CHAPTER 2 REVIEW OF LITERATURE

SOURCE OF LITERATURE

RSH PROGRAMS

RSH AND YOUNG PEOPLE

RSH COMMUNICATION BETWEEN YOUNG PEOPLE AND ADULTS

DYNAMICS OF INTERACTION AND COMMUNICATION (BETWEEN MARRIED COUPLE)

RSH AND YOUNG MEN
CHAPTER II- REVIEW OF LITERATURE

For the purpose of this study, the available relevant literature was looked at from the period 1990 to 2011, i.e. a period of 21 years. But in relation to theories which were developed before 1990, the literature review has included those as part of historical and theoretical findings (1980 onwards).

The literature review has been done from the following sources:

1. Books
2. Journals
3. Census of India data 2001 (published data) and 2011 (provisional data)
4. NFHS I, II, III (National Family Health Survey) data.
5. Reports of various international and national NGOs like, WHO, UNICEF, UNDP, UNAIDS etc.
6. Reports of various government bodies like, Ministry of health and family welfare, NACO, government policies of various departments.
7. News papers

There is a lot of literature available on the topic of Reproductive and Sexual Health for young people. Abundant evidence on the presence of RSH related communication from adults to young people and between peers is also available. But there is meagre information on the reverse pattern of communication, i.e. the RSH related communication from young people to adults and its impact on the KAP of adults. There is negligible detail available on the contents or reverse communication.

Similarly there is enough documented evidence of the link between couple communication and contraceptive use or MMR and IMR. There is enough data supporting the fact that in rural India the age gap between wife and husband is higher (approx. 6 years) and this has negative effect on the wife’s autonomy to take decisions regarding RSH and other personal and family matters. But there is meagre information on the exact dynamics of communication between RSH educated young women with her
Husband and its impact on the various aspects of RSH. There is negligible study available to show the link between contraceptive method decision maker’s gender and its impact on the type of method chosen. In addition to this there isn’t enough data on gender based violence and the fact that the wife is RSH educated whereas the husband is not. There is abundant literature on the RSH program for men and how it affects their individual health and that of their wives and society. But there is no documented evidence regarding men’s attitude towards a RSH educated wife and whether there is any link between deciding the prospective bride or groom based on the RSH education status.

All the literature points towards providing RSH education to young people to improve RSH related indicators. The reasons cited for poor RSH indicators despite RSH education are ‘patriarchal society, age gap between couple, low educational status, poverty, poor RSH infrastructure and services etc. but very few studies have tried to look at the Module for RSH training as one factor. There are negligible studies which have critically analysed the components of the training modules to look for empowerment factors and training delivery mechanism as one of the factors for poor RSH indicator.

*For the purpose of organizing the current Literature Review, this chapter has been divided into 5 parts:*

1) RSH Programs
2) RSH and Young People
3) RSH COMMUNICATION BETWEEN YOUNG PEOPLE AND ADULTS.
4) DYNAMICS OF INTERACTION AND COMMUNICATION (BETWEEN MARRIED COUPLE)
5) RSH AND YOUNG MEN

This categorization is only for the purpose of organizing the literature review for presentation. This categorization does not imply that the mentioned literature in one category has no link with other categories. These categories are not water-tight-
compartments. Literature mentioned in one category may also have relation and implications related to other categories.

RSH PROGRAMS

Jim Burns (2010)\(^{11}\) talks in detail about teaching healthy sexuality to our children. The author says that despite innumerable studies suggesting that the best sex education happens at home from parents, very little is being done about implementing it. The author also says that a parent is the person who has the best interest of the child in mind when it comes to sexuality. The author suggests that while dealing with sexuality education, we must keep ‘age appropriate developmental issues’ in mind’. Sexuality education begins in childhood, and parents should raise confident kids who are aware of their body and not ashamed of it. Parents should also talk to their children about ‘good touch- bad touch’.

The Yellow Book of TARSHI\(^ {12}\) highlights and emphasizes the same that we should not assume that sexuality education is the responsibility of the school. Parents should be involved as much as possible in their children’s sexuality education. TARSHI reasserts the point made by Jim Burns that sexuality education begins in childhood, as toddlers and pre-schoolers are curious about their bodies and bodily functions. A study conducted in Mumbai, India by TRAC (Training, Research and Action Centre) and published in 2009, has tried to explore the opinion of teachers, parents and adolescents on the issue of RSH. The findings indicate that adolescents, who underwent an FLE program, had better knowledge and attitude towards RSH and showed more responsible behaviour. Most of the teachers (68%) and parents (71%), agreed that FLE is good for adolescents and must continue. Parents and teachers were of the opinion that it is the shared responsibility of both parents and teachers to impart this education. Most teachers felt that the biology teacher should deal with it and classes should be same gender.

\(^ {11}\) Teaching Your Children Healthy Sexuality. Author- Jim Burns. Publisher- Good Times Books Pvt. Ltd.
Bali Nagar New Delhi

\(^ {12}\) The Yellow Book- A parent’s guide to sexuality education. Author- TARSHI. Publisher- Zubaan
(Shahpur jat, New Delhi) and TARSHI (East of Kailash, New Delhi)
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Okobiah OS, 1981\textsuperscript{13}, compared the population education strategy and modules being used in USA and Thailand. The author wanted to compare the differences between population education in a developed country and a developing country. The findings indicated that the content of population education in Asian and American curriculum was more focused on population issues and on the causes and consequences of population growth. But the American curriculum laid more stress on environmental consequences and policies. Whereas the Asian material laid stress on family planning policy, effects of population growth on family, community, sociocultural and personal factors. The American methodology encouraged the students to be aware of population issues and analyse them with environmental consequences. Whereas the Asian methodology was making the teachers deliver the content in such a way which would lay more stress on population control, sexual behaviour altering to reduce population. Okobiah felt that the Asian model was a failure in the long run as it was not preparing the students to understand issues and make informed choices in adulthood. The curriculum and methodology being used in India is quite similar to the findings of Okobiah.

Parakh B S, 1982\textsuperscript{14}, has highlighted the development of RSH education in India from 1980s. The goal of the government was to reduce the population growth and family size of 4.2 children per couple to 2.3 children per couple. The 1\textsuperscript{st} National Seminar on Population Education (1969) suggested the induction of population content in school and college curriculum. National Council for Education Research and Training (NCERT) set up a Population Education cell in its department of Social Sciences and Humanities. The Population Education Cell developed education material for schools, colleges and teachers. Since these efforts were not reaching the local schools, regional workshops were organized in 1979. Many workshops and seminars were undertaken thereafter to ensure that students understand the issues around population and make rational decisions related to family size etc.


\textsuperscript{14} Parakh B S, population education in countries of the region 1982
At present the population education in India is like a headless creature, which is neither dead, nor alive.

Kannapiran C et al 1992\textsuperscript{15} have outlined various ways of imparting health education in India. The authors opine that India has one of the most extensive health education programs among developing countries but still our MMR and IMR are very high. The authors state that the most effective communication strategies are those which inculcate cultural attitude and behaviour of the community. But more often than not this is not considered while developing material. The authors’ mention that prints media is not as effective in communicating health messages as the visual media. Other way of communicating is folk media (puppet shows, drama, story-telling etc.). Health workers at health centres and traditional health practitioners also serve as potential sources of imparting health education.

The authors do mention that the greatest sources- religious leaders, traditional healers and dais have yet not been included in health promotion.

Singh S, 2003\textsuperscript{16}, also in a study has used a sample of 200 college female students and done a baseline survey with them to ascertain their knowledge, behaviour and motivation levels regarding AIDS. The group was then divided into 2 groups of 100 each- experiment group and control group. The experiment group underwent a 3 session intervention program to enhance their IMB. After the intervention, the result showed significant increase in the level of IMB related to HIV/ AIDS, as compared to the control group.

The findings of this study are helpful for the current research as this also verifies that the structured RSH program being administered to the young women, does have an improved level of Knowledge, Attitude and Practice related to RSH, as compared to those who did not attend any such training program.

\textsuperscript{15} Kannapiran C, Ganguly I, Shiva M, Sehgal M, Khanna P, Bhatia R Health Education Health Millions. 1992 Feb-Apr

\textsuperscript{16} Singh S, study of the effect of Information, Motivation and Behavioural Skills (IMB) intervention in changing AIDS risk behaviour in female university students. \textit{AIDS Care 2003}
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Daniel Wight et al 2002\textsuperscript{17} published a study in 2002. It was conducted in East Scotland with 25 schools (8430 pupils aged 13-15 yrs.). There was an INTERVENTION GROUP (teacher led sex education) and a CONTROL GROUP (existing sex education program a mix of teacher, older pupils, outside experts). The objective of the program was to see whether a theoretically based sex education program for adolescents, delivered by teachers reduced unsafe sexual intercourse compared with current practice. The findings suggested that there was no difference in outcome between both the groups. It is a widespread assumption that sex education delivered by teachers reduces sexual risk taking in young people. But most randomized trials do not show this to be true. The teacher led sex education definitely improves the quality of young people’s sexual relationships but they do not influence sexual behaviour.

Stephenson J M et al (RIPPLE Study team), 2004\textsuperscript{18}, divided 29 schools into Intervention schools (peer led) or Control school (Teacher-led). A total of 8000 pupils were studied under this study. The average age of the peer educators was 16-17 yrs. And they did 3 sessions of sex education in their own school with 13-14 yr. old students. The result showed lower level of unintended teen pregnancy in Intervention group as compared to the control group. This difference was borderline. Students were more satisfied in the peer-led group than in the teacher-led group. There was also preference towards single-sex sessions. The authors suggested that the role of single-sex sessions should be investigated further.

There are also many studies which point towards the important role that peers and peer educators play in RSH education programs. Phelps and Mellanby 1994, 1995\textsuperscript{19} opine

\textsuperscript{17} Daniel Wight, Gillian M Raab, Marion Henderson, Charles Abraham, Katie Buston, Graham Hart and Sue Scott, Limits of Teacher Delivered Sex Education: Interim Behavioural Outcomes From Randomized Trials, \textit{British Medical Journal} 2002


that peer educators can also act as effective role models, thereby facilitating positive changes in adolescent behaviour norms. While Senderowitz 2000 questions the sustainability of peer projects, but states they are important. Meekers et al 1997 believe that youth should be involved in program planning to make a positive approach of viewing young people as assets and not merely as embodiments of problems. Lewis, 2001, suggested that study how the broader cultural perspective of the community will greatly influence the feasibility of delivering an intervention within that community and will also affect how the recipients respond to it.

Hardene et al, 2001 and Lindsey did a comparison between peer led health education and adult led health education suggests that peer led education was at least as effective as adult led health education.
Parwej et al, Wolf et al. 2003 reported similar results in a study in Chandigarh India, among adolescent girls. But Erulkar et al. 2003 refer to a study in Ethiopia to say that

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among youth, peer education (20%) is more effective than youth centre based (12%) education in matters of reproductive health. Parwej et al, also found that the peer education delivery took 1/3 lesser time than conventional education. In addition to educating adolescents either in or out of school, there is also interest in educating parents about issues relating to adolescent sexuality, with the aim of improving their communication with young people and helping them act as educators/advisors. Haseen et al. 2004 too observe that involvement of community, parents and teachers is important in imparting RSH education. Some programmatic recommendations given by SIDA 2000-2003 include focus on work with adolescent boys and girls, strategy of working through peer educators. SIDA evaluation 2000-200).26

Since RSH education ultimately aims at improving behaviour, it becomes difficult to measure the impact of these programs. Analysis largely remains self-reported change in behaviour. Cowan, 200227 says that with complex behaviour intervention, which aims to change skills, attitudes, peer norms, behaviour, and the measures for determining impact need to reflect the aims of the intervention. In reality measuring changes in all these areas using scientifically robust outcome measures in well-designed studies is difficult to do. Therefore many studies determine impact of such intervention by measuring changes in knowledge and self-reported behaviour and intentions, rather than including externally valid measures such as STI rates or abortion statistics. Peterman et al. 2000 and Aral et al.199628.


27Cowan FM. Adolescent reproductive health interventions (An editorial published in STI 2002).

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This section broadly outlines the dimensions of RSH programs internationally and in India. The various target audiences referred to by different authors and studies range from adolescents to young people, from women to men, from families to communities, from schools to medical practitioners, from couple to mothers in law and so on. There is no discrepancy in the understanding across all authors and studies that RSH education improves life skills of people and adolescents. RSH education is a shared responsibility between the various pillars of society, like teachers, schools, medical practitioners, parents, community, NGOs and religious leaders. Most studies advocate age and development stage appropriate RSH education.

RSH and YOUNG PEOPLE

Clark 2004\(^{29}\) observes that married adolescent and young women have received little attention as a vulnerable group with distinct needs because marriage is assumed to be safe. But this group needs attention, as the trend of adolescent girl’s marriage is here to stay in south Asia over the next decade UNICEF 2005, IIPS and Macro 2000\(^{30}\). 15% of births to adolescent married girls in India were unplanned Pachauri et al. 2003\(^{31}\) and unmet need for contraception tends to be higher among adolescents (27%) than older women (19%) Santhya et al 2003\(^{32}\). The reasons for this unmet need range from lack of awareness to limited communication and negotiation skills among married young


women. Santhya et al 2003; Pachauri et al 2003, Ram et al. 2006, discuss two models for married adolescents where the existing PHC services are used and health workers visit the young married couples and guide them in contraception. But the evaluation of both the models is pending to ascertain affectivity and replication. Speizer et al. 2003 opine that there is more stress on school based awareness than community based, and that interventions have generally been more successful in influencing knowledge and attitudes than changing behaviour. Aggleton et al 2005 believe that the content of the training module is also a limiting factor in the efficacy of the intervention. Sharma et al. 1993 state that there is a significant KAP-Gap among women in rural south Rajasthan due to low status of women in rural areas of south Rajasthan.

A study by Chandick et al.2003 says that contraception use in rural India is mainly with the consent of the husband and the overall contraception prevalence rate is 37 – 48% NFHS-2, 1998-99, India, Balaiah et al. 1999, Kumar et al. 1999. There have been


37 Chandhick N, Dhillon BS, Kambo I, Saxena NC. Contraceptive knowledge, practices and utilization of services in the rural areas of India (an ICMR task force study) Indian journal of medical science 2003; 57:303-10.

numerous efforts to improve the RSH related KAP among women in rural India, where efforts through Mahila Samakhya are applaud able. Projects involving Mahila Samooha or Mahila Sangha in states like UP, Gujarat, Karnataka and AP have been very successful in achieving the above said aim. This was mainly done through Sahyoginis (helpers in RSH related matters) and peer discussions among women. (Mahila Samakhya 2004)

*Chandhick et al. 2003* report that the major suppliers of contraceptives among women in rural India are hospital (42.1%) closely followed by PHC (31.5%).

The outcome of this discussion summarizes the following:

- Adolescents are at great risk if RSH needs are not addressed in an appropriate manner.
- The RSH related indicators are worse off in rural areas than urban areas.
- The husband and mother in law play a very crucial role in deciding the contraception needs and usage of women.
- Young married adolescent girls are more likely to not get appropriate services.
- Communication between the couple is a major deciding factor for leading a healthy life, protection from all types of gender based violence, access and utilization of RSH services.
- The content of RSH module also plays important role in the improvement of RSH indicators.

RSH COMMUNICATION BETWEEN YOUNG PEOPLE AND ADULTS.

*Shanmugam A V 1981* has highlighted the gist of health communication. Health communication effectiveness can be judged by 3 parameters:

1) **Physical reception of message by intended audience.**
2) **Interpretation or understanding of the message by the audience in accordance with the intention of communicator.**
3) **Effectiveness of the communication on the cognitive, affective and behavioural dimensions of the audience.**

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The author has done a study of the SITE (Satellite Instructional Television Experiment) program intended for rural audience in India.

*Scott Spear et al, 2007*, have discussed the issue of confidentiality of RSH care for adolescents. Dealing with the issue of confidentiality relating to RSH for adolescents is not easy for, policy makers, parents, caregivers and institutions. They have discussed the pros and cons of situation where *PI (Parental Involvement)* laws are mandatory, i.e. parental consent for adolescents undergoing abortion or using contraception. The authors have referred to many studies which point at decline in adolescents taking services where PI laws are mandatory. In these cases there is a rise in teen pregnancy, rise in STD, HIV, and reproductive tract infections.

As we deal with two different scenarios in RSH in India, this paper puts light on some crucial issues of confidentiality with adolescents. The situation in urban India is very different from that in rural India. In urban India adolescent are getting sexually active at an early age, there is a rise in STD, HIV/ AIDS and there is rise in teen-pregnancy. Whereas in rural India, though these problems exist, but due to early and child marriages, there is no problem of parental involvement and confidentiality issues. A teen pregnancy within marriage is justified and has parental sanction. But a teen pregnancy out of wedlock does not have parental or societal sanction. Parental Involvement (PI) laws are very much active in India and adolescents need parental consent and presence to undergo services like abortion or contraception.

*Contraception Journal Editorial 2007*- The editorial in this issue of Contraception focused on the issue of communication between parents, care providers and adolescents. This editorial had reference to many authors work on this issue.

Many findings indicate that youth delay sexual activity and use contraception if the channel of communication is open and healthy between them and parents. *Hacker KA*,

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*Scott Spear, Abigail English , Protecting confidentiality to safeguard adolescent’s health, Contraception Journal, 2007, August*

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*Amare Y, Strunk N, Horst L.*\(^{42}\) in their paper titled “Listening to youth: teen perspectives on pregnancy prevention” (*Journal of Adolescent Health 2000*), state the following: “Teens want to turn to parents, teachers and health care providers for clear, concise contraception and reproductive health advice”. At the same time teens are also very selective about who to confide in about sexuality.

*Sulak PJ et al 2005 and Miller BC et al 2001*\(^{43}\) say that the family doctor should start educating parents of teens about sexuality, unintended pregnancy prevention and STD in the regular health visits. Trusted family doctors and caregivers could be the missing link in life long sex-education that starts from home. Clinicians are in a better position to provide unbiased and correct information. This will empower parents with the correct knowledge to give to their children. Teens around the world respond positively to messages about sex from parents. If doctors educate parents, teens are more likely to get medically accurate messages on sex from home.

*Kirby D, 2001 and TrenholmC et al 2007*\(^{44}\) state that since youth spends most of its active time in educational institutions, the institutions should take the responsibility of educating them about socially responsible behaviour. But more and more schools are choosing not to do so. Despite evidence that teaching abstinence with effective contraception techniques is proven to be good for delaying sex and using safe sex methods. It postpones sex among virgins and increases contraception usage among sexually active teens.

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\(^{44}\) Kirby D, No easy answers: research findings on programs to reduce teen pregnancy- summary. 2001AND TrenholmC, Devaney B, Fortson K, Quay L, Wheeler J, Clark M. Abstinence education program. 2007
Editorial- Contraception Journal 2004\textsuperscript{45} says that many states and schools are propagating “abstinence till marriage”. They don’t want to discuss about safe sex practices and contraception but want to discourage sex till marriage. What this approach does is that it does not take into consideration that if somebody is not married by age of 25 yr., does not mean that person does not have the maturity to handle the consequences, but that person will not be able to protect him/ herself with lack of knowledge. Secondly, this approach classifies sex into two categories- ‘good sex within marriage’ and ‘bad sex outside marriage’. This gives complete approval to anything that happens in the name of bad sexual practices within marriage, as acceptable.

In case of India where there is a high rate of child marriage, children get sexually active as soon as they hit puberty (girls-11 to 13 yr.) and boys-13-15 yr.). Marriage gives them the social sanction to be sexually active but this sanction does not in any way protect them from early and unwanted pregnancies, STD, HIV/ AIDS, Reproductive tract infections and so on and so forth. We need to prepare our young people to face life with full knowledge.

Kevin C Davis et al 2010\textsuperscript{46} state that prior research supports the notion that parents have the ability to influence their children’s sexual life related decisions. But these parent-based approaches have not been explored.

In order to understand the impact of parental communication on sexual behaviour of children, the researchers in this study conducted in the USA studied a group 1969 parents (1125 mothers, 844 fathers) of 10-14 yr. olds. The study was conducted using randomized efficacy trial. The group was divided into ‘Experiment group’ and ‘Control group’. Experiment group was given a structured sexual education input to be used on their children whereas the control group was not given any such input.

The result suggested that there was desired result in terms of sexual behaviour among children of parents in experiment group, especially those of mothers. The fathers in both the groups showed no difference.

\textsuperscript{45} Editorial- Contraception Journal 2004, Faulty assumptions, harmful consequences: coming to terms with adolescent sexuality.

\textsuperscript{46} Kevin C Davis, Jonathan L Blitstein, W Douglas Evans and Kian Kamyab, Impact of parent-child sexual communication campaign: from a controlled efficacy trial of parents. Journal of Reproductive Health 2010
There is a need to determine what other factors affect children’s sexual behaviour, like parent-child relationship, individual socio-demographic characteristics and other variables and the variation by parent gender. There is little evidence to show how parent-based communication programs translate into changes in outcomes among children of parents who receive these messages. Self-report from children can give idea about this.

*Asha Banu Soletti et al 2009* undertook a family based HIV prevention program for adolescents in the tribal rural area of Maharashtra. Since very little evidence is available on the success and feasibility of such interventions, the study was carried out to observe and report findings.

The findings suggested that if families were given accurate, culturally appropriate knowledge, it did have positive effect on the adolescent behaviour in relation to HIV prevention. The barriers to participation had to be concurred.

In many families the adolescents too had knowledge of HIV, but there is no documentation on whether it has a reverse effect of communicating from adolescents to adult family members.

There are studies which have documented that parent to child sexual health communication exists and a few studies have also studied the extent of impact on child sexual behavior. It re-affirms the finding that parents healthy communication with children, improve their overall responsible behaviour, delays sexual debut and keeps the channel of communication open. But there are no documented studies to reveal the reverse communication, i.e. child to parent communication regarding sexual health and its impact on parent/adult KAP. It may sound a little odd to most of us because we all have been brought up in a society where sexuality and issues related to it are taboo. Usually Parents educated children on these issues when needed but children don’t and are not supposed to educated parents on issues related to reproductive health and sexuality.

But there is a prominent situation where the children are getting RSH education from

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other sources too like school, NGOs; media etc. there is no documentation of the result of this on the communication pattern between parent and child. The available literature is lacking in these kinds of studies.

**DYNAMICS OF INTERACTION AND COMMUNICATION**
**(BETWEEN MARRIED COUPLE)**


**Main Findings**

Nearly half—45%—of young women in India marry (begin cohabiting with their husband) before age 18, the legal age at marriage for women. A majority, 63%, marry before age 20. Few women (12%) marry before age 18 in Goa and Himachal Pradesh, while nearly three-fifths (57–61%) do so in Rajasthan, Jharkhand and Bihar. Differences by area of residence are also stark: 28% in urban areas vs. 53% in rural areas.

**The timing of first births:** The proportion giving birth before age 18 declined by six percentage points during the same period (from 28% to 22%), and the proportion giving birth before age 20 fell by seven points (from 49% to 42%). Contraceptive use remains very low: Just 7% of married 15–19-year-old women use a modern method, and 6%, a traditional method. Current use of modern methods ranges from a high of 18% in Delhi to a low of 2% in Bihar. Forty-three per cent of married 15–19-year-old women have an unmet need for modern contraception. Unplanned childbearing among adolescents is not uncommon: 14% of all adolescents’ recent births were unplanned in 2006. Adolescent-specific reproductive health services continue to be scarce and inadequate, and targeted toward married adolescents. However, the government’s recent enactment of policies to address the information and service needs of adolescents is encouraging.

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Programs to keep girls in school hold promise for decreasing early marriages; since childbearing outside marriage is rare, delays in marriage will go a long way toward reducing adolescent childbearing.

_Guttmacher Institute_

**Key Findings of the study**

In India, the persistence of early marriage reinforces women’s low status and social isolation, leading to end their education for household responsibilities. Early marriage reduces women’s employment prospects as well. It leads directly to childbearing, under pressure exerted by mothers’ in-law through their sons, for a young bride to have a baby relatively quickly.

Marriage offers little protection to adolescent women who lack the power to decide on sex and contraceptive use with older partners (husbands are six years older than brides on average and age differences are significantly greater for child brides). Marriage also puts adolescents at greater risk of unwanted pregnancies and sexually transmitted infections (STIs).

According to prevailing practices in many areas (especially in poorer, more traditional states) where child marriages are a mark of prestige, girls are promised in marriage yet may not live with their husbands until they have reached puberty and the marriage is consecrated through the ceremony of _gauna_ (*ceremony marking the girl leaving her maternal home to live with husband in marital home*). These young girls have no say in when to marry, whom to marry and when to do _gauna_. The notion of pre-marital sex is a rarity in rural India.

The trend of _early childbearing_ is also quite overwhelming. As of 2006, 8% of all Indian women (20-24 yr.) became mothers before age 16 yr. Most adolescent mothers are less likely to receive a professional institutional care while child birth and pregnancy.

The scenario for _contraceptive use_ is equally dismal. In 2006, only 7% of married 15-19 yr. olds used any modern contraceptive method. Women living in urban areas are more
likely to use modern contraception than their rural counterparts. As compared to Bangladesh, Sri Lanka, married adolescent girls in India are less likely to use modern contraception. West Bengal has the highest use of modern contraception among married adolescent women.

According to a small-scale study, two-third of young married Indian women want to postpone their first pregnancy, but only one quarter has ever used any contraception. The reasons are, - lack of autonomy and access to services among adolescents. Young wives are forced to bear a child soon after marriage, to cement the marriage. Though female sterilization age limit in India is 22 yr., still many (1%) of adolescents in India opt for female sterilization.

Due to the stigma attached to pre-marital sex and unwed pregnancies, adolescents in this situation opt for unsafe abortions, even though abortion is legal in our country irrespective of marital status.

**Unmet need for modern contraception** is high among adolescents in India. More than 4 out of 10 adolescents have an unmet need. Unmet need is when an individual does not want a pregnancy but does not use a modern contraception to stop that pregnancy. Unmet need has reduced over the last decade though.

*Anu Manchikanti Gomez et al 2008*, studied the “Age Differences at Sexual Debut and Subsequent Reproductive Health: Is There a Link?” The study area for this topic was in Port Au Prince Haiti. They tried to study whether there was any link between age difference at sexual debut, use of contraception at last intercourse and the risk of HIV and related STI.

The findings revealed that age differences were not linked to recent STI diagnosis. But there was a link between age difference and contraception use. Women whose sexual partners were 9-10 years older to them were less likely to use contraception than those whose partners were 5 yrs. or less old than them.

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The findings suggest that due to the man being much older than the woman, the young woman is socially and financially dependent on older man for survival. This leads to less negotiation, less condom use and more sexual coercion. This leaves her with little power to negotiate safe violence.

Thus the authors conclude that programs focusing on delaying sexual debut should also consider age and gender based power differentials between younger women and older men. They also suggest that future research should be carried out to ascertain the exact effect of cross-generational sexual relation on the reproductive health of young women.

Sunday E Adaji et al 2010, report a cross-sectional study conducted in Kenya in 2002, to examine the attitude of Kenyan in-school adolescents towards premarital sex, unwanted pregnancies/ abortions and contraception. The research design was descriptive research, using structured questionnaires.

Sample size was 1159 students in age group of 13-19 yrs.

The findings suggested that Kenyan adolescents had conservative attitude towards premarital sex, teen pregnancies and contraception. But the findings about the basic health indicator did not match the conservative outlook. The rate of teen pregnancy was high, HIV, STD infections were high and contraceptive usage was low. There was gender differential in RSH related attitude. Boys did not want to use condoms despite its knowledge. Whereas girls did not negotiate the right to safe sex due to societal norms.

The RSH related indicators are quite similar between India and Kenya. Thus the present study could use the findings for comparison. Especially the findings related to the gender differentials. The age difference and its impact on sexual behaviour negotiations have been studied, but the link between age difference and use and type of contraception needs to be explored.

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**Harrison a et al 1997**\(^{51}\) conducted an *Ethnographic research* using Qualitative research in South Africa. The respondents were 7 men and 8 women who underwent a series of 15 open ended interviews.

The objective of the study was to explore the pattern of communication among partners and the predominant pattern of sexual networking.

The findings showed clear gender variation in the patterns of sexual networking, where men were more likely to discuss multiple partners. Both sexes expressed anxiety to declare their STD to the partner, but women were anxious due to fear whereas men were anxious due to embarrassment.

The study suggested that stronger health promotion messages will be able to facilitate communication among partners. The authors felt that the pattern of communication studied in this study has major implications for the STD epidemic.

There is a problem and gap in communication between sexual partners in India too. The result of this communication gap is sexual coercion, spread of STD, HIV. There is a need to do a study to understand the dynamics of this communication so that an intervention strategy could be suggested.

**Joyce Wamoyl et al 2010**\(^{52}\), in their study have tried to decipher the motivation and culture behind transactional sex and its consequences in a group of young women in Tanzania. The findings show that though women decide their motivation to have transaction sex, they do not have control over negotiating condom use or safer sex options. This puts them in danger of contracting HIV infection too.

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\(^{52}\)Joyce Wamoyl, Daniel Wight, Mary Plummer, Gerry Hilary Mshana and David Ross, Transactional Sex amongst young people in rural northern Tanzania: ethnography of young women’s motivations and negotiations. *Reproductive Health Journal 2010.*
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Link to the present study - the current study is providing a similar analysis in different settings. Though compared to Indian rural scenario, the situation is different for Tanzania and India, but the bargaining power of women in a sexual relation remain low in both the cultures. Young women in India are not able to negotiate their rights within sexual relations and suffer from unintended pregnancies, forced sexual relations etc. similarly women in transactional sexual relations though women could use their sexuality to gain economic favours, but their ability to negotiate safe sex and condom usage remained low, like in India.

Chukwunenye I Okereke, 2010\(^{53}\) conducted a study with adolescents in Owerri region in Nigeria. Contraceptive usage among adolescents was very low due to various reasons like, condom considered as taboo among adolescents, pre-marital sex is taboo, gender-inequality leading to lesser autonomy to women to decide on protection. Many adolescents have got STIs, pregnancies and abortions.

Women’s autonomy and her RSH status is one area which many researchers have explored. Dev R Acharya et al 2006\(^{54}\). The authors in this study have tried to explore the links between women’s household position and their autonomy in decision making. They used the data from the NDHS (Nepal Demographic Health Survey) 2006. A total of 8257 women in the age group of 15-49 yr. were studied under this. It looked at decision making at home and derived the level of autonomy shared by women in household. The finding suggested that women’s autonomy in decision making is positively associated with their age, employment and number of living children. Women from rural areas have

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less autonomy in decision making. Women’s increased education is positively associated with her own health care decision making.

**Link to the present study**- women’s autonomy is directly linked to her sexual health and the findings of this study from Nepal are very similar to the situation in the current study. In this study too, women from rural area show lesser autonomy. Women, who are more educated, do take care of their own health.

A similar study conducted in Pakistan by *Shabana Saleem and Martin Bobak, 2005*\(^5\), analysed the data from Pakistan Reproductive Health and Family Planning Survey 2000. This is the data for 6579 ever married women in the age group of 15-49 yr. the contraceptive use was low in Pakistan (20%) at the time of publishing this study.

It is a well-documented fact that women’s education affects their autonomy. The findings of this analysis say that contraceptive use was strongly associated with women’s education but this relation was not mediated by women’s autonomy. The authors say that women’s decision autonomy is significantly associated with contraceptive use but it does not appear to mediate the link between woman’s education and contraception.

The scenario in other parts of South Asia is that women have a considerably lower social status and autonomy than men which is associated with lower fertility control. In Bangladesh, women’s autonomy played a major role in acting as the link between education and contraceptive usage. *Cleland J, Kamal N, Sloggett A, Sage 1996*\(^6\). In

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\(^6\) Cleland J, Kamal N, Sloggett A: **Links between fertility regulation and the schooling and autonomy of women in Bangladesh.** In *Girls schooling, autonomy and fertility change in South Asia.* Edited by: Jeffrey R and Basu A. New Delhi, Sage; 1996.
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India the data found that autonomy did not mediate the link between education and contraception, similar to Pakistan. *(Moursund A, Kravdal O, Population studies 2003)*

*Lisa M Williamson et al 2009* published this paper which has the data from 7 countries (6 Sub Saharan and 1 South East Asia). The respondent age was 13-19 yrs.

The study tried to analyse the low use of modern contraception in developing countries and the reason for the same.

A crucial finding from the study was that young women felt they were not given any knowledge about sex and contraception by the parents, health services or elsewhere. Any education they had was only reinforcing the existing myths. These women had inaccurate perceptions and knowledge on RSH related issues.

One very important finding was “*partner pressure*” most of the partners were reported to manipulate, force, threaten and use violence to get young women not to use contraception. This was particularly the case with condoms.

Due to low social acceptance of the contraceptive needs of unmarried adolescents, young women were more likely to use traditional methods of contraception which were less effective, leading to unsafe abortions as abortions for unmarried teens is also not approved socially.

*K G Santhya, 2004 and IIPS and ORC Macro 2000* report that 84% of modern contraceptive use in India is sterilization. *Pachauri and Santhya, 2002* state that

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58 Lisa M Williamson, Alison Parkes, Daniel Wight, Mark Petticrew and Graham J Hart, limits to modern contraceptive use among young women in developing countries: a systematic review of qualitative research. *Reproductive Health Journal 2009*


STERILIZATION was the most common method used among married adolescents. India is the only country in Asia where adolescents use sterilisation as contraception. OCPs, Condoms and IUD are used only by 14%. Only 1 in 10 married couple was using male based method like, condom, male sterilization or withdrawal.

Santhya also states that younger women (15-24yr) were more likely to discontinue contraception compared to older ones. The tendency to discontinue is more apparent in rural areas. According to NFHS 2 data, younger women (15-24yr) were likely to have an unmet need for contraception.

Santhya has outlined various barriers to meeting contraceptive needs, like:

Contextual and structural factors (illiteracy, poor access to resources, poverty, gender and non-gender based disparities), like:

1. Limited knowledge
2. Gender inequalities and limited male involvement
3. Limited informed choice
4. Limited access and availability of services
5. Poor quality of services

K Krishnakumari (2001)\textsuperscript{61} cites contraception as one of the ways for improving maternal health. She says that contraception improves maternal health by:

1. Reducing the number of pregnancies
2. Reducing the likelihood of complications during pregnancy
3. Improving outcomes of pregnant women with complications.

N Ravichandran (2002)\textsuperscript{62}, describes how there is a high prevalence of abortions in India and that too unsafe abortions leading to high MMR and Maternal morbidity. The author says that even though the contraceptive prevalence rate has increased, the rate of abortion


\textsuperscript{62}N.Ravichandran, Population, Reproductive Health and Development (Edition = 2002). Pp 104-06; 118-20
is still very high. This is due to unplanned pregnancies. The author advocates for improvement in resource and services.

Alka Barua and Kathleen Kurz (2008)\textsuperscript{63}, talk about the reproductive health seeking by married adolescent girls. They say that in India 40% girls get married before they complete 18 yr. Barnett 1998, Dyson and Moore 1983\textsuperscript{64}, add that when these adolescent girls leave their house to live with husband’s family, they are in a subordinate role, under the pressure to give birth to children. Jejeebhoy 1998\textsuperscript{65} adds that early marriage and child bearing bring new health problems especially related to reproductive health. This fact cannot be attributed only to lack of services.

Dyson and Moore 1983, Santow 1995\textsuperscript{66}, have highlighted the dominant and sometimes determining role of mother-in-law in the reproductive behaviour of young couple. Prakash, Swain and Negi 1994\textsuperscript{67}, state a study in Uttar Pradesh, India, on a sample of 100 young women, 56% young women deferred the decision regarding their health to mother-in-law. 15% deferred it to their husbands.

Alka and Kathleen further recommend that if husbands, mothers-in-law and girls agreed upon the importance of health needs, it would be addressed quickly. At times husbands agree but want the wife to seek the service on her own, which becomes an impediment.


\textsuperscript{64}Barnett B 1998. “Family planning uses often a family decision”. Network 18(4) AND Dyson T and M Moore 1983, “on kinship structure, female autonomy And demographic behaviour in India” population and development Review.


\textsuperscript{66}Dyson T and M Moore 1983, “on kinship structure, female autonomy And demographic behaviour in India” Population and development Review.

Mothers-in-law need to be included in any program planning as one of the target audience.

Shiva Raju (1987) in his study in Andhra Pradesh concluded that, inter-spousal communication on family planning was greater among users of FP than among non-users. Sujatha Murthy, 1993⁶⁸, says that husband-wife communication is one of the significant factors which influence the fertility behaviour of couple.

A common thread which might connect the above discussions is Gender Based Violence (GBV).

USAID(WID)⁶⁹ elaborates on this connecting thread, GBV results in physical, sexual and psychological harm to both men and women and includes any form of violence or abuse that targets men or women on the basis of their sex, although women and girls are usually the prime victims.

On the issue of GBV and gender inequality, USAID says that unequal power relation between men and women lead to GBV. GBV is often intended at maintaining gender inequalities and reinforce traditional gender roles for both the sexes.

USAID (WID) further elaborates on the various forms of GBV:

- Battering
- Marital Rape
- Sexual violence
- Dowry-related violence
- Female infanticide
- Honour crimes
- Early marriage
- Female genital cutting
- Sexual harassment at work place and educational institution


⁶⁹USAID, 2009. Fact Sheet on Youth Reproductive Health Policy- Gender Based Violence. Website: www.healthpolicyinitiative.com
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- Commercial sexual exploitation
- Trafficking of girls and women
- Violence against domestic workers


Journal of Adolescent Health, special issue focusing on sexual violence, various authors \((JAH 2005)\)^\(^7\), and this edition has several articles that focus on factors associated with rape and coercive sex, including sexually transmitted infections, other forms of violence, early menarche, and psychosocial problems.

Multi-Country Study on Women’s Health and Domestic Violence against Women \((WHO, 2005)\)^\(^7\). It included interviews with 24,000 women in 15 sites in 11 countries (Bangladesh, Brazil, Ethiopia, Japan, Montenegro, Namibia, Peru, Samoa, Serbia, Tanzania, and Thailand). Findings report the prevalence of intimate partner violence and its association with women’s physical and mental health. The data cover non-partner violence, sexual abuse during childhood, forced first sexual experience, women’s responses to violence, and incidence of violence by age group.

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*Profiling Domestic Violence: A Multi-Country Study (Kishor and Johnson, 2004)*

This report looks at data from nine countries: Cambodia, Colombia, Dominican Republic, Egypt, Haiti, India, Nicaragua, Peru, and Zambia.

A lot of studies have documented that there is a lack of communication on RSH between husband and wife, due to which the couple especially woman suffers. There is also evidence on the link between women’s education and her autonomy. There is documentation on plight of adolescent wives and partner-pressure. But there is meagre documentation on the link between RSH education status of young adolescent girls and their RSH status within marriage. The exact process of communication and negotiation with husband and how the RSH education helps in negotiating RSH rights, needs to be explored.

**RSH AND YOUNG MEN**

“*Men are frequently described as forgotten reproductive health clients, particularly in family planning services and perinatal care*” *(John M et al)*

*Wegner MN et al 1998* stated that over the years, RSH has become synonymous with women. All the programs and interventions target women, whereas it is a well-established fact that men play the most crucial part in the reproductive and sexual lives of women. In addition to that men themselves need RSH education and intervention services to improve their own lives. But ironically their participation ends at the door of RSH services. Program managers and policymakers in many countries have routinely assumed

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that men are not interested in family planning or contraceptive use, even though recent research studies state otherwise. Research also indicates that many women want men to become more involved in reproductive health decision-making and activities. Pachauri S, 2001 stated that involving men actively in RSH will improve the overall indicators for RSH. The following papers and studies highlight researches and publication done in the field of male reproductive and sexual health.

Martine Collumbien et al 1999, reported in a DFID and British Council funded research to conduct a comprehensive study of male sexual health problem in the state of Orissa in eastern India.

The findings of the study suggested that men had a wide range of culturally constructed beliefs or myths around RSH. Awareness about HIV was spreading fast, 90% urban and 50% rural men were aware of HIV.

Men expressed strong need and desire for male sexual health services in the form of well-informed, client centred counselling.

Heise et al, 1994 opine that domestic and sexual violence is a problem of public health significance worldwide. The link of intimate partner violence with women’s reproductive health as well as the impact on child survival and health has been documented (Heise, 1994; Jejeebhoy, 1998; Maman et al., 2000; Moore, 1999). An ecological model of factors associated with partner abuse has been proposed by Heise et al, 1999. This

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framework includes factors at the individual level (of the perpetrator), the level of family and relationship, the community and societal level, and emphasizes that no single factor alone causes violence. *Ravi K Verma et al*\(^7\) refer to studies in South Asia that reveal that men beat their wives for variety of cultural reasons situated in the gender norms about male superiority, economic issues etc.

*Bloom SS et al 2000*\(^8\), say that women in North India are dependent on their husbands for their reproductive care and decisions, therefore the knowledge, attitude and behaviour of men has a direct impact on women’s RSH health and that of the couple. This study has explored the RSH KAP of men and found that very few men had basic knowledge on fertility, maternal health and STDs.

*Ravi K Verma et al 2006*, report the findings from a pilot intervention in 2005-6 to promote gender equity among young men from low income communities in Mumbai, India. The project was based on Brazilian model and named *Yaari-Dosti to make GEM (gender equitable men)* and included 31 young men from slums in Mumbai (18-29 yr.). Six months intervention resulted in positive change in attitudes towards gender and sexuality, behaviour in relationships. The results showed significant decrease in support for inequitable gender norms and sexual harassment of girls and women. The pilot had succeeded in engaging men to critically discuss gender dynamics and health risk leading to shift in gender-related attitudes.

\(^7\)Ravi K Verma, Julie Pulerwitz, Vaishali Mahendra, Sujata Khandekar, Gary Barker, P Fulpagare and SK Singh. Challenging and changing gender attitudes among young men in Mumbai, India. *Reproductive Health Matters, 2006*

\(^8\)Bloom SS, Tsui AO, Plotkin M and Bassett S, What husbands in Northern India know about reproductive health: correlates of knowledge about pregnancy and maternal and sexual health. *Journal of Biosocial Science, 2000*
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Isaiah Ndong et al 1999\(^8\) designed a model for men’s reproductive health care. The model is a very comprehensive and detailed model which specifies the family based care, institution based care and educational care. It deals with the issue in a holistic manner, taking care of emotional, social, psychological and physiological aspects of RSH for men. It also deals with sexual abuse, domestic violence, substance abuse, mental health, sexuality, fertility, male role definition, interpersonal communication in addition to medical services.

Kenyan and Pakistani experts stated on the model that it should be implemented through established female-oriented programs for sustainability issues.

*Four basic needs for men’s programs were highlighted as;*

1) Need to provide information to men  
2) Need to train providers to communicate with men and address their concerns  
3) Need to create linkages to other services, both in community and at clinic  
4) Need to use existing facilities and providers

The success requires committed and compassionate service provider working closely with community based organizations.

A study from Orissa and Bangladesh reveal that men want the services to address more of psychosocial disorders rather that only STI. (*Collumbien M et al, 2000*)

WHO/PAHO 2001 designed a programme for male involvement in reproductive health. The report is based on the findings of various studies and data. The report reasserted the need for *increasing male sensitization, involvement, response and services*. It urged for more *advocacy programs* for male involvement. One interesting suggestion was the **Targeting of adolescent males**. The report also mentioned that for complete outreach, the government needs to collaborate with local organizations, communities, private sector, traditional healers and NGOs.

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\(^8\)Isaiah Ndong, Robert M Becker, Jeanne M Haws and Mary Nell Wegner, Men’s reproductive health: Defining, designing and delivering services. *International Family Planning Perspectives, 1999*
WHO/ PAHO 2001 also elaborate the influence of men in the reproductive decisions of women and the couple. The report suggests that by well-designed interventions to target men, they can be used to play a constructive and important role in the reproductive lives of the couple and women. As has been seen in many studies and findings, when men are involved, women tend to continue family planning methods.

Ravi K Verma 1997 has also focussed on the same issues as highlighted by WHO/ PAHO recommendations. The author puts light on the most intriguing fact - INTER-SPOUSAL COMMUNICATION. He says that family planning discussion between couple is not an indication of the quality of Inter-spousal communication. He says that if a wife gets sterilization done on her own without husband’s knowledge, then it reflects badly on the communication between the couple.

Ravi K Verma also asserts that there is a dearth of literature on men’s perceived notion about women, which to a great extent is related to the socialization process, and this needs to be examined.

Narayana 1996 reported in a study conducted in Uttar Pradesh that about 2/3rd men reportedly mistreat their wives by shouting, hitting, yelling and slapping. This study also examined men’s attitude towards women and found that men always expected their wife to respect them and verbal and physical violence is justified if the wife does not obey.

Pandian 1996 said it was necessary to examine the socio cultural and demographic factors which influence intentions to practice certain sexual behaviour, because it is

\[82\text{WHO/ PAHO, report of the meeting of WHO Regional Advisors in Reproductive Health. WHO/ PAHO, Washington DC, USA. September 2001 “Programming for Male Involvement In Reproductive Health”}

\[83\text{Ravi K Verma, Julie Pulerwitz, Vaishali Mahendra, Sujata Khandekar, Gary Barker, P Fulpagare and SK Singh. Challenging and changing gender attitudes among young men in Mumbai, India. Reproductive Health Matters, 2006}

\[84\text{Narayana G, 1996. Family violence, sex and Reproductive Health Behaviour among Men in Uttar Pradesh, India.}

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behavioural and social factors, which are generally more modifiable than biological factors.

Various studies have been conducted, reported and documented regarding men and RSH. All the studies including the resolution of ICPD have unanimously suggested that men must be as much a part of the RSH intervention programs at all levels as women. Whether it is awareness generation, education or products and services, men are the forgotten gender. We all see that very less is being done with this group and for this group. There is a lot of evidence to show that men do support RSH education programmes. But there are also instances where the RSH educated girls have hidden their RSH education status from their husbands and in-laws for the fear of rejection. This brings us to another glaring question: “Does the RSH education status of the prospective bride or groom affect the final marriage decision?” This aspect too hasn’t been explored in detail. Thus we can conclude that there are some research gaps in the above mentioned discussions. There is an effort in this study to bridge these gaps and find a few answers.