ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH STATUS IN INDIA:

A SITUATIONAL ANALYSIS

A Capstone project submitted to

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in partial fulfilment of the requirements for

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by

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MPH - Cohort VII (2019-21)

Under the guidance of

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ABSTRACT

Adolescence gives an idea that instigates a thought of conflicting emotions, a body that can be addressed as adult and mind as sensitive as a child. Adolescence is a period of mixed vulnerability to parents, educationists, social scientist, and public health specialists[1].

However, in India, adolescence is a phase that is deeply rooted to cultural associations. While age implies power, knowledge to education and respect, for adolescent girls, hitting puberty means marriage is not far away. Over the years data from National Health and Family Welfare revealed a decline in sex ratio of "939 in 2011 as compared to 961 in 1971 and is projected to decline further to 904 in 2021"[2], but on the other hand, there has been a welcome downward shift in the level of married women in younger age of group of 15-19 years over the past years. Mean age of effective marriage has also gone up to 22.3 years for young males in India over the past years[1][2].

With adolescence, come the common rites of early marriage, teenage pregnancy in countries like India. In phase of getting empowered with knowledge and turn wiser and shine bright in life, question arises; Is a 16 year old girl or a 19 year old boy responsible for their fate because they are married due to social norms? Or are they responsible for their detrimental sexual health because they are victims of sexual violence? Why should sexual health needs of adolescents still be tabooed even in 2020?[1].

If not then how does an adolescent claim his/her personal fate?

Th government thus have realized the vulnerability of this group and have made initiative to empower adolescents about their sexual and reproductive health rights. This study is a situational analysis that refers to the current state of adolescents, based on the indicators and secondary analysis of NFHS 4 data.

ACKNOWLEDGEMENT

I would like to express my deep heartfelt gratitude to ***Prof. Dr Dhirendra Kumar*** *for providing me this golden opportunity to prepare this capstone project.*

I convey my special thanks to ***IIHMR University*** *for enabling me to come in proximity with such an eminent professor who guided me and gave clear idea about the work.*

I would also like to thank my ***parents*** *& my* ***partner****, who despite all hurdles gifted me the opportunity to pursue this degree from an institute of such stature. Last but not least I would like to thank* ***Dr Seema Mehta*** *and* ***Ms. Richa Agarwal*** *for the constant motivation and trigger to complete this project and my* ***friends from MPH cohort 7*** *who helped me stay motivated and complete this project in such trying times.*

Dr Sudipta Ghoshal,

MPH Cohort 7

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By

Dr SUDIPTA GHOSHAL, MPH 7

GUIDED BY- Prof Dr DHIRENDRA KUMAR, IIHMRU

OCTOBER 2020

Dedicated to the vibrant and dynamic adolescent population of India,

~ the future of our country

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ASRH- Adolescent Sexual and Reproductive Health

ASRHS – Adolescent Sexual and Reproductive Health Strategy

ASFR – Age Specific Fertility Rate

AFHC – Adolescent Friendly Health Clinic

DALY – Disability Adjusted Life Years

GBD – Global Health Data

IHME – Institute of Health Metrics

MoHFW – Ministry of Health and Family Welfare

MoHRD – Ministry of Human Resource Development

MHS- Menstrual Hygiene Scheme

NFHS – National Family and Health Survey

NGO – Non-Governmental Organization

PE – Peer Educator/Education

RKSK – Rastriya Kishor Swasthya Karyakram

RPR – Rapid Program Review

SDG - Sustainable Development Goal

SEAR- South East Asia Region

SRH - Sexual and Reproductive Health

SRS – Sample Registration System

STD – Sexually Transmitted Diseases

STI – Sexually Transmitted Infections

UNAIDS – The Joint United Nations Program on HIV and AIDS

UNFPA- The United Nations Populations Fund

WHO – World Health Organization

INTRODUCTION

WHO defines "'Adolescents' as individuals of 10-19 years age and 'Youth' as 15-24 year age and 'Young People' covers the age range of 10-24 years"[3]. Globally more than 1.2 billion are adolescents[3]. This reveals that approximately one in every six persons is an adolescent. About 350 million are adolescents covering about 22 percent of the population in the countries of the South-East Asia Region[3] and 21 percent of Indian population is adolescents (about 253 million) of whom about 72 percent resides in rural India[4][5]. Figure 1 is a visual representation of state wise comparison in percentage change of adolescent population across the decade from 2001 to 2011 in India.

Adolescence is a transitional stage of physical, physiological and psychological development from puberty to lawful adulthood[5]. It is a time of extraordinary cognitive and physical growth and powerful experiences of new-fangled notions, feelings, and ambitions. It is a period of intense learning and progress, but it is also a high-risk period for impulsive behavior and passionate sexual drive[6]. They have individual needs which vary with gender, life circumstances and socio-economic conditions. They encounter difficulties like poverty, lack of access to health care services, and precarious environments[5].

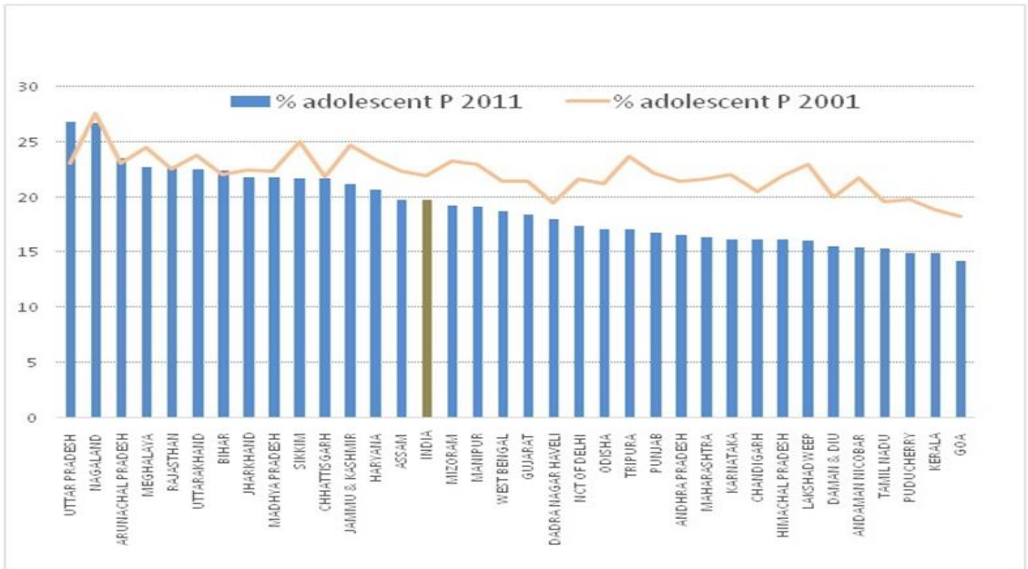

Figure 1: State-wise comparison of distribution for youth population over a decade in India[7].

The figure indicates an increased percentage population of adolescents in states of Uttar Pradesh, Nagaland, Arunachal Pradesh followed by other states with lowest percentage population of adolescents in Goa.

Figure 2 is a visual representation of the Population age structure of India in 2020 from Global Health Data, India.

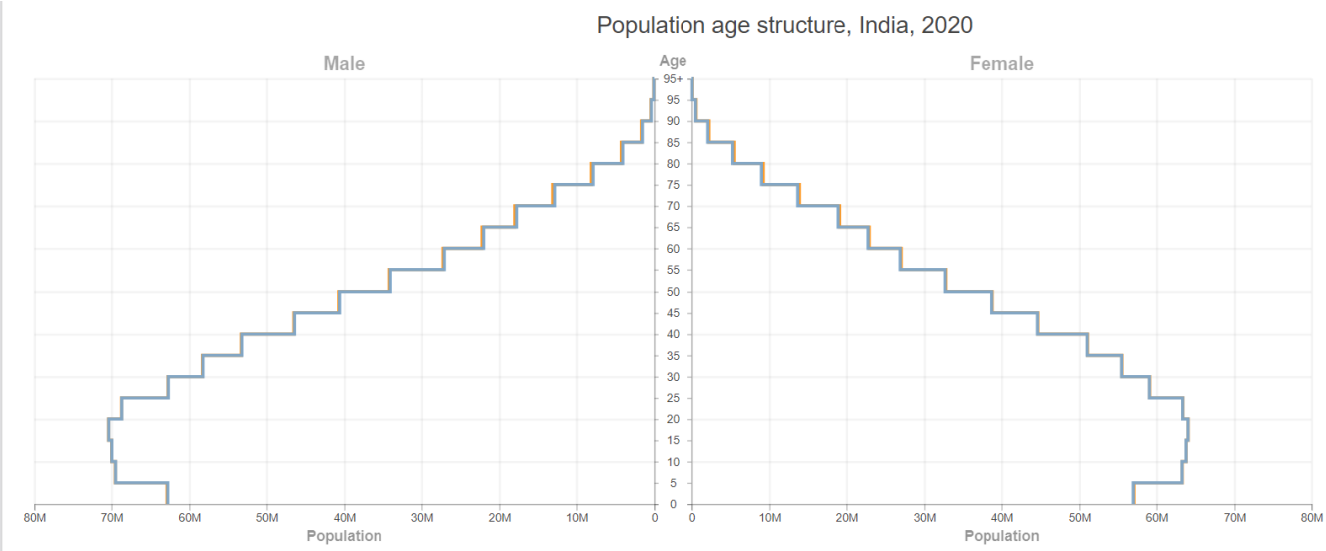

Figure 2: Population age structure pyramid 2020 [8].

The figure reflects the huge amount of young people in India. The broad base of the age pyramid that is gradually moving upwards is a clear indication of the maximum population within 10-25 years of age which is going to turn into the working group population in future. This signifies a demographic window for the Indian economy.

Investing in this change in age structure or more specifically investing in health and well-being of the youth population can turn this demographic window of opportunity into a demographic dividend that might be beneficial for the country's economy.

LITERATURE REVIEW

In India, given the fact that adolescents comprises an enormous segment of the population, policies and programs in India have concentrated very modestly on the adolescent group in spite of a proper and well organized family planning program in India[9]. Albeit the situation of adolescents in India has considerably improved compared to earlier generations. They are healthier, more urbanized, better educated but this is also true that a sizeable percentage of adolescent who experience risky and undesirable sexual activity, do not receive a swift and appropriate care, and face adverse reproductive health outcomes[10].

In recent years, The Government of India along with the policymakers and planners have understood that the adolescents have certain health and age-related demands. There is a growing awareness about adolescence a crucial bridge between childhood and adulthood. Unfortunately, the special requirements of adolescents are seldom referred by the health, educational and family welfare programs in India[9].

AIM

To assess the current situation of sexual and reproductive health among adolescents in India.

OBJECTIVES

1) To study issues related to sexual health among adolescents/youth.

2) To review the policies and schemes focused towards Adolescent Sexual and Reproductive Health Needs (ASRH) and study the gaps in utilization of ASRH services by adolescents in India.

METHODOLOGY

The study is based on secondary data analysis and available reports on the topic. Further, these secondary information from NFHS 4 report and studies conducted by UNFPA,

MoHFW, Statistics from Institute of Health Metrics (IHME) have been reviewed and analyzed to achieve the objectives. Also, various national policies, strategies and initiatives relating to the target population and youth has been considered. We have also discussed on few social determinants that influences Adolescent Sexual and Reproductive Health (ASRH) based on the literature review.

This study has tried to address three research questions:

1) *What do we mean by Adolescent Sexual and Reproductive Health (ASRH) and supporting ASRH rights?*
2) *What is the current situation of Adolescents sexual and reproductive health in India?*
3) *What are the policies and programs initiated by the Government to pay special attention towards adolescent sexual and reproductive health needs?*

ANALYSIS AND DISCUSSION

What we mean by ASRH and supporting ASRH rights?

Defining Sexual and Reproductive health in terms of adolescents, includes dissemination of appropriate knowledge through delivery of education and counselling, on human sexuality and reproductive health[11]. This may include a wide range of cognizance and information about sexual and reproductive health issues vacillating from prevention and management of the consequences of abortion, prevention, care and treatment of STIs, HIV/ AIDS and other reproductive tract infections, Inhibition and surveillance of sexual violence against adolescents as well as care for survivors of violence and other actions[11].

By reinforcing ASRH rights we imply a proper provision of availability to thorough sex education; services to prevent, identify and seek treatment for STIs; and counselling on family planning. It also means empowering adolescents to realize and practice their

rights including the right to delay marriage and the right to refuse unwanted sexual engagements[12].

Addressing Adolescent Sexual and Reproductive Health - a need of the hour

Adolescence is a phase that not only brings physical and bodily changes but also new vulnerabilities regarding mental health that might be due to various causes. One of the most important cause due to a vulnerable state of psychological health is abuses predominantly in the arenas of sexuality, marriage, and reproduction. The increasing numbers of sexual violence each passing day in the country, such as rape on adolescent girls is also clear. Figure 3 is a representation of occurrence of sexual violence among both sexes aged 10-24 years in all states of India measured in terms of DALYs in the year 2019.

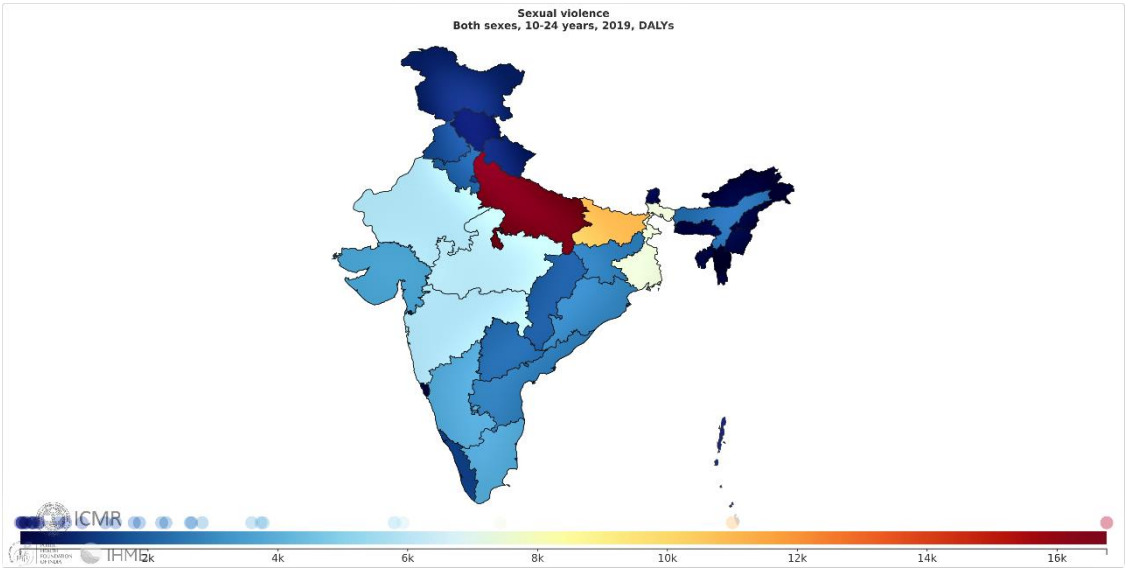

Figure 3: Sexual violence in India, 2019 for age 10-24years both sexes [8].

The figure indicates the highest occurrence of sexual violence in states like Uttar Pradesh, Bihar, West Bengal, Rajasthan. Let us analyze the trends of occurrence of sexual violence over the years in these states.

Figure 4 is a graphical representation of the trends in occurrence of sexual violence cases in all states over the years among 10-24years of age for both sexes.

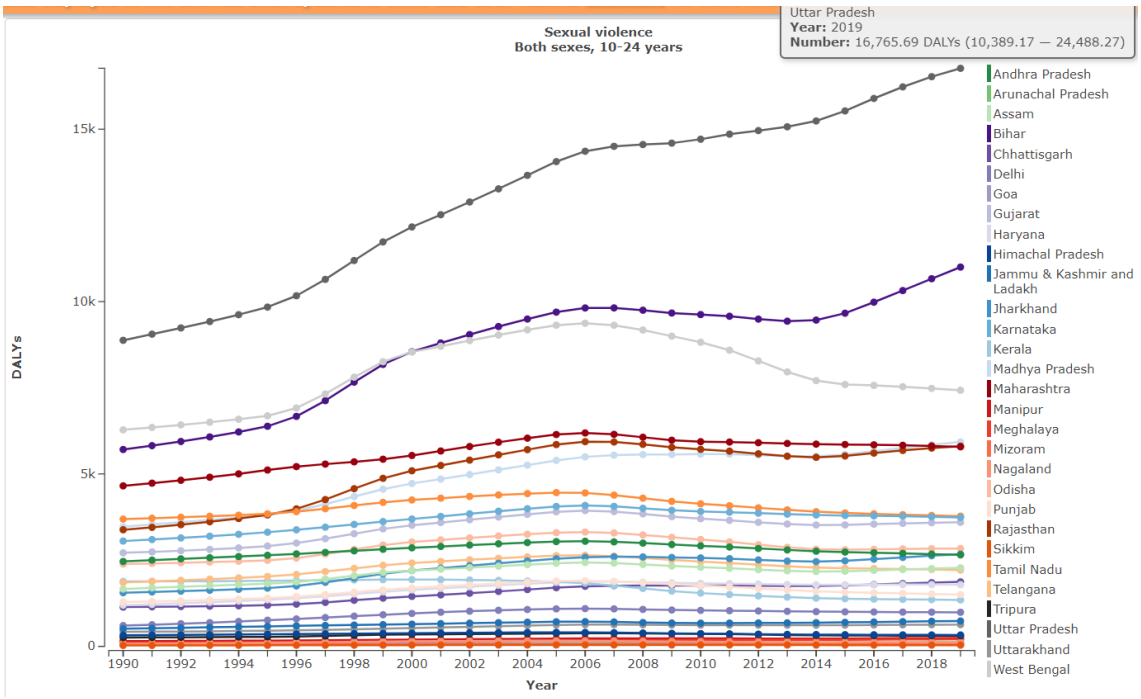

Figure 4: State-wise trends in occurrence of sexual violence, India 1990-2019, 10-24 yeras. both sexes[8].

The figure indicates that in all states the occurrence of sexual violence among both sexes aged 10-24 is found to be in increasing trends from level of 10k to more than 20k such as Uttar Pradesh, Bihar, Maharashtra except in West Bengal where trend has seen a reverse before reaching 10k. A group of states such as Kerala, Himachal Pradesh, Tripura, Uttarakhand, trend is recorded as low as 2k and does not increase linearly.

Chief health issues among adolescents includes dietary disorders counting malnourishment as well as obesity, drug abuse, unsafe sexual behavior, stress, common psychological disorders as well as injuries more specifically like road traffic accidents, different kind of vehemence and most importantly suicides which a major cause of global mortality[13].

Every year hundreds and thousands of adolescents and young people commits suicide globally. Dr Poonam Khetrapal Singh, Regional Director of WHO, SEAR very recently

in 2020 said that *"suicide claims almost 8,00,000 lives every year globally and is the leading cause of death among young people aged 15-29 years."*

These health issues are mostly stressors or origins of many communicable and non-communicable disease that causes elevated morbidity, mortality, infirmity and financial burden on adolescents, their families and health systems[13].

"Millions of adolescent girls in India are coerced into unwanted sex or marriage which puts them at a risk of unwanted pregnancies, unsafe abortions, sexually transmitted infections (STIs) including HIV, and dangerous childbirth"[12]. This is both applicable for adolescent boys as well, they too are at risk as of girls and are affected by HIV[12]. Below Figure is a visual representation of trends in occurrence HIV and STDs collected in all states among population aging 10-24 years for both sexes in India.

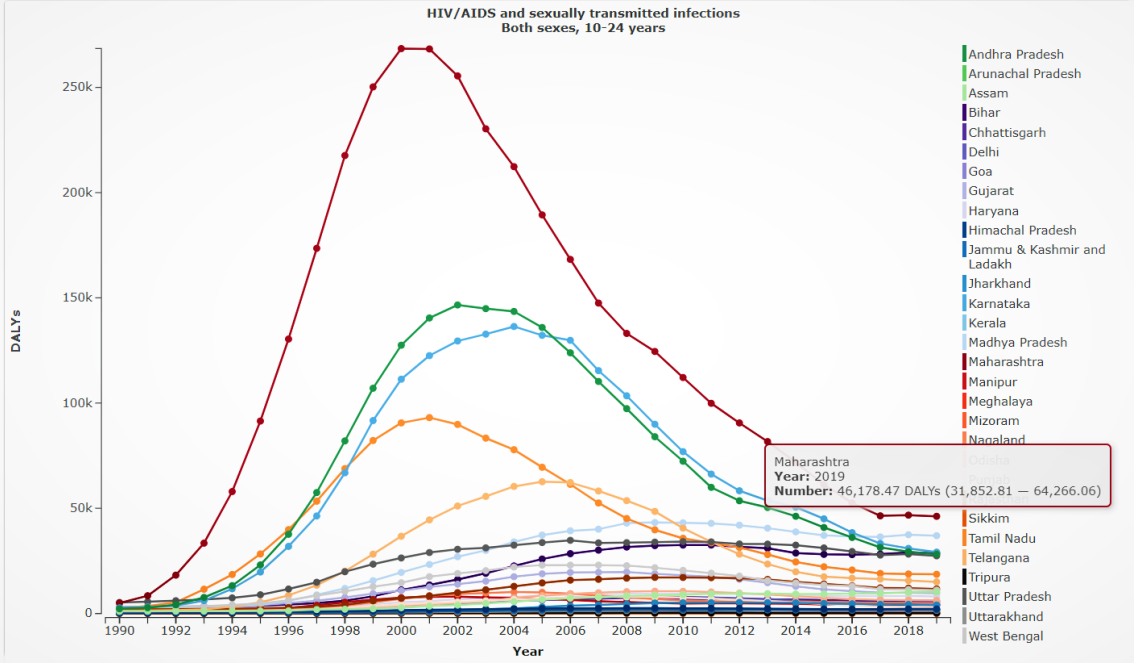

Figure 5: Trends in occurrence of sexually transmitted disease including HIV in India among age 10-24years from 1990-2017[8].

This indicates the burden of HIV and other Sexually Transmitted Diseases (STDs) measured in terms of DALYs. All states showed an increasing trend in occurrence of HIV and STDs during early 2000s with states like Maharashtra, Andhra Pradesh, Karnataka

exceeding 100k DALYs but has experienced a gradual decline in recent years possibly due to the contribution of an effective family planning program running in India except in states of Uttar Pradesh and Bihar which is increasing in a linear fashion.

Figure 6 is a visual representation of state wise trends in occurrence of STDs apart from HIV such as Syphilis, Chlamydial Infection, Gonococcal Infection, Trichomoniasis, Genital herpes[8] across years among population age 10-24 years for both sexes.

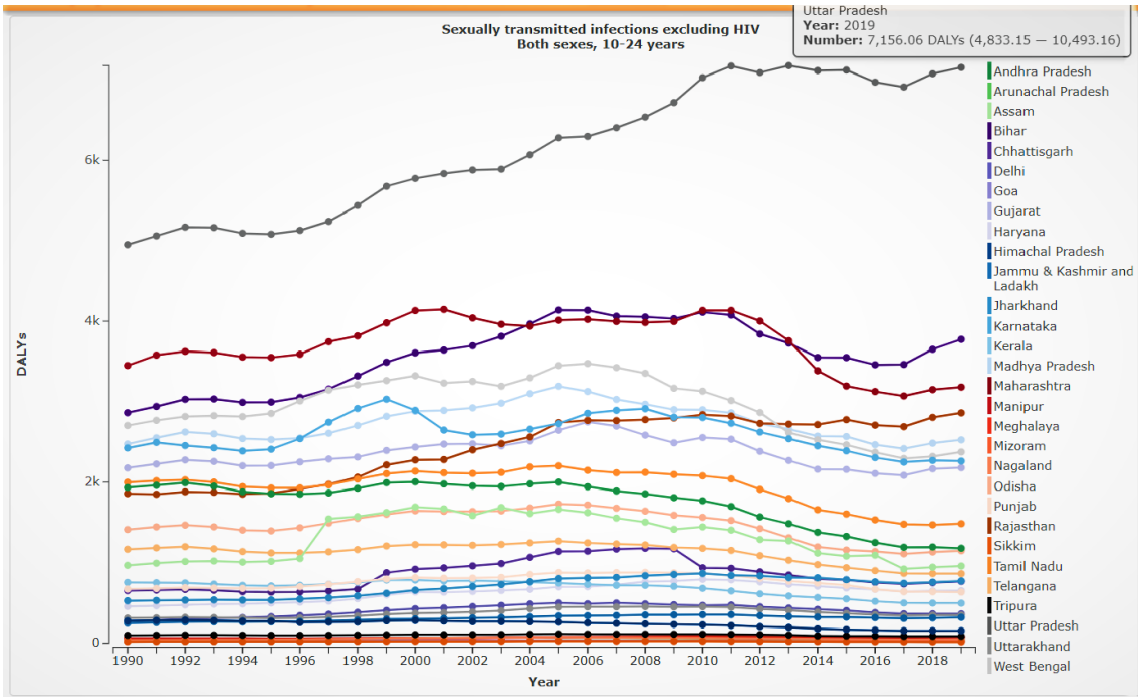

Figure 6: DALYs per year for sexually transmitted diseases excluding HIV in India among age 10-24 years from 1990-2017[8].

Trend indicates that over years Uttar Pradesh has the highest occurrence exceeding 6k DALYs per year (accounting to the fact that Uttar Pradesh has highest percentage of adolescent population) followed by Maharashtra, Bihar and lowest in states like Tripura, Sikkim, Uttarakhand.

The foremost problem is that too many adolescents face hurdles to access reproductive health care and information. And often those who find correct info are not capable in gaining access to the essential services vital to protect their health whereas despite ASRH

needs being spoken about time and again, there has been a lack of glaring attention to it until recent years[12].

Adolescent Sexual and Reproductive Health (ASRH) Indicators in India

In this section, we will be addressing our second research question and try to find out the current situation of adolescent sexual and reproductive health based on some indicators from NFHS4.

Proportion of Adolescents

Over the previous 50 years, the population has grown at a rapid pace and so has the adolescent population. With increasing adolescent population, their sexual and health issues have also increased. Projections for this increase in adolescent population indicates towards 8 billion adolescent population worldwide subsequently with an exponential growth in India[7]. Figure 8 represents a projection of growing proportions of young population in India which also includes adolescents.

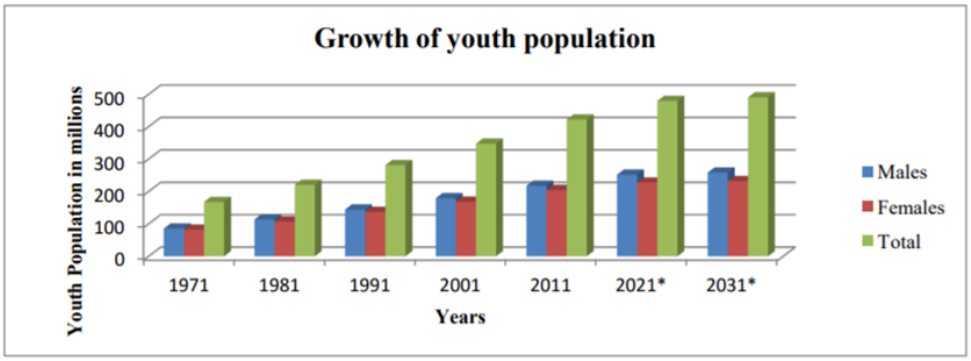

Figure 7: Growth of youth population in India[2].

The WHO claims that “at least 777,000 girls under 15 give birth annually mostly in low- and middle-income countries”[14]. Every year, around 3.9 million girls globally aged 15 to 19 years undergo unsafe abortions[14]. Child marriages accounts for 39 000 every day, they also predict that more than 140 million girls will marry between 2011 and 2020.

As per UNAIDS, “youth in India constitute a large proportion of the HIV-positive population and it is estimated that over 35 percent of all reported HIV infections in India occur among young people aged 15–24 years” [10]. Therefore we can clearly state that the course of HIV and Sexually Transmitted Disease epidemic in the upcoming years will be determined by the type of sexual engagement be it safe or risky is being practiced by the current cohort of young population[10]. Making sure that adolescents can safeguard their health during each phase of growth is a global public health urgency. Such ventures may defer first pregnancy, decrease maternal mortality and enhance health outcomes for women and their children along with contributing to Sustainable Development Goals (SDGs), population control and poverty reduction[15].

Adolescent Marriage Indicator

The tradition of early marriage of girls is still broadly supported in India. The belief in the Indian sociocultural environment of early pregnancy followed immediately after early marriage of adolescent girls fosters early onset of maternity and higher adolescent fertility. “Among 15-19-year-old, 43.44 percent were married (48.80 percent in rural areas and 28.08 percent in urban areas)”[16]. Although in few states traditional customs sometimes decree that marriage is not effectuated until quite a few years after the marriage has passed until a second ritual (return marriage/ Gauna). Married young girls in our country are often pressured for children by their husband's family, and without literacy there is not much option[16].

Age at first marriage

According to National Family and Health Survey, “age at which half of the respondents (women and men) have been married is considered as age at first marriage India”[17].

As per NFHS 4 data “28 percent of females age 18-29 and 17 percent of men age 21-29 marry before reaching the legal minimum age at marriage” [17]. Which means these

people are getting married in their adolescence before reaching the lawful age of marriage of 21 and 18 years for male and female, respectively[17].

For male, about one-fourth of male aged 21-29 years in Rajasthan and Madhya Pradesh with 28 percent each get married before reaching their legal age of marriage followed by Bihar and Jharkhand with 27 percent each. Dadra & Nagar Haveli and Gujrat with 26 percent each and Arunachal Pradesh with 24 percent has male marrying before the legal age of 21 years for marriage[17].

The lowest proportion of female getting married before their legal age is in Lakshadweep (5 percent), Jammu & Kashmir and Kerala with 9 percent each and Himachal Pradesh and Punjab with 10 percent each. Whereas the minimal proportion of men getting married before their legal age is Kerala with 2 percent, Chandigarh with 4 percent, Puducherry and Goa with 5 percent each , Himachal Pradesh with 6 percent followed by Tamil Nadu and Andaman & Nicobar Islands with 7 percent respectively[17].

Figure 8 and 9 represents age at first marriage for women and men of age 15-29 years in India during 2015-16.

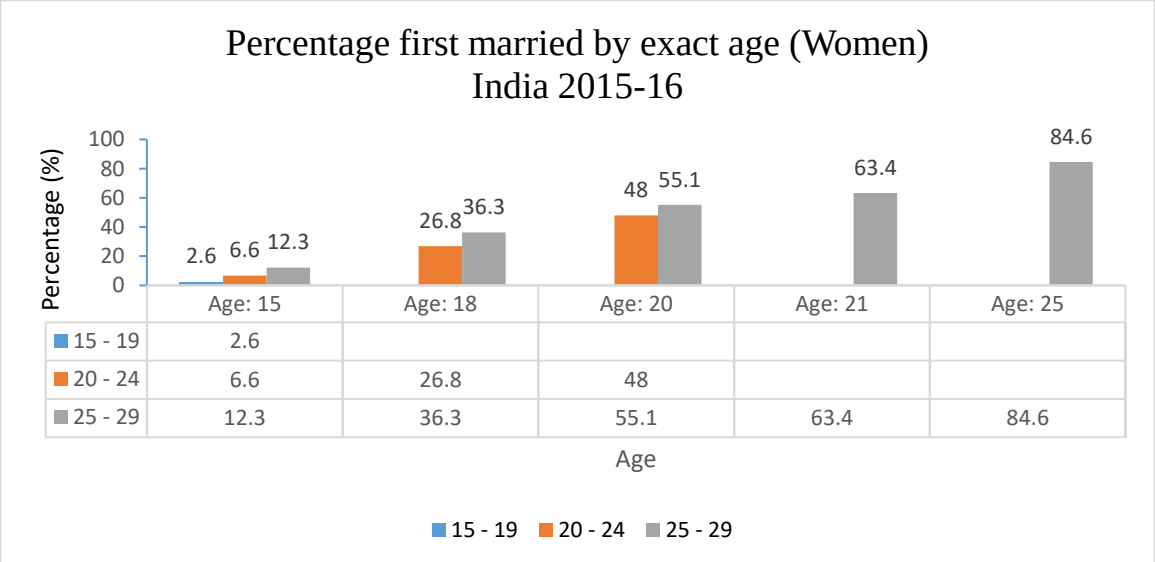

Figure 8:Exact age at first marriage for women, India 2015-16 [17].

About 2.6 percent of women currently aging 15-19 years got married by 15 years before reaching the legal age of marriage, 18.9 percent young women currently aging 20-29 years got married by the age of 15years.

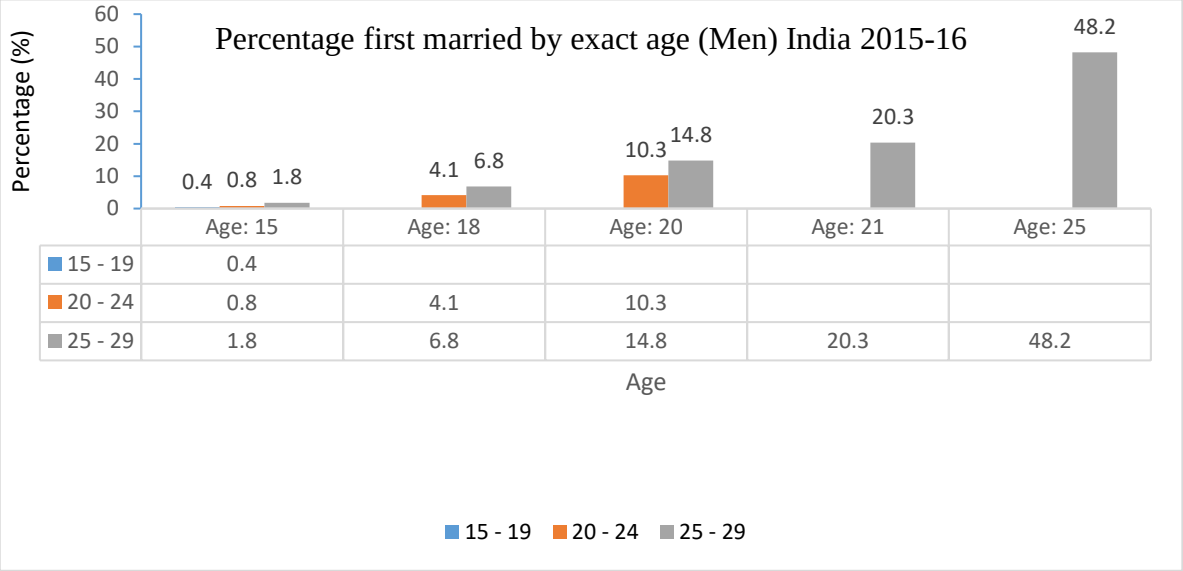

Figure 9: Exact age at first marriage for men, India 2015-16[17]

Figure indicates that a 3 percent, 10.9 percent, and 15.1 percent of men currently aging between 15-29 years got married by the age of 15,18 and 20 years respectively before reaching the legal age of marriage. Below figures 10-16 visualizes data from NFHS 4 representing percentage of male and female who gets married by exact age of 21yrs and 18yrs respectively (legal age for marriage) for India as well as states.

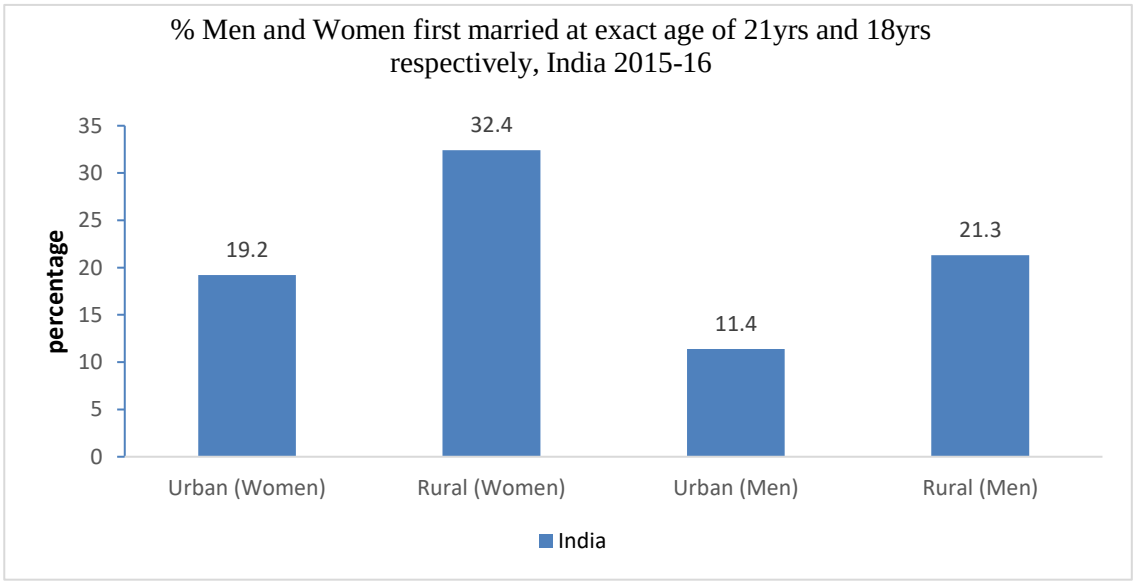

Figure 10: Percent men and women first married at exact age of 21 and 18 years respectively, India 2015-16

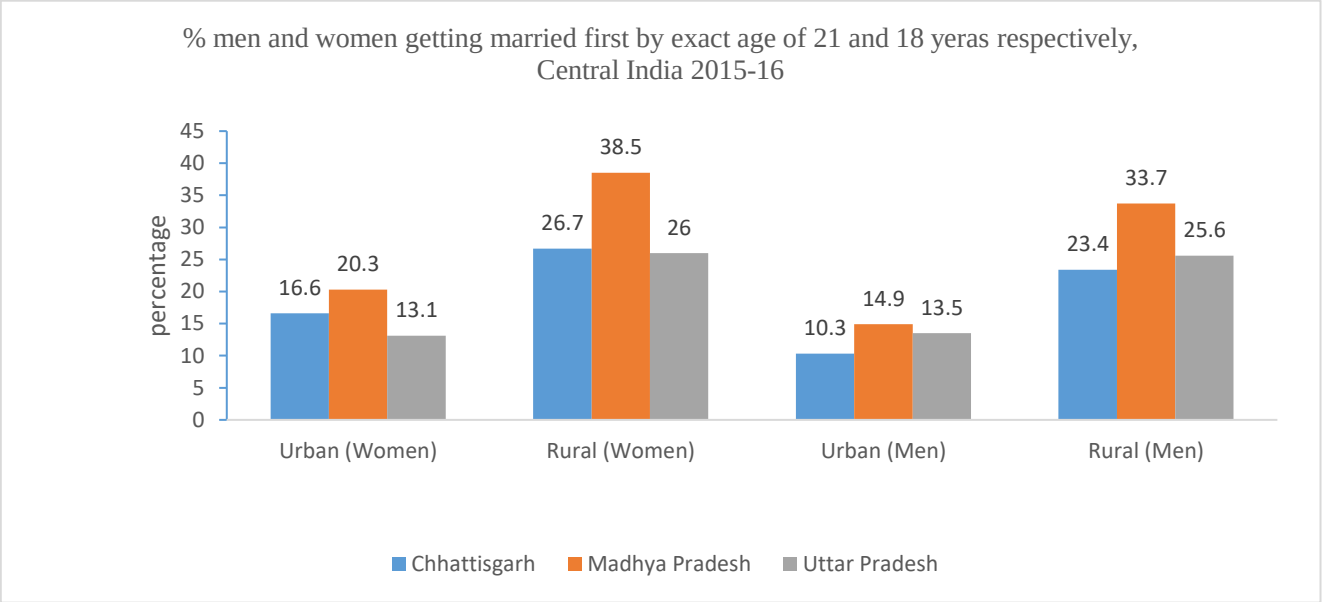

Figure 11: Percentage of Men and Women getting married by exact age of 21 and 18 years, Central India 2015-16 [17]

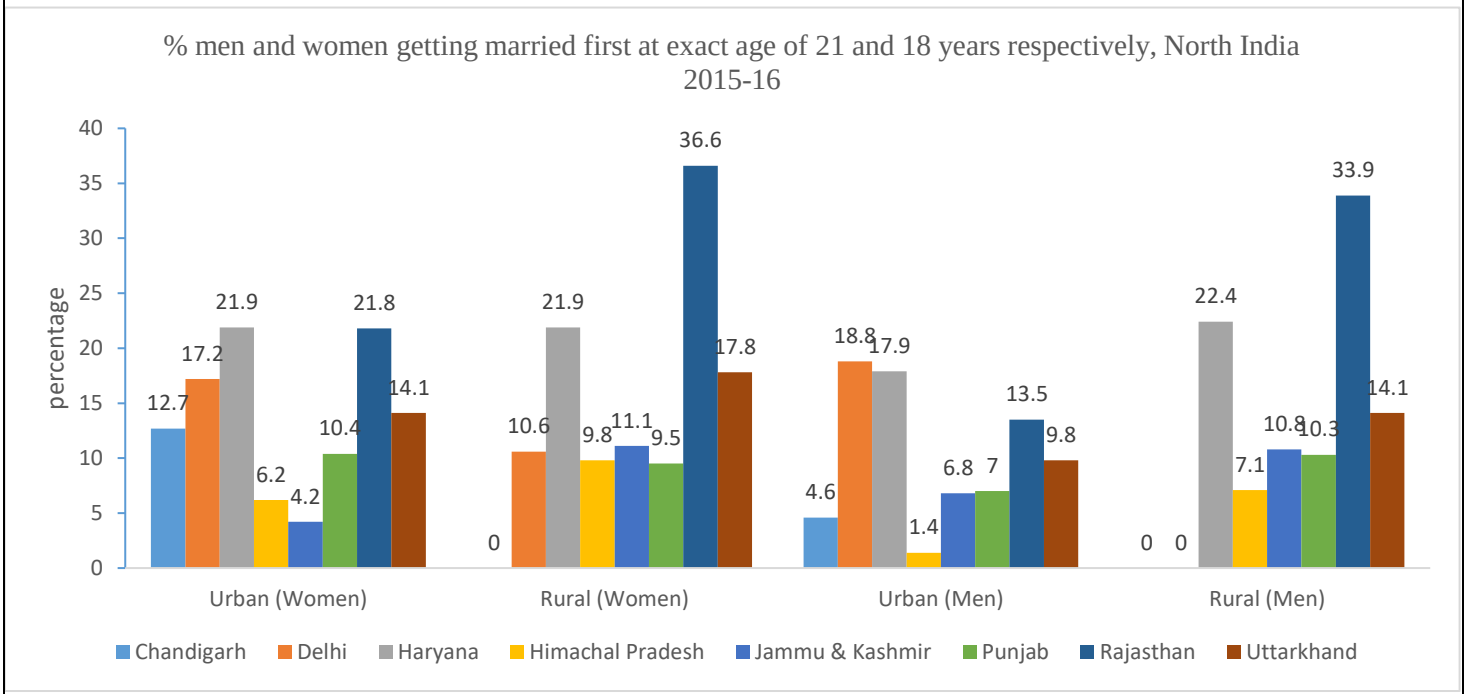

Figure 12: Percentage of Men and Women getting married by exact age of 21 and 18 years, North India 2015-16 [17]

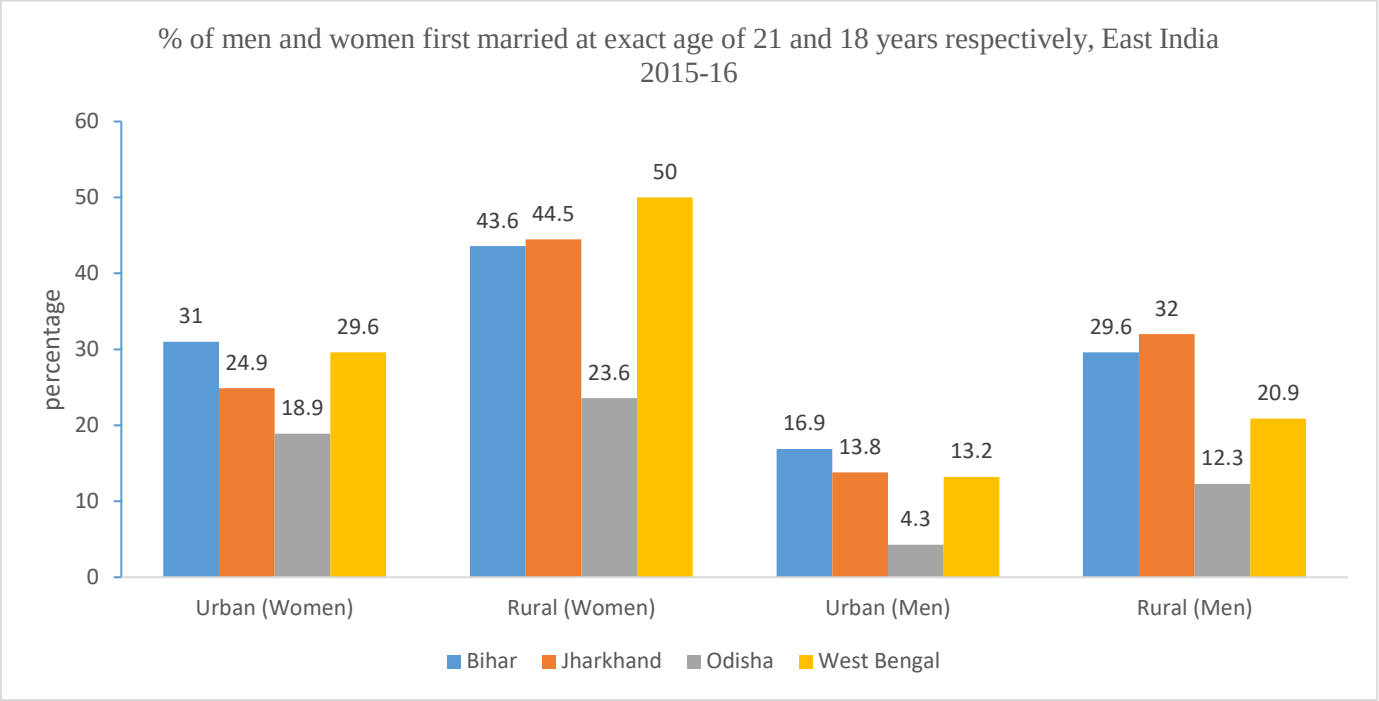

Figure 13: Percentage of Men and Women getting married by exact age of 21 and 18 years, East India 2015-16 [17]

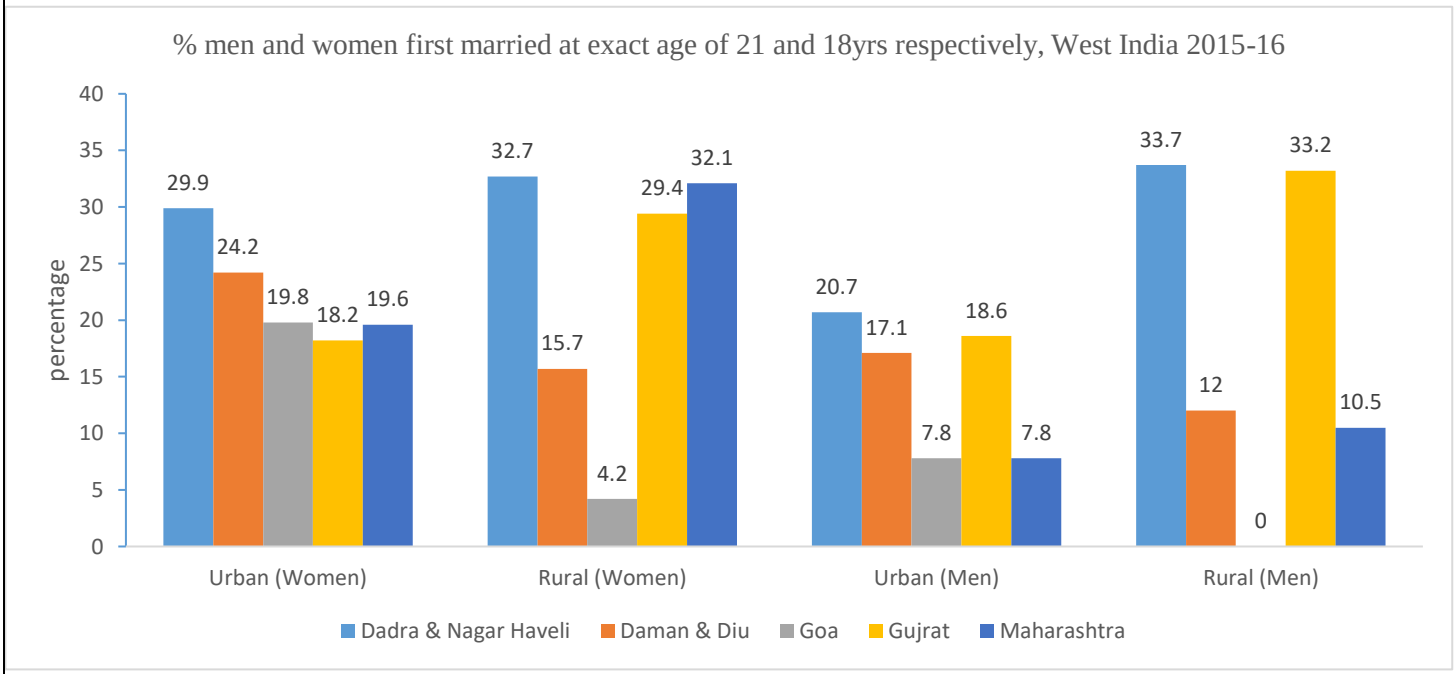

Figure14: Percentage of Men and Women getting married by exact age of 21 and 18 years respectively, West India 2015-16 [17]

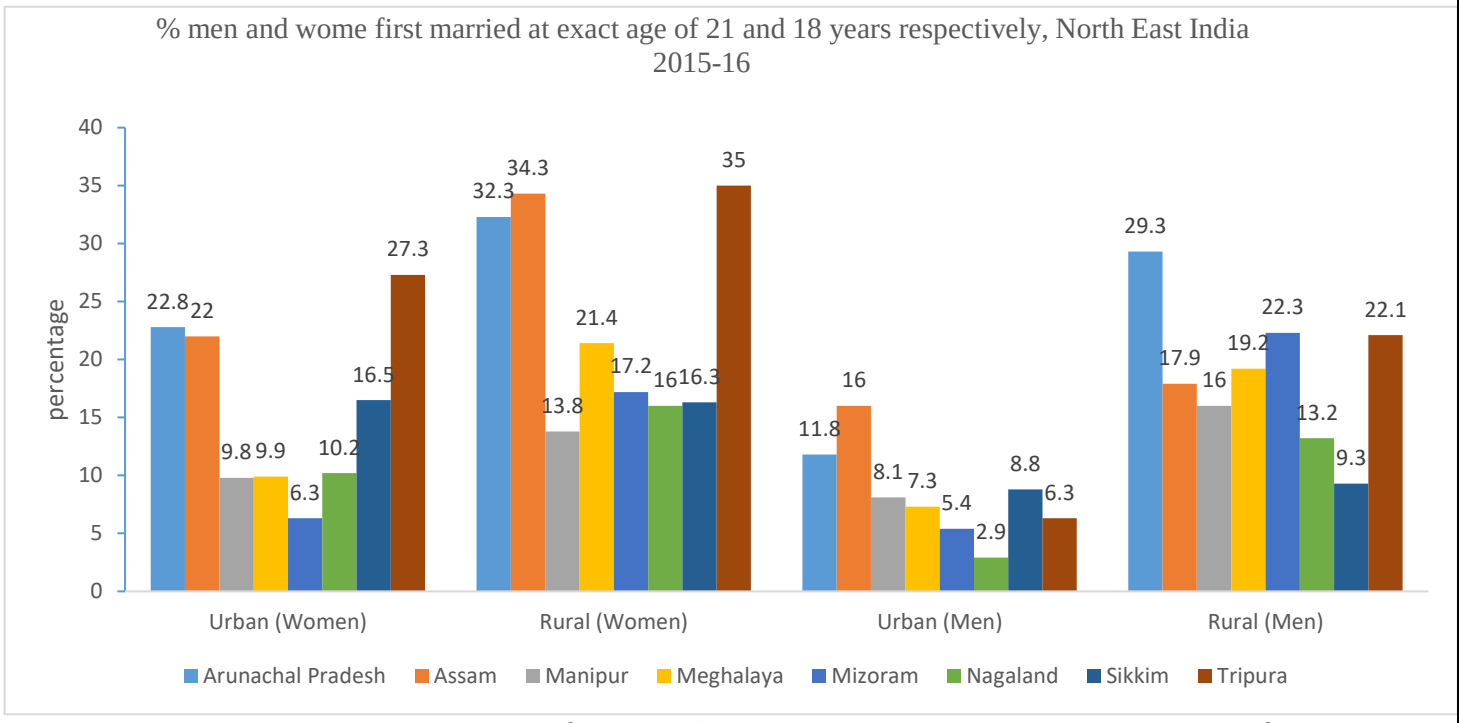

Figure15: Percentage of Men and Women getting married by exact age of 21 and 18 years respectively, North East India 2015-16 [17]

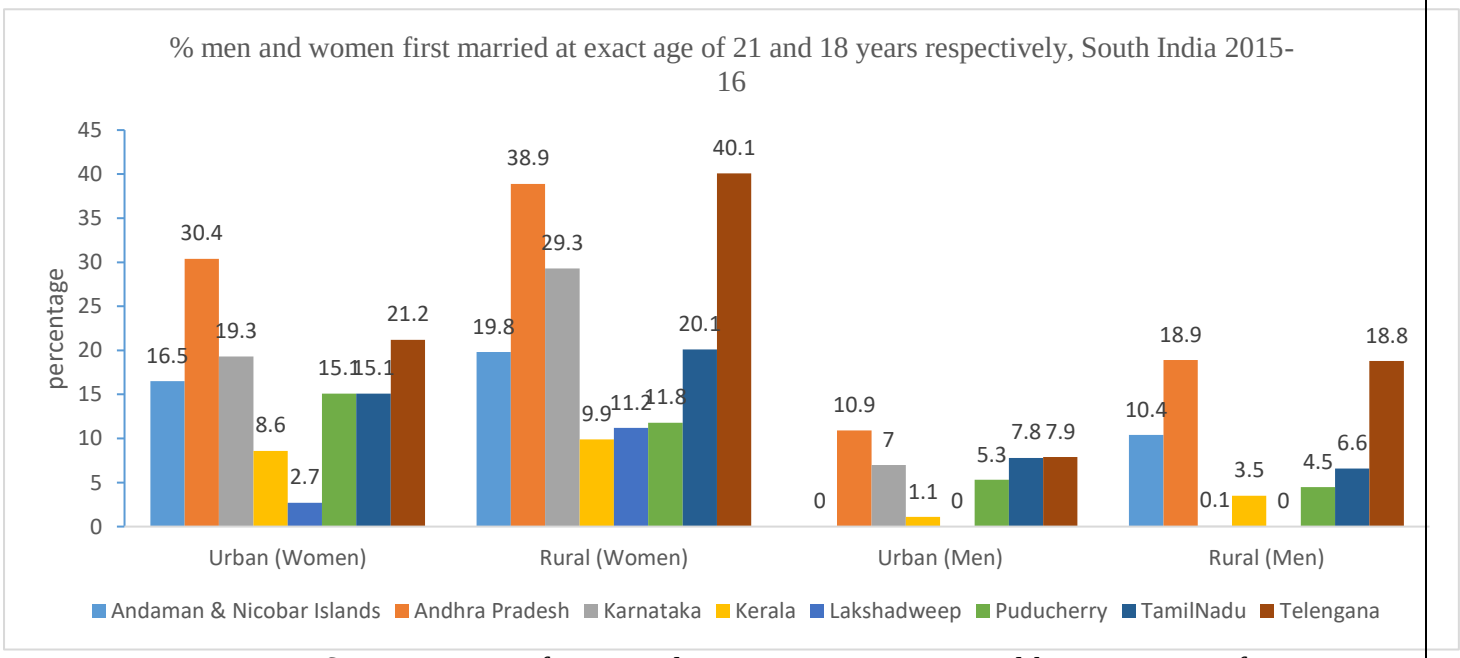

Figure 16: Percentage of Men and Women getting married by exact age of 21 and 18 years respectively, South India 2015-16 [17]

The data was collected from sample population currently aging 21-29 years of age and shows a considerably fair percentage of population getting married by the legal age. The

percentage is higher among women in most states mainly in rural areas and early marriage by the age of 18 years is more prevalent among women in rural areas.

Adolescent Fertility Indicators

India has one of the highest rates of early marriage in the world. Estimates from recent National Family Health Survey (NFHS) 2016 estimates that "27 percent of girls in India are married before their 18th birthday", that's a third of all our adolescent girls.[16].

Evaluation by UNFPA runs to "11.8 million teenage pregnancy for the country"[19]. An early marriage unavoidably put adolescent girls at the risk of being pregnant with minimal preventive awareness[19]. High fertility and halted education after marriage remain the other façades of fear, but the biggest threat of teenage pregnancy is greater rate of pregnancy-associated complications, leading to soaring mortality[19].

Sexual Initiation/Age at first sexual intercourse

According to NFHS, "age at which half of the respondents have had sexual intercourse"[17]. Age at first marriage is generally deemed as a substitute indicator for the age at which women initiate to be subjected to the risks innate in sexual activities[17]. About 11 percent of women who are now in 25-49 year of age group have had first sexual intercourse before the age of 15 years[17].

The median age at first sexual intercourse for female as per NFHS 4 is 19 years which is during their adolescence and aligns with the age of first marriage. For men, the median age at sexual initiation is 24.5 years. Yet another positive aspect seen in the trend from 2005-06 NFHS3 to 2015-16 NFHS4 is that the median age of sexual initiation for females increased from 17 years to 19 years and so for men from 22 years to 24 years.

Figures 17 and 18 represents the percentage of women and men having first sexual intercourse by exact age of 15 – 25 years.

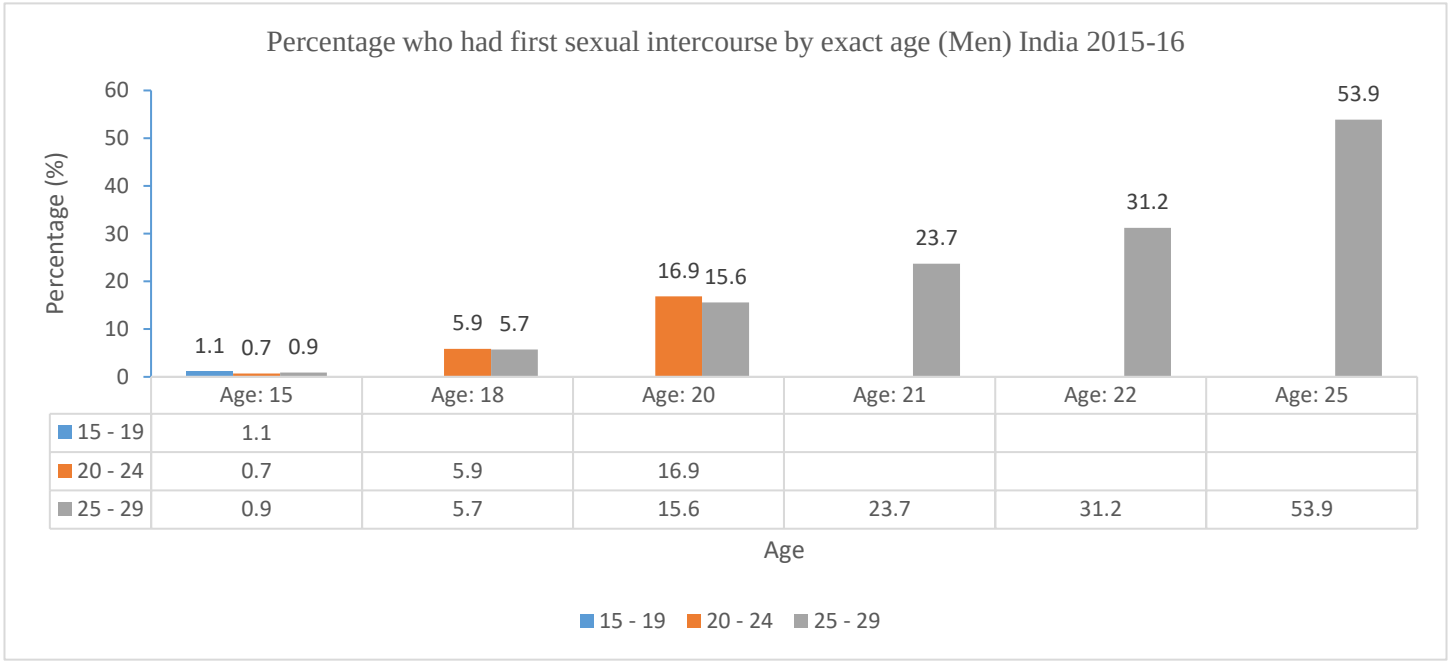

Figure17: Percentage women having first sexual intercourse by exact age, India 2015-16 [17].

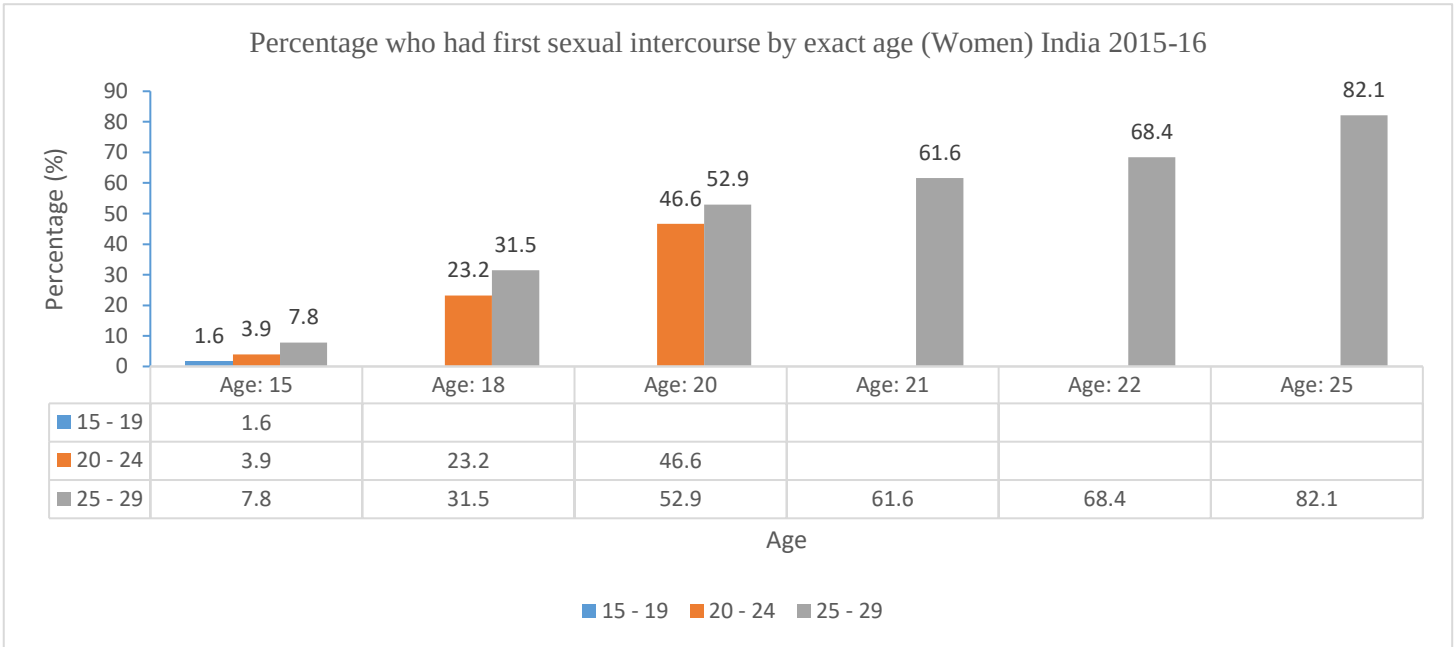

Figure 18: Percentage men having first sexual intercourse by exact age, India 2015-16 [17].

Both the figures indicate a clear evidence of sexual initiation of women as well as men by the age of 15 years[17]. About 13.3 percent women currently aging 15-29 years and 2.7 percent men currently aging 15-29 years have had sexual intercourse by the age of 15 years[17].

Teenage Childbearing

Teenage childbearing indicates "women who have given birth or are pregnant with their first child within the age of 15-19 years"[17]. About 8 percent female in India aged 15-19 years have begun childbearing, which is a positive indication compared to NFHS 3 (2005-2006) data which indicated about 16 percent of female aged 15-19 years began childbearing[17]. Also, teenage pregnancy is relatively higher in rural India which is about 1 in every 10 female of age 15-19 years have begun childbearing. A proximate determinant to this indicator is level of schooling. With increased level of schooling teenage pregnancy seemed to have decreased. 20 percent of female without schooling has initiated gestation contrasted to only 4 percent of women who had 12 or more years of schooling[17].Teenage childbearing is also higher among scheduled tribe female of 15-

19 years of age which is around 11 percent compared to other caste, tribes, or groups[17]. Figure 19 represents state/Union Territory wise percentage of teenage childbearing.

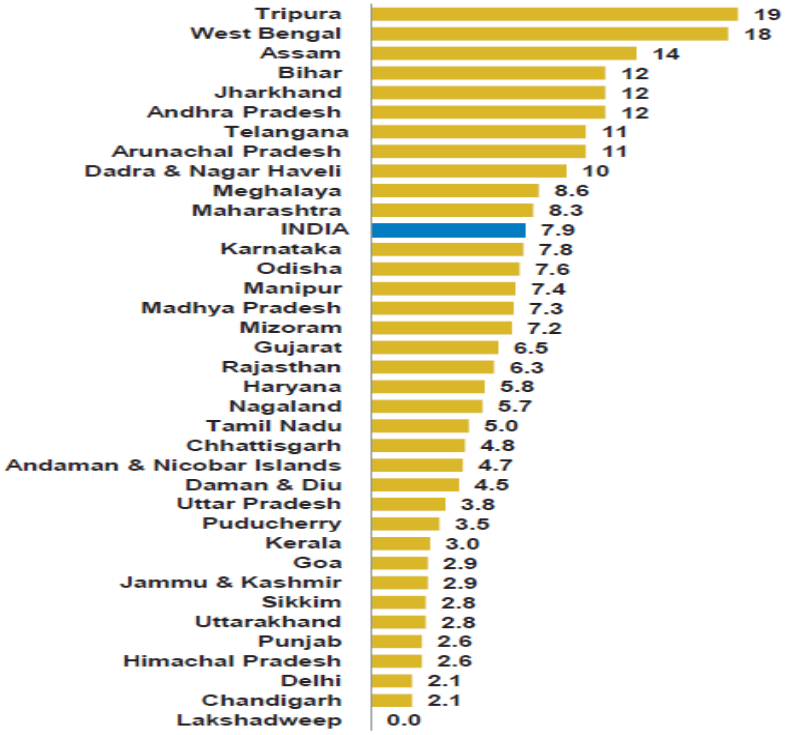

Figure 19: Teenage Childbearing by State/UTs in India 2015-16 [17].

State wise, this indicator is highest in Tripura, West Bengal and Assam correlating to the fact of the early age of marriage of female before reaching their legal age of marriage. Below figure 20 visualizes **Age Specific fertility Rates (ASFR)** from Sample registration system 2018.

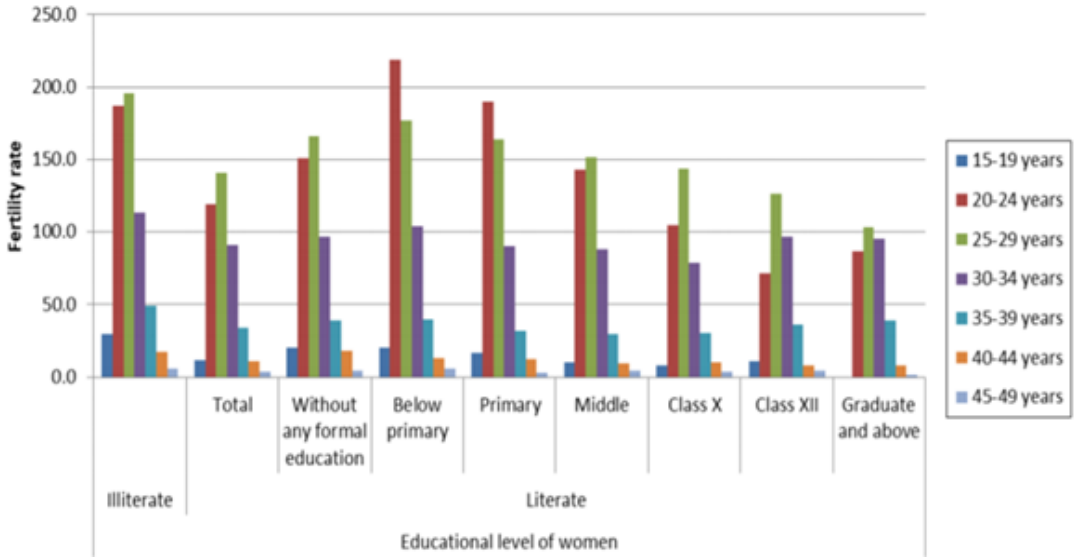

Figure20: Age specific fertility rate by level of education of women, India - 2018[20].

Figure indicates similar correlation of fertility along with the level of schooling as of Teenage Fertility among 15-19 years of age. With increased education fertility decreased pertaining to the fact that with increased education there are lower rates of early marriage and thus lower rate of childbearing at an early age[20].

Pregnancy Outcomes

According to NFHS, "Percentage of women whose pregnancies ended in a non-live birth (abortion, miscarriage, or stillbirth) in the five years preceding the survey"[17].

Following the trends of the above indicators percentage of women experiencing pregnancy outcomes have also improved from 14 per cent during 2005-06 to 12 per cent in 2015-16 which accounts a maximum number of females experiencing live birth of babies. The percentage of pregnancies with an outcome of non-live birth has though varies from 8 per cent to 15 per cent with the maximum percentage of non-live births among teenagers of age 15-19 years and older population of 35-49 years[17]. The percentage of non-live birth was exceptionally high in the state of Manipur with 13 per cent followed by Uttar Pradesh and Tripura with 12 percent each. The report indicates that miscarriages are also high among teenagers of 15-19 years of age which is around 10 percent which is also illustrated in figure 21[17].

Below figures represents pregnancy outcomes for women of age 15-24 years by age, residence, based on NFHS4 data.

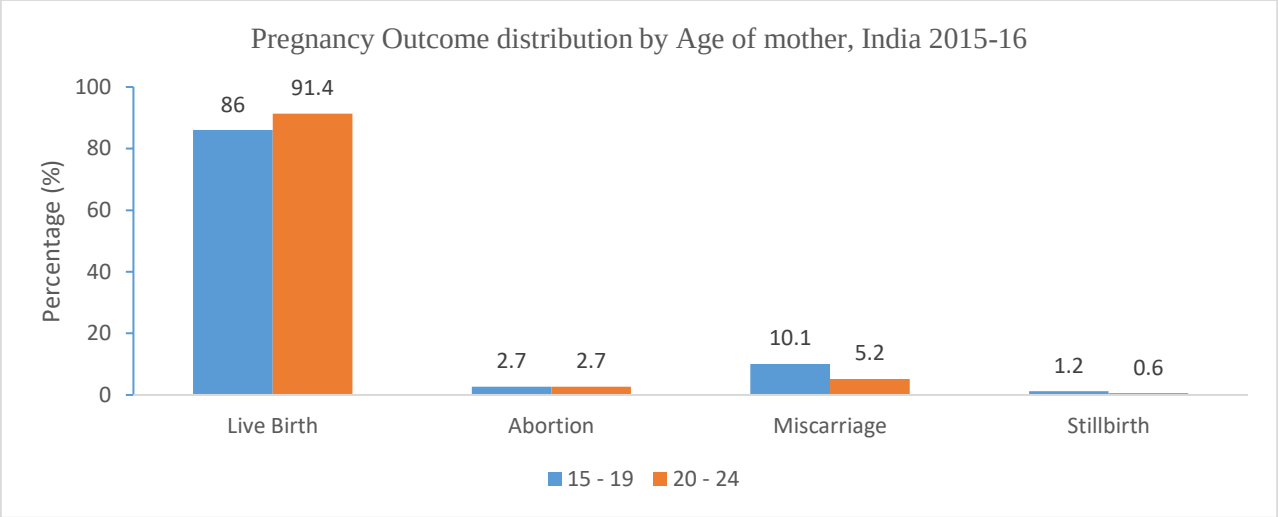

Figure21: Pregnancy outcome by age of mother, India 2015-16 [17].

Above figure indicates 10.1 pregnancy outcome accounts for miscarriage among adolescent mothers of 15-19 years of age, 2.7 percent for abortion and only 1.2 percent for stillbirth for adolescent mother

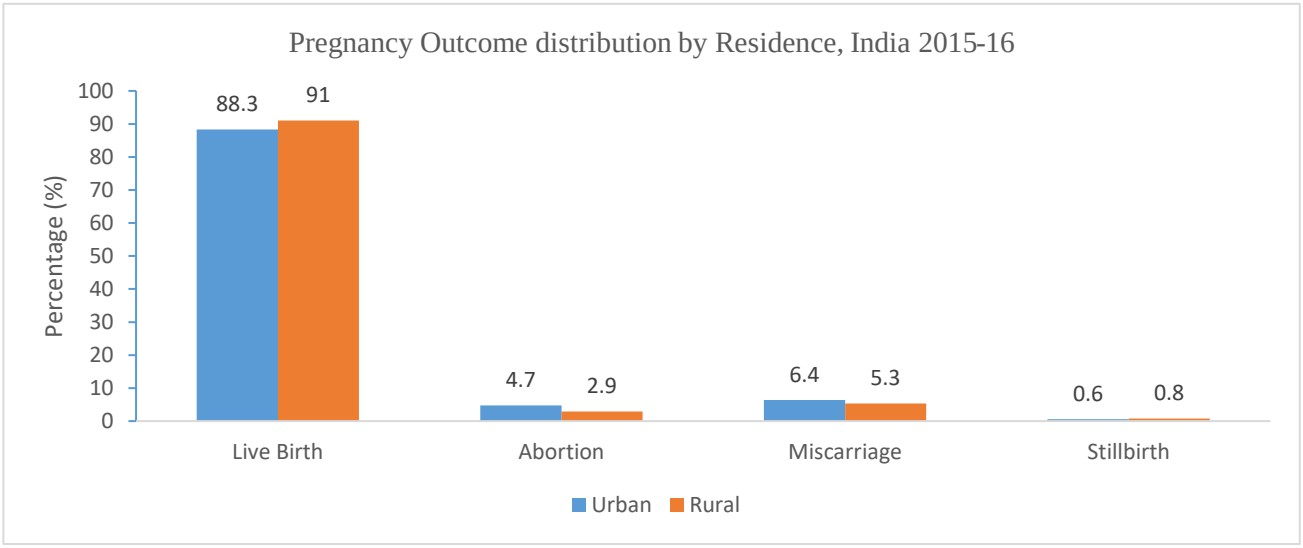

Figure22: Pregnancy outcome by residence, India 2015-16 [17].

About 4.7 percent and 6.4 percent of pregnancy outcomes accounts for abortion and miscarriage respectively for mothers residing in rural India

Social Indicator – Education/Schooling & Literacy

Education is fundamental to the achieving excellence an perfection in lives of adolescents universally, and as such has been acknowledged as a significant area in globally approved development goals and the World Programme of Action for Youth[21]. Learning is crucial in exterminating poverty and hunger and in encouraging continuous, comprehensive, and equitable fiscal growth[21]. Increased endeavours towards education by improving its convenience, superiority and affordability are pivotal to macro-developmental efforts[21].

According to data from NFHS4, the literacy rate (participants who have attended standards six or higher are considered to be literate in India) has increased substantially over years for both male and female. Only 7 per cent of young female respondents of age 15-19 years has no schooling[17]. But rate of literacy in rural India is still lower than urban India.

FACTORS INFLUENCING ASRH ISSUES IN INDIA

The looming phase of adolescence, starting with the inception of puberty, is a key shift into adulthood. Most of the adolescents go through this phase with almost little or no knowledge of the body's physical, psychological, and biological changes. Sexual wellbeing for adolescents has barriers that include issues related to empowerment and choice at individual level, social stigma, access to educational and clinical services and most importantly discrimination and sexual violence [22].

India, despite being the land of "Kama sutra" has an extremely conservative society that is ambivalent about sex, discussions on sex and sex education in high schools[22]. Though situations ae improving yet, in a country like India dialogue about sexuality with

adolescents is nearly non-existent and thus, they are not prepared psychologically to deal with these transformations[9].

Menstruation - a taboo for adolescent girls

Menstruation is an extremely vital part of reproductive life of a woman. Though it is a natural process but it is still deemed as an episode that portrays a woman "dirty"[23]. This thought process and phenomenon in the society is deeply encompassed and linked as a chain of deceptive myths, beliefs and sociocultural curbs towards menstruation related practices and disorders in a developing country like India. The fact of hesitancy, shyness and apprehension in sharing problems faced by young girls is due to the lack of awareness and correlated taboos. Menstrual problems such as emotional disturbances, dysmenorrhea, pre-menstrual syndrome, poly-cystic ovarian syndrome (PCOS) amongst adolescent girls often adversely affects quality of their reproductive life[23].

To access a healthy menstrual life and to show a treatment seeking behavior in case of adolescent girls is often influenced by the rigid adherence of traditional norms and practices, ignorance, social taboos, and lack of an adolescent friendly health care services[23]. These false perceptions, negative attitudes are responsible for hampering the menstrual health seeking behavior and under-detection of menstrual disorders in adolescent girls.

Menstrual disorders that are mostly untreated are because of limited access to adolescent friendly care and more importantly unavailability of female doctors in health centers. The increasing prevalence of menstrual related disorders and low proportion of adolescent girls seeking treatment for their problems makes the health system of the country responsible to address these health issues and deliver necessary education as well as resources to effectually tackle the situation[23].

Below figure 23 is a visual representation of data from NFHS 4, which shows the type of protection used by females aging 15-24 years during their menstrual cycle. Usage of cloth napkins are more prevalent among females in rural India and usage of sanitary napkin is more in urban areas. the type used and the duration of using the same napkins be it cloth or marketed sanitary napkins also determines the menstrual health of the adolescent girls. Knowledge and perception regarding usage of protection during menstruation needs to be measured and understood because realizing the health problems related to menstruation, the health seeking behavior, and choice of protection of the adolescent girls will help us in planning effective programs for this vulnerable group[23].

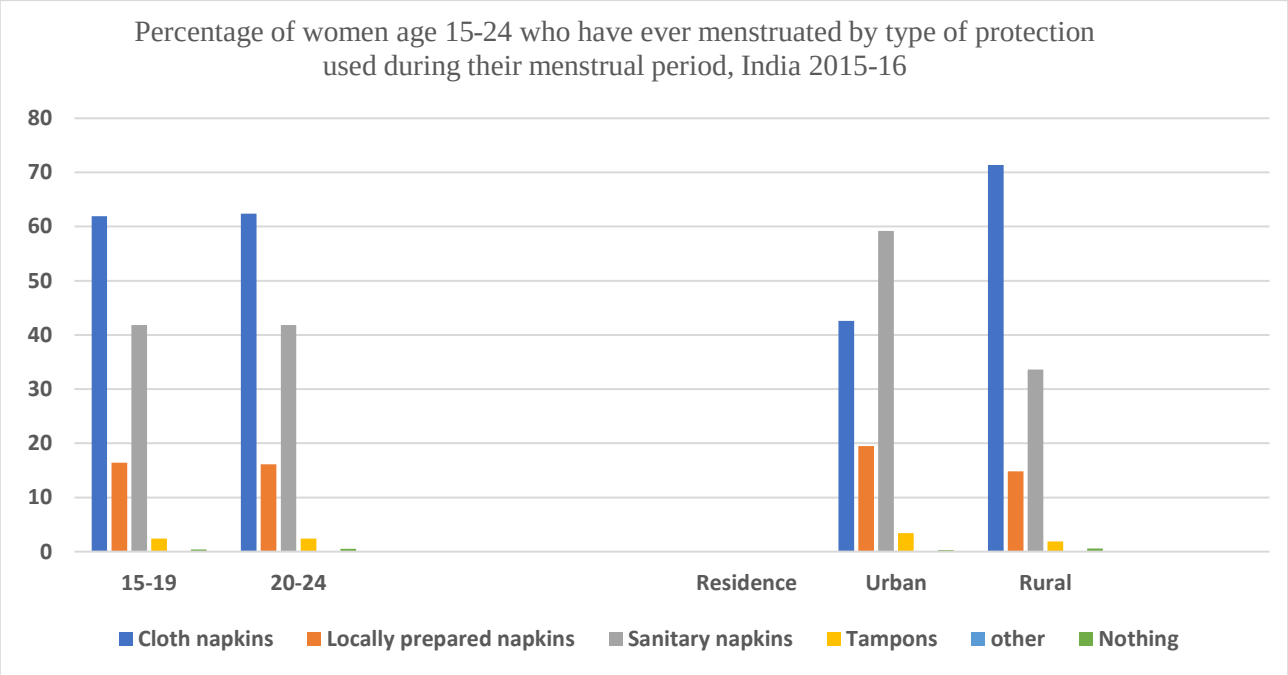

Figure 23: Percentage of women age 15-24 years who have ever menstruated by type of protection used during menstruation, India 2015-16 [17].

Access to sexual and reproductive healthcare

The rapid economic growth over the past two decades has headed to better health outcome and development of the country's adolescents. With increasing GDP, educational status has also improved for adolescents, they are empowered, percentage of early marriage has

also declined over the years. However, despite these bright sides, there are challenges for adolescents.

Mostly in rural India these challenges are more prominent due to lack of understanding about sexual and reproductive health and its outcomes in the long run in due course of life. Access to health-care facilities with a provision of a female doctor is also another reason for which adolescents are less prone to visit public health facility or camps compared to women of older age groups. In urban areas it was noticed that utilization of private-sector health care facilities was more ubiquitous[24].

Identifying the barriers that poses to be reasons for which adolescents shy away from accessing the reproductive health services can be accessibility to health services, privacy issues, odd clinical hours for availability of a female physician, feeling of isolation among adults in the que of the waiting lobby, stigma related to visiting a clinic can be the reasons to step back and shy away from accessing reproductive health care services in a country like India. Apart from accessibility issues, another major determinant is the socio-economic status and challenges revolving around the economic position of the adolescent to access health care. Also, the built environment, familial status, verbal and mental support, distance from the health care facilities are proximal determinants that influences adolescent health seeking behavior.

Important role-players in Adolescence

Parents: Adolescents are often vulnerable to psychological transitions and get pressurized by the expectations of parents, friends, teachers and also most importantly by their own drives that influences them towards pre-marital sex, jeopardized behavior, substance-abuse exposure and other self-disparaging behaviors[24]. Though adolescents in India tend to live with their family and parents but often in a developing country like India where discussing about sexual drives, young partners, any kind of sexual risk and

violence with their parents is not very common. And even if parents come to know about it, often they react furiously and abuses their kid rather than finding out the root cause and understanding the phase of life they are going through. Therefore, despite living under one roof, parents are often unaware of their kid's mental health and a parents' role to play each day that influences, supports, and help to shape up the life of their adolescent. Adolescents are susceptible to emotional challenges due to pressure of outlooks of parents, friends, teachers and their own selves which propels them to premarital sex, toxic behavior, and other self-injurious tendencies. The World Health Organization states five dimensions which have an important impact on adolescent health. These are: "connection–**'love'**; behavior control–**'limit'**; respect for individualism–**'respect'**; modeling of appropriate behavior–**'model'** and provision and protection–**'provide' "**[24].

Teachers: The adolescents devote a crucial time and major proportion of their life in their schools. The very onset of puberty and transition from a child to adolescent is experienced in school. The main role player in school is teachers. It is often seen that when teachers portray a friendly and supportive character, students are more comfortable in sharing their problems with the teacher than their parents. Teachers can therefore play an powerful role in forming up the adolescent's wellbeing by screening for common disorders, offering nutritional counseling, education on sexual and reproductive healthiness, life-skill education, etc.

Community: Community is also an important factor in determining adolescent health. A suitable psychological environment can thwart hazardous behavior, unsafe sexual practices and spread of STIs and HIV. The built environment of the adolescent, their neighborhood, educational status of people living there culture, practices, and beliefs, level of stigma in that specific community determines whether the adolescent can live a healthy life, be vocal about his/her reproductive health, move around safely or not.

Recognition about detrimental effects of early marriage and childbearing in community and understanding of family planning can be helpful[24].

COVID 19 AND ITS IMPACT ON ASRH

The World Health Organization declared the Novel Coronavirus outbreak as a global pandemic on March 11, 2020 and called for government action to halt the spread of the virus[25].

With acceleration of the COVID-19 pandemic, concerns are increasing about the impact of the deadly disease on women's and girls' sexual and reproductive health and their access to care.

UNFPA predicts “there could be up to 7 million unintended pregnancies worldwide because of the crisis, with potentially thousands of deaths from unsafe abortion and complicated births due to inadequate access to emergency care”[26].

In retort to these concerns, WHO announced acting guidance for sustaining essential services during an outbreak, which included prioritizing services related to reproductive health and make efforts to prevent maternal and child mortality and morbidity[26]. But, globally most of the reproductive health care services such as contraception or abortion are either unavailable or shut down[27]. Guidelines by the Ministry of Health and Family Welfare advised continuation of routine reproductive health services and only walk in family planning services. But there has been interruption in case of all health care services due to the obligation of COVID19- related services[27].

This pandemic has unveiled the inequities in our society and regrettably, the most vulnerable and marginalized population bear the burden of these inequities be it poor health systems and its response, increased violence, or lack of access to technology.

To detect some effects of the lockdown during COVID19 on adolescent lifestyle as well as reproductive health, first comes domestic violence. With the enforced lockdown, lack of movement and access towards support services, networks for emotional liberation have put survivors of violent relationships even in greater turmoil[28]. Youngs girls, who are already in unsafe homes, have increased risk of physical, mental, and sexual violence within the family is an added stress along with the stress of a pandemic[28]. In other words, it is a pandemic within a pandemic. This trauma will leave a long-term impact of physical and mental health and may lead to chronic depression and stress.

Besides, there has been a temporary halt in education for many young boys and girls in India. Data suggests that only 8 percent of household with young people during the onset of COVID19 lockdown had computers and internet access[28]. Adolescents who have minimal or no access to technology and internet might be dropped off from school totally during this lockdown. In many parts of the country this can also in turn lead to early marriage and drop out from education[28].

Massive job cuts have pushed back many families to poverty. A healthy nutrition has become a luxury for them during this tough time. “About 40 percent of girls and 18 percent of boys are anemic”[28]. Anemia adversely influences growth, resistance to infectious diseases (more importantly during this pandemic), cognitive enhancement, and work efficiency[28]. Vulnerable girls will also have a compromised nutrition, for example girls who are anemic may be unable to reach out to the prescribed Iron-folic tablets[28]. They might also be uncovered to hygiene and menstrual health related diseases because of the lack of water and sanitation facilities and will have little access to health care facilities during a pandemic[28].

NATIONAL POLICIES AND SCHEMES FOR ADOLESCENT NEEDS: A JOURNEY TOWARDS PROGRESS

The Government of India, during early 2000s recognized that the country's huge adolescent population are bare to substantial health hazards in the passage of its evolution to adulthood and lacks the knowledge, support and empower to make well-informed choices and to carry out these adoptions to protect their health and wellbeing[29].

They then came up with the "***Adolescent Sexual and Reproductive Health Strategy (ASRHS) (2005–2013)"***[30] and then in subsequent years they introduced "***Rastriya Kishor Swasthya Karyakram (RKSK) or National Adolescent Health Program (2014-present)"***[30] which clearly reflects the government's responsibility to shield and boost adolescent health and well-being, both ASRHS and RKSK targets males and females residing in urban or rural areas of age ranging from10-14 years and 15-19 years[30] [29].

RKSK aims to make sure that **"*all adolescents in India are able to realize their full potential by making informed and responsible decisions related to their health and well-being, and by accessing the services and support they need to do so*"**[29]**.** RKSK also has extended its focus further than sexual and reproductive health to incorporate communicable and non- communicable diseases, nutrition, substance misuse, injuries, mental health, and violence[29]. Execution of RKSK is presently ongoing with an increased concentration on 213 districts across the country[29].

Apart from RKSK, the Government of India came up with its flagship programs such as ***Ayushman Bharat Health and Wellness Centers***, ***Beti Bachao Beti Padhao, Menstrual Hygiene Scheme*** to focus on adolescent sexual and reproductive health[31].

The United Nations Population Fund (UNFPA), a key stakeholder has been a principal organization in improving ASRH in India. They have been providing technical assistance to the Ministry of Health and Family Welfare (MoHFW) for selected marginalized states

as recognized by the Government, they are Bihar, Madhya Pradesh, Orissa and Rajasthan for rolling out these integral parts of Ayushman Bharat i.e. health and wellness centers and school heath programs targeted towards adolescents[31]. Ministry of Human Resource Development (MoHRD) has also been assisted to build core curriculum on Health and Wellness for adolescents and school goers. They have implemented Life Skills Education across 6000 schools with an outreach of 1.6 million adolescent girls and boys[31].

GAPS IN ASRHS AND RKSK

In spite of these commendable efforts for implementation of national level programs, the question lies whether the designed programs and efforts are being able to reach the targeted population, whether they are able to utilize these services and enjoy the benefits and if not, then where do the gap exist.

In the year of 2016, the World Health Organization on a request from Government of India undertook a Rapid Program Review (RPR) of Adolescent Sexual and Reproductive Health Strategy (ASRHS) and Rastriya Kishor Swasthya Karyakram (RKSK) at the national level to find and file lessons learnt in relation to four realms of the programs. They are – "**Governance, Implementation, Monitoring** and **Linkages"**[29]. The motive behind this rapid review was to use the report and improve the present and forthcoming adolescent programming in India [29]. The Gaps in this study will be discussed based on the empirical findings of the RPR.

The findings of RPR by WHO through the lens of Governance indicated that there is a inadequate planning of program, there is a lack of distribution of human and financial resources pertaining to the existing vacancies in community level of the program. For instance, in some states, NGOs were contracted by the government, but their involvement stopped midway. Therefore, in many states the ASRH strategy lingered in a *"project-*

mode" all over its duration. For RKSK, adequate funds were assigned for state level operation, but the rules and regulations for their usage were rendered to be "too rigid" by some key informants which hampered the responsiveness of the program. Both in ASRHS and RKSK adolescents were not involved in governance[29].

Likewise, program activities were not well managed; For example, "in several cases, training on the Menstrual Health Scheme (MHS) occurred months before necessary commodities, such as sanitary pads, had been secured"[29].

Implementation was categorized into multiple sections and analyzed accordingly in the RPR by WHO. In case of Adolescent Friendly Health Clinics (AFHC), the RKSK try to bring services close to adolescents than they were under the ASRH Strategy who focused on higher level of health system. Still, due to geographical barriers there were accessibility issues. Also, an important fact of "Protection of Children from Sexual Offenses Act" [29] that criminalizes sexual act with minors (below 18years) is creating a fiasco. This act makes no discrimination with consensual sexual relationship between minors. Therefore, leads to a multiple reporting issues to the relevant authorities given which it is being modelled that healthcare providers are denying SRH services to adolescents in a few states[29].

With regard to counselling services during implementation, there is a lack of refresher training of the counselors apart from the initial training, also counsellors are overburdened with work at AFHCs and dearth of transport allowance and equivalent safety measures undesirably impacts their outreach services mostly in places with geographical barriers.

Evidence in case of Peer Education (PE) indicates that a lack of financial remuneration and absence of steady transport system is affecting the retention and motivation of Peer Educator (PE).

This is a lack of coordination in program activities. For example in a number of states the Menstrual Hygiene Scheme (MHS) that was launched by MoHFW in 2011 is not being implemented due to resource procurement issues also in many cases, trainings on MHS are performed long before required products such as sanitary pads has been obtained.

Gaps in monitoring has also been found during the RPR. Lack of monitoring services in case of counselling leads to non-measurable quality and content of service delivered. In Peer Education activities, a poor monitoring system to track the activities delivered in communities puts the level of implementation in question.

RECOMMENDATIONS

The World Health Organization based on its analysis through Rapid Program Review (RPR) suggested multiple recommendation for each domain of reference. They include developing a robust recruitment and retention strategy to fill up all the vacancies, aligning synergistic activities, ensuring follow up trainings, supports and supervision for counsellors, involving adolescence and communities in decision making process, etc.

On a personal point of view, the government should include a strong screening program in the adolescent health programs to diagnose undetected sexual health disorders. Keeping COVID19 into context, a strong digital screening program can be developed that adolescents can access through from their homes. Now that the era of online education has started, it is quite evident that adolescents are very much tech savvy mostly in urban areas. Designing screening apps, that would help them diagnosing undetected sexual health disorders, and would guide them whom to seek for treatment. For adolescents in rural areas, ASHAs, ANMs and Anganwadis could be their key informant and can also help them respond to the screening if they are equipped with proper equipment such as tablets through which they can record the responses. Utilizing Health Management

Information System for proper monitoring through online database can help in resolving issues about Monitoring.

Along being vocal regarding flagship programs such as Beti Padhao Beti Bachao, the government should take initiatives to voice for ASRH rights and awareness together among adolescents, their parents, and the community. Linkages and collaborations with mass media, branding and communicating through advertisements will also help in bringing social and behavioral outlook towards sexual and reproductive health of adolescents rather than tabooing them.

ATTACHMENTS


MPH Capstone-Graphs final.xlsx


Capstone ppt charts.xlsx

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