the yp foundation

Adolescent Sexual and Reproductive Health in **Maharashtra**

Findings from literature and multi-stakeholder consultation

1. Introduction

The total number of adolescents in the age group 15-19 years in Maharashtra was 10.6 million according to the 2011 Census data (Census 2011).

To understand the context of adolescent sexual and reproductive health situation in Maharashtra, 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 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 27th February 2021.

The online consultation was attended by 70 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. Pune, Satara, Gadchiroli, Solapur, Nagpur, Mumbai, Akola, Ahmednagar, and Thane.

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 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 Maharashtra which has been drawn based on published literature and data, and also the points raised during the discussion on the same.

2.1 Awareness about SRH issues

In a poll conducted during the consultation, 56% of the participants were aware of contraceptives and their use. According to NFHS-4, among adolescent males aged 15-19 years (n=767), 19 percent believed that contraception is a woman's business and a man should not worry about it and 13 percent believed that women who use contraception may be promiscuous. Nearly 48 percent of the males who were interviewed felt that condoms if used properly can prevent pregnancy most of the time (NFHS 2018).

Adolescent girls in the online consultation shared their interest to know about sexual and reproductive health issues, they also added that such interest causes judgment from society. This points out the stigma attached to the SRH topics. They also added there is hesitation to discuss these issues with their family members and shared their experience of realizing that ignorance and misconceptions are perpetuated when such information is not available from credible sources.

Young people who participated in the consultation were not aware of the legal gestational age permitted to undergo MTP. Adolescent girls had little or no awareness of the legality of abortion, many of them considered it illegal (Ganatra and Hirve 2002). The discussion also brought out that though abortion is legal in India, female feticide is a crime (selective abortion of female fetus after sonography).

Young people were aware of the side effects of some of the contraceptives and were interested to know about various other contraception to take an informed decision. They had limited knowledge of types of contraceptives.

Young girls in the consultation said that girls and women in their community use cloth during menstruation, do not maintain hygiene, and still observed menstrual rituals such as keeping the menstruating girl and her belongings separate from others in the family. They also shared the negative impact and misinformation that movies and social media propagate about women's pleasure. They also added that the burden of contraception often falls on the women despite the fact that childbirth is not merely a women's responsibility.

2.2 Teenage pregnancy and unmet need for contraception

The NFHS-5 (2019-20) report shows no significant reduction in teenage pregnancy in the state. The NFHS-5 reported that 7.6 percent of adolescents in the age group 15-19 years were pregnant or has a child at the time of the survey and it was 8 percent in NFHS-4 (2015-16). The childbearing at age 17 is 5 percent (n=915) and this increased to 13 percent (n=1000) at age 18 and to 21 percent (n=912) at 19 years. Among currently married adolescents aged 15-19 years, ~11 percent (n=792) were using some form of contraception with ~8 percent using modern contraceptives and 3 percent using traditional methods. The total demand for family planning was 27 percent among adolescents in the age group 15-19 years (n=792), of which more than half (17 percent) had an unmet need for family planning (NFHS 2018).

According to NFHS-4, 3 percent of adolescents who were pregnant reported that the pregnancy ended in abortion and 10 percent reported it ended in miscarriage (n=307) (NFHS 2018).

2.3 Access to abortion and contraceptive services in Maharashtra

Adolescents felt that the providers were moralistic and judgmental (Santhya et al 2014). The community-level health workers (like ASHAs and AWWs) said they were providing service mostly to married adolescents and women (Jejeebhoy et al 2014). Adolescents in Maharashtra preferred private health facilities due to easy access and quality of care (Santhya et al 2014).

In the online consultation, adolescent girls mentioned that they received information on contraceptives from ASHA workers, while boys mentioned their source of information was male friends and advertisements. Contraceptive counselling and supply was predominantly provided to married adolescents and was seen as a part of the general responsibility by the health care providers (Jejeebhoy et al 2014). The barriers to accessing contraceptives were the shame and stigma associated with it according to the participants in the consultation. The inability to talk to health care providers due to embarrassment to discuss sensitive matters prevented the adolescents from seeking care (Santhya et al 2014).

Regarding accessing abortion services, it was pointed in the consultation that due to the stigma associated with abortion and also the lack of awareness of the side effects of unreliable means of abortion, many resorted to home remedies rather than availing abortion services from a hospital. Adolescents mostly approached providers who were not trained. The choice of provider by adolescents centered on multiple factors like cost of the services, the provider's gender, number of visits needed, and they chose those in which the procedure was done in a single visit and there was no need for overnight stay. The providers' skill was also another factor that was taken into account, those providers with no history of abortion-related death (Ganatra and Hirve 2002)
The providers referred the unmarried adolescents who approached abortion as 'illegal' cases as these pregnancies did not occur within the marriage. Unmarried adolescents were charged three to five times the normal rate for abortion services (Ganatra and Hirve 2002).

The need for spousal consent was a major barrier for married adolescent girls. Unmarried girls were insisted on having an accompanying guardian, while some private practitioners were ready to forgo this for a fee (Ganatra and Hirve 2002).

"I insist on a signature. I tell them, bring your husband, bring your mother. Not that it is really needed. But otherwise, everything is too easy for these girls. They will go on doing such things and then coming for abortion." (Female gynecologist, large city hospital) [Ganatra and Hirve, 2002]

In spite of the availability of services in the same geographical area as that of the married adolescents, there was a propensity among unmarried girls to use traditional or informal providers in the same village or a place near to their village. The reason for this was to maintain the secrecy of the pregnancy from the community. This forbids them from frequent and prolonged travel which limited their access to care. Although private practitioners assured them of confidentiality and the facilities were at an accessible distance, the cost of care was too high for many who did not have support to access the services from private providers (Ganatra and Hirve, 2002).

2.4 Existing ARSH programme, the reach and the challenges

2.4.1 Rashtriya Kishor Swasthya Karyakram (RKSK)

Rashtriya Kishor Swasthya Karyakram (RKSK) is a central government programme launched in 2014 for the holistic development of the adolescent population. Under this programme, the counselling clinics for adolescents are called Maitri clinics in Maharashtra. Main health service providers of the government are Auxiliary Nurse Midwife (ANM) and Accredited Social Health Activist (ASHA) workers. The six themes of this programme are SRH, nutrition, non-communicable diseases, violence and injuries, structural misuse, mental health. There are three layers of implementation viz., individual or facilitation level that provides counselling to those adolescents who come to Maitri clinics, second is community level that is to work with the community in creating a supportive environment and third is peer educator level that aims at creating peer educators from amongst the adolescents. Peer educators are trained for six days. Under this scheme, iron tablets are distributed to adolescent girls who are prone to anemia.

Peer educators also play the role of promoting awareness of government programmes. There are no criteria for initiating a peer educator programme. It is rolled out into action once a State government makes a proposal demanding implementation of such a programme to the Central government which then disburses funds to the State government. Once the finance is disbursed the Centre monitors the programme. The decision to implement the programme in all districts or few is taken by the State government.

In Maharashtra, RKSK programme is implemented in 34 districts. There were high-priority districts, which are now called aspirational districts. Aspirational districts are those districts that lagged behind in the development process. Current aspirational districts are Osmanabad, Gadchiroli, Wasim, and Nandurbar. Adolescent Health Day and Adolescent Club meetings are observed in these districts.

Awareness of the RKSK programme and maitri clinic was limited among the adolescent and young people of Maharashtra.

2.4.2 Adolescent Friendly Health Clinics (AFHCs)

There was an increase in the utilisation of AFHCs during the financial year 2016–17 as compared to the previous year (Barua et al 2020). The awareness about AFHCs was very low among the adolescents, while these facilities were located 5-10 km within the house of the adolescents. This was also corroborated with the evidence from the providers who also felt the lack of awareness as the reason for the low utilization of the AFHCs (Santhya et al 2014).

"Very few young people take advantage of the centre; very few. They don't come to the centre; there is not enough awareness." [MO, aged 31, working at the AFHC for one year, Maharashtra, ID-10] [Jeejebhoy et al., 2014]

From the providers' perspective, they noted that there was reluctance among adolescents and youth to approach providers for sexual and reproductive matters. The adolescents also lacked awareness of the AFHCs and were also concerned about the quality of services. These factors prevented from accessing the services by the adolescents. The health care providers also mentioned the barriers at home like parents or mothers-in-law not permitting the adolescents to access services from the AFHCs (Jejeebhoy et al 2014).

Lack of privacy and confidentiality at the AFHCs was another major barrier in utilising the services by the adolescents (Jejeebhoy et al 2014).

"There is a social reason, that is if someone sees them (young boy or girl) coming here (to the AFHC), what will that person say? There may be fear about confidentiality—what if the ANM tells someone about their discussion?" [Staff Nurse, aged 42, working at the AFHC for one year, Maharashtra, ID-2] [Jejeebhoy et al 2014]

2.4.3 Other schemes and programmes for adolescents

The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG) also known as SABLA is a centrally sponsored programme of the Government of India initiated in 2011 under the Ministry of Women and Child Development. It is hailed as a comprehensive programme as it addresses not only the health concerns of adolescents but also their educational and job concerns.

Young girls were aware of SABLA scheme that is operational in many districts of Maharashtra. SABLA scheme exclusively addresses the SRH needs of adolescent girls only and the service is provided through ASHA and Anganwadi workers. The main focus of SABLA scheme according to young girls has been the nutritional aspects and menstruation. They added that SRH meetings under the scheme are not regular.

Indira Gandhi Matritva Sahyog Yojana (IGMSY) is a maternity benefit programme commenced in 2010 by the Ministry of Women and Child Development, Government of India. It is a conditional cash transfer programme for pregnant and lactating mothers of 19 age or above for the first two live births. It provides partial wage compensation to the women for wage loss during childbirth and child care and it also provides for conditions of safe delivery and good nutrition and feeding practices. As of 2017, the programme is being implemented on a pilot basis in 53 districts spread over 36 states/Union Territories of the country.

2.4.4 Gaps and barriers in implementing SRH programmes

The gaps in the existing programmes were pointed out by the young people in the consultation. There is stereotyping of the sexuality of the adolescents in the SRH programmes (only considering the needs of a heterosexual) and thereby excluding LGBTQIA+ adolescents and their needs. NGO field workers pointed out that government does not have programmes that are inclusive of marginalised people who are highly vulnerable to both sexually transmitted diseases and violence because of their social location. Many adolescents and young people are unaware of the central and state government programmes that address SRH issues and concerns.

The barriers of accessing SRH services or implementation of SRH service were spelled out by participants in the consultation. Shame and stigma attached to sexuality were one of the main barriers in disseminating information on SRH. It was also pointed out that ANM and ASHA workers's workload exceeds the remuneration they receive and hence there is a need of increasing the workforce for improving the implementation of the programme. The SRH programme currently being run by the government like RKSK which is meant for adolescents is largely focusing on the girls and therefore these services are not reaching adolescent boys.

3. Recommendations from the Consultations

(i) Increase door to door campaigning to improve the reach of SRH information among vulnerable youth

(ii) Chemists should have posters on adolescent helpline numbers to increase awareness.

(iii) Increase young people's participation in the planning and designing of adolescent centric programmes.

4. Next steps and commitments from the government and NGOs

(i) Maitri clinics that were operationally at block and district level will be made functional at primary health care (PHC) units in the next five years.

(ii) The School Health Programme will have two teachers who are appointed as health ambassadors. This programme will be initially launched in nine districts in Maharashtra.

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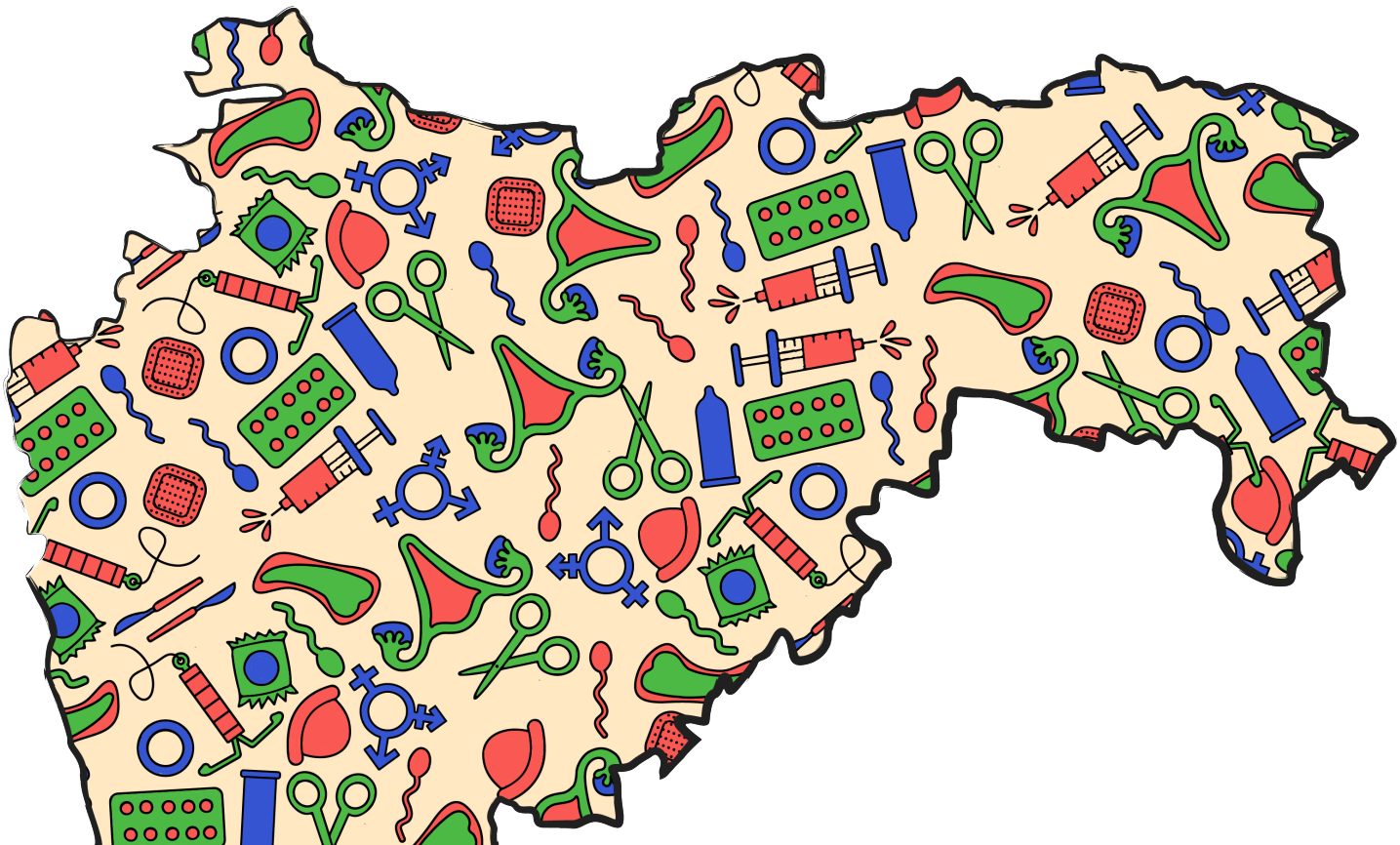

Teenage pregnancy and motherhood

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	0.4	0.3	0.7	906
16	0.7	1.1	1.8	871
17	3.2	1.5	4.7	915
18	7.7	5.1	12.8	1000
19	16.9	4	20.9	912
Residence				
Urban	4.1	1.9	6	2168
Rural	7.5	2.9	10.4	2436
Schooling				
No Schooling	20.6	3.3	23.9	102
<5 years completed	12.9	3	15.9	103
5-9 years completed	8.8	3.4	12.2	1740
10-11 years completed	3.8	2.1	5.9	1639
12 or more years completed	2	1.3	3.3	1021
Marital status				
Never Married	0.0	0.0	0.0	3800
Currently Married	33.4	14.3	47.7	792
Religion				
Hindu	6.1	2.4	8.5	3488
Muslim	5.3	3.6	8.8	662
Buddhist / Neo-Buddhist	5.8	1.3	7.1	386
Other	-1.1	0	-1.1	68
Caste/Tribe				
Scheduled Caste	7.3	1.8	9.1	801
Scheduled Tribe	7.6	4.3	11.8	610
Other Backward Class	3.8	2	5.7	1164
Other	5.5	2.5	8	1987
Don't know	-29	0	-29	42
Total	5.9	2.5	8.3	4604

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	10.6
Any Modern Method	7.6
Female Sterilization	1
Male Sterilization	0
Pill	1.1
IUD or PPIUD	0.2
Injectables	0
Condom/Nirodh	5.2
LAM	0
Other Modern Method	0
Any Traditional Method	3.0
Rhythm	1.8
Withdrawal	1.2
Not Currently Using	89.4