

# Adolescents Knowledge and Attitude towards Sexual and Reproductive Health in Bhopal (Madhya Pradesh)

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## Abstract

*With a staggering adolescent population of 253 million, India stands as the world's epicenter of youth. Adolescence, a distinctive phase marked by active physical and psychological growth, often initiates the exploration of romantic and sexual realms. Adolescents are particularly susceptible to various reproductive and sexual health vulnerabilities such as unintended pregnancies, sexually transmitted infections, reproductive tract infections, and the heightened risk of maternal and infant mortality. This susceptibility is accentuated in regions where healthcare services are constrained and knowledge regarding health matters is limited. A descriptive cross-sectional survey was conducted in the year 2022, with due ethical considerations, among students in the 9th to 12th grades (n=322) in Bhopal District, Madhya Pradesh, a region where utilisation of Adolescent Reproductive and Sexual Health (ARSH) services remains notably modest. The objectives were to assess the knowledge and attitudes of adolescents regarding SRH and to find the relationship between the knowledge and attitude. Data was collected in schools from adolescents aged 14 to 18 years, using researcher-developed structured questionnaires. The findings revealed that the majority (50.9%) of participants had poor knowledge, 34.5 percent showed moderate knowledge and 14.6 percent exhibited good knowledge. About 60 percent of the participants expressed a favorable attitude towards sexual and reproductive health (SRH). The relationship between knowledge and attitude was positive but weak. These outcomes collectively underscore the need for improving adolescents' SRH knowledge and attitudes in the region. Focusing efforts towards comprehensive SRH education and promoting well-informed attitudes may help reduce the adolescents' susceptibility to SRH vulnerabilities.*

**Key words:** Adolescents, Reproductive and sexual health, Knowledge

The transitional phase between childhood and adulthood, known as adolescence, heralds rapid transformations encompassing physical, cognitive, and psychosocial domains. During this period, adolescents establish unique patterns of behaviour that encompass dietary choices, physical activities, experimentation, substance use, and burgeoning sexual explorations. The decisions made during these formative years are pivotal in shaping their future health and overall well-being.

In the Indian context, which houses an adolescent population of 253 million, constituting nearly 20 percent of the global youth cohort, addressing Sexual and Reproductive Health (SRH) concerns becomes imperative (Census of India, 2011). Acknowledging this, the Government of India introduced the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014, a comprehensive

programme tailored for adolescents. Central to this initiative are the Adolescent Friendly Health Services (AFHS), which predominantly focuses on matters about sexual and reproductive health (Bali et al, 2020).

The need for SRH services is greater in Madhya Pradesh for a few reasons. The adolescent population in MP is growing rapidly (the decadal growth rate of the adolescent population is 19% between 2001 and 2011). Inadequacies of nutrition (32% of adolescents are moderately or severely thin, and 36% are anaemic), the prevalence of teen marriages, gender-based violence, and poor utilisation of Adolescent Friendly Health (AFHS) services render adolescents susceptible to SRH problems. Bali et al (2020) unveiled inadequacies in AFHS attributed to deficient knowledge levels, inadequate training, and substandard counselling skills among health service providers. There is a lack of research on the knowledge and attitude of adolescents on SRH in the Bhopal District of Madhya Pradesh. Hence, a systematic inquiry was

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undertaken to bring out strategies for improving the SRH education in Bhopal.

## Review of Literature

Major developments in sexuality and reproductive ability occur in adolescence, and several factors influence the SRH of adolescents. Studies across India reveal poor or fair knowledge of SRH and attitude (Hoopes et al, 2016; Deshmukh & Chaniana, 2020; Royal et al, 2018; Kuberan et al, 2017; Shankar et al, 2017; Siva et al, 2021; Kumar et al, 2019; Baghel et al, 2019; Nayak et al, 2016). Knowledge and attitude of school-going adolescents in India were associated with higher age, grade, and social media (Deshmukh & Chaniana, 2020; Saha et al, 2022). School teachers were the most common source of information on SRH, whereas parents were the least common. Adolescents' feared family-level controls if they were to initiate discussions on SRH with parents. Nearly 50 percent of adolescents were unaware that having multiple STDs at once was possible (Kuberan et al, 2017). With early initiation of sexual activity, lack of knowledge of contraception, its actual use, or sexual rights, adolescents are particularly susceptible to female genital mutilation, early pregnancy, and developing STDs.

Kagesten & Reeuwijk (2021) proposed a conceptual framework encompassing six competencies for sexuality development, namely, sexual literacy, gender-equal attitudes, respect for human rights and understanding consent, critical reflection skills, coping skills, and interpersonal skills. The conceptual framework is helpful to prepare the tools for assessing knowledge and attitude on SRH and to plan measures to improve AFHS. However, the methodological quality of knowledge and attitude studies across India is poor, for they lack a conceptual basis for developing items of the tools. AFHS initiatives to enhance the knowledge and attitude of adolescents are underway in India (Hoopes et al, 2016); however, the literature reveals that context/country-specific, rights-based, and adolescent-friendly sex and reproductive health education programmes and policies is the need of the hour (Siddiqui et al, 2020).

## Objectives

The objectives of this study were: (1) To assess the knowledge concerning reproductive and sexual health among adolescents; (2) To evaluate the prevailing attitudes towards reproductive and sexual health among adolescents; and (3) To find the relationship between knowledge and attitude concerning SRH.

## Materials and Methods

### Research Design, Setting, and Sample

The present study used a descriptive cross-sectional survey design to investigate the knowledge and

attitudes of adolescents towards reproductive and sexual health. It was conducted in 2022 within higher secondary schools in Bhopal. Among the 157 higher secondary schools in Bhopal (47 government and 110 private), 50 schools were selected through a random sampling technique by lottery method. Among these 33 schools were private, and they declined permission to collect the data. Eight of the 17 government schools were co-educational, and permitted to conduct the study. Government schools adhered to dress codes for male and female students but lacked the provision for school health nurses or counsellors. Sex and moral education were not part of the curriculum in these schools.

The sample size was calculated based on the NFHS-4, wherein the prevalence of knowledge on reproductive and sexual health was 28 percent (IIPS & ICF, 2017). With the absolute precision of 0.05 percent points and type 1 error of 5 percent, the sample size calculated was 323, using the formula  $n=4pq/d^2$ . Considering a non-response rate (likelihood of incompletely filled questionnaire) of 10 percent, 355 participants were administered the questionnaires, of which 322 filled in every item. The participants encompassed adolescents aged 14 to 18 years enrolled in higher secondary schools who could speak and read Hindi or English and could provide either their own or parental consent. Exclusions were restricted to adolescents absent during data collection.

### Data Collection Instruments

Three distinct tools were developed by the researcher from an intense review of the literature and were validated by a panel of 10 experts.

*Background Performa:* This captured demographic and socioeconomic characteristics, encompassing variables such as age, gender, grade, study in the co-ed school (in the past), parent's education and occupation, place of residence, familial decision-makers, and family members affiliated with the health sector and a section on individual habits and reproductive and sexual history.

*Knowledge Questionnaire:* It comprised of 30 multiple-choice questions across five domains namely puberty and reproduction, sexual health and sexuality, contraceptives, sexually transmitted diseases, and national health programmes on reproductive and sexual health. Each question offered four alternatives. Each correct response was scored as one. Knowledge scores were categorised as poor (0-15), fair (16-21), and good (22-30).

*Attitude Questionnaire:* It featured 31 statements that participants rated on a five-point Likert scale (5-Strongly Agree, 4-Agree, 3-Uncertain, 2-Disagree, 1-Strongly Disagree) inclusive of 10

positive and 21 negative statements. Negative statements were reverse-scored. A score of above 95 was considered favourable attitude.

**Translation, reliability, and pretesting:** Two bilingual language experts translated the tools to Hindi and back-translated to English. The reliability assessment of the knowledge questionnaire using split half method (r) was 0.798, and the internal consistency of the attitude questionnaire (Cronbach alpha) was 0.802. A pilot study was conducted among 30 participants to assess the feasibility of the study.

**Data collection procedure:** The initial introduction of the study to adolescents occurred on school premises, facilitated under the class teacher’s presence. For participants below 18, parental consent forms were sent home through the adolescent, along with the participant information sheet. Subsequent data collection involved the administration of the tools within the school premises to adolescents with parental consent.

**Ethical considerations:** Ethical approval was granted by the Institutional Human Ethical Committee of AIIMS Bhopal (IHEC-PGR/2021/MSc Nursing/July/12). Permissions were secured from the District Education Officer (Bhopal District) and school principals. Parental consent and assent was obtained. Participation was entirely voluntary. Confidentiality and anonymity of data were assured.

Results

Participant Description

The study encompassed adolescents from 9th to 12th standard, with a predominance of females. A substantial portion hailed from urban locales (81.4%), while 53.11 percent were aged below 16. The majority attended co-educational schools (61.8%), and 64.91 percent of the participants belonged to Hindu religion. Moreover, 53.42 percent lived in joint families. About 84.47 percent of adolescents’ fathers and 55.3 percent of their mothers were employed. The father was the prime decision-maker (80.4%) in the family. Only 30 percent of fathers and 16 percent of mothers had higher secondary education, and few (8%) had no formal education. About 98 percent of adolescents reported no current use of substances (alcohol, cigarette smoking, or drugs), and 96 percent did not receive reproductive and sexual health education sessions in school. About 20 percent of the participants reported a history of urinary tract infections, and 52 percent of female

participants reported premenstrual symptoms.

Knowledge and Attitude Scores

The minimum, maximum, mean, Standard Deviation (SD), median, and quartiles, illustrating the distribution of participant responses concerning their knowledge and attitudes toward reproductive and sexual health, are presented in Table 1.

Knowledge and Attitude levels

About 50.9 percent had poor knowledge, and 14.6 percent had good knowledge (Table 2 and 3). About 61 percent had a favourable attitude. Most (87.25%) adolescents were unaware of the Government of India’s services for Adolescent Reproductive and Sexual Health (ARSH). About 70 percent agreed for incorporating sex education into the school curriculum.

Knowledge and attitude level in terms of gender, age, place of residence, grade, type of family, and study in co-ed school in the past reveal that, as the age and grade increased, the knowledge level improved (Tables 2 and 3). Female participants’ knowledge level was better. Male participants had a favourable attitude compared to females. Most (69.8%) of the adolescents who studied in co-ed schools had poor knowledge but a favourable attitude. While 50 percent of the rural and urban adolescents had poor knowledge levels, most of the rural adolescents had favourable attitudes towards SRH.

The scatter plot diagram (Fig 1) presents the relationship between the knowledge and the attitude scores. Spearman’s rank correlation revealed a positive and weak relationship between knowledge and attitude scores ( $\rho = 0.383$ ). This statistical insight is noteworthy suggesting a certain degree

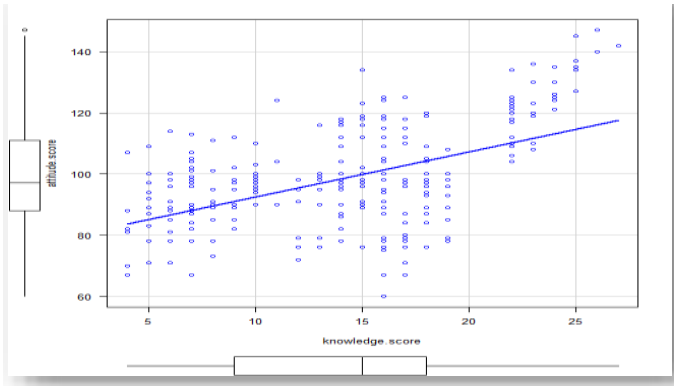


Figure 1: The relationship between knowledge and attitude scores of SRH.

Table 1: Description of knowledge and attitude scores on SRH (n=322)

| Variable        | Minimum | Maximum | Mean  | SD    | Median | Q1    | Q3     |
|-----------------|---------|---------|-------|-------|--------|-------|--------|
| Knowledge score | 4       | 27      | 14.39 | 5.52  | 15.00  | 9.00  | 18.00  |
| Attitude score  | 147     | 97.00   | 60    | 98.91 | 87     | 88.00 | 111.00 |

**Table 2: Frequency and percentage distribution of knowledge level concerning demographic variables (n=322)**

| Variables                            | Knowledge level      |       |      |      |       |      |       |
|--------------------------------------|----------------------|-------|------|------|-------|------|-------|
|                                      | Poor                 |       | Fair |      | Good  |      | Total |
|                                      | F                    | %     | f    | %    | f     | %    | f     |
| Age (in years)                       | ≤16                  | 136.0 | 79.5 | 19.0 | 11.1% | 16.0 | 9.4   |
|                                      | >16                  | 28.0  | 18.6 | 92.0 | 60.9  | 31.0 | 20.5  |
| Gender                               | Male                 | 87.0  | 64.0 | 38.0 | 27.9  | 11.0 | 8.1   |
|                                      | Female               | 77.0  | 41.4 | 73.0 | 39.2  | 36.0 | 19.4  |
| Place of residence                   | Rural                | 30.0  | 50.0 | 20.0 | 33.3  | 10.0 | 16.7  |
|                                      | Urban                | 134.0 | 51.1 | 91.0 | 34.8  | 37.0 | 14.1  |
| Grade                                | 9 <sup>th</sup> std  | 55.0  | 90.2 | 5.0  | 8.2   | 1.0  | 1.6   |
|                                      | 10 <sup>th</sup> std | 59.0  | 67.1 | 15.0 | 17.0  | 14.0 | 15.9  |
|                                      | 11 <sup>th</sup> std | 23.0  | 26.7 | 49.0 | 57.0  | 14.0 | 16.3  |
|                                      | 12 <sup>th</sup> std | 27.0  | 31.0 | 42.0 | 48.3  | 18.0 | 20.7  |
| Type of family                       | Joint                | 87.0  | 50.6 | 63.0 | 36.6  | 22.0 | 12.8  |
|                                      | Nuclear              | 77.0  | 51.3 | 48.0 | 32.0  | 25.0 | 16.7  |
| Studying in Co-ed school in the past | Yes                  | 139   | 69.8 | 41.0 | 20.7  | 19.0 | 9.5   |
|                                      | No                   | 25.0  | 20.3 | 70.0 | 56.9  | 28.0 | 22.8  |

**Table 3: Frequency and percentage distribution of Attitude level concerning demographic variables (n=322)**

| Variables                            | Attitude level |       |              |      |       |     |
|--------------------------------------|----------------|-------|--------------|------|-------|-----|
|                                      | Favourable     |       | Unfavourable |      | Total |     |
|                                      | f              | %     | f            | %    | f     |     |
| Age (in years)                       | ≤16            | 107.0 | 62.6         | 64.0 | 37.4  | 171 |
|                                      | >16            | 89.0  | 59.0         | 62.0 | 41.0  | 151 |
| Gender                               | Male           | 92.0  | 67.7         | 44.0 | 32.3  | 136 |
|                                      | Female         | 104.0 | 56.0         | 82.0 | 44.0  | 186 |
| Place of residence                   | Rural          | 42.0  | 70.0         | 18.0 | 30.0  | 60  |
|                                      | Urban          | 154.0 | 59.0         | 108  | 41.0  | 262 |
| Grade                                | 9              | 39.0  | 64.0         | 22.0 | 36.0  | 61  |
|                                      | 10             | 60.0  | 68.2         | 28.0 | 31.8  | 88  |
|                                      | 11             | 41.0  | 47.6         | 45.0 | 52.4  | 86  |
|                                      | 12             | 56.0  | 64.4         | 31.0 | 35.6  | 87  |
| Type of family                       | Joint          | 94.0  | 54.7         | 78.0 | 45.3  | 172 |
|                                      | Nuclear        | 102.0 | 68.0         | 48.0 | 32.0  | 150 |
| Studying in Co-ed school in the past | Yes            | 136.0 | 68.3         | 63.0 | 31.7  | 199 |
|                                      | No             | 60.0  | 49.0         | 63.0 | 51.0  | 123 |

of correlation between adolescents' knowledge levels and their corresponding attitudes towards reproductive and sexual health matters.

## Discussion

The description of adolescents' knowledge and attitudes regarding SRH among the school-enrolled adolescents in Bhopal informs the need to strengthen SRH education and ARSH services in the region. The present study revealed inadequacies in the level of knowledge on SRH, a finding similar to that of studies on SRH in Jabalpur and Ujjain in MP (Baghel et al, 2019;

Nayak et al, 2016) and neighbouring Maharashtra (Deshmukh & Chaniana, 2020). However, a similar study in New Delhi reported a good knowledge level (Royal et al, 2018). Studies across India revealed that the knowledge level improved with age and progressed to higher grades. While boys showed a firmer grasp of the SRH knowledge in Maharashtra, studies in MP revealed the females had better knowledge (Deshmukh & Chaniana, 2020; Baghel et al, 2019; Nayak et al, 2016). Studies in Bihar and Uttar Pradesh found an association of knowledge with exposure to social media and higher socioeconomic status

(Saha et al, 2022), and the studies in MP showed no such association. The differences in knowledge levels and the factors associated with knowledge reported across studies in India should be interpreted in the context of the tools used and the research methodology, the prevailing socio-cultural practices, the methods of curriculum implementation in higher secondary schools, and the quality and adequacy of AFHS services in the region (Saha et al, 2022; Siddiqui et al, 2020; Igras et al, 2014).

In the present study, the positive weak correlation between knowledge and attitude substantiates the hypothesis that informed knowledge fosters a constructive attitude towards SRH. This interplay between knowledge and attitude emphasises the need for targeted educational interventions that enhance awareness, shape favourable attitudes, and empower informed decision-making. Tailored SRH education approaches (such as peer education programmes, incorporating sex education within the school curriculum, structured open conversations/discussions on reproduction, contraception, sexually transmitted diseases, and organisation of SRH camps/campaigns/awareness programmes) with the involvement of every stakeholder (adolescent, parent, teacher, counsellors/the health care providers and local administration), must be crafted to effectively bridge knowledge gaps and promote positive attitudes toward reproductive and sexual health among young adolescents (Kagesten & Reeuwijk 2021; Siddiqui et al, 2020). The vast majority reporting that they did not receive sex education sessions in school and most favouring incorporation of sex education in school curriculum implies that the adolescents are receptive to SRH knowledge in school premises. Rigorous training of healthcare providers and school teachers to address the unmet needs of adolescents and strengthening Adolescent Reproductive and Sexual Health (ARSH) services is pivotal to bridging the current gaps in adolescent knowledge and attitudes and healthcare services (Bali et al, 2020; Hoopes et al, 2016; Siddiqui et al, 2020).

### Limitations and Recommendations

The present study included adolescents from government co-ed schools, limiting the findings' generalizability to a broader population. A methodologically sound systematic inquiry with or without an intervention component comprising adolescents irrespective of enrolment in co-ed schools in Madhya Pradesh is recommended as it would offer a holistic understanding of SRH awareness in the region.

### Implications to nursing practice

The study revealed a lack of SRH education programmes in schools, though RKSK advises identifying one male and female teacher as the ambassador of SRH. The Community Health Officer in the community should be active in ensuring the role of teachers and initiating SRH education and their involvement in Adolescent Friendly Health Clinics in schools/communities. Capacity building of a few adolescents and ASHA focussing on must-know areas of SRH and engaging them in peer education/young adolescent awareness campaigns in the community may help reach out to the very young adults/school dropouts at the community level. Nursing personnel should motivate parents to discuss SRH issues with their adolescents with due respect to socio-cultural aspects and without undue pressures of family control. Health and wellness centres in central India and Bhopal district, in particular, should lead to the capacity building of adolescents, parents, and teachers on SRH knowledge and attitude.

### Conclusion

The study highlights inadequate SRH knowledge among adolescents and a disconnect between knowledge and attitude. The findings emphasise the need for comprehensive SRH education to build well-informed attitudes in shaping responsible adolescent behaviour. Concerted efforts can be directed towards improving the quality of SRH services and education, aiming to empower adolescents to make informed choices for their overall well-being.

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## नवयुवतियां और उनका प्रजनन स्वास्थ्य

प्रजनन स्वास्थ्य के बाबत जरूरी ज्ञान के अभाव में हमारे देश की बहुत सी नवयुवतियां गंभीर रोगों की चपेट में आ सकती हैं, कभी उनका जीवन खतरे में पड़ जाता है। एक अनुमान के अनुसार देश में बीस लाख नवयुवतियों को आधुनिक गर्भनिरोध प्रयोग में लाने की सख्त आवश्यकता है। इसके साथ ही, उन्हें गर्भ निरोधकों, गर्भ निरोधक विकल्पों, गर्भ गिराने, इनके लिए उचित परामर्श और जानकारी उपलब्ध करा दी जाए तो वे बेहतर जीवन बिताने में सक्षम होंगी। इस दौर में नवयुवतियों को व्यक्तिगत हाइजीन का खास खयाल रखना जरूरी होता है। इस दृष्टि से उन्हें यहां उल्लिखित उपाय अपनाने चाहिए।

प्राइवेट अंगों की साफ-सफाई पर ध्यान देना बहुत जरूरी है अन्यथा यौन संचारित संक्रमणों की आशंका रहेगी। भौगोलिक स्थिति (उष्णकटिबंधीय यानी ट्रॉपिकल जलवायु) को देखते हुए दो बार स्नान करें तथा जननांग व गुदा (एनल) क्षेत्र को गुनगुने पानी से साफ रखें, इससे हानिकारक बैक्टीरिया से बचाव रहेगा। प्राइवेट अंगों के गिर्द साबुन और सुगंधित उत्पादों से योनि को न धोना बेहतर होगा, इससे सूजन, जलन, खुजली आदि हो सकता है।

अंडरगार्मेंट्स ढीले होने चाहिए; पैटी टाइट न हो, आरामदायक और सूती हो जो नमी को भी सोख लेती है। नम अंडरवियर पहनने से फंगल संक्रमण हो सकता है। यौन क्रिया से पहले स्नान करें। यौन गतिविधियों के दौरान पुरुष कंडोम का और महिलाएं गर्भ निरोधकों का प्रयोग करें अन्यथा सिफलिस, गोनोरिया क्लैमाइडिया आदि जैसे यौन संक्रमणों का भय रहेगा। सेक्स टॉयज का इस्तेमाल करने वाले इन्हें दूसरों से साझा न करें। इसके अतिरिक्त अल्कोहल या नशीली दवाओं के प्रभाव में सेक्स न करें, एकाधिक व्यक्ति के साथ सेक्स संबंध आपके स्वास्थ्य को खतरे में डाल सकता है। स्त्री रोग विशेषज्ञ के परामर्श से सेक्स स्वास्थ्य की जांच करवाते रहें।