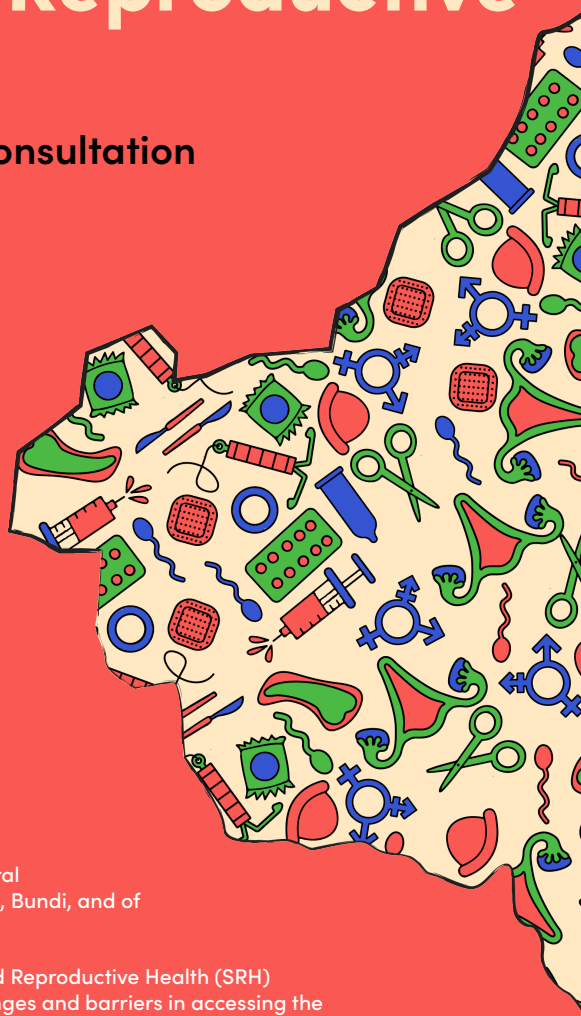
the yp foundation

Adolescent Sexual and Reproductive Health in **Rajasthan**

Findings from literature and multi-stakeholder consultation



1. Introduction

The number of adolescents in the age group 15-19 years in Rajasthan is 7.3 million according to the census of India 2011 data (Census 2011). If we consider the ages 10-19 years, nearly 23 percent of the adolescent population of India is contributed by Rajasthan with nearly 16 million adolescents in this age group in Rajasthan. Many adolescents become sexually active without access to timely, accurate, and gender-responsive information about their sexual and reproductive health and rights. This can leave them unable to protect themselves from unintended pregnancy and sexually transmitted infections.

To understand the context of the adolescent sexual and reproductive health situation in Rajasthan, literature on the issue was reviewed, along with drawing impressions about Adolescent Sexual and Reproductive Health (ASRH) situation based on the national level data like National Family Health Survey (NFHS) and a multi-stakeholder online consultation was conducted. The online consultation was organised by The YP Foundation in collaboration with the Guttmacher Institute. The multi-stakeholder state-level consultation was held on 20th and 21st February 2021.

The online consultation was attended by 67 stakeholders (including young people between the ages of 15-25, NGOs and CSOs working on Adolescent and Youth SRH in the respective states, state and district level officials working on Rashtriya Kishor Swasthya Karyakram (RKSK), healthcare providers, educators, lawyers, activists, UNFPA officials, and representatives of AH division of Ministry of Health and Family Welfare (MoHFW) from several districts viz., Udaipur, Rajsamand, Tonk, Dungarpur, Sansera, Aburod, Dabi, Bhilwada, Sirohi, Bundi, and of Rajasthan.

Through this exercise, it is expected to understand the adolescent's awareness of Sexual and Reproductive Health (SRH) matters, access to SRH services particularly contraception, abortion and capture the challenges and barriers in accessing the services. It also aims to understand the existing and ongoing efforts from government stakeholders towards ASRH. The consultation helped in charting the immediate next steps and way forward.

2. Key findings and outputs of the exercise

This section will give an overview of the existing situation of ASRH situation in Rajasthan which has been drawn based on published literature and data, and also the points raised during the online discussion on the same.

2.1 Awareness about SRH issues

A study among 1119 adolescent girls in the age group 15-19 years found that majority of them were aware of modern contraceptive methods. While they were aware of female sterilisation, male condom, and pills, the knowledge regarding emergency contraception was low. Even though the majority of the girls were aware of the methods to space or delay pregnancy, misconceptions regarding contraceptives were prevalent in this group, and nearly 40 percent said they would be seen promiscuous if they used contraceptives (Moreau et al 2019).

The online consultation with adolescents, where polls were generated to capture awareness of the participants on SRH matters, also found that majority of them (75%) were aware of abortion and contraception. The young girls who had attended sessions on SRH were aware of topics such as menstruation, abortion, and contraception but this knowledge is not comprehensive as many of the programmes on SRH do not cover topics like abortion and contraception in detail. The focus of such programmes is largely on menstruation and when it comes to abortion and contraception the focus is limited to population control and family planning. There is no focus given to the health implications of adolescent pregnancy and/or abortion to the health of the woman.

According to NFHS-4, among adolescent males aged 15-19 years (n=1208) 42 percent believed that contraception is a women's business and a man should not worry about it and 18 percent believed that women who use contraception may be promiscuous. More than half of the males who were interviewed felt that condoms if used properly can prevent pregnancy (NFHS 2017). It was highlighted in the consultation that the focus of the Government and NGOs is on imparting SRH programmes mainly to adolescent girls and it was noted that the level of awareness among boys was limited to the information they received from their male married friends or male family members. The participants in the consultation knew about the sources of information on SRH. According to them, SRH information was received from the NGO workers, ASHA workers, and hospital/Ujala clinics. Many of them also pointed out the lack of reliable sources of information on SRH matters.

Young people also mentioned about the limited reach of the NGO programmes as it is organised only in certain places. Both adolescent boys and girls were apprehensive about seeking SRH information as they feared being judged, shamed, and ridiculed.

2.2 Teenage pregnancy and unmet need for contraception

According to NFHS-4, 6 percent (n=8137) of the adolescents aged 15-19 years have started childbearing at the time of the survey. At age 15, only 0.2 percent have started childbearing, but this proportion was 9 percent among those who were 18 years old and 21 percent at 19 years (NFHS 2017).

Among currently married adolescents aged 15-19 years (n=1250), 14 percent were using some form of contraception with 10 percent using modern contraceptives and approximately 4 percent using traditional methods. A study reported that the demand for contraception and levels of contraceptive utilization were lowest among adolescent girls compared to any other age group. The total demand for family planning was 37.5 percent among adolescents in the age group 15-19 years (n=1250), of which 23 percent had an unmet need for family planning. According to NFHS-4, 3 percent of adolescents reported having an abortion and 15 percent who were pregnant reported that the pregnancy ended in a miscarriage (n=376) (NFHS 2017).

2.3 Access to abortion and contraceptive services in Rajasthan

2.3.1 Access to abortion services

The lack of knowledge, decision-making agency, and choice were some of the barriers at the individual level that prevented young women from accessing timely and safe abortion services [study reported women in the age groups 15-24 years]. The lack of awareness of the abortion procedures and the legality of abortion services were also factors that prevented the utilization of services. This was highlighted in the study which found that few young women (13%, n=166) in the age group 15-24 years have used unsuccessfully medication abortion using drugs that were obtained over the counter (10 women) and home-made concoctions or ayurvedic medicines (9 women). There was greater use of private sector providers including pharmacies (90%) and limited use of public sector facilities compared to the use reported in NFHS (public sector-20-24%).

In spite of the fact that abortion is legal in India, a population-based study to understand the incidence of abortion and the safety in Rajasthan found that a significant proportion of abortions that were done used non-recommended methods from non-clinical sources [this includes all women in the age group 15-49 years]. Another study reported that the two-fifths of abortion seekers reported that they used condoms (21%) or traditions methods (12%) prior to the pregnancy that was terminated [this includes women in the age group15-24 years, 6 percent (n=166) who had an abortion were in the age group 15-19 years]. The majority of the women who underwent abortion took the decision jointly with their husbands, while around 12 percent took the decision independently (Ahmad et al 2020; Zavier et al 2020).

2.3.2 Access to contraceptive services

In the state consultation, more than half of the adolescents reported being embarrassed to seek contraceptive services and said they preferred accessing over-the-counter medicines for contraception. They also added that they were comfortable using self-administered injectables.

It was also reported in the online consultation, that access to contraception in many districts is limited due to factors such as underdeveloped public infrastructure (lack of proper roads connectivity), shame in buying contraceptives, excessive interrogation on asking for contraceptives or its information, fear of being shamed by society and family members. Contraception and hygiene products are available at medical stores, hospitals, and ASHA workers.

Lack of access to both information and contraceptives to girls and women who stay in distant geographical areas was mentioned as a barrier by the participants in the online consultation.

2.3.3 Barriers to accessing SRH services by adolescents

ASHAs and ANMs acknowledged providing services to adolescents but perceived it as a secondary responsibility and the majority of the medical officers (MOs) who were interviewed as part of a study felt providing ARSH services were less important, nevertheless, some of the MOs acknowledged it as a key responsibility. It was found that ANMs and ASHAs focused more on married adolescents compared to unmarried girls. It was also found adolescents boys were rarely given services by them, if at all such services were given it was more on more general issues like body image, growth of body and facial hair, voice change, and acne. The community-level workers also felt that they were giving advice to the girls since girls were having more problems than boys (Jejeebhoy et al 2014).

The services offered to the adolescents on sexual and reproductive health matters focused largely on menstrual hygiene, breast development and diet for unmarried girls, and growth of facial hair, voice change, nocturnal emission, and so on for unmarried boys. The provider-adolescent interaction was highly gendered, where female providers gave services mostly to girls and the male providers to the boys. The ASHAs and ANMs discussed in detail providing contraceptives to married adolescents while such narratives were absent in the case of unmarried adolescents. Unmarried girls who sought such services were referred by them to the medical officer. The adolescents all reiterated that the providers were unfriendly and judgemental, especially to unmarried adolescents (Jejeebhoy et al 2014).

The state consultation pointed out that the lack of adequate and updated training of government service providers (ANM, ASHA workers, nurses, doctors) in hospitals, NGO field workers was a barrier. Lack of platforms to create synergies of learnings (strategies to overcome challenges) from different social, economic, linguistic, geographical, cultural settings of service providers and institutions that they represent is another barrier mentioned by the participants. The prevalence of gender discrimination and violence of women were also seen as barriers in addressing the SRH of adolescents. Social conditioning of shame that is a crucial part of the cultural setup was seen as a barrier in mobilization and participation of adolescents. Due to shame, NGO field workers talked about how difficult it is and has been to make the young girls communicate their menstrual issues. This process of educating young girls required a safe space and a non-judgemental environment.

The providers mentioned that inadequate and erratic supplies were a major barrier in providing services. Infrastructural limitations leading to the inability of AFHCs to ensure privacy for adolescents was another barrier reported in the literature. Although there was a judgmental attitude that was reported by the adolescents, they were quite satisfied with the services offered but they were concerned by the lack of privacy and felt the information shared by providers was not comprehensive (Jejeebhoy et al 2014).

The health care providers felt that the lack of awareness regarding the AFHCs and their services among the adolescents as well as the frontline workers prevent them from accessing the service. The health care providers also felt that the difficulty in opening up about sexual health matters to the providers especially those of the opposite sex may be a barrier in accessing care. Another reason the health care providers mentioned was the lack of privacy and confidentiality of the services were a concern for the adolescents (Santhya et al 2014).

Lack of family support was one of the reasons for not accessing SRH services by the adolescents. Inconvenient clinic timings and distance to the AFHCs were other major barriers in accessing the services (Santhya et al 2014).

2.4 Menstrual Hygiene and Services

In some districts of Rajasthan sanitary pads were distributed to adolescent girls after being demanded by them and with the cooperation of NGOs in their area. However, youth from many districts brought out the lack of availability of both medical stores and sanitary pads to them. NGO workers shared that they conducted online sessions with young girls teaching them to make sanitary pads at home and the way to use and dispose of them. Though stigma and myths about menstruation have been largely tackled, sanitary pads still remain controversial in many contexts for instance when their distribution is carried out by a male teacher or worker.

2.5 Existing adolescent ASRH service programmes, the reach, and challenges

2.5.1 Rashtriya Kishor Swasthya Karyakram (RKSK)

The RKSK programme has been implemented in 10 districts in the state viz. Bundi, Barmer, Banswara, Dhoplur, Dungarpur, Jalore, Jaisalmer, Karauli, Rajsamand, and Udaipur.

The state consultation also pointed out the RKSK programme for the holistic development of the adolescent population. RKSK operates only in 10 districts in Rajasthan and the process of scaling up RKSK has been acknowledged as lagging behind. Full functionality of RKSK in the 10 districts has not been attained till now. The official showed an attitude of openness and cooperation in addressing SRH of adolescents and young people of Rajasthan.

2.5.2 Adolescent Friendly Health Clinics (AFHCs)

The facility-based intervention - the AFHC clinics known as Ujala Clinics are functional in all the District Hospitals, Sub-District Hospitals, and all the CHCs, and some chosen PHCs in the 10 districts. A total of 314 facilities are selected for establishing Ujala Clinics. The clinics provide counselling, supply contraceptive and sanitary napkins for adolescents. These clinics are operational from 9 am to 4 pm daily in District Hospitals, Subdistrict Hospitals & CHCs, and once a week for two hours in PHCs. The community-based approach includes imparting services through peer educators The peer educator approach will be implemented in a phased manner, in the first phase three districts viz., Jalore, Udaipur, and Bundi. A total of 1272 peer educators have been chosen from these three districts and 90 percent of them have been trained.

It was reported that the ANM and ASHA workers provided services under the scheme and Ujala clinics were available under RKSK in some districts and offers counselling services to the adolescents.

2.5.3 Other schemes and programmes for adolescents

Another programme is the Nirogi Rajasthan scheme which was launched on 17th Dec 2019 with the aim of spreading awareness on health issues among the general public. There are two components in the scheme- namely a website and a toll-free number for citizens to get information about any disease.

The government official talked about the app FP-LMIS to know the stock of contraception made available by the government to service providers like ANM and ASHA workers.
NGOs too have different projects and/or educational modules that address various aspects of SRH. Examples of such projects include Meena Manch, Bal Manch, project 'race' and 'fire', online sessions on how to make a sanitary pad, its use, and disposal.

The NGO representatives who participated in the online consultation pointed out that while the SRH programme are for both girls and boys, the sessions are usually taken separately. The educational session makes use of videos, games, and sports. Adolescent scorecards are used by some NGOs to map the consistency and progress of SRH and the availability of contraceptives in the respective districts where they are operational.

NGOs act as intermediaries between the public and the government. Some NGOs train the ANM in the government hospitals and other health providers that work at the primary and secondary health centers. NGOs have been playing a role of mobilizing and organizing adolescent and young girls particularly empowering them to put forth their demands and grievances directly in front of government officials and institutes such as the Rajasthan Commission for Protection of Child Rights.

2.5.4 Gaps and barriers in the implementation of ASRH programmes

During the online consultation, the adolescents mentioned that shame and stigma attached to sexuality is the main barrier in disseminating information on SRH. Lack of parental support was reiterated by the participants by mentioning that the communication gap between the parents of adolescent girls and boys and the service providers (NGO workers or government health providers viz., ANM, ASHA workers) acted as a barrier. Some parents have often been suspicious of SRH programmes as against their traditional value system.

They also noted that the chapter on reproduction in schools was not taught to students as the teachers were not comfortable or not trained to teach it. However, there were instances where both adolescents girls and boys were taught about reproduction in the same class.

3. Recommendations from the Consultation

(i) As the class or subject teachers are not trained in imparting SRH education to young people, participants suggested that there should be a health teacher in every school who can educate them on SRH issues.

(ii) Young adolescent girls demanded that sanitary pads should be made available either free or at a subsidised cost as it is an essential product.

(iii) School textbooks should provide a toll-free number of counselling service providers such as Ujjala clinics that come under the RKSK programme of the government.

(iv) Organizing regular meetings or platforms either online or offline once a month at least to talk about the working progress of SRH in various villages, blocks, and districts. To run a campaign to popularise such meetings or platforms for better mobilization and participation of the public.

(v) To allot a day to recognize the importance of SRH and to promote it.

(vi) To create avenues or programmes for out-of-school adolescent girls and boys.

4. Next steps and commitments from the Government during the Consultation

(i) Instead of training only a nodal teacher which was the practice in the past and continues to be in the present too, the recommendation of training all the teachers is now under official consideration.

(ii) Newly wedded couples in the age group of 15 to 25 as the target audience will be brought under the service provision of ANM and ASHA workers. This provision exists already however the couples receive information and contraceptives only when they approach the hospital. This new provision is going to ensure that information reaches young couples rather than they approaching for the information and contraceptives but by bringing them under the target audience of ASHA and ANM

(iii) Expanding the Nirogi Rajasthan scheme.

References

Moreau C, Mmari K, Shannon A, Khanna A, Ahmad D, Radloff S. Performance Monitoring and Accountability 2020 – Adolescent Health Module in Rajasthan, India. :24.

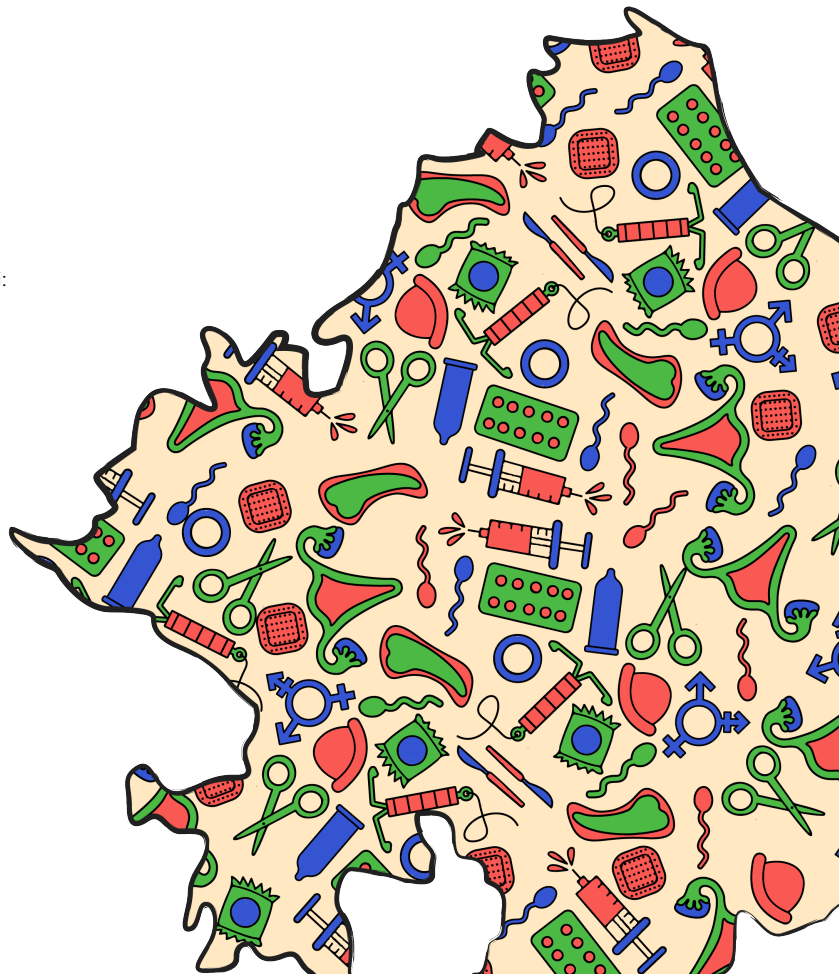
International Institute for Population Sciences (IIPS), ICF. National Family Health Survey (NFHS-4), India, 2015-16: Rajasthan. Mumbai: IIPS 2017.

Ahmad D, Shankar M, Khanna A, Moreau C, Bell S. Induced Abortion Incidence and Safety in Rajasthan, India: Evidence that Expansion of Services is Needed. Stud Fam Plann. 2020 Dec;51(4):323–42.

Zavier AJF, Santhya KG, Jejeebhoy SJ. Abortion among married young women: findings from a community-based study in Rajasthan and Uttar Pradesh, India. J Biosoc Sci. 2020 Sep;52(5):650–63.

Jejeebhoy SJ, Santhya KG, Singh SK. Provision of adolescent reproductive and sexual health services in India: Provider perspectives. Population Council. 2014.

Santhya, K. G., R. Prakash, S. J. Jejeebhoy and S. K. Singh. 2014. Accessing Adolescent Friendly Health Clinics in India: The Perspectives of Adolescents and Youth. New Delhi: Population Council.



Teenage pregnancy and motherhood

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, by background characteristics, Rajasthan, 2015-16 (NFHS-4)

TABLE 1

Background characteristic	Percentage of women age 15-19 who:		Percentage of women age 15-19 who have begun childbearing	Number of women
	Have had a live birth	Are pregnant with first child		
Age				
15	0.1	0.1	0.2	1609
16	0.3	0.4	0.8	1677
17	0.6	1.3	2.0	1558
18	4.9	3.9	8.8	1863
19	14.3	6.9	21.3	1430
Residence				
Urban	2.9	1.6	4.5	18250
Rural	4.1	2.7	6.9	6311
Schooling				
No Schooling	9.5	5.2	14.7	993
<5 years completed	4.0	1.7	5.7	293
5-9 years completed	4.2	2.6	6.8	3641
10-11 years completed	1.5	1.5	3.0	1909
12 or more years completed	1.8	1.7	3.5	1301
Marital status				
Never Married	0.0	0.0	0.0	6865
Currently Married	6.2	16.2	40.9	1250
Religion				
Hindu	3.8	2.2	6.0	7223
Muslim	4.9	4.6	9.5	793
Christian	6.2	16.2	40.9	1250
Caste/Tribe				
Scheduled Caste	5.4	2.8	8.1	1219
Scheduled Tribe	7.6	2.4	10.0	1382
Other Backward Class	4.3	2.2	6.5	1891
Other	4.2	1.3	5.5	1056
Total	5.4	2.2	7.6	5572

Current use of contraceptives

Percent distribution of currently married women by contraceptive method currently used, according to background characteristics, Rajasthan, 2015-16 (NFHS-4)

TABLE 2

Background characteristic	Age 15-19
Any Method	23. 4
Any Modern Method	13. 2
Female Sterilization	0.0
Male Sterilization	0.0
Pill	5 . 6
IUD or PPIUD	0.9
Injectables	0.2
Condom/Nirodh	6.1
LAM	0. 4
Other Modern Method	0.0
Any Traditional Method	10.2
Rhythm	2.7
Withdrawal	7.5
Not Currently Using	76.6
Total	**100**
Number of Women	761