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BACKGROUND OF THE PROBLEM

India is the second most populous country in the world after China. Post-Independence India focused mainly on its industrial and agricultural development. Health and education sectors caught on during the fifth five year plans (1974-1979). But still the per capita expenditure remained way too less on these sectors as compared to the others and in proportion to the number of educationally and health wise deprived population. Even when health became an important sector for the government to focus, it was mainly “curative approach” initially which later on transcended to “Preventive, Promotional, Curative and Rehabilitative approach”. Under the umbrella of “Promotional Approach”, came the aspect of Child survival (nutrition, immunization and childhood diseases), Safe Motherhood (ante natal post natal care, institutional deliveries and maternal health), Communicable diseases, Tuberculosis and many more.

One of the most important promotive approaches at this time was “Family Planning”, to curb the ever growing population. As the policy makers looked at ‘reducing the family size’ as a means to achieving population control. This also meant ‘family health’ and better quality of life, lesser poverty, more employment opportunity etc. As a part of family planning and population control came the infamous “HITTS Approach” (Health Dept. Implemented, Target oriented, Time bound, Sterilization Approach” in the late 1970s. This issue became so politically charged that the then ruling government of the National Congress Party had to lose the term and bow out of Government. Then came an era of “Cafeteria Approach” of family planning, where the government run health centres gave advice to “married couples” on different methods of family planning and each method’s pros and cons. It was then left to the married couple to decide whether they want to opt for any method of contraception. There was no use of force, there were no targets but there were incentives for those who opted for sterilizations.
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A majority of the population - the adolescents and unmarried young people were still not catered to as the government was focusing on the married couple and the adolescents were considered to be sexually inactive whereas the unmarried young population beyond adolescence was believed to be not needing the family planning services anyways.

But all this was changed forever with the entry of HIV/AIDS in India in the 1980s and first diagnosed case in 1986. HIV/AIDS spread rapidly in the 1990s. This called for desperate measures and more expenditure on “HIV/AIDS control programs”. This program tested the government’s health sector commitments at all levels- Preventive, promotional, curative and rehabilitative. HIV/AIDS came with its own stigma and the tag of being ‘incurable’, thus it required a massive educational and awareness strategy. HIV/AIDS required the whole population to be educated and not merely the married couple. Thus came the era of massive educational and awareness programs in schools, colleges, slums etc. in an endeavour to reach all adolescents and people in the reproductive age group.

Around the same time globally there was a campaign going on to make the concept of “Reproductive and Sexual Health” more holistic and pay equal attention to adolescents and young people’s reproductive and sexual health, irrespective of their marital or socio economic status. The ICPD (International Conference on Population and Development) held in Cairo in 1994 was focused on the same. 184 United Nations Member States met to consider the broad issues of and interrelationships between population, sustained economic growth, health, education, economic status and empowerment of women. The consensus this meeting reached is known as the ICPD Program of Action - a 20-year program, remarkable because for the first time the world’s governments set out to invest in people, not demographic targets. ICPD came out with a more comprehensive definition of Reproductive Health, Sexual Health and Sexuality. In the wake of all these developments in the field of RSH many countries all over the world started shifting their focus in health programs to make it more holistic.

India too has been involved in many RSH related programs run by government and non-government sector. It is a well-researched and well documented fact that the informal
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Education of RSH for adolescents happens in the hands of their parents, elders in the family, peer/ friends and media. But in an endeavour to impart correct knowledge to adolescents, government and non-government programs started as a parallel education. This parallel education of RSH was more structured, formal and in some cases assessment based to gauge whether the adolescent has grasped the correct information.

REPRODUCTIVE AND SEXUAL HEALTH

Before discussing the issues any further, we need to take a look at the details of RSH and the meaning of various terms and concepts used in this field.

The WHO defines reproductive health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes. This definition suggests that people with adequate reproductive health have a satisfying and safe sexual life, can have children, and can make a choice as to whether they would like to have children and if so, when and how to have them.

Within the framework of WHO’s definition of health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (WHO)\(^1\)

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\(^1\) UNDP/ UNFPA/ WHO/ World Bank special programme of research, development and research training in human reproduction. Dept. of reproductive health and research. *WHO, Geneva 2002*
SEX

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean “sexual activity”, but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

SEXUALITY

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

SEXUAL HEALTH

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

SEXUAL RIGHTS

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:
• the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
• seek, receive and impart information related to sexuality;
• sexuality education;
• respect for bodily integrity;
• choose their partner;
• decide to be sexually active or not;
• consensual sexual relations;
• consensual marriage;
• decide whether or not, and when, to have children; and
• Pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

NORMAL ADOLESCENT DEVELOPMENT

Adolescence is the transitional period between childhood and adulthood. It begins with the biological changes associated with puberty and proceeds through a process of psychosocial changes. Each aspect of maturation does not develop at the same rate. Development in adolescence can be uneven.
And deviations from the norm can cause alarm in the adolescents and those around them.

PUBERTY

Puberty refers to the sequence of physical events by which a child is transformed into a young adult. The characteristic physical changes include those in the reproductive organs and the external genitalia in both sexes, breast development and hip enlargement in the female, facial hair growth and change in voice-pitch in the male. Puberty leads to menarche (onset of menstrual flow) in females and to the onset of ejaculation (of seminal fluid) in males.
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ADOLESCENTS AND YOUNG PEOPLE

UNESCO report of 2004 (Saldanha, 2007)\(^2\) mentions that half the world’s population is under 25 yr., forming the largest generation of young people ever. More than 1 billion people are between ages 12-20 yr. It is estimated that by year 2020, 87% of world’s young people will be living in developing countries where they are already a majority.

One fifth of the world’s population are adolescents and there is a trend in their increase. There is a lot of discrepancy in the definition of adolescents and young people.

- **The Draft Youth Policy defines adolescence as 13-19 yr.**
- **ICDS (Integrated Community Development Services) define adolescents as 10-19 yr.**
- **Constitution of India and Labour laws define child as below 14 yr.**
- **Various documents of Govt. of India define adolescents as 13-19 yr. and maturity attained at 20-30 yr.**
- **NCERT (National Council for Educational Research and Training) divides adolescents into 3 categories- Early adolescence (9-13yr) - Mid adolescence (14-15yr) - Late adolescence (16-19yr)**
- **UNICEF, WHO, UNFPA define adolescence as 10-19yr**
- **WHO defines - Adolescence as 10-19 yr. - Youth 15-24 yr. - Young people 10-24 yr.**
- **UNFPA defines adolescence as 10-19 yr.**
- **Planning Commission of India defines adolescence as 10-19 yr.**

For the purpose of this study, young people are being studied in the age group of 10-24 yr. and Married female relatives in the age group of 15-45 yr.

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\(^2\)Saldanha Denzil, Education of Adolescents for development in India- The Case of Doosra Dashak. Publisher- Rawat Publications, Jawahar Nagar, Jaipur
Thus we know that the majority of the world’s adolescents and young people are in South Asia (335 million). As India and China are worlds most populated countries, and are situated in South Asia, it means that a majority of this population is in these countries. In India, more than one-fifth of the population (22.1%) belongs to adolescent group (age-group of 10-19) and around one-third (31.3%) belong to young people category. These definitions and explanations are very comprehensive and will be used in this thesis.

**RSH or RSH (Reproductive and Sexual Health OR Sexual and Reproductive Health)**

*RSH (Reproductive and Sexual Health) and RSH (Sexual and Reproductive Health)* are two acronyms with the same meaning. Often in development sector these terms are used interchangeably, but they convey the same meaning. 

**RSH educated young women and RSH educated girls**- these two terms have been used interchangeably at places but for the purpose of this study, they convey the same meaning.

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3 United nations, Dept. of Economic and Social Affairs, Population Division, World Population Prospects: the 2008 revision

4 www.sankalp.org/youngpeople
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THEORIES, MODELS AND APPROACHES IN RSH

THEORIES OF SEXUALITY

V K Rao (2007)\(^5\) refers to various theories and models of sexuality in his book.

- The *Multifactor models* of sexuality, mentioning that in the early 1900s, human sexuality was referred to as “instinctual Behaviour”. **Freud** postulated sexual instinct and explained people’s sex drive in terms of an instinctual energy which he called ‘libido’. The current theories of sexuality recognize that sexual behaviour involves multiple components. The most basic being reflex mechanism.

- The *‘childhood development theories’* which believed that masculine and feminine roles are biologically based and remain consistent throughout entire lifespan. Any individual who deviated from the normal prescribed role was seen as someone with psychosexual problem.

- The *‘social learning theory’* supported by theorists such as **Bandura**. This theory propagates that unlike what **Freud** believed that sexuality and related behaviour are learned through imitation and observation of parents and role models.

- The *‘cognitive developmental theory’* such as **Kohlberg**’s. This theory believes that child’s perception of sex role identification precedes sex appropriate behaviour. This theory also assumed that both children and adults maintained a relatively consistent concept of themselves as male or female.

- The *‘Adult developmental theory’* propagators - **Neugarten, Gutmann and Block**, studied the changes in gender roles expectations in adulthood. These roles were supposed to be based upon social expectations and major developmental

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• Tasks. They found that sex roles were not only a function of biological demands but also of the economic system, historical moment and philosophical system. Thus sex roles are depended upon the individual change and the social and cultural climate.

• The ‘Systems theory’. The authors who provided excellent explanations for this were Van Bertalanffy and Miller. This theory believes that sex roles are ways by which people and social system can regulate the flow of energy or effort, while managing survival needs. In the early stages of these systems, the roles are disordered and there are no clear roles. Later stages are associated with more specific concrete roles. Masculinity and feminity may emerge in the individual and group. Final stages have role rigidity and the system fails to respond to the changing times.

*Systems theory* suggests that this may be the kind of transition we are seeing in the society today and in the individual after the reproductive and parental period.

Thus we can conclude that the various theories of sexuality have explained the reason for the difference between the masculinity and feminity, how gender roles have evolved and categorised themselves. These theories also help us understand the reasons behind the sexual evolution of human beings.

• *The 6 Tunes Methodology for Teen Empowerment*

Saurabh Saklani (2005)\(^6\) has described this model in his book titled “What teens need but can’t quite say”. This model/ methodolgy say that if 6 conditions (Tunes) are fulfilled in a child’s life through the growing years, then it may lead to an empowered adolescent.

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\(^6\) WHAT TEENS NEED BUT CANT QUITE SAY, Author : By Saurabh Saklani (Edition = 2005). Publisher: Rupa and company, Daryaganj, New Delhi.
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These 6 tunes are:

1. Spend time wisely
2. Create happy memories
3. Be mentors
4. Provide love, praise and support
5. Help gain external awareness
6. Help increase internal awareness

- Family Life Education: Aparajita Choudhury (2006)\(^7\) has discussed the importance of Family Life Education (FLE) especially in Indian Context. She says that the purpose of FLE is to change or modify individual behaviour through new information and skill. This leads to communicating and loving more effectively. FLE helps families to develop healthy attitudes, values and beliefs so that the family members bond with each other in a more effective manner and become productive citizens. This adopts the life cycle approach.

Reproductive and sexual health is a very vast topic and includes a lot of issues. In this chapter we will look at the various issues within the purview of RSH and discuss related dimensions. We need to understand various related concepts before discussing the research topic, to develop a comprehensive understanding.

Components of RSH:
- Maternal and child health
- Adolescent health
- Immunization
- Child survival
- Family planning,
- STD prevention and management
- Prevention of maternal and prenatal mortality and morbidity.
- Pre and post natal care

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- Safe child birth
- Harmful RSH practices
- Unwanted pregnancy
- Unsafe abortion
- Reproductive tract infections including sexually transmitted diseases and HIV/AIDS
- Gender-based violence
- Infertility
- Malnutrition and anaemia
- Reproductive tract cancers.
- Homosexuality

By and large the components are specific to a particular country or community and their needs.

*The Main Components Of RSH Education Program In India Are:*

- Changes during adolescence.
- Menstruation
- Pregnancy
- Family planning
- Safe motherhood
- Abortion
- Safe childhood
- Sexually transmitted diseases
- HIV/ AIDS
- Substance abuse
- Peer pressure
- Develop skills and abilities to cope with challenges of responsible citizenship.
- Developing life skills, social skills, reflective skills, and negotiating skills.

These are broad components but the dissemination of knowledge and methodology used are dependent on many factors. The age group of participants- for the below 12 yr.
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Respondent, topics of pregnancy, family planning, abortion, STD and HIV/AIDS are usually not considered by trainers. The main focus for this group is changes during adolescence, safe childhood, substance abuse, peer pressure and menstruation. But there is no such hard and fast rule regarding this. It mostly depends on the program coordinator’s judgment about the need of the group, the relevance of these topics for the group and its subsequent use by the respondent. For instance there are groups in rural Rajasthan where there is a high prevalence of child marriages. Children are married off at ages 5yr to 8yr and are allowed to live together as husband and wife at the onset of puberty. This means that these children are sexually active beings at the age of 11yr to 13yr. in these situations there is a felt need to cover all the components of RSH education program. Sometimes it is also the pressure from the parents of young respondents to leave out some components because of stigma and taboo.

POLICIES AND PROGRAMS RELATED TO RSH

- The 2001 National Policy for the Empowerment of Women defines child marriage as a form of “discrimination against the girl child” and calls for compulsory registration of marriages (and of births, since many girls lack birth certificates and thus are unable to assert their right to refuse to marry when they are younger than the legal minimum age). It predicted that “by 2010 child marriages are to be eliminated” through consistent improvements in education, better marriage registration and increased use of financial incentives to keep girls unmarried and in school.

- 2003 National Youth Policy identifies adolescents, defined as 13–19-year-olds, and females in particular, as a priority target group and stresses the needs for separate general health clinics for them. It emphasises on teaching adolescents the correct age to marry, spacing between births etc.

- National Plan of Action for Children 2005 talks about preventing and eliminating child marriage (by 2010) and underage childbearing. It asserts that all adolescents (defined as young people aged 10–18)—irrespective of their marital
• Status—receive sexual and reproductive health information, including information on HIV/AIDS, in school curricula. It identifies stopping sex-selective abortions to promote the rights of girls.

• The Adolescent Health Section of the National Program Implementation Plan details out the policy framework for adolescent services in Phase II (2005–2010) of the country’s Reproductive and Child Health program. National-level recognition of the importance of adolescents’ reproductive health and well-being.

• The adolescent unit in the Ministry of Health and Family Welfare was created only within the past decade. Other ministries that deal with various aspects of young peoples’ lives are the Ministry of Youth Affairs and Sports, and the Ministry of Women and Child Development. Many states also have their own policies, which vary widely in content and funding levels. The majority of adolescent oriented policies address the needs of this age-group in education, health, HIV

• The 2000 National Population Policy
  - Educating adolescents about the risks of unprotected sexual activity.
  - Acknowledges the heterogeneity of adolescents (here defined as 10–19-Year-olds).
  - Needs of both married and unmarried adolescents to receive confidential And non-judgmental contraceptive services.
  - Providers be trained in working with adolescents, that they refer Adolescents for early and safe abortion, and that they provide adolescents With spacing methods in particular.

• Eleventh Five Year Plan 2007–2012
  - Adolescents’ issues to be “incorporated in all reproductive and child Health training”;
  - Providers to be given knowledge and skills to cater to their needs;
  - Separate, adolescent-friendly services.
  - To combat adolescent marriages, the plan also insists on the compulsory Registration of marriages and on verification of age at the time of marriage.
• **Cash incentives to induce behaviour change** are common in India. Conditional cash transfer programs to delay marriage and childbearing. These cash incentives are part of the schemes to eliminate child marriages, delay child birth, promote a healthy child sex ratio in India and promote schooling and education for girls.

*Janani Suraksha Yojana* is a national scheme to encourage adolescents to postpone childbearing. In some states, direct payments to the mother for making each of three prenatal visits and a post-partum care visit are dependent on her being at least 19 years old.

*Balika Samriddhi Yojana* aims to improve the status of girls through multiple, interrelated steps. In order to balance the sex ratio, it pays couples on the birth of a girl. It promotes girls’ education by paying into an interest-bearing account for each year that a girl remains in school. The money is released to families only when the girl reaches age 18 and then only if she is unmarried.

These cash incentive schemes, mainly target the poor, and do not address the root cause of behaviours they seek to modify. The use of such incentives always makes one wonder the efficacy and sustainability of these approaches.

**LEGISLATION AND ADOLESCENTS’ REPRODUCTIVE HEALTH**

In addition to policies, the Indian government has enacted several laws that likewise hold promise for improving the reproductive well-being of all women, including adolescents.

• **Medical Termination of Pregnancy Act in 1971**, which made induced abortion legal under some conditions. When pregnancy results from contraceptive failure among married women, when it results from rape, when it poses a threat to the pregnant woman’s physical or mental health, and when the foetus has severe abnormalities.
• **Pre-Conception and Pre-Natal Diagnostic Techniques Act of 1994.** This law has placed strict limits on the use of technology to determine the sex of the foetus. The act is meant to counter the increasingly skewed sex ratio caused by sex-selective abortion.

• **Prohibition of Child Marriage Act of 2006.** The act imposes harsh new penalties on underage marriages, but retains the gender imbalance in the minimum age at marriage, which is three years lower for women than it is for men. It allows married adolescents younger than 18 to nullify their marriage, but retains legitimacy for any children born in the union. The law directs states to have district magistrate act as prohibition officers to ensure compliance.

Guttmacher Institute 8

RSH EDUCATION

During the course of my work as RSH facilitator and project manager in the towns and villages of Rajasthan, Delhi, Madhya Pradesh and Maharashtra, I came across many such instances where adolescents reported that they have more accurate and better knowledge on RSH than their elders in the family. This was also an eye opener to another question—“does this mean there has been a role reversal in the channel of RSH communication?” OR “has the channel of RSH communication become two-way?” The documented research did not throw much light on this aspect, but it did mention that the adolescents were getting more self-aware and more informed. The adolescents had started to assert their own sexual identities and started to question the knowledge being delivered. This ‘reasoning and questioning’ was not limited to only RSH. This phenomenon was evident in all spheres of education, partly because the focus of education has shifted from ‘ROTE LEARNING’ to ‘SCIETIFIC LEARNING’. The present generation has so many avenues of getting information that they just don’t rely on one source and accept what comes their way. This generation is rather more of a ‘Seeker’ than ‘taker’.

8 www.guttmacher.org/sections/adolescents
Another noteworthy phenomenon is that the knowledge source which was earlier only
schools and family has expanded to cover NGOs, media, peer and so on. Talking of RSH
education, it was more of a taboo topic earlier but is now a part of the formal structured
education. Earlier this information was given by the older family members to the younger
ones. Now the more scientific and accurate and up-to-date version of this information is
being given to young people through schools, NGOs, Government programs etc. Thus
empowering the youth with power of knowledge.

It is worthwhile to know what the young people do with this knowledge. It is a well-
documented fact that:

- This knowledge is used by them to improve their own lives.
- More confident about self and sexuality.
- Make informed choices.
- Influence the knowledge and behaviour of peer.

This brings us to the question that- by coming in contact of a well informed and RSH
educated young person, a peer can gain knowledge and show changes in his/ her RSH
related KAP (knowledge, attitude, practice). Then is it possible that the older members of
the family of such informed, educated young people will also show the same trend? If the
answer to this question is YES, then what is the extent of this change? If the answer to
this question is NO, then why there is no change despite the potential? There hasn’t been
much recorded evidence for the same.

Many studies have been conducted on the learning patterns of adolescent girls and how
the knowledge trickles down to their peer through informal interactions and how the
adults, family members educate these adolescent girl about RSH related issues. These
studies try to analyse how this form of RSH is related to the Knowledge, Attitude and
Practice (KAP) of adolescent girls. But not much has been studied regarding the
“Reverse Communication” i.e. how the knowledge acquired by the adolescent girls
through a structured RSH education, trickles down to her immediate female family
members. Traditionally it is believed that the older female members of the family impart
RSH related knowledge to adolescent girls. This practice is present in all societies but
Accuracy of knowledge varies depending on various factors. These factors may be the educational status of the older female family member, the myths and misconceptions she has, level of comfort with the adolescent girl, prevalent practices in the community, the adolescent girl’s own level of education and exposure to any structured RSH program. There are many studies to show the content, extent, outcome and impact of the ‘traditional channel’ of RSH education from older female relative to adolescent girls. But there has been no scientifically studied and documented evidence of the ‘reverse’ i.e. transfer of RSH education from RSH educated girl to older female relative. Thus there is no documentation of the content, extent, outcome and impact of the ‘Reverse Communication’.

Women have suffered reproductively and sexually due to lack of knowledge, incomplete knowledge and incorrect knowledge. Two decades ago they had no option but to follow whatever little- right or wrong they knew. But with the expansion of health awareness programs, health camps, media and increased female school enrolment, the situation has improved. The young women are getting far better chance to have an informed life, and they are trying to pass some of this knowledge to their disadvantaged older counterparts. Since it is traditionally considered that adolescent and sexually inexperienced girls don’t know anything about RSH thus they need to be told about these issues by older experienced female relatives. Thus it is also worthwhile to see whether the older female relatives are able to accept the new knowledge coming their way from young ones. The process of this communication needs to be understood and explored.

Another major drawback has been the selection of target audience. Initially the target audience was “married couple”, then the focus shifted to “young people”, but among this group too mainly “young women” were chosen as the target audience. Various demographic indicators like- MMR, IMR, Maternal Morbidity etc. are cited as the reason for targeting more women but the needs, rights and responsibilities of young men in relation to RSH has been largely ignored. Regarding this issue the Secretariat of the United Nations Inter-Agency Task Force on the Implementation of the ICPD Program of Action, observes that “Reproductive health affects, and is affected by, the broader context
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of people's lives, including their economic circumstances, education, employment, living conditions and family environment, social and gender relationships, and the traditional and legal structures within which they live. Sexual and reproductive behaviours are governed by complex biological, cultural and psychosocial factors. Therefore, the attainment of reproductive health is not limited to interventions by the health sector alone. Nonetheless, most reproductive health problems cannot be significantly addressed in the absence of health services and medical knowledge and skills. The status of girls and women in society, and how they are treated or mistreated, is a crucial determinant of their reproductive health. Educational opportunities for girls and women powerfully affect their status and the control they have over their own lives and their health and fertility. The empowerment of women is therefore an essential element for health. Women bear by far the greatest burden of reproductive health problems. Women are at risk of complications from pregnancy and childbirth; they also face risks in preventing unwanted pregnancy, suffer the complications of unsafe abortion, bear most of the burden of contraception, and are more exposed to contracting, and suffering the complications of reproductive tract infections, particularly sexually transmitted diseases (STDs). Among women of reproductive age, 36% of all healthy years of life lost are due to reproductive health problems such as unregulated fertility, maternal mortality and morbidity and sexually transmitted diseases including HIV/AIDS. By contrast, the equivalent figure for men is 12%. Biological factors alone do not explain women's disparate burden. Their social, economic and political disadvantages have a detrimental impact on their reproductive health. Young people of both sexes are also particularly vulnerable to reproductive health problems because of a lack of information and access to services.”

But at the same time ICPD and all the concerned global bodies do emphasize the need and importance of a holistic RSH package for both- men and women.

The ‘gender differentials’ in RSH education programs; have varied implications for the young population, as well as the policy makers and implementers. Since we are focusing mostly on women, we are in a way putting the burden of setting things on the right track on them. Whereas we are well aware of the patriarchal society that India is. This not only makes the efforts from the implementing agency futile, but it also has ripple effect in the
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form of distress for the women who know everything about RSH and their rights but have no control over anything.

As our society is primarily patriarchal and all major decisions in a household are governed by finances. Since men are the main bread winner for the family, it is he who decides, ‘when’ and ‘how many’ of children. Due to lack of proper structured RSH program targeting men in rural and semi urban areas, there are lots of myths and misconceptions about sexuality and gender roles. This leads to an added burden on women who are fighting alone in a relationship of “unilateral knowledge”! Thus a young woman, who has attended RSH education program run by government or NGO, does not find it easy to negotiate her RSH related rights.

There are instances where men look at an educated woman as a threat to the stability and smooth running of marriage. Talking of the rural and semi urban areas in India, due to gender stereotyping, men assume that their role is to dictate terms whereas women assume that their role is to accept the authority of husband. But a scenario where the gender stereotyping has been broken by some kind of sensitization, education, awareness program, it challenges these stereotypical norms.

Thus there is a need to look into the PROCESS and OUTCOME of the RSH training of adolescent girls and young women and its impact on the marital roles. To study the exact process of negotiation-

- To understand whether the RSH educated girl makes any kind of effort to negotiate her RSH rights. If ‘yes’ then what and how and if ‘no’ then why not?
- To understand the outcome of the effort or non-effort from the RSH educated girl.
- Also to see whether RSH educated wives are preferred over non RSH educated wives, will be an angle worth investigation.
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There is also a lot to be explored in terms of the outcome and impact of these interventions. One way of looking at it has been the quantitative outcome in terms of number of people made aware on issues or number of people using contraception. But another intriguing fact that remains to be explored is what actually happens between the phase when the adolescent completes the RSH education program to the phase where she/he is able to exercise what she/he wants or is unable to exercise it. The “dynamics of interaction and communication” between the RSH educated adolescent and her/his spouse, in-laws, parents and other female relatives, needs to be explored to see how empowering and useful the education program has been for them. It will be worthwhile to explore the dynamics of interactions, communications and negotiations between them.

RSH programs target only people in the reproductive age group (15-45yr), thus assuming that addressing only this group will sort out all the problems. But the RSH issues are as complicated as the family relations especially in rural and semi urban India. The reproductive and sexual health decisions like- when to have baby, how many babies to have, which place to have the delivery at, what to eat during pregnancy, duration of breastfeeding, immunization, abstinence, myths and misconceptions regarding menstruation, pregnancy, abortion, infertility, still birth, STDs, so on and so forth. The list is endless where it is not only the young people who make a decision; these are the grey areas where older female members of the family Dictate, Influence and Control the sexuality of young people. There are innumerable studies and evidence to show the influence of older female family members on young people’s sexuality. But there is no study to show whether the RSH educated young women have any such effect on the sexuality and sexual behaviour of elder female family members.

As mentioned above, there is a big gap between knowledge acquired and its transition to behaviour change. Many socio economic and political reasons have been cited for this gap and it has also been suggested that if the socio economic, political obstacles are taken care of then the knowledge-practice gap might reduce. But the “Module aspect” has been left out i.e. if some practical skill oriented elements are involved in the modules then that also might act as a catalyst for change.
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Another factor which needs to be studied is the attitude of both young women and young men on the “RSH education of young men”. Since there are much lesser RSH education programs being conducted with the young men but still they remain one of the most important stakeholders in the decisions related to their own reproductive health and that of their wives. It is important to study their perspective too.

STATEMENT OF THE PROBLEM and RESEARCH QUESTIONS

The problem of this study is to find the presence and extent of RSH related communication flowing from the RSH educated girls to their elder female family members and to study the influence of RSH education status of young women on the dynamics of interaction and communication with their husbands.

RESEARCH QUESTIONS

- Is there any “REVERSE COMMUNICATION” between the young women trained in RSH and the RSH untrained married female relatives who have been the traditional sources of this information?

- Does the dispelling of myth occur and right information coming from younger generation is accepted or shunned?

- Does the RSH related knowledge gained by adolescent girls through structured training, have a cascading effect on her married female relatives and her peers?

- Does the RSH education status of the prospective bride or groom, influence marriage decisions?

- Are the existing RSH modules well equipped to give the adolescent girls “bargaining skills” within their relationships with their families, in-laws and husbands. This pertains to the change in practice/behaviour related to RSH?
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- Will equal stress on RSH training for adolescent boys and young men, improve the overall KAP especially Practice/ behaviour among young people?

- How does the RSH training Module and the procedure of conducting training and the trainer profile, affect the KAP of the adolescent girls?

PURPOSE OF THE STUDY

The purpose of this study is to understand the process and content of RSH communication between RSH educated girls and older female relatives, in order to design holistic intervention programs. This study will help professionals and academicians to get information on the effect of RSH education of young girls on the dynamics of interaction and communication with their husband. This in turn will help in designing relevant intervention strategies.

As has been emphasized in all development program policy documents of Millennium Development Goals (MDG), International Conference on Population and Development (ICPD), World Health Organization (WHO), National AIDS Control Organization (NACO), the development programs have to have a more holistic approach to design and implementation. This holistic approach would mean not addressing only HIV/ AIDS or only safe motherhood or only RSH. The holistic approach would mean RSH, education, general health, employment, infrastructure, insurance, social security etc. All of this to be planned and implemented in such a way that the target audience remains the individual and combined targeted interventions is made with all the above mentioned elements of development. The findings of this study will strengthen the program planning and implementation.

SIGNIFICANCE OF THE STUDY

Reproductive and sexual health by themselves is very important aspects of our life, but when we look at it in connection to the overall wellbeing, it assumes even greater role. It affects economy, politics, religion, society, education and almost everything it comes in relation with. According to ICPD the importance of reproductive health is-
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The importance of reproductive health (ICPD)

“Reproductive health is a crucial part of general health and a central feature of human development. It is a reflection of health during childhood, and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men, and affects the health of the next generation. The health of the new-born is largely a function of the mother's health and nutrition status and of her access to health care. Reproductive health is a universal concern, but is of special importance for women particularly during the reproductive years. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. Men too have reproductive health concerns and needs though their general health is affected by reproductive health to a lesser extent than is the case for women. However, men have particular roles and responsibilities in terms of women's reproductive health because of their decision-making powers in reproductive health matters.”(ICPD- International Conference on Population and Development)

ICPD further elaborates that “At each stage of life individual needs differ. However, there is a cumulative effect across the life course of events at each phase having important implications for future well-being. Failure to deal with reproductive health problems at any stage in life sets the scene for later health and developmental problems. Because reproductive health is such an important component of general health it is a prerequisite for social, economic and human development. The highest attainable level of health is not only a fundamental human right for all; it is also a social and economic imperative because human energy and creativity are the driving forces of development. Such energy and creativity cannot be generated by sick, tired people, and consequently a healthy and active population becomes a prerequisite of social and economic development.

ICPD looks at Reproductive health as “not starting out from a list of diseases or problems - sexually transmitted diseases, maternal mortality - or from a list of programs - maternal and child health, safe motherhood, family planning. Reproductive health instead must be understood in the context of relationships: fulfilment and risk; the opportunity to have a
Desired child or alternatively, to avoid unwanted or unsafe pregnancy. Reproductive health contributes enormously to physical and psychosocial comfort and closeness, and to personal and social maturation. Poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy, and death."

The most significant achievement of the Cairo Conference was to place people firmly at the centre of development efforts, as protagonists in their own reproductive health and lives rather than as objects of external interventions. The aim of interventions is to enhance reproductive health and promote reproductive rights rather than population policies and fertility control. This implies the empowerment of women (including through better access to education); the involvement of women and young people in the development and implementation of programs and services; reaching out to the poor, the marginalized and the excluded; and assuming greater responsibility for reproductive health on the part of men. (Secretariat of the United Nations Inter-Agency Task Force on the Implementation of the ICPD Program of Action.)

This concept of reproductive health differs from existing family planning and maternal and child health programs. Programs dealing with various components of reproductive health exist in some form almost everywhere. But they have usually been delivered in a separate way, unconnected to programs dealing with closely interdependent topics. For example, the objectives, design and evaluation of family planning programs were largely driven by a demographic imperative, without due consideration to related health issues such as maternal health or STD prevention and management. Evaluation was largely in terms of quantity rather than quality - numbers of contraceptive acceptors as opposed to the ability and opportunity to make informed decisions about reproductive health issues. In general, such programs exclusively targeted women, taking little account of the social, cultural and intimate realities of their reproductive lives and decision-making powers. They tended to serve only married people, excluding, in particular, young people. Services were rarely designed to serve men even though they have reproductive health concerns of their own, particularly with regard to sexually transmitted diseases. Moreover, the involvement of men in reproductive health is important because they have

An important role to play as family decision-makers with regard to family size, family planning and use of health services.

In the 1990s the outlook of policy makers and implementing agencies shifted from treating people as demographic targets to addressing them and their holistic needs to excel as equal citizens. Though ICPD, WHO, United Nations called for an integrated holistic approach to Reproductive and Sexual Health, this integration is still in its infancy.

Post ICPD, adolescents have emerged as a very significant target audience for RSH related interventions. One of the main strategies to address adolescents is to organize RSH training at schools, colleges, and communities and peer-education. Peer education has been cited as one of the important ways of getting the message across. Since adolescents and younger adults, (age 10-24yrs.) make up for 1/3 of the world’s population of which 80% live in developing countries, it is worthwhile to study how they learn issues related to RSH and how they influence others around them. RSH education programs have been active in India for more than two decades. The main focus initially was the newly married couple and the couples in the reproductive age group (15-45 yrs.), where the focus was family planning. With the changing socio cultural perspective, and the emergence of adolescents as a very important segment, the focus of RSH education widened to include them and many other issues ranging from sexuality to HIV/AIDS. The more obvious reality that sexual activity was not only restricted to the wedlock and the adolescent and youth had started to experiment with their sexuality had led the Govt. to sit up and take notice of the gaping need to spread awareness and education among the adolescents. The easiest and most practical way of reaching out to them was through schools. But since India has a large population of “out of school” children and the numbers were higher for the rural adolescents, the whole population was not being addressed. Various programs have been running since then to include “in school” and “out of school” adolescents through government and non-government efforts. This is where the community involvement too comes into picture.
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Many government and non-government efforts to support the above said resolutions and to make a difference in the lives of people have been undertaken in India. The interventions mainly range from creating awareness among people, providing education and training, provision of required infrastructure, services etc. A lot of stress is being given to community participation for better accountability. One of the main aims of these interventions is to improve the knowledge, attitude and practices among the target audience regarding RSH matters. For this purpose there is continuous community process in the form of media campaigns, adolescent, youth, married women and men’s education, building community support through opinion building and sharing responsibility.

With complex behaviour intervention, which aims to change skills, attitudes, peer norms, behaviour, and the measures for determining impact need to reflect the aims of the intervention. In reality measuring changes in all these areas using scientifically robust outcome measures in well-designed studies is difficult to do. Therefore many studies determine impact of such intervention by measuring changes in knowledge and self-reported behaviour and intentions, rather than including externally valid measures such as STI rates or abortion statistics.

When these programs are held in a formal school setup, the school management has an important role to play. The management’s perspective and outlook on RSH education for young people and their own attitude towards sensitive issues, plays a very important role in deciding whether they want to have RSH education in their schools. The facilitators are usually not given a free hand to speak about many taboo topics. The scenario is slightly different in government run or aided schools where the individual managing committee does not decide the RSH education curriculum, but it is decided by a centralized committed (NCERT (National Council for Educational Research and Training) with inputs from NACO (National AIDS Control Organization), WHO (World Health Organization), UNICEF (United Nations Children’s Fund).

After a lot of protest, reconsiderations, political pressures, now the focus of NCERT designed RSH education has been shifted to ‘how to abstain’ from ‘how to use the
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Condom for safer sex. The teachers will stress on ‘prevention is the best cure’ for HIV and other sexually transmissions infections (STIs), said a NCERT official to the media in 2008.

Seven states including Gujarat, Madhya Pradesh and Maharashtra had objection on the current syllabus prepared for educating school-level students and asked NCERT and NACO to delete the objectionable contents including graphic pictures of human physiology and anatomy from the syllabus.

NACO had also advised NCERT to prepare such a syllabus that can suit the rural public too and also allow the states to make it more flexible according to the local areas and cultures.

The purpose of this sex education is to provide proper and complete sex education in the right direction so that students can protect themselves from wrong and incomplete sources of education, which is more malicious to them.

“YUVA, School Life Skills Program: Handbook for Teachers and Parents” (by NCERT) is the module which is being followed in Delhi and is more comprehensive in dealing with the concept of “Developing Responsible Citizen”. It does touch upon the Reproductive and Sexual Health education part but the focus is “How to abstain” and not “How to protect”.

There are innumerable programs being run for ‘out of school’ adolescents and young people. 20% of India’s population is adolescents (10yr. – 19yr.) (UNICEF 2009). Out of this only 54% attend school at Secondary Education level. This implies that though a lot of effort is pumped into RSH education at school level, still we will be able to reach only half of this population if only schools are addressed. Secondly if we look at the population of young people (10 – 24yr) - There are 315 million young people aged 10–24 years in India, representing 30 per cent of the country's population. “This cohort is healthier, more urbanized, and better educated than earlier generations. At the same time, these young people face significant risks related to sexual and reproductive health, and

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10 http://ncert.nic.in/ncert/aerc/pdfs/A_Education_AE1.pdf
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Many lack the knowledge and power they need to make informed sexual and reproductive health choices” (Population Council). Thus to reach out to the whole population meant reaching out to the out of school population too. Thus the government and NGO/INGOs started many awareness education programs in rural communities, semi urban and urban slums to reach out to maximum young people. These programs have been running at local level with participation of the community. Various NGOs are using different training modules for this purpose. The contents are decided by considering the needs of the target audience, the comfort of community, the focus of implementing agency on a certain issue (female feticide, child marriage etc.). Broadly speaking these programs have been running for nearly two decades but are still evaluated quantitatively (no. of trainings, no. of participants, no. using contraception, no. who delayed marriage etc.). The need is to do a qualitative evaluation and assessment, to see whether the input influenced the ‘bargaining power’ of the participant in relationship?

Thus the research problem becomes significant in more than one ways, as it is

- Going to give more information about the process, content and outcome of RSH education programs in India.
- The outcome of the study will help policy makers and implementers to understand the process in a more holistic way.

OBJECTIVES:

- To understand the process, content and channel of RSH related communication, between RSH educated young women and her husband, in- laws, married female relatives and peer.

- To understand the pattern of practice and behaviour related to RSH issues among young people trained and not trained in RSH.

- To understand the need for RSH training among adolescent boys and young men and its probable impact on the KAP of young people, especially on Practice/ behaviour.
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- To understand the marriage preferences of the young people in rural India in terms of the RSH education status of their prospective partner.

- To arrive at recommendations for RSH training for young people and contribution of Social Work methods and practice skills in RSH training.

IMPORTANT INDEPENDENT AND DEPENDENT VARIABLES IN THE STUDY:

INDEPENDENT VARIABLES:

1. Educational qualification of RSH educated young women
2. RSH educated girls education status of wife/ young woman
3. Rights based training of wife
4. Educational qualification of wife
5. Sex of spouse who initiated family planning discussion
6. Sex of respondent

DEPENDENT VARIABLES:

1. Change in RSH related KAP of MFR
2. Family planning discussion with husband
3. Initiation of family planning discussion
4. Perception about the sex of spouse who should initiate family planning discussion
5. Revealing RSH educated girls education status to husband and in laws
6. Family planning method used
7. Spouse selection criteria (RSH educated girls education status)

To study the dynamics of interaction and communication, there will be an analysis of the relationship and correlation between the above mentioned Independent and Dependent variables.
NEED OF THE STUDY

RESEARCH GAPS

- “Reverse communication” regarding RSH needs to be explored i.e. whether the RSH educated adolescent girls communicate this knowledge to their married female relatives (mother, sister, sister in law, aunt).

- The impact on the KAP of Married female relatives of the RSH trained adolescent girl’s needs to be studied in more detail.

- The process of negotiation between the RSH trained girl and her husband, in-laws and her own family is a crucial factor indicating the change in Practice, but not much has been explored on this front.

- The perspective of adolescent boys and young men’s training on RSH needs to be explored further from the viewpoint of young people. Also how the inclusion of young men in the RSH training, would affect the decision making between couples and within families, needs to be studied further.

- Marriage preferences of young people in terms of the RSH education status of the prospective partner, needs to be studied further.

- Impact of RSH trainer profile: motivation, commitment, knowledge, training skills, and socio-economic and cultural background on effectiveness of training.

- Use of social work knowledge and practice skills in providing RSH training to rural young people.

This study will attempt to analyse the socio-economic and cultural backgrounds of the adolescent girls and their RSH related training needs. It will also analyse the training
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Modules being followed by different organizations to impart these training in India. The training procedure and the difficulties faced in organizing and conducting these training. The RSH related KAP (Knowledge, Attitude and Practice) of these adolescent girls will be analysed and also the trickle-down effect of the knowledge of the adolescent girls on her peer and married female family members. Throughout this study, the focus will remain on the dynamics of interaction and communication related to the negotiations of RSH related matters between RSH educated girls and their husbands, in-laws and a comparative of Non RSH educated girls with their husbands and in-laws. The aim behind this comparative study is to see not only the differences in the negotiation process of RSH educated and Non RSH educated girls, but also to see the factors which influence these differences.

As outline by ICPD, MDG (Millennium Development Goals), WHO, United Nations and various other organizations, working not for profit that the need of the hour is to integrate. All the sectors affect and are affected by various interrelated factors. Thus working in isolation does not achieve the full potential and desired results. The role of NGO sector in India has grown immensely from its earlier focus of “Charity” to the current focus of “Sustainable Development”. Since the social sector deals with the quality of life of people, their rights, educational opportunities, health, access to and control over basic services and a life which has all the opportunities to excel. Since family is the basic core unit of the society and community, all efforts to excel begin with the individual and his/ her family. Since NGOs have been working closely with individuals and their families to bring about desired change and development, it is important for them to have the required updated research to improvise on their efforts. Currently the hurdles that the government is facing are partly because of the lack of political will to achieve excellence in RSH and partly because some links in knowledge and practice are missing. The NGOs too are grappling with many issues like shortage of funding, shortage of trained and committed professional staff, the stigma and taboo attached to RSH at community level, socio-economic condition of target audience, sporadic and disconnected use of RSH training modules, training modules not being localized according to the needs of the target audience and many such issues.
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SCOPE OF THE STUDY FOR SOCIAL WORK INTERVENTION

RSH education program is facing a lot of resistance in the government implementation. Therefore in rural Indian context, the NGO’s role in implementation of these programs has increased manifold. The findings and recommendations of this study will also help the SOCIAL WORK field in program planning, implementation, monitoring and evaluation. At the same time the study will also help in fine-tuning the skills and methods of social work intervention with rural young people. It will help in better understanding of the program gaps and implementation strategy. The profile of rural young people will be explored with context to RSH. But in addition to this, the profile of social workers and RSH trainers and how it affects the RSH training program, will also be explored.

SOCIAL WORK TECHNIQUES

RSH program planning, monitoring, evaluation use the various approaches, methodology, like-

- Community development, Group Work, Case Work, Counselling, FGD, Social Work Education and Training, Specific skills to work with young people

The findings of this study and the methodology used to conduct this study will give an insight into all of the above mentioned approaches and methodologies. The Social Worker will be able to use the techniques of Social Work in a more effective manner by understanding how the various tools and approaches can be used in RSH programs for better planning and delivery.

RESEARCH RATIONALE:

The study attempts to find out some of the details which are crucial to understanding the outcome of the RSH education program with young people in our country. The central question of the study is whether the RSH education is helping the young people in any way in practicing their sexual and reproductive rights. If they are helping in achieving RSH rights, then how are they helping? If they are not helping in achieving RSH rights,
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then why they are not? The study also tries to find out the major stakeholder’s in the Sexual and reproductive lives of young people and the extent to which they influence them and also get influenced. Since the findings of most of the research in this regard, has confirmed that RSH education does change and improve the knowledge and attitude, but it is not resulting in corresponding change in practice. Thus the bottom line of this research is to get down to the level and space between the young couple and try to understand the process of interaction, communication and negotiations between them. It is to try and identify the specific factors in the dynamics of interaction and negotiation, which are significant and how they are influenced. Since all the RSH education programs with young people are “Module Based”, there is an effort to analyse all the modules being used to interpret whether they are only focusing on providing knowledge and attitude change or they are also providing “Practical Negotiation Skills” to young people to deal with real life situations. There is also a focus on the “trainer profile” and how it is influencing the outcome of the training.

LIMITATIONS

1) Due to many political, social and religious reasons, the RSH education in many states of India have been banned, discontinued or limited to basics. Thus prompting the young people to rely on other sources of information. Thus there is no standardized information which is available for assessment across India.

2) The respondents in this study have attended the same training program based on same training module. But we cannot be sure that their level of knowledge and motivation is same. The reason is that there is no way to control the informal inflow of information from media and other sources. Thus even though we will be able to relate and correlate variables, their exact influence in terms of causal relationship cannot be tested through hypothesis, as there are other sources of information.

3) In this study the married female relatives of the RSH educated girls and the Young Men are the ones who have never attended any structured RSH education
program. But it does not rule out the other sources of information including media, spouse, relatives etc. thus when we enquire about Reverse Communication or KAP (Knowledge, Attitude and Practice), we completely rely on the ‘self-reported’ behaviour change due to Reverse Communication.

DEFINITIONS OF TERMS

1) REPRODUCTIVE HEALTH

“Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life.”

Cairo definition of reproductive health

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”
2) SEXUAL HEALTH
Sexual health is a state of physical, emotional, mental, and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health needs a positive and respectful approach to sexuality and sexual relationships, and the possibility of having pleasurable and safe sexual experiences that are free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all individuals must be respected, protected, and satisfied.

3) SEXUALITY
Sexuality is a central aspect of humanity and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles, and relationships. Although sexuality can include all of these dimensions, not all are always experienced or expressed. Sexuality is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors.

4) SEXUAL RIGHTS
Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all individuals, free of coercion, discrimination and violence, to:
• The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
• seek, receive, and impart information related to sexuality;
• Sexuality education;
• Respect for bodily integrity;
• choose their partner;
• decide whether or not to be sexually active;
• Consensual sexual relations;
• Consensual marriage;
• decide whether or not, and when, to have children;
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• pursue a satisfying, safe and pleasurable sexual life.
The responsible exercise of human rights requires that all individuals respect the rights of others.
These working definitions were elaborated as a result of a WHO-convened international technical consultation on sexual health in January 2002, and subsequently revised by a group of experts from different parts of the world.

5) YOUNG PEOPLE
In 1989, the joint WHO/UNFPA/UNICEF Statement gave the following definitions:
Adolescents: 10-19 year olds;
Youth: 15-24 year olds;
Young People: 10-24 year olds.
...the meaning of the term ‘youth’ varies in different societies and changes continuously in response to political, economic and socio-cultural circumstances.”

6) ADOLESCENT GIRLS/ YOUNG WOMEN
All the girls in the age group of 10 yr. to 24 years.

7) ADOLESCENT BOYS/ YOUNG MEN
All the boys and men in the age group of 10 yr. to 24 years.

8) KAP: Knowledge, attitude and practice related to RSH issues.

9) MARRIED FEMALE RELATIVES: Includes all the married female relatives (of adolescent girls) who are staying with their husbands and sharing the same house with the adolescent girls. Includes Mother, Sister in law, aunt (age group 15-45yrs.)

10) MODULES: Refers to the Reproductive and Sexual Health training Modules currently being used by organizations to impart education/ training to the adolescent girls.
11) **PEER EDUCATION:** The education of adolescents through their peer by both formal and informal channels.

12) **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.”

13) **STRUCTURED REPRODUCTIVE AND SEXUAL HEALTH (SRSH) EDUCATION PROGRAM:** The education and training program, which is done with the adolescent girls by using the above said module.

14) **TRAINERS:** Adults who impart training based on the above said modules to the adolescent girls.

15) **YOUNG PEOPLE:** men and women in the age group of 10-24yrs.

**SUMMARY**

In this study we are going to look at and understand the following Aspects-

- To understand the process, content and channel of RSH related communication between RSH educated girls and their married female relatives.
- To see if any instances of REVERSE COMMUNICATION are reported. If they are reported then to understand the extent and impact of this communication.
- To understand the process of dynamics of interaction and communication between young women and their husband with regard to RSH.
- To understand the process of dynamics of interaction and communication between the married female relatives and their husband.
- To draw a comparison between the process and outcome of dynamics of interaction and communication with husband under 3 groups-
  1) RSH educated girl and her husband.
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2) Married female relative of RSH educated girl and their husband.

3) Non RSH educated girl and her husband.

- Understanding the perspective of young people on the RSH education of young men and its repercussion for the society and individuals.
- Evaluating the RSH training module from the empowerment aspect. To understand whether the modules being used are well equipped to empower the young women against ‘Gender Based Violence’.