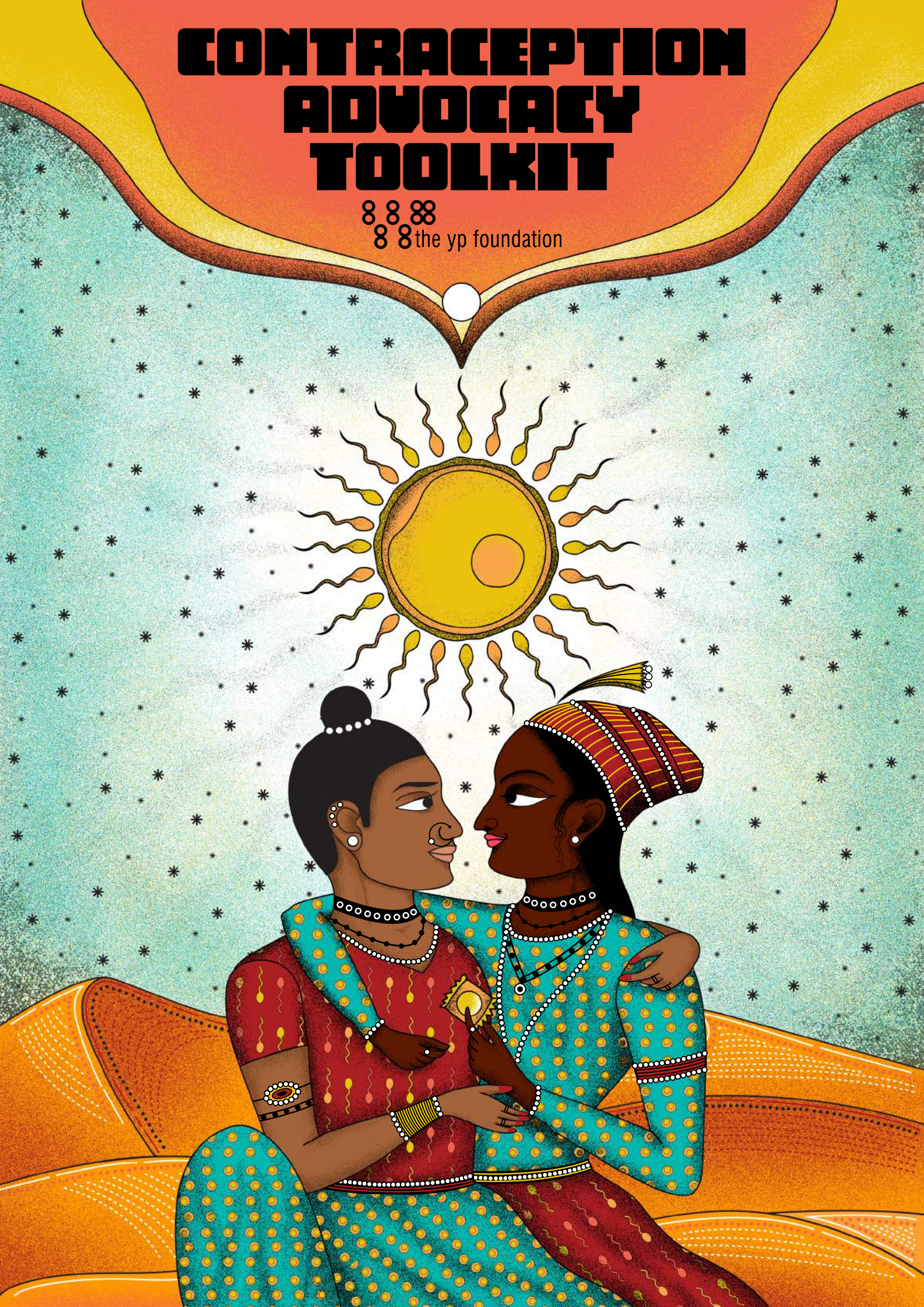
CONTRACEPTION ADVOCACY TOOLKIT

the yp foundation



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ABOUT THIS TOOLKIT

The dominant discourse and context in India, in which contraceptives have been located, promoted, and disseminated has been that of population control and family planning. Consequently, it has overlooked a whole gamut of issues as well as the needs of large groups of populations who have been denied relevant access and information. They include: the pursuit of sex for pleasure beyond procreation; the needs of young and unmarried persons; the unique contraceptive needs of trans and non-binary persons; sexual and reproductive health issues of persons with disabilities; the issues of access and gender discrimination; and contraceptivescas a way to protect against sexually transmitted infections, are just a few. One of the core influencers of the ecosystem determining information, access, and design is the policy of the government and the programmes that flow from it. To change the reality of contraception and ensure it meets the needs of all, there is an urgent need to advocate with the government to change its approach and policy. This toolkit attempts to help young people do that – advocate with the government to build its contraceptive policies and programmes around inclusion, self-determination, and the right to bodily autonomy of young persons.

The toolkit is broadly divided into:

- Understanding how contraceptives are a matter of young people's rights and access
- The trajectory of India's contraceptive policy, programmes, and the rights and inclusion issues therein, with specific reference to young people
- How advocacy for policy change can be designed, anchoring it around existing national policies and budgetary allocation, international human rights commitments, and evidence on the ground
- Tools and templates that can help young people action advocacy at local, national, regional, and international levels

Some examples of how advocacy has worked in countries like India, have also been included. A glossary is provided as a ready reckoner for important terminologies and concepts. Every section also contains suggested readings to help go deeper into some of the ideas discussed here.

It is envisaged that this toolkit will help you understand the range of social, political, economic, and governance questions that underlie contraception and access for young people in India. Some of the urgent and pressing themes that need to be taken up through advocacy and which this toolkit hopes to help you understand better in the context of contraceptive rights are discriminatory gender norms; the oversight of sexual and bodily autonomy of young people; the inclusion of all in accessing contraceptives of their choice; adequate programming and budgetary allocation to ensure sexual & reproductive health (SRH) for all young people, without discrimination; building an ecosystem of sensitive and high quality SRH services, among others.

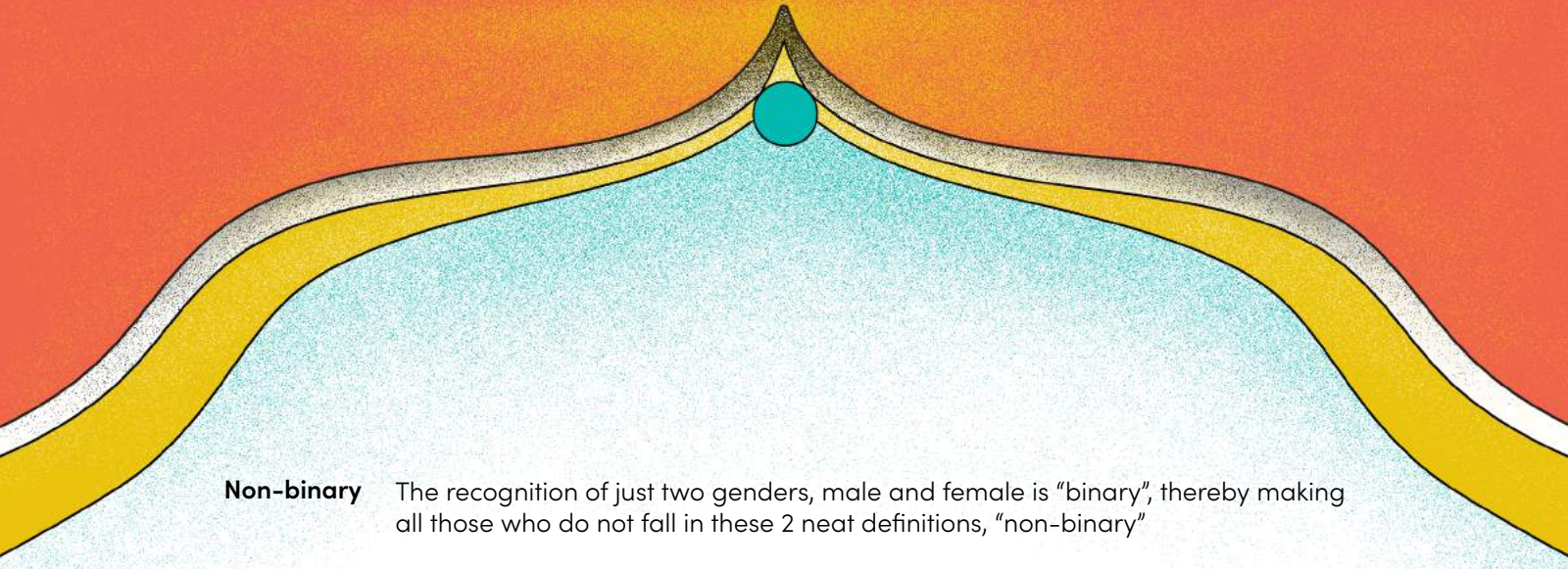
TABLE OF CONTENTS

GLOSSARY

This glossary aims to clarify some of the terms used in this toolkit and is to be used as a ready reference. It has been compiled from various web-based sources and has further explained the terms in the context of sexual & reproductive rights, bodily autonomy, and advocacy.

Adultism	The power that adults have over children accompanied by prejudice and systematic discrimination against young people
Agency	The power by which an individual or group acts on their behalf. Therefore, there is a distinction between individual agency and collective agency (like a social movement)
Ayushman Bharat	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (also referred to as Ayushman Bharat National Health Protection Scheme or NHPS) is a scheme of the Government of India aimed at providing free access to healthcare for 50 crore economically vulnerable people in the country
Bodily autonomy	The right to governance over our bodies. Specifically for women, nonbinary, and trans people, this means making decisions about one's physical self. It also means the freedom to take up space in the world. Unfortunately, it is not always seen as a right
Chronic health conditions	Conditions that last a year or more and require ongoing medical attention or limit activities of daily living or both. For instance, diabetes, heart conditions, hypertension
Citizen report cards	A tool that engages citizens in assessing the quality of public services such as health, education, public transportation, and other public distribution systems. It is a collective and quantitative reflection of citizens' feedback on the performance of a service provider formed by their experience of actually having used a particular service for a period of time
Contraception and Contraceptives	Contraception is the use of methods or devices to prevent pregnancy, and contraceptives are the methods and devices used. Some, not all, contraceptives also protect against sexually transmitted infections, although in common parlance, this aspect is not emphasised as much
Data fields	The heading under which data is collected during a survey. For instance, age, location, income level, satisfaction rating
Discriminatory gender role expectations	Gender roles imply how we are expected to act, speak, dress, groom, and conduct ourselves based upon our assigned sex. While they differ across groups and cultures, the expectations based on gender identity or sex differences result in discrimination and disadvantages of one or more groups
Dominant discourse	A way of speaking or behaving that is most prevalent within a given society
Ecosystem	A complex web of natural/ecological and human/social components that interact to affect system dynamics and influence how societies organize governance and institutions
Eugenist organisations	Organisations built on the premise of 'eugenics' or a set of beliefs and practices that aim to improve the genetic quality of a human population, by excluding people and groups judged to be inferior or promoting those judged to be superior

Formula feeding	Feeding a baby with manufactured food (formula), as opposed to breast milk
Heteronormativity	The belief that heterosexuality is the default, preferred, or normal mode of sexual orientation. It assumes the gender binary and that sexual and marital relations are most fitting between people of the opposite sex. It imposes certain expectations of role and behaviour on the binary – heteronormative femininity and heteronormative masculinity
High Level Political Forum	The United Nations High-level Political Forum on Sustainable Development is a body responsible for its policy on sustainable development
Human trafficking	The unlawful act of transporting or coercing people in order to benefit from their work or service, typically in the form of forced labour or sexual exploitation
Indian Medical Association	A national voluntary organisation of Doctors of Modern Scientific System of Medicine in India, which looks after the interest of doctors or the well-being of the community at large
Low- and middle-income countries	A definition that the World Bank uses to classify countries based on their gross national income (GNI) per capita of USD 1,035 or less in 2019; lower middle-income economies are those with a GNI per capita between USD 1,036 and USD 4,045, and so on. (For the fiscal year 2021) It indicates the value of the total income of a country distributed across its entire population
Mine Action Centres	An agency established in a region under the auspices of the United Nations to coordinate the clearing of the explosive remnants of war, including landmines and unexploded ordnance
Mission Parivar Vikas	A scheme of the government of India aimed at improving access to contraceptives and family planning services in 145 High Fertility Districts in 7 states
Modern contraceptive methods	Methods involving surgery or hormonal interventions which impact a woman's ability to conceive. They are expected to respond to the desire for sexually active persons to act on natural impulses with diminished risks of pregnancy. They aim to overcome biology through technological advances
Modern Contraceptive Prevalence Rate	The proportion of women (in reproductive age) who are currently using, or whose sexual partner is currently using, at least one method of modern contraception, regardless of the method being used
Moral policing	Moral police is an umbrella category of vigilante groups that act to enforce a code of morality. Some instances of moral policing are disruption of the celebration of valentine's day, harassment of inter-caste couples, preventing women from going to pubs, and so on
National Health Mission	The National Health Mission (and its two Sub-Missions, the National Rural Health Mission and the National Urban Health Mission) of the government of India is a comprehensive plan to achieve universal access to equitable, affordable, and quality healthcare services that are accountable and responsive to people's needs
'Nirbhaya' assault case	The case of sexual assault, gangrape, and murder of a 23-year-old woman in Delhi in December 2012. Among other issues that the case highlighted, one was that of how to approach the case of one of the 6 men who were accused since he was not 18 at the time of the assault. It opened up an additional aspect in the ongoing debate of age of sexual consent



Non-binary	The recognition of just two genders, male and female is "binary", thereby making all those who do not fall in these 2 neat definitions, "non-binary"
Output and outcome indicators	An output indicator typically counts numbers that have been impacted by an activity, like the number of people who benefitted from a programme. An outcome indicator communicates the ways in the resultant changes in those people by being part of the programme. For instance, the number of out-of-school children admitted to schools through a campaign is the output indicator, whereas an enhancement in their knowledge, by being in school is the outcome indicator. Outputs and outcomes are often related
Patriarchy	The dominance of the male or the 'masculine' in a relationship. In the context of the family, it is seen as the force which prevents women and the 'feminine' from reaching their full potential
Perception bias	The tendency to form simplistic stereotypes and assumptions about certain groups of people, like poor people are lazy, or women are not good drivers
Ratification	The act of not just consenting to an agreement but also committing to putting in place the systems and resources required to achieve it on the ground (United Nations context)
Reproductive justice	The belief that human beings have the right to maintain personal bodily autonomy, have children, not have children, and parent the children they have in safe and sustainable communities
Self-determination	The ability to make decisions and choices about who we are, and our future, without external pressure or violence (mental/physical)
Signatory	A country that has signed a treaty (United Nations context) declaring its support to its contents and its obligation to refrain from acts that would defeat its purpose, until ratification
Sustainable Development Goals	The Sustainable Development Goals or Global Goals are a collection of 17 interlinked global goals designed to be a blueprint to achieve a better and more sustainable future for all. Set up in 2015 by the United Nations General Assembly, they are intended to be achieved by the year 2030
Total Fertility Rate	The total fertility rate, sometimes also called the fertility rate, is the average number of children that would be born to a woman over her lifetime (with assumptions of ability to bear children and life expectancy)
Trans person	Transgender, often shortened as trans, is an umbrella term including people whose gender identity is the opposite of their assigned sex (trans men and trans women), it may also include people who are non-binary or belong to a third gender. The term transgender may be defined very broadly to include cross-dressers
United Nations Population Fund	The United Nations Population Fund, formerly the United Nations Fund for Population Activities, is a UN agency aimed at improving reproductive and maternal health worldwide
Unprotected sex	Sexual activity that does not use methods or devices to reduce the risk of transmitting or acquiring sexually transmitted infections, especially HIV

ABBREVIATIONS

AEP – Adolescent Education Program

AHFC – Adolescent Friendly Health Clinics

AHS – Annual Health Survey

ANM – Auxiliary Nurse Midwife

ARSH – Adolescent Reproductive and Sexual Health

ASHA – Accredited Social Health Activist

AWW – Anganwadi Workers

BCC – Behaviour Change Communication

CHC – Community Health Centre

DLHS – District Level Household Survey

DPMA – Depot medroxyprogesterone acetate

HLPF – High Level Political Forum

ICDS – Integrated Child Development Services

IEC – Information, Education, Communication

IUCD – Intra-uterine Contraceptive Devices

LGBTIQA+ – Lesbian, Gay, Bisexual, Trans, Intersex, Queer, Asexual, Agender, Aromantic + Other diverse sexual orientations and gender identities

LMIC – Low- and Middle-Income Countries

mCPR – Modern Contraceptive Prevalence Rate

MIS – Management Information System

MPV – Mission Parivar Vikas

NCERT – National Council of Educational Research and Training

NHM – National Health Mission

NFHS – National Family Health Survey

POCSO – Protection of Children from Sexual Offenses (Act)

PPIUD – Post-Partum Intra Uterine Device

PRI – Panchayati Raj Institution

RKSK – Rashtriya Kishor Swasthya Karyakram

RMNCH+A – Reproductive Maternal Newborn Child plus Adolescent Health

SDG – Sustainable Development Goals

SRH – Sexual and Reproductive Healthcare

SRHR – Sexual and Reproductive Health and Rights

STI – Sexually Transmitted Infections

1

CONTRACEPTION

A matter of young people's right and access

An overview of the socio-legal-political context of contraceptives and access in India and what it means for young people's bodily autonomy, sexuality, and rights?

Simply put, contraception is the use of methods or devices to prevent pregnancy, and contraceptives are the methods and devices used. Some, not all, contraceptives also protect against sexually transmitted infections. However, underlying these fairly straightforward definitions is a web of critical issues of right to access, affordability, and quality. A web that is made even more complex by its interlinkage with the overarching issues of patriarchy, adultism, and heteronormativity.

While patriarchy and heteronormativity norms impose discriminatory gender role expectations, those around adultism enforce obedience to adult authority, which severely affects children, adolescents, and youth to have a say in decisions that affect their life options, including health. When applied specifically to contraception and contraceptives, norms that control and regulate the sexuality of young people disregard their right to bodily autonomy i.e. the right to govern one's body and make informed decisions about it.

While it is not surprising that adolescent girls, nonbinary and trans people are the recipients of the worst forms of discrimination in bodily autonomy, young boys are not much better off. Norms and expectations of heteronormative masculinity become barriers to their decision-making and access to contraceptive services and products.

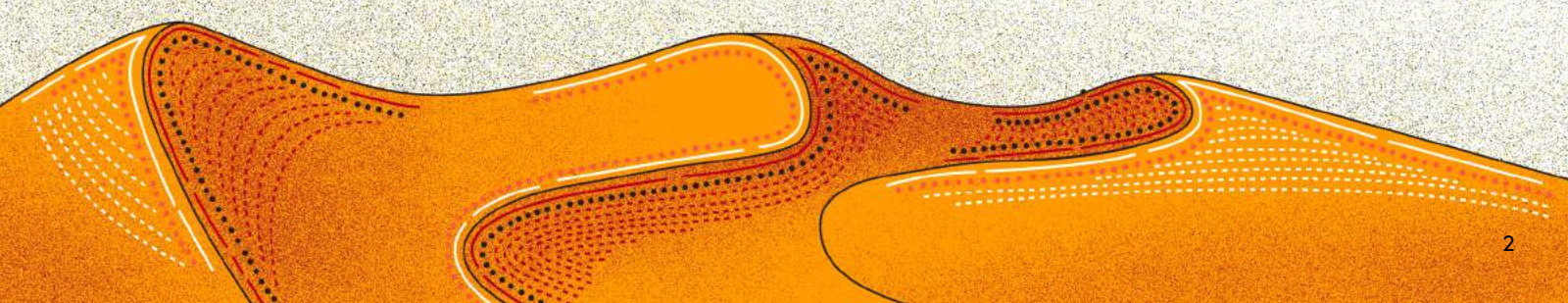
Contraception: why do we need to advocate for it?

Young people have the right to lead healthy lives across the entire spectrum of preventive, promotive, and curative health. They have the right to pursue pleasure, without discrimination and harm. They must have access to the tools they need to protect their choices, including their sexual and reproductive health. This can only be possible if, in policy, law, and practice, they are recognised as those who could be sexually active, independent of marriage.

The most basic need is access to reliable information, services, and products pertaining to sexual health even before they become sexually active, with the assurance of confidentiality. They need to understand how various methods of birth control work, the benefits and challenges of using particular methods, and where to get them. Further, they must be ensured affordability of contraceptive methods and devices chosen, of an environment not biased by moral policing, and of a supportive ecosystem of law, education, media, family, and policy to exercise their sexual choices and agency.

For this, contraceptives must be located in a framework of bodily autonomy and reproductive justice, with a commitment to be recognised as an essential service that is much larger than family planning. In practice, there are two broad kinds of barriers that restrict contraceptive access for young people — one governed by laws and policies that might limit choices or make it illegal for them to obtain contraceptive or abortion services; secondly, challenges stemming from socio-cultural norms, specifically gender attitudes that prevent access to information and services.

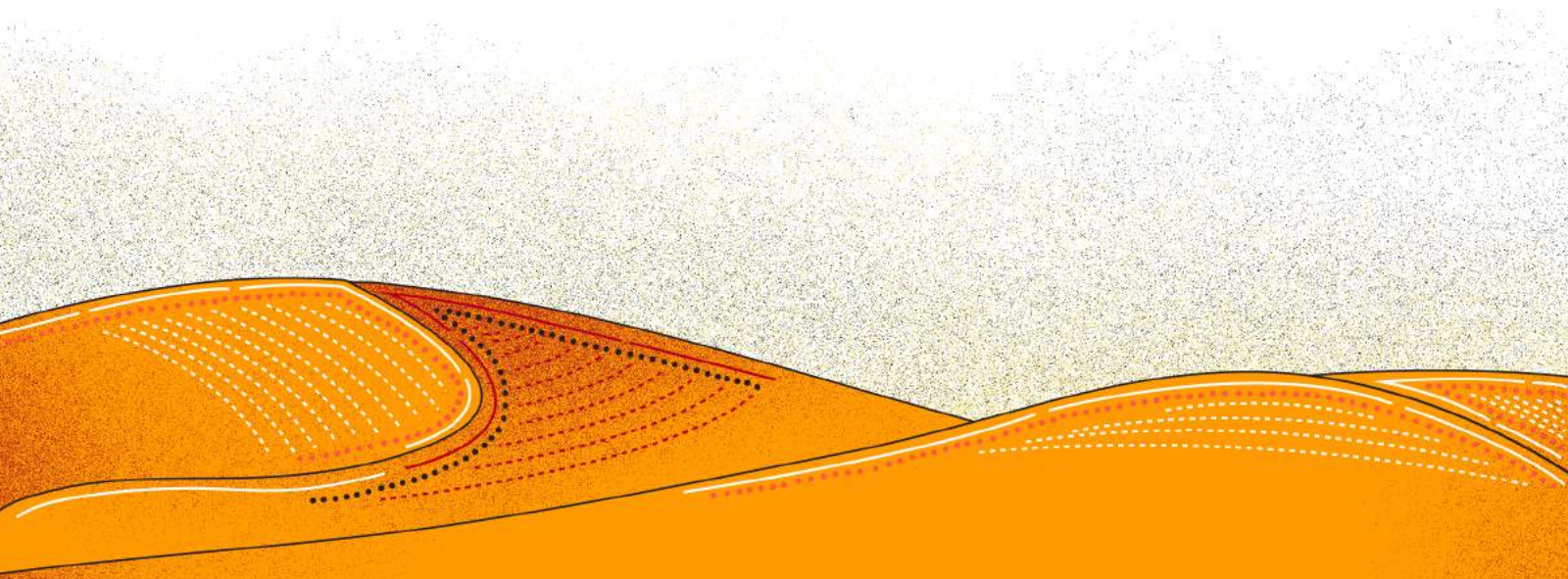
To catalyse an enabling and supportive ecosystem requires large-scale, community mobilisation, awareness, and committed action to align social norms with the human rights of all, including young people. Young people will have to advocate for themselves and equally across boys, girls, nonbinary and trans people, and those with disabilities, to explore safe, healthy, and pleasurable sexual lives and intimate relationships that help them transition to adulthood on an empowered and informed footing.



Young people's sexuality: a missing piece in the dominant discourse

Adolescence, youth, and sexuality are rarely seen as interrelated in the dominant discourse. If ever they are spoken of in the same breath, it is cloaked under layers of moralistic prescriptions of abstinence-until-marriage. There is a misplaced assumption here at play, that speaking about sexuality will increase sexual "experimenting" and promiscuity, rather than help young people understand the feelings, thoughts, attractions, and behaviours that will empower them to make informed choices about their bodies, their relationships, and their sexual health. Read more about the "promiscuity propaganda" here.

The concept of "adolescence" (and youth, by extension) as a distinct, critical life stage with unique potential, strengths, and needs, does not largely exist, let alone the recognition of how they differ for girls, boys, nonbinary and trans people. Given that it is a stage of increased desire for autonomy and exploration, by blocking information and exposure, young people across the spectrum are exposed to greater emotional, physical, and sexual vulnerabilities. These vulnerabilities could well be overcome through the concerted effort of families, schools, the government, and law, all of whom seem to be hindered by their lack of exposure and discomfort in talking about and dealing with sexuality.



Age of consent: pushing sexual health services further away

Simply put, the age of consent is when a person is considered to become legally competent to consent to sexual acts. Until May 2012, the age of consent in India was 16 years. It was raised to 18 in the POCSO Act (Protection of Children from Sexual Offences Act) that deals with child sexual abuse. The other law that lays out the age of consent is the Criminal Law (Amendment) Act, 2013 (popularly known as the anti-rape law) which has also increased the age of consent to 18. This Amendment came about after a public uproar in the aftermath of the 'Nirbhaya' assault case in response to the demand to try one of the accused who was 17 years old, as an adult. Even as the definition was changed by law, there continued to be a debate on what age should be and its implications on sexuality and moral policing of young people. Read more about the debate around the age of consent here.

In sum, while the ostensible reason and intent for increasing the age of consent were to protect children from sexual assault and abuse, what it overlooked is the need to create a legally acceptable framework for young people below 18, to engage in consensual, sexual relationships. It has also overlooked the fact that maturity and ability to consent are not uniform across the entire category of adolescents and youth. This has had a cascading effect on recognising young people's agency which has further absolved everybody of the need to address their unique needs. It has moved sexual and reproductive health services and products even further away from young people. Click here for a synthesis of the key issues around the age of consent.

In India, even as abortion continues to be a matter of intense moral, ethical, political, and legal debates, a recent amendment in the Medical Termination of Pregnancy Act, 1971has brought legal relief by extending it to cover unmarried women 'and her partner', and a clause to penalise medical practitioners who fail to protect the privacy and confidentiality of women who wish to terminate their pregnancy. One of the clauses in the POCSO Act pertains to mandatory reporting of sexual activities with children below 18, by anybody who may know about it. The failure to report is made punishable by law. While some have welcomed this clause for its potential to protect children from future harm, a lot of people do not agree with this clause on several grounds, including its oversight of participation in consensual sex by a person below 18.

In many countries, however, laws restrict access to sexual and reproductive health services based on age or marital status. As a consequence, they create further barriers in young people's ability to exercise the choice to prevent or plan their pregnancies.

- This map provides an overview of the countries across the world where lesbian, gay, bisexual, and transgender people are criminalised. Many of these countries not only criminalise same-sex sexual activity but also organizations and individuals who promote human rights for LGBTI individuals.

- Around the world, some countries have taken away the woman's right to choose and have decided for all women by making abortion illegal. Read here about Savita Halappanavar, a 31-year-old dentist originally from Karnataka, who died of septicaemia in 2012 after she was refused an abortion at University Hospital Galway, Ireland. A grassroots movement, catalysed by her death, led to a change in the country's abortion law.

Access barriers for girls: blocking critical information and services

Whereas both unmarried and married girls face barriers in accessing information and services to control their sexual and reproductive health, the unmarried are also subject to the norms of control and regulation that disapprove sexual activity before marriage.

This creates barriers that disregard access for them to the whole range of sexual and reproductive health services, including contraceptives. Even in the context of marriage, while child and adolescent marriages continue at a declining but significant rate in a country like India – in 2015-2016, nearly 27% of girls below 18 were married[1] - the continuing access barriers result in most of them beginning their marital lives with inadequate or no knowledge of sexuality, contraceptives, or reproductive health.

The Guttmacher Institute, in 2019 conducted a study, Adding it Up[2], in low and middle income countries (India being one) to gauge the need to invest in their sexual and reproductive healthcare (SRH). At that time, approximately 218 million women of reproductive age (15–49) in these countries reported to have had an unmet need for modern contraception.

The unmet need is much higher for adolescents than it is for all women in the reproductive age bracket, for whom it is estimated at 24%. Adolescents have 21 million pregnancies each year, of which 10 million are unintended, and 5.7 million end in abortions. Due to the lack of access to information, and safe abortion facilities, many abortions take place in unsafe and risky circumstances.

Contraceptives in India: making an appearance in family planning

Any document on contraception and contraceptives in India will almost certainly be built on the assumption of it being a part of family planning, where the "family" needless to say, is a heteronormative, marital union of a man and woman. Infamous for many reasons (discussed in subsequent chapters), the overriding tone of family planning has been that of directives by people in power and authority to manage the nation's fertility rates and population problem. With no effort to incorporate ideals of justice, sexual and bodily autonomy, and reproductive rights, contraceptives have been equated to birth control in a marriage.

Sexuality, especially that of women, nonbinary and trans people have never found place in the narrative of family planning and nothing about the policy, including contraceptives has been designed through a lens of empowerment or agency pertaining to sexuality.[3] This historical asymmetry has left a legacy that impacts us till today – when it comes to how we think about family planning and contraception, it has become a 'population problem' alone.

Although some of India's policies, like the Rashtriya Kishore Swasthya Karyakram recognises the need to address the lack of information on contraception through school and community programmes, they do not call for comprehensive sexuality education. This implies that the programme's focus largely stays on 'safer' topics like nutrition, menstruation, and pregnancy related care, and more socially complex issues like pre-marital sex, condom, and contraceptive use, informed contraceptive choice, unintended pregnancy, abortion, and sexual violence get ignored. This potentially exposes them to sexual violence and abuse. Read this policy brief looks deeper into how comprehensive sexuality education has the potential to address the discomfort and lack of preparedness within the health and education administrative systems to provide information on sex and sexuality.

In the Sustainable Development Goals to which India is committed, Target 3.7 pledges: "By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes."[4] However, in the last voluntary disclosure of achievements in 2017 the only mention of achievement pertains to childbirth, infant and maternal mortality. It is not surprising that the only indicator that is related to contraception is built around married women: "3.8.1: Percentage of currently married women (15-49 years) who use any modern family planning methods".

Effects of unintended pregnancies[5]

- Adolescent mothers aged 10–19 years face higher risks of childbirth related infections than those in the age group 20-24
- About 3.9 million unsafe abortions among girls aged 15–19 years occur each year adding to maternal mortality, morbidity and long term health problems.
- Girls below the age of 18 who are pregnant experience more marital and intimate partner violence.
- It often also leads to increased school dropout rates and a lack of future employment and educational opportunities.

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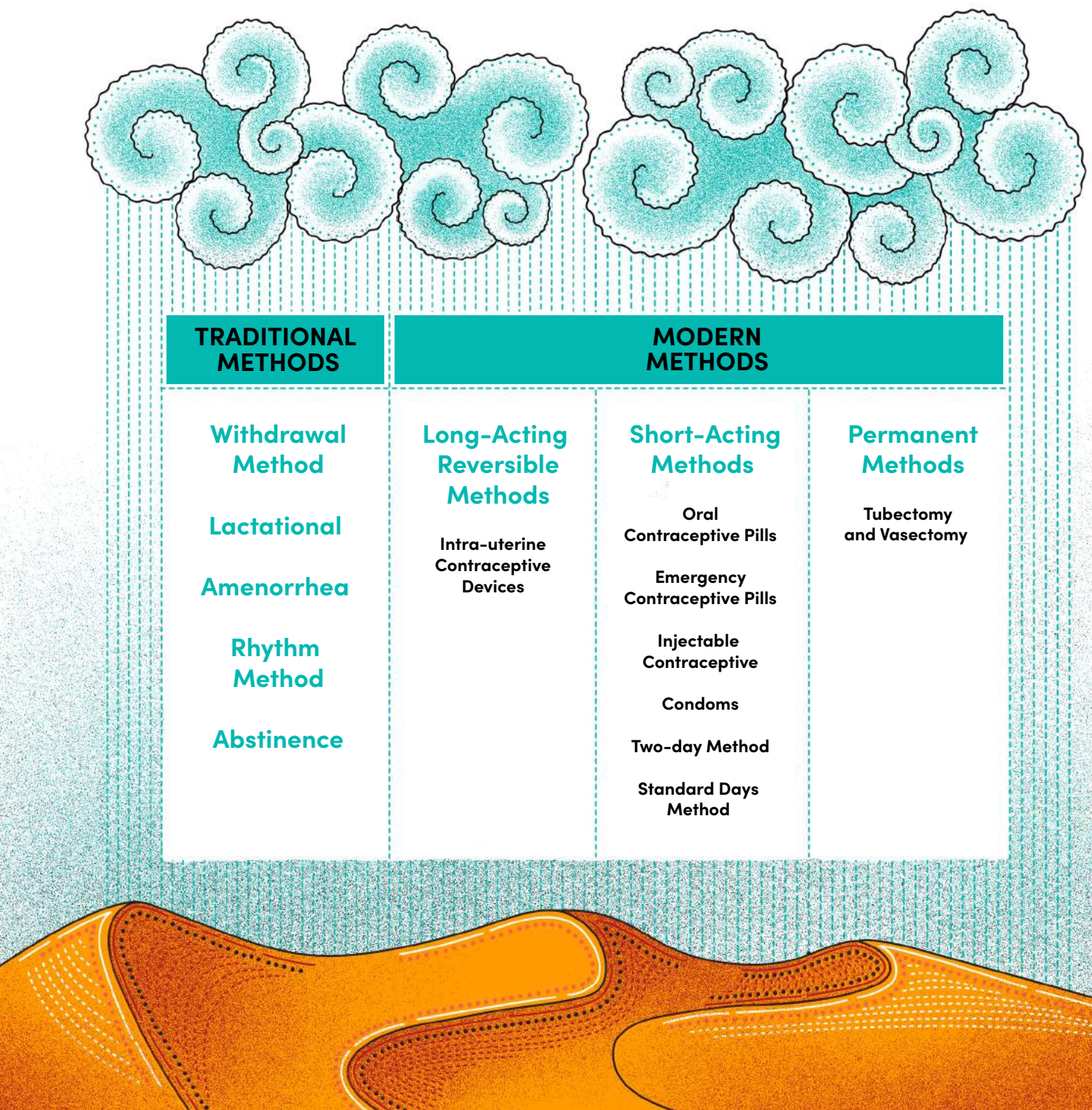
CONTRACEPTIVES

Is it truly a menu of options?

The range of contraceptives available in India and what do they tell us about how policies and programmes perceive access and responsibility contraception?

Anyone can use contraception and everyone has the right to do so! This is irrespective of their age, marital status, gender, disability, whether they have children, or have had abortions. Those who have chronic health conditions or those who smoke and/or consume alcohol too can use contraception. A person's contraceptive needs change over time, and they may like to use different methods at different points in their sexually active life. Let's have a look at the range of options available.

Broadly, contraceptive methods are classified under 'Modern' and 'Traditional', where the former involves surgery or hormonal interventions and the latter ranges from abstinence to tracking hormonal changes which impact a woman's ability to conceive. Modern contraceptive methods largely respond to the desire for sexually active persons to act on natural impulses with diminished risks of pregnancy. They aim to overcome biology through technological advances.



TRADITIONAL METHODS: PREDATING THE MODERN

Withdrawal method

The withdrawal method of contraception (known as coitus interruptus) is the practice of withdrawing the penis from the vagina and away from a woman's external genitals before ejaculation to prevent pregnancy. Also "pulling out" aims to prevent sperm from entering the vagina. One in five couples who practice the withdrawal method for one year is estimated to get pregnant.[6]

Pros: Many couples use the withdrawal method because they do not want to undergo any intervention on their bodies or consult a doctor. It is free and readily available to use.

Cons: The withdrawal method requires self-control and does not guarantee the prevention of pregnancy. Moreover, it does not offer protection from sexually transmitted infections (STIs), as many other methods do.

Rhythm method

The rhythm method also called the calendar method or a calendar rhythm method is a form of natural family planning in which the menstrual cycle is tracked to predict ovulation. It is used both, to determine the best days to get pregnant (at the time of ovulation) and those when one must avoid unprotected sex to not get pregnant. On average, the rhythm method is said to be between 76 and 87% effective at preventing pregnancy, mostly because abstinence has to be practiced on more than just one or two days — it can take up to 10 days without sex to prevent pregnancy.[8]

Pros: Like other traditional methods, the rhythm method too does not cost anything and is non-invasive. For couples who are open to getting pregnant but would like to avoid it in the short-term, this could be a preferred method because they can plan and control it themselves.

Con: Using the rhythm method requires careful record keeping and persistence. It is also known to be less effective than other methods – among 100 women in their first year of using the rhythm method, 24 will typically become pregnant. Also, it requires regularity in the menstrual cycle which, many women, may not have for a variety of reasons.

Lactational Amenorrhea

Also known as the 'Breastfeeding Method' this can be used by women who are exclusively breastfeeding their child (every 4 hours in the day, and every 6 hours at night). During this time, a woman stops ovulating and, therefore, cannot get pregnant. This method can usually be used until the child is 6 months old, or till the woman starts her periods (whichever is earlier). As a contraceptive method, Lactational Amenorrhea is estimated to be 98% effective, as much as the pill and other modern methods.[7]

Pros: While breastfeeding itself is said to have many benefits for the baby, as a method for contraception the breastfeeding method is a preferred one for those who are looking for free, natural and, non-invasive ways to prevent pregnancy for 6 months after one child is born. It is not known to have any side effects and is accepted by all religious groups. Learn more about religious and cultural influences on contraception here

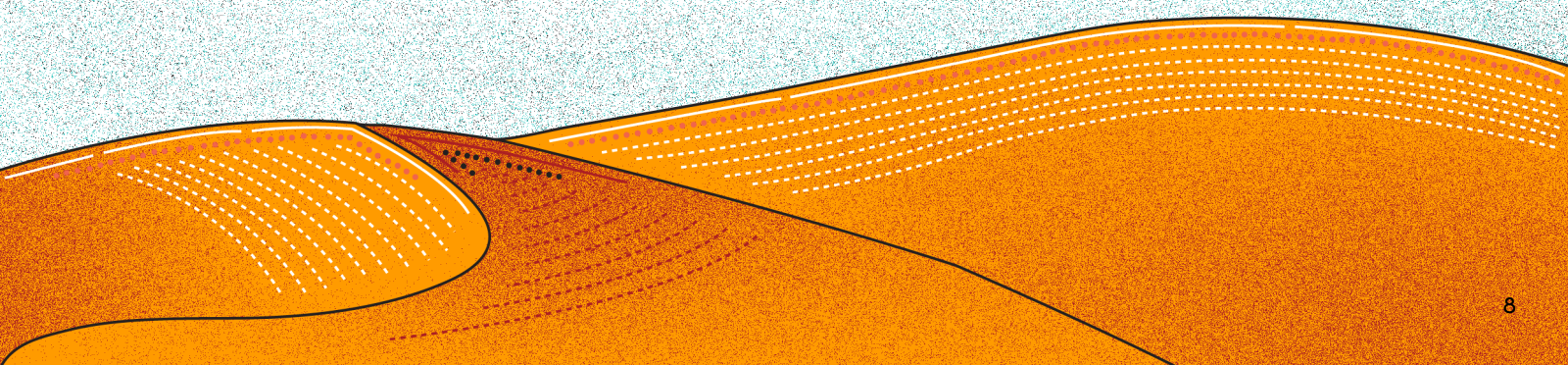
Cons: The breastfeeding method lasts only up to 6 months and does not protect against STIs. It requires full breastfeeding (not in combination with formula feeding) which is not practised by many women for various circumstantial reasons.

Abstinence

Abstinence, or not having sex at all is the contraceptive method of 100% success. However, abstinence could also mean not engaging in vaginal sex, but rather having oral and anal sex which does not allow for the sperm and egg to fuse. Sexual partners may pursue abstinence for a long period of time and engage in other forms of pleasure, or they may use it only during the fertility window when a woman is most likely to become pregnant.

Pros: A no-cost, natural method that is 100% effective!

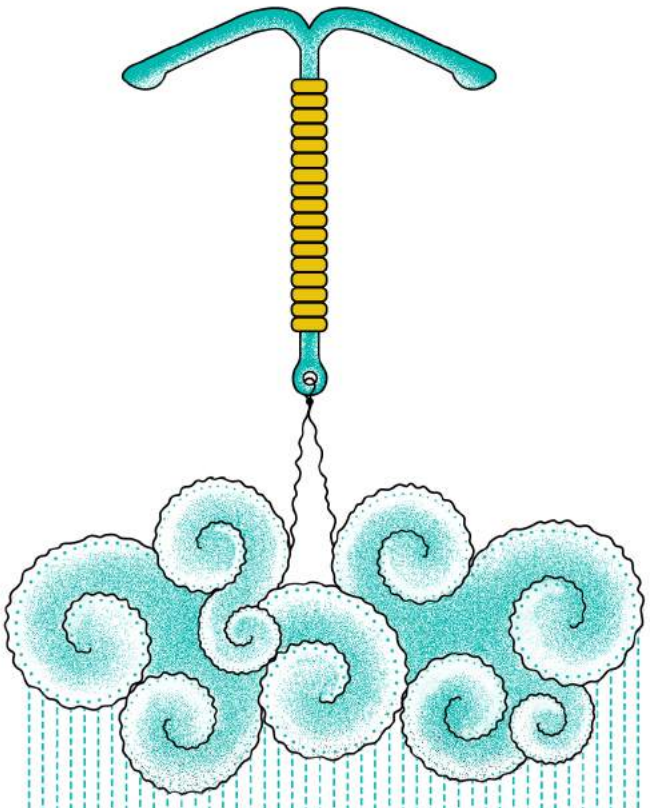
Cons: Abstinence, even when practised partially, assumes the ability of the woman to negotiate not having vaginal sex. This, as we discuss below, is not borne out by evidence at all.



MODERN METHODS: SURGICAL AND HORMONAL INTERVENTIONS

The contraceptives that fall under 'modern' methods could be Long-acting Reversible Methods, Short Acting Methods, or Permanent Methods. As the names suggest they are divided in keeping with their duration of effectiveness in helping to avert pregnancy and the possibility of reversal.

LONG-ACTING REVERSIBLE METHODS



Intra-uterine Contraceptive Devices

Intra-uterine Contraceptive Devices (IUCD, also known as 'Copper-Ts' because it is made of plastic and copper and is shaped like the letter 'T') can be inserted, by a trained doctor, into the uterus. The device stops the union of sperms and eggs and lines the uterus in a way that a fertilised egg is unable to attach to the lining, which would be the beginning of a pregnancy.

Under the government's family planning program in India, two kinds of IUCD devices are available – IUCD-380A (effective for 10 years) and IUCD-375 (effective for 5 years). They were introduced in 2002 and 2012, respectively and free of charge but their prevalence rate (among married women, to whom it is targeted) is only 1.5 percent.[9]

Other IUDs such as Mirena (Levonorgestrel/LNG-IUS) are available in the private sector at a very high cost, but there are conversations to add this to the basket of choices available through the National Family Planning Programme.

Pros: IUCD has a very high rate of success in contraception and are reversible i.e. it is possible to remove them at any time. They have a long life from 5-10 years and do not interfere with breastfeeding or medications. It is a feasible alternative for many women who are unable to use hormone-based contraceptives (described below).

Cons: IUCD, however, do not protect against STIs and many women complain of irregular flow during periods after its insertion. There are very low chances (1%) of acquiring a uterine infection during IUCD insertion if the woman is prone to STI. There is a possibility of the expulsion of the device within the first 3 months (5%) and uterine perforation during insertion (0.1%).[10]

SHORT ACTING METHODS

Oral Contraceptive Pills

Hormonal pills or non-hormonal pills are very commonly used to prevent pregnancy. They are effective only if taken regularly and consistently, at the same time every day. They act as a contraceptive by thickening the cervical mucus and preventing ovulation. Once a woman stops taking the pill, she can conceive again. In the government's basket of free/-subsidised options, one can get Mala-D or Mala N which contain the hormone, progesterone, and oestrogen which work to prevent ovulation.

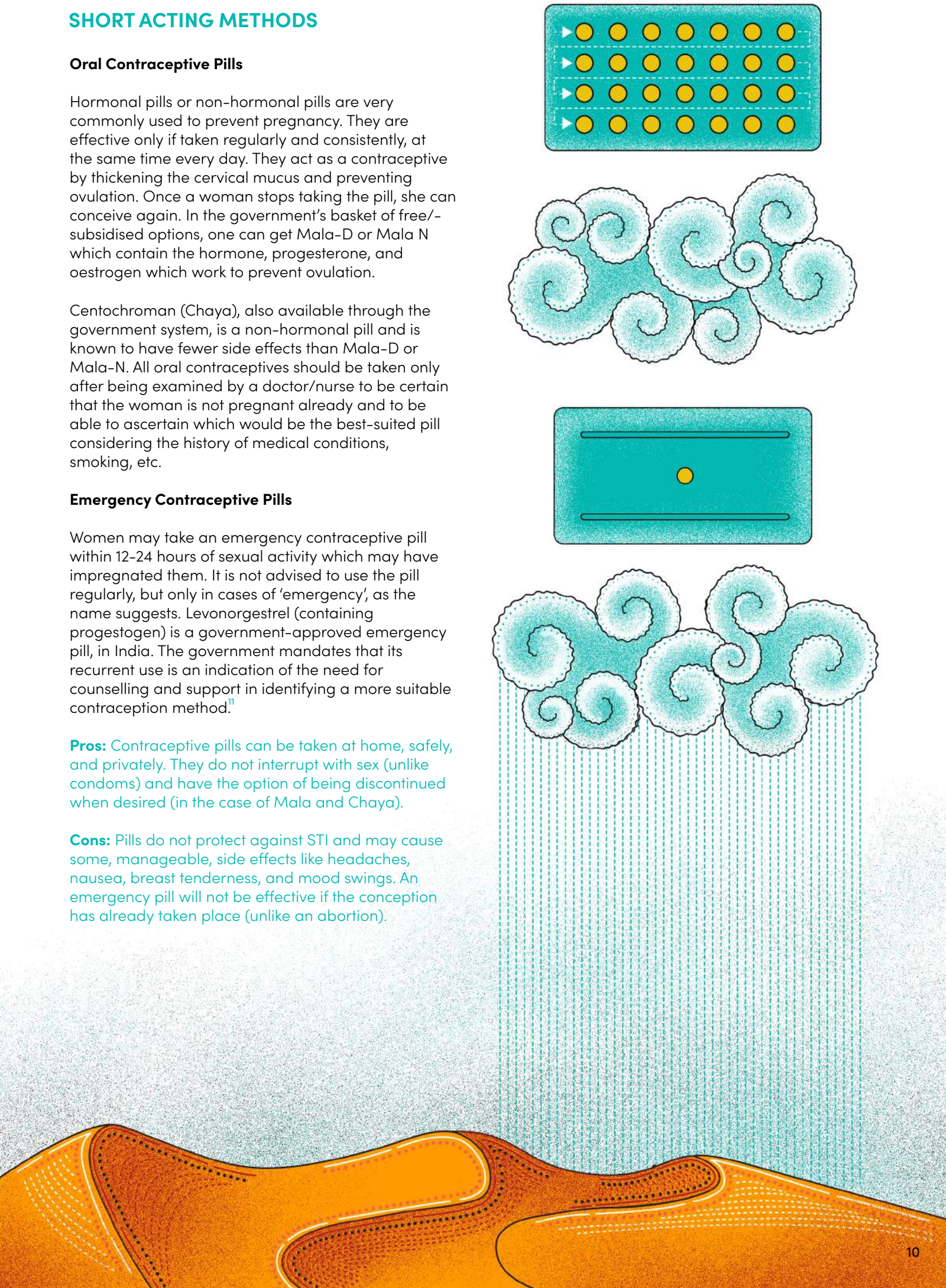
Centochroman (Chaya), also available through the government system, is a non-hormonal pill and is known to have fewer side effects than Mala-D or Mala-N. All oral contraceptives should be taken only after being examined by a doctor/nurse to be certain that the woman is not pregnant already and to be able to ascertain which would be the best-suited pill considering the history of medical conditions, smoking, etc.

Emergency Contraceptive Pills

Women may take an emergency contraceptive pill within 12-24 hours of sexual activity which may have impregnated them. It is not advised to use the pill regularly, but only in cases of 'emergency', as the name suggests. Levonorgestrel (containing progestogen) is a government-approved emergency pill, in India. The government mandates that its recurrent use is an indication of the need for counselling and support in identifying a more suitable contraception method.[11]

Pros: Contraceptive pills can be taken at home, safely, and privately. They do not interrupt with sex (unlike condoms) and have the option of being discontinued when desired (in the case of Mala and Chaya).

Cons: Pills do not protect against STI and may cause some, manageable, side effects like headaches, nausea, breast tenderness, and mood swings. An emergency pill will not be effective if the conception has already taken place (unlike an abortion).



Injectable Contraceptive

An injection of Medroxyprogesterone acetate (MPA) can prevent pregnancy by preventing ovulation in women. One injection is effective for 3 months, and for long-term use, the dose needs to be repeated. Once stopped, the woman can potentially conceive. The injectable contraceptive has been recently added to the government's basket of options after a lot of advocacy. They are administered by trained doctors after a thorough examination.

Pros: Considered a safe and effective method, injectable contraceptives have been seen to be useful for those who cannot take oral contraceptives, and those with anaemia because it reduces or completely stops periods.

Cons: It could take 7-10 months for a return to fertility after discontinuation of the injection and might have some side effects. Injectables do not protect against STI.

Two-day Method

To use the two-day method, a woman has to check for cervical discharge twice a day. No discharge for two consecutive days indicates that pregnancy is unlikely even from unprotected sex. The "infertile" days typically occur a few days after menstruation. It is crucial to understand the kind of discharge from a health professional before resorting to this method.[12]

Pros: The two-day method is a non-invasive, no-cost method, especially relevant for those who have difficulty in accessing other methods. It is estimated to be effective for 86 to 96% of women who use it.

Cons: Yet again, the two-day method does not protect against STI and is not a reliable one for women who do not have much discharge. The method may have to be adapted in places where female genital mutation or other vaginal practices are culturally followed.

Standard Days Method

Based on an algorithm of a woman's menstrual cycle, the Standard Days Method is built on the evidence that the period between the 8th and 19th day of her menstrual cycle is the window when she is most likely to get pregnant. To exercise contraception she must avoid penetrative intercourse during this time. The government of India has included this method in its family planning norms and has mandated health providers to make information and support available.

Pros: An effective, natural, and no-cost method, this can be used by a woman tracking her menstrual cycle.

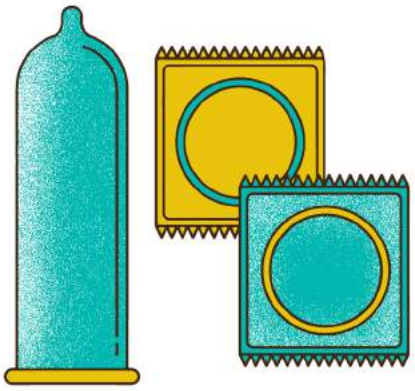
Cons: The Standard Days method cannot be used by women who have irregular periods and it does not protect against STI.

Condoms

A condom is a thin layer of rubber that is rolled onto the penis before intercourse. 'Female' condoms which are less prevalent, are made of latex and are inserted into the vagina before intercourse. Both types of condoms prevent the sperm from entering the vagina and are called 'barrier methods'. 'Male' condoms are widely accessible through the government's contraceptive basket as well as medical stores but 'female' condoms can be bought through private channels. A 'male' condom should only be used once, and the two types of condoms should not be used together.

Pros: Condoms protect against pregnancy and significantly, against STI. Their effectiveness as a contraceptive is estimated to be almost 95%.

Cons: The use of 'male' condoms is often difficult to negotiate because of perceptions of discomfort or loss of pleasure. Purchasing condoms from a store is typically not easy, especially for women and young people below 18.



PERMANENT METHOD

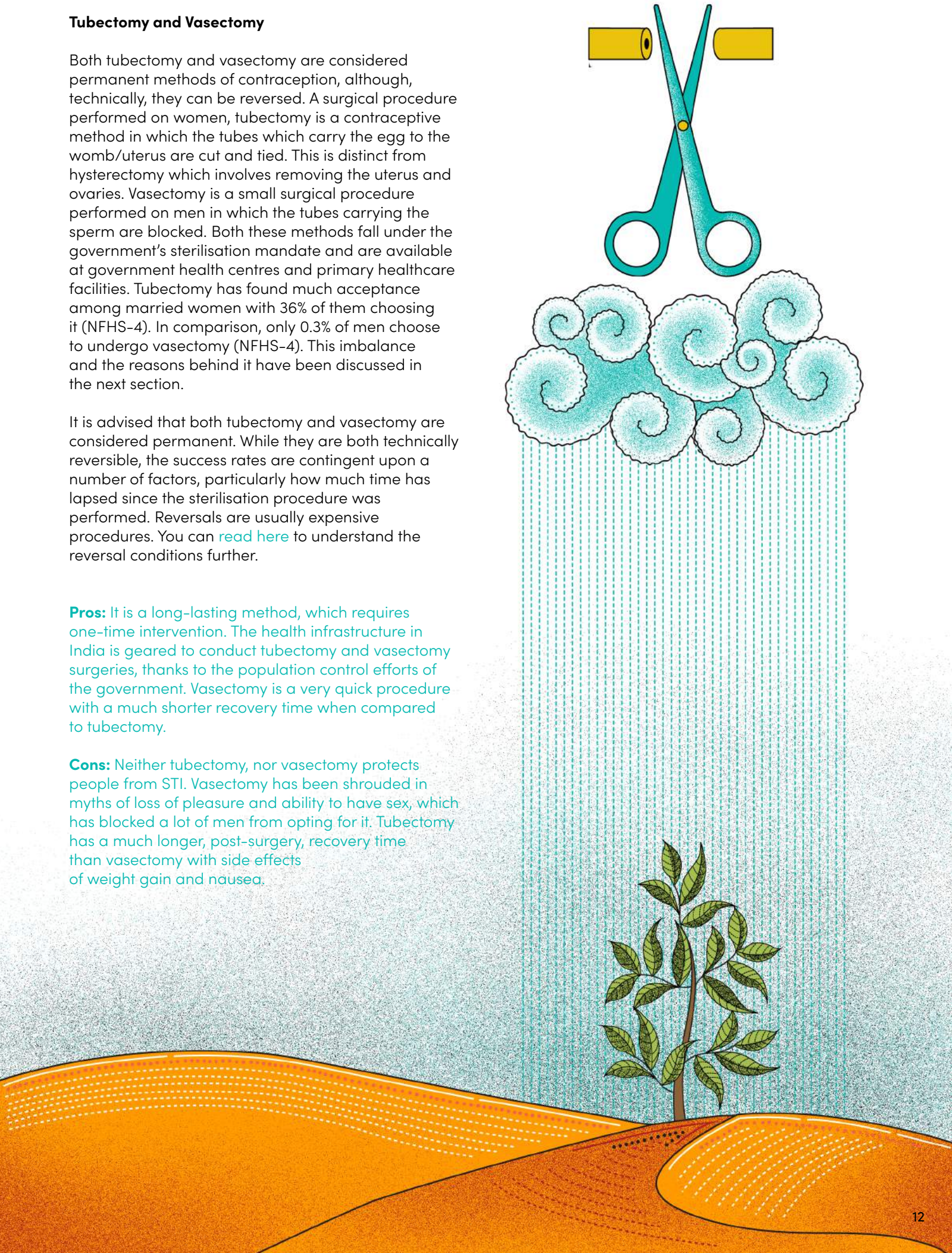
Tubectomy and Vasectomy

Both tubectomy and vasectomy are considered permanent methods of contraception, although, technically, they can be reversed. A surgical procedure performed on women, tubectomy is a contraceptive method in which the tubes which carry the egg to the womb/uterus are cut and tied. This is distinct from hysterectomy which involves removing the uterus and ovaries. Vasectomy is a small surgical procedure performed on men in which the tubes carrying the sperm are blocked. Both these methods fall under the government's sterilisation mandate and are available at government health centres and primary healthcare facilities. Tubectomy has found much acceptance among married women with 36% of them choosing it (NFHS-4). In comparison, only 0.3% of men choose to undergo vasectomy (NFHS-4). This imbalance and the reasons behind it have been discussed in the next section.

It is advised that both tubectomy and vasectomy are considered permanent. While they are both technically reversible, the success rates are contingent upon a number of factors, particularly how much time has lapsed since the sterilisation procedure was performed. Reversals are usually expensive procedures. You can read here to understand the reversal conditions further.

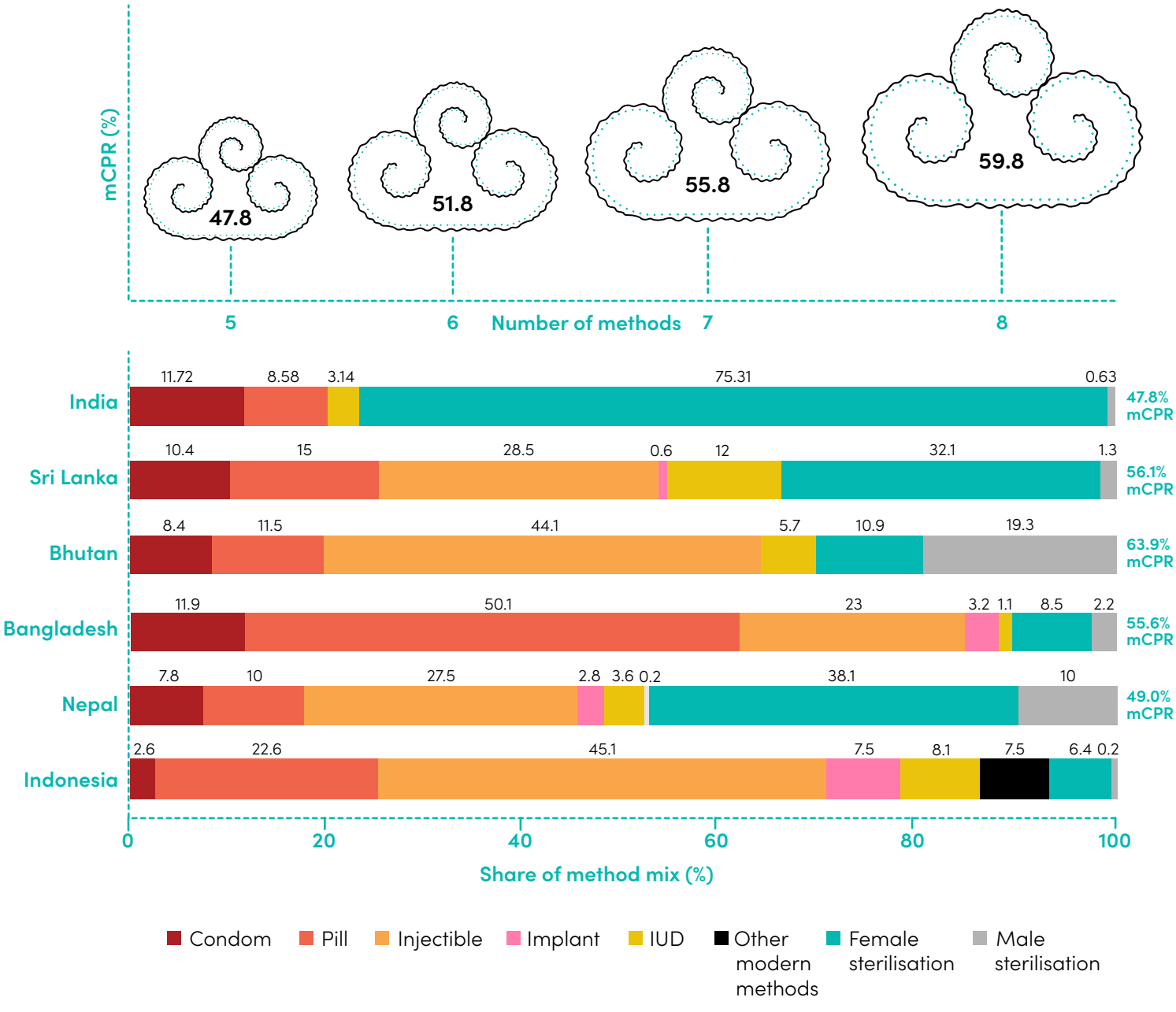
Pros: It is a long-lasting method, which requires one-time intervention. The health infrastructure in India is geared to conduct tubectomy and vasectomy surgeries, thanks to the population control efforts of the government. Vasectomy is a very quick procedure with a much shorter recovery time when compared to tubectomy.

Cons: Neither tubectomy, nor vasectomy protects people from STI. Vasectomy has been shrouded in myths of loss of pleasure and ability to have sex, which has blocked a lot of men from opting for it. Tubectomy has a much longer, post-surgery, recovery time than vasectomy with side effects of weight gain and nausea.



While we review the range of modern contraceptives possible, we must also recognise that till 2017 India offered only five methods of contraception, compared to seven in neighbouring countries like Bangladesh, Bhutan, Indonesia, Nepal and Sri Lanka who offer a more balanced mix of methods which results in a higher adoption of modern contraceptive methods.

FIG 1



Abortion and contraception

Birth control and abortion (medical termination of pregnancy), by definition, are different – while the former prevents pregnancy in the first place, the latter end an existing pregnancy. Nonetheless, since they are closely related, there have been many comparisons and opinions on how they should be controlled in similar or distinct ways. Some groups that are against abortion are also against contraceptives that hinder the egg from being implanted because they consider this the termination of "personhood" which begins from the time of fertilisation.

The scientific definition of pregnancy reflects the fact that most fertilized eggs naturally fail to implant in the uterus and therefore, argues that abortion and contraception cannot be equated.[13] From a rights perspective, terminating a pregnancy is the choice of the pregnant woman and a part of her reproductive rights. Every woman has the right to safe, affordable, and confidential abortion facilities. In India, the law governing abortions is the Medical Termination of Pregnancy (Amendment) Bill, 2020. You can read more about the Act here.

Contraception: a married woman's responsibility?

From the range of contraceptive options available and enlisted above, some things become evident about who they are targeted to and who does not even qualify to be on the radar.

Contraceptives – only for the married!

In the government's perception, contraception is linked only with marriage and family. There is no recognition of young people (below 18) or those who are unmarried as being sexually active. All the methods and devices are aimed at planning marital "families". Contraception and sex are, thereby, related only to procreation, without any possibility of sex for pleasure.

There is a vast menu of contraceptive options which could potentially be used by young people. There is, however, an absence of a supportive network of health professionals and counsellors who can help young people navigate this space and choose the best combination of options for them. This absence pushes young people to stumble through information (some of it, unreliable) and figure it out themselves. Not surprisingly, the scale is tipped further against women, trans and nonbinary people in the availability of options and the ability to procure them.
With little investment in understanding their sexuality, there is even lesser commitment in catering to their sexual and contraceptive needs.

Women bear the burden but not the decision-making

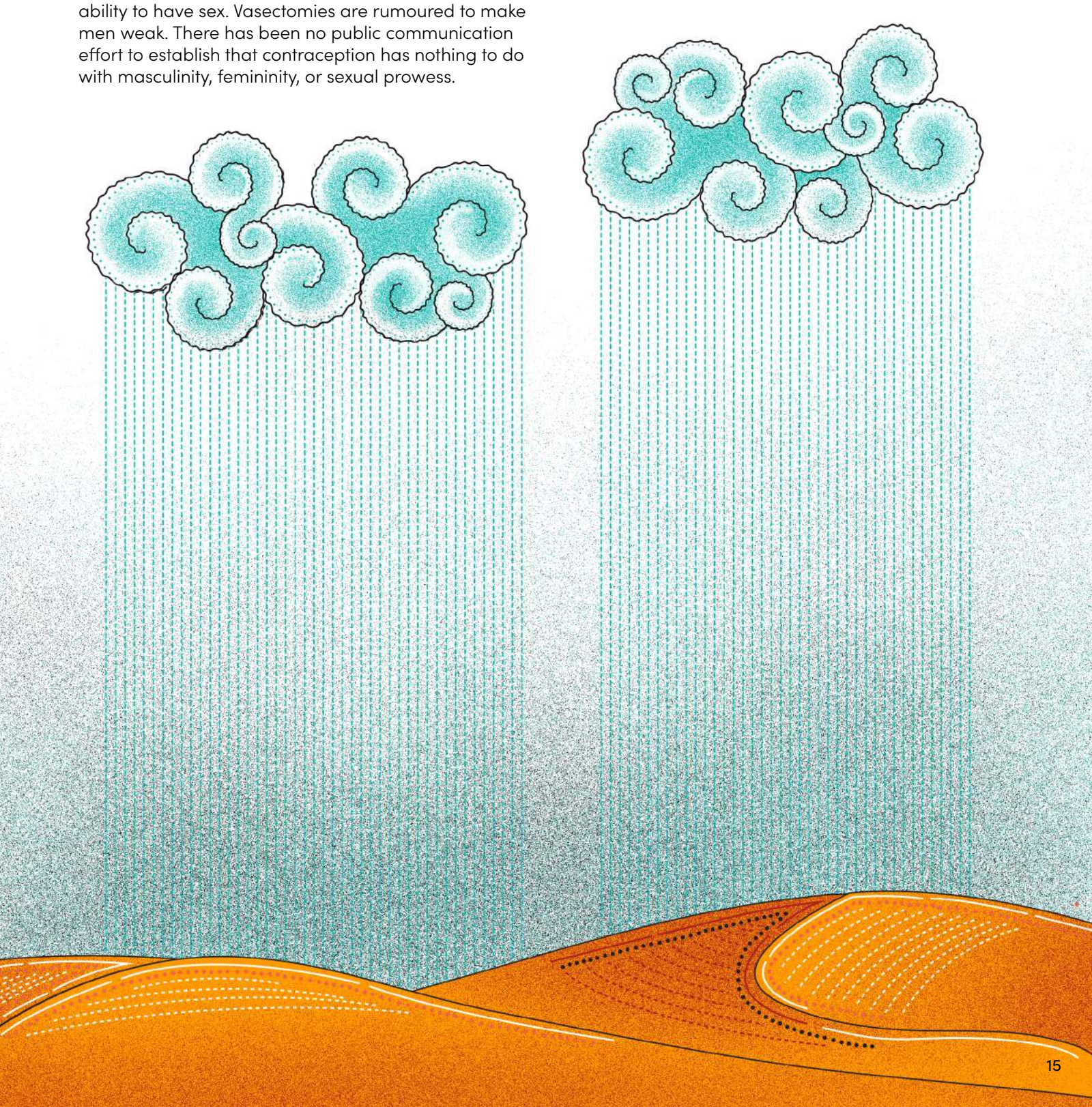
Women are expected to bear the burden of contraceptive responsibility. While this could potentially create bodily autonomy for women, due to the patriarchal framework of the institution of families, it has resulted in women having greater awareness and responsibility of contraception while men control the decision making about procreation. The two-day and standard day methods, for instance, assume that the woman can control her reproductive and sexual activity based on her hormonal cycle. This is very often, not possible. As a proxy indicator, let us consider that Mumbai's municipal corporation's health infrastructure conducted 1000 vasectomies in 2018-19 as compared to nearly 20,000 tubectomies in the same time period.[14]

It has been over 50 years since the first contraceptive pills for women were approved for use, yet no similar drug has been developed for men. Some clinical trials have been successfully conducted. However, they were abandoned because of the side effects of depression and mood swings reported by participants.
It is important we remind ourselves that all the long-acting reversible methods currently used in India, and the rest of the world also have side effects on women including depression, mood swings, irregular or heavy periods, weight gain, headaches, etc. Yet they have been sanctioned and popularised for use.

A number of myths and misconceptions have surrounded men's use of contraception. For instance, some of the most common excuses to not wear a condom are that they reduce pleasure or impact the ability to have sex. Vasectomies are rumoured to make men weak. There has been no public communication effort to establish that contraception has nothing to do with masculinity, femininity, or sexual prowess.

Access asymmetry

Even where young people, and among them, women, trans, and nonbinary people may have accurate information, being able to procure a condom from a store or get an IUD inserted before marriage, is a Herculean task. It is no wonder then that a host of unlicensed and risky set-ups cater to their needs. Contraceptives available through the public health system require interaction with ASHA, ANM, doctors, nurses, pharmacists – none of whom are known to be open to the possibility of young people of diverse sexualities engaging in sexual activity, for pleasure. The assumption that they will frown upon and, perhaps, alert the family about the young person seeking contraceptives, is not completely unfounded.



3

ADOLESCENTS' ACCESS TO CONTRACEPTION

Building the evidence

What are the ways in which young people can build data-based, empirical evidence to bolster their advocacy effort?

Evidence: the cornerstone of advocacy

The effort to advocate for change in policy and practice for any issue requires bringing to the table a combination of lived experiences, stories, research, and, most importantly, data. It is the research and data that builds the evidence for what we believe in. Data from a reliable source, collected through scientific methods, is indisputable even though there may be differences of opinion on how it should be analysed and interpreted. By assigning data to a phenomenon, we could move it out of the realm of perception bias and build the proof to substantiate what we see around us and believe to be true.

Those who work in the realm of advocacy cannot stress the importance of how data and evidence change the course of our effort and dialogue with policymakers, donors, and influencers. Just like evidence in a courtroom, it makes people sit up and listen, and it could steer the conversation towards action and results.

For instance, we discussed that only 1000 vasectomies and 20,000 tubectomies were conducted by Mumbai's municipal health infrastructure in 2018-'19. If we were to advocate for the urgent need for a campaign to popularise vasectomies among men, this data will help in building our argument. Layered on information about the socio-economic profile of users of the municipal health services, we can get an idea of who this campaign must be targeted to. The assumption here, of course, is that the data released by the Corporation is reliable.

Let us look at some of the categories under which data can help in advocating for young people's improved sexual and reproductive health pertaining to contraceptives. This is an indicative, and not an exhaustive list.

Profile

- How many young people currently/ potentially need contraceptive services and products?
- What is their age, location, economic and marital status?
- How do they define their sexuality?

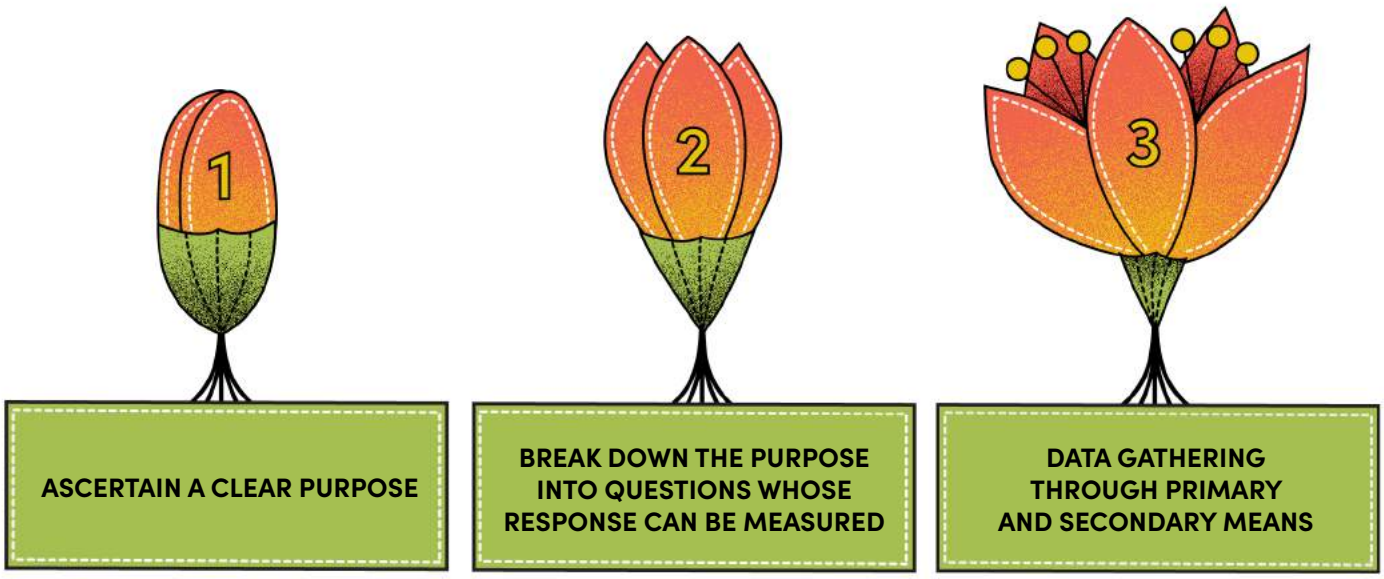
Access

- What are the sources of information young people have?
  How do they access them?
- What percentage of young people show evidence of accurate (from reliable and unbiased sources) and adequate information regarding contraception?
- How many young people report to be able to be able to access counselling and guidance for identifying their contraception needs?
- How many young people report to have been able to procure the contraceptive of their choice based on informed decision-making and through official channels at prescribed prices?

Discrimination

- How many young people report to have faced discrimination in their effort to access contraceptive services and products?
  - How do their experiences differ across marital status, age, sexuality, location, economic status, and so on?
- What are the different ways in which they have been discriminated and how many young people report having faced them?
- How have young people responded to their experience of discrimination?
  They could report to have:
  a) Not attempted to access contraceptives again
  b) Sought out alternative options for accessing contraceptives
  c) Joined a peer group of people to act against such discrimination

MAKING DATA WORK FOR US: HOW TO BUILD EVIDENCE



The first step in building evidence using data is to ascertain a clear purpose for what the data is expected to do for you. Sharper the definition of the purpose, better the chances of seeking out the appropriate data. The purpose could be one or more, but in case they are multiple, they should all be interlinked and logically connected. The purpose could be:

- To illustrate a need
- To press for action
- To inform public opinion
- To strengthen one's learnings of lived experiences

Once the purpose is clearly defined, we break down the purpose into questions whose response can be measured. For instance, to press for the need for contraceptive counselling among young people we will have to find data that proves that there is a gap in the available counselling services. This gap could be in terms of:

- Number of young people reached
- Where they are located (how many in Tier I cities, how many in rural areas, and so on)
- Their marital status
- How they identify their sexuality
- How they rate the counselling services that they have accessed (on a scale of 1-10)

Once we have the purpose and key questions in place, we set out to collect data that helps build the evidence. Data could be collected through primary means or by secondary/desk research. The former entails launching one's own data collection and analysis exercise. Secondary or desk-based data collection involves seeking out reliable and relevant data from existing sources.

It is important to remember that data from secondary sources will not be tailormade for your advocacy purpose. Rather, you will have to use it to build your argument. While conducting secondary data collection, it will also become evident where the gaps lie. The questions that have not been asked and for which no data-based evidence exists. This is a critical contribution to the advocacy effort – identifying data gaps!

5

To fill the gaps in data, you can work with researchers and organisations to collect data and information through surveys to understand the experiences of these groups. Additionally, you can conduct surveys yourself. For example, you can talk to the local ASHA worker, or counsellors at the AFHC, or your peers in your community to understand their experiences in accessing or providing contraceptives to young people.

WHERE TO LOOK FOR RELEVANT, RELIABLE SECONDARY DATA

This section will guide you to some of the reliable sources of data for the purpose of advocating for contraceptives for young people. This is not an exhaustive list, rather it is indicative. As you delve into the data sources, you will be able to identify additional reports and documents that will be useful for your purpose.

Government ratified sources

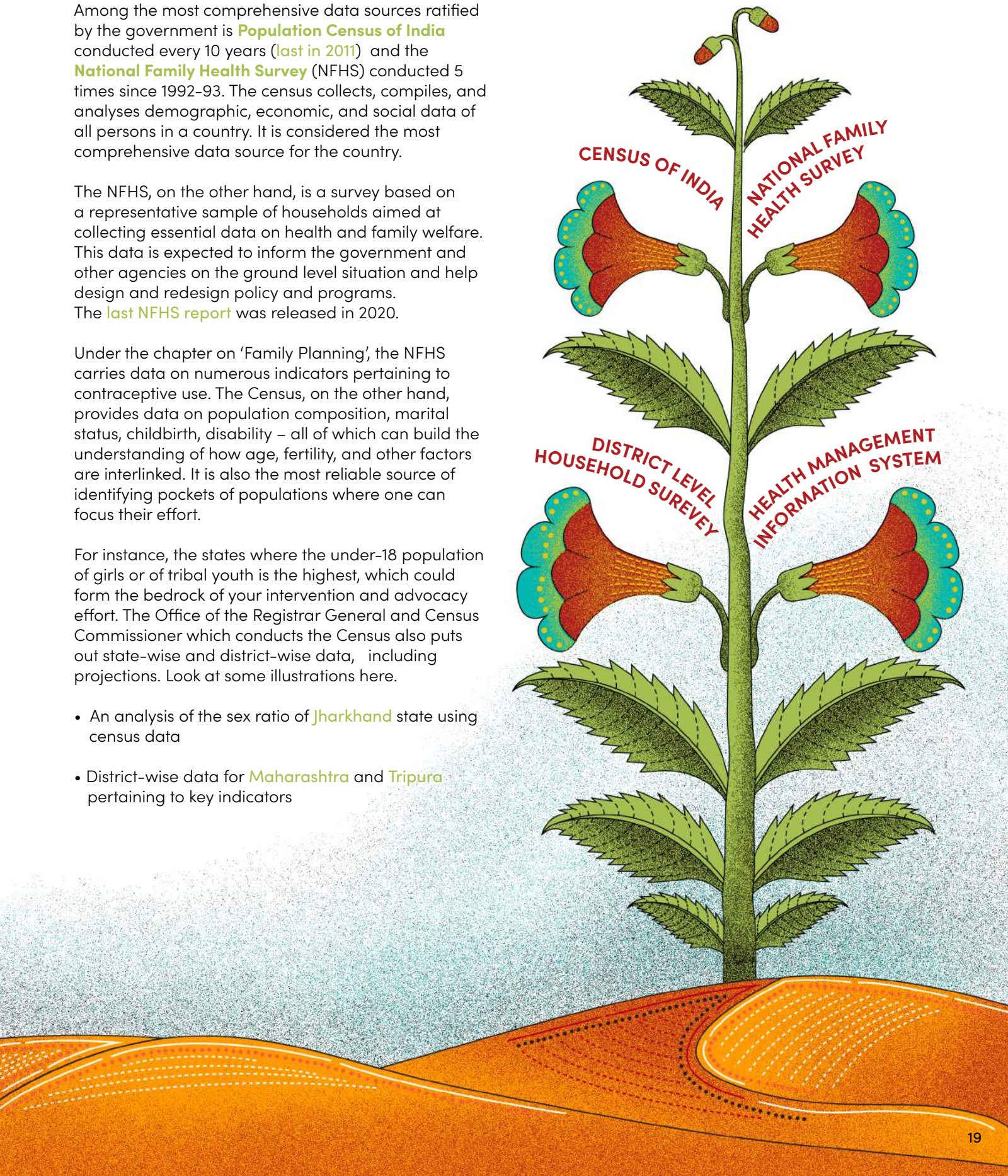
Among the most comprehensive data sources ratified by the government is **Population Census of India** conducted every 10 years (last in 2011) and the **National Family Health Survey** (NFHS) conducted 5 times since 1992-93. The census collects, compiles, and analyses demographic, economic, and social data of all persons in a country. It is considered the most comprehensive data source for the country.

The NFHS, on the other hand, is a survey based on a representative sample of households aimed at collecting essential data on health and family welfare. This data is expected to inform the government and other agencies on the ground level situation and help design and redesign policy and programs.
The last NFHS report was released in 2020.

Under the chapter on 'Family Planning', the NFHS carries data on numerous indicators pertaining to contraceptive use. The Census, on the other hand, provides data on population composition, marital status, childbirth, disability – all of which can build the understanding of how age, fertility, and other factors are interlinked. It is also the most reliable source of identifying pockets of populations where one can focus their effort.

For instance, the states where the under-18 population of girls or of tribal youth is the highest, which could form the bedrock of your intervention and advocacy effort. The Office of the Registrar General and Census Commissioner which conducts the Census also puts out state-wise and district-wise data, including projections. Look at some illustrations here.

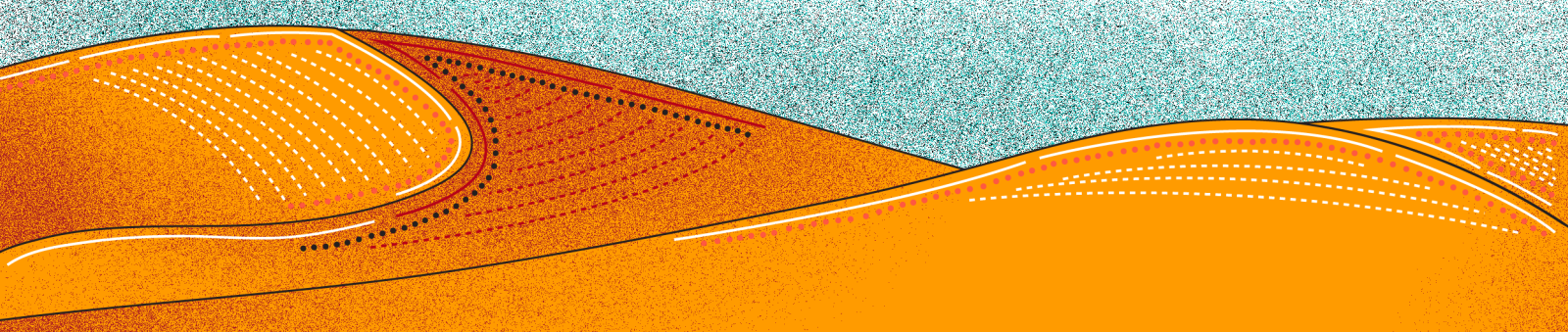
- An analysis of the sex ratio of Jharkhand state using census data
- District-wise data for Maharashtra and Tripura pertaining to key indicators



The information from the NFHS and Census feeds into the data aggregated at an international level to ascertain global population trends, like this report compiled by the United Nations Population Fund. In an earlier section, we spoke of the Sustainable Development Goals to which India is committed and puts out voluntary disclosure. From the report, which is also in the public domain, we can access data on "Percentage of currently married women (15-49 years) who use any modern family planning methods". The UNFPA also puts out an annual 'State of the World Population report'. The 2021 report focussing on sexual autonomy and self-determination can provide key data and insights for further advocacy.

The Ministry of Health and Family Welfare also conducts **District Level Household Survey** (DLHS) focussing on collecting district level data pertaining to family planning, maternal and child health, reproductive health. However, the last survey was conducted in 2007-08. Since it zooms in on the district level, the DLHS provides data on the status of public health facilities at the community and district. The chapter on 'Characteristics of Women and Fertility' and 'Family Planning' could be especially useful if updated data were to be available.

The government of India's flagship National Health Mission (comprising National Rural Health Mission and National Urban Health Mission) collates data on a web-based portal – **Health Management Information System**. While this data is not available in the public domain and can be accessed via government officials, it contains data on health service delivery including reproductive health.



What lies beneath the data

A scan of the data and information available pertaining to contraceptives and reproductive health makes it clear that contraceptives for young people fall in a government blind spot. Contraceptives, as discussed earlier, are tracked in the realm of marital families and have completely overlooked its need for young people and the unmarried. While the Census (and all government surveys) have mandated the inclusion of 'transgender' as a category, there is no effort to gather empirical evidence on the availability of contraceptive services for nonbinary and trans people.

This data gap itself is a matter of advocacy and needs to be taken up with the government. The first step in creating policy and programs to address the needs of a community is to understand the current status. To be able to do that, the contraceptive needs of young people and those who do not fall into the government's definition of "family" have to be included in all government surveys such that official data can emerge from it.

To go beyond what lies in official documents, it is also useful to look at media reports and analytica pieces in journals that are based on this data. For instance, this article in Down to Earth has analysed the latest NFHS data to talk about the extent of unmet needs for contraceptive services in the country. Publishing articles such as this is, in itself, a very significant advocacy effort. Further, this paper in the Indian Journal of Medical Research suggests a forward for contraceptive use in India building on government data.

Private sources

Many civil society organisations and academic institutions undertake research, some of which will help in the effort to advocate for contraceptive access for young people. Portals like **Google Scholar** and **PubMed** can help search and reach a large number of such papers and reports. For instance, this report on 'Choice of contraceptive methods in public and private facilities in rural India' can be found through a search on Google Scholar. PubMed focuses exclusively on biomedical literature.

Centre for Catalysing Change (C3) works across India on ensuring reproductive health and rights of women. C3 works closely with "government ministries and their departments, practitioners and think-tanks to build, incubate and develop policies and solutions that have positively impacted, and continue to impact, millions of girls and women in India." They put out reports and documents based on their work and field surveys.

FHI360 is an "international non-profit working to improve the health and well-being of people in the United States and around the world". They partner with governments and civil society organisations and aim to influence through research and evidence to design and deliver programs that can lead to behaviour change and improved access to services.

FP 2020 is a global movement that supports the right of women and girls to control their reproductive decisions. They put out papers and factsheets which provide data from research and surveys conducted globally.

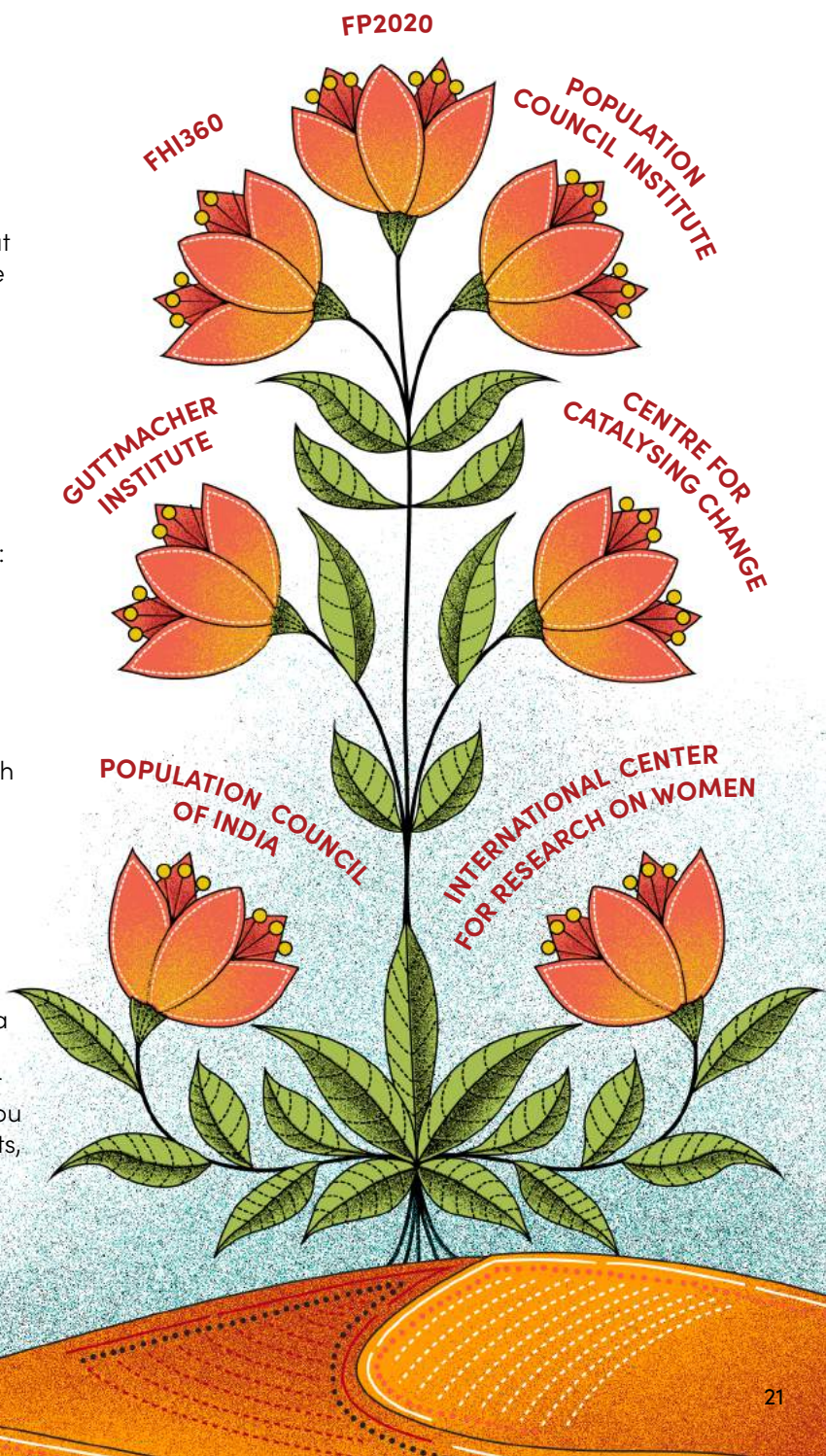
Guttmacher Institute, a leading research and policy organization committed to advancing sexual and reproductive health and rights worldwide, works through a three-pronged approach – high quality research, evidence-based advocacy and strategic communications.

International Center for Research on Women put out a report on improving youth sexual and reproductive health through DISHA, a large scale integrated program to address the broader context of young people's sexual and reproductive health needs.

Population Council of India, a partner of the Government of India has pioneered research on young people's health and development; sexual and reproductive health; and HIV prevention, care, and treatment. Some of the areas of research have been: Adolescent Girls' Empowerment; Child Marriage Prevention and Supporting Married Girls' Contraceptive Development; Family Planning; Safe Abortion and Postabortion Care; Sexual and Gender-Based Violence; Youth and HIV.

Population Council Institute undertakes public health research to design innovative solutions for access to health services, including reproductive health (in the framework of gender equality).

As you start exploring the sources mentioned above, you will be able to familiarise yourself with other sources where relevant and reliable data can be found. In your search, you may not come across data in the exact way that you need but will come across numerous data fields which can be stitched together to form a rich base of data and information. Once you have identified relevant data from various documents, they will come together to form a base for you to interpret and draw inferences from. Some of the key terms that you will come across specific to research on contraception are mentioned below.



KEY DEFINITIONS FOR SECONDARY RESEARCH ON CONTRACEPTIVE USE

These definitions are typically what get reported in data sources or are used in literature which talk about the degree of access young people have to sexual and reproductive health services. Knowing these definitions is part of understanding the problem and to then proceed to find a solution to it. (The definitions here have drawn from the Guttmacher Institute and FP2020's sources)

1. Women with an unmet need for contraception are those who want to avoid a pregnancy but are currently using a traditional contraceptive method or no method.

2. Women wanting to avoid pregnancy are those who are: (a) using a contraceptive method (traditional or modern), (b) unmarried, sexually active, able to become pregnant and do not want a child in the next two years or at all, (c) pregnant and identify their pregnancy as unintended, or (d) experiencing post-partum amenorrhea (missed period) after an unintended pregnancy.

3. Women with demand satisfied for modern contraception ("met need") are those who want to avoid pregnancy and are using a modern method. Women using a traditional method are assumed to have an unmet need for modern contraception.

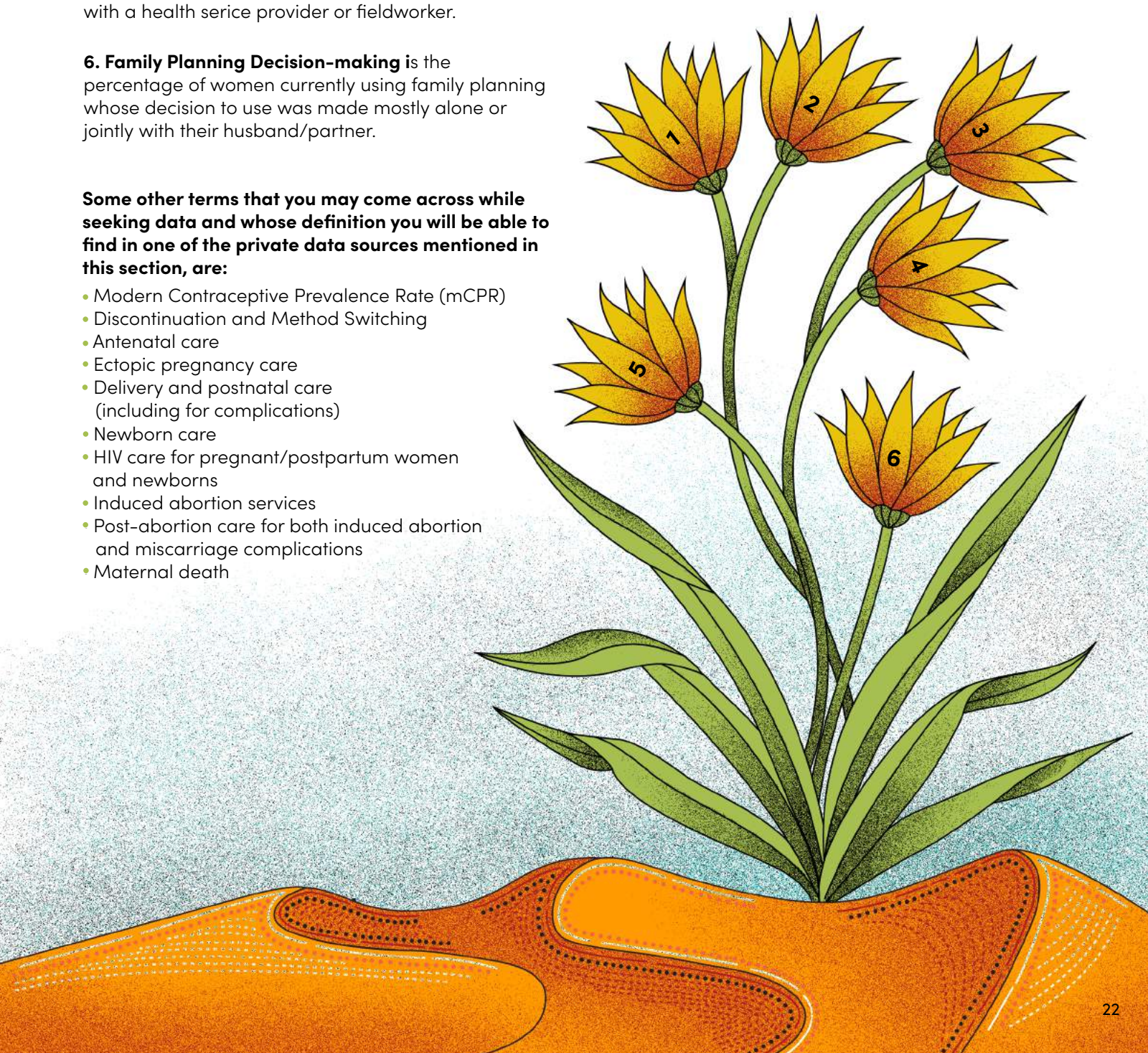
4. Unintended pregnancies are pregnancies that are reported to have been either unwanted (i.e., they occurred when no children, or no more children, were desired) or mistimed (i.e., they occurred earlier than desired).

5. Family Planning Counselling is the percentage of women who were provided information on family planning within the last 12 months through contact with a health serice provider or fieldworker.

6. Family Planning Decision-making is the percentage of women currently using family planning whose decision to use was made mostly alone or jointly with their husband/partner.

Some other terms that you may come across while seeking data and whose definition you will be able to find in one of the private data sources mentioned in this section, are:

- Modern Contraceptive Prevalence Rate (mCPR)
- Discontinuation and Method Switching
- Antenatal care
- Ectopic pregnancy care
- Delivery and postnatal care (including for complications)
- Newborn care
- HIV care for pregnant/postpartum women and newborns
- Induced abortion services
- Post-abortion care for both induced abortion and miscarriage complications
- Maternal death



WHAT DOES SOME OF THE KEY DATA-BASED EVIDENCE TELL US?

Female sterilisation accounts for more than 75 percent of the overall modern contraceptive use in India[15](Fig. 1). As per NFHS-4 data, there is very low use of the two methods of contraception available to men — vasectomy and condoms. Together, they account for about 12% of the overall mCPR. The data suggests that 31.5% of adolescent boys between ages 15-19 think that 'contraception is women's business and a man should not have to worry about it'. Further, 18% thought that 'women who use contraception may become promiscuous.[16]

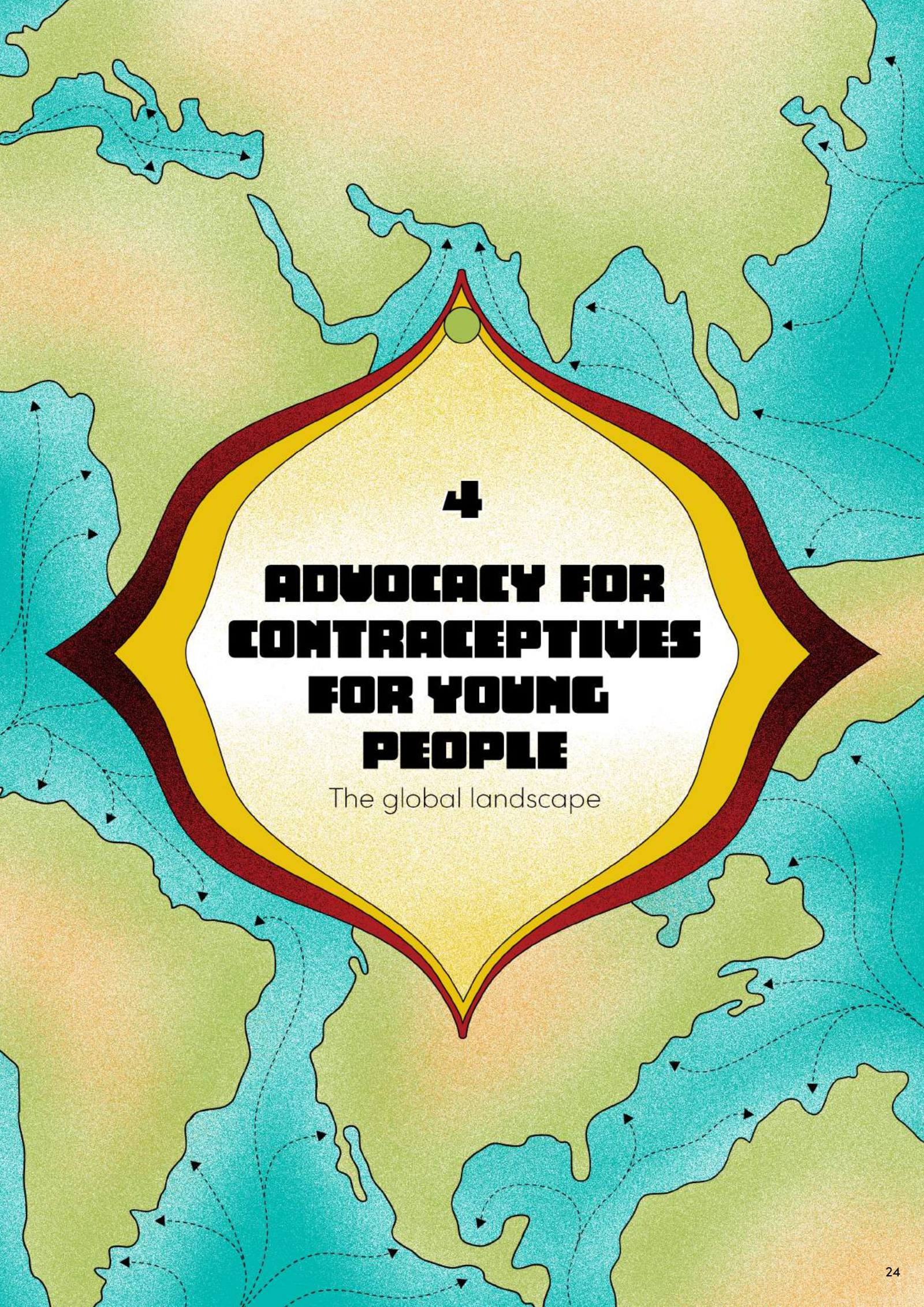
The lack of a family, partner, and community support, means that adolescents often do not have accurate information about correct usage or side effects of contraceptive methods. For instance, a study in India found that only 26% knew that a condom should be used only once, and only 34% understood that oral contraceptive pills must be taken daily.[17]

Another study found that adolescents rarely get information or guidance on SRH matters from their parents. Barely 1% of youth reported that a parent had discussed reproductive processes with them.[18]

According to a study conducted in Jharkhand, Maharashtra, and Rajasthan, fewer than 10% of young people were aware of existing clinics, while less than 1% had ever accessed services from these clinics.[19] While barriers of inaccessible service location and cost affect everybody, adolescents face them in a more acute way due to their lack of financial autonomy and inability to move around independently.

Data on the play of socio-economic factors on contraception establishes some key facts. NFHS4 data shows that among married adolescent girls aged 15-19 from urban areas, 12.1% reported using a modern method and 83.2% reported using no method. In rural areas, 9.5% of adolescents reported using a modern method while 85.6% reported using no method. Similarly for women aged 15-49 the use of modern contraceptive increases with wealth, from 36% of women in the lowest wealth quintile to 53% women in the highest wealth quintile.

According to the NFHS3, those who belong to Scheduled Tribes and Castes face a disproportionate burden of lack of proper healthcare services. They have the highest total fertility rates in the country - 3.12 and 2.92 respectively, compared to 2.35 for other social groups. The lack of access to information and healthcare is said to result in low contraception use as well. Women from Scheduled Tribes have a contraception prevalence of 48%, and those from Scheduled Castes of 55% compared to 68% for other social groups.



4

ADVOCACY FOR CONTRACEPTIVES FOR YOUNG PEOPLE

The global landscape

How do we use international policy and agreements in the advocacy for contraceptives for young people?

Advocacy for change in policy and practice requires a coordinated effort, strategic thinking, and communication. To be effective, advocacy efforts have to be located across all levels – local, regional, national and international. At every level, relevant stakeholders must be identified and engaged with – communities, service providers, and district officials at the local level; at the national level, policy, and law makers; relevant committees and bodies at the regional level; and, those involved in international policy and agreements, at the international level. Read here to see how advocacy builds and advances from the 'local' to the 'international' levels.

Access to and availability of Sexual Health and Reproductive Health (SRHR) services, like contraception and abortion care, depending on the policies and laws that each country has for them. For instance, in some countries access to contraceptives is restricted based on a person's age or marital status. There are also several global agreements and instruments through which multiple countries make commitments towards specific goals. While some agreements like the Sustainable Development Goals (SDG) and Family Planning 2020 lay down time-bound goals, other UN Conventions and Covenants (listed below) act as guiding principles. In both cases, once countries sign global agreements, it is expected they will ensure that their national laws, policies and practices are in-line with their international obligations. Their commitment, however, is not legally binding. Their achievements are tracked on a regular basis by Committees set up for the purpose.

International instruments for advocacy

India is a signatory to a number of international conventions and agreements. While it may not be legally binding on India to fulfil the commitments in these agreements, they provide a way to advocate for change and to seek responsibility to align with their spirit and goal. India has also ratified some of these agreements i.e. it has committed to set up systems and processes to meet the objectives of the agreement.

Often, countries may sign or ratify an international agreement with some reservations and exemptions. In other words, they commit to the convention in part, and not in its entirety. UN conventions have independent committees of experts to monitor their progress and implementation on a regular basis. These committees get regular reports from countries and often ask countries to report on specific issues.

International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966 urges member states (i.e. countries that are members of the UN, also known as 'states') to recognise every individual's right to enjoy the highest attainable standard of physical and mental health. States should ensure that services are affordable and implement education and awareness programmes on sexual and reproductive health (SRH).

The Covenant took specific note of the unmet need for reproductive health education and contraception services among adolescents and directs states to bridge these gaps to reduce high rates of pregnancy among adolescents. It further says that adolescents' realisation of their right to health depends on developing youth-friendly health care, which respects confidentiality and privacy and includes appropriate SRH services.[20]

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), is essentially a bill of rights for women. It addresses the civil and reproductive rights of women, as well as the impact of cultural factors on gender norms. The preamble sets the tone by stating that, "the role of women in procreation should not be a basis for discrimination". Different articles of the Convention call for equal health rights of men and women; the specific focus required by women from rural and resource-poor areas; and that women have the right to decide "freely and responsibly on the number and spacing of their children and have access to the information, education, and means to enable them to exercise these rights."

States are urged to increase the availability of sexual education and family planning services to adolescent girls and boys, to reduce rates of teenage pregnancy and high rates of abortion.[21]

Convention on the Rights of the Child, 1989 defines a child as every human being below the age of eighteen years, unless national laws define an earlier age for attaining majority. It encourages states to provide family planning and contraception education, information, and services as essential health services to reduce rates of early pregnancy and unsafe abortion.

The Committee has recommended enacting legislation, conducting research, implementing counselling services, and increasing resource allocation as concrete measures for states to ensure the reproductive rights of adolescents. It also recommends the collection of disaggregated data to understand the specific situation of groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, working adolescents, etc.

To ensure that the information is understood and utilised in an adolescent-sensitive way, adolescents should participate in the analysis. It recognises the reproductive rights of children with disabilities and calls for a prohibition on the practice of forced sterilisation of children on grounds of disability. The Committee asked states to promote the use and acceptance of contraception among men and make efforts to change male sexual behaviour.[22]

The International Conference on Population and Development (ICPD), 1994 was a landmark meeting which brought women's reproductive health and rights centre-stage. It emphasised that both reproductive health and women's empowerment are necessary for society's advancement.

The Programme of Action called for all people to have access to comprehensive reproductive health care, including voluntary family planning, safe pregnancy, and childbirth services, and the prevention and treatment of STI. Following the Conference, governments and NGOs were urged to design programmes with adolescents, to provide them education and counselling on gender equality, violence, responsible sexual behaviour, and family planning, STI, as well as prevention and treatment of sexual abuse or incest. The ICPD's Programme of Action is an important one to monitor for those working on SRH. The Commission for Population and Development plays a key role in this and regularly holds expert group meetings and consultations.[23] [24]

Following the Nairobi Summit[25] which celebrated 25 years of the ICPD, there was a renewed commitment to report progress on the ICPD and SDG. Countries participate in Voluntary National Reviews and organise National Consultations before findings are presented at the UN. These consultations are good opportunities to present examples of successful practices, and challenges.[26]

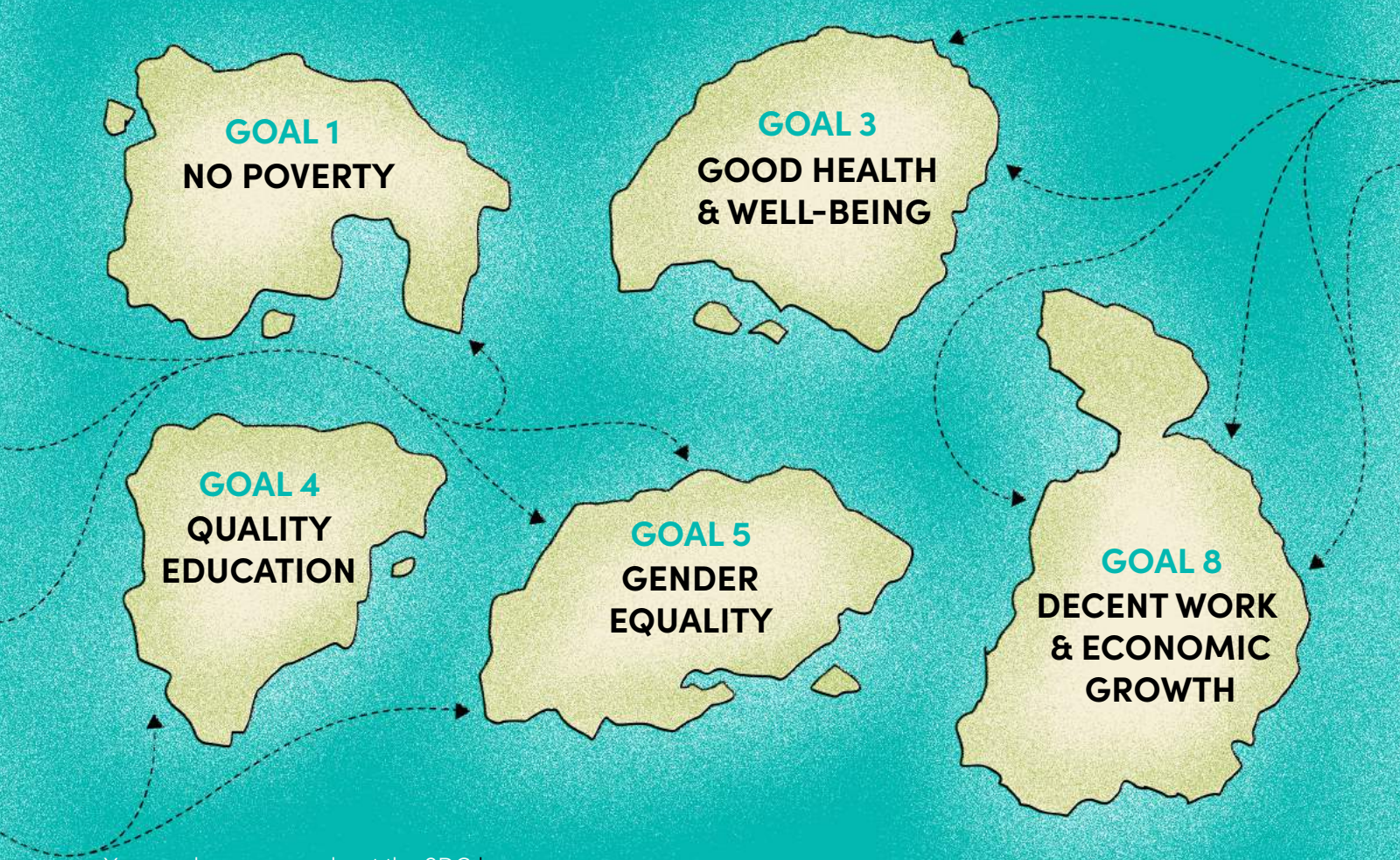
Beijing Declaration and Platform for Action, 1995 recognises that reproductive health "implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." By framing it as a fundamental right, it says that people should not face discrimination, coercion, and violence while making decisions about their reproductive health, including family planning.

States should promote "mutually respectful and equitable gender relations" while creating laws and policies. Specifically, the needs of adolescents with regards to educational and service delivery should be met in a way that they understand their sexuality in positive and responsible ways.[27]

Convention on the Rights of Persons with Disabilities, 2007 reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms and the highest attainable standard of health, free of discrimination, which includes SRH services. The Convention acknowledges that people with disabilities should have the right to decide freely and responsibly on the number and spacing of children, and have access to reproductive and family planning education and services. Coerced medical procedures such as those related to contraception and abortion have been recognised as a form of violence against people with disabilities. Therefore, states must protect the legal capacity of women with disabilities to take autonomous decisions such as those related to medical treatment and decisions on fertility and reproduction.[28]

Sustainable Development Goals, 2015 (SDG) also called the Global Goals, were adopted in 2015 by all United Nations Member States, including India. The SDGs carried forward the agenda of the Millennium Development Goals. They act as a universal call to action to end poverty, protect the planet, and ensure that all people enjoy peace and prosperity by 2030. With its key theme of 'Leave No One Behind', the SDG recognise that adolescents have been previously neglected, and must be addressed to meet the 17 interlinked goals. The SDG will guide action in many countries, including India, to achieve the 17 goals by 2030.

There are five goals that can be considered important in the context of SRH.



You can learn more about the SDG here

Ensuring that young people, including adolescents, who are sexually active have access to a choice of contraceptives and can exercise their right to prevent or delay pregnancies or have adequate space between pregnancies has far-reaching benefits beyond health. Ensuring access to comprehensive sexuality education in schools is a great opportunity for adolescents to get the information they need.[29] The knowledge of delaying pregnancies and early marriage can help them stay in school longer (goal 4) and make way for further socio-economic aspirations (goal 8).

Family planning is recognised as vital to achieving gender equality (goal 5) because it empowers women with knowledge and agency over their bodies and reproductive choices by accessing contraceptive methods. Ensuring adequate birth spacing helps reduce malnutrition (goal 2) and ensures that both, mother and child have long-term good health (goal 3). Access to contraceptives lowers overall healthcare costs and ensures that more girls complete their education, enter and stay in the workforce, eventually creating gender parity at workplace. In a previous section of this toolkit, we spoke of how India has committed to Target 3.7 (mainly pertaining to family planning and childbirth) and what its achievement indicators are.

Another important opportunity to look out for is the **Asian and Pacific Population Conference**, which is held every ten years. The last Conference was organised in 2013, the report of which is shared in the public domain. This will usually involve regional consultations, and also provide opportunities to share adolescent perspectives on equal access to SRH.

Family Planning 2020 (FP2020) was an outcome of the London Summit on Family Planning held in 2012 and is based on the premise that women across the world should have access to lifesaving contraceptives. Since 2012, a total of 46 countries have made commitments to address the policy, financing, delivery, and socio-cultural barriers to women accessing contraceptive information, services, and supplies. The commitments were to be achieved by 2020 and will go a long way in achieving the SDG related to health by 2030. The need to improve adolescent access to and use of contraception became a priority for FP2020 during the midpoint review in 2016-17.

The 'Momentum at the Midpoint' report stated, "In order to meet the diverse needs of youth and adolescents, countries and stakeholders must examine their policies and programmes, and develop a process of evaluation and revaluation that genuinely reflects a youth perspective, and implement evidence-based programmes that work". Read more about the status of commitments in the latest report here.

Translating policy into advocacy: some illustrations

While all these agreements, conventions, and commitments provide us tools to base our advocacy effort in, they do not by themselves act as advocacy mechanisms. This is where advocates like you have a role. To identify the commitments and question those who are responsible as to why and how they will fulfil them. Some of the opportunities for advocacy using international commitments have been mentioned above. These are hooks that can be used to engage with governments and press for change in policy and practice.

At the regional, an important opportunity to look out for is the Asian and Pacific Population Conference, which is held every ten years where regional consultations are held to share adolescent perspectives on equal access to sexual and reproductive health.

Here are some instances of how other organisations have utilised the international policy and commitment framework to advance their advocacy.

- Convention on the Rights of Persons with Disabilities Advocacy Toolkit to support efforts by United Nations-managed and supported mine action centres to advocate for the ratification and implementation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol. Read here.
- This Advocacy Toolkit was developed to assist MenEngage Africa Youth Structures to design, develop and implement advocacy strategies focused on Sexual and Reproductive Health and Rights. (Link:
- A compilation of a selection of international, regional, and national organizations engaged in promoting sexual and reproductive health and rights and economic justice. The advocacy, research, and policy-making initiatives have been highlighted in the document provided for readers who want to investigate or engage more deeply.
- Journal articles focusing on how political action of governments, NGOs, activists, and others combine for the benefit of SRH access for marginalised populations.

5

CONTRACEPTIVE POLICY

India's trajectory

What does India's contraceptive policy trajectory look like? What are some of the pegs to hook national advocacy around?

In the previous sections of the toolkit, we have discussed the framework in which contraceptives have been developed and popularised in India. The approach to contraceptives in policy and practice is characterised by:

- Firm location in the perceived birth control needs of heterosexual, married partners without any recognition of the contraceptive needs of the unmarried, of the young, and of non-binary and trans people;
- Complete disregard of the pursuit of sex for pleasure, and not just for procreation;
- Disproportionately higher emphasis on averting getting pregnant than on protecting from STI through sexual interactions;
- Placing the burden of contraception on women, without addressing their inability to influence decision-making or the need for men and women to share the responsibility equally.

In short, contraception has been designed to respond to the population problem pertaining solely to the needs of married couples, to be carried forward by women. It has been centred around a notion of 'overpopulation' which is hindering economic progress, whereas in fact the Total Fertility Rate in most states has declined significantly over the last decade as this article about the myths underlying population control policy in India, argues. Another manifestation of the target-driven, coercive approach is that of the 'two-child norm' which encourages married couples to limit their families by creating disadvantages for those with more than two children. This article urges that rather than imposing a coercive two-child norm, the government must focus on meeting women's sexual and reproductive healthcare needs.

Tracing the contraceptive timeline in India

Birth control first began to be discussed in India as a national necessity by the elite and was not voluntarily expressed or demanded as a personal necessity by "ordinary" Indians. This asymmetry has left a legacy when it comes to how we think about family planning and the so-called "population" problem. The responsibility of the population problem was squarely placed on the shoulders of the middle and poor classes attributing "irresponsible breeding" to them.

Thus, birth control began in India not as a free choice by individuals to manage their fertility, but as a compulsory prescription by elites (policy makers and implementers) to manage the nation's fertility rates. It was a prescription of what was seen to be 'good' for the lower and middle classes, with no regard for empowerment for sexual and reproductive health.[30]

Birth control was promoted extensively in India from the 1930s onwards, funded initially by eugenicist organisations in England (such as the London Eugenics Society), and in the 1950s onwards by international organisations in the USA (such as the Ford Foundation and the Population Council).

The families targeted for the use and sale of birth control were overwhelmingly from economically and socially vulnerable backgrounds. Among those who championed birth control in India, there was almost unanimous agreement that large populations symbolised cultural and economic backwardness and were a threat to the development of the emerging nation.

It was in the early 1930s that women social and political activists, particularly the All India Women's Conference joined the public discussion on fertility regulation. They supported the use of contraception to improve female and infant health. While they put greater emphasis on women's health, particularly for poor and working class women, the majority supported the nationalist image of the Indian woman as mother. It was a small minority of Indian women who saw birth control as a means to greater female autonomy.[31]

Dr BR Ambedkar, however, while supporting the need for birth control, linked it to his advocacy for women's empowerment asserting the need to treat women as individuals, deserving of respect, and as independent from their presumed familial responsibilities. It gave cognisance that many women did not, and should, have control over the number of children they have to bear. He pushed for a limit on the number of children in a family due to the health of the woman, instead of the conventional reason of population control. While emphasising the need for women to be equal to their husbands, he also spoke of delaying marriage until they were able to bear its financial responsibility. Thus, although he was pre-empting the issue of sexual consent and women's voice, he, too, embedded it in the context of marriage.[32]

An interesting observation from the freedom movement that connects with the modern-day approach to contraceptive policy and practice is that for a variety of reasons including the patriarchal nature of the Indian freedom struggle and its dominance by people like MK Gandhi, many women activists and feminists found it difficult to freely express their thoughts on birth control and female sexuality. It was feared that a strong emphasis on feminist politics might divert attention away from nationalist/independence politics and might be read as a declaration of a gender-based confrontation in India.[33]

Gandhi said about the sexual act, "The union is meant not for pleasure, but for bringing forth progeny, and the union is a crime when the desire for progeny is absent." Also, "Sex urge is a fine and noble thing. There is nothing to be ashamed of in it. But it is meant only for the act of creation. Any other use of it is a sin against God and humanity."[34] He was against birth control, and had written about it in a letter to Edith How-Martyn that "I'm quite at one with you that women are the greater sufferer in this matter, only the remedy suggested is worse than the disease." Martyn was a birth control activist.[35]

By the time Indian women could begin contributing meaningfully to this discourse, its tone had already been set. Overpopulation, per se, was not seen as the problem; rather the growth of economically and socially marginalised groups was. Restricting their numbers was seen as a solution to solving many of India's problems. Famines, for instance, were blamed on overpopulation rather than administrative inefficiencies.

Timeline of India's contraceptive policy and programmes

It is said that contraceptive policies and programmes in India, post-Independence, has evolved from (a) a targeted approach to achieve population stabilisation, to (b) adopting a target-free approach, finally to (c) a more holistic approach which also seeks to reduce maternal and child mortality and morbidity. Let us look at some of the key milestones and events that have defined this journey.

Year	Milestone	Focus[36 37]
1952	National Family Planning Programme launched	In the initial phase the focus was to reduce the birth-rate to the extent necessary to stabilise the population and secure wider economic growth. The focus was on getting people to limit family size, and this was pitched as something good for the health and welfare of the family. This continues to be the overarching programme which guides access to contraception in India
1969	Fourth Five Year Plan (1969-1974) set out the 'target-based approach' to family planning	In the Plan, target was set for a birth rate reduction from 39% to 25% per 1,000 people within the next decade was proposed. To meet this target, sterilisation clinics were set up and incentives as well as compensations were offered to undergo sterilisation. Read 'The Sterilisation Chronicle' to learn more about the politics around sterilisation
1975	Declaration of Emergency	In 1975, the then Prime Minister, Indira Gandhi ordered the declaration of a national emergency. She seized dictatorial powers, imprisoned her political rivals, and embarked, with the help of her son Sanjay Gandhi, on a mass, compulsory sterilization program.
1976	First National Population policy	The National Policy of 1976 laid down strict targets for family planning through sterilisation and IUD. The coercive nature of the policies contributed to a collapse of the government of the time, and many provisions of the 1976 policy were dropped in 1977. There was a return to voluntary adoption of family planning. Towards the end of the 1980s, the target-based approach to family planning continued, but with increased attention given to the health of women and children, including reduction in infant, child and maternal mortality.
1983	First National Health policy	
1994	Case of forced hysterectomies on women with mental health conditions	The practice of forced hysterectomies became public when they were found to be conducted on women with mental illness, between the ages of 18 and 35 at Sassoon General Hospital, Pune. The hospital claimed that the operations were done to maintain the women's hygiene during menstruation. Questions were raised about hysterectomies being carried out so that the girl does not become pregnant if sexually abused. This expose led to questions about a larger conspiracy of silence about sexual abuse of mentally challenged women.

Year	Milestone	Focus
1996	Return to Target Free Approach	There was a paradigm shift in the basic approach to family planning and the focus was to meet 'felt needs'. The target-based approach was replaced with a community needs-based approach. Family planning became just one component of a wider focus on child survival and safe motherhood. A key objective of India's National Population Policy adopted in 2000, was to achieve a total fertility rate of 2.1 by 2010. This goal was not achieved in the stipulated time.
1997	Reproductive and Child Health I launched	
2000	Second National Population policy	
2002	Second National Health Policy	A number of vertical programmes (comprising intervention strategy, monitoring and evaluation, and intervention delivery) for family planning and maternal and child health were integrated into health care for women and children. The Department of Family Welfare was merged with the Department of Health. There was a push to meet all unmet needs of contraception to reduce unwanted pregnancies. The launch of the National Rural Health Mission decentralised planning and allowed states to make implementation plans. However, by bringing defined targets for community needs assessment there was a return of the targeted approach to family planning efforts. Health and women's rights activists expressed a fear, not unfounded in experience, that gullible and poor women will be administered the injectable contraceptive without consent, using the benefit of their faith in injections to treat any ailment. They argue that these contraceptives are likely to cause irreversible damage to their own and their progeny's health. Read a statement to the then Union Minister for Health and Family Welfare signed by 62 individuals and health organisations in India.
2004	Introduction of Emergency Contraceptive Pill by the Ministry of Health and Family Welfare (MoHFW) (The pill was made into an over-the-counter drug in 2005)	
	Indian authorities relaxed drug regulations pertaining to hormonal contraceptives such as injectables (Net En and Depo Provera) and sub-dermal implants (Norplant)	
2005	National Rural Health Mission + Reproductive and Child Health II	
2012	National Rural Health Mission extended to 2017	
2013	Incorporation of RMNCH+A strategy comprising Reproductive, Maternal, Newborn, Child and Adolescent health	The launch of these two strategies brought a conscious focus on adolescent needs, by providing a continuum of care through different stages of a person's life. It recognised a much more holistic approach and acknowledged that unmet need of contraception leaves young people, especially girls, at the risk of unintended pregnancies and contracting sexually transmitted infections. This in turn results in reduced productivity, increased likelihood of unsafe abortions, morbidity and mortality.[38]

Year	Milestone	Focus
2014	Rashtriya Kishori Swasthya Karyakram (RKSK) launched	The RKSK programme provided a comprehensive framework for addressing adolescent needs – both information and service access. The implementation framework specifically mentioned contraceptive counsellingand products to be made available in outreach and awareness activities as well as through Adolescent Friendly Health Clinics. However, in actual implementation, the reach of contraceptive information, products and services remained limited to married adolescents and primarily to married adolescent girls through front line health workers or maternal health outreach and service provision. In implementation, the RKSK programme did not really expand contraceptive access to unmarried adolescents. Read the RKSK implementation guideline here
2014	The tragic deaths of 13 women and the critical condition of 70 others following laparoscopic sterilisation procedures in Bilaspur district, Chhattisgarh	In November 2014, four sterilisation camps for women were held in Takhatpur block of Bilaspur district. Nearly 140 women were brought to these camps for sterilisation, including 83 women on whom the procedure was conducted within 3-4 hours, in a non-functional health facility. In all 13 women (in their 20s or 30s) died at these camps and 70 others were in a critical condition following the procedure. Twelve of the 13 unfortunate deaths were of women who had undergone sterilisations in the camp held at the hospital building. The surgeries were performed by a doctor who had been honoured by the state government for the 'distinction' of conducting the 'maximum number of sterilisations'.[39]
2016	Landmark judgement by the Supreme Court of India that concluded a five-year long fight against conditions of mass sterilization drives (Devika Biswas versus Union of India and Ors, Writ Petition (C) No. 95 of 2012)	In response to a large effort of advocacy by health and women's rights activists, the Supreme Court took cognizance of the over-whelming number of sterilization procedures being targeted towards women and directed the Central government to undertake key measures including phasing out the camp approach in three years and instead strengthen health facilities for better services, and ensure improved access, education and empowerment. Read about the highlights of the landmark judgement here
2016	Introduction of Injectable Contraceptive Medroxyprogesterone Acetate (MPA) under the Antara Programme	Upon the introduction of MPA, health activists reminded us of the concerns raised earlier – of the possible risk of public hospitals overusing the injections as they are the easiest means of birth control, of the need for consent following adequate counselling, and the fear of further increasing the burden of contraception on women.
2017	Introduction of Post Abortion IUCD (PAIUCD) services	Post abortion IUCD was introduced to follow surgical abortions, and financial incentives given for the one receiving the service as well as the ASHA delivering it (INR 300 and INR 150, respectively in 2017)

The sterilisation chronicle

In the years leading up to the national Emergency in 1975, when civil liberties were suspended, the Indira Gandhi government led an aggressive sterilisation campaign and there were reports of men being forcibly sterilised. The drive to sterilise began in the 1970s when encouraged by loans amounting to tens of millions of dollars from the World Bank, the Swedish International Development Authority, and the UN Population Fund, India embarked on an ambitious population control programme. In fact, among all population-control measures, sterilisation camps have been most enforced by the Government of India. Subsequently, mass sterilisation camps were organised in rural communities, some of which were in unsanitary conditions. They reiterated the belief that the population of the poor and marginalised needs to be curtailed through government sponsored efforts.

India has focused its population control efforts on women – nearly 4 million sterilisations were conducted in 2013-2014, of which less than 100,000 surgeries were done on men. The NFHS- 4 (2014-2015) clearly shows the gendered focus on long term sterilization with 36% of women being subjected to long term sterilization, with only 0.3% of men getting long term sterilizations done.[40] Health activists argue that it is not such incentives but spending money on counselling and providing good quality, reproductive, health services that will benefit.[41] [42]

India's policy trajectory and global conventions

In the previous chapter, we looked at the global policy and conventions' landscape and how it can be used for advocacy at the local and national levels. The commitments and policies discussed have been the result of long years of advocacy. CEDAW, ICPD, and the Beijing Platform were all influenced by a wider ecosystem of feminist movements which asserted the need to recognise the reproductive health rights of women. These, in turn, affected India's policies and programmes. For instance, the removal of a target-based approach and including reproductive and child health within the remit of family planning were both a result of the ICPD. Let us look at a few other illustrations of how the international conventions' framework has impacted India's response to contraceptive needs.

- India's report for the 2020 **High Level Political Forum** (the United Nations platform that tracks achievement of sustainable development goals), recommends preparing periodic reports on the status and progress of youth, and women which take a bottom-up approach to identify priority areas. It also calls for "adequate budgetary allocation and expenditure on psycho-social programming within the present schemes for sensitising and supporting adolescents" outside the school system. There is a commitment to apply a gender lens to national and state policies to make sure that they are inclusive. At the national level, it is expected that relevant members of civil society (NGOs, researchers, activists, and thinkers) would share results of any data that they may have gathered around access to contraceptives, and related challenges.

- The Government of India's commitment in FP2020 was to "drive access, choice and quality of FP services so as to increase the modern contraceptive usage from 53.1% to 54.3% and ensure that 74% of the demand for modern contraceptives is satisfied by 2020". The overarching goals were to drive access, choice, and quality of family planning services to increase the use of modern contraceptive devices. The commitment was also to expand the range and reach of contraceptive options, including full-service packages to the remotest areas. Among others, it significantly also committed to enable young people to access sexual and reproductive health information and services, and ensuring that civil society organisations can participate and deliver in awareness building, community mobilisation and uptake of services.
  You can view the core indicator sheet of FP2020 which is the country's tracking and reporting of achievements against commitments.

It is likely that the FP2020 commitments will continue to guide policy over the next few years and are, therefore, important for advocates to keep track of. In the next section, we will drill down into some of the significant new strategies and programmes that the government of India has launched in around sexual and reproductive health, including that for adolescents - including Mission Parivar Vikas, RMNCH+A, and Rashtriya Kishori Swasthya Karyakram.

6

POLICIES IN INDIA

What is in store for young people?

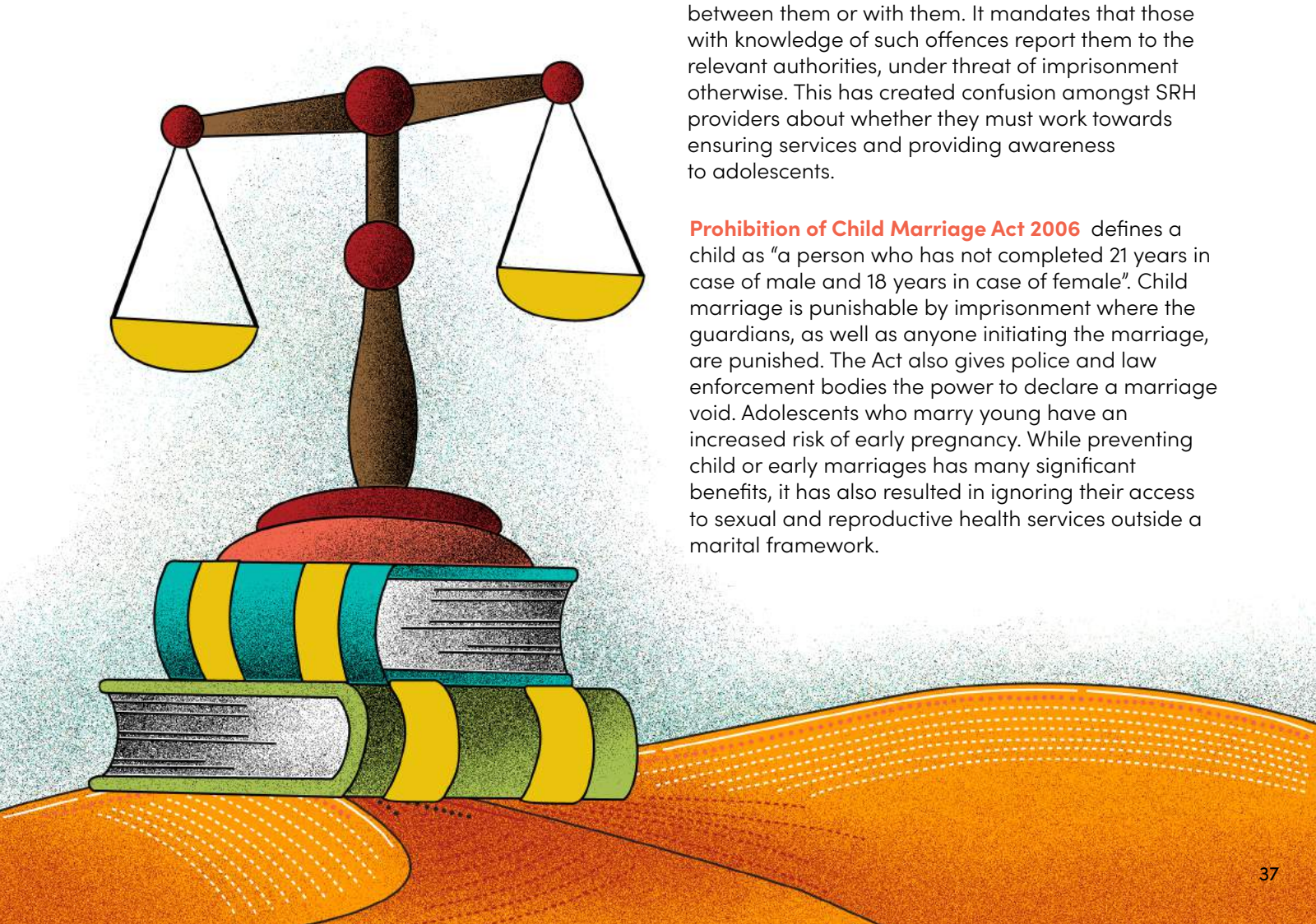
A review of the larger landscape of laws that impact young people in India. How do they influence SRH even when they are, apparently, not pertaining to them.

In the previous sections, we looked at the landscape of international and national agreements and policies, and how they can be used as a hook, by young people, around which to centre their advocacy for sexual rights and contraceptive access. In this section, we will look at the larger landscape of laws that impact young people in India. While many of them may not, apparently, be about contraceptive rights, there are elements in them that influence young people's right to assert their sexuality, bodily autonomy, and sexual and reproductive health (SRH) access. Familiarising oneself with them to understand how they impact the pursuit of contraceptive rights, and the gaps in them that are detrimental to young people's rights plays a critical role in building the base for advocacy.

Some significant Policies, Laws, Programmes

It is a combination of policies, laws, and programmes that determine a country's approach, commitment, and execution framework towards any ideal that it upholds. Policies are based on the framework of rights guaranteed in the Constitution and indicate what a government hopes to achieve (like, the Family Planning Policy). Laws set out the standards, procedures, and principles that must be followed in the effort of the government to fulfil its commitment (like, the Medical Termination of Pregnancy Act, 1971).

Amendments are recommended in laws as and when deemed necessary (like in 2020 for The Medical Termination of Pregnancy Act). Programmes/Schemes are interventions in the short- or medium-term that help in achieving the commitments laid out in the policy (for instance, the ASHA programme under the National Health Mission).



Protection of Children from Sexual Offences (POCSO) Act, 2012 criminalises sexual acts with minors (people under age 18) and makes no exception for consensual sexual relationships between them or with them. It mandates that those with knowledge of such offences report them to the relevant authorities, under threat of imprisonment otherwise. This has created confusion amongst SRH providers about whether they must work towards ensuring services and providing awareness to adolescents.

Prohibition of Child Marriage Act 2006 defines a child as "a person who has not completed 21 years in case of male and 18 years in case of female". Child marriage is punishable by imprisonment where the guardians, as well as anyone initiating the marriage, are punished. The Act also gives police and law enforcement bodies the power to declare a marriage void. Adolescents who marry young have an increased risk of early pregnancy. While preventing child or early marriages has many significant benefits, it has also resulted in ignoring their access to sexual and reproductive health services outside a marital framework.

The National Family Planning Programme was launched in India in 1952. It was also referred to as Hum Do and continues to be the umbrella Programme through which contraceptive services, counselling, and SRH education are provided to people through the public health system. All the other programmes and policies that we have enlisted below come under this umbrella. The key point to remember is that while the National Family Planning Programme is operational in all states and districts, some of the other programmes like RKSK and MPV (detailed below) are applicable only in specific high-priority states or districts.

Launched in 2005, the **Adolescent Education Program (AEP)** was an initiative by the government of India to upscale existing educational programs like the National Population Education Project, School AIDS Education Program and the Project on Adolescent Reproductive and Sexual Health (ARSH). Given that these existing programs had limited outreach, the AEP was to be an umbrella program. India's sex education program continues to battle backlash and controversy, both in reference to content, as well as implementation.
The provision of school-based sex education remains banned in several states due to political pressure and conservative social pressures .

You can read more about the importance of sex education and the issues surrounding it, here:

- An article that summarises the author's view on the ground realities of sex education in India
- The relevance of sex education in India synthesised by a civil society organisation
- An analysis of the importance, reality, myths and issues surrounding sex education in India

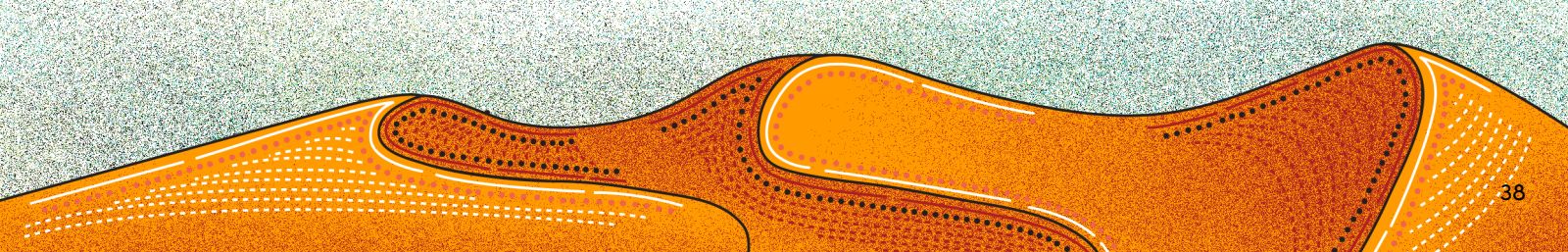
What Adolescent Education envisioned

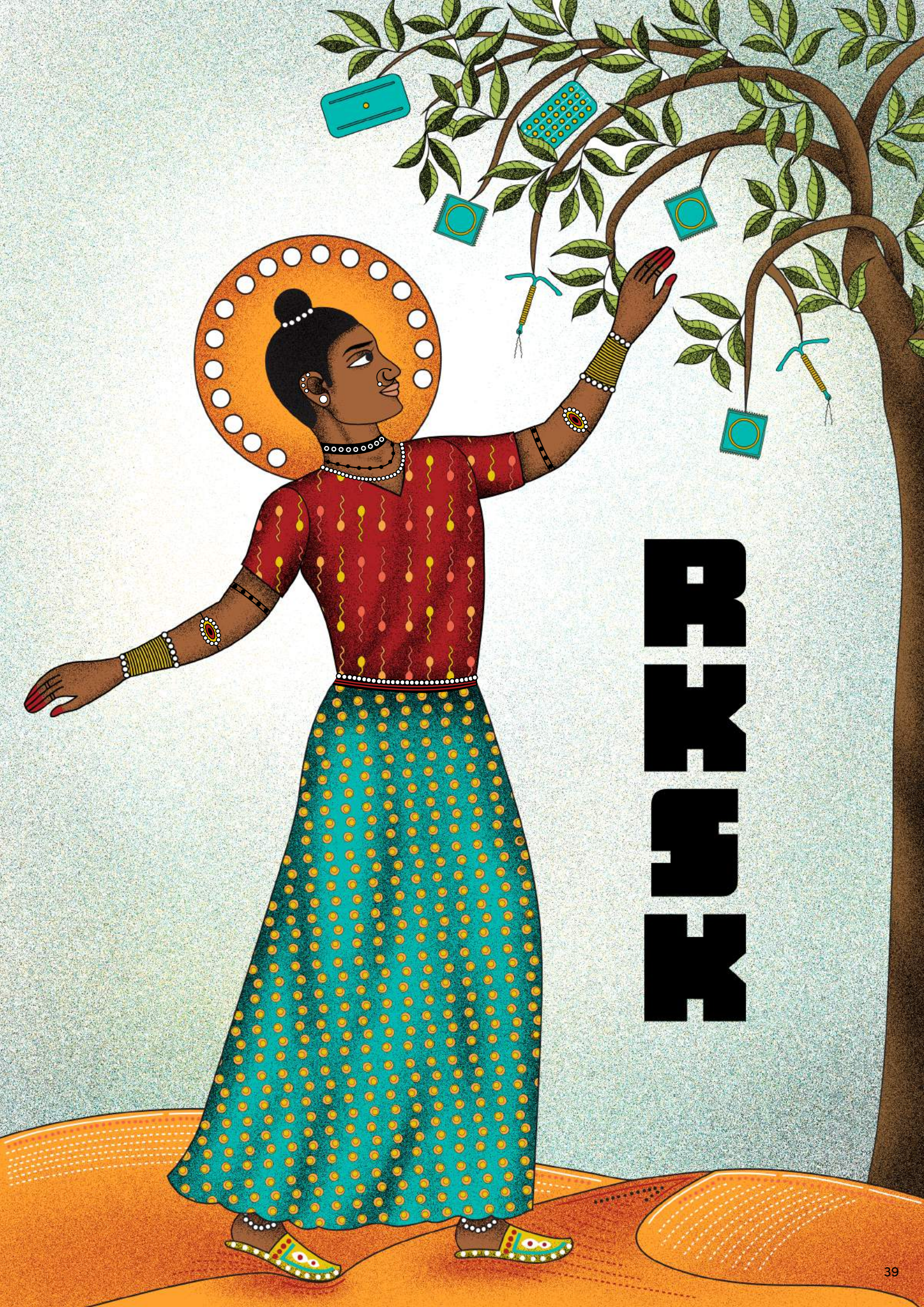
The AEP was targeted at all learners at secondary and senior school at government, and government-aided schools, and learners of open schooling systems. It aimed to provide knowledge, information, and sensitization to adolescents on their needs and issues related to adolescence, and develop life skills to enable them to live informed and responsibly. This includes providing age-appropriate information on HIV/AIDS prevention, managing ARSH issues and concerns, providing linkages to youth-friendly services, and providing accessible resources for additional information. The National Council of Educational Research and Training (NCERT) coordinated the program, in collaboration with the Ministry of Human Resource Development (MoHRD) and the United Nations Population Fund (UNFPA). It was implemented using a 16-hour curriculum-based module developed for adolescents and youth both, in and out of formal schools. The programme included advocacy sessions with schools, training sessions for nodal teachers, and sensitization sessions with parents.[43]

An evaluation of AEP[44] showed that while students found themes and sessions like life skills development, growing up and adolescent health, self-esteem, positive relations as interesting, themes like peer pressure, RTI/STI and substance abuse did not hold their interest. Male students preferred themes on adolescent health, gender sensitivity, RTI/STI, and HIV/AIDS, whereas female students preferred themes on self-esteem, emotions and stress, and anger management. The evaluation also suggested that the students showed moderate to low benefits from themes like HIV/AIDS, sexual abuse, and substance abuse. Not surprisingly, teachers surveyed identified these topics as the themes they felt least comfortable conducting.

In 2020, the **School Health Programme** was incorporated as part of Health and Wellness in Ayushman Bharat. Focused on health promotion, disease prevention, improved access to health services it called for an enhanced engagement with social factors like substance abuse, violence, risky sexual behaviour, and mental health. Read more about the operational guidelines of Ayushman Bharat here

The **National Education Policy**, 2020 sought to create an outstanding adult education curriculum framework to include at least five different programs on foundational literacy and numeracy, critical life skills (including financial and digital literacy, childcare and education, and family welfare), vocational skill development, and continuing education. The policy has no specific component on comprehensive sexuality education or adolescent health.




RKSK

Rashtriya Kishor Swasthya Karyakram (RKSK), a programme launched in January 2014, takes a holistic approach to adolescent health "based on the principles of participation, rights, inclusion, gender equity, and strategic partnership". It has six priority areas including, access to SRH services, and caters to 10-14 year-olds and 15-19 year-olds with "universal coverage" which should ideally cover everybody in those age brackets. RKSK has a multi-pronged strategy to achieve its objectives. One of its key strategies is 'Convergence', or bringing together relevant departments and agencies of the government to ensure adolescent health needs are met. Read more about the programme here

The RKSK programme is implemented at school, community, as well as facility-based levels, that is through Adolescent Friendly Health Clinics (AHFC), set up under the National Health Mission.[45]

RKSK and its relevance to contraceptive services

RKSK covers six priority areas for adolescent health, and each area has sub-goals that the programme aims to achieve. The strategic goal to "enable sexual and reproductive health" has outlined three further objectives which aim to achieve not only population stabilisation but also reduce maternal mortality, infant and child mortality. A target-free approach based on unmet needs for contraception; equal emphasis on spacing and limiting methods; and promoting 'children by choice' in the context of reproductive health are the key approaches to be adopted for the promotion of family planning and improving reproductive health. The operational guidelines for RKSK also prescribe the outcome and output indicators against which progress can be tracked. These are very helpful to track achievement and press for implementation through advocacy, wherever there may be gaps.

Some of the key indicators (not all), useful for the purpose of advocacy for young people's access to SRH services have been outlined below. Like, we discussed earlier, identifying the gaps in what is being tracked is also an important element of advocacy since it highlights the areas which are not being seen as significant.

Objective	Output indicator	Outcome indicator	Means of Verification
1. Improve knowledge, attitudes and behaviour, in relation to SRH	**1.** Percentage of married adolescents reporting unmet need for contraceptives (separately for spacing, limiting and total) **2.** Contraceptive prevalence rate among married adolescents **3.** Percentage of adolescents who used condom during first sexual intercourse **4.** Percentage of adolescents aged 15-19 who had sexual debut before age 18	**1.** Percentage of adolescents correctly reporting that a woman can get pregnant at first sex if not used any contraception **2.** Percentage of adolescents aged 15–19 with knowledge of at least one modern method of contraception **3.** Percentage of adolescents with comprehensive knowledge about HIV/AIDS **4.** Percentage of adolescents aware of at least one symptom of RTI/STI **5.** Percentage of caregivers such as AWW, teachers, peer educators, ASHAs and parents, who have correct knowledge of adolescent SRH management **6.** Percentage of adolescents accessing adolescent clinics for RTI/STI, abortion and puberty related problems	Ongoing rapid assessments of nutritional and health outcomes among adolescents Periodic surveys (AHS, DLHS, NFHS) measuring knowledge, attitudes and practices AFHC MIS Sample Registration System yearly statistical report

Objective	Output indicator	Outcome indicator	Means of Verification
2. Reduce teenage pregnancies	**1.** Percentage of adolescents married in age group 15–19 **2.** Percentage of married adolescents aged 15-19 who have begun childbearing (either had a live births or pregnant with first child) **3.** Median Age at first Marriage **4.** Age-specific fertility rates (15-19 years) **5.** Percentage of married adolescents aged 15-19 years using any modern method of contraception	**1.** Percentage of adolescents indicating positive attitude about delaying first conception after marriage **2.** Percentage of married adolescent couples having comprehensive knowledge on risks of early pregnancy **3.** Percentage of married adolescent couples accessing adolescent clinics for contraceptives or counselling on family planning services	
3. Improve birth preparedness, complication readiness and provide early parenting support for adolescent parent	**1.** Percentage of pregnant adolescents who received antenatal care within the first trimester of pregnancy **2.** Percentage of pregnant adolescents who received at least three antenatal care checkups **3.** Percentage of adolescent mothers who delivered in a health facility during last one year **4.** Percentage of adolescent mothers who received assistance during delivery from health personnel during last one year	**1.** Percentage of adolescents reporting correct knowledge of care during pregnancy **2.** Percentage of service providers (such as, ASHAs, ANMs, AWWs etc.) reporting correct knowledge of care during pregnancy **3.** Percentage of adolescents accessing adolescent clinics for counselling on pregnancy care	

While it is true that the RKSK aims to reach all young people in the defined age group, it does not call out vulnerabilities that create unique and specific needs for some, like those living with disabilities, those who identify as LGBTQIA+, or those who belong to SC/ST and other marginalised, among others. The first step in addressing these unique and specific needs is, recognising and calling out the vulnerabilities. Not surprisingly, it does not talk about contraceptive needs of the unmarried or of how it responds to the criminalisation of sexual act, even consensual, of those below 18, under POCSO Act.

Despite its limitations and oversight of some critical aspects of the rights of young people, the RKSK does provide an opportunity for advocates of sexual and reproductive health rights. First, the peer education component, often implemented through civil society organisations, is an opportunity to create awareness of SRH rights and bodily autonomy. Secondly, the call for civil society organisations to be consulted in developing district- and state-level implementation plans provides space to influence curriculum and awareness building.

MISSION PARIVAR VIKAS

Mission Parivar Vikas (MPV) was launched in 2016 with the aim of "stabilising" population growth in 146 districts of seven states that account for nearly 28 per cent of the country's population.
High fertility districts (HFD) are those where the total fertility rate is more than 3. A programme built around family planning focuses on "eligible couples" i.e. those who are married and where the woman is between the ages 15 and 44 years (child bearing age). While there is no mention of young people in the scheme, those who fall in the intersection of adolescent, youth, are in the child-bearing age, and are married, would technically be covered.[46]

MPV focuses on: delivering assured (contraceptive) services; promotional schemes to generate demand for family planning; and ensure commodity security (or, adequate supplies of goods at the ground level); and capacity building for enhanced service delivery. Like the RKSK, MPV also a strong element of convergence.

One of the criticisms of MPV is that while it, ostensibly, aims to increase the choice of contraceptives available, it actively incentivises PPIUCD and sterilisation, specifically the latter by providing financial compensation for it. The scheme, as expected, excludes unmarried adolescent's contraceptive needs by focusing only on eligible, married couples. Like the RKSK, it does not make any mention of provisions for vulnerable adolescents.

How MPV relates to contraception

Delivering assured (contraceptive) services

• Deliver various short- and long-acting methods of contraception in high fertility districts. The focus of the rollout is primarily on the newly launched injectable contraceptive (Antara), and of two kinds of PPIUCD. This is made possible through the provision for identifying and training doctors, staff nurses, and ANM to provide both injectables and PPIUCD services. Another provision involves placing condom boxes at strategic locations like health facilities, and gram panchayat bhavan. These are stocked monthly or as frequently as supplies are finished.

• There is also a new HFD compensation scheme for men and women who undergo sterilisation procedures. For procedures carried out at a government facility, it provides INR 2000 for tubectomy (Interval and Post Abortion); INR 3000 for post-partum Sterilisation, and INR 3000 for a vasectomy.

• Under MPV on-ground awareness campaigns are to be organised at the block, district, and state levels which involve relevant departments including ICDS, PRI, RMNCH+A lead partners, and other organizations at the state and district levels, civil society organisations, including professional bodies such as Indian Medical Association.

• It also makes provisions for 'fixed day' family planning services at institutions with the high delivery caseload. Fixed days are dedicated to providing sterilization services in a health facility by trained providers posted in the same facility, on fixed days, throughout the year in a regular and routine manner.

Promotional schemes to generate demand for family planning

• Behaviour change communication and informational activities like Nayi Pehl (New Beginning) kits, (informative kit for newlyweds) are distributed by ASHA to generate awareness, increase uptake, as well as to promote family planning services. The kit includes informational pamphlets; 3 condoms; 2 cycles of oral contraceptives (Mala N); 2 emergency contraceptive pills; 2 pregnancy tests and a hygiene bag.

• Saas Bahu Sammelan (Mother-in-Law/Daughter-in Law Gatherings) aim to facilitate improved communication between mothers-in-law and daughters-in-law through interactive games and exercises so that they talk about their attitudes and beliefs about reproductive and sexual health. The gatherings are a way to help bring changes in attitudes on these issues, especially considering that the mother-in-law is a key decision-maker in a household.[47]

• The SAARTHI (Awareness on Wheels) programme is meant to generate awareness and distribute contraceptives in hard-to-reach areas. Clinical Outreach Teams (mobile teams of trained health care personnel and equipment) are to provide family planning services, specifically sterilisation. They are engaged through private, accredited, civil society organisations (NGOs).

Ensure commodity security

• To make sure that there are adequate commodities for family planning, MPV involves creating a management information system to track the supplies and consumption to different facilities.

Capacity building for enhanced service delivery

• MPV recognises that HFD has severe shortage of trained service providers and the high demand generated through other activities, mentioned above, can only be satisfied by improving service provision. It aims to train approximately 47,600 providers (medical officers and Nurses) for injectables and approximately 9500 providers to make PPIUCD/IUCD available.

Creating an enabling environment through convergence

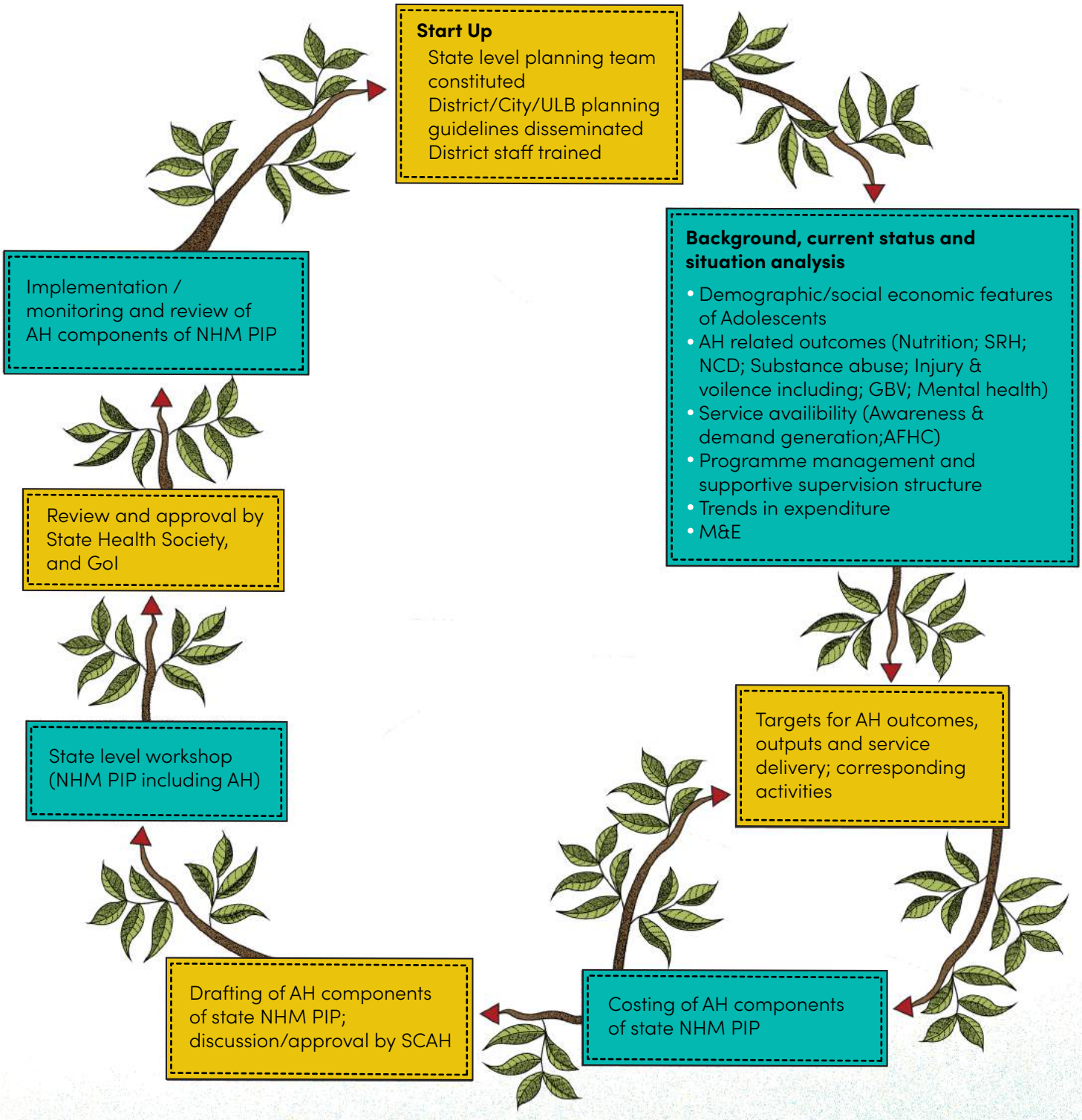
• Like the RKSK, MPV also brings together various departments and ministries to work together to deliver its targets. You can read the guidelines here to see how the progress is proposed to be tracked through the block, district, and state-level meetings among government officials.

How are programmes implemented?

As it is evident from the description of the RKSK and MPV, there are a number of bodies, across departments, involved in the planning and implementation of such programmes. RKSK, MPV, as well as their sub-schemes have different actors implementing them. However, the planning process for them is essentially the same and the administrative bodies are similar for each.

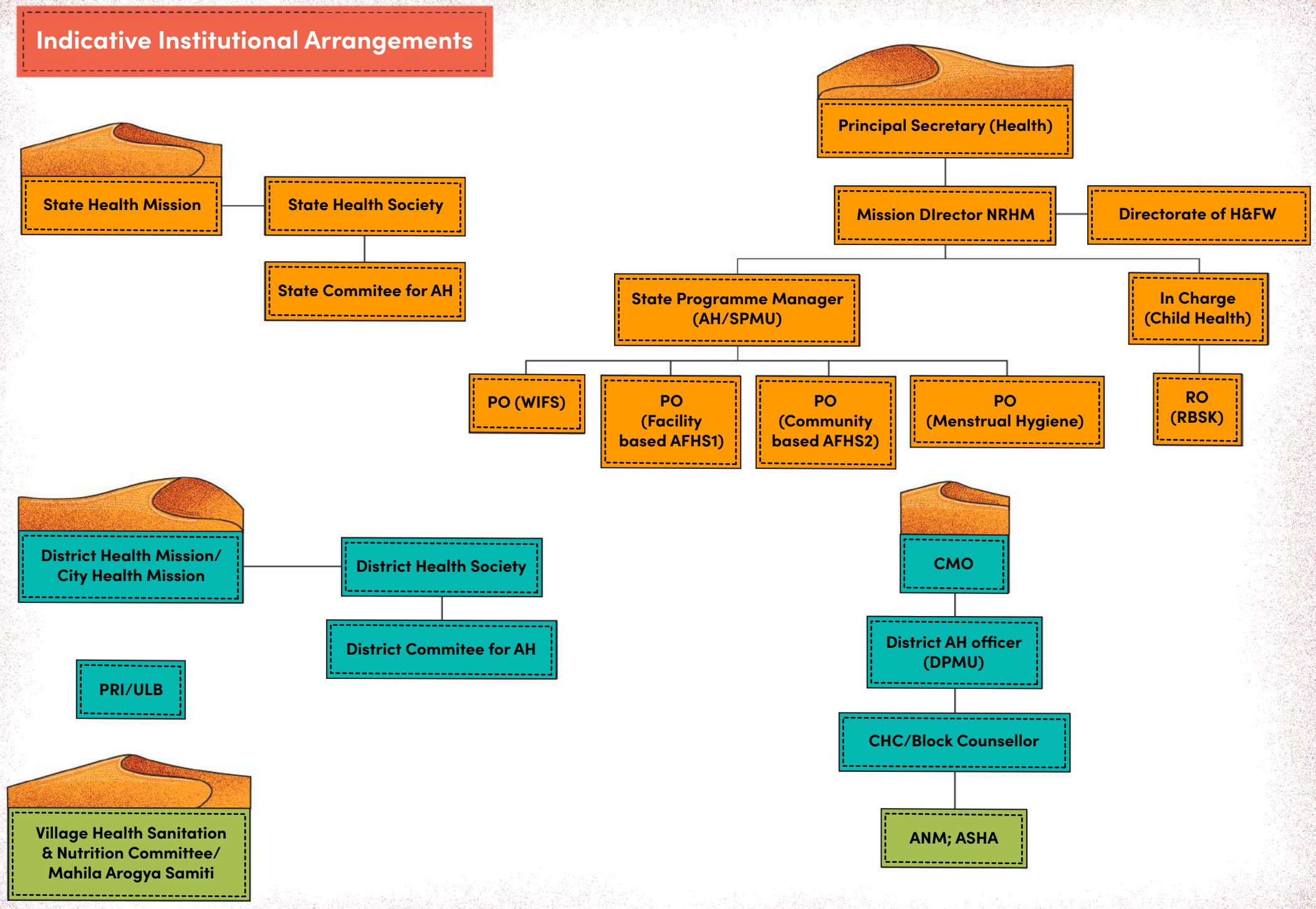
The key components are the state and district PIP through which the central government grants money to the states. Developing the PIP is through a decentralised, planning process. Every year, each district does a gap and needs assessment for their district and submits a District Health Action Plan (DHAP) to the state NHM. For example, it will include the number of ASHA who will work to provide contraception; level of stocks required for different contraceptive products; the capacity building training programmes needed; budgets for organising on-ground events like Fixed Day Schemes or Saas-Bahu Sammelan. The DHAP are consolidated to prepare a state PIP which are submitted to the central government which analyses the plan, discusses with the state representatives and approves the activity along with the funds.

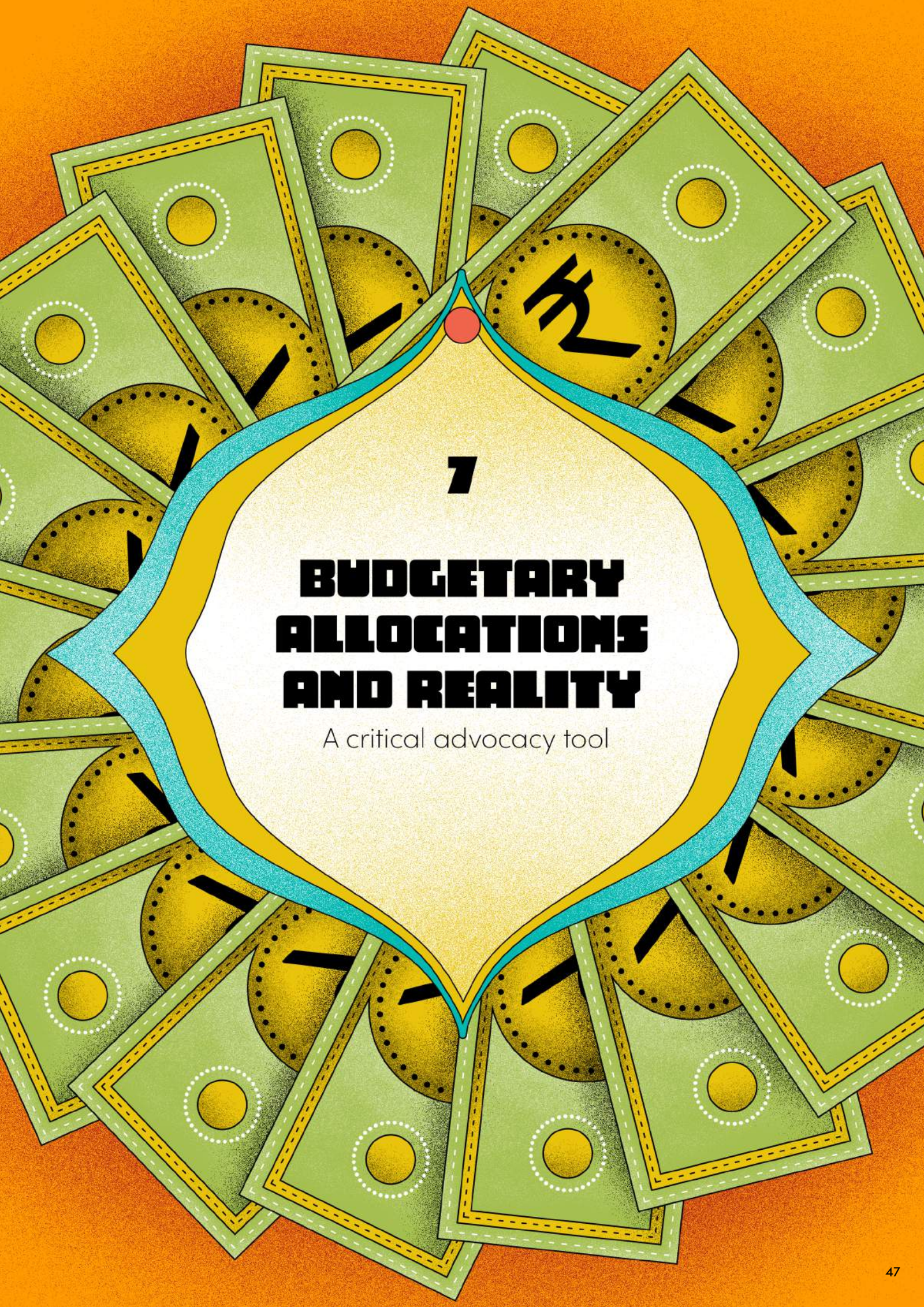
Overview of State AH Planning, Implementation and Monitoring Process



At the village level, the AWW and ASHA will work closely with the Village Health Committee to formulate the Village Health Plan. At the block level, the CDPO and the PHC staff will work together to review the Village Health plans in their jurisdiction, plan monthly health days, and discuss additional visits of ANM as required, based on feedback from their respective functionaries- AWW, Supervisor, ANM, and LHV. At the district level, planning for convergence would be enabled through the District Health Mission

Indicative Institutional Arrangements





7

BUDGETARY ALLOCATIONS AND REALITY

A critical advocacy tool

How do we know if the government is making funds available for SRH programmes and what is the way in which these funds are being utilised?

So far, we have reviewed the status of contraceptive access (or the lack of it) for young people in India and examined the national and international provisions around them. This is expected to provide a strong peg for our advocacy for contraceptive access and services. Another element which must be critically examined is how much financial resources the government is committing to address the issue and towards what aspects. A commitment in policy will have no meaning without making funds and resources (human, technical, infrastructural) to fulfil them. In this section, we will delve into some of these issues.

An overview of financial allocations

In 2018 the International Monetary Fund (IMF) had identified poor public health as one of the important hurdles in 'ease of doing business', listing it ahead of crime and policy instability. In its suggestions for market reforms, it has included health and working conditions as key. As we know, a continued lack of access to high quality sexual and reproductive health care and services keeps women and adolescents at risk. 35 million women in low- and middle-income countries (LMIC) are reported to have abortions in unsafe conditions, while an estimated 27,000 adolescent women die from complications of pregnancy (including unsafe abortion) or childbirth, every year. There is a globally acknowledged need for improved access to contraception and sexual and reproductive health (SRH) services, especially for adolescents. Compared with the current situation, fulfilling all need for modern contraception would result in 70,000 fewer maternal deaths each year – a 23% decline, even without improvements in pregnancy-related care.[48]

India has one of the largest global adolescent populations, and furthering their health and wellbeing is crucial for the future of the country. Central and state governments are both responsible for provision of primary health care. India had committed nearly USD 3 billion for Family Planning through central funds in the period of 2012-2019. This includes the allocation for different initiatives such as Mission Parivar Vikas, the 360-degree media campaign underlining the role of men in family planning, etc. This excludes the State Budgets allocated towards Family Planning.

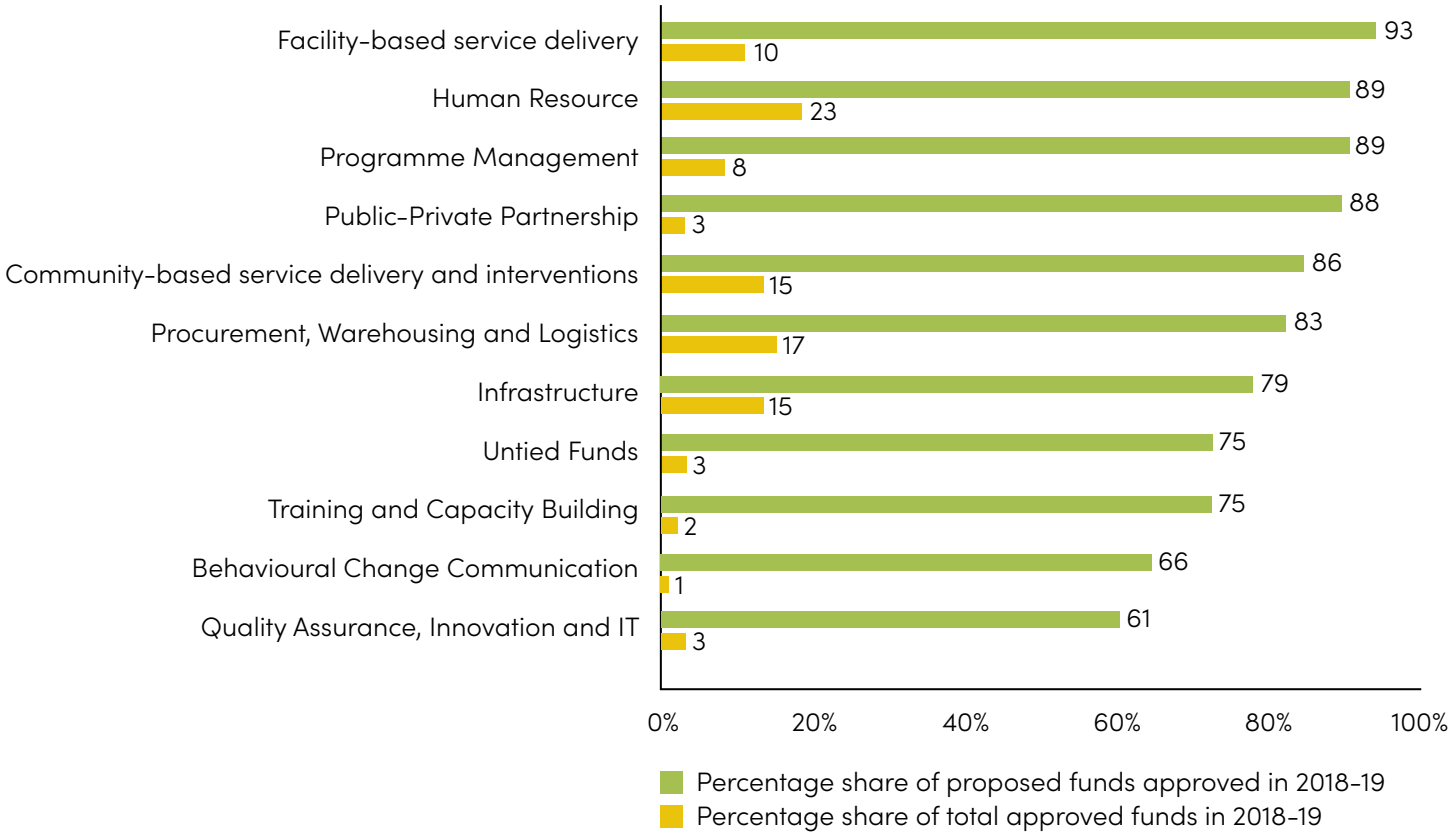
A closer look[49] at the budgetary allocations over the years reveal the decline in allocations towards Family Planning and contraception[50]. As of 2018, State governments were spending more than 60% in the total public health expenditure. A later analysis[51] of the NHM report of 2019-2020 revealed that the allocation for NHM saw a decrease from 55% of the total MoHFW budget to 50%.

The total expenditure by both Centre and states for FY 2020 was ₹2.6 trillion, barely a little over 1% of GDP. Even among the BRICS nations, India spends the least! Given the limited government expenditure in public health, the shortfall is met by the private sector, pushing up the out-of-pocket expenditure incurred by citizens. India's total expenditure (including out-of-pocket and public) was 3.6% of GDP.

Understanding the budget trend under NHM

Allocations for NHM expenditure consist of six major components, of which the 'RCH Flexipool' funds maternal and child health, family planning and, Janani Suraksha Yojana (JSY) programmes. This also includes funds for immunisation (both routine and pulse polio) as well as the National Iodine Deficiency Disorders Control Programme (NIDDCP).

LARGEST SHARE OF APPROVED FUNDS WENT TOWARDS HUMAN RESOURCES IN 2018-19



This analysis, conducted by the Centre for Policy Research, highlights critical trends in 2018-19. Understanding these data and commitment trends is essential for building one's advocacy effort. For instance,

• While overall allocations of the government for Health and Family Welfare activities increased marginally (by 2%) over the previous year, the allocation to NHM was reduced by the same proportion.

• The commitment for reproductive and child health has declined significantly (25%) over 2 years indicating the government's view of the need to address this area

• The commitment to enhancing the quality of public health infrastructure, especially in rural and remote areas, is indicated by the declining number of Sub-centres, Primary Health Centres (PHC), and Community Health Centres (CHC) that meet Indian Public Health Standards (IPHS). The IPHS is a set of standards to assess and improve the quality of health care delivery in India. In 2018, 15 states reportedly had zero facilities functioning as per IPHS norms!

• A shortfall of 82% in specialists required at CHCs, across the country, indicates the need to invest in building up this critical cadre.

Further, from the Centre for Policy Research's analysis, you will see how funds flow from the central government to the states. About 20% of NHM funds (not including infrastructure maintenance) are earmarked as incentive grants. This means that 20% of funds approved for a state are released only depending on whether the state performs as per agreed conditions.

While RKSK has seen increased resource allocation for service delivery of sexual and reproductive health services, and therefore an improvement in engaging the community, there remain several gaps in allocation, expenditure, implementation and, monitoring of the programme. A rapid programme review of RKSK[52] in 2016 revealed that at the state level there were adequate budgets allocated for implementation of RKSK. However, a deeper analysis revealed these execution hurdles, which need to be addressed while ensuring adequate financial allocation:

Rigid regulations on the use of these budgets which did not allow for responding to ground realities

Poor coordination of programme activities

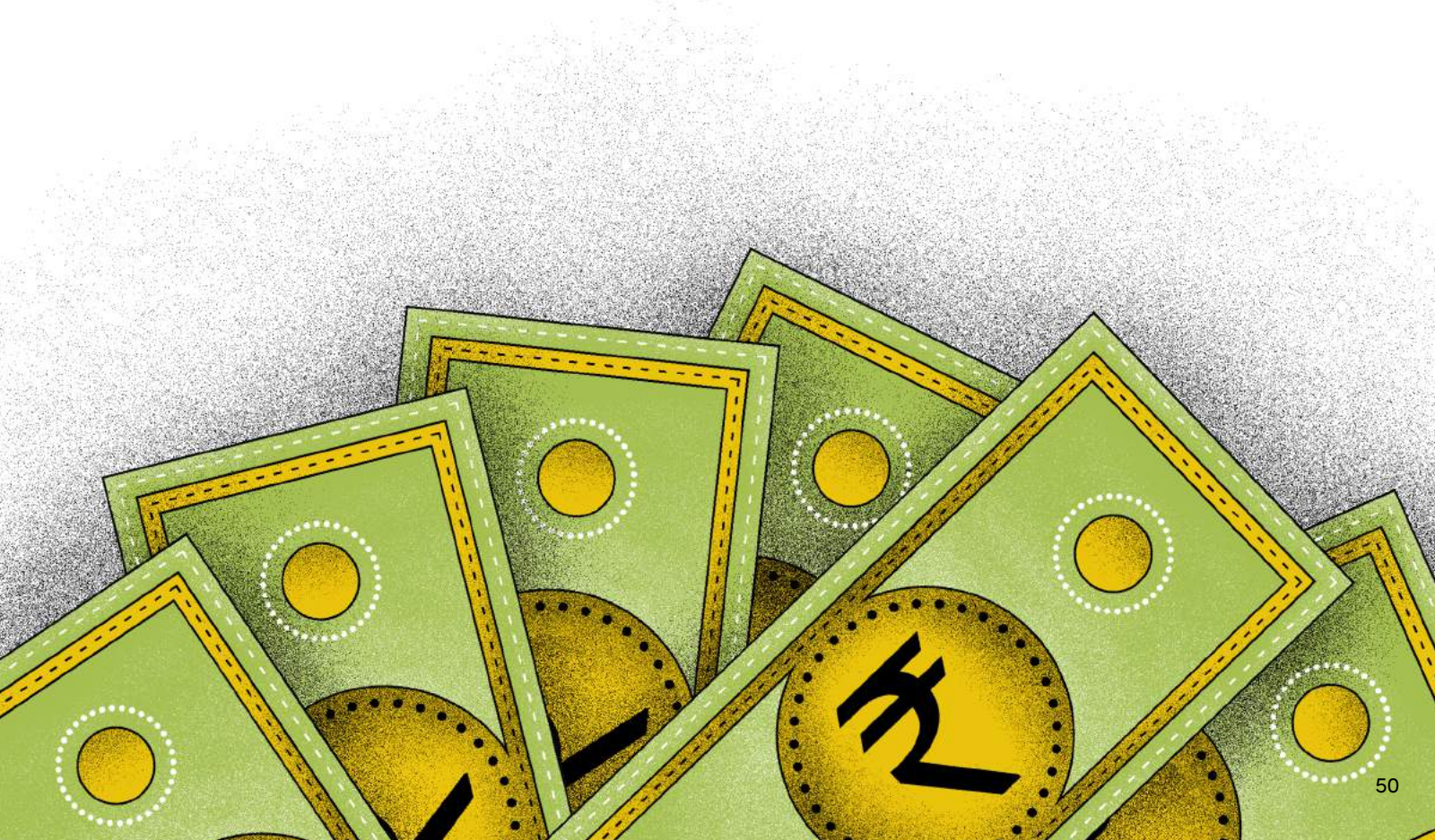
Little involvement from adolescents in RKSK's governance and in AFHC

Vacancies in crucial counselling services, particularly of male counsellors

Gaps in assessing quality of training of staff like, ASHA, counsellors, and peer educators

An absence of refresher training for service providers

In sum, the budgetary allocation and expenditure for SRH services reveals the inadequate focus on training and monitoring of service providers and on Information, Education, and Communication. These are both crucial issues considering last mile delivery of services as well as the urgent need to build awareness about them.
The inordinately high investment in promoting terminal methods clarifies how the government continues to address SRH as a population control and family planning measure.



Where does budget data lie?

Getting comprehensive information on Central or State budgets seems daunting. The good news is, the information is put out by the government in the public domain. Research organisations and specialists also undertake budget analysis and publish them, especially in the weeks before and after the budget announcement, at central and state levels.

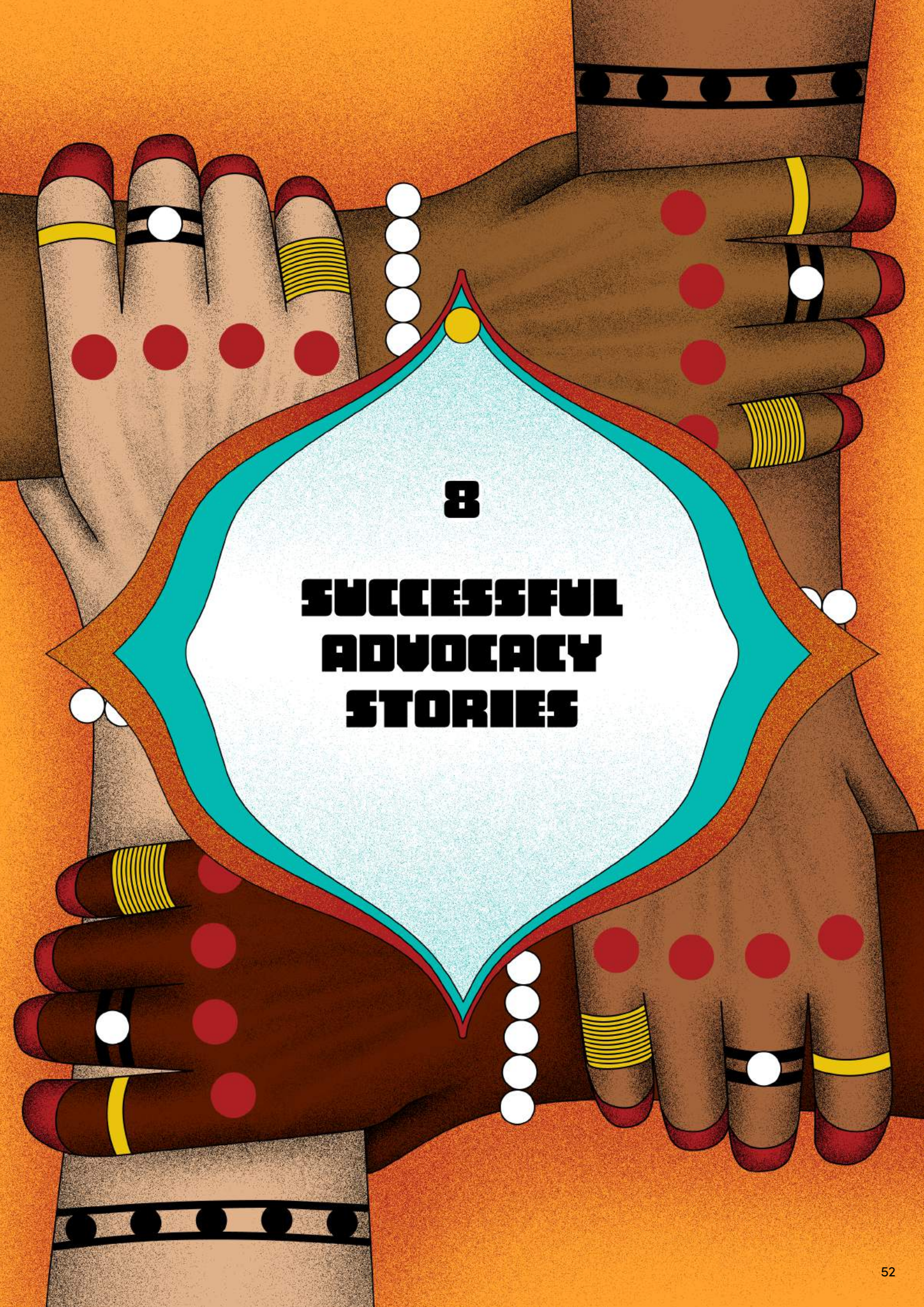
Government resources:

- The Union Budget website
- Reserve Bank of India
- Some state government websites contain information about the budget and financial performances, although many of them are not updated regularly.
- Economic Survey is published just before the budget by the Department of Economic Affairs in the Finance Ministry. It is the flagship annual document of the finance ministry which reviews the economic development in India over the past financial year by giving detailed statistical data of all the sectors.

Specialists and organization resources:

- PRS Legislative Research, in its effort to deepen and broaden the legislative process by providing MPs with the necessary data and analysis for debates in Parliament, carries out in-depth research of budgets and financial utilisation. Here, you can see an analysis of the financial allocation trends and key issues concerning the health sector.
- Open Budgets India, led by Centre for Budget and Governance Accountability (CBGA) is a portal of comprehensive, free and, user-friendly data that with budget information of different tiers of government in India. Using visualizations and infographics, it makes it easier to cull out the key details and implications of the budget.
- Accountability Initiative, a part of Centre for Policy Research, is a research group that works on strengthening transparency and accountability in governance. One of its activities is to publish a Budget Briefs series every year, which provides timely trend analyses on budgetary promises by the Government of India and allocations to major centrally sponsored welfare programmes.

Just as we discussed in the earlier section on building up evidence for advocacy, articles in newspapers and journals, are very helpful in understanding trends analysis. The Economic Times, carries a detailed budget analysis, a day after the Union budget is released. Articles such as this one help us get a specialist view on budgets and their implications



8

SUCCESSFUL ADVOCACY STORIES

What are the methods, nuts, and bolts to action one's advocacy effort?

In this toolkit, so far, you have read about the issues surrounding contraceptive access, especially for the vulnerable and marginalised; why contraceptive access for young people needs to be advocated for; the framework in which policy and practice view contraceptives; the pegs around which young people can anchor their advocacy effort. In this section, we will look at the nuts and bolts of advocacy and also review some tools and templates that may be useful in our effort.

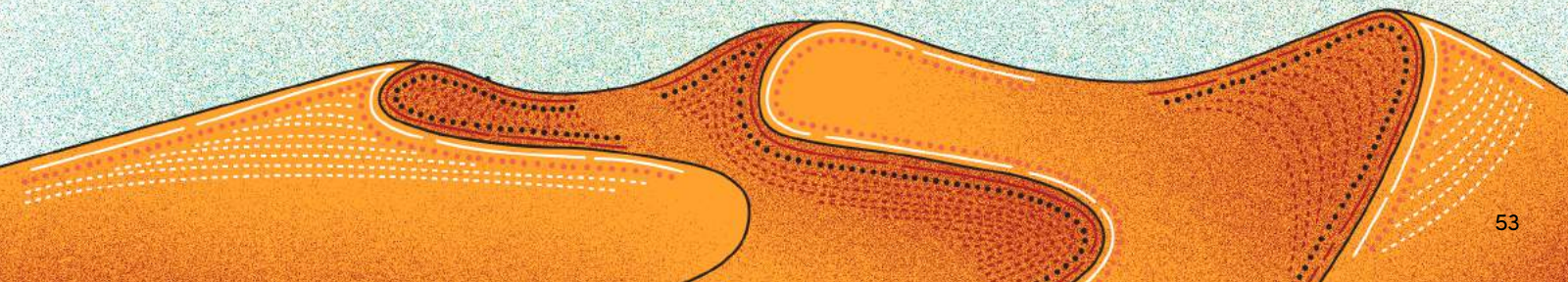
The tenets of advocacy: stitching it all together

By way of definition, advocacy is the process of building support for a specific issue or cause to influence stakeholders to take action[53]. It is a derivative of 'advocate' or, a person (or group) who takes up a case on someone else's behalf. Advocacy is usually aimed at achieving policy change, and uses information, symbolism, leveraging, and accountability[54] to achieve desired changes. Social Accountability[55] is advocacy that involves various stakeholders like citizens and civil society to hold government and government representatives accountable to their promises. It uses tactics like public campaigns, demonstrations, citizen report cards, etc. These processes provide a system of citizen-led checks and balances and can be supported by non-state actors like the media, the private sector etc.

The 2016 report by the Lancet Commission on Adolescent Health[56] describes adolescents as a 'force for change and accountability within communities'. Active involvement from adolescents in planning, implementation and, evaluation of programmes that directly impact their access to information, education and SRH services has been crucial in creating successful rights-based programmes for adolescents. As you will read in these stories from the ground (LINK TO CHAPTER 9), when adolescents are engaged in deciding and prioritizing their SRH needs, there are higher chances of not just ensuring adequate access to services, but also significantly boosting national socio-economic benefits.

SRH for young people: advocacy essentials[57]

- Identification of objectives of adolescent and youth participation.
- Review national and international policy frameworks vis-à-vis their recognition of the importance of meaningful participation of adolescents and youth.
- Institutionalize structures and processes to ensure adolescent participation in relevant areas of public policy, finance, programme implementation, and monitoring at every level – national, district, and local.
- Call for multiple platforms (including technological) to ensure adolescent and youth participation at the grassroots.
- Provision for training and mentorship for adolescent and youth leaders to build capacity and competency in playing effective roles in governance and accountability processes.
- Legal awareness building among adolescents and youth about their rights.



While pressing for policy and practice changes, a key role of advocacy by young people is also to hold their governments and its agencies, accountable for delivering on its commitments. Some of the ways in which groups of adolescents can hold governments accountable are :[58]

- Monitoring progress and tracking implementation at national and regional levels;
- Data collection to assess service delivery gaps, bias, discrimination and, violation of rights and privacy.
- Integrating adolescent-focused processes into local governance systems like public policy creation and budget allocation; and

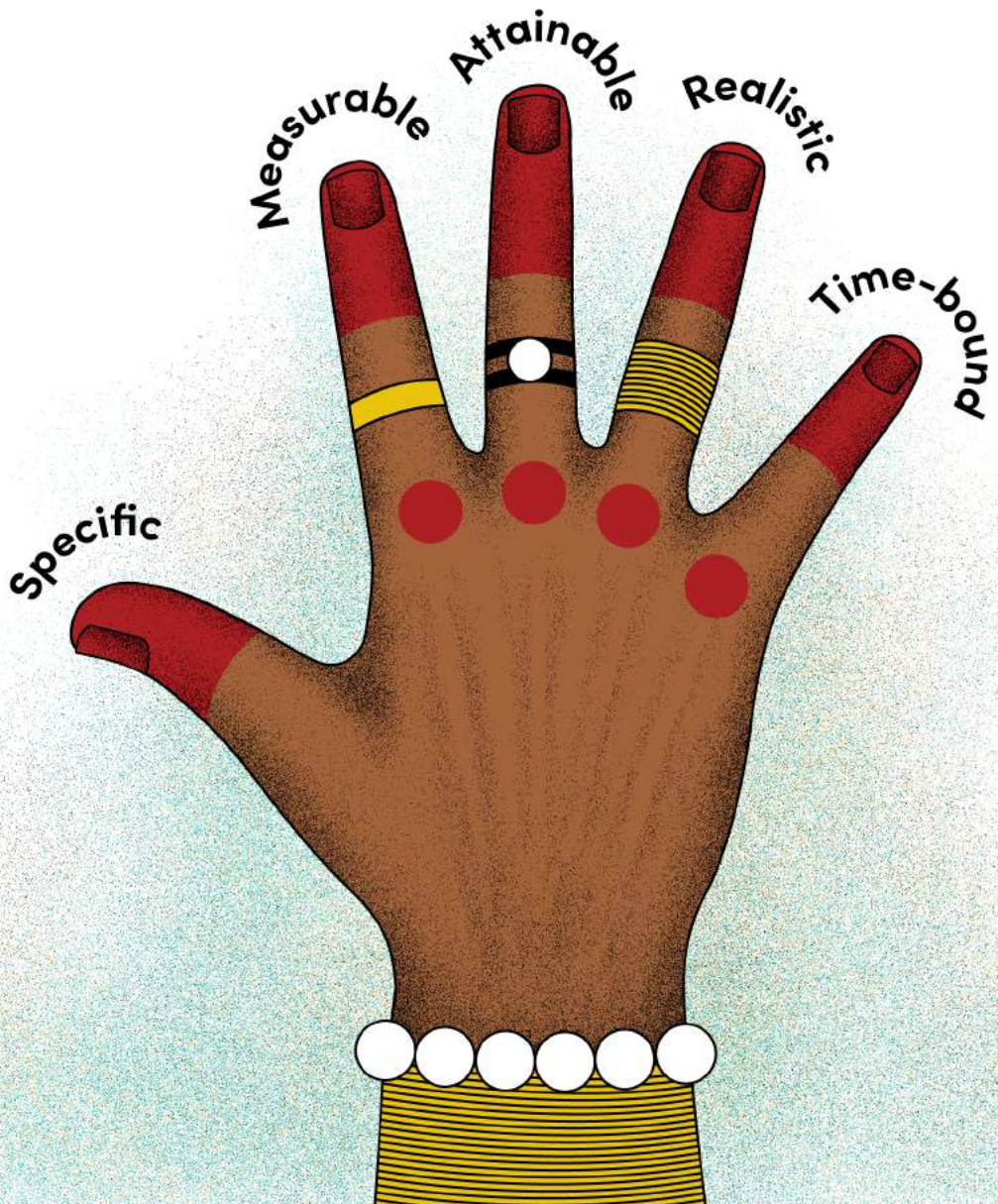
Launching your advocacy effort: essential steps

Step 1: What needs to change?

A good place to initiate one's advocacy effort is to understand what needs to change and understanding it to a degree of as much specificity as possible. For instance, what needs to change is: the blind spot regarding contraceptive needs of young, trans persons with disability. The underlying reason for this is the complete disregard of the sexuality and bodily autonomy rights of this group. This can be evaluated by a review of policy, programmes and practice as they exist. Further, an assessment of budgetary allocations and utilisations will clarify how much investment has been made towards the rights and entitlements of trans persons with disabilities (in SRH and beyond).

Step 2: What are the goals and objectives?

A sharp identification of the short-, medium-, and long-term goals and objectives that you would like to achieve in addressing the problem. Objectives help us clarify what we are working towards and how we will know we are on the right track. It also helps us to efficiently communicate to others precisely what change we are working towards. A good way to test the efficacy of one's objective is by keeping it **SMART.**



Step 3: Who is your target audience?
The primary target group of an advocacy effort is decision-makers like policymakers and legislators. The secondary target is those who can influence decision-makers like, review committee members and researchers who review policy and recommend changes in them. Assessing policies enable us to understand where the gaps lie, and thereby, who are the decision-makers and influencers who can be the target audience.

Step 4: How will you influence your target audience?
Once the purpose, objectives, and target audience have been identified, the approach to the advocacy effort and the tools, activities, and key messages can be built to maximum effectiveness. For instance, addressing a policy gap at an international Covenant level and one at a state level will require very different approaches and tools. It will also need a different set of allies in the government and civil society, who can help further the advocacy effort.

Allies and opposers can be classified:
Active Allies - influencers, decision-makers who support you and work with you to further your advocacy effort
Passive Allies - those who may agree with you but do not actively do anything about it
Neutrals - those who are not engaged and claim to be neutral on the issue
Passive Opposers - those who may disagree with you but do not actively do anything about it
Active Opposers - influencers, decision-makers who do not support you, and actively work against you to the detriment of your advocacy effort

Mapping allies automatically helps us understand what alliances and partnerships we ought to build for effective action. Potential partners could be non-profit organizations, youth clubs, students' alliances and different stakeholders from civil society (like, parents and grandparents), private sector and even members of the government. Building partnerships help pool resources, develop new ideas and strategies, identify best practises and build capacity. They also provide crucial support to engage further and avoid duplication by building a better representative base of stakeholders.

A key strategy to effective advocacy campaigns is timely, and time-bound activities which help keep in mind key moments or decisions that ought to be the focus of the campaign, and while planning activities. The former could be external events that create opportunities to further your advocacy campaign, while the latter is a specific timeline of activities you require for campaign implementation.

Campaign message and communication are crucial. In a very succinct manner, they help articulate to a wide audience what the campaign seeks to achieve. Like, Black Lives Matter or All Human Rights for All. The next level of messaging communicates why the objective is worth achieving, how the campaign would achieve it (including specific actions), and the positive impacts of this achievement. There are several ways of further amplifying campaign communications, including:

- **Presentations in panel discussions**
- **Representation in meetings with decision-makers who may have influence over policy or program implementation. This could be a delegation to the decision-maker or an invitation for on-site meetings with affected stakeholders.**
- **Public meetings like press conferences and general conferences with multiple stakeholders, citizen scorecards, public hearings, etc.**
- **Using technology and digital media, including community radio, social media campaigns, independent media, blogs, websites, survey platforms, signature collecting platforms, etc.**
- **Mainstream media, including press conferences, interviews, letters to the editor, op-eds, etc.**

Step 5: How will you measure your success?
To be able to track that the advocacy effort is proceeding in the right direction, you will have to identify indicators and ways to collect data to periodically assess what it has achieved. It is essential to have short-, medium-, and long-term indicators to undertake any course correction required. Indicators could be anything from the number of people who signed an online signature campaign, to how many attended advocacy meetings or the number of shares your social media post had. Beyond data, success (and its barriers) must be measured through case studies and stories from the ground.

While 'monitoring' your campaign is essential to assess whether you're making progress on a regular basis, 'evaluation' helps assess whether the outcomes of your campaign are being met. Other methods could include

- **Regular surveys or interviews with stakeholders via online or in-person methods.**
- **Collecting case studies**
- **Focus groups and review meetings**
- **Literature review and media tracking**
- **Policy tracking**

Group Work : Broad Goal and one SMART objective[59]

Decide on a broad goal that all the participants agree upon. You can split into smaller groups, if you prefer. Each group writes up their objective after discussion. Each group is to display their objective, and the other groups assess whether these are SMART. This will help the group come to a single objective that they will further work on.

It's possible to narrow down on more than one SMART objective. However, remember that each objective will require its own advocacy strategy. To decide the objective which should get highest priority you can consider the following:

- Which objective is most achievable?
- Can the group handle more than one objective at the same time?

Shishu's Advocacy[60]

Case Study: In 2018, Shishu, a young college student in Jharkhand, India had an opportunity to volunteer with a program where he learnt about SRHR for the first time. As a newly trained youth accountability advocate, Shishu realized that there was a need to increase awareness and knowledge about contraception amongst his peers. He knew from his training that there were already programs in place, but how would he get the government to deliver on their commitments?

Below are some examples and steps that would help plan the campaign.
First, Shishu would need to verify the gaps in knowledge. For this, he spent the first few months of his project speaking with young people in colleges across Ranchi city. Using data he collected on existing attitudes and knowledge on contraception, he could then use the below situation analysis chart to understand how to proceed.

SITUATION ANALYSIS CHART

Issue	Data and source (Local)	Data and source (National)	Data and source (Global)	Notes
Unmet need for contraception in adolescents	<This would contain the data collected from the different colleges in Ranchi.>		The highest unmet need for family planning is observed among adolescents at 25%. Only 46% of adolescents have their family planning needs met. (UNFPA)	
Adolescent fertility rate (births per 1,000 women aged 15-19)			45.3 in 2013 (World Bank)	
HIV prevalence rate: young women aged 15-24			0.4% in 2013 (UNAIDS)	
HIV prevalence rate: young men aged			0.3% in 2013 (UNAIDS)	
15-24				

The **Situational Analysis Chart** helps in narrowing down relevant national policies, leading to an exercise in policy assessment.

NATIONAL POLICY AND STRATEGY ASSESSMENT

Laws and policy frameworks	Do they exist?	List the policy source	Are they being enforced?
National plan or policy for youth- and adolescent-friendly health services	Yes, partially	RKSK	Partially
National/State plan for comprehensive sexuality education	Yes, State plan exists		
National strategy/ plan to address HIV and AIDS	Yes		
Legal impediments preventing access to contraception by unmarried adolescents			

Each of the policies listed above would then need to be assessed followed with identifying global commitments which can be used to support advocacy. In Shishu's project, he chose to focus on commitments made by the Indian government towards achieving gender equality (SDG5) and enabling more women and girls to use contraceptives (FP2020).

This step is crucial in drawing up a GOAL and an OBJECTIVE.

GOAL: To support the Jharkhand government to deliver on their commitments to enable more women and girls to use contraceptives.

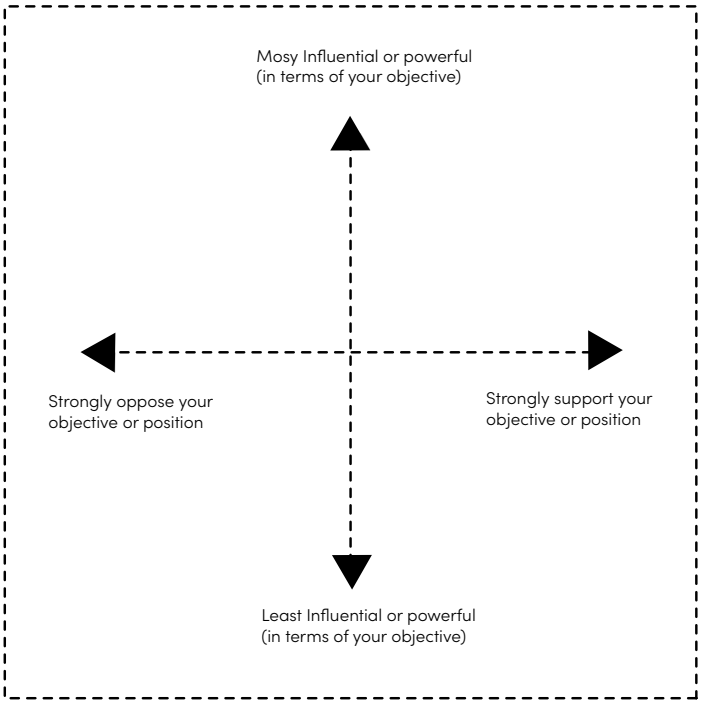
DISCUSS: Is Shishu's goal SMART?

OBJECTIVE: To increase the usage and access to contraceptives among young people.

DISCUSS: Does Shishu's objective answer the following:

WHO will be reached
WHAT change will be achieved
WHEN the change will be achieved
WHERE (in what location)

Group Work
Power Mapping Allies and influencers[61]



This exercise should involve everyone in the group. Ask yourselves the following to identify your influencers:

Who is the person who can make a decision that achieves your goal? (name the person(s) and their role)?

Who are the other organized stakeholders and influencers? (NGOs, organizations, individuals, institutions can be included here)?

Who are the core constituencies directly affected here (e.g. adolescents in x location, who may not necessarily be organised)?

Who are the people who would directly oppose your campaign?

Use the quadrant diagram to now plot your influencers. Your group must decide the position based on two factors:

influence over the decision-maker

support for your goal

Remember the idea is to understand influencer relative to each other, not who is 'right' or 'wrong'. Once there's a general agreement on where each influencer goes, identify any known links or influences or relations each of these players may have with each other. This helps identify connections and potential ways to influence these influencers.

Example: Hello, I Am, Bangladesh

GOAL: To prevent child marriage, reduce school dropouts and reduce underage pregnancies, to help adolescents realize their sexual and reproductive health and rights (SRHR).

OBJECTIVE: To address the socio-cultural norms underlying the continued practice of child marriage in Bangladesh, and to advocate for information access for, and meaningful participation by adolescents.

ALLIES AND STAKEHOLDERS : Important stakeholders who have significant influence over adolescents' lives include:
Parents of adolescents
Grandparents of adolescents
Community/Religious leaders
School teachers
Government officials (who work on programs for prevention of child marriage)
NGOs working on child rights or prevention of child marriage programs

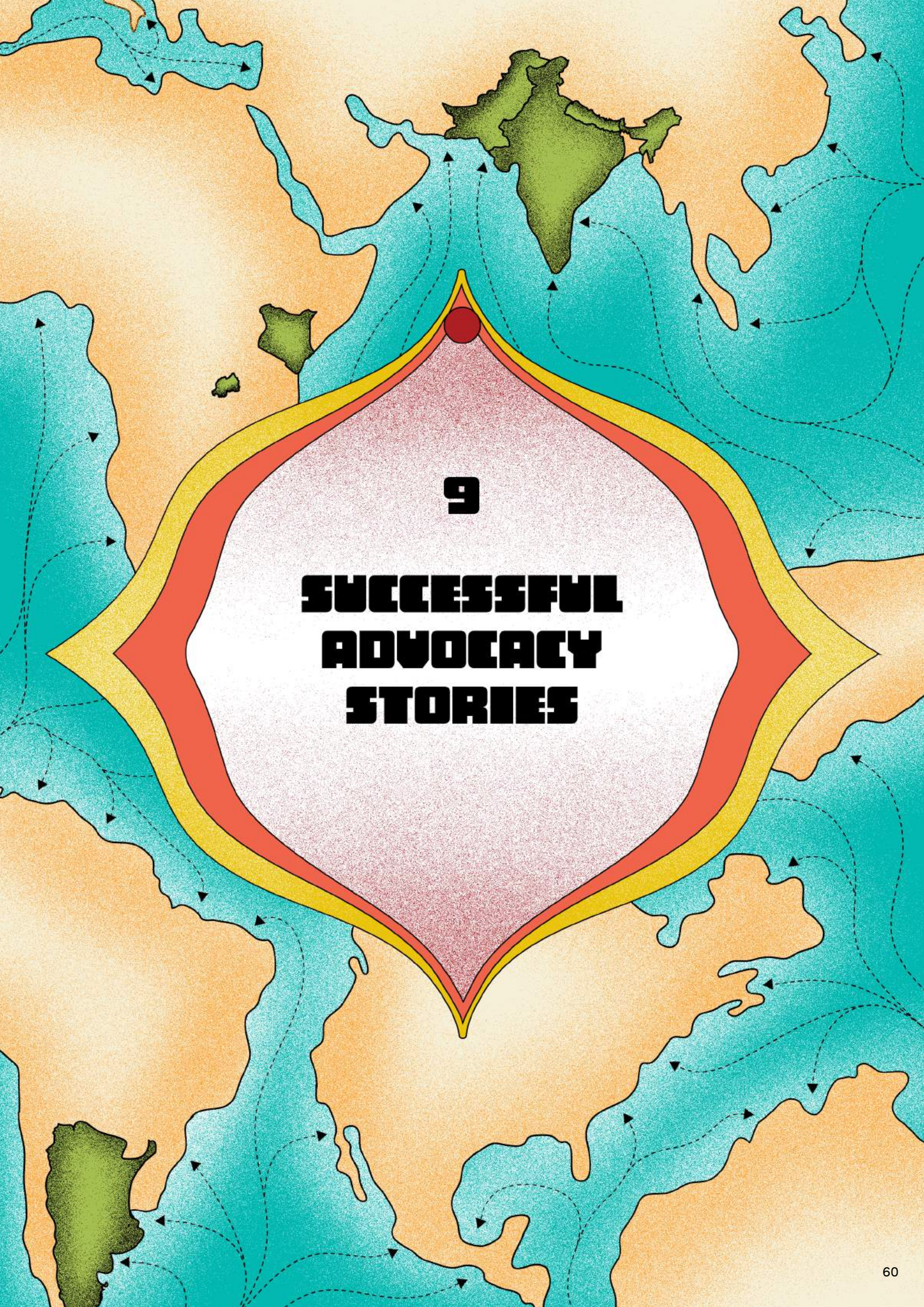
Using the exercise and diagram described above, a list of potential allies and opposers was mapped (see below).

Group Work
Assessing Advocacy Activities[62]

The group can collectively use the following template to assess various activities they have conducted. An example is included below. After this assessment of activities completed, the group should discuss the following key questions:

What should we STOP? - here the group needs to discuss what didn't work, and can be discontinued.
What can we CONTINUE? - here the group needs to discuss what worked well, and should be continued.
What should we START? - here the group needs to discuss what are the changes required to help achieve our objectives.

Advocacy activity	What worked	The evidence	What didn't work	Changes to improve advocacy
Example: You organized a Press Conference	The content was well researched and presented well.	The YouTube video of the conference was shared widely, and greatly appreciated	Minimal interest from mainstream media journalists.	Focus on digital and independent media houses Identify one or two mainstream media channels/publications for exclusive partnership



9

SUCCESSFUL ADVOCACY STORIES

How have young people used the advocacy route to press for access to SRH, especially in countries like India? What learnings can we draw from them? ?

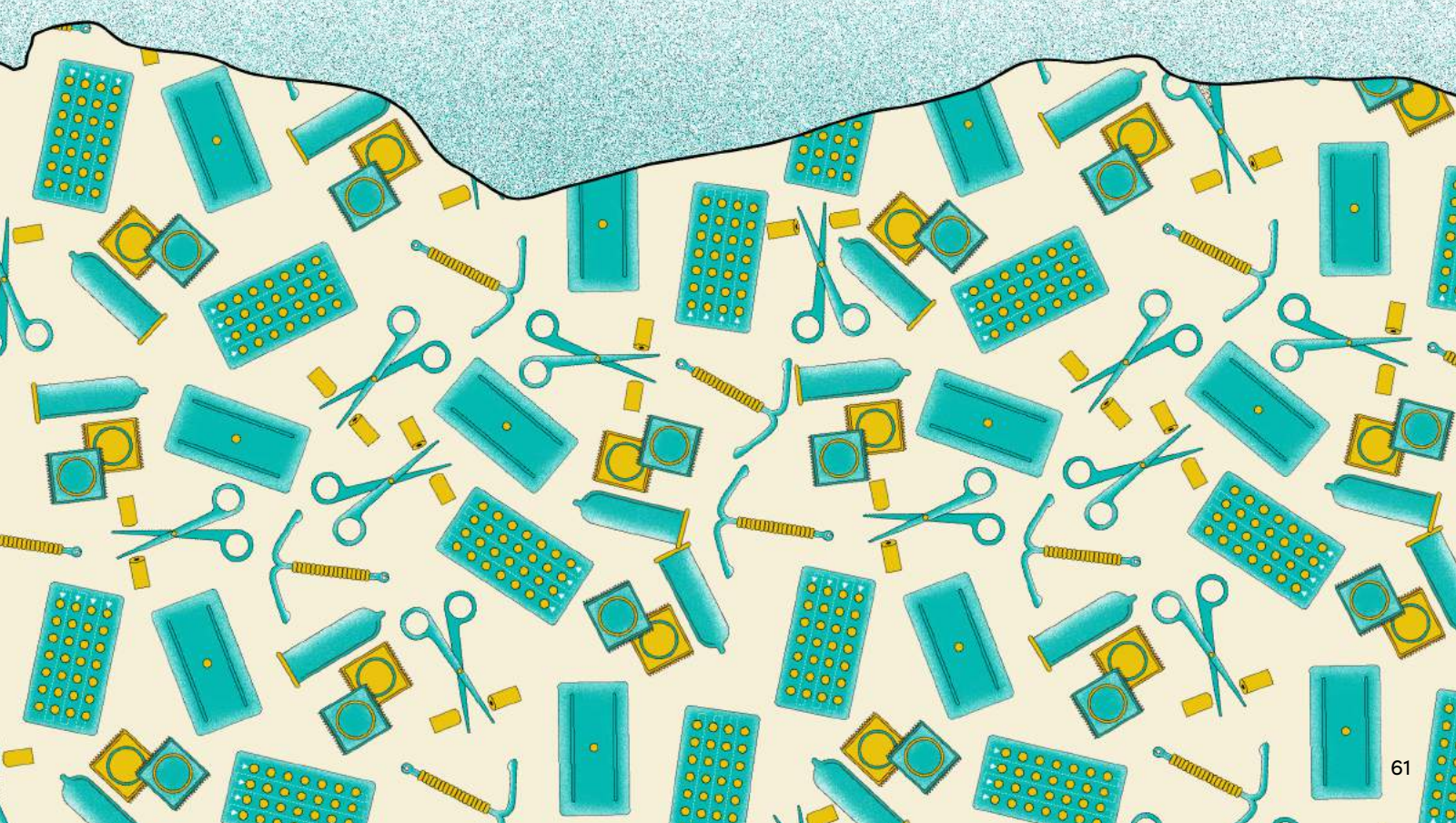
Advocacy for change appears like an arduous route, especially for issues pertaining to young people's sexuality and bodily autonomy. A look at how other countries, especially low- and middle-income countries (LMIC) like India, have used policy and advocacy successfully to address such issues. They may have learnings for you, for your advocacy effort.

Policies and Programs in India and other LMIC

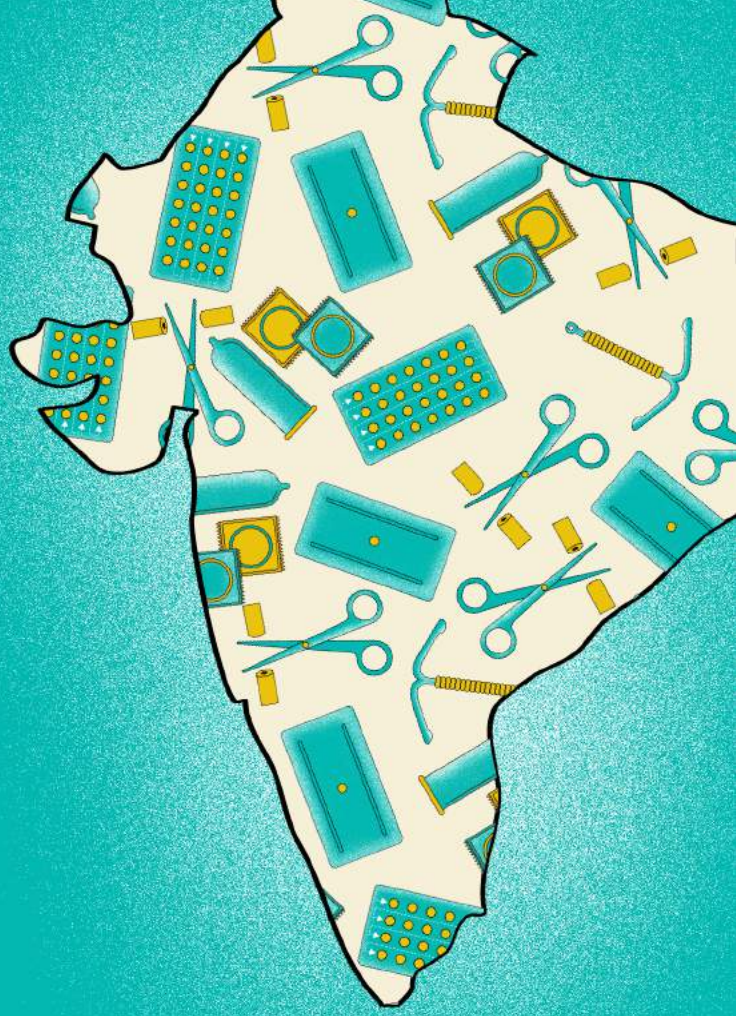
Policies addressing adolescent issues must not only protect their rights but also promote their well-being. Effective policies further and protect adolescents' rights to autonomy and privacy and present opportunities for participation. A comprehensive range of policy measure recommendations[63] to effectively address adolescent health issues by the World Health Organisation (WHO) includes recommendations that recognize that adolescents are heterogeneous, constantly evolving, and changing and that their needs are dependent on a wide range of varying socio-economic and cultural contexts. The recommendations acknowledge that even as adolescents require protection from harmful situations, they also need support and guidance to make independent decisions. These combined with other WHO guidelines[64], call for a combination of actions which build knowledge, skills, provide safe environments, and promote health and counselling. The guidelines also consider a variety of reasons including poverty, social norms, poor governance or restrictive laws which limit opportunities for educational and personal growth of adolescents.

There could be many different reasons why policies and programmes for adolescent health are ineffectively implemented. These include incoherent planning, inadequate monitoring systems, budgetary constraints or gaps, failure to protect adolescents from harmful community practices and customs, and poor or non-existent adolescent engagement.[65]

Programmes are most impactful when they effectively take into account perspectives and needs of adolescents, including those facing additional vulnerabilities of disability, sexuality, caste, class, and so on. There are several Life Skills Based Education (LSBE) programmes in India and other LMIC which are successfully providing SRH information and awareness to adolescents.



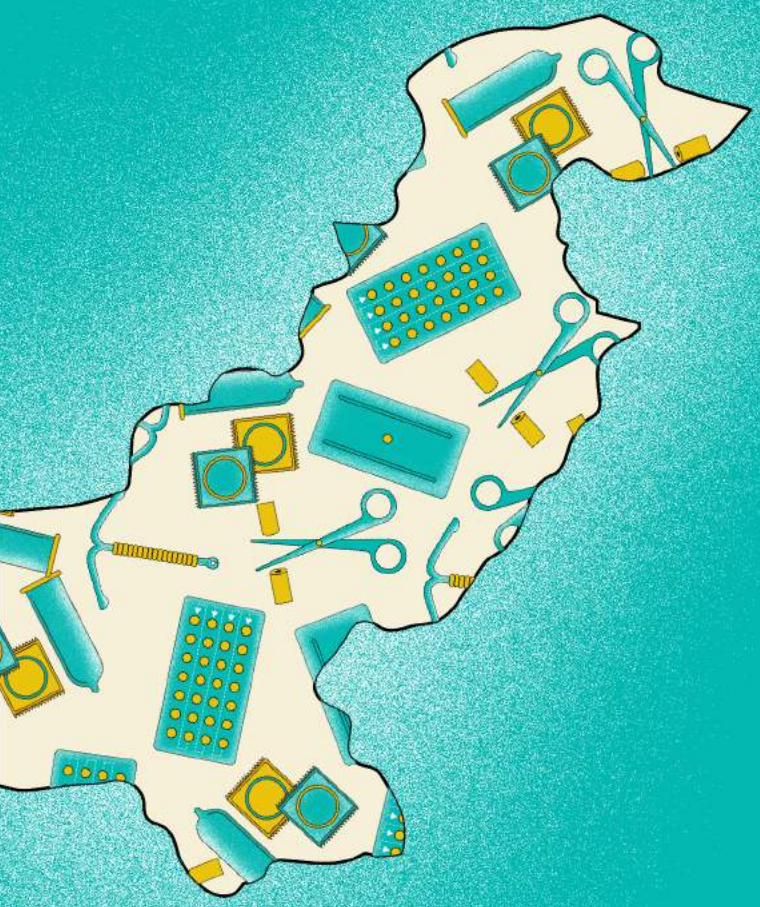
How advocacy has worked: some stories from the ground



1. Udaan, India

Udaan was a programme [RD2] initiated in 2006, by the Centre for Catalysing Change (C3) in collaboration with the Government of Jharkhand. Implemented by the Jharkhand Council for Education, Research and Training (which comes under the State Department of School Education and Literacy), the programme is supported by C3 with technical assistance. The 13-module curriculum covers: life-skills; values; gender; sexual harassment and violence; adolescence; growing up and adulthood; information on sexual and reproductive health. The teaching methods include participatory tools like games, stories and quizzes, and caters to girls and boys between the 6th and 11th grades.

The successful implementation of Udaan was possible because of a supportive policy environment, both at the national and state level. Jharkhand is one of the first states in India to have a youth policy, issued in 2007, such that a climate for working towards empowering young people and promoting their health and wellbeing has been built.[66] Strategies, like sensitizing school principals and District Education Officers, or using efficient MIS to promote accountability helped Udaan succeed as a programme. A review of the Udaan[67] revealed that while there were issues in implementing it, what remained vital was the commitment of the state government and of C3 in keeping all stakeholders engaged and accountable. Udaan successfully reached over 900,000 students in nearly 2,000 schools in Jharkhand.



2. LSBE-SRH Programme, Pakistan

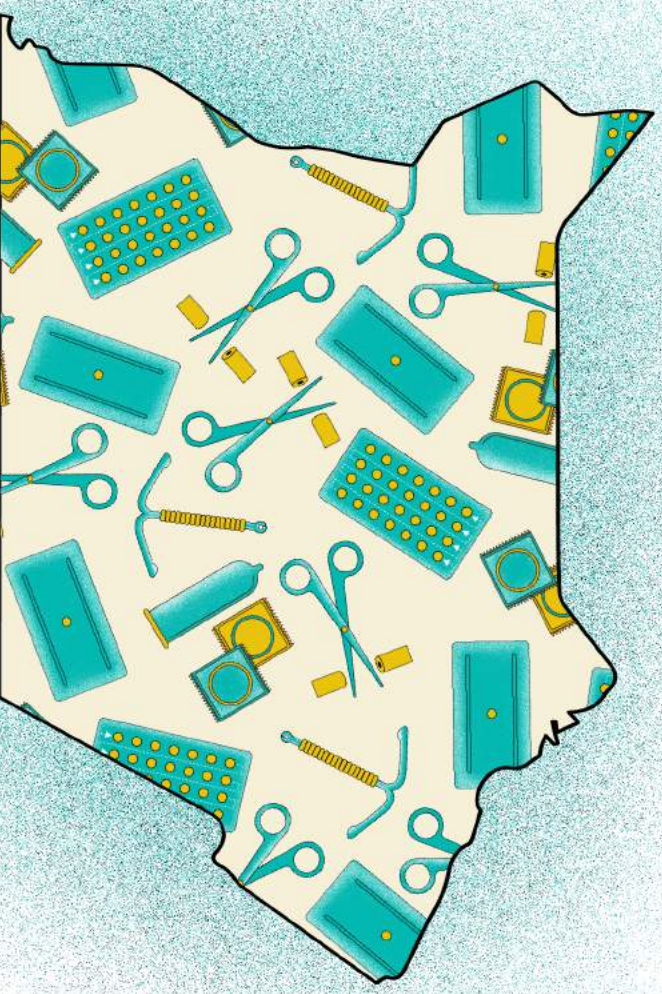
Pakistan too has had a glaring absence of adolescent-friendly SRH services and programmes in the public sector. Barely a handful of NGOs offer SRH information and services to Pakistani adolescents, creating a massive gap in access. Aahung, and Rutgers WPF Pakistan were two organizations that collaborated with various agencies of the Pakistani government like the Dept. of Education, the Curriculum Bureau, and the Textbook Board to roll out very successful life skills-based education (LSBE) and rights-based programmes offering SRH information and awareness.

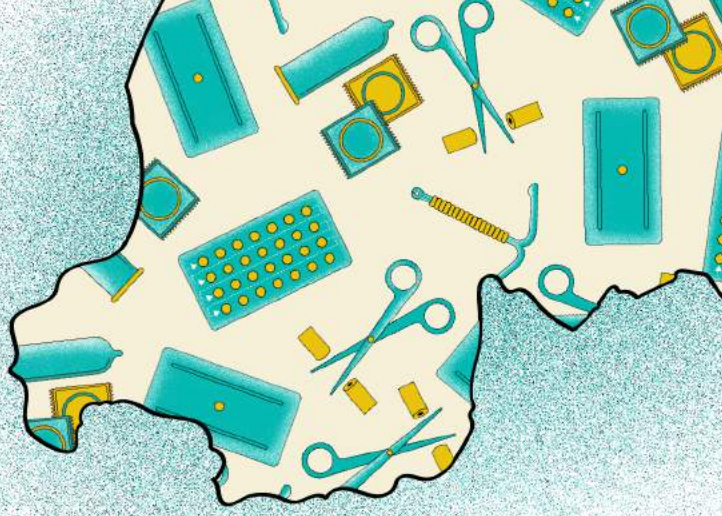
Beginning in Sindh and spreading very quickly to Balochistan and other provinces, the LSBE programme reached nearly 1200 schools and over 500,000 students between 2004 and 2013. Despite resistance from conservative communities and religious groups, the LSBE succeeded in reaching a large cohort of students because a wide range of stakeholders was involved in developing a conscious and culturally appropriate curriculum.[68]
The stakeholders included adolescents, their parents, members of the community, religious leaders, and school authorities.

3. Comprehensive School Health Policy, Rwanda

In Rwanda, the government has recognized how a variety of factors can affect adolescents' mental health and physical wellbeing and keeping that in mind, has developed a comprehensive school health policy. Factors like poverty or limited access to water and sanitation also play a major role in affecting adolescents' access to sexual and reproductive healthcare and services.

The national school health policy recommends action across key areas including: promotion of health; prevention of HIV/AIDS/STI; environmental health; nutrition and physical education; mental health; and finally, gender and gender-based violence issues. The interventions are focussed on enhancing school curriculum as well as infrastructure, health services, and building better links with the community. It comes with recommendations on education, on health and promotion of the same, provision of safe water and sanitation, and is implemented by 9 different ministries.[69]





Making adolescent voices heard.

One way of ensuring that adolescents' needs and perspectives are taken into account is for them to be directly involved in making new policies and programmes, or help in improving existing ones. Here are some interesting ways in which adolescents made sure their voices were heard.

1. Collaboration between Governments and Youth-led Organisations, Organization of African Youth's (OAY), Kenya

In order to increase adolescents' access to SRHR information and services, the project took a multi-pronged approach. First, there were efforts to collaborate with the government to create youth-friendly and evidence-based IEC material to reduce pregnancy and HIV infections among Kenyan adolescents. Second, the programme built capacities of youth-led and youth-serving organisations to advocate for increased access to services and information on adolescent health and wellbeing. Third, the programmed fostered dialogue between adolescent groups and the government to adopt new practices.

OAY worked with the Ministry of Health (MoH) to adapt and disseminate a toolkit. For instance, various government officials and the National Youth Council all championed the final toolkit so it would be widely used. The toolkit was widely disseminated to help adolescent advocates plan, implement and monitor their work in over 15 counties (districts). They also built capacities of 47 youth-led and serving organisations to use it effectively. OAY also worked with seven youth-led organizations to adapt the toolkit to a Nigerian context, making their work expand across many countries and yet remaining locally relevant.

2. Creating Culturally Specific Interventions, Kalyani and KIRDARC, Nepal

For many women in Nepal menstrual hygiene management is a major health and social issue because of the stigma associated with menstruation. Like in India, many girls tend to drop out of school or practice Chhaupadi, where they are ostracized from their homes during their periods. Kalyani, a youth-led organisation, worked in collaboration with KIRDARC, a local NGO based in Surkhet to address this issue through a culturally specific intervention. The team began by collecting baseline data which measured how people viewed periods, and what sanitary methods they used. They found that only 27% girls viewed menstruation as a normal biological process and that 78% practiced Chhaupadi.

Based on this evidence the organisations carried out menstrual hygiene management awareness sessions with over 1,600 people in different target groups, including: school going adolescents, adolescent groups, youth committees, women's and mothers' groups, female community health volunteers, community leaders and other general community members. They also taught women and girls how to make reusable cloth sanitary pads. Kalyani and KIRDARC presented their work to government officials in the district. The officials recognised their efforts and the need to replicate the programme in other villages.

3. Youth Participatory Budgeting, Argentina

Since 2004, the Municipality of Rosario in Argentina has been conducting annual participatory youth budgeting, which engages young people across six districts. Through an intensive process, young people get to identify the priority issues in their neighbourhood which require municipal spending. Neighbourhood assemblies are set up in each district, through which young people decide the priority issues as well as elect representatives to talk about these issues. The participatory councils meet regularly for many months where they develop project proposals depending on the neighbourhood priorities, and then present these proposals at district assemblies. Another round of voting is done at this stage to decide which activities get implemented.

This entire process not only results in accurate identification of gaps and of actions to address them, but it also builds skills in young people for their civic participation. While the German Technical Cooperation (GTZ) funded the initial pilot in 2004, subsequently funds for this exercise have been sourced from the municipal budget. It has resulted in budgets being allocated to music and dance workshops, recreational sites, and a community library, among other investments.

CONTRACEPTION ADVOCACY TOOLKIT

the yp foundation

FURTHER READINGS AND RESOURCES

In every chapter of this toolkit, links to additional readings have been provided, which will help you go deeper into the subject matter of contraception, policies, evidence and advocacy. These are recommended readings to gain better understanding of the subject and the processes discussed. Here is a chapter-wise summary of all the additional readings.

CHAPTER 1

Contraception – a matter of young people's right and access

- The "promiscuity propaganda"
- POCSO Act (Protection of Children from Sexual Offences Act) and the clause of mandatory reporting of sexual activities
- Criminal Law (Amendment) Act, 2013 (popularly known as the anti-rape law)
- The age of consent debate and a synthesis of the key issues therein
- Global view of criminalisation in the realm of sexuality and reproductive rights
  - A map of the countries across the world where lesbian, gay, bisexual and transgender people are criminalised.
  - Countries that have taken made abortion illegal.
  - The movement to change Ireland's abortion law arising from the case of Savita Halappanavar
- Potential of comprehensive sexuality education to change the landscape
- Voluntary disclosure of achievement of Sustainable Development Goals by India and indicators used to measure the achievement

CHAPTER 2

Contraceptives – is it truly a menu of options?

- The influence of religion and culture on the approach to contraception
- Conditions that impact the success of 'permanent contraceptive' reversal procedures
- The Medical Termination of Pregnancy (Amendment) Bill, 2020

CHAPTER 3

Adolescents' access to contraception: Building the evidence

- The last Population Census of India conducted in 2011 and analysis using the data
  - An analysis of the sex ratio of Jharkhand state using census data
  - District-wise data for Maharashtra and Tripura pertaining to key indicators
- National Family Health Survey (NFHS) Repo
  - NFHS3
  - NFHS4
  - NFHS5
- Articles and reports that have utilised Census and NFHS data:
  - Global population trends compiled by the United Nations Population Fund
  - National indicator framework on adoption of modern family planning methods
  - 'State of the World Population report', 2021 put out by the UNFPA
  - An analysis of the unmet needs for contraceptive services in the country
  - Paper in the Indian Journal of Medical Research that suggests a way forward for contraceptive use in India building on government data
  - Report on 'Choice of contraceptive methods in public and private facilities in rural India'
- The last District Level Household Survey conducted by the Ministry of Health and Family Welfare child health, reproductive health.

CHAPTER 4

Advocacy for contraceptives for young people: the global landscape

- Documents and reports that influence advocacy for SRHR at the global level
  - Sustainable Development Goals
  - Family Planning 2020
  - Report of the Asian and Pacific Population Conference, 2013
  - Convention on the Rights of Persons with Disabilities Advocacy Toolkit
  - SRHR Advocacy Toolkit developed to assist MenEngage Africa Youth Structures
  - A compilation of a selection of international, regional and national organizations engaged in promoting sexual and reproductive health and rights and economic justice.
  - Journal articles focusing on how political action of governments, NGOs, activists, and others combine for the benefit of SRH access for marginalised populations.

CHAPTER 5

Contraception – a matter of young people's right and access

- Statement by individuals and health organisations in India about the concerns around injectable contraceptives
- India's report for the 2020 High Level Political Forum of the UN
- Core indicator sheet of FP2020 which gives an idea of the degree of contraceptive access and adoption
- Statement - Union Minister for Health and Family Welfare

CHAPTER 6

Policies in India: what is in store for young people?

- Articles pertaining to comprehensive sex and sexuality education
  - An article that summarises the author's view on the ground realities of sex education in India
  - The relevance of sex education in India synthesised by a civil society organisation
  - An analysis of the importance, reality, myths and issues surrounding sex education in India
- Operational guidelines of Ayushman Bharat
- The operational framework of Mission Parivar Vikas

CHAPTER 7

Budgetary allocations and reality: a critical advocacy tool

- An analysis of the financial allocation trends and key issues concerning the health sector by PRS Legistlative Research
- A portal of comprehensive, free and user-friendly data pertaining to budget implications
- Specialist articles like this in leading newspapers to help us get a specialist view on budgets and their implications

ADDITIONAL ADVOCACY TOOLKITS YOU CAN REFER TO:

Here is a list of additional resources that you could go through to help you understand how young people can engage in advocacy and access some useful tools to do so.

- Toolkit: Young People as Advocates, The International Planned Parenthood Federation (IPPF), 2011
- Toolkit: An Advocate's Guide: Integrating Human Rights in Universal Access to Contraception, by Asian-Pacific Resource & Research Centre for Women (ARROW), 2016
- Toolkit: Advocating for change for adolescents! A Practical Toolkit for Young People to Advocate for Improved Adolescent Health and Wellbeing, by The Partnership for Maternal, Newborn & Child Health (The Partnership) and Women Deliver, 2018
- Youth Activist Toolkit, from Advocates for Youth, 2019.
- Power to Womxn and Girls, A global advocacy toolkit, for the Beijing+25 process and beyond, Women Engage for a Common Future (WECF), 2020
- General resources, reading and training material at Beautiful Rising.
- Information, courses and tools on YOU(TH) Do IT! an online resource hub by CHOICE for Youth and Sexuality.

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