SEXUAL AND REPRODUCTIVE HEALTH AND UNMET NEEDS OF FAMILY PLANNING AMONG YOUNG PEOPLE IN INDIA: A REVIEW PAPER

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This technical paper is prepared to present an overview on status of Sexual and Reproductive Health and Family Planning (SRH & FP) of Young People in India, including the unmet needs of SRH and FP of the young People. The review has been supported by International Council on Management of Population Programmes (ICOMP), and prepared by the Centre for Operations Research and Training, CORT, Vadodara. The technical paper is prepared in preparation for a follow-up Asia-Pacific Regional Workshop to review the status of implementation of the Call for Elimination of Unmet Needs of Family Planning with specific focus on SRH and FP needs among adolescents and young people, both married and unmarried in the region, being jointly organized by ICOMP and UNFPA APRO in 2012.

Demographically, India is a young country today. As per 2001 Census, more than 31 percent of the population of India is young population between the ages of 10-24 years constituting almost 315 million, and 22 percent is adolescents (aged 10-19 years). Some adolescents and young people have greater access to education and information and ability to make well informed choices about their lives, while many others have poor or no access to information. Similarly, while boys have greater mobility, opportunity, autonomy, access and power, many girls are systematically deprived of these advantages. In India, still early marriages, early pregnancy, poor access to information and services related to reproductive and sexual health, poor life skills, sexual exploitation, morbidity related to risky behaviour, poor nutrition are some of the challenges faced by the adolescents and young people. Besides, societal pressure to perform as an adult notwithstanding the physical, mental, and emotional changes during adolescence make them vulnerable to risky health behavior.

Adolescent and young men and women, married and unmarried all have different priorities and needs and must overcome a different set of obstacles in accessing information and family planning related services. There is a huge knowledge gap about adolescents and young peoples’ needs and access and use of services. The use of health services by adolescent and young people is limited due to poor knowledge and lack of awareness. There is negligible use of contraceptives among both married and unmarried adolescents and limited use of male/couple-dependent methods, and substantial levels of discontinuation. Improved access to and use of contraception has the potential to reduce poverty and hunger, avert 32 percent of maternal deaths and nearly 10 percent of childhood deaths, contribute substantially to women’s empowerment, and help achieve universal primary schooling and environmental sustainability - and thus contribute significantly to addressing the Millennium Development Goals (MDGs) set forth by the United Nations.

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This review paper attempts to present the policy and programmes focusing on adolescents and young people, a brief profile of young people in India, age at marriage, child bearing, contraceptive knowledge and use, unmet needs of contraceptive, barriers for using contraceptives, reproductive and sexual health needs, health seeking behaviour, contact with health system and health workers, role of service providers, source of information, exposure to media, and nutritional status. The paper is largely based on desk-review of available primary and secondary data and other reference materials. Besides desk review, primary data was collected during focus group discussions held with adolescents and young person’s in five states of India including Gujarat, Madhya Pradesh, Jharkhand, Bihar, and Maharashtra as well as in-depth interviews (IDI) with selected health workers in Maharashtra.

<table>
<thead>
<tr>
<th>States</th>
<th>Number of FGDs</th>
<th>Types of informants</th>
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<tbody>
<tr>
<td>Gujarat</td>
<td>2</td>
<td>10 young females (married and unmarried)</td>
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<tr>
<td></td>
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<td>10 young males (married and unmarried)</td>
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<tr>
<td>Maharashtra</td>
<td>1 FGD</td>
<td>7 young females (married and unmarried)</td>
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<td></td>
<td>2 In-depth interviews</td>
<td>Two in-depth interviews with LHV and ANM</td>
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<td>Jharkhand</td>
<td>2</td>
<td>12 young females (married and unmarried)</td>
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<td></td>
<td>10 young males (married and unmarried)</td>
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<td>Madhya Pradesh</td>
<td>4</td>
<td>10 unmarried males</td>
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<td>10 young males (married and unmarried)</td>
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Several papers related to contraceptive use and unmet needs of contraceptives among adolescents and young people were reviewed. However, these papers are largely based on secondary analysis of NFHS and DLHS data. Moreover, the analysis was mainly for 15-24 years age group and not analysed separately for 15-19 years and 20-24 years. Studies based on primary data collections focusing on adolescent and young women reproductive health were very few.

**Policies and Programmes for Young People in India**

India was a pioneer in initiating its family planning programme in 1952. The Family Welfare Programme in India and service delivery points has significantly expanded during Five Year Plans, and under National Rural Health Mission, the ranges of services provided have also been broadened. Multiple stakeholders including the private sector and non-governmental sector have been engaged in providing contraceptive services. Besides, there has been a paradigm shift in the national family welfare program from the method-specific family planning target based performance to client-centred, demand driven quality services. Family planning was the focus in policies since 1950s but till 2000s the focus remained on family planning for the married group. In none of the policies till 2000, there has been mention of the adolescents need for family planning. Only recently policy recognized adolescents as an important group and their unmet need for family planning or contraception.

The Government of India (GOI) has now prioritized the issue of health of adolescent and young people by formulating several national policies and programmes including the National Population Policy 2000, the National Youth Policy 2003, the Tenth and Eleventh Five-Year Plans, the National Adolescent Reproductive and Sexual Health
Strategy under the National Rural Health Mission. Each of these has been briefly discussed below:

**Eighth Five Year Plan (1992-97)** focused on younger couples, who were reproductively most active, as a strategy to achieve the goal of population stabilization, necessarily to put a greater emphasis on spacing methods. Here though youth were considered, it was just for spacing method, rather than promoting the family planning for protection and as a behaviour and right of youth. The International Conference on Population and Development in 1994 and the Beijing Women’s Conference in 1995 further catalysed the process of policy change.

**In Ninth Five Year Plan (1997-2002)** the reduction in population growth rate was recognized as one of priority objective and focus was on meeting all felt needs for contraception. Here the age group was not mentioned and there was nothing specific mentioned about needs of adolescents or youth. Now, the focus was more on maternal and child health.

The Reproductive and Child Health Programme, which was launched in 1997, adopted the principles of client satisfaction and high quality comprehensive and integrated health services. It focused on integrating services for the prevention and management of unwanted pregnancy, promoting safe motherhood and child survival, and the preventing and managing of reproductive tract infections and sexually transmitted infections. The programme aimed to expand services to meet the needs of hitherto under-served and neglected population groups, including adolescents, and economically and socially disadvantaged groups, such as urban slum and tribal populations. The Reproductive and Child Health Programme was carried out with varying intensity and understanding in different parts of the country.

The National Population Policy, adopted in February 2000, further legitimised the paradigm shift to client-based services. The National Population Commission was set up in May 2000 to guide the translation of policy rhetoric into programmes. The National Population Policy provides a policy framework for achieving the twin objectives of population stabilisation and promoting reproductive health within the wider context of sustainable development. The immediate objectives of the National Population Policy were to address the unmet need for contraception, the limitations in health care infrastructure and the shortages in health personnel, and to provide integrated service delivery for basic reproductive and child health care (MOHFW 2000).

Besides, in 2000s, when National Population Policy was framed, the adolescents were recognized as an essential group and specified the goals of educating adolescents about the risks of unprotected sex. The Policy mentioned about need to attend sexual and reproductive needs of adolescents and special requirements for accessible and affordable contraceptive services in rural areas where adolescent marriage and pregnancy are widely prevalent. To delay early marriage, the policy called for stricter enforcement of the minimum age at marriage and also recommended financial incentives to induce both postponing first births and having fewer births.

**In Tenth Five Year Plan (2002-07)** the focus was on improving services related to MCH and providing quality services. Yet, the Tenth FYP did mention about method specific contraceptive targets to meet all the unmet needs for contraception to reduce unwanted pregnancies. The programme focus shifted away from vertical family
planning services towards the provision of comprehensive integrated reproductive health care at all levels of the health sector. Thus, until Tenth Five Year Plan focus was just limited to the spacing and providing services to the married group. The adolescent’s sexual health was not at all mentioned and thought. There was gap and lack of services for adolescents for family planning or contraception as such.

The 2003 National Youth Policy identified adolescents, defined as 13-19 year olds, and females in particular, as a priority target group and acknowledged their needs for separate general health clinics. Although it included text on sensitizing adolescents on the correct age to marry and begin a family (and on birth spacing and limiting family size), it admitted that, despite government initiatives, the social climate still encourages young couples to produce their first child soon after marriage.

**Eleventh Five Year Plan (2007-12)** focuses to ensure access to affordable health care to reduce inter and intra regional disparities in access to health care and health outcomes. Besides, the XIth FYP gave special attention to the health of marginalized groups like adolescent girls, women of all ages, children below the age of three, older persons, disabled, and primitive tribal groups. Adolescent issues were added to the RCH training programmes, materials for behaviour change communications were developed and service delivery points were made adolescent friendly by arranging special space for their needs.

The **Adolescent Health Section of the National Program** Implementation Plan lays the policy framework for adolescent services (2005-2010) of the country’s Reproductive and Child Health program. It acknowledges the heterogeneity of adolescents (here defined as 10-19 year olds) and the needs of both married and unmarried adolescents to receive confidential and nonjudgmental contraceptive services. The plan is unique in advocating that providers be trained in working with adolescents, that they refer adolescents for early and safe abortion, and that they provide adolescents with spacing methods in particular.

In 2006, keeping in the mind the need for health interventions of adolescents, government identified Adolescents Reproductive and Sexual Health (ARSH) as a key strategy under the Reproductive and Child Health programme and National Rural Health Mission (NRHM).

**Adolescent Reproductive and Sexual Health Program**
A strategy for ARSH was approved as part of the National RCH II Programme Implementation Plan (PIP). This strategy focuses on reorganizing the existing public health system in order to meet the service needs of adolescents. Steps are to be taken to ensure improved service delivery for adolescents during routine checkups at sub centre clinics and to ensure service availability on fixed days and timings at the PHC and CHC levels. A core package of services includes preventive, promotive, curative and counseling services. The framework of services in the ARSH Strategy describes the intended beneficiaries of the adolescent friendly reproductive and sexual health services (target group), the health problems/issues to be addressed (service package) and the health facilities and service providers to be involved.

The key ‘friendly’ characteristics of services for adolescents are at the levels of the user, provider and health system. These in turn are the determinants of quality of the services. It is mentioned that from the user’s perspective, health services must be: (i)
accessible – ready access to services is provided; (ii) acceptable – that is, healthcare meets the expectations of adolescents who use the services;

From the provider’s and manager’s perspective, services must be: (i) appropriate - required care is provided, and unnecessary and harmful care is avoided; (ii) comprehensive - care provision covers aspects from prevention to counseling and treatment; (iii) effective - healthcare produces positive change in the health status of the adolescent. The health system must focus on efficiency in service delivery, that is high quality care is provided at the lowest possible cost. (iv) equitable - services are provided to all adolescents who need them, the poor, vulnerable, marginalized and difficult-to-reach groups/areas (Implementation guide of ARSH, May 2006).

Achievements have been made to improve health standards, such as life expectancy, infant mortality, child mortality, and maternal mortality. The contraceptive prevalence rate has gone up from over 10 percent in 1970s to 56 percent by 2005-06. Nevertheless, there are pressing issues and challenges in meeting the goals: delaying age at marriage, unmet needs of contraceptives for many women, poor access to and poor quality of contraceptive services, especially to under-served groups including adolescents and young people, high proportions of unplanned pregnancies, unsafe abortions, and pregnancy and childbirth related complications that contribute to maternal morbidities and maternal mortality.

Available statistics also show that, performance of the programme is not uniform all over the country. For example, while the states in the Hindi-belt, particularly Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh have failed in their attempt to implement the programme effectively and increase contraception to the desired level, states like Kerala, Maharashtra, and Tamil Nadu have performed quite well in terms of both health and FP programme.

The Government aims at reducing Maternal Mortality Ratio (MMR) below 100 (at present it is 172 per 1,00,000 live births) and reducing Total Fertility Rate (TFR) from 2.8 to 2.1 for population stabilization, and one of the important step towards this is addressing multiple reproductive and sexual health and family planning needs of adolescents and young people in India. A few studies recently conducted present the situation and needs of this group. Else, there remains lack of evidence on young people’s needs till recently.

Key Findings

Education and Employment of young people in India

As per NFHS-3 in India, 22 percent women aged 15-19 years and 31 percent of women aged 20-24 years had no education compared to less than 8 and 12 percent men in the same age groups. The percent of literate married women increased from only 38 percent in NFHS-1 to 46 percent in NFHS-2, and around 73 percent by NFHS-3. However, education attainment is low as only 19 percent women aged 20-24 years and 27 percent men aged 20-24 years have completed 12 or more years of education. It is also evident that gender disparities continue at all levels of education putting girls at a disadvantage.

Nearly, 27-28 percent of women aged 15-24 years were employed in agricultural work or as production workers, and almost half of men aged 15-19 and more than 81 percent of men aged 20-24 years were employed.
Age at marriage and sexual debut
Data on education and marital status of young people in India shows high levels of early marriages among young people, which compels them to be out of school, and start family life, work, and start child bearing. Almost one-fifth of young women aged 20-24 years married before age 15 and more than 47 percent of women in the same age group got married by 18 years of age (NFHS-3, 2005-6). Another major study reveals that around 40 percent women marry before the legal age at marriage for girls of 18 years and 15 percent of men marry before 21 years (Jejeebhoy and Santhya, 2007). In the rural areas, as high as 23 percent girls are married before age 15 years (IIPS and Macro International, 2007). More than half of women marry before reaching 18 years in Bihar, Jharkhand, Rajasthan, Andhra Pradesh, West Bengal, Madhya Pradesh, Uttar Pradesh and Chhattisgarh. Marriage continues to take place in adolescence for large proportions of young women and often they meet their spouse for the first time on the wedding day. Moreover, there are reports of forced sex. Nearly 5 percent of women age 15-19 years and 9 percent of women aged 20-24 years report having experienced sexual violence and almost half the women reported their current husband as the perpetrator of the violence.

Besides, there is growing evidence of premarital sexual activity among youth, particularly men. Approximately, around 15 percent of young men and fewer than 10 percent of young women have experienced pre-marital sexual relations (Jejeebhoy and Santhya, 2007).

Child bearing among young people
As a result of early age at marriages in India, women experience early sexual debut, early pregnancy and child birth, often multiple, also at an early age. There are few instances of young women giving birth before age 15, age at which the risk of maternal mortality is 5 times higher. However, around 19 percent young women aged 20-24 had their first birth in childhood, i.e., before 18 years of age. Moreover, 13 percent currently married young women aged 20-24 years already had 3 children (IIPS and Macro International, 2007). This also indicates closely spaced pregnancies. As regards the timing of first births, the proportion giving birth before age 18 declined by six percentage points (from 28 percent to 22 percent) between NFHS-2 and NFHS-3 and the proportion giving birth before age 20 fell by seven points (from 49 percent to 42 percent).

Adolescent childbearing is common in India. NFHS-3 shows that 12 percent of all adolescents (married and unmarried) aged 15-19 years have become mothers and 4 percent were first time pregnant. Among currently married women in the same age group 58 percent have begun childbearing and 44 percent were mothers. State-wide variations exists as over 25 percent of adolescent in Jharkhand, Bihar and West Bengal have begun child bearing, whereas the level of adolescent child bearing is low in the states of Himachal Pradesh, Goa, and Jammu and Kashmir.
Preferred time to have the first and birth interval

During focus group discussions, both young men and women believed that first child should be within 1-2 years after marriage, but the birth of second child can be delayed by 3-4 years as mentioned in seven of the FGDs and even up to 5 or 6 years as mentioned in three FGDs among young men and women in Madhya Pradesh and Jharkhand.

As regards the benefit of delaying the birth of second child the main reasons mentioned included care of first child, women’s health, limiting family size, and financial stability. Moreover, they also pointed out that standard of living and education of children is becoming costly.

Unmarried males and females in Madhya Pradesh and Gujarat raised concerns about lack of facilities and resources, if the family size is large.

It is revealing that a married male in Madhya Pradesh said that “Once I get a son, then I will myself go for Vasectomy” reflecting the son preference.
Around 56 percent of the total fertility is contributed by young women aged 15-24 years, of which 17-18 percent is during adolescence. This accounts for high maternal mortality and maternal morbidity. Figure 2 shows that in India, 41 percent of all maternal deaths take place among those aged 15-24 years. One of the main causes of mortality in young mothers is obstructed labour which primarily is caused by immaturity of the birth canal (Hasan, M. T, Solution Exchange, April 2012). Obstructed labour is reported to be a little higher among younger women, 72 percent among women aged 15-19 and 68 percent in the age group 20-24 (DLHS-3 2007-08).

Pregnancy experience
Circumstances of the first birth suggest that institutional delivery and skilled attendance at delivery are limited: only about half of first births (47-54 percent) among young married women were delivered institutionally and just two-thirds reported delivery by a skilled attendant. Two-thirds (67 percent) adolescents and 63 percent young women had complications during delivery and post delivery complications were reported by 42 and 47 percent respectively. Only around 55 percent adolescents and 58 percent young women sought treatment for the complications (DLHS-3, 2007-08).

Pregnancy outcome: Women in 15-19 years reported relatively higher levels of spontaneous abortion (8.3 percent). Moreover, women who were pregnant below 20 years age had a higher proportion of still birth (2 percent) (DLHS-3, 2007-2008). Higher negative outcomes of pregnancy among adolescent mothers in rural areas can be related to the lack of availability and access of health care in rural areas (NFHS, 2005-06).
Unplanned pregnancies: As per NFHS-3, 17 percent of the total births to young married mothers were unwanted, which leads to abortion, mostly unsafe. Adolescent mothers (less than 15 years and 15-19 years) are more vulnerable to risks related to pregnancy and childbearing. They are also more disadvantaged in terms of health services like antenatal and postnatal care, delivery and assistance during delivery. They suffer higher levels of postpartum complications and risk of having low birth babies along with higher levels of neonatal, postnatal, infant and child mortality (NFHS-3)

Knowledge of contraceptives is almost universal among young people. Almost 99 percent of currently married women aged 15-24 years knew of some method of contraception (NFHS-3). The awareness about methods of family planning is also increasing over the years. However, adolescents and young women from the rural areas are less likely to have information about the spacing methods of family planning. The awareness of reversible method is relatively limited among young people. Nationally, for example, women are more likely to know about pills and least likely to know about IUD.

For preventing pregnancy, oral contraceptive pills, choice, Mala D, pearl, condom, copper-T that is used by female were known to adolescents and young people in six out of 11 FGDs in Jharkhand, Gujarat and Madhya Pradesh. In three FGDs, of Jharkhand, Maharashtra and Madhya Pradesh, male operation (vasectomy), female sterilization, contraceptive injections and female condoms were also mentioned. Emergency contraceptives and I-pills were known to young informants in all the states. It was noted that only in one FGD, informants mentioned about withdrawal but Lactational Amenorrhea, and rhythm method was not mentioned at all. As mentioned briefly in the following paragraphs, for each method young men and women had some knowledge, but also had some misconceptions.

Young men and women preferred female sterilization as a permanent and safe method, as once adopted there is no fear of failure or pregnancy. Unmarried boys and girls knew about Laproscopic Tubectomy and Tubectomy, in which the fallopian tube is blocked. Young informants preferred machine operation (Laproscopy) ‘as it is very easy’, ‘done in 5 minutes’ and ‘requires less rest and care’. Some young women in Jharkhand did not prefer female sterilization as “it would change their figure and look”. Unmarried boys in Madhya Pradesh knew that Vasectomy is easy as there is no cut and non-scalpel Vasectomy is a laser operation but perceived that “male becomes weak and he cannot work properly after Vasectomy”.

Young women in all the states and services providers knew that OCPs are temporary method of family planning that has to be taken daily, weekly or monthly. Even males mention about side effects of OCP including vomiting, giddiness, obesity, fear and do not feel like eating. Talking about condom young men and women in the study states described it as ‘the most convenient and easiest method’, it is ‘reversible’, ‘accessible at many places’ and ‘can protect against HIV and STI’, but feared that it can burst.

Both young men and health staff including LHV and ANMs mentioned that Copper T or IUD are easy to use and can be used for 3, 5 or 10 years, but did perceive that ‘it can come up in stomach’, ‘cause pain and or hurts during intercourse’. Similarly, young women had heard about injectable contraceptives from its users, but could not tell about its usage. They knew that ‘it has to be taken once in three months, and costs
around Rs 60-100 and have certain problems like bleeding and pain in stomach.’ Women feared that due to usage of injectables, ‘they may not be able to conceive ever’.

Females in few FGDs mentioned about emergency contraceptives, and particularly I-pills that is brand name of emergency contraceptives in India and widely advertised, that should be consumed within 72 hours of intercourse to prevent unwanted pregnancy. Young women in Gujarat mentioned about Misopristol as pills for abortion, if women get pregnant unwantedly, probably considering abortion as one of the method of contraception.

**Ever use of Contraceptives**

Only 23 percent of 15-19 years and 46 percent of 20-24 years old currently married women have ever used some contraceptive method (NFHS-3). In similar lines, ever use of contraceptive has been 21 and 41 percent respectively as per DLHS-3, 2007-08. Ever use of contraceptive among young people has significantly increased since NFHS-2 (1998-99). Recent study by Jejeebhoy, et al reported ever use of contraceptive by 24-25 percent among young men and women. Young people in urban areas are more likely to use contraceptive compared to rural. Further analysis of NFHS-3 shows that even among those young persons who are aware of a particular contraceptive method, the use of FP method was low except for the traditional methods and condom.

**Current Use of Contraceptives among young people**

Access to contraceptives and overall use of contraception has increased over time both in rural as well as urban areas, but has remained less than desirable. According to NFHS-3, 13 percent of 15-19 years married adolescent women and 33 percent of 20-24 years old reported to be currently using some methods of family planning. The couple protection rate (CPR) among adolescent married women increased from 7 percent in NFHS-1 to 8 percent in NFHS-2 and 13 percent in NFHS-3. Similarly for married women aged 20-24 years, CPR increased from 21 percent in NFHS-1 to 26 percent in NFHS-2 and 33 percent by NFHS-3. As per DLHS-3, 11 percent women aged 15-19 years and 28 percent those aged 20-24 years reported to be currently using some method of family planning.

Only few young people practiced contraceptives to delay the first birth—just 12 percent of young men and 5 percent of young women. For three-fifths of young women, pregnancy occurred within a year of marriage (Jejeebhoy, et al, 2007).

The percentage of users of family planning increased from 15 percent to over 25 percent among rural young married women between NFHS-2 and NFHS-3 and from 12 percent to 35 percent among urban young married women during the same time. Further, about 28 percent of young married women aged 15-24 belonging to SC and non-SC/ST group reported using any contraception in NFHS-3 as against 20 percent among ST groups. The users of modern spacing methods have gone up over time from women across various education categories. Use of contraceptives increased with the educational status of women. Further analysis by standard of living index revealed
that 20 percent of young married women belonging to low SLI and 36 percent of those belonging to high SLI were users of family planning (Ram, U. 2009).

There are wide variations between the states and between the districts within the state. Current use of contraceptives among currently married young women aged 15-24 years within states ranged from 6 percent in Bihar and 10 percent in UP to 32 percent in Tripura, 35 percent in Delhi, and 47 percent in West Bengal (NFHS-2). For repositioning of family planning and catch up with the lost momentum of India’s Family Welfare Programme, the GoI is identifying districts with poor health indicators to provide extra attention from policy to practice. Use of contraceptives is not just a need but is the reproductive right of the people, and hence right based approach is the need of the hour.

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<thead>
<tr>
<th>Table 2: Percentage of married youth reporting ever and current use of contraceptive methods within marriage</th>
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<tbody>
<tr>
<td>Married women (15-19)</td>
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</tr>
<tr>
<td>Ever used any method</td>
</tr>
<tr>
<td>Ever used any modern method</td>
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<tr>
<td>Currently using any method</td>
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<td>Currently using any modern method</td>
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The predominance of sterilisation is observed in almost all states. Use of reversible contraceptives remains very low. A review of data on contraceptive behaviour of adolescents in Asian countries shows that India is the only country where such a pattern prevails (Pachauri and Santhya 2002). Just 7 percent of married women aged 15-19 year used a modern method, and 6 percent, a traditional method. Current use of modern methods ranges from a high of 18 percent in Delhi to a low of 2 percent in Bihar (Moore, April 2009).

Moreover, large proportions of youth (14-25 percent), particularly young women, reported experiencing unintended pregnancy saying that their last pregnancy was mistimed or unwanted (Jejeebhoy and Santhya, 2007).

Among the spacing methods of contraception, use of condoms is very essential as it helps to prevent both pregnancy and sexually transmitted infections (STIs). Unfortunately, only 5 percent (3.5 percent rural and 8 percent urban) young persons were currently using condoms, though condom is the most likely to be used contraceptives among young people. The use of an intrauterine device (IDU) is only less than 1 percent and that of oral contraceptive pills is around 3 percent. In spite of their young age, the predominance of female sterilization is observed even among adolescents and young women. For instance, around one percent adolescent and 13 percent young women had accepted female sterilization. Use of male methods of contraceptives has remained low among the youth, as is the case with older group.

**Condom Use for Dual Purpose**

Reposition of the condom as a suitable method for youth is very essential. Findings have suggested that consistent condom use has been rarely practiced by those reporting pre-marital sexual relations, and few married youth reported the use of condoms at the time of the interview. At the same time, widespread misconceptions prevailed about the condom, including that it can slip off and lack of sexual pleasure. Moreover, large proportions of youth reported discomfort about seeking contraceptives, including condoms, from a health care provider or pharmacy. It is important that the IEC and BCC programmes are implemented that aimed at youth for
normalising use of condom; and at the same time, service delivery structures and providers enable youth to access condoms easily and confidentially.

Moreover, as mentioned earlier, only a negligible proportion of young women (15-24 years) were using spacing family planning method, and hence updated data on contraceptive continuation or discontinuation, switching methods and failure are, limited. There were few studies done in 90s to understand contraceptive use dynamics, but, recent data are limited. Young people are more likely to discontinue using contraceptives as they desire for a child (IIPS and ORC Macro 2000). A prospective study of women using IUDs and oral pills in Gujarat reveals that 43 and 62 per cent respectively discontinued the method by the end of the twelfth month, and after eighteen months, the proportion discontinuing the method increased to 62 and 73 per cent respectively (Gandotra and Das 1996).

**Contraceptive practice among the unmarried**

Available evidence suggests that a substantial proportion of unmarried adolescent boys and girls are sexually active, placing them at risk of unintended pregnancy and sexually transmitted infections. A review shows that 15-30 per cent of adolescent boys and up to 10 per cent of girls in India were sexually active before marriage (Jejeebhoy and Sebastian 2003). Little is known about the contraceptive behaviours of unmarried adolescents. National surveys have largely excluded this group and only a few small scale studies have explored the contraceptive behaviours of unmarried adolescents. Because relatively few unmarried adolescents report being sexually active, data on contraceptive use from these studies may not accurately reflect their contraceptive behaviours. These studies indicate, however, that a large majority of unmarried, sexually active adolescents do not use any contraceptive method or depend on natural methods (Pachauri and Santhya 2002). NFHS-3 for the first time collected data on the ever use of contraception by adolescent unmarried women who ever had sex. NFHS-3 shows that only about 18 percent of 15-19 years old and 30 percent of 20-24 years old unmarried women who ever had sex had used any form of contraception. Access to contraception might be more difficult for unmarried adolescents as reflected by the difference in ever use of contraception among married and unmarried adolescent (Figure 5).

According to a review of studies on premarital sexual behaviour among adolescent boys in India, the vast majority had engaged in unprotected sex, even with commercial sex workers (Jejeebhoy, 1996).

**Unmet need of Contraceptive**

Unmet need for family planning was added to the fifth Millennium Development Goal (MDG) in 2006 as an indicator for tracking progress on improving maternal health. Family planning has an important role to play in achieving the MDGs and ensuring that health is within reach for all people. Unmet need for family planning is an important indicator for assessing the potential demand for family planning services. By definition, currently married women who are not using any method of contraception but who do not want any more children are defined as having an unmet need for limiting and those who are not using contraception but want to wait two or more years
before having another child are defined as having an unmet need for spacing. The sum of the unmet need for limiting and the unmet need for spacing is the unmet need for family planning.

There is substantial unmet need for family planning among married adolescents and young women, which is about 27 percent among adolescent aged 15-19 years and 21 percent among married young women aged 20-24 years. The unmet need for spacing is around 20 percent and for limiting it is 4 percent among young people (NFHS-3). According to DLHS-3, the unmet need both for adolescent and for young women is around 28 percent, a large share being that for spacing (26 percent for 15-19 years and 19 percent for 20-24 years). Furthermore, unmet need of family planning among youth is twice that of older populations. The analysis indicates that though the overall percentage of demand satisfied for family planning has increased over the years, the young married women remained at a disadvantage with a much lower percentage of their demand for family planning services being satisfied, especially more so for adolescents in the age group of 15-19 years old. It is estimated that if all unwanted births could be eliminated, the total fertility rate would drop to the replacement level of fertility.

State-wise information shows the highest unmet need of around 32-41 percent in the states of Bihar, Uttar Pradesh, Manipur, Meghalaya, Nagaland and lowest of about 12 percent in Jammu and Kashmir, Himachal Pradesh and Haryana.

Analysing the unmet need in Uttar Pradesh, which is around 30 percent, the authors concluded that the unmet need is especially high among younger women, women with few living children, and women with no living sons. By socioeconomic characteristics, the unmet need is especially high among women who are from rural areas, illiterate, whose husbands are illiterate, who are Muslim, scheduled-tribe, and those not exposed to media messages on family planning. The authors further concluded that unmet need does not vary much by child loss, family type, or (in villages) by the presence of an all weather road or distance from a family planning source (Radha Devi D. Et.al. 1996). Another study in Thiruvananthapuram Corporation revealed that the unmet need of family planning was higher in urban slums (17 percent) than in general population.

In addition, there is huge unmet need for immediate post-partum contraception among women who deliver at public sector facilities under the Janani Suraksha Yojana in high focus states. These women are brought to the facility by the ASHA worker as a part of her compensation regulated work and after delivery are discharged within 4-6 hours due to heavy work load and lack of space. The whole focus of JSY has been only on safe institutional delivery driven by compensation package for the delivering woman and ASHA worker. However, these women do not receive any FP information during ANC or PNC period (FPA India, 2012)

Figure 6 presents the total demand for family planning among young people by states, which is equal to contraceptive prevalence (met needs) plus unmet family planning needs. The total demand for family planning was over 50 percent among young married women in the states of West Bengal, Tripura, Delhi, Kerala, Maharashtra, Manipur and Meghalaya and less than 40 percent in eight states of Rajasthan, Orissa, Bihar, Madhya Pradesh, Haryana, Jharkhand, Chhattisgarh, and Karnataka.
Sources of information of contraceptives
Sources of information for contraceptives are mostly hospital, nurse, doctors and health workers. Frontline workers including ANM, ASHA were mentioned in four of the FGDs in Jharkhand, Maharashtra and Gujarat. Mass media sources including TV, newspaper, radio, posters, exhibitions and friends were some of the other sources. NGOs and organizations working for the benefit of people are also source of information for female in Gujarat. Red Ribbon Express, run by National AIDS Control Organization, was also mentioned as a source of information for condoms by unmarried men and women in Madhya Pradesh. Users of injectables contraceptives themselves were a source of information for women in the community in Jharkhand, Madhya Pradesh and Gujarat.

Sources of availability of contraceptive services
ANMs, ASHAs, AWWs and medical stores were mentioned as major sources for procuring contraception, and some procure from sub center or hospital. Condoms were procured free as they are available free of cost and also at subsidized price in hospitals or with frontline workers, at medical and grocery stores, pan shops and bus depots. Some get it through unmanned condom boxes kept in public places as told by unmarried boys in Madhya Pradesh.

Reasons for young people not using contraceptives to delay or avoid pregnancy
Unmarried group of men from Madhya Pradesh stated that lack of awareness about contraceptives and lack of awareness about programs are the main causes for not using contraceptives among young people who want to delay or avoid pregnancy.

Even married men pointed out that apart from lack of knowledge regarding methods of contraceptives, and its use, shyness in buying condoms from medical store in presence
of other people, difficulty in storing condoms at home, unavailability of enabling
environment to discuss family planning with family members and pressure of having
children from elderly members in family are also reasons for not using contraceptives.

Unmarried women also suggested that lack of awareness is the main cause that people
do not use contraceptives. Besides, fear of side effects including infection affecting
the reproductive system, weight gain, and nausea refrain young women from using
contraceptives. More seriously some of these unmarried women said, ‘*doctors
suggested not using any contraceptives until first pregnancy*’.

Reasons put forth by married women for not using contraceptives included fear, lack
of knowledge regarding its use. Some of the women came out during at least five FGDs
that government condoms are not good, and that women become pregnant even after
sterilization and vasectomy. Informants also mentioned about relying on home-made
remedies that can prevent pregnancy instead of using modern methods.

Female sterilization and use of condom is not allowed in Islam religion has come
through in four FGDs in Jharkhand, Madhya Pradesh and Bihar. Moreover, those who
have undergone sterilization, either male or female, cannot go for ‘*Haj*’ (The religious
visit to pilgrim Mecca).

Young informants also mentioned about ‘*pressure from family members on not using
any contraception, as they want first child early*’ and also believe that ‘*children are
blessings of god, so pregnancies should not be prevented*’. Even unmarried men in
Madhya Pradesh said that,

> “If couple is using contraception and family members come to know about it,
and if later after stopping family planning, by chance woman could not
conceive, then they have to listen and bear the torture for lifetime”.

### Barriers to Use of Family Planning

Married adolescents and young people are registered as eligible couples and can
freely attend family planning centres and avail reproductive health services.
Unmarried youth do not access these services due to social stigma and the
judgmental attitude of health providers in the public health facilities and
family planning centres. In some cases, contraceptives may simply be unavailable or
unaffordable for young individuals. Several barriers to use of family planning are
briefly discussed in the following section.

### Lack of understanding:

General awareness of contraceptives is universal, as 99 percent of currently married women aged 15-24 years were aware of at least one
contraceptive method. But, understanding about spacing family planning methods and its details is limited. Family planning programs typically incorporate educational components only to help women choose a family planning method, but understanding each method, its appropriateness, its advantages and disadvantages, and process of adoption is limited.

Adolescent health is not a mainstream strategic component of health care in India. Of late, adolescent health has been included as a component of the reproductive health package in the RCH Services Program. But, there is no clear definition of a strategic approach and hence program is implemented with different understanding, clarity, and activities to provide adolescent health care.

There are very few research papers that have analysed the information to understand the special reproductive health needs of married and unmarried adolescents. Nonetheless, there are only few programs that have distinguished between various reproductive health needs of married and unmarried adolescents.

Poor counseling skills and services are the major constraints to improved adolescent reproductive health. Health care providers have not received any training in sexual and reproductive health counseling and are not sensitized to adolescent health needs. Counseling services hardly exist.

The health care providers are seldom approached by married and unmarried adolescent and young people, but the providers lack understanding of assessing the needs and providing quality services to young people. Besides, stigma among providers in providing services to the adolescents, drive the young beneficiaries away from health workers.

One of the major reasons for not using contraception is concern about the health effects of contraception, cited by one-fifth of the respondents. This is because young people lack understanding about the contraceptive and the benefits of its use, as such counselling or information sharing is not done by the health workers.

**Availability of FP services:** Regular and adequate supply of contraceptives is essential for providing family welfare services. In India, oral pills, IUD and Nirodh were available in only 58, 56, and 59 percent of population in the PHCs respectively according to Facility Survey 2003 (Uttekar, B. V. 2011).

<table>
<thead>
<tr>
<th>Table 3: Stock of selected items of health care in primary health centre</th>
<th>Percent of PHCs having some stock on the day of survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral pill</td>
<td>61</td>
</tr>
<tr>
<td>IUD</td>
<td>59</td>
</tr>
<tr>
<td>Nirodh</td>
<td>56</td>
</tr>
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During FGDs, women said that accept for injectable contraceptives all other methods of contraception are easily available. They also said that they had heard of female condom, yet these are not accessible easily in market.

**Accessibility to services:** When newly married adolescents are the intended target of formal programs, many are unable to receive services because they lack freedom of movement, autonomy and access to resources. Even more important, decisions about
care are often out of young women’s hands, and are instead made for them by husbands and mothers-in-law.

Government of Gujarat initiated 41 ARSH centres in 2006. Out of 21 ARSH centers visited for assessment by Centre for Operations Research and Training, 17 (81 percent) centers were functional at the time of fieldwork. Besides providing reproductive and sexual health (RSH) services to the adolescents, ARSH centers carried out various other related activities for strengthening the ARSH program, such as offering preventive, curative and informative services including follow-up and counseling, and carrying out adolescent vaccinations.

Though efforts were made to generate awareness about ARSH centres by talks in schools, communities, slums, Anganwadi centers, hospital OPDs, and by exhibitions, handbills, leaflets, meetings with private doctors, and through media, adolescents in the community were not aware of the ARSH centres. Hence, out of 28 FGDs conducted, in only two FGDs with adolescent girls and one with boys, the informants had heard of ARSH center at their schools from the visiting doctors of government hospitals. Branding of the centers helped adolescents to identify themselves; For example, the two ARSH centers with highest turnover of adolescents had given a unique brand name to the center.

A major challenge faced in implementation of ARSH centers was lack of human resources for running ARSH center efficiently or creating an enabling environment, staff turnover/transfers, and low utilization of the center. In addition, adolescents were not interested in knowing about reproductive sexual health information. Besides, the informants felt that, “ARSH center should not be in hospital setting. Adolescents needed their own space to express themselves”. Only half of the health staff mentioned that they could ensure confidentiality, maintain cleanliness, and provide all essential services and information (Uttekar, B. V., 2008).

**Reproductive and Sexual Health needs**

Unmet needs for Reproductive and Sexual Health (SRH) among young people are varied and huge, coupled with lack of programmatic efforts and inadequate understanding of the significance of SRH information and services.

**Knowledge of reproductive health:** Centre for Research in Development and Change (CRDC) is implementing an Operations Research among adolescents for providing sexual and reproductive health information and services as supported by Indian Council of Medical Research (ICMR). A panel of peer educators have been trained to reach the adolescents with correct information. A baseline study conducted by CRDC among adolescent girls and boys in rural areas of Vadodara reveals interesting and thought provoking results. The baseline study reveals lack of correct and complete information about menstruation, sexual relationship, family planning method, pregnancy, delivery, and also STI and RTI. Myths are still prevailing among adolescents related to menstruation and family planning methods. No proper guidance and services were available to them. Adolescent lacked proper knowledge about health and hygiene issues and about consequences of not maintaining cleanliness. Conventional norms and mind set of parents about SRH issues, particularly for girls remained a paradox.
Around the developing world, digital technology, mobile communications and social media are connecting young people as never before - not only to one another, but to the world of information and ideas - and inspiring them to find innovative ways to improve their own lives. In the favelas of Rio de Janeiro, teenagers use cameras tied to the strings of kites to map the risks in their neighbourhoods. In Uganda, and other nations, young people use SMS texting to report on conditions in their communities, and to offer their ideas for how to address problems (Lake, A, 2012). There has been exponential growth in the use of social media such as Facebook and Orkut, etc. However, internet use is more likely with higher income and education, and more men than women (Jejeebhoy, S., et al, 2007). While young people's knowledge and awareness about sexual and reproductive health is increasing, much of this knowledge remains superficial and ridden with myths, misperceptions and a sense of invulnerability (Jejeebhoy, S. and Sebastian, M. P. 2003). In 1998, Huges and McCauley suggested that adolescents must be taught generic and health-specific skills necessary for adopting healthy behaviours (Blanc and Ann, 1998). However, millions of adolescents, particularly girls, still do not have access to information and communication technologies, which further excludes and marginalizes them. Among young mothers, more so among adolescents, knowledge about RTI and STI, its mode of transmission, and HIV and AIDS (47 percent), its mode of transmission, prevention, has been low whereas misconceptions about transmission of HIV and AIDS are high. They also lacked information about the place where HIV/AIDS test can be done.

Apart from self, adolescents and young women also lacked knowledge about child-care practices. For instance, for knowledge of each danger signs of new born (blue tongue on lips, difficulty in breathing, cold/hot to touch, develop yellow staining on palm of soles, abnormal movements, poor sucking of breast or baby did not cry) has been found to be low among adolescents and young women compared to their other counter parts (DLHS-3, 2007-08).

Similarly, providing colostrums, initiating breastfeeding within one hour of birth, exclusive breast feeding up to 6 months, knowledge of diarrhoea management, knowledge of treatment of acute respiratory infection invariably has been found to be relatively low amongst adolescent mothers and young women aged 20-24 years as compared to other older women (DLHS-3, 2007-08).

Health seeking behaviour
Women (48 percent) are facing many socio-economic challenges in accessing health services. The most common of these are distance to a health facility, transport, and concern over non-availability of health provider especially the female health provider, and/or drugs at the health facility and not wanting to go alone (NFHS-3).

Contacts with Health System and Health Workers
Besides, the public health system at present does not adequately address the sexual and reproductive health and family planning needs of adolescents and young people due to various reasons. There are no clear policies governing how health service providers should serve adolescents. Existing protocols also do not clearly state how adolescent rights; confidentiality and privacy issues need to be protected. Service providers also need orientation and sensitization on Adolescent Sexual & Reproductive Health (ASRH) issues. Referral mechanisms from one level to another level of service delivery are yet to be organized and networking between institutions for addressing adolescent reproductive health needs strengthening. Large sections of youth who are
sexually active are still excluded from the family welfare programmes, which is still a big challenge to be met.

Moreover, adolescents in particular, are not involved in decision making for their own health, and only 23 percent were allowed to go alone to the health facility. Younger mothers experience higher rates of spontaneous abortions and induced abortion. It is important to note that the lack of availability and access of health care in rural areas is related to higher negative outcomes of pregnancy among adolescent mothers in rural areas (NFHS-3, 2007). Young women are powerless, and voiceless in matters relating to their own lives. Most couples do not discuss with each other when to have their first child, birth spacing, or contraception (Khan and Patel, 1999, NFHS-3 2007).

**Role of Service Providers:** Young women or recently married couples are less likely to be contacted by a health worker, as the workers may assume that young people do not need family planning services. Encouragingly, NFHS-3 reveals that once contacted, most of the adolescents are satisfied with the amount of time spent by the health worker with them and majority felt that the health worker spoke nicely to them.

**Sources of information for reproductive health**
Reproductive health information and service needs of young men and women are quite different. Although the RCH Programme has advocated special services for youth, including the unmarried, these services have not reached the youth. For example, only few seek care for symptoms of STIs or gynaecological problems, and most youth who seek care prefer private to public sector facilities. There is a need to sensitise health care providers about the special needs of young people, heterogeneity and vulnerability of unmarried and married young women and men, and to orient them to the need for developing appropriate strategies to reach these diverse groups, including newlyweds (Jejeebhoy, et al, 2007). Health care providers should cater to married and unmarried young people and recognize their need and right to sexual and reproductive health information and services. Counselling and contraceptive services must be made available to all young people, married and unmarried, in a non-threatening, non-judgmental and confidential environment.

**Exposure to Media**
Mass media plays an important role in providing information and awareness on a range of issues including health and family planning. According to NFHS-3, 29 percent of young women and around 12 percent men are still not exposed to any form of media. Besides, there is a large gender differential in exposure to media as is revealed by NFHS-3. Television is the most common form of media viewed by 59 percent women and 71 percent men. Low percentage of women reads a newspaper or magazine and visits the cinema/theatre compared to men.

Moreover, the current information and services that are available are not specific to adolescents and the quality of such information and services is often poor, inappropriate and inadequate for this age group. Furthermore, their sources (friends or peers) of information are often unreliable and equally uninformed, whereas...
traditional norms by and large discourage adolescents to discuss their sexual and reproductive health and rights with their parents, elders and teachers.

Television has been reported to be the major source of awareness about methods of family planning (NFHS-3). More than half of the young people reports that they have seen family planning messages on television and one-third have heard it from radio. A higher proportion of young men are exposed to family planning messages as compared to their women counterparts. Nearly 36 percent of adolescent and young women are not exposed to any media source for information about FP as compared to only 6 percent of men.

According to DLHS 3, only 46 percent adolescents and 56 percent young women ever received family life education mainly from school or college (80 percent). Besides such gender differentials also exist in other areas as well, including, exposure, access to media, mobility, and participation in decision making processes including their own health care.

The state of Gujarat has initiated 35 Adolescent Friendly Health Centers (AFHC) for imparting adolescent friendly health services, education and counseling for preventing early marriage, HIV/AIDS, and other reproductive and sexual health related problems. Assessment of the AFHC centres by CORT shows that adolescents are reluctant to visit hospitals and absence of medical officers and para medical staff poses serious problems. Adolescent boys and girls, and their parents need to be informed about adolescent RSH problems, services offered at the center and its timings and location. Health staff needs to be first oriented on ARSH issues to provide services to adolescents. The clinical services need to be easily accessible and culturally acceptable.

Furthermore, the psychological and social barriers included shyness of adolescents to discuss the reproductive health issues, keeping reproductive health problems secret, traditional values, norms and myths, and parents/guardians and elderly people (who act as gatekeepers) who are uninformed about ARH needs. Because sexuality and sex education is discouraged by the religiously sanctioned culture, multifaceted programmes are to be strategized providing ASRH services in rural areas (Hasan, M. T., solution exchange, April 2012).

Nutritional Status
Almost half of adolescents (both women and men) come below the normal range of nutrition varying from totally thin to severely thin and more than half of the young women are anaemic. Acute anaemia is crippling India's youngsters, especially those aged 15-19 years. Union health minister, Ghulam Nabi Azad, said on April 24th 2012 that more than five Crore adolescents are anaemic in India. Adolescent girls are more vulnerable to anaemia due to the multiple pregnancies effecting the growth of mothers who is otherwise nutritionally depicted and due to loss of blood during menstruation. As per District Level Health Survey (DLHS) (2002-04), as high as 73 percent adolescent girls were anaemic in India with prevalence of severe anaemia among them much higher (21 percent) than that in preschool children (2 percent).

Around 12 percent women (15-19 years) were under 145 cm in height increasing their risks in pregnancy and probability of giving birth to low-birth-weight babies. During the last few years, the Centre as well as the State Governments has initiated a wide variety of public-private-partnership arrangements to meet peoples’ growing health
care needs. Contracting services is the predominant model for PPP in India and the existing PPP services does not allow easy generalization.

Thus to sum up, the use of modern family planning methods has increased significantly, yet there are still significant levels of unmet needs for family planning among young people. It is important to meet this unmet need by repositioning family planning to reduce the number of unintended pregnancies, and improve women’s health and lives, which would also result in lowering maternal mortality rates.

Way forward

• Recently, policies and programmes have laid focus on adolescent and young people in India. There is a need to have standard guidelines in implementation of the strategies to address adolescent sexual and reproductive health needs for better implementation of the same.
• Integrate family welfare services with other health sector ensuring access to contraception at the community level can increase if information and referral services are coordinated and available through HIV/AIDS and maternal and child health systems.
• Change in the mind set of service provider to respect and provide information and services to adolescents and young people.
• Training is required of health workers to help ensure good planning for and access to family planning commodities and supplies. Also, support is needed not only for public clinics but also for social marketing approaches, and franchising schemes.
• Knowledge and skills will be given to health service delivery personnel catering to the adolescents’ reproductive and sexual health needs.
• Need to invest on education and retaining adolescents, particularly girls, in school that would go a long way in empowering women, delaying age at marriage, delaying childbearing and improving health status of women and new borns.
• Livelihood programmes for young people not only help them in learning new skills and getting better employment, but also provide a platform and exposure to new learnings, interact with various people, and gives an opportunity to discuss new aspects including reproductive health.
• Advocacy for delay in age at marriage to ensure optimum health and nutrition status. Marriages after the legal age at marriages would help in reducing the incidence of pregnancy loss, which otherwise is higher amongst the adolescents.
• There is a need to increase correct and complete knowledge about contraceptives especially spacing methods among young people through clinic and community-based programmes.
• Delaying child bearing, particularly first birth, until the women is physically and emotionally matured and economically stable. This would also give the couple an opportunity to understand each other better, minimize unplanned pregnancies, and enhance child care practices.

Box 4: Suggestions by young informants to improve the use of contraceptives

• Awareness regarding all contraception methods should be spread
• Frontline workers themselves should provide pills to women
• Condoms should be made available at depots manned by men and women in villages, so that others men and women can access that without shy and difficulty
• Injections should be made available free of cost in government hospitals for women
• Hoardings and advertisements should be used as a medium to spread awareness
• Sex education should be provided in the school, parents and teachers should be sensitized
• Government should do branding of Nirodh for better presentation so that people’s misconceptions are taken care of related to the quality of condom provided by government.
• Advocacy for small family norm, gender equity to reduce son preference are cross cutting issues.
• Ensure the availability of family planning commodities appropriate to age, reproductive intentions or health needs of young people.
• Provide informed choices as per the preferred methods of the people under reproductive age.
• Ensure the quality of family planning services focusing on the choice of contraceptive methods, information given to clients, the technical competence of providers, interpersonal relations between providers and clients, follow-up and continuity of services, and the constellation of services offered. Good-quality services not only attract new clients but can also help prevent contraceptive discontinuation (Khan, Gupta, and Patel, 1999).
• Condoms need promotion for dual protection for unintended pregnancy and infection prevention.
• Male involvement and concern is required for increasing the acceptability and prevalence of contraceptive use, and enhancing spousal communication and support apart from sharing responsibilities and resources.
• Programs should put emphasis on appropriate counselling and involvement of male partners in decision-making to reduce discontinuation of contraception and unmet needs. Misconceptions among young men and women regarding various methods of family planning needs to be dispelled.
• Expand access to and demand for a broader mix of contraceptive methods by involving community stakeholders and others. There is an urgent need to bring down the unmet needs of contraceptives among adolescents and young people.
• Equity in terms of services provided to women from different religions, caste, socio-economic levels, and particularly the disadvantaged group. Similarly, there are huge variations between the states and districts, rural and urban areas, slum and non-slum areas that need to be minimized.
• Supply systems that support family planning need to be reliable, to ensure continuity in use and access to quality assured contraceptive supplies. Regular indents, forecasting problems such as floods or festival holidays, adequate systems of supply and logistics management, and fund flow needed to ensure supply of contraceptives.
• Social marketing, franchising systems, and other reliable public private partnerships can be worked out to ensure supplies.
• Focus beyond married women to engage men and address the needs of unmarried youth regarding contraception. Couple communication about family planning needs more emphasis.
• Ensure full antenatal care services, institutional delivery, proper information of complications during antenatal, natal and post natal care and treatments, referrals to be made to reduce maternal morbidity and mortality.
• It is necessary to improve the nutritional status of adolescent girls to make a significant dent on low-birth weight (LBW) babies and infant/child maternal mortality.
• The paper provides important information related to the situation of adolescent and young people in India, and also highlights the information gap. There is a need to have primary data analysed by age and gender. It is fortunate and laudable that MOHFW did secondary analysis of data from three rounds of NFHS for the age group of 15-19 and 20-24 years. For example, Annual health survey has recent data up to district level in the selected Empowered Action Group states, but not complied by age group, particularly of adolescent and young group.
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