CHAPTER 6 FINDINGS AND DISCUSSIONS

REVERSE COMMUNICATION

RSH CONTENT SHARED DURING REVERSE COMMUNICATION

CHANGES IN KAP (KNOWLEDGE, ATTITUDE AND PRACTICE) RELATED TO RSH AMONG MFR

REVERSE COMMUNICATION MODEL

DYNAMICS OF INTERACTION AND COMMUNICATION OF YOUNG PEOPLE WITH SPOUSE AND FAMILY

FAMILY PLANNING/ CONTRACEPTION

RSH EDUCATION AND SPOUSE SELECTION CRITERIA

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

PERSPECTIVES ON MEN’S RSH EDUCATION

TIMING OF RSH EDUCATION

RSH TRAINING MODULES
CHAPTER VI: FINDINGS AND DISCUSSIONS

This chapter will focus on the findings of the study. As we have seen in the earlier chapters, we are looking at the dynamics of interaction and communication between RSH educated young women and their husband, married female relatives, peer and other family members. At the same time we are also looking at the dynamics of interaction and communication of non-RSH educated young women with their husband and other family members.

*This chapter has been divided into 5 parts to categorise the results for better comprehension.*

1) Reverse Communication
2) Dynamics Of Interaction And Communication Of Young People With Spouse, Family And Peers
3) Sexual And Reproductive Health Rights
4) Perspectives Of Young People On RSH Education Of Men
5) RSH Training Modules Analysis

FINDINGS

1. **REVERSE COMMUNICATION:**

As discussed in the introductory chapter, the concept of “REVERSE COMMUNICATION” is new to the documented facts about RSH. Due to the concept being new, a schedule was especially designed to collect all the required data form the field. This schedule was divided into 5 sections- 1) data about KAP (knowledge, attitude and practice related to RSH), 2) Reverse Communication, 3) Dynamics of interaction and communication, 4) RSH rights and 5) RSH education for young men.
CHAPTER 6 FINDINGS AND DISCUSSIONS

Reverse Communication

“Any RSH related communication from the young people to the older family or non-family members in the form of verbal/ non-verbal communication, leading by example method or motivation by interaction, which leads to direct or indirect influence on the RSH related Knowledge, Attitude and Practice (KAP) of the older people in question, would be termed as Reverse Communication.”

Traditionally in all societies, the responsibility of imparting RSH education has been with the older family members, teachers in schools or Government and non-government bodies in RSH awareness campaigns. There is also informal imparting of knowledge in the form of peer interaction, print media, audio-visual media and health promotion messaging. The traditional transfer of knowledge has been in practice from times immemorial and till the 1970s, it was the main source of RSH education to young people. Young people had no knowledge to share with adults when it came to RSH. They were only at the receiving end of the knowledge whether accurate or inaccurate. Many a times the biases and prejudices of older members got transferred to the young people in the form of RSH knowledge. Many myths and misconceptions, which have traditionally been a part of reproductive and sexual beliefs of people, also got transferred to the young people like a legacy. Few of the myths that made way into the RSH knowledge of young people for generations are:

- Myths related to menstruation, like
  - Menstrual blood is dirty
  - Do not bathe during menstruation
  - Do not enter kitchen during menstruation
  - Do not touch pickles during menstruation
  - One does not get pregnant with intercourse during menstruation
  - Missing a monthly cycle always means pregnancy

- Myths related to physical changes during adolescence:
  - Eating pickles leads to pimples during adolescence
  - Fast breast development means more fertile girl.
  - Late onset of menstruation means less fertility
CHAPTER 6  FINDINGS AND DISCUSSIONS

- Size of the penis decides the fertility of man
- Myths related to pregnancy and child birth
  - Various myths related to eating during pregnancy
  - Immunization during pregnancy leads to deformity in children
  - New born baby should not be given the first yellow milk (colostrum) of mother as it is dirty.
  - Baby should be bathed immediately after birth.
  - Gap between pregnancy leads to difficulty in conception
  - When a child has diarrhoea, mother’s milk and other fluid should be stopped to reduce watery stools.
- Myths related to contraception
  - Any use of family planning method leads to permanent infertility
  - Male sterilization leads to impotency in men.
- Myths related to HIV/ AIDS, STI/D (Sexually Transmitted Infections and Diseases)
  - HIV is spread by touching or eating in same utensils
  - HIV can be cured by having intercourse with a virgin girl.
- Myths related to infertility, homosexuality and bisexuality
  - Only women are responsible for infertility
  - There is no treatment for infertility
  - Only women are responsible for the sex of the child who is born
  - Homosexuality and bisexuality are diseases which can be cured by medication.

There are many such RSH related myths and misconceptions apart from the list mentioned above. All these myths and misconceptions affect the lives of all young people at physical, emotional, psychological, financial, social and educational level. During the process of informal RSH communication from adults to young people, many of these myths and misconceptions too get transferred along with the valuable knowledge.

With the change in focus from married couples to young people, a lot of RSH education programs started for young people (10-24 yr.) by government and non-government
bodies, schools and some community based initiatives. At this point the young people are not solely dependent on RSH education coming from the older family/no-family members. But they also have these other sources which are giving scientific information which is accurate, precise and non-judgemental. Thus the young people who have the privilege of being a part of this RSH education program also have the option of deciding which information is accurate, useful, and important and which is not.

The traditional communication from the older members especially the female relatives to young women has not stopped. It still continues in addition to the structured RSH education programs. But the young people have the power of knowledge to decide which information is accurate.

There are various questions arising out of this introduction, such as:

- What happens to the young people who have the accurate knowledge?
- Does it change the lives of young people in any way?
- Do the young people communicate this knowledge back to the older members? If ‘no’, then why? If ‘yes’ then why?
- What do the older members do with this knowledge coming from the young people?
- Do they accept and implement it or do they shun the knowledge?
- If they accept the knowledge coming from the young people, then does it change the lives of these older people in any way?

This section of the chapter will look at all the above questions based on the sample that has been studied in this research. The groups in consideration here for REVERSE COMMUNICATION are:

1) The RSH educated young women (75)

2) Married Female Relatives (MFR) of the RSH educated young women (75), henceforth referred to as MFR.

The relationships in different parts of India are known by different names. For the purpose of this documentation the English names known universally for these
relationships are being used. But for data collection the local names were used. The local names for relationship are also given along with the English names. The following MFR (married female relatives) have been a part of the study:

- behen/ didi (Sister)
- Bhabhi (brother's wife)
- Devrani (younger sister in law)
- Jethani (older sister in law)
- Chachi (younger aunt)
- Taai (older aunt)
- Bua (Father’s sister)
- Masi (Mother’s sister)
- Maa (Mother)
- Saasu Maa (Mother-in-law)

During the pre-testing of schedules, when the RSH educated young women were asked whether they shared any knowledge with their MFR, mostly the respondents denied sharing anything. But during latter part of the interview they mentioned how they had influenced the RSH behaviour of the MFR. Similarly the MFR initially denied having received any RSH knowledge from RSH educated girls, upon direct questioning, but the response change upon indirect question.

The following table summarises the questions designed initially for the schedule specific to Reverse Communication Section. Later on after the Pre Testing, some questions were re-worded to make them more comprehensible for the respondents.
### TABLE 6.1.1
SCHEDULE DESIGN FOR REVERSE COMMUNICATION

<table>
<thead>
<tr>
<th>RESPONDENT GROUP</th>
<th>DIRECT QUESTION (pre-test of schedule)</th>
<th>REVISED QUESTION (final schedule)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSH EDUCATED YOUNG WOMEN</td>
<td>Did you share any RSH knowledge with your MFR?</td>
<td>• When you came back from RSH education program, did anyone in your family ask you about what you did at training?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If yes, who asked (MFR relation)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What did they ask?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What did you tell?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component of the RSH education could you share easily?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component you shared with hesitation?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component did you decide not to share and why?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which content was our MFR most interested in?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Who was more comfortable in this sharing (you or MFR)?</td>
</tr>
<tr>
<td>MFR</td>
<td>Did the RSH educated young woman from your family, who attended an RSH education program, share any knowledge after returning from training?</td>
<td>• Do you have any RSH educated young woman in your family?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If yes, tell the relation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do you think they have benefitted from this training in any way?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When the RSH educated girl came back from training, did you ask her what she had learnt there?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If yes, why did you ask her?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What did she tell you?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Who was more comfortable in this exchange?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Did you feel that they were giving you accurate information?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component was easier for you to discuss?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component did you discuss hesitatingly?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component did you not discuss deliberately?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Which component were you most interested in?</td>
</tr>
</tbody>
</table>

This table explains the questions used to understand the process of Reverse Communication, in the schedule. The first column pertains to the respondent category; second column reflects the question used in pre-test schedule and the third column shows the changed questions after the pre-test. This helps in understanding the manner in which
the questions were asked to rule out any interviewer generated or schedule generated biases.
Thus the outcome of the schedule based interview was very fruitful in understanding the REVERSE COMMUNICATION pattern between RSH educated girl and their MFR. The findings are as follows:

**REVERSE COMMUNICATION REPORTING BY RSH EDUCATED YOUNG WOMEN (MFR RELATION WISE)**

**Multiple Response Table**

Interpreting the multiple response frequency table— The total number of respondents for this table was n=75. The counts (number of responses) in the first column of the table do not add up to 75, but rather to 361. That is the total number of responses; since each respondent could give up to 3 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses of 361.

**TABLE 6.1.2**

**REVERSE COMMUNICATION REPORTING BY RSH EDUCATED YOUNG WOMEN (MFR RELATION WISE)**

<table>
<thead>
<tr>
<th>MFR who enquired about RSH education from RSH educated girls</th>
<th>No. of RESPONSES from RSH educated girls</th>
<th>Percentage of RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sister</td>
<td>71</td>
<td>19.7%</td>
</tr>
<tr>
<td>Brother’s wife</td>
<td>71</td>
<td>19.7%</td>
</tr>
<tr>
<td>Younger Sister in law (devrani)</td>
<td>16</td>
<td>4.4%</td>
</tr>
<tr>
<td>Elder sister in law (jethani)</td>
<td>16</td>
<td>4.4%</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>24</td>
<td>6.6%</td>
</tr>
<tr>
<td>Older aunt (taai)</td>
<td>12</td>
<td>3.3%</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>5</td>
<td>1.4%</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>23</td>
<td>6.4%</td>
</tr>
<tr>
<td>Mother</td>
<td>74</td>
<td>20.5%</td>
</tr>
<tr>
<td>Friends</td>
<td>46</td>
<td>12.7%</td>
</tr>
<tr>
<td>Others</td>
<td>3</td>
<td>0.8%</td>
</tr>
</tbody>
</table>
CHAPTER 6 FINDINGS AND DISCUSSIONS

This table depicts the instances of enquiring about RSH education programme by the MFR, as reported by the RSH educated young women. All the 75 RSH educated young women reported instances of Reverse Communication where at least one MFR had enquired about the RSH contents. This question was multiple response type of question; therefore the total number of responses is 361. Many RSH educated girls reported that more than one MFR enquired about RSH. Nearly twenty per cent (19.7%) responses by RSH educated girls indicated that sister enquired about the training, 19.7% responses from RSH educated girls indicated that bhabhi enquired about training, 20.5% responses were for the mother. Nearly 4.4% responses indicated that younger sister in law enquired about the training while the same percentage of older sister in law also enquired about the training. 6.6% responses came for younger aunt enquiring about the training whereas 3.3% responses suggested that older aunt enquired about the training. 6.4% responses were for the mother’s sister (masi) enquiring about the training whereas 12.7% responses were for the friends. Only 1.4% responses suggested that father’s sister enquired about training. Others categories includes neighbours and unmarried female relatives etc. 0.8% reported that others enquired about the training.

The MFR which enquired the most are: Mother (20.5%), Sister (19.7%) (only married sisters), Brother’s wife (19.7%). The MFR which enquired the least were: Father’s sister (1.4%), Elder aunt (3.3%), Younger sister in law (4.4%), Older sister in law (4.4%).

REASONS CITED BY MFR FOR ENQUIRING ABOUT RSH EDUCATION PROGRAM

This table depicts the results of a pre-coded response about the 4 main reasons for the MFR to enquire about RSH education program from young women. These reasons were-

1) curiosity
2) Authority
3) Educational
4) Casual
TABLE 6.1.3
REASONS CITED BY MFR FOR ENQUIRING ABOUT RSH EDUCATION PROGRAM

<table>
<thead>
<tr>
<th>REASONS FOR ENQUIRING ABOUT RSH EDUCATION PROGRAM FROM RSH EDUCATED GIRLS</th>
<th>No. of MFR</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CURIOSITY</td>
<td>15</td>
<td>20%</td>
</tr>
<tr>
<td>AUTHORITY</td>
<td>10</td>
<td>13.3%</td>
</tr>
<tr>
<td>EDUCATIONAL</td>
<td>24</td>
<td>32%</td>
</tr>
<tr>
<td>CASUAL</td>
<td>26</td>
<td>34.7%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>100%</td>
</tr>
</tbody>
</table>

This table is based on the response collected from the MFR on the reason why they enquired from the RSH educated girls. 34.7% MFR said that they had enquired casually about RSH education and what the young women had learnt. Though 32% MFR reported that they had enquired from educational purposes, the RSH educated girls reported very high instances of positive changes in KAP (knowledge, Attitude and Practice) of MFR. 20% MFR said that they asked out of curiosity. Only 13% MFR said that they had enquired as an authoritative figure. It is important to know the reason behind enquiring because enquiring in itself is a way of learning new things in an intentional or unintentional manner.

COMFORT LEVEL WHILE DISCUSSING RSH ISSUES

The comfort level while discussing the RSH related issues is very crucial for the person who is communicating and the person who is at the receiving end. The communication bears favourable results if there is more ease while discussing issues around RSH. The RSH educated girls and MFR were asked this question separately to assess the level of comfort as they perceive it.
TABLE 6.1.4 a
COMFORT LEVEL AS REPORTED BY RSH EDUCATED YOUNG WOMEN
WHILE DISCUSSING RSH RELATED ISSUES

<table>
<thead>
<tr>
<th>AS REPORTED BY</th>
<th>RSH EDUCATED GIRL</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More Comfortable</td>
<td>Less comfortable</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
<td>%</td>
<td>No. of RSH edu. girls</td>
</tr>
<tr>
<td>RSH EDUCATED YOUNG WOMEN</td>
<td>41</td>
<td>54.7%</td>
<td>34</td>
</tr>
<tr>
<td>MFR</td>
<td>34</td>
<td>45.3%</td>
<td>41</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>50%</td>
<td>75</td>
</tr>
</tbody>
</table>

TABLE 6.1.4 b
COMFORT LEVEL AS REPORTED BY MFR WHILE DISCUSSING RSH RELATED ISSUES

<table>
<thead>
<tr>
<th>AS REPORTED BY</th>
<th>MFR</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>More Comfortable</td>
<td>Less comfortable</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>No. of MFR</td>
<td>%</td>
<td>No. of MFR</td>
</tr>
<tr>
<td>RSH EDUCATED YOUNG WOMEN</td>
<td>32</td>
<td>42.7%</td>
<td>43</td>
</tr>
<tr>
<td>MFR</td>
<td>43</td>
<td>57.3%</td>
<td>32</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>100%</td>
<td>75</td>
</tr>
</tbody>
</table>

These tables depict the comfort level of the respondents while discussing RSH related issues. The measure of comfort level is very subjective and differs from respondent to respondent on how they perceive their or other person’s comfort level. In these tables the
comfort level is as reported by the two respondent groups- RSH educated girls and MFR. The RSH educated girls felt that they were more comfortable at 54.7% than their MFR at 42.7%. The MFR on the other hand felt that they were more comfortable at 57.3% than the RSH educated girl at 45.3%. Considering the social stigma attached to RSH discussion especially reverse communication, even 40% comfort level between the RSH educated young women and MFR is a significant report. According to RSH educated young women, the **MFR which were most comfortable were**: Brother’s wife (Bhabhi) and Sister. **MFR which were least comfortable were**: Mother and Elder aunt.

**RSH CONTENT MENTIONED AT FIRST INTERACTION BY RSH EDUCATED YOUNG WOMEN**

The various components of RSH education program which was *mentioned at first interaction* by RSH educated young women with their MFR. The following table depicts the percentage of cases where a particular component was *MENTIONED not discussed*, as reported by RSH educated girl and as reported by MFR. This question was multiple responses.

**RSH CONTENT MENTIONED AT FIRST INTERACTION BY RSH EDUCATED YOUNG WOMEN**

**Multiple Response Table**

Interpreting the multiple response frequency table-

The total number of respondents was n=150 (RSH educated girls 75 + MFR 75). *The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 272 and in second column (MFR) total response is 195. The Total responses column adds up to 467 responses. This is the total number of responses; since each respondent could give up to 5 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.*
### TABLE 6.1.5
RSH CONTENT MENTIONED AT FIRST INTERACTION BY RSH EDUCATED YOUNG WOMEN

<table>
<thead>
<tr>
<th>RSH content mentioned</th>
<th>Acc. To RSH educated Young women</th>
<th>Acc. To MFR</th>
<th>Total Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of RESPONSES</td>
<td>%</td>
<td>Number of RESPONSES</td>
</tr>
<tr>
<td>Changes during adolescence</td>
<td>35</td>
<td>12.9%</td>
<td>59</td>
</tr>
<tr>
<td>Menstruation</td>
<td>34</td>
<td>12.5%</td>
<td>31</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>16</td>
<td>5.9%</td>
<td>16</td>
</tr>
<tr>
<td>Family planning</td>
<td>19</td>
<td>7%</td>
<td>0</td>
</tr>
<tr>
<td>Safe motherhood</td>
<td>24</td>
<td>8.8%</td>
<td>0</td>
</tr>
<tr>
<td>Safe childhood</td>
<td>21</td>
<td>7.7%</td>
<td>16</td>
</tr>
<tr>
<td>STD/ STI</td>
<td>28</td>
<td>10.3%</td>
<td>14</td>
</tr>
<tr>
<td>HIV/ AIDS</td>
<td>21</td>
<td>7.7%</td>
<td>0</td>
</tr>
<tr>
<td>Health and hygiene</td>
<td>46</td>
<td>16.9%</td>
<td>59</td>
</tr>
<tr>
<td>Balanced diet</td>
<td>28</td>
<td>10.3%</td>
<td>0</td>
</tr>
</tbody>
</table>

**FIGURE: 6.1**

RSH CONTENT MENTIONED AT FIRST INTERACTION BY RSH EDU. GIRLS BUT NOT DISCUSSED
This table and figure depict the specific RSH content \textit{MENTIONED AT FIRST INTERACTION BUT NOT DISCUSSED} during Reverse Communication. There are two columns depicting the number and percentages of respondents. One column gives the details of RSH content mentioned as reported by RSH educated girls and the other column depicts the RSH content mentioned as reported by the MFR. The total column depicts the sum total of RSH educated girls and MFR responses for the particular RSH content. This question was multiple response type in nature, thus one respondent has given more than one option as answer.

12.9\% responses from RSH educated girls reported that they mentioned “changes during adolescence” with their MFR, whereas 30.3\% responses from MFR reported that the RSH educated girls mentioned this component with them. 12.5\% responses from RSH educated girls reported mentioning “menstruation “with MFR, while 15.9\% responses from MFR reported this topic. 5.9\% responses from RSH educated girls said that they mentioned “pregnancy” with MFR as compared to 8.2\% responses from MFR reporting for the same topic.

7\% responses from RSH educated girls said that they mentioned about “family planning” with MFR whereas none of the MFR reported this topic as mentioned by RSH educated girls. 8.8\% responses from RSH educated girls reported the mentioning of “safe motherhood” as compared to 0\% responses from MFR. 7.7\% responses from RSH educated girls mentioned “safe childhood” as compared to 8.2\% responses from MFR.

10.3\% responses from RSH educated girls reported that they mentioned “STD/ STI to MFR, whereas only 7.2\% responses from MFR reported for the same topic. 7.7\% responses from RSH educated girls reported mentioning “HIV/ AIDS” to MFR as compared to 0\% responses from MFR. 16.9\% responses from RSH educated girls reported mentioning “health and hygiene” to MFR as compared to a whopping 30.3\% responses from MFR. 10.3\% responses from RSH educated girls reported mentioning “balanced diet” to MFR as compared to 0\% responses from MFR reporting for the same topic.
If we look at the “TOTAL COLUMN”, we can depict that “health and hygiene was the most reported response at 22.5%, followed by “changes during adolescence” 20.1% and “menstruation” at 13.9%.

According to the RSH educated young women, the top three topics shared with MFR were - health and hygiene, changes during adolescence and menstruation. Similarly according to MFR, the top 3 topics shared by RSH educated girls were also: Health and hygiene, Changes during adolescence and Menstruation

There are various reasons for this difference between the reports from both the groups, like: 1) Time gap between the actual event of reverse communication and data collection leading to gap in recall. 2) Stigma associated with certain components of RSH. 3) MFR mixing the traditional RSH knowledge delivery to young girls with that of topics mentioned by RSH educated girls immediately after training. Thus at times the percentage for a particular topic as mentioned by MFR are higher than that mentioned by RSH educated girl for the same topic.

RSH CONTENT WHICH WAS SHARED EASILY BETWEEN RSH EDUCATED GIRLS AND MFR

Out of all the contents of RSH, there were some which the RSH educated young women found easier to talk about. There were some content which the MFR found easy to discuss. These components were reported by the RSH educated girls and MFR as easy for them to discuss. Since these are self-reported, perception of “easy” differs from respondent to respondent. The following table summarises the easily shared content as reported by both the groups. This table is being analysed to develop an understanding of the type of topics which have been shared easily between the two respondent groups, leading to the quality and degree of Reverse Communication.
CHAPTER 6  FINDINGS AND DISCUSSIONS

RSH CONTENT WHICH WAS SHARED EASILY BETWEEN RSH EDUCATED GIRLS AND MFR

Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was \( n=150 \) (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 279 and in second column (MFR) total response is 144. The Total responses column adds up to 423 responses. This is the total number of responses; since each respondent could give up to 5 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE 6.1.6
RSH CONTENT WHICH WAS SHARED EASILY BETWEEN RSH EDUCATED GIRLS AND MFR

<table>
<thead>
<tr>
<th>RSH content shared easily</th>
<th>Acc. To RSH educated Young women</th>
<th>Acc. To MFR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Changes during adolescence</td>
<td>55</td>
<td>19.7%</td>
<td>21</td>
</tr>
<tr>
<td>Menstruation</td>
<td>29</td>
<td>10.4%</td>
<td>37</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>27</td>
<td>9.7%</td>
<td>1</td>
</tr>
<tr>
<td>Family planning</td>
<td>4</td>
<td>1.4%</td>
<td>2</td>
</tr>
<tr>
<td>Safe motherhood</td>
<td>26</td>
<td>9.3%</td>
<td>8</td>
</tr>
<tr>
<td>Safe childhood</td>
<td>75</td>
<td>26.8%</td>
<td>48</td>
</tr>
<tr>
<td>STD/ STI</td>
<td>43</td>
<td>15.4%</td>
<td>24</td>
</tr>
<tr>
<td>HIV/ AIDS</td>
<td>16</td>
<td>5.7%</td>
<td>2</td>
</tr>
<tr>
<td>Health and hygiene</td>
<td>2</td>
<td>0.7%</td>
<td>1</td>
</tr>
<tr>
<td>Balanced diet</td>
<td>2</td>
<td>0.7%</td>
<td>0</td>
</tr>
</tbody>
</table>
The table and figure above depicts the RSH content which was reported as “shared easily” by RSH educated girls and by MFR. As part of the Reverse Communication process, this finding is useful to see the perceptions of inhibitions in both the groups. This question was multiple response type and each respondent gave at-least 5 responses.

19.7% responses from RSH educated reported that it was easier to discuss “changes during adolescence” related issues with MFR, whereas 14.6% responses from MFR reported the same for this topic. 10.4% responses from RSH educated girls said that they found the topic of “menstruation easy to discuss as compared to a higher percentage of MFR at 25.7%. 9.7% responses from RSH educated girls found the issues related to “pregnancy” as easy to discuss as compared to only 0.7% responses from MFR for the same issue. Only 1.4% responses from both respondent groups felt that “family planning” was easy to discuss. 9.3% responses from RSH educated girls indicated that it was easy to discuss “safe motherhood” as compared to 5.6% responses from MFR who indicated the same for this topic.

A high percentage of RSH girls (26.8% responses) felt that it was easy to discuss “safe childhood” as compared to an even higher percentage of MFR at 33.3% responses for the same topic. 15.4% responses from RSH educated girls and 16.7% responses from MFR
indicated that it was easy to discuss “STD/ STI”. 5.7% responses from RSH educated girls indicated that it was easier to discuss “HIV/ AIDS” as compared to only 1.4% responses from MFR. Only 0.7% responses from both the categories reported that it was easy to discuss “health and hygiene”. Whereas only 0.7% responses from RSH educated girls said that they could easily discuss “balanced diet” as compared to 0% responses from MFR for the same topic.

If we look at the totals column then the easiest topic to discuss was “safe childhood” at 29% of the total responses. **The RSH educated girls felt that the 3 most easily sharable component of RSH for them were:**

1) Safe childhood, 2) Changes during adolescence, 3) STD/ STI

**The MFR felt that the 3 most easily discussed components were:**
1) Safe childhood, 2) Menstruation, 3) STD/ STI

Though the issue of STD/ STI is associated with stigma and people don’t talk about them easily, the problem in the study area is different. Here nearly 80% women have some symptoms of RTI (reproductive tract infections) or STD/ STI. Since the health facility lacks doctors or are far away, most of the women don’t use them. The other reason for not seeking medical help is that they feel that their health is not so important. Thirdly there is a stigma attached to visiting doctor for any symptoms related to genital areas. Due to these reasons, there is a high level of anxiety and curiosity around, RTI, STI, and STD. It was surprising to see that the most benign issues of health and hygiene and balanced diet die not get reported as “easy to discuss topics”. The reasons cited by the respondents for the above was that they thought that health and hygiene and balanced diet related information is available everywhere and people talk about it. Therefore they did not focus on these issues while discussing RSH. It does not mean that these topics are difficult to discuss.
CHAPTER 6  FINDINGS AND DISCUSSIONS

RSH CONTENT SHARED HESITANTLY BETWEEN RSH EDUCATED GIRLS AND MFR

There were some components of the RSH education program which the RSH educated girls shared with hesitation or the MFR discussed with hesitation. These components are either socially or culturally considered taboo. The following table shows the result for the same.

Multiple Response Table

Interpreting the multiple response frequency table:
The total number of respondents was \( n=150 \) (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 203 and in second column (MFR) total response is 129. The Total responses column adds up to 332 responses This is the total number of responses; since each respondent could give up to 5 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

<table>
<thead>
<tr>
<th>RSH content shared hesitantly</th>
<th>Acc. To RSH educated Young women</th>
<th>Acc. To MFR</th>
<th>Total RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
</tr>
<tr>
<td>Changes during adolescence</td>
<td>18</td>
<td>8.9%</td>
<td>25</td>
</tr>
<tr>
<td>Menstruation</td>
<td>25</td>
<td>12.3%</td>
<td>22</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>9</td>
<td>4.4%</td>
<td>30</td>
</tr>
<tr>
<td>Family planning</td>
<td>35</td>
<td>17.2%</td>
<td>11</td>
</tr>
<tr>
<td>Safe motherhood</td>
<td>11</td>
<td>5.4%</td>
<td>14</td>
</tr>
<tr>
<td>Abortion</td>
<td>43</td>
<td>21.2%</td>
<td>10</td>
</tr>
<tr>
<td>Safe childhood</td>
<td>1</td>
<td>0.5%</td>
<td>0</td>
</tr>
<tr>
<td>STD/ STI</td>
<td>28</td>
<td>13.8%</td>
<td>2</td>
</tr>
<tr>
<td>HIV/ AIDS</td>
<td>33</td>
<td>16.3%</td>
<td>15</td>
</tr>
</tbody>
</table>
The above table and figure depict the RSH related content which was reported by RSH educated girls and MFR as “discussed with hesitation”. This was a multiple response question and each respondent has given at-least 5 responses to this question.

8.9% responses from RSH educated girls felt that they were hesitant while discussing “changes during adolescence” as compared to 19.4% responses from MFR who reported hesitation for this topic. 12.3% responses from RSH educated girls indicated that they were hesitant to discuss “menstruation” as compared to 17.1% responses from MFR who reported hesitation for this topic. Only 4.4% responses from RSH educated girls reported hesitation for discussing “pregnancy” as compared to a huge percentage of 23.3% responses among MFR for the same topic.

17.2% responses from RSH educated girls indicated that they were hesitant to discuss “family planning” as compared to only 8.5% responses from MFR who felt hesitant for the same topic. 5.4% responses from RSH educated girls found the topic of “safe motherhood” to be difficult to discuss as compared to 10.9% responses from MFR for this topic. The most hesitantly discussed topic for RSH educated girls was “abortion” which was reported by 21.2% responses from RSH educated girls as compared to only
CHAPTER 6 FINDINGS AND DISCUSSIONS

7.8% responses from MFR for the same topic. “safe-childhood” was the least hesitantly discussed with only 0.5% responses from RSH educated girls reporting for this as compared to none from MFR group.
13.8% responses from RSH educated girls reported that they found the topic of “STD/STI” to be difficult to discuss as compared to only 1.6% responses from MFR for the same topic. 16.3% responses from RSH educated girls reported that they were hesitant while discussing “HIV/ AIDS” with the MFR as compared to 11.6% responses of the MFR who reported for this topic.

If we look at the “total column”, the most hesitantly discussed topics were “abortion” at 16%, “HIV/ AIDS” at 14.5% and “menstruation” at 14.2%. The RSH educated girls felt that the 3 most hesitantly shared component of RSH for them were:
1) Abortion, 2) Family planning, 3) HIV/ AIDS

The MFR felt that the 3 most hesitantly discussed components were:
1) Pregnancy, 2) Changes during adolescence, 3) Menstruation

Since this was a multiple response question, every respondent gave more than 3 or 4 answers, thus one of the top most easily shared content was ‘menstruation’ and for some respondents, one of the top most hesitantly shared content was also ‘menstruation’

There is a difference of opinion on the hesitation faced while discussing. The RSH educated girls felt that the MFR found the abortion, pregnancy and HIV/ AIDS more hesitant because, they were feeling shy asking or discussing about it. Whereas the MFR felt that they found the issues related to pregnancy, changes during adolescence and menstruation more hesitant. The reason given for this disparity by RSH educated girl is that the MFR were interested in the topics of abortion etc. but were not asking for clarifications. The MFR say that the RSH educated girl was not telling in detail about menstruation and growing up, therefore they felt that they were hesitating.
RSH CONTENTS NOT DISCUSSED DELIBERATELY

Due to cultural and social stigma, some issues were not discussed at all by the respondents. The 3 top most issues as reported by both groups are given below.

Multiple Response Table

Interpreting the multiple response frequency table

The total number of respondents was $n=150$ (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 131 and in second column (MFR) total response is 147. The Total responses column adds up to 278 responses. This is the total number of responses; since each respondent could give up to 5 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE 6.1.8

RSH CONTENT NOT DISCUSSED DELIBERATELY

<table>
<thead>
<tr>
<th>RSH content not discussed deliberately</th>
<th>Acc. To RSH educated Young women</th>
<th>Acc. To MFR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Changes during adolescence</td>
<td>2</td>
<td>1.5%</td>
<td>7</td>
</tr>
<tr>
<td>Menstruation</td>
<td>12</td>
<td>9.2%</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>17</td>
<td>13%</td>
<td>15</td>
</tr>
<tr>
<td>Family planning</td>
<td>17</td>
<td>13%</td>
<td>17</td>
</tr>
<tr>
<td>Safe motherhood</td>
<td>24</td>
<td>18.3%</td>
<td>1</td>
</tr>
<tr>
<td>Abortion</td>
<td>37</td>
<td>28.2%</td>
<td>56</td>
</tr>
<tr>
<td>Safe childhood</td>
<td>6</td>
<td>4.6%</td>
<td>0</td>
</tr>
<tr>
<td>STD/ STI</td>
<td>12</td>
<td>9.2%</td>
<td>28</td>
</tr>
<tr>
<td>HIV/ AIDS</td>
<td>4</td>
<td>3.1%</td>
<td>22</td>
</tr>
</tbody>
</table>
The table and figure above depict the RSH content which was reported by the RSH educated girls and MFR as “deliberately not discussed”. This was a multiple response question and both the group of respondents have given at least 5 responses under this category.

1.5% responses from RSH educated girls reported that they deliberately did not discuss “changes during adolescences” as compared to 4.8% responses from MFR for the same topic. 9.2% responses from RSH educated girls reported that they did not discuss “menstruation” with their MFR as compared to only 0.7% responses from MFR. 13% responses from RSH educated girls reported not discussing pregnancy as compared to 10.2% responses from MFR. 13% responses from RSH educated girls reported “family planning” as deliberately not discussed as compared to 11.6% responses from MFR for the same topic.

18.3% responses from RSH educated girls indicated that they did not discuss “safe motherhood” with their MFR as compared to 0.7% responses from MFR reporting the same for this topic. A high per cent of responses from RSH educated girls (28.2%) indicated that they did not discuss (abortion) with their MFR as compared to an even higher per cent of 38.1% responses from MFR. 4.6% responses from RSH educated girls reported not discussing “safe childhood” as compared to 0% responses from MFR. 9.2% responses from RSH educated girls reported that they did not discuss “STD/STI” with
their MFR as compared to 19% responses from MFR. Only 3.1% responses from RSH educated girls reported that they did not discuss “HIV and AIDS” as compared to 15% responses from MFR.

If we look at “total” column, the highest per cent of RSH educated girl’s topic not discussed deliberately is “abortion” at 33.5% and “STD/STI” at 14.4%.

The RSH educated girls felt that the top 3 deliberately not shared component of RSH for them were:

The MFR felt that the top 3 deliberately not discussed components were:
1) Abortion 2) STD/STI 3) HIV and AIDS.

These were the issues which the respondents felt that they wouldn’t be comfortable at all to share. Abortion, family planning and HIV/AIDS remain on top of the list for both the groups. These issues are still not talked about with ease in families and do not form an essential part of the traditional transfer of knowledge from mother to daughter.

RSH CONTENT IN WHICH MFR WERE MOST INTERESTED IN
The following table depicts the components of RSH in which the MFR were most interested in. this question was asked to understand the specific issues related to RSH educated girls in which the MFR were most interested in. the RSH educated girls were asked to recall about the components about which the MFR showed more curiosity or interest, asked more questions or shared more problems related to that particular issue.

The same question was also asked to the MFR as to which topic they found most interesting. The table below has consolidated the data given by both respondent groups.
Interpreting the multiple response frequency table. The total number of respondents was n=150 (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 203 and in second column (MFR) total response is 173. The Total responses column adds up to 376 responses. This is the total number of responses; since each respondent could give up to 5 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE 6.1.9**

**RSH CONTENT IN WHICH MFR WERE MOST INTERESTED IN**

<table>
<thead>
<tr>
<th>RSH content in which MFR were most interested</th>
<th>Acc. To RSH educated Young women</th>
<th>Acc. To MFR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Changes during adolescence</td>
<td>17</td>
<td>8.4%</td>
<td>29</td>
</tr>
<tr>
<td>Menstruation</td>
<td>53</td>
<td>26.1%</td>
<td>37</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>26</td>
<td>12.8%</td>
<td>3</td>
</tr>
<tr>
<td>Family planning</td>
<td>15</td>
<td>7.4%</td>
<td>9</td>
</tr>
<tr>
<td>Safe motherhood</td>
<td>25</td>
<td>12.3%</td>
<td>22</td>
</tr>
<tr>
<td>Abortion</td>
<td>3</td>
<td>1.5%</td>
<td>0</td>
</tr>
<tr>
<td>Safe childhood</td>
<td>35</td>
<td>17.2%</td>
<td>37</td>
</tr>
<tr>
<td>STD/ STI</td>
<td>26</td>
<td>12.8%</td>
<td>35</td>
</tr>
<tr>
<td>HIV/ AIDS</td>
<td>3</td>
<td>1.5%</td>
<td>1</td>
</tr>
</tbody>
</table>
FIGURE: 6.5

**RSH CONTENT IN WHICH MFR WERE MOST INTERESTED IN**

The table and figure above depict the *RSH contents, which the MFR were most interested in*. The table shows the RSH contents as reported by RSH educated girls and MFR. This was a multiple response question and each respondent has given at-least 5 responses for this question.

8.4% responses from RSH educated girls reported that the MFR were interested in “changes during adolescence” as compared to 16.8% responses from MFR who found this topic to be most interesting. 26.1% responses from RSH educated girls and 21.4% responses from MFR reported “menstruation” as the most interesting topic for MFR. 12.8% responses from RSH educated girls and 1.7% responses from MFR reported that “pregnancy” was the most interesting topic for MFR.

7.4% responses from RSH educated girls and 5.2% responses from MFR reported that “family planning” was the most interested topic for MFR. 12.3% responses from RSH educated girls and 12.7% responses from MFR reported that “safe motherhood” was the most interesting topic for MFR. Only 1.5% responses from RSH educated girls indicated that MFR were most interested in the topic of “abortion” whereas none of the MFR reported the same for this topic. 17.2%
responses from RSH educated girls and 21.4% responses from MFR reported that “safe childhood” was the most interesting topic for MFR. 12.8% responses from RSH educated girls indicated that their MFR were most interested in “STD/STI” as compared to 20.2% responses from MFR for the same topic. Only 1.5% responses from RSH educated girls and 0.6% responses from MFR reported that HIV and AIDS were of interest to the MFR.

The “total” column reflects “menstruation” as the topic which MFRs found most interesting at 23.9% followed by “safe childhood” at 19.1%.

**The RSH educated girls felt that the MFR were most interested in:**
1) Menstruation 2) Safe Childhood 3) Pregnancy 4) STD/STI.

**The MFR reported that they were most interested in:**
1) Menstruation 2) Safe Childhood 3) STD/STI.

These issues were the ones about which the MFR were most inquisitive and were asking various questions and clarifications.

**SUMMARY OF RSH COMPONENTS DISCUSSED & FINDINGS FROM FGD**

The table below depicts the summary of the various components of RSH as reported by RSH educated girls and as reported by MFR. In this table the findings from the interview with community health worker is also shown in order to synthesize the self-reported data.

**TABLE 6.1.10 SUMMARY OF RSH COMPONENTS DISCUSSED in REVERSE COMMUNICATION**

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>% who reported Instances of Reverse Communication</th>
<th>Most easily Shared RSH Content</th>
<th>Most hesitantly Shared RSH Content</th>
<th>Most deliberately Not shared RSH content</th>
<th>RSH content married females most interested in</th>
</tr>
</thead>
<tbody>
<tr>
<td>As reported By RSH education. Girls</td>
<td>100%</td>
<td>Safe childhood</td>
<td>Abortion</td>
<td>Abortion</td>
<td>Menstruation</td>
</tr>
<tr>
<td>As reported by married female relatives of RSH education. Girls</td>
<td>100%</td>
<td>Safe childhood</td>
<td>Pregnancy</td>
<td>Abortion</td>
<td>Menstruation</td>
</tr>
<tr>
<td>As reported by community health workers</td>
<td>100%</td>
<td>Safe childhood</td>
<td>Pregnancy Abortion HIV/ AIDS STI/ STDs</td>
<td>Family planning abortion</td>
<td>Menstruation</td>
</tr>
</tbody>
</table>

193
Thus we can see that the health worker’s feedback is also on similar lines of what has been reported by the two respondent groups. Almost everyone has reported the presence of ‘Reverse communication’. The degree of reverse communication has varied by the self-reports. Almost all the RSH educated girls reported that at least one MFR enquired about the RSH issues learnt at training.

Usually those MFR who had friendly terms with the RSH educated girls, were the ones to enquire more. Though the MFR said that the most important reason for them to ask was ‘casually’ or for ‘educational purpose’, the interaction with the MFRs gave an impression that it was more ‘authoritative’. As they wanted to know why the young girls were taken away for 5 day residential training, and of what use will it be?

The judgment about comfort level was very subjective. As the respondents were asked to judge their own comfort level and that of the other person in communication. The RSH educated girls felt that they knew more about RSH issues and had the latest information on the topic, thus they had more confidence. The MFR on the other hand felt that due to the age gap between them and the RSH educated girls and the social hierarchy of respect within the family, the girls were shyer about discussing RSH issues.

In most of the cases, RSH educated girls reported that they were not desperate to pass on the information to the MFR as they felt that it was like ‘inviting trouble’. They feared that the MFR will become judgmental about them. The RSH educated girls felt that they had the knowledge and they should use it for their own benefit. But once the MFR started showing interest in the RSH education of these young women, the girls obliged them by discussing some issues.

Lesser age gap between the RSH educated girls and the married female relatives, RSH educated girls staying at their maternal homes, educational status of RSH education. Girl and married female relative, other rights based training, exposure, have a direct positive influence on the level of Reverse communication and also the knowledge, attitude and practice among the married female relatives. Increased age gap , living in marital home,
strict social hierarchy, lower educational qualification, lack of any rights based training/exposure, level of social taboo attached to a particular RSH issue, have an adverse effect on the instances and impact of reverse communication.

Among those who shared RSH related knowledge, most of them agreed that talking about “safe childhood (diarrhoea, pneumonia, and immunization) was easier than discussing about abortion and family planning. **One very significant finding from the study has been the nature of communication. “Reverse communication” is not only about ‘intentional, verbal’ communication. It is also about ‘unintentional non-verbal’ communication.** The knowledge gained or attitude changed or practice improved does not always happen by verbal communication of knowledge. Most of the times, the changes in KAP are brought about by ‘seeing’ and ‘observing’ a desired practice. In many instances the respondents have not mentioned a particular component as that of interest but have observed the RSH educated girl following it and have got influenced, leading to a change in knowledge, attitude and practice by non-verbal, unintentional communication leading to desired change. **Example of this could be:** use of contraception by a newly married RSH educated girl to delay the first child. An MFR in the family who also wishes to delay or space the child birth might get motivated by this example and follow it.

**CHANGES IN KAP (KNOWLEDGE, ATTITUDE AND PRACTICE RELATED TO RSH AMONG MFR**

The findings from the above mentioned data has conveyed the presence of “Reverse Communication”. The next logical step to the findings is the change in KAP. Since the findings have established the presence of reverse communication, one would like to see whether this reverse communication has led to any change in Knowledge Attitude and Practice (KAP) related to RSH. Since this is not a longitudinal study of the MFR over a period of time to track the various RSH indicators, the study relies on the self-reported change in KAP of MFR and the change in KAP as reported by RSH educated girls and community health workers.
CHAPTER 6 FINDINGS AND DISCUSSIONS

Various indicators of change in KAP of MFR

- KAP related to child marriages
- KAP related to changes during adolescence
- KAP related to menstruation
- KAP related to pregnancy
- KAP related to family planning
- KAP related to safe motherhood
- KAP related to abortion
- KAP related to safe childhood
- KAP related to STD/STI
- KAP related to HIV/AIDS
- KAP related to balanced diet
- KAP related to RSH education for young people (both men and women)

CHANGES IN KNOWLEDGE

As we all know that the first step in change in practice is change in Knowledge. In this section we will look at whether the reverse communication has led to any change in the knowledge of the MFR. To measure this change in knowledge, direct question to MFR, RSH educated girl and community health worker has been used. The respondents have been asked directly whether they have observed any change in the RSH knowledge of MFR.

TABLE: 6.1.11

Positive Change in RSH related knowledge of MFR as reported by RSH educated girls and MFR

<table>
<thead>
<tr>
<th>Change in RSH related knowledge in MFR</th>
<th>TYPE OF GROUP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acc. To RSH educated girls</td>
</tr>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
</tr>
<tr>
<td>YES</td>
<td>68</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
</tr>
</tbody>
</table>

Interpretation of Table- the total number of respondents for the above table is n= 150

(RSH educated girls- 75 and MFR- 75. 75+75= 150)
CHAPTER 6  FINDINGS AND DISCUSSIONS

The above table depicts the positive change in RSH related knowledge of MFR as reported by RSH educated girls and MFR. **91% RSH educated girls** felt that they observed positive changes in the RSH knowledge of the MFR after the reverse communication following RSH education of young girls. **100% MFR** felt that they have observed positive changes in their RSH knowledge, after the RSH education of the young girls in their family. **Approximately 50% community health workers** felt that there is positive change in the RSH knowledge of the MFR after the RSH education of at least one girl from their family.

**Multiple Response Table**

*Interpreting the multiple response frequency table.* The total number of respondents was n=150 (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 219 and in second column (MFR) total response is 181. The Total responses column adds up to 400 responses. This is the total number of responses; since each respondent could give up to 3 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE: 6.1.12**

**SPECIFIC CHANGES IN RSH RELATED KNOWLEDGE OF MFR**

| Specific change in RSH Knowledge | TYPE OF GROUP | | | | | |
|---|---|---|---|---|---|
| | RSH edu. Girls | MFR | Total | | |
| | No. of RESPONSES | % | No. of RESPONSES | % | Total RESPONSES | % |
| Discussion of RSH issues with mother in law | 34 | 15.5% | 27 | 14.9% | 61 | 15.3% |
| Menstrual hygiene | 66 | 30.1% | 75 | 41.4% | 141 | 35.3% |
| Reduction in menstrual myths | 64 | 29.2% | 75 | 41.4 | 139 | 34.8% |
| Reduction in pregnancy related myths | 37 | 16.9% | 2 | 1.1% | 39 | 9.8% |
| Equal treatment of girls | 18 | 8.2% | 2 | 1.1% | 20 | 5% |
The above table depicts the specific positive changes in RSH related knowledge of MFR. This reporting is based on the feedback of RSH educated girls and MFR. This question was multiple response type and thus each respondent has given at-least three responses for this question.

15.5% responses from RSH educated girls and 14.9% responses from MFR reported that their knowledge about “Discussion of RSH related issues with mother-in-law” increased and they were able to identify the benefits of sharing RSH related concerns with her. 30.1% responses from RSH educated girls and 41.4% responses from MFR felt that their knowledge about menstrual hygiene had increased after reverse communication with RSH educated girls. 29.2% responses from RSH educated girls and 41.4% responses from MFR reported “reduction in menstrual myths”. 16.9% responses from RSH educated girls and 1.1% responses from MFR reported “reduction in pregnancy related myths” after reverse communication. 8.2% responses from RSH educated girls and only 1.1% responses from MFR reported positive change in knowledge regarding “equal treatment of girls” after reverse communication.

Maximum positive change in knowledge has occurred in the issues related to menstruation, menstrual hygiene and menstrual myths. In discussion with community health workers, **Approx. 40%** community health workers felt the MFR had reduced myths and misconceptions regarding menstruation and pregnancy. **Approx. 35%** community health workers felt the MFR had more knowledge of managing child immunizations and safe practice for child deliveries. **Approx. 65%** community health workers felt the MFR had increased knowledge of contraception.
**Multiple Response Table**

*Interpreting the multiple response frequency table.* The total number of respondents was $n=75$ (RSH educated girls 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 200. This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE: 6.1.13**

**MFR WHO GAINED MAXIMUM KNOWLEDGE**

<table>
<thead>
<tr>
<th>MFR who gained maximum knowledge</th>
<th>Acc. To RSH educated girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Sister</td>
<td>54</td>
</tr>
<tr>
<td>Brother’s wife (Bhabhi)</td>
<td>67</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>17</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>10</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td>13</td>
</tr>
<tr>
<td>Friends</td>
<td>38</td>
</tr>
</tbody>
</table>

**FIGURE: 6.6**

*MFR who gained maximum knowledge from Reverse Communication*
The above table and figure depicts the MFR (relationship wise) who have gained maximum knowledge out of reverse communication related to RSH issues. These reports are based on the responses given by RSH educated girls. 27% responses from RSH educated girls reported that the “sister” displayed maximum positive change in RSH related knowledge as compared to 33.5% responses for “brother’s wife” and 8.5% responses for “younger aunt”. 5% responses from RSH educated girls reported that “father’s sister” displayed maximum positive change in knowledge in RSH issues as compared to only 0.5% responses for “mother’s sister” and 6.5% responses for “mother”. Though “friends” do not fall in the category of MFR, but still this data came up during open ended question and reflects the “peer-discussion”. 19% responses from RSH educated girls reported that they saw positive changes in the RSH related knowledge of their “friends”.

According to the RSH educated young women, the MFR relations who gained maximum knowledge were: 1) Brother’s wife – bhabhi (33.5%) and 2) Married sister (27%).

The discussions with the community health worker reflected that the MFR who gained maximum knowledge were: 1) Brother’s wife, 2) Married sister.

This finding re-emphasizes the fact that lesser age gap between RSH educated girls and the MFR leads to better quality interaction and deeper impact on the KAP (knowledge, attitude and practice).

The following table depicts the MFR who gained minimum RSH related knowledge according to RSH educated girls.

The following table discusses the percentage of MFR who gained minimum RSH related knowledge after Reverse Communication. This data was provided by RSH educated girls.
Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was n=75 (RSH educated girls 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 117. This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE: 6.1.14
MFR WHO GAINED MINIMUM KNOWLEDGE

<table>
<thead>
<tr>
<th>MFR who gained minimum knowledge</th>
<th>Acc. To RSH educated girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>25</td>
</tr>
<tr>
<td>Elder aunt (tai)</td>
<td>3</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>13</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>33</td>
</tr>
<tr>
<td>Mother</td>
<td>42</td>
</tr>
</tbody>
</table>

FIGURE: 6.7
MFR WHO GAINED MINIMUM KNOWLEDGE
CHAPTER 6 FINDINGS AND DISCUSSIONS

The above table and figure depicts the MFR (relationship wise) who have gained minimum knowledge out of reverse communication related to RSH issues. These reports are based on the responses given by RSH educated girls.

35.9% responses from RSH educated girls reported that the “mother” gained minimum knowledge after the reverse communication as compared to 28.2% responses for “mother’s sister” and 21.4% responses for “younger aunt”. 11.1% responses from RSH educated girls reported that “father’s sister” gained minimum knowledge out of the reverse communication as against 0.9% “sister” and 2.6% “older aunt”.

According to the RSH educated young women, the MFR relations who gained minimum knowledge were: 1) Mother (35.9%), 2) Mother’s sister- masi (28.2%), 3) Younger aunt (21.4%).

Discussions with the community health worker showed that the MFR who gained minimum knowledge were: 1) Mother, 2) Mother in law.

Here again we can see that the bigger age gap between RSH educated girls and MFR leads to lesser impact on KAP (knowledge, attitude and practice).

CHANGE IN ATTITUDE

Attitude is the bridge between knowledge and practice. Often people have the right knowledge but do not have the required attitude towards implementing it. Example: people know that girls have equal right to education; this knowledge does not convert into practice because they don’t believe in equal right to education. Similarly people have the knowledge that it is unethical and illegal to do female foeticide and infanticide but the attitude is not the same towards the issue, thus the practice does not change.

In this section the study tries to see whether the Reverse Communication led to any change in attitude of MFR. The findings are again “self-report” of MFR, RSH educated young women and community health workers.
TABLE: 6.1.15
POSITIVE CHANGE IN RSH RELATED ATTITUDE AMONG MFR

<table>
<thead>
<tr>
<th>Change in RSH related ATTITUDE in MFR</th>
<th>TYPE OF GROUP</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acc. To RSH educated girls</td>
<td>Acc. To MFR</td>
<td>TOTAL</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
<td>%</td>
<td>No. of MFR</td>
<td>%</td>
<td>Total</td>
</tr>
<tr>
<td>YES</td>
<td>68</td>
<td>90.7%</td>
<td>75</td>
<td>100%</td>
<td>143</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
<td>9.3%</td>
<td>0</td>
<td>0%</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>100%</td>
<td>75</td>
<td>100%</td>
<td>150</td>
</tr>
</tbody>
</table>

Interpretation of Table- the total number of respondents for the above table is n= 150
(RSH educated girls- 75 and MFR- 75. 75+75= 150)

This table depicts the percentage of MFR who displayed positive change in RSH educated girls related attitude after reverse communication, as reported by RSH educated girls and MFR. 91% RSH educated girls felt that they observed positive changes in the RSH related attitude of the MFR after the reverse communication following RSH education of young girls. 100% MFR felt that they have observed positive changes in their RSH attitude, after the RSH education of the young girls in their family. Based on the discussions with community health worker, approximately 50% community health workers felt that there is positive change in the RSH attitude of the MFR after the RSH education of at least one girl from their family.

The following table highlights the specific changes in RSH related attitude among MFR. These reports are according to RSH educated girls and MFR. The question was posed to both these respondent groups. The respondents were asked as to what specific positive change in attitude they have observed among MFR. This was an open ended question and was multiple responses. The respondents have given more than one response for this question.

SPECIFIC CHANGES IN RSH RELATED ATTITUDE OF MFR
The following table describes the specific changes in RSH related attitude among MFR as reported by RSH educated girls.
Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was \( n = 150 \) (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 182 and in second column (MFR) total response is 223. The Total responses column adds up to 405 responses. This is the total number of responses; since each respondent could give up to 3 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE: 6.1.16**

**SPECIFIC CHANGES IN RSH RELATED ATTITUDE OF MFR**

<table>
<thead>
<tr>
<th>Specific change in RSH Attitude</th>
<th>TYPE OF GROUP</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RSH educ. Girls</td>
<td>MFR</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>No. of RESPONSES</td>
<td>Total RESPONSES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Child marriage</td>
<td>1</td>
<td>0.5%</td>
<td>1</td>
<td>0.4%</td>
<td>2</td>
<td>0.5%</td>
</tr>
<tr>
<td>RSH related discussions with husband</td>
<td>26</td>
<td>14.3%</td>
<td>72</td>
<td>32.3%</td>
<td>98</td>
<td>24.2%</td>
</tr>
<tr>
<td>Attitude towards self and sexuality</td>
<td>50</td>
<td>27.5%</td>
<td>31</td>
<td>13.9%</td>
<td>81</td>
<td>20%</td>
</tr>
<tr>
<td>RSH discussion with Mother in law</td>
<td>48</td>
<td>26.4%</td>
<td>0</td>
<td>0%</td>
<td>48</td>
<td>11.9%</td>
</tr>
<tr>
<td>Equality for girl child</td>
<td>7</td>
<td>3.8%</td>
<td>3</td>
<td>1.3%</td>
<td>10</td>
<td>2.5%</td>
</tr>
<tr>
<td>Menstrual hygiene</td>
<td>1</td>
<td>0.5%</td>
<td>44</td>
<td>19.7%</td>
<td>45</td>
<td>11.1%</td>
</tr>
<tr>
<td>Family planning</td>
<td>49</td>
<td>26.9%</td>
<td>72</td>
<td>32.3%</td>
<td>121</td>
<td>29.9%</td>
</tr>
</tbody>
</table>
FIGURE: 6.8

Specific changes in RSH related attitude of MFR after reverse communication

The table above and the figure show the specific changes in the attitude of MFR towards RSH related issues after reverse communication. This report is based on the feedback from RSH educated girls and MFR regarding the attitude changes of MFR. This was a multiple response and each respondent has given at-least 3 responses.

Only 0.5% responses from RSH educated girls and 0.4% responses from MFR reported attitudinal changes among MFR regarding “child marriage”. 14.3% responses from RSH educated girls and 31.3% responses from MFR reported attitudinal change in MFR regarding “RSH related discussion with husband”. 27.5% responses from RSH educated girls and 13.9% responses from MFR reported attitudinal changes among MFR regarding “attitude towards self and sexuality”. 26.4% responses from RSH educated girls and 0% responses from MFR reported attitudinal changes among MFR regarding “RSH discussion with mother in law”.

3.8% responses from RSH educated girls and 1.3% responses from MFR reported attitudinal changes among MFR regarding “equality for girl child”. Only 0.5% responses from RSH educated girls and 19.7% responses from MFR reported attitudinal changes among MFR regarding “menstrual hygiene”. 26.9% responses from RSH educated girls and 32.3% responses from MFR reported attitudinal changes among MFR regarding
“Family Planning”. The maximum attitudinal change among MFR was reported for “Family Planning” “RSH related discussion with husband” Attitude towards self and sexuality”.

According to community health workers, approximately 40% felt the MFR had improved motivation regarding use of family planning. Approximately 30% felt the MFR had more improved motivation to discuss RSH issues with husband and mother in law. Approximately 50% felt the MFR had improved self-image and attitude towards sexuality.

If we co-relate the data on knowledge change among MFR with change in practice among MFR, then we can conclude that the change in knowledge related to “menstrual hygiene” is 35.3% and change in practice related to “menstrual hygiene” is 22.9%. Thus we can say that the self-reported change in attitude towards “menstrual hygiene” by MFR (19.7%) is more relevant that the 0.5% change in attitude reported by the RSH educated girls

**MFR WHO DISPLAYED/ REPORTED MAXIMUM POSITIVE IMPROVEMENT IN ATTITUDE**

**Multiple Response Table**

*Interpreting the multiple response frequency table. The total number of respondents was n=75 (RSH educated girls 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 202. This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.*
CHAPTER 6  FINDINGS AND DISCUSSIONS

TABLE: 6.1.17
MFR WHO DISPLAYED/ REPORTED MAXIMUM POSITIVE IMPROVEMENT IN ATTITUDE

<table>
<thead>
<tr>
<th>MFR who displayed/ reported maximum change in attitude</th>
<th>Acc. To RSH educated girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Sister</td>
<td>64</td>
</tr>
<tr>
<td>Brother’s wife (Bhabhi)</td>
<td>66</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>5</td>
</tr>
<tr>
<td>Elder aunt (tai)</td>
<td>9</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>11</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
</tr>
<tr>
<td>Mother</td>
<td>14</td>
</tr>
<tr>
<td>Friends</td>
<td>30</td>
</tr>
</tbody>
</table>

FIGURE: 6.9
MFR WHO DISPLAYED/ REPORTED MAXIMUM POSITIVE IMPROVEMENT IN ATTITUDE

MFR who displayed maximum positive change in attitude
CHAPTER 6 FINDINGS AND DISCUSSIONS

The above table and figure represent the relationship wise MFR who displayed maximum positive change in their attitude towards RSH related issues. This report is as per the information provided by the RSH educated girls based on their observations. This question was multiple response type.

32.7% responses from RSH educated girls reported that the “brother’s wife” displayed maximum positive change in attitude towards RSH related issues as compared to 31.7% responses for “sister”, 14.9% “friends” 6.9% “mother”, 5.4% “father’s sister”, 2.5% “younger aunt” and 1% “mother’s sister”.

According to the RSH educated young women, the MFR relations who showed maximum positive improvement in attitude were 1) Brother’s wife – bhabhi (32.7%), 2) Married sister (31.7%).

Here again we can see the same trend as we saw in “knowledge”. The lesser the age gap between RSH educated girls and MFR, the more is the displayed attitudinal change among MFR.

During the discussion with community health worker, they reported that the MFR who showed positive maximum improvement in attitude were 1) Brother’s wife 2) Married sister.

MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN ATTITUDE

Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was n=75 (RSH educated girls 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 136. This is the total
number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE: 6.1.18
MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN ATTITUDE

<table>
<thead>
<tr>
<th>MFR who displayed/ reported minimum change in attitude</th>
<th>Acc. To RSH educated girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Sister</td>
<td>1</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>18</td>
</tr>
<tr>
<td>Elder aunt (tai)</td>
<td>21</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>13</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>33</td>
</tr>
<tr>
<td>Mother</td>
<td>49</td>
</tr>
<tr>
<td>Mother in law</td>
<td>1</td>
</tr>
</tbody>
</table>

FIGURE: 6.10
MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN ATTITUDE
The above table and figure represent the relationship wise MFR who displayed minimum positive change in their attitude towards RSH related issues. This report is as per the information provided by the RSH educated girls based on their observations. This question was multiple response type.

36% responses from RSH educated girls reported that the “mother’s” displayed minimum positive change in attitude towards RSH related issues as compared to 24.3% responses for “mother’s sister”, 15.4% for “elder aunt” 13.2% for “younger aunt”, 9.6% for “father’s sister”, 0.7% for “sister” and 0.7% for “mother in law”.

According to the RSH educated young women, the MFR relations who showed minimum positive improvement in attitude were 1) Mother (36%) 2) Mother’s sister - masi (24%) and 3) Elder aunt (15.4%)

During the discussion with community health worker, they reported that the MFR who showed minimum positive improvement in attitude were 1) Mother 2) Mother in law and 3) Aunts

**CHANGE IN PRACTICE**

The ultimate goal of all the IEC (Information, Education, and Communication) and behaviour change communication is to see the desired change or improvement in the behaviour/ practice of the target group. Thus the desired change in practice/ behaviour is often the main indicator to judge the success of any intervention.

In this section we will look at the RSH related change in practice/ behaviour of MFR, due to reverse communication.
TABLE: 6.1.19
POSITIVE CHANGES IN RSH RELATED PRACTICE AMONG MFR

<table>
<thead>
<tr>
<th>Change in RSH related PRACTICE in MFR</th>
<th>TYPE OF GROUP</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acc. To RSH educated girls</td>
<td>Acc. To MFR</td>
<td>TOTAL</td>
<td>%</td>
</tr>
<tr>
<td></td>
<td>No. of RSH edu. gir</td>
<td>RSH</td>
<td>No. of MFR</td>
<td>%</td>
</tr>
<tr>
<td>YES</td>
<td>68</td>
<td>90.7%</td>
<td>75</td>
<td>100%</td>
</tr>
<tr>
<td>NO</td>
<td>7</td>
<td>9.3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>75</td>
<td>100%</td>
<td>75</td>
<td>100%</td>
</tr>
</tbody>
</table>

Interpretation of Table- the total number of respondents for the above table is n= 150 (RSH educated girls- 75 and MFR- 75. 75+75= 150)

This table depicts the percentage of positive change in RSH related practice as reported by RSH educated girls and MFR. 91% RSH educated girls felt that they observed positive changes in the RSH related practice/ behaviour of the MFR after the reverse communication following RSH education of young girls. 100% MFR felt that they have observed positive changes in their RSH related practice/ behaviour, after the RSH education of the young girls in their family. Approximately 30% community health workers felt that there is positive change in the RSH related practice/ behaviour of the MFR after the RSH education of at least one girl from their family.

SPECIFIC CHANGES IN RSH RELATED PRACTICE/ BEHAVIOUR
The following table describes the specific RSH related change in practice. This report is based on the responses from RSH educated girls and MFR. This was an open ended question and multiple response type. The respondents have given more than one response for this in most of the cases.

Multiple Response Table
Interpreting the multiple response frequency table. The total number of respondents was n=150 (RSH educated girls 75 + MFR 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 179 and in second column (MFR) total response is 196. The Total responses column adds up to 375
responses. This is the total number of responses; since each respondent could give up to 3 responses, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE: 6.1.20**

**SPECIFIC CHANGES IN RSH RELATED PRACTICE/ BEHAVIOUR**

<table>
<thead>
<tr>
<th>Specific change in RSH related PRACTICE</th>
<th>TYPE OF GROUP</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RSH edu. Girls</td>
<td>MFR</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
</tr>
<tr>
<td>Child marriage</td>
<td>10</td>
<td>5.6%</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>RSH related discussions with husband</td>
<td>49</td>
<td>27.4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Menstrual hygiene</td>
<td>38</td>
<td>21.2%</td>
<td>48</td>
<td>24.5%</td>
</tr>
<tr>
<td>Equality for girl child</td>
<td>4</td>
<td>2.2%</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Family planning</td>
<td>51</td>
<td>28.5%</td>
<td>73</td>
<td>37.2%</td>
</tr>
</tbody>
</table>

**FIGURE: 6.11**

Specific changes in RSH related practice/ behaviour
The above table and figure depict the specific positive changes in RSH related practices amongst MFR. These reports are based on feedback from RSH educated girls and MFR after the reverse communication.

Only 5.6% responses from RSH educated girls and 0.5% responses from MFR reported positive change in practice related to “child marriage”. 27.4% responses from RSH educated girls and 0% responses from MFR reported positive change in practice related to “discussing RSH educated girls with husband”. 21.2% responses from RSH educated girls and 24.5% responses from MFR reported positive change in practice related to “menstrual hygiene”. Only 2.2% responses from RSH educated girls and 1% response form MFR reported positive change in practice related to “equal treatment for girls”. 28.5% responses from RSH educated girls and 37.2% responses from MFR reported positive change in practice related to “family planning”. Maximum change in RSH related practice post reverse communication among MFR was reported for “Family Planning” (33.1%) and “Menstrual Hygiene” (22.9%). According to community health workers, approximately 40% felt the MFR were using family planning methods, especially sterilization. Approximately 30% felt the MFR were discussing RSH issues with husband and mother in law.

**MFR WHO DISPLAYED/ REPORTED MAXIMUM POSITIVE IMPROVEMENT IN PRATICE/ BEHAVIOUR**

The following table describes the MFR who have displayed maximum change in RSH related practice, according to RSH educated girls. This was a multiple response open ended question.

**Multiple Response Table**

*Interpreting the multiple response frequency table. The total number of respondents was n=75 (RSH educated girls 75). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 189. This is the total number of responses; since each respondent could give more than one response, the total*
number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

**TABLE: 6.1.21**

**MFR WHO DISPLAYED/ REPORTED MAXIMUM POSITIVE IMPROVEMENT IN PRACTICE/ BEHAVIOUR**

<table>
<thead>
<tr>
<th>MFR who displayed/ reported change in PRACTICE</th>
<th>Acc. To RSH educated girls</th>
<th>No. of RESPONSES</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sister</td>
<td></td>
<td>64</td>
<td>33.9%</td>
</tr>
<tr>
<td>Brother’s wife (Bhabhi)</td>
<td></td>
<td>66</td>
<td>34.9%</td>
</tr>
<tr>
<td>Elder sister in law</td>
<td></td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>younger aunt (chachi)</td>
<td></td>
<td>3</td>
<td>1.6%</td>
</tr>
<tr>
<td>Elder aunt (tai)</td>
<td></td>
<td>8</td>
<td>4.2%</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td></td>
<td>10</td>
<td>5.3%</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td></td>
<td>3</td>
<td>1.6%</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>14</td>
<td>7.4%</td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td>19</td>
<td>10.1%</td>
</tr>
</tbody>
</table>
The above table and figure represent the relationship wise MFR who displayed maximum positive change in their practice towards RSH related issues. This report is as per the information provided by the RSH educated girls based on their observations. This question was multiple response type.

34.9% responses from RSH educated girls reported that the “brother’s wife” displayed maximum positive change in practice towards RSH related issues as compared to 33.9% responses for “sister”, 10.1% responses for “friends”, 7.4% responses for “mother”, 5.3% responses for “father’s sister”, 4.2% for “elder aunt”, 1.6% responses for “younger aunt” and 0.5% responses for “elder sister in law”.

According to the RSH educated young women, the MFR relations who showed maximum positive improvement in practice were 1) Brother’s wife – bhabhi (34.9%), 2) Sister (33.9%).

Here again we can see the same trend as we saw in “knowledge and attitude”. The lesser the age gap between RSH educated girls and MFR, the more is the displayed positive change in practice among MFR.

During the discussion with community health worker, they reported that the MFR who showed maximum positive improvement in attitude were 1) Brother’s wife 2) Married sister

**MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN PRATICE/ BEHAVIOUR**

The following table describes the MFR who have displayed minimum change in RSH related practice, according to RSH educated girls. This was a multiple response open ended question.
Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was \( n = 75 \) (RSH educated girls), The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 116. This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE 6.1.22

MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN PRATICE/ BEHAVIOUR

<table>
<thead>
<tr>
<th>MFR who displayed/ reported minimum change in PRACTICE</th>
<th>Acc. To RSH educated girls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
</tr>
<tr>
<td>Younger aunt (chachi)</td>
<td>25</td>
</tr>
<tr>
<td>Elder aunt (tai)</td>
<td>3</td>
</tr>
<tr>
<td>Father’s sister (bua)</td>
<td>14</td>
</tr>
<tr>
<td>Mother’s sister (masi)</td>
<td>33</td>
</tr>
<tr>
<td>Mother</td>
<td>41</td>
</tr>
</tbody>
</table>

FIGURE: 6.13

MFR WHO DISPLAYED/ REPORTED MINIMUM POSITIVE IMPROVEMENT IN PRATICE/ BEHAVIOUR
CHAPTER 6  FINDINGS AND DISCUSSIONS

The above table and figure represent the relationship wise MFR who displayed minimum positive change in their practice towards RSH related issues. This report is as per the information provided by the RSH educated girls based on their observations. This question was multiple response type.

35.3% responses from RSH educated girls reported that the “mother’s” displayed minimum positive change in practice towards RSH related issues as compared to 28.4% responses for “mother’s sister”, 21.6% responses for “younger aunt” 12.1% responses for “father’s sister”, 2.6% responses for “elder aunt”.

According to the RSH educated young women, the MFR relations who showed minimum positive improvement in practice were 1) Mother (35.3%)  2) Mother’s sister - masi (28.4%) and 3) younger aunt (28.6%)

During the discussion with community health worker, they reported that the MFR who showed minimum positive improvement in attitude were 1) Mother 2) Mother in Law and 3) Aunts

EXAMPLES FROM FIELD

A) An RSH educated girl from village Ravasar reported:

“The elder sister was married off at 14yrs but after the girl was edu in RSH the other sister was married off at completing 18 yrs.”

B) An RSH educated girl from village Ravasar reported:

“Earlier the MFR used to dry the menstrual cloth in shady places but now they dry it in sun. Earlier MFR never thought it was right for them to care about their sexual health but now they do and ask questions too. Now MFR discuss RSH related matters with their husbands and also give them knowledge on the same.”

C) An RSH educated girl from village Ravasar reported:

“Bua (father’s sister) got sterilization done after one child, with the help of RSH educated girl’s mother.”
D) An RSH educated girl from village Ravasar reported:

“Elder sister got sterilization done with help of mother after the birth of a son and a daughter.”

E) An RSH educated girl from village Nakodesar reported:

“Sister used sand for periods earlier, now uses cloth.”

F) An RSH educated girl from village Sabania reported:

“MFR of family do what they want to do, they don’t listen or ask us. MFR observe us and our changed RSH behaviour and ask us why we are doing that. But then they mock at us”

G) An MFR from 1 SLD village

“Change in behaviour mostly related to Menstrual hygiene, Sterilization, Spacing (copper T)”

H) An MFR from 1 SLD village reported

“When we wanted and needed the information, then nobody told us anything. Now when our whole life is ruined and gone, what use is this information of? We wish that our daughters should not have life like us.”

I) An MFR from Bakhusar reported:

“It is odd to talk to these young girls about these issues, but when the source of knowledge is living with you in the same house and hospital and doctor are far away, you get tempted to ask them.”
CHAPTER 6  FINDINGS AND DISCUSSIONS

FINDINGS FROM FGD

The most interesting fact about Reverse Communication is that it was not intentional, planned or goal oriented. The whole process of reverse communication has been taking place spontaneously. At the end of the training program the RSH educated young women were told to spread the knowledge to their peer in their villages and schools. But the transfer of knowledge to MFR was neither planned nor expected.

Adolescents are a good source to send home messages related to hygiene, balanced diet etc. but the same was believed to be not so true for sexuality related issues.

- There has been significant improvement in menstrual health and hygiene of MFR.
- The MFR are using more family planning methods and also opting for sterilization.
- In some cases the mothers got so motivated that they got sterilization done for themselves.
- There is increased reporting of institutional deliveries in these families where there is an RSH educated girl.
- Mothers felt that they did not have the accurate knowledge and support from their families and mothers when they were young. They feel that the RSH educated young women should not let anyone ruin their lives.
- One measure of change in RSH KAP is ‘child marriages’. In the schedules, no respondent has mentioned the change in KAP related to child marriage.
- The FGD have shown that there is tremendous improvement in attitude towards child marriages. The change in practice is meagre but present.
- Many MFR have started discussing about their reproductive health to their husbands and motivated them to take part in RSH decisions of the couple.
- Many older MFRs felt that the knowledge that the RSH educated girls have got is very crucial and is of little help to them at this age when they have already completed the crucial stages of their lives. They expressed that if this knowledge would have come to them at the time they needed it the most, their lives would have been much better.
- The self-image and confidence among some MFR has also improved.
It will not be completely true to credit all this change in KAP of MFR to reverse communication. There are other factors like media (street theatre, radio), community health worker and doctors, teachers of local schools etc. but looking at the sudden improvement in the KAP of MFR after the RSH education of girls in family, we can say that Reverse Communication has played an important role in improving the RSH related KAP of MFR. Not only has it improved the overall quality of interaction between the girls and their female relatives but also their own lives.
CHAPTER 6  FINDINGS AND DISCUSSIONS

FIGURE: 6.14

Factors affecting Reverse Communication

REVERSE COMMUNICATION MODEL

- Financial position
- Formal Education of self, husband, family
- Informal RSH Education of all stakeholders
- Structured RSH Education of all stakeholders
- Rights and Empowerment Training
- Level of authority in relation and family
- Change in KAP
- General Education
- Financial Position
- Level of authority in family
- Informal RSH Education

Mode of Communication
- Verbal
- Non Verbal
- Behaviour Demonstration

RSH RELATED COMMUNICATION

RSH EDUCATED YOUNG WOMEN

MARRIED FEMALE RELATIVES

Age of MFR
Beliefs, Values and Attitudes of MFR
Quality of Relationship between MFR and RSH Educated Girl
Age Gap Between MFR and RSH Educated Girl
Relationship Hierarchy in Family

Change in KAP
CHAPTER 6 FINDINGS AND DISCUSSIONS

REVERSE COMMUNICATION MODEL

Based on the findings of this study, a model of REVERSE COMMUNICATION has been developed to understand the whole process of reverse communication and the factors affecting it.

Various components of Reverse Communication Model:

A) MODE OF COMMUNICATION

The communication regarding RSH between RSH educated girls and MFR is a two way process. The whole process is informal in nature. The communication is not one time like structured RSH education, rather it is life-long. The various forms of communication are as follows:

1) Verbal communication

This form of communication takes place when the information related to RSH is communicated verbally. Example: a 15 year old RSH educated girl whose mother was suffering from lower abdomen pain and discharge and due to failing health, this girl was taking care of younger siblings and the house, told her mother that she might be suffering from Reproductive Tract Infection (RTI) and that she should visit doctor. This form of communication is usually prompted by some phenomenon or questioning and is often but not always a response to a question or situation.

2) Non-verbal communication

This form of communication occurs when the RSH educated girl does not communicate the knowledge verbally but uses non-verbal means to transfer the knowledge. Example- after attending the RSH education program, a 14year old girl went back home where the women of the family were preparing for the elder daughter’s delivery at home. This RSH educated girl just went to the room and replaced the dirty blade with a new one. Nobody said anything to her at that time, but praised her later on.
3) **Behaviour demonstration**

This form of communication takes place when the MFR observes certain RSH related behaviour in the RSH educated girl after her training. The MFR notices that the behaviour in demonstration is having a positive implication on the RSH girl. This behaviour demonstration might motivate the MFR to replicate or copy that behaviour in her own life. Example: a newly married RSH educated girl negotiated with her husband to delay the first pregnancy and started using OCP. Her Devrani (husband’s brother’s wife) observed the happy and tension free life the RSH educated girl was leading and did not show any side effects of the OCP too. Thus she had a discussion with her and started using OCP to delay her first pregnancy.

**B) PERSONAL DEVELOPMENT INPUTS**

For the overall personality development, no one factor contributes single handed. It is a combination of various factors and inputs that together form a personality. These inputs start getting into the individual from birth and continue life-long. Some of these inputs which affect the changes in KAP of RSH educated girl and MFR are listed below.

1) **Formal education**

The schooling attended in a formal setup, has an overall impact on the learning of people. The more number of years spent actively in school result in more knowledge and more confidence in using that knowledge. This is for all stakeholders (self, husband, family)

2) **Informal RSH knowledge**

The informal RSH knowledge transfer that begins from childhood, in the traditional mode (from older family members to younger ones). This knowledge transfer though has many myths and misconceptions, but also has much useful information. Traditionally everyone has been getting this knowledge by the informal means. It is not one time but life-long.

3) **Structured RSH education**

The structured RSH education program is the module based RSH education which is designed and implemented by authorized government or non-government
bodies with the purpose of giving accurate knowledge to bring about positive change in KAP. This kind of education or knowledge transfer is usually one time. In some cases there is follow up or refresher courses too.

4) Rights and empowerment training
The rights based empowerment trainings attended by the individual also gives additional practical knowledge and attitude to negotiate ones rights. This factor, coupled with formal education, personality trait and independence, is very crucial in exercising the RSH related KAP.

5) Financial position
Another crucial factor is the financial position of the women. Many a times we have that despite knowledge, education, and will power women are not able to take tough decisions or negotiate. One of the main reasons is their “fall-back position”. They know that if they take a decision against the will of their husband or family, they might just throw her out of the house. If she is in a position to manage her life on her own, she might be able to take some tough decisions. But finances alone does not decide the fall back position of women. It is also the social acceptability of the act.

6) Level of authority in marital relationship and family
This is usually the strength of the marital relationship and the family relationship. Usually a newly-wed girl does not have much authority in the family or in relationship with husband. Thus she does not challenge any norms or rules. But as the relationship gets older or the financial position of the couple gets better in the family, the woman gets more authority in the relationship. At this point she is in a better negotiating position. Also the oldest daughter-in-law has more authority and say in the family than the youngest. Another factor is the weight of dowry or the size of land holding of the wife’s maternal family. Usually in these cases the girl is treated better and she has more confidence in negotiating her rights.
CHAPTER 6  FINDINGS AND DISCUSSIONS

C) FACTORS AFFECTING REVERSE COMMUNICATION

1) Age of MFR

Usually the younger the MFR (bhabhi, sister in law), more likely she is to interact with the RSH educated girl on these issues. The relationship is not very formal as compared to the older MFRs (mother, mother in law). The older MFR maintain a very formal authoritative relationship with the younger girls in the family. Thus there the quality of RSH communication is not as vibrant as that with younger MFR. The other reason is that the younger MFR are still in the reproductive age group thus they have a lot of queries and need lot of information which they can use. The older MFR have usually crossed the reproductive age and have fulfilled all their reproductive targets, thus are not much interested in the RSH related knowledge.

2) Values, attitudes and beliefs of MFR

The process of learning something new is easier than the process of de-learning something and then learning new way of doing the same thing. There are lots of biases, myths, values and attitudes that we all have regarding certain issues. Thus the quality of RSH communication depends upon how and how much these values and attitudes affect MFR in learning and implementing the knowledge coming to them. In many cases even if they do get exposed to this knowledge, they are not readily willing to shun their ages old beliefs and prejudices.

3) Quality of relationship between MFR and RSH educated girl

The friendlier the relationship between the RSH educated girl and MFR, the more the chances are of learning from verbal, nonverbal and demonstration effect.

4) Age gap between MFR and RSH educated girl

Lesser age gap between RSH educated girl and MFR leads to a friendlier and less formal interaction between them. The lesser age gap creates a peer like situation at times. Also that the reproductive health related concerns are similar at similar
age for MFR and RSH educated girl, thus the chances of meaningful communication increase.

5) **Relationship hierarchy in the family**

Most of the families in rural India are joint families and there is an unsaid hierarchy in the family. Usually the oldest married female member controls the other women in the family. If the RSH educated girl is somewhere in the middle of the hierarchy, it is easier for her to influence the other MFR in the family.

Thus looking at the REVERSE COMMUNICATION MODEL we can say that the “PERSONAL DEVELOPMENT INPUTS” shape the individual and empower her to bring about positive changes in her RSH related KAP (knowledge, attitude and practice). The stronger the personal development inputs, the more the changes in KAP. The personal development inputs do not affect the quality of reverse communication directly, but they influence the individual in such a way that along with the other factors, like the age gap between RSH educated girl and MFR, the quality of relationship between the two groups, the relationship hierarchy within family, age of MFR, the values attitudes and beliefs of MFR together affect the quality of reverse communication and overall KAP of the person is influenced.

**DISCUSSIONS- REVERSE COMMUNICATION**

- **Incidence of reverse communication**

Almost all the RSH educated girls and all the MFR reported that communication (verbal, non-verbal or demonstrating behaviour) related to RSH issues has taken place from RSH educated girl to MFR.

The top 3 enquirers were – MOTHER, SISTER and BHABHI (brother’s wife). But **when we look at the changes in KAP of MFR, the MOTHER is not the top gainer**. While most of the MFR said that they enquired about the education program for “educational” and “curiosity” purpose, some MFR said that their purpose was “authoritative”. The
reasons might be different for different MFRs, for enquiring. But one advantage of the whole process was that it broke some ice between the RSH educated young woman and the MFR and proved to be a communication starter.

These relatives (mother, sister and Bhabhi) were also the most common relatives found in almost all families. Aunts were not present in all the families but mother, married sister/sister-in-law and bhabhi were present in almost all the families. This could be another reason for the high number of these relatives enquiring about training programme.

- **Nature of topics discussed**

Though RSH education involves a long list of topics but the process of Reverse Communication saw a particular interest in certain topics/issues from the point of view of MFRs.

While RSH educated young women felt that the **most easily discussed topics** were- Safe childhood, Changes during adolescence and STD/STI. The MFR felt that the 3 most easily discussed components were- Safe childhood, Menstruation and STD/STI. Whereas the top 3 topics discussed **most hesitantly** were- Abortion, Family planning, HIV/AIDS, Pregnancy, Changes during adolescence and Menstruation. Some topics which both the respondent groups reported that they **deliberately did not discuss** them were- Abortion, Safe motherhood, Family planning, Pregnancy, STD/STI and HIV/AIDS.

Some topics are overlapping between categories, like STI/STD have been reported as most easily discussed and also deliberately not discussed. Similarly “changes during adolescence” has also been mentioned as most easily discussed and at the same time most hesitantly discussed. The overlap is due to the nature of response being **“multiple responses”**. Since each respondent has given at-least 5 responses to each category, there are some who found a particular topic easy, while others found it difficult to discuss.

**The perception of ease or hesitation is a part of social construct and socialization process.** The issues related to RSH have never been very easy to discuss in our society due to the cultural and social stigma attached to it. But that is not the only factor which decides which topic is easy and which is difficult to discuss. There are other factors like-
- Specific physical or emotional problem being faced by an individual and level of concern regarding it. This can be understood from the following example: The incidence of symptoms related to RTI (reproductive tract infections) are very high in the study area, thus there was more than expected discussion on these issues.

- Strength of desire to improve certain aspect of RSH. This could be highlighted by the individual desire of a respondent to improve a certain aspect of her life, like reducing the number of pregnancies or going for safer options for abortion. This might prompt a particular MFR to enquire more and ask more questions regarding these issues.

- Presence of credible source of information which is easily accessible. If a community has a trained medical or health worker within easy reach then the respondents prefer to seek information from them. But in cases where this ease of access is not available, an unconventional source like RSH educated girl is not a bad option for MFR.

- Behaviour demonstration is a very powerful tool to induce behaviour change by motivation and setting example.

❖ *Comfort level while discussing*

As discussed above, the perception of ease and comfort while discussing RSH related issues is a function of social construct and socialization process. The MFRs felt that they were more comfortable than the RSH educated young woman while discussing RSH issues. While the RSH educated young women felt that they were more comfortable than the MFR while discussing RSH issues.

The MFRs gauged the comfort level of RSH educated girls from the details of explanations they were giving for each discussion. Due to age difference and various other factors like quality of relationship with MFR, stigma and hesitation, the RSH educated girls were more comfortable in “behaviour demonstration” mode of Reverse Communication than the verbal mode.
CHAPTER 6 FINDINGS AND DISCUSSIONS

preferred source of knowledge (MFR and RSH edu)

For the MFR, RSH educated girl was not the most preferred source of RSH knowledge. Not at least by verbal mode of communication. The MFR felt that they would be more comfortable in asking questions to a health worker, doctor, nurse or a friend who has accurate knowledge as that does not affect the level of authority within the family and relationship.

They accepted that the behaviour demonstration way of reverse communication is easier than the verbal mode of reverse communication.

change in KAP

As we have seen in the previous chapter, the MFR who has shown the maximum level of positive change in KAP (knowledge, attitude and practice) related to RSH are married sister and Bhabhi. The MFR who has displayed the least change in KAP are Mother and older aunts.

If we correlate this to the fact that mother was among the MFR who enquired the most, it brings us to the conclusion that mere enquiring does not lead to changes in KAP there are other factors which contribute in changes to KAP. The mother and other older relatives did enquire because they had an authoritative role in the lives of the young women of their families. Since it was a residential training away from home for many of them, the figures in authority within the family felt it imperative to ask the girls about what they had learnt at the training.

The younger MFR showed more changes in their KAP because they were still in the process of pregnancy, child birth, taking care of young child and contracting RTI, STI. Whereas for most of the older MFR, the cycle of reproduction and related events was coming to an end, thus they were not much inclined to implement the new knowledge which was coming in from the RSH educated girls.
FINDINGS

2. DYNAMICS OF INTERACTION AND COMMUNICATION OF YOUNG PEOPLE WITH SPOUSE AND FAMILY:

RSH education is meant to improve the knowledge of the young girl in such a way that she can improve her life. This education is supposed to empower her to make the right choices and fulfil her fundamental rights and RSH related rights. But at the same time we know that despite RSH education, the only aspect in her life that changes is the Knowledge and the Attitude (KA). There is very little or sometimes no change in Practice (P). Thus the very goal of behaviour change communication is defeated if it does not lead to behaviour change.

Many studies and papers have highlighted the different reasons for this gap in knowledge, attitude and practice. It is a well-documented fact various social, economic, political and cultural reasons are behind this snarling gap in knowledge, attitude and practice.

In this study there is an attempt to look at the process of this failure to change practice. The attempt is to understand:

1) What does the RSH educated young woman do with the improved knowledge and attitude?
2) Does she try to bring about change in practice (self, others, as couple)?
3) What is the exact process of negotiation she adopts to exercise her RSH rights?
4) How does she communicate with her husband and family on these issues?
5) Is there any difference in the process and dynamics of interaction and communication of the RSH educated girl with her spouse and family vis a vis the non RSH educated girl’s interaction with her spouse and family?
6) What are the factors that influence the dynamics of interaction and communication of the RSH educated girl with her husband and family vis a vis the Non RSH educated girl?
CHAPTER 6 FINDINGS AND DISCUSSIONS

This section of the chapter is going to focus on the above mentioned issues and correlate them with the findings of the study.

We are looking at the dynamics of interaction and communication of young women (RSH and Non RSH educated) with their husband and family. There are many aspects of reproductive and sexual life which could be discussed. But for the manageability of this study, the aspect that affects the lives of married young people the most is being looked at. This issue is FAMILY PLANNING. As it affects the:

1) Overall health of the women (nutrition, immunizations, productivity, general wellbeing)
2) Overall health of children (birth weight, immunizations, nutrition, general wellbeing, education)
3) Bargaining power of women within family and marriage.
4) Overall quality of relationship between the couple and among the family members.

DYNAMICS OF INTERACTION AND COMMUNICATION
This section looks at the dynamics between the:

- RSH educated young women and her husband,
- MFR and her husband
- Non RSH educated young women and her husband.

FAMILY PLANNING/ CONTRACEPTION

Contraception discussion
Contraception discussion is the very first step to using the contraception. Very often the newly-weds are hesitant to talk about contraception initially and when the hesitation goes away, they already have children which could have been spaced well leading to good health for the mother and the children both.
TABLE: 6.2.1  
CONTRACEPTION DISCUSSION EVER WITH HUSBAND

<table>
<thead>
<tr>
<th>Was contraception discussed with husband ever?</th>
<th>Acc. To RSH edu. Girls</th>
<th>Acc. To Non RSH edu. Girls</th>
<th>Acc. To MFR</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. Girls</td>
<td>%</td>
<td>No. of Non RSH edu. Girls</td>
<td>%</td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td>83.8%</td>
<td>27</td>
<td>67.5%</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>6.45%</td>
<td>13</td>
<td>32.5%</td>
</tr>
<tr>
<td>Did not answer</td>
<td>3</td>
<td>9.67%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>20.66%</td>
<td>40</td>
<td>26.66%</td>
</tr>
</tbody>
</table>

Interpretation of the Table: \( n = 146 \). This question was asked to ONLY FEMALE MARRIED RESPONDENTS who were administered Schedules for data collection. (Married RSH educated girls-31, MFR-75 and Married Non-RSH educated girls-40).

Thus the total number of valid cases for this table was \( 31 + 40 + 75 = 146 \)

FIGURE: 6.15

Contraception discussion ever with husband

![Contraception Discussion Graph]

The table and figure given above, depict the percentage of instances of contraception discussion between three sets of respondents: 1) RSH educated young women, 2) MFR of RSH educated young women and 3) Non RSH educated young women. This table is
CHAPTER 6 FINDINGS AND DISCUSSIONS

based upon the responses gathered from the above mentioned respondents in ‘yes’ and ‘no’ format.

83.8% RSH educated married young women reported that they did have contraception discussion with their husband as compared to 67.5% Non-RSH educated girls and 26.7% MFR. Only 6.45% RSH educated girls did not report contraception discussion with husband and 9.67% refused to answer this question, as compared to 32.5% Non-RSH educated girls and 73.3% MFR of RSH educated girls. Of all the respondents taken together, 50% respondents reported contraception discussion as against 49% who did not report contraception discussion.

In this table we can see that the number of RSH respondents is much lesser (31) as compared to Non-RSH educated girls (40) and MFR (75). Still the percentage of respondents reporting contraception discussion is higher among RSH educated girls than their non-RSH counterpart and MFR. Since the attributes of the groups are similar, this higher percentage might be due to the formal RSH education received by this group of RSH educated young women.

**TABLE: 6.2.2**

**WHO SHOULD INITIATE THE CONTRACEPTION DISCUSSION**

<table>
<thead>
<tr>
<th>Who should initiate contraception discussion</th>
<th>Acc. To RSH edu. Girls</th>
<th>Acc. To MFR</th>
<th>Acc. To Non RSH edu. Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. Girls</td>
<td>%</td>
<td>No. of MFR</td>
<td>%</td>
</tr>
<tr>
<td>Wife</td>
<td>12</td>
<td>39.3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Husband</td>
<td>7</td>
<td>21.4%</td>
<td>59</td>
<td>78.7%</td>
</tr>
<tr>
<td>Whoever has knowledge</td>
<td>12</td>
<td>39.3%</td>
<td>16</td>
<td>21.3%</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>19.6%</td>
<td>75</td>
<td>52.4%</td>
</tr>
</tbody>
</table>

**Interpretation of the Table:** n= 146. This question was asked to ONLY FEMALE MARRIED RESPONDENTS (Married RSH educated girls-31, MFR-75 and Married Non-RSH educated girls-40). Thus the total number of valid cases for this table was 31+40+75=146
The table above depicts the percentage of responses regarding the perception of the three respondent groups (1- RSH educated young women, 2- Non-RSH educated young women and 3- MFR). These responses are categorized as “wife should initiate contraception discussion- WIFE”, “husband should initiate contraception discussion- HUSBAND” or “whoever has the knowledge should initiate contraception- WHOEVER HAS KNOWLEDGE”.

39.3% RSH educated girls felt that the wife should initiate contraception discussion as compared 0% MFR and 22.5% Non-RSH educated girls. 21.4% RSH educated girls felt that the husband should initiate the contraception discussion as compared to 78.7% MFR and 42.5% Non-RSH educated girls who felt that the husband should initiate contraception discussion. 39.3% RSH educated girls felt that whoever has knowledge (husband or wife) should initiate the contraception discussion as compared to 21.3% MFR and 35% Non-RSH educated girls. If we look at the total response for all the three categories of respondents, we can see that a majority of respondents (56.8%) felt that the husband should initiate contraception discussion.

These findings point towards the patriarchal mind sets which put the responsibility of controlling fertility of both men and women on the shoulders of men. The RSH educated girls were in majority saying that the person who has more knowledge should initiate the discussion or the wife should initiate the discussion. But among the Non-RSH educated group and MFR, the opinion was more tilted towards husband initiating the discussion.

**WHO ACTUALLY INITIATED THE CONTRACEPTION DISCUSSION?**

The following table gives details of who actually initiated contraception discussion. This is an indicator of RSH educated girls rights as well as empowerment and family planning usage.
CHAPTER 6  FINDINGS AND DISCUSSIONS

TABLE: 6.2.3
WHO ACTUALLY INITIATED THE CONTRACEPTION DISCUSSION?

<table>
<thead>
<tr>
<th>Who initiated contraception discussion</th>
<th>Acc. To RSH edu. Girls</th>
<th>Acc. To MFR</th>
<th>Acc. To Non RSH edu. Girls</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. Girls</td>
<td>%</td>
<td>No. of MFR</td>
<td>%</td>
</tr>
<tr>
<td>Wife</td>
<td>18</td>
<td>69.2%</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>Husband</td>
<td>8</td>
<td>30.8%</td>
<td>15</td>
<td>75%</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
<td>35.6%</td>
<td>20</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

Interpretation of the table- n=73. This question was asked to those RESPONDENTS WHO REPORTED THAT CONTRACEPTION WAS DISCUSSED WITH HUSBAND (refer to Table 6.2.1). RSH educated girls-26, MFR- 20, Non-RSH edu. girls- 27. Thus the total number of respondents for this question was 26+ 20+ 27= 73.

FIGURE: 6.16
Who actually initiated the contraception discussion?

The table and figure above depict the actual discussion of contraception between husband and wife. This table shows-“who actually initiated contraception discussion”. The result is based on the response from RSH educated girls, Non-RSH educated girls and MFR.

69.2% RSH educated young women reported that they (wife) initiated contraception discussion as compared to only 22.2% Non-RSH educated girl and 25% MFR where the wife initiated contraception discussion. 30.8% RSH educated girls reported that the husband initiated contraception discussions as compared to 77.8% Non-RSH educated...
girls and 75% MFR reporting the same. If we look at the total percentage for all the respondent groups combined then we can see that a majority of 60.2% respondents have reported that the husband initiated contraception discussion. 39.7% respondents reported the wife as the initiator of contraception discussion. Out of this 39.7%, a majority of 62% are RSH educated girls.

From the above data, we can see that there is consistency between the knowledge and attitudinal changes as a result of formal RSH education. The behavioural changes amongst RSH educated girls are consistent with the change in knowledge and attitude as this group has reported higher percentage of wife initiating contraception discussion.

**TIMING OF CONTRACEPTION DISCUSSION**

The timing of contraception discussion is very crucial in deciding the benefits of contraception. If a couple discusses contraception after the birth of four children with no gap in between, then it has lesser benefits for the mother and children as it has already adversely affected the health of the mother and children. Also if a couple where the wife is below the age of 20 years, discusses contraception after the birth of first child, then the benefits are lesser, as the mother has already delivered the child when her body was not fully prepared to do so, leading to bad health for herself and low birth weight and other complications for the baby.

Thus we understand that the timing of contraception discussion and usage has to appropriate to the individual health goals and that of the family.
### CHAPTER 6  FINDINGS AND DISCUSSIONS

#### TABLE 6.2.4
TIMING OF CONTRACEPTION DISCUSSION

<table>
<thead>
<tr>
<th>TIMING OF CONTRACEPTION DISCUSSION</th>
<th>RSH EDUCATED GIRL</th>
<th>NON RSH EDUCATED GIRL</th>
<th>MFR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
<td>%</td>
<td>No. of Non RSH edu. girls</td>
<td>%</td>
</tr>
<tr>
<td>First night of marriage</td>
<td>18</td>
<td>58%</td>
<td>8</td>
<td>20%</td>
</tr>
<tr>
<td>During first month of staying together</td>
<td>2</td>
<td>6.4%</td>
<td>9</td>
<td>22.5%</td>
</tr>
<tr>
<td>During first 6 months of staying together</td>
<td>7</td>
<td>22.5%</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>During first year of staying together</td>
<td>2</td>
<td>6.4%</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>After birth of first child</td>
<td>0</td>
<td>0%</td>
<td>4</td>
<td>10%</td>
</tr>
<tr>
<td>After birth of second child</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>5%</td>
</tr>
<tr>
<td>After first pregnancy</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>2.5%</td>
</tr>
<tr>
<td>Never</td>
<td>2</td>
<td>6.4%</td>
<td>13</td>
<td>32.5%</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>21.2%</td>
<td>40</td>
<td>27.3%</td>
</tr>
</tbody>
</table>

**Interpretation of the Table:** \( n=146 \). This question was asked to **ONLY FEMALEMARRIED RESPONDENTS** (Married RSH edu. girls-31, MFR- 75 and Married Non-RSH edu. girls- 40). Thus the total number of valid cases for this table was 31+40+75= 146
The above table and figure depict the timing of contraception discussion as reported by RSH educated girls, Non-RSH educated girls and MFR. The timing has been divided into eight categories namely 1) First night of marriage 2) During first month of living together 3) First six months of living together 4) First year of living together 5) After the birth of first child 6) After the birth of second child 7) After first pregnancy 8) Never

58% RSH educated girls reported that contraception discussion took place during first night of marriage as compared to 20% Non-RSH educated girls and only 1.3% MFR. 6.4% RSH educated girls reported that contraception discussion took place during first month of living together as compared to 22.5% Non-RSH educated girls and only 0% MFR. 22.5% RSH educated girls reported that contraception discussion took place during first six months of living together as compared to 5% Non-RSH educated girls and only 0% MFR. 6.4% RSH educated girls reported that contraception discussion took place during first year of living together as compared to 2.5% Non-RSH educated girls and 10.7% MFR. 0% RSH
CHAPTER 6 FINDINGS AND DISCUSSIONS

educated girls reported that contraception discussion took place after first child as compared to 10% Non-RSH educated girls and 10.7% MFR. 0% RSH educated girls reported that contraception discussion took place after the second child as compared to 5% Non-RSH educated girls and 4% MFR. 0% RSH educated girls reported that contraception discussion took place after first pregnancy as compared to 2.5% Non-RSH educated girls and only 0% MFR. 6.4% RSH educated girls reported that contraception discussion never took place as compared to 32.5% Non-RSH educated girls and 73.3% MFR.

DISCUSSION

If we look at the total column, maximum number of respondents (47.9%) reported that contraception discussion did not take place ever. 18.4% respondents reported contraception discussion during first night of marriage and 8.2% reported contraception discussion after first child.

This data shows that there is a higher percentage of RSH educated girls and Non-RSH educated girls who reported contraception discussion during early period of marriage as compared to MFR who have the contraception discussion during the latter period of their marriage. The RSH educated girls and Non-RSH educated girls have reported early contraception discussion (first night, first month, first six months and first year). This could be attributed to the younger generation’s attitude towards family size, increased awareness and higher education as compared to the older counterparts (MFR).

As we can see from the data above, there is a very high percentage of MFR (73.3%) who have never discussed contraception as compared to 32.5% Non-RSH girl and only 6.4% RSH educated girls. Since most of the social, cultural, economic profile is similar for these groups, we can conclude that the higher percentage of contraception discussion among RSH educated girls is due to the RSH education they have received.
EXAMPLE FROM FIELD
An RSH educated girl from village Ravasar, reported:
She has talked about FP with her husband and is very sure about not having a child so young. Husband never shared his opinion about her RSH edu. Status, so she doesn’t know what he feels. Hasn’t told in laws. She was very assertive with her husband on the first night about abstinence.

REASONS FOR NOT DISCUSSING CONTRACEPTION
We know that the percentage of respondents who have never discussed contraception is much higher, thus in this section we look at the reasons for them to not discuss contraception.

TABLE: 6.2.5
REASONS FOR NOT DISCUSSING CONTRACEPTION AS REPORTED BY RSH EDUCATED GIRLS, NON-RSH EDUCATED GIRLS AND MFR

<table>
<thead>
<tr>
<th>REASONS FOR NOT DISCUSSING CONTRACEPTION</th>
<th>RSH EDUCATED GIRL</th>
<th>NON RSH EDUCATED GIRL</th>
<th>MFR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
<td>%</td>
<td>No. of Non RSH edu. girls</td>
<td>%</td>
</tr>
<tr>
<td>Husband wanted child</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Couple wanted child</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Felt shy to discuss</td>
<td>0</td>
<td>0%</td>
<td>5</td>
<td>42.9%</td>
</tr>
<tr>
<td>Lack of knowledge</td>
<td>1</td>
<td>50%</td>
<td>8</td>
<td>61.5%</td>
</tr>
<tr>
<td>Husband did not like wife discussing family planning</td>
<td>1</td>
<td>50%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>0.02%</td>
<td>13</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

Interpretation of the Table-n= 70. This question was asked to only those participants who did not discuss contraception (refer to Table 6.2.1). There were a total of 70 respondents (RSH educated girls-2, Non-RSH educated girls-13, MFR-
55) who did not discuss contraception. Total respondents for this question were (2+13+55=70)
The table above depicts the various reasons cited by the respondents for not discussing or using contraception. This data is based on the responses from the three respondent groups (RSH educated girls, Non-RSH educated girls and MFR). The responses have been categorized into 5 categories- 1) husband wanted child, 2) couple wanted child, 3) respondent felt shy to discuss contraception, 4) lack of knowledge regarding contraception and 5) husband did not like wife discussing family planning.

0% RSH educated girls and Non-RSH educated girls reported the reason for not discussing contraception as “husband wanted child” as compared to 27.2% MFR. 0% RSH educated girls and Non-RSH educated girls reported “couple wanted child” as the reason for not discussing contraception as compared to 72.8% MFR. 0% RSH educated girls and MFR cited “felt shy to discuss” as the reason for not discussing contraception as compared to 42.9% Non-RSH educated girls who reported this to be the reason. 61.5% Non-RSH educated girls (4 respondents) and 50% RSH educated girls (1 respondent) reported that lack of knowledge was the reason for them to not discuss contraception as compared to 0% MFR for the same reason. Only 1 respondent from RSH educated girls reported that her husband did not like the wife talking about contraception and therefore they did not discuss it.

The totals column reflects the most significant reason for not discussing contraception as “couple wanted children” (57.1%).

**DISCUSSION**

Only 2 respondents in RSH educated girls group did not discuss contraception. The reasons cited were: Lack of knowledge by 1 respondent and “Husband did not like wife discussing contraception” as the reason cited by the other respondent. It is commendable to note that almost all the married respondents in this group did have contraception discussion, which is a good indicator for the formal education and formal RSH training. Only 13 respondents in the Non RSH educated young women category reported that they did not discuss contraception. 5 respondents reported that they felt shy to discuss
contraception and 8 respondents reported that they did not have the knowledge about contraception. This group does not have formal RSH education but has similar level of educational qualification and informal inputs for RSH knowledge through mass media campaigns. The MFR respondents form the major part of respondents who did not discuss contraception (78.5%). This group had lower educational qualifications and schooling as compared to the RSH educated girls and Non-RSH educated girls. The main reasons cited by them for not discussing contraception were – “couple wanted child” and “husband wanted child”. If we look at the type of reasons which this group has cited, then we can see that these are very “patriarchal” in nature. There is a gap of one generation between MFR and RSH educated girls/ Non-RSH educated girls. A decade ago the kind of pressure that was there on a newly married couple especially the bride has reduced slightly in the present context. Thus the reasons cited by the MFR are not “lack of knowledge or feeling shy, but “desire for children”.

**CONTRACEPTION/ FAMILY PLANNING METHOD USED**

Before we look at the findings of this section, it will be worthwhile to look at the various methods of contraception available in the Indian scenario.

**CONTRACEPTION METHODS**

1) **NATURAL METHODS**
   A) Rhythm method (safe period)
   B) Withdrawal method
   C) Abstinence
   D) LAM (lactation amenorrhea)

2) **ARTIFICIAL METHODS**
   A) Barrier method
      i) Condom
      ii) Diaphragm
      iii) Spermicidal gel
   B) Hormonal method
CHAPTER 6 FINDINGS AND DISCUSSIONS

i) OCP (oral contraceptive pills)
ii) Injectable contraceptive
iii) IUD (intra uterine devices like copper T, multi load etc.)

C) Sterilization
   i) Female sterilization (tubectomy)
   ii) Male sterilization (vasectomy)

D) Emergency contraception
   i) OCP (oral contraceptive pills)
   ii) IUD (intra uterine devices)

Efficacy of various contraceptive methods

The table below indicates that the success rates are higher for contraceptives that are more invasive:

TABLE 6.2.6

Efficacy of Different Contraceptive Methods 96

<table>
<thead>
<tr>
<th>CONTRACEPTIVE METHOD</th>
<th>SUCCESS RATE/ EFFICACY (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhythm method</td>
<td>80% on average</td>
</tr>
<tr>
<td>Spermicidal Foam</td>
<td>80% on average</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>85% on average</td>
</tr>
<tr>
<td>Condom</td>
<td>90% on average</td>
</tr>
<tr>
<td>Combination pill</td>
<td>97% on average</td>
</tr>
<tr>
<td>IUD</td>
<td>99% on average</td>
</tr>
<tr>
<td>Tubectomy</td>
<td>99.5% on average</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>99.8% on average</td>
</tr>
</tbody>
</table>

As we can conclude from the table above that ‘rhythm method’ is the least effective method (80% effective). ‘Vasectomy and tubectomy’ are the most effective methods of contraception (99.8% and 99.5% effective respectively).

96 Source- www.indiaparenting.com/sexedcuation/contraception
CHAPTER 6  FINDINGS AND DISCUSSIONS

Now we can look at the findings of the study to see what methods the respondents are using and interpret the results.

TABLE 6.2.7
CONTRACEPTIVE METHODS BEING USED AND REPORTED BY RESPONDENTS

<table>
<thead>
<tr>
<th>FP METHOD USED</th>
<th>RSH EDU. GIRL</th>
<th>NON RSH EDU. GIRL</th>
<th>MFR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RSH edu. girls</td>
<td>%</td>
<td>No. of Non-RSH edu. girls</td>
<td>%</td>
</tr>
<tr>
<td>OCP</td>
<td>3</td>
<td>8.7%</td>
<td>15</td>
<td>38.5%</td>
</tr>
<tr>
<td>CONDOM</td>
<td>3</td>
<td>8.7%</td>
<td>14</td>
<td>34.6%</td>
</tr>
<tr>
<td>RHYTHM METHOD</td>
<td>15</td>
<td>47.8%</td>
<td>11</td>
<td>26.9%</td>
</tr>
<tr>
<td>NO METHOD</td>
<td>10</td>
<td>34.8%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
<td>37.7%</td>
<td>40</td>
<td>42.6%</td>
</tr>
</tbody>
</table>

Interpretation of the Table: n=146. This question was asked to ONLY FEMALE MARRIED RESPONDENTS (Married RSH educated girls-31, MFR-75 and Married Non-RSH educated girls-40). Thus the total number of valid cases for this table was 31+40+75=146

FIGURE: 6.18
CONTRACEPTIVE METHODS BEING USED AND REPORTED BY RESPONDENTS
The above table and figure depict the methods of contraception being used currently by respondents from the three groups (1- RSH educated girls, 2- Non-RSH educated girls and 3- MFR). As can be seen from the table above, the most commonly used methods among the respondents are: OCPs (Oral Contraceptive Pills), Condoms and Rhythm method.

Only 8.7% RSH educated girls are using OCP and a similar percentage is using condoms as compared to 38.5% of Non RSH educated young women reporting using OCP and 34.6% reporting their husbands using condoms. 33.3% MFR reported using OCP and 66.7% MFR reported husband using condoms. 47.8% of the RSH educated young women are using Rhythm method as contraception as compared to 26.9% Non-RSH educated girls and 0% MFR for the same method. 34.8% RSH educated girls are not using any method of contraception at all as compared to 0% Non-RSH educated girls and MFR. Nobody in MFR group is using Rhythm method.

**DISCUSSION**

We can see from the above table that the most aware group (RSH edu. Girls) are using the least effective method *(rhythm method or Safe Period method)*. Despite the availability of so many methods in the market, the preference in this group was for the OCP, Condom and rhythm method. Due to the “newly-wed” status of these girls and the pressure to prove fertility, they are not allowed by their husbands to use any contraceptive method. Contraception has mostly been possible where the husband wants to delay the pregnancy. The choice of OCP and condoms is pronounced because these products are easily available in the PHC and local medical stores. The most common method used by women in this region after the desired number of children have been born, is FEMALE STERILIZATION. Many a times women don’t inform the husbands and get the sterilization done by themselves. But a surprising fact is that none of the MFR has reported STERILIZATION, though it is informally known in the group that many women have got sterilization surgery done. A probable explanation could be that the husband and family were not consented before the sterilization and therefore the MFR did not want to reveal this.
TABLE 6.2.8
SUMMARY OF DYNAMICS OF INTERACTION AND COMMUNICATION

<table>
<thead>
<tr>
<th>Responder Group</th>
<th>Was family planning ever discussed between you and spouse</th>
<th>Family planning discussion initiation</th>
<th>Most commonly used contraceptive among respondents</th>
<th>Most common reason cited for not using contraception among respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Who initiated</td>
<td>Who should initiate</td>
</tr>
<tr>
<td>As reported by RSH education. Girls</td>
<td>83.8%</td>
<td>6.4%</td>
<td>69.2%</td>
<td>30.8%</td>
</tr>
<tr>
<td>As reported by non RSH education. Girls</td>
<td>67.5%</td>
<td>32.5%</td>
<td>22.2%</td>
<td>77.8%</td>
</tr>
<tr>
<td>As reported by married female relatives</td>
<td>26.7%</td>
<td>73.3%</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

The table given above summarises the main components of “dynamics of interaction and communication” related to RSH between husband and wife. This is a summary of the data and facts we have already discussed in the previous sections.

EXAMPLES FROM FIELD

A) Village 4 SLD- Elder sister got sterilization done with help of mother after the birth of a son and a daughter.

B) Village Sabania- Chachi got sterilization done after one son and one daughter, with the help of mom-in-law.
C) Village Nathusar- Husband is illiterate, thus RSH educated girl took the initiative to talk about FP. Not able to use FP as mother-in-law says that she will not let her stay in the house if she ever uses FP.

D) Village Ravasar- Men don’t want to get sterilization done, but they don’t oppose the wife getting it done now, unlike earlier times.

SPOUSE SELECTION CRITERIA (RSH/ NON RSH EDUCATED)

All the female respondents (both RSH and Non RSH educated) said that the criteria for selecting husband are:

1) Educational qualification
2) Financial condition
3) Land holding
4) Physical features
5) Religious criteria
6) Social status

The female respondents (RSH educated girls, Non-RSH educated girls and MFR) said that if all the above mentioned criteria remain same and the only difference between two prospective grooms is the RSH education status, then they would prefer to marry RSH educated boy because of various reasons mentioned below.

REASONS FOR SELECTING RSH EDUCATED HUSBAND

Since all the female respondents have reported that if given a choice they would prefer marrying an RSH educated man than a non RSH educated man. Thus they were asked as to what are the reasons for wanting to marry an RSH educated man. The following table describes the various reasons cited by the female respondents for wanting to marry an RSH educated man. This was an open ended multiple response question.
CHAPTER 6  FINDINGS AND DISCUSSIONS

Multiple Response Table

Interpreting the multiple response frequency table. The total number of respondents was n=200 (RSH educated girls 75 + MFR 75 + Non-RSH educated girls 50, 75+75+50=200). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 521. This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the total responses.

TABLE 6.2.9
REASONS FOR SELECTING RSH EDUCATED HUSBAND

<table>
<thead>
<tr>
<th>REASON FOR SELECTING RSH EDUCATED HUSBAND</th>
<th>ALL FEMALE RESPONDENTS (RSH EDU., NON-RSH EDU., MFR</th>
<th>No. of RESPONSES</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More knowledgeable</td>
<td></td>
<td>199</td>
<td>38.2%</td>
</tr>
<tr>
<td>Better care for wife</td>
<td></td>
<td>163</td>
<td>31.3%</td>
</tr>
<tr>
<td>Prevent child marriage</td>
<td></td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Prevent early pregnancy</td>
<td></td>
<td>15</td>
<td>2.9%</td>
</tr>
<tr>
<td>Better care of children</td>
<td></td>
<td>26</td>
<td>5%</td>
</tr>
<tr>
<td>Use family planning</td>
<td></td>
<td>89</td>
<td>17.1%</td>
</tr>
<tr>
<td>No marital rape</td>
<td></td>
<td>28</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

FIGURE: 6.19
REASONS FOR SELECTING RSH EDUCATED HUSBAND
The above table and figure depict the various reasons cited by the female respondents (RSH educated girls, Non-RSH educated girls and MFR) for preferring an RSH educated husband over a non RSH educated one. 36.6% responses from RSH educated girls said that they would prefer an RSH educated husband because he will be more knowledgeable. A similar percentage of 35.2% responses from Non-RSH educated girls reported the same reason and 42.4% responses from MFR reported the same reason for preferring an RSH educated husband.

29.2% responses from RSH educated girls and 21.8% responses from Non-RSH educated girls reported that an RSH educated husband would take better care of wife. 41.2% responses from MFR reported for the same reason. Only 0.5% responses from RSH educated girls and nobody from Non-RSH educated girls and MFR indicate that RSH educated husband would prevent child marriage for themselves and their children. 7.4% responses from RSH educated girls reported that RSH educated husband would prevent pregnancy at younger age but nobody from Non-RSH educated girls or MFR feel the same.

6.4% responses from RSH educated girls reported that RSH educated husband would take better care of children and 9.2% responses from Non-RSH educated girls agree with this. Nobody from the MFR group feels the same for this reason. 18.3% responses from RSH educated girls indicate that RSH educated husband would use family planning methods and 16.9% responses from Non-RSH educated girls and 15.8% responses from MFR also indicate the same. Only 1.5% responses from RSH educated girls reported that RSH education would prompt husband to stop marital rape whereas 16.9% responses from Non-RSH educated girls and 0.6% responses from MFR feel that it will reduce marital rape.

The most cited reason for choosing an RSH educated husband for all the female respondents is “more knowledgeable” (38.2%) and “better care of wife” (31.3%). 17.1% respondents feel that it will encourage the husband to use “family planning”, 5.4% feel it will reduce “marital rape” and 5% feel it would result in better care for children.
DISCUSSIONS

Though only 5.4% responses have indicated that it will reduce marital rape, but during FGDs almost all the RSH educated girls said that it will reduce marital rape and nearly 30% NON RSH educated girls reported the same. The MFR were not very convinced with the idea of marital rape and felt that it was the duty of the wife to oblige husband whenever he wants to have sexual intercourse.

Another interesting finding is the problem of “CHILD MARRIAGES”. All the female respondents have felt that RSH education of husband will not have any positive effect on preventing child marriages. This response also comes in the wake of personal experiences of the respondents that the RSH education does not help to end the menace of child marriages. Though people have knowledge about the ill-effects of child marriages and the illegality of it but still there is not enough attitudinal change to stop this practice.

REVEALING RSH EDUCATION STATUS TO THE HUSBAND AND IN-LAWS

During the interviews and FGDs it was evident that the RSH educated young women were not very comfortable about talking to their husbands about the knowledge they had. Thus they were asked whether they had discussed their RSH educated status to their husbands and in-laws. The findings were shocking-

<table>
<thead>
<tr>
<th>Whether revealed RSH education status to husband and in laws</th>
<th>Acc. To RSH edu. girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>15</td>
</tr>
<tr>
<td>NO</td>
<td>11</td>
</tr>
<tr>
<td>Did not respond</td>
<td>5</td>
</tr>
<tr>
<td>TOTAL</td>
<td>31</td>
</tr>
</tbody>
</table>

Interpretation of the Table- n=31 as there are only 31 married RSH educated girls. This question was specifically for the RSH educated girls and was asked only to the MARRIED RSH EDUCATED GIRLS, for whom this was relevant and applicable.
CHAPTER 6  FINDINGS AND DISCUSSIONS

The above table depicts whether the RSH educated girls revealed their RSH education status to their husband and in-laws. The responses are as reported by the RSH educated girls and are categorised as “YES” and “NO”.

Nearly 48.3% RSH educated girls revealed their RSH education status to their husbands. 35.4% RSH educated young women did not reveal their RSH education status to their husbands and in-laws. 16.1% respondents did not answer this question as they were not comfortable talking about it. **The most commonly cited reason for not revealing the RSH education status was:**

1) The young women assumed and thought that the husband and in-laws will not like it and will be angry.
2) Less interaction with husband.
3) Don’t think it is important to tell husband about it.
4) Wanted to tell but afraid.

**The most commonly cited reasons for revealing the RSH education status:**

1) Told the husband when he asked about the source of all RSH related knowledge.
2) To educate husband 3) To educate MFR

**TABLE: 6.2.11**

<table>
<thead>
<tr>
<th>REASONS FOR LIKING/ DISLIKING WIFE’S RSH KNOWLEDGE</th>
<th>Acc. To RSH edu. Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of RSH edu. girls</td>
<td>%</td>
</tr>
<tr>
<td>Husband never talks about it</td>
<td>8</td>
</tr>
<tr>
<td>Husband does not want wife to know more than him</td>
<td>2</td>
</tr>
<tr>
<td>Husband likes knowledge of wife about health</td>
<td>8</td>
</tr>
<tr>
<td>Husband does not like wife’s knowledge on health</td>
<td>8</td>
</tr>
<tr>
<td>Did not respond</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>31</strong></td>
</tr>
</tbody>
</table>

**Interpretation of the Table- n=31 as there are only 31 married RSH educated girls.**

This question was specifically for the RSH educated girls and was asked only to the MARRIED RSH EDUCATED GIRLS, for whom this was relevant and applicable.
CHAPTER 6  FINDINGS AND DISCUSSIONS

This table depicts the various reasons for the husband for liking or not liking the RSH education status of the RSH educated wife. These responses have been collected from the RSH educated girls as their perception about the reaction of their husband and in laws. 25.8% RSH educated girls said that their husband never talks about what they feel about their wife’s RSH education status. 6.4% respondents said that their husband does not want their wife to know more than him. 25.8% respondents said that the husband likes the fact that their wife is aware about health related issues. 25.8% RSH educated girls felt that their husband did not like wife’s knowledge on RSH. 16.1% respondents did not answer this question.

SEXUALLY TRANSMITTED INFECTION AND HIV/AIDS

Since the young women are reporting a lower percentage of condom usage, they are also at high risk of contracting sexually transmitted infections\diseases (STI\STD). These women are unable to negotiate the usage of condoms and safe sex practices, despite the knowledge about the same. This scenario reinforces the need for the RSH education programs with both the sexes.

The following section deals with the statistical tests performed to see correlation between independent and dependent variables. Since all the variables are NOMINAL in nature, the PHI TEST of correlation has been used.
### TABLE: 6.2.12 STATISTICAL TESTS: CORRELATION TESTING PHI test

<table>
<thead>
<tr>
<th>INDEPENDENT Variable</th>
<th>DEPENDENT Variable</th>
<th>PHI Value</th>
<th>Significance Value</th>
<th>INTERPRETATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational qualification of RSH educated girl.</td>
<td>Family Planning discussion with husband.</td>
<td>.355</td>
<td>.001</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is WEAK</td>
</tr>
<tr>
<td>RSH education status of wife</td>
<td>Family Planning discussion with husband.</td>
<td>.844</td>
<td>.001</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is HIGH</td>
</tr>
<tr>
<td>Rights based training of wife</td>
<td>Family Planning discussion with husband.</td>
<td>.600</td>
<td>.001</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is MILD</td>
</tr>
<tr>
<td>Educational qualification of wife.</td>
<td>Sex of the spouse who initiated Family Planning discussion.</td>
<td>.516</td>
<td>.001</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is MILD</td>
</tr>
<tr>
<td>RSH education status of wife</td>
<td>Sex of the spouse who initiated Family Planning discussion.</td>
<td>.289</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is WEAK</td>
</tr>
<tr>
<td>Rights based training of wife</td>
<td>Sex of the spouse who initiated Family Planning discussion.</td>
<td>.236</td>
<td>.025</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is WEAK</td>
</tr>
<tr>
<td>RSH education status of wife.</td>
<td>Who should initiated Family Planning discussion.</td>
<td>.600</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is MILD</td>
</tr>
<tr>
<td>Rights based training of wife</td>
<td>Who should initiated Family Planning discussion.</td>
<td>.600</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is MILD</td>
</tr>
<tr>
<td>Educational qualification of</td>
<td>Who should initiated Family Planning discussion.</td>
<td>.727</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation</td>
</tr>
<tr>
<td>Educational qualification of</td>
<td>Revealing RSH education status to husband and in laws.</td>
<td>.350</td>
<td>.002</td>
<td>HIGHLY SIGNIFICANT correlation.</td>
</tr>
<tr>
<td>Sex of spouse who initiated Family Planning discussion.</td>
<td>Family Planning method used.</td>
<td>.844</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is HIGH</td>
</tr>
<tr>
<td>Sex of respondent</td>
<td>Spouse selection when RSH education status is a criteria</td>
<td>.533</td>
<td>.000</td>
<td>HIGHLY SIGNIFICANT correlation. STRENGTH of correlation is MILD</td>
</tr>
</tbody>
</table>
The phi correlation has a particular formula: 97

\[ \phi = \sqrt{\frac{\chi^2}{n}} \]  

(1)

Where

\[ \chi^2 = \sum_i \sum_j \frac{(o_{ij} - e_{ij})^2}{e_{ij}} \]  

and

- \( e = \text{expected frequency} \)
- \( o = \text{observed frequency} \)

1) **There is a direct highly significant correlation** between the educational qualifications; Rights based training and RSH education of married women (Independent variables) and Family Planning discussion with husband (dependent variable). The same may be true for the population.

2) **There is a direct highly significant correlation** between the educational qualifications; Rights based training and RSH education of married women (Independent variables) and sex of the spouse who initiated Family Planning discussion (dependent variable). The same may be true for the population.

3) **There is a direct highly significant correlation** between the educational qualifications, Rights based training and RSH education of married women (Independent variables) and who should initiated Family Planning discussion (dependent variable). The same may be true for the population.

4) **There is a direct highly significant correlation** between the sex of the spouse who initiates Family Planning discussion (Independent Variable) and the

---

CHAPTER 6  FINDINGS AND DISCUSSIONS

Family Planning method used (Dependent Variable). The same may be true for the population.

5) There is a direct highly significant correlation between the sex of the respondent (Independent Variable) and spouse selection- RSH educated or non RSH educated (Dependent Variable). The same may be true for the population.

✓ As we can understand from the above statistical tests, the INDEPENDENTENT VARIABLES like:
  - Educational qualification of the wife
  - RSH education status of the wife
  - Rights based training of wife

Have direct highly significant correlation with the DEPENDENT VARIABLE:
  - Family planning discussion with husband
  - Sex of the spouse who initiated family planning discussion

These findings are also supported by the FGDs, and observations. The respondents who were more qualified in formal education had more instances of reporting FP discussion with husband and in many cases, initiated the discussion themselves. The RSH education status and rights based training also played a very crucial role in FP discussion or initiative in discussion.

The probable factors for the above correlation are as under:

- Education and schooling have given the required confidence, knowledge and personality thrust to the girls and the more time they have spent in formal education, the more personality and overall grooming it has done. This has led to more confidence in the girls to do the rightful and needful.

- The structured RSH education program has provided the young women with the exact, specific and accurate knowledge about the issues which have remained taboo for generations. The RS education program has provided them with the
knowledge and right attitude to bring about the change in behaviour of self and family.

- The Rights based trainings (child rights, educational rights, rights of the backward classes, local governance related rights and rights related to gender empowerment) have given the knowledge about rights related to various aspects of their lives, which affect the day to day living.

- All of the above mentioned form the various components of holistic learning-formal education, informal education, NFE non-formal education etc. this is one part of the INTEGRATED APPROACH to education which leads to all round development of individual.

- Thus if the thrust on HOLISTIC and INTEGRATED EDUCATION is implemented with full political will and commitment, it does lead to positive changes in behaviour.

- Similarly the **INDEPENDENT VARIABLE**: Sex of the spouse who initiates FP discussion has a highly significant correlation with the **DEPENDENT VARIABLE**: Family planning method used

This is a very crucial finding of this study. The data and the FGD and interviews have shown that

- **couples where the husband initiated FP discussion,**
  1) The chances of using contraception were high.
  2) The method of contraception used was more invasive and more effective (successful).

Traditionally in India, due to patriarchy, men control the lives of their wives where women lack financial authority in relationship and many other cultural factors. In addition to various other factors like:

- Desire for child immediately after marriage
- Pressure to prove fertility
- Myths and misconception about contraceptive
There is one more crucial factor that many of the husbands where the wife initiated contraceptive discussion, did not like the wife talking about contraception as they felt that husband should be the one to decide on these issues as he is the one who earns for the family.

- **Couples where the wife initiated FP discussion,**
  3) The chances of using contraception were much lesser.
  4) The method of contraception used was traditional, less effective (less successful)

The wives who initiated the FP discussion felt that their husbands did not like the wife talking about contraception and therefore despite wanting to delay pregnancy did not use any method.

**There is highly significant correlation** between the **INDEPENDENT VARIABLE:** Sex of respondent And the **DEPENDENT VARIABLE:** Spouse selection criteria (RSH educated Vs. Non RSH educated)

This was a very interesting finding, where all the female respondents (Both RSH educated and Non RSH educated) said that given a choice where all the educational, social, religious, economic conditions are similar for two prospective grooms, but one is RSH educated and one is not, they would prefer the RSH educated boy as their husband. When the similar question was asked to young men, nearly 33% reported that they would not like to marry RSH educated girl. They felt that RSH educated girl would unnecessarily upset the peace in family and the gender balance in marriage. They will try to break the gender roles and expect men to do things they don’t want to.

**FINDINGS FROM FGD**
- If we look at the findings reported earlier in this section, 83.8% RSH educated girls reported that contraception discussion had taken place between them and husband, as compared to nearly 67% Non RSH educated girls and 27% MFR.
- Another intriguing fact is the timing of contraception discussion. 58% RSH educated girls reported that they had the discussion on the first night with husband; as compared to only 20% Non RSH educated girls and 1.3% MFR.
• 69% RSH educated said that they initiated the contraception discussion as compared to 22% Non RSH educated girls and 23.5% MFR.

Looking at the above findings, one might think that the RSH educated girls have shown tremendous change in knowledge, attitude and behaviour as compared to their Non RSH educated counterparts. But when we look at the high number of RSH educated girls who are not using any contraceptive methods (34.8%) it is a bit intriguing. Another fact that most of them are using Rhythm Method (47.8%), which is only 80% successful as compared to OCP (success rate 97%) and condoms (success rate 90%), we might wonder as to why the most knowledgeable group of respondent wanting to delay the first birth or space the child, is using the least effective method.

**A few explanations for the above mentioned gap might be found in the outcome of the FGDs**

The less efficient method of contraception is being used by the RSH educated group, which reported more wives initiating the contraception discussion.

✓ The average age of the RSH educated girls is 15-18yr. whereas that of the Non RSH educated group is 17-20yr. thus the Non RSH educated group has more maturity and authority in the marital relationship as compared to the 15-16 year old newly married girl. This also put her in a little more advantageous position than her younger counterpart to negotiate.

✓ Formal Education profile is similar for both the above mentioned groups. Education has given its own set of empowerment to both the groups. They know what is right for them. It is the interplay of various other social, cultural and economic factors which decide the final outcome.

✓ The average age gap between husband and wife in both the categories is 7-8 years. The trend of husbands older to wife is quite prominent in Rural India. This puts husband in more authoritative role. As the wife is not only younger to the husband by at least 7-8 years on an average, but also she is married off at a very young age (approx. 15 yr.), with very little or no formal education. All of this puts her in a very week bargaining position within the relationship. There are various ways by which men control their wives, like controlling her visits to maternal
house, controlling finances by not allowing to have employment and income of
own, controlling her fertility by encouraging or imposing early child birth and
child birth with lesser gap. All of these make the women quite dependent on the
husband for acceptability in society and her own survival.

✓ Approx. 45% RSH educated girls were pregnant at the time of data collection.
Approx. 20% Non RSH educated girls already had one child and nearly 30% of
them were pregnant at the time of data collection. The trend of more effective
contraceptive method being used is higher in Non RSH educated category,
because maybe 20% respondents have already delivered one child, thus some
pressure has been relieved to prove fertility.

✓ Almost all the Non RSH educated girls have been living with their husbands at
the time of data collection. Whereas 80% of RSH educated girls were not actively
living with the husbands. These girls were shuttling between the maternal homes
and husbands home ever since marriage. Usually spending one month with
husband and three months with mother. The reasons the girl’s mothers have given
for this are:

1) The girl is too young to take care of the entire household work and cooking at
husband’s house.

2) This will delay the child birth and also space it out. Abstinence is the safest
contraception.

3) The pregnant girl needs more rest and care which will not happen at husband’s
house.

4) Once the girl has given birth to a child, then she will start living actively with her
husband.

5) One of the most disturbing reports came from nearly 40% respondents who said
that their husbands were using ‘sexual coercion’ on them to make them pregnant
because they did not like their wives talking about contraception.

6) Some RSH educated respondents also reported that their husbands were thinking
that the wife has had previous sexual experience therefore she knows so much
about contraception. Thus ‘marital rape’ is subjected upon them as a way of
controlling them and punishing them.
7) Most of the RSH educated respondents felt that they are not able to delay pregnancy despite knowledge because the husband and family want them to have child as soon as possible. If they fail to conceive within a year of marriage, the husband might re marry someone else and the whole village will label the first wife as “infertile” and her whole life will be ruined.

8) Because of the above mentioned reasons in case of RSH educated girls, many of them feel better off at their maternal home because it gives them one form of contraception- ‘abstinence’.

9) Husbands especially the newly-weds, do not want to use condoms, even if they want to delay pregnancy. This pushes the couple to use less effective method as “rhythm method” and “withdrawal Method”. There is a myth associated with hormonal contraception that it leads to infertility among women. Even though the young women have attended RSH training, five day training is not able to change a mind-set which has been developed over a period of many years. Secondly even if the young couple want to use hormonal methods, the elder female family members who control the fertility decisions of the newly-weds, do not allow them to do so.

10) Young men’s group stated that nearly 71% had a discussion on family planning and in all cases it was the husband who initiated the discussion. Majority of them feel that husband should initiate FP discussion.

11) The dynamics of sexual and reproductive health of young couples is not decided only by the couple. Apart from the education, health and awareness of the couple, there is an interplay of many factors like-

   - the wish of the parents and in-laws,
   - property and monetary support,
   - general awareness and attitude of members of the family especially older female relatives,
   - family’s relations and support system in neighbourhood,
   - political image of the family,
   - weight of dowry received
   - employment opportunities within or outside village
- access to health care services and products
- Peer pressure (on men- to dominate wife. On women- to prove fertility)
- fall- back position of woman (support system)

**DISCUSSIONS- DYNAMICS OF INTERACTION AND COMMUNICATION**

- **Contraception discussion, usage and efficacy**

The incidence of contraception discussion between the couple is the highest for RSH educated group and the lowest for MFR. The RSH educated group had maximum percentage of wives initiating the contraception discussion; still this group has lowest contraception usage.

The efficacy of method of contraception used is lowest in case of RSH educated group. The efficacy of method of contraception is high in case of Non RSH educated group and MFR.

The sex of the spouse, who initiates FP discussion, is directly related to the FP method used by couple. In cases where the husband initiated FP discussion, the chances of using contraceptive was not only higher but also the efficacy of the method used.

Couples where the husband initiated contraception discussion, the methods used were mainly condoms, OCP, which have a success rate of more than 90%.

Couples where the wife initiated contraception discussion, the method mainly used was either rhythm method which has less than 80% efficacy or no method was used at all.

There are various reasons for the use of less effective contraception in case of couples where the wife was RSH educated and the wife had initiated contraception discussion:-

i) Desire for a child

ii) Fear or myths related to use of hormone based contraception (OCP) and dislike for using condom.

iii) **Patriarchy, where the husband decides the ‘whether’, ‘when’ and ‘how many’ about pregnancy.** Since husband is not the one who initiated the contraception discussion, it is least likely that he will use or allow his wife to use any. The couples where the husband initiated discussion were very
well using effective contraception. These effective method users were mostly husband initiated discussions.

iv) Though the RSH educated girls said that they were using rhythm method (safe period), not only the efficacy for this method is low but it also involves various factors in negotiation. The couple has to abstain from sexual intercourse for nearly 10 days every month (day 10 to day 20) of the menstrual cycle. *The onus of abstinence and the struggle to abstain is completely on the wife. This leads to wife battering, violence and marital rape at many a times.*

- **Factors affecting bargaining power in relationship**

The educational qualification, personality trait of the wife, support within the family and financial position of the wife, are some of the factors which determine how much the wife will be able to negotiate.

The findings from the study show that thought he mother of the girls are supportive and don’t want them to get pregnant too early, the mother in law is not equally supportive. Various tactics used by mother in some cases is to keep the girl in maternal home for as long as possible so that it acts as a natural contraception and at the same time the girl gets physically and emotionally mature to spend time with husband and in laws.

Cases where the husband is educated, the incidence of early pregnancy and too many pregnancies is rare. Educated husbands have been more encouraging for the wife to delay first pregnancy and space the child birth.

The MFR at husband’s house have not been supportive for the newly wed girl in order to protect her from marital rape or wife battering. The RSH education has given knowledge but has not empowered and prepared the girls to deal with real life situations. The training has not prepared the young women to negotiate their rights and wishes.
CHAPTER 6 FINDINGS AND DISCUSSIONS

❖ RSH education and husband reaction

Most of the RSH educated young women did not tell their husbands and in laws about their RSH education status. In our society each and every small and big qualification the girl has, is told to the prospective groom and family. It is surprising that this training and the other rights based training the girls attended were not told to the prospective or current husband.

Most of the girls who did not share the RSH education status, said that their husband did not like the wife to know more than him. Some also informed that husband would think that the wife has had prior sexual exposure therefore she knows so much.

There were very few RSH educated girls who could share the RSH status with husband. Few of the husbands liked the fact that their wife knew about health and will take good care of herself and children.

The percentage of husbands liking the RSH education status of wife might be higher, provided the wife shares the status with husband. In most of the cases it is the presumption of the wife that the husband will not like it. This presumption is not completely baseless. It is based upon the socialization process, the experience of friends who have shared the status with their husbands and that personal interaction with husband.

❖ Spouse selection criteria

This was one of the most interesting findings of the study. All the women (RSH, NON RSH, MFR and PEER) want to marry an RSH educated man. This is based on the condition that the educational, physical, financial and social profile of the groom should be acceptable to her and family. Given that all the other conditions are fulfilled and they have a choice between an RSH educated groom and a Non RSH educated groom, they would like to marry the RSH educated one.
CHAPTER 6  FINDINGS AND DISCUSSIONS

The women feel that RSH education for men will make them more civilized in dealing with their wives. It will reduce marital rape, sexual and physical violence and increase care for self, wife and children. The women feel that it is easier to communicate with a husband who also has the similar knowledge and attitude as the wife.

In case of young men, more than 30% do not want to marry an RSH educated girl. They feel that the man should know everything and he will tell his wife what needs to be done. The husband has to decide the timing and number of pregnancies and children and therefore he should be the one to know and decide.

The other less than 70% male respondent feels that it is good to have a wife who is aware of her health and takes care of self. They feel that deciding about family matters should be done jointly by the couple.

The gender stereotyping and patriarchy have been ruling the lives of young people in rural setting. To break this cycle of oppression and deprivation of rights, one needs to work effectively with both men and women.

The age gap between husband and wife (wife younger to husband by 7-8 years), is one of the crucial factors in women’s ability to negotiate with husband. Older husband in patriarchal set up has more authoritative position within the marital relationship and it becomes very difficult for the wife to tell her husband that she has the right knowledge and what needs to be done.

The women in the study area said that it is a known fact that the wife should be much younger to the husband for a happy marriage. When asked about the meaning of “happy marriage”, they said that a happy and successful marriage is where the couple does not fight, the wife obeys the husband, and the sexual life is good. For the sexual life to be good, the wife should be much younger because, women age faster than men and they hit menopause much earlier than the desire in men for sexual activity. Thus if the wife is younger, it will lead to more number of happy sexual life for the couple. At the same time
the wife should not be too old at the time of marriage because then she will develop her identity, values and attitude and will find it difficult to adjust in husband’s house. It was also reported that a wife who is much younger to husband will not get older than her husband in his old age and therefore the husband will always find her young and youthful.

FINDINGS

3. SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

As discussed in the introduction chapter, the concept of SEXUAL AND REPRODUCTIVE HEALTH RIGHTS (RSHR) was introduced in the 1990s with the sanctioning of ICPD (International Conference on Population and Development), Cairo. Many countries have ratified to the ICPD including India. The concept of RSHR is not very new in India but is definitely not as widely talked about as family planning or HIV/AIDS.

The RSHR being studied in the current study are as follows:

 ✓ Right to decide age of marriage
   In India the legal age of marriage for girls is 18 and boys is 21 yr. but the RSHR says that every individual irrespective of their sex, caste or creed can decide any age on or after the legal age, to get married and if an individual does not want to get married at that age, then it is his/ her right to decide that.

 ✓ Right to choose the spouse
   Every individual has the right to choose his/ her own life partner without fear, coercion or pressure, provided it is within the legal norms of the society.

 ✓ Right to be protected from sexual violence/ consent for intercourse with spouse
   Every individual has the right to be protected from sexual violence even if it includes the sexual violence inflicted upon by spouse. The individual has the right to give consent for sexual intercourse (not minor), without which intercourse should be looked at as violation of right.
CHAPTER 6 FINDINGS AND DISCUSSIONS

- **Right to decide the timing and number of children**
  This was one very significant right which says that every individual has the right to decide whether to have children, when to have children, how many children to have and how much gap to be maintained between children.

- **Right to correct information and education on reproductive and sexual health**
  Every individual has the right to get ‘age-appropriate’ RSH related information, which is correct and accurate. It is the duty of the government to provide this education to the people.

- **Right to access and control over reproductive and sexual health products and services**
  This right means that all the people have the right to get RSH related products (contraceptives) and services (doctors, hospital) at reasonable distance and affordable.

The findings in the table below are only the findings from the schedules. The findings of FGDs will be discussed in detail after the table.

**This section discusses the RSH educated girls related rights as reported by all the female respondents.**

The respondent groups in this table are:

1) RSH educated girls
2) Non-RSH educated girls
3) MFR of RSH educated girls
4) Peer of RSH educated girls

**SEXUAL AND REPRODUCTIVE HEALTH RIGHTS FULFILLED OF FEMALE RESPONDENTS (SELF-REPORTED)**

This table reveals the percentage of fulfilment of the **RIGHT TO DECIDE AGE OF MARRIAGE**, as reported by different female respondent groups. **Interpretation of Table- n= 250. This question was asked to all the female respondents (RSH educated**
CHAPTER 6 FINDINGS AND DISCUSSIONS

girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50).
Total respondents- 75+50+75+50= 250.

TABLE 6.3.1a
FULFILMENT OF RIGHT TO DECIDE AGE OF MARRIAGE

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfillment of Right to decide age of marriage</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of respondents who said YES</td>
<td>No. of respondents who said NO</td>
</tr>
<tr>
<td></td>
<td>No. of respondents</td>
<td>%</td>
</tr>
<tr>
<td>As reported by RSH educated girls</td>
<td>12</td>
<td>16%</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td>3</td>
<td>7%</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>As reported by Peer of RSH edu. girls</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>22</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled.

Only 16% RSH educated girls, 7% Non RSH educated girls, 0% MFR and 15% peer reported that they were able to decide and negotiate the age at which got married. Whereas 84% RSH educated girls, 93% Non-RSH educated girls, 85% Peer of RSH educated girls and 100% MFR have reported that their right to decide the age of marriage was not fulfilled. A total percentage of only 9.6% respondents felt that this right was fulfilled as compared to 90.4% respondents who felt that this right did not get fulfilled.

India has this serious problem of CHILD MARRIAGES. The worst child marriage data is for Bihar, Rajasthan, Uttar Pradesh, Madhya Pradesh and Jharkhand. Most of the girls whether RSH educated or not, know that child marriages are illegal. Still they are not able to negotiate the right age of marriage for themselves. Marrying off girls early and that too to boys who are at least 7-8 years older is a well-accepted social norm in this part of country. This early marriage leads to early pregnancy, multiple pregnancies, poor maternal health, poor child health and increasing the dependence of women on men. The
CHAPTER 6 FINDINGS AND DISCUSSIONS

RSH/ Non RSH educated girls who did try to negotiate this had a really tough time convincing the elders in family. Only few were able to negotiate the “Gauna” date, to at-least 16 or 17 year.

TABLE 6.3.1b
FULFILLMENT OF RIGHT TO CHOOSE THE SPOUSE
The table below reveals the percentage of fulfilment of the RIGHT TO CHOOSE THE SPOUSE, as reported by different respondent groups. Interpretation of Table- n= 250. This question was asked to all the female respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50). Total respondents- 75+50+75+50= 250.

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfillment of Right to choose the spouse</th>
<th>No. of respondents who said YES</th>
<th>No. of respondents who said NO</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>As reported by RSH educated girls</td>
<td></td>
<td>12 respondents</td>
<td>63 respondents</td>
<td>75 respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16%</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td></td>
<td>7 respondents</td>
<td>43 respondents</td>
<td>50 respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14%</td>
<td>86%</td>
<td>100%</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td></td>
<td>0 respondents</td>
<td>75 respondents</td>
<td>75 respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>As reported by Peer of RSH edu. girls</td>
<td></td>
<td>5 respondents</td>
<td>45 respondents</td>
<td>50 respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>24 respondents</td>
<td>226 respondents</td>
<td>250 respondents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10.6%</td>
<td>89.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled. Only 16% RSH educated girls, 14% Non RSH educated girls, 0% MFR and 10% peer reported that they were able to decide and negotiate the age at which got married. Whereas 84% RSH educated girls, 86% Non-RSH educated girls, 90% Peer of RSH educated girls and 100% MFR have reported that their right to decide the age of marriage was not fulfilled. A total percentage of only 10.6% respondents felt that this right was fulfilled as compared to 89.4% respondents who felt that this right did not get fulfilled.
Upon detailed interviews and observation it was found that there is not a single respondent who chose her own life partner. The trend of "marriage of choice" or more commonly known as "love marriage" is not at all socially acceptable in this area. The whole process of socialization is such that nobody even thinks of opposing their family to marry a person of their choice as they fear "social ostracization". Though the respondents said that they were able to choose, it was actually that the families had asked them whether they were comfortable with the groom that was chosen for them. In none of the cases did the family say no to a groom only because the girl did not like him.

**TABLE 6.3.1c**

**FULFILLMENT OF RIGHT TO BE PROTECTED FROM SEXUAL VIOLENCE/CONSENT FOR INTERCOURSE WITH HUSBAND**

The table below reveals the percentage of *FULFILLMENT OF RIGHT TO BE PROTECTED FROM SEXUAL VIOLENCE/CONSENT FOR INTERCOURSE WITH HUSBAND*, as reported by different respondent groups. *Interpretation of Table- n= 250. This question was asked to all the female respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50). Total respondents- 75+50+75+50= 250.*

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfillment of Right to be protected from sexual violence/consent for intercourse with husband</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fulfillment of Right to be protected from sexual violence/consent for intercourse with husband</td>
<td>Total no. of respondents</td>
</tr>
<tr>
<td></td>
<td>No. of respondents who said YES</td>
<td>No. of respondents who said NO</td>
</tr>
<tr>
<td>As reported by RSH educated girls</td>
<td>12</td>
<td>63</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td>32</td>
<td>18</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td>8</td>
<td>67</td>
</tr>
<tr>
<td>As reported by Peer of RSH educ. girls</td>
<td>7</td>
<td>43</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>59</strong></td>
<td><strong>191</strong></td>
</tr>
</tbody>
</table>
The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled.

Only 16% RSH educated young women and 15% peer reported that they were protected from sexual violence and their right to consent for sexual intercourse was honoured. 64% Non RSH educated young women reported that their right to protection from sexual violence and marital rape was respected. Only 10.7% MFR reported that their right to protection from sexual violence and consent for sexual intercourse was respected. Whereas 84% RSH educated girls, 36% Non RSH educated girls, 89.3% MFR and 85% Peer reported that this particular right was not fulfilled.

A total of 23.6% female respondents reported that their right to protection from sexual violence was fulfilled as compared to 76.4% respondents who felt that this right was not fulfilled.

The whole process of socialization in our society, especially in rural areas, is such that women believe that it is their duty to fulfil the demands of their husbands at any time. And if they don’t do then they deserve to be beaten up. Whereas men think that it is their right to expect their wife to fulfil all his desires at any time that he wants. With more education among men and awareness, this trend is changing but gradually. The RSH educated girls and their peer were very clear about the idea of marital rape and sexual violence therefore they were able to categorize and identify it within their marriage. Whereas the non RSH educated girls found the idea of marital rape as alien and considered sexual intercourse in marriage as taken for granted. Surprisingly in the age group of 15-45 years (married female relatives) nearly 90% have reported sexual violence and marital rape. It is worthwhile to mention that most of them have had high level of reverse communication on RSH issues and rights with RSH educated girls.
TABLE 6.3.1d
Fulfilment of Right to decide the timing and number of children

The table below depicts the percentage of FULFILLMENT OF RIGHT TO DECIDE THE TIMING AND NUMBER OF CHILDREN, as reported by different respondent groups. Interpretation of Table- n= 250. This question was asked to all the female respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50). Total respondents- 75+50+75+50= 250.

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfillment of Right to decide the timing and number of children</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of respondents who said YES</td>
<td>%</td>
<td>No. of respondents who said NO</td>
<td>%</td>
</tr>
<tr>
<td>As reported by RSH educated girls</td>
<td>12</td>
<td>16%</td>
<td>63</td>
<td>84%</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td>19</td>
<td>38%</td>
<td>31</td>
<td>62%</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td>0</td>
<td>0%</td>
<td>75</td>
<td>100%</td>
</tr>
<tr>
<td>As reported by Peer of RSH edu. girls</td>
<td>7</td>
<td>15%</td>
<td>43</td>
<td>85%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>38</td>
<td>15.2%</td>
<td>212</td>
<td>84.8%</td>
</tr>
</tbody>
</table>

The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled.

Only 16% RSH educated girls and 15% peer reported that their right to decide when to have a child was fulfilled. Nearly half of RSH educated girls and their peers were pregnant against their wishes at the time of data collection.

38% Non RSH educated young women reported that their right to decide timing and number of children was fulfilled. Some of these respondents already had one child at the time of data collection. Many were pregnant at the time of data collection.

0% MFR reported that their right to decide timing and number of children was fulfilled.

84% RSH educated girls, 62% Non-RSH educated girls, 85% peer and 100% MFR reported that the right to decide number and timing of children was not fulfilled. A total of 15.2% female respondents reported fulfilment of this right against 84.8% who felt that this right was not fulfilled. Here again we can see the influence of Reverse Communication on MFR and also the self-realization with age that has come along in
case of MFR. During the FGD and interviews with MFR, it was felt that this group was very dissatisfied with the way their lives had gone by and they did not wish the same for their daughters.

Most of the RSH educated girls who do not want to be pregnant, know that the contraception they are using will not give them enough protection but still they are not able to negotiate because the husbands are not cooperative and the in-laws are indifferent or want the girl to prove fertility as soon as possible.

**TABLE 6.3.1e Fulfilment of Right to correct information on reproductive and sexual health**

The table below depicts the percentage of *FULFILLMENT OF RIGHT TO CORRECT INFORMATION ON REPRODUCTIVE AND SEXUAL HEALTH*, as reported by different respondent groups. Interpretation of Table- *n= 250. This question was asked to all the female respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50). Total respondents- 75+50+75+50= 250.*

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfilment of Right to correct information on reproductive and sexual health</th>
<th>No. of respondents who said YES</th>
<th>No. of respondents who said NO</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. of respondents</td>
<td>%</td>
<td>No. of respondents</td>
</tr>
<tr>
<td>As reported by RSH educated girls</td>
<td></td>
<td>27</td>
<td>36%</td>
<td>48</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td></td>
<td>32</td>
<td>64%</td>
<td>18</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td></td>
<td>0</td>
<td>0%</td>
<td>75</td>
</tr>
<tr>
<td>As reported by Peer of RSH edu. girls</td>
<td></td>
<td>14</td>
<td>30%</td>
<td>36</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>73</td>
<td>29.2%</td>
<td>177</td>
</tr>
</tbody>
</table>

The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled. 36% RSH educated young women and 30% peer said their right to receive correct information on RSH was not fulfilled. This was surprising as it was coming from the only group of respondents which had received RSH education. The reason behind this data was that the respondents felt that they did not get this information as a matter of right (from government, school, and community health worker). Rather they got this
information as a matter of favour from an NGO. 64% Non RSH educated young women felt that they got the information related to RSH from various sources like, media, school, friends, family). 0% MFR reported that they ever got any correct information on RSH. They were very unhappy with the whole government system as well as their own family for not giving them the crucial information when they need it the most.

64% RSH educated girls, 36% Non RSH educated girls, 100% MFR and 70% Peer felt that their right to correct information and education on RSH was not fulfilled.

A total of 29.2% female respondents felt that this right was fulfilled as compared to 70.8% respondents who felt that the right to correct information was not fulfilled.

**TABLE 6.3.1**
**Fulfilment of Right to access and control over reproductive and sexual health products and services**

The table below reveals the percentage of **FULFILLMENT OF RIGHT TO ACCESS AND CONTROL OVER REPRODUCTIVE AND SEXUAL HEALTH PRODUCTS AND SERVICES**, as reported by different respondent groups. **Interpretation of Table- n= 250. This question was asked to all the female respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR-75 and Peer of RSH educated girls- 50). Total respondents- 75+50+75+50= 250.**

Reproductive and Sexual Health related products and services include, contraceptives supply for free or easy and economic availability, doctors and surgery facility related to RSH, Ante natal care services, family planning counselling etc.

<table>
<thead>
<tr>
<th>Respondent group</th>
<th>Fulfilment of Right to access and control over reproductive and sexual health products and services</th>
<th>No. of respondents who said YES</th>
<th>No. of respondents who said NO</th>
<th>Total no. of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No. of respondents %</td>
<td>No. of respondents %</td>
<td>No. of respondents %</td>
</tr>
<tr>
<td>As reported by RSH educated girls</td>
<td></td>
<td>27 36%</td>
<td>48 64%</td>
<td>75 100%</td>
</tr>
<tr>
<td>As reported by Non-RSH educated girls</td>
<td></td>
<td>32 64%</td>
<td>18 36%</td>
<td>50 100%</td>
</tr>
<tr>
<td>As reported by MFR</td>
<td></td>
<td>0 0%</td>
<td>75 100%</td>
<td>75 100%</td>
</tr>
<tr>
<td>As reported by Peer of RSH edu. girls</td>
<td></td>
<td>15 35%</td>
<td>35 65%</td>
<td>50 100%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>74 29.6%</td>
<td>176 70.4%</td>
<td>250 100%</td>
</tr>
</tbody>
</table>
CHAPTER 6 FINDINGS AND DISCUSSIONS

The table depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights in the form of “yes” or “no”, for whether the respective right was fulfilled.

Only 36% RSH educated young women and 35% peer felt that they had access to RSH products and services. Many of them had a functional and proactive PHC or private hospital in vicinity. 0% MFR reported this right fulfilled.

64% Non RSH educated girls reported that they had access to and control over RSH products and services. Apart from the real accessibility of RSH services and products, the other reason could be perception. As the Non RSH educated girls were also taking into consideration the untrained traditional Dai and local quack selling local medicines for various diseases including RSH related.

64% RSH educated girls, 36% Non RSH educated girls, 100% MFR and 65% Peer of RSH educated girls reported that their right to access and control over RSH related products and services was not fulfilled.

A total of 29.6% female respondents reported this right was fulfilled as compared to 70.4% respondents who felt that this right to access and control over RSH products and services was not fulfilled.

The following figure is a consolidation of all the six RSH related rights discussed in this section. This graph shows the “yes” response for all the rights for the four respondent groups.
FIGURE: 6.20
RSH related rights fulfilled as reported by female respondents

The figure above depicts the percentage of different RSH rights fulfilled as reported by different respondent groups. The figure depicts the percentage of each respondent reporting the fulfilment of their respective RSH rights. This figure only has the data for responses which said “yes” for whether the respective right was fulfilled. Thus there is no “total column” because this table is a compilation of all the RSH related rights tables (Table 6.3.1a, b, c, d, e, and f) for all the respondents and their RSH rights. This figure is depicting the percentage of respondents who reported that their rights were fulfilled.

As we all understand from our discussion till now and from the literature review that to bring about any change in the reproductive and sexual lives of women or men, the active participation of both (men and women) is required. In most of the countries especially the developing countries, the RSH education and program has focussed more on women and
men have been left far behind in the list of priorities for both government and NGO sector. If we really want to improve the RSH indicators then men have to be included at all steps. 

This study also tried to look at what the men and women feel about the RSH education of young men.

DISCUSSIONS- RSH RELATED RIGHTS

❖ Child marriages

The trend of child marriages is very much present in the study area and elsewhere in Rajasthan, Bihar, Uttar Pradesh, Madhya Pradesh, Chhattisgarh and Jharkhand. Child marriages have taken place across all the respondent groups irrespective of their RSH education status. Child marriages are a deep rooted social evil, which will require more political will and social mobilization, sensitization and motivation to curb the practice.

❖ Early pregnancy and Marital rape

There is a very high percentage of a pregnancy or child births before the age of 20 yr. Even though the husband or wife or both know about the various ways to delay or space child birth, there are many hurdles which don’t allow it. The girl is not allowed to decide the timing or number of pregnancies. It is just imposed upon her. Sexual coercion (marital rape) is very prominent. But it has been reported more by the RSH educated girls, MFR and peer. Less instances of marital rape have been reported by Non RSH educated girls. The probable reasons for this difference in reporting marital rape could be the education and sensitivity of the husband. Another reason for difference in reporting marital rape could be the “perception of marital rape”. A very high number of Non RSH educated girls said that sex within marriage whether consensual of forced, cannot be termed as rape. They felt that it was the duty of the wife to please her husband if and when he wanted to.
CHAPTER 6  FINDINGS AND DISCUSSIONS

In India the law to address marital rape is not applicable. The criminal law has made it a punishable offence for the husband if he has sexual intercourse with his wife, if she is below the age of 15 years\(^\text{98}\). But the marriage is still valid. Whereas there is no law for marital rape in India for other women above the age of 15 years. They might seek divorce on grounds of cruelty if there is excessive perverse demand for sexual intercourse from the husband\(^\text{99}\).

EXAMPLES FROM THE FIELD

A) An RSH educated girl from village Sabania:

“I knew that it is illegal to marry off a girl below 18 yr. and boy below 21 yr. still my uncle married off my 14 yr. old cousin to a 19 yr. old boy from another village”. I’m 15 yr. old and they are finalizing my marriage too. Soon I will be married off against my wish. My mother opposes it and my father beats her up. If we oppose more, the family will throw us out of the house or will ostracize us”.

“This whole thing about RSH rights are only in books, in reality there is no such thing as rights...nobody respects them anyways”

B) A Non RSH educated girl from village Ravasar:

“I don’t know why we talk about rights and disturb the whole peace of family. Eventually we all have to get married and have sexual relationship with our husbands. Eventually we all have to get pregnant and have lots of children. Then what difference does it make whether we do it at 15 yr. or 18 yr. that is the ultimate fate for all of us and we shouldn’t make such a big fuss about it. Our parents know the best for us.”

“If we are not married off at attaining puberty or immediately after, we will be teased by other boys in village, till when will our fathers and brother protect us? The older we grow the more difficult it will be to arrange dowry and a good boy for us”

C) MFR from 4 SLD

\(^{98}\) Indian Penal Code (IPC), Sections 375 and 376, 498A
\(^{99}\) Hindu Marriage Act 1955, Clause for Divorce
“My husband never asked me whether I wanted to sleep with him or whether I wanted to get pregnant or how many children I wanted. The only time that he asked for my wish was when I was pregnant with my ninth child and had lost a lot of weight. The nurse had told my husband that this pregnancy will prove fatal if my health does not improve. My husband had asked me at that time whether I wanted to continue with the pregnancy or terminate it.”

“There is no point in teaching only the girls about RSH rights if we are not going to teach the same to boys. How do you expect us women to fight this alone with no support and all opposition? The more we talk about rights the more it upsets the husband and more violence we have to face. But if the husband is educated, then he himself does not want too many children and listens to his wife.”

FINDINGS

4. PERSPECTIVE ON MEN’S RSH EDUCATION

The respondents from all the five categories were asked to give their opinion on the various aspects of RSH education for young men, and how it was going to benefit them and the society.

As we have seen in the introduction chapter and literature review, the important role that men play in the society and that of women can’t be ruled out. One of the main reasons cited by all the studies, for the inability to transform knowledge into action is- non-cooperation from men. As we have strategically kept men out of the RSH programs, how do we expect the same amount of sensitization among men as is occurring among women?

This section of the study has made an effort to understand RSH education for young men from the perspective of all the 5 respondent groups.

The following table summarizes the findings for this section in a quantitative manner but the main findings for this section are qualitative because the men’s group was a part of FGDs and not interviews and schedules.
TABLE 6.4.1
PERSPECTIVE ON RSH EDUCATION FOR YOUNG MEN

<table>
<thead>
<tr>
<th>Respondent Group</th>
<th>% which feels young men should also be given RSH education.</th>
<th>Most cited benefit of RSH education. For young men</th>
<th>Marriage preference by RSH education. Status criteria</th>
<th>Timing of RSH education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>As reported by RSH educated Girls</td>
<td>(75) 100%</td>
<td>-decrease in child marriages</td>
<td>(75) 100%</td>
<td>0%</td>
</tr>
<tr>
<td>As reported by non RSH educated Girls</td>
<td>(50) 100%</td>
<td>-decrease in child marriages</td>
<td>(50) 100%</td>
<td>0%</td>
</tr>
<tr>
<td>As reported by married female relatives</td>
<td>(75) 100%</td>
<td>-better care for children</td>
<td>(75) 100%</td>
<td>0%</td>
</tr>
<tr>
<td>As reported by young men</td>
<td>(50) 100%</td>
<td>-increase knowledge about self</td>
<td>(33) 67%</td>
<td>(17) 33%</td>
</tr>
<tr>
<td>As reported by peer of RSH educated girls</td>
<td>(50) 100%</td>
<td>-decrease in child marriages</td>
<td>(50) 100%</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>300 (100%)</td>
<td>283 (94.3%)</td>
<td>17 (5.6)</td>
<td></td>
</tr>
</tbody>
</table>

Interpretation of the Table - n=300. These questions were asked to all the respondents (RSH educated girls- 75, Non-RSH educated girls- 50, MFR- 75, Peer of RSH educated girls- 50, Young men-50)Total respondents- 75+50+75+50+50= 300.

This table depicts the perspectives of different respondent groups on the RSH education of young men. All the respondents (100%) from the 5 groups felt that the young men should receive RSH education. When asked whether they would prefer to marry a person who is educated in RSH, all the female respondents (100%) said that they would prefer to marry RSH educated man. But among the RSH educated men, 67% reported that they
would like to marry an RSH educated girl, 33% men responded by saying they would not be interested in marrying RSH educated girl.

When asked about the preferred timing for RSH education, the RSH educated girls, Non-RSH educated girls and Peer of RSH educated girls said that they would prefer RSH education before marriage, MFR said that they suggest RSH education should be given after marriage and young men said that RSH education should either take place before marriage or immediately after marriage.

RSH educated girls and their peer felt that RSH education for men will decrease child marriages and sexual violence. Non-RSH educated girls and MFR felt that men’s RSH education will decrease child marriages and lead to better care of wife and children. The young men felt that RS education for men will to improvement in self-knowledge.

**SHOULD YOUNG MEN RECEIVE RSH EDUCATION**

There is enough evidence in the documented literature about the usefulness of RSH education for men. This study is trying to examine the findings already recorded. This study is looking at both the sides of the coin from the point of view of the success of RSH intervention for young women. This aspect is being looked at to provide a complete explanation to the issues faced by young women in improving their reproductive and sexual lives.

All the respondents agree that young men should receive quality RSH education.
Interpreting the multiple response frequency table. The total number of respondents was n=200 (RSH educated girls 75 + MFR 75 + Non- RSH educated girls 50, 75+75+50= 200). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 194 and in second column (Non-RSH educated girls) total response is 130. In the MFR column the total response is 177. The Total responses column adds up to 501 responses This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the corresponding total responses.

<table>
<thead>
<tr>
<th>Reasons for equal RSH edu. For young men</th>
<th>RSH EDU. GIRL</th>
<th>NON RSH EDU. GIRL</th>
<th>MFR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
</tr>
<tr>
<td>Knowledge needed for both</td>
<td>74</td>
<td>38.1%</td>
<td>50</td>
<td>38.5%</td>
</tr>
<tr>
<td>Equal right to knowledge</td>
<td>11</td>
<td>5.7%</td>
<td>14</td>
<td>10.8%</td>
</tr>
<tr>
<td>Men need more knowledge</td>
<td>1</td>
<td>0.5%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Awareness about everything</td>
<td>1</td>
<td>0.5%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Better care of own health</td>
<td>43</td>
<td>22.2%</td>
<td>7</td>
<td>5.4%</td>
</tr>
<tr>
<td>Better care of children</td>
<td>52</td>
<td>26.8%</td>
<td>11</td>
<td>8.5%</td>
</tr>
<tr>
<td>Awareness about female health</td>
<td>12</td>
<td>6.2%</td>
<td>10</td>
<td>7.7%</td>
</tr>
<tr>
<td>Men will stay clean</td>
<td>0</td>
<td>0%</td>
<td>28</td>
<td>21.5%</td>
</tr>
<tr>
<td>Men will use family planning</td>
<td>0</td>
<td>0%</td>
<td>10</td>
<td>7.7%</td>
</tr>
</tbody>
</table>
CHAPTER 6  FINDINGS AND DISCUSSIONS

FIGURE: 6.21
Reasons for equal RSH education for young men

The table and figure above depict the various reasons cited by the RSH educated girls, Non-RSH educated girls and MFR for equal RSH education of young men. The responses have been categorised into 9 categories: 1) knowledge needed for both, 2) equal right to knowledge, 3) boys need more knowledge, 4) awareness about everything and everyone, 5) better care of own health, 6) better care of children, 7) awareness about female health, 8) men will stay clean and 9) men will use family planning methods.

This was a multiple response question and each respondent gave at-last 3 responses to this question.

38.1% responses from RSH educated girls, 38.5% responses from Non-RSH educated girls and 42.4% responses from MFR reported that RSH education for men is necessary because knowledge is needed for both men and women. 5.7% responses from RSH educated girls, 10.8% responses from Non-RSH educated girls and 41.2% responses from MFR reported that RSH education for men is necessary because men too have equal right to knowledge. 0.5% responses from RSH educated girls, 0% responses from Non-RSH
CHAPTER 6  FINDINGS AND DISCUSSIONS

educated girls and 0% responses from MFR reported that RSH education for men is necessary because men need more knowledge about RSH.

0.5% responses from RSH educated girls, 0% responses from Non-RSH educated girls and 0% responses from MFR reported that RSH education for men is necessary because they will have awareness about everything related to RSH. 22.2% responses from RSH educated girls, 5.4% responses from Non-RSH educated girls and 0% responses from MFR reported that RSH education for men is necessary because it will help them take better care of their own health. 26.8% responses from RSH educated girls, 8.5% responses from Non-RSH educated girls and 0% responses from MFR reported that RSH education for men is necessary because it will help them take better care of their children.

6.2% responses from RSH educated girls, 7.7% responses from Non-RSH educated girls and 16.4% responses from MFR reported that RSH education for men is necessary because men will be more about female health. 0% responses from RSH educated girls, 21.5% responses from Non-RSH educated girls and 0% responses from MFR reported that RSH education for men is necessary because it will help them stay clean. 0% responses from RSH educated girls, 7.7% responses from Non-RSH educated girls and 0% responses from MFR reported that RSH education for men is necessary as it will help them use family planning.

If we look at the “total column”, then we can say that the overall percentage of “knowledge needed for both” is higher at 39.7% and is the most cited reason. According to Peer of RSH educated young women, they feel that knowledge is needed for both, men will take better care of self and children. According to young men, they need the knowledge to take care of themselves and better care of their wives.
CHAPTER 6  FINDINGS AND DISCUSSIONS

**BENEFITS OF RSH EDUCATION FOR YOUNG MEN**

*Multiple Response Table*

*Interpreting the multiple response frequency table.* The total number of respondents was \( n=200 \) (RSH educated girls 75 + MFR 75 + Non- RSH educated girls 50, 75+75+50= 200). The counts (number of responses) in the first column of the table (RSH educated girls) do not add up to 75, but rather to 195 and in second column (Non-RSH educated girls) total response is 124. In the MFR column the total response is 219. The Total responses column adds up to 538 responses This is the total number of responses; since each respondent could give more than one response, the total number of responses is naturally greater than the number of respondents. The “percentage of responses column” depicts the percentage of a particular response out of the corresponding total responses.

**TABLE 6.4.3**

**BENEFITS OF RSH EDUCATION FOR YOUNG MEN**

<table>
<thead>
<tr>
<th>Benefits of equal RSH edu. For young men</th>
<th>RSH EDU. GIRL</th>
<th>NON RSH EDU. GIRL</th>
<th>MFR</th>
<th>TOTAL RESPOSSES</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
<td>No. of RESPONSES</td>
<td>%</td>
</tr>
<tr>
<td>Discriminate child marriage</td>
<td>46</td>
<td>23.6%</td>
<td>0</td>
<td>0%</td>
<td>73</td>
</tr>
<tr>
<td>Prevent early pregnancy</td>
<td>43</td>
<td>22.1%</td>
<td>31</td>
<td>25%</td>
<td>73</td>
</tr>
<tr>
<td>More understanding men</td>
<td>4</td>
<td>2.1%</td>
<td>10</td>
<td>8.1%</td>
<td>0</td>
</tr>
<tr>
<td>Care for women’s health</td>
<td>1</td>
<td>0.5%</td>
<td>37</td>
<td>29.8%</td>
<td>0</td>
</tr>
<tr>
<td>Prevent HIV/AIDS</td>
<td>25</td>
<td>12.8%</td>
<td>11</td>
<td>8.9%</td>
<td>27</td>
</tr>
<tr>
<td>Better child care</td>
<td>40</td>
<td>20.5%</td>
<td>2</td>
<td>1.6%</td>
<td>0</td>
</tr>
<tr>
<td>Increased male sterilization</td>
<td>24</td>
<td>12.3%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Men will keep genital clean</td>
<td>12</td>
<td>6.2%</td>
<td>13</td>
<td>10.5%</td>
<td>0</td>
</tr>
<tr>
<td>Men will use family planning</td>
<td>0</td>
<td>0%</td>
<td>20</td>
<td>16.1%</td>
<td>46</td>
</tr>
</tbody>
</table>
CHAPTER 6  FINDINGS AND DISCUSSIONS

**FIGURE: 6.22**

**Benefits of RSH education for young men**

The above table and figure reveals the opinions of the respondents (RSH educated girls, Non-RSH educated girls and MFR) regarding the benefits of men’s RSH education. The benefits cited here are very similar to the reasons cited for men’s RSH education. This was a multiple response question and each respondent gave at-least three responses.

23.6% responses from RSH educated girls, 0% responses from Non-RSH educated girls and 33.3% responses from MFR reported that men’s RSH education will discourage child marriage. 22.1% responses from RSH educated girls, 25% responses from Non-RSH educated girls and 33.3% responses from MFR indicated that men’s RSH education will prevent early pregnancy. 2.1% responses from RSH educated girls, 8.1% responses from Non-RSH educated girls and 0% responses from MFR reported that men’s RSH education will make them more understanding.

0.5% responses from RSH educated girls, 29.8% responses from Non-RSH educated girls and 0% responses from MFR indicated that men’s RSH education will present HIV and AIDS. 20.5% responses from RSH educated girls, 1.6% responses from Non-RSH...
educated girls and 0% responses from MFR reported that men’s RSH education will improve child care. 12.3% responses from RSH educated girls, 0% responses from Non-RSH educated girls and 0% responses from MFR indicated that men’s RSH education will increase male sterilization. 6.2% responses from RSH educated girls, 10.5% responses from Non-RSH educated girls and 0% responses from MFR reported that men’s RSH education will keep genitals clean. 0% responses from RSH educated girls, 16.1% responses from Non-RSH educated girls and 21% responses from MFR reported that men’s RSH education will use family planning methods.

DISCUSSION
The “totals column” reflects that a majority of responses (27.3%) indicated that RSH education for men will prevent early pregnancy. Whereas 22.1% indicated that it will discourage child marriage. It is also interesting to note that in the section “reasons for selecting RSH educated husband”, the respondents did not feel that RSH educated husband would help in saying no to child marriage. Only 0.5% responses from RSH educated girls said that RSH educated husband would reduce child marriage. But 0% Non-RSH educated girls and MFR felt the same. Whereas in the current section 22.1% responses said that men’s RSH education will reduce child marriage. When this cross questioning was put back to the respondents, the explanation was rather explicit. The respondents said that when it comes to one single man (RSH educated husband), it is difficult to deal with the deep rooted social problem because one person cannot do it. But when we talk of all the men together as RSH educated, then it is possible to work upon the deep rooted problem without much resistance.

According to Peer of RSH educated young women: RSH education for men will decrease sexual violence, decrease child marriages, reduce early pregnancy and improve child care. According to young men, RSH education for men will improve knowledge about own health and the ability to take better care of wife.
CHAPTER 6  FINDINGS AND DISCUSSIONS

SPOUSE SELECTION CRITERIA BASED ON RSH EDUCATION STATUS

All the female respondents across all age groups, educational qualification and RSH education status, said that given a choice where all the educational, social, religious, economic conditions are similar for two prospective grooms, but one is RSH educated and one is not, they would prefer the RSH educated boy as their husband. When the similar question was asked to young men, nearly 33% reported that they would not like to marry RSH educated girl. They felt that RSH educated girl would unnecessarily upset the peace in family and the gender balance in marriage. They will try to break the gender roles and expect men to do things which are traditionally not done by them, like child care, seeking wife’s opinion on important matters, seeking wife’s consent for deciding timing and number of children etc.

Though only 33% men said that they would not like to marry a RSH educated girl, the interaction with RSH educated girls puts the numbers at a higher percentage. One way to look at it would be to feel that men are not telling the truth and the actual numbers will be more. Whereas the other way to look at it would be that there is some change in attitude of men towards the RSH education of young women. This change in attitude is making them realise that RSH education for women is good but they are not able to accept it in their own lives. At this point in time if a little more sensitization is done with men’s group, it might bring about a lot of change in behaviour and acceptance levels.

TIMING OF RSH EDUCATION

RSH educated young women, Non RSH educated young women, peer of RSH educated young women felt that RSH education should be provided before marriage. Whereas MFR felt that RSH education should be provided after marriage. Some young men felt that RSH education should be provided before marriage while the others feel it should be provided immediately after marriage.
The RSH educated young women were able to utilize the knowledge in their real life thus they were strongly in favour of RSH education before marriage, provided the husband also has got the education, so that she does not have to struggle to explain and convince. MFR however felt that RSH education is very important but should be given immediately after marriage. Though on further probing they said that after marriage the in-laws will not allow the girls to go for this education, thus it was the responsibility of the parents to do that before marrying off the daughter.

Men were mostly of the opinion that the education should be given after marriage, as before marriage it will lead to promiscuity and experimentation. But when asked whether they would allow their wife to attend these classes, they said that they will themselves educate the wife at home.

**FINDINGS FROM FOCUSED GROUP DISCUSSIONS (FGDs):**

- Almost all the respondent groups have stressed the need for RSH education for young men. Whereas the RSH educated group looks at it more from the point of view of decrease in child marriages and sexual violence (marital rape and other forms of sexual violence), the non RSH educated group looks at it as a catalyst for decreasing child marriages and a better care of wife’s health. Most of the married female relatives feel that it will decrease child marriages and provide better care for children. Most of the young men feel that this education will increase their self-awareness.

- All the female respondents said that they would prefer to marry an RSH educated man if all the other criteria remain same. Whereas nearly 33% of young men reported that they would like to marry a girl who does not have RSH education. They said that women don’t need to know these things as it is the men who are supposed to take decisions and lead family.

- Most of the men with higher educational qualification felt that women should have equal say in all matters including RSH, but when it came to practice; they felt that they will be made fun of by their peer.
• Nearly 90% men also felt that it was wrong to term sexual intercourse between husband and wife as “MARITAL RAPE”. They feel that marriage is an agreement and understanding between husband and wife that the wife will satisfy her husband without condition. It is worthwhile to note that most of these wives are child brides.

DISCUSSIONS- RSH EDUCATION FOR YOUNG MEN

❖ RSH education for men opinions

Almost all the respondents (male female), agreed that RSH education should be provided to the young men.

The female respondents felt that it will lead to better care for wife, children and self.

The RSH educated young women and peer felt that it will reduce sexual violence.

Almost all the respondents agreed that RSH education for men will lead to delay in marriage and pregnancy.

These findings again highlight the importance of male involvement. It is not that all men are insensitive and they should be looked upon as the perpetrators of the right of women. It also might be true that without proper knowledge, good intentions don’t help. Men have traditionally been deprived of RSH knowledge. Neither the fathers nor other men in the family gave any informal RSH knowledge unlike the girls. This has led to a greater number of myths and misconceptions around RSH.

Men have been projected as villains in the whole scenario, whereas a more logical way of looking at the problem would be to look at them as the most crucial target audience which has been left out. Rather than looking at men as the opposing team.

EXAMPLES FROM THE FIELD

A) A young man from village Ravasar

“It is good to know that people are thinking about teaching men about RSH issues. Men also have issues about which they can’t talk to anyone. Girls can discuss these issues
with mother or other women in family but boys can’t talk to father or uncle. The relation between boy and father in our family is not such that the father will entertain such kind of talk. Where do we go for knowledge?”

B) A young man from Bakhusar

“Though I know it is good for the wife to know about her health and take care of her health, but still there are some things which the husband has to decide because after all he is the one who is going to earn for the family and feed the children.”

C) Peer of RSH educated girl

“My best friend is RSH educated and got married last year. She always used to tell me that she will not get pregnant immediately after marriage. My friend is pregnant now against her wishes and her husband has been beating her up if she talks about family planning. I think she should have married a boy who had the education like her and thinking like her. They are a complete mismatch.”
CHAPTER 6  FINDINGS AND DISCUSSIONS

SWOT ANALYSIS OF RESPONDENT GROUPS BASED ON FOCUSED GROUP DISCUSSIONS (FGD)

SWOT ANALYSIS is a method used to evaluate the STRENGTHS, WEAKNESSES, and OPPORTUNITIES AND THREATS (SWOT) in relation to a particular project, organization or individual. This technique is credited to Albert Humphrey. Usually this technique is used to look at the strengths, weaknesses, opportunities and threats of an organisation, concept, project or intervention. This technique can also be used for individuals.

In the present context, SWOT ANALYSIS is being used to look into the respondent groups and their Strengths, Weaknesses, Opportunities and Threats, based on the Focussed Group Discussions with them. There are 5 respondent groups- 1) RSH educated young women, 2) Married Female Relatives (MFR) of RSH educated young women, 3) Non-RSH educated young women, 4) Peer of RSH educated young women and 5) Non-RSH educated Young Men.

STRENGTHS OF RESPONDENT GROUPS
This section looks into the strengths of various respondent groups based on the FGDs.

1) RSH EDUCATED YOUNG WOMEN, 2) PEER OF RSH EDUCATED YOUNG WOMEN

(i) Access to accurate RSH related knowledge
This group of respondents had the privilege to receive a structured RSH education program. By virtue of this programme, most of the respondents in this group, know the basics of issues related to RSH.

(ii) Access to rights based trainings
Many of the respondents from this category had the advantage of attending “rights based” trainings in relation to education, health, panchayati raj and law. These training programs gave them knowledge about the practical issues related to the abovementioned
CHAPTER 6 FINDINGS AND DISCUSSIONS

topics and the redressal mechanisms. By virtue of these trainings the respondents got to know their rights in relation to health, education, law and panchayati raj. They were also informed about RSH rights as listed in ICPD.

(iii) **Mother’s support**
Since these respondents attended the RSH education programme with the consent of their families, there was an appreciable level of support from the mother and few female family members from the maternal family. Though in most cases the mother was not able to delay a child marriage but she considerably delayed the “Gauna” i.e. the sending off of daughter to husband’s home.

(iv) **Improved attitude towards RSH education of young people (men and women)**
This respondent category was highly aware of RSH issues and by practical experience knew that only knowledge for girls will not improve the situation. Thus this group had a very positive approach towards the RSH education of young men.

(v) **Stronger Peer Support**
Due to strong bond of friendship and interaction with peer, this group had a good amount of support system in the form of peer and friends. This group could ventilate feelings, seek advice and share problems with each other.

3) **MARRIED FEMALE RELATIVES (MFR) OF RSH EDUCATED YOUNG WOMEN**

(i) **Improved RSH related knowledge**
This group of respondents had the privilege of receiving RSH education from the traditional source (mother and family members) as well as mass media and RSH educated girls within family. Thus their level of RSH knowledge was quite appreciable.
CHAPTER 6  FINDINGS AND DISCUSSIONS

(ii) Improved family support in making RSH related decisions
By virtue of the presence of an RSH educated girl in the family, the attitude of other female members of the family has also changed towards RSH related issues of women. Women in these families are more supportive of each other in terms of collective bargaining.

(iii) Increased awareness about symptoms of Sexually Transmitted Infection (STI) and Reproductive Tract Infections (RTI)
The instances of STI/ STD (sexually transmitted infections and diseases) and RTI (reproductive tract infections) are very high in this area. Many women do not seek treatment for it because they are not aware of symptoms and keep suffering in silence. Due to Reverse Communication and mass media, these women are more aware of the symptoms and are taking steps to seek treatment.

4) NON-RSH EDUCATED YOUNG WOMEN
   (i) Educational qualification
   The formal educational qualification among this group is better than their RSH educated counterparts. This has also enabled the respondents in this category to be more informed about their bodies.

   (ii) Informal RSH education
   This category of respondents has had its share of informal RSH education from the traditional source (mother, aunts etc.). Due to the better educational status these respondents have been able to imbibe the knowledge by ruling out some of the myths that get transferred along-with informal RSH knowledge.

5) NON-RSH EDUCATED YOUNG MEN

   (i) Age gap between husband and wife (age differentials)
   Due to the trend of younger wives in this area, the husbands have an advantage to control the decisions for the couple. The age gap is usually 6-8 years. This age differential gives
a lot of power and autonomy to the male in the patriarchal society. Most of the time he does not have to argue with his wife as she does not question his authority.

(ii) Lesser burden of controlling child birth
As child birth and pregnancy has always been a woman’s blessing and a woman’s bane, the man is not bothered to prevent frequent pregnancy or to prevent early pregnancy (before 20 yr). The burden to control the pregnancy lies more on the shoulders of the woman.

(iii) Family and social support in all decisions due to patriarchy
Another strength of this group is the family and social support due to patriarchy. The male doesn’t have to struggle too much to have his way in a marriage. The patriarchal norms give a tacit power to him to do things his way. Though it proves to be disadvantageous for the woman, it acts in the man’s favour.

(iv) Less prone to reproductive tract related diseases as compared to female counterparts
Due to the anatomy and physiology of female body, women are more prone to sexually transmitted diseases and infections. The risk increases more with pregnancy and child birth. Men on the other hand do not have to face these issues and are less prone to the related complications.

(v) Better educational qualification and lesser school drop-out rate as compared to female counterpart
The patriarchal society works for the advantage of the men. Similar is the case with education and schooling. The boys and men have more number of years in school and better educational qualification than their female counterparts.
WEAKNESSES OF RESPONDENT GROUPS

1) RSH EDUCATED YOUNG WOMEN

(i) Child marriage
The bane of child marriage is very prominent in North India, Rajasthan being one of the notorious states. Due to getting married as a child, the girls are not able to develop completely physically, emotionally and intellectually. RSH education does not benefit them as much as it could if they were adults at the time of marriage.

(ii) Educational qualification
Due to patriarchy and child marriages, the girls in this area are unable to get formal education for the required number of years. Either they are not enrolled in school or are made to drop-out of school. Education for girls is not considered important by family and at times girls themselves. Less education or no education has its own poor implications in terms of ability to be independent and assertive.

(iii) Age gap between husband and wife (age differentials)
The wives in this region are married off as children and to make matters worse for them, they are younger to their husbands by 6-8 years. This makes it very difficult for them to negotiate their RSH rights or any other rights. The age difference and patriarchy act as double deterrents to the ability to negotiate RSH related rights. The RSH education gives the required knowledge to the respondents and brings about a desired degree of attitudinal change. But the change in practice is not possible without the support and cooperation of husband and other family members.

(iv) Prone to multiple child births
The lack of formal education and high rate of school drop-out coupled with child marriage and patriarchy, lead to multiple pregnancies and lesser gap between respective children. These girls become sexually active at the onset of puberty (12-15 yr.). thus the period for them to bear children starts early at 12-15 yr. and goes on till menopause (45-50 yr). With lesser control over their bodies and their lives, these girls are more prone to undergo many pregnancies. The TFR (total fertility rate) for rural women in Rajasthan according to NFHS 3 data is 3.62 (i.e. an average of 3.62 children per woman). 36% young women start bearing children by the age of 19 yr.
According to NFHS 3, 18% women with no education had a live birth as compared to 1% for women who completed 10 years of formal education.

(v) *Increased risk of high MMR, IMR and maternal morbidity*

According to NFHS 3, the IMR (infant mortality rate) was 74.6 and child mortality rate was 97.6 for Rural Rajasthan. The various causes for this are underage mothers, malnourished or anaemic mother, unsafe delivery, untreated STI/RTI etc. it also poses a great threat to the health and life of young mothers who either die due to frequent and early pregnancies or remain ill often.

(vi) *Non-RSH educated status of husband and family (in-laws and maternal)*

The RSH knowledge that this respondent group has, is not effective to practice the safe and healthy RSH behaviour, because the husbands in most cases do not have accurate knowledge about RSH related matters and are biased due to peer pressure, patriarchy and cultural norms. Thus it becomes difficult for the RSH educated girls to negotiate and convince the husbands. Similar is the case with the family (in laws and maternal family). The RSH educated girls do not have the support of the husband family to implement RSH related knowledge into practice. The support they get from their own mother is very weak in comparison to the social norms of the community. A girl is supported at times by her family only to an extent where her marriage is not broken. This limits the scope of support from the maternal family.

2) *MARRIED FEMALE RELATIVES (MFR) OF RSH EDUCATED YOUNG WOMEN*

3) *NON-RSH EDUCATED YOUNG WOMEN*

4) *PEER OF RSH EDUCATED YOUNG WOMEN*

(i) *Educational qualification*

This respondent group is the least educated among all the respondent groups, in terms of formal education. As discussed above, these respondents haven’t been able to exercise
their RSH related rights because neither did they have the knowledge nor did they have the bargaining power that formal education gives.

(ii) **Age differentials**
The age gap of 6-8 years between husband and wife where the wife is younger to husband, it becomes difficult for the younger wife to negotiate and discuss with an authority figure. This practice is also reinforced by the joint family system where the whole family complies with the norm and looks at any deviation as non-acceptable and destabilizing. Thus there is no support from anywhere to break this systematic oppression of rights.

(iii) **No formal structured RSH education**
The MFR is the group which has never attended any structured formal RSH education programme. The source of RSH knowledge for them has been informal education from family, peers and self-experiences. RSH educated girls have also contributed to this knowledge in the form of Reverse Communication. But the knowledge that they have is not complete and carries many myths and misconceptions around these issues. The husbands and family too have no formal RSH education.

(iv) **Prone to multiple child birth**
The lack of formal education, structured RSH education, child marriages, patriarchy and various other cultural norms, this group has been the most disadvantaged in terms of access to RSH services. They have been prone to multiple child births and related complications. The present generation has a better life as compared to the older generation due to increased awareness and education.

(v) **Increased MMR, IMR and maternal morbidity**
According to NFHS 3, the IMR (infant mortality rate) was 74.6 and child mortality rate was 97.6 for Rural Rajasthan. The various causes for this are underage mothers, malnourished or anaemic mother, unsafe delivery, untreated STI/RTI etc. it also poses a
great threat to the health and life of young mothers who either die due to frequent and early pregnancies or remain ill often.

5) **NON-RSH EDUCATED YOUNG MEN**
   
   (i) **Child marriage**
   
   Child marriages are not only disadvantageous for women but they are also disadvantageous for men. The marriage limits their scope to go for further studies and forces them to take on the responsibility of wife and children at a much younger age. They are not able to develop their full potential and are thrown into the routine of life which prohibits their progress.

   (ii) **No formal RSH education**
   
   The young men in this region do not have any formal structured RSH education programme. Their only source of RSH education is friends, pornography, mass media messages, and audio visual aids. The knowledge gained about RSH is sometimes accurate and sometimes full of myths and misconceptions. These young men enter a relationship like marriage, with this half-baked knowledge about sexual intercourse and child birth etc. the lack of proper knowledge on the part of male in a patriarchal society does no good to the man or to his wife and family.

   (iii) **Socialised to practice gender stereotypical role of suppression and control**
   
   Coupled with lesser number of schooling years, no formal RSH education and a socialization which teaches the gender stereotypes and use of power to suppress women, it is a dangerous cocktail for a healthy balanced relationship and marriage. The end result is a young wife who gets raped by her husband, physically abused and gets pregnant before the age of 18 or 20 years. This results in low birth weight of children, death of children or mother and ill health of both.
CHAPTER 6  FINDINGS AND DISCUSSIONS

(iv) Lesser family support to discuss RSH matters
The cultural norms are such that the fathers or other male members of the family do not try to educate the young men at all about RSH (unlike their female counterparts). Neither the young men are encouraged to discuss or ask any related issues to family members. This leaves the young men to the mercy of the myths and misconception laden RSH knowledge coming from sources such as friends, pornographic films and printed material. At times they do get accurate knowledge from credible sources such as government and NGO led mass media campaigns. But that is not enough.

OPPORTUNITIES FOR ALL RESPONDENT GROUPS

(i) Increasing recognition of RSH programs from government and Non-Government sector
Post ICPD, the thrust on RSH programs have increased from government and non-government sector leading to sensitization among all stakeholders. This has also shown promise of improvement for young men. Earlier the thrust on RSH education and services for men was not a priority, but increasingly men are emerging as active recipients of the programme.

(ii) Increase in social support for women
With various government and non-government efforts and policies, like janani suraksha yojana, balika samriddhi yojana etc. women are receiving a lot of boost. Gradually the situation should become more conducive for them to be able to exercise their RSH related rights, provided the efforts in this direction are persistent and include all stakeholders.

(iii) Improvement in RSH services in rural areas
The government efforts to improve RSH services in rural areas are increasing and new initiatives like proposed introduction of medical degrees like “Bachelor of rural medicine” is going to improve the health infrastructure of rural areas. The upgrade of all PHCs and training and induction of village level health workers like ASHA (Accredited
CHAPTER 6 FINDINGS AND DISCUSSIONS

Social Health Activist) is also a promising step for improvement of RSH services in rural areas.

(iv) Increasing advocacy efforts to include men in RSH programmes
Various seminars, papers, conferences, studies and researches have indicated towards the active involvement of men in RSH programmes. The policy level initiatives are taking care of this need and the thrust is increasing on the involvement of men too in RSH programmes not only as stake holders but also as participants and target audience.

(v) New inventions in the field of contraception
With the invention of new contraceptive methods like the emergency contraception, the injectable contraception etc., the chances for getting better contraceptive care with less failure rate are increasing. There is also active research on for introducing new contraception for men in addition to condoms, spermicidal jellies and vasectomy. This will give more options to men to choose from.

(vi) Increasing thrust on education of girls
With new laws and policies, programmes to encourage girl child education, it is promising to see that girls will receive more years of formal school education. Parents are being sensitized to send their daughters to school. Free education for girls is another boost for the education of girls. This will help reduce the suppression faced by girls and will make them more independent.

(vii) More political efforts to eradicate child marriages
The efforts to eradicate child marriages are slow but progressing. The law prohibiting child marriages is being implemented across the country. Though it is not being dealt with firmly and lots of loose ends are encouraging people to perform child marriages. But the positive side is that the child marriages have reduced considerably after the implementation of this law. In addition there are several schemes like Balika Samriddhi Yojana which promises a sum of money if the girl is not married till the age of 18 years and is sent to school.
CHAPTER 6  FINDINGS AND DISCUSSIONS

THREATS TO RESPONDENT GROUPS

1) RSH EDUCATED YOUNG WOMEN, 2) PEER OF RSH EDUCATED YOUNG WOMEN 3) MARRIED FEMALE RELATIVES (MFR) OF RSH EDUCATED YOUNG WOMEN

(i) Lack of social, political and legal support
Though these groups of respondents are educated in RSH either directly or by way of peer education or Reverse Communication, the big challenge in front of them is to convert this knowledge and attitude gain into positive behaviour change. But due to the lack of social, political and legal support these respondents are unable to exercise the knowledge gained.

(ii) Increased risk of sexual coercion from husband
The findings from this study show increased reporting of sexual and physical coercion from husbands for the respondents who initiated contraception discussions. Since the inputs on RSH related knowledge is one sided for this group of respondents and the husbands have not received similar inputs, it becomes very difficult for the RSH educated women, their peer or MFR to exercise their RSH rights or to negotiate safe sexual practices.

(iii) Increased chances of friction within marriage and family
As mentioned in the above paragraph, the negotiations about RSH related rights in a family which does not have the same understanding about RSH rights becomes very difficult to negotiate. The RSH educated girls, peer and MFR find it very difficult to negotiate their RSH related rights due to the friction and abuse caused by husband and other family members.

(iv) Increased threat of abandonment from husband or family
These women are also at the threat of being abandoned by their husbands and families if they try to be too assertive towards their RSH rights. As discussed earlier the social,
cultural and political situation is not such that it will support an uneducated woman who has been deserted by her husband.

4) **NON-RSH EDUCATED YOUNG WOMEN**

   (i) **Inability to exercise RSH rights and safe sex practices**
   This group of respondents has not received any formal education on RSH and related rights. The findings of the study also indicate that this group has very low awareness about RSH rights. Thus they are less likely to exercise them too.

   (ii) **More likely to not be able to recognise symptoms of STD/STI**
   STI/RTI (sexually transmitted infections and Reproductive tract infections) are very common in this study area. But the most of the times the women either ignore these symptoms or are not aware that these can cause various other long term problems. In the absence of RSH education, these young women too are likely to ignore the symptoms of STI/RTI leading to further complications.

5) **NON-RSH EDUCATED YOUNG MEN**

   (i) **More likely to suffer loss of child or wife due to early or repeated pregnancy**
   Due to pregnancy at early age (before 20 year) and no gap between pregnancies, the chances of death of mother or child during pregnancy or child birth are high. The trend of home deliveries is also one contributing factor.

   (ii) **More likely to get STD/STI**
   During the non-agricultural season, most of the young men leave their villages to work at other sites. As they spend time away from family, many of them indulge in paid sex with commercial sex workers. In the absence of any formal RSH education, this group of respondents are more likely to contract STI/STD and HIV. Since they are not much aware of the symptoms, they are more likely to not be able to recognise symptoms of STD/STI and pass it on to wife as well.
### TABLE: 6.4.4
**SWOT ANALYSIS OF RSH EDUCATED YOUNG WOMEN BASED FGD**

<table>
<thead>
<tr>
<th>ITEMS OF STRENGTH</th>
<th>ITEMS OF WEAKNESSES</th>
<th>ITEMS OF OPPORTUNITIES</th>
<th>ITEMS OF THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to RSH education</td>
<td>Child marriage</td>
<td>Increasing recognition of RSH programs from government and Non-Government sector</td>
<td>Lack of social, political and legal support</td>
</tr>
<tr>
<td>Access to rights based training</td>
<td>Educational qualifications</td>
<td>Increase in social support for women</td>
<td>Increased risk of sexual coercion from husband</td>
</tr>
<tr>
<td>Mother’s support</td>
<td>Age differentials between husband wife</td>
<td>Improvement in RSH services in rural areas</td>
<td>Increased chances of friction within marriage and family</td>
</tr>
<tr>
<td>Improved attitude towards young men’s RSH education</td>
<td>Multiple child births and pregnancies</td>
<td>Increasing advocacy efforts to include men in RSH programmes</td>
<td>Increased threat of abandonment from husband or family</td>
</tr>
<tr>
<td>Stronger peer support</td>
<td>High instances of infant death, child death or maternal death and maternal morbidity</td>
<td>New inventions in the field of contraception</td>
<td></td>
</tr>
<tr>
<td>No RSH education of husband or family</td>
<td></td>
<td>Increasing thrust on education of girls</td>
<td>More political efforts to eradicate child marriages</td>
</tr>
</tbody>
</table>

---

303
### TABLE: 6.4.5
SWOT ANALYSIS OF MFR of RSH EDUCATED YOUNG WOMEN BASED ON FGD

<table>
<thead>
<tr>
<th>ITEMS OF STRENGTH</th>
<th>ITEMS OF WEAKNESSES</th>
<th>ITEMS OF OPPORTUNITIES</th>
<th>ITEMS OF THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved RSH related knowledge</td>
<td>Child marriage</td>
<td>Increasing recognition of RSH programs from government and Non-Government sector</td>
<td>Lack of social, political and legal support</td>
</tr>
<tr>
<td>Improved family support in making RSH related decisions</td>
<td>Educational qualifications</td>
<td>Increase in social support for women</td>
<td>Increased risk of sexual coercion from husband</td>
</tr>
<tr>
<td>Increased awareness about symptoms of Sexually Transmitted Infection (STI) and Reproductive Tract Infections (RTI)</td>
<td>Age differentials between husband wife</td>
<td>Improvement in RSH services in rural areas</td>
<td>Increased chances of friction within marriage and family</td>
</tr>
<tr>
<td></td>
<td>Multiple child births and pregnancies</td>
<td>Increasing advocacy efforts to include men in RSH programmes</td>
<td>Increased threat of abandonment from husband or family</td>
</tr>
<tr>
<td></td>
<td>High instances of infant death, child death or maternal death and maternal morbidity</td>
<td>New inventions in the field of contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No formal structured RSH education</td>
<td>Increasing thrust on education of girls</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More political efforts to eradicate child marriages</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE: 6.4.6 SWOT ANALYSIS OF NON-RSH EDUCATED YOUNG WOMEN BASED ON FGD

<table>
<thead>
<tr>
<th>ITEMS OF STRENGTH</th>
<th>ITEMS OF WEAKNESSES</th>
<th>ITEMS OF OPPORTUNITIES</th>
<th>ITEMS OF THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational qualification</td>
<td>Child marriage</td>
<td>Increasing recognition of RSH programs from government and Non-Government sector</td>
<td>Inability to exercise RSH rights and safe sex practices</td>
</tr>
<tr>
<td>Informal RSH education</td>
<td>Educational qualifications</td>
<td>Increase in social support for women</td>
<td>More likely to not be able to recognize symptoms of STD/STI</td>
</tr>
<tr>
<td>Age differentials between husband wife</td>
<td>Improvement in RSH services in rural areas</td>
<td>Increased chances of friction within marriage and family</td>
<td></td>
</tr>
<tr>
<td>Multiple child births and pregnancies</td>
<td>Increasing advocacy efforts to include men in RSH programmes</td>
<td>Increased threat of abandonment from husband or family</td>
<td></td>
</tr>
<tr>
<td>High instances of infant death, child death or maternal death and maternal morbidity</td>
<td>New inventions in the field of contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No formal structured RSH education</td>
<td>Increasing thrust on education of girls</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More political efforts to eradicate child marriages</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE: 6.4.7

**SWOT ANALYSIS OF PEER OF RSH EDUCATED YOUNG WOMEN BASED ON FGD**

<table>
<thead>
<tr>
<th>ITEMS OF STRENGTH</th>
<th>ITEMS OF WEAKNESSES</th>
<th>ITEMS OF OPPORTUNITIES</th>
<th>ITEMS OF THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to RSH education</td>
<td>Child marriage</td>
<td>Increasing recognition of RSH programs from government and Non-Government sector</td>
<td>Lack of social, political and legal support</td>
</tr>
<tr>
<td>Access to rights based training</td>
<td>Educational qualifications</td>
<td>Increase in social support for women</td>
<td>Increased risk of sexual coercion from husband</td>
</tr>
<tr>
<td>Mother’s support</td>
<td>Age differentials between husband wife</td>
<td>Improvement in RSH services in rural areas</td>
<td>Increased chances of friction within marriage and family</td>
</tr>
<tr>
<td>Improved attitude towards young men’s RSH education</td>
<td>Multiple child births and pregnancies</td>
<td>Increasing advocacy efforts to include men in RSH programmes</td>
<td>Increased threat of abandonment from husband or family</td>
</tr>
<tr>
<td>Stronger peer support</td>
<td>High instances of infant death, child death or maternal death and maternal morbidity</td>
<td>New inventions in the field of contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No formal structured RSH education</td>
<td>Increasing thrust on education of girls</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More political efforts to eradicate child marriages</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE: 6.4.8 SWOT ANALYSIS OF NON-RSH EDUCATED YOUNG MEN BASED ON FGD

<table>
<thead>
<tr>
<th>ITEMS OF STRENGTH</th>
<th>ITEMS OF WEAKNESSES</th>
<th>ITEMS OF OPPORTUNITIES</th>
<th>ITEMS OF THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age differentials between husband wife</td>
<td>Child marriage</td>
<td>Increasing recognition of RSH programs from government and Non-Government sector</td>
<td>More likely to suffer loss of child or wife due to early or repeated pregnancy</td>
</tr>
<tr>
<td>Lesser burden of pregnancy and child birth</td>
<td>No formal RSH education</td>
<td>Increase in social support for women</td>
<td>More likely to get STD/ STI</td>
</tr>
<tr>
<td>Family and social support in all decisions due to patriarchy</td>
<td>Socialized to practice gender stereotypical role of suppression and control</td>
<td>Improvement in RSH services in rural areas</td>
<td>More importance given to women in RSH programmes than men</td>
</tr>
<tr>
<td>Less prone to reproductive tract related diseases as compared to female counterpart.</td>
<td>Lesser family support to discuss RSH matters.</td>
<td>Increasing advocacy efforts to include men in RSH programmes</td>
<td></td>
</tr>
<tr>
<td>Better educational qualification and lesser school drop-out rate as compared to female counterpart</td>
<td></td>
<td>New inventions in the field of contraception</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increasing thrust on education of girls</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>More political efforts to eradicate child marriages</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 6 FINDINGS AND DISCUSSIONS

From the above discussion regarding SWOT ANALYSIS of FGD (Focussed Group Discussion), the Strengths, Weaknesses, Opportunities and Threats of the respondents have been analysed in relation to RSH. The strengths and weaknesses are more of the personal factors of the respondents. The opportunities and threats are more of external factors at the meso and macro level.

FINDINGS

5. **RSH TRAINING MODULES**

Till now we looked at the social, political, economic, familial, personal and cultural factors influencing the dynamics of interaction and communication of RSH educated and Non RSH educated women with their husbands and family.

Since this study is focussing on the structured RSH education program, it will be worthwhile to see how the RSH training module used for the training affects the dynamics of interaction and communication and also the change in KAP.

- Most of the RSH training modules evaluated are focusing on various aspects of RSH, FLE (family life education), peer pressure and substance abuse.
- The sections on peer pressure and substance abuse are not only providing knowledge but also give practical situations and skills to deal with them.
- The sections on Safe Motherhood also have been dealt with well in most of the modules. It is a good combination of knowledge and how to negotiate safe delivery and ante natal check-ups.
- The section on child survival too has a lot of handy tips to implement the knowledge.
- The section on Family Planning is loaded with knowledge, it has details of various forms of contraception, each methods advantage-disadvantage, who should use which method etc.
- But the section on Family Planning does not prepare the young girl on what to expect in real life, how to talk about contraception in such a way which is persuasive and productive.
CHAPTER 6 FINDINGS AND DISCUSSIONS

✓ This section does not equip the young girl with skills to negotiate appropriate Family Planning method for herself and the couple.

✓ There is very little focus on GBV (Gender Based Violence). The young girls have not been given the knowhow to deal with sexual coercion within marriage and how to negotiate within marriage and relationships.

✓ The section on HIV/AIDS is very elaborate and talks about all the causes, mode of transmission, symptoms etc. but it does not equip the young girl with the negotiation power to discuss the HIV status of spouse and precautions to use. Every year lots of wives get HIV infection from their husbands. Many of these wives got it unknowingly whereas many knew that the husband is HIV positive but did not know how to tell her husband to use condom with her.

✓ There is a lot of stress at the end of the training to go back to village and give the information to the peer. But as we have seen the knowledge does reach the MFR too leading to considerable change in their KAP, this aspect could be highlighted too.

EXAMPLES FROM THE FIELD

A) An RSH educated girl from village Bakhusar

“I was very happy that I had all the knowledge to make my life better and my life will not be like my mother’s. But when I got married I realised that only knowledge is nothing, it only leads to frustration and inability to do what we want to do. I hope the training also taught us how to deal with husbands and in laws.”
CHAPTER 6  FINDINGS AND DISCUSSIONS

CASES

(Names have been changed to maintain the confidentiality of the cases)

CASE 1

**NAME: SHANTI**  
**AGE: 16 Years**  
*RSH Educated. Child-rights education*  
*Formal education-* class 5.  
*Married at age-* 15 years  
*Age at which sent to live with husband-* 15 years  
*Pregnancy/ child-* N/A  
*Type of family-* JOINT FAMILY  
*Husband’s age-* 21 years  
*Husband’s education-* class 8

Shanti was the most assertive, confident young woman interviewed during this study. She was especially recommended by the RSH trainer, as the trainer felt that Shanti was one of the trainees who asked the most number of questions and had been very assertive. The researcher met Shanti in the Aanganwadi compound. Unlike most of my other respondents who were usually very shy to meet and talk about their family lives, Shanti was one very eager girl who was waiting for me start the dialogue. At first The researcher could see a young girl…a child who was not even showing any signs of physical maturity and looked like she was yet to grow up to even look like a 15 year old. She barely looked 13 year old to me. Upon exchanging my observation with her, she promptly told me that she was going to complete 16 years soon and start on 17 years. She had worn all the ritualistic symbols of marriage- the Sindoor, Mangalsutra, bangles, Toe-rings, covered head and a nose-ring. Upon asking about her husband, she got very shy and told me that his name was Mahesh and that he did not know that she had come to meet me. When I asked her about what will she do if Mahesh came to know that she was talking to me about her married life and other related issues? Her prompt answer was
“pooch ke toh dekhe, koi chori toh nahi kar rahi” (let him ask…I’m not stealing anything).

The conversation and dialogue carried on for nearly an hour, in which Shanti told The researcher about how she had no option to delay the marriage, even though she wanted to. Her father was poor and he had three daughters to marry off. He chose to marry them off at the same time to save cost of venue, food and priest. Shanti is the second number daughter. Eldest daughter was 16 years at the time of marriage and youngest was 12 years. Shanti and her older sister were sent to live with their husbands after marriage because the family thought that they were old enough to manage in husband’s house. Whereas the youngest daughter is still with parents and will be sent off to husband’s house by the time she is 15 years old or maybe earlier if the husband’s family puts a lot of pressure. Shanti very sadly said…”hum toh samaan hain…maa-baap rakh le toh wahan reh lein…saasre bula le toh wahan bhej deve”(we are like luggage…if parents keep us, we stay with them… if the in-laws call us… we are sent there).

The researcher asked Shanti whether she has been able to use any of her knowledge gained during RSH education program and whether she faced any difficulty in implementing those in her life. She reported that she had been living with her husband for the past five months and still hadn’t allowed him to touch her. The researcher was surprised at it and asked her how she had managed to do that. She told me that she had told her husband that she did not want to get pregnant before 18 years. Husband is an educated man and he also did not want to have children so soon. Thus he agreed upon this condition. Upon ‘abstinence’, Shanti told me that she told her husband to leave her alone till she completes 16 years as she was still a child. The husband does not like that and tried to force himself upon her, but her Bhabhi (husband’s elder brother’s wife) came to rescue twice and told Mahesh not to use force and give time to Shanti to adjust and grow up. Shanti says that her bhabhi is her saviour but it not mean that her husband is bad. She said that she had started to like him and may not complain to anyone if she is forced into intercourse against her wishes. “apne beendh ko police pakadwaaongi kya?” (will I get my husband caught by the police?)

When The researcher asked her whether she has any back up plan ready for delaying the first pregnancy if the Abstinence method is not able to last for long? She told The
researcher that she has already bought a packet of “Mala D” and is planning to use it without the knowledge of any one. She also told The researcher that Mala D will not save her for long because if she did not get pregnant within few months, her husband might get suspicious or might label her “infertile”.

Shanti was confused but not scared. Shanti was full of knowledge but did not have enough social support to implement it. Shanti was determined but had a week fall-back position; she knew if the husband threw her out of the house…her parents too will not accept her.

Shanti’s bhabhi (married female relative) helped her in her initial months in the family partly because of her own formal education (class 7) and partly because of her own personality and beliefs.

Till the social and cultural environment does not improve, till husbands and young men are not educated and till girls are considered a luggage to be sent off to husband’s house as soon as possible…the situation of girls in our society will not improve. As The researcher is writing this chapter she also wonder as to what would have happened to Shanti, whether she is happy or pregnant or beaten up or labelled infertile.

This is also for the RSH education program to decide whether they want to give themselves a pat on their back for enabling a young girl with right knowledge and “rights based training”. Or whether they should think that the effort was incomplete without involving the husband. Whether the government and the civil society should think that they have not been able to ensure the elimination of child marriages.
CHAPTER 6  FINDINGS AND DISCUSSIONS

CASE 2

NAME: DHAPU
AGE: 16 Years
RSH Educated
Formal education- class 3.
Married at age- 14 years
Age at which sent to live with husband- 16 years
Pregnancy/ child- 8 months pregnant at time of interview
Type of family- JOINT FAMILY
Husband’s age- 23 years
Husband’s education- class 5

Dhapu’s mother invited the researcher home to talk to Dhapu as she could not go out of the house in the 8th month of her pregnancy. It was a small kuchcha house made of clay and hay. Dhapu’s mother greeted the researcher with a lot of love and offered the researcher and Dhapu some tea. She talked for a while before leaving us alone for the interview.

Dhapu was an extremely shy girl. During the whole course of interview, she only spoke not more than 5-6 sentences. Most of the answers she gave were by nodding her head. Dhapu sat with her head and face covered in a long “ghoonghat” (veil) for the entire duration of the interview. She did not look pregnant at all! To the surprise of the researcher, her pregnant tummy did not look anywhere like carrying an 8 month old foetus. The researcher had to ask for her immunization card to be sure of the gestation period. She looked quite pale and week. Her pregnancy chart made by the ANM showed only a weight gain of 2 kg during the entire period of pregnancy.

When The researcher asked Dhapu about her husband, she told that he was a very angry man. She told The researcher that he was forcing her to have intercourse with him even during pregnancy when it was painful and uncomfortable for her. To save her life and
that of the child, Dhapu’s mother had brought her home on the pretext of ill health and
delivery. Dhapu said that she wished herself dead than going back to him after delivery.
When asked about the family planning discussion, Dhapu informed that there was no
time to discuss anything as the husband did not even ask her introduction and before she
could realise anything or think about discussing family planning, she got pregnant. Her
mother in law was very strict and made her do all household and animal care work. There
was no time to rest and if she did not want to sleep with her husband, mother in law and
husband used to keep her hungry.
The child born to her might be severely underweight or premature or have some other
health problems. Dhapu’s health also did not look very promising; we don’t know
whether she will be able to survive the child birth.
Dhapu’s family (mother) is very supportive of her and has gone to the extent of arguing
with the in laws so that Dhapu could come home for a few months. But due to the social
pressure and cultural norms, Dhapu will have to return to her husband…and if the
situation in terms of family support (MFR), social and cultural norms do not change then
Dhapu will again go through the same cycle.
Since there is not enough education of husband, that is one of the reasons for this
unreasonable behaviour. The other is of course the socialization process of boys to prove
masculinity and girls to prove fertility. In this case the mother in law too is a main factor
in Dhapu’s poor condition. This again brings us back to the conclusion of inclusion of all
the stake holders in the sensitization and awareness programmes.

CASE 3
NAME: RUKMANI DEVI
AGE: 40 Years
Mother of RSH educated young woman
Formal education- Illiterate
Married at age- 15 years
Age at which sent to live with husband- 15 years
Pregnancy/ child- 7 children (3 daughters, 4 sons), 4-5 miscarriages, 2 still-births.
Type of family- JOINT FAMILY

Husband’s age- 50 years

Husband’s education- class 5

Rukmani Devi is the mother of one of our respondents (DHAPU). Rukmani Devi got married at the age of 15 years and had her first child at the age of 16 years. She had either pregnancy or child birth every year and there was hardly any break from the cycle of pregnancy till she was fertile. Her menstrual cycle stopped at the age of 37 year (early menopause). She did not go to doctor to seek medical help for early menopause because she was glad that she couldn’t get pregnant any more…

Her family did not support her at all in her decision of not having too many pregnancies. He says that she loves her husband a lot and that he is a good man who cares for her. But she regrets that this kind of care was missing when she actually needed it during her youth. There was no question of the husband asking for her wish for anything.

Rukmani Devi decided that her daughters should not have a life similar to her and she struggled a lot to keep them in school and delay their marriage. But she was not able to do much alone. She feels bad now when she looks at Dhapu who is going through the same cycle. Rukmani Devi said, “ise swasthya ki training kara ke kya fayada hua…yeh toh pet le ke baith gayi. Hum toh kisi ko dosh nahin de sakte kyoki hamari ma ne toh hamein padhaya hi nahin par inko padha ke bhi kya fayada hua?”(what is the use of sending her for RSH training…she has got pregnant. I can’t blame anyone for my condition because my mother never sent me for any kind of education, but what use was this education for her either?)

Rukmani Devi was quite frustrated that even education does not improve the status of girls and women. She said that in addition to knowledge to girls one also needs to give adequate knowledge to boys so that they can understand what is good for them and their wives. She said that the situation of girls will not improve till the men do not want it to improve.

Rukmani Devi’s own life was full of problems mainly due to repeated pregnancy and poor health care. She wanted a better life for her daughter. But the improvement will not
happen only by addressing one segment of the target audience. The program has to be designed in such a way that it takes care of all stake holders and works with them.

None of the RSH rights of Rukmani Devi were fulfilled- right to decide the age for marriage, right to decide family size, right to give consent for sexual intercourse, right to receive correct knowledge about RSH related matters and right to access of RSH products and services. The only RSH right she could ensure for her daughter, was the right to get correct knowledge about RSH related matters. But in the absence of a suitable social and cultural environment and the non-cooperation from husband, the daughter was not able to get maximum gain out of the knowledge.

CASE 4

NAME: Imarti Devi
AGE: 25 Years
Married sister of RSH Educated girl
Formal education- class 5.
Married at age- 14 years
Age at which sent to live with husband- 15 years
Pregnancy/child- 3 children (2boys& 1 girl), 2 died before age of 1 year.
Type of family- JOINT FAMILY
Husband’s age- 35 years
Husband’s education- class 3

Imarti Devi was one of the many Married Female Relatives, who reported that none of their RSH related rights were fulfilled.

Imarti Devi said that the death of her young infants happened due to premature home deliveries. As she was not taken to hospital because the pains started at home and hospital was far away. She also said that she was not even 16 year old when she delivered her first child who died within a month. She had to go through a lot of physical and emotional
pain and there was no one who was willing to help her or guide her correctly. She said that she was happy for her sister who has got the right knowledge at the right time. Imarti also said that she will not let her father marry off her 15 year old sister so early and have the same fate as herself.

Imarti reported that after the RSH education of her sister, her mother took Imarti to the health centre and got the sterilization surgery done for her. Mother told her not to tell the husband about it till he asks too much.

This case throws light on the aspect of Reverse communication in form of mother’s improved RSH related KAP. It also shows that the dynamics of interaction and communication between wife and husband about RSH, gets affected by factors like RSH education status, formal education etc. but it also affects the RSH related KAP of people, example- the experience faced by Non-RSH educated sister prompted her to be more protective towards her younger sister.

CASE 5

NAME: LAKSHMI
AGE: 18 Years
Non-RSH Educated
Formal education- class 5.
Married at age- 15 years
Age at which sent to live with husband- 16 years
Pregnancy/ child- 1 child, pregnant at present
Type of family- JOINT FAMILY
Husband’s age- 25 years
Husband’s education- class 10

Lakshmi said that she was lucky to have an understanding husband who does not beat her up unnecessarily. She also reported that it was her husband who did not want a child immediately after marriage and told her to use Mala D Oral Contraceptive Pills. It was only after a lot of pressure from the mother in law that she they had to get pregnant a year after marriage. The child was healthy and it was an Institutional delivery. Since there was
a lot of pressure to have a son, they had to try for another child soon after the first one. Lakshmi was pregnant at the time of interview and hoped that it is a boy this time so that it saves her the trouble to get pregnant again and again.

This case again highlights the dominant role played by husbands in the overall RSH life of the couple and that of the wife. This case also highlights that the chances of using contraception is higher among couple where the husband initiates FP discussion, in a patriarchal society and family. There is also the mention of the influence of mother in law in the reproductive life related decisions made by the couple.

CASE 6

NAME: KAALI
AGE: 17 Years
Peer of RSH Educated girl
Formal education- class 5.
Married at age- 15 years
Age at which sent to live with husband- 15 years
Pregnancy/ child- 5 months pregnant
Type of family- JOINT FAMILY
Husband’s age- 25 years
Husband’s education- class 8

Kaali was a very shy girl and did not even lift her veil once during the interview. She thought that the RSH educated friends of her were very lucky to have the right knowledge. When she was asked about how her friend’s RSH knowledge has helped her. She was quiet and then said that she was unable to conceive after months of staying with husband and her in laws had started talking about her being infertile. She was visiting her maternal village for some time and told her RSH educated friends about it. They told her about how to calculate the fertile period and trying to conceive during that time. Since Kaali’s husband used to work in a nearby town, he was home only few days a month. She calculated her fertile period and told her husband the days that he needed to be home. The tip helped her in a few months.
CHAPTER 6  FINDINGS AND DISCUSSIONS

She said that if it was not for their help, she would not have been able to prove her fertility to her in-laws.
At the same time she also feels that RSH education is not good for those girls whose husbands are not educated, because the uneducated husbands don’t like educated and knowledgeable wife. She said that the girl’s parents should see the education level of the prospective groom before marrying their educated daughter off.