Research/Program Brief #4

Preventing adolescent motherhood in Uttar Pradesh and Bihar: Evidence for policy and programming

Problem statement: Recently released data from the National Family Health Survey (NFHS) 5 for 2019–21 show that 6.8% of adolescent girls (a staggering 81 million) were pregnant or mothers in India during that period, a slight decline from 7.9% in NFHS-4 for 2015–16. Programming for young people has often neglected the issue of adolescent motherhood, even though it has serious implications through the life course for women and girls' agency, development, health, and rights, along with intergenerational impacts on the health and development of their children. Rural girls are more vulnerable to teenage motherhood compared to urban girls (7.9% vs. 3.8% respectively), and associations are noted with poverty and caste.

There is also significant geographic variation across Indian states in terms of the proportion of 15–19-year-old girls who were already mothers or pregnant at the time of the 2021 survey. Bihar (11%), Assam (11.7%), and Jharkhand (9.8%) reported higher rates in relation to the national average compared to Rajasthan (3.7%) and Uttar Pradesh (UP) (2.9%).

Within adolescent and youth programming, several social protection and health interventions can act as key levers of change. These include programs and interventions that increase girls' schooling years and target their higher education; interventions to prevent child marriage and delay the marriage of girls; interventions providing early exposure to family life and sexuality education; and interventions that address the unmet need for contraception and increase access to it for married adolescents.

Using data from the Indian family planning ecosystem, we examine the current status of key determinants and correlates of adolescent motherhood as well on key metrics of adolescent development in UP and Bihar that can guide us to develop and deliver more effective sexual and reproductive health programming. These include:

A — **indicators on the education of girls, child marriage and early gender equitable attitudes;**

B — **indicators on sexuality education and contraceptive awareness among adolescent boys and girls; and**

C — **indicators on fertility preferences and contraceptive access among married adolescent girls.**

Data sources: *We used national and sub-national data sources to examine key issues in adolescent sexual and reproductive health. These datasets included the NFHS-5 (2019–21) and NFHS-4 (2015–16); Understanding the Lives of Adolescents and Young Adults (UDAYA) (2015–16); and Family Planning Monitoring, Learning and Evaluation (FP-MLE) surveys by Technical Support Units (TSUs) in the states of UP and Bihar (2021).*

A Indicators on the education of girls, child marriage and early gender equitable attitudes

Key findings

- Data from UP and Bihar showed that, in 2021, seven in 10 girls (67.4%) in UP and three in five girls (61.1%) in Bihar aged six and above attended school, which was lower than the national average of 71.8%. However, girls did not sustain their school attendance through adolescence with only 39.3% and 28.8% of women in UP and Bihar respectively reporting 10 or more years of schooling (compared to the national average of 41%).
- School dropout has been a predictor of girls' early marriage, with married girls less likely to continue their education. The UDAYA study (2015–16) found that only 13.4% (Bihar) and 5.2% (UP) of married 15–19-year-olds were enrolled in school or college, compared to 66.2% (Bihar) and 52.2% (UP) of unmarried 15–19-year-old girls. Despite several programmatic efforts to prevent and delay child and early marriage in India, one in five girls (23.3%) continued to report marrying prior to 18 years of age (NFHS-5) (a slight decline from 26.8% in 2015–16) with Bihar reporting high rates of child marriage (40.8%).
- Marriage in adolescence was also associated with loss of economic agency. The UDAYA study (2015–16) reported that married adolescent girls were less likely than unmarried adolescent girls to have a bank account (Bihar: 33.6% vs. 49.6% unmarried and UP: 33.3% vs. 45.8% unmarried) and less likely than unmarried adolescent girls to have engaged in paid work in the past year (Bihar: 11% married vs 16.8% unmarried and UP: 12.2% married vs 23.6% unmarried).
- Early gender equitable attitudes are formative and improved over time for both older and younger adolescents, except older boys, therefore shaping them early was critical. These gender equitable attitudes were shaped by life aspirations, vocation, gender-discriminatory attitudes at home and adolescent/ school health programs (Patel et al., 2021).

Key focus areas for programs and policies

1. Evaluating interventions that target schooling and higher education of girls, as well as interventions for delaying child marriage, including those acting on social and structural barriers in preventing child marriage.
2. Shaping gender equitable beliefs and attitudes among adolescents as well as their families is crucial, especially during early adolescence as these can go on to enhance these beliefs in later adolescence and adulthood.
3. Examining the effects of the COVID-19 pandemic on girl child schooling and early marriage (Cousins, 2020).
4. Identifying and promoting multisectoral interventions encouraging girls' education, their delayed marriage, marital agency and gender equitable attitudes.

B Indicators on sexuality education and contraceptive awareness among adolescent boys and girls

Key findings

- While data on young people's romantic attachments has been sparse, preliminary findings from the UDAYA study (2015–16) showed that one in four boys (25.7%) and three in 20 girls (15.6%) in UP, and one in five boys (19.3%) and one in 10 girls (13.6%), reported ever having a romantic partner of the opposite sex. Data also indicated that 17.4% of boys in UP and 14.1% of boys in Bihar, as opposed to 6% of girls in both states, reported being sexually active. Of these sexually active boys, three in 10 boys in UP and one in five boys in Bihar reported using condoms consistently.
- Awareness of contraception differed by gender. The UDAYA study (2015–16) showed gender differences in condom awareness among 15–19-year-olds (unmarried boys in UP: 86.5%, as opposed to unmarried girls in UP: 43.5%; unmarried boys in Bihar: 81.7%, as opposed to unmarried girls in Bihar: 38.1%).
- Girls primarily become aware of contraception after marriage, and not instead through school health or adolescent health and wellbeing programs. In both states, married girls reported having a higher awareness of condoms (UP: 86.2%, Bihar: 65.8%) than

Cousins, S., 2020. https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2932112-7
Patel SK, et al., 2021. https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0248766

unmarried girls (UP: 43.5%; Bihar: 38.1%). Married girls also reported having a higher awareness of oral contraceptive pills (UP: 84.8%; Bihar: 80.4%), compared to 45.1% among unmarried boys and 56.7% among unmarried girls (UP) and 42.8% unmarried boys and 58.2% of unmarried girls (Bihar).

- However, married girls reported a low level of specific knowledge about contraceptive methods and correct use. Married adolescent girls in the UDAYA study reported low level of correct knowledge of OCPs and ECPs in Bihar (OCPs: 17.6% and ECPs: 2.3%) and UP (OCPs: 24.9% and ECPs: 4.9%) compared to condom use (Bihar: 37.9% and UP: 59.1%).
- School health/family life/sexuality education can be a critical avenue to achieve reproductive health and contraceptive knowledge and use outcomes among adolescents (Chandra-Mouli et al., 2015). However, a careful content and access review on their current status in India is needed including challenges in their design and delivery. Data on family life education from the UDAYA study indicates that unmarried 15-19 year old girls were twice as likely to have received family life education compared to married 15-19 year old girls (Bihar: married: 11% vs unmarried: 22.4%; UP: married: 11.1% vs unmarried: 17.5%). Boys however remained excluded from receiving family life education, with low rates in both Bihar (5.2%) and UP (9.3%). In the absence of these programs, knowledge on family planning and contraception use is gained from other sources including social networks.

Key focus areas for programs and policies

1. Increasing adolescent and youth access and participation in school health and family life education programs, reinvigorating adolescent health programs and services with focus on sexual and reproductive health. Improving upon the content to include comprehensive information on building agency and choice, sexual health and access to regular or emergency contraception services.

2. Improving social and behavior change communication programs that raise awareness of contraception, consent, safety from violence in relationships, and adolescent and youth mental health. Also increasing the capacity for family planning and adolescent and youth programming to develop content and address these challenging and sensitive issues among this population.

3. Investing in and expanding the data ecosystem on adolescent and youth relationships, social networks and access to sexual and reproductive health services. Present data are sparse and often suffer from reporting challenges, and this can have implications on our understanding of young people's need for these services.

C Indicators on fertility preferences and contraceptive access among married adolescent girls

Key findings

- Contraception use was low among married adolescent girls, especially early in marriage. Per the UDAYA study (2015–16), among married girls 15-19 years of age, fewer than one in 10 in Bihar (8.2%) and one in 10 in UP (13.1%) reported using contraception to delay their first birth. The same study reported that one in 10 married girls in Bihar (11.2%) and one in five in UP (17.8%) reported ever using contraception.
- Unmet need for spacing contraception among married adolescent girls was high. Per the UDAYA study, one in two married girls in Bihar (45.2%) and one in three married girls in UP (37.9%) reported an unmet need for spacing contraception. The study also found that 9% of married girls from Bihar and 12% of married girls from UP reported experiencing a pregnancy loss.
- Son preference was a major driver of fertility decision-making and continues to be a policy challenge in India. Per the NFHS-4 (2015–16), one in three women (33.2%) in India expressed a desire to have more male children than female children. This statistic rose as high as one in two in both UP (53.3%) and Bihar (47.9%), compared to 14.6% in Kerala, 9.6% in Tamil Nadu, and 13% in Karnataka.
- Data from the UP Integrated Family Planning Survey (IFPS, 2021) and the Bihar Integrated Family Planning Survey (BIFS, 2021) showed pressure among young brides to demonstrate early fertility. Among women aged 15–24, the difference between mean age at marriage and first birth was 1.3 years in Bihar and 1.2 years in UP. Data also showed that the mean birth interval was substantially briefer if the firstborn was a girl (28–35 months) than if the firstborn was a boy (39–51 months).
- Interaction with health services, especially frontline worker (FLWs) was low among low parity women, and could be an important instrument for FP programs to increase knowledge and access of contraception among the youth. Data from the UP IFPS (2021) demonstrated that only 2% of women with no children had any interaction with FLWs on family planning, compared to 12% of women who had at least one child. FLW interaction was a particular concern for adolescents. Per UDAYA data, only 3.7% and 9.3% of unmarried older adolescent girls reported an interaction with ASHA in UP and Bihar respectively compared to 24.2% and 30.3% of married adolescent girls. Awareness of adolescent health clinics was low, around 4% for 15-19 year olds in both states, irrespective of marital status.

Chandra-Mouli V, et al., 2015. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4570008/

Key focus areas for programs and policies

1. Increasing the focus on contraceptive self-efficacy, couple counseling, contraceptive dynamics and family planning communication at couple and household levels within family planning programming.

2. Developing interventions that target key influencers (e.g. family members, husbands, in-laws and social networks) with programs that can creatively engage them (e.g. Nayi Pahal; Saas-Bahu Sammelan) to change fertility and contraceptive norms and to increase contraception use before first and second births.

3. Strengthening FLW engagement with young and low-parity women, especially married adolescents in order to improve coverage, delivery, and access of family planning programs.

4. Engaging stronger monitoring, evaluation, and implementation approaches to address barriers to young people's engagement with sexual and reproductive health programs as well as with youth programming with peer educator programs, adolescent-friendly health clinics, and adolescent health days.

Conclusion

India is home to a substantially large adolescent population. Adolescence is a period of developmental, biological, and emotional changes; it involves romantic attachments, sexual relationships, and individuals taking an interest in their sexuality. Vulnerabilities related to schooling losses, early marriage, lack of avenues for knowledge and engagement as well as sexual and reproductive health issues, and limited access to health workers are critical challenges for family planning programming, with particular impacts for adolescents from marginalized social and economic groups. Preventing adolescent motherhood requires action on multiple determinants through the life course, including creating positive gender norms and life aspirations among girls as well as boys, and enhancing agency and choice among adolescents. Policy and programmatic support are essential to this, in terms of enforcing laws that prevent child marriage, reduce violence against women and girls, and ensure vocational and economic support for youth career development. Increasing awareness of sexual and reproductive health issues, as well as developing life skills and seeking gender equity in relationships, can play an important role in strengthening sexual and reproductive agency, ensuring safe sexual relationships and in preventing unwanted pregnancies and adolescent motherhood.

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The Family Planning Monitoring, Learning and Evaluation (FP-MLE) consortium is constituted to provide grounded evidence on efforts to improve family planning in India, with particular reference to Bihar and Uttar Pradesh. The consortium, led by the Population Council, brings together technical support units led by CARE India Solutions for Sustainable Development (CISSD) in Bihar and the India Health Action Trust (IHAT) in Uttar Pradesh, the International Center for Research on Women (ICRW) and the Center on Gender Equity and Health (GEH), UC San Diego, to collectively support the family planning program with data/evidence. This brief is based on research carried out by researchers of the consortium using multiple sources of data. The work of the consortium is funded by the Bill & Melinda Gates Foundation. The findings and conclusions contained within are those of the authors and do not necessarily reflect positions or policies of the Bill & Melinda Gates Foundation.

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