the yp foundation

Adolescent Sexual and Reproductive Health in **Madhya Pradesh**

Findings from literature and multi-stakeholder consultation

1. Introduction

According to Census of India 2011 data, there is 7 million adolescent in the age group 15-19 years in Madhya Pradesh (Census 2011).

To understand the context of adolescent sexual and reproductive health situation in Madhya Pradesh, 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). In addition to this, a multi-stakeholder online consultation meeting 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 28th February 2021.

The online consultation was attended by 52 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. Harda, Shedo, Rajgargh, Bhopal, Panna, Singrauli, Barwani, Raisen, Timarni, Singrauli, and Barwani.

Through this exercise it is expected to understand the adolescent's awareness on 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 also 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 Madhya Pradesh 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

The knowledge on the contraceptive methods was adequate while married girls were not aware of emergency contraceptive pills, the majority of the unmarried girls were aware of it. In spite of the knowledge about the various methods, it does not translate into use among adolescents, since many married adolescents are using standard days method for preventing pregnancy (Gupta et al 2017). In the online consultation, it was highlighted that there is a lack of awareness of menstrual hygiene and SRH issues.

According to NFHS-4, among adolescent males aged 15-19 years 34 percent (n=1769) believed that contraception is "a women's business and a man should not worry about it" and 17 percent believed that women who use contraception may be promiscuous. A little less than half (47%) of the males who were interviewed felt that condoms if used properly can prevent pregnancy (NFHS 2017).

2.2 Teenage pregnancy and unmet need for contraception

There is a significant reduction in the teenage pregnancy among adolescents in the age group 15-19 years in Madhya Pradesh from 14 percent in NFHS-3 to 7 percent in NFHS-4. At age 15 years, the proportion who have started childbearing is 0.2 percent (n=24422) but it increased to 11 percent (n=2585) among those who are 18 years old and to 23 percent among women who are 19 years old (n=2057) (NFHS 2017). Among currently married adolescents aged 15-19 years (n=1677), 9 percent were using some form of contraception with 7 percent using modern contraceptive and approximately 2 percent using traditional methods. The total demand for family planning was 34 percent among adolescents in the age group 15-19 years (n=1677), of which 25 percent had an unmet need for family planning (NFHS 2017).

It was also reiterated in the online consultation that there is unmet needs for contraception and the services are not accessed freely by the beneficiary due to a lack of knowledge and stigma.

"Condoms are available but we don't know how to use them or what are they used for" - Youth, (district not mentioned)

According to NFHS-4, 2 percent of the adolescents who were pregnant reported that the pregnancy ended in abortion and 9 percent had reported miscarriage (n=585) (NFHS 2017).

2.3 Access to abortion and contraceptive services in Kerala

A poll raised among adolescents and young people during the online consultation showed that 86 percent of them were aware of why contraceptives and abortion services are accessed. There is a greater reliance on private providers particularly chemists for spacing viz., oral contraceptive pills (OCPs), emergency contraceptive pills (ECPs), and condoms. These services are used by married and unmarried adolescent boys (Gupta et al 2017).

It is also important to note that adolescent boys were frequently left out from the community level services (Gupta et al 2017). This was reiterated in the online consultation also where the participants pointed out that only married women attend the awareness programmes organised by Accredited Social Health Activist (ASHA) or Anganwadi workers. Such initiatives do not reach unmarried youth, especially unmarried men.

2.3.1 Access to abortion services

The community-level workers felt that there is low levels of sexual activity and abortion among adolescents, while other health care providers felt the unmarried adolescents are having abortion and they felt it was a serious issue (Gupta et al 2017).

In the online consultation it was reported that abortion services are provided free of cost in primary health centres (PHCs), and community health centres (CHCs) in Rashtriya Kishor Swasthya Karyakram (RKSK) districts. Although there are free services in the government facilities, it was also mentioned that abortion seekers avoided going to government health centres near their area and chose private facilities because of privacy concerns.

It was also found in the literature that private facilities were frequently used by adolescents.
The providers agreed to the fact that abortion is frequently happening among the adolescent group in the State and such services are mainly accessed from the private facilities or from the chemists, some district hospitals also deliver the services (Gupta et al 2017).

According to health care providers, fear of stigma was the major barrier to accessing abortion services. In addition to this, they also mentioned lack of information about safe services, cost of the services, difficulty to access the facility either due to distance or due to constraints of transportation, and the fear of legal repercussion as the other barriers (Banerjee et al 2017).

Women reported that the unwillingness of the staff or the facility to perform abortion due to many factors was a major hindrance in accessing service. These factors included the lack of consent from the partner or other family members, unmarried adolescents were not provided with the services, or in cases where the woman had no living children. The cost of abortion services was a major barrier in accessing the services, this included both direct and indirect costs (Hussain et al 2018).

It was also reiterated by the participants in the consultation that there is stigma and insensitivity of doctors towards unmarried sexually active young people.

"I once consulted a gynecologist for my PCOS. She asked me if I was married or not, and how sexually active I was.... They judge you throughout the consultation. If this is happening in a city like Bhopal, I am not sure how accessible it is for the rest of the cities."- Youth, Bhopal

"It is difficult to talk about abortion to doctors, however, counsellors are approachable. Counsellors direct cases to doctors and anonymity are maintained." Youth, Panna

There is a lack of information about the safe service among adolescents and also the legality of the procedure (Hussain et al 2018). In the consultation, it was mentioned that the major source of information on abortion and SRH for adolescents and youth is through media and films. This often misguides and perpetuates existing misconceptions and stigma. Teachers and parents, with whom the adolescent spend the most time, are neither approachable nor are aware of SRHR issues or services.

2.3.2 Access to contraceptive services

The medical officers said around 20-50 percent of the unmarried adolescent girls are sexually active and they believed that unmarried girls should be given family planning services (Gupta et al 2017)

It was reported in the consultation that contraceptives such as external condoms and emergency contraceptive pills are available in all PHCs, CHCs, and local medical pharmacies. ASHA workers reached out to eligible couples and gave information on different contraceptive methods. They also delivered five condoms to eligible couples free of cost. While it is reported that contraceptives are available in government facilities, studies show lack of supply was an important factor that prevented adolescent girls from using contraceptives (Gupta et al 2017).

During the consultation, the government officials reflected that information on contraceptives can be disseminated to unmarried youth through government or school-level initiatives but access to contraceptives like buying condoms, ECPs from local pharmacies, or health centres would be difficult due to the stigma attached to unmarried adolescents using it. The attitude of the health worker like hesitancy about contraception and abortion was also seen as a barrier in accessing services. It was also reported in the consultation that ASHA workers are unable to reach every couple and especially unmarried youth and adolescents. Fear of community and family members was cited as a reason for not using the services by the adolescents. Providers mentioned that adolescents were shy to seek SRH services and this was a major barrier to seeking service (Gupta et al 2017).

2.4 Existing ARSH programme, the reach and the challenges

2.4.1 Rashtriya Kishor Swasthya Karyakram (RKSK)

The RKSK was initiated in the state in 2015 and is currently run in 13 districts out of the 51 districts of Madhya Pradesh. The initiative is aimed at making adolescents aware of mental health, nutrition, non-communicable diseases, sexual violence, and sexual and reproductive rights. There are two levels to the RKSK initiative viz., institutional-based and community-based.

In the institutional-based initiative, a counsellor is appointed in every community health center to address adolescent health issues. They provide counselling services and also conduct awareness sessions in schools.

In the community-based initiative a mentoring chain is created i.e., under every ASHA worker, two peer educators are appointed, a boy and a girl in the age group of 15-19 years old. The peer-educators are trained in six adolescent issues on six Sundays. There are 24 comic books developed for them covering different issues that adolescent faces. Every trained peer educator will make their collective, 'Saathiya Brigade', where under the supervision of a master trainer, they address these issues with the fellow adolescents of their assigned village. Similarly, the ASHA workers have their regular meetings, 'Sahyogni Baithak'. This mentoring and awareness chain is across the block, district, and state-level. The services are extended to three non-RKSK districts viz., Khandwa, Bhuna, and Vidisha, where two teachers in every school are appointed as the 'Health Wellness Ambassador', who are given training and who later provide awareness classes on adolescent issues.

A poll generated among adolescent and young participants showed that 67 percent of them had accessed some form of adolescent SRH services in their district. Participants from Panna and Petla shared that they are aware of RKSK initiatives and there are awareness programmes that Anganwadi and ASHA workers organise. They also mentioned the different school-level initiatives under RKSK. There is a significant visible reach in the Panna district. Banners on contraceptive methods and access are put up by the National Programme on Family Planning.

While a study was done found that the demand-creation aspect of RKSK is poor, and the adolescents are receiving services as disintegrated groups viz., married and unmarried, male or female, mother or not (Gupta et al 2017).

A participant from Harda mentioned the 'Jugnoo Programme' organised by an NGO named Synergy that holds discussions on SRH issues with the youth and provides for online learning that has been particularly helpful during the pandemic. Along with the help of Anganwadi workers, they show informational videos on YouTube covering menstruation taboos and myths. Participants from other districts such as Raisen, Bharwani, and Rajgarh differed from the above-shared experience and had not been exposed to similar programmes in their districts.

There is a significant discussion on 'menstrual hygiene' however, SRH issues on contraceptive methods and abortion are still not prioritised. The challenges of such initiative were discussed and it was mentioned that the stigma attached to such topics makes it difficult to discuss them and hinders the reach of the programs, especially in smaller villages.

2.4.2 Adolescent Friendly Health Clinics (AFHCs)

Adolescent Friendly Health Clinics (AFHC) clinics are functioning in every block and district hospital of the RKSK districts. These are government-approved clinics that offer counseling services to adolescents and are referred if there is a need for other services.

Only one participant from the Panna district mentioned the counselling service that she has come across. Participants from the rest of the districts did not share their experience of being aware of AFHC services or the helpline services.

2.4.3 School Initiatives

The UNFPA Representative shared that there are life skill modules that are developed for ITIs and for secondary and higher secondary government schools that address adolescent issues including SRH, under the name 'Jeevan Tarag' and 'Umang'. Tele-counselling services, 'Umang Helpline' is available at the school level, especially for adolescents. A male and female teacher is appointed in every Block-level school for in-person counselling but these services are not extended to non-government schools. Only two participants from Panna and Petla shared awareness classes taking place in school.

The challenges of the school-level initiatives were that the school authorities censor the topics and mostly limit the discussion to menstruation. Topics on contraception or abortion services are not addressed in such intervention classes. Also, such classes are often taken separately for boys and girls.

3. Recommendations

(i) Regular intervention and sensitisation of school authorities, educators, staff, and health providers (including nurses, counsellors, and ASHA workers) should be conducted to destigmatize SRHR in educational and health institutions.

(ii) Men, boys, and unmarried women should be included at the school and district level awareness programmes.

(iii) Government initiatives should tie up with existing campaigns and youth networks such as the Red Ribbon Express where adolescents and youth are actively involved. This could be one method of contraception-related engagement to reach unmarried youth.

(iv) Existing schemes can be strengthened while implementing in non-RKSK districts. A comprehensive framework should be drafted that ensures accountability. Clear demarcation of roles and expectations should be drafted to address the workload on ASHA workers.

(v) There are provisions to adopt feedback from adolescents, such as under the Ayushman Bharat, where different departments work on-ground with young people and take their inputs into consideration. Increasing awareness around these avenues can help in institutionalizing the voices of adolescents while planning policies for them.

(vi) Under Mission Parivar Vikas, unattended condom boxes are kept in different locations. Such initiatives can be expanded so that condoms also reach unmarried couples.

(vii) Self Help Groups (SHGs) can be encouraged to talk about reproductive health in their respective villages and meetings. Information on SRH issues and access to services can be disseminated in such meetings to avoid delays in accessing health services.

4. Commitment from Government and NGO Stakeholders

(i) An NHM official suggested that adolescents can be reached out through Saathiyas on contraceptive methods and abortion services as Saathiya work closely with the adolescents. This will be proposed to the National Health Ministry (NHM). For adolescent youth who are to be married, Saathiyas can reach out to them and give adequate information on contraceptives and abortion services, along with explaining 'Basket of Choice' and voluntary family planning. There is a need to work on enabling access to these services and programmes, especially for unmarried youth.

(ii) UNFPA officials have stated to focus on contraception access among unmarried adolescents through rights-based messaging in their SBCC material.

(iii) State Officials in Madhya Pradesh have affirmed to adopt a collaborative approach between NGOs and the state to scale up existing adolescent health-focused initiatives beyond RKSK districts.

(iv) UNFPA officials have stated to increase efforts in improving contraceptive access among unmarried adolescents. Unattended condom boxes to be placed in several locations across districts and washrooms.

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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, 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	2422
16	0.4	0.4	0.8	2339
17	1.5	1.4	2.9	2222
18	6.7	4.3	11	2585
19	14.7	8.5	23.2	2057
Residence				
Urban	2.6	1.2	3.9	3188
Rural	5.2	3.4	8.6	8436
Schooling				
No Schooling	19	7.6	26.5	778
<5 years completed	9.1	4.7	13.8	329
5-9 years completed	4.4	2.9	7.3	6854
10-11 years completed	1.2	1.8	3.1	2399
12 or more years completed	1.1	0.9	2	1264
Religion				
Hindu	4.5	2.8	7.4	10775
Muslim	4.7	2.7	7.4	778
Christian	NA	NA	NA	NA
Buddhist / Neo-Buddhist	NA	NA	NA	NA
Other	NA	NA	NA	NA
Caste/Tribe				
Scheduled Caste	3.9	2.9	6.8	2094
Scheduled Tribe	7.4	3.2	10.6	2521
Other Backward Class	3.9	2.7	6.6	5225
Other	2.4	2.4	4.8	1757
Don't know	-26.9	-3.6	-30.6	28
Total	4.5	2.8	7.3	11624

Current use of contraceptives

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

TABLE 2

Background characteristic	Age 15-19
Any Method	9.1
Any Modern Method	7.5
Female Sterilization	1
Male Sterilization	0
Pill	0.5
IUD or PPIUD	0.3
Injectables	0.1
Condom/Nirodh	5.5
LAM	0.0
Other Modern Method	0.1
Any Traditional Method	1.6
Rhythm	1.3
Withdrawal	0.3
Not Currently Using	90.9