

YOUTH FRIENDLY SERVICES FOR SEXUAL AND REPRODUCTIVE HEALTH: A HANDBOOK FOR SERVICE PROVIDERS







PREFACE

There are 251 million young people in India between the ages of 15-24 years, contributing to nearly one fifth of its total population. Youth is the most valuable section of the population, with highest potential for development. Life events and circumstances during adolescence and youth shape individuals' entire lives, and nations in consequence. That period of life provides them with opportunities to achieve a satisfying life and ability to contribute to the society. The onset of adolescence brings not only opportunities, but also, along with changes to their bodies, new vulnerabilities in the areas of sexuality, marriage and childbearing.

Both unmarried and married young people in the age group 15-24 years face significant challenges in obtaining age-appropriate sexual and reproductive health (SRH) information and services in India and many parts of the World. Even when a young person is able to overcome their family and society level challenges, they may face barriers in a health facility, including negative provider attitudes.

The needs of young people are reflected in the fact that 27 percent of girls in India are married before the age of 18, and only 5.6 % of married women use a modern contraceptive before having their first child (NFHS-2015-16). These factors increase the likelihood of a pregnancy during adolescence or young age, which in turn can adversely affect the health of the girl, as well as her ability to pursue educational aspirations and employment opportunities.

In order to improve access of health services for young people, it is essential to go beyond the providers in Adolescent Friendly Health Clinics. It is important that all health care providers in facilities as well as community, follow the principles of youth friendliness. Such a mainstreamed approach will have a much larger impact; this has been demonstrated to be both scalable and sustainable in many countries.

UNFPA has developed this Youth Friendly Services (YFS) training package, which consists of a handbook and a facilitator's guide. Through a series of case scenarios, this training package enables the health providers to understand the common SRH needs of young people, and helps to build their skills to provide respectful, confidential and non-judgmental SRH services to young people.

We expect that by addressing the health system barriers faced by young people, the package will enable improved health outcomes and help to contribute to India's efforts towards achieving its commitments for FP 2030, and SDG indicators 3.7 and 5.6.

A handwritten signature in blue ink, belonging to Argentina Matavel Piccin, is positioned above her name.

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Recognising the rapidly changing situation of young people especially under the challenges posed by the Covid -19 Pandemic, the contents may have to be adapted for different situations. The content may be used freely for non-commercial purposes, with acknowledgement to UNFPA India.

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1. Setting the Context

This is a reference handbook for service providers, posted at Primary Health Centers (PHCs), Community Health Centres (CHCs) and tertiary care hospitals (DH), who are engaged in providing care and support services to the adolescents and young people. The target audience for this reference handbook include following cadres of service providers:

- Doctors
- Nurses, and Auxiliary Nurse Midwives (ANMs)
- Counsellors.

This handbook aims at sensitising and equipping service providers with the perspectives, adequate knowledge and skills required to provide stigma-free, non-judgemental and comprehensive sexual and reproductive health services to young people.

1.1 Who are Adolescents, Youth and Young People?

While there is no strict definition for the term 'youth', most UN documents use the age-group of 15-24 years to refer to youth. WHO defines 'Adolescents' as individuals in the 10-19 years' age group and 'Youth' as the 15-24 years' age group. While 'Young People' covers the age range 10-24 years. In this handbook, the age specific categories have been defined as follows:

Adolescence	10-19 years
Early Adolescence	10 to 14 years
Late Adolescence	15 to 19 years
Youth	15 to 24 years
Young People	10 to 24 years

Youth are defined as those aged 15 to 29 in the national youth policy (2014). This age-group constitutes 27.5% of India's population 24-Oct-2014.

1.2 Policy Landscape in India

India is proudly known as a young country as its population comprises of a large number of young people. Recognizing the importance of protecting and supporting health and well-being of its young population, the Government of India is committed to strengthening its programmes and systems for adolescents. This is visible through the Governments commitment towards the Adolescent Reproductive and Sexual Health Strategy (ARSH) launched in 2005 and, subsequently, through the National Adolescent Health

Programme (Rashtriya Kishor Swasthya Karyakram or RKSK) launched in 2014. Under the ARSH program, in 2006 under the RCH II strategy Government of India established Adolescent Reproductive Sexual Health (ARSH) Clinic to provide counselling on sexual & reproductive health issues to the adolescent population. Further, since 2014, under the National Adolescent Health Programme (NAHP), the Government of India has established Adolescent Friendly Health Clinics to address clinical and counselling services on diverse adolescent health issues ranging from Sexual and Reproductive Health (SRH) to Nutrition, Substance abuse, Injuries and Violence, Non Communicable Diseases and Mental Health. As of 2020, 8099 AFHCs¹ are active and functional. In the state of Uttar Pradesh, only 0.4% adolescents were aware of the existence and relevance of AFHCs. According to a study conducted by Population Council² awareness on AFHCs remains limited and varies across states. This low awareness when combined with the critical deficiency in infrastructure (7381 facilities for 253 million youth) points towards the urgent need to fill the gap in service delivery, for all young people. Even though youth is in general the healthiest period of life, there are evidences that show that differences of mortality amongst youth are striking in different countries. In more developed regions, Northern Africa, Eastern Asia and Western Asia only 1 per cent or less of 15-year olds do not survive to their 25th birthday. Concurrently, the odds of dying during youth are almost twice as high in South Asia.⁵

This handbook has been written with the objective of training and sensitizing the service providers on youth friendly service delivery across the public health system. It is not just limited to RKSK counsellors as we recognise that there is a need to increase the medical service provider base by mainstreaming youth-friendliness in the system.

1.3 SRH Status of Youth in India

Following evidence on youth health indicators points towards the urgent need to address service delivery for improving the SRH status of youth.

- 35.4% of the women (20-24 years) reported being married before the age of 18.
- 8% of adolescents aged between 15 – 19 years have started child bearing. Of these 5% had already experienced a live birth and 3% were pregnant with their first child.
- Unmet need of contraception for women in the age group 20 – 24 years was 22% or more than one in five couples.
- Among men in the 20 – 24 age-groups the knowledge of contraceptives is also nearly universal, but usage is low with less than 20% of married or sexually active men using any modern contraceptive. Only 63% of young men knew that a condom was an effective contraceptive.

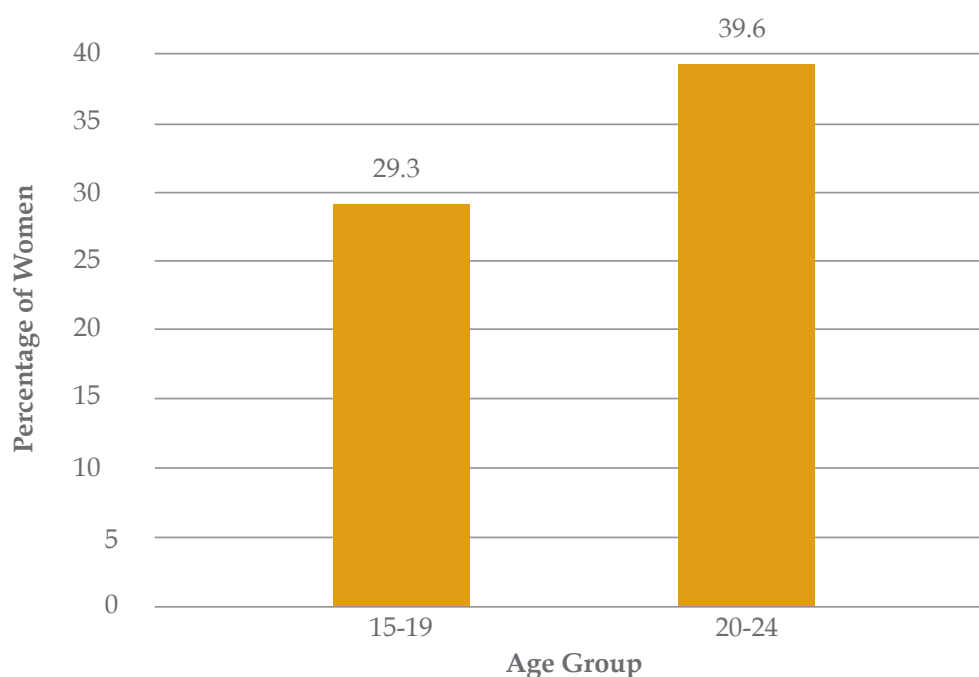
¹ J Family Med Prim Care v.6(3); Jul-Sep 2017 PMC5787938

² Page no. 25, https://www.popcouncil.org/uploads/pdfs/2017PGY_UDAYA-ExecSummUP.pdf

³ <https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>

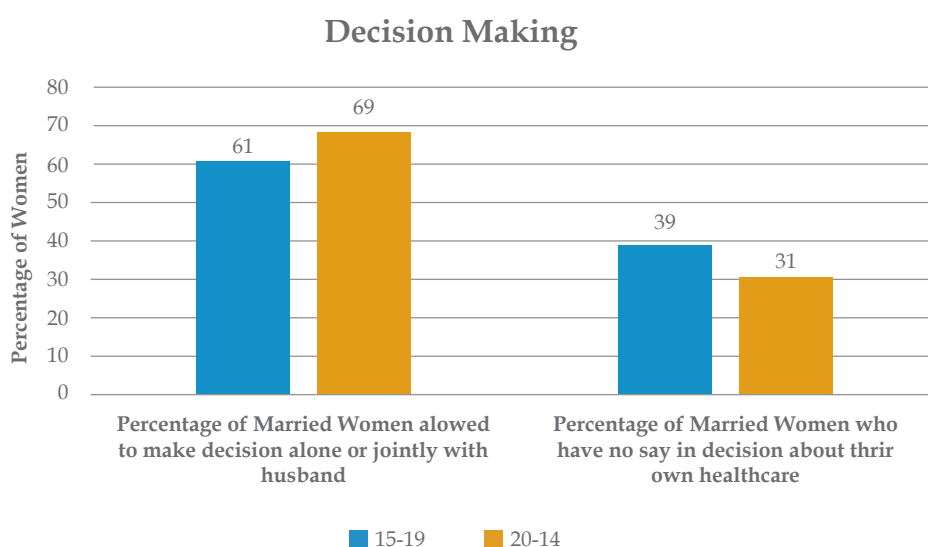
- There is higher risk of maternal deaths in the younger age groups, between 13 and 19 years⁴.
- 63 per cent of all suicide deaths reported in India were in the 15-39 age group. Suicide ranked first in India as the cause of death compared to its third rank globally in this age group, it said.⁵ There was an increase of 40 per cent in the number of suicide deaths between 1990 and 2016, with an estimated 2,30,314 deaths in 2016 indicating that “disproportionately high suicide deaths in India are a public health crisis”.
- The factors because of which youth are not able to access services is that they are not allowed to take decisions to access health services independently and they are allowed freedom of movement. According to NFHS-4:
 - Only 29% and 40% of women in the age group of 15-19 years and 20-24 years’ age group are allowed to go to health facility alone.
 - Only 36% of married women without a living child are allowed to visit a health facility alone.
 - Only 61% and 69% of currently married women aged 15-19 and 20-24 years make decisions about their own health care alone, or jointly with their husbands, while one fourth 39% and 31% respectively in these age groups do not have any say in decisions about their own health care (NFHS-4).

Percentage of Women Allowed to go alone to Health Facility



⁴ Horwood G, Opondo C, Choudhury SS, et al. Risk factors for maternal mortality among 1.9 million women in nine empowered action group states in India: secondary analysis of Annual Health Survey data. *BMJ Open* 2020;10:e038910.

⁵ The Global Burden of Disease Study 1990-2016 published in the *Lancet Public Health* journal said



1.4 Why is it Difficult for Young People to Access SRH Information and Services?

Very few young people are able to access SRH information and services. Some of the simultaneous challenges that make it difficult for young people to access the quality SRH services are listed below⁶:

- 1. Social norms:** Prevalent social norms that deem conversation on SRH a 'taboo' and discourage information seeking around the same.⁷ As a result, there is fear of getting recognised by family and community members amongst youth when seeking SRH services.
- 2. Viewed as 'minors' and inexperienced:** Owing to their social position/status adolescents and young people are viewed as 'minors' and are discouraged to visit the health facilities alone. Youth are often viewed as inexperienced and as lacking the knowledge and skills required to make healthy decisions or choices.⁸
- 3. Lack of information:** Lack of access to timely, accurate and comprehensive information on youth-friendly SRH services especially for youth who have dropped out of schools.^{9,10}
- 4. Attitude of the providers:** Provider attitudes are oftentimes uninformed, judgmental and disrespectful discouraging youth from seeking SRH services.¹¹ Additional barriers such as stressing upon parental/guardian consent discourage unmarried youth from approaching the service providers.

⁶ Adapted from Jacobs et al (2011), Addressing access barriers to health services: an analytic 4 framework for selecting appropriate interventions in low income Asian countries, *Health Policy and Planning* 2011; 1-13 doi:10.1093/heapol/czr038

⁷ Jain, Nutan P., S.D. Gupta and L.P. Singh (2004). Meeting reproductive and sexual health needs of adolescents: A strategic approach for Rajasthan, India. IIMR, Working Paper No. 4. Jaipur: Indian Institute of Health Management Research.

⁸ Page no,32, https://www.popcouncil.org/uploads/pdfs/2017PGY_UDAYA-ExecSummUP.pdf

⁹ Page no. 14, page no.16 https://www.popcouncil.org/uploads/pdfs/2017PGY_UDAYA-ExecSummUP.pdf

¹⁰ Sathe PP, Sathe PP, Kotnis SD, Mangulikar SK. Assessment of knowledge of reproductive health of adolescent school girls from 13-16 years with special reference to HIV-AIDS. *Int J Community Med Public Health* 2016;3:340-6.

¹¹ Page no,23 https://www.popcouncil.org/uploads/pdfs/2017PGY_UDAYA-ExecSummUP.pdf

5. **Health facility characteristics:** Lack of privacy and confidentiality and unfriendly environment in health facilities and non-availability of a range of SRH services, further discourages young people from approaching these facilities.
6. **Legal barriers:** On one hand, there are no legal restrictions for a young person to be provided with contraceptive services, however, the Prevention of Children from Sexual Offences (POCSO) Act, 2012 is a law which seeks to protect children (any person below the age of eighteen) from sexual abuse. A provision in the law on mandatory reporting however, makes it difficult to access SRH services by women below the age of eighteen as the law views any form of sexual encounter (even if consensual) as violence. Hence, service providers are mandated to file a medico-legal case if a young person below 18 seeks any SRH service like delivery, contraception, abortion or HIV testing. Though many adolescents are not aware about POCSO Act if there are encounter medico-legal situation while availing services, it result into compromise to their privacy and confidentiality, and severely discourages young people to seek services.
7. **Lack of affordability:** Since many young people do not like to go to public health facilities due to issues such as privacy and confidentiality, there could be lack of affordability due to high cost at private facilities. On the other hand, the services in private facilities are often costly. A majority of the youth, whether school going or out-of-school, married or unmarried lack financial independence and/or capacity to procure health services especially from high cost private facilities.

As individual practitioners, awareness of the context in which a young client is located can change the way you approach him or her. A more sensitive, empathetic and rights-based approach towards the client will likely improve provider - client interaction, client compliance and health outcomes. The handbook consists of good practices for the services providers to overcome legal challenges in service provision.

2. Mainstreaming Youth Friendly Health Services

While a lot of SRH information is available on the internet/ unreliable sources of information, young people often run into more misinformation than easy to understand facts. Although health service centers and providers continue to be source for accurate and comprehensive sexual and reproductive health information for young people, however, they are often embarrassed to discuss sexual health issues and are scared of being judged and labelled if they raise these concerns. This is why young clients are highly intimidated in approaching a health facility, leading to low health seeking behaviour across genders. To change this and mainstream youth friendly, **it is important that all persons at the facility including the administrative and OPD staff, nurses and doctors ensure a safe, welcoming and non judgemental environment for young people who want to access health information and services.**



2.1 Youth-Friendly Services: Some Key Principles

In order for a health service to be 'Youth-friendly', it must incorporate some essential elements at

- the provider level,
- the services level, and
- the facility level.

2.1.1 The Provider

It is important that all health service providers (including doctor, a nurse, a counselor or an ANM in charge of a primary healthcare facility) have required competencies for providing youth friendly health services.

- “Youth”, is not a single category, and includes diverse cross-sections of youth belonging to multiple and overlapping social categories and backgrounds Eg. educated/ uneducated, married/ unmarried; having low / high socio-economic status; migrant/ non-migrants; tribal, dalit; trans youth, youth living with HIV etc. Thus, providers must listen attentively to the client’s case, and ask pertinent questions to understand the circumstances the client is bound by.
- Simple practice like addressing them by their name, communicating in a sensitive, non-judgmental and non- threatening tone will go a long way in building trust and rapport with the client.

The below principles directly align with and reinforce the *principles of ethical medical practice* familiar to all health service providers.

1. Autonomy and Informed Consent

- Youth, just like anybody else, have the right to acquire correct information and make informed decisions about their own bodies. The provider has the ethical responsibility to uphold the youth client’s autonomy, by explaining diagnosis and treatment in non-medical language, so that young people can decide for their own health. Remember, no law prohibits the provision of medically accurate and comprehensive SRH information to youth with the intent of advancing their awareness and wellbeing.
- Providers should not assume that they can share any details (e.g. what service did the young person come for, the problem they have, the sexual history, the results of tests if done, the treatment chosen by them, etc.) with their parents, spouse, and/or other family members. Revealing sensitive information to family members can severely compromise the situation of young people, and could result in stigma, and even severe physical and emotional violence, and in some cases, marital problems.
- It is important to maintain a balance between the provision of SRH service and the requirements of Protection of Children from Sexual Offences (POCSO) Act, 2012 which is for protection of minors from sexual offences. The service provider should be mindful of fulfilling the requirements of the POCSO Act and, if the client is a mature minor, the provider may ask the client to suggest a trusted adult of their preference, in place of the legal/natural guardian. This is recommended, especially because the perpetrator of sexual offence could be a family member.

For instance:

If a 19-year-old young woman has approached you for information related to abortion, which are the responses from you that show or indicate openness:



While having fun with your friend you should have thought of the outcome! Now bear with the consequences! Just think about what your parents will go through when they find out about what all you have been upto!



Do not worry. You have done the right thing by approaching me. The decision to have an abortion is entirely yours. I will ensure that this remains confidential. If there is anything that is bothering you, please do not hesitate to share with me.

2. Privacy and Confidentiality

- Young people seeking SRH services often fear the risk of peers and elders finding out. Such fear is reasonable, because the taboo attached to reproductive health issues health is so significant that it could result in the young person's social stigmatisation and eventual social exclusion.
- Therefore, it is important that service providers and facility staff maintain privacy during the consultation, do not reveal the identity of clients while sharing medical records for official purposes, or discussing medical history with colleagues, support staff or even friends.
- There may be situations where a family member or neighbour asks a provider to reveal why the young person came to them for services. In such cases, the providers should not reveal the actual service sought by the young person and can tactfully give a response or refusing to give details.

For instance:

If a young married woman has approached you for an emergency contraceptive pill and there are other clients present there, how will you talk to her?



Ask in front of the others why she has come and what help she needs. And send her back without a one-on-one private sharing.



You could request the other clients to wait outside saying that you have a report to complete. You could then speak to the young woman after everyone has left.

3. Non-judgmental attitude

- Any sign of judgment around masturbation, bodily changes, unplanned pregnancy, abortion etc. will inhibit the young person from truthfully revealing their problem or query, impede service provision and ultimately, the client's good health and well-being.

For instance:

If a young woman talks to you about her irregular menstrual cycle, then what would be the appropriate sensitive and respectful response?



You are so thin and weak, you don't eat properly and so you are facing these problems. If you don't take care of your health then your menstrual cycle will remain irregular.



This is common when girls are growing up. There is no need to worry. First, could you tell me a bit about your diet? Do you eat three proper meals a day?

4. Provider attitudes and practices

- When young people visit the health facility, for their reproductive health-related issues, it is appropriate to equip them with evidence-based and comprehensive health information that will help them to make informed decisions beneficial to their health and wellbeing.

Remember: Denying access to quality SRH information and services can lead to adverse health outcomes of the young client, and also, in doing so, the provider is in violation of the principle of 'truthfulness' and, 'doing no harm'.

2.1.2 Essential Package of Services

As mentioned earlier, 'youth' is a time when critical milestones such as physical, mental and emotional maturation, sexual activity, marriage and pregnancy are commonly navigated. It is important that young people are ensured respectful and dignified SRH services. Thus the following package of services are essential for ensuring their good health and well-being.

<p>Integrated Counseling Services</p>	<p>Provide comprehensive and integrated counseling on a full range of issues such as puberty, menarche, nightfall, sexual attraction, masturbation, violence especially gender based violence and intimate partner violence, conception, contraception, abortion and STIs/RTIs, and safe sex practices.</p> <p>If the young client is seeking a pregnancy test, provide information on pregnancy testing, as well as contraception and abortion towards maximising, clients' autonomy and choice.</p> <p><i>Youth clients seeking SRH services approach health facilities, with great nervousness. They are unlikely to honestly share concerns at once. Exercise patience, and probe sufficiently so that the actual problem of the client can be understood.</i></p>
<p>Menstrual Health and Hygiene Management</p>	<p>Create awareness about menstruation and menstrual hygiene.</p> <ul style="list-style-type: none"> • Inform them on where they can access and use sanitary pads or other methods of sanitary protection, and how to dispose them. • Tell them that puberty is the time of growth spurt, body changes and onset of menarche is a normal physiological change, and is also transformation in the lives of adolescent girls. • Address various myths and misconceptions around menstrual taboos, that restrict their movement, education, other activities and health during menstruation. • Provide treatment for irregular period or menstrual problems.
<p>Provision of Contraception</p>	<p>Provide the full range of contraceptives offered by the Family Planning programme (eg. condoms, EC, Oral pills, injectables etc.) irrespective of their marital status.</p> <p>This should also include pre-marital counselling for girls and boys.</p> <p>Age should not be a restriction to provide low dose combined contraceptive pills to adolescents.¹²</p> <p>Emphasis should be placed on encouraging male participation where contraceptive uptake is concerned.</p>
<p>Safe Abortion Services</p>	<p>Ensure that young women are able avail safe abortion (upto 20 weeks of gestation) under circumstances mentioned in the Medical Termination of Pregnancy (MTP) Act. They should also get post abortion care, contraceptive services and referral services on priority irrespective of their marital status.</p> <ul style="list-style-type: none"> • Young clients' must have access to an appropriate abortion method as per their eligibility and choice of method (medical abortion pills, vacuum aspiration). • For women 18 or above, the woman herself can give consent and providers should not insist on signatures of their family members as per MTP Act. • In case of girl below 18, written consent must be obtained from a guardian. A guardian can be any person who is major and consents

¹² Contraceptives Update Reference Manual for Doctors, October 2005. Ministry of Health and Family Welfare and UNFPA.

	<p>to take her care for abortion care related procedure. In case of a minor the provider should inform the police as per the requirements of the Protection of Children from Sexual Offences Act (POCSO), 2012. In such cases mandates under the POCSO Act must not delay or impede the client's access to safe abortion services.</p>
Maternal Health-related Services	<p>All facilities should offer maternal health services in a non-judgemental manner, to young teenage girls and women, irrespective of marital status. Respectful along with evidence based maternity care should be provided to young mothers, and they should be provided a proper counseling on contraceptive methods to delay next pregnancy.</p>
RTIs/STIs Management Services	<p>Since RTIs/STIs are often under-reported especially in women, screen women for high risk and possible symptoms when they seek care.</p> <ul style="list-style-type: none"> • Integrate screening for STI/RTI into routine clinical practice, especially SRH and HIV related services, • Provide treatment if available or • Have close referral links to a clinic where such services are provided.
Diagnosis and management of other SRH issues	<p>Young people might need other SRH services such as early detection of pregnancy, menstrual disturbances, or hirsutism (which could be linked to polycystic ovarian disease). Diagnosis and appropriate management of these conditions are an essential component of youth-friendly services.</p>
Care for Survivors of Violence	<p>Cases of violence including rape, domestic violence, intimate partner violence and child sexual abuse are usually undisclosed. Instances of violence can be physical, mental, emotional and sexual in nature, and it is important that all providers are sensitive to these issues, and are oriented on the law (PWDVA, POCSO, The Criminal Law (Amendment) Act 2013) and associated guidelines on 'Strengthening Health Sector Response to Violence'¹³.</p> <p>Providers should be able to:</p> <ul style="list-style-type: none"> • detect signs of violence based on clients' history, and undertake screening procedures for those clients who display these signs. • <i>Remember that the first step is to offer medical aid/services. Mandatory reporting is the second step, after informing the client and connecting them to a support NGO.</i> • Establish referral linkages with government and non-government/ support institutions who can facilitate redressal for victims of violence.
Interconnection of SRH and mental health	<p>Mental health problems remain a widely unaddressed issue at large. They could be linked to various social barriers, educational attainment, personal relations, or health issues such as unwanted pregnancy, or postpartum depression. Providers should be competent to:</p> <ul style="list-style-type: none"> • Identify mental health needs and its interconnectedness with SRH issues. • Identify the symptoms and make proper referrals to specialists for advanced care for medication or therapy.

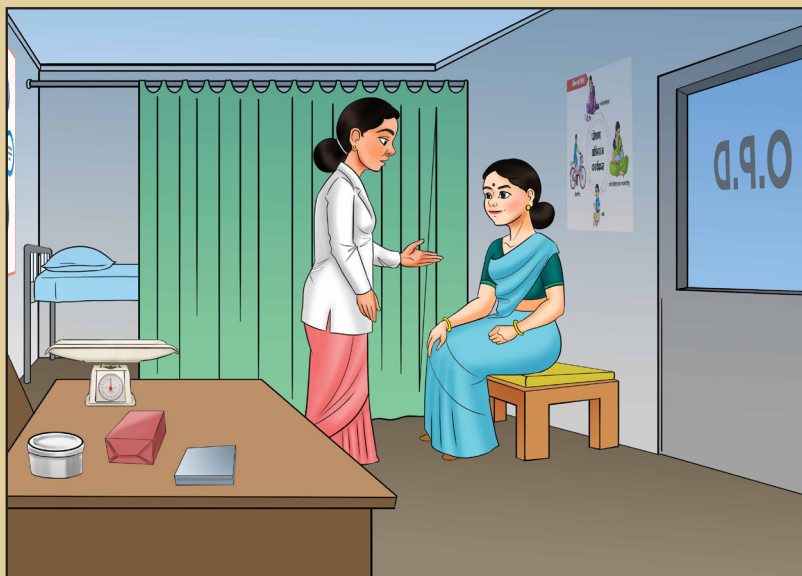
¹³ <https://india.unfpa.org/sites/default/files/pub-pdf/Violence%20Kit-1.pdf>

2.1.3 The Facility

All facilities which provide RMNCHA health services should be youth-friendly. Some of the considerations that experts have found useful for developing youth-friendly atmosphere in a facility are as follows:

- **Visual and Auditory Privacy:**

Ensure visual and auditory privacy of the client so that youth feel safe and comfortable to consult the doctor and procure relevant services. For ensuring visual and auditory privacy include following



1. Curtains in the examination area; close the door of the OPD while client consultation. In case of a consultation of a female client by a male provider, it is essential to have a female chaperone in the room.
2. Unless otherwise requested by the client, keep other persons out of the room during examination;
3. To the extent possible, ensure other people in the OPD are not over-hearing the conversations with the client;
4. Install condom boxes in non-crowded sections of the clinic or health facility, and in locations where they can go discreetly.

- **Availability of female attendant:**

1. As far as possible, it should be ensured that a female client is seen by a female provider and a male client is seen by a male provider.
2. During the consultation and examination of a young woman by a male provider, ensure that a female attendant is available. This should be ensured even for interactions between female clients and male lab technicians, X ray technicians, OT assistants etc.

- **Facility Environment:**

1. Install signages for various services, so that young people can easily navigate the facility.

2. Train the support staff like the people at registrarion counter, cleaner staff etc., they should be assisting young people in navigating the facility and maintain confidentiality.

- **IEC Material:**

Display IEC material in the waiting area and the provider's room that is useful to young people's SRH needs, and helps destigmatize young people's need to seek SRH services such as contraception, abortion, mental health etc.

- **Stocking of commodities and other supplies, for example:**

1. Ensure availability of the different types of contraceptive methods, e.g. condoms, oral contraceptive pills, EC pills, Injectable contraceptive (Antara),
2. Pregnancy test kits
3. STI and HIV testing kits
4. Medical Abortion pills
5. Pamphlets / brochures/ IEC material for young people n various topics

- **Youth Feedback and Engagement:**

Organise a mechanism to get feedback from the young people on their experience of services, or willingness to receive services. It can function as a sub-group of the Rogi Kalyan Samiti or be drawn from the Village Health Nutrition and Sanitation Committees.

Feedback may be written on a piece of paper anonymously or a feedback form may be developed and dropped in the feedback box. Feedback box can be opened periodically and facility in-charge may address all the concerns (if any).

The forum can serve the following purposes, among others:

1. Provide inputs about the range and nature of services available as well as generate feedback on the effectiveness of the services being provided.
2. Provide feedback from the young people who did not visit the facility despite having a need.
3. Conduct a periodic assessment/audit of the facility based on a simple checklist.

At the end of this handbook, a suggestive checklist (**Annexure 2**) is given for Medical Officers In-charge of the facility to monitor regularly if their facility is youth-friendly or not and, based on assessment, they can take the required measures to rectify any deficiency in the facility or services.

3. Good Practices for Youth Friendly Service Provision

In this section some situations on youth friendly service provisioning and facility readiness in providing youth friendly services will be discussed. The situations are presented in the form of case studies followed by discussions. These are common situations which you may come across while dealing with SRH issues of young people

SRH NEEDS OF YOUNG WOMAN

Case Study 1: Assessing Rinku's Immediate and Long- Term Needs

Rinku is 16 years old and works in a garment factory in a nearby town, 20 kms away. In the last couple of weeks, she has been experiencing pain in her vagina and having foul smell discharge and itching while urinating. She comes to the District Hospital and is directed to a female gynecologist.



The provider counsels Rinku in a private room, and Rinku explains that she is experiencing some discomfort in her genitals whilst urinating. The provider asks her if she is sexually active. Rinku says that she is in an intimate relationship but has never engaged in sexual intercourse. The provider then explains to Rinku that she would have to examine Rinku's genitals, and obtains Rinku's consent for the same. After the examination, the provider assures Rinku that there is nothing to worry about, and that she is just experiencing a mild fungal infection in the vagina, that is causing the foul smelling discharge and pain during urination. She writes down a prescription for a vaginal cream, and hands it to Rinku. Rinku thanks the doctor and leaves.

Important Observations from the Case

1. Rinku is young and therefore it could have been difficult for her to access the clinic.
2. Rinku clearly states that she has a partner with whom she gets intimate. Thus she would require comprehensive and integrated counselling on safe sex, contraception and abortion.

What did the gynecologist get right?

1. The gynecologist counselled the client in private.
2. The gynecologist does not enquire about 'marital status' but specifically asks if the client is 'sexually active'. This is a good practice as it is common for young people to engage in sex irrespective of their marital status!
3. The gynecologist does not display any signs of judgment throughout the counseling, thereby normalising SRH seeking.

Did Rinku receive comprehensive SRH counselling and services?

While recording client history, be attentive to the clients' immediate as well as long-term SRH needs/concerns. In this case, Rinku mentions that she has a partner with whom she gets intimate. Therefore, alongside STI counselling, the gynecologist should have also provided counselling on contraceptive options, unwanted pregnancy and other issues as needed. Integrated counselling and service provision optimises clients' time in the facility, and reduces the burden on young people - who face severe barriers in making multiple visits to the clinic, due the restriction of their mobility and financial constraints.

When Dealing Young Woman and Issues on Gender Preference

Case Study 2: What are Laxmi's Needs?

Laxmi is 20 years old and has been married for around 3 years. She has 2 daughters and she lives with her husband, children and mother-in-law in the city. One day, Laxmi realises that she has missed her period

for 2 consecutive months, and purchases a pregnancy testing kit. The pregnancy test result confirms that Laxmi is pregnant. Thus, Laxmi accompanied by her mother-in-law visits the nearby district hospital, to consult a gynecologist.

Laxmi does not want another child but she knows that her mother-in-law is waiting for a son in the family. The doctor asks the two of them to take a seat, and listens silently to the details provided by Laxmi's mother-in-law. The doctor asks Laxmi as to how she would like to proceed. Laxmi tells the doctor that she wants to know



if she is pregnant or not. The doctor examines Laxmi and confirms that Laxmi is 2 months pregnant. Laxmi's mother-in-law is overjoyed and asks the doctor what are the chances of a male fetus. The doctor says that she will be unable to predict the same, and also informs the mother-in-law that sex determination is illegal. The doctor also congratulates Laxmi and requests the nurse prepare Laxmi's antenatal schedule.

Important Observation from the Case

1. In the span of 3 years, Laxmi had already given birth to 2 girls *without adequate spacing*. Therefore, a third child at this stage poses significant risk and may adversely impact health of both pregnant woman and fetus.
2. Moreover, In India, 'male preference' is a social norm that manifests in families applying undue pressure on women to conceive a male child. Even in Laxmi's case, 2 girl children and the lack of spacing can be indicative of undue pressure from the family.
3. Therefore, Laxmi and her husband may be in need of counselling on contraception and abortion. It is important to counsel on discrimination and violence at home due to gender preference and moreover, due to the desire for a son in the family, she may not be able to negotiate for contraception use with her husband.

What did the doctor do right?

1. The doctor listened attentively. Attentiveness and eye-contact while taking history, helps build client's trust and promotes honesty.
2. The doctor specifically asked Laxmi how she would like to proceed, and not the mother-in-law.
3. The doctor denies fetal sex-determination, which is as per the requirements of Pre Conception Pre Natal Diagnostic Techniques (PCPNDT) Act, 1994. PCPNDT Act renders sex determination illegal and penalises medical service providers offering sex selective diagnostic techniques and selective abortion services.

Did the doctor uphold the principles of youth friendly health service delivery?

1. No. The doctor violated the principles of 'privacy', 'confidentiality' and 'autonomy'.
2. Since the doctor counselled the client in the presence of her mother-in-law, the client did not get a chance to decide the course of her pregnancy herself. Within the family structure, mother-in-laws carry more authority than their daughter-in-laws. For instance, the mother-in-law spoke on behalf of Laxmi twice, even though Laxmi was the client.

3. The doctor assumes that Laxmi would want to bear a child. Thus, she does not counsel Laxmi about the options available, including the option of terminating the pregnancy, contraceptive counseling with her husband for long-term family planning. In doing this, the doctor has limited Laxmi's choice and her autonomy to make decision.

How could the doctor have provided comprehensive counselling services?

1. A provider should always counsel the client in **private**. The spouse/family member/friend can be present initially, but should be requested to step out. The stigma attached to SRH is so high that clients are honest only when **privacy and confidentiality** is guaranteed.
2. Ideally, the provider should have asked the mother-in-law to step out, disclosed the test results to Laxmi in private, obtained her informed consent OR given Laxmi the chance to decide if she wants to continue the pregnancy or not. Depending on her choice, the doctor should have supported Laxmi if she wants to not disclose the information to her mother-in-law and husband.
3. Even in the case of a minor, the client should be counselled separately, because they are likely to withhold information in the presence of the guardian.
4. The provider should have informed Laxmi of the possibility of terminating the pregnancy, on grounds of 'contraceptive failure' or 'causing harm to the pregnant person's mental health'. Therefore, while recording the history of the client, be attentive to the clients' multiple SRH needs/concerns.
5. The provider should have also counselled Laxmi on how to deal with family pressure. If the provider suspects/client inform about gender based violence based on gender preference at home, he/she she should connect her to support and care services for ensuring that she receives sustained support in addressing the matter. At every stage, inform the client of the comprehensive list of services available to them, to maximise clients' **choice and autonomy**.

Young People and Contraceptive Counseling

Case Study 3: Contraceptives Counselling is for Everyone

Rajesh and Seema, 20 and 19 years old respectively, are from neighboring villages. They are both studying in college and have their classes only on Sundays. They work

in the same garment factory on weekdays in a nearby town. They have known each other for the last 3 years and have been in a romantic relationship for the last 2 years. Since both of them have elder siblings as well as family responsibility, they cannot think of getting married for the next 2-3 years. However, both of them get intimate occasionally.

They come to the district hospital which is far from their village but close to their factory to seek contraceptive services. The privacy was maintained during the consultation, there were no other clients in the room. The service provider begins with asking Seema her name, age and the problem. When Seema tells the provider that she wants to use contraception, the service provider immediately asks if they are married. Rajesh and Seema look at each other and Rajesh responds, “no, but we will get married next month.” The service provider says that they can come back next month and she will provide them oral contraceptive pills as that would be a good option for her to avoid pregnancy.



Important Observations from the Case

1. Rajesh and Seema have an intimate relationship and they cannot marry each other due to the family situation at home.
2. Both of them come together to the facility which is far from their village to seek contraception so that nobody recognises them. Upon enquiry, they lie that they will get married next month and are still denied services.

What did the provider do right?

1. The provider ensured that the privacy is maintained. No other client was allowed to enter the room during the consultation.

What did the provider not do right?

1. The provider did not give them information on all available reversible contraceptive options, and allowed them to decide which one they wanted. She straightaway jumped to advising oral pills. She should have offered them contraception options and ensured that they leave with at least one contraceptive.
2. The service provider asked them their marital status. As highlighted previously, marital status is not a qualifier to receive the services and the providers should refrain from asking the marital status. Provider cannot impose their opinion on their clients and need to be non-judgmental towards it.
3. The provider did not provide them any contraceptives and asked them to come back after they were married.

Is it okay to provide contraceptive counselling to unmarried youth?

1. Yes, it is okay.
2. Young people have a right to be in a consensual sexual relationship and seek healthcare services as an adult at the age of 18 and above, irrespective of marital status. They do not require guardian consent and can take independent decisions. The service provider should not delay or deny them services on any grounds. They should offer them proper counselling on contraception and help them choose from the available basket of contraceptive choices.

What additional steps could the provider have taken?

1. The provider should have taken a history of last unprotected contact and use of contraceptives. If needed, the provider could have offered emergency contraceptive pills.
2. The provider needs to ensure a sensitive and non-judgmental attitude towards premarital sex. This can be communicated through words, body language as well as facial expression.
3. The provider can ask if they are sexually active to record sexual history. Inform them that an accurate record will enable them to provide better services and that their sexual history will remain confidential.
4. The provider can enable them to make an informed decision on contraception usage. This can be done by providing counseling on each method and introducing the basket of choices.

Young People and Fertility Choices

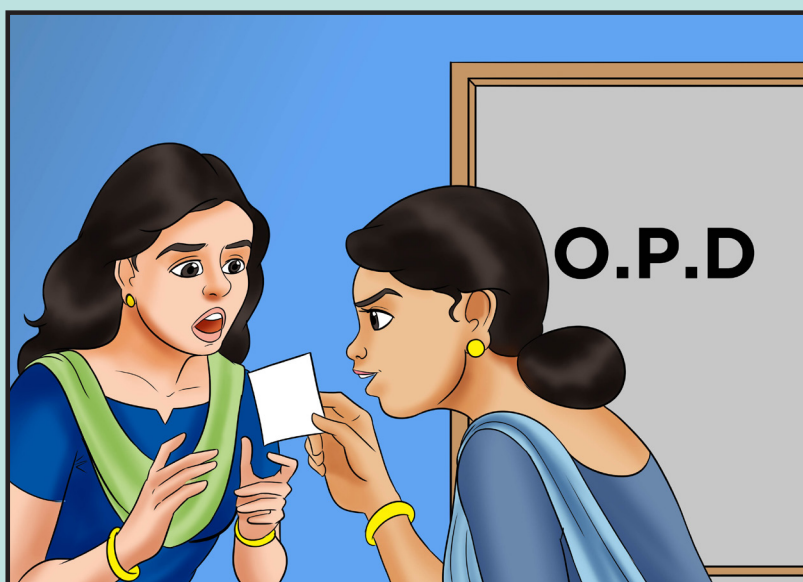
Case Study 4: Rubina is the Authority of Her own Fertility Outcomes

Rubina is 19 years old and resides in a slum dwelling with her parents. She runs a general store with her father. Rubina has a boyfriend who lives close to her house.



Rubina has missed her period in the last two months and she visits a female doctor for a pregnancy test with a friend. The doctor was accompanied by the nurse in the consultation room. There were no other patients in the room. The service provider asks Rubina if she had had sex with someone. Rubina says that she had had sex with her boyfriend 2 months back. After testing, the provider confirms that Rubina is 9 weeks pregnant. Rubina begins to feel very scared of the consequences of her parents getting to know about the pregnancy.

The service provider tells Rubina that she should have thought of her parents earlier and now she should not complain. Rubina asks the provider about abortion and the provider says that she will only be able to do it if she brings her mother along. Rubina leaves the consultation room unsatisfactorily and is approached by the nurse who was there in the consultation room.



The nurse tells Rubina that she can do abortion for her without the guardian's consent. She will charge 15,000 (INR). The nurse gives her the contact number to get in touch. When Rubina asks when and where she has to come, the nurse says that she will call Rubina to her house.

Important Observations from the Case

1. Rubina's age is more than 18 years and she considered it important to visit a doctor after missing her period. Rubina was accompanied by her friend to the provider. Her friend's support was an enabler for her to access the services.
2. The doctor undertakes a pregnancy test and informs Rubina to come with her mother for the abortion. Since she is unmarried, there are high chances that parental consent would be a barrier for her to access abortion.
3. While the intention of the nurse was to provide abortion services to Rubina, she also breached her right to confidentiality by offering to do it outside the facility. She also overcharges Rubina and in accordance to MTP Act only providers approved by the Act can provide abortion services and an unapproved provider can be penalised for terminating a pregnancy.

What did the doctor do right?

1. The doctor informed Rubina that she is 9 weeks pregnant.
2. The doctor took Rubina's sexual history.
3. The doctor ensured privacy during the consultation as there were no other patients in the room.

Is it okay to provide her abortion services without the guardian consent?

1. Yes, according to the Medical Termination of Pregnancy (MTP) Act, if the woman's age is above 18 years, only her consent is needed. The consent of guardian/parents not required. It is more important to ensure that they have access to safe abortion services irrespective of the marital status. There was no need for the doctor to ask Rubina to bring her mother.
2. Denying abortion services may encourage unsafe abortions as woman may seek abortion services from an illegal and unsafe, back street abortion provider like in this case.

Was the doctor right in delaying the procedure?

1. The doctor delayed the abortion procedure. Since abortion is a time-sensitive matter, it is highly inadvisable to delay the procedure. Moreover, Rubina was confident and decisive about what she wanted, there was no reason to delay the procedure.

Was the action of the nurse correct?

1. The nurse advised Rubina to opt for abortion services outside the facility. Along with ensuring privacy, the doctor and the support staff need to ensure confidentiality of the client too.
2. The nurse offered to provide services at her home at an overcharged rate. It is illegal

and unethical to take advantage of Rubina's vulnerability by offering to provide services at a higher rate.

How can one ensure confidentiality?

1. The providers should not disclose the case history to anyone outside the facility. The verbal communication and the written records should remain within the professional boundaries of the facilities and should not be discussed outside.
2. All the support staff should be trained in maintaining the confidentiality norms and protocols.

What additional steps could the doctor have taken?

1. The doctor could have accepted Rubina's decision to terminate the pregnancy as she is not doing anything illegal. She is an adult and her independent decision is the only prerequisite to provide the services. The doctor is bound to provide her services by maintaining privacy and confidentiality as per her request.
2. The doctor can provide quality abortion services using methods in accordance with the MoHFW¹⁴ guidelines.
3. The doctor can ensure that the nurses and support staff are trained in your facility on following protocols and maintaining rights including right to privacy and confidentiality of the clients. They must follow ethical practice and be duty-bound to maintain confidentiality in such cases.

Young Woman and Menstrual Health Issues

Case Study 5: Hema's Search to Get Answer for Her Menstrual Cycle

Hema is 16 years old. It has been 2 years since she started menstruating. Her menstrual cycle is not very regular. Her cycle is disturbed and she bleeds every 1.5 to 2 months.



¹⁴ Ministry of Health and Family Welfare. *Comprehensive Abortion Care: Training and Service Delivery Guidelines*. New Delhi, India: MOHFW; 2010.

Sometimes the bleeding is only for 2 days and sometimes there is spotting for 7-8 days. When she tells this to her mother, she says that it is very common and it will get regular. However, she continues to feel worried and decides to visit the female doctor in the PHC with her elder sister.

The doctor asks her about her menstrual cycle, prescribes a medicine and tells her to visit again after her next cycle. When Hema asked the doctor why her cycle was disturbed, the doctor also says that it is very common and there is nothing to worry about. The session lasted only for 2 minutes.

Hema was not satisfied with the response as she didn't understand the reason for her irregular cycle and how the medication would regularise her cycle. She however, decides to take the medication prescribed and make the visit next month.

Important Observations from the Case

1. Hema feels worried about irregular menstrual flow and when she communicates it to her mother, she does not receive a satisfactory response.
2. Hema convinces her sister to visit the doctor. The doctor gives only 2 minutes of time to her, prescribes medicine and schedules a follow-up visit.

What did the doctor do right?

1. The doctor took a note of Hema's irregular menstrual cycle.
2. The doctor prescribes a medicine and suggests a follow-up visit.

What was not right and what additional steps could the doctor have taken?

1. The doctor rushed the consultation and did not properly counsel Hema. She did not understand what concerns Hema had, and did not provide an answer to Hema's question about why she was having an irregular cycle. Based on Hema's existing knowledge, the provider could also have counseled her on hormonal changes, physiology of menstruation, and nutritious diet.
2. The doctor could have encouraged the client to ask questions. As young people are curious to ask questions related to their bodies, it is the doctor's duty to ensure that they provide comprehensive information to them.
3. The doctor did not give sufficient counselling on menstrual issues and menstrual hygiene, and she did not ask Hema if she had any further questions. This would have led to Hema being more satisfied with the consultation, and she would have come back for follow-up visits.

Enabling Young People to Decide About Services

Case Study 6: Who's Right to Decide?

Aradhana is 25 years old and lives with her husband and father-in-law in Gwalior. Aradhana and her husband have completed one year of marriage. Aradhana works in a bank and enjoys her work. Last month Aradhana missed her period and when she did a pregnancy test at home, the result was positive.

As it was an unwanted pregnancy, she feels that she is not prepared for it yet and wants to focus on her professional life. Aradhana visits a female doctor in a private clinic. She is accompanied by a colleague. She tells the doctor that undertook a pregnancy test and feels unprepared for it.

The doctor repeated the pregnancy test, and found it as positive. The doctor congratulates her for her first pregnancy. Aradhana explains to her that she is not ready yet. The doctor tries to cheer her up and says that she should think of her family's happiness also. If she aborts her pregnancy, she may not be able to conceive again and become a mother. She tells Aradhana that it is better not to have this abortion, and if she still wants, she should come back with her husband for his consent.

Important Observations from the Case

1. Aradhana is certain about her decision to not have a child from this pregnancy. Since she visits the facility with her friend, she has her friend's support.
2. The doctor believes that since this is Aradhana's first pregnancy, she should continue it. In the counseling, she says that if Aradhana aborts, she may not be able to get pregnant again.

What did the doctor do right?

1. The doctor undertook Aradhana's pregnancy test immediately.
2. The doctor's attitude towards Aradhana was respectful and she listened to her concern.

What did the doctor not do right?

1. The doctor forced/ coerced Aradhana to involve her husband.
 - According to the Medical Termination of Pregnancy (MTP) Act, it is Aradhana's legal right to get safe abortion as per her decision. It is a pregnant woman's independent decision to terminate the pregnancy. Service providers must acknowledge her decision and provide the services accordingly. It is the service provider's duty to support her in this and abide by the principle of Justice.

- **Should the doctor be concerned about what the family would like or respect Aradhana's decision?**

Neither the doctor, nor Aradhana are under no legal obligation to consult her husband or family members for termination of pregnancy if she does not wish to. The provider may counsel her husband if needed, but only after seeking her consent. It is the woman's right to decide whether to continue the pregnancy or undergo termination of a pregnancy and make a choice on the abortion procedure she wants to undergo and postabortion contraception she wants to use.

2. The doctor provided inaccurate information.

- **It is incorrect to say that if a pregnancy is aborted, a woman will not get pregnant again. If the abortion is provided hygienically using saf technique, there are almost no chances of woman developing infertility.**

It is a common myth that abortion leads to infertility. Research has shown that it is unsafe abortion that may lead to developing an infection and an infection can cause tubal infertility. If abortion is done using safe technique (medical abortion or manual vacuum aspiration), and by a skilled provider, it cannot lead to infertility. It is mandatory for the doctors to have accurate information and not propagate myths. For comprehensive pre-abortion counselling, MoHFW guidelines can be followed.¹⁵

What additional steps could the doctor have taken?

1. Without any delay, the doctor could have acknowledged Aradhana's decision and affirmed her right by starting with counselling on the procedure.
2. The doctor could have provided her proper counselling and help her decide whether she wanted to continue or terminate the pregnancy, and based on that, if Aradhana decided to terminate, the doctor should have helped her access comprehensive abortion care services.

Key messages

1. For a client above 18 years, she is entitled to take her independent decision to abort. The MTP Act affirms the same. The doctor should not insist on consent from a parent or guardian or spouse.
2. Safe abortion does not lead to infertility. The doctors should refrain from propagating this myth.
3. The service provider should enable a client to access comprehensive abortion care (CAC) services, if they chose to do so.

¹⁵ https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/CAC_Training_and_Service_Delivery_Guideline.pdf

Adolescents And SRH Issues

Case Study 7: Experiencing Nightfall

Sohail is 14 years old. He lives in a town in Jhansi. He and his friends come back from school together in the afternoon. One day Sohail tells his friends that he has been waking up in the morning with wet underwear. He sometimes also feels pressure in his penis and the urge to rub his penis. Two of his friends begin to make fun of him and start saying, “you have grown up.” Sohail is confused and does not get an answer to his question. He feels disgusted and thinks that something is wrong with him. One day Sohail secretly asks one of his other friends to visit a doctor with him. They had heard about a counselor in CHC and decided to make a visit there. He meets the male counselor there. Privacy was maintained during the consultation. He tells Sohail that what he is having is wet dreams. It is a very normal phenomenon and that the white fluid is semen which gets discharged from his body. When Sohail asks the counselor why this is happening, the counselor says that this is because he watches adult films. If he avoids watching adult films, he will not get wet dreams. Sohail feels shy to ask anything further and returns back.

Important Observations from the Case

1. Sohail is having wet dreams and he feels confused, curious as well as disgusted with it. Even when he attempts to confide in his friends, they do not provide him the correct information.
2. Sohail manages to visit the counselor in CHC with a friend and the counselor explains to him that there is nothing wrong with his body. However, the provider’s suggestion of avoiding watching adult films did not encourage Sohail to ask any further questions.

What did the counselor do right?

1. The counselor maintained the privacy norms during the consultation.
2. The counselor explained to Sohail that having wet dreams is normal which makes him feel relaxed.
3. The counselor also provides him with correct information about the white fluid (semen) which encourages Sohail to ask the next question.

What did the counselor not do right?

1. The counselor provided inaccurate information.

It is a myth that pornographic films cause wet dreams. The provider should ensure that they have accurate information so that they do not end up propagating myths. The fact about wet dreams is that it is common for adolescent boys to have wet dreams

as they grow up. This happens because sometimes semen comes out of the body at night, during sleep. It is also called Nocturnal Emission, or Night Fall. Nocturnal Emission is not necessarily accompanied by sexual feelings or sexual dreams. These start happening around puberty and some boys get quite embarrassed or frightened by this. Masturbation leads to a reduction of nocturnal emission. Nocturnal Emission is a normal occurrence.

2. **Wet dreams are not signs of an illness and do not lead to weakness.** Because semen is produced continuously in the body, it does not lead to exhaustion of semen. Semen cannot be stored in the body at the rate at which it is produced and therefore, it comes out of the body involuntarily during sleep in puberty.

What additional steps could the counselor have taken?

1. The counselor should have provided comprehensive information and created a safe space to tell him about masturbation.
2. The counsellor should have taken verbal feedback to ensure that all his questions were answered and he had an overall positive experience.

Adolescents and Body Image Issues

Case Study 8: Arshi Goes for Counselling for Experiencing Bullying

Arshi is 17 years old and studies in a co-ed private school in Bhopal. She is an average performing student in her class. Since a few years, she has become very conscious of her body. Everyone in her class teases her for having big breasts. She feels embarrassed and uncomfortable in sharing this with anyone.

Arshi begins to limit herself from making friends also. She remains aloof and finds it hard to concentrate in class. One day, a school teacher discovers that the students have been bullying her. The school teacher requests her to bring her mother to school.

The school teacher informs her mother that the students have been teasing her because of her breast size. She tells her mother to take her to a doctor. Arshi develops extreme fear after witnessing this conversation between them. She begins to blame



herself for the situation, resulting in poor mental health. Following her teacher's advice, her mother takes her to a female doctor in a government paediatric hospital.

The doctor gives 2 minutes of time attentively. Her mother is there with her throughout the session. She explains to her mother that there is nothing wrong with her, it's completely normal to experience an increase in the breast size during adolescence. The doctor tells Arshi a few exercises that can help in reducing the breast size. Arshi returns back home with intensified pressure of reducing her breast size.



Important Observations from the Case

1. Arshi is being bullied and body shamed by her peers because her breast size is increasing. Due to shame attached to women's breasts in society, Arshi is unable to confide in anyone to discuss her problem and feels the pressure of reducing the breast size. The medical service provider attempts to normalise the increase in breast size as part of the development stage.
2. Arshi's mother and school teacher show concern for her but their intervention does not improve Arshi's mental health situation and she feels the pressure of reducing the breast size.

What did the provider do right?

1. During the session, the doctor communicates that it is normal to have big breasts.
2. The provider is attentive during the session.

What did the doctor not do right?

1. The doctor missed the opportunity to have a private and confidential discussion with Arshi in her mother's absence. **If the doctor had maintained privacy, it probably would have helped the doctor in getting a comprehensive understanding of Arshi's mental health needs.**

2. The doctor did not probe to understand any signs of deteriorating mental health. The doctor must ask probing questions in the session. For example, “How do you feel now that you are in adolescence and your body is going through physical changes?”, “what makes you uncomfortable if your breast size is increasing?”, “has anyone ever teased you for it?”, “have you confided into anyone when you were teased?” Many experiences related to bodily changes and bullying impact mental and emotional wellbeing of a person. Unlike physical health, mental health symptoms are not always visible. Being attentive to issues of overall mental health and wellbeing of the young people can help providers in identifying the symptoms.

The doctor can refer the clients to the correct department for mental health screening tests, if they are not trained in undertaking screening tests and providing therapy or medication. Non-specialists should remember that prolonged experiences of harassment and bullying are drivers of adverse mental health outcomes and impact the overall wellbeing of a person with symptoms that manifest in various forms for example, lower self-confidence, feeling lonely, aloof and depressed.

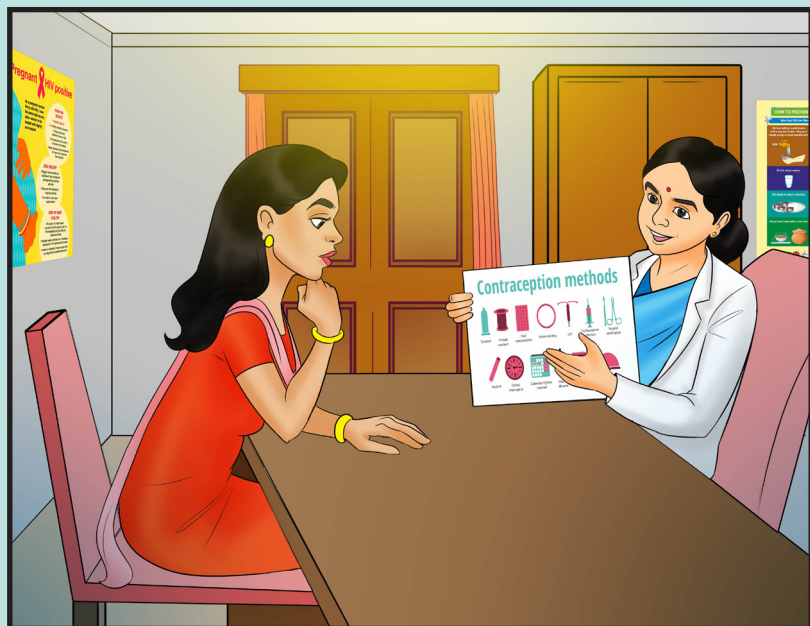
3. The doctor did not help Arshi understand the biological factors responsible for the increase in breast size. **The doctor could have provided information about the size of breasts, she should have told that** Estrogen and progesterone hormones are primarily responsible for the development of breasts. This information about hormonal changes during adolescence would also have helped Arshi understand her body better.
4. **Doctor did not provide enough time to Arshi.** She was given only 2 minutes of time. Arshi also does not feel better after the session. It is important to ensure that the provider provides enough time to the client and take feedback at the end of the session.

Right Age for Women to Have Autonomy

Case Study 9: Affirming Kajal's Autonomy

Kajal is a 24-year-old woman working as a clerk in the Indian Railways. She has been married for 2 years and her husband travels frequently on the job. She is not interested in having children any time soon. So Kajal visits the nearby PHC for contraceptive counselling.

There she is directed to a separate room where the ANM greets her and closes the door behind the client.



The ANM then asks Kajal how she can help her. Kajal gives the ANM details about her background and informs her that she is seeking contraceptive counselling. The ANM points out that Kajal is already 24, and that the longer Kajal waits, she is bound to develop complications during child-birth. The ANM asks Kajal why she doesn't want to have any children. Kajal explains that she and her husband have decided that they would like to focus on their respective careers and think about having children only when their financial situation improves.

The ANM advises Kajal that 25 is an ideal age for first delivery, and that by 30 a woman's reproductive capabilities begin to decline. Kajal looks worried but continues to ask for contraceptive counselling. Thus, the ANM gives Kajal information about condoms, emergency contraception and non-hormonal oral contraceptive pills (Centchroman) but also asks Kajal to consider not delaying her pregnancy further.

Important Observations from the Case

1. Kajal is clear that she does not want to have children any time soon.
2. The provider's repeated warnings and her provision of only short acting contraception is indicative of provider bias.

What did the provider do right?

The ANM upheld Kajal's **privacy** by closing the door behind her so that Kajal could comfortably share all details assured of **confidentiality**.

What information should the ANM provide on the right time to have a child?

1. There is no fixed or right age to have a child. It depends on when the couple is ready to plan and become parents. Economic factors, professional careers, individual preference are some of the factors that are important for family planning.
2. Biologically, each woman's individual's body and sexual and reproductive fertility is unique and different from another individual's. Women are able to have children from post-menarche through their menopause. As long as women are ovulating, they can conceive and have a child unless they have been diagnosed with a condition.
3. Moreover, a woman's fertility is not the only factor responsible for pregnancy. Sperm count of the male partner is also a factor.
4. Not all women desire to become mothers. If a woman does not want to have children, her right should be respected by the service providers and she should be provided contraceptives to manage her fertility.

Do you think that the ANM respected Kajal's autonomy?

By propagating inaccurate and highly generalised information on women's age of fertility, the ANM is placing unwarranted pressure on the client to influence her decision around pregnancy and childbirth, not respecting that Kajal was financially unprepared to bear a child. If Kajal, threatened by the potential decline of ability to conceive and her fertility were to bear a child, she may be unable to access the resources necessary to support the health, growth and well-being of the child leading to adverse health outcomes of the newborn. Thus, the ANM is violating Kajal's right to make autonomous choice to delay child birth, as well as not acting in the best interest of the client.

How can the ANM provide the method of contraception according to Kajal's need?

The ANM should have asked if and when she wants to have children in future? Depending on her short-term/ long-term need, the ANM should have provided comprehensive information on long-acting and reversible contraceptives like condoms, emergency contraception, different types of oral contraception, injectables, IUCDs etc. and left it to the client to make a decision as to which contraceptive would best respond to her needs. Instead of withholding comprehensive information on the full range of contraception including emergency contraception, the ANM has limited the client's choice, and invading their autonomy.

Discussion on Masturbation

Case Study 10: Samar's Privacy is Paramount

Samar is 16 years old and masturbates regularly. When he reveals this to close friends, they tell him that masturbating will lead to decline in his 'masculinity' (*mardaangi*).

Samar is anxious and approaches the PHC. At the OPD, he is directed to the nurse in charge of providing youth friendly health services. Samar walks into a large room where two nurses are seated. He walks up to one of them, and she asks him to draw a curtain that separates her from the adjacent provider, and then asks him to tell her what the issue is. Samar is conscious because there are many clients, old and young, are within earshot and consulting other doctors simultaneously. So Samar tells her that he is undergoing a lot of pressure and stress. The nurse asks him what the reason behind the stress is. Samar says in a low tone, 'exams and friends'.

The nurse counsels Samar on peer pressure and advises him that he should feel no compulsion to do anything that he is not comfortable with. She asks him if there is anything in particular that his friends have been taunting him about. Samar says that his friends make fun of him saying that he touches his 'private parts'. The nurse immediately warns Samar that it is easy to get addicted to masturbation and hands Samar a prescription for a muscle relaxant and asks him to leave.

Important Observations from the Case

1. Samar is hesitant and ashamed to talk openly about his actual concern - masturbation.
2. The nurse is not the same sex as Samar, and this could further prevent Samar from talking about masturbation.
3. Samar fears judgment from both the nurse, as well as the clients within earshot.

What did the nurse do right?

The nurse counselled Samar on peer pressure and reassured him that he need not do anything that he is not comfortable doing.

Do you think Samar received the information he was looking for? Do you think Samar will ever consult the nurse again?

No, Samar did not receive comprehensive and non-judgemental counselling on safe sexual health practices for the following reasons.

1. *The first and foremost duty of providers is to promote SRH health seeking behaviours by normalising all SRH concerns including sexual health related concerns.*

As mentioned earlier, SRH seeking behaviours among youth, especially adolescents, is very low. Most clients seeking SRH services are embarrassed to talk about the issue, due to the stigma attached to SRH issues. Hence, in the initial moments, it is common for the client seeking an SRH service to be vague and less descriptive. However, it is the provider's duty to patiently probe and draw out the specific issue that the client seeks to redress. In Samar's case, the nurse demonstrates both judgment and discomfort by hurriedly prescribing a muscle-relaxant upon learning that Samar was seeking information on masturbation'.

2. *Providers themselves must be equipped with evidence-based knowledge on sexual health and reproductive health issues, and must be comfortable with facilitating honest and open dialogue on the full range of SRH issues including sexual health concerns such as masturbation and STIs.*

Masturbation is not addictive unless and until one becomes dependent on it for deriving stress relief. However, one does not masturbate only to relieve themselves from stress. Masturbation is more commonly, a healthy and safe way for all youth to derive pleasure, as well as explore their sexuality. In this case, the provider neither probes into the cause or frequency of masturbation. Instead, provider bias and stigma leads to the transaction of misinformation and false panic. Masturbation is a healthy and safe way for all youth to explore their sexuality and derive pleasure, as long as it is undertaken

- in private, or
- in front of a partner, after having obtained their consent.
- does not replace healthier coping mechanisms for stress management

As providers, it is important to normalise sexual health and provide evidence-based information towards promoting the health and well-being of youth.

Consent for Medical Examination

Case Study 11: Sharon can Consent to a Medical Examination

Sharon is a 15-year-old girl who has been sexually abused by her father 3 days ago. Sharon's mother and aunt are refusing to believe Sharon, and are saying that incident may have occurred in her dreams. Confused and scared, Sharon confides to a teacher from school, who in keeping with the POCSO Act of 2012, reports the incident to the nearby police station as well as accompanies Sharon to the district hospital, for a medical examination.

Sharon and the teacher are directed to the CHC where a male doctor invites them to his cabin. He shuts the door, asks them to take a seat and enquires as to what the problem is. Sharon sits in silence and does not speak. The teacher explains to the doctor the details regarding Sharon's case, and requests the doctor to undertake a thorough medical examination.

The doctor says that medical examination cannot be undertaken without obtaining the consent of Sharon's natural guardian, her mother. He asks Sharon to return with her mother.

Important Observations from the Case

1. Medical examination presents a critical opportunity to treat the client in case of sustained cuts, bruises, infections and/or injuries. It is also an opportunity to gather evidence of sexual assault.
2. Neither Sharon's mother nor aunt are ready to believe Sharon or support her. Thus they are unlikely to accompany her to the hospital.
3. Sharon is at risk of being dissuaded or emotionally manipulated by her mother and aunt, once she returns home. This could result in her medical examination being delayed indefinitely, which is a setback to securing her health, wellbeing and Rights.

What did the service provider do right?

The provider ensures Sharon's privacy by counselling her in a separate room and ensuring that there was visual and auditory privacy. She ensured that the door is shut and that another trusted female (her teacher) is with her.

Did the service provider adhere to the guidelines of the POCSO Act of 2012?

No, the provider did not provide appropriate services.

As per the POCSO Act of 2012¹⁶, a female victim of Child Sexual Abuse can only be examined by a female service provider. Therefore, the provider should have referred this case to a qualified female colleague.

As per the guidelines, the provider should obtain the informed consent of the survivor between the ages of 12 and 18 and no one else. The guidelines have been drafted to privilege the *autonomy of the survivor* over paternalistic agency of the provider/parent/guardian. Therefore, both ethically and legally, important things to remember while taking informed consent are as follows:

- Sharon's consent must be sought at each and every stage:
 - Before undertaking the medical examination, before collection of sample for medical/forensic evaluation and
 - Before filing a medico-legal case and providing information to the police.
- If the medical procedure or modalities use too much technical language, then it must be revised to a language that the survivor/victim understands and must incorporate comprehensive explanation of procedure of examination, evidence collection from body/genitals and treatment modalities.

What is the role of the providers in case client reports consensual sexual activity before the age of 18?

If the provider gets a client who reports to have had consensual sexual activity before 18 and needs abortion or HIV testing, the provider must ensure taking the following steps:

1. The provider cannot deny services and must focus on provision of services.
2. The provider is mandated to file a medico-legal case as per the POCSO Act, even if it is consensual sexual activity. The law fails to respect the sexual autonomy of young people by having the mandatory reporting clause because the reporting results in compromising their confidentiality. Since it is a huge legal barrier, the role of providers becomes more crucial here to protect the sexual autonomy of young people. The **providers can support the client by** building their own network with human rights lawyers and activists who are trained in providing legal and emotional support in such cases. The providers can put the client in touch with the trained lawyers and activists, be non-judgemental towards the client and remember the clause of 'doing no harm'.

¹⁶ <https://wcd.nic.in/sites/default/files/POCSO%20Act%2C%202012.pdf>

Young Woman And Postpartum Contraception

Case Study 12: What's the Client's Need!

Sahiba is a 27-year-old mother of 1 male child and is currently 8 months pregnant. She is visiting the PHC for her antenatal check up, and is directed to an ANM. Once the ANM concludes Sahiba's physical examination, the ANM encourages Sahiba to start thinking about postpartum contraception by explaining the health benefits of postpartum contraception. Sahiba asks the ANM about the contraceptive options that would be available to her

The ANM gives Sahiba comprehensive information on the health benefits and procedure of insertion of PPIUCD. Sahiba is reluctant and says that she would prefer to try some short-term options. The ANM again warns Sahiba that since she would have just given birth to a child and that she would have to ensure at least 2-3 years of gap so that her own health can be restored.

She even emphasises that the PPIUCD is immediately reversible and does not impede lactation. Sahiba is still hesitant to choose the PPIUCD, as she is scared of inserting something in her uterus, and asks the ANM for information regarding some other short acting options. The ANM says, "Why? Are you thinking of bringing more children into this world? Aren't 2 enough?" Then, she once again emphasises that the PPIUCD is the best and safest postpartum method, and urges Sahiba to think about it. She also assures Sahiba that her mother-in-law will never find out about the PPIUCD insertion.

Important Observations from the Case

1. The woman is clearly uncomfortable with the IUD option and is repeatedly asking the provider for other options.
2. The ANM is ignoring the woman's discomfort and promoting a single contraceptive option, thereby violating the principles of autonomy and truthfulness.

What did the ANM do right?

1. The ANM initiated an important discussion around postpartum contraception with Sahiba, thereby enabling Sahiba to think about the same.
2. The provider gave comprehensive information on PPIUCD to Sahiba.
3. The provider informed Sahiba about the importance of spacing in between child birth.

What did the ANM not do right?

1. The ANM did not offer the different contraceptive options to Sahiba and straight away suggested PPIUCD.
2. The ANM breached Sahiba's autonomy. She urged Sahiba to choose PPIUCD without telling her about other contraceptive choices.
3. The ANM did not provide full counselling and the need for postpartum contraception to woman, e.g. the risk of fertility is as early as 4 weeks after delivery, and that the LAM is 98% effective if exclusive breastfeeding is used and all other conditions are fulfilled.
4. Even if the client chooses to bear a third child, the provider cannot humiliate the woman for it. The ANM's accusatory and judgmental tone is a form of obstetric violence and will directly lead to client withdrawal. Sahiba may not return for antenatal check-ups, or withdraw from contraceptive services altogether.

What are the different contraceptive choices the ANM could have told her about?

National Family Planning Program offers a wide range of reversible contraceptives for postpartum period, e.g. (a) Centchroman (Chhayaa), (b) Injectable contraceptive MPA or Antara (can be taken 6 weeks after delivery), (c) Condoms (male partner), (d) Lactational amenorrhea method, or LAM, and (e) PPIUCD. Some women may want to start an IUD after 6 weeks of delivery. Many women may not be willing to have PPIUCD inserted at the time of delivery and may instead want to use one of the other methods. The ANM should have told her about all these choices of letting woman decide what she wanted, instead of assuming what was in her interest.

Young People and Need for HIV Counseling, Testing and Treatment

Case Study 13: Sunil's Entitlement to Treatment

Sunil is 19 years old, unmarried young boy and lives in a village. He is studying in college. He volunteers his time at an NGO where he educates people on safe sex and HIV prevention.



Sunil visits the male service provider once for his HIV testing. The service provider inquires “why do you need HIV testing?” Sunil says that he had had unprotected sex with his partner a few days ago. The service provider further asks if he is married to his partner. Sunil says that he has a male partner and they are not married. The service provider in a polite manner responds “Sunil, how do you have sex with a man? I want to know”.

Sunil gets embarrassed and asks if he can get his test done. The provider then responds, “Sunil, I want to talk to you as my own child. I’m telling you so that you can learn early in life and develop interest for girls. If someone gets to know about it, it will bring shame to your family. And your families will be ostracized from society.” After saying this, the provider gets him tested and tells him to visit again the next day to collect the report.

Important Observations from the Case

1. Sunil is a confident and affirmative young boy who visited independently to seek HIV testing services.
2. In the initial part of the session, the service provider assumed that Sunil is in a heterosexual relationship. Whereas, Sunil responded affirmatively and disclosed his same-sex sexual relationship. The service provider invaded his privacy by asking how he has sex with a man. Even though the provider used a polite tone in the counseling session but also advised him to develop interest in girls.

What did the provider do right?

1. The provider addressed Sunil by his name in an attempt to build trust.
2. The provider provided HIV testing services to him and attempted to take his sexual history.

What did the provider not do right?

1. The provider asked the client why they needed a sexual health service. It is the right of a young person to access sexual health services, and the reason for HIV testing is not important to receive the services.
2. The provider asked the marital status of the client. This was perhaps to understand the sexual history of the client.

Is it necessary to ask the marital status from all the clients?

1. Can the provider instead ask if they are sexually active or not? Unmarried youth who are sexually active feel uncomfortable in disclosing their sexual history. Marital status

should not be a qualifier to receive the services and the providers should ask the sexual history of the client with a non-judgmental tone and empathetic body language.

2. The provider communicated the societal value judgment to Sunil on his relationship with a man. The service provider did not treat Sunil as an individual who can make decisions for himself or feel attracted to men.

What should the provider do if a client disclosed that they are gay?

1. They should understand that people have diverse sexual desires and sexual practices. Not everyone in our society feels attracted to people of opposite sex. It is highly recommended that they do not advise clients to feel attraction towards opposite sex as it is against the principle of rights-based access to healthcare.
2. The provider can affirm the client's right to choice. If the client discloses that they are gay or lesbian, tell them that there is nothing wrong in it. They should acknowledge the courage it took to disclose this information.
3. Provider should counsel them on the need for having some tests regularly such as VDRL, HIV and other tests if needed.
4. They should reassure the clients that they would protect their confidentiality.

How should providers ask about the sexual history?

1. The provider can begin by telling the client that to provide them good care, they need to know the sexual history. Ask politely "Can I know if you are sexually active?" Further probes can be, "do you have a male partner/ female partner?", "do you use protection while having sex?", "when did you last have unprotected sex?"

What additional steps could the provider have taken?

1. The provider could have done sexual health counseling with comfort, ease and calmness. Sexual health counseling includes discussion on safe and unsafe sexual practices. The provider should be comfortable in talking about anal sex and multiple other sexual practices. Condom use in anal sex is an important part of the safe sex counseling that can be stressed upon.
2. Young clients can be extremely scared and in a vulnerable situation if they have had unsafe sex, it is important to make them feel comfortable during the session.

4. Clarifying Myths And Misconceptions

In this section prevailing myths and misconceptions among adolescents and young people are discussed. It is important that service providers should address the myths on SRH issues prevalent among this population group. They should not ridicule clients while probing the myths and misconceptions, instead they should have a nonjudgmental attitude, should discuss the views and questions of clients and should dispel them through evidences or scientific explanations.

MYTH	CLARIFICATION
<p>1. Giving unmarried and/or minor youth information regarding sexual intercourse and contraception will encourage sexual activity and risk taking behaviour among youth.</p>	<p>On an average, adolescent development begins right from the age of 10, young people begin to enter into puberty and experience physical, mental and emotional transformation. Between the ages of 10 and 15, adolescents experience menarche or their first nightfall, and around the same time it is commonplace for them to begin to experience pressure of getting married.</p> <p>At this critical juncture, their lack of knowledge when combined with their diminished personal autonomy renders them vulnerable to sexual exploitation and adverse SRH outcomes. To deny them relevant information on SRH is to deny their diverse needs and realities. Thus, it is imperative for adolescents and youth to have access to evidence based and medically accurate information around their bodies and sexuality, so that they are equipped to take informed decisions that safeguard their health and wellbeing.¹⁷</p>
<p>2. Regular use of emergency contraception is harmful to health.</p>	<p>Emergency contraceptive pills are not dangerous to a woman's health and have no known serious medical complications. There is no evidence that if a woman uses ECPs multiple times, it causes any health risks. They can cause minor side effects, such as menstrual irregularities and nausea, which typically last only a short time. This is because the dose of hormone is very small, and there is only one dose involved. These effects are not medically harmful.</p> <p>Women should feel free to use the emergency contraceptive pill whenever they think it's necessary¹⁸. Each woman should decide for herself whether they are acceptable for her¹⁹.</p>

¹⁷ https://www.euro.who.int/__data/assets/pdf_file/0008/379043/Sexuality_education_Policy_brief_No_1.pdf

¹⁸ <https://www.cecinfo.org/icec-publications/repeated-use-emergency-contraceptive-pills-facts/>

¹⁹ <https://www.cecinfo.org/wp-content/uploads/2015/01/Repeat-Use-Fact-Sheet-for-distribution-Nov-2.pdf>

MYTH	CLARIFICATION
<p>3. Giving women ECPs in advance (before they need them) will discourage them to use regular contraceptive use.</p>	<p>No, giving ECPs in advance does not discourage regular contraceptive use, and it is essential so that women can start ECP as early as possible, but definitely within 72 hours of unprotected intercourse. Studies of women given ECPs in advance report these findings²⁰:</p> <ul style="list-style-type: none"> • Women who had ECPs on hand took them sooner after having unprotected sex than women who had to seek out ECPs. Progestin-only ECPs are more likely to be effective when taken sooner. • Women given ECPs ahead of time were more likely to use them when needed than women who had to go to a provider to get ECPs. • Women continued to use other contraceptive methods as they did before obtaining ECPs in advance. • Women did not have unprotected sex more often. <p>Additionally, ECPs help a woman avoid pregnancy after:</p> <ul style="list-style-type: none"> • Any unprotected sex, including sexual coercion and rape and • Mistakes or failures in using contraception, such as: <ul style="list-style-type: none"> • Condom was used incorrectly, slipped, or broke, • Centchroman missed by > 7 days • Woman has missed her MPA injection by more than 4 weeks after scheduled date and has unprotected sex • Fertility awareness method not used correctly (failed to abstain or use another method during fertile days), • Man failed to withdraw before ejaculation, • Woman had unprotected sex after missing 3 or more combined oral contraceptive pills or after starting a new pill pack 3 or more days late, • IUD has come out
<p>4. If a woman wants to buy ECPs, she needs a prescription from the doctor.</p>	<p>Taking ECPs is simple, and medical supervision is not needed. The label and instructions are easy to understand. In India, ECPs are approved for over-the-counter sales by chemists without a prescription.</p>

²⁰ <https://www.fphandbook.org/questions-and-answers-about-emergency-contraceptive-pills>

MYTH	CLARIFICATION
<p>5. The ECP is not recommended as a regular form of contraception because it's not as effective at preventing pregnancy as regular contraceptives.</p>	<ul style="list-style-type: none"> • On average, LNG ECPs reduce pregnancy by 59 to 95% for each individual act of intercourse; UPA ECPs reduce pregnancy by 85% and have been found to be comparatively more effective than LNG. The precise efficacy of ECPs depends mostly on the woman's cycle day when ECPs are taken and how soon they are taken after unprotected sex. There is no evidence to suggest that ECPs become less effective when used repeatedly. Repeat use of ECPs is classified as Level 1 in the World Health Organization's Medical Eligibility Criteria.²¹ • Moreover, although ECP can be used more than once in the same cycle, women who need continuous protection should be advised to use a regular contraceptive method since ECPs are not as effective as regular contraceptive methods.
<p>6. Easy availability of emergency contraception will encourage irresponsible sexual activity.</p>	<ul style="list-style-type: none"> • Emergency contraception plays an undeniably important role in the following scenarios: <ul style="list-style-type: none"> • When one is unable to negotiate safe and protected sex • In case of contraceptive failure. • When one has limited or no access to other contraceptive options. <p>Remember, it can be upto 95% effective if used within 24 hours, while its effectiveness declines with time. Therefore, if it is easily available, wide availability and access is essential to advance one's control over their own fertility outcomes. Comprehensive counselling on how emergency contraception does not prevent sexually transmitted infections (STIs) can deter unsafe sexual intercourse.</p> <p>Irresponsible behaviour bears no connection to the availability of a commodity, instead could be a result of lack of accurate information and inappropriate shaping of gender related attitudes.</p>
<p>7. ECPs are not appropriate for adolescents.</p>	<ul style="list-style-type: none"> • ECPS are safe for adolescents. A study of ECP use among girls 13 to 16 years old found it safe, and all of the study participants were able to use ECPs correctly. Also, access to ECPs does not influence sexual behavior^{22,23}.

²¹World Health Organization. Medical Eligibility Criteria for contraceptive use Fifth edition 2015 http://apps.who.int/iris/bitstream/10665/172915/1/WHO_RHR_15.07_eng.pdf

²²Gold MA. Emergency contraception: a second chance at preventing adolescent unintended pregnancy. *Curr. Opin. Pediatr.* 1997 Aug;9(4):300-309.

²³<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1783598/#:~:text=Several%20emergency%20contraceptives%20exist%2C%20including,avoided%20for%20a%20few%20days.>

Adolescents might particularly need ECPs because of high rates of forced sex, stigma about obtaining contraceptives, limited ability to plan for sex, and errors in using contraceptives.

MYTH	CLARIFICATION
<p>8. Spousal consent is essential in matters of contraceptive use by women.</p>	<ul style="list-style-type: none"> • Spousal/partner consent delays and deters a client’s access to contraception. Most importantly, conditional access to contraception is in direct violation of the medical principle of client autonomy that guarantees clients the right to choose whether, when and which (contraceptive method) to uptake. • In many parts of India, a prevalent misconception is that contraception encourages adultery, owing to which males often restrict their female partners or wives from accessing contraception. Similarly, sometimes men avoid using condoms, as they are under the misconception that condoms will diminish their masculinity²⁴. Under such circumstances, if providers insist that woman brings her husband/ partner for consent to use contraception, it will only serve as an additional barrier for a woman’s access to their SRHR.
<p>9. Getting an abortion results in infertility.</p>	<ul style="list-style-type: none"> • If abortion is done using safe technique (medical abortion or manual vacuum aspiration), and by a skilled provider, it cannot lead to infertility. • Induced abortions by using medical abortion (MA) drugs (Tab mifepristone and misoprostol) doesn’t affect future fertility.^{25,26} • Usually a safe surgical method of abortion (such as vacuum aspiration) will not affect future fertility of the woman. However, if proper infection prevention procedures are not observed, there is a very small risk of infertility²⁷ if a woman develops a uterine infection and it is not treated promptly which can spread and lead to pelvic inflammatory disease (PID). • Infact, getting unsafe abortions may lead to developing an infection and the infection may cause tubal infertility. • When surgical abortion is done using D&C technique, very rarely, there can be a risk of uterine scarring due to deep curettage (known as Asherman syndrome), resulting into infertility. However, please note that D&C is not a recommended technique of abortion.

²⁴ Char, A., Saavala, M. & Kulmala, T. Assessing young unmarried men’s access to reproductive health information and services in rural India. BMC Public Health 11, 476 (2011). <https://doi.org/10.1186/1471-2458-11-476>

²⁵ <https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/how-safe-is-the-abortion-pill>

²⁶ <https://www.healthline.com/health/womens-health/can-abortion-cause-infertility>

²⁷ <https://www.nhs.uk/common-health-questions/womens-health/can-having-an-abortion-affect-my-fertility/>

MYTH	CLARIFICATION
<p>10. Aborting is morally incorrect.</p>	<ul style="list-style-type: none"> • The need for abortion can arise at any point in a woman’s reproductive lifespan. It is in difficult circumstances that women decide to abort pregnancy. Reasons for abortion can be the following: <ul style="list-style-type: none"> • Unmet need of contraception resulting in unintended and unwanted pregnancy, • Sexual violence or coercion from partner, • Failure of contraception resulting in unintended and unwanted pregnancy • Lack of autonomy for women to use a contraceptive of their choice • Change in circumstances of a pregnant woman’s life, for example divorce or death of the husband/ partner, • Detected foetal anomaly • Trained service providers should be sensitive to these issues and should not deny providing comprehensive abortion care to women as per MTP Act, since continuation of pregnancy or denial of services can result to adverse health outcomes.
<p>11. Medical abortion method (using the mifepristone and misoprostol pills) is a dangerous method and will result in incomplete abortion.</p>	<ul style="list-style-type: none"> • Medical abortion method has been approved by WHO as a safe, effective and acceptable method of abortion²⁸. The Indian government has approved this method in its national guidelines indicating mifepristone and misoprostol may be provided upto the 63rd day of gestation period.²⁹ It is a non-invasive method of abortion and women can use the pills as per instructions by themselves. <p>The risk of serious complications after medical abortion is extremely low, are very rare - the chances of incomplete abortion needing treatment is only 2-3%³⁰.</p>

²⁸ file:///C:/Users/ki/Downloads/9789241550406-eng%20(1).pdf

²⁹ Ministry of Health and Family Welfare. *Comprehensive Abortion Care: Training and Service Delivery Guidelines*. New Delhi, India: MOHFW; 2010.

³⁰ <https://www.ipas.org/resource/clinical-updates-in-reproductive-health/>

MYTH	CLARIFICATION
<p>12. Being transgender is a mental disorder</p>	<ul style="list-style-type: none"> • Transgenders do not have a mental disorder. Because the mainstream society only recognises two genders, men and women, transgender persons are stigmatised in society. • When a child is born, a doctor typically assigns the sex ‘female’ or ‘male’ on the basis of genitals. However, gender-specific stereotypes related to one’s behaviour traits, roles, responsibilities, clothing and accessories are not inherited, but taught to us by society. Growing up, some people may choose to follow these norms/stereotypes, while others may challenge the same. People around us challenge and break gender norms and stereotypes all the time and gender norms and stereotypes keep changing too. • A transgender person is someone who rejects their gender assigned at birth, and makes a conscious decision to identify with an alternate gender of their choice. Transgender is an umbrella term for people who do not identify with the gender assigned to them at birth. According to the Census of India, 2011 there is a population of 4.9 lakh transgender persons in the country. This was the first Census which included an official counting of transgender people in the country. This counting only included transgender women (assigned gender male at birth) and not, transgender men (assigned gender female at birth). • The Constitution of India guarantees citizens the right to make such decisions around their own bodies (personal autonomy) and expression, and the NALSA Judgment³¹ protects transpersons from discrimination and violence. • In 2020, WHO also removed gender nonconformity (behavior or gender expression by an individual that does not match masculine or feminine gender norms) from the category of “disorder”. • It is important to ensure that the transgender community is not excluded from their access to quality healthcare, education and livelihood opportunities. Discrimination and violence pushes them to margins. It is important to build a society that upholds their right to equality.
<p>13. If any adolescent girl has irregular periods it is a sign of pregnancy</p>	<p>Irregular periods occur due to hormonal changes in the body. It cannot simply be assumed that a late or irregular period is due to pregnancy. Irregular periods are common during adolescence.</p>

³¹ <https://translaw.clpr.org.in/wp-content/uploads/2018/09/Nalsa.pdf>

MYTH	CLARIFICATION
<p>14. The right age for women to have children and complete the family is before thirty.</p>	<ul style="list-style-type: none"> • Some providers believe that women should have children before 30 since their fertility may decline after that age, and to avoid complications. • Biologically the fact is that each woman’s body and fertility is unique and different from another individual’s. Women are able to have children from post-menarche through their menopause. As long as women are ovulating, they can conceive and have a child unless they have been diagnosed with a condition. • It is important to remember that there is no fixed or right age to have a child. It depends on when the couple is ready to plan and become parents. Economic factors, professional careers, individual preference are some of the factors that are important for family planning. • Moreover, a woman’s fertility is not the only factor responsible for pregnancy. Sperm count of the male partner is also a factor. • Not all women desire to become mothers in their twenties. Providers should help individuals and couples to have children when they are ready for it, and should provide contraceptives to manage their fertility. • If a woman does not want to have biological children, her right should be respected by the service providers. Except biological reproduction, adoption and assisted reproductive technology are also methods of having children.
<p>15. If a young woman wears revealing clothes or is friendly with boys, she is inviting abuse/ violence against herself</p>	<p>Several studies have shown that women who wear conservative clothing like salwar-kameez or sarees also experience violence. Clothes are not the reason for sexual violence. It is the patriarchal society and thinking that gives some men the thought that they have the license to abuse women. Therefore, this idea that women invite violence through their clothes needs to be challenged. It is important to stress the need for consent in any sexual relationship rather than blame women.</p>

MYTH	CLARIFICATION
<p>16. Masturbation leads to blindness or impotency</p>	<ul style="list-style-type: none"> • No, masturbation does not lead to blindness or impotency. Neither does it lead to a loss of sperms because they are being regularly produced by the body. • Masturbation is a natural and completely safe and secure method of obtaining sexual pleasure through stimulation of one's own sexual organs. It is nothing to be ashamed about. All of us have sexual needs and this is a common way of fulfilling them. Only if it starts interfering with our day-to-day functioning in any way then a counsellor or medical practitioner may be referred to.
<p>17. A menstruating woman should not cook food or even enter kitchen. As dumping so would spoil food items in the kitchen and anyone consuming them will fall sick.</p>	<p>Entering the kitchen during menstruation will not harm anybody. As long as general hygiene measures are followed, menstruating women can prepare and handle food just like any other day</p>

Annexure 1

Checklist for Medical Officers³²

S.N.	Indicators	Yes	Partially	No
1.	Accessible			
	Appropriate Conduct Showing Respect and Dignity			
	Does the facility have signages showing package of services provided, location, time of services etc.?			
	Does the facility display health material and posters with messages for the youth?			
	Does the provider listen to them without getting the conversation interrupted by mobile or entry of other staff?			
2.	Privacy			
	Are the doors of doors of the OPD/ consultation room shut during consultation?			
	Are more than one clients present in consultation room simultaneously?			
	Is there auditory privacy during the consultation (conversations of one client cannot be heard by others)?			
3.	Confidentiality			
	Does the facility ensure confidentiality regarding both the consultation(s) and medical records?			
	Is all staff (including support staff) aware that matters of one client should not be discussed with anyone else (e.g. other clients, any neighbours, villagers, family members) except facility staff directly involved in the care of client?			
4.	Package of Services [Note: The package may vary depending on the type of facility and the services offered at that level of facility as mandated by the MOHFW.]			
A	Are the following services offered to the youth on-site:			

³² Program Manger or provider himself/herself should administer the checklist for assessment of the youth friendliness of the facility.

S.N.	Indicators	Yes	Partially	No
	Information and counseling on sexuality, safe sex and reproductive health?			
	Does the facility provide the following services?			
	<ul style="list-style-type: none"> At least 5 reversible contraceptive methods 			
	<ul style="list-style-type: none"> STI diagnosis and management? 			
	<ul style="list-style-type: none"> HIV risk screening, counseling and testing (and referral for care)? 			
	<ul style="list-style-type: none"> Pregnancy testing, ante-natal, delivery and post-natal care, 			
	<ul style="list-style-type: none"> Safe abortion services, post-abortion care (PAC), counseling and contraception? 			
	<ul style="list-style-type: none"> Counseling on sexual violence and abuse (and referral for needed services)? 			
5.	Range of FP Methods Offered			
	Are the following FP methods offered? condoms? COCs? injectables? emergency contraception? Other available reversible methods?			
	Does the service provider explain each method with its advantages and disadvantages?			
	Does the facility have regular supply of condoms, OCs and emergency contraception (no stockout of these commodities in last 3 months)?			
	Do the providers offer contraceptives to newly married women and men coming alone, without family members?			
	Do the providers offer contraceptives to unmarried women and men coming alone, without family members?			
6.	Safe Abortion Services			
	Is the facility certified as a MTP centre?			
	Is it displayed outside the facility and in the waiting area that the facility provides safe abortion services?			

S.N.	Indicators	Yes	Partially	No
	Do the providers provide abortion services to a newly married woman without insisting on consent / signatures of a family member?			
	Do the providers provide abortion services without insisting on consent by a family member to unmarried women (above 18 years)?			
	Are women seeking abortion offered a choice between medical and surgical methods?			
	Do providers give abortion services without insisting on specific contraceptives?			
7.	Youth Involvement and feedback			
	Are there mechanisms set to involve the youth in planning and programmes?			
	Do young adults have representation in Rogi Kalyan Smiti?			
	Is there a confidential mechanism for the youth to provide feedback?			
	Is there a feedback box placed where the youth can conveniently drop her/his feedback without any hesitation?			



United Nations Population Fund

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