CHAPTER 7  MAIN FINDINGS, OBSERVATIONS, AND RECOMMENDATIONS

REVERSE COMMUNICATION: MAIN FINDINGS, OBSERVATIONS, CONCLUSIONS

DYNAMICS OF INTERACTION AND COMMUNICATION: MAIN FINDINGS, OBSERVATIONS AND CONCLUSIONS

RSH RIGHTS: MAIN FINDINGS, OBSERVATIONS AND CONCLUSIONS

RSH EDUCATION FOR YOUNG MEN: OBSERVATIONS AND CONCLUSIONS

IMPLICATIONS AND INFLUENCES ON SOCIAL WORK PRACTICE

USE OF SOCIAL WORK TECHNIQUES IN THE STUDY AREA

RSH EDUCATION PROGRAMS AND SOCIAL WORK TECHNIQUES

RECOMMENDATIONS
This chapter is going to focus on the main findings of the study, with related discussions, observation and conclusions. There are few recommendations for the implementation of RSH programs for better RSH indicators.

MAIN FINDINGS

This section will look at the main findings, discussions, observations related to the study. The section has been divided into 5 sections:

1) REVERSE COMMUNICATION
2) DYNAMICS OF INTERACTION AND COMMUNICATION
3) RSH RIGHTS
4) RSH EDUCATION AND YOUNG MEN
5) IMPLICATIONS AND INFLUENCES ON SOCIAL WORK PRACTICE

REVERSE COMMUNICATION

- GAP IN KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) OF MFR
  1) Gap in Menstrual Hygiene related KAP

A cross examination of TABLES- 6.1.12 (specific change in knowledge), 6.1.16 (specific change in Attitude) and 6.1.20 (specific change in Practice), reveal considerable amount of gap in RSH related Knowledge, Attitude and Practice (KAP).

Table 6.1.12 (specific change in knowledge) indicates that 35.3% respondents (RSH educated girls and MFR) feel that there has positive change in knowledge of MFR regarding “menstrual hygiene”. Table 6.1.16 (specific change in Attitude) shows that the
reported change in attitude for the same component is only 11.1%. Whereas Table 6.1.20 (specific change in Practice) indicates that 22.9% respondents feel that there has been positive change in “menstrual Hygiene related practice”.

There is a gap the reported change in knowledge and attitude change, where the percentage of respondents reporting change in attitude related to “menstrual Hygiene related practice” is lower than the reported change in knowledge for the same component. If we look at the difference between change in attitude and practice for the same component, we can see that the percentage reported for change in practice is more than the reported change in attitude for the same component.

Further analysis into this trend brings forth the fact that it is easier to deliver knowledge or increase knowledge but all of the knowledge gained does not transform into attitude change. Similar is the case with practice. In this respondent group many RSH educated girls felt that most of the change in practice took place because of change in practice, but much of it also happened due to “copy effect". The RSH educated girls were like role models in the eyes of many of the MFR. The MFR looked upon them because of their better educational status, formal RSH education, better RSH educated girls related behaviour etc. thus the RSH educated girls felt that at time the positive change in RSH related practice among MFR was due to change in attitude but at times it was merely due to the “copy effect” of the RSH educated girls.

2) Gap in Family Planning related KAP

The cross examination of TABLES- 6.1.12 (specific change in knowledge), 6.1.16 (specific change in Attitude) and 6.1.20 (specific change in Practice), reveal considerable amount of gap in RSH related Knowledge, Attitude and Practice (KAP) related to “FAMILY PLANNING”.

In TABLE- 6.1.12 (specific change in knowledge), none of the respondents reported Family Planning as a component in which they have observed positive change. As it was an open ended question, the respondents mentioned components according to their analysis and observation. But in the change in attitude and practice sections table 6.1.16 (specific change in Attitude) and table 6.1.20 (specific change in Practice) the respondents reported “Family Planning” as a component which showed positive changes.
According to table 6.1.16, 29.9% respondents reported that there is a change in the “family planning” related attitude among MFR and according to table 6.1.20, 33.1% respondents reported a positive change in “family planning” related practice.

Upon further questioning from the respondents, the RSH educated girls reported that they did not know whether the MFR have the correct knowledge about “family Planning”, because they do not talk about it openly. But the attitude change is there because many of them say that they want to keep gap between children. The change in practice is also similar (33.1%) because the MFR have actually started going to doctor for sterilizations and copper T insertion. The practice of using family planning (sterilization and copper T) was present in the MFR before the Reverse Communication too. The practice increased after Reverse Communication, according to RSH educated girls and MFR.

3) Gap in equal treatment of girl child

The cross examination of TABLES- 6.1.12 (specific change in knowledge), 6.1.16 (specific change in Attitude) and 6.1.20 (specific change in Practice), reveal considerable amount of gap in RSH related Knowledge, Attitude and Practice (KAP) related to “Equal Treatment of girl child”. we can see the 5% respondents reported positive change in knowledge related to “equal treatment of girl child” but only 2.5% reported change in attitude for the same and 1.6% reported positive change in practice.

Since equal treatment for girls and child marriage are such issues which have very deep roots in patriarchy, thus a small term intervention like RSH education does not affect the KAP related to these issues. It requires more intensive, continuous and long term intervention which is holistic in nature. These kind of interventions are already in place in the form of education, health, livelihood related interventions. But the intervention related to sensitization of people and awareness issues is still not optimum.

4) Change in KAP and MFR age

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.
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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.

OBSERVATIONS

- Though the mother and older MFR have not shown a high degree of improvement in KAP as per the RSH educated girl’s perception, the researcher felt that the issue was not as simple as the RSH educated girls felt. The RSH educated girl looked at improvement in KAP for self, like taking care of own health, using contraception for self etc. but KAP is not only about self, it is also about the knowledge, attitude and practice related to RSH which affects other people’s lives. The very fact that the mothers sent their daughters for RSH training was an indicator that there was improvement in KAP even before the RSH education of girl. The mother did not show much improvement in KAP towards herself but showed tremendous improvements in KAP towards others in family. Example-taking younger women in family for sterilization or supporting a younger woman for using copper T.

- The MFR were more comfortable in discussing the RSH related issues than the RSH educated girls during reverse communication. This could be partly due to the confidence that the MFR had due to seniority in age and partly due to the more
authoritative position they enjoyed in the family. The girls did not have as positive approach towards sharing knowledge as the MFR had towards seeking that knowledge. Many of the RSH educated girls felt that they have the knowledge and they will use it for the betterment of their lives. The MFR are too rigid and if they share their knowledge with MFR, they will never accept it and will create difficulties for RSH educated girl too to implement them in their own lives.

- The **improvement in KAP of MFR is not only because of REVERSE COMMUNICATION. This improvement in KAP is due to many factors together, like-**
  - Informal RSH education of MFR from own family
  - Formal education
  - Peer interaction
  - Visits to health centre
  - Community health worker
  - Media
  - Awareness programs by government and NGOs.
  - Reverse communication from RSH educated girls

- The RSH related KAP of MFR of the Non RSH educated girl was also assessed during FGDs with Non RSH educated girls. The result suggests that the KAP of MFR of Non RSH educated girl is not very low. Thus it reflects upon the finding that there are other factors too which are influencing improvement in KAP for MFR (of RSH educated and Non RSH educated).

- The KAP of the RSH educated girl was also measured during the study and it was found that they have forgotten a lot of things they learnt during the RSH education program. Though there is substantial improvement in attitude, they are struggling to achieve behaviour change due to non-cooperation from spouse and family.
CONCLUSIONS

- There are various ways by which people (women and men) learn about issues related to RSH. Most of this knowledge is gained by means of informal communication from various sources like adults in the family, interaction with peer, audio visual media.

- Sometimes people also learn about RSH related issues from ‘structured RSH education’ which is conducted by either schools or government or non-government bodies. But this form of formal RSH education is not wide spread in India due to the political, social and cultural protests it has been facing.

- The informal RSH education comes with its own set of myths and misconceptions, which affects the lives of young people. Whereas the structured RSH education program gives accurate knowledge. Since the structured program is usually “one time, short term and no refresher or follow up” training is provided, it does not have as long term an impact as should be.

- There is a great degree of “reverse communication” present in families where at least one young woman has attended RSH education program.

- The quality of reverse communication depends upon the age of MFR, age gap between MFR and RSH educated girl, quality of relationship between RSH educated girl and MFR, values, attitude and beliefs of MFR, relationship hierarchy in the family. These factors decide the degree to which RSH communication will take place from RSH educated girl to MFR. The more favourable these factors, the better the quality of discussion will be.
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- Certain issues like, menstruation, changes during adolescence, child survival and safe motherhood are easily discussed as compared to other more conservative issues like abortion, family planning, HIV/ AIDS.

- The formal education or rights based training of the RSH educated girl does not have any direct correlation with the change in KAP of MFR. The personal educational qualification of RSH educated girl has a direct correlation with the change in their own KAP.

- The change in the RSH related KAP of MFR and RSH educated young women depends upon the level of formal education, informal RSH education, structured RSH education, Non formal education, financial independence, level of authority in marital relationship and family and position in family hierarchy.

- The structured RSH education program needs to be more focused on refresher classes and follow up trainings, to keep the knowledge fresh in the minds of the target audience.

DYNAMICS OF INTERACTION AND COMMUNICATION

1) Contraception discussion and usage

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 and lowest contraception usage. 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.

❖ OBSERVATIONS

- Going by the above mentioned discussion, it appears that the whole scenario is a systemic violation of various rights and at the same time it is a vicious cycle of oppression, where the girls are purposefully married off at younger age (13-17 yr.). They are married off to boys who are 7-8 years older to them. In addition to all this the girl’s education is not given importance, they are not sent to school and can’t study after marriage. Contraception is discouraged leading to an endless cycle of “emotional bondage”.

- The RSH educated and Non RSH educated group was very shy and reserved during one to one interview but was quite interactive during Focused Group Discussions. The main reason was that they were more carefree during FGD as it was held away from their house and they had no fear of relatives hearing the discussions. Whereas individual interviews were held at the residence of the girls, thus making them very conscious of the surroundings.

- Despite the RSH education many girls felt that they knew nothing to improve the quality of their lives.

- Nearly 40% of RSH educated girls were not able to recall basic knowledge about sexual and reproductive health. Most of them attribute this to the lack of any follow ups and a stimulating environment to continue the discussion beyond classrooms. The researcher also felt that the girls did not feel privileged at being the recipients of this training (55% of RSH educated girls).
CONCLUSIONS

- The RSH education, the connected reverse communication and the interaction with peer has led to some degree of improvement in KAP of all the three groups (RSH edu. MFR and peer).

- RSH education is not the only factor responsible for the improvement in KAP. There are other factors like, formal education, empowerment training, financial position, hierarchy and husband’s education, which have also influenced improvement in KAP.

- Mothers of RSH educated girls and that of peer of RSH educated girls were more supportive of their daughter’s well-being than the in laws.

- The success of contraception is more possible with the active involvement and initiative of husband, in cases where the husband does not let the wife decide.

- Women are more likely to choose an RSH educated husband as compared to men. Because they see that as a step closer to a happier life with less violence and more healthy life.

- The frustration, opposition and struggle that some RSH educated young women are facing in their lives should not be understood as failure of the program. In fact it should be looked at as an indicator towards making it multipronged in approach, to involve men, older family members and the community. This multipronged approach will ensure more cooperation between different target audiences and ease of improving RSH related KAP.
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RSH RIGHTS

The perceived notion of RSH educated girls related rights is different for RSH educated girls and Non-RSH educated girls. Whereas the RSH educated girls knew about their RSH related rights their non-RSH educated counterparts did not know about these rights and did not think it to be important to have rights related to aspects of life which are taken for granted (like sexual intercourse with husband, pregnancy and child birth etc.)

The RSH educated girls felt that RSH educated girls education should either be done with both men and women or it should not be done at all. Because if girls are the only ones to have the knowledge, then the onus to implement it also lies on the girls only. This leads to a lot of friction in the relationship resulting in frustration.

**OBSERVATIONS**

- The concept of RSH rights is new to urban and educated population too. Thus when we talk of RSH right for rural population and that too in Rajasthan, where the gender equality indicators are not faring so well, we are talking about a steep uphill task.

- Rights are not something which can be taught in a two hour session and then the girls are expected to start exercising it in their lives. Rights are and should be a part of our general upbringing and socialization. Young people should be growing up in a society where they have role models who negotiate their rights and demonstrate how they negotiate.

- It is not the fault of the RSH education program that the young women are not able to exercise their rights, as it is not a unilateral input. For the realization of rights, a multipronged approach is needed where all the stakeholders are involved in the awareness and sensitization.
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• At present the young women and MFR who are aware of their rights and want to implement it are more frustrated and helpless than their unaware counterparts. Most of their sexual and reproductive rights were not fulfilled and they sounded quite frustrated about it. Many of them felt that in our society we shouldn’t talk about rights for girls if we don’t engage the whole society to fulfil it.

• There has been certain amount of frustration and helplessness seen among RSH educated group, which feels that their peer who did not attend these trainings are much at peace with their lives, as they are not aware of their RSH RIGHTS and therefore are also unaware that they are being violated.

❖ CONCLUSIONS

• RSH related rights awareness only to one group has led to frustration and anguish among them. But this frustration and anger does not mean that RSH rights education should be discontinued. Frustration and struggle are the beginning of any positive change in the social norms.

• Whether the rights are being respected or violated is also a function of the individual perception. But with appropriate stimulation, people will be able to decide for themselves.

• Men too have RSH rights and the education program needs to focus on them too.
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RSH EDUCATION FOR MEN

❖ OBSERVATIONS
- Men were quite interested in attending RSH education programs, as they felt that they needed accurate knowledge for themselves and wife.
- There was a very strong influence of peer among men which was observed. Men wanted to look very strong in the eyes of their peer. The perception of a strong man was that he does not listen to his wife, beats up the wife when she does not obey and has sexual intercourse every day. These beliefs among the men were driving them to act the way they were behaving at times.
- There were instances where the peer of men used to tease each other by calling them “hen pecked” because they allowed the wife to go to her parent’s house or because they agreed with wife to use contraception.

IMPLICATIONS AND INFLUENCES ON SOCIAL WORK PRACTICE

According to the latest report of UN (October-November 2011), India ranks at 129 out of 146 countries in Gender Inequality Index (GII). This ranking is the second lowest in south Asia. This report has brought forth the appalling state of affairs in our country, when it comes to women’s health and rights.

A lot of programs and projects are being implemented by the government and Non-government (NGO) sector, in order to improve the lives of people and especially women. The policy of “positive discrimination” was adopted by our government long time ago to beat the gender differentials in welfare and development.

The findings of this will help the government to understand the dynamics of interaction and communication between young people and how RSH education influences this dynamics. Hopefully it will influence policy level changes which will trickle down to the target audience.

One of the most crucial implementing sectors is the Non-Government organizations (NGO) or the voluntary sector. NGOs have always been the catalysts of change and development in areas related to women, children, backward classes, education, health,
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livelihoods and many more. The government has been pondering over the program for RSH education for more than a decade now. Various reports and studies suggesting the improvement in RSH education program and adding more teeth to the implementation have been lying low due to steep social, cultural and political pressure. This is again the time for Social Work professional (NGO) and government to design a comprehensive strategy to de-stigmatize issues and implement program with full political will.

USE OF SOCIAL WORK TECHNIQUES IN THE STUDY AREA

The following techniques of social work were used while starting work in the study area.

COMMUNITY DEVELOPMENT

The first and foremost level of entry was achieved by local NGOs which conducted
- Sensitization programs, Awareness programs, via various media like group meetings, nukkad naatak (street theatre), baalika mela,
- NFE (non-formal education) classes for school drop outs.
- Health check-up camps
- Immunization camps

Once friendly and cordial relations were established with the community, the next phase of intervention started- NEEDS ASSESSMENT.

The community was involved in needs identification along with the panchayat samiti representatives and the local NGO social workers.

Findings from NEEDS ASSESSMENT
- Need to stop school drop out
- Encourage girl child education
- Improved access to drinking water
- Improved access to health care
- Improvement in livelihood conditions
- Reducing the rate of maternal mortality and child mortality
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- Improvement in infrastructure like roads, transport, electricity etc.

As the next step many of these issues were taken care of with the help of government involvement and “shramdaan” (free labour by beneficiaries). Some of the issues especially related to education, health and livelihoods were worked upon more rigorously by the SOCIAL WORKERS. One of the main issues which is directly connected to the study is “adolescents and young people”

- **GROUP WORK**

Various platforms were created by the social work organizations in this area to engage the young people in meaningful and fruitful programs in order to improve their status.

- The young people were involved in identification of issues they wanted to be addressed. One of the main issues was RSH education, stopping child marriages, improving girl child education.

- Various ways of working with this group were formulated like:
  - FGD (focused Group Discussion)
  - Balika mela (girls mela)
  - RSH education and training
  - Rights based education

- Various dynamics within group at different stages were handled by the social workers.

- **CASE WORK**

- As part of working with the community and groups, the social workers also identified some cases which needed more than group work and community development initiatives. These cases needed immediate personal attention.
- “Home visits” were conducted for the “situation assessment”.

- After situation assessment and home visits, a detailed plan for

- Intervention was drawn.

- Various methods and principles of case work were followed:
  
  ✓ Confidentiality
  ✓ Empowerment
  ✓ the non-judgmental attitude
  ✓ controlled emotional involvement
  ✓ self-determination
  ✓ respect for the individual
  ✓ empowerment

**FINDINGS OF THE STUDY AND USE OF SOCIAL WORK TECHNIQUES**

*Based on the process of conducting the study and the findings of the study, the following conclusions can be made, which can be used by social work practitioners.*
## TABLE: 7.1 RSH EDUCATION PROGRAMS AND SOCIAL WORK TECHNIQUES

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<th>DRIVEN BY</th>
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<th>ROLE OF SOCIAL WORKER</th>
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<td>1)Participation</td>
<td>1)Conduct appropriate research from time to time to improve policy &amp; implementation</td>
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<td>2)Empowerment</td>
<td>2)Mobilization &amp; coordination between different parts of civil society</td>
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<td>3)Democracy</td>
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<td><strong>COMMUNITY INVOLVEMENT</strong></td>
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<td>1)Government</td>
<td>1)Participation</td>
<td>1)Mobilization</td>
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<td></td>
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<td>2)Involving schools</td>
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<td>3)Involving health services</td>
<td>3)Local governance bodies</td>
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<td>4)Involving religious leaders, influential people</td>
<td>4)People of community</td>
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<td>5)Schools</td>
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<td>6)Provide analysis from time to time on projected aim and real achievement</td>
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<td><strong>GROUP WORK</strong></td>
<td>1)Work with young women</td>
<td>1)Respect for people and their autonomy</td>
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<td></td>
<td>2)Young men</td>
<td>2)Strengthen human capacity</td>
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<td>4)Objectivity</td>
<td>4)Assessment of pre and post KAP</td>
<td>4)Assessment of pre and post KAP</td>
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<td><strong>CASE WORK</strong></td>
<td>1)Capacity building</td>
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<td>1)Counseling</td>
<td>5)Provide more skill and information</td>
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<td></td>
<td>2)Counseling</td>
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<td>5)Referrals</td>
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The social worker needs to carry out a detailed study of the RSH related problem from all perspectives without any bias and conduct the research in such a way that its result can be used to advocate the right cause. Policy level changes require sound ground level data, understanding of situation and ability to design a program which can address the ailing issues.

The social worker needs to work with the community and all the stake holders to ensure that they are involved right from the beginning i.e. needs assessment, identification of SWOT (Strength, Weaknesses, Opportunities and Threats). The SWOT analysis of RSH intervention will help the social worker to involve the target audience and make them feel accountable for the intervention and outcome. By doing SWOT analysis, the social worker will also help people to understand the achievability of the goal in a realistic manner.

The community development/involvement, group work and case work require the social worker to use various techniques appropriate to the age, socio-economic profile, and educational status of the target audience. In rural areas, the issues of RSH cannot be the entry point in the community, as people will not be receptive and think of this as against the culture. Thus the entry point could be some education or general health related issues. Once the rapport with community is established, then the community can be involved in RSH programs too and the sensitization in the preparatory phase should be done in a way that the inhibitions of the community have lowered by the time RSH interventions start.

The role of Social worker in case work is more of a “family situation analysis”, home visits and counselling. But if the intervention required is medical in nature, e.g. Pregnancy complication, contraception side effect or contraception failure, then the role of social worker becomes more of a “referral point person”. In these cases the social worker should have the secondary referral services list ready with her/him and be sure where to refer which case.

Apart from all of the above, the social worker may also help in “training of trainers (TOT)” for RSH module. Training of trainer is conducted by the RSH education implementation organization before starting trainings with target audience. The social
worker might help the implementing agencies with the details she/ he has about the community, local social and cultural problems, status of RSH indicators and local myths/practices. This information might be helpful for the trainer to “localise” the training as per the profile of the target audience. Similarly the social worker might also help in assessing any change in KAP before or after the training (pre-post-test) and also in “follow up programs.

**SUMMARY- CONTRIBUTION OF STUDY TO SOCIAL WORK PRACTICE**

1) **ADVOCACY**

The findings of this study indicate a lot of gap between what is desired and what is being implemented. There is a lack of strong laws and political will in implementing the prohibition of child marriages, induction of RSH educated girls education programmes for young people, integrating RSH educated girls programs with other sectors, stronger and clear law on marital rape and various such issues. As part of advocacy efforts, the Social Work sector needs to design and implement effective strategies to advocate for these causes with mass people motivation and empowerment.

2) **EDUCATION**

As we have seen in the findings from the study, education plays a very crucial role in the overall personality and development of an individual. Lack of sufficient education affects all aspects of life including RSH educated girls related KAP (Knowledge, Attitude and Practice). Advocacy efforts in the late 1990s brought about the RTE (RIGHT TO EDUCATION) Act. But even after more than a decade India has very poor school enrolment and school-dropout rate. The Social Work sector needs to influence all the stakeholders in a positive manner for improving the education system and education related indicators. It might require advocacy efforts, direct implementation, forming liaisons with government efforts for education or mobilising and sensitizing all stakeholders.
3) **RSH and POVERTY**
As we have seen from the findings of this study, due to early marriages and early onset of sexual activity, the period for delivering children increases (15-45 yrs.). In addition to this problem is the non-usage of contraceptives among young people, leading to more children per couple and more poverty. Poverty has been a chronic mother of all problems in our country where 37% of our population lives below the poverty line (According to Tendulkar Committee report of 2010). Most of the social problems are due to poverty and illiteracy. Thus the role of Social Work sector remains significant in fighting poverty and increasing quality of lives of people.

4) **CREATING SPACE IN GOVERNMENT IMPLEMENTED RSH PROGRAMS**
The Social Work sector can help the RSH educated girls programs by being a part of it at the grass root level. As most of the Social Work effort has established credibility at the grass-roots, there is better acceptance of these organizations and their representatives. Thus they can act as a catalyst in the process of change.

5) **CONDUCTING STUDIES AND RESEARCH ON RSH PROGRAMS**
Since the Social Work sector has the expertise of working with people directly, they can use this as also a way of documenting the effects of RSH programs on the lives of people. They can study the best practices and document them for all stakeholders and implementing agencies to use it for improvement in the programs.

6) **CREATING SPACE IN THE EXISTING GROUPS OF BENEFICIARIES OF RSH EDUCATION**
By creating space within the existing RSH education beneficiary groups, the Social Work sector can assess the intervention and identify any new needs arising out of the existing programs as a third party. The feedback can be utilised by all stakeholders in further improvement of the programme.

7) **MOTIVATING RSH EDUCATED PEOPLE TO FIND COLLECTIVE SOLUTIONS TO THEIR PROBLEMS.**
CHAPTER 7  MAIN FINDINGS, OBSERVATIONS AND RECOMMENDATIONS

The findings of the study have highlighted various problems that young people are facing especially the RSH educated girls. Social Workers can mobilize and motivate this group of people to come together and find solutions to their problems by collective efforts. Social Workers can stimulate discussions and provide logistical support in terms of referral services and legal help where ever needed.

RECOMMENDATIONS

1) Integrated and holistic education for both sexes

As we have seen in the discussions and findings that RSH education alone is not sufficient to bring about substantial changes in the RSH related KAP of target audience, especially women.

- There is a need to put more stress on completing at least 12 years of formal education for both boys and girls.
- This formal education should not mean only academics, rather it should be a healthy and balanced integration of
  ✓ Academics
  ✓ Moral education
  ✓ Spiritual education
  ✓ Technology
  ✓ RSH education
  ✓ FLE (family life education)
  ✓ Gender related sensitization
  ✓ Rights
  ✓ Sports
  ✓ Vocational training
  ✓ Managing finances for self
  ✓ Law and constitution
- There should be a stress on implementing all of the above with equal importance and political will. This kind of integrated education will prepare the right foundation for responsible behaviour during adolescent and adult life.
- Integrated Education should be provided with equal thrust to both boys and girls.

2) **Follow-up and refresher courses on all types of LIFE SKILL & RIGHTS BASED TRAINING**

There are a lot of FLE and other rights based training programs which are conducted by government and NGOs. Most of the times these trainings just impart knowledge over a period of few hours to 2 days. After this there are no follow up classes and no refresher classes to inform of any changes or new trends in the issues. This kind of “one time” training is not able to capitalize on the improvement in behaviour of target audience. The concept of RSH rights is new to people. Somebody who has grown up being socialized to believe that they don’t have any right to say no to sexual coercion from husband or that they don’t have any right to get RSH education, will take time and effort to think and behave in a different manner. A one-time education definitely informs them and motivates them, but it does not equip them to suddenly start negotiating these rights and way of life.

Refresher courses and follow up classes will keep the motivation up and will encourage them to change and improve their situation.

Another factor deciding the follow ups is the residence of target audience. Usually in the case of young women, during the time gap between first training and follow up, many might get married and change the residence from one village to other or one district to other. This makes it difficult for the implementing agency to cover all the beneficiaries. Thus a standardized program for each level (beginner, refresher 1, refresher 2 etc.) should be in place and with the coordination of NGO, Govt. PHC; these programs can be administered to beneficiaries wherever they are.
3) **Policy level changes to provide more social and legal support**

a) **Marital rape** - Though rape is a punishable offence in our country, rape within marriage (Marital Rape) is a controversial issue for us. Societies where girls (aged 10, 11, 12 or even 7 year) are married off to boys or men much older to them, face a whole lot of sexual abuse and rape from their husbands. But since it is happening within the wed lock, the policy makers do not want to take a strong stand on it.

At present the criminal law says that any sexual intercourse with wife, if she is younger than 15 years, is a punishable crime. But states that the marriage is legal. In our society where the fall back position of women is so poor, even if she is being raped by her husband at age 10, 11, 12 15, 16 or 17 or even 25 years, she will not have the family or social support to go and lodge a complaint against her husband.

If the law and social policies be modified in such a way that they create a suitable environment for women to seek justice and for society to stop child marriages and enhance education for girls, the scenario might be improved.

b) **Child marriages** - The trend of child marriages is quite prevalent in South Asia. India ranks poorly on Gender Inequality Index (GII) released in 2011, which puts India on rank 129 out of 146 countries. The scenario is very poor for children and women both. Many children especially girls are married off at young age mostly by 15 or 16 years. Sometimes children as young as below 10 are also married off. Early marriage leads to dropping out of school, not being able to develop social skills and going through early pregnancy and many pregnancies.

The law in India prohibits marriage of girls below 18 years and boys below 21 years. But the implementation is not at all effective. The law requires more teeth.

c) **RSH education program** has stopped being a part of school curriculum due to its own set of friction with social, culture and political pressure. There
needs to be more detailed policy and political will to implement the RSH education program for everyone.

4) **Sensitizing all types of media for gender equality**

The whole process of “gender stereotyping” and socialization begins at childhood. The various sources from where we learn are – parents, family, friends, school and media. The media needs to be motivated to project gender neutral content which does not lead to misconceptions based on gender. The media could project a more equitable role of men and women.

5) **Special focus on RSH education of married women even beyond reproductive age**

As we have seen in many previous studies and this one too, the Married female relatives have a strong influence on the lives especially the RSH related life of young couples. The mother in law and aunts and mothers of the family love to control the fertility of the young couple. Due to the relationship hierarchy in family and due to the young age of young couple, they completely rely on the information coming from the older female members. The RSH education programs focus on people within reproductive age group only (15-45 year). The older female family members have a great deal of influence on the RSH decisions of young couple and also the decision to marry off children at young age. Thus RSH related education program which not only gives information but also sensitizes the age group even beyond 45 year should be implemented.

6) **Educate all stakeholders in the society**

The RSH indicators of women or men or couple are also a function of the social indicators. Thus the effort should be to integrate and to educate all stake holders. The stakeholders concerned are

- Young women
CHAPTER 7 MAIN FINDINGS, OBSERVATIONS AND RECOMMENDATIONS

- Young men
- Parents
- School authorities
- PHC staff
- panchayat samiti
- police (gender sensitization)

7) **Training modules to include not only knowledge but also skills for practical use**

The RSH training modules used for structured RSH education programmes tend to give a lot of crucial information and motivate the young people for behaviour change. But rarely do they equip them with practical skills for negotiations. The module should try to integrate the concepts of

- Personality development
- Skills to be assertive
- How to negotiate out of tricky situations
- How to ask your spouse about HIV/ AIDS status?
- How to negotiate contraception use?
- How to negotiate the number of children?

There are many such issues which are faced by young people in their day to day life. Since most of the girls did not go to school or dropped out of school, got married early, they have not developed the required social skills to negotiate in a relationship. The practical skills in the module might give them the required confidence and skills to deal with the sticky practical situations.

8) **Access & control over educational, health, political & legal services & infrastructure**

When we talk of improving the RSH indicators or fulfilling the RSH related rights, we also need to make sure that everyone has access to the basic services for empowerment and redressal. Everyone irrespective of their caste, creed, religion, language and socio-economic status should receive equal and quality education,
health care and health related services. There should be no bias in administering these services to anyone.

9) Educating family & community to generate support

There should be proper sensitization for all the family members of young people to make them understand the transition that the young people are going through. The sensitization should also involve efforts to generate support for young people in their decisions.

10) Creating local employment opportunities

Most of the times the men of the family go out to find work in nearby towns, during the non-agricultural months. There should be locally available employment opportunities especially for women, in case they want to. Employment will increase their financial position and bargaining power in the marital relationship and family.

11) Special emphasis on RSH and overall education of boys from younger age to limit the effect of gender stereotyping

As discussed earlier also there needs to be equal thrust on the RSH education of young men. Not only RSH education but the holistic education for them is imperative to reduce gender stereotyping and increase in responsible gender sensitive behaviour. As many of the RSH educated girls have said that they would prefer to marry RSH educated man as it will be easier to negotiate with them. This education for both men and women should be conducted preferably before marriage.
FIGURE: 7.1  
SUGGESTIONS: FACTORS TO BE CONSIDERED BY POLICY MAKERS AND IMPLEMENTATION AGENCIES FOR A COMPREHENSIVE IMPROVEMENT OF SEXUAL AND REPRODUCTIVE HEALTH STATUS OF YOUNG PEOPLE.

- **SRH education for young men before marriage**
- **Integrated and holistic education for both sexes**
- **Follow-up and refresher courses on all types LIFE SKILL & RIGHTS BASED TRAINING**
- **Policy level changes to provide more social and legal support**
- **Sensitizing all types of media for gender equality**
- **Educate all stakeholders in the society**
- **Creating local employment opportunities**
- **Educating family & community to generate support**
- **Access & control over educational, health, political & legal services & infrastructure**
- **Training modules to include not only knowledge but also skills for practical use**
- **Special focus on SRH education of married women even beyond reproductive age**

**IMPROVED SEXUAL AND REPRODUCTIVE HEALTH STATUS OF YOUNG PEOPLE**