



## Young People in Jharkhand : Sexual and Reproductive Health

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*Jharkhand is, one of the few states in the country that has developed a specific youth policy in which its commitment to redressing youth vulnerabilities is outlined. The Jharkhand Youth Policy 2007 recognises the need to empower youth and reduce their vulnerabilities. It advocates multi-sectoral actions in the areas of education, employment and health; and it recognises the importance of making youth friendly services accessible and of strengthening the capacity of service providers to address the needs of youth in acceptable ways. Moreover, it underscores the importance of providing counselling and services to youth, addressing their nutritional and reproductive health vulnerabilities and countering early marriage. Efforts to improve the sexual and reproductive health of youth are reiterated in the state's Health Policy. The objective of this paper is to synthesise, from available evidence, what is known about the sexual and reproductive health of young people in Jharkhand, and draw from this synthesis, implications for policy and programmes.*

**Keywords : Reproductive Health, Jharkhand**

### Introduction

The past decade has seen a growing concern in India about the unique sexual and reproductive health needs of the youth, a group whose needs remain poorly understood and served. Available evidence on their sexual and reproductive health suggests significant state-wise heterogeneity in levels and patterns of access to services and in socio-cultural, gender and health system determinants. Jharkhand which is characterised by a large rural population, high dependence on agriculture and widespread poverty with significant proportions living below the poverty line (NSSO, 2007). It contained , a total of 8.3 million young people aged 10-24, who accounted for 31% of the state's population (Office of the Registrar General and Census Commissioner, 2001b). Compared to India as a whole, young people in Jharkhand are less educated, marry earlier, are less likely to practise contraception and are less likely to have access to pregnancy-related care, all factors that exacerbate their vulnerability. Moreover, evidence on young people's sexual and reproductive health in Jharkhand is relatively sparse. While lessons learned from evidence obtained from other settings can be extrapolated to Jharkhand, the dearth of evidence focused specifically on the state has meant that neither the levels nor the patterns of various aspects of sexual and reproductive health, nor the contextual and socio-cultural factors impeding sexual and reproductive health have been understood in depth. Correspondingly, strategies and actions to enhance sexual and reproductive health in the 21<sup>st</sup> century in the state remain generic and uninformed by the special needs of women and men in the state.

Jharkhand is, however, one of the few states in the country that has developed a specific Youth policy in which its commitment to redressing youth vulnerabilities is outlined. The Jharkhand Youth Policy 2007 recognises the need to empower youth and reduce their vulnerabilities. It advocates multi-sectoral actions in the areas of education, employment and health; and it recognises the importance of making youth friendly services accessible and of strengthening the capacity of service providers to address the needs of youth in acceptable ways (Department of Art, Culture, Sports and Youth Affairs, Government of Jharkhand, 2007). Moreover, it underscores the importance of

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providing counselling and services to youth, addressing their nutritional and reproductive health vulnerabilities and countering early marriage. Efforts to improve the sexual and reproductive health of youth are reiterated in the state's Health Policy; specifically, the policy describes an adolescent health education programme, reproductive health services for newly-married adolescent girls, and more generally, efforts to raise the age at marriage (Department of Health, Medical Education and Family Welfare, Government of Jharkhand, n.d)

The objective of this paper is to synthesise, from available evidence, what is known about the sexual and reproductive health of young people in Jharkhand, and draw from this synthesis, implications for policy and programmes. The paper draws on findings from the recent National Family Health Survey (NFHS-3) (IIPS and Macro International, 2007a; 2007b), the 1998-99 round of the National Family Health Survey (NFHS-II, IIPS and ORC Macro 2000), the *Youth in India: Situation and Needs Study* (IIPS and Population Council, 2007); as well as small studies that have focused on the sexual and reproductive health situation of young people in the state.

## **Socio-demographic Context**

As can be seen from Table 1, literacy rates, both of the general population, and women aged 15-49 in particular, are far lower in Jharkhand than in India on average. Two indicators suggesting socio-economic conditions are presented in Table 1—type of house and ownership of television that also reveal that the situation in Jharkhand is far below the all-India average: 28 percent of the population of Jharkhand resides in a *pucca* house, compared to the all-India average of 41 percent; and only 27 percent of households in Jharkhand own a television, compared to the national average of 44 percent. Availability of health care facilities are also skewed: fewer than one in three rural women live in a village with a primary health centre or sub-centre (compared to 45% all-India); and fewer than two in five live in villages with a middle school or a post-office (all-India 45% and 43% respectively (IIPS and ORC Macro, 2000).

Among demographic indicators, as Table 1 shows, both infant mortality rates and fertility rates are considerably higher in Jharkhand than in India on average. Correspondingly, household size is somewhat larger, the contraceptive prevalence rate much lower and proportions of women expressing unmet need for contraception much larger than in India more generally.

**Table 1**

### **Selected Socio-economic And Demographic Indicators For India And Jharkhand, 2000s**

Indicators	India	Jharkhand
Population 2001 ( 000s) <sup>1</sup>	1,028,610	26,946
Sex ratio, 2001 (females/1,000 males) <sup>1</sup>	933	941
Population aged 6+ that is literate <sup>2</sup>	67.6	58.6
Women aged 15-49 who are literate <sup>2</sup>	59.0	41.0
Child sex ratio, 2001 (0-6 years) <sup>1</sup>	927	966
% residing in a <i>pucca</i> house <sup>2</sup>	41.4	28.1
% households owning a television <sup>2</sup>	44.2	27.1
% population living below the poverty line <sup>3</sup>	27.5	40.3
Infant mortality rate (estimated 2005) <sup>2</sup>	57	69
Total fertility rate (2005-6) <sup>2</sup>	2.68	3.31
Mean household size <sup>2</sup>	4.8	5.4

Sources: <sup>1</sup>RGI, 2001; <sup>2</sup>IIPS and Macro International, 2007a; 2007b

## Sexual and Reproductive Health Vulnerabilities of Young People in Jharkhand

Available evidence underscores the extent to which sexual and reproductive health of young people in Jharkhand is compromised. For one, sexual relations are initiated early, both within and before marriage. Second, relations are largely unsafe and unprotected, with implications for unintended pregnancy and infection. Third, childbearing occurs at an early age, before the young woman is physically mature enough to endure pregnancy without risk to her own health and well-being. Fourth, marital relations are too frequently characterised by physical and sexual violence. Finally, youth lack awareness of sexual and reproductive health promoting behaviours, young women have limited ability to make decisions about or seek health care and services are not geared to addressing the unique sexual and reproductive health needs of youth. Evidence relating to each of these issues is presented in this section. Because evidence on sexually transmitted infections and the context of abortion is not available, these will not be discussed here.

### Early Onset Of Sexual Relations

While international attention focuses on the onset of sexual relations before marriage, it is clear that in Jharkhand, as in India more generally, for huge proportions of young people, the onset of sexual relations occurs early and within the context of marriage, notwithstanding laws that prohibit early marriage (before age 18 and 21, respectively) among young women and men.

Indeed, marriage in adolescence is far more prevalent in Jharkhand than in India more generally. As Table 2 indicates, marriage continues to take place before the minimum legal age for both young women and men: while 45 percent of women aged 20-24 were married by age 18 in India as a whole, three in five were married by this age in Jharkhand; and while 29 percent of men aged 25-29 were married by age 21 in India on an average, about more than two in five young men in Jharkhand were married by this age. Moreover, one quarter of young women aged 15-19 were already mothers or were experiencing their first pregnancy at the time of interview. Rural-urban differences were pronounced with twice as many rural as urban youth marrying before the legal minimum age at marriage and twice as many young women in rural areas already mothers or pregnant for the first time (IIPS and ORC Macro, 2007).

**Table 2**  
**Age At Marriage, In India and Jharkhand (2005-06)**

	India	Jharkhand	Urban	Rural
Women aged 20-24 married by 18 years (%)	44.5	60.3	33.6	71.0
Women aged 15-19 already mothers or pregnant (%)	16.0	25.0	12.2	32.7
Men aged 25-29 married by 21 years (%)	29.3	43.0	26.8	54.7

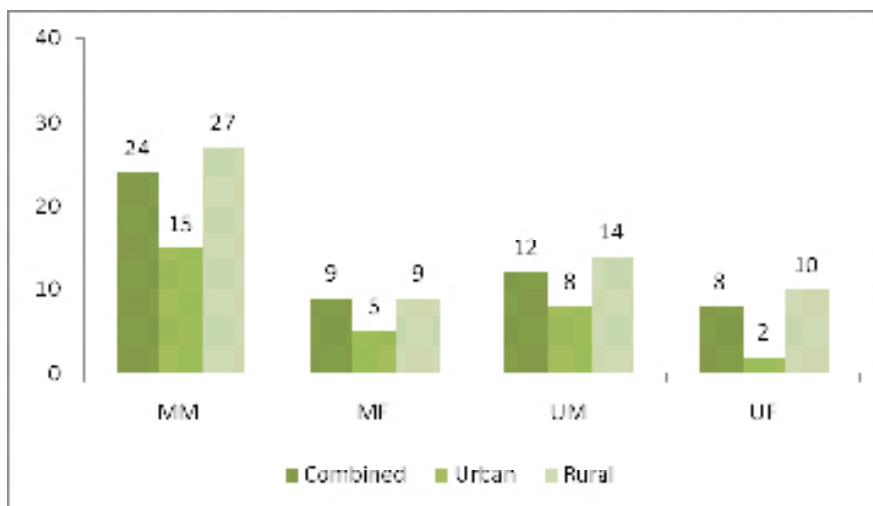
While marriage marks the onset of sexual activity among the large majority of young women and significant proportions of young men, there is growing evidence of opportunities for the development of pre-marital relationships, both those that include sex and those that do not. For example, evidence from the *Youth in India: Situation and Needs* study (IIPS and Population Council 2007) suggests that more than one-fifth of married and unmarried young men and 14-17% of married and unmarried young women in Jharkhand reported that they had an opposite sex romantic partner (before marriage among the married). Moreover, as evident from Figure 1, considerable minorities, notably young men, reported premarital onset of sexual activity. Almost one-quarter of married men aged 15-29 had experience sexual relations prior to marriage, compared to 12% of unmarried young men aged

15-24. Among young women, 9% and 8% of the married and unmarried, correspondingly, reported premarital sexual experience. Percentages fall within the range of these reported in a review of available small studies across India, suggesting that 0-10 per cent of young women and 15-30 per cent of young men reported premarital sexual experience (Jejeebhoy and Sebastian, 2004). There may, however, be some over-reporting among males and some underreporting among females.

**Figure 1**

**Pre-marital Sexual Relations, 2006-2007**

Rural-urban differences suggest that while somewhat more urban than rural youth (with the exception



of unmarried young women) reported an opposite sex romantic partner (prior to marriage among the married), rural youth were consistently more likely than their urban counterparts to have experienced sexual relations, irrespective of marital status or sex of respondent.

While the Youth Study provides evidence at state level, evidence from a small case-study of rural-rural and rural-urban young migrant men up to age 24 in Palamu district suggests that sexual experience among them was considerably higher than that reported by non-migrants: 30% of young migrant men compared to 15% of their non-migrant counterparts had reported sexual experience (Dhapola et al. 2007).

### Limited Contraception And Condom Use

Pre-marital and marital sexual relations are characterised by limited contraception or condom use among most youth, irrespective of whether relations take place before or within marriage. As far as pre-marital relations are concerned, for example, the *Youth in India: Situation and Needs* study (IIPS and Population Council 2007) reports that fewer than 10% of all those reporting pre-marital sex had used a condom consistently (Table 3). Evidence suggests wide differences by rural-urban residence and sex of respondents. Consistent condom use was rarely reported by young women; indeed, not a single married woman and not a single unmarried woman living in urban areas reported consistent condom use. Among young men, rural-urban differences were pronounced

with urban youth considerably more likely than rural youth to have used condoms consistently in all sexual encounters. Even so, however, just 15% and 22% of married and unmarried young men reported consistent condom use.

In comparison, the study of migrant and non-migrant unmarried young men in Palamu district reports an even riskier situation. Migrants were twice as likely as non-migrants to have engaged in sexual relations, but both groups were equally likely to report unprotected sex. Indeed, among the sexually experienced, condoms were never consistently used and multiple partner relations were reported by about one third of young men (Dhapola et al. 2007). While these findings reiterate those of other studies that highlight the vulnerability of migrants, they also suggest that among migrant young men, sex was more likely to take place not in their areas of destination but in their areas of origin—both before and especially during regular visits home. Typically, partners are girlfriends and relatives and not sex workers as often hypothesised. Author suggest that in this poorly developed setting, migration affords young men considerable social status and migrant young men have substantially more resources at their disposal than do non-migrant youth. Indeed, it is this enhanced status and these additional financial resources that appear to enable them greater access to girlfriends and relatives when they return to their areas of origin. Similar findings are also noted in studies of youth in sub-Saharan Africa and Nepal (see Chirwa, 1997; Poudel et al., 2004).

Table 3

### Condom And Contraceptive Use In Pre-marital And Marital Sexual Relations (2006-2007)

	Married men	Married women	Unmarried men	Unmarried women
Consistent condom use in pre-marital relations				
Combined	7.3	0.0	0.2	(6.9)
Urban	14.7	0.0	21.7	0.0
Rural	5.5	0.0	2.7	(7.3)
Ever practised a method of contraception in marriage (%)				
Combined	23.3	22.5	--	--
Urban	40.1	39.0	--	--
Rural	18.1	21.4	--	--
Ever practised contraception to delay the first pregnancy (%)				
Combined	12.2	4.5	--	--
Urban	21.1	9.8	--	--
Rural	9.6	4.2	--	--
Currently practising contraception (%)				
Combined	14.0	16.3	--	--
Urban	25.1	27.9	--	--
Rural	10.6	15.5	--	--

Source: IIPS and Population Council, 2007

Within marriage too, contraception was practised by small numbers of youth. Indeed, as evident from Table 4, just one fifth had ever practised contraception within marriage (and two fifths of those in urban areas), and just 14-16% were practising contraception at the time of interview. Despite the early age at marriage, only 5-12% reported attempting to delay the first pregnancy by practising contraception (IIPS and Population Council 2007).

### **Early Pregnancy And Poor Access To Pregnancy Related Care**

Pregnancy occurs early among young women in Jharkhand and its consequences are dire. Maternal mortality is considerably higher in Jharkhand than in India more generally. Indeed, in the period 1998-2003, the maternal mortality ratio was 531 in Jharkhand and Bihar (only a combined estimate is available) compared to 398 in India more generally (RGI, 2001).

In Jharkhand, married young women aged 15-24 have already had an average of 1.4 children ever born. Despite the fact that pregnancy occurred during adolescence for the wide majority of these young women, relatively few, just two in five, reported that their first – and most dangerous – pregnancies were delivered by a trained attendant. While urban youth were more likely to report that the first birth was attended by a health professional, even among them, skilled attendance was reported by just two in three young people (Table 4).

**Table 4**

#### **Health Care During Pregnancy And Childbearing**

	COMBINED		URBAN		RURAL	
	Married men	Married women	Married men	Married women	Married men	Married women
First birth attended by health professional (%)	45.1	41.7	67.0	67.8	38.1	40.0
Children ever born (mean)	1.2	1.4	1.2	1.3	1.2	1.4

Source: IIPS and Population Council, 2007

Available case studies shed light on the poor pregnancy related situation in Jharkhand. One study of the experiences of childbirth of women—largely young but also adult—in rural Bokaro district, Jharkhand, has documented the host of potentially life-threatening problems that rural women in Jharkhand experience during delivery and the multiple socio-cultural and systemic obstacles that deny them access to quality care during pregnancy and delivery. Deliveries in this setting were by and large conducted within the home and there was a clear preference for home- rather than facility-based deliveries; the poor and insensitive quality of care, and abusive/rude and unsupportive providers in facility settings were key factors underlying this preference. While many of the traditional birth practices adopted by women were not harmful, several were; for example, not seeking care for heavy bleeding following childbirth because of the perception that it is “normal,” and heavy massaging of the abdomen following delivery. At the same time, women were moving towards adopting certain “modern” allopathic practices, for example, relying on registered medical practitioners (RMPs), all of whom were untrained, for care during labour and to administer pre-delivery injections of oxytocin to speed up delivery, rather than using the services of trained birth attendants. This combination of traditional and so-called “modern” practices is likely to be detrimental to women’s health and also result in potentially life-threatening delays in addressing pregnancy-related complications. Women’s narratives in this

study suggest that many have experienced potentially life-threatening complications-heavy bleeding, prolonged labour, retained placenta and birth asphyxia – yet poor rural communities have few options other than the RMP and untrained *dais* (traditional birth attendants), as quality, accessible, affordable emergency obstetric services are effectively unavailable.

A second case-study highlights the lack of pregnancy related care among tribal adolescent girls in Lohardaga district, Jharkhand, using data from a cross-sectional survey. Findings suggest that the majority of young women (59%) received some antenatal services (check-ups, iron and folic acid tablets or immunisation). However, only 12 percent of these women received all of these services; most received no more than immunisation and the provision of iron and folic acid supplements. Far fewer (under 10%) delivered in an institution, were delivered by a trained attendant (24%) or received a post-partum check-up (15%). In contrast, nearly three-fifths of young mothers reported that their babies had been immunised. While health care seeking in this tribal setting is limited in general, multivariate analyses reveal a clear link between young women's levels of education and their pregnancy-related practices and experiences (Sandhya Rani et al. 2007).

## Physical And Sexual Violence

Violence within marriage – that is, perpetration by young men and experience by young women was reported by large minorities of married youth in Jharkhand. For example, as evident in Table 5, about one quarter of young men reported perpetrating physical violence on their wives (26%) and an equal percentage reported experiencing violence perpetrated by their husbands (27%). Differences in reporting sexual violence were relatively wide, nevertheless, as many as 23% of young men acknowledged forcing their wives to engage in sexual relations at some time in the marriage and as many as 41% of young wives reported that they had been forced by their husbands to engage in sexual relations against their will.

Table 5

### Physical And Sexual Violence Within Marriage (2005-06)

#### Limited Awareness And Agency To Adopt Health Promoting Behaviours

Many studies have concluded that lack of awareness, lack of agency and lack of accessible and

	COMBINED		URBAN		RURAL	
	Married men	Married women	Married men	Married women	Married men	Married women
Ever perpetrated (men)/ experienced (women) physical violence within marriage	26.4	27.0	22.8	22.3	27.5	27.4
Ever perpetrated (men)/ experienced (women) sexual violence within marriage	22.5	40.7	17.4	30.5	24.2	41.4

Source: IPS and Population Council 2007

youth-oriented services pose a huge barrier to the adoption of health promoting behaviours among youth in India (see for example, Jejeebhoy and Sebastian 2004).



In Jharkhand too, As evident from **Table 6**, youth are poorly informed about the physiological changes associated with maturation and about contraceptive methods. For example, fewer than half of young men and women – including the married – are aware that a woman can become pregnant at first sex. As far as awareness of contraceptive methods is concerned, the Youth Study inquired not only about whether youth had heard of a method but if so, whether they were aware about a simple fact associated with that method (for example that oral pills must be taken daily or weekly; that one condom can be used for just one sexual act). Findings suggest that method awareness is limited and that differences by sex, marital status and rural-urban residence are wide. Condom awareness was most likely to be reported by married young men in urban areas, but even among them, awareness was not universal (89%); in contrast, method awareness was least likely to be reported by rural young women among whom just 15% and 26% were correctly aware of the condom and oral pills, respectively.

**Table 6**  
**Awareness Of Sexual And Reproductive Matters (2006-2007)**

	Married men	Married women	Unmarried men	Unmarried women
Know that a woman can become pregnant at first sex (%)				
Combined	46.3	41.8	32.4	29.4
Urban	47.5	41.0	29.9	24.0
Rural	45.0	41.8	34.3	31.1
Know and have correct specific knowledge about condoms (%)				
Combined	73.4	36.6	69.6	18.0
Urban	88.6	58.6	76.5	28.3
Rural	68.7	35.1	64.1	14.8
Know and have correct specific knowledge about oral pills (%)				
Combined	41.8	45.1	30.3	30.4
Urban	53.8	67.2	32.9	45.1
Rural	38.0	43.6	28.4	25.8

Source: *NPS and Population Council, 2007*

Comprehensive awareness of HIV – that is about modes of transmission on the one hand and about common misconceptions on the other – was reported by disturbingly small proportions of youth as evident from Figure 2. Indeed, just one tenth of married young women, compared to about one in five unmarried young women and married young men and one in three unmarried young men were correctly informed about HIV, underscoring the extent to which lack of awareness may be responsible for the unsafe behaviours observed earlier.

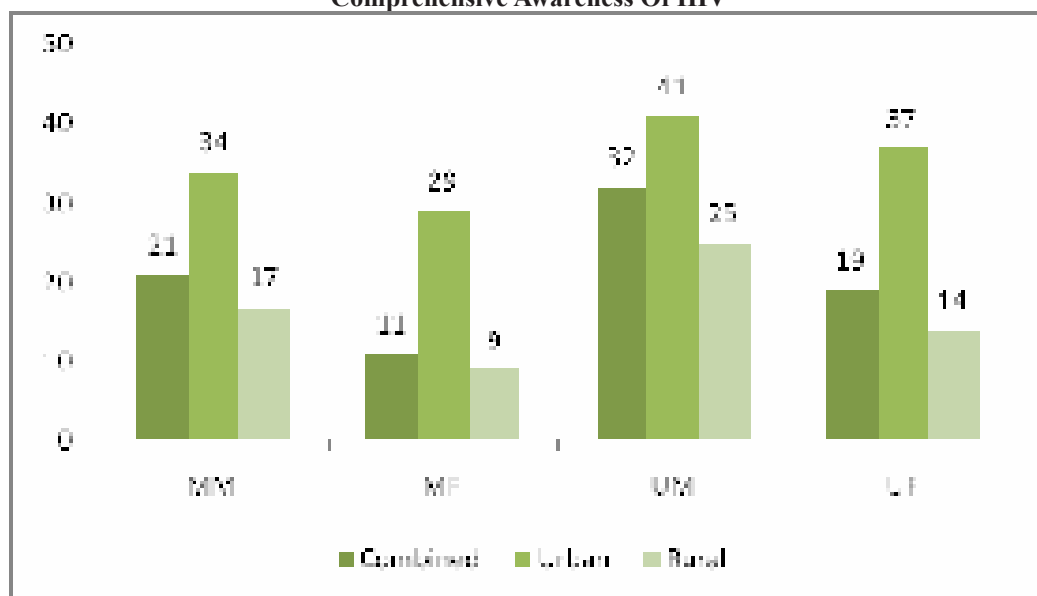
Findings from the study of unmarried migrant young men in Palamu district discussed earlier also highlight lack of awareness (Dhapola et al. 2007). Indeed, even in comparison to similarly aged young men who had never left their areas of origin, migrant young men were poorly informed about



HIV and the role of condoms in preventing its spread, a finding attributed to the generally poorer educational attainment levels of young migrants. Qualitative evidence from this study reiterates that even when there is basic awareness of HIV, several misperceptions abound, including that only sex worker relations put youth at risk of HIV (Dhapola et al. 2007).

**Figure 2**

**Comprehensive Awareness Of HIV**



Source: IIPS and Population Council, 2007

**Box - I**

**Misperception about HIV/AIDS**

I know about HIV. We can get it if we touch or eat with an infected person. Also by getting bitten by a mosquito that has bitten someone who is infected. I have had sex only once. I don't think that one time sex can cause HIV infection. (*Migrant male, 18 years*)

People who go to sex workers need condoms. I have always had sex with girlfriends so there was no need to use a condom. I do not have sex with girls who are over 18 years of age or who are married. I know I am safe if she has not had sex with anyone else. All three girls I had sex with were virgins. I know by looking at a girl if she has had sex with someone else or not. (*Migrant male, 23 years*)

I only have sex with my girlfriend, whereas the sex worker has sex with 10 to 20 people every day. I don't see any reason to use a condom. (*Male migrant, 16 years*)

Gender double standards and lack of agency can also undermine young people's – notably young women's — ability to make informed sexual and reproductive choices. Young females have a limited voice in matters relating to their own lives – whether to continue schooling, decisions on when and whom to marry, physical mobility and sexual relations. Young men are affected by a different set of gender-based expectations, including social pressure to have sex at an early age, often under

conditions that place them at risk of infection. Gender power imbalances are observed in both and marital and premarital partnerships. In many cases, male partners, parents or in-laws play a leading role as decision makers.

Available evidence from Jharkhand suggests that decision-making authority and mobility are limited among women. Young women are considerably less likely than young men to make independent decisions about the purchase of clothes for example: 66-84% among young men compared to 28-37% among young women. At the same time, married and unmarried young women are far less likely to be permitted freedom of movement: while 85% of unmarried young men were permitted to move around the village or urban neighbourhood freely, only 45-51% of young women, irrespective of marital status were free to visit friends inside their villages or neighbourhoods without an escort. More relevant for health seeking behaviours, while just 9-11% of young women are permitted to visit a health centre unescorted, as many as 64% of young men so reported. What is notable is that among young women, it was the unmarried who had more decision-making authority and mobility than the married: while 37% of unmarried young women made decision about buying clothes, only 28% of married young women expressed such decision making authority; and while 51% of the unmarried were permitted to visit friends inside the village or urban neighbourhood unescorted, just 45% of the married were so permitted (IIPS and Population Council 2007).

Findings from at least one case study reports that young women who reported autonomy in terms of household decision-making and access to money were indeed more likely than other women to have received appropriate pregnancy-related care, even after such factors as household economic status and women's education were controlled. Other key factors included peer or social support and spousal communication, suggesting that in settings in which services are generally inaccessible, it is women's own ability to exercise informed choice and the nature of support they receive from their husbands and social networks that critically influence appropriate pregnancy-related practices (Sandhya Rani et al 2007).

Finally, access to services is limited. For example, the National Family Health Survey reports that as recently as 2005-6, just 17% of women (many of whom were likely aged under 25) had received at least three ante-natal care visits for their last birth and just 15% of those who delivered at home received post-natal care within two days of delivery; this compared with 51% and 36% nationally (IIPS and Macro International, 2007). As noted earlier, many women access care from untrained providers (RMPs for example) whose dangerous practices have been noted but who provide more accessible and better quality of care than providers in public sector facilities (Barnes 2007).

## **Moving Ahead**

This synthesis of available empirical evidence on young people's sexual and reproductive health highlights the extent to which the sexual and reproductive health of youth in Jharkhand is compromised. Several themes can be drawn from the findings of these studies. First, findings suggest that young people— rural and urban — engage in unsafe sex and are vulnerable to risky sexual and reproductive health outcomes. Lack of awareness, agency and access to appropriate services are limited and may be key factors inhibiting safe practices and prompt treatment seeking. Moreover, in the context of pregnancy- related experiences, also, practices remain unsafe and a host of socio-cultural and systemic obstacles deny women access to quality care, and judgemental and insensitive provider attitudes— for example, unwillingness to accommodate harmless traditional delivery-related practices—continue to deter women from seeking institutional care.

While sexual and reproductive health needs of young people are firmly on the state agenda, much remains to be done before programmes can be said to have responded to meeting their needs. Young

people are a heterogeneous group whose situation, vulnerabilities, strengths and needs vary greatly, and policies and programmes will have to address these diverse needs through a multi-sectoral approach. Successful interventions will have to involve a wide constituency—including youth themselves, as well as parents, teachers and religious and community leaders.

Findings suggest a number of multi-pronged programmatic actions that must be taken in order that sexual and reproductive health or youth in Jharkhand improves.

### ***Build Awareness Of Sexual And Reproductive Matters Among Youth***

Young people need to be equipped with knowledge and information on diverse issues, ranging from risk and protective sexual behaviours, including the role of condoms, to physical maturation, formation of partnerships, sources of information, counselling and services, their rights in accessing services and exercising choices. Sex and family life education must be imparted in ways that meet the needs of those in and out-of-school, responding to, rather than obfuscating, their sexual health questions. Programmes are needed, moreover, that are tailored to the unique situations of different groups of youth. For example, evidence that migrant young men are more likely than their non-migrant counterparts to have engaged in sexual relations and that relations are more likely to have been experienced in the area of origin rather than destination highlights that it is not enough to focus on their sexual networks and sex worker contacts in their places of destination but that efforts must simultaneously be made in areas of origin.

### ***Enable Youth To Make Informed Choices And Adopt Egalitarian Gender Role Attitudes***

Equally important is the acquisition of life skills that will enable youth to put information into practice, encourage them to break down gender stereotypes and relate to each other as equals, develop self-esteem, as well as strengthen their abilities in problem-solving, decision-making, communication and inter-personal relations and negotiation.

### ***Expand Services To Reach The Unmarried***

Findings that considerable proportions of young women and especially young men have engaged in pre-marital sex and that consistent condom use was practised by small minorities (at best) suggest the need to enhance condom promotion activities for the unmarried in ways that are non-judgemental and ensure privacy.

### ***Ensure Pregnancy Related Services For Youth***

Available evidence concerning the limited access of married young women and notably those from tribal settings to health care calls for service delivery strategies that are sensitive to this lack of access and to women's limited mobility to seek services: for example, actions may include ensuring the provision of skilled home-based services for women experiencing normal deliveries by training available attendants in sound modern practices, allowing the continuation of harmless traditional practices employed by communities during delivery, such as burying the placenta, and reversing misperceptions and unsafe practices adopted by traditional attendants. Strategies also need to acknowledge the role played by RMPs, ensure that dangerous practices adopted by RMPs are checked, and ensure that RMPs are trained to recognise and refer a potentially complicated delivery. Indeed, the RMP is an acceptable alternative in a setting in which qualified public and private sector providers are inaccessible. At the same time, much more effort needs to be made towards providing a workable referral channel for emergency obstetric care so that emergency care is immediately

available to all women who really need it. An institutional environment needs to be created that is supportive of both useful and harmless cultural practices, and providers need to be perceived by rural women, their families and their attendants to be caring, respectful and non-judgemental.

### ***Involve The Gate-keepers***

Parents, teachers and the adult community must facilitate and be involved in this process, whether through free and open communication, or by creating environments that protect adolescents from abuse, and enable them to access information and the full range of services. Programmes are needed at the family and community levels that enable parents and other community members to overcome their discomfort, enhance their knowledge of adolescent health and development, and improve their communication skills. Programmes are also needed that convince parents of the advantages of delaying the marriages of their sons and especially their daughters.

### ***Expand The Evidence Base***

Evidence remains limited on several aspects of the sexual and reproductive vulnerabilities of youth in Jharkhand. Notable gaps exist in the areas of, for example, abortion and infection and the kinds of obstacles faced by those in need in accessing safe abortion or STI treatment.

This is a challenging agenda. However, a number of programmes – both those implemented by the government and those implemented by the NGO sector – exist that are intended to meet the needs of young people – to foster educational attainment, inform youth about sexual and reproductive health matters, delay marriage, address nutritional deficiencies, provide livelihoods training and build leadership skills and mobilising communities to support young people's access to information and services. Several of these programmes may have already initiated the kinds of actions recommended in this article; it is important however that the kinds of actions suggested in this review of evidence are implemented more broadly and in ways that tailor to the heterogeneity of youth that characterise the state.

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