence, and the quality of reproductive health and family planning services they have access to.

Premature entry into marital life and childbearing

Early marriage among girls compounds their vulnerability, as they are ill-equipped physically, emotionally, socially and economically to cope with the profound changes in their lives. Overall, according to data from NFHS-5, women marry much earlier than men. Almost a quarter of women (23%) in the 20 to 24 age-group had married by 18 years, and 5 percent had married by 15 years. On the other hand, just 3 percent 20- to 24-year-old men had married by the age of 18 years, and almost none by the age of 15. Although child marriage in India has declined over the years, there are significant differences in the levels by region, place of residence, educational and economic status.

Analysis of the NFHS-5 data shows that girls with lower or no education were 12 to 15 times more likely to marry below 18 years as compared to those who had received higher education[20]. The odds of girls from the poorer wealth quintiles marrying before the age of 18 were almost 50 percent higher than of those from the richest wealth quintile. Girls from rural areas were also more likely to marry before 18 years than those from urban areas.

Household poverty and insufficient economic opportunities for girls have been found to be a key driver for child marriages[21]. The practice not only deprives young girls of opportunities to fulfil their educational and career aspirations and be fully mature to take on marital responsibilities, it also leads to early and frequent childbearing due to limited decision-making autonomy, and social pressures to prove their fertility soon after marriage.

Overall 7 percent teenage girls in the age-group of 15 to 19 years began childbearing, just a single percentage point less than in 2015-16, and with significant differentials based on geographic location, educational levels and socio-economic status (***Figure 4***).

Reproductive health and contraception among young women

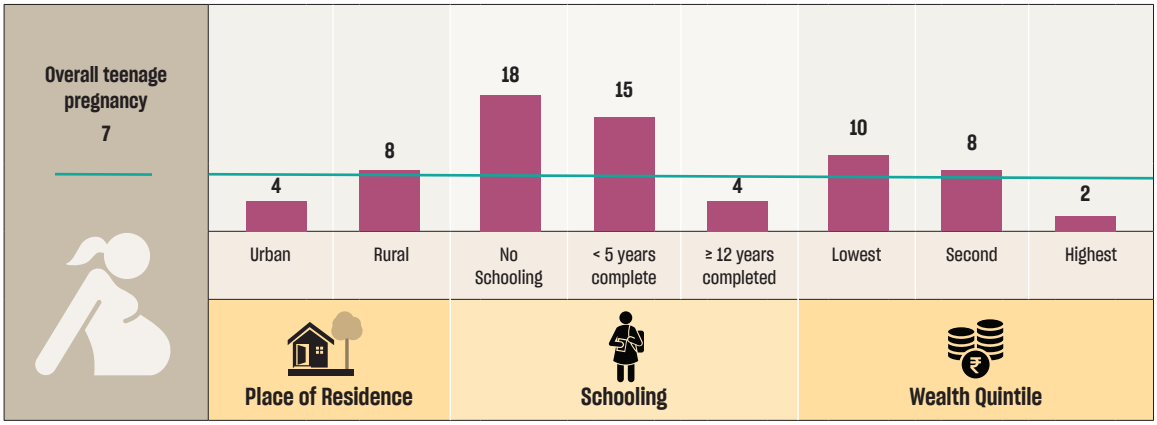
The use of modern contraceptive methods by young married women has increased significantly between 2015-16 and 2019-21. However, it is well below the modern contraceptive prevalence rate for currently married women in the age-group of 15 to 49 years (***Figure 5***). 7 percent each of married young women under the age of 20 years, and those between 20 to 24 years, reported unplanned pregnancies (those they wanted later – mistimed, and those they did not want at all – unwanted)[22]. In addition, the unmet need of family planning among married adolescents (15 to 19 years) and young women (20 to 24 years) was almost

double of the unmet need among all married women (15 to 49 years) (***Figure 6***), reflecting a gap in accessibility to this age bracket.

Reproductive health outcomes are closely related to interaction with frontline health workers, especially information on contraceptive methods, ante- and post-

Figure 4

Percentage of teenage girls who have begun childbearing, by background characteristics, 2019-21

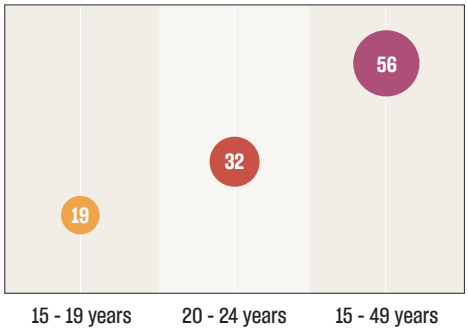


For women in the age-group of 15 to 19 years; Source: NFHS-5

Twice the share of girls living in rural areas began childbearing (8%) as compared to those from urban areas (4%). More than four times as many girls with no schooling began childbearing (18%) compared to those who had completed 12 years or more (4%). Similarly, girls from the poorest wealth quintile were five time more likely to begin childbearing (10%) as compared to those from the richest wealth quintile (2%).

Figure 5

Percentage of currently married women using any modern method of contraception* by age, 2019-21

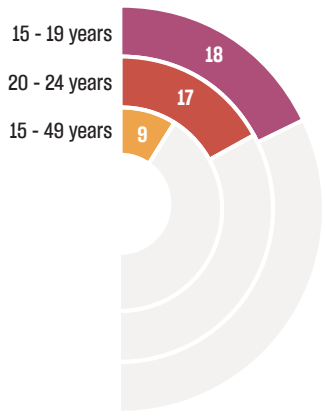


*Female sterilization, male sterilization, pill, intrauterine devices, injectables, male condom, female condom, emergency contraception, lactational amenorrhoea method (LAM), and other modern methods

Source: NFHS-5

Figure 6

Percentage of women with unmet need for family planning by age, 2019-21



Source: NFHS-5

natal care, and abortion services. Findings of NFHS-5 show that health workers have limited interaction with younger married women, especially adolescents. While about one in five (21%) currently married adolescents (15 to 19 years old) not using any family planning method were contacted by health workers and informed about contraceptives in three months prior to the survey, nearly one in three (30%) older currently married non-user women in the age-group of 20 to 24 years had similar interaction with health workers.

A longitudinal study with adolescents and young people found that health workers were less likely to meet married adolescents and young women when they did not have any children, thereby losing the opportunity of counselling young people who are beginning their reproductive life. The study also found that married girls who interacted with health workers had higher chances of using contraception and exercising decision-making autonomy[23].

Apart from compromising the freedom of choice, childbearing at an early age can also lead to adverse pregnancy outcomes and heighten the risk of infant and child mortality rates. NFHS-5 estimates show that with the exception of 40- to 49-year-old women, infant mortality rates are the highest for young women who are less than 20 years old at the time of birth. The risk of mortality in the first five years of birth among mothers less than 18 years old was almost double of those who were not in a high-risk category[24]. Early and unintended pregnancy among adolescent girls is not only associated with poor health outcomes, and unfulfillment of their educational and economic goals, but also translates into a substantial burden on the country's economy and health systems[25].

The economic gains of investing in comprehensive SRH for adolescent girls

An estimation projects that providing a comprehensive SRH package to all adolescent girls in India who need these services would cost a little over 11 rupees per capita annually[26]. The projection calculates that every additional 100 rupees spent on contraceptive services above the current level would save 252 rupees in the cost of maternal, newborn and abortion-related care by averting unintended pregnancies.

Policy recommendations to address young people's sexual and reproductive health and well-being

Operationalising adolescent health and well-being education in schools

Adolescents and young people require timely and accurate information on their sexual and reproductive health and well-being in order to have the knowledge and skills to make responsible choices. Studies show that SRH education does not increase risky behaviours[27]. India's National Health Policy 2017, the draft National Youth Policy 2021, and the School Health & Wellness Programme being implemented under the Government of India's Ayushman Bharat recognise the importance of imparting age-appropriate adolescent and sexual health education, beginning at the primary school level.

However, despite programme commitments, there is unequal reach of age-appropriate sexuality education for adolescents, and most awareness programmes focus on non-taboo subjects such as menstrual health, nutrition, or reproductive health at an older age[28]. At the same time, increased access to online communication often exposes young people to misinformation, and reinforces harmful gender norms and attitudes towards SRH. Information and education programmes on SRH for adolescents and youth need to be operationalised as an integral part of school health programmes across the country.

School-based programmes are found to be most impactful when complemented with community activities, including youth-friendly health services, training and engagement with health providers to deliver those services, and involvement of parents, teachers, and community leaders. Multi-component programmes are particularly important for reaching marginalised young people, including those who are not in school[29].

At the national level, joint initiatives through convergence between key ministries such as Health & Family Welfare, Education, Women & Child Development, Youth & Sports Affairs, and Skill Development & Entrepreneurship are necessary to address the intersecting needs of India's large and diverse young population.

Higher investments in social and behaviour change communication (SBCC) strategies to address the social determinants of young people's SRH

Investments in transmedia behaviour change communication strategies that address the age-, gender- and location-specific needs of young people should be prioritised in programme implementation plans. SBCC campaigns need to reflect the voices of adolescents, sexual minorities, and adolescents with disabilities, and extend to families and communities that are primary influencers, especially in adolescence.

Focusing on specific measures to retain adolescents in school

Apart from better information and behaviour change, secondary school education is the most significant factor seen to be associated with better SRH outcomes, especially for girls, including delaying marriage, sexual initiation and childbearing, and increase in contraceptive use[30].

Ensuring that girls have access to educational institutions with provision for transportation, and adequate sanitation and hygiene facilities, would help retain them in school[31]. Similarly, scholarships and livelihood opportunities linked to secondary school and college education would help adolescents from socio-economically underprivileged backgrounds to complete their education, and be better equipped to handle their healthcare needs. Assuring higher education and workplace participation for girls would also address the economic distress that leads poorer families to marry them off at an early age.

Engaging men and boys in shifting regressive social norms

Regressive gender norms that perpetuate child marriage and early childbearing, and toxic notions of masculinity need to be addressed through community-level SBCC programmes, especially by engaging with men and boys and to promote gender equality and more equitable norms. The key to gender norm change is to provoke it and speed it up from within, acknowledging and forming alliances with those men and boys who already believe in gender equality, and identifying the conditions necessary to scale programs up in schools, the workplace, the health sector and other spaces where millions can be reached.

Investing in adolescent- and youth-friendly SRH services and counselling

Young people continue to grapple with limited avenues for understanding their physical, sexual and mental health issues and receiving services in a non-judgemental atmosphere. Dedicated adolescent-friendly health clinics with trained counsellors and health service providers that offer equitable, non-discriminatory SRH services while maintaining privacy and confidentiality, need to be operationalised. At the same time, India's family planning programme needs to prioritise access to reversible spacing methods of contraception for its young population, so that they can exercise their reproductive health choices and reduce the unmet need for family planning.

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