"Sexual Health of Adolescents in India: A Female Scenario from NFHS-3"

Introduction: Adolescent girls in India are a particularly disadvantaged group in relation to sexual and reproductive health due to their ignorance of matters related to sexuality, lack of factual knowledge about contraception, early marriage and child birth and their inability or unwillingness to use most family planning and health services despite a number of national and state-specific programmes have been implemented to raise awareness about the sexual and reproductive health among the young people. Gender and sexual violence, sexually transmitted diseases, reproductive tract infection and HIV/AIDS are some of the risks associated with sexual activity under these circumstances. Adolescence is shrouded in myths and misconceptions about sexual health and sexuality. In Indian culture, talking about sex is taboo. Consequently, little information is provided to adolescents about sexual health. Instead, young people learn more about sexual and reproductive health from uninformed sources, which results in the perpetuation of myths and misconceptions about puberty, menstruation, secondary sex characteristics, physiological and body changes, masturbation, night emissions, sexual intercourse, and STIs. In India, one-half of all young women are thought to be sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15. There are approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. A study conducted in 1997 of boys and girls from the selected colleges of Mumbai revealed that a large percentage of boys and girls reported engaging in non-penetrative sexual experiences (e.g., kissing, hugging, touching sexual organs), but only 26 percent of boys and 3 percent of girls reported that they had experienced sexual intercourse. The study also revealed that less than 50 percent of the boys who reported that they had experienced sexual intercourse had used a condom, although all of them said they knew about condoms and their function. Another study on sexual behavior and attitudes among urban college students reported that 28 percent of males and 6 percent of females were sexually active. A study in 2000 in Madras found that 13 percent of male school-going adolescents and 10 percent of female school-going adolescents clearly approved of premarital sex. The study also revealed that 14 percent of the students, both boys and girls, stated that premarital sex is allowable for males only. A study conducted in Rajasthan on adolescent boys' and girls' knowledge and awareness of sexual behavior revealed that more than half of the adolescent boys (ages 15–21 years) reported that they masturbated, and the practice was reported more often among rural and older boys. More than one-third of the

adolescents said they touched their body in some sexual manner, and about 20 percent had touched their genitals. The study also revealed that 15 percent of the adolescents had experienced sexual intercourse and 21 percent of those reported having had a homosexual relationship.

Focus: This paper exclusively focuses on adolescent girls from age 15-19 examining their sexual health scenario where the data sources were extracted from the NFHS-3. This NFHS-3 interviewed a total of 124,385 de facto women age group 15-49, out of which 24,811 adolescents were filtered for analysis. Majority of the adolescents were represented from the state of Uttar Pradesh (18.8%), followed by Bihar (9.5%) and Maharashtra (9.1%) and the least were represented from the state of Sikkim, Nagaland, Goa, Mizoram and Arunachal Pradesh. Majority (70%) of the adolescents represented from the rural place of residence while 30 percent were from the urban setting. Seventy-eight percent were belonging to Hindu religion followed by Muslim (16%), Christian (2.1%) and Sikh (1.6%). Eighty-nine percent of the adolescent were belonging to Caste and only 7 percent were of Tribal. Nearly 70 percent were unmarried, about 27 percent were currently married and only 2.9 percent were married but not performed gauna, while .3 were either divorced/widowed/deserted and .2 were found to be separated. Majority of the respondents had 8-9 years complete level of education (23.6%) while 21.7 percent had no education at all at the time of the survey. Overall 73.7 percent were found to be literate among the adolescents. Around 73 percent were found to be unemployed while only 26.6 percent were currently employed. Most of the adolescent were engaged in agricultural sector (20.6%) and nearly 10 percent were of unskilled and skilled manual works and only 1.4 percent were in service sector.

Sexual activity: About 27.7 percent of the female adolescents had reported to have first sexual intercourse at the time of the survey out of where 3 percent had pre-marital sex while 24 percent had sex at their first union. Around 8 percent had first sexual intercourse before the age of 15. The mean age at sexual debut is 16.98 and only 3 percent had used condom at their first sexual encounter. Only 0.4 percent of the unmarried adolescent had recent sexual activity in the last 12 months and about 18 percent had used condom in the last sexual encounter. The differentials in age at first sex for young women reflect the influence of factors associated with delayed marriage, eg., young women in urban areas are much less likely to have had sex by age 15 or by

age 18 than young women in rural areas. Education, exposure to media, and wealth quintiles also display a negative association with all three indicators.

Pregnancy and Motherhood: Overall, 12 percent of women age 15-19 have become mothers and 4 percent of women age 15-19 are currently pregnant with their first child. This means that one in six women age 15-19 have begun child bearing. The percentage of women who have begun childbearing increases sharply with age, from 3 percent at age 15 to 36 percent at age 19. The child bearing is more than twice as high in rural areas (19%) as in urban areas (9 percent). The level of adolescent pregnancy is 9 times higher with women with no education than among women with 12 or more years of education. The adolescent motherhood is fives times as high for women in households with the lowest wealth index than for women in households with the highest wealth index. The proportion of adolescent's child bearing is highest in Jharkhand (28%), West Bengal (25 percent) and Bihar (25%). The lowest level of Adolescent child bearing is in the state of Himachal Pradesh, Goa and Jammu & Kashmir.

Contraception: Ever use of contraception provides a measure of the cumulative experience of a population with family planning. Majority of the married adolescent uses modern method of contraception such as Condom/Nirodh (3.3%) followed by using Pill (2.2%). Among the sexually active unmarried adolescent majority uses Condom/Nirodh (7%) followed by injectables (1.2%). Generally, over the past 13 years there has been a steady increase in the CPR from 41 percent in NFHS-1 (1992-93) to 48 percent in NFHS-2 (1998-99) and further to 56 percent in NFHS-3. The use of contraception has increased steadily in both urban and rural areas, but the pace of change has been somewhat faster in rural areas (16% points) than in urban areas (13% points)

Sexually Transmitted Infections: Information about the incidence of sexually transmitted infections (STIs) is not only useful as a marker of unprotected sexual intercourse, but also as a co-factor for HIV transmission. In view of the importance of STIs in HIV prevention programmes, since the inception of NACP-1, NACO has been making special efforts to promote early diagnosis and treatment of STIs as part of its family health awareness campaign. About 1.4 percent of adolescent had reported having had STI, while 9.8 percent had a bad smelling, abnormal genital discharge, 1.7 percent had a genital score or ulcer. The overall reported prevalence of STIs/STI symptoms among adolescent is higher for those in rural areas, those with

little or no education, those not regularly exposed to media, those belonging to scheduled tribes, those in the lowest two wealth quintiles and women who are production or agricultural workers. The report having an STI is highest in Madhya Pradesh (5%), followed by Uttar Pradesh, Bihar and Delhi (3 %).

Access to Health Services: Many factors can prevent women from getting medical treatment for themselves when they are sick and want to seek treatment or advice. Nearly 47 percent reported that there is to be at least one big problem for themselves in obtaining medical care. The most commonly reported problem is distance to a health facility reported to be a big problem by one-quarter of women. As one would expect, distance is a more common challenge to be a big obstacles to obtaining medical care. Forty-four percent of women from scheduled tribes report to be a big problem. Three other problems are each cited by as many women as concern that no providers available, concern that no drugs available and having no transport. The mean number of big problems reported decreases from 2.6 to 0.5 as wealth status increases from the lowest to the highest wealth quintile.

Conclusion: Findings suggest that significant strides have been made in articulating a commitment to addressing many of the sexual and reproductive health needs of adolescents and youth. However, there remains a considerable schism between the commitments made in policies and programmes, the implementation of these commitments and the reality of young people's lives in India. At the state level too, the implementation of programmes to meet these commitments varies considerably. Policies and programmes have recognised the importance of improving sexual and reproductive health and choice among young people and the importance of healthy youth in shaping India's future. Efforts have been initiated to translate this commitment into practice; what is needed is a similar level of commitment to ensuring that programmes do indeed reach young people, that the scope and content of programmes are expanded, and promising lessons are assimilated and scaled up.

References:

Greene, M.E., S. Razekh, K-A. Amen et al. 2002. *In This Generation: Sexual and Reproductive Health Policies for a Youthful World.* Washington, D.C.: Population Action International.

Jejeebhoy, S.J. and M.P. Sebastian. 2004. "Young people's sexual and reproductive health," in *Looking Back, Looking Forward: A Profile of Sexual and Reproductive Health in India*, ed. S.J. Jejeebhoy. New Delhi: Rawat Publications.