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Investing in Adolescent Health: Harnessing India's Demographic Dividend

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ABSTRACT

Adolescents comprise a significant proportion of India's population. Despite improvements in various outcomes, this demographic continues to face serious challenges to their health and well-being, including high levels of teenage pregnancies, low rates of antenatal care checkups for adolescent pregnancies, and lack of safe menstrual practices among adolescent girls. Investing in adolescent health should therefore be a policy priority. This report outlines adolescent health issues and makes an assessment of initiatives across the country to address them. It also explores the potential for scaling up some of the best practices among these measures, and highlights the need for policy to be supported by reliable data.

INTRODUCTION

There are 1.2 billion adolescents in the world, of whom nearly 90 percent live in low- and middle-income countries (LMICs). In many of these countries, collaborative and adolescent-led approaches to health have had an impact.[1] India is home to over 250 million adolescents[2] (between the ages of 10 and 19) who constitute 20 percent of the total population, making adolescent health crucial to achieving the country's Sustainable Development Goals (SDGs).

Adolescence is a critical phase for achieving human potential. Investing in adolescents not only ensures that they are healthy today, but that they grow into healthy adults in the future, who will in turn have families of good health.

The fourth National Family Health Survey (NFHS-4) found that 31 percent of married Indian women who have given birth at that time, did so before the age of 18.[3] While a number of interventions have been developed for married adolescents, these have not been scaled up to meet the needs of this cohort. There is ample evidence that teenage pregnancy leads to undernutrition in the infant and has acute negative impacts on the teenage mother's health.[4] To have healthy mothers, healthy babies, and consequently for the future, a healthy population, it is imperative to prevent pregnancies among adolescents. Despite a fall in the number of child marriages in India over the past decades, teenage pregnancies are a lingering challenge in many states such as Assam, Tripura and West Bengal; this needs urgent attention. If the incidence of child marriages and teenage pregnancies is arrested, there is a chance of bringing down maternal and infant mortality rates as well.[5]

Data reveals that only 57 percent of pregnant adolescents are registered during their first trimester, and only half receive the four mandated antenatal care (ANC) checkups during their full term.[6] While 85 percent of public health facilities in India have delivery facilities, 15 percent of deliveries still take place at home. This can put the health of the mother and her child at risk, especially for younger mothers.[7]

Four of every ten adolescents have anaemia, which creates various health issues and affects their school attendance.[8] This is an issue that should be urgently addressed as part of India's adolescent health initiatives. There are many other goals, including promoting sexual and reproductive health, and mental health, preventing injuries, violence and substance abuse, and addressing non-communicable diseases. For such programmes to succeed, stakeholders must employ multi-pronged strategies, and leverage technology and the media for better delivery and impact. The 2016 Lancet Commission Report,[9] *Our Future: a Lancet Commission on Adolescent Health and Wellbeing* found that among the most serious health concerns among adolescents are road accidents, suicide, tuberculosis, and mental ill health.

Knowledge of sexual and reproductive health even among the 15-24 age group is limited, although a considerable proportion of this group is sexually active.[10] The risk of contracting sexually transmitted diseases is high in this age group, aggravated by lack of access to correct information.

To be sure, there are wide disparities in the state of health for adolescents belonging to different economic cohorts. The invisible, out-of-school adolescents, who belong mostly to marginalised communities, as well as the young people in detention or care and protection homes—face even more serious threats to their well-being. Meaningful participation of such adolescents should be ensured, and their views considered while planning and implementing intervention programmes.

The United Nations Children's Fund (UNICEF) has launched a campaign called *Generation Unlimited*, known in India as *YuWaah!*, to make transformative changes in children and prepare them for life after school.[11] To support the campaign, progressive linkages and employment opportunities have to be created.

Issues pertaining to boys are often neglected in programmes for adolescents, where focus is predominantly on girls. These could be related to their sense of masculinity, the violence they can be subjected to, and the

challenges they face because of the gender roles ascribed to them as boys. For example, boys' specific needs like calcium and vitamin D that supplement their growth must be studied,[12] as well as issues of sexual and reproductive health. Their vulnerabilities, such as the likelihood of them engaging in unsafe sex, or their insufficient understanding of their gender roles, should be studied. They may also suffer from mental health issues, but may be reluctant to seek help because of social norms that force boys to hide their frailties.[13] Therefore, conducting parenting workshops, and engaging boys specifically, are important.

Indeed, India has been a frontrunner in making commitments on adolescent health on international platforms and in designing corrective policies, within its broader journey towards universal health coverage. The Adolescent Reproductive and Sexual Health (ARSH) policy of 2006 was a milestone in India's journey to achieving sustainable adolescent health; and so were the Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) strategy of 2013, and the *Rashtriya Kishor Swasthya Karyakram* (RKSK – the National Programme on Adolescent Health) of 2014.[14]

SEXUAL AND REPRODUCTIVE HEALTH AMONG ADOLESCENTS IN INDIA: CONTEXT

Adolescence is a complex transitional stage and is one of the most rapid phases of human development. It is important therefore to correlate adolescent health to underlying developmental issues. Adolescents can be divided into two categories – the younger (10-14 years) and the older (15-19 years), based on their behavioural attitudes and needs. Younger adolescents are a considerable sub-group of the overall population but they remain understudied and their needs are often neglected.[15]

Sexual health

One of the most important aspects of adolescent health is sexual health, defined as "a state of physical, mental and social well-being in relation to sexuality, which requires a positive and respectful attitude to sexuality and sexual relations".[16] Key issues pertaining to sexual health among India's adolescents include menstruation. The NFHS-4 report has found that about 58 percent[17] of adolescent girls engage in unhygienic or unsafe menstrual practices. Data also shows that many girls are sometimes unable to attend school during their period because of problems associated with their lack of menstrual hygiene. While there are initiatives that aim to improve the

situation, such as the teaching of menstrual hygiene management (MHM) across schools in India, there is a need to broaden access to these.[18]

Adolescents' sexual health also involves the issue of child marriage. While NFHS data shows a decline in the rate of child marriages from 2006-2016, the absolute number remains unacceptably high.[19] According to NFHS-4, the median age at first sexual intercourse among women aged 25-49 increased from 17.6 years in 2005-06 to 19.0 years in 2015-16. The median age at first sexual intercourse for men aged 25-49 at the time of the survey, also increased, from 22.6 years in 2005-06 to 24.3 years in 2015-16. Further, the survey found a gap of 5.2 years in the median age of first sex between those with no schooling and those with 12 or more years.[20] The use of contraception was found to be higher in girls living in urban areas as compared to those in rural areas.

Although teenage pregnancies have reduced by 50.8 percent, there were still an estimated 11.8 million teenage pregnancies in 2016 in India.[21] Data shows that the proportion of women aged 15-49 in India who received ANC has increased from 77 percent in NFHS-3 (2005-06) to 84 percent in NFHS-4 (2015-16).[22] These antenatal checkups allow pregnant women to receive services vital to their health and that of their children. However, only 55 percent of mothers under the age of 20 receive ANC checkups within less than four hours of delivery.[23]

Undernutrition

Undernutrition also remains a significant factor in poor adolescent health. A recent study linking nutrition and adolescent health showed that stunting and underweight prevalence were 10 percentage points higher in children born to adolescent mothers than in those born to adult mothers.[24] Considering Body Mass Index, in 2016, 26.3 percent of adolescent boys and 14.2 percent of adolescent girls in India in the age group of 15-19 years were found to be moderately or severely thin. Although there has been a three-percent decline in anaemia for both boys and girls from 2006 to 2016 according to NFHS figures, India's Comprehensive National Nutrition Survey (CNNS)[25] shows that between the ages of 10-19 years, undernutrition still stands at an alarming rate of 28.4 percent.

ADOLESCENT HEALTH PROGRAMMES: CHALLENGES

Organisations working with adolescents tend to focus on how they use technology, and how that can be taken forward into the health domain.

Institutions like the World Bank focus on the two institutional goals of poverty alleviation and boosting shared prosperity. They deal largely with the broad human development bracket that includes health, nutrition, population, education and social protection. Their main entry point is human development and human capital accumulation. For example, the World Bank's World Development Report[26] highlights the importance of adolescents as a group, towards which investment should be made and nurtured.

Communication

Organisations working on adolescent health can often fail to align their programme messaging with the needs of adolescents. Outreach staff who are older lack knowledge in the language that is easily understandable for adolescents. This is a significant weakness, as issues like reproductive and sexual health can be highly sensitive and require empathetic language to communicate.

Indeed, young people themselves must be engaged in the entire programming process, and not only as a token. It is important for those working with adolescents to listen to them. They should act as facilitators providing information, and encourage adolescents to make their own decisions. This would allow adolescents to identify their problems and work out solutions from existing resources. UNFPA-India has emphasised the importance of developing policies backed up by data. This pushes the government to employ scientific methods in identification and implementation of key interventions. Policies based on evidence—integrating key aspects of adolescent life including marital status, fertility, education, and mental health needs—will allow planners to achieve positive outcomes. At the same time, it is important to look into societal norms in India and how adolescents are perceived. The ability to define and accommodate needs of young people differs for different parents, schools and health contexts in India.

There is sufficient global evidence to show how different approaches work. India has well thought out policies, but not enough evidence on how existing systems implement them. What is measured is the work done, not the quality of the systems being used. At present, India is not faring too well in fulfilling its targets. School health programmes have come up in different forms, with different names, most recently as part of the flagship Ayushman Bharat initiative, but they still lack clear-cut outcomes.

One of the major concerns at the school level is the lack of conversations on managing menstrual pain among adolescent girls. Distribution of sanitary pads was only a step, and a lot more needs to be done. Conversations around mental health need to be encouraged, too, since many adolescents face severe pressures during exams, and many out-of-school children live under highly stressful circumstances. Other programmes that need to be addressed include provision of mid-day meals, which is necessary until Class XII, not just for nutrition, but also to ensure increased and continued attendance of girls in schools.

Streamlining Programmes

While measuring indicators of adolescent health in India, too many indicators are often taken up, which may overburden systems – given the staff shortages – and lead to discrepancies in outcomes. The first step to streamline programming would be to acknowledge the needs of adolescents in a more holistic way. There should be a set of indicators to fine-tune programming through ongoing assessment – a task which government agencies can take up in consultation with programme donors.

Various ministries deal with adolescents in different ways. The Lancet Commission's report on adolescent health focuses on three points: child marriages, school retention, and fundamental sexual and reproductive health knowledge. India needs a functional convergence model for adolescents, especially for sexual and reproductive health. It has been found that convergence efforts at the district level have proved effective, with their impact going beyond the targeted indicators of wellness. There has been improvement in areas of education outcomes, as well as nutritional and health outcomes, for adolescent girls and boys.

However, there are still gaps in implementation, between what has been achieved and what could be possible. Accountability becomes imperative when implementing different models aimed at multiple and often overlapping objectives. Further, India mirrors global patterns wherein nutrition and health programmes for adolescents are prominently visible, but ineffectively implemented.

Convergence within programme implementation has to be transformational. A multi-sectoral approach is necessary, including the enhancement of health, nutrition and education services. It is equally important to increase awareness, not only among adolescent girls and boys,

but also their families, and even religious and community leaders— wherever there is an opportunity to address barriers embedded in societal norms. Adolescent health needs to be viewed under the umbrella of the overall well-being of adolescents, with greater involvement of ministries other than health alone.

Measurement

Another major issue with programmes for adolescents relates to the measurement tools. While there are measurement tools available, most of them follow Western benchmarks. Adapting such tools to Indian social conditions is important. Robust process-based indicators, starting from the pilot phase, help in strong monitoring and evaluation. Resource allocation is also crucial, as it is important for evaluations to not become tedious and expensive. Online measurement tools can also be used efficiently to help cut down costs during research.

A national level, comprehensive status report tracking policy and indicators on adolescent health needs to be prepared to guide action. Accountability of initiatives will depend largely on availability of disaggregated information – including on budgets– right down to sub-district levels. Given the low fund utilisation within the health system, there is a need to make information on financial flows available at the grassroots level, in a form that is understandable to enhance the awareness of stakeholders. Multiple partners can work on one issue combining their strengths—this is essential to nurturing adaptive decision-making.

PROMOTING ADOLESCENT HEALTH: STATE EXPERIENCES

Programmes should be accessible to the "last adolescent" – especially those in the margins, including the poorest, the homeless, and those in institutions with little or no access to health services. Success should be defined by the extent to which resources reach the very last adolescent.

One of the important components of the Rashtriya Kishor Swasthya Karyakram (RKSK) is the toolkit on adolescent health for peer educators (who are called Saathiyas). The RKSK is a national programme, but states can learn from its successful implementation, to improve their own complementary programmes. The Saathiya programme is active at the district level. Saathiyas are acknowledged and given certificates for their work. This empowers them at the community level and makes them responsible citizens. For example, peer

educators often talk to adolescents who are about to get married. The integration of adolescent health and mental health is a crucial part of these programmes at the state level. There is also the Samarthan programme, where educators engage with adolescents about mental health issues. Adolescents are also educated about non-communicable diseases, maternal health, and family welfare programmes.

Adolescent health programmes at the state level are still at a nascent stage, but there has been a steady increase in the number of individuals getting involved. Separate budgeting for adolescent health has also begun.

For a deeper understanding of the grassroots situation, adolescent health in different states needs to be examined. In a country as vast and diverse as India, every state is at a different phase of addressing their adolescent health needs. For example, a metropolitan city like Delhi comprises a heterogeneous group of adolescents— those in school, school drop-outs, some even on the streets. Provision of sanitary napkins, for example, to different groups of adolescent girls is emerging as a big challenge for the government. Another problem is increasing cases of anaemia, where reasons range from access to nutritional food to genetic deficiency.[27]

In a state like Jharkhand, meanwhile, one of the major goals is to reduce teenage pregnancies and marriages. Multi-dimensional approaches have been adopted to sensitise girls, their parents, teachers, and peer groups. There are information campaigns about issues like teen marriage and pregnancy, and the use of contraceptives. School textbooks include information about pregnancy, nutrition, communicable diseases, and substance abuse. Thousands of packets of sanitary napkins are distributed every year to schools.

In Uttar Pradesh, too, the RKSK programme has made nutrition and mental health of adolescents among its priorities. Many teams are working together, including those with the Integrated Child Development Services (ICDS). Occasional health checkups under the scheme are working well. Specific meetings are held on issues like sexual and reproductive health, adolescent health and teenage pregnancy, where adolescents receive correct and relevant information.

Internet Saathi,[28] a joint initiative of the Tata Trusts and Google launched in 2016 in collaboration with six local partners, promotes digital literacy among women in rural India. Part of the program is the "Smart Betiyan Project" that addresses issues like child marriage, adolescent nutrition, and education of

girls. Adolescents who are part of the programme have produced some 600 educational videos that aim to engage the community in social issues. Another important initiative is Project Udaan in Rajasthan,[29] funded by the Children's Investment Funds Foundation (CIFF) and started in 2016, which aims to arrest the incidence of adolescent pregnancies. It uses a multifaceted approach: keeping girls in schools; improving their knowledge of and access to sexual and reproductive health; increasing their options of contraception; and changing practices that perpetuate early marriage and teenage pregnancy.

Under the 2006 ARSH policy, clinics for adolescents have been set up in different parts of the country, but they have seen little footfall. It is necessary to find out why adolescents do not visit ARSH clinics often, and thereafter make necessary changes in the programmes. The responses received so far imply that such clinics are perceived by adolescents as unfriendly places. This could be attributed to lack of awareness, and misconceived notions of these being 'girls only' clinics. To be sure, there are barriers at the community level, as families dislike the idea of their children visiting these clinics and healthcare providers are lacking in resources to make the clinics more accessible and comfortable. With further fieldwork, options should be explored for improving the privacy and comfort levels of adolescents in these clinics.

Second, it is important to integrate adolescent engagement by involving schools and other agencies with an interface with adolescents. For instance, focusing on a particular issue every month increases the involvement of young individuals in peer education. Third, convergence is important across schemes to broaden coverage. Fourth, the system should be made aware that there may arise fresh issues pertaining to adolescent health that would need to be addressed. These issues can be understood by promoting iterative processes, thereby finding them as they arise. Additionally, new issues must be proactively identified and discussed by the policy leadership to arrive at solutions. Here, media can play a pivotal role, covering issues that are not easily visible. Lastly, it is important to make adolescents a part of the initiative to improve programmes like RKSK.

Over 600 new ARSH clinics have been set up for adolescents since 2014 under RKSK, taking the overall number to 7,470 across the country.[30] Initially, lack of awareness led to low footfalls at these clinics. With outreach initiatives stepped up, there has been a 36-percent increase in adolescents coming to the clinics, but the figure needs to rise even higher. Helplines have been largely useful in certain states. Media coverage of the role of these clinics has also substantially increased with time.

Research is also being carried out in cities like Delhi and Mumbai, in association with NGOs, to understand adolescent issues better, and to know how they want services delivered. The emphasis is on 'life skill education' and how best it can be imparted. A barrier that researchers often face is the poor quality of documentation. Therefore, it is important to provide unique platforms for conducting research. Government and private medical colleges should be involved, which will help inform initiatives aimed at improving service provision.

THE WAY FORWARD

Investing in adolescents will enable India to leverage the advantages of a young population. India has a high proportion of young citizens in a transient phase of life who require nutrition, education, counselling and guidance to ensure their growth into becoming healthy adults. This demographic is highly susceptible to largely avoidable health risks including early and unintended pregnancy; unsafe sex leading to sexually transmitted infections such as HIV/AIDS; nutritional problems; alcohol, tobacco and drug abuse; mental health problems; and injuries and violence. Bringing sexual and reproductive health services to India's adolescent population should be a policy priority.

Under the RKSK, the ARSH clinics have been renamed Adolescent Friendly Health Clinics (AFHCs) and their scope has been expanded; however, the limitations of these clinics remain. One of the major challenges faced by adolescents at AFHCs involves contraceptive use, as often, service providers can be too condemnatory towards unmarried adolescents accessing such services and information. Young women in rural areas, for example, often feel uncomfortable approaching healthcare providers or medical stores for contraceptives, due to either lack of knowledge, fear of their side effects, or wariness about social sanctions. The interventions, therefore, should not only include provisioning but also focus on increasing awareness of contraceptive use. Indeed, healthcare providers have found a decline in the use of contraceptives among young married women.

A reasonable intervention would be to address the unmet needs of women by providing better quality healthcare facilities, with access to contraceptive choices being an essential component. The quality of counselling services should improve, and there should be regular follow-ups. The high number of child marriages reported through surveys suggests that an intervention to increase the efficiency of legal reporting could be introduced.

This report focuses on Uttar Pradesh because its challenges are immense: it has a large adolescent population, and it occupies bottom position on the Healthy States India Progressive Report.[31] The key findings of a recent comprehensive analysis of adolescent health in the state[32] showed the extent to which UP lagged behind.

For example, the percentage of adolescent girls engaging in hygienic menstrual practices was even lower in UP (43.4 percent) than the already low national level (58 percent); the use of contraception was also found to be lower (11.9 percent)[33] than the national level (14.9 percent). Furthermore, antenatal checkups stood at 75.6 percent,[34] with the national average at 84 percent; and nutritional outcomes studied included a decline of thinness by 14.8 percent in boys and a mere, worrisome 2 percent in girls.[35] Of the 7,470 AFHCs in the country as of 2019, only 347 were in Uttar Pradesh.[36] Contrary to the national decline in anaemia, UP saw a rise, both among boys and girls.

Overall, across India, research has found that about 60.8 percent of adolescents were unaware of AFHCs. Over 45 percent of adolescent girls were unaware that these clinics provided services related to menstruation and other matters of their sexual and reproductive health. Under Universal Health Coverage (UHC)-linked initiatives, it was found that little or no importance is given to adolescents as they are considered the "healthy" part of the population. Screenings in most health programmes is carried out for adults aged 30 and above. The inclusion of adolescents in screening is important for prevention and better access to healthcare.

To overcome the prevalent issue of undernutrition among both girls and boys, a multi-pronged approach should be adopted. The link between climate change and malnutrition should be acknowledged, and communicated: as climate change worsens, the quality of food, and food security declines. This in turn leads to an increase in undernutrition. The government has implemented various schemes and programmes under the ICDS as direct, targeted interventions to address the problem of malnutrition in the country. The Prime Minister's Overreaching Scheme for Holistic Advancement (POSHAN) Abhiyaan,[37] part of the National Nutrition Mission, is one of the flagship interventions of the Ministry of Women and Child Development (MWCD), which ensures its convergence with other programmes such as Anganwadi Services, Pradhan Mantri Matru Vandana Yojana (PMMVY), Scheme for Adolescent Girls (SAG), Janani Suraksha Yojana (JSY), the National Health Mission (NHM), and Swachh Bharat Mission. The goals of India's nutrition programme are to improve the nutritional status of children in the age group

0-6 years, adolescent girls, pregnant women, and lactating mothers in a time-bound manner over three years beginning 2017-18.

Despite some improvements in nutrition as well as in health indicators among adolescents, data shows that the pace of improvement is not rapid enough to attain the SDG targets by 2030. Efforts must be accelerated. To do so, the government must include creation of new models, review of food systems, and promotion of civil society involvement to eradicate undernutrition and improve healthy behaviour. The availability and use of existing nutrition supplementing programmes have to be effectively monitored to ensure they have the desired impact.

Schools are important because health, nutrition and education are interrelated. They have a strong positive correlation and they constantly influence one another. Finally, there is a need to include adolescent boys – and not just girls – in interventions so that these schemes are able to address the foundation of gender-based violence and injuries. A healthy relationship between genders is an important area for intervention.

RECOMMENDATIONS

This report offers three recommendations:

1. Teenage pregnancies constitute a national emergency and must be reduced immediately.

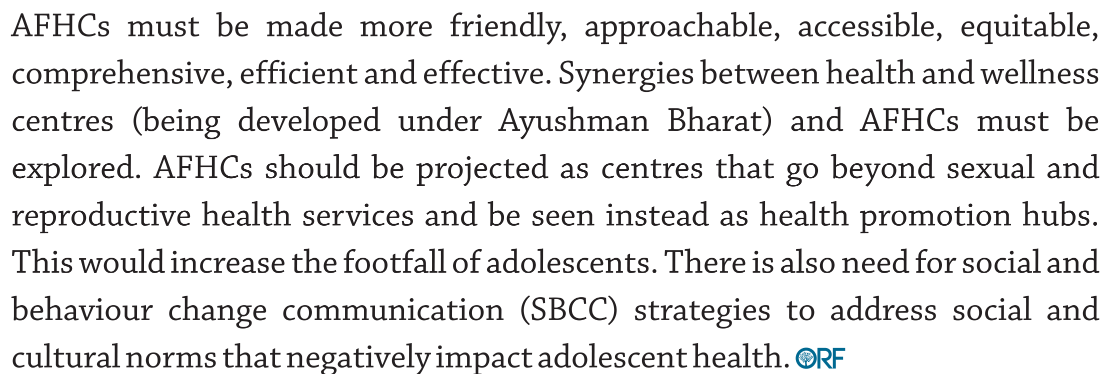
At 11.8 million in 2016, teenage pregnancies are still high in India.[38] This may well be a conservative figure, since such pregnancies are often incorrectly tabulated, with official data being manipulated to avoid penalties. Interventions to increase reliability of data need to be adopted. There is a need to leverage existing platforms like the *Beti Bachao, Beti Padhao* programme to progressively increase the marriage age of girls to well above the current legal minimum of 18 years. Consistent messaging by the government and civil society to change societal attitudes is needed to remove the taboos associated with the sexual and reproductive rights of adolescents.

2. Schemes like RKSK should be customised to regional ground realties.

A homogenous scheme is unlikely to work in a country as diverse as India. There is need to develop and follow local models, so that change can be seen at the district level. There is need for a comprehensive multi-sectoral approach to

address on-ground challenges. Existing initiatives around adolescent health need to be streamlined according to ground requirements. Synergies could be developed between district, state and union levels to ensure that future programmes are aligned. The Indian government's move to review the programme design of the ICDS is welcome, and a similar approach should be tried in adolescent health programmes.[39]

3. Adolescent healthcare services ought to be taken out of medical centres and made more accessible.



AFHCs must be made more friendly, approachable, accessible, equitable, comprehensive, efficient and effective. Synergies between health and wellness centres (being developed under Ayushman Bharat) and AFHCs must be explored. AFHCs should be projected as centres that go beyond sexual and reproductive health services and be seen instead as health promotion hubs. This would increase the footfall of adolescents. There is also need for social and behaviour change communication (SBCC) strategies to address social and cultural norms that negatively impact adolescent health. ORF

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ANNEXE

A consultation workshop was jointly hosted by the Ministry of Health and Family Welfare and the Observer Research Foundation on 14 December 2019 in New Delhi. "**Investing in Adolescent Health: Harnessing the Demographic Dividend**" discussed the possibilities of scaling up state-level best practices to address adolescent sexual and reproductive health amidst the continued challenges of early marriage, teenage pregnancy, anaemia, and high incidence of maternal mortality. This report is based on the proceedings on the workshop, expanded with the aid of a literature survey.

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