

UNIVERSITY OF BIELEFELD

Faculty of Health Sciences

School of Public Health

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Doctor of Public Health

(Dr. P.H)

Sexual and Reproductive Health Needs of Young People

A study examining the fit between needs and current programming responses in India

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Declaration

This thesis is the result of independent investigation. Wherever the work is indebted to the work of others, it has been acknowledged.

I declare that it has not been accepted in substance for any other degree, nor is it concurrently being submitted in candidature for any other degree.

Shuby Kolencherry

Bielefeld, 3 September 2004

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Sexual and Reproductive Health Needs of Young People

A study examining the fit between needs and current programming responses in India

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"No one is born a good citizen; no nation is born a democracy. Rather, both are processes that continue to evolve over a lifetime. Young people must be included from birth. A society that cuts itself off from its youth severs its lifeline."

- UNITED NATIONS Secretary General, Kofi Annan's address to the World Conference of Ministers responsible for youth, Lisbon, 8 August 1999.

CHAPTER 1

Sexual and Reproductive Health of Young People

1.1 Global concerns

The response of societies to the reproductive health needs of adolescents should be based on information that helps them attain a level of maturity required to make responsible decisions. In particular, information and services should be made available to adolescents to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility.

(United Nations (UN), 1995a. International Conference on Population and Development (ICPD), Cairo, 1994. Program of Action, Para: 7, Article 41)

No longer children, not yet adults – a frequently echoed near universal definition for young people¹. Of the six billion world population, more than 50% is below the age of 25 years (UNFPA, 2003) with one fifth - over 1 billion - of age 10 to 19 years (WHO, 1997a) and more than one fourth - 1.7 billion - between the age of 10 to 24 (Population Reference Bureau, 2000; Chart 1.1). Those between the ages of 15 - 24 years are estimated to be 1.04 billion world-wide (UNFPA, 2000a).

Majority of young people live in developing countries. As per the Population Bureau estimates, 86% of the 1.7 billion young people live in developing countries (Population Reference Bureau, 2000). For youth², the corresponding figures are estimated to be 87% (UNFPA, 2000a). The less economically developed the country, the younger the population seem to be. This makes it needless to say that the growing capabilities of young people are simply the raw materials of human development and one of the most important investment a country can make is enabling its young to grow up as healthy citizens.

Today, young people are living in a rapidly changing world. Processes like urbanisation and migration are rampant. The current generation is noted to be the

¹ Young people refers to those between the ages of 10-24 years

² Youth refers to those between the ages of 15-24 years

most urbanised in history (Population Reference Bureau, 2000). While in 1950, 17% of people in developing countries lived in urban areas, the figure is 47.1% in 2000 (UN, 1996). Much of the population movement is from the rural areas to the peri-

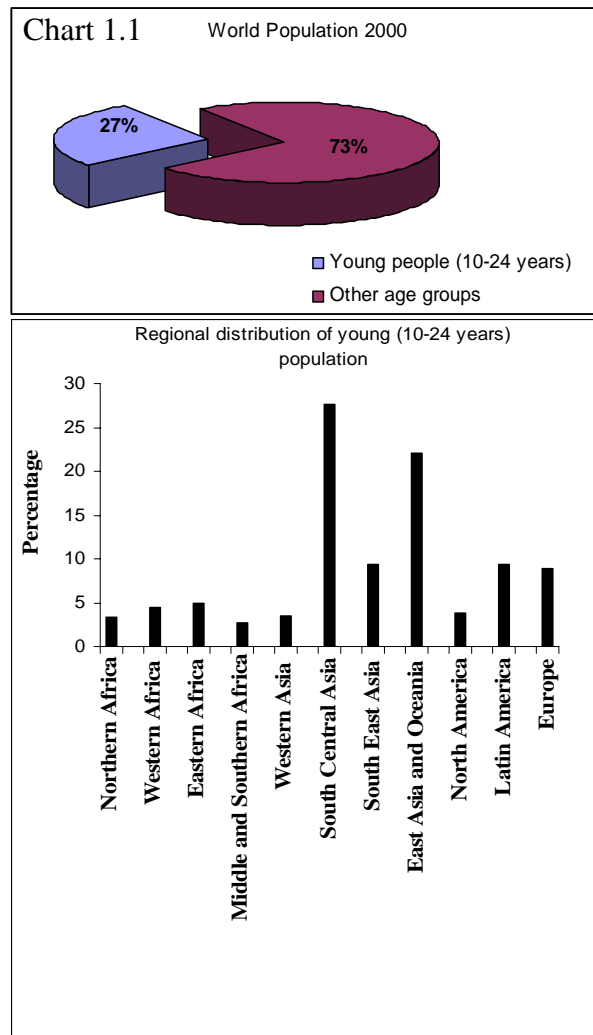
urban slums of rapidly growing megalopolises which do not have the health, education or social services infrastructure to replace that what was provided in other forms in the rural traditional setting.

Migration to other countries is also affecting the status of families and young people. The family unit itself is in transition. The trend has been from multigenerational extended families to nuclear families, to single parent families most often headed by young women, to the non families of street children.

Moreover, telecommunications of many kinds have expanded across the globe, carrying ideas and information with unprecedented speed and quantity, which can have profound impact on

young people. While on one hand these mass media channels of communication offer great opportunities, on the other hand much of what is currently conveyed may put young people at odds with the value systems of their own families and cultures.

Adolescence³ and youth are periods of rapid development when young people acquire new capacities. It is a time of self-discovery and considerable risk taking. As a stage of transition from childhood to adulthood, standing at the brink of maturity and a future filled with possibilities, young people may believe that they have acquired capacities that they have not adequately acquired. While constructive risk taking aids



Data source: Population Reference Bureau, 2000

³Adolescence refers to the age group of 10-19 years

the developmental task of becoming a mature, confident adult with a sense of mastery of self and the world, ill judged and misinformed risk taking can have serious and life long consequences. This in turn would mean that risk taking in adolescence presents not only opportunities for progress, but also can endanger health and well being (Mitchell and Smith, 2000). Furthermore, as many of the behavioural patterns acquired during the early years last a life time, adolescence provides opportunities to prevent the onset of health - damaging behaviours and their future repercussions.

Generally, the health of adolescents and the young seems to have been neglected to a large extent in the past- perhaps because as a group they are relatively disease free. Though this situation has been changing over the past two decades, young people still seem to be remaining as a marginalised social group, both in terms of their access to health care and their relative neglect by policy makers (Mann and Tarantola, 1996). Coming to matters related to sexual and reproductive health, the situation seems to have been worse. Many of the young people across the world have had to navigate their way through sexual maturity without the benefit of any information or services which are known to promote healthy sexual and reproductive life. Adolescence has been noted to represent the period with the highest frequency of negative consequences associated with sexual activities like Sexually Transmitted Diseases and unwanted pregnancies (De-Seta et al., 2000).

1.1.1 Sexual and reproductive life of young people – Recent trends

In many parts of the developing world, especially in rural areas many girls and young women still marry very young (Singh and Samara, 1996; Savitridina, 1997; CEPED, 1997; Shawky and Milaat, 2001; Shrestha, 2002) and are exposed to sexual relations before they are physically and emotionally mature. The other major set of problems arise from sexual relations outside marriage. Young people now attain biological maturity earlier than in previous generations, as witnessed by the gradual decline in the average age of onset of puberty and menarche. Likewise western countries where menarche has declined from ± 15 years to ± 12.5 years, the urban populations and high income groups of developing countries have noted the same trend (Bongaarts and Cohen, 1998). Most of this change is attributed to better health and nutrition (McCauley and Salter, 1995). Another key influence which have strongly influenced adolescent sexual behaviour is the increasing parental demand for children's schooling over the years and to large new investments in the education sector by

many governments. This has resulted in increased number of adolescent years spent in school coupled with a rise in the timing of marriage which potentially increases the length of time that unmarried adolescents are exposed to pregnancy (Bongaarts and Cohen, 1998), depending upon the age at which sexual activity starts (Treffers et al., 2001)

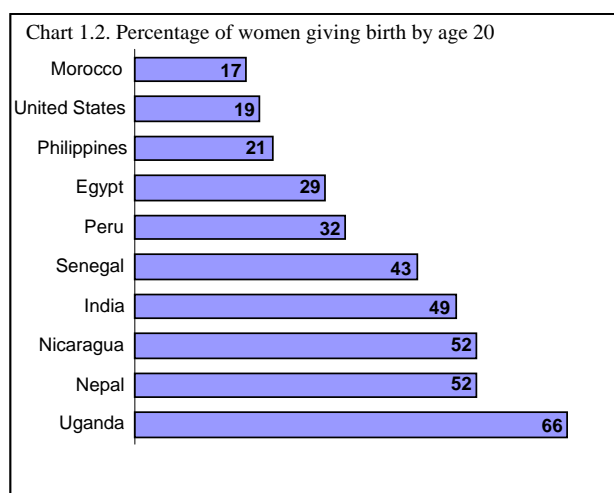
It has been documented in many places that young people around the world are becoming more and more sexually active outside marriage at a early age (Rahlenbeck and Uhagaze, 2004; Manzini, 2001; Sedlecki et al., 2001; Anochie and Ikpeme, 2001; Odimegwu et al., 2002; Okpani and Okpani, 2000) willingly or unwillingly as a result of economic conditions, later age at marriage, peer pressure, mass media influences, migration, coercion, abuse or other forces of social change (CEPED, 1997; Hawkins and Meshesha, 1994; WHO, 1989b; Population Reference Bureau, 1992). In some parts of Africa for example, 50-80% of those aged 12-20 have experienced sexual intercourse (Population Reference Bureau, 1992; Matasha et al., 1998; Kamtchouing et al., 1997; Manzini, 2001). By age 19, more than 90% of all Latin American males have reportedly had intercourse, as have 45-60 percent of females (Sing and Wulf, 1990). In Asia, the existing data is relatively few and variation across countries may be big. The situation is described more in detail in the later sections.

Since the subject of adolescent sexuality remains taboo in most societies, there is a widespread ignorance among young people about their own bodies and of the risks associated with unprotected sexual activity. Sources of information and contraceptive advice are rarely available or accessible to them (Langhaug et al., 2003; Mashamba and Robson, 2002; Zheng et al., 2001). They are also most often unwilling or unable to use most of the family planning and health services (Ford et al., 1992; Kim et al., 1997; Webb, 2000). A big challenge facing healthcare providers internationally seems to be the widespread failure of national healthcare services to optimally address the sexual and reproductive health issues of young people.

1.1.2 Reproductive ill-health indices

Data available globally suggest that sexually active young people are at significant risk of hazardous consequences, such as health complications from pregnancy and child birth (UN, 1989c; CEPED, 1997), unsafe abortions (WHO, 1989b; Scommegna, 1996; Webb, 2000; Rasch et al., 2000), STIs including AIDS (UN, 1989c; UN, 2003), social rejection and destructive sexual relations (Sing and Wulf, 1990). As depicted below, these health problems seem to be exerting heavy illness burden on young people often with long-term physical and social consequences.

World-wide some 15 million pregnancies occur every year among young women aged 15-19 (WHO, 1997b) constituting more than 10% of all births (Scommegna, 1996). In some of the developing countries around 50% of women give birth by age 20 (Population Reference Bureau, 2000; Chart 1.2) Moreover, the proportion of teen births to unwed mothers seems to be rising at least in some countries.

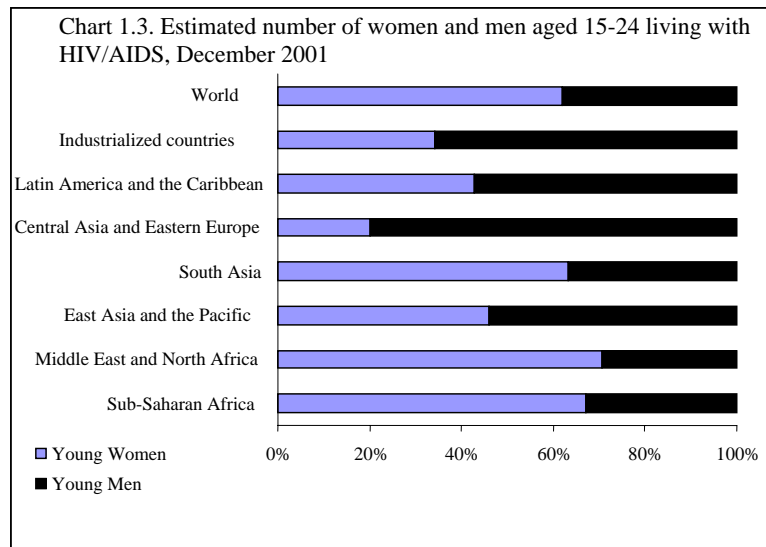


Data source: Population Reference Bureau, 2000

For instance, teen births to unwed mothers have risen by almost 70% in Kenya during the 1980s and by 50% in the US since 1980 (Scommegna, 1996). In many developed and developing countries adolescent pregnancies seem to be an important health issue due to physical and social concerns (Treffers et al., 2001). Surveys done in developing countries show that between 20-60% of these pregnancies and births are mistimed or unwanted (WHO, 1997a). Young people who become pregnant, face serious health risks as they may not be physically mature to handle the stress of pregnancy and child birth. Women aged 15-19 are three times more likely to die from complications of pregnancy than women aged 20-24 years, especially if they are unmarried and thus less likely to receive prenatal care. Pregnancy-related complications are among the main cause of death for 15-19 years old women world-wide (World Bank, 1993; Zabin, 1996). Infants born to adolescent mothers are more likely to be born before term and have low birth weight. They have an additional 24% high risk of dying in

the first month of life and this risk continues during early childhood (WHO, 1995b). Furthermore, pregnant adolescents may be denied important educational and employment opportunities. For young men too, early fatherhood can disrupt educational plans and increase economic responsibilities (Macro International Incorporated, 1993). Young unmarried mothers in some countries seem to have been forced to turn to prostitution to support themselves and their children.

Many young women resort to abortion rather than carry an unwanted pregnancy to term. Current estimates suggest that approximately 4.4 million girls below the age of 20 undergo induced abortion every year (WHO, 1997a; UNFPA, 1998) with at least 10% of all abortions world-wide occurring



Data source: United Nations, 2003

among those aged 15-19 years (Scommegna, 1996). In many developing countries, induced abortions tend to be unsafe. It has been estimated that 2 million unsafe abortions are performed in developing countries alone (Population Reference Bureau, 1996). Unsafe abortions put many women at grave risk of impaired health and, sometimes, of dying (Singh et al., 1997). Unsafe abortion is preventable and yet remains a significant cause of maternal morbidity and mortality in much of the developing world. Over the last decade, the WHO has developed a systematic approach to estimate the regional and global incidence of unsafe abortion. Estimates based on figures around the year 2000 indicate that there are approximately 20 million unsafe abortions performed each year, that is, approximately one in ten pregnancies ended in an unsafe abortion giving a ratio of one unsafe abortion to about seven live births (Ahman and Shah, 2002). Again, as per WHO estimates, the number of maternal deaths as a result of abortion range between 60,000 and 100,000 per year (Bernstein and Rosenfield, 1998).

In such settings, young people seem to be particularly at risk of going for unsafe abortions as suggested by the greater amount of complications due to unsafe abortions among adolescents than adults (WHO, 1993; WHO, 1995b; WHO/UNICEF, 1995; Lema et al., 1996). Hospital records of women treated for abortion complications in some of the developing countries have suggested that between 38-68% of such complications occur among those under 20 years of age (WHO, 1993). It has also been noted that groups at risk of increased mortality and morbidity from unsafe abortions include persons of young age, null parity and lower socio-economic status (Olukoya et al., 2001). Thus voluntary abortions seem to have particularly serious consequences for young girls especially in developing country settings.

Sexually Transmitted Infections (STIs) also seem to be posing major health risks to all sexually active adolescents. Every year more than one out of 20 adolescents contracts a curable STI, not including viral infections (WHO, 1997a). STIs are the second reason after maternity related disorders, for the loss of healthy years in women of child bearing age due to their prevalence and incidence and complications such as ectopic pregnancy (World Bank, 1993). Another important issue related to adolescent sexual activity is HIV infection. Since the start of the HIV/AIDS pandemic, at least 12 million young people have been infected with HIV. In fact, about half of all HIV infections world-wide have occurred in young people under age 25 (Merson, 1993; Scommegna, 1996). Presently 11.8 million young people are living with HIV/AIDS and every day nearly 6,000 become HIV infected (UN, 2003). It has been shown that currently young women are getting the infection at a much faster rate than young men in many regions (Chart 1.3) and younger adolescents are being exposed to the virus with increasing frequency (UN, 2003). Girls seem to be extremely susceptible to STIs (including HIV) in regions with high prevalence (WHO, 1999a) and in many countries women account for 40% of all new HIV infections (Scommegna, 1996). In addition, HIV infection in female adolescents is more likely to be recent and have a high viral load (WHO, 1999a).

1.1.3 Health policy and services

While it is encouraging to note the striking increase in global recognition in recent years about the importance of addressing the needs of young people related to sexuality and reproduction, much remains to be done in countries. In general, many

governments have failed to adequately address the needs of young people for reproductive health services and their access to appropriate SRH services seems to be limited in many countries, both developed and developing (Cernada, 1986; Barker and Rich, 1992; Klein et al., 1993; Carter et al., 1994; Hawkins and Meshesha, 1994; Nabila et al., 1996; WHO, 1998; Arjona, 1998). This is due to a variety of factors, ranging from socio-cultural factors, geographical accessibility, unfavourable health policies, high costs of care, lack of information on SRH services, negative attitudes of care providers, quality of care and a user-unfriendly organisation of service delivery (UNFPA, 1995; WHO, 1998). The public in general and key decision makers in particular may be unaware of the need for concerted action and their uncertainty is further compounded by the sensitivity of the subject. It is frequently the case that no coherent policy exists for the protection and maintenance of sexual and reproductive health of the young, or that existing policy is inadequate to meet specific needs. Health care providers also seem to have their own fears that policies and local laws restrict their capacity to give contraceptive and other services to adolescents (Cook and Dickens, 2000). Another factor is countries' default in living up to the international legal commitments they have made under human rights treaties 'to ensure that no child is deprived of his or her right of access to.....health care services' (UN, 1989a: *Convention on the rights of the child*) including commitments to reproductive health as an aspect of 'preventive health care.....and family planning education and services' (UN, 1989b: *Convention on the rights of the child*).

Ignorance, myths and misinformation about adolescent sexuality and sexual behaviour prevalent among young people as well as adults make it necessary to undertake education of young people in the facts of responsible and safe sexual behaviour, and of adults, including those in political power, in the facts of adolescent sexuality. However, even in more developed countries, sex education is a controversial area of public policy and it has also been highly politicised (Monk, 2001). Public and political awareness of the extent of unplanned adolescent pregnancy, childbirth, abortion and STI in a country may bring to light the limits and dysfunctions of repressive laws and moralistic rhetoric, and direct attention to collaborative clinical, public health and legal strategies to achieve adolescent reproductive health standards that both adolescents and their communities desire. Another step could be to encourage governments to determine whether their domestic laws and policies,

recognise that adolescents can obtain confidential services to protect their reproductive health. If they can not, the next step could be to encourage governments to comply with the international human rights commitments their countries have made to afford adolescents access to appropriate health care services.

Though few, there have been excellent examples of explicit governmental as well as nongovernmental efforts designed to improve the quality of adolescent health services at the primary care level and to strengthen the public sector's ability to respond to adolescent health needs. For instance, Dickson-Tetteh et al. (2001) has described the National Adolescent-Friendly Clinic Initiative (NAFCI), an accreditation programme currently being piloted in ten government clinics in South Africa. The major objectives are making health services more accessible and acceptable to adolescents, establishing national standards and criteria for adolescent health care in clinics throughout the country, and building the capacity of health care workers to provide quality services. Achieving NAFCI accreditation involves clinic self-appraisals, quality improvements, external assessments and award of achievement stars. One of the indicators for success of NAFCI is the increased utilisation of public sector clinics by adolescents. Again, Pick et al. (2000) has described the work of a Mexican non-governmental organisation, IMIFAP, which has designed and evaluated sexuality education programmes for children from pre-school age through adolescence and for their parents, based on formative research. IMIFAP has also been advocating with others for the wider provision of sexuality and life skills education in schools, as a result of which the Ministry of Education announced its support for comprehensive sexuality education in the standard school curriculum.

For youth to be able to develop fully and protect their health, a friendly environment is required; an environment in which equity between the sexes is valued and they are given the support and opportunities needed to exercise their capacities, and an environment in which information, counselling and other services can be provided in a confidential manner by people whom they trust and who are empathetic to their needs (WHO, 1998). Evidence also suggests that providing teens with accurate information is much more effective than “disease, death and disability” messages (Brindis, 2002). Responding to the needs of young people and helping them in solving the problems related to the sexual and reproductive life of young people would go a

long way in enabling them to grow up as healthy citizens. As WHO Director-General, Dr. Hiroshi Nakajima has said in a message sent to the Youth Heal March, “Young people are, in many ways, our greatest resource. Investing in youth is investing in the future.” (WHO, 1995b).

1.2 South Asia and India

1.2.1 Overview

In the South Asia region - Bangladesh, India, The Maldives, Nepal, Pakistan and Sri Lanka - more than 30% of the total population is between the ages of 10 and 24 years (IPPF, South Asia Regional Bureau, 1994). Though relatively few data exist on young people’s sexual activity in the region, it has been documented that youth or adolescent sexuality was not considered a major problem till early 1980s because of strict religious and cultural mores. Also, early marriage seems to be used in many parts of Asia to control girls’ sexuality and limit it to purposes of reproduction (UN, 1989c). Age at marriage is reported to be quite low in this sub region — ranging from 14.1 years in Bangladesh to 18.1 in Pakistan — and adolescent girls are closely supervised by their families (Singh et al., 1997). As Caldwell et al. (1998) has pointed out, *“in Asian societies, most females probably still enter marriage as virgins. Few babies are born outside marriage, and the age at first marriage is an important determinant of the societal fertility level”*.

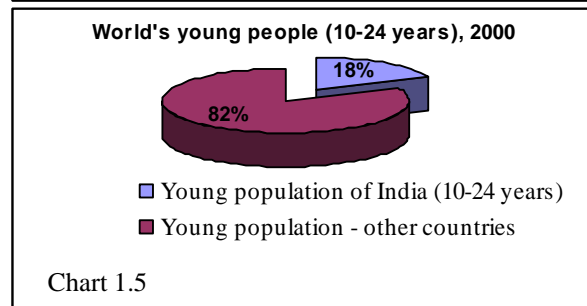
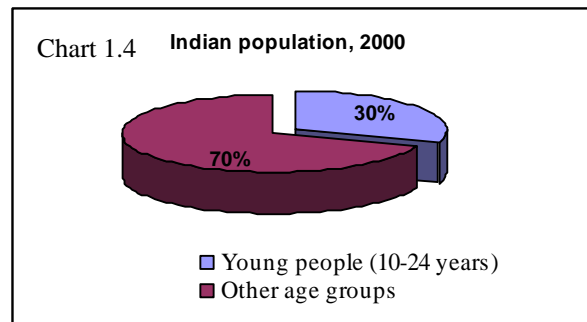
On the other hand, as the social transformation processes got strengthened, there was a continuous degradation of traditional values and practices especially in urban and semi-urban settings. Earlier sexual maturity, later marriage and greater opportunities for sexual contacts due to urban life style have brought in increased problems in almost all the countries of the region (IPPF South Asia Regional Bureau, 1994). Though the traditional constraints with respect to sexuality still remain, they are less controlling. It has been suggested by some of the available reports from the region that 25% of single adolescents are sexually active (UN, 1989c). Boys and girls now spend more years in school, enter the labour market and marry later and this brings in a widening gap between sexual and social adulthood exposing them to the risk of socially unacceptable sexual relations. The ignorance about aspects related to sexuality and reproduction are also shown to be substantial in this region. Since sexuality is a highly taboo subject between parents and children, lack of

communication leaves many youngsters unaware of what to expect of their bodies. Even the most basic landmarks of puberty - menarche and nocturnal emissions - come as a distressing shock to many young people, and can lead to the association of sexuality with anxiety and shame (IPPF, 1994). Though families are increasingly likely to seek clandestine abortions for unmarried pregnant daughters, nearly all Asian family planning services find it almost impossible to offer contraceptives to single females (Caldwell et al., 1998).

1.2.2 Young people's sexuality and fertility – The scenario in India

India, the second largest populated country of the world with a population of more than a billion, young people aged 10-24 years represent around 30 % of the population (Population Reference Bureau, 2000; Chart 1.4). Moreover, young people in India constitute 18% of the world's total young population (Population Reference Bureau, 2000; Chart 1.5).

In view of its size and implications for the future, though it is imperative to give due attention to the challenges facing young people, very little attention seems to have been given to their problems. Also, very little solid information is available about their status or behaviour.



Data source: Population Reference Bureau, 2000

1.2.2.1 Conjugal patterns

On matters related to sexual and reproductive health, it has been noted that adolescent and youth sexuality and fertility pose health related problems of a special kind in India. As is illustrated in Table 1.1, by the age of 24, more than three fourth (76%) of Indian women are married with marked differences in the proportions between urban (61.8%) and rural (81.7%) areas. Again almost one fourth (23.5%) of those currently in the age group of 20 - 24 years were married by the age of 15 and half (50%) by the

age of 18. The median age at marriage for the 20-49 age group is 16.7 years where as the age of first cohabitation is slightly higher, 17.4 years.

Table 1.1 Conjugal patterns among young people in India

			Current age (year)	
1. Proportions ever married (1998-1999) %			15-19	20-24
Total	Male		4	32.3
	Female		29.5	76
Rural	Male		4.9	37.6
	Female		34.4	81.7
Urban	Male		2	20.7
	Female		16.4	61.8
2. % of women married by ages				
13 years	Total		4.7	8.9
	Rural		6	11.4
	Urban		1.1	2.8
15 years	Total		14.3	23.5
	Rural		17.8	29.1
	Urban		4.8	9
18 years	Total		NA	50
	Rural		NA	58.6
	Urban		NA	27.9
3. Median age at first marriage (20-49 age group)				
Total			16.7	
Urban			18.7	
Rural			16	
4. Median age at first cohabitation ⁴ (20-49 age group)				
Total			17.4	
Urban			18.9	
Rural			16.8	

Data source: International Institute of Population Sciences (IIPS), 2000

1.2.2.2 Martial fertility and child bearing

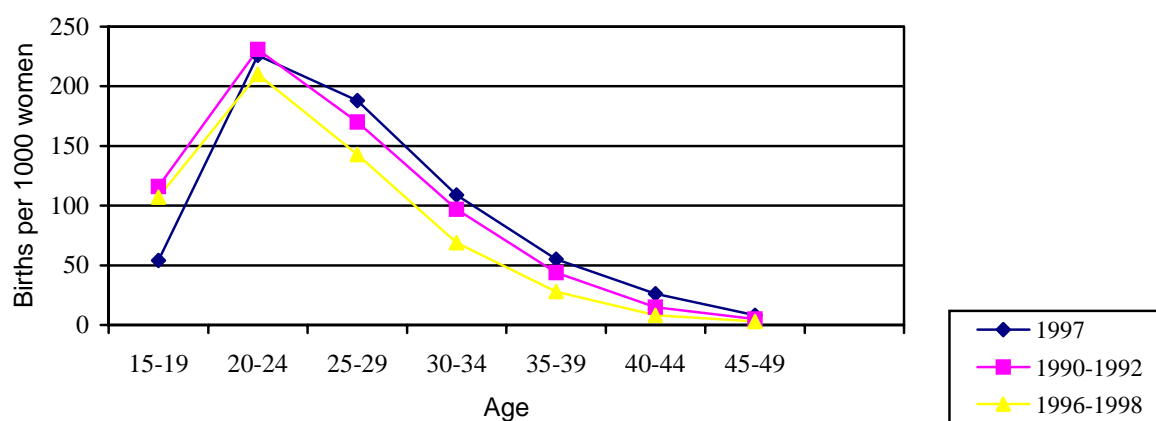
Current fertility in India is characterised by a substantial amount of early child bearing with a high concentration in the 15-29 age group. In 1990-92, it was found that 17% of total fertility is accounted for by births to women in the age group of 15-19 and in 1996-98, fertility at age 15-19 has been found to be accounting for 19 %, almost one fifth of overall fertility. Then it peaks in the 20-24 age group and start declining steadily after age 25 reaching very low levels for women in their forties.

⁴ In India as formal marriage is not always immediately followed by living with the husband, it generally occurs after the *gauna* ceremony.

Consistent with the strong emphasis placed on female chastity, fertility occurs mainly among married adolescent females (Jejeebhoy, 1996).

As regards child bearing, as illustrated in Chart 1.6, in 1990-92, among all the women who are currently in the age group of 20-49, more than half (54.5%) have had their first birth in their teens with the median age of first birth as 19.6 years. In, 1996-98 the median age at first birth for women of current age 25 - 49 has been found to be constant at 19.6 years (IIPS, 2000).

Chart 1.6 : Age-specific fertility rates 1990-92*, 1996-98* and 1997



*The rates are for three years preceding the period considered
Data Source: International Institute for Population Sciences (IIPS) and ORC Macro, 2000.

1.2.2.3 Premarital sexual activity

Like most of the South Asian countries, sex and sexuality are very sensitive to be talked about in India and is hardly ever discussed in public. On the other hand, urbanisation is bringing about changes in the social and sexual behaviour of youngsters which is most evident in the cosmopolitan cities. In contradiction to the general belief that sexual activity occurs overwhelmingly within the context of marriage, there have been studies indicating a relatively consistent picture of high rate of premarital sex among the male unmarried adolescents and some evidence of premarital sex among unmarried female adolescents (Watsa, 1993; Goparaju, 1993; Savara and Sridhar, 1994; Bansal, 1992). Of particular concern here is the high risky unprotected sexual behaviour with relatively early and spontaneous initiation.

As regards the reproductive ill health indices, data from studies of the general population and facilities warn that young people constitute a neglected but high risk

group for Sexually Transmitted Infections, whose numbers may have doubled since the 1980s (Watsa, undated). At the end of 2001, the percentage of young people living with HIV/AIDS in India is 0.5-1.0 females and 0.2-0.5 males (UN, 2003). While abortion has been legal in India since 1972, limited availability and poor quality have kept abortion beyond the reach of most poor women. Of the estimated five million induced abortions that occur annually in India, only half a million are performed under the health services network (UNICEF, 1991). Adolescents have been found to be constituting a significant proportion of abortion seekers (Chhabra et al., 1988; Solarpurkar and Sangam, 1985). It has also been noted that adolescents are considerably likely than older women to delay seeking abortion services and hence undergo second trimester abortion (Divekar et al., 1979; Chhabra, 1992). Delays in seeking services were largely the result of lack of awareness of pregnancy, ignorance of services and fear of social stigmatisation. Contraception awareness also seems to be equally vague, even among married adolescents (ORG, 1990).

1.2.2.4 Social paradoxes

The risky sexual behaviour of adolescents in India can be attributed to several factors, including some of the paradoxes in the Indian social set-up itself. While, traditionally known to be the land of 'Kamasutra' (an analytic treatise on love and sex written more than 1500 years ago by Vatsyana, a Indian philosopher) and erotic temple sculptures, where sexual symbols are routinely worshipped, sexuality still remains to be a highly sensitive topic and there is a total rejection of formal forms of sex education (Mutatkar and Apte, 1999; Sharma and Sharma, 1996). On the other hand, in many parts of the country, with the advent of the western media, there seems to be unlimited access to various television programmes often with explicit sexual scenes. Consequently, young people in India find themselves sandwiched between a glamorous western influence encouraging free expression of sexual feelings, and a stern conservatism at home that forbids any such activities. There seems to be a pseudo-liberal attitude in the society too, which has resulted in increased interaction between the two sexes. More young people now go to co-educational institutions as compared to the past, and an increasing number of working ladies get more opportunities to interact with males. In general, conservatism exerts a dual but mutually antagonistic influence on the reproductive health of adolescents. It does help to limit the number of pre-marital sexual exposures to different partners, thereby

minimising the risks of STIs and unplanned pregnancies. It also reinforces the sanctity of the institution of marriage. Paradoxically, strict social pressures of this nature seem to be contributing to the propagation of myths and confusion (Sharma and Sharma, 1996).

1.2.2.5 Response from the care systems

Reproductive health in general and reproductive health of young people in particular are poorly understood and ill served in India (Jejeebhoy, 1996). In addition, the culture of silence surrounding sexual and reproductive health issues especially outside marriage along with widespread seclusion of young women makes adolescents particularly unlikely to seek or obtain reproductive health care or information, including antenatal and delivery services. There seems to be only very few opportunities for unmarried youngsters to seek information or counselling on matters concerning their sexual and reproductive life. Though India has one of the oldest National Family Planning (Welfare) Programme in the world, it was always tailored around the reproductive health care needs arising inside the context of marriage. Furthermore, due to cultural constraints, the concept of reproductive health has traditionally been confined to the concept of family planning, maternity services, and provision for abortions (Sharma et al., 2000). (The National Reproductive Health Strategy is detailed to some extent in the coming sections). While the needs of children and pregnant women are acknowledged in national programs, neither services nor research have focused on adolescents and their unique health and information needs (Jejeebhoy, 1998).

1.2.2.6 Reproductive health policies and programs for young people

- **Government policies & programs**

In India, there are no specifically designed comprehensive national policies or programmes as such regarding the sexual and reproductive health of young people at present and they have not been the target group for specific health activities. However, some aspects of young people's SRH are dealt with in other national policies and programme though limited in its size and scope (UNPF, 1999). Since the early 1980s, the government has been implementing a programme of population and development and family life education in order to prepare young people to make

personal and socially responsible choices within the framework of population growth and its effect on development. The programme is envisioned to form an integral part of the existing educational system with the involvement of the society, teachers and parents (Singh, 1999). The government has also launched a number of HIV/ AIDS prevention education programmes in universities and schools and as well as through social marketing activities and media campaigns. Some examples are University Talks AIDS initiated in 1991 in 59 universities through the National Service Schemes. The aim is to identify the level of AIDS awareness among university students and to raise awareness through a series of activities. Similarly education departments at the state level conduct AIDS prevention programmes in secondary schools through a system of peer educators, nodal teachers and district Tuberculosis officers. In some states, Departments of Education and Health also collaborate to implement programmes of HIV/ AIDS prevention in the school system (Singh, 1999; UNFPA, 2000).

The International Conference on Population and Development (1994) paved for a change in the orientation and direction of reproductive health and population policies in India. Proactive in translating the ICPD agenda, the Government of India launched the Reproductive and Child Health Programme (RCH) in 1997. Under the programme, adolescent girls have been recognised as a distinct group with specific needs and a comprehensive package of services for girls is being formulated. The government has also initiated some efforts in involving Non Governmental Organisations for future partnerships in implementing programmes at the field level (Singh, 1999).

The new National Population Policy, 2000, adopted by the Government of India has set as its immediate objective the task of addressing the needs of adolescents and youth for information, counselling, population education, making contraceptive services accessible and affordable..... and enforcing the Child Marriage Restraint Act, 1976 (Ministry of Health and Family Welfare, 2000). This policy which includes adolescents and youth as a under-served category recognises the invisibility of this group in other policies. Another significant aspect of the policy is its emphasis on enforcing the Child Marriage Restraint Act.

The other government plans and policies which have articulated the needs of young people in terms of education, empowerment, employment, food security, nutrition and so on which can have direct or indirect impact on SRH include the Ninth Five Year Plan (1997-2002); National Youth Policy (2000); National Plan of Action on children (1992) and SAARC Decade of the Girl Child (1991-2000); Health Policy (Draft 1999); National Nutrition Policy (1983); National AIDS Policy (2000); National Education Policy (1986, modified in 1992); National Policy for the Empowerment of Women (Draft-1996). Among programmes, those with an explicit mention of adolescents is the Support to Adolescents under ICDS run by the Department of Women and Child Development and to a certain extent, and the adolescent component of the Reproductive and Child Health Programme of the Department of Family Welfare (UNFPA, 2000).

- **NGO Programs**

The increasing recognition of the unique needs of young people have resulted in a number of NGO programs targeted at young people though relatively recent in origin. The observed positive trend has been the emphasis on young people as a target group instead of categorising them under other groups like women or children along with a holistic and integrated approach in projects and programs (UNFPA, 2000). In most of the community based programmes, the approach has mostly been depended on the stated needs, on a felt need basis from the adolescents themselves, the feasibility of providing the required services and most importantly, the cultural and social norms of the target population to be served (Mamdani, 1999).

There are two identifiable models among NGO programs: 1) Programmes that focus solely on the provision of sexual information to unmarried adolescents 2) Programmes that are providing information and limited medical services; a few are even attempting to reach out to adolescents with literacy programmes and skill training activities. The first model with focus on the provision of sexual information try to reach out to adolescents on an informal basis individually or collectively in a peer group environment in the village setting or at residential camps away from the village. Many of these programmes aim to provide adolescents with sexual information with a view to change behaviour. Some address only girls, others are reaching out to boys as well. Some of the examples from different states are Baroda

Citizen's Council, Deepak Charitable Trust, Orissa Institute of Medical Research and Health, Krishan Nath Baba Memorial Charitable Trust and Health Centre, Society for Rural Education and Development - Tamilnadu, and Society for Social Uplift through Rural Action – Himachal Pradesh. On the whole a number of these programmes are service – based though they do not offer reproductive health services that are tailored to adolescent needs. Concerning the second model, very few programmes have been infact able to go beyond and into actual service provision. In addition to the social and cultural constraints, there are also restrictions imposed by scarce resources. Some of the examples are Action India, Deccan Development Society and Sarada Valley Development Society, Prerana – Delhi, Rural Women's Social Education Centre – Tamilnadu and Society for Education, Action and Research in Community Health. Some of the most effective programmes seem to be those that include more than information and services. They have incorporated a skill training component as well (Mamdani, 1999).

1.3 Purpose and structure of the Study

1.3.1 Study context

As stated at the very out set of this chapter, the Programme of Action proposed at the International Conference on Population and Development (ICPD) held in Cairo in 1994 set out very clearly that governments should protect and promote the rights of adolescents to sexual and reproductive health information and services, and take efforts to reduce the number of adolescent pregnancies (UN, 1995a). The adopted Programme of Action also articulated that the quality of all reproductive health services is to be improved. During the years leading up to and following the ICPD conference, the global understanding of adolescent reproductive and sexual health was emerged and several governments affirmed this commitment. Though India is one of the countries which has taken a lead to begin the process of translating the concepts of ICPD in to its national programmes, the task seems to be largely unaccomplished (Datta and Misra, 2000). Though no developing country can claim to have accomplished this task, many seem to be searching answers for how they should go about it.

A comprehensive and effective approach to addressing health concerns depends on knowing answers to questions about the prevalent concerns as well as the existing

mechanisms to promote it, the obstacles in using them and perspectives about what works better. A balanced and enlightened approach to this endeavour is necessary because sexuality and particularly adolescent sexuality has been conceptualised within a context of the negative and the problematic, a context of behavioural risk, rather than one in which the social, cultural, biological and psychological factors that shape sexual behaviour are duly examined without prejudice. Towards this a great deal of scientific research is needed as a first step.

Research interest in the sexual and reproductive health of young people has been growing over the past two decades in India in response to the advent of HIV and other sexually transmitted infectious diseases. Though the global attention on the adverse health implications of adolescent sexuality and fertility has boosted this interest, much of the research in this area seem to be limited in terms of their design and sample selection (Jejeebhoy, 1998). Many of them also do not seem to be using a scientifically established theoretical framework or conceptual model. Given that many of the effective risk reduction programs are based on scientific data along with the application of prevailing theory, it is logical to think that many of the existing programs and services might not be effectively meeting the sexual and reproductive health of young people nor produce sexual health promoting behaviour. Though there are hardly any studies relating to the sexual and reproductive health programming scene from India, previous research from many parts of the world have indicated a poor fit between existing programs and needs. As Hughes and Mccauley (1998) have noted “demand is growing for expanded sexual and reproductive health programming for young people in developing countries, but few evidence based answers have been found to the question, “What kind of programs work?”. As suggested by them the absence of definite answers means that planners must devise new and expanded programs that build upon the evidence about adolescents’ needs, preferences and health seeking behaviours; and insights drawn from behavioural theories considering the reality of various constraints. In such a broad contextual background, the present study attempts to explore the risky sexual behaviour of young people and its hazardous consequences and examine the fit between their health needs and the existing programming responses using both empirical data and theoretical framework.

The study is mainly based on the hypothesis that there is a poor fit between young people's sexual and reproductive health needs and the existing programming in India.

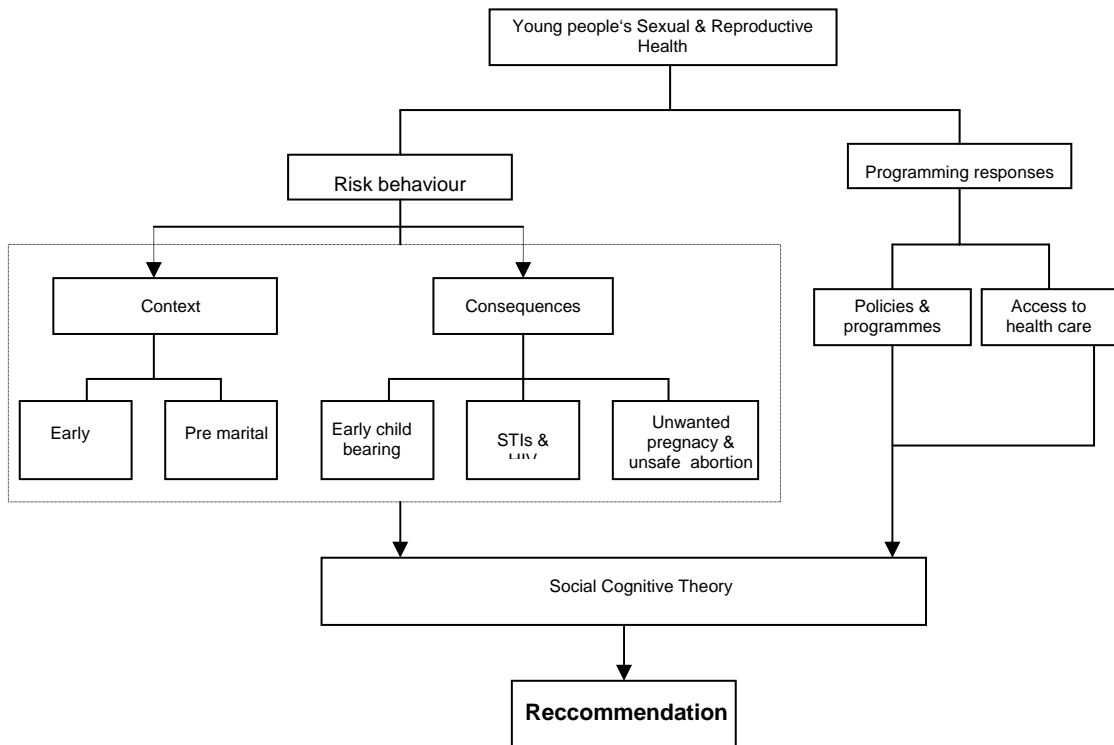
Programming is meant here to imply both the preventive and curative activities in terms of policies, programs and the responses from the health care systems. The fit between needs and programming responses is examined using the constructs from Social Cognitive Theory (Bandura, 1986) and recommendations for future programming are evolved.

The study is based on the perspectives of stakeholders especially influential adults and young people themselves. The adult stakeholders in the study include planners and policy makers in the concerned ministries, program managers of governmental as well as non governmental organisations working for young people, UN agency representatives (categorised as Inter Governmental Organisation), health service providers and key informants like parents, teachers and media representatives. In addition to proving the above mentioned hypothesis, a secondary line of analysis focuses on the attitudes of the stakeholders towards young people's sexuality, constraints faced by the programmers in planning and implementing programs and services which would be an added input towards successfully planning and implementing programs and services in future. Their suggestions in improving the situation are also solicited and considered in formulating the recommendations. The study is based on the example of Gujarat, one of the most urbanised states in India.

1.3.2 Structural framework of the study

As per the framework mentioned in Chart 1.7, first the risky sexual behaviour of young people is explored both in terms of the context and consequences. Using this empirical evidence and Social Cognitive Theory constructs, a model for risky behaviour and a framework for intervention is evolved. Subsequently, the existing programming responses in terms of the policies, programmes and access to the health care system are examined against this model intervention framework to explain the fit and to evolve recommendations for future programming.

Chart 1.7 - Structural framework of the study



The constraints faced by the stakeholders in the planning and implementation of programmes and delivery of services along with their views about improving of the situation were also explored. The theoretical constructs used in the study are detailed to some extent below.

1.3.3 Role of Social Cognitive Theory (SCT)

Social Cognitive Theory (SCT, Bandura, 1986; Bandura, 1992) is a model of interpersonal behaviour that emphasises the influence of social norms and social support, and explains human behaviour in terms of a dynamic, triadic and reciprocal model in which behaviour, personal factors and environmental influences interact (Bandura, 1986; Goodson and Evans, 1997). Social Cognitive Theory provides a conceptual model for examining the interactions among the three factors involved in human behaviour: the person, the behaviour, and the environment in which the behaviour takes place; a change in one factor inevitably influences the other two factors (Stewart et al., 1999). The components of SCT have done much to explain the relative successes and failures of various attempts at behavioural change (Bandura, 1992). SCT was chosen in the present study because in the absence of a well accepted model or theory of adolescent sexual behaviour, it has been applied across several

primary prevention domains and have been effective in producing positive results including behaviour change (Kirby and DiClemente, 1994; Smith et al., 1996; Garrett, 1997; St. Lawrence et al., 1997). Many adolescent pregnancy and HIV prevention interventions, especially later generations of school-based and community-based interventions, have incorporated the primary components of SCT into their programmes, suggesting the relative strength of this model for preventive interventions (Stewart et al., 1999). Moreover, there is compelling evidence supporting the hypothesis that the most effective sexual risk reduction programs for adolescents are the ones developed within this theoretical framework and that programs based on this have generally been successful in encouraging adolescents to adopt safer sex practices (Kirby and DiClemente, 1994).

Self efficacy or confidence in skills and outcome expectancies are the two key constructs that are used in the present study to apply the results and to evolve recommendations. These constructs have been widely used in defining sexual risk reduction among adolescents and youth practices (Kirby and DiClemente, 1994). Previous research has also shown that these two factors are significant in delaying the initiation of sexual activity as well as promoting safe sex practices (Reitman et al., 1996; Sieving et al., 1997; DiIorio et al., 2001). In addition, the concept of observational learning based on role modelling has also been used. This is the central concept in Social Learning Theory which is based on the work of Bandura and colleagues (Peck et al., 1981; Perry and Sieving, 1993; Milburn, 1995).

- **Self-efficacy**

Self-efficacy, considered a key construct within Social Cognitive Theory, is the individual's belief that she or he is capable of executing a specific behaviour towards the attainment of a desired goal (Bandura, 1986; Bandura, 1997). Although not directly addressed by Bandura in his description of self-efficacy, acquiring and mastering skills such as decision making, self assertiveness and social communication are regarded as fundamentally important to the enhancement of a young person's ability to make rational decisions and to act on them (Scriven and Stiddard, 2003). According to the self-efficacy construct, a person's expectations as to whether she can and should exercise component behaviour will determine initiation and persistence in achieving a desired goal.

- **Outcome Expectancies**

In Bandura's social-cognitive theory, most human actions are thought to be goal directed (Bandura, 1986). Typically this means that actions are performed to obtain anticipated and valued outcomes or to avoid dreaded ones. Individuals engage in actions that they believe result in desirable consequences such as increased understanding and receiving rewards, status, and affiliation, or they try to avoid undesirable consequences such as pain, loss of status, or loss of affiliation. Bandura (1986) has referred to these anticipated outcomes as outcome expectancies. They serve as incentives for action. They guide the choice of actions and influence the level of effort and persistence directed toward attaining the outcomes. Three aspects of outcome expectancies as suggested by Bandura (1986) are self evaluative, physical and social.

The greater the personal value of the anticipated outcomes (outcome expectancies) and the stronger the belief that one is capable of generating the behaviours needed to obtain the outcomes (self-efficacy beliefs), the greater the likelihood that action will be taken to obtain them and that effort will be expended in their pursuit. Thus, the combined impact of outcome and efficacy expectations provides the motivation for taking and sustaining action to attain valued outcomes.

- **Observational Learning**

Based on the work of Bandura and colleagues, Social Learning Theory (Peck et al., 1981; Perry and Sieving, 1993; Milburn, 1995) claims that modelling is an important component of the learning processes. Put simply, a person can learn from other people, not only by receiving reinforcements from them but also through observing them and utilising his or her symbolic capability.

1.3.4 Why include adult perspectives?

Engaging adults as positive actors in young people's lives is one of the most critical elements in creating a safe and supportive environment to young people (Hughes and McCauley, 1998). This leads to the logical conclusion that little can be done to improve the sexual and reproductive health of adolescents without the support of adults in their private roles as parents and family members and in their public roles as policy makers, programme managers, health service providers, teachers and community leaders. As the examples from some European countries show, many

adults, in their roles as parents, teachers or sport coaches, are in a position to become reliable, sympathetic and accurate sources of reproductive health information and teach young people to be sexually responsible (Jones et al., 1989; Scott et al., 1995 quoted in Hughes and McCauley, 1998). Adult's willingness to fill the role greatly extends coverage of reproductive health information and skills to the adolescent population. However, this does not seem to be the case always; often adult attitudes concerning adolescent sexuality seems to be the greatest barrier to creative and effective programs that reach large numbers of young people. It has been indicated by previous researchers that wherever, adults ignore and oppose the sexual and reproductive health of young people, programs remain small and adolescents receive inadequate information (Hughes and McCauley, 1998). Thus, it assumes great significance to engage adults in creating a safer and a more supportive environment, in which young people can develop and learn to manage their lives, including their sexual and reproductive health.

The adults in the present study include policy makers, planners and programme managers of from governmental and non governmental organisations, health service providers, teachers, parents, and media representatives. As the key decision makers in the planning and implementation of programmes, carefully eliciting the views of planners, policy makers and programme managers in governmental and non governmental organisations regarding the various issues of young people's sexuality and their access to services and programmes would be a good measure of their sensitivity to the situation. Understanding the difficulties faced by them in policy formulation or service delivery would also be worthwhile. The other core group which comes under the study are the service providers. Listening to their perspectives about young peoples' sexuality, the various barriers that young people face in accessing services with respect to sexual and reproductive health and the difficulties faced by them would provide insights into how to plan service delivery more effectively. Parents and teachers assume great roles in helping young people in the acquisition of knowledge and skills thereby developing healthy behaviour patterns. Media can also play a significant role in terms of its impact on the minds of the young.

Against such a background, as indicated by previous research frameworks (WHO, 1997a), a situational analysis based on adult perspectives, in addition to bringing out a picture of the situation, would serve to:

- expand knowledge about what influential people believe are adolescents needs or how they perceive the situation with respect to programs and services
- open a channel of communication among them, and between them and the researchers
- pave the way for the feed back of findings from the situation analysis for improving policy and practice.

1.4 Objectives of the study

The major objective of the study is to explore the magnitude and characteristics of sexual and reproductive health risks of young people in Gujarat, India and to examine the fit between needs and the existing programming responses based on stakeholder perspectives and Social Cognitive Theory constructs.

1.4.1 Specific objectives and research questions

The specific objectives and the corresponding research questions formulated are:

1. To explore the magnitude and characteristics of risky sexual involvement among young people in Gujarat in the context of early marital and pre-marital relations.

Research questions

- What is the perceived extent and the contributing factors of too early marriage in Gujarat?
 - What is the perceived levels of occurrence of premarital sexual activity in Gujarat?
 - What are the background factors contributing to premarital sexual activity among young people?
 - What is the attitude of the stakeholders towards young people's sexual behaviour?
2. To explain the observed risk pattern in early marital and premarital relationships and to construct a conceptual model for risk behaviour.

Research questions

- What is the observed risk pattern in marital as well as premarital relationships?

- What are the contributing factors for risk behaviour?
 - What could be a possible conceptual model for risky sexual behaviour based on SCT constructs?
3. To explore the consequences of risky sexual behaviour in terms of too early pregnancy and child bearing, STIs and unwanted pregnancies and unsafe abortions.

Research questions

- What is the reported occurrence of too early pregnancy and childbearing in Gujarat?
 - What are the common physical hazards found as a result of too early pregnancy and childbearing?
 - What is the perceived prevalence of STIs among young people in Gujarat?
 - What is the observed health care seeking behaviour of young people for STIs?
 - What are the reported causes for unwanted pregnancies among young people in Gujarat?
 - What are the reasons for pregnancy terminations among young people in Gujarat?
 - What is the observed health care seeking behaviour of young people in the context of pregnancy termination?
 - What are the contributing factors for unsafe abortions?
 - What are the frequently found consequences of unsafe abortions?
4. To define a framework for intervention based on the emerging needs and the concepts of Social Cognitive Theory

Research question

- What could be a possible intervention framework for based on the needs of young people and Social Cognitive Theory constructs?
5. To list out the possibilities and constraints in the existing policies and programs intended towards meeting the sexual and reproductive health needs of young people.

Research questions

- Which are the reported policy statements and international declarations having provisions on adolescent sexual and reproductive health issues?
- Which are the major sex education approaches for young people in Gujarat?

- What is the orientation, coverage, activities and approach adopted by various sex education programs?
 - Which are the SRH programs with multiple components?
 - What are the constraints faced by planners and policy makers in the planning and implementation of programs and services?
6. To examine the suitability of existing policies and programs towards meeting the sexual and reproductive health needs of young people using the intervention framework.

Research question

- How do the existing policies and programs meet the sexual and reproductive health needs of young people in comparison with the intervention framework?
7. To elicit the barriers young people face in accessing health care services for sexual and reproductive health problems.

Research questions

- How does the stakeholders perceive the access dimensions of availability, acceptability and affordability of SRH services in terms of contraception, STI care and pregnancy termination?
 - What are the other reported barriers?
 - What are the constraints faced by the service providers in the delivery of services?
8. To evolve recommendations for future programming

Research question

- What are the opinions of the stakeholders to make the situation better?

1.5 Location of the study – Gujarat state in India

1.5.1 India – Country profile

India is the largest country in South Asia covering over 3287590 square kilometres from the Himalayas in the north to the Indian ocean in the south (IPPF, undated) (Annex:1 Map of India). The administrative division consists of 25 states and 7 union territories. Each state of India has its own set of norms to live by. Culture, in India, although diverse and varied, still binds the country together in some form of common identification. Indians, even today, are highly influenced by their own traditions and values despite the recent movement toward westernization. There is a vast variety of

ethnic types having differences in their domestic arrangements and social practices. The major ethnic groups are Indo-Aryan (72%), Dravidian (25%), Mongloid and others (3%). While the dominant religion is Hinduism with a following of 80%, the other religious groups comprise of Islam 14%, Christianity 2.4%, Sikhism 2%, Buddhism 0.7%, Jainism 0.5% and others 0.4%. Though English enjoys an associate status, the most important language for national, political, and commercial communication is Hindi which is the primary language of 30% of the people. There are more than 24 languages each spoken by a million or more persons; numerous other languages and dialects, for the most part mutually unintelligible. India is a male dominated society in which the low status of women is reflected in discriminatory marriage and property laws. Marriage is almost universal with little or no social acceptance of never-married women.

1.5.1.1 Population and development indicators

India is one of the most populous places in the world, contributing around 20 percent of world births (IPPF, undated). According to Population Reference Bureau, the mid-2003 population is estimated to be 1,068.6 million with a natural increase rate of 1.7% and a population density of 842 persons per square Mile (Population Reference Bureau, 2003). The age structure of the population remains a near perfect pyramid, with 36% aged below 15 years and 4% over 65 years (Population Reference Bureau, 2003). The percentage of urban population is 28% in 2000 (UNPD, 2002). The GNP is estimated to be US \$ 380 per capita (IPPF, undated). The gross secondary school enrolment ratio⁵ as of 1995-97 is 59 for males and 39 females (UNESCAP, 2001). As per the United Nations Development Programme, Human Development Report 2000, the Human development Index as of 1998 is 0.563 (UNDP, 2000).

According to mid-2003 estimates, India has a total fertility rate⁶ of 3.1 per woman, a crude birth rate⁷ of 25 per 1000, a crude death rate⁸ of 8 per 1000 and a life expectancy in years at birth of 62 for males and 64 for females. The infant mortality

⁵ The gross secondary school enrolment ratio is the number of children enrolled in secondary-school level, regardless of age, divided by the population of the age group which officially corresponds to the secondary-school level.

⁶ Total fertility rate is the sum of the age-specific fertility rates in a given year

⁷ Crude birth rate is the number of births per 1,000 of a population in a year.

⁸ Crude death rate is the number of deaths per 1,000 of a population in a year.

rate⁹ is 67 per 1000 live births (PRB, 2003). For the period, 2000-2005, the age specific fertility rate has been estimated to be 44.77 for the 15- 19 year age group and 232.12 for the 20-24 age groups per 1000. Of women aged 15-49 years, 48% in India use a method of contraception and 43% using a modern method of contraception (UNPD, 2002).

85% of the population has access to health services and 81% has access to safe water. The doctor-population ratio is 1 per 2439. The literacy rate for men is 66% and for women, it is 38%. The rate of employment is 38%. 76% of the workforce comprises of men and the rest by women (IPPF, undated).

A comparison of the selected population and development indicators India and other South Asian Countries as well as some of the industrialised countries is given in Table 1.2 and Table 1.3 respectively.

Table 1.2. Comparison of selected population and development indicators India and other South Asian Countries – 2003

Indicators	India	Srilanka	Pakistan	Nepal	Maldives	Bangladesh	
Population (in millions) Mid 2003	1,068.6	19.3	149.1	25.2	0.3	146,7	
Rate of natural increase (%)	1.7	1.3	2.7	2.4	2.0	2.2	
Life Expectancy	male	62	70	60	59	71	59
	Female	64	74	60	58	72	59
Infant Mortality Rate /1000 live births	66	13	91	77	17	66	
Crude Birth Rate /1000	25	19	37	34	24	30	
Crude Death Rate / 1000	8	6	10	10	4	8.0	
Total Fertility Rate (per woman)	3.1	2.0	4.8	4.5	3.7	3.6	
Human Development Index (as of 1999)	0.571	0.735	0.498	0.480	0.739	0.470	

Data Source: 1. Population Reference Bureau, 2003; 2. UNDP, 2001

⁹ Infant mortality rate is the number of deaths to infants under 1 year of age per 1,000 live births in a given year.

Table 1.3. Comparison of population and development indicators of India and selected industrialised countries – mid 2003

Indicators		India	Germany	United Kingdom	U.S.A
Population (in millions) Mid 2003		1,068.6	82.6	59.2	291.5
Rate of Natural Increase (%)		1.7	0.1	0.1	0.6
Life Expectancy at Birth	Male	62	75	75	74
	Female	64	81	80	80
Infant Mortality Rate /1000 live births		66	4.3	5.4	6.9
Crude Birth Rate /1000		25	9	11	14
Crude Death Rate / 1000		8	10	10	9
Total Fertility Rate (per woman)		3.1	1.3	1.6	2.0
Human Development Index (as of 1999)		0.571	0.921	0.923	0.934

Data Source: 1. Population Reference Bureau, 2003; 2. UNDP, 2001

As given in Table 1.2, though India is doing much better than most of the other south Asian countries in terms of population and development indicators, there is the example of Srilanka, a smaller country with much more favourable indicators. Again, in comparison with some of the industrialised countries, India still has a long way to go in terms of social development as shown in Table 1.3.

1.5.1.2 Indian health care system

- **General health policy & organisational framework**

Health care is a state subject in India as per the constitution. The states are largely independent in matters related to the development of health infrastructure and the delivery of health care to the people. The central responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and co-ordinating the work of the state health ministries and controls certain health programmes of national importance (Park, 1997). The central government also acts as the intermediary between state governments and international- and bilateral agencies. It sponsors numerous health schemes, which are implemented by state governments. While goals and strategies for the public sector are established in a consultative process involving all levels of government through the Central Council of Health and Family Welfare, states are free to formulate their own health policy and health programmes (World Bank, 1993).

The public sector provides health services through a three-tier network of health facilities consisting of PHCs (1 for 30,000 population), CHCs (1 for 100,000

population), DHs (1 for about 2 million population) and teaching/tertiary hospitals. The private sector including traditional health care and those from NGOs also play a major role in the provision of health care in India unlike many other countries. 57% hospitals and 32% of hospital beds are in private sector. The health care services provided, include both outpatient and in-patient care. Outpatient care is provided through PHCs and their sub centres in the public sector and by general practitioners or specialists in the private sector. CHC and DH in the public sector along with private and NGO hospitals provide in-patient care involving overnight stays of the patient in a health facility.

The share of health and family welfare in the total state revenue budget has declined since 1990. Total government spending is only 2-3 US \$ per capita for health services. The private sector in India also takes care for primary health needs financed by out-of-pocket spending for which there is no control or regulation; this puts a heavy burden on the poor. Health insurance has low penetration and awareness levels in India with only about 5% of the population being insured under health schemes run exclusively by state owned enterprises and organised industry. Personal insurance including health, accident etc. covers about 12 percent of Indian general insurance premium. With the exception of employees in the organised sector, very few people have social security coverage. The social security component mainly comprises of provident funds, gratuities and pensions. Two major quasi-public insurance schemes, viz., Employees State Insurance (covering 28 million employees) and Central Government Health Scheme (covering 4 million Government employees), serve a fraction of the population. India's life insurance premium as a percentage of GDP is just 1.3% as against the world average of 7.8%. It is ranked 57th in insurance per capita spending (US \$6). It is expected that the liberalisation of the sector would widen the choice of insurance programmes, reduce the existing high premium charges and improve quality of services, thereby bringing more number of beneficiaries under health insurance (World Bank, 1993).

The Ministry of Health and Family Welfare, Government of India, evolved a National Health Policy in 1983 keeping in view the national commitment to attain the goal of 'Health for All' by the year 2000 by specifying quantitative targets for health and fertility gains and a timetable to the year 2000 for meeting them. The targets strongly

emphasised the reduction of preventable mortality and morbidity affecting mothers and young children and were closely identified with the primary health care approach. Significantly, the national health policy also recognised the need for government to "cooperate" with the private sector, although actual efforts in that direction have been limited (World Bank, 1993). In 2001, a new draft National Health Policy (NHP-2001) has been worked out in the context of the very marked changes since 1983 in the determinant factors relating to the health sector. The new policy will attempt to set out a new policy framework for the accelerated achievement of Public health goals in the socio-economic circumstances currently prevailing in the country (Ministry of Health and Family Welfare, 2001).

- **National reproductive health strategy**

The Indian government was one of the first to formulate a national family planning programme as early as 1951, which was later expanded to encompass maternal and child health, family welfare and nutrition. The government is committed to promoting the small family norm and legislates to support population control and development programmes.

Besides, promotion of maternal and child health has long been recognised as one of the most important objectives of the family welfare programmes in India. High rates of infant, child and maternal mortality prevailed in the country made it critical for the Government to take concrete steps to strengthen Maternal and Child Health Services as early as the First and Second Five Year Plans (1951 –56 and 1956-61). During the fifth five year plan (1974-79), maternal, child health and nutrition services were integrated as part of the Minimum Needs Programme. The prime objective of this approach was to provide basic public Health Services to vulnerable groups of pregnant women, lactating mothers and pre-school children (Kantitkar, 1979). In 1992-93, the Child Survival and Safe Motherhood Programme continued the process of integration by bringing together several key child survival interventions with safe motherhood and family planning activities in India (Ministry of Health and Family Welfare, 1992). Again in 1996, safe motherhood and child health services were incorporated in to the Reproductive and Child Health (RCH) Programme. The RCH programme seeks to integrate maternal health, child health and fertility regulation interventions with reproductive health programmes for both women and men. With

regard to maternal and reproductive health the important elements of the programme are antenatal care, encouragement of institutional deliveries or home deliveries assisted by trained health personnel, provision of post-natal care, including at least three post-natal visits, identification and management of reproductive tract and STIs. The provision of antenatal care includes three antenatal care visits, iron prophylaxis for pregnant and lactating mothers, two doses of tetanus toxoid vaccine, detection and treatment of anaemia in mothers and management and referral of high risk pregnancies (Ministry of Health and Family Welfare, 1997; 1998).

In the rural areas of India, maternal and child health services are delivered through government run Primary Health Centres and subcentres. The services can also be obtained from private and public maternity homes, hospitals or practitioners. A female paramedical worker, called Auxiliary Nurse Midwife (ANM) is posted at a subcentre specifically to provide basic maternal health, child health and family welfare services to women and children either in their homes or in the health clinic. The ANM and Lady Health Visitor (LHV) posted at the Primary Health Centre also assist the Medical Officer at the PHC where health services including antenatal and post natal care are provided (Ministry of Health and Family Welfare, 1997; 1998). In urban areas, Maternal and Child Health (MCH) services are available mainly through government or municipal hospitals, urban health posts, hospitals and nursing homes operated by nongovernmental voluntary organisations, and various private nursing homes or maternity homes.

The India Government's commitment to safe motherhood within the wider context of reproductive health was further reiterated with the adoption of the National Population Policy in 2000 (Ministry of Health and Family Welfare, 2000). Some of the socio-demographic goals set by the policy for 2010 like, 80% of all deliveries should take place in institutions, 100% of deliveries should be attended by trained personnel, and the maternal mortality ratio should be reduced to a level below 100 per 100, 000 live births specifically pertain to safe motherhood. Empowering women for improved health and nutrition is 1 of the 12 strategic themes identified in the policy to be pursued in stand alone or intersectoral programmes. The new National Population Policy has set as its immediate objective the task of addressing unmet need for contraception in order to achieve the medium term objective of bringing the total

fertility rate down to replacement level by the year 2010. One of the 14 national socio-demographic goals identified for this purpose is to achieve universal access to information/ counselling and services for fertility regulation and contraception with a wide range of choices (Ministry of Health and Family Welfare, 2000).

1.5.1.3 Adolescent and youth status in India

All over India the situation of adolescents varies widely by gender and religion, with adolescent girls and those from northern states at a particular disadvantage. Table (1.4) illustrates a brief overview of the situation of adolescents and youth in India. As the above mentioned profile clearly indicates, the 10-14 year age group comprises of 12 % of the population followed by 10.4 % by the 15-19 year group and 8.9 % in the 20-24 year age group. As regards the literacy rates, it is striking to note that more females are literate than males. However, more numbers of males have completed formal schooling compared to females. While 86.5% of the males in the age group of 20-24 years are in the work force, the corresponding percentage for females is 40.6 %, less than half compared to males. Age specific mortality rates are also higher among girls in all the age groups.

- **Gender differentials**

Strong gender differentials become evident from very early days of the birth of a girl with a difference even in the magnitude of celebrations, during naming ceremony between a male and a female child (Mutatkar and Apte,1999). As daughters in India are sent away in marriage and that she will spend most of her life in another household, parents do not see the benefits of the resources invested in them as children. Furthermore, for a marriage transition to take place, the girl's family of origin should organise the dowry (money given to the bridegroom in marriage) too. As the treatment of boys and girls differs with preferential access to nutrition, health care and education for boys, substantial differences can be observed in measures of health and sickness for boys and girls. The relative age-specific mortality rates for adolescent boys and girls between ages 10-14 and 15-19 indicate that girls' mortality is substantially higher than boys' in this period (Greene, 1997). Adolescent girls in the rural areas could be at greater risk of nutritional stress because of early marriage and early conception before completion of their physical growth (Venkaiah et al., 2002).

Table 1.4 Profile of young people in India

		Total	Male	Female
1. Young people's (%) share of the population (2000) (a)				
	10-14 years	12	12.2	11.7
	15-19 years	10.4	10.3	10.4
	20-24 years	8.9	8.4	9.5
2. Literacy rates % (a)				
	10-14 years	18.2	13	23.9
	15-19 years	23.1	14.7	31.8
	20-29 years	33	19.2	45.8
3. Educational attainment : % who have completed (a)				
Primary school (10-14 years)		37.8	40.3	35.1
Middle school (15-19 years)		26	30.3	21.5
Middle school (20-29 years)		14.3	18	10.8
4. Work force participation rates (19) (b)				
	10-14 years	NA	NA	NA
	15-19 years	42.7	54.7	30.7
	20-24 years	63.5	86.5	40.6
5. Age specific mortality rates (1994) (c)				
A. Rural				
	10-14 years	1.4	1.4	1.4
	15-19 years	1.9	1.7	2.2
	20-24 years	2.7	2.2	3.3
B. Urban				
	10-14 years	0.8	0.7	0.9
	15-19 years	1.3	1.1	1.5
	20-24 years	1.9	1.9	1.9

Data Sources:

- (a) International Institute of Population Sciences (IIPS) and ORC Macro, 2000.
(b) International Labour Organisation (ILO). Visaria (1998). Unemployment among youth in India.
(c) Foundation for Research in Health Systems (FRHS) 1997. Health Monitor 1997

- **Policies and programmes for young people**

Though young people in India represent a large segment of the population, they have so far remained largely invisible at the policy level with very little effort focussed on this group (Singh, 1999; Gupta, 2003). However there have been some recognition on the potential of youth and efforts thereby to harness this potential for social and economic development. In 1985, the International Year of Youth, an independent Department of Youth Affairs and Sports was established within the Ministry of Human Resource Development and parallel departments were set up at the state level. The National Youth Policy was formulated in 1986 and youth was defined to include those between 15-35 years. The policy viewed youth as a vital and vibrant natural resource that need to be nurtured for the development of the country (Government of

India, Department of Youth and Sports Affairs, 1985 quoted in Singh, 1999; UNFPA, 2000).

The preliminary National Population Policy drafted in 1993, clearly recognised the growing proportion of youth as a significant group in the context of population momentum and population control and noted for the first time the need for “vigorous population, family health and sex education modules as part of syllabi at various levels in order to crystallise the concept of responsible parenthood and safe sex” (Government of India, 1993).

The current national youth policy (2000) which redefined the age group as 13-30 years (earlier identified as 15-35 years) places the participation of youth as primary stakeholders. The thrust areas of empowerment, gender equity and an intersectoral approach points more towards a right approach. (Government of India, 1997; UNFPA, 2000).

As regards the various programmes targeting youth in the social development field, while there are a number of programs such as adventure sports and awareness camps, two major ones in the Department of Youth Affairs and Sports are the *National Service Scheme* and the *Nehru Yuvak Kendras Sangathan*. Launched nation-wide in 1969, the former targets university students with a focus on all-round self development through community service in five focal areas- national integration and social harmony, literacy, gender justice, village adoption and life style education. A number additional activities are held including awareness camps, sports competitions and issue based activities are held in order to expose the students and foster a health environment for their growth and development (Government of India, 1997; UNFPA, 2000). *Nehru Yuvak Kendras Sangathan* is a grass roots levels autonomous organisation catering to the needs of out-of school, rural youth between the ages of 15-35 years who are enrolled through village based youth clubs. The programmes undertaken mostly include vocational training, training for self-employment, work camps, youth leadership and awareness campaigns, cultural and social programmes, national integration efforts and health awareness camps (Government of India, 1997). As a powerful network for mobilisation, while both programmes have been successful in dealing with the employment and education aspects of youth at some level, there

continues to be a major gap in addressing the social roles of youth and issues related to their health and sexuality (Singh, 1999; UNFPA, 2000).

On issues related to health and empowerment, the South Asia Association of Regional Cooperation (SAARC) Decade of the Girl Child (1991-2000) paved way to some government efforts especially focused on girls. The schemes launched include the Adolescent Girl's Scheme within the existing Integrated Child Development Scheme (ICDS) initiated in 1991-92 (it focuses on the nutritional and health needs of mother and child). The Adolescent Girl's Scheme attempt to address the needs of out-of-school girls between the ages of 11-18 years through nutrition programmes, health awareness and education, and skill training (Government of India, 1996-1997). The impact of this scheme is yet to be assessed (Singh, 1999). The situation with respect to the sexual and reproductive health policies and programmes has been discussed earlier.

Education is a major area of importance for adolescents and youth. The National Education Policy (1986 modified in 1992) has reflected a commitment to the eradication of illiteracy, particularly in the age group of 15 – 35 years (UNFPA, 2000). Furthermore, the Indian constitution guarantees free education to all citizens up to the age of 14 years. However literacy levels continue to be low especially among girls (Singh, 1999). Labour force participation indicates disproportionately high and invisible work burden on girls who have to get in to domestic responsibilities as early as 5 years of age (Government of India, 1998; ICRW, 1997; Chaudhury, 1998; Jejeebhoy, 1996). The government is making many efforts to fulfil the terms of the Constitution in terms of primary education through formal and informal educational opportunities throughout the country. The Ministry of Social Justice and empowerment has schemes that focus on the education and empowerment of tribal girls. The Ministry of Rural Development and Employment under its Integrated Rural Development Programme (IRDP) has a sub-programme called Development of Women and Children in Rural areas which was initiated in 1982 involving programmes of health, literacy and credit activities. Training of youth and self employment is another programme which aims at providing basic technical and managerial skills to rural youth between the ages of 18 and 35 years from families living below poverty line. Two other programmes undertaken in collaboration with

the Swedish and the Dutch governments focusing on education and empowerment of women are *Lok Jumbish* and *Mahila Samakya* (Singh, 1999). Both the programmes are underway in some of the states.

The government owned media had also picked up issues related to the social problems facing youth. The government owned All India Radio (AIR) network aired two radio serials on youth by its 'Yuva Vani' or Youth Voice station. The first series, 'Jeevan Saurabh' (Fragrance of Life) broadcast in 1988 and the second 'Dehleez' (Threshold) aired in 1994 highlighted the emotional, social and psychological problems of youth and addressed the important need of providing accurate information in a confidential manner (Singh, 1999).

1.5.2 Gujarat state and its health care system

Situated in the North Western corner of India with an area of 196,024 square km, Gujarat state is famous for its remains of Harappan civilisation dating back to 2000 BC and the last of Asiatic lions (Annex 2 : Map of Gujarat).

As per the provisional results of 2001 Census, Gujarat state has a total population of 50.6 million and constitutes 4.93% of the country's total population. The population density is 258 persons per square km in 2001 compared to 324 for the whole of India. Gujarat has 23 districts each with average population of about 2 million. In terms of per capita income Gujarat ranks third from the top in India. In terms of growth of GDP, it is estimated that Gujarat's economy has grown at an average rate of 9.5% during the last one decade. The proportion of people living below poverty line is 39%. As of the year 2001, the literacy percentage is 70% where as the national average is 65.4% (Government of India, Office of the Registrar General and Census Commissioner, 2001). As one of the leading industrialised states in the country, though Gujarat is a relatively rich and urbanised with an above average literacy level, health indicators are relatively unfavourable in comparison many other leading states in India (Government of Gujarat, Social Infrastructure Development Board, 2000).

Table 1.5 Health indicators: Gujarat and India

Indicators		Year	Gujarat	India
Life Expectancy ¹	Male	1996-2000	61.5	62.4
	Female		62.8	63.4
Infant Mortality Rate /1000 live births ²		2000	62	68
Maternal Mortality Rate / 100,000 live births ³		1998	28	407
Crude Birth Rate ¹		1998	25.3	26.4
Total Fertility Rate ²		1998	3	3
Couple Protection Rate ¹		1997	57.4	45.4

Data sources

1. Government of Gujarat (2000) Vision 2010 : Social Sector
2. Planning Commission, Tenth Plan (2003-2007)
3. Government of India (2001), 'National Human Development Report', Planning Commission, New Delhi

Likewise other places in India, the public sector provides health services through a three – tier (primary, secondary and tertiary) network of health facilities comprising of 6 teaching hospitals (around 900 beds each) at the apex in major cities, 25 DHs (with a total bed capacity of 5,536 beds), 22 Cottage hospitals (with bed capacity of 2,050) 243 CHCs (about 30 beds each and serving 100,000 population each) and 984 PHCs and more than 7,274 sub-centres. 4-5 PHCs are situated in one CHC area. The private sector is also quite active in delivering health care, except in peripheral and remote areas, though no reliable data is available on the existing facilities. The traditional health systems including Ayurveda and homeopathy, is available all over Gujarat. NGOs working in the health sector including religious mission are also present in some districts and cities (Government of Gujarat, Department of Health and Family Welfare, 1999).

As of year 2001, the population per allopathic doctors for Gujarat is 1482¹⁰ Over the years, there has been substantial improvement in the availability of medical personnel, but their distribution is not uniform. However, the non-availability of adequate skilled personnel is still posing difficulties in reaching health care to the people, especially in the rural and hilly areas of Gujarat. 71.3% of the total doctors reside in urban areas where as only 35% of the people reside in urban areas (Government of Gujarat, Social Infrastructure Development Board 2000).

¹⁰ Source: Department of Health, Gandhinagar, Gujarat, India

The Integrated Child Development Scheme (ICDS) the largest nutritional and health programme in India operating under the Department of Women and Child Development of the Government of India at the national level is providing child care and health services such as vitamin A capsules, iodised salt, weaning food, folic acid and iron tablets (Government of Gujarat, Social Infrastructure Development Board, 2000).

The percentage spending on the health sector has increased in Gujarat as compared to the other states in India. However the share of the Plan Non Plan outlay on health in recent years has decreased as a percentage of the total budget. The maximum share of current plan outlay goes towards: (1) Basic Minimum Services Programme, which has a substantial share in construction of SCs, PHCs and CHCs with a share of capital expenditure of 34%, (2) Prevention of communicable diseases including T.B, Malaria, Leprosy, (3) Research and Education (Government of Gujarat, Social Infrastructure Development Board, 2000).

CHAPTER 2

Research literature on sexual and reproductive health of young people and programming

2.1 Review of terminology

2.1.1 Who are adolescents, youth & young people?

WHO/UNFPA/UNICEF defines the term 'adolescence' as those aged between 10-19 years, and 'youth' as those between 15-24 years. The term 'young people' has been used to cover both the age groups, i.e. from 10-24 years (WHO, UNFPA, UNICEF, 1989).

Though for convenience and comparability, it is easy to follow the numerical definitions, it can be said that there can not be any world-wide definition of the time span of adolescence and youth.

There can not be any world-wide definition of the time span of adolescence and youth. Rather, these are historically based, socially specific period of transition from childhood to adulthood, with distinct physiological, sexual and psychological characteristics.

Adolescence and youth being the time of physical, psychological and social maturing from childhood to adulthood, there seems to be biological, legal, socio-cultural demographic and behavioural markers, which render these concepts constantly dynamic (Dehne and Riedner, 2001). Thus with its specific age pattern and characteristics in each cultural context, adolescence and youth seem to be emerging concepts in some countries, while in some others it is well established (Dehne and Riedner, 2001).

Besides the numerical definition, the other approaches to define the terms can be the biological and psychological changes in the individual (Friedman, 1989). While the biological changes (development of secondary sex characteristics and a marked acceleration in size caused by a complex interplay of hormones) are more or less comparable in different societies, the maturation processes are influenced by social and economic development (Hofman, 1984). Even some of the most basic markers of physical maturation are being subjected to change over time given the evidence that age of entering puberty for boys (Senanyyake, 1990) and age of the onset of menarche for girls is decreasing in many parts of the world owing to better nutritional status

(Wysack and Frisch, 1982; UNFPA, 1996; Bongaarts and Cohen, 1998; WHO, 1995). It is also quite likely that a group of 14-year-olds may include boys and girls who still look like children as well as some whose bodies are those of adult men or women (Daniel, 1982). The psychological changes are analysed and described to some extent for industrialised countries. However, like biological development, emotional maturity and cognitive development vary greatly among young people of the same age. Although they are beginning to develop the ability to think abstractly and to plan for the future, most young adults reach sexual maturity before they attain emotional or social maturity or economic independence. Many decision-making models have tried to explain young adults' sexual activity and decision-making with little success in explaining definitively the influences on behaviour (Kirby, 1995; Langer and Warheit, 1992). Some of the studies concerning contraceptive behaviour describes the psychological characteristics of adolescence as inability to appreciate long-term consequences of current acts, inconsistency between moral values and behaviour and in consequence the tendency to take risk of an unwanted outcome of sexual behaviour (Hofman, 1984). But world wide relevance of this analysis is unproved and the circumstances of being accepted as a man or woman differ largely.

Legal markers have been used in many of the western European societies for the passage to adulthood, usually set at age 16, 18 or 21 years (Dehne and Riedner, 2001). However, cross cultural differences can be seen in a variety of laws or customs such as the minimum age of marriage, which is often different for men and women, implying differing views about the ages at which the sexes mature. Looking at from a social dimension, it can be seen for example that "A 15 year old might well be considered a 'youth' in one society, a 'mature adult' in another and a 'child' in yet another" (WHO, 1986). This might be relevant with respect to different ethnic groups in one country as has been shown for the Yoruba/ Ibo in the South and the Hausa/ Fulani in the North of Nigeria (Barker and Rich, 1990).

There is also a historic dimension which comes with the interaction of social and economic factors and the roles young people play within a society. This comes in with the development of the societies (WHO, 1986) while moving towards a global economy and society as a result of massive economic, institutional and social changes and in the process adolescence being shaped both by education and urbanisation

(Caldwell et al., 1998). While comparing the traditional, transitional or modern societies too, urbanisation or rural transformation seem to be playing an important role in defining the place of young people differently (UNAIDS, 1999). This could be even found within one society where traditional (mostly in the rural context), transitional (semi urban) and modern (urban) settings prevail at the same time. Thus the concepts of adolescence, youth and young people “*characterises a historically based, socially specific period of transition from childhood to adulthood, as well as a distinct physiological, sexual and psychological life stage*” (Dehne and Riedner, 2001).

2.1.2 Sexual and reproductive health - Concepts

According to Aitken and Reichenbach (1994), sexual and reproductive health as a concept encompasses a coherent set of specific health problems or diseases associated with the physical and social risks of human sexuality and reproduction. In addition to dealing with identifiable clusters of client groups, sexual and reproductive health is concerned with distinctive program goals and strategies (Aitken and Reichenbach, 1994).

Sexual and reproductive health implies a state of complete physical, mental and social well-being in matters related to sexuality and reproduction
--

Dixon-Mueller (1993), while examining the linkages between the sexuality - gender framework and reproductive health divides the elements of reproductive health into two separate categories of sexual health and reproductive health with specific components as given below:

Sexual health

- Protection from STIs
- Protection from harmful practices and violence
- Control over sexual access
- Sexual enjoyment
- Information on sexuality

Reproductive health

- Safe, effective protection from (and termination) of unwanted pregnancies
- Protection from harmful reproductive practices
- Contraceptive choice and satisfaction with method

- Contraceptive and reproductive information
- Safe pregnancy and delivery
- Treatment of infertility

It was at the International Conference on Population and Development (ICPD, 1994) that a paradigm shift in the global understanding of the concepts of sexual and reproductive health emerged. The ICPD defines reproductive health as 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”* Sexual health is *“the enhancement of life and personal relations, and sexual health services should not consist merely of counselling and care related to reproduction and sexually transmitted diseases”* (UN 1994, ICPD Programme of Action).

Subsequently, the Fourth World Conference on Women in Beijing (1995) reaffirmed that *“reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents”*.

Coming to adolescent or youth sexual and reproductive health, most of the scientific literature on health problems of adolescents and young people classify health states, problems and risks related to the reproductive career of an individual under reproductive health (Friedman and Edström, 1983) and those related to the whole

range of satisfying to traumatic sexual experiences seeing reproduction only as one possible consequence under sexual health (IPPF, 1991). The other dominant literature on sexual and reproductive health of adolescents and youth come from the major international agreements and declarations. The prominent of those who have emphasised these concepts are:

1. International Conference on Population and Development (ICPD) at Cairo in 1994
2. The United Nations International Strategy -- the World Programme of Action for Youth to the Year 2000 and beyond adopted in 1995.
3. Review of progress since the Cairo Conference (ICPD + 5) in 1999 culminating in a special session of the United Nations General Assembly.
4. The Beijing Declaration and Platform for Action adopted at the September 1995 Fourth World Conference on Women (FWCW)
5. Beijing + 5, a Special Session of the General Assembly entitled "Women: 2000: Gender Equality, Development and Peace for the twenty-first Century" that took place in June 2000 at UN Headquarters in New York.
6. The Convention on the Rights of the Child (CRC), which was drafted over the course of 10 years (1979-1989)
7. The United Nations Millennium Declaration unanimously adopted at the conclusion of the Millennium Summit

A detailed discussion on the language used by each of these agreements is beyond the scope of the review here; but some of the components repeatedly addressed by them include early and unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS; promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence; provision of appropriate services and counselling specifically suitable for the age group; welfare of the girl child, especially in regard to health, nutrition and education; elimination of the discrimination of pregnant adolescents and young mothers and support of their continued access to information, health care, nutrition, education and training; provision of comprehensive sexual and reproductive health care services and access to those services.

2.1.3 Sexual and reproductive health services - Components

Germain and Ordway (1989), define a reproductive health approach that enables women and men, including adolescents,

Services that enable women and men, of all ages, to regulate their own fertility safely and effectively

everywhere to regulate their own fertility safely and effectively by conceiving when they desire, terminating unwanted pregnancies and carrying wanted pregnancies to term; to remain free of disease, disability or death associated with reproduction or sexuality; and to bear and raise healthy children.

As put forward by WHO (1997), based on international declarations, sexual and reproductive health services within the primary health care context should seek to include the following components

- quality family planning counselling, information, education, communication and services;
- prenatal, safe delivery and post-natal care, including breast-feeding;
- prevention and treatment of infertility;
- prevention and management of complications of unsafe abortion;
- safe abortion services, where not against the law;
- prevention, diagnosis, and treatment, wherever possible, of reproductive tract infections, sexually transmitted diseases and other conditions of reproductive system;
- information, education and counselling on human sexuality, sexual and reproductive health, and responsible parenthood, including on effective prevention of sexually transmitted diseases and HIV;
- promotion, supply and distribution of high-quality condoms;
- active discouragement of harmful practices, such as female genital mutilation;
- information for women about the factors which increase the risks of developing cancers and infections of the reproductive tract;
- medical and mental health services for girls and women of all ages who have experienced any form of violence;
- referral for additional services related to family planning, pregnancy, delivery and abortion complications, infertility, reproductive tract infections, sexually transmitted disease and HIV/AIDS, and cancers of the reproductive system, including breast cancer.

2.2 Sexual and reproductive health of young people on the international research agenda

The grid methodology used by WHO (Friedman and Edström, 1983; WHO, 1997a) has classified the problems related to the sexual and reproductive health of the young using 10 stages in individual development (from sexual maturation to child bearing) and 6 areas of concern (psychological, social, medical, economic, educational, legal).

This grid (Table 2.1) has been accepted as a flexible tool for cross referring particular issues with the influences upon these issues (WHO, 1997a). Though not strictly followed, the events in this framework have been used with modifications in the present study to describe the problems and need for services arising in the context of the sexual and reproductive health of young people. The specific events addressed here in this review in terms of the existing evidence include marriage or consensual union, sexual behaviour, contraception, STIs, pregnancy and induced abortions.

Table 2.1: Grid for analysis of needs and problems of the young

Stages/ Events	Areas of concern						
	Physical	Psychological	Social	Medical	Educational	Economic	Legal
Sexual maturation							
Marriage/Consensual union							
Sexual behaviour							
Contraception							
Pregnancy							
Induced abortion							
Spontaneous abortion/ still birth							
Live child birth							
Adoption							
Child rearing							

2.2.1 Early marriage / consensual union

Marriage (or any type of consensual union) has long been used as a determinant of exposure to sexual relations, and the age at entry into first union has been viewed as the age of initiation into sexual intercourse (UN, 1989). Looking at the available literature, it can be seen that marriage as a condition for sexual debut is being increasingly neglected as a focus of study, the possible reason could be that it is getting more and more recognised as a passing phenomenon. This could be attributed to some of the developments over the past two three decades. Marriage, or first union formation, is

Though, marriage, or first union formation is increasingly getting late in many countries of the world, significant rates of marriage at a very young age seem to be existing in certain places and is more widespread than it looks to the outside world

increasingly getting late in many countries of the world, and increasingly informal in developed countries, which sets the stage for a decoupling of sexual initiation from the start of conjugal life through marriage or consensual union (Bozon, 2003). In addition, the rising prevalence of sexual relationships and child bearing outside of marriage means that the implications of age at first marriage or union are changing (Singh and Samara, 1996).

- **Prevalence**

Marriage or socially sanctioned union still marks the start of sexual debut for a substantial proportion of women in developing countries who get married as adolescents even though the traditional patterns of early marriage are giving way to later ages at first marriage (McCauley and Salter, 1995; Singh and Samara, 1996). While the timing of marriage is much diverse among countries and regions, significant rates of early marriage seem to be existing in many places around the world. Overall, 20-50% of women marry or enter a union by age 18, and 40-70% do so by their 20th birthday (Singh and Samara, 1996). Nevertheless, the situation varies greatly by country and region. The practice of marrying girls at a young age is noted to be most common in Sub-Saharan Africa and South Asia. However, in the Middle East, North Africa and other parts of Asia, marriage at or shortly after puberty is least common except among those living traditional lifestyles (Singh and Samara, 1996; UNICEF, 2001). There are also specific parts of West and East Africa and of South Asia where marriages much earlier than puberty are not unusual, while marriages of girls between the ages of 16 and 18 are common in parts of Latin America and in pockets of Eastern Europe (UNICEF, 2001).

The essential problem in assessing the prevalence of early marriages is that so many are unregistered and unofficial and are not therefore counted as part of any standard data collection system (UNICEF, 2001). Except for small scale studies, very little country data exist about marriages under the age of 14, even less about those below age 10 (UNICEF, 2001) though it has been well indicated that marriage at a very young age is more widespread than it looks to the outside world. For instance, a study from Java, Indonesia using data from the 1991 Demographic and Health Survey on 5816 ever married women, 15-49 years old showed that 70% of ever married woman had their first marriage before age 20 (Savitridina, 1997). While retrospectively

exploring the contributing factors of adolescent pregnancy in rural Nepal by comparing mothers who had their first pregnancy above or below 19 years using cluster sampling technique, Shrestha (2002) has found out that the adolescent mothers were married at mean age of 15.9 years. Using data from married women with an infant ≤ 12 completed months of age from six randomly selected primary health care units in Jeddah City, Shawky and Milaat (2001) have found that early marriage of girls before the age of 16 years accounted for 26.5% of the study population and was reported by a third of mothers currently below the age of 20 years. CEPED (1997) has presented the major results of a study of adolescent sexuality in five Sahel countries: Burkina Faso, Gambia, Mali, Niger, and Senegal where marriage age is among the lowest in the world. 51% of uneducated rural girls in Niger are married by age 15, as are 26% who are educated. But at age 20, 38% in Ouagadougou, 52% in Niamey, and 71% in Dakar are still single. Again, from Nigeria it has been reported that, though the national average of the age of marriage for girls is 17 years, in some of the northern states, it is just over 11 years (Centre for Gender and Social Policy Studies, 1998). Thus, the available data world-wide suggests that the prevalence of early marriage among adolescents is a current issue with its own patterns and determinants and is a definite concern for policy makers and service providers.

- **Determinants**

Researchers have examined the empirical linkages between early marriage and dimensions of socio-

A number of social, cultural and economic factors contribute to the perpetuation of early marriages

economic development. The most often cited predictors in this category seem to be women's educational attainment, urbanisation and women's labour force participation of which education remains the strongest predictor (Singh and Samara, 1996; Savitridina, 1997; UNICEF, 2001). Education and age at first marriage seem to be strongly associated both at the individual and at the societal level: a woman who has attended secondary school is considerably less likely to marry during adolescence, and in countries with a higher proportion of women with a secondary education, the proportion of women who marry as adolescents is lower. It has also been pointed out in general that, gender equality in education is associated with a lower prevalence of

early marriage among women (Singh and Samara, 1996). Again, Shawky and Milaat (2001) have noted that illiterate women constituted one category who reported the highest proportion of marriages before their sixteenth birthday in Jeddah city. Though studies have not yielded any statically significant association between early marriage and women's labour force participation or current working status and the pattern of working status (Singh and Samara, 1996; Savitridina, 1997), women who married late were found to be more mobile and were more likely to have a higher occupational status (Savitridina, 1997). Though urban women are less likely than rural women to marry during their teens in most of the countries (Singh and Samara, 1996; Savitridina, 1997), changes in urbanisation and changes in the prevalence of early marriage reveal no statistically significant relationship suggesting that many other factors determine levels of early marriage (Singh and Samara, 1996).

The most often cited socio economic predictors of early marriage seem to be women's educational attainment, urbanisation and women's labour force participation of which education remains the strongest predictor. Poverty is another factor cited responsible for early marriages.

Poverty is another factor cited responsible for early marriages. This could be true in the case of some of the traditional societies like in Sub-Saharan Africa where the brides family may receive cattle from the groom as bride price for their daughter or young girls being married off to much older rich men like some poor villages in Egypt or in Bangladesh where poverty stricken parents are persuaded to send their daughters abroad in promises of marriage or in false marriages (UNICEF, 2001). As pointed out by Mikhail (2002), it may happen that a girl find herself trapped within a marriage because she sees no other means of survival. Where young women's access to resources – be they cattle, money or jobs – is restricted, they are likely to have few alternatives to marriage and child bearing if they can not support themselves. Studies have clearly indicated that in a situation of economic privation and dearth of social opportunities, early marriage and child bearing may appear to be a means of obtaining necessary resources or as markers of social or personal achievement (Geronimus, 1992; Zabin, 1994).

Authoritarian exercise of power by parents and other family members could also end up

Authoritarian exercise of power by parents and other family members could also act as very strong influential factor in early marriage

getting girls married off at a very early age. This has been found to be the case of adolescent mothers in Nepal who were married off at a mean age of 15.9 years for whom parents or elders, with/without the girl's consent, decided the majority of adolescent marriages (Shrestha, 2002). Sharma et al. (2002) have noted that marriages at young age and pregnancy during teens in Nepal are associated with less social acceptance and poor support in the family. Again in another study from Nepal using participatory exercises like mobility mapping, focus group discussions, lifelines, body mapping, and reproductive health problem trees along with personal interviews with multiple groups, including married and unmarried male and female adolescents, adult community members and service providers in a rural and urban community, it was shown that adolescent girls have dreams and aspirations for a better future and that adults acknowledge and support these ideals. However, social norms and institutions are restrictive, especially for girls, who are often unable to realise their hopes for continuing education, finding better paid work or delaying marriage and childbearing, and this directly impacts reproductive outcomes (Mathur et al., 2001). Thus, though it is rather impossible to point out one single factor responsible for the phenomenon of early marriages, there seems to be a number of social, cultural and economic factors contributing to its perpetuation.

- **Consequences**

A holistic approach in determining the consequences of early marriage would mean examining every implication of the practice, from its limitation upon personal freedom to its impact upon

Key concerns in early marriage are the denial of childhood and adolescence, the curtailment of personal freedom and the lack of opportunity to develop a full sense of selfhood as well as the denial of psychosocial and emotional well being, reproductive and educational opportunity
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health and education. As the UNICEF (2001) comprehensive report on early marriage shows, the three key concerns are the denial of childhood and adolescence, the curtailment of personal freedom and the lack of opportunity to develop a full sense of selfhood as well as the denial of psychosocial and emotional well being, reproductive and educational opportunity. Though research data are sparse on the psychosocial and emotional consequences, some of the factors like loss of adolescence, forced sexual relations and the denial of freedom and personal development attendant have been pointed out by studies. Divorce as a explicit result of early marriage and large differences in ages of spouses has been pointed out from

India (Singh, 1996). The same study showed that as age at marriage increased and passed the average age of menarche, the level of divorce decreased. Associated factors which explained the variability in the incidence of divorce were differences in age of spouse, educational achievements of women and the husband and their caste (Singh, 1996). Girls who marry before 15 years of age are indicated to be more likely to have higher rates of infant mortality, and to be most vulnerable to sexual violence. In many cases, intercourse is initiated before the girl begins to menstruate. Although adult women also face sexual violence within marriage, this problem is all the more traumatic for girls who lack any information about sexuality (Ouattara et al., 1998).

The most explicit physical hazard arising from too early marriage is in terms of too early pregnancy and child bearing which is reviewed in detail in the later sections.

2.2.2 Premarital sexual relations

While on one side sexual relations strictly take place within consensual unions, this no longer seems to be the case with many societies across the world as young people get in to pre-marital sexual relationships. Interests in adolescent sexual behaviour have been increasing in the past decades possibly in response to the advent of the AIDS epidemic. In addition, premarital sexual activity carries the same risks of early pregnancy, with the additional social and economic consequences inherent in non-marital fertility. Of particular concern here is the risky sexual behaviour among young people. Though it is extremely difficult to measure the sexual behaviour of unmarried youth, as it is highly sensitive, in a number of surveys, premarital behaviour is indirectly constructed from questions about the age at first marriage and age at first intercourse (UN, 1989; Djamba, 1995).

Evidence suggesting that young people are sexually active outside the context of marriage or socially sanctioned unions

- **Extent and regional variations**

There is ample survey data and qualitative evidence suggesting that young people are sexually active outside marriage. While analysing World Fertility Survey data from 28 countries, Hobcraft (1985) found that in nearly one third of all countries at least one tenth of recently married women have experienced a first birth before their first union. Again, based on data from five comparable surveys carried out in Brazil, Costa

Rica, Guatemala, Mexico city and Panama, Morris (1987) found out a significant proportion of women aged 15-24 years had had premarital conceptions and that in many cases marital unions had probably been precipitated by a premarital pregnancy.

However, there seems to be considerable variation in the levels of pre-marital sexual activity among countries and regions.

Considerable variations in the levels of premarital sexual activity among countries and regions

Region wise, while considerably higher proportions of single teenagers are sexually experienced in Africa, the countries in Latin America, the Caribbean, and Asia had lower proportions sexually experienced (mainly fewer than 25%) (UN, 1989). In Sub-Saharan Africa, Demographic and Health Survey (DHS) have shown that more than half of teen age women (both married and unmarried) aged 15-19 have had sexual relations at least once; more than half the young women with sexual experience are unmarried (Population Reference Bureau, 1992). World Fertility Survey (WFS) data suggest that unmarried adolescents in Sub-Saharan Africa are about as sexually active as youth in Europe and North America (Ajayi, 1991; Population Reference Bureau 1992; WHO, 1989 b). From North America, it has been estimated that by the end of high school, nearly two thirds of the youth are sexually active, and one in five has had four or more sexual partners (Starkman and Rajani, 2002).

A number of studies from Africa have assessed the extent of premarital sex across different regions. Though the design and methodologies employed in the studies are different, they reflect widespread pre-marital sex among different populations of young people. For instance, in Kenya, while data from a study among primary school children indicate 48% of boys and 17%

of girls as being sexually active (Kiragu, 1992), another study of 2,059 secondary

Widespread pre-marital sex among different populations of young people in the African region

students show that 69% of the males and 27% of the females were sexually experienced (Kiragu and Zabin, 1995). Again in the Eastern African region, studies from Tanzania have also noted relatively high percentages of young people as sexually active. In a questionnaire survey carried out among 1041 students in secondary schools and colleges in Dar-es-Salaam, self-reportedly, 54% of students (75% of the boys and 40% of the girls) were found to be sexually active (Maswanya et al., 1999). Another cross-sectional questionnaire survey conducted in four

communities of Mwanza Region in Tanzania among 892 randomly selected primary and secondary school pupils, aged 12 and above, eighty per cent of primary school boys and 68% of primary school girls were already sexually active; the corresponding figures were 89% for secondary school boys and 48% for secondary school girls (Matasha et al., 1998).

In Western Africa, from Nigeria, while Aziken et al. (2003) has made the estimates that 43% of the 880 randomly selected sample of female undergraduate students at the University of Benin, as sexually active, Amazigo et al., (1997) has found out 40% as having had intercourse among the 2,460 secondary school students from the two south-eastern Nigerian states. More or less the same estimates have been presented by some other studies as well from different parts of Nigeria. Again, in another survey on aspects of sexual activity and contraceptive use among seven hundred and sixty-eight randomly selected single senior secondary school girls from Port Harcourt (mean age 16.32 years), 190 girls (24.7%) were found to be sexually active at the time of the survey (Okpani and Okpani, 2000). While studying the sexual activity among 534 Nigerian female secondary school students using self-administered questionnaire, Anochie and Ikpeme (2001) has found out the prevalence of sexual intercourse as 25.7%, with no significant difference between the junior (48.2%) and senior (51.8%) students. The same study also noted that the frequency of sexual exposure was high, with 34.3% of the students having intercourse more than once a week. The other West African countries like Niger, Liberia and Guinea have also reported high levels of premarital sexual activity (Odimegwu et al., 2002; Parr, 1996; Kamtchouing et al., 1997). In a study conducted in Bida Local Government Area of the Niger State, the data gathered through structured interview with 400 adolescents aged 12-24 years using a three-stage random sampling procedure showed that more than one third of the adolescents interviewed had sexual intercourse in the month preceding the survey (Odimegwu et al., 2002). Remarkably high fertility levels among women who have never married or lived with a man has again been indicated in the 1986 Liberia Demographic and Health Survey data reflecting widespread pre-marital sex (Parr, 1996). Among the students of randomly selected secondary schools of the city of Yaounde, Guinea in the age group of 12 to 19 years, 52% were sexually active. The

average number of sexual intercourse was 5 times during the month before the survey (Kamtchouing et al. 1997).

The estimates presented from the Southern African region also do not differ significantly from the above mentioned picture (Buga et al., 1996; Manzini, 2001; Pillai and Yates, 1993). In a cross-sectional descriptive study using self administered questionnaires the Transkei region of the Eastern Cap in South Africa, among 1,072 girls and 903 boys from standard 5, 6 and 7 pupils of both sexes (mean ages of the girls and boys, 15.29 and 16.25 years, respectively) from twenty-six schools in 22 rural districts, overall, 76% of the girls and 90.1% of the boys were found to be sexually experienced (Buga et al., 1996). From KwaZulu Natal, a 1999 survey in a sample of 796 adolescent girls, has found that almost half have had first sexual intercourse already (Manzini, 2001). In the urban provinces of Lusaka-Central and Copperbelt, Zambia, among the 516 female high school students aged 13-20 years, 71% had boyfriends of which 67% had a steady or close relationship with 48% being considered to be at high risk of sexual intercourse. Sexual activity in the 2-month period preceding the survey was reported as "rarely or more often" for 27.3% (Pillai and Yates, 1993).

From Central Africa, in a survey conducted among 474 (213 female and 261 male) students (mean age 21 years) in three secondary schools in rural Rwanda, 44% reported sexual experience (Rahlenbeck and Uhagaze, 2004). Again from Kinshasa, Zaire, Djamba, (1995) while analysing retrospective data from a random sample of 515 married women and 507 married men has found that 52% of currently married women had premarital intercourse.

The existing data on young people's sexual activity in Asia is relatively few with the available data showing a great amount of variation across different

Though existing data on young people's sexual activity in Asia is relatively few, there is enough evidence suggesting that young people are getting sexually active outside marriage

countries of the region. In many South Asian countries girls still marry young (UN, 1989) and cultural values strictly prohibit premarital sexual activity (WHO, 1987). Although more pronounced in some countries and less so in others, there is also evidence suggesting that the median age at marriage is rising with education playing a

crucial role in delayed marriage. In India for example, as many as 70% of all adolescent females aged 15-19 were currently married in 1961 where as this proportion fell to 44% and by 1992-1993 to 39% (Pathak and Ram, 1993). This along with a number of other factors have resulted in young people getting into premarital sexual relations. The Indian situation is discussed more in detail in the coming sections. In the neighbouring Nepal too, it has been reported that unmarried adolescents are sexually active. The Makwanpur study (CREHPA, 1996a) showed that in villages, one in 10 unmarried adolescent boys of age between 15-19 years are sexually active. In another study from Nepal conducted by CREPHA (1996 b) among men in five border towns, it was shown that 41% of unmarried adolescents aged 18-19 were sexually active. Again from Nepal, Suvedi et al., (1992) in a survey of sexual behaviour patterns, found out that 67.3% of women and 39.7% of men reported sexual intercourse before the age of 20 reflecting the early age of marriage, while 23.2% of the men and 14.9% of the women reported premarital sex and 20.5% of men and 11.7% of women reported extra marital sex. These findings were corroborated in a survey (NCAC / UoH STD/ HIV Project, 1996). Nearly 11% of the 500 police men interviewed and 8.8% of the 250 male campus students reported as having had sex with two to five persons in the preceding four months. A survey from Bangkok using self-administered questionnaires among 377 randomly selected adolescents aged 12-22 years in a slum community, 18.8% of the adolescents were sexually experienced (Somrongthong et al., 2003). Such findings contradict the prevailing impression in many settings that sexual activity occurs in the context of marriage. However, there have also been studies indicating sexual abstinence by the majority, for instance, in the Philippines, it has been shown that majority of members of a convenience sample of 1,355 urban university students in metropolitan Manila, were sexually abstinent (83%). It was also indicated that approximately 90% of all students held nonaccepting attitudes toward premarital and recreational sex (Lacson et al., 1997).

- **Age at sexual debut**

Among young people, though varying ages of initiation of sexual debut have been reported from different regions, overall many

Overall many young people are sexually active by age 18 or earlier. Statistically significant positive relationship between age and likelihood of intercourse. The proportion of sexually experienced increases significantly with age

young people are sexually active by age 18 or earlier as shown below. For instance,

among single senior secondary school girls (mean age 16.32 years) in Port Harcourt, Nigeria, the mean, modal and youngest ages of initiation into sexual activity were found to be 15.04, 15 and 12 years respectively (Okpani and Okpani, 2000). Again, from Nigeria Anochie and Ikpeme (2001) have reported initiation of sexual intercourse before 11 years by 12.4% of the female secondary school students. From the other West African city of Yaounde, Kamtchouing et al., (1997) have found out the age of first sexual intercourse of more than half (56%) the sexually experienced secondary school students in the age group of 12 to 19 years as between 15 and 17 years. In Central Africa, from Kinshasa, Zaire, using retrospective data from a random sample of 515 married women and 507 married men, Djamba (1995) has shown that 51% of all women had intercourse before the age of 18 years. 75% of women with premarital sexual activity had intercourse before the age of 18 years with the median age of 17.4 years (Djamba, 1995). Among adolescent girls in KwaZulu Natal, South Africa, in a sample of 796 girls, it was found that almost half had already had first sexual intercourse at a mean age of 16 (Manzini, 2001).

More or less the same pattern was reported in some of the studies from the European region as well. De-Seta et al. (2000) has found out the age of sexual intercourse as below 15 in 44.4% of adolescents in an epidemiological study conducted among symptomatic patients attending an outpatient STD Clinic over a four year period in Italy. In Serbia, among 300 sexually active adolescent females aged 19 years, the first sexual intercourse was at 16.9 years on average (Sedlecki et al., 2001).

In Asia, the mean age of first sexual contact was found to be 17.9 years, among the sexually active unmarried men in Nepal with a large majority (77%) having their first sexual contact while they were 19 years or below (CREPHA 1996b). Again, in a non random study from Nepal of female prostitutes practising in Kathmandu valley, Bhatta et al., (1993) found the average age of the women as 21 years with the majority between 15-24 years of age. The average age of entering the sex trade was 18 years. Another non random study (NCASC, 1996) of 56 female sex workers has also found the average age of the women as 24 years ranging from 14 to 41 and the average age of entering the sex trade as 20 years. From Bangkok, the average age of first intercourse has been reported as 15 years (Somrongthong et al., 2003).

Though age at first sexual intercourse varies among countries and regions (McCauley and Salter, 1995), researchers have found statistically significant relationship between age and likelihood of intercourse (UN, 1989; Pillai and Yates, 1993; Amazigo et al., 1997). A typical instance is a 1997 study conducted in two south-eastern Nigerian states in which among 2,460 secondary school students surveyed, of the students who gave information about their sexual activity, the proportion who were sexually experienced climbed from 26% of 14-year-olds to 54-55% of 18-19-year-olds (Amazigo et al., 1997). Besides, analysis of the data from Young Adult Reproductive Behaviour Surveys (YARBS), Demographic and Health Surveys (DHS), World Fertility Surveys (WFS) and other small surveys canvassing special populations, has shown that the proportion of single adolescents who are sexually experienced increases steeply with age in Africa (and in Jamaica in the Caribbean) and increases more gradually in the other countries of Latin America and the Caribbean (UN, 1989). Another attempt has been to positively correlate the age of initiation of sexual activity with the age of first dating and the age of menarche and semenarche (Buga et al., 1996).

- **Gender differentials**

Generally, young men seem to initiate sexual activity at an earlier age than young women. Furthermore, it has also been noted that in many countries, sexual intercourse during the teenage years occurs

Young men seem to initiate sexual activity at an earlier age than young women. Males seem to be more likely than females to have ever had sexual intercourse and boys tend to have sexual intercourse more regularly and more frequently, and had more lifetime sexual partners than the girls did

predominantly outside marriage among men but largely within marriage among women (Singh et al., 2000). The possible reason could be that premarital sex is accepted for males, whereas women are expected to postpone the initiation of intercourse until they marry (McCauley and Salter, 1995; Buga et al., 1996). The gender differences in the sexual behaviour of young men and women have been revealed by a number of studies from different regions. In a survey conducted among 3,603 unmarried men and women aged 15-24 in three towns in Guinea, Gorgen et al., (1998) has found that the average age at first intercourse is 16.3 years for young women and 15.6 for young men. In another survey conducted among 474 (213 female

and 261 male) students (mean age 21 years) in three secondary schools in rural Rwanda, reported age at first encounter was lower in boys (16.8 years) than in girls (18.3 years) (Rahlenbeck and Uhagaze, 2004). In the rural areas of the Transkei region of the Eastern Cap, among the sexually active school students, boys had sexual intercourse more regularly and more frequently, and had more lifetime sexual partners than the girls did (Buga et al., 1996).

Young adult Reproductive health surveys (YARHS) from Latin America reports the average age of sexual debut for boys as ranging from 13-16 years and from 16-18 years for girls (Morris, 1994). By age 19, more than 90% of all Latin males have reportedly had intercourse, as against 45-60% of females (Singh and Wulf, 1990). In Thailand and the Philippines, the average age for sexual activity for males ranged from 16-17 and from 17-18 for females. In the Philippines, among members of a convenience sample of 1,355 urban university students in metropolitan Manila, males were found to be more likely than females to have ever had sexual intercourse (30% vs. 7%), and they were better informed about condoms and about contraception in general (Lacson et al., 1997).

- **Sexual partnership**

Given its association with risk behaviours, the nature of sexual partnership assumes great significance in the context of premarital sexual relationships. Of particular importance here is relations with multiple partners. Many of the study findings have suggested that sexually active young people engage in sexual relations with

Sexually active young people tend to engage in sexual relations with more than one partner

more than one partner. For instance, in Guinea, Gorgen et al., (1998) have found out that in premarital sexual relationships while the first sexual partner typically is a peer, the majority of young women later become involved with older, wealthy partners, whom they view as more attractive spouses than young men or as more likely to provide support if they become pregnant. Young males, who feel they cannot compete with older, wealthy men, have sex with much younger females (Gorgen et al., 1998). In a questionnaire survey carried out among 1041 students in secondary schools and colleges in Dar-es-Salaam, Tanzania, self-reportedly, 39% had a regular sexual partner and 13% had multiple partners in the previous year (Maswanya et al., 1999). Exposure to multiple sexual partners in Nigeria has been reported by Okpani and

Okpani (2000) among senior secondary school girls from Port Harcourt. While evaluating the behaviour pattern of the adolescent population attending Outpatient STD Clinic over a four year period in Italy, it has been found that 61.1% of the adolescent population (13-19 years-old) had more than one sexual partner and 20.4% had changed partners in the last 6 months (De-Seta et al., 2000). In Serbia, among sexually active adolescent females, two-thirds (63.7%) have reported more than one partner, 21.7% more than three and 10.2% more than five sexual partners. Almost half of girls (40.7%) experienced sexual intercourse in casual acquaintance, and 10.3% with a 10 or more years older partner (Sedlecki et al., 2001). From Nepal, the Makwanpur study reported multiple sex partners by more than half (54%) among the sexually active adolescent boys (CREHPA, 1996a). Again, from Nepal, it has been pointed out that one in five men of age 18-19 have had a non regular sex partner in the last 12 months preceding the study (CREPHA, 1996b).

The sex partners reported in various studies are varied ranging from commercial sex workers to teachers and relatives. While in Nepal, the first sex partner for one in ten adolescent boys was a commercial sex worker (CREHPA, 1996a), or adolescents: either younger (42%) or the same age (35%) (CREPHA, 1996b), in the Mwanza

The reported sex partners are varied ranging from commercial sex workers, peers, older men to teachers and relatives. The reported sexual acts are also varied.

Region in Tanzania, almost half of primary school girls have had sex with adults, including teachers and relatives (Matasha et al., 1998). Among 2,460 secondary school students surveyed in two south-eastern Nigerian states, of the students who gave information about their sexual activity only 36% of the young women had had sexual partners who were roughly their age, 25% had been involved with older businessmen; the young women said they have intercourse more frequently and are less likely to restrict intercourse to the safe period of their cycle when they are involved with older partners than when they have boyfriends of their own age (Amazigo et al., 1997). Somrongthong et al., (2003) has reported 63.1% of the adolescents in Bangkok having unprotected sexual intercourse with lovers or friends. Premarital sexual behaviour with a man does not seem to be a precursor to marriage with the same man. Djamba (1995) while analysing retrospective data from a random

sample of 515 married women and 507 married men from Kinshasa, Zaire, has found that first premarital partners were an average of 4 years younger in age than first marriage partners. 49% of all women and 92% of women with premarital experience had first intercourse with males other than their husbands (Djamba, 1995).

The reported sexual acts are also varied. In Tanzania, Matasha et al., (1998) has found vaginal sex as the most common first sexual act reported by secondary school pupils. In the same study, 40% of primary school pupils reported orogenital sex and 9% of primary school pupils reported anal sex as their first sexual act (Matasha et al., 1998). In a recent review on adolescent sexual behaviour, Feldmann and Middleman (2002) has noted that attention must also be directed at non-coital activities such as masturbation, mutual masturbation and oral sex, as the riskier of these behaviours appear to be increasing

- **Correlates of premarital sexual activity**

Kirby (2002) has identified the most important (statistically significant) antecedents associated with adolescent initiation of sex, contraceptive use, and pregnancy by identifying and summarising more than 250 American studies. The results indicated that more than 100 antecedents create a complex and detailed picture of the correlates of adolescent sexual behaviours. They describe characteristics of the adolescents themselves, their partners, peers, families, schools, and communities, as well as relationships to these entities. The

Wide range of attributes describing characteristics of the adolescents themselves, their parents, partners, peers, families, schools, and communities have been correlated with adolescent sexual activity
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correlates included antecedents that were inherently sexual and nonsexual (Kirby, 2002). Again in the United States, poverty, race, ethnicity, religiosity, age at puberty, peer relations, school performance, involvement in other risk-taking behaviours and family composition and relationships have all been identified as determinants of adolescent sexual behaviour among youth (Santelli and Beilenson, 1992). Using longitudinal data from the National Survey of Children, Baumer and South (2001) could find significant positive effects of a multi-item index of community socio-economic disadvantage on all but the timing of first premarital intercourse, net of controls for the socio-economic and demographic status of adolescents and their families. None of the most commonly cited explanations for neighbourhood effects on

adolescent behaviour can fully explain these associations. Only the attitudes and behaviours of peers account for even a small portion of the observed impact of community disadvantage on youth sexual behaviour. Adolescents' acceptance of premarital childbearing, educational aspirations and attachment to school, and parental supervision, although frequently associated with youth sexual behaviour, do little to mediate the impact of community disadvantage on sexual activity.

The influence of changing social context in shaping the sexual behaviour of young people has also been indicated in India as well as abroad (Speizer et al., 2001; Gardner and Blackburn, 1996; Mutatkar and Apte, 1999; Abraham and Kumar, 1999). As communities undergo rapid social transformation and as a result of the juxtaposition of traditional and modern values, adolescents often find themselves faced with conflicting definitions of their rights and responsibilities and of their sex roles and gender expectations (Gage, 1998).

The effect of familial attributes on adolescent sexuality has been indicated by studies from different regions. While investigating factors associated with the sexual experiences of 523 underprivileged Mexican adolescents, Huerta-franco and Malacara (1996) have found positive affective responsiveness in the family as one of the major factors affecting adolescent sexual activity and number of sexual partners. The same study also pointed out the association of family problem solving and roles with sexual activity (Huerta-franco and Malacara, 1996). Slap et al. (2003) has determined whether family structure (polygamous or monogamous) is associated with sexual activity among school students in Nigeria using a cross sectional school survey with a two stage, clustered sampling design. The participants included 4218 students aged 12-21 years attending 39 schools in Plateau state, Nigeria and responses from 2705 students were included in the analysis. The results indicated that sexual activity was more common among students from polygamous families (42% of students) than monogamous families (28%). This effect is partly explained by a higher likelihood of marriage during adolescence and forced sex (Slap et al., 2003). The negative effect of family instability on adolescent sexuality has been indicated by Odimegwu et al. (2002) in their study conducted in Bida Local Government Area of Niger State,

Nigeria, among 400 adolescents aged 12-24 years using a three-stage random sampling procedure through structured interview.

In addition to familial aspects, parental attributes have also been examined as a possible correlate of adolescent sexual activity. In the above mentioned study from Nigeria, Odimegwu et al. (2002) has found out that adolescents with whom parents had discussed family life issues were less likely to be sexually active than those with whom parents had never discussed family life issues. Again it has been reported that adolescents who reported a greater number of topics discussed with their mothers were more likely not to have initiated sexual intercourse and to have conservative values, whereas adolescents who reported a greater number of topics discussed with their friends were more likely to report the initiation of intercourse and more "liberal" sexual values (Dilorio et al., 2002). If an adolescent talks more with the mother about sexual issues than with friends, he/she is less likely to initiate sexual intercourse and more likely to have conservative values (Dilorio et al., 2002). Slap et al. (2003) has pointed out lower sense of connectedness with parents, having a dead parent, family polygamy and lower educational level of parents as variables independently associated sexual activity. Parental education in terms of father's attainment of at least a secondary education has been indicated as a potential predictor of premarital sexual activity from Kinshasa, Zaire. Women with high rates of premarital activity were found to be women with highly educated parents (Djamba, 1995).

Attributes like church attendance, attitude towards premarital sex etc. have also been examined as correlates of adolescent sexual activity. In the Philippines, among urban university students in metropolitan Manila, it has been shown that sexually abstinent students were more likely than sexually active students to attend church regularly (76% vs. 64%) and to feel that premarital sex was unacceptable (92% vs. 67%). Males who disapproved of premarital sex were nearly three times as likely, and females who did so were nearly seven times as likely, to abstain from sex as were their peers who held more accepting views. Young women who did not have a sister who had experienced an adolescent pregnancy were nearly six times more likely than those with such a sibling to abstain from intercourse (Lacson et al., 1997).

Peer influence is an often cited predictor of early sexual activity. There is evidence that young people are affected by the sexual attitudes and behaviours of their friends (Rowe, et al., 1989). Though scant research exist on the impact of sexualised media on young viewers whether on television, in movies, video games or internet or through music lyrics, adolescent service providers and public health professionals are increasingly become aware of the potential impact of media messages and images among young people (Hogan, 2000). Though there is hardly any scientific evidence to indicate the availability of contraceptives and other corrective measures like abortion as a possible factor explaining promiscuity, prevalent views that provision of reproductive health services like contraceptives and abortion to young people might increase promiscuity is far from new (Furstenberg, 1998).

Some of the independent variables associated with sexual activity as commonly reported in studies include male sex, older age, lower sense of connectedness with school (Slap et al., 2003); age, education, ethnic group or culture (Djamba, 1995); age, knowledge about sexually transmitted diseases and attitudes toward sexuality (Huerta-franco and Malacara, 1996). Among ethnic minority groups, unprotected sex was found to be associated with behavioural intentions to use condoms, pregnancy, having a steady partner, more frequent church service attendance, and ever having anal sex. (Koniak-Griffin et al 2003). In Bangkok, Somrongthong et al. (2003) has shown that gender and age range were found to be the factors that significantly related to the adolescents' opinions that premarital sexual activity was acceptable and having sexual intercourse with a lover was safe (Somrongthong et al., 2003).

A connection between sexual onset or age at first birth and menarche has been demonstrated in the west and cross-culturally (Zabin et al., 1986a). The age of menarche is declining over the years (Wysack and Frisch, 1982) the dominant reason being attributed to better nutritional status (Bongaarts, 1980; Gray, R. 1983). This coupled with a increase in the age of marriage as is happening in some of the more advanced developing countries, could lead to a higher prevalence of pre marital sexual activit (Senderowitz and Paxman, 1985).

- **Sexual decision making**

Statistics present only one part of the picture: they can not explain how young people in developing countries make decisions about sexual behaviour. Unfortunately, comprehensive studies on this aspect seems to be rarely undertaken (Gage, 1998). In the case of sexual activity, decisions to engage in sex are not driven solely by fear of negative consequences and in many instances, adolescents in developing countries may have positive motivations for these behaviours as indicated below. Focus group discussions conducted among young people aged 15-20 attending secondary schools in Benin City, Nigeria have brought out that though physical attraction is the main reason for romantic relationships (which might include sex), the desire for material or financial gain is the primary motivation for sexual relationships (Temin et al., 1999). In Dar es Salaam, Tanzania, although most of the girls were in love with and enjoyed sex with their partners, they also entered these relationships to obtain money or gifts in exchange for sex (Rasch et al., 2000). Financial gains as a motive for the girls' sexual activity has again been suggested among the sexually active single senior secondary school girls from Port Harcourt with older working men as their male consorts (Okpani and Okpani, 2000). Some of the motives for the initiation of sexual activity include love, curiosity, physical attraction and passion, peer pressure and boyfriend's insistence (Sedlecki et al., 2001). When marriage is imminent, great number of women seems to indulge in premarital sex even in conservative settings. Gao (1998) (quoted in WHO 2001) has observed exceptionally high rate of sexual activity among a sample of about-to-be married Chinese women in Sahngahai who received their "obligatory" health examination prior to marriage.

Apart from physical attraction, desire for material or financial gain has been pointed out as a major motivating factor for engaging in sexual activity for adolescents in developing countries.

It has also been pointed out that young women's sexual decision making process involves a series of choices (Hayes, 1987). For girls in particular, the need for affection and a strong emotional relationship has been found to be an important motivating factor for initiating sexual activity. This has been found to be

Need for affection and a strong emotional relationship seem to be important motivating factors for initiating sexual activity for girls. Pleasing male partners play an important role in unprotected sex

worse for girls who have poor relationships with their parents (Berglund et al., 1997) and for those whose partners view the sexual act as a demonstration of a girl's love (Orubuloye et al., 1992). Pleasing male partners as playing an important role in unprotected sex has also been reported from China among young women aged 16-25 (Zheng et al., 2001). The assumptions such that partners are trustworthy, that having sexual intercourse with a lover is safe, and that having sexual intercourse was the best way to prevent the lover from having sexual activities with other partners have been reported from Bangkok as leading many women to engage in sexual intercourse (Somrongthong et al., 2003).

For male adolescents, apparently, sexual intercourse is driven largely by the need for physical pleasure and the desire to increase their status among same sex friends (Berglund et al.,

For male adolescents, sexual intercourse is driven largely by the need for physical pleasure and the desire to increase their status among same sex friends. Need to conform to social prescriptions of male prowess has also been indicated.

1997). These utilitarian considerations often outweigh considerations of the costs of unprotected sexual activity to themselves or their partners. Some studies (Barker and Rich, 1992) observe that adolescent boys did not perceive any cost to themselves of engaging in sexual activity but focused instead on the potential costs to girls of pregnancy. The need to conform to social prescriptions of male prowess, early sexual experience, and having more than one partner has been accounted for high risk behaviour among adolescent school boys in rural eastern Kenya, even when their feelings about this behaviour are ambiguous and contradictory. The boys tend to consider getting girls pregnant and having had a treatable STD as marks of masculinity, blame girls for not protecting themselves (and girls' parents), and want to boast about their sexual conquests to their peers (Nziok, 2001).

Studies also have indicated how social norms affect the behaviour and attitudes of young people in their sexual behaviour. While factors that can help adolescents to avoid unsafe sexual behaviour has not been discovered, there are documented evidences about social pressures on adolescents to adopt unhealthy sexual behaviours like non use of condoms (Childhope and NESAs, 1997), multiple sex partners (Praditwong, 1990) and sanctioning of older men to have sexual intercourse with young girls (Baron et al., 1993).

- **Exploitative sexual practices**

Violence against and sexual abuse of young people are widely reported in studies as well (Heise et al., 1994; Nowrojee, 1993). Young women in many parts of the world seem to undertake sexual activity often unwillingly as a result of force, coercion and abuse (Coker and Richter, 1998; Omorodion and Olusanya, 1998). It has also been indicated that young people are not always in a position to control the choices they make including the decisions to choose healthy behaviour. Sexual abuse, sex out of economic necessity etc. are examples for this. For instance, in non random study from Nepal of female prostitutes practising in Kathmandu valley, majority between 15-24 years of age, economic hardship was reported by over half as the main reason for entering the sex trade (Bhatta et al., 1993).

Forced sex, offering sex for money or having intercourse as result of force or coercion appear to be more common among teenagers than among adults

Concern about exploitative sexual practices involving children and adolescents has been rising over the past several years. The media have increased awareness by documenting instances of young women and girls being sold into prostitution or sexual slavery, coerced into child pornography or trafficked across borders into bonded sexual labour (Branigin, 1993). Furthermore, engaging in certain types of sexual behaviour such as offering sex for money or having intercourse as result of force or coercion appear to be more common among teenagers than among adults (Gage, 1998). 'Forced sex' has been cited by nearly half of primary and secondary school girls in Mwanza Region in Tanzania (Matasha et al., 1998). Deteriorating economic conditions in many countries also place young people at increased risk of abusive, exploitative and unsafe encounters for material benefits (Standing and Kisekka, 1989; IPPF, 1991). Poverty or financial gains play an important role in women's sexual conduct (Philipson and Posner, 1995; Weiss, 1993; Okpani and Okpani, 2000). Power disparities based on economics, age, and gender make adolescent girls more vulnerable than adult women to exploitative and coercive sexual practices, especially if pressures on them to earn income are strong because of their own needs or because of demands from their parents or close kin (Podhisita et al., 1994).

Studies have also reported the behaviours young people perceive to be sexually coercive and the contexts in which these occur. For instance, an exploratory study is reported from Ibadan, Nigeria in to the problem of

Perceived sexually coercive behaviours included rape, unwanted touching, incest, assault, verbal abuse, threats, unwanted kissing forced exposure to pornographic films, use of drugs for sedation and traditional charms for seduction, and insistence on abortion if unwanted pregnancy occurs

sexual coercion from the perspectives of 77 young people aged 14-27 through four narrative workshops. The participants drawn from two secondary schools and 15 apprentice workshops, identified similar coercive behaviours and developed narratives of the events that typically lead up to them (Ajuwon, 2001). Behaviours included rape, unwanted touching, incest, assault, verbal abuse, threats, unwanted kissing forced exposure to pornographic films, use of drugs for sedation and traditional charms for seduction, and insistence on abortion if unwanted pregnancy occurs. Men were typically the perpetrators and young women the victims. Perpetrators included acquaintances, boyfriends, neighbours, parents and relatives. All the narratives revealed the inability of young people to communicate effectively with each other and resolve differences (Ajuwon, 2001).

The later effects of sexual abuse in females, in pre or early adolescence has also been explored by researchers. In an American

Evidence of sexual abuse led to numerous harmful later outcomes for their victims

study, Johnson (2001), based on interviews with a sexually abused group and a comparison group, has indicated that incidents of sexual abuse led to numerous harmful later outcomes for their victims. In contrast to a similar but non abused sample, the victims of abuse were characterised by: harbouring thoughts of depression, death and suicidal ideation; experiencing lower self-esteem; having fewer close friends; experiencing more verbal altercations with their parent or parents; running away from home; having multiple sexual partners; engaging in sexual activity at an earlier age; not using birth control; having an increased chance of becoming pregnant, and/or an increased risk of contracting sexually transmitted disease, including HIV and AIDS (Johnson, 2001).

- **Impact of socialisation patterns**

Socialisation patterns also have a profound impact on adolescent sexual relationships and on certain kinds of male and female sexual behaviour. In cultures where women are not considered decision makers in their own right, males are found to be far more likely to take the initiative in sexual encounters while girls remain passive or even apprehensive (Orubuloye et al., 1992; Berglund et al., 1997). In some such studies it has been reported that adolescents of both sexes believed that boys had a “natural right” to make more demands in sexual relationships (McLean, 1995).

Socialisation patterns in terms of gender and class seems to weaken young women's bargaining power in sexual relationships

Along with gender, another interlocking category is that of class which seems to weaken young women's bargaining power in relation to safe sexual behaviour thus rendering them more vulnerable. Based on in-depth interviews and questionnaires among 782 girls aged 14-20 in two secondary schools, one attended primarily by working-class and one primarily by middle-class students in Maputo, Mozambique, Machel (2001) has indicated that while gender dynamics work against women overall, middle-class young women had fewer sexual partners, used condoms more often, seemed willing to challenge gender norms and were more assertive than their working class counterparts, which placed them at potentially more of an advantage in sexual negotiation. Working-class young women, for whom the interlocking categories of gender and class operated, were more accepting of gender power differentials, were less assertive and tended to be dependent on their partners for material needs more often, which served to weaken their bargaining power (Machel, 2001).

Who influences the decisions adolescents make, to what extent do they influence them and why are questions that researchers working in developing countries are now attempting to answer. But it has been noted that through the employment of positive and negative sanctions or by altering the individual's assessment of risk, social groups can affect an individual's assessment of the relative costs and benefits of engaging in a particular sexual activity (Vanlandingham et al., 1995).

2.2.3 Contraception among youth and need for contraceptive services

Concerns about the adverse consequences of unprotected sexual behaviour among young people as well as the recognition of the fact that young people can have enormous impact on future population growth should bring forth contraception among young people as a significant issue for research and policy. However, it has been noted that relatively little is known on this issue regarding adolescents in developing countries, especially about males and those who are unmarried (Blanc and Way, 1998; McCauley and Salter, 1995). Following is an overview of some of the research literature on aspects related to knowledge about contraceptive methods, contraceptive practice, methods used, emergency contraception and factors influencing contraceptive use.

- **Knowledge about contraceptive methods**

Data from the World Fertility Surveys indicate that in almost every country, teenagers are quite knowledgeable about contraception (UN, 1989). Again, analyses of data

In general, teenagers seems to be quite knowledgeable about contraception, though they lack information on specific methods or knowledge of effective contraception. Isolated studies have also indicated low levels of knowledge on contraceptive methods

from the Demographic and Health Surveys show consistently high levels of knowledge about contraceptive methods among adolescents in developing countries, especially in Asia, Northern and Southern Africa and Latin America (Curtis and Neitzel, 1996). Drawing data from Demographic and Health Surveys since 1990, Blanc and Way (1998) have found that majority of adolescent women in 37 countries recognise at least one contraceptive method, and in 21 countries, eight in ten or more young women know about at least one method. Greater variability was found in the levels of knowledge among adolescent women in sub-Saharan Africa than other regions. Levels are lowest in Madagascar and Nigeria, where fewer than half of all teens know about any method, and highest in Kenya, Rwanda and Zimbabwe, where at least 90% of adolescents are familiar with some contraceptive method. In Asia, the Near East and North Africa, knowledge levels exceed 90% among adolescent women surveyed in all of the countries, except in Pakistan (67%) and Yemen (56%). A similar pattern was also evident in Latin America and the Caribbean except in Bolivia (74%), Guatemala (68%) and Paraguay (89%) (Blanc and Way, 1998).

On the other hand, it has also been indicated that though many young people are knowledgeable of contraception in general, they lack information on specific methods or knowledge of effective contraception. For instance, in the Philippines, among a convenience sample of 1,355 urban university students in metropolitan Manila, while most were knowledgeable about contraception in general (60–88%), only 20% had adequate knowledge about condoms (Lacson et al., 1997). Few studies have also noted rather low levels of contraceptive knowledge as is the case of an exploratory study from China on reproductive and sexual health knowledge and sexual behaviour of young, unmarried women who migrate to cities from rural areas for work, and their access to and needs in relation to family planning in Beijing, Guangzhou, Shanghai, Guiyang and Taiyuan. Focus group discussions with 146 young women aged 16-25 and 58 in-depth interviews with key informants revealed that most of the women lacked basic information about reproduction and contraception, and did not know where or how to obtain contraception (Zheng et al., 2001) Okpani and Okpani (2000) has also reported a rather low level (56%) of knowledge of effective contraceptive methods, among senior secondary school girls from Port Harcourt, Nigeria. Poor knowledge of and negative attitude toward contraception has also been reported from the rural community of Gbongan in the south-west Nigeria (Okonofua,1995).

- **Contraceptive practice**

It has been documented that in many developing countries, contraceptive prevalence among currently married women of reproductive ages has been growing rapidly, but has not yet

Varied findings with respect to contraceptive practice among young people. While the level of current use seems reasonably well established by some studies, many other studies reflect low use of contraception among adolescents.

reached the levels of use that exist in developed countries (UN, 1989). It is difficult to assess contraceptive practice with respect to unmarried youth as it is difficult to get them admit their sexual activity, especially where such behaviour is not considered socially acceptable prior to marriage. However, several studies have tried to elicit information on contraceptive practice among the unmarried as well and have come out with varied findings. In Blanc and Way's analysis (1998) drawing data from DHS showed that the level of current use is frequently higher among sexually active, unmarried adolescents than among currently married teenagers. This has been found

to be the case with most countries in Sub Saharan Africa, and in half of these countries, unmarried users are most likely to be using modern methods. In contrast, in Latin America and Caribbean (except Haiti), current use levels are higher among married teens, and those who are married are more likely than unmarried users to be using a modern method. Fewer than 10 % of unmarried sexually active adolescents in all the countries included used condoms which suggest that few sexually active teens are protected from sexually transmitted diseases. In Asia, it has been indicated that contraceptive use is reasonably well established and available to adolescents. 11% adolescents aged 15-19 in China, 44% in South Korea, 43% in Thailand, 24 % in Indonesia, 20 % in Sri Lanka and 18% in the Philippines were using some form of family planning including traditional methods, according to studies in the late 1980s (IPPF, 1994).

Contradictory to the above observation that the use of contraceptives is reasonably well established among young people, low levels of contraceptive use has been reported by many studies from different regions. For instance, among the 2,460 secondary school students surveyed in two south-eastern Nigerian states, only 17% of sexually active students had ever used a contraceptive method other than abstinence (Amazigo et al., 1997). Again another study from Nigeria, involving 400 adolescents aged 12-24 years has found that only less than one fifth of the sexually active adolescents were using a method of contraception to either prevent infections or avoid unwanted pregnancy (Odimegwu et al., 2002). A third study from Nigeria among randomly selected sample of female undergraduate students at the University of Benin, Aziken et al. (2003) has found out that 39% had ever practised contraception while many more were sexually active. A fourth study from Nigeria, a community-based case-control study conducted in the rural community of Gbongan in south-west part, comparing one hundred and thirty-two pregnant girls aged 20 years or less with 131 non-pregnant girls of similar age using household confidential interviews and focus group discussions with parents and adolescents have shown that both pregnant and non-pregnant adolescents had poor knowledge of and negative attitude toward contraception, and only a small percentage of them had ever used contraceptives (Okonofua, 1995). In Guinea, another West African country, among 3,603 unmarried men and women aged 15-24 surveyed in three towns, more than half of sexually

active respondents have never used a contraceptive (Gorgen et al., 1998). Again from West Africa, in a study among the students of randomly selected secondary schools of the city of Yaounde in the age group of 12 to 19 years, Kamtchouing et al. (1997), have found contraceptive use reports by 41% of the sexually active students.

Among the sexually active girls in KwaZulu Natal, South Africa, while 44 per cent reported having communicated with their first partner about preventing pregnancy, only 36 per cent were able to use a contraceptive method (Manzini, 2001). In the East African region, Alene et al, (2004) has conducted a cross-sectional study in North Western Ethiopia among 260 students from two rural high schools, and have found out that use of condoms among sexually active single male students (49%) was insufficient but was higher than among adolescents in many other African settings. In the urban provinces of Lusaka-Central and Copperbelt, Zambia in the southern African region, Pillai and Yates (1993) has done a survey of 516 female high school students aged 13-20 years and has found that 94% had never used modern family planning methods though 65% had heard of modern methods.

Relatively low levels of contraceptive use have been reported from other regions as well. Among the symptomatic patients attending Outpatient STD Clinic over a four year period in Italy, De-Seta et al. (2000) has found that 50% of teenagers did not use any method of contraception and barrier methods were only used by 20.4%. In china, among unmarried women who migrate to cities from rural areas for work, only a small proportion were using contraception, with induced abortion often being the outcome of unprotected premarital sex (Zheng et al., 2001). Among the 523 underprivileged Mexican adolescents, Huerta-franco and Malacara (1996) have found that more than half of the sexually active were not using contraceptives.

Another interesting observation is that adolescents appear to be unlikely to use contraceptives the first time they have sex

Adolescents appear to be unlikely to use contraceptives the first time they have sex

(Morris, 1994; Blanc and Way, 1998). The data from the 1989 survey of 2,059 secondary students in Nakuru District of Kenya show that among the sexually experienced students, while 49% of the males and 42% of the females had ever used a contraceptive, only 25% of the males and 28% of the females had used a method the

first time they had sex (Kiragu and Zabin, 1995). In a study done in the Mother and Child Health Care Institute of Serbia over a 2-year period, among the 300 sexually active adolescent girls surveyed in the age group of 19 years, Sedlecki et al., (2001) have found out that only less than one-third of the total number (31.3%) had contraceptive protection at the first intercourse.

Inconsistent and sporadic use of contraceptive methods during each sexual encounter seems to be a problem even among young people in

Inconsistent and sporadic use of contraceptive methods during each sexual encounter among young people

developed countries. The same has been reported in a 75-question anonymous survey in a sample consisting of 49% females and 51% males in 10th and 11th grades from diverse racial and ethnic backgrounds in six Boston high schools. Among the sexually experienced, while 35% were consistent contraceptors, the large majority, 65% were inconsistent users of contraception (Hacker et al., 2000). Erratic and non regular use of condoms with new partners have been reported from Serbia among the sexually active girls (Sedlecki et al., 2001).

In addition, research findings from some of the developed countries has indicated that contraceptive failure is a much greater

Contraceptive failure is a much greater problem than non-use of contraception for teenagers in some of the developed countries

problem than non-use of contraception for teenagers (Wielandt et al., 2002). A study from Denmark (Wielandt et al., 2002) using a sample of 16-20-year-olds selected at random revealed that while ninety-five per cent of the young women who had experienced sexual intercourse used contraception at the most recent sexual intercourse, contraceptive failure is a much greater problem than non-use of contraception.

- **Methods used**

Male condom seem to be the most frequently reported method in various studies. For instance, among the sexually experienced secondary school students in

Male condom is the most frequently reported method. Dual use of condoms and hormonal contraception seems to have increased but remains low even in developed country settings

Kenya, condom was the method most frequently used at last intercourse (Kiragu and Zabin, 1995). In Serbia, Sedlecki et al., (2001) have noted that among the 300 girls

surveyed in the Mother and Child Health Care Institute, in the age group of 19, among those who used contraception at the first intercourse, condom was most frequently used (28.3%) and was the method of contraceptive choice in one-third (34.3%) of girls. However, the same study also noted that condom use was erratic in the sense that with a new sexual partner condom was used regularly by 55.6% of adolescents; and the remaining percentage of girls used condom irregularly (24.7%), or never (19.7%). The other artificial methods of choice were "birth-control pill" in 10.7% and spermicides in 0.7% of subjects (Sedlecki et al., 2001). Among the adolescent girls in KwaZulu Natal, South Africa, Manzini (2001) has reported majority who were able to use a contraceptive using a male condom, the pill or injectable. Similarly, at the first sexual experience, of the 30 per cent who had used a method, almost all used a male condom (Manzini, 2001). Again, among the unmarried men and women aged 15-24 surveyed in three towns in Guinea, Gorgen et al., (1998) have reported more than one fourth (29%) using a condom.

Dual use of condoms and hormonal contraception seems to have increased but remains low, especially among those most at risk. Anderson et al., (2003) have studied the extent of dual use among adolescents, to estimate trends in dual use 1991-2001 and to assess factors associated with dual use in 2001, using 6 Youth Risk Behaviour Surveys of U.S 9th-12th graders conducted between 1991-2001. Each survey used an independent, nationally representative sample with sample sizes ranging from 10,904 to 16,262, and overall response rates ranging from 60-70%. The results indicated that dual use increased significantly throughout 1991-2001, from 3.2% in 1991 to 7.2% in 2001. During this period, condom use increased and pill use did not. In 2001, 32% of all users of hormonal methods (pill or injection) also used condoms. Students in a number of categories had higher rates of dual use: those who were white, 12th graders, and those aged 17 and older (Anderson et al., 2003).

Studies have also reflected a general and sometimes heavy reliance on natural methods like coitus interrupts (withdrawal of the phallus), rhythm and periodic abstinence. In Serbia, Sedlecki et al., (2001) have found that more than half (54.3%), among the 19 year old girls surveyed, relied on traditional forms of contraception, like withdrawal of the phallus. Among the students of randomly selected secondary schools of the

General and sometimes heavy reliance on natural methods by young people

city of Yaounde in the age group of 12 to 19 years, periodic abstinence (31%) was found to be one of the two main contraceptive methods used (Kamtchouing et al., 1997). Okpani and Okpani (2000) have reported limitation of contraceptive method use by sexually active girls, largely to the rhythm and withdrawal methods among senior secondary school girls from Port Harcourt, Nigeria. Kiragu and Zabin, (1995) have found out the 'safe period' as the most frequently followed contraception among the sexually experienced secondary school students in Kenya. Of particular concern here is the questionable efficacy of such natural methods like periodic abstinence and coitus interrupts in the prevention of STD and unwanted pregnancies as noted by some of the researchers (Kamtchouing et al., 1997).

- **Emergency contraception**

Emergency contraception (EC) refers to methods that women can use to prevent pregnancy after unprotected sexual intercourse, method failure, or incorrect use (Baiden et al., 2002). There is growing world-wide acceptance and promotion of EC as a measure to reduce the

Awareness about emergency contraception seems to be poor among adolescents
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level of unwanted pregnancies and, hence, unsafe abortions (Baiden et al., 2002). The potential of emergency contraceptives to prevent unwanted pregnancy in developed countries has been described (Aziken et al., 2003), but in some developing countries, the awareness about the method seems to be poor among adolescents though studies in this respect are rather few as well. Aziken et al., (2003) while surveying a randomly selected sample of female undergraduate students at the University of Benin, Nigeria, have found out that overall, 58% of respondents reported knowing about emergency contraception; sexually active respondents were significantly more likely than those who were not and those who had ever practised contraception were more likely than those who had not to be aware of emergency contraceptives. However, only 18% of those who reported knowing about emergency contraception knew the correct time frame in which emergency contraceptives must be used to be effective. Again, Baiden et al., (2002) has undertaken a study to assess knowledge and attitude toward EC among a sample of students at the University of Ghana chosen by random sampling using a two-page, self-administered questionnaire in a cross-sectional study. Less than half (43.2%) of the 194 respondents (88 males and 106 females) had heard of modern emergency contraceptive methods. Postinor-2, a

dedicated emergency contraceptive product, which was already on the Ghanaian market, was known to 1.5% of respondents. Only 11.3% of respondents indicated correctly the recommended time within which emergency contraceptive pills (ECPs) are to be taken after unprotected sex. Taking concentrated sugar solutions, having an enema, and douching were commonly used traditional methods of emergency contraception. More than half (55.0%) of the male respondents indicated that they would either "certainly" or "probably" reduce how often they used condoms once they knew that emergency contraception was available. Almost all the respondents wanted to learn more about emergency contraception (Baiden et al., 2002). Such studies provide some indication towards the desirability of the promotion of emergency contraceptives among young people.

- **Factors influencing contraceptive use**

While considerations as desired family size and child spacing influence contraceptive prevalence among married women, a range of other factors seem to be influencing contraceptive use among the unmarried. At

Regulations like minimum age and marital status as eligibility requirements to get contraception
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the macro level, laws and regulations and social policies could be important factors that determine access to contraception to both the married as well the unmarried. Additionally, there seem to be regulations in many settings which specifically affect young unmarried women. While in some countries, unmarried women are not permitted access to contraception, in some others a minimum eligibility age may be specified for certain kinds of services (Paxman and Zuckerman, 1987). In the United Nations Sixth Population Inquiry among Governments, among those countries which expressed concern about adolescent fertility, 12 out of 18 in Africa and 6 out of 10 in Asia reportedly provide contraceptives to adolescents regardless of their marital status. In comparison, 18 out of 21 countries in Latin America and the Caribbean provide contraceptives to any adolescent regardless of their marital status (UN, 1989). MacPhail and Campbell (2001) has highlighted community and social factors that hinder condom use among young women and men. In their study in the township of Khutsong, near Carletonville, seeking to complement existing individual-level quantitative findings with qualitative finding among youth, in the 13–25 year age group, six factors have been found to be hindering condom use: lack of perceived risk; peer norms; condom availability; adult attitudes to condoms and sex; gendered

power relations and the economic context of adolescent sexuality. While there was clear evidence for the existence of dominant social norms which place young peoples' sexual health at risk, there was also evidence that many young people are self-consciously critical of the norms that govern their sexual behaviour, despite going along with them, and that they are aware of the way in which peer and gender pressures place their health at risk (MacPhail and Campbell 2001).

Some of the factors that hinder condom use are lack of perceived risk; peer norms; condom availability; adult attitudes to condoms and sex; gendered power relations and the economic context of adolescent sexuality

Apart from external social and policy influences, individual level factors also affect the young's contraceptive behaviour. Some of this may include contraceptive knowledge, prior

Individual factors like knowledge, attitude, prior experience, stability of the relationship between the partners and partner approval, and whether the sexual experience is planned also seem to affect the contraceptive behaviour of the young.

experience, and the stability of the relationship between the partners and whether the sexual experience is planned. Surveys that focus only on teenagers have managed to elicit information on individual factors which influence contraceptive use among unmarried youth. In Uganda, 42% of in school and out of school respondents aged 12-19 said that they did not know where they could get condoms (Lewicky and Wheeler, 1996). The same findings are documented by Araoye and Adegoke (1996). Data from a 1989 survey of 2,059 secondary students in Nakuru District of Kenya shows that for females, high socio-economic status, high academic achievement and a favourable attitude toward contraception were the most important factors predicting use of a contraceptive method at first sex and use at last sex. None of these factors predicted male contraceptive use. Males who said their partner approved of contraception were twice as likely to have used a method at last sex (Kiragu and Zabin, 1995). Rahlenbeck and Uhagaze (2004) have evaluated young people's attitudes towards condoms in a survey among 474 (213 female and 261 male) students (mean age 21 years) in three secondary schools in rural Rwanda. The results indicated that male students and those with sexual experience had more favourable attitudes towards condom utilisation than female students and those without prior sexual contacts. In addition, those with prior

Socio-economic status, high academic achievement and attitude toward contraception seem to affect contraceptive use among the young

use of condoms and those having multiple partners were more likely to report future use intentions than others (Rahlenbeck and Uhagaze, 2004). Negative attitude towards condom use has been reported from Serbia too among sexually active adolescent females and their partners (Sedlecki et al., 2001). From Burkina Faso, G6rgen et al. (1993) have noted that the reluctance to use modern methods is due to a fear that it might cause infertility, that the contraceptive pill might produce damaging side effects and that forgetting to take the pill was a serious risk. Caraballo and Kenya (1994) have brought out the perceptions abound among adolescents that AIDS is a disease of prostitutes, foreigners and promiscuous people, and that they themselves are invulnerable. Studies of the pros and cons of condom use provide compelling evidence that adolescents often make sound decisions regarding use after a careful consideration of comparative gains and losses. For instance concerns that condoms are off-putting; apprehensions that insisting on condom use suggests one has AIDS (Wilson and Lavelle, 1992); beliefs that condoms are unnatural and reduce pleasure or sensation (Agyei et al., 1992) and that their use indicates a general lack of respect for the female partner. Condoms are available from street sellers in many Latin American cities, but condom use is reported to be low and as elsewhere, misunderstandings and misconceptions amongst adolescents make it difficult for partners to negotiate their use. Such findings point to the need for focussing on sensitising adolescents to a more positive attitude towards condoms and reducing condom misconceptions and stigma.

Concerns that condoms are off-putting; apprehensions that insisting on condom use suggests one has AIDS; beliefs that condoms are unnatural and reduce pleasure or sensation and that their use indicates a general lack of respect for the female partner have been indicated as hindering condom use

A lack of decision-making autonomy within relationships seem to be constraining girls' ability to practice safer sex. Harrison et al. (2001) while exploring influences on safe sex behaviour in repeated peer group discussions with girls aged 14- 15 and boys aged 16- 19 have found that girls had not used condoms, would have preferred to delay sexual relationships and feared pregnancy as well as HIV/AIDS. Both sexes deemed it difficult for girls to initiate condom use, although both sexes viewed condoms favourably. Girls saw condoms as a sign of love and protection, whereas boys tended

Lack of decision-making autonomy within relationships seem to be constraining girls' ability to practice safer sex.

to use them with casual partners (Harrison et al., 2001). Women, expected to be passive sexually, fear they will be thought unfaithful if they suggest condom use (IPPF, 1994).

2.2.4 STIs among youth and need for STI care

The recognition of the importance of STIs as a major threat to public health at the global level seem to have increased dramatically since the early 1980s. This new position of prominence of STI within the public health arena has been the consequence of a number of factors, most significantly the advent of the HIV/AIDS pandemic, along

Adolescents bear an increased risk of exposure to infection with STIs and STIs are more prevalent among the young rather than adults

with the changing epidemiology of this group of diseases as well as their serious medical and socio-economic consequences (Fuglesang, 1997). Small scale studies have shown that for both behavioural and biological reasons, adolescents bear an increased risk of exposure to infection with STIs and STIs are more prevalent among the young rather than adults (Brabin et al., 1995, World Bank, 1989). The United States would be a typical example in this respect where half of all new human immunodeficiency virus (HIV) infections and two thirds of all sexually transmitted diseases (STD) occur among young people under the age of 25 (Starkman and Rajani, 2002). It has also been documented that more than half of all new HIV infections are among 15-24 year olds (UNAIDS/ WHO, 1996). Again, evidence from some African countries suggest that HIV/ AIDS infection are greater among adolescent girls than among older women (US Department of Commerce, 1996).

Previous research has indicated that reporting of STIs is poor in many settings; and as a consequence, the actual prevalence among adolescents could be higher than the available inadequate figures indicate (NRC, 1997).

Significant levels of STI infection among the young

Though studies estimating the prevalence of STIs specifically among young people seem to be rather few, there are some which have found significant levels of STI infection among the young. For instance, in a study that explored sexual behaviour of young people in the Mother and Child Health Care Institute of Serbia over a two year period in 300 sexually active adolescent females, aged 19 years, Sedlecki et al. (2001), have found Chlamydia trachomatis genital infection in 30.3% of girls. The

same study also noted that *Chlamydia trachomatis* (Ct) infections are the most common bacterial sexually transmitted diseases with the highest age-specific found in adolescents (Sedlecki et al., 2001). Again, estimates of STI incidence in Nepal, show that patients aged 15-25 constitute the largest proportion of reported STI cases in government hospitals (WHO/ SEARO, 1993). Again from Nepal, in the Adolescent Reproductive Health Care Study, one in every four of the respondents complained about burning with urination, one in eight experienced foul smelling discharge, and one in twenty complained about sore or ulcer around genital area. It is quite likely that some of these symptoms could be of sexually transmitted infections (CREHPA, 1996a). In Northern Nigeria, out of 1104 sexually active asymptomatic males and females, it was found that 24% of college females had laboratory evidence of gonorrhoea (Bello, 1983). While such evidence suggest that STIs are a major health threat among young people world-wide, there seems to be a lot of under reporting of STIs, one possible reason could be that most initial STI infections are associated with annoying but not worrisome local symptoms that do not appear to need a clinical visit (Lande, 1993) or that many are asymptomatic (Zabin and Kiragu, 1998). Even though their immediate effects on adolescents are not always apparent, once left unattended, the effects of STIs may manifest themselves much later in life, in the form of female or male infertility, ectopic pregnancy, and pregnancy wastage (NAS, 1996).

- **Social, behavioural and biological factors**

As regards the increased susceptibility to STIs observed among youth, though it is unclear what proportions account for social, behavioural or biological reasons, the association of increased infection with early sexual onset, multiple partners and unprotected sex is well documented almost in every social setting (McCauley and Salter, 1995; Rosentahl et al., 2001; Wagstaff et al., 1995). Such partnerships seem to be normally associated with early non marital sexual activity. A typical example would be the Serbia study (Sedlecki et al. 2001), in which adolescent girls with *Chlamydia trachomatis* genital infection were mostly characterised by : first sexual intercourse before the age of 17, first sexual partner as older, a great number of sexual partners, sexual intercourse during casual contact and

Association of increased infections with early sexual onset, multiple partners and unprotected sex is well documented

high coital frequency. The study noted significant association with coital frequency and the probability of Chlamydial genital infection. It was also indicated that the level of safe sexual practice was low in the majority of girls, despite the presence of Chlamydial genital infection (Sedlecki et al., 2001). Greater number of lifetime partners has been found to be significantly associated with self-reported STD occurrence among adolescents in the United States as well. The study included 44 male and 88 female adolescents from their source of primary care (Rosentahl et al., 2001). Almost all of the 20% of sexually active males among 260 students from two rural high schools, North Western Ethiopia who had previously experienced an STD, had had visited a commercial sex worker (Alene et al., 2004).

Social practices such as sugar-daddyism in Sub Saharan Africa and others that link middle aged men to young girls has been found to be increasing the

Certain social practices increase the teenagers` risk of infections

teenagers` risk of infection (Weiss et al., 1996; Network, 1997). Another pattern is that of older women in search of very young partners. Research in Uganda suggests that older women seek younger boys for sexual favours (DISH Project, 1996) where as in Malawi, younger boys seek older women (Dodd, 1995). The risk of HIV infection seems to be especially high if the age difference among sexual partners is large (Anderson et al., 1991). In Thailand and the Philippines, growing commercial sex sectors have increased sexual exploitation and the incidence of STIs. Selling young girls into prostitution to supplement the family income is well established in Thai society leading to the growth of sex tourism (IPPF, 1994). The tradition for boys to gain their first sexual experience with prostitutes also facilitates the spread of STIs. Cultures that marry daughters at early ages, often to older polygamous men, seem to be increasing the likelihood of STI transmission to adolescents (Network, 1997).

The physiology of the developing cervix is thought to increase the susceptibility of young women to sexually transmitted diseases (NAS, 1996; Sedlecki et al., 2001). While it is clear

Physiology of the developing cervix is thought to increase the susceptibility of young women to sexually transmitted diseases

that a young person of either sex may have an immature, previously unchallenged

immune system; female adolescents are noted to be more susceptible to STDs than older women because their cervical anatomic development is incomplete and especially sensitive to infection by certain sexually transmitted pathogens (Sedlecki et al., 2001). Sedlecki et al., (2001) have also found out statistically significant differences in clinical findings of cervical ectopy which was more frequent in girls infected with Ct in comparison to healthy girls.

- **Knowledge and awareness**

It has been indicated that though young people are aware about STDs, especially HIV and AIDS, many seem to have only superficial knowledge and gross misconceptions have been recorded by studies. For instance, single-sex focus group discussions conducted among young people aged 15-20 attending secondary schools in Benin City, Nigeria

Though young people are aware about STDs, especially HIV and AIDS, many seem to have only superficial knowledge and gross misconceptions have been recorded

revealed that young people had some knowledge about STDs, especially HIV and AIDS, many believed infections were inevitable (Temin et al., 1999). In their cross-sectional study in North Western Ethiopia among 260 students from two rural high schools, Alene et al. (2004) have found that though the general awareness of HIV was high, correct knowledge of the virus and its modes of transmission were shown in only 44% of adolescent boys and 41% of adolescent girls. Knowledge of HIV and condoms was lower among students whose parents were farmers, significant so among girls. Knowledge of STDs was generally low: 82% of adolescent males and 37% of adolescent females had some awareness of STDs (Alene et al., 2004). In Nepal, while more than half of the sexually active unmarried adolescent boys had multiple sex partners, almost half of them did not feel to be at risk of contracting STI and HIV/ AIDS and only one fourth perceived to be at risk of contracting such diseases. Only 23% girls and 47% boys had ever heard about STIs where as knowledge about AIDS was somewhat higher (44% girls & 65% boys) (CREHPA, 1996a).

Marked gender differences with respect to knowledge of AIDS have also been indicated from some settings. For instance,

Marked gender differences with respect to knowledge of AIDS in favour of men have been indicated from some settings

a Knowledge, Attitude and Practice (KAP) study (Parajuli and Schilling, 1996) conducted among students in Pokhara, Nepal found that overall knowledge about HIV/AIDS was high, with a marked difference in favour of men in the level of AIDS knowledge. This gender difference with respect to knowledge of AIDS was again noted to be high in another KAP study (NCASC / UoH STD/HIV Project, 1996) conducted in Nepal Gunj among policemen, ANC clients, campus students and high school students. The knowledge about AIDS was highest among male campus students and police men (94% and 89% respectively) and lower among female students (78%).

Thus though the awareness about STIs and HIV/ AIDS is sexually transmitted has gone through most segments of the adolescent population, many young people seem to have only superficial knowledge.

2.2.5 Teen age pregnancy

Teen age pregnancy has been a topic of considerable research, in efforts both to understand its extent and to address it as a problem. Even though the number of teenage pregnancies world-wide is declining, it has been estimated that 15 million babies, 10% unplanned, are born annually to teenage mothers (Westall, 1997). Studies in developed countries have shown a high incidence of adolescent exposure to the risk of pregnancy (Jones et al., 1986). In Europe, the incidence of pregnancy has been estimated to be well over 20 per 1,000 (Treffers, 2003).

Although teenage birth rate has decreased over time, adolescent pregnancy still remains a medical and social problem in many developed as well as developing countries.

The incidence of adolescent pregnancy has been noted to be highest in Sub Saharan Africa (143 per 1,000 girls aged between 15-19 years) (Trefferes, 2003). In some of the African countries like Uganda in the eastern part and Nigeria in the western part, a large proportion of adolescents are exposed to the risk of conception, resulting in a high incidence of adolescent childbirth (Gage-Brandon and Meekers, 1993; Agyei and Epema, 1992; Adesobuye, 1992). From Nigeria, individual studies have also reported high rates of pregnancies among the sexually exposed – for

Many African countries seem to have especially high rates of teen age pregnancy

instance, Okpani and Okpani (2000) have found out two hundred and ten pregnancies (24 deliveries and 186 induced abortions) out of 605 (78.8%) senior secondary school girls who admitted being sexually exposed. In the southern part, research in South Africa has indicated that in most respects, South Africa's situation resembles that prevailing in developing societies in Africa and Latin America (O'Mahony, 1987; Flisher et al., 1992). It has been indicated that 1 in 3 South African young women had babies by the time they were 18 years old. But only 33% of these pregnancies were planned, and almost 50% were to youth enrolled in school (Haffajee, 1996). Again, in South Africa there have been reports that about half among the sexually active adolescent girls in KwaZulu Natal had ever been pregnant with a large percentage indicating that the pregnancy had been unwanted (Manzini, 2001).

Among other less developed regions also, many young people seem to be at risk of early pregnancy in the teen years. In East Europe, from Serbia, unwanted pregnancy during adolescence was reported among 16.5% of girls with Ct cervicitis and 15.8% of healthy girls over a 2-year period in 300 sexually active 19 year old adolescent females (Sedlecki et al., 2001). Research in Latin America has also shown a relatively high proportion of teenagers to be exposed to the risk of pregnancy (Singh and Wulf, 1993). Given that access to sexuality education and to family planning services are poor among adolescents in this region, the incidence of teenage childbearing is high. From Brazil, it has been noted that the contribution of adolescent fertility (among 15-19-year-olds) to the total fertility rate is increasing over time (Gupta and Leite, 1999). It has also been indicated that nearly one in three Bolivian adolescent females becomes pregnant prior to reaching age twenty (Lipovsek, 2002). At Mbabane Government Hospital in Swaziland 25% of the deliveries are by women aged 10-19 years (Mngadi et al. 2003). Results from Asia vary, with early marriage and childbirth persisting in many areas, like the typical instance of rural India (Ramabhadran, 1987)

Among less developed regions like in East Europe, Latin America and Asia, many young people seem to be at risk of early pregnancy in the teen years

Though there are differences in the number of teenage pregnancies between industrialised countries which is mainly caused by the availability of effective contraception for adolescents (Treffers, 2003), in some of the countries the estimates

point out the grave magnitude of the problem. For instance, a study from England using the medical records of two university departments of Obstetrics and Gynaecology, has estimated the incidence of adolescent pregnancies

Though there are differences in the number of teenage pregnancies between industrialised countries, relative high incidence has been reported from some settings.

for the period 1985-1998. The results showed that from a total of 71,680 births, 5,398 (7.53%) occurred in adolescent mothers, aged 14-19 years old. Among the teenage pregnancies, 34% resulted in birth, 57% in abortions and 9% in miscarriage (Creatas and Elsheikh, 2002). Again, in a 20-year longitudinal study of 533 New Zealand women, Woodward et al. (2001) has found that by age 20, nearly a quarter of the sample had been pregnant at least once, with the majority of first pregnancies occurring between the ages of 17 and 20 years.

- **Correlates of teen pregnancy**

A number of potential risk factors associated with too early or teen age pregnancy have been brought out by researchers. Examining data from three Demographic and Health Surveys

In Brazil, young woman's level of education has been indicated as the factor most strongly and consistently associated with the probability of giving birth during adolescence.

conducted in North-eastern Brazil in 1986, 1991 and 1996, Gupta and Leite (1999) found out that a young woman's level of education is the factor most strongly and consistently associated with the probability of giving birth during adolescence. In particular, an adolescent with no more than primary schooling is more than twice as likely to have had a first birth than an adolescent with at least a secondary education (Gupta and Leite, 1999).

Social factors and prevalent norms in the community can also determine the proportion of teenage pregnancy in the community. While examining the socio-cultural determinants of teenage pregnancy in eastern Nepal using a case-control study

In Nepal, teenage pregnant women tend to be less educated, had poor economic background. They are more likely to have accidental pregnancies and love marriages. Husbands were more likely to decide about continuation of pregnancy. They had less psychological and social support from the family.

design comparing seventy adolescent pregnant women with seventy primigravida

women in the 20 to 29 years age group., Sharma et al. (2002) have found out that the teenage pregnant women were less educated, had poor economic background, more likely to have accidental pregnancies as compared to the other group and more likely to have love marriages. Husbands were more likely to decide about continuation of pregnancy. They had less psychological and social support from the family (Sharma et al., 2002). Another retrospective exploratory study (Shrestha, 2002) which compared a sample of 575 mothers, who had their first pregnancy at an age below 19 years, with an equal number of mothers who had their first pregnancy at the age of 20 years or above using cluster sampling has determined factors contributing to adolescent pregnancy in rural Nepal. The adolescent mothers were married at a comparatively younger age with a mean age of 15.9 years. And the age at marriage exposed women to early pregnancy regardless of who decided the marriage. Comparatively, most adolescent mothers were from a low social class, engaged in agricultural work, and they had low literacy rate. Majorities of the mothers from both groups had no prior knowledge about conception until they conceived. Peers were the main source of information regarding conception. Although the majority of the respondents knew at least one method of contraception, less than 1% had used it before their first pregnancy (Shrestha, 2002).

Comparatively, adolescent mothers were married at a younger age, had a low social class, engaged in agricultural work and had low literacy rate.

Among the individual level factors, being married and doing an income job as opposed to being an apprentice seem to be associated with early pregnancy (Okonofua, 1995). This has been found in a community-based case-control study conducted in the rural community of Gbongan in Southwestern Nigeria, comparing one hundred and thirty-two pregnant girls aged 20 years or less were with 131 nonpregnant girls of similar age using household confidential interviews and focus group discussions with parents and adolescents. Though a number of potential factors came out, being married and doing an income job as opposed to being an apprentice were the statistically significant factors

In Nigeria, being married and doing an income job seem to be significantly associated with early pregnancy

associated with early pregnancy. The study concluded that pregnancy among adolescents in this community is mostly associated with completion of formal education at an early age by the girls and to their lack of knowledge of reproductive health (Okonofua, 1995).

Exposure to social and individual adversity during both childhood and adolescence seem to be making independent contributions to an individual's risk of an early pregnancy. Such findings which are most consistent

The profile of early pregnancy in New Zealand seem to be an early-maturing girl with conduct problems who had been reared in a family environment characterised by parental instability and maternal role models of young single motherhood.

with a life course developmental model of the aetiology of teenage pregnancy have been reported by Woodward et al. (2001). In a 20 year longitudinal study of 533 New Zealand women, who were pregnant by age 20, the profile of those at greatest risk of a teenage pregnancy (<20 years) was that of an early-maturing girl with conduct problems who had been reared in a family environment characterised by parental instability and maternal

role models of young single motherhood. As young adolescents, these girls were characterised by high rates of sexual risk-taking and deviant peer involvement (Woodward et al., 2001). Supportive family environment has been reported as significant factor in other studies as well. From La paz, Bolivia, while comparing the girls who got pregnant in adolescent years and who did not, using mixed qualitative-quantitative methods based on a case-control design, Lipovsek (2002) has found that girls who had experienced a pregnancy

In Bolivia, girls who experienced early pregnancy characterised by lack of affectionate and supportive parents,

were less likely to have reported affectionate and supportive parents, more likely to have reported fighting in their home, and exhibited lower levels of self-esteem than those who had never been pregnant. Reporting on a study of induced abortion among adolescent girls in Dar es Salaam, Tanzania, who were admitted to a district hospital in Dar es Salaam because of an illegally induced abortion in 1997, Rasch et al. (2000) has noted that girls were getting pregnant expecting their boyfriends to

In Britain, early pregnancy is associated with truancy, low academic achievement and poor sex education.

marry them, or because they did not think they could become pregnant or failed to use

contraception correctly. Findings from Britain have also indicated that high pregnancy rate in among women 15-19 years old is associated with truancy, low academic achievement and poor sex education (Westall, 1997).

Thus, while education seems to be the most significantly associated factor with early pregnancy, some of the other emerging correlates include social factors and prevalent norms in the community, lack of psychological and social support from the family, lack of knowledge of reproductive health, exposure to social and individual adversity during childhood and lack of supportive family environment.

- **Consequences**

Early pregnancy and unplanned childbirth have far-reaching physical, psychological and social consequences to the adolescent girl and her offspring. In both developing and developed countries, teenage pregnancy is found to be associated with long-term poor social, economic, and health outcomes for the mother and child (Westall, 1997; Treffers, 2003; Mngadi et al., 2003). Early child-bearing remains an impediment to improvements in women's educational, social and economic status; motherhood at an early age entails a risk of maternal death much greater than average, and children of young mothers have higher levels of morbidity and mortality (Family Care International,

Adolescent childbearing is associated with higher fertility, a greater tendency to be a boarder, father absence and lack of financial support, and more grandparents taking over responsibility for child care. Adolescent motherhood was further associated with poor earning opportunities for the teenage mother and poverty

1994). While reviewing the findings from Barbados, Chile, Guatemala and Mexico, Buvinic (1998) has shed light on the consequences of adolescent childbearing for mothers' economic and social opportunities and the well-being of their first-born children. The studies include retrospective information and a comparison group of adult child bearers to account for the effects of background factors (poverty) and the timing of observations. The findings show that adolescent childbearing as associated with higher fertility, a greater tendency to be a boarder, father absence and lack of financial support, and more grandparents taking over responsibility for child care. Adolescent motherhood was further associated with poor earning opportunities for the teenage mother and poverty (Buvinic, 1998).

Of widespread concern are the problems related to pregnancies occurring outside a socially sanctioned union, including reduced educational

Unplanned premarital pregnancies can cause reduced educational opportunities for young women, unsafe abortions, high-risk deliveries, poor economic outcomes and compromised social status

opportunities for young women, unsafe abortions, high-risk deliveries, poor economic outcomes and compromised social status. As presented by Marcelino-Perez et al. (1997), such pregnancies at teen ages can have an elevated social and emotional cost. Women who experienced unplanned premarital pregnancy faced personal and familial shame, compromised marriage prospects, abandonment by their partners, single motherhood, a stigmatised child, early cessation of education, and an interrupted income or career, all of which were not desirable options. Further more, children born to single women often are neglected or abandoned (World Health Organisation and UNICEF 1995, Görge et al., 1993). Abortions, forced marriages, undesired motherhood, adoptions and emotional problems that can lead to depression and suicide are all reported to be some of the principle consequences of adolescent pregnancy. In sub-Saharan African countries girls are expelled from school if they become pregnant (Barnett, 1997). Young women were only able to legitimately continue premarital pregnancy through marriage. In the absence of an offer of marriage, single women necessarily resorted to abortion to avoid compromising their futures (Bennett, 2001).

Promotion of the norm of unmarried women and general acceptance of child-bearing outside marital unions,

Very rarely societies seem to be promoting the norm of unmarried women and acceptance of non-marital child bearing as is the example from Transkei in South Africa

though relatively rare, is not unknown. A study of adolescent unmarried pregnancy conducted in 1994 in the Transkei, Eastern Cape (South Africa), included a survey of 2,290 married and unmarried women, ages 15 to 49 years, and qualitative data collected from adolescents, parents and family planning officials. While only 11 percent of women were ever-married by age 19 years, 43 percent have had children. Marriage is late, with 64 percent of women 20-24 years never-married, a marked departure from universal and early marriage regarded as characteristics of most African societies (Makiwane, 1998). From Vietnam, it has been pointed out that while the majority of adolescents do not favour premarital sex and premarital pregnancy,

their choice is to keep and deliver the baby in case of a premarital pregnancy (Minh-Thang 1999).

Though labour in teenagers is generally easier (Treffers, 2003), the main obstetric complication reported is preterm birth, especially if the interval between menarche and conception is short (Treffers, 2003; Creatsas and Elsheikh, 2002). In a study from England using the medical records of two university departments of Obstetrics and Gynaecology, Creatsas and Elsheikh (2002), have found the mean gestational age at delivery was 38 weeks and 3 days for adolescent mothers. The same study also noted that while the mode of delivery was normal in 84% of cases, 9.6% were delivered by Caesarean Section and 6.4% by forceps delivery (mainly vacuum extraction). Toxaemia and anaemia were seen in 1.2% and 0.23% of the cases, respectively. Premature separation of the placenta and placenta previa were seen in 1.08% and 1.29% of cases, respectively (Creatsas and Elsheikh, 2002).

The main obstetric complication reported in teenagers is preterm birth

In developing countries, maternal mortality in girls under 18 is 2 to 5 times higher than in women from 18 to 25 years (Harrison, 1985). The risk of maternal death during childbirth is 2-4 times greater for mothers 17 and younger, in comparison to mothers age 20 and older (Westall, 1997). It has also been shown that support from families, community and health professionals are generally poor for adolescent mothers (Mngadi et al., 2003).

Both the risk of maternal mortality and maternal death during child birth seem to be higher in teen age pregnancies

Regarding the health of the new born, it has been pointed out that children born to adolescent mothers tend to be of low weight at birth. Among the adolescent mothers in the two university departments of Obstetrics and Gynaecology in England, Creatsas and Elsheikh (2002) have reported the mean birth weight as 2,880 g. However, Buvinic (1998) has found out that the first-born child's height-for-age was below the norm only when the mother was poor. Among the poor, adolescent childbearing is associated with lower monthly earnings

Children born to adolescent mothers tend to be of low birth weight and lower nutritional status

for mothers and lower child nutritional status. Also, among this group of women only, improvements in the child's well-being are associated with mother's education and her contribution to household income (Buvinic, 1998).

Thus, as the above review shows, adolescent child bearing is associated with a number of negative physical, social and economic consequences for the mother and the child.

2.2.6 Unsafe abortions among young people

Since the beginning of recorded history, women have attempted to terminate unwanted pregnancies (Bernstein and Rosenfield, 1998). While abortion has been restricted by law in several countries, studies conducted in some of the more developed countries show that generally

Generally abortion has been indicated as a painful necessity and is noted to have a fertility reducing effect

legal abortion still remains a painful necessity. This has been indicated in a study involving Swedish women seeking abortion which highlighted that contradictory feelings in relation to both pregnancy and the coming abortion are common but are very seldom associated with doubts about the decision to have an abortion (Kero et al., 2001). In addition, on average, abortion appears to have an influence on fertility similar to that of contraceptive use, this influence being particularly strong in some countries. This reductive effect appears to have increased over time (Johnston and Hill, 1996).

- **Unsafe abortions**

In developing countries, induced abortion is a generally undocumented, often ignored and frequently dangerous procedure obtained by millions of women. Despite the safety of modern techniques of abortion, in parts of the world where abortion is illegal or allowed only on very narrow grounds, or where it is legal but difficult to obtain, many women go to extreme measures to avoid unwanted births placing themselves at

Many women go to extreme measures to avoid unwanted births; going for clandestine abortions performed under unsanitary conditions and by unskilled practitioners using dangerous techniques

considerable risk. These measures often involve clandestine abortions performed under unsanitary conditions and by unskilled practitioners using dangerous techniques.

Almost all unsafe abortions take place in the developing world. In Latin America and the Caribbean, 3.7 million unsafe abortions are estimated to take place each year, with an abortion rate of 26 per 1000 women of reproductive age, almost one unsafe abortion to every three live births. Asia has the lowest unsafe abortion rate at 11 per 1000 women of reproductive age, but 10.5 million unsafe abortions take place there each

Almost all unsafe abortions take place in the developing world.

year, almost one unsafe abortion to every seven live births. However, excluding East Asia, where most abortions are safe and accessible, the ratio for the rest of Asia is one unsafe abortion to five live births. In Africa, 4.2 million abortions are estimated to take place per year, with an unsafe abortion rate of 22 per 1000 women, or one unsafe abortion per seven live births. In contrast, there is one unsafe abortion per 25 live births in developed countries (Ahman and Shah, 2002).

- **Extent of induced abortions among young people**

Many researchers have attempted to explain the extent of induced abortions among young people in different country settings. For instance, De-Seta et al. (2000) have reported high percentages (41.6%) of voluntary abortions among pregnant teenagers, attending an outpatient STD Clinic in Italy. Anochie and Ikpeme (2001) while studying sexual activity among 534 Nigerian female secondary school students found that one fourth of the pregnancies (24.8%) end up in induced abortion. Again, among a randomly selected sample of female undergraduate students at the University of Benin, Nigeria, Aziken et al. (2003) has found 34% as ever having had an induced abortion. In a study from England using the medical records of two university departments of Obstetrics and Gynaecology, among the teenage pregnancies, more than half resulted (57%) in abortions (Creatsas and Elsheikh, 2002). In the Netherlands, it has been noted that the percentage of teenage pregnancies ending in abortion is high (abortion ratio 61%), but the number of abortions among teenagers is low (abortion rate 8.6 per 1,000) (Treffers, 2003).

Adolescent abortions are estimated as between 1 and 4.4 million per year, most of which are unsafe because performed illegally and under hazardous

Most of the adolescent abortions seem to be unsafe. Also, induced unsafe abortions seem to be more common among adolescents and youth (< 25 year olds), school girls and currently unmarried

circumstances by unskilled practitioners (Population Reference Bureau and Centre for Population Options, 1994). It has been indicated that though illegally induced unsafe abortions were common among both rural and urban dwellers, and women from almost all social and economic strata, they were more common among the youth (< 25 year olds), school girls, those with high formal education, in formal employment, and currently unmarried (Lema et al., 1996). Two hospital-based studies have reported that of the women who said they had had an induced abortion, or whose symptoms indicated that they had had an induced abortion, about 70% were adolescents. (Archibong, 1991; Megafu and Ozumba, 1991). Another hospital-based cross-sectional descriptive study of adolescent post-abortion patients and of their male partners, in Blantyre, Malawi showed that unmarried adolescents comprised of 43.9% and students 38.6% (Lema et al., 2002). From Nepal where induced abortion is legally restricted, it has been reported that one in five women visiting government hospitals for treatment of abortion related complications are adolescents. Estimates also show that 19% of the women charged for abortion and infanticide are aged 20 years and below (CREHPA, 2000).

In spite of the costs and awareness of abortion dangers, adolescents seem to be taking the risk of abortion (Mutungi et

Though many adolescents are aware of abortion dangers, and endure heavy direct and indirect costs, they still seem to be taking the risk of abortion

al., 1999a). A cross-sectional, descriptive study done in the schools and health facilities in Kiambu and Nairobi districts in Kenya which covered 1820 adolescents including school girls, boys and post-abortion clients among adolescents aged 10-19 years indicated that many adolescents were aware of abortion dangers, with the awareness being significantly lower among the boys whose girlfriends had aborted than those whose girlfriends had not. The practice of abortion was reported among 3.4% school girls, 9.3% school boys' girl friends and 100% post abortion clients. The same study also indicated that direct and indirect costs of abortion seem to be heavy

on the girls. Knowledge of the abortion dangers had no influence on the choice of the abortionist. Abortion encounter positively influenced

Great many adolescents seem to be aware of induced abortion and abortion related complications, the most common being infections, death and infertility

approval by the adolescents, of abortion for pregnant school girls (Mutungi et al., 1999b). As regards the perceptions regarding induced abortions among adolescents (Mutungi et al., 1999b), it has been indicated that more than 90% were aware of induced abortion. Knowledge of induced abortion correlated positively with level of education. Seventy one per cent of school girls, 84% of post-abortion girls and 40% of school boys were aware of abortion-related complications, the most common being infections, death and infertility. Eighty three per cent of post-abortion girls felt that complications were preventable by seeking care from a qualified doctor compared to one quarter each for the school boys and school girls. 56% of post-abortion girls, 69% school boys and 72% school girls felt that abortions were preventable. However, less than 40% proposed abstinence as a primary strategy. The most important source of information on abortion was the media followed by friends and teachers.

Webb (2000) has explained the perceptions of adolescents regarding the issue of unwanted pregnancy and abortion. Pregnancies were deemed to be a common occurrence amongst the adolescents, with an estimated two-thirds of unwanted pregnancies ending in unsafe abortion. The decision to abort is primarily determined by the reaction of the boyfriend and his willingness to accept paternity and the associated financial implications. Other crucial influences are the desire to stay in school and the stigma attached to unwanted pregnancy. The decision-making process regarding the abortion itself is related to the perceived advantages and disadvantages of various service providers. Around 40% of the respondents stated that in the event of an abortion being carried out, it would be performed either by the girl herself or with the assistance of other non-medical personnel. Less popular but still significant are traditional healers and private doctors (Webb, 2000).

- **Induced abortion – Determinants and associated factors**

Reasons for having an abortion

Among adolescents, reasons for having an abortion include the desire to remain in school, financial and fear of social reprisal because of an out-of-wedlock

Some of the most frequently sounded reasons for having an abortion include the desire to remain in school, financial and fear of social reprisal because of an out-of-wedlock pregnancy

pregnancy (Adebusoye, 1991; Feyisetan and Pebley, 1989). Small-scale studies point to a high likelihood of increased use of abortion by unmarried adolescents who accidentally become pregnant but wish to finish school. Although economic circumstances have been less of a focus, an increasingly important reason to seek abortion may be the desire to improve one's standard of living, combined with the inability to afford to bring up an additional child; this is most likely in the South, where women play a greater role in supporting the household. Research in a northern Nigerian Muslim community suggests that in communities where births have traditionally been spaced at least two years apart and women have used abortion as one means to achieve such spacing, the use of abortion may decrease, at least in the short run, as women gain some education and reject such a large birth interval as an old-fashioned norm, although it is the most beneficial for the health of women and their infants. However, the use of abortion by schoolgirls is likely to be increasing in this region (Renne, 1996).

Unwantedness or unplanned nature of the pregnancy seems to be the main determining factor for termination of

Generally, unwantedness or unplanned nature of the pregnancy seems to be the main determining factor for abortion. either because of inappropriate timing, the type of man responsible, the relationship itself and the social and economic implications thereof.

pregnancy amongst older women as well as the young. This was specifically pointed out in an epidemiological survey in Kenya among 1007 women, including young people, admitted to 8 hospitals for incomplete abortion or its complications. The pregnancy was unwanted and/or unplanned, either because of inappropriate timing, the type of man responsible, the relationship itself and the social and economic implications thereof.

One of the most common reasons for women to seek an abortion was that the woman was not married. This is contributed to by poor contraceptive use in spite of very good awareness, and/or desire to use (Lema et al., 1996). Again, in another survey about various aspects of induced abortion among a purposive sample of health professionals in South Central and Southeast Asia, one of the two choices listed by a substantial proportion of informants as the most common reasons for women to seek an abortion was that the woman was not married. But, this reason carried far less weight in South Central than in Southeast Asia. This contrast may result from the societal assumption in much of South Central Asia that women simply do not have intercourse before marriage. In the same study, small proportions of participants thought that women frequently or very frequently have abortions because of their young age or because they have learned that the foetus is deformed. Protection of the life of the pregnant woman is thought to be a significant factor in Bangladesh, Indonesia and Vietnam (one-third to one-half). Only in India and Nepal do substantial proportions of respondents perceive rape or incest as a frequent reason for abortion (close to one in four) (Singh et al., 1997).

One of the most common reasons for women to seek an abortion was that the woman was not married

Using quantitative and qualitative data, Ankomah et al. (1997) have presented selected characteristics of 626 women who reported complications of induced abortion in five hospitals: one in Nairobi, two in Lima, and two in Manila. Although there are some similarities, the findings showed marked differences in demographic characteristics. In Nairobi nearly all respondents were single, nulliparous, and 25 years or younger; in Lima and Manila most were either married or in union, usually aged 25 years or older and had at least one child. In general, Nairobi abortion seekers tended to be young women who migrated to the city and were concerned pregnancy would impede their social mobility. In Lima and Manila, abortion was sought to limit births within union, generally for financial reasons. Never-use of contraception was reported by 80% of Kenyan women, 65% of Manila women, and 48% of those in Lima. When presented with 11 scenarios that might justify an abortion, the only indication the majority in all three cities supported was pregnancy resulting from rape. There was evidence of

Marked differences in demographic characteristics have been noted from different settings among abortion seekers.

repeat abortions, especially in Nairobi where 26% had had at least one previous abortion (Ankomah et al., 1997).

Though researchers and practitioners alike have long been aware of the existence and dangers of self-induced abortions, virtually no research seem to be existing on the topic of the methods of self-induced abortion (Smith, 1998). Based on available reports, the most popular method of self-induced abortion seems to be overdosing on chloroquine (Webb,

Some of the methods of self-induced abortion seems to be overdosing on chloroquine, use of traditional medicines, use of hazardous local abortifacients, instrumentation, cervical dilation, and trauma

2000). Other methods involve the use of traditional medicines such as various types of roots, as well as more modern methods such as ingesting washing powder (Webb, 2000). Again, Ankomah et al., (1997) have listed a number of potentially hazardous local abortifacients range from the drinking of strong Kenyan tea to dangerous practices such as insertion of sharp objects into the uterus or drinking chemicals and toxic substances. Women reported use of abortifacient agents such as livestock droppings, drinking chemicals and detergents, herbal medicines, and overdoses of over-the-counter medications, as well as insertion of sharp objects into the uterus (Ankomah et al., 1997). Smith (1998) have reviewed the current and historical literature on methods used to attempt self-induced abortion in the United States and has pointed out 70 cases of attempted quinine induced abortion resulting in three abortions and 11 maternal deaths. Other methods listed for self-induced abortion, are use of drugs, instrumentation, cervical dilation and trauma. It has also been noted that adolescents may be particularly susceptible to such attempts because of their limited resources and limited access to legal abortions (Smith, 1998).

- **Barriers to obtain safe abortion**

Adolescents have been noted to face unique barriers to obtain a safe abortion: while they are slower to

Adolescents seem to face unique barriers to obtain a safe abortion – both posed by their own situation as well as those service related

recognise and accept the pregnancy; they are less likely than older, more experienced women to know where to seek advice and help; may be unable to afford a physician's fee and may use ineffective methods to attempt to induce an abortion (Okagbue, 1990). All of these factors may cause delays and in contrast to women above 20 years

of age, pregnant teenagers were found to be more likely to present late for abortion and the later an adolescent seeks an abortion, the more likely she is to suffer complications that may lead to hospitalisation (Singh et al., 2002). In addition, access to safe abortions seems to be severely restricted in many settings (Ankomah et al., 1997). While presenting selected characteristics of 626 women who reported complications of induced abortion in five hospitals: one in Nairobi, two in Lima, and two in Manila using quantitative and qualitative data, Ankomah et al. (1997) have found that abortions are obtained through a secret referral system. All of the women in Kenya and 89% in the Philippines reported it was difficult or very difficult to obtain an abortion; most were obtained through a secret referral system and involved unsanitary conditions (Ankomah et al., 1997). From Indonesia, Bennett, (2001) has indicated that while abortion for married women is tacitly accepted, especially for women with two or more children, premarital pregnancy and abortion remain a highly stigmatised and isolating experience for single women. Abortion providers were highly critical of unmarried women who sought abortions, despite their willingness to carry out the procedure. The quality of abortion services offered to single women was compromised by the stigma attached to premarital sex and pregnancy (Bennett, 2001).

- **Complications from induced / illegal abortions**

High levels of maternal mortality and other complications from induced abortions has been brought out by studies from different settings. For instance, in Guinea, it is estimated that 50% of maternal deaths resulted from complications arising from illegal abortions (Hyjazi and Diallo, 1996). In Argentina, unsafe abortions are the primary cause of maternal mortality, accounting for 32% of maternal deaths (Gogna et al., 2002). The other reported complications included sepsis (34.3%), anaemia (17.8%), genital injury (16.6%) and haemorrhage (12.4%) (Lema et al., 1996). From Ethiopia, a cross sectional descriptive study carried out in all but two of the regions in Ethiopia has noted that in hospitals, an average of 17 patients with post-abortion complications were seen per month, in lower level health facilities providing post-abortion care the estimate was one patient per month (Jeppsson et al., 1999).

The problems related to abortion may be particularly severe for adolescent women

Problems in terms of morbidity and mortality related to abortion may be particularly severe for adolescent women
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(Brabin et al., 1995; Backer and Rich 1992). Van den Broek (1998) has described the pattern of gynaecological morbidity found among adolescents using data from 7176 files during 1994-95 at the Queen Elizabeth Hospital, Blantyre, Malawi. In the 1153 sets of written diagnosis, sepsis and/or result of induced abortion complication accounted 12% of the cases. A free admission of attempted criminal abortion was recorded in 25 cases (Van-den-Broek, 1998). Again, two hospital surveys (Hyjazi and Diallo, 1996) have been reported from Deen and Donka, Conakry, respectively, determining the prevalence of complications related to illegal or unsafe abortions and establishing the proportion of adolescents within this high-risk group. The first study was prospective and covered the period of January-December 1992 and revealed 83 patients with complications resulting from illegal abortions, 31 (37.35%) of which were adolescent girls. Complications of induced abortion identified were infection (50%), haemorrhage (37%), and medicinal poisoning (12%). Out of the 83 patients, 10 died from complications. The second study was retrospective and covered the period 1990-93 and revealed 94 patients with complications associated with illegal abortion. Adolescent girls represented 31.9% of the cases, of which 80% were single and 40% were schoolgirls. The most frequent complications among adolescents were haemorrhage (50%) and infection (37%). The death rate was 20% (Hyjazi and Diallo, 1996).

2.3 Sexual and reproductive health programs

2.3.1 Sexual and reproductive health needs

World-wide research has indicated a widespread need for information for all kinds of young people (Jaccard and Dittus, 1993; Castillo, 1993; Hawkins

Young people are poorly informed about basic sexual and reproductive health topics as reproductive physiology, contraception, and HIV/ AIDS

and Ojaka, 1992). Many studies have indicated that young people are poorly informed about basic sexual and reproductive health topics as reproductive physiology, contraception, and HIV/ AIDS (Agyei et al., 1992; Barker and Rich 1992). For instance, among 2,460 secondary school students surveyed in two south-eastern Nigerian states, only 36% could correctly identify the most likely time for conception to occur (Amazigo et al., 1997). Oyediran et al. (2002) has discussed the reproductive health knowledge of Nigerian in-school adolescents, with special reference to

pregnancy occurrence at first coitus using the data from interviews with 828 secondary students in Ibadan, Nigeria. The results revealed that the majority of sexually active adolescents were not aware of the consequences of their actions (Oyediran et al., 2002). In Nepal, the Adolescent Reproductive Health Care Study (CREHPA, 1996a) has shown that adolescent girls lack knowledge about genital hygiene or safe sanitation practices during menstruation. While 58% of the 297 adolescent girls of age 13-19 interviewed in villages, had attained menarche, one in every six could not tell the date of their next menstruation. Most of them used some absorbent, particularly a piece of rag or cloth, which was reused (CREHPA, 1996a). While presenting the findings of a survey evaluating the adolescent reproductive health program by the Vietnamese Government, Minh-Thang (1999) has indicated that adolescents have no knowledge of pregnancy, sexually transmitted diseases, and HIV/AIDS prevention; and that adolescents have poor knowledge of reproductive health. Again examining the needs that young people in Guadalajara, in the state of Jalisco, Mexico, expressed in phone calls, Rasmussen et al. (2001) has shown that young people do seek information on issues on reproductive health like pregnancy, sexuality and family problems. The study also noted significant differences by gender and age, in the type of information required (Rasmussen et al., 2001). Again, another qualitative study conducted drawing data from seven focus group discussions and twelve mails of adolescent boys (15-19 years old) residing in two townships outside Lusaka and Kitwe in Zambia showed that growing up to a man entails a certain level of ambiguity and contradictory perceptions in terms of supposedly appropriate social and sexual behaviour but indicates a few alternatives. The respondents themselves suggested that an educational programme that will pay due attention to their needs and answer their questions should be designed and implemented with active involvement of male adolescent peers (Dahlback, 2003). Thus, there is a widespread need for information for all young people, be they married or unmarried, male or female, sexually active or inactive.

Widespread need for information for all young people, be they married or unmarried, male or female, sexually active or inactive

When the need for information has been pointed out, adolescents and youth are noted to receive poor sexuality and contraceptive education, in many settings (Singh and Wulf, 1993; Gage-Brandon and Meekers, 1993; Agyei and Epema, 1992; Adebuseye 1992). There seems to be poor or no communication and information from parents and the community on sexuality and reproductive health to adolescents. Though formal initiation ceremony, which provides the traditional methods of sex education has been reported from some settings, such practices seem to be declining (Pillai and Yates, 1993) and communities also do not offer services aimed at providing adolescents with information and skills regarding safe sexual behaviour (Mngadi et al., 2003). Studies of teachers and health centre personnel has found out their unpreparedness to discuss sexuality with young people, often because they feel uncomfortable or overworked, or because they disapprove of young people who express an interest in sexuality (Population council, 1991; Hawkins and Ojaka, 1992). Many adults avoid the topic because they think that it might lead to increased sexual activity, although a number of studies have shown that this is not the case (Grunseit and Kippax, 1993).

Adolescents and youth are noted to receive poor sexuality and contraceptive education from parents as well as the community

The need for early school-based reproductive health education programmes, incorporating correct information on reproductive biology and the subsequent prevention of reproductive ill health has been pointed out by researchers (Mbizvo et al., 1997). For instance, the refusal in Kenya to provide adolescents with information and services has left the ‘safe period’ as their only protective option and pregnancy as the overriding concern (Ahlberg et al., 2001).

- **Sources of information**

The most commonly reported source of information about sex for young people seem to be friends/peers or the media (McCauley and Salter, 1995; Mngadi et al., 2003; CEPED 1997; Kamtchouing et al., 1997). For instance, among the students of randomly selected secondary schools of the city of Yaounde in the age group of 12 to 19 years, Kamtchouing et al. (1997) has found out

Most commonly reported source of information about sex for young people seem to be friends/peers or the media

that knowledge on contraception was more from the mass media, school, peers, than parents. From Vietnam, it has been reported that adolescents favour radio, television and newspapers as sources of reproductive health information (Minh-Thang, 1999). Again the radio has been reported as a powerful means to reach adolescents and to address their concerns, particularly those that are not being addressed by their families or by the school curriculum. Proving this point is a radio program, "Sandhikhan" (Bengali for adolescence), which aired on national radio covering adolescent health issues, particularly reproductive health in West Bengal, India. In a subsequent survey assessing the program's impact among adolescent radio listeners, about 79% (369 individual listeners) of the respondents rated the radio program very good, with only a negligible 1% describing it as unnecessary. Only 21% of respondents listened to the program alone, with the majority listening in the company of friends, mothers, sisters, brothers, fathers and other relatives. This suggested a wider group of listeners in addition to the program's primary target audience. Clearly, findings pointed

to the effectiveness of teaching adolescent health on the air and in developing healthy attitudes and habits among its young audience (anonymous, 1999). As presented by CEPED

Health agents, family members, and teachers seem to be least frequent sources of information on reproductive health issues.

(1997) in a study of adolescent sexuality in five Sahel countries: Burkina Faso, Gambia, Mali, Niger, and Senegal, health agents, family members, and teachers are among the least frequent sources. In single-sex focus group discussions conducted among young people aged 15-20 attending secondary schools in Benin City, Nigeria, media campaigns were voiced as the best way to educate young people about STDs and condom use (Temin et al., 1999).

- **Teen preferences**

Many parents and young people have been found to be reporting that they would prefer parents to be the main source of

Many parents and young people prefer parents and schools to participate for providing information about sexuality and reproductive health

information for the young about sexuality and reproductive health (Kumah et al., 1992). For instance, in focus groups and in-depth discussions, secondary school students in two south-eastern Nigerian states, recommended that both schools and

parents participate in educating young people about reproductive health (Amazigo et al., 1997). Teens also seem to be perceiving that having more information from parents, school, and health arenas can prevent pregnancy. This has been indicated in a survey to ascertain views of public high school students in 10th and 11th grades on preventing teen pregnancy using a 75-question anonymous survey in six Boston high schools (Hacker et al., 2000). Students believed that having more information on pregnancy and birth control, education about relationships, parental communication, improved contraceptive access, and education about parenting realities would prevent teen pregnancy. Males were more likely than females to prefer their information on contraception from parents and health education classes, whereas females were more likely than males to prefer the health arena. Teens using contraception were also more likely to be having frequent conversations with parents (Hacker et al., 2000).

Teens want parents and other adults to be involved in helping them understand sexuality and make decisions about sexual

Young people want caring adults to help them to understand sexuality and make decisions about sexual behaviour

behaviour. They want to discuss sexual feelings as well as the mechanical aspects of sex. They also do not want to be told not to have sex, but rather wanted to be guided in their own decision making. Such were the elicited views of teens concerning effective strategies to prevent pregnancy in a study from the United States using qualitative methods and a focus group approach among male and female adolescents, 14 to 19 years of age, in grades 9 to 12 (Aquilino and Bragadottir, 2000). It was also found out that teens were concerned about teen pregnancy, and supported a comprehensive approach to sex education beginning in the early elementary grades, with age and developmentally appropriate content and reinforcement from late grade school through high school. Generally, teens thought that teaching abstinence in grade school followed by contraception education in junior high and high school was a realistic strategy for pregnancy prevention. The view that improved knowledge about sexuality, reproduction and contraception as the best way of popularising contraception among youth has been reported by young people in other settings too (Sedlecki et al., 2001). In the opinion of the sexually active adolescent girls in Serbia, this could be done by introduction of sexual education in school programmes or through mass media. As expressed by them, a successful health care service for young

people should include: a gynaecologist who will have enough time and patience for an adolescent patient; a female gynaecologist; and other health care workers. In order to increase the number of adolescents who will use a condom, the following measures are necessary: a better quality of condoms, installation of condom machines, mass media education programmes on the significance of the condom role in the prevention of sexually transmitted diseases, attractive design of condoms, free condoms and universal accessibility of condoms (Sedlecki et al., 2001)

Improved knowledge about sexuality, reproduction and contraception as the best way of popularizing contraception

Studies have also indicated that while professionals favoured dedicated young people's services, young people emphasised the need for young person-centred services. Comparing the views of young people and professionals about ways to reduce the frequency of teenage pregnancy in North Staffordshire community in England using a comparison of consensus emerging from adult and teenagers' workshop discussions and subsequent modified two-round Delphi questionnaires for each subject group, Chambers et al., (2002) have indicated that young people emphasised the importance of interventions being young person-centred, whereas professionals stressed that re-organisation of sexual health and education services as the key. Young people suggested more creative ways of communicating health and education messages than did professionals. Both groups advocated peer education and recognised the need for developing help and services for young men. Both suggested that staff should be educated to be more sensitive in relating to young people. Professionals and young people advocated the locating of sexual health services for teenagers in youth settings (Chambers et al., 2002).

Young people emphasise the need for young person-centred services

2.3.2 Adult attitudes

In many of the developing countries, there is a growing concern about the sexual and reproductive health of young people in part because of their real or perceived increases in their sexual activity and rates of pregnancy outside marriage, and in part because of

Consensus has begun to build that young people need expanded information, skills, and services concerning sexual and reproductive health

high rates of HIV infection among the young. Though the subject of adolescent or youth sexuality is a matter of near universal adult discomfort, consensus has begun to build that young people need expanded information, skills, and services concerning sexual and reproductive health (Huges and McCauley, 1998). For instance, in a survey of local Parent Teacher Association (PTA) presidents in a south-eastern state in the United States, in comparison with similar data gathered 12 years earlier, increased support for family life education was evidenced, as well as increased support for behavioural interventions related to AIDS, sexually transmitted diseases and teen pregnancy. In comparison, support declined for some traditional topics such as going steady, engagement, living together, and religious influences on sex (Algozzine et al., 1995).

The views of significant adults especially parents assume great relevance in planning and implementing programs and services as it can facilitate as well as hinder young peoples' access to programs and services. Studies have examined the attitude and viewpoint of parents on reproductive health of young people and the provision of various sexual and reproductive health services to them. For instance, Briggs (1998) has examined the attitude of parents in Port Harcourt, an urban centre in Nigeria, towards contraceptive use among sexually active adolescent daughters. 148 parents aged 25-59 years of pregnant adolescents were interviewed. On finding that their daughters were sexually active, only a very small percentage (2.3%) reported advising their children to use contraception while the great majority advised staying away from men. Only 12.2% of mothers reported freely discussing sexual issues with their daughters. Great majority, 79.1% of parents, opposed the use of contraception by adolescents. The opposition to adolescent contraception use was due to the beliefs like contraceptives kill, contraceptive use promote promiscuity, and not knowing about contraception. A great majority (93.2%) supported the inclusion of sex education in school curricula (Briggs, 1998). The level of acceptance of parents, teachers and students of the introduction of sex education into the school curriculum have been further explored in Nigeria using questionnaires sent out to teachers, students and parents of eight secondary schools located within Ile-Ife

Many parents seem to be ambivalent with regard to sexual activity among young people and the provision of services. While many support the provision of sex education, support for contraceptive practice seem to be sparse

town (Orji and Esimai, 2003). The study which covered a total of 1000 respondents (400 students, 400 parents and 200 teachers) showed that majority of the parents (92%), teachers (90%) and students (78%) supported its introduction into the school curriculum. The prevailing beliefs was that sex education would prevent unwanted pregnancies, enhance healthy relationships between opposite sex, prevent transmission of HIV infections and STDs, provide the knowledge of sexual interactions, consequences and responsibilities and would help to educate the students on the basic processes of human reproduction. One hundred and fifty-four (15.4%) of the respondents opposed the introduction of sex education because they believed that it would corrupt the students, it might lead to experimentation and that it should be the responsibility of the parents at home (Orji and Esimai, 2003).

CEPED (1997) in their study in five Sahel countries: Burkina Faso, Gambia, Mali, Niger, and Senegal, have shown that while some parents implicitly approve of contraceptive use by adolescents, others feel that it would encourage sexual activity. The ambivalence of parents with regard to sexual activity among young people and the provision of services to them has been indicated in another study which sought the views of Chinese parents on sex education and contraception for unmarried youth, using data from 16 focus group discussions conducted in eight sites in China with parents of unmarried children aged 18-24 (Cui et al., 2001). The study revealed parents' willingness for government to establish educational and service delivery programmes for the unmarried, even when the parents expressed ambivalent feelings with regard to adolescent sexuality (Cui et al., 2001).

Women seem to be holding more conservative attitudes than men toward adolescent sexuality, especially in their views on contraceptive use among adolescents (Speizer et al., 2001). Such findings have been reported in a study from Togo in Sub-Saharan Africa, in which data was collected from 1,027 adults aged 30 and older as part of an evaluation of a youth centre. The results indicated that 58% of adult women and 48% of adult men disapprove of premarital sex among adolescents. Moreover, nearly one-half (48%) of women disapprove of young people using

Women seem to be holding more conservative attitudes than men toward adolescent sexuality, especially in their views on contraceptive use among adolescents

contraceptives, compared with fewer than one-third (31%) of men; on the other hand, 40% of women and 25% of men disapprove of unmarried couples practising contraception. Older and less-educated adults were found to be more likely to hold conservative attitudes than younger and more-educated adults. Women were also found to be significantly more likely than men to have held a reproductive health discussion with a daughter, but there is no difference by gender of the adult in the likelihood of having had such a discussion with a son (Speizer et al., 2001). It has also been noted that though many parents seem to prefer parents to be the main source of information for the young about sexuality and reproductive health, many of them in fact do not talk to their children as they feel confused, ill informed or embarrassed about these topics (Kumah et al., 1992).

Dilorio et al. (2002) has identified the content, characteristics, and comfort level of discussions about sexuality held between

Both male and female adolescents were more likely to discuss sexual topics with their mothers than their fathers

mothers and their early adolescent children to determine the extent to which the conversations predicted sexual values and initiation of sexual intercourse of the adolescent among low-income predominately African-American adolescents, ages 13-15 years. Four hundred five adolescents and 382 mothers were involved in the study. The results showed that both male and female adolescents were more likely to discuss sexual topics with their mothers than their fathers. Both male and female adolescents were less likely to discuss sex-based topics with their friends than with their mothers, but more likely to discuss these topics with their friends than their fathers. Content of conversations of male adolescents was fairly consistent among mothers, fathers, and friends, and sexually transmitted disease/acquired immune deficiency syndrome and condom use were popular topics of discussion. Female adolescents tended to talk about the menstrual cycle with their mothers, sexual abstinence with their fathers and sexual intercourse with their friends. Male adolescents were less comfortable talking to mothers, but more comfortable talking to their fathers than were females. Mothers were likely to report feeling very comfortable talking about almost all discussion areas. The study concluded that early adolescence (13-15 years old) is characterised by more sex-

Gender differences in the issues discussed with parents

fathers. Daughters and sons discuss different topics with their fathers, although discussion by both genders with fathers is limited. The feelings that it was easy to discuss sexual matters with their mothers and that it was difficult to discuss sexual matters with their fathers has also been reported in a survey of 516 female high school students aged 13-20 years in urban provinces of Lusaka-Central and Copperbelt, Zambia (Pillai and Yates, 1993).

2.3.3 Sex education programs

The largest intervention in adolescent sexual and reproductive health in most developing countries seems to be some version of school based sex education (Hughes and McCauley, 1998). There seems to be a general growing consensus that 'education' is necessary to prevent adolescent pregnancy, abortion, STI/HIV and sexual abuse. Attempts to reach agreement as to what kind of education and where, and how and when to provide it often fail, however, because of the conflicting views of sexuality upon which they are based (Munoz, 2001).

Going through the literature it can be seen that lately there have been a multitude of different approaches for imparting sexual and reproductive health information to young

Worldwide, there seems to be a multitude of different approaches for imparting sexual and reproductive health information to young

people even in conservative societies where people are usually unwilling to openly discuss issues of sex. For instance, from China, Gao et al., (2001) have described in some detail a four-year programme entitled the Australian-Chinese AIDS/STD/Safer Sex Peer Education Programme for Youth. The programme has so far reached over 40000 university and school students. Evaluation results show that the programme is effective in both significantly increasing students' knowledge about AIDS/STDs and changing their attitude towards AIDS patients. In addition, the programme is highly praised by the students (Gao et al., 2001). There are also examples of using indigenous institutions in providing community sex education to adolescents.

Use of indigenous institutions in providing community sex education to adolescents in Uganda

For instance, the senga (father's sister), is the traditional channel for socialising adolescent girls into sex and marriage among many ethnic groups in Uganda. Muyinda et al. (2004) has described the implementation and community acceptability of 'modern' sengas who were trained to

provide HIV-related counselling to adolescent girls. Fourteen sengas were trained in two villages and, in the course of the 1-year study, 247 individuals made a total of 403 visits to them. By including both traditional services (such as advice on and assistance with labial elongation) and modern health and sex education, the sengas provided a 'middle road' between tradition and modernity. As a result, despite initial suspicion by the community, their activities were supported by the community generally and members of all ages and both sexes attended for a wider variety of reasons than anticipated. Adolescent girls in the intervention group showed improved knowledge, attitudes and practices related to HIV and STDs (Muyinda et al., 2004). Another approach that has been reported, primarily from the United States is to offer information on how to obtain contraceptives and most schools increasingly teach abstinence-only-until-marriage (or "abstinence-only") education. Despite evidence suggesting a high incidence of sexually transmitted infections and a high rate of sexual activity among young people, less than half of all public schools in the

"Abstinence-only" education from the United States

United States follow this approach even when there is little evidence that abstinence-only programs are successful in encouraging teenagers from delaying sexual activity until marriage, and consequently, avoiding pregnancy, or STD or HIV infection (Starkman and Rajani, 2002).

Evaluation of the effectiveness of various sexuality education approaches, though few, have been reported from different settings. For instance, Martiniuk et al. (2003) have evaluated the effectiveness of a responsible sexuality education programme (RSP) in changing knowledge associated with sex and sexuality; along with changes in attitudes and behavioural intent using a cluster randomised design randomising high school classes

In Belize city, sex education intervention resulting in greater changes in knowledge on sex and sexuality, but no change in the attitudes or behavioural intent domains

in Belize City among 13-19 years olds. After controlling for gender and previous sexual experience, it was indicated that the intervention was associated with no change in the attitudes or behavioural intent domains. Greater changes in knowledge were observed in the intervention group than in the control group following the intervention (Martiniuk et al., 2003).

Rusakaniko et al. (1997) has determined the impact of an intervention package on knowledge levels of various reproductive health issues through trend analysis using a Randomised controlled trial of a health education intervention in rural and urban secondary schools in Zimbabwe stratified for representatives. The study which included 1,689 students (mean age, 13.5 years) recruited from 11 secondary schools in Mashonaland Central using the outcome measure of knowledge level before and after intervention completed a baseline questionnaire. 1159 (68.7%) were randomly allocated to the intervention schools and 530 (31.3%) to control schools; evaluations were conducted after 5 and 9 months. While the results indicated an overall increase in knowledge on menstruation, students from the intervention schools were more likely to have correct knowledge over time on aspects of reproductive biology. Worth noting was that in all the areas the intervention group had knowledge above that in the control group. At baseline, few students in either group had correct information on when a girl was likely to get pregnant during the menstrual cycle. Although follow-up revealed improved knowledge in this area, the intervention effect was significant only among the youngest students. Students in the intervention schools were more likely than controls to know that menarche is associated with the ability to become pregnant, but fewer were knowledgeable about the association between wet dreams in boys and the capability of making a girl pregnant. Attendance at family life education lectures had the most significant positive impact on both knowledge and use of contraception. Knowledge increases in other areas of reproductive health, sexually transmitted diseases, and AIDS increased to a greater extent among exposed than non-exposed youth (20-96% gains), but the trend was not significantly linear (Rusakaniko et al., 1997).

Intervention in Zimbabwe resulting in improved knowledge of reproductive biology, but the effect significant only among the youngest students

Boyer and Shafer (1997) have evaluated the efficacy of a school-based knowledge and cognitive behavioural skills building STD/HIV prevention intervention among 513 ethnically and racially diverse students attending four urban public high schools. The sample was 59% female and had a mean age of 14.4 years. A quasi-experimental design was utilised to evaluate the

Intervention was effective at increasing STD knowledge, and skills related to prevention of risky sexual and drug use behaviour

intervention which consisted of three class sessions. Results of hierarchical regression analyses, controlling for baseline scores and demographic factors, indicate that this intervention was effective at increasing STD knowledge, and skills related to prevention of risky sexual and drug use behaviour (Boyer and Shafer, 1997).

It has also been indicated that successful sexuality education programmes use a variety of teaching methods, focus on personalising the information, present basic and accurate information about the risks of and avoidance of unprotected intercourse, and provide opportunities to practice communication, negotiation and refusal skills (Kirby, 2001). Didactic education alone does not change reproductive behaviour. Positive effects have been documented only for interactive education (Kirby and Diclemente, 1994) or education in the context of appropriate medical services (Zabin et al., 1986b). While many of the approaches have some positive effects upon

Positive effects have been documented only for interactive education or education in the context of appropriate medical services

some outcomes (such as greater knowledge), four groups of programs have been described which have reasonably strong evidence that they delay sex, increase condom or contraceptive use, or reduce teen pregnancy or childbearing. These include (a) sex and HIV education curricula with specified characteristics, (b) one-on-one clinician-patient protocols in health settings with some common qualities, (c) service learning programs, and (d) a particular intensive youth development program with multiple components. The most effective ones used teaching methods that involved students directly and included modelling and practice in communication, negotiation and refusal skills (Kirby, 2002).

However, studies have also shown that compared with conventional sex education some specially designed intervention did not reduce sexual risk taking in adolescents though the lack of behavioural effect could not be linked to differential quality of delivery of intervention. Wight et al.

(2002) has determined whether a theoretically based sex education programme for adolescents (SHARE)

Compared with conventional sex education some specially designed intervention did not reduce sexual risk taking in adolescents

delivered by teachers reduced unsafe sexual intercourse compared with current

practice using a cluster randomised trial with follow up two years after baseline (six months after intervention) among 8430 pupils aged 13-15 years in twenty five secondary schools in east Scotland. A process evaluation investigated the delivery of sex education and broader features of each school. The intervention comprised of SHARE programme (intervention group) versus existing sex education (control programme), using the outcome measures of self reported exposure to sexually transmitted disease, use of condoms and contraceptives at first and most recent sexual intercourse, and unwanted pregnancies. When the intervention group was compared with the conventional sex education group, there were no differences in sexual activity or sexual risk taking by the age of 16 years. However, those in the intervention group reported less regret of first sexual intercourse with most recent partner. Pupils evaluated the intervention programme more positively, and their knowledge of sexual health improved (Wight et al., 2002).

In spite of knowledge of safe-sex behaviour, lack of responsibility especially of young males for the outcomes of their behaviour has been identified as an important barrier to improved sexual health. This has been indicated by Hulton et al. (2000) while studying adolescents in Mbale District, Uganda using single-sex focus-group discussions, six with young people aged 17-18 who were still attending school and six with people of the same age who were not. It was found out that knowledge of safe-sex behaviour and reported behaviour have little in common and that the fundamental barriers to behavioural change lie within the economic and socio-cultural context that moulds the sexual politics of youth and that young males' lack of responsibility is an important barrier to improved sexual health (Hulton et al., 2000).

Lack of responsibility especially of young males for the outcomes of their behaviour has been identified as an important barrier to improved sexual health.

Sanderson and Cantor (1995) have examined 2 age-typical goals that adolescents may pursue in social dating (intimacy goals related to open communication and mutual dependence and identity goals related to self-reliance and self-exploration) and the implications of these different goal sets for responsiveness to educational and daily life situations. Education about safer sexual activity that emphasised interpersonal communication skills was more effective in increasing intentions regarding safer sex

for adolescents with predominant intimacy goals in dating, whereas education that focused on technical skills was more effective for those with predominant identity goals. Adolescents were also less likely to engage in risky sexual behaviour when they were in dating situations that encouraged goal-relevant activities for ensuring safer sex (Sanderson and Cantor, 1995).

2.3.4. Response from health care systems – Access to services

- **Young people’s health care seeking for sexual and reproductive health concerns**

Though adolescent health care behaviour is noted to be poor (Sedlecki et al., 2001), there are evidences to suggest that young people seek services for a variety of sexual and reproductive health concerns ranging from obtaining contraceptives, treating STIs, prevention counselling, fearing pregnancy, complications of abortions, pelvic inflammatory disease, antenatal care and medical problems and so on. For instance, data from a 1989 survey of 2,059 secondary students in Nakuru District of Kenya show that among the sexually experienced students 33% of males and 46% of females visited clinics to obtain contraceptives (Kiragu and Zabin, 1995). Among the sexually active 19 year old girls in the Mother and Child Health Care Institute, the reasons for the first gynaecological visit were found to be: fear of getting pregnant, suspicion of contracting a sexually transmitted disease and symptoms indicating a pelvic inflammatory disease. One-third of girls had their first gynaecological examination as a regular control examination or to get some contraceptive advice. The time interval between the initiation of sexual activity and the first gynaecological examination was more than 6 months in 56.7% of cases, and from one to three years in 31.0% of tested adolescent females. The existence of STD previous to examination was noted in 7.9% of infected girls and 7.7% of healthy subjects (Sedlecki et al., 2001). At the Queen Elizabeth Hospital, Blantyre, Malawi, the most important reasons for hospital admissions among adolescents were found to be complications of abortion, pelvic inflammatory disease, Bartholin’s abscess or sexually transmitted disease (van den Broek, 1998). The study which used data from 7176 files during 1994-95 revealed that 24-72 teenagers were admitted each month, with an average duration of admission of 5 days (van den Broek, 1998). Observing

Young people seek services for a variety of sexual and reproductive health concerns

418 consultations with clients aged 12-24 years at 38 health facilities throughout Zimbabwe and interviewing both the clients and providers, Kim et al. (1997) has found that compared with older clients, those aged 12-16 years came more often for antenatal care and medical problems and less often for family planning. In sessions with 12-16 years, the most common topics were STDs and school, while sessions with older clients focused more on family planning. Providers rarely discussed adolescence or non-sexual problems such as alcohol and drugs. Younger clients were less likely than older clients to ask questions without prompting, expressed their concerns, and they were more likely to appear embarrassed (58%) and shy (64%) (Kim et al., 1997).

Some of the reported reasons for visiting health care services include obtaining contraceptives, treating STIs, prevention counselling, fearing pregnancy, complications of abortions, pelvic inflammatory disease, antenatal care and medical problems.

Using data from the 1999 Youth Risk Behaviour Surveillance survey, a nationally representative survey (N = 15,349) of high school students, Burstein et al. (2003) has found that more than half of the US high school students surveyed have had a preventive health care visit in the 12 months preceding the survey: 60.4% of female students and 57.5% of male students. Of the students who reported a preventive health care visit in the 12 months preceding the survey, 42.8% of female students and 26.4% of male students reported having discussed STD, HIV or pregnancy prevention at those visits (Burstein et al., 2003). Several studies of sexually transmitted disease – related care seeking among adults have reported that men are faster than women in seeking care (Moses et al., 1994).

In addition to resorting to the formal health care system, various forms of reproductive health practices have also been reported. For instance, findings from community based studies under way in India indicate that adolescents often treat themselves with patent medicines or home remedies and pay visits to private providers such as traditional healers, pharmacists or physicians (Joseph et al., 1997). From Nigeria, a wide range of folk practices and do-it-yourself

Various forms of reproductive health practices like treating themselves with patent medicines or home remedies and paying visits to private providers such as traditional healers, pharmacists or physicians; folk practices and do-it-yourself procedures have been reported

procedures have been reported to maintain personal hygiene, prevent and treat STDs as well as prevent and terminate unwanted pregnancies (Alubo, 2001). These practices, which involve the use of every day commodities such as lime, antacid and other drugs in particular ways, are learnt from and passed on through peers. The practices are considered more confidential and are preferred to the reproductive health services in the institutions' clinics. This study which employed in-depth interviews and focus group discussion techniques, covered 2,510 respondents from four tertiary educational institutions in Nigeria (Alubo, 2001).

- **Health care provider perspectives**

Given the prominent role health care providers can play in the effective delivery of services, their perspectives assume significance. Studies have elicited the attitudes, views and dilemmas faced by health care providers in the general provision of sexual and reproductive health services as well as addressing the specific concerns relating to young people. For instance, Gogna et al. (2002) have presented the results from a study carried out in 1998-1999 of the views of 467 obstetrician-gynaecologists from public hospitals in Buenos Aires and its Metropolitan Area on abortion using focus group discussions and interviews. The great majority believed abortion was a serious public health issue; that physicians should provide abortions which are not illegal; that abortion should not be penalised to save the woman's life, or in cases of rape or foetal malformations; and that women having illegal abortions and abortion providers should not be imprisoned. Some 40% thought abortion should not be penalised if it is a woman's autonomous decision. Those who were better disposed towards the de-penalisation of abortion cited a combination of public health reasons and the need for social equity. Such views on service provision can definitely affect service delivery to young people too.

Some of the studies have looked more specifically in to the views relating to service provision to young people. For instance, the professional dilemma among nurses in respecting confidentiality in the case of abortions of those under 16 years of age has been presented by Allmark (2002). As noted in their article, the first question as to what to do

Professional dilemma among nurses in respecting confidentiality in the case of abortions to minors
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in the face of a request that the young person's parents not be involved, is whether or not the young person is competent to request confidentiality. A younger person who is competent is owned the same duty of confidentiality as an adult which in practice would mean that some such requests can be granted straightforwardly. However, in cases where the teenager's pregnancy raises concern about child abuse, the obligation to respect confidentiality is overridden and

can not be respected fully in such cases. It was also indicated that a policy of failing to do so may lead young people to seek (illegitimate) help elsewhere and therefore,

Service providers tend to believe that parents should be notified if a young, unmarried client was pregnant, had HIV/AIDS, or engaged in sex at "an early" age

reform of the current system may be needed (Allmark, 2002). Again, on the issues of confidentiality, Kim et al., (1997) in their study from Zimbabwe have noted that most service providers believed that the parents should be notified if a young, unmarried client was pregnant, had HIV/AIDS, or engaged in sex at "an early" age.

Attitudes and practices relating to counselling of adolescents about sexuality, including abstinence have been reported among attending physicians and residents at a south-eastern rural teaching hospital specialising in family practice and paediatrics, as well as local family practice physicians and paediatricians in the United States (Patton, 2001). More than 60% of physicians reported regularly addressing the issues of HIV, STD, pregnancy prevention, and responsible sexual behaviours. About 35% of the physicians reported regularly counselling adolescents regarding 17 other issues pertaining to pregnancy and disease prevention, sexual abuse, or related medical aspects of sexuality. While none of the respondents felt "very effective" in their counselling, some agree they would be helped by additional training (Patton, 2001).

- **Access to Services for SRH Concerns**

While it has been indicated that young people want easy access to health care services that is delivered in a respectful and confidential way (Jones, 2003), this does not seem to be the case always. Health services in most areas do not accommodate the special needs of adolescents and often discourage attendance even when the need for care is well understood (Burton, 1985; NAS, 1996). Following is a review of the studies reporting access barriers and some examples of good practice.

Access Barriers

Even though young people rank sexual health as their primary health issue, many formal health services tend to be rejected due to their poor perception by young people, centred on the lack of privacy and confidentiality, and the de facto illegal nature of some of the services itself (Webb, 2000). Research findings have also suggested that young people may be reluctant to seek advice at health facilities because of legitimate concerns about privacy, providers' attitudes and narrow focus on reproductive health. The same has been reported by Kim et al. (1997) after observing 418 consultations with clients aged 12-24 years at 38 health facilities throughout Zimbabwe and interviewing both the clients and providers. Less than one per cent of clients at these facilities were aged 12-14 years; between 5% and 20% were aged 15-19 years (Kim et al., 1997).

Privacy, confidentiality, illegal nature of the services and providers' attitudes seem to be some of the prime concerns in the use of services by young people

A number of other studies have also looked in to factors hindering health care service access to young people. For instance, Mashamba and Robson (2002) in their study via an urban youth advisory centre in Bulawayo, Zimbabwe using data from exit questionnaires with users and focus groups with non-users have suggested that even where clinics are spatially accessible, barriers to access include temporal factors, lack of factual knowledge and stigmatisation (Mashamba and Robson, 2002). Again from Zimbabwe in rural Masvingo, focus group discussions with secondary school pupils aged 16-19 and nurses and community meetings with parents of adolescents, revealed that the accessibility of existing services for young people is poor. This was partly because nurses were reluctant to provide such services due to lack of clarity in legislation and also through fear of condoning adolescent sexual activity. Although the clinical acumen of staff was recognised as sound, service delivery was perceived to be judgmental and lacking in confidentiality and privacy. There was a widely held belief that teaching young people about sex will promote sexual activity (Langhaug et al., 2003). The disapproving attitude of health workers preventing adolescents from seeking contraception and other needed reproductive health services has been reflected in a number of studies. Case studies have shown

Other access barriers include temporal factors, lack of factual knowledge and stigmatisation

that adolescents are often scolded, refused information or turned away while approaching for help (Population council, 1991). Single-sex focus group discussions conducted among young people aged 15-20 attending secondary schools in Benin City, Nigeria showed that for STD treatment, most went to traditional healers; and they were unlikely to seek treatment from doctors because of high cost, slow service, negative provider attitudes toward young people and a perceived lack of confidentiality (Temin et al., 1999). Associated with the privacy and confidentiality concerns are the reported barriers like fear of being seen by adult family member or neighbours (Paxman, 1996), and the thought that clinic personnel will report them (Senderowitz, 1997). In urban Zambia, owing to privacy concerns, the services of nurses are sought outside of the clinic setting by young people (Webb, 2000). The adolescent school boys in rural eastern Kenya are unwilling to get condoms from places where anonymity is not assured and feel embarrassed and reticent about discussing sexual issues with adults as they know their sexual activity is not sanctioned (Nziok, 2001).

In China, focus group discussions with 146 unmarried young women who migrate to cities from rural areas for work, aged 16-25 and 58 in-depth interviews with key informants revealed that there are social, psychological and economic barriers to accessing services (Zheng et al., 2001). In Indonesia, single women are not legally permitted to obtain contraception from government family planning services (Bennett, 2001). In South Africa, adolescents' access to contraception has traditionally been restricted by legislation requiring parental consent. Although adolescent exposure to the risk of pregnancy creates pressures on service providers to react, their initiatives are likely to be constrained if they lack strong legislative support (Zanele, 1998). From Vietnam it has been reported that adolescents give a poor rating to the quality of RH/family planning services at the centres; poor interest in RH/family planning service facilities all of which could hinder their use of services (Minh-Thang, 1999).

Legal, social, psychological and economic barriers affecting access have also been reported

Again it has been shown that what young people wanted from consultations with health care workers and their experiences

While young people want the time and opportunity to discuss their options, many seem to feel being rushed through the service

of the consultation process often seem to conflict (French, 2002). Such findings were reported from England by young people aged 16-21 years from health services (young people's contraceptive and sexual health clinics and a termination of pregnancy clinic), secondary schools and community projects (a youth club, a young mothers' support group, a community education project and a young women offenders unit). In-depth interviews and focus groups revealed that that a five to ten minute consultation was not enough to discuss personal factors that may affect contraceptive decision making and effective use of methods. Many described a feeling of being rushed through the service and did not feel they had the opportunity to ask questions. They wanted the time and opportunity to discuss their options. Often the young men, who were accessing services, described how initially they had gone in to collect condoms, but once they knew the clinic and staff, would consider making an appointment (French, 2002).

- **Medical barriers**

"Medical barriers" are defined as "dysfunctional practices derived at least partially from a medical rationale that

Medical barriers can limit the use of services generally as well as among young people

result in a scientifically unjustifiable impediment to, or denial of, contraception" (Shelton et al., 1992). These are restrictions that are imposed by family planning providers resulting from their own cultural attitudes and norms, often with unfounded medical justifications. Seven categories of medical barriers have been identified: inappropriate contraindications, eligibility barriers, process or scheduling hurdles, provider bias, regulatory barriers, limits on who can provide services and inappropriate management of side effects (Shelton et al., 1992). Even where family planning services are physically accessible and economic barriers to access are few, „medical barriers“ can limit the use of services generally as well as among young people.

Very little empirical research has been done on this issue in developing countries. Typical examples of provider biases were found in Kenya and Nigeria,

Some of the reported medical barriers include age and parity restrictions; spousal consent; conditions such as perfect physical health and live birth imposed by providers

including denial of access to services on the basis of age, number of children and marital status (Askew et al., 1994). Again, situation analyses in Tanzania and Nigeria have indicated providers reporting having age restrictions for oral contraceptives, injectables and female sterilisation, as well as parity restrictions for users of injectables and female sterilisation. Spousal consent was more important in Tanzania than in Nigeria. Providers in the two countries also showed biases for and against different methods (Mundy, 1993). Again, analysis of the data from the 1996 Tanzania Service Availability Survey indicates that relatively high proportions of providers restrict eligibility by age, particularly for oral contraceptives, the most widely used method among Tanzanian women. Between 79% and 81% of medical aides, trained midwives, maternal and child health aides and auxiliary staff (the most common types of family planning service providers in rural Tanzania) impose age restrictions for the pill. Among all providers, 10-13% report that there is at least one modern method they would never recommend, and 13% report having sent a client home until her next menses, an inappropriate process hurdle for the provision of most hormonal methods. In general, these restrictions severely limit access to contraceptives for young, unmarried women. Those who are not menstruating at the time of their visit would encounter one or more barriers or process hurdles at more than 70% of urban facilities and at 80% of rural facilities (Speizer et al., 2000). In a report on a provider survey in Senegal, it was noted that providers call clients "les malades," or "the sick," and examine their clients as thoroughly as their medical environment permits (Galway, 1992). The report also noted that providers are very concerned about the health dangers of contraception, and often deny the pill or IUD to women unless they are in perfect health and have had a live birth which could be a severe barrier to young women.

A study from Ghana involving 46 identified facilities offering family planning services where clients were at high risk of facing medical barriers and other obstacles, identified some of the restrictive practices and probed providers about their reasons for these practices. Marriage and spousal consent requirements, minimum and maximum age restrictions and parity restrictions were the most commonly reported medical barriers. Concerns about client

Concerns about client safety and morals often based on misbeliefs among the providers seem to be the most often cited rationales for restricting services

safety and morals that single women should not be allowed to use family planning were the most often cited rationales for restricting services according to age and parity. The most common reason for enforcing minimum age requirements was that family planning should not be allowed for anyone younger than a certain age, or that a minimum age discourages promiscuity, or that women younger than this age are not mature enough for family planning. A few providers said that minimum age limits were intended to forestall teenage pregnancies. Many providers were especially concerned that contraceptives might cause future fertility problems, and used minimum age or parity requirements, to ensure that only women of proven fertility could obtain contraceptives. A number of providers apparently believed in particular that injectable contraceptives cause permanent infertility. Providers also cited health concerns as the reason for enforcing strict resupply and revisit schedules, as well as for routinely conducting laboratory tests. The study concluded that providers often--if inadvertently--tried to protect society's morals by denying services to unmarried clients and by speculating on the fidelity of married ones (Stanback and Twum-Baah 2001). Likewise, in Pakistan, about one-third of women would not have been eligible to use hormonal contraceptives as a result of popular misconceptions about age and parity requirements (Ministry of Population Welfare, 1993).

- **Creative strategies**

Creative strategies in providing services to young people though few has also been reported. From south Africa, Haffajee (1996) has reported the Youth Information Centre, which is part of the Planned Parenthood Association, helping young people to make realistic choices by providing contraception and health education and using creative strategies to teach adolescents about the effects of teenage pregnancy.

Creative strategies in providing services to young people though few have been reported

One example is that girls are given a life-sized doll tied to their backs that is carried around town and on buses. Bystanders react usually by staring and making the girls feel uncomfortable. The program director explains afterward that people are staring because of the young age of the pretend "mother." In addition to providing information men are given condoms for free. The strategies are popular with youth because the old mode of family planning is being changed and replaced with improved programs (Haffajee, 1996)

Again, Baraitser et al., (2002) has described the evaluation of a model of contraceptive service provision for young people which significantly increased service access. In this model, the quality mainstream services (open to clients of all ages) with extended hours and no appointment necessary is combined with targeted outreach to facilitate access by the under-25s. The outreach programme included the development of close links between the clinic and local schools, youth services, social services and voluntary sector organisations. The evaluation was done using an anonymous questionnaire that collected demographic details and data on their source of information about the service among patients registering in the 6 months before and 18 months after the development of the new service. The results indicated that the number of clients of all age groups registering at the new service in the first year doubled. The number of new users aged under 16 years increased by 12-fold in the first 18 months. The number of young people citing a school sex education class as their source of information about the clinic increased by more than five-fold (Baraitser et al., 2002). Studies have indicated that whilst there may be barriers to improving sexual and reproductive health, young people have enthusiasm for and commitment to finding solutions to the problems that local communities face (Miles et al., 2001).

2.4 Research from India regarding SRH of youth and access to services

- **Sexuality research - Early marital and premarital**

As marriage tend to be early, especially for adolescent girls, the onset of sexual activity occurs largely within the context of marriage for adolescent females in India. About half of all young women are thought to be sexually active by the time they are 18; and almost one in five by the time they are 15 (Jejeebhoy, 1996). Though social reformers got concerned about early marriage in India (UNICEF, 2001), very little research seem to be existing on early marital sexual activity except for the studies on too early pregnancy resulting from this practice.

Indication that the practice of early marriage exist at significant levels
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As regards the extent of early marriage in India, as happens in other places, the National Statistics often seem to be disguising significant rates of very early marriage. However, as is reported in UNICEF comprehensive report on early marriages in

India, there have been isolated studies indicating that the practice of early marriage exist at significant levels (UNICEF, 2001). For instance, a 1998 survey in the Indian state of Madhya Pradesh found that nearly 14 per cent of girls were married between the ages of 10 and 14 (Somerset, 2000 quoted in UNICEF, 2001). Indian researchers on child marriage in Rajasthan and Madhya Pradesh state that girl spouses suffer more than boys: “Inadequate socialisation, discontinuation of education, great physiological and emotional damage due to repeated pregnancies devastates these girls.” If the husband dies, even before consummation, the girl is treated as a widow and given in *nata* to a widower in the family. Officially she is then his wife, but in fact under the practice of *nata* she becomes the common property of all the men in the family (Saxena, 1999, quoted in UNICEF, 2001).

Coming to premarital sexual behaviour, very few studies have examined sexuality and sexual behaviour among unmarried youth in the past, as it was widely believed that premarital sex has been rare for a variety of reasons like the practice of early marriages, the rigid social norms and the practice of sex segregation among young people. However, in recent years, increases in unintended teenage pregnancies, the spread of reproductive tract infections and sexually transmitted diseases (STDs), and the imminent threat of the HIV epidemic have increased the significance of sexuality research in India (Abraham and Kumar, 1999) resulting in a number of studies examining adolescent sexuality. Recent reviews of research on sexual behaviour (Nag, 1996) and adolescent sexuality (Jejeebhoy, 1996) have cautioned that these studies are limited and that their findings cannot be generalised, because they are based on very small samples or convenience samples, made up mainly of males (Abraham and Kumar, 1999)

However, the incidence of relatively high rates of premarital sex among adolescent males has been suggested by a number of recent studies (Bansal, 1992; Bhende, 1994; Gupta, 1994; Goparaju, 1993; Sathe, 1992; Savara and Sridhar, 1994; Sharma and Sharma 1994; Sharma and Sharma 1995; Sharma, 1996; Sharma, 1998; Watsa, 1993). Though rare, there is also evidence of sexual activity among unmarried female adolescents too

Incidence of relatively high rates of premarital sex among adolescent males has been suggested by a number of recent studies

(Watsa, 1993; Goparaju, 1993; Savara and Sridhar, 1994; Bansal, 1992). It has also been indicated that the sexual behaviour of adolescents in the country seems to be generally unsafe and hazardous including early and spontaneous initiation mostly unprotected among unmarried males.

As regards the extent of premarital sexual activity, some of the studies have estimated that in urban areas, 20-25% of unmarried young males and 6-10% of unmarried young females have experienced premarital sex (Savara and Sridhar, 1993; Goparaju, 1993; Rangaiyan, 1996). Results of a recent survey conducted among 966 low-income college students in metropolitan Mumbai (Bombay) to identify levels of sexual behaviour and their correlates indicated that some 47% of male participants and 13% of female respondents had had any sexual experience with a member of the opposite sex; 26% and 3%, respectively, had had intercourse (Abraham and Kumar, 1999). Such results indicate the contrast between assumptions that in a traditional and moralistic society like India adolescents do not engage in premarital sexual activity, and the reality, that some adolescents are sexually active.

The strongest predictors of sexual behaviour in Mumbai seemed to be knowledge about sexuality-related issues, attitudes toward sex, and levels of social interaction and exposure to erotic materials. However, the results differed for young men and women, and the effect of knowledge was inconsistent (Abraham and Kumar, 1999). Again, Selvan et al., (2001) while describing the intended sexual and condom behaviour patterns among teenage higher secondary school students in India has found out that perceived norms and perceived peer group norms showed significant association with intended sexual behaviour and actual sexual behaviour and that children of more highly educated parents are less likely to engage in sexual activities in their adolescent years (Selvan et al., 2001).

- **Awareness of reproductive health issues**

While adolescents' attitudes toward premarital sex are becoming more liberal, their awareness of reproductive health issues remains poor (Verma et al., 1997; Sharma and Sharma, 1996; Sharma and Sharma, 1998; Sharma and Sharma, 1997; Sharma,

Poor awareness of reproductive health issues among young people

1998). The lack of awareness has been detailed by Sharma (1998) using the results of 4 community-based surveys from a district in the state of Gujarat, India. The 1st survey determined and compared sexual behaviour patterns of 368 adolescent boys (mean age 18.1 yrs) from rural and urban areas, to assess knowledge about sexually transmitted diseases and AIDS and the correct use of condoms. Survey 2 determined knowledge about human sexuality, physiology of reproduction, and contraception among 530 17-19 year-old first year female college students. Survey 3 was conducted among 492 female high school students to determine age at and preparation for menarche. Survey 4 (house-to-house in randomly selected villages) determined factors related to knowledge about correct use of condoms among sexually active 18-55 year old men. The results indicated that the overall knowledge score among the studied girls were poor. It was also observed that a large number of the girls who felt that they possessed enough knowledge on such issues were in fact quite ignorant in such matters. Another observation that merits attention was that the knowledge scores were significantly higher among those girls who had learnt about sexuality from their elders (mostly parents and teachers) (Sharma, 1998). Again, another study by the Thoughtshop Foundation in collaboration with AIMS Research in Calcutta of the sexual health problems and information needs of both male and female adolescents in the 12-19 age group, both in and out of school, in urban and rural West Bengal used a content analysis of letters received by the AIDS, Sex, Knowledge column; focus group discussions; interviews with key personalities who exert major influence on young people; and an institutional analysis of sexual health services available to the target population. The findings pointed an almost lack of sexual awareness of sexual health issues and knowledge of the human anatomy among the target population and the people who influence them most (e.g., parents and teachers). While the institutional analysis indicates some progress in the provision of sexual health services to young people (e.g., awareness programs, counselling and condom promotion), access to reliable sources of information, including the mass media, is not available to many of them.

It has also been indicated that for a majority of girls in India, their first menstrual period is a traumatic and painful experience. The agony of menarche has its roots in the fact that mothers do not prepare their young daughters for such an expected life-

event. Social misbeliefs and restrictions associated with the process of menstruation add to their woes in later life (Sharma and Sharma, 1994; Sharma, 1998). Again, the general culture of silence surrounding menarche has been reported by Garg et al. (2002) as part of a larger study of reproductive tract infections in women in Delhi, in the socio-cultural context of an urban Indian slum, by collecting observations, using both qualitative and quantitative methods. The qualitative phase consisted of 52 in-depth interviews, three focus groups discussions and five key informant interviews. In the quantitative phase, inferences were drawn from 380 respondents. While the mean age at menarche was found to be 13.5 years, menarche seemed to be an event which took the women interviewed almost by surprise. Most were previously unaware that it would happen and the information they were given was sparse. Menstruation is associated with taboos and restrictions on work, sex, food and bathing, but the taboos observed by most of the women were avoidance of sex and not participating in religious practices. The taboo on not going into the kitchen, which had been observed in rural joint households, was not being observed after migration from rural areas due to lack of social support mechanisms (Garg et al., 2002).

- **Undesirable consequences**

Undesirable consequences of unprotected sexual activity including Sexually Transmitted Infections, unwanted pregnancies and unsafe abortions have been noted by studies. As regards Sexually Transmitted Infections, though studies of such infections among adolescents are rare in

India, it has been reported that young people embark on their first sexual relationships in a threatening climate of

Studies noting significant levels of undesirable consequences like STIs and unsafe abortions among young people

Sexually Transmitted Infections and constitute a high risk group for STIs and HIV/AIDS (Watsa, undated), and a great majority of STD clinic patients are of 18-19 years of age (Urmil, 1989). Even when abortion is legal in India, a large majority of abortions seem to be provided by private or traditional practitioners who are most likely to be unqualified (Ganatra and Hirve, 2002; Varkey et al., 2000; Bhatt, 1998). Again it has been pointed out that though the law in India has permitted medical

termination of pregnancy on broad legal grounds for over two decades, unsafe abortions carried out by unqualified providers show no signs of decreasing (Varkey et al., 2000). Various small-scale studies indicate that private doctors in India perform legal abortions for a fee not much higher than that charged in the Public sector (Khan et al., 1996), very few private doctors report these procedures to the government data collection system (Barge et al., 1994; Chhabra and Nuna, 1994). There are hospital based studies on abortion which suggest that adolescents constitute a significant proportion of abortion seekers (Chhabra et al., 1988; Solarpurkar and Sangam, 1985) and the typical adolescent abortion seeker is unmarried (Divekar et al., 1979). For instance, in a study in rural Maharashtra, India, adolescents constituted 13.1% of the 1717 married women who had an induced abortion during an 18-month period in 1996-1998. While spacing and sex selection were the main reasons for married adolescents seeking abortion, pregnancies resulting from non-consensual sex mainly accounted for never-married and separated adolescents seeking abortion. Prior contraceptive use was noted to be low among adolescent abortion seekers and they were less likely to receive post-abortion contraceptive counselling or to adopt contraception (Ganatra and Hirve, 2002).

Cost, limited mobility, lack of family and partner support and the need for privacy to prevent stigma are noted to be the reasons leading many to go to traditional providers,

Cost, limited mobility, lack of family and partner support and the need for privacy to prevent stigma are noted to be the reasons leading many to go to traditional providers.

even though safer options existed (Ganatra and Hirve, 2002). Small-scale studies have shown that government providers may be uncaring toward women, fail to ensure confidentiality, require women to obtain the consent of their husbands (even though this is not legally necessary) and often require that women obtaining an abortion accept sterilisation or an IUD. Conditions such as these may prevent a large number of women including young people to obtain abortions through the official health system (Khan et al., 1996). It has also been noted that adolescents are considerably likely than older women to delay seeking abortion services and hence undergo second trimester abortion (Divekar et al., 1979; Chhabra, 1992). They also seem to have a lesser role in the decision-making process on abortion than women older than them (Ganatra and Hirve, 2002). Delays in seeking services were largely the result of

lack of awareness of pregnancy, ignorance of services and fear of social stigmatisation. Contraception awareness is also equally vague, even among married adolescents (ORG, 1990; Verma et al., 1997).

- **Sex education**

Recent researches from India have indicated that education in human sexuality is required in our schools, as this need is currently not being

Studies pointing the need for education in human sexuality in schools in India

addressed adequately in our society. As part of a course on Human Sexuality and Adolescence for school children Saksena and Saldanha (2003) has ascertained the prior knowledge of children on sexuality aspects, source of their knowledge and whether the course was a felt need of the children. The method adopted was by giving the students a questionnaire before the course and few selected questions were asked again after the last session. The course dealing with anatomy, physiology, social and psychological aspects of growing up, HIV and contraception was conducted in a private co- educational English medium school in urban Bangalore involving 392 students 13 - 15 years of age. The results indicated that misconceptions about anatomy, childbirth, HIV were common. 55 - 70% of class VII, IX and X students had learnt about sex from friends, 30% from movies, 15% from text books and only 10% from parents. This in turn indicates that in spite of chapters on reproduction in textbooks, children turn to peers or media to gather information on sexuality. 90% of tenth class students felt that education in human sexuality was necessary (Saksena and Saldanha, 2003).

Pattanaik et al. (2000) has gathered information on areas required for the planning of family life education strategies using a cross-sectional study using a interview schedule in the government schools and anganwadi premises of three villages of the primary health centre, Chhainsa, Ballabgarh, Haryana. The participants were 254 girls aged 13 to 17 years, who had attained menarche. The knowledge and attitudes regarding age at marriage, concept of small family norm, family size and preference for a son were assessed. The results indicated that all the girls were aware that there is a law regarding legal age of marriage but only 165 (65%) of them knew the correct legal age. Early marriage was preferred by 7.6%. Though 84.3% of the girls were aware of the small family norm, only 8.8% knew the exact norm. A preferred family

size of two or less was reported by 59.2%. Preference for a son was reported by 91.7%. Though many girls seem to be aware of the small family norm, few could correctly define it. Though most girls preferred a two-child family, almost all of them had a preference for at least one son. This preference for a son could dominate their future decision-making.

An innovative model for imparting reproductive health education to youngsters has been developed in recent years and has been extensively tested (Sharma and Sharma,

The '*letter box approach*' being tested as a innovative model for imparting reproductive health education to youngsters

1994; Sharma and Sharma, 1995). This model, *the letter box approach*, essentially centres on "*letter boxes*" that are placed in educational institutions. Students are encouraged to drop anonymous letters containing questions on any aspect of their health/bodies in these boxes. Letter boxes are periodically opened on pre-notified days and students are asked to come in groups to attend such sessions. Trained teachers from the same school, along with experts, provide answers to the letters from students. This approach ensures confidentiality and also enables a wider dissemination of correct, scientific knowledge helping to dispel myths, misconceptions and misbeliefs (Sharma and Sharma, 1994; Sharma and Sharma, 1995).

- **Reproductive health services**

India accounts for the largest number of teenage pregnancies in the world, yet, most of the reproductive health services in this country seems to have been developed for the married and the grown ups. In recent years, studies have pointed out the need for comprehensive reproductive health services for the benefit of unmarried young people (Sathe, 1992; Sharma and Sharma, 1996; Sharma and Sharma, 1997). Some insights into whether and how the reproductive health needs of adolescent girls are met, especially for gynaecological problems, family planning and perceived fertility problems can be gathered from a study conducted in 1995-97 in Ahmednagar district of Maharashtra, India. It included a survey among 302 married girls in the age group of 15 –19 years, and in-depth interviews with 74 girls, 37 husbands and 53 mothers-in-law. The results indicated that girls were treated quickly for illnesses interfering

with domestic work and were expected to conceive in the first year of marriage. Menstrual disorders and symptoms of reproductive tract infection often went untreated. Household work, protection of fertility and silence arising from embarrassment related to sexual health problems were the strongest factors influencing care-seeking. Husbands made the decision whether their wives could seek care and mothers-in-law sometimes influenced these decisions; girls had neither decision-making power nor influence (Barua and Kurz, 2001)

2.5 Relevant behavioural theories

While reviewing a decade of research on the correlates of early onset of sexual intercourse among female adolescents in the United States, Goodson et al., (1997) has pointed out that many studies lacked a theoretical framework or conceptual model to guide their investigations. However, the theoretical perspectives that have been most influential in shaping interventions in adolescent sexual and reproductive health are the cluster of health-risk-behaviour theories, encompassing such models as the health-belief model and social learning theory, seeking either to predict risky behaviour or to predict behavioural change (Hughes and McCauley, 1998; Auerbach et al., 1994). Building on the health belief model (e.g. Rosenstock, 1974) and the theory of reasoned action (Fishbein and Ajzen, 1975), a variety of models have been used to map out the cognitive correlates of safer sexual behaviour, and particularly condom use (Abraham and Sheeran, 1994). With consistent predictive power in explaining risk taking behaviour, this model has been widely used in studies of AIDS related behaviour (Brown et al., 1991; Carmel, 1990; Hingston et al., 1990; Kirscht and Joseph, 1989; Montgomery et al., 1989 quoted in Vanlandingham et al., 1995). This model has also been found to be particularly useful in predicting adolescent sexual and contraceptive behaviour (Gage, 1998). Little if any of this body of theory is specific to adolescents, although models based upon it have been applied to them, including many in developing country settings (Hughes and McCauley, 1998).

Cluster of health-risk-behaviour theories reported to be most influential in shaping interventions in adolescent sexual and reproductive health

Some of the other researchers (Lerner and Castellino, 2002; WHO, 1993) have demonstrated the potential of contemporary developmental theory for understanding the character and dynamics of adolescent development and for using this knowledge

for the design of effective policies and programs that promote positive youth development. This school of thought defines adolescent development as a complex process of physical, cognitive, social, emotional and moral maturation (WHO, 1993). Adolescent - development theory posits that a young person is shaped by his or her environment, both the immediate environment of home, family, and community and the wider environment created by the media, prevailing policy and cultural norms (WHO/ UNFPA/UNICEF Study Group, 1998 quoted in Hughes and McCauley, 1998)

As per the thrust of the study, reviewed below are the existing research literature with respect to the first line of thought, the health risk behaviour theories, especially Social Cognitive Theory, and their application to both studies and intervention programmes relating to the sexual and reproductive behaviour of young people and youth. Theories like Health Belief Model (HBM), Theory of Reasoned Action (TRA), and SCT have successfully been used to explain a wide range of health-protective behaviours, including safer sex practices (Wulfert and Wan, 1995). Wulfert and Wan (1995) has quoted Weinstein (1993) that such theories '*contain at least a grain of truth (so that) empirical tests typically yield some degree of confirmation, enough to keep the theory under scrutiny from being rejected*' (p. 324). It has therefore been advocated that, in the interest of scientific progress, these theories be compared against each other to establish which models or variables are more influential than others in understanding specific preventive behaviours. Perhaps these theories can be used to predict a given behaviour equally well because they partially overlap or embrace nominally different, yet functionally analogous constructs (Wulfert and Wan; 1995).

Numerous adolescent pregnancy and HIV prevention programs have used Social Cognitive Theory as their conceptual basis and one of the more popular theories that underlies these programs is Social Cognitive Theory (DiIorio et al., 2001), and programs based on this theory have generally been successful in encouraging adolescents to adopt safer sex practices both in terms of the delay of sexual intercourse and the use of condoms (Basen-Engquist et al., 1997; Kirby and DiClemnete, 1994). While investigations of the association between social

One of the more popular theories that underlies prevention programs is Social Cognitive Theory

cognitive factors and condom use are more numerous, the results seem to be equivocal (DiIorio et al., 2001). Higher levels of expressed self-efficacy to use condoms or talk to their partner about using condoms have been found to be associated with higher likelihood of intentions to use condoms (Basen-Engquist and Parcel, 1992; Basen-Engquist et al., 1997) or actually to use condoms (Basen-Engquist and Parcel, 1992; DiClemente et al., 1996). However, it has also been reported that self-efficacy is not a consistent correlate of condom use (Richard, 1991). Condom use in heterosexual relations has also been reported to be dependent to a significant degree on three key factors: the expected consequences of condom use, perceived social support for using condoms, and self-efficacy (Wulfert and Wan, 1995). These findings were emerged in the course of a study examining how well social cognitive theory and constructs from other model like the health belief model, the theory of reasoned action are capable of explaining heterosexual persons' safer sex intentions and condom use. This finding was evolved in three studies; the first study being conducted with sexually active young adults (college students) who completed an anonymous questionnaire about their sexual behaviour and concepts pertaining to the three models. The analyses identified conceptually analogous concepts in the three models that explained a significant part of the variance in intentions to practice safer sex. These concepts referred to cognitive-affective reactions toward condom use and the social context of using condoms. A concept unique to social cognitive theory, self-efficacy explained additional variance. In the second study, these findings were replicated with sexually active older adults (members of a singles network). In both studies, the model based on social cognitive theory explained more than 70% of the variance in intentions to use condoms. In Study 3, this model was then tested longitudinally over a three-month interval with sexually active college students and explained 50% of the variance in condom use (Wulfert and Wan, 1995).

Association between social cognitive factors and condom use are more numerous, but the results reported to be equivocal

Again, Adih and Alexander (1999) has identified the psychosocial and behavioural factors that influence condom use to reduce the risk of human immunodeficiency virus (HIV)

Conceptual framework involving constructs from SCT and HBM found to be successful in explaining condom use in Ghanaian context

infection among young men in Ghana using constructs from Social Learning Theory (SLT) and from the Health Belief Model (HBM) in the Ghanaian context as conceptual framework. This cross-sectional study which collected data from a community-based sample of 601 young men, 15-24 years of age, using a household survey instrument indicated that while 65% of the sexually active male respondents had used condoms at least once, only 25% had used condoms at last intercourse. Perceived susceptibility to HIV infection, perceived self-efficacy to use condoms, perceived barriers to condom use, and perceived social support were significant predictors of condom use. The most important finding, however, is that perceived barriers significantly interacted with perceived susceptibility and self-efficacy. Subjects who perceived a high level of susceptibility to HIV infection and a low level of barriers to condom use were almost six times as likely to have used condoms at last intercourse, compared to others. Similarly, young men who perceived a high level of self-efficacy to use condoms and a low level of barriers to condom use were nearly three times more likely to have used condoms at last intercourse when compared to others (Adih and Alexander, 1999)

Koniak-Griffin et al., (2003) have examined the sexual behaviours and attitudes toward condom use of adolescent mothers ($N = 572$) from ethnic minority groups using constructs from social cognitive theory (SCT), the theory of reasoned action (TRA), and the theory of planned behaviour (TPB). Intentions to use condoms, self-efficacy and outcome expectancies were measured and using hierarchical regression analysis, 13% of the variance for factors associated with unprotected sex was accounted for by TRA constructs. Other variables contributed an additional 17% of the variance (Koniak-Griffin et al., 2003).

Dilorio et al (2001) have examined the role of self-efficacy, outcome expectancies, and perception of peer attitudes in the delay of onset of sexual activity and the use of condoms among 13- through 15-year-old adolescents using separate interviews among adolescents in this age group and their mothers recruited from a community-based organisation that offered afterschool and summer programs for youth. The

Self-efficacy, outcome expectancies and perception of peer attitudes in the delay of onset of sexual activity seem to affect the use condoms among adolescents

average age of the 405 adolescent participants was 13.86 years, and approximately 30% of them had engaged in sexual intercourse. Slightly more than half (56%) of the participants were male, and 82% were African-American. The results indicated that participants who were less likely to believe that their friends favoured intercourse for adolescents and who held more favourable attitudes about the personal benefits of abstaining from sex were less likely to have initiated sexual intercourse. Among sexually active adolescents, those who expressed confidence in putting on a condom, and in being able to refuse sex with a sexual partner, and who expressed more favourable outcome expectancies associated with using a condom were more likely to use condoms consistently (Dilorio et al, 2001)

Levinson (1995) has utilised a social learning theory perspective to investigate the relationships among teenage women's Contraceptive Self-Efficacy (CSE), Reproductive and Contraceptive Knowledge (RCK), and contraceptive behaviour among 521 respondents from two diverse samples of teenage women attending family planning clinics. Although no significant relationships were found between RCK and behaviour, the four-factor model of CSE explained 12% and 28% of the variance in RCK in the two samples. Results on the RCK items revealed sample differences and common areas of misinformation that are critical to effective contraceptive and prophylactic use (Levinson, 1995)

- **Evaluation studies**

Eisen et al. (1990) has reported a controlled field study involving 1,444 adolescent males and females 13-19 years of age performed to compare a sexuality education program based on the health belief model

and social learning theory with community-based and school-based interventions. It was indicated that among males who had never had intercourse prior to participating

Regardless of the type of intervention program attended, consistent use of effective methods among teenagers significantly increased who had been coitally active before attending the programs

in the study, those in the experimental program were more likely than those in the comparison programs to maintain abstinence over the next year; there was no program effect, however, among females. Among female adolescents who initiated intercourse after the start of the study, attendees of the comparison programs were

more likely to have used an effective contraceptive at most recent intercourse and to have used an effective method more consistently than were those who attended the experimental program; no such association was seen among comparable young men. Both experimental and comparison programs significantly increased the consistent use of effective methods among teenagers who had been coitally active before attending the programs. Among males, however, when pre-intervention contraceptive efficiency was held constant, the experimental program led to significantly greater contraceptive efficiency during the follow-up year than did the comparison programs; among females, the two approaches produced an equivalent degree of improvement. Finally, prior exposure to sexuality education was associated with greater contraceptive efficiency at the one-year follow-up among almost all sexually experienced and gender groups, regardless of the type of intervention program attended (Eisen et al., 1990)

Boyer (1997) has evaluated the efficacy of a school-based knowledge- and cognitive-behavioural skills-building STD/HIV prevention intervention among 513 ethnically and racially diverse students with a mean age of 14.4 years attending

Knowledge- and cognitive-behavioural skills-building prevention intervention effective at increasing STD knowledge, and skills related to prevention of risky sexual and drug use behaviour.

four urban public high schools. A quasi-experimental design was utilised to evaluate the intervention which consisted of three class sessions. Results of hierarchical regression analyses, controlling for baseline scores and demographic factors, indicated that the intervention was effective at increasing STD knowledge, and skills related to prevention of risky sexual and drug use behaviour, even though significant changes in risk behaviours were not detected.

While such findings as discussed above point to the need for broad-based prevention efforts that build on theoretical concepts and address the realities of young people's lives, they can also be used to identify possible factors responsible for risky behaviour and to recommend content for educational interventions.

2.6 Literature review on methodology

- **Qualitative methods**

The aim of qualitative research is to “discover the unknown”, to determine “what exists” and “why it exists” rather than “how much of it is there” (Maier et al., 1994). They allow the observer to

Qualitative research is to discover the unknown to determine what and why of a phenomenon

give meaning to a reality based on a holistic and naturalistic inquiry. Qualitative research is based on open procedures which can be adapted to the context, using the researcher as the research instrument. With this method, there are three basic ways of collecting data which are: interviews, observations and written documents (Patton, 2001).

As the study is intended at exploring people’s views and perceptions, a qualitative approach has been found to be more relevant in the present study. There are many techniques for qualitative research but only four of them are reviewed here. These four common techniques are judged to be suitable and are used for the present study.

- **Semi structured in-depth interviews**

Interviews consist of open – ended questions and probes that yield in-depth responses about people’s experiences, perceptions, opinions, feelings and

Interviews consist of open – ended questions and probes that yield in-depth responses about people’s experiences, perceptions, opinions, feelings and knowledge

knowledge. Data consist of verbatim quotations with sufficient context to be interpretable (Patton, 2001). Semi structured interviews are the preferred method for people who are accustomed to efficient use of time such as managers, bureaucrats and elite community members (Bernard, 1990). In such interviews, though the interviewer uses an interview guide which provides the themes on which information has to be elicited, the interviewer is free to follow leads or probe deeper. The strength of this method is that the outline increases comprehensives of data, and makes data collection somewhat systematic for each respondent. Logical gaps can be anticipated and closed and interviews remain fairly conversational and situational. The

weaknesses are that important and salient topics may be inadvertently omitted. Interviewer flexibility in sequencing and wording questions can result in substantially different responses reducing comparability of the methods (Patton, 1982).

- **Key informant interviews**

Key informants are people who have a special position within a social group and are looked upon as representative of the opinions and experiences of a whole group; they often see the problems of the group rather than of an individual (Maier et al., 1994). They control a lot of information about the culture and are able to yield a lot of information about a community in a fairly short time to the researcher. Two things vital while selecting a key informant are; 1. the person should be competent and knowledgeable about the issue being talked about and 2. the ability of the researcher to elicit the information from the person (Bernard, 1990). However, as the key informants are often in a superior position within their group, they may not always represent the views of minorities or vulnerable communities. This may introduce a bias as they may not represent the views of the vulnerable groups of their communities which needs to be watched (Maier et al., 1994)

Interviews with those having a special position within a social group and are looked upon as representative of the opinions and experiences of a whole group.

- **Observation**

Observations are fieldwork descriptions of activities, behaviours, actions, conversations, interpersonal interactions, organisational or community processes, or any other aspect of observable human experience. The data consist of field notes: rich, detailed descriptions, including the context within which the observations were made (Patton, 2001). The observation technique can be either open if the role of the observer is known by the observed or hidden if not. With this method we have a high degree of participation of the researcher and a low degree of participation of the observed. An observation form or a checklist is used in a structured observation. Checklists may involve the use of closed ended questions or the use of rating scales (Stone, 1993). The criticism to this technique is that it can easily introduce bias because when people know they are being observed they may change their behaviour to a more acceptable one; this is the “Hawthorne effect”

Fieldwork descriptions of observable human experience

(Maier et al., 1994). Therefore bias introduced has to be taken into consideration in the analysis of the data.

- **Document content analysis**

Written documents and other materials from organisational, clinical or program records; memoranda and correspondence; official publications and reports; personal diaries, letters, artistic works, photographs and memorabilia; and written responses to open ended surveys. Data consist of excerpts from documents captured in a way that record and preserves context (Patton, 2001). Document reviews provide information and are a ready source of data. The advantage is that records are usually readily available, cheap and cover a long span. However, it is difficult to check the accuracy of the records which may sometimes be incomplete. Written documents give researchers background information and baseline data which can be helpful in understanding situations and also useful in comparison with actual findings (Walker, 1996).

Analysis of written documents and other materials

- **Sampling procedures**

The method of selecting a portion of the ‘universe’ or ‘population’ with a view to drawing conclusions about the universe *in toto* is known as sampling (Wilkinson and Bhandarkar, 1984). Most studies are not done on the total universe for it is consuming too many resources (time and money). Therefore sampling is important in studies. As noted by Patton (2001), one of the most important difference between quantitative and qualitative methods is the different logic that undergrid sampling approaches. Qualitative inquiry typically focuses in-depth on relatively small samples, even single cases (N=1) selected purposefully. Purposive sampling is used to select specific populations and generally does not allow wider generalisation. Quantitative methods typically depend on larger samples selected randomly (Patton, 2001). There are several different strategies for both purposeful as well as random sampling which are beyond the scope of this review.

Method of selecting a portion of the ‘universe’ or ‘population’ with a view to drawing conclusions about the universe *in toto*.

In qualitative studies, Patton (2001) recommends that sampling designs specify minimum samples based on expected coverage of the phenomenon given the purpose of the study and the stakeholder interests. The general rule for the number of key informants to be chosen is to the point of redundancy, i.e. until you find yourself receiving the same answers from informants (WHO, 1997a)

- **Reliability and validity of data**

“Validity is an expression of the degree to which a test is capable of measuring what it is intended to measure” (Beaglegole et al., 1993; Wilkinson and Bhandarkar, 1984). An instrument of measurement is *reliable* to the extent that the independent and comparable measures of the same object give similar results (provided that the object being measured does not undergo change in between the measurements) (Wilkinson and Bhandarkar, 1984) Smith (1982) states that combining methods and using a wide variety of research techniques can improve validity and reliability.

Validity is an expression of the degree to which a test is capable of measuring what it is intended to measure

An instrument of measurement is *reliable* to the extent that the independent and comparable measures of the same object give similar results

The more unstructured a method is the higher degree of its unreliability as in the case of qualitative approaches (McNeil, 1988). The same author has stressed that reliability and validity of quantitative approaches can also be influenced by the amount of responses generated, the more varied the responses to predefined questions and observations, the more difficult it is to understand the people’s definition of reality. In qualitative studies, validity issues are more complex than in quantitative ones. According to Patton (2001), “the validity and reliability of qualitative data depend on the methodological skill, sensitivity and integrity of the researcher”. He points out that a combination of interviews, observation and document analysis is expected in much social science field work which requires hard work, knowledge, creativity, training and practice.

- **Triangulation**

Triangulation is the way to strengthen the study designs and to improve the quality and reliability of collected data. This can mean using several kinds of methods or data, including using both quantitative

Triangulation involve using several kinds of methods or data, including using both quantitative and qualitative approaches

and qualitative approaches (Patton, 2001). There are four basic types of triangulation; *data triangulation* using a variety of sources of data in a study; *investigator triangulation* using researchers of different backgrounds; *theory triangulation* using multiple perspectives to interpret a single set of data and *methodological triangulation* using several methods to study the same problem (Denzin, 1978 quoted in Patton, 2001).

CHAPTER 3

Research methods and materials

As described in the previous section, broadly the study intended at describing the risky sexual behaviour of young people in India and at examining the fit between the sexual and reproductive health concerns and the existing programming to meet the needs based on Social Cognitive Theory constructs. The empirical data regarding the sexual and reproductive health concerns and the existing programming responses were collected through original field research using qualitative methods.

In the study, the terms 'adolescents, youth and young people' have been used interchangeably. Adopted definitions for 'adolescents' as those aged between 10-19 years, and 'youth' as those between 15-24 years . The term 'young people' has been used to cover both the age groups, i.e. from 10-24 years (WHO, UNFPA, UNICEF, 1989)

The study was intended to be descriptive and partly exploratory in nature. The qualitative methods consist primarily of in depth semistructured individual interviews, supplemented with observations and analysis of some policy documents, programme reports and other sources like newspaper clips. Unstructured field notes made during the data collection were also used subsequently to supplement and interpret the findings.

Following is an account of the study population, study method and main focus of investigation.

3.1 Study population

The study population comprised of planners and policy makers in the Departments of Health, Education and Family Welfare, programme managers or other officials from relevant state government bodies, representatives from local, national as well as international N.G.O s working with young people, health service providers, young people and key informants like parents, teachers and media representatives. A sample of 50 respondents from diverse backgrounds and expertise were interviewed to determine the scope of young people's needs and potential solutions. Most of the interviewees were actively involved in some way or the other in planning or

delivering programs and services for young people. The others who were selected were considered to be knowledgeable about young people's sexual reproductive health needs, the existing policies and programmes and young people's access to services (Table 3.1). Respondents were identified through a combinations of convenience and purposive sampling, the use of key informants and programme and service reports and records. Some of the interviewees could point out other possible respondents who are knowledgeable about the situation or who are running programs for young people. The respondents comprised of both men and women, belonged to the age group of 14-50 years of age and almost all of them were married except the young people themselves (Annex 3: Profile of the respondents).

The whole field study was done with the assistance of the RCH Project of the Indian Institute of Management, Ahmedabad (IIM-A). The personnel from the project were consulted and assistance was sought in contacting the respondents and fixing up appointments etc. The inclusion of new respondents in each category was stopped when no further new information seemed to be coming up.

3.2 Time frame of the study

The entire field study was covered during the period from May to October 2001. Preliminary activities like meeting the concerned officials, social scientists and experts in the field and activities like the pre-testing and adaptation of the interview guidelines were done during the second week of June. During this time appointments with the officials and other respondents were made with the assistance of the RCH project personnel from Indian Institute of Management, Ahmedabad. Then the interviews were started. Some of the documents relating to laws and policies concerning the reproductive health of young people were also collected simultaneously.

Table 3.1 - Study population, study method and main focus of investigation

STUDY POPULATION	SIZE	STUDY METHOD	MAIN FOCUS OF INVESTIGATION	
<p><u>Government officials</u></p> <ul style="list-style-type: none"> ❖ <u>Planners and Policy makers</u> Department of Health 2 Department of Family Welfare 1 Department of Education 2 ❖ <u>Programme Planners/Managers of State Government Bodies</u> 5 			<ul style="list-style-type: none"> ❖ Extent and characteristics of risky sexual behaviour among young people. ❖ Magnitude and characteristics of hazardous consequences ❖ Existing policy and programme strategies to meet the needs ❖ Access to the health care services for problem relating to sexual and reproductive health. ❖ Constraints faced by the officials in the planning and implementation of programmes and services for young people ❖ Perspectives regarding the strengthening of existing programmes and policies and services 	
<p><u>NGO representatives</u></p> <ul style="list-style-type: none"> Local 5 National 1 Intergovernmental Organisations (IGO) 2 		In-depth semistructured individual interview		
<p><u>Health Services Providers</u></p> <p><u>Public Health Care System</u></p> <ul style="list-style-type: none"> Primary Health Centre 2 Community Health Centre 3 District Level 4 <p><u>Hospitals:</u></p> <ul style="list-style-type: none"> Teaching Hospital 5 <u>Private Practitioners</u> 5 				
<p><u>Young people</u> 6</p>				
<p><u>Key informants</u></p> <ul style="list-style-type: none"> Parents(3), Teachers (3) Media Representative (1) 7 		Key Informant Interview		
<p><u>Total</u> 50</p>				
<p>Health facilities 3</p>		Observation		To gather objective information about services
<ul style="list-style-type: none"> 1. Documents relating to the laws and policies pertaining to young people's access to SRH services 2. Program reports and record of different programs 3. News paper clips 		Document Review		<ul style="list-style-type: none"> ❖ The possibilities and constraints in the existing policy and legal regulations for young people to get access to SRH services ❖ Detailed accounts of different programs ❖ Newspaper reports concerning SRH issues of young people

3.3 Data collection

3.3.1 Methods used

The following qualitative techniques were used in this study.

3.3.1.1 Semi-structured interviews

In-depth semi-structured interviews were the predominant method used to assess the perspectives of government officials, N.G.O representatives, health service providers and young people using a standard but flexible guideline. More or less same guidelines were used for planners and policy makers in the concerned ministry departments, *viz*: Department of Health, Department of Family Welfare, and Department of Education, Programme Planners/ Managers of State Government Bodies and NGO Representatives both national and international. The main areas covered are perspectives regarding risk behaviour policy and programme strategies and interventions currently exist both at the governmental and at the NGO level to meet the needs of young people, access to health services for SRH problems of young people, the risky sexual behaviour consequences, perspectives regarding the strengthening of existing services programmes and policies or the introduction of new ones and the constraints faced in the planning and implementation of programmes and services for young people. All together eighteen (18) interviews were made in this category. (Annexure 4: Guidelines for interviews with planners and programme managers)

Most of the health service providers interviewed were from Ahmedabad (urban) and Sanand (rural) districts. In each interview, the interviewer first asked the providers a series of simple questions about their clinical practices in the case of unmarried young people. The response protocol was then used to probe responses to the original questions regarding the sexuality of young people and the issues of priority concern in their sexual and reproductive lives, programmes and policies in meeting the sexual and reproductive health needs of young people, service practices that might be construed as access barriers, the constraints faced by the providers in the delivery of services and the recommendations for improvement. (Annexure 5: Guideline for interview with health service providers). All together nineteen (19) health service providers were interviewed.

For young people also more or less the same guidelines were used with questions directed at explaining their perspectives about their own situation or the situation in general (Annexure 6: Guidelines for interview with school going young people). Six interviews were conducted in this category. The interviews were conducted in Hindi and in English when the interviewee was able to speak English.

The duration of one interview on an average was 45 to 1 hour. Some interviews lasted more depending on the willingness to talk and the time constraints of the respondents. Except for the interview with one health service provider, all the interviews were tape-recorded with the consent of the interviewee. Most of the interviews were conducted at the office room of the interviewees.

3.3.1.2 Key informant interviews

Key informant interviews were held with seven key informants including parents (3), teachers (3), media representative (1) using a standard but flexible guideline (Annexure 7: Guidelines for interview with key informants). The aim here was to elicit their perspectives regarding sexuality of young people and the issues of priority concern in their sexual and reproductive lives, the efficacy of existing services, programmes and policies in meeting the sexual and reproductive health needs of young people and the barriers young people face in accessing the services.

3.3.1.3 Direct observation

Health workers as well as the organisation of the selected facilities were observed in an open non-participant role using a checklist (Annexure 8: Check list for structured observation in health facilities). Observations within each setting was identified, interpreted and quantified through brief on-the-spot notes compiled during service hours. Information was compiled on the service provision process, on the health educational materials used, on the availability of equipment and on privacy.

The guide included items on policies of the clinic, procedure followed by the clinic, the clinic staff, the clinic environment and the utilisation of the clinic. A total of four centres including two departments of a teaching hospital and two clinics of private practitioners were observed by the researcher in order to get information about the existing practices in the units dealing with sexual and reproductive health problem.

3.3.1.4 Document content analysis

Documents reviewed include the National Health Policy, the Medical Termination of Pregnancy Act, the Immoral Trafficking of Women Act, the Population Education Project, Status Survey Report, National AIDS Control Organisation Report.

3.3.2 Tools of data collection

For the collection of data through individual interviews and observation, the WHO rapid assessment tools developed in „Improving the accessibility of health services that meet the SRH needs of adolescents (1997c) were used as a guide to construct the guidelines.

The guidelines used are:

- Guidelines for interviews with planners and programme managers (Annexure 4) adapted from WHO Instrument II: Check-list to cover individual interviews with staff in relevant government department and youth serving NGO at district level
- Guideline for interview with health service providers (Annexure 5) adapted from WHO Instrument VIII: List of questions for individual interview with health care providers
- Guidelines for interview with school going young people (Annexure 6) adapted from WHO Instrument III: Guidelines for focus group discussions with school going young people
- Guidelines for interview with key informants (Annexure 7) adapted from WHO Instruments II, V and VI : Check list to cover individual interviews with staff in relevant government department and youth serving NGO at district level, checklist for focus group discussions with parents and teachers
- Check list for structured observation in health facilities (Annexure 8) adapted from WHO Instrument IX: Check list of issues for gathering objective information about the health facility

The instruments have been modified to suit the research objectives and the informant's position and area of work. The term "adolescent" has been changed into "young people".

The following raw data were compiled for analysis:

- Interviews with planners and policy makers in the concerned ministries, state government bodies and N.G.Os
- Interviews with health service providers
- Interviews with young people
- Key informant interviews
- Observations
- Document content

3.3.3 Data processing and analysis

All the recorded interviews were transcribed. The reliability of interpretations were counter-checked with notes and memory protocols. Data analysis was done manually. Transcripts were hand coded using a provisional coding list that was developed from the guidelines and those emerged during data collection. Codes were then revised through an iterative process of reading and rereading the transcripts. Coded data were examined for similarities and differences between sub-groups, and matrices were developed. The analysis was made focusing on emerging patterns by identification of the domains of responses and answers grouped accordingly.

3.4 Validity and reliability

- Assurance of strict confidentiality to ensure maximum reliability and validity of the data.
- The guidelines were pre-tested and changes were made accordingly in order to improve the quality of the data.
- Internal consistency: With respect to the interviews all of them were tape-recorded and transcribed and compared with hand written notes.
- External validity: Comparing the results with those reported in the literature indicated a considerable degree of agreement with findings from within the country as well as those from similar socio- cultural backgrounds.
- Triangulation involving different information sources was employed to improve the validity and reliability of the collected data.

3.5 Ethical considerations

Informed consent was sought from the respondents after explaining the objectives of the study and how the data were going to be used. Participation was absolutely voluntary and respondents were informed that they can drop out at any time during the interview. Full anonymity was also ensured during the interviews. No incentives were given to any one of the participants.

3.6 Limitations of the study

- This study is a qualitative one and the generalisation of findings is limited and the comparison with quantitative studies is difficult.
- The geographical spread of the respondents also does not provide basis for generalising the results to the state as a whole.
- The approach followed in the present study involved collecting information about young people's sexual and reproductive lives based on secondary reports from adult stakeholders. This could perhaps limit the reliability of the study findings in making precise estimates regarding the magnitude of risky behaviour as well as consequences.
- Though the study made use of Social Cognitive Theory constructs in defining a model for risky behaviour as well as intervention framework, direct associations between behaviour and the SCT concepts was not estimated.

CHAPTER 4

Sexual risks of young people and programming responses

Presentation of research results

Presented here are the empirical findings with respect to the sexual risks of young people and the existing programming responses to meet the needs. The magnitude and characteristics of sexual risks are presented both in terms of the context of sexual involvement and the hazardous consequences. Programming is meant here to encompass any organised primary prevention or care activity designed to make sexual and reproductive health information and services available to young people. The programming responses as designated here comprise of policies and programmes as well as access to existing health care services.

As mentioned before, the information was collected from 5 categories of respondents; government officials, non-governmental organisations (N. G.O) representatives, health service providers, young people and key informants. The views are presented in 3 sections; section 1 dealing with the sexual risks of young people along with a conceptual model for risky behaviour, the need for intervention and a model for intervention based on Social Cognitive Theory; section 2 dealing with the current policies and programmes intended at providing information and services to young people along with an examination of its suitability and section 3 describing the barriers in accessing health care services. The constraints faced by the programmers and service providers are also presented respectively in sections 2 and 3. Their recommendations for improvement are integrated in to the study recommendations.

4.1 Sexual risks of young people and framework for intervention

As mentioned above, sexual risks are presented both in terms of the context of sexual involvement and the hazardous consequences. With respect to the context of risky sexual involvement, a cautious classification of the views of the stakeholders are made in terms of marital and premarital sexual relations. The consequences are presented in terms of the prevalent hazardous outcomes like too early child bearing, Sexually Transmitted Infections including HIV /AIDS and unsafe abortions. Marked

differences in opinions between different categories of the respondents are also presented wherever applicable. By way of conclusion, the need for intervention is indicated and a formulation of the type of intervention based on SCT concepts is attempted.

Before going on to present the precise views of the respondents regarding the health hazards arising from sexual behaviour as such, it is important to make a note of the views about other issues which could have serious implications on sexual and reproductive health. For instance, some of the respondents especially government officials and some providers from the public health system came out with issues like malnutrition among adolescents and the prevalence of diseases like sickle cell disease which can have important repercussions on reproductive health. However, in accordance with the thrust of the study, the results presented here pertain directly to those arising in the context of sexuality and sexual behaviour.

4.1.1 Context

4.1.1.1 Early marriage

i Extent of the practice

Though marriage or union is an important context for the socially accepted expression of sexuality in the Indian set up, sexual behaviour occurring within too early marriage seems to be posing serious health risks as expressed by some of the stakeholders in the present study. This was mentioned as a priority issue affecting young people's sexual and reproductive health by eleven of the respondents (Table: 4.1). According to them, early marriage widely continues to be the norm in rural areas and among certain religious groups in urban slums though the legal age of marriage in India is 18 years. The practice of giving the girl in marriage *at the age of 12, 13 or 14 years* seems to be mostly prevalent in rural village communities though.

An associated custom is the performance of "Gauna" (formal marriage ceremony) at a very young age. After gauna, the girl goes back to her parent's home and then she makes occasional visit to the in-laws' for festivals and such things. When she is able to look after the household chores, *as reported at 15, 16 or 17 years*, she comes to the in-laws and start living together with the boy. Though sexual relations are not expected to take place before the official cohabitation, this does not seem to be the

case always as presented by two of the respondents in this category who elicited their own experiences of witnessing pregnancy before the formal marriage ceremony.

“Sometimes gauna is performed even at the age of 8 years or so. And normally the girl and the boy is not supposed to have physical relations. But I have personally seen two cases of pregnancy, the girls were 12 or 13 years, the ‘Gauna’ had been done and before going to the in-laws house, the girl got pregnant, and then it was a big problem as the purity of the girl is gone and it can cause the marriage to break, nobody knows who is responsible for the pregnancy” (Auxiliary Nurse Midwife 1)

Here though the respondent seemed to be more concerned about the social consequence in terms of ‘breaking the marriage’ it also reveals how such practices can contribute to very early sexual initiation.

ii **Contributing factors**

Declining age at menarche, parental attitudes and cultural norms were the factors pointed out to be responsible for the practice of early marriage.

- **Declining age at menarche**

Declining age at menarche as a responsible factor for too early marriage was pointed out by 8 of the respondents including 4 government officials, 1 local NGO Representative, 1 IGO representative, 1 service provider from the public health system and 1 media representative.

“As you see globally, basically what has happened is before say 15-20 years back, menarche was 14.8 years average, this has come down to 12 years or so. This is a biological change which could be attributed to better nutritional status and so the risk period has enlarged” (IGO Official 1)

As presented below, in rural areas and some urban slums, onset of menarche is often taken as a mark of reproductive maturity which is closely followed by marriage and child bearing.

- **Parental attitude and parental control**

Parental attitudes coupled with higher degrees of parental control over the timing of marriage seems to be an important factor causing too early marriages as perceived by the stakeholders. As pointed out by 7 of the respondents, the first menstrual period is often taken as the sign of maturity by parents in such communities.

“When menstruation starts, the parents start worrying and as soon as possible they want to get the girl married. Actually it takes longer time for these girls to be physically and emotionally mature, may be around 5 years more, but in the villages they equate the first menstruation with maturity. And parents have the total say in the marriage of their daughter” (IGO official 1)

- **Socio- cultural norms**

Social and cultural factors seems also to play a big role in underlying the practice of early marriage though their direct effect could not be fully comprehended from the responses.

“And you see in such communities, if the boy or girl goes 20 or 25 then, they will not be able to get a partner in marriage” (IEC Officer, CHC)

One prominent factor is the virginity till marriage expressed as ‘purity’ which is an important consideration for marriage itself in the cultural context. As brought out by the respondents, early marriage is a means of protecting the girl’s virginity as the virgin status is said to *reflect her good character and is an important criterion for marriage itself.*

Here, the concerns of one fourth of the respondents about the prevalence of early marriages corresponds to the situation still prevailing in rural areas and some traditional orthodox societies characterised by too early marriage and early child bearing . Here the start of menstruation is often taken as a sign of maturity which is further combined with marriage or at least a formal marriage ceremony. Given that menstruation is happening at earlier ages than previously, this practice leads to many girls marrying very young with the onset of puberty.

Early marital sexual activity - Highlights

- The practice of too early marriage or “Gauna” reported to be **widely prevalent** in villages and certain urban slums initiating sexual intercourse very early.
- **Declining age at menarche, parental attitudes and cultural norms** seem to be the major factors responsible for the practice of early marriage.

4.1.1.2 Premarital sexual activity

i Prevalence

While early marriage has been presented as a major reproductive health issue in rural areas, the other grave concern is of premarital sexual activity among young people involving unprotected risky behaviour. Sexual activity among both male and female adolescents and youth seems to be a fact of the times. More than half of the interviewees (27) pointed that pre-marital sexual activity has assumed great proportions among young people (Table: 4.1). Although the systematic collection of information on pre-marital sexual activity was found to be difficult, some broad patterns of sexual behaviour among young people could be identified during the course of the study.

While majority of the respondents seemed to be perceiving premarital sexual activity as an urban problem, almost half of them seemed to base their perspectives on school and university populations, and the other half focussed on out of school youth.

“I am absolutely sure that pre marital sexual activity has increased because the kind of data we get every year from the schools shows that it has come in such a big way, even here in GandhiNagar, people have found boys and girls from schools, even those from (mentioning one prestigious private school), in the park in indecent positions, but before it was not like that, children used to meet each other, there used to be love affairs, but the physical aspect was not there this much ”(Official, Local NGO 3)

“I am 100% sure that problems related to pre marital sexuality are increasing day by day” (Teacher 1)

Though making precise estimates about the prevalence of premarital sexual activity was out of the scope of the study, a few of the respondents could present specific data regarding the extent based on their own experiences of working with young people.

“Premarital sex is very much there, and not just in Gujarat, but all over India. We were just keeping a blind eye to it. In around 1989 and 1990, as we started talking about condoms in the community, we realised that many young couples or young adolescents who are married were sexually active even before marriage. We conducted surveys and found the prevalence of premarital sexual activity to be some where between 15 to 25%. We have it documented too. We have also data from other states which is almost similar. It is not that Gujarat and Uttarpradesh and Tamil Nadu are different” (IGO Official 2)

Table 4.1 : Risky sexual involvement – Frequency of expressed views

STUDY POPULATION	SIZE	Risky sexual involvement				
		Context		Consequences		
		Early marital	Premarital	Too early pregnancy	Sexually Transmitted Infections	Unwanted pregnancy and Unsafe abortions
<u>Government Officials</u>						
<u>Planners and Policy makers</u>						
Department of Health	2	1	-	1	-	1
Department of Family Welfare	1	-	-	-	1	1
Department of Education	2	-	1	-	1	1
<u>Programme Planners/ Managers of State Government Bodies</u>	5	2	2	2	4	4
<u>NGO Representatives</u>						
Local	5	2	4	4	4	3
National	1	-	-	-	-	1
IGO	2	1	2	1	2	2
<u>Health services providers</u>						
<u>Public Health Care System</u>						
Primary Health Centre	2	2	-	2	-	-
Community Health Centre	3	2	-	2	-	1
District Level	4	1	2	1	2	-
<u>Hospitals:</u>						
Teaching Hospital	5	-	3	-	2	2
Private Practitioners	5	-	4	-	1	4
<u>Young people</u>						
	6	-	4	-	2	4
<u>Key informants</u>						
Media Representatives (1) Teachers (3), Parents(3)	7	-	5	-	5	5
Total	50	11	27	13	24	29

The data put forward by a local NGO representative who is also a public health consultant indicated the alarming rates of premarital sexual activity involving risky behaviour among young people in certain communities like urban slums.

“The urban slum where I work, it is a very free society; 90 – 95% of the unmarried young boys in the age group 13 – 25 years have at least one exposure to sexual intercourse, most of them may have several instances, and among adolescent girls at least 40 - 50% have experienced sexual intercourse. As I work with them, young people in the age group 16 - 22 frankly discuss their problems and they always say - I visit such and such places (meaning commercial sex workers) 10 times a month, 5 times a month - frankly... ..no inhibitions” (Official, Local NGO 1)

Another pattern of pre-marital sexual behaviour pointed out was among couples who are engaged, but have to wait for reasons like employment, education etc. for some time before they can marry and can officially stay together. As noted by a private medical practitioner who caters mostly to the upper socio-economic class of people:

“This type of pre-marital sexual activity is so rampant, if I take 10 people who are engaged 8 of them are having sex before they get officially married” (Private Medical Practitioner 1, Obstetrician and Gynaecologist)

Though these are only isolated reports and could not be judged to present the exact measure of the prevalence of premarital sexual activity, these could well be taken as reliable indicators for the gravity of the situation. Moreover, as a proxy for defining the actual extent of the situation, these reports when supplemented with quantitative information could yield reliable measures of the extent of premarital sexual activity.

Among the rest of the respondents, on prompting, nobody seemed to be strongly disagreeing with the notion that young people are sexually active before marriage. However, majority of them seemed to be ambivalent with varied responses which could be categorised into two based on the extent of ambivalence. The first category consisted of respondents who expressed awareness about associated problems, but do not want to admit it in the absence of reliable data.

“I know cases of premarital pregnancies, that means premarital sex is going on, but we do not have any reliable data and can not say a definitive yes or no”(Health Service Provider 1, Teaching Hospital, Obstetrician and Gynaecologist)

The other category of responses were on the lines that it is more of a western phenomenon which might be slowly setting in the Indian society too. Surprisingly most of the governmental officials from the concerned ministries belonged to this category.

“I don’t have the data, as I see it is more of a western problem, but may be, as people advance, the so called advance, there may be some influence and things like that might be happening”(Official 1, Department of Health)

However, Many of the respondents who expressed ambivalence indicated hazardous consequences of risky sexual behaviour which are presented in later sections. Such apparent contradictions show the dilemma faced by at least some of the stakeholders involved in the planning and implementation of programmes and services.

Considering the reports of more than half of the respondents and the detailed estimates presented by some of them, it can be safely concluded that many young people do involve in sexual relationships before marriage.

ii Contributing factors to premarital sexual activity

Great majority of the respondents (35) came out with a number of predisposing and interplaying biological, social and economic factors to explain premarital sexual activity. Urbanisation and the changing social context (16), rising age at marriage coupled with declining age at menarche (15), sexual abuse and coercion (13), peer pressure (8) greater reach of the media and media influence (7), increase in the availability of contraceptives and other corrective measures (2) were all pointed out as possible reasons for young people to get into sexual relations before marriage.

• Urbanisation and the changing social context

Urbanisation and the changing social context with the associated phenomena of migration and modernisation have been cited as playing a major role even in fundamental matters of sexuality, marriage and reproduction by 16 of the respondents including government officials, local NGO representatives, key informants and health service providers. Increasing modernisation seems to be undermining the societal and cultural rules that formerly controlled adolescent sexuality. As a result of the decline in the authority of parents and elders, girls and boys are getting more chances to mingle with each other, which seems to be resulting in intimate physical relationships too.

“Gujarat is the most urbanised state in India, has the highest number of small towns, 242 or something like that; every 22 to 25 km, there is a small town, and these towns are supporting several things like the villages around and all that. As far as I

understand, this is one of the states where problems related to adolescent sexuality are reported on a big scale” (Official, Local NGO 2).

“There is also migration and external influences, I do not mean to say people who migrate are fully responsible, but modernisation is coming and the culture itself is changing and girls and boys now are getting more opportunity to interact with each other and be together, then it is natural that they develop intimate relationships so such things are definitely happening.” (Official, State Government Body 1).

“It is more of a social problem. As the society gets modernised, the licence for girls to stay outside during the night and their frequency of interactions with boys go higher. Probably this situation is taken advantage of” (Official 1, Department of Health)

- **Rising age at marriage coupled with declining age at menarche**

As is everywhere, girls today are marrying later than they did in the past where as the age at menarche is declining and this enlarged gap has been perceived by 15 of the respondents as possible reason for increases in premarital sexual activity

“You see basically what has happened is, say 15-20 years back, menarche was at 14.8 years average, this has come down and this is a biological change, on the contrary the age of marriage has gone up. So there is this the long gap between sexual maturity and marriage which is getting further and further enlarged” (IGO Official 1)

“Earlier we used to get married at a early age, now the marriages are taking place at 26 , 27 or 28 years; as part of the of the physical and mental changes it is very natural that young people get interested in the opposite sex” (Official, Local NGO 3)

“You see now it is the way of living. When the parents of today were adolescents themselves, they used to get married at 15 or 16 years, and there was no gap between sexual maturity and marriage. But now the girls attain puberty at 10 years or so and they might be getting married at 30 years. So there is a big gap of say 20 years, and this has evolved over the years and there is no way to bypass this. So we tell the parents, since you have created this gap, you need to have some social mechanism to cope up, this is what the community need to know” (IGO Official 2)

The respondents in this category included government officials, local NGO officials, IGO officials, teachers and private practitioners.

- **Sexual abuse and coercion**

When sexual activity is undertaken unwillingly as a result of force, coercion and abuse, there is a higher chance that it leads to unwanted pregnancies and infection. Sexual abuse and coercion coupled with economic disadvantage is also perceived to be major factor pushing young people in to sexual relations before marriage. This reason was pointed out by as many as 13 of the respondents including health service providers from public health services and private practitioners, local NGO officials and IGO official and key informants .

Many including young children who end up living on the street often seems to be victims of abuse and violence in the streets.

“I have seen children coming to the general hospital, they have been used for other purposes, sexual abuse and sodomy. These are railway boys, canteen workers, street kids. This is very common” (Health Service Provider 2, Teaching hospital, Department of Skin and Venereal Diseases (STI))

“A couple of months back, we got a case who came in for termination, she was hardly seventeen years, but had gone through everything, she lives on the street and was in the third trimester of her pregnancy and we found her HIV positive, and she did not want to keep the pregnancy at all, but finally we could not do anything” (Health Service Provider 4, Teaching hospital, Obstetrician and Gynaecologist)

Sexual coercion and harassment that takes place on big scales in schools, families or in work places is pointed out as an issue which has not been tackled so far in the local context. The official of the local NGO who work in an urban slum brought out the vulnerability of many girls being sexually exploited at work places:

“There are high risk groups like construction workers, rag pickers, vegetable vendors, community kitchen workers – Rag pickers normally we find from age 10-20 years, there are many young girls, they start their work early in the morning at 4 or 5 o'clock and there are people who offer them money and take them to lonely places and abuse them sexually. The construction workers, their contractors select amenable young girls with certain views in their mind and sexually exploit them at the sites of construction work. They can not reject as it is their livelihood. In community kitchen which cater to marriage ceremonies or things like that, serving food for say 500 people or so, they have to work overnight, it is mostly young girls who are chosen to work there, and it is very easy for them to be forced to sexual acts. All these girls are very amenable and exploitable” (Official, Local NGO 1)

The same notion was fully agreed by another local NGO official too,

“Absolutely. I have seen young girls from slums being taken in full load of trucks to construction sites, not men nor older women.” (Official, Local NGO 3)

Those who live in poverty have few choices and may have unsafe sex from economic necessity. It was also voiced that there are many young people taking up commercial sex work due to economic disadvantage.

“In Ahmedabad 10% of the sex workers are below 18 years, all over India the percentage is 25% and economic necessity is pushing many into this trade” (Official, Local NGO 2)

- **Peer pressure**

Many young people seems to be pressured into their first sexual experiences by peers. In the present study, 8 of the respondents noted peer pressure as a possible reason for young people getting into premarital relations.

“Peer pressure is an important factor, many boys who come to me say they just got ‘hooked up’ by friends” (Health Service Provider 2 - Teaching hospital, Department of Skin and Venereal Diseases (STI)

“Basically awareness is the main thing. Because the young girls and boys who indulge in sexual activity, most of them do not do it on their own volition, it will be peer pressure or some elderly man pushing them into sex. They do not know how to refuse the advance. So the situational advantage or pressure would be the real factor, and do not know the consequences, that is the problem.” (Official, National NGO 1)

- **Greater reach of the media and media influence**

Regardless of age, marital status and income level, young people are exposed to mass media images of sexuality, violence and gender roles that influence their values, material aspirations and interactions with one another, their families and their communities. In the present study too, greater reach of the media and media influence was a factor perceived to be responsible for increases in sexual activity among young people by all the seven NGO Representatives.

“In the slums, they are socio-economically backward, but they earn Rs. 1500 - 2000 per month and almost every household has a TV and they spend quite a lot of time watching TV too” (Official, Local NGO 1)

“And you see, now the media influence is too much I think. Some movies depict it in such a way that life is meant for just love and fun and all that. Our adolescents and young people are in this environment and they can not escape it. They try to enact these distorted images” (Official, Local NGO 3).

The local availability of pornographic videos was indicated by two of the respondents. It was rather shocking to listen to the story cited by a local NGO representative, which reportedly came out in the local newspapers of a 18 year old boy who after watching pornographic video movie wanted to enact the scenes with his 40 year old aunt who on refusal was murdered.

- **Increase in the availability of contraceptives and other corrective measures**

While on one side the lack of protection in sexual intercourse was noted a possible factor taking the risk high in premarital sexual relations, the availability of

contraceptives and other corrective measures was perceived as a factor causing youngsters to have sex on the other side. General increase in the availability of contraceptives and other corrective measures like abortions was pointed out by two government officials responsible for policy formulation.

“And I would even say may be in the absence of corrective measures like contraception, or abortions, like before 30 years, probably there may not be any premarital sex (Official 1, Department of Health)

Such views though expressed by a few assumes significance in that it reveals a mind set which could well be carried over to the planning and implementation of programs.

iii Attitude of the stake holders towards young people’s sexuality

Sexuality, in all its ramifications and with all its consequences, remains one of the most controversial aspects of adolescent health. Many adults view and treat adolescent sexuality as deviant behaviour. In the present study, the attitude of the stake holders towards young people’s sexuality was explored to some extent as it assumes great significance in facilitating or preventing young people to acquire the knowledge, skills and behaviours they need in their sexual and reproductive lives.

- **Ambivalence**

The overwhelming attitude was that of ambivalence along with the recognition that premarital sexual activity can not be prevented altogether. A great majority (32) of the respondents seemed to be ambivalent with mixed feelings towards pre-marital sexuality. While on one side they seemed to be disapproving premarital sexual activity, on the other side they are of the opinion that it is natural for young people in today’s society to get into intimate physical relations and have sex before marriage due to many reasons. The respondents in this category included 7 government officials, 4 local NGO officials, 2 IGO officials, 14 health service providers (10 public health service providers and 4 private medical practitioners) and 2 teachers and 2 youth. All of them perceived that pre-marital sex can not be fully prevented due to various reasons, so the best thing is to help young people to make it safe.

“There are so many physical and mental changes taking place, so we can not blame them even if it is not a good thing to have sexual relations before marriage. So we have to help them to make it safe” (Teacher 2)

But at the same time, some of the respondents were of the view that the stigma of premarital sex is not to be removed altogether as it might end up promoting premarital sexual activity which is not desirable.

“ I don’t think we should go actively go around removing the stigma of premarital sex so much. Then we are telling them that it is very OK to have sex which is not a good thing. On the other hand, unmarried sex is going to occur anyway, let the society accept it and lets try to make it safe. It is something like, travel will be there, so you make the road safe. So, the first message that should go out is that avoid sex before marriage. It disturbs your education, diverts your mind. But at the same time, the message that sex is harmful will cause misconceptions and myths. They might also start thinking that if sex is harmful, how was it that my parents did it and I am here. So, the message should be try to avoid sex as far as possible but if you end up in problems, please seek help from a qualified person.” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

It was also striking to note the opinion put forward by one of the policy makers that too many efforts at spreading the message of safe sex will create more problems, so putting fear into people’s mind by talking about AIDS might help reduce premarital and extra marital relationships.

“ If we start saying premarital sex is bad, then the AIDS fellows will cut through our noses; be it pre-marital or extra marital, the important thing is to make it safe. But if we go too much preaching about how to make sex safe, may be we end up in another mess. The better solution might be scare and fear, probably we can take it up through AIDS” (Official 1, Department of health)

These perspectives demonstrates vividly the complexity and contradictions embedded in the notion of educating young people on matters of sexuality and reproduction in contemporary Indian society. Denial of the fact that young people are sexually active and need information about the risks they run and how they can protect themselves is widespread in India like in many other regions.

- **Non decriminalising attitude**

Three of the respondents, 1 private medical practitioner, 1 media representative and 1 IGO official came out with a rather positive attitude towards premarital sexual behaviour. All of them seemed to be reflecting on the fact that though premarital sexual activity among young people are increasing, the median age at first intercourse has gone up over the years. As marriages are getting late, there has to be an outlet.

Furthermore, another reason for them to take positive stance is that many marriages are not working when the couple find out that they are not sexually compatible.

“As I see, there is nothing wrong with premarital sex. I think premarital sex is even healthy to some extent, now marriages are getting late and there has to be an outlet. Lots of marriages are not working as they find out that they are not sexually compatible. But when they do not know what they are doing and the female ends up being pregnant, or when they get some infection that is where the problem starts” (Private Medical Practitioner 1, Obstetrician and Gynaecologist)

- **Apprehension and fear**

Among the parents, the overwhelming attitude was of that of apprehension and fear. As could be sensed, the developing sexuality of young people as a part of the process of growing up creates a barrier between them and their parents.

“For me, now it is no more the neighbour’s problem; I dread myself when Navarahtry comes, when my daughter comes home late in the night, you never know what they are up to in this age” (Parent 1, Father)

Such developing barriers could hinder the transfer of sexual and reproductive health related information from parents to their children, who are supposed to be the most reliable sources of information. Although there is widely held consensus that parents should have the primary responsibility of teaching their children about the risks and responsibilities of sexual activity and preventing undesirable consequences and the comfort level necessary to communicate these lessons to their children, it seems to be hardly ever happening so in the Indian social context.

Premarital sexual activity - Highlights

- **Significant proportions** of young people indulging in pre marital sexual activity as reported by more than half of the respondents.
- Possible contributing factors in premarital sexual activity : **Urbanisation and the changing social context** with the associated phenomena of migration, modernisation and loss of parental control, **rising age at marriage coupled with decreasing age at menarche, sexual abuse and coercion, ignorance and peer pressure, greater reach of the media and media influence and general increase in the availability of contraceptives and other corrective measures.**
- Prevailing attitude among the stakeholders towards young peoples’ sexuality is that of **ambivalence with mixed feelings**. Very few came out with **positive** attitude. **Apprehension and fear** seemed to be the prevailing attitude among parents.

Thus many of the factors responsible for increases in premarital sexual activity as expressed by the stakeholders are environmental or situational where as the prevailing attitude is that of ambivalence.

4.1.2 Observed risk pattern

The observed risk pattern assumes significance in the context of developing a framework for preventive and curative services and programs. While very early initiation of sexual intercourse seems to be the risk behaviour in early marital relationships, multiple partnership and unprotected relations were the major risk behaviours reported in premarital relationships.

4.1.2.1 Early initiation of sexual intercourse

As mentioned before, in early marital relationships, when 'gauna' is done at a very early age, though *the girl and the boy is not supposed to have physical relations*, this does not seem to be the case always. As evident from the reports, this could lead to sexual relations very early even before the regular start of menstruation. Furthermore, when the marriage is done at *15, 16, or 17 years*, it results in early pregnancy and child bearing, the associated physical hazards of which are presented in the later sections.

4.1.2.2 Multiple sexual partners

Most of the relationships before marriage seems to be rarely steady, and many seem to have sexual relations with more than one partner. Twelve of the respondents including 6 health service providers and 6 of the NGO representatives could comment on the type of partner based on their experience of working with young people. While half of them perceived commercial sex worker as the most frequently found sex partner, the other half said the relationship is mostly with changing boy / girl friends.

“Most of the time the exposure is with a commercial sex worker or some time with girl friends or boy friends. It depends on the individual whether they stick to one person or change” (Health Service Provider 2 - Teaching hospital. Department of Skin and Venereal Diseases (STI)

Sexual activity with multiple partners especially with commercial sex workers was noted to be a major factor responsible for STI and HIV transmission among young people by the health care providers in general.

“Sometimes we find young patients with multiple infections; and more complicated infections too; usually they come with the history of sexual exposure several times with different partners, usually commercial sex workers” (Health Care Provider 3 - Teaching Hospital. Department of Skin and Venereal Diseases (STI))

As noted by the respondents, it is mostly the *'personality'* factors and peer pressure which is responsible for multiple partnership. However, none of the interviewees could point one specific personality character which could be attributed to youngsters going for multiple partners.

Homosexual contacts are also not unknown. Without prompting, two of the respondents, one local NGO official and one health service provider from the teaching hospital, came out on their own with instances of risky homosexual behaviour.

“The unmarried mostly come with history of homosexual contacts. I had the typical case of a young boy who came with ulcers on his genital organ. When I took his case history, he had several instances of homosexual contacts. We did a blood test and found him to be HIV positive. The boy said, in the beginning he was approached and forced to sexual act in a public park and then later on he himself goes to public parks or public latrines in areas which are known centres for this. I think in certain areas of the city, such activities are going on in a big way, more than what we know” (Health Service Provider 5 - Teaching hospital, Department of Skin and Venereal Diseases (STI))

4.1.2.3 Unprotected sexual intercourse

It is not having sex, but rather having unprotected sex, that places young people at serious health hazards. While a few of the respondents came out with progressive remarks that contraceptive use in general has increased over the years, many were of the opinion that great majority of sexually active young people indulge in unprotected sexual intercourse failing to use condoms or other contraceptives consistently and appropriately.

“On the contrary, what I feel is that over the last 10 years, the girls are getting more educated and they are using contraceptives, and boys are using condoms....but the use is still not sufficient to significantly decrease the acquisition of STIs and the problems still remain” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

“In rural Gujarat, where relations with sex workers are freely admitted, as many as 80% of sexually active adolescent boys have never used a condom, we have it documented too” (IGO Official 2)

Furthermore the effectiveness of condoms in preventing unintended pregnancy and acquisition of STIs depends on consistent and proper use avoiding breakage, slippage,

or leakage. As was mentioned before, despite noted improvements in the use of condoms, the significant problem among young people is the inconsistent and incorrect use.

The incorrect use is reported to be stemming from ignorance as to how to use them. Though it was quite encouraging to note the reports from some of the health care providers as to how they demonstrate the correct use of condoms to their patients, a great deal seems to be still remaining.

“It is critical to know when and how to put on and to remove a condom. Many times young people are grossly ignorant about it. So we demonstrate it using this model (*pointing to the model on the table*) very often to the individual patients. Again, it is also important to know how to select condoms for purchase” (Health Service Provider 5 - Teaching hospital, Department of Skin and Venereal Diseases (STI))

The lack or inconsistent use of contraceptives, as reported could be stemming from a variety of reasons. The major reasons pointed out by the respondents are the unplanned nature of sex along with the unavailability of contraceptives or condoms at the moment, lack of accurate information as where to get them, cultural acceptability along with the fear of being found out and subjective feelings of invulnerability.

“Many do not know where to get condoms. Moreover, most of the time these relationships are unplanned, just happening like that if they are alone and if there is privacy, so they will not be prepared nor have condoms” (Health Service Provider 2 - Teaching hospital, Department of Skin and Venereal Diseases (STI))

“For example Nirodh (condoms) are easily available in pan shops, but many people do not know about it. It is not very expensive too. And there are many condom advertisements, they only talk about the product and they do not say anything about where it is available” (IGO Official 1)

Furthermore, as could be gathered from the responses, among girls, in addition to inadequate awareness of contraception, ignorance on matters related to sexuality and reproduction, or more precisely ignorance as to how pregnancy occurs, seem to be enormous even among the educated.

“I have seen quite a few girls saying they did not know that a couple of times would lead to pregnancy. I have also seen pregnant girls who first went to General Practitioners for the treatment for vomiting. Even the most educated girls do not seem to understand that a single sex meeting can result into pregnancy and that even the

semen let off near the pubic area can lead to pregnancy if the timing is just right” (Private Medical Practitioner 2. Obstetrician and Gynaecologist)

“Very young girl, barely 13 or 14 when her regular menstruation does not start, and she was vomiting, was taken to the doctor who found out she is pregnant. She could not say anything about who is responsible, but talked about the ‘strange type of plays’ she used to have with a boy from the neighbourhood” (Private Medical Practitioner 2. Obstetrician and Gynaecologist)

The cultural acceptability of contraceptive use and the fear of being found out by parents is another possible factor being pointed out as hindering contraceptive use. From the point of pregnancy prevention, though oral contraceptive pills are the most reliable method, these were perceived to be unsuitable for young people even by medical practitioners because of the fear of being found out by parents or others.

“Oral contraceptive pills are unsuitable for young people, especially the unmarried, as there is a chance that the parents get to know about it. It may be possible for girls staying in hostels to hide it; but for those staying with their parents, it is very easy for parents to find out that their daughter is taking pills which is not acceptable in the Indian society” (Private Medical Practitioner 2. Obstetrician and Gynaecologist)

At this point it is also worthy to note that carrying condoms or other contraceptives along could be one of the most unexpected and stigmatic thing to do even for those who are known publicly to be sexually active and could even lead to punishment. At the time of data collection, the researcher came across an article in the regional column of a leading national newspaper stating that the local police were arresting commercial sex workers as they were found to be carrying condoms along.

Subjective feelings of invulnerability is a major factor enhancing the levels of objective risk among young people (Peterson, 1982) as such feelings may motivate them to dispense safety precautions that they know objectively to be effective in reducing disease risk. A typical example as presented by a NGO representative is the remarks by some of the youngsters as they freely discuss about their sexual life from the slums where he works.

“Some of them even say - I can go anywhere to do it (meaning to have sex) , if I spent around 60-100 Rs.- I will not get any HIV or AIDS, it is only foreigners who get it” (Official 1, Local NGO)

Another example pointed out by some of the stake holders to illustrate feelings of invulnerability is that sometimes the girls think that they know the boy or the man they have sex with.

“Many young girls do not realise that appearances do not reveal the inside of the person. Attitudes like he scores good percentage of marks in the school examinations, or he is well mannered, or my mother knows his mother or we have a common uncle, can often end up in undesirable outcomes” (Parent 2, Mother)

On one side such examples reveal how youngsters can be misled with feelings of invulnerability, on the otherside it seriously point to the need to counter misinformation.

In addition to the factors mentioned above, health care service related factors also seem to affect the use of contraceptives in general which are discussed in later sections. Thus based on the reports, it comes up that sexually active young people in the study area do indulge in sexual relationship with multiple partners, the relationship being mostly unprotected making it highly unsafe.

Observed risk pattern – Highlights

- **Too early initiation** of sexual intercourse in early marital relationships
- **Multiple partnership** in premarital relationships – **commercial sex worker or boy / girl friend** most frequently found sex partner. Multiple partnership being attributed to **'personality' factors and peer pressure**. **Homosexual contacts** are also not unknown.
- Premarital sexual relations tend to be **unprotected** failing to use condoms or other contraceptives consistently and appropriately.
- Unprotected relations stemming from **ignorance, unplanned nature of sex** along with the **unavailability of contraceptives at the moment, lack of accurate information** as where to get them, **cultural acceptability** along with the **fear of being found out** and **subjective feelings of invulnerability**.

4.1.3 Risky sexual behaviour – Conceptual model

Based on the empirical findings of the current research and the assumptions put forward by the Social Cognitive Theory Framework, a possible conceptual model could be constructed as depicted in Chart 4.1 to explain the phenomenon of risky

sexual behaviour among young people in Gujarat. As is evident from the empirical findings presented above, the sexual and reproductive health scenario of young people in Gujarat seems to be characterised by significant risky sexual involvement in the context of too early marital as well as premarital sexual relations involving early

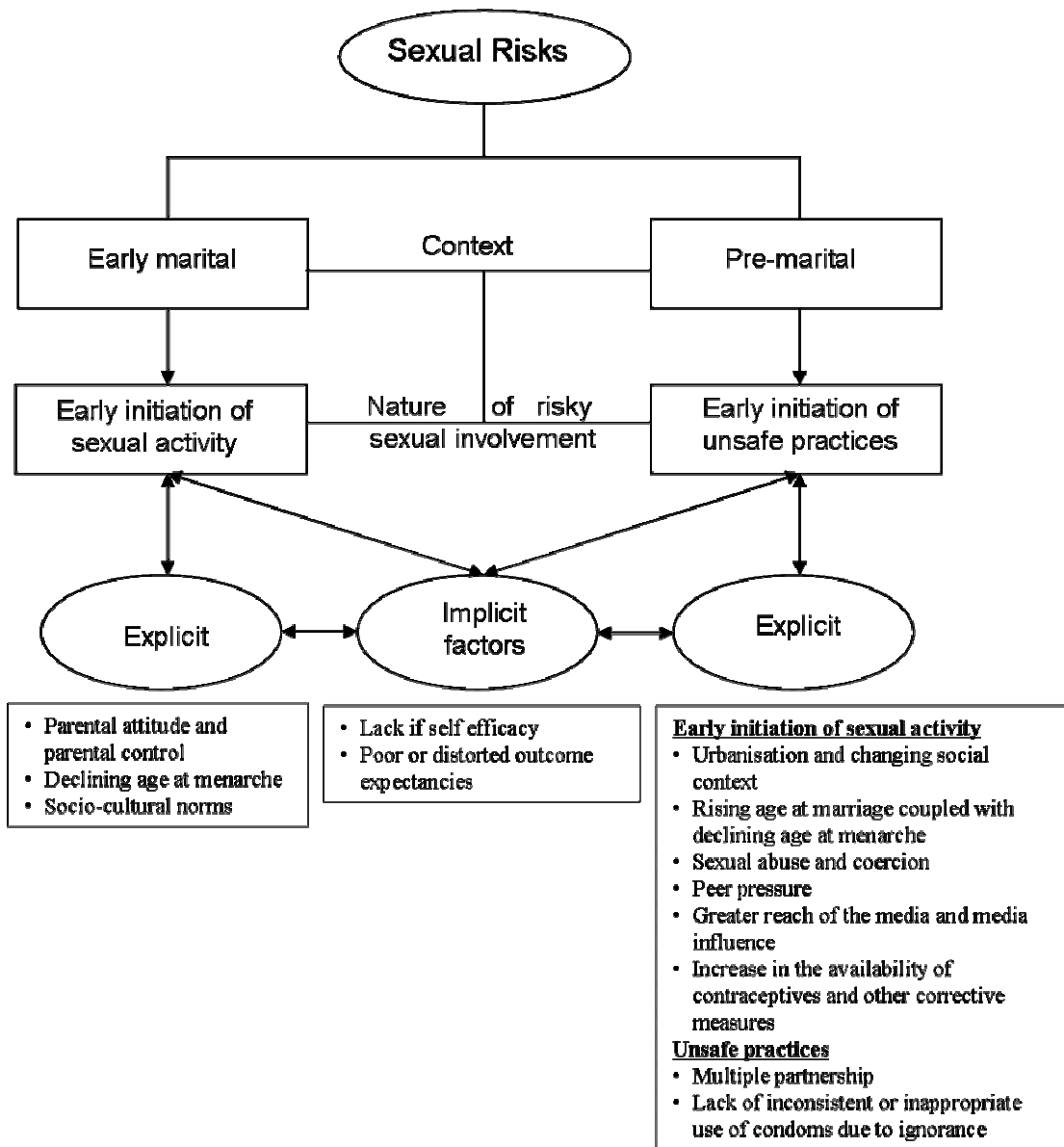


Chart 4.1 Risky sexual behaviour - Conceptual model

initiation of sexual intercourse and unsafe sexual practices. Looking from a Social Cognitive Theory perspective, the behaviour which is of interest here, sexual activity, could essentially be seen as arising in a context of dynamic interactions among multiple and complex factors, both implicit personal (cognitive) and explicit environmental (social). The key cognitive factors used in the study are self efficacy

(the degree of confidence in skills) as well as outcome expectancies (perceptions about outcomes). The two components of self efficacy addressed here include - self efficacy for resisting pressures to have sex and self efficacy for safer sex behaviour. The components of outcome expectancies as described by Bandura (1986) include self-evaluative, physical, and social.

These two constructs can be applied across most of the contributing factors with respect to the initiation of sexual intercourse as well as risky sex practices in the current research. Most of the factors presented by the stakeholders imply lack of self-efficacy for resisting pressures to have sex or to adopt safe practices by using condoms or contraception and distorted outcome expectancies. For instance, in too early marital relationships resulting in early initiation of sexual intercourse, the responsible cognitive factor could be the lack of self efficacy in resisting parental control to enter in to the relationship. In terms of the other contributing factors like social norms, the readiness to enter in to the marriage could be due to the positive outcome expectancies of confirming to the social group or fulfilling the wishes of parents or others in the family. In the context of premarital relationships, multiple partnership could be arising from the lack of efficacy in resisting peer pressure. It could also be due to the positive or negative expectancies related to benefits or rewards. This in turn could be in terms of negative expectancies related to losing the employment by refusing to have sex (self-evaluative) as in the case of sexual exploitation in work places, or losing recognition among peers by not having sex (social) as in the case of peer pressure or positive expectancies in terms of avoiding the risk of pregnancy by not indulging in sexual activity (physical). Thus the risky sexual relations may very well assumed to be stemming from the perceived susceptibility to the behaviour and the perceptions about the costs and benefits.

4.1.4 Consequences

4.1.4.1 Too early pregnancy and childbearing

i Extent

As sexual relations and pregnancy become socially and legally acceptable with marriage, the next urgency is to prove fertility. The most serious health consequence of early marriage as put forward by 13 of the respondents (Table.4.1) is in terms of too early pregnancy and child bearing which could be hazardous both to the mother and the child.

“Soon after marriage the girl has to prove her fertility. Once married, then parents are not at all worried about the girl’s pregnancy, their only worry is the unmarried pregnancy, once married, even if the mother dies or the child dies it is no problem” (IGO Official 1)

This view gets added credibility in the context that adolescent fertility seem to be accounting for more than one third of total fertility in India and involve women who are married as perceived by some of the experts in the present study.

ii **Physical hazards**

The most commonly reported physiological problems by the respondents are anaemia along with a deterioration of general health and hypertension.

- **Anaemia**

As many of the respondents remarked, anaemia resulting from nutritional deficiencies especially of iron and folic acid as such is a big problem among adolescents and youth in the study area.

“We have seen that in Gujarat almost 70% of the adolescents especially girls suffer from blood Anaemia, which in turn will affect their reproductive health. When they get pregnant and become mothers the danger is so enormous” (Official 2, Department of Health)

The already prevalent anaemia gets exacerbated with pregnancy in the absence of adequate nutrition. As a result or in addition, the general health also seem to be deteriorating very much with the onset of pregnancy as reported by some of the health care providers.

- **Hypertension**

Pregnancy-induced hypertension is another major complication cited by some of the respondents.

“Sometimes they marry even at the age of 14 years or lower and they become pregnant soon, so in such communities, pregnancy related anaemia and hypertension is so widely prevalent” (Official, State Government Body 2)

The length of sexual cohabitation and the exposure to the partner’s sperm before conception has been noted to be an important factor that contributing to the incidence of pregnancy induced hypertension (Robillard et al., 1994). Owing to this, it is quite likely that pregnancies resulting soon after cohabitation with a relatively short

exposure to the partner's sperm could result in an increased risk of hypertensive disorders.

Early pregnancy and child bearing – Highlights

- **Early pregnancy and childbearing** is the most frequently reported consequence of early marital sexual activity
- Pregnancy induced **anaemia and hypertension** reported to be the widely prevalent in communities where they marry at an early age

4.1.4.2 Sexually Transmitted Infections

i Magnitude and characteristics

By dispensing safety precautions, sexually active adolescents seem to be subjecting themselves to tremendous risk of contracting Sexually Transmitted Infections. In the present study, while almost half of the respondents (24) perceived that STIs and HIV/AIDS is a serious health issue among young people with significant prevalence (Table 4.1), the rest were of the opinion that except for high risk groups, the prevalence is not so high generally as well as among young people.

As observed by some of the officials in the first category, the less empowered groups are at higher risk of getting a STI or HIV infection and young people certainly constitute a high risk category. Many of the public and private practitioners treating STIs came out with first hand reports indicating that many of the STI patients are young people, both married and unmarried.

“Most of the patients we get are young males in the age group of 20-35 years” (Private Medical Practitioner 3, Skin and Venereal Diseases (STI))

“I get 2-3 adolescent patients everyday of which most are unmarried” (Health Service Provider 3. Teaching Hospital, Skin and Venereal Diseases (STI))

“I get around 70 patients per month mostly young males, and most of them are married. Females we get hardly one or two per year.” (Health Service Provider 2-Teaching hospital, Skin and Venereal Diseases (STI) Department)

Among those infected, Herpes was stated to be the most commonly found infection. The next common is genital warts. Gonorrhoea and Non-gonochorial Urethritis,

Syphilis and Chancord are also reported to be found occasionally. It was also remarked that sometimes young patients come with simple dermatitis, or some other bacterial infection due to friction or improper hygiene thinking that it is some serious STI.

Associated with STI prevalence is also the issue of HIV /AIDS. In the present study many of the respondents seemed to be of the opinion that HIV / AIDS is a serious threat to young people. In addition to the general observation that “*HIV is very much there, though not very common*” there were also precise remarks based on own experiences indicating the presence of HIV infection in the study area

“ In the last one year I have personally seen 4 AIDS cases too, 2 of them below 25 years of age (Health Service Provider 5 - Teaching hospital, Skin and Venereal Diseases (STI) Department)

In addition, it was also pointed out that the pattern of HIV infection is shifting from high risk groups in urban areas to the general population and that young people constitute a secondary high risk group.

ii **Misconceptions relating to STIs**

As per some of the reports, there seem to be many myths and misconceptions relating to STIs in general as well as among young people causing considerable over treatment, unnecessary anxiety and stigma. The respondents in this category included some of the government officials and health service providers.

The typical instance as cited by a medical practitioner is the myths about regular vaginal discharge among women. As elaborated by him, Indian women have severe notions about discharge, with the slightest staining of underclothes, they think that they have contracted some infection, and are losing their strength through that which is more of a mind set.

“Many unmarried girls occasionally come to seek treatment for discharge which is a regular phenomenon. Many women I have examined say they have discharge. When we ask them in detail, we find that most of them do not have anything above. That is the traditional kind of thinking and as a girl when she grows, she is told this. So, if you put all cases of discharge in women and call them STI, then you may find it as quite high. Otherwise, overall I don’t think it is that high. (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

While pointing the absence of reliable data regarding the prevalence of STIs among young people, the respondents in this category tend to be thinking that it is not very high except in certain groups who indulge in high risk behaviour.

“Regarding the STIs we do not have any data regarding the prevalence of STIs. But I think overall STI prevalence is not very high. But if you go into a particular group of people, who indulge in high risk behaviour, that is different” (Health Service Provider - Teaching hospital 1, Obstetrician and Gynaecologist)

It was pointed out that among unmarried males also, misconceptions coupled with anxiety and fear of AIDS seem to be the reason for *more than 50% coming for general check up soon after an unprotected exposure* to see if they are having any infections. As opined by a health care provider, one reason for this is that though they are aware of HIV /AIDS and STI, the knowledge is very superficial. As a consequence, there tend to be some amount of over reporting too with respect to the STI prevalence.

One of the typical responses in this regard was that,

“The problem I would tell you is that STI as such is very much over-reported. Most of the doctors who would say that they find patients with STI, they do not identify what infection as it involves many laboratory investigations and mostly patients are reluctant to do this. Then what happens is when they see a discharge, they give a blanket treatment and stamp that patient is STI which is not correct. The patient may not have STI (Health Service Provider 1 - Teaching hospital, Obstetrician and Gynaecologist)

In India like in most of the developing countries in the absence of laboratory diagnosis, syndromic approach has been adopted, where by the presenting symptoms suggest the possible etiological cause and behavioural risk assessment is introduced secondarily as a way of assessing exposure. Some of the health service providers in the present study seemed to be of the opinion that perhaps this approach is not the correct approach in the long run as it does not say anything about the prevalence “*as not even 5% of the infections are diagnosed*” and it might as well “*stamp many patients as STI infected based on a clinical suspicion when they might not have STI*” At the same time, they noted that this approach is beneficial on a short term as it may be possible that a few more patients get treatment.

iii Health care seeking

Health care seeking refers to the interval between the recognition of a health problem and its clinical resolution and to the accompanying cognitive and behavioural responses (Pescosolido, 1992). It is a central issue in the control of Sexually Transmitted Infections as the duration of infection increases the probability of harmful consequences and of transmission of the infection to others. In the present study, 10 of the respondents perceived delayed health care seeking as a possible behavioural factor responsible for higher prevalence as well as complications among young women. As per the reports, in addition to the delay in recognising the need for treatment, some of the factors that may contribute delayed or no health care seeking, may be out of the patient's control. It was also pointed out that health services also seem to be posing several barriers for young people to seek treatment. These are discussed in detail in later sections.

Boys seem to be faster than girls in seeking care for STI related symptoms. In the present study, most of the health care providers perceived that young males take the advice of a doctor immediately for anything which happens after a unprotected sexual exposure.

“Even if it is a simple burning sensation in the genital area, they immediately rush to the doctor or a specialist or to the family physician”(Health Service Provider 2 - Teaching Hospital, Skin and Venereal Diseases (STI) Department).

Sexually Transmitted Infections –Highlights

- **Differing views regarding the prevalence of STIs and HIV/ AIDS** among young people. Significant prevalence noted by almost half of the respondents, others noting that it is not very high except in high risk populations. However, supplementary reports seem to confirm that STIs including HIV / AIDS are a **significant health threat** to young people.
- **Misconceptions** about STIs and AIDS to over-treatment, anxiety and stigma. Though young people are aware of HIV /AIDS and STI, the knowledge is very superficial.
- **Delayed health care seeking** reinforcing transmission and complications of STIs among women.

4.1.4.3 Unwanted pregnancies and unsafe abortions

Pregnancies can be unintended both inside and outside the context of marriage and can also lead to abortion in both the cases. However, with respect to unmarried young people, as has been indicated by different information sources, the pregnancy seems to be unwanted in almost all the cases and end up in termination most of the time. Of particular interest here in the study are terminations which tend to be unsafe and can pose serious health hazards. As reported by a great many (29) of the respondents complications from unsafe abortions tend to be a serious health hazard for sexually active young people (Table: 4.1). Given below are the perspectives relating to the magnitude of medical abortions and the available picture about the hazard of unsafe abortions.

i Magnitude of medical abortions among young people

Though it was pointed out often that there is no reliable documented data, most of the specialist medical practitioners in the present study could comment on the extent of medical abortions among young people in the study area based on their experience.

“On an average 15 cases a month. During Navarathry* I get around 100 cases a week for three four weeks, post-Navarathry is the time when it peaks” (Private Medical Practitioner 1. Obstetrician and Gynaecologist)

“MTP at the government hospitals, you will not even see the tip of the ice berg, but in the private sector there are so many which goes absolutely undocumented. If you ask me about the probable no of MTPs coming to some gynaecologists in district centres, it is between 15-20 a day. This is including all age groups, but 20-30 percent would be pre-marital and bulk of them from colleges. And there is a running joke in our profession - MTP is such an emergency that if you do not operate the patient immediately, you will loose the case - someone else will take it over in minutes ” (Private Medical Practitioner 2. Obstetrician and Gynaecologist)

While most of the private practitioners came out with such reports which shows relatively high occurrence of induced abortions among young people, the practitioner from a public tertiary level hospital seemed to have a different account of the situation. This could perhaps be considered as an indicator of the low levels of use of such services in the public sector

* Navarathry is a 9-day festival in Gujarat when young people are allowed to stay outside till very late in the night

“There is some data showing that 4 out of ten adolescent pregnancies end up in termination, but we don’t know how many pregnancies do occur. But I still think that they are not many. In my hospital occasionally yes, that being a referral hospital, you find one or two every week married or unmarried” (Health Service Provider 1 - Teaching Hospital. Obstetrician and Gynaecologist)

Though the absence of reliable data is evident, it can be very well inferred that there are a significant number of terminations among young people, many of them done in the private sector which goes undocumented. This also points to the grave unmet need for contraception among young people

ii Reasons for Pregnancy termination

While the unwantedness or unintendedness of a pregnancy generally explain the decision for termination, there could be specific reasons among young people especially the unmarried to resort to abortion. Some of such specific reasons which came out in the present study include social condemnation of premarital pregnancy, victim of rape or incest and being forced to abort the baby.

- **Social condemnation of premarital pregnancy**

As pregnancy before marriage is considered immoral and highly condemned, unmarried girls go for termination even at the cost of their life. This reason was pointed out by 23 of the respondents who perceived unsafe abortions as a serious reproductive health issue among young people. Carrying a pre-marital pregnancy to term and giving birth to an ‘illegitimate ‘ baby means destruction of the chance of a socially respected subsequent life for the girl and can bring considerable shame and condemnation not only to the girl, but also to the parents and the family too.

As noted by a private medical practitioner, an Obstetrician and Gynaecologist catering mostly to the upper socio-economic classes, many of his unmarried clients come with tremendous anxiety as if the whole life is ending.

“When the girls miss their monthly periods, it is like they are hit by a thunder and life is coming to an end. Many of them tend to think of suicide even. To deliver a baby before marriage might even cause the girl to be thrown out of the family. An unmarried mother is a virtual social outcast” (Private Medical Practitioner 1. Obstetrician and Gynaecologist)

- **Victim of rape or incest**

Pregnancy resulting from rape or incest has been pointed out as a reason for termination by some of the respondents. It was indicated that rape and *sexual abuse of very young girls, less than 15 years*, within the family as well as outside are happening much more than reported.

- **Being forced to abort the baby**

The decision to abort a pregnancy sometimes come from parents or significant others in the family and not the girl herself. In the present study, this was pointed out by 8 of the respondents. The shame and condemnation associated with a illegitimate pregnancy force parents or others in the family to overrun the interests of their own child and to take any extreme steps to get the pregnancy terminated.

“When a unmarried girl get pregnant, generally they are scolded by their parents and they go through several bitter experiences till they come to us. Sometimes you can really see the force from parents for the abortion” (Private Medical Practitioner 2. Obstetrician and Gynaecologist)

At this point, it is also interesting to note the comments of a young girl respondent who insisted that even if the girl is unmarried, she should keep her baby inspite of the pressure to abort.

“I think the girl should keep her baby even if unmarried, many girls would like to keep the baby too, it is the pressure from family and relatives which leads them to abortions” (Young girl 2)

On being prompted with such responses among the parents the immediate comment of the parents seemed to be that it is some wild imagination or crazy thoughts depicted in movies and that such ideas are not realistic on any grounds.

“These are just crazy thoughts based on films. I think they showed something like that very recently in one of the films” (Parent 2, Mother)

iii Health care seeking behaviour

As came up in the study, the health care seeking behaviour of young people in the context of pregnancy termination is often characterised by delay in seeking abortion, resorting to unskilled practitioners and absence of follow up even after complications have been developed.

- **Delay in seeking an abortion**

As many as 16 of the respondents noted that though abortion is legal in India, unmarried young people often seek abortion very delayed leading to abortion related complications. As perceived by the stakeholders, initially most of the girls try to keep it as a secret, sometimes even to a stage when it can not be hidden anymore.

“Then she may tell her boy friend about the pregnancy, and then both approach a doctor, find out the cost. By the time, they arrange for the money and have the courage to go to a Gynaecologist, the girl will pass into the second trimester of pregnancy” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

Ignorance in recognising the pregnancy was also perceived as a major factor responsible for the delay in seeking care. The experience cited by the Gynaecologist,

“I know three or four cases in which the girls went first to the GP for vomiting and even getting treatment for jaundice. Later on only they find that they were pregnant” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

It was also noted that generally educated girls and those with enough family support come in the first trimester. Thus as is evident, the delay could be caused from a number of factors ranging from ignorance, fear of stigmatisation, absence of family support and cost considerations.

In spite of the safe window period set by the law which is 8 –12 months, it was reported that many providers do terminations outside this period.

“Some of the abortion clinic in the city are thriving on abortions done in the second or even the third trimester, you can say it is the most inhuman thing” (Private practitioner 1, Obstetrician and Gynaecologist)

- **Resorting to unskilled practitioners / or places without proper facilities**

As mentioned before, many young people tend to resort to private practitioners for terminations. There seem to be many private medical as well as non-medical practitioners in the study area who are unskilled in performing terminations nor have proper facilities but they do terminations on a large scale at low costs. It was repeatedly voiced that, “*there are a number of so-called ‘abortion clinics’ in the city*” which seems to be running without even the basic facilities and they thrive on unweid and illegal abortions i.e., abortions done outside the safe window period as is set by law.

“There are so many MTPs done by private providers. There are quite a few practising specialists- gynaecologists and surgeons who survive only on MTPs, they do not have any proper facilities; but they do nothing but MTPs. And these are in district centres, go to interior places, you will find no proper facilities, no proper equipment, no sceptic precautions, even then things are going on at a large scale” (Private Medical Practitioner 2 , Obstetrician and Gynaecologist)

Owing to their low cost offers, as remarked, young people are very likely to resort to them eventually leading to complications and even mortality in some cases.

- **Absence of follow up**

Absence of follow up after a termination even in the presence of complications was another major negative feature of the abortion related health care seeking among young people. In the present study, except two, all the health care providers noted that there is absolutely no follow up after an abortion is performed for an unwed pregnancy.

“Follow up is also another major problem. It is almost zero. There is practically no follow up in the case of termination of unwed pregnancies” (Health Service Provider 1 - Teaching Hospital. Obstetrician and Gynaecologist)

“Unless the girl has really been brought with the mother or another responsible member of the family, we can not get a proper follow up, most of the time follow up is not there” (Private Medical practitioner 2, Obstetrician and Gynaecologist)

However, one of the private practitioners reported that his patients come for follow up after the abortion is done.

iv Unsafe abortion- Contributing factors

Unsafe abortion has been defined as the termination of a pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both by (Olukoya et al., 2001). As reported by a large number of the respondents, young people seem to be resorting to unskilled medical or non-medical providers or providers without the necessary facilities to a large extent in the study area. This could be primarily due to the barriers they face in obtaining safe abortions. In addition to the health service related barriers which are discussed in later sections, both socio-cultural and financial factors were pointed out to be responsible for unsafe abortions in the present investigation.

- **Socio – cultural factors**

In a setting where children are afraid of letting their parents or elders know that they are sexually active before marriage and consider abortion as highly immoral, a young unmarried girl has to seek it secretly within a limited time.

“Often young women act in panic, fearing the reaction of those around them should the pregnancy be discovered. Then the priority is just to get out of it. Issues of safety and complications come only when you can think clearly and properly”(Official, National NGO 1)

“If a unmarried girl gets pregnant, it is a big social stigma, so secrecy assumes the top most priority, the girl wants to hide it and get rid of it at any cost” (IGO Official 1)

“As a *business trick*” unskilled providers will ensure secrecy at any cost. An associated factor as brought by the respondents is the weakened links in the extended family systems and between generations by social changes like industrialisation and rapid urbanisation which used to be the source of great support to its members earlier. In addition, the partner himself might not be caring and may be he will leave the girl when he find out about the pregnancy.

- **Financial considerations**

The consideration of the financial costs is a major factor contributing to unsafe abortions among young people.

“There are people who provide abortion services even for Rs. 75/-, then why should they go for somebody who charges Rs.5000/-” (Private Medical practitioner 2, Obstetrician and Gynaecologist)

In general, young people have less access to economic resources than adults do, and when they have to pay it from their pockets, affordability assumes a significant role. In India, though abortion services are provided free of charge in the Public health sector, but many do not use these services due to variety of reasons which are discussed in detail in the later sections.

v Unsafe abortion- Consequences

While a legal medically induced abortion does not carry much risk for a woman’s health, illegal and unsafe abortions may end up with several unhealthy consequences. Owing to reasons like delayed care seeking, resorting to unskilled providers, and

absence of follow up, it is quite logical to think that induced abortions can result in health hazards among young people. In the present study complications including infections and mortality were presented as the major hazardous consequence of unsafe abortions.

- **Complications**

Both physiological and psychological complications arising from unsafe abortions were cited by the respondents. While the health care providers, could talk about the physiological complications, the categories of respondents like NGO officials and key informants talked more about psychological complications. The major physiological complications pointed out were reproductive tract infections. The occurrence of sepsis, haemorrhage, tetanus, and spontaneous abortion in subsequent pregnancies have also been noted.

“Though sepsis, haemorrhage, tetanus, and spontaneous abortion in subsequent pregnancies are all seen due to unsafe abortions, reproductive tract infections are the number one as they are reported so much among post abortion clients in Gujarat ”
(Private Medical practitioner 2, Obstetrician and Gynaecologist)

The major psychological complication cited were long term feeling of guilt which extends beyond the abortion and sometime carried over in marital relationships causing problems among the spouses.

- **Mortality**

Mortality though not often was also pointed out to be a consequence of unsafe abortion by a few of the service providers.

Before concluding it would be worth noting that many of the views presented here came out from the respondents are based on young people who manage somehow to reach the health care system either for complications or for the abortion itself. As is evident there could be a greater number who fail to reach the health care system at all. Thus, looking at the hazardous consequences of unsafe sexual activity, though the exact incidences of problems like too early pregnancies and child bearing, sexually transmitted infections and induced/ unsafe abortion as well as the related morbidity and mortality are difficult to establish from the study, the views of stakeholders suggest that these could be posing serious and costly health problems to young people.

Unwanted pregnancies - Highlights

- **Significant numbers of** induced abortions among young people, reported from the **private** sector
- **Social condemnation of premarital pregnancy, victim of rape or incest and being forced to abort the baby** were the major reasons pointed out for termination.
- Health care seeking in the context of pregnancy termination among young people seem to be often characterised by **delay in seeking abortion, resorting to unskilled practitioners and absence of follow up** even after complications have been developed.
- In addition to the health service related barriers, **socio-cultural and financial considerations** were perceived to be contributing to unsafe abortions.
- **Reproductive Tract Infections** were presented as the most frequently reported hazard.

4.1.5 Intervention framework based on Social Cognitive Theory

The above mentioned picture undoubtedly point to the need for intervention and the attempt here is to formulate a theoretically guided risk-reduction intervention framework tailored to meet the needs of young people based on some of the primary components of SCT. If early onset of sexual intercourse and unsafe practices are the major risk behaviour patterns, intervention towards risk reduction would mean behaviour change in terms of delayed onset of sexual intercourse and adoption of safe sex practices. SCT posits that the environment, person and behaviour interact, modifications in the environmental or social factors and the personal or cognitive factors could result in behavioural change. This in turn would mean that risk reduction intervention efforts in terms of policies, programmes and health care services could involve modification of the environmental or social factors and the personal cognitive factors. Environmental modification in terms of bringing positive changes in the environment through programs like community education, parent education etc. Of particular interest in the study are the individual cognitive factors of self efficacy beliefs and outcome expectancies. As per the theoretical framework, it is assumed that an increase in self efficacy with better outcome expectancies would lead to behavioural modification. A model based on these concepts can be applied in the case of all the individual risk behaviours (Chart 4.2). For instance, in the case of early

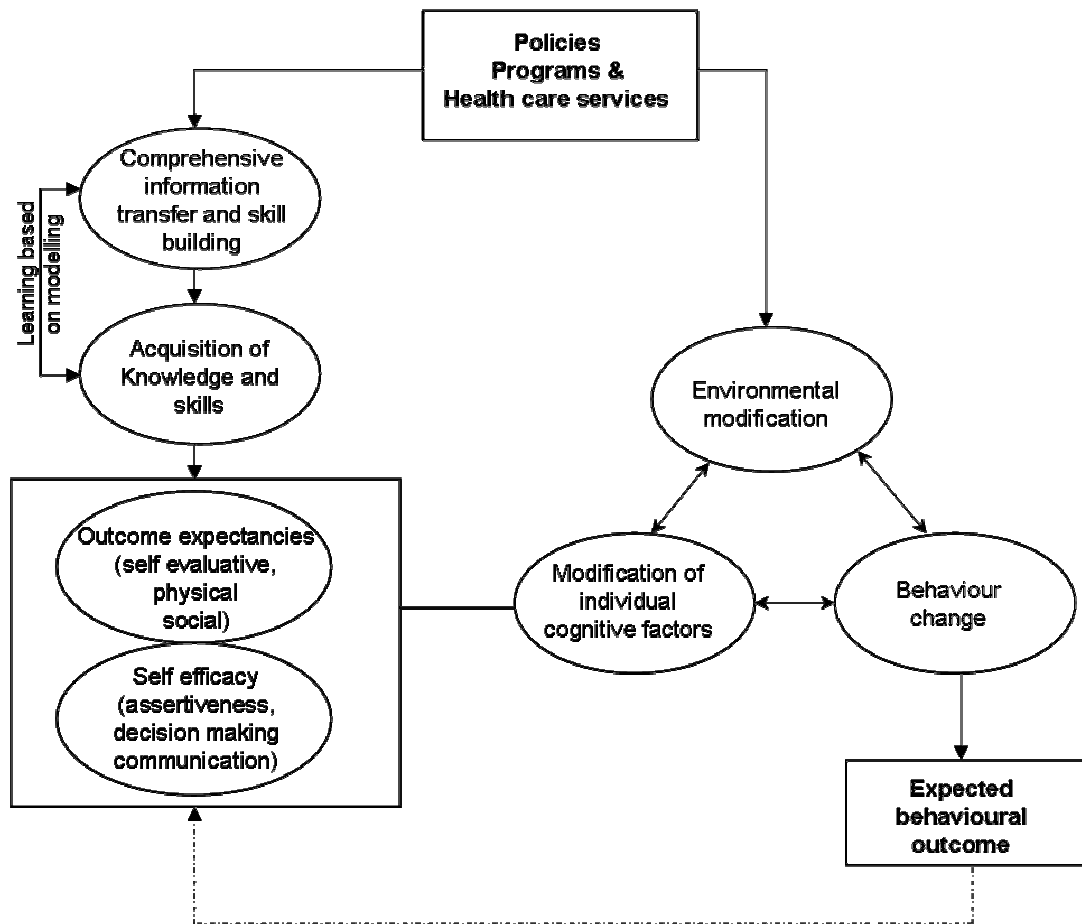


Chart 4.2 - Framework for intervention based on Social Cognitive Theory

onset of sexual behaviour with in the context of marriage, to bring about the targeted behaviour of delayed onset of sexual intercourse, would mean dealing with the explicit environmental or social factors as well as the explicit or implicit individual cognitive factors. In the case of early marriage this would mean addressing the environmental factors like parental attitudes and social norms and the implicit individual cognitive factors like lack of self efficacy in resisting the pressure or modifying distorted outcome expectancies. Improvement in self efficacy should include skills in decision making to delay the marriage, the skills needed to be assertive with respect to the decision and the skills in communicating and negotiating the decision to parents or other. Improvement in outcome expectancies related to delayed marriage could produce positive outcome expectancies in terms of better quality of life, more personal freedom, better educational opportunities and so on. The occurrence of the expected outcome in one instance itself would lead to further improvement in self efficacy and outcome expectancies which will enable the person to resist the behaviour in future too.

The cognitive components need to be addressed through education, skill building and empowerment. Role play has been indicated by Bandura as an effective learning method. Social learning theory also claims that modelling is an important method of the acquisition of skills and knowledge. Put simply subjects observe behaviour taking place and then go on to adopt similar behaviour. Subjects need an opportunity to practice modelled behaviour and positive reinforcement if it is to be adopted successfully.

Thus, as per the hypothetical model presented above, successful interventions to delay the onset of sexual intercourse and promote the adoption of safe sex behaviours among young people, could effectively incorporate some of the above mentioned components in terms of comprehensive information transfer and skill building through learning based on modelling.

4.2 Policies and programs relating to the sexual and reproductive health concerns of young people

As the need for intervention and the framework for needed programming are defined in the previous section, the next task would be to look at the existing programming responses to examine the fit. Young people 's overall health and development are shaped by many factors of which policies and programs are two. While programs represent explicit actions in terms of the articulation of a vision, policies are sets of implicit or explicit values underlying the action, translated into a legal framework and expressed through ideologies. Policies in turn shape the actions. Policy reform and improvement in the programs can be a partial solution towards addressing the issues that concern young peoples' health. Nevertheless, program and policy change are two of the factors most susceptible to change in a short term.

The results presented here cover the perspectives of the key stakeholders on the existing policy strategies and programme interventions to deal with the sexual and reproductive health needs of young people. The other part of programming in terms of the access to the health care system is presented in the next section. Though the focus is on all the approaches intended to assist young people to obtain, in addition to information, skill building opportunities, counselling and needed clinical services, most of the existing programs seem to be oriented to the provision of sex education in

some or the other form. There seems to be some, though very few, programme efforts with more components.

As the attempt here was to make a state of the art review of the policies or institutional guidelines and programmes, the officials concerned were approached who in all the cases came out with detailed accounts. The evaluation reports and other materials available were also reviewed wherever possible to get an in depth picture of the situation.

- ***Awareness about policies and programs among the stakeholders***

Before proceeding on to the precise views on the various policies and programmes, it is important to make a cautious note on the level of awareness among the various categories of stakeholders. In general, except a few, many of the stakeholders did not seem to have in-depth knowledge about the policy and program scenario with respect to the sexual and reproductive health of young people. Almost half of the respondents (23) expressed that they are not aware of any explicit policy statements from the concerned ministries or legal regulations from the legislature for the provision of sexual and reproductive health information or services as such in schools or out – of – school based (Table: 4.2). The rest (26) could point out some policy statements or institutional guidelines which directly or indirectly has some bearing on the provision of sexual and reproductive health information and services to young people. With respect to programmes, awareness among the stakeholders was found to be better compared to policies. 32 of the respondents could point out one or more programmes (Table: 4.2)

While looking at the responses in different groups of the stakeholders, it can be seen that the awareness is minimum among health service providers both from the public as well as the private sectors. Many of the private practitioners, who reportedly have a very good share of young patients for clinical services like pregnancy terminations and STI treatment seems to be grossly unaware of any policy or programme initiatives with respect to young peoples' sexual and reproductive health. Explicit remarks like "*I did not get what you mentioned now.....What is this ICPD? Can you tell me a bit more about it*" were often reflected in many interviews with health care providers.

The lack of in-depth awareness among some of the government officials was also surprising. Young people also were grossly unaware of the policy situation, but could point out school based education programs. Overall, as a group NGO representatives and UN agency officials seemed to be well informed about the policy and program situation.

4.2.1 Policy statements

The National Population Policy 2000, the International Conference on Population and Development Directives (1994) and some of the NGO policy statements were pointed out as having explicit components on the provision of sexual and reproductive health information and services to young people.

4.2.1.1 National Population Policy 2000

The National Population Policy 2000 was pointed out by 16 of the respondents (Table: 4.2) as having a strong component on adolescents' access to reproductive health information and services. As expressed by them, it has already mentioned clearly that adolescents should be given information and services to meet their sexual and reproductive health needs. As the text reads:

“The needs of adolescents including protection from unwanted pregnancies and sexually transmitted diseases (STD) have not been specifically addressed in the past. Programmes should encourage delayed marriage and child bearing, and education about the risks of unprotected sex. Reproductive health services for adolescent boys and girls is especially significant in rural India, when adolescent marriage and pregnancy is widely prevalent. Their special requirements comprise of information, counselling, population education, and making contraceptive services accessible and affordable, providing food supplements and nutritional services through the ICDS, and enforcing the child marriage restraint Act” (Government of India, Ministry of health and family Welfare, 2000)

At the time of the study, the state of Gujarat did not have a separate population policy and it followed the national population policy set by the Government of India. However, as brought out by one of the officials from the Ministry of Health, actually the state (Gujarat) government was in the process of forming a state specific population policy,

"The draft is ready and it is to be approved by the high level committee. The draft policy has incorporated all the aspects where we need to implement the Reproductive and Child Health (RCH) agenda and adolescent health is one part of it” (Official 2, Department of Health)

- **More on paper - no concrete action**

Among those who spoke about the National Population Policy, a few of the NGO representatives, were of the opinion that it is more of a document on paper and very little concrete action is being taken.

“In fact, very recently two or three years back, Government of India included adolescent health in RCH, but prior to that they were never thinking. And even today, the fact is that it is more on paper than there is hardly anything concrete being done on adolescents. Perhaps, government is very worried about how people would respond that is what the policy makers are very much worried. So they have included on paper, practice, if you ask them, what is the performance that they have envisaged, they do not have anything” (Official, National NGO 1)

4.2.1.2 International Conference on Population and Development (ICPD) Declaration

As was mentioned previously, it was at the International Conference on Population and Development (ICPD) in 1994, a paradigm shift in the global understanding of reproductive and sexual health emerged and the concept of adolescent sexual and reproductive health took shape. Almost one fourth (14) of the respondents (Table : 4.2) pointed out the ICPD programme of action and India’s commitment to its directives as a definite indicative for the provision of reproductive health information and services to young people.

- **Hypothetical approach**

Among those who pointed out India’s commitment to the ICPD Declaration, about half do not seem to be satisfied with the action taken by the Government of India so far with respect to implementing the directives relating to ICPD conference.

“The government of India has a hypothetical approach, they are signatory to it and proclaimed that adolescent health is part of RCH, but in practice it is zero. There is hardly anything happening” (Official, National NGO 1)

Again commenting on the commitment of government officials towards adolescent reproductive health issues, some of the respondents were of the opinion that “*they have other priorities*”

“Very recently I have had a meeting with the Secretary and the Director of the Health Department to discuss issues relating to adolescents. As far as I understand, they are sincerely committed. But till now, the priority is more on Maternal and Child Health which still continues” (IGO Official 2)

Table 4.2 - Policies, Laws or Institutional Guidelines and programmes for the provision of SRH information - Awareness

STUDY POPULATION	SIZE	Policies		Programmes					
		National Population Policy 2000	ICPD Declaration	Population Education Programme	Gujarat Vidyapeeth	State AIDS Cell	Gujarat Text Book Board	NGO /	International Organisations
<u>Government Officials</u>									
<u>Planners and Policy makers</u>									
Department of Health	2	2	2	1	-	1	-	1	2
Department of Family Welfare	1	1	1	-	-	1	-	1	-
Department of Education	2	-	-	2	1	-	1	2	1
<u>Programme Planners/ Managers of State Government Bodies</u>	5	3	3	3	-	3	3	3	1
<u>NGO Representatives</u>									
Local	5	4	2	3	1	3	2	5	-
National	1	1	1	1	-	-	1	1	-
Intergovernmental (IGO)	2	2	2	2	1	1	-	2	2
<u>Health services providers</u>									
<u>Public Health Care System</u>									
Primary Health Centre	2	-	-	-	-	-	-	-	-
Community Health Centre	3	-	-	-	-	-	-	-	-
District Level	4	2	2	-	-	1	-	1	-
<u>Hospitals:</u>									
Teaching Hospital	5	1	1	-	-	3	1	3	-
Private Practitioners	5	-	-	-	-	-	-	1	-
<u>Young people</u>	6	-	-	2	1	2	5	-	-
<u>Key informants</u>									
Media Representatives (1) Teachers (3), Parents(3)	7	-	-	3	1	4	7	5	-
Total	50	16	14	17	5	19	20	25	6

However about half, consisting mostly of government officials and some public health service providers were of the opinion that both the national as well as the state government is committed to the ICPD agenda and actions have been initiated both at the policy and programme level.

“Up to 1994, we were worried only about pregnant ladies, now we have a womb to tomb approach. Women come to pregnancy only after so many stages, right from the intra uterine period to adolescence and then only the woman becomes pregnant, so we need to give care to all the previous stages; so now we have high emphasis on adolescent programmes, it is a very new approach” (District Medical Officer 1)

4.2.1.3 NGO Policies

Some of the NGOs including professional organisations seem to be making pioneering contributions by way of explicit policy statements for the provision of sexual and reproductive health care. For instance, the policy statements of ‘The Federation of Obstetric and Gynaecological Societies of India’ one leading professional organisation covers three aspects, right for information and care, privacy and access to services.

As worded in the policy statement:

“The Federation of Obstetric and Gynaecological Societies of India endorses access to comprehensive health services to adolescents delivered in a variety of sites including schools, physician offices, community based and other health care facilities. Comprehensive services should include, at a minimum, such reproductive health services as sexuality education, counselling and access to contraception” (Federation of Obstetric and Gynaecological Societies of India, 2000)

Furthermore, the other statement in the policy adds:

“Unmarried young people and females in particular of any age whose sexual behaviour exposes her to possible conception should have access to the most effective methods of contraception. In order to accomplish this the individual physician, whether working alone or in a group or in a clinic, should be free to exercise his best judgement in prescribing contraception and therefore, the legal barriers which restrict his freedom should be removed”(Federation of Obstetric and Gynaecological Societies of India, 2000)

Policy Scenario - Highlights

- **General lack of in depth awareness** about the policy and programme situation among stakeholders. Better awareness about programs than policies. As a category NGOs and IGO representatives quite well informed about the policy and programme situation.
- The major policy statements having some component related to sexual and reproductive health information are the **National Population Policy 2000**, the **International Conference on Population and Development Directives (1994)** and some of the **NGO policy statements**.
- Conflicting views about the translation of the National Population Policy 2000 and the International Conference on Population and Development Directives, 1994 in to action. **Predominant views** on the lines like; **‘more on paper’, ‘other priorities’, ‘action is being initiated’**

4.2.2 Programme initiatives

Sexuality education and provision of services to the young and unmarried was one of the most controversial issues at the population conference in Cairo in 1994, though it was established that such education should be the right of all young people. In many developing countries, this seems to have led to a proliferation of various programme approaches, the most popular being some version of sex education. In India, though the ICPD conference has boosted interest in the sexual and reproductive health issues of young people, as noted by an IGO official, *“along with the population issues, the scare and fear of HIV and AIDS was the starting point for many of the existing adolescent reproductive health programmes”*. However, seemingly most of the programs still continue to be predominantly educational in nature with relatively few with more components. The Reproductive and Child Health Programme from the Ministry of Health and Family Welfare, some of the NGO programs and IGO programs those from the UN Agencies are examples of programs with multiple components. Following are the perspectives regarding the various programme approaches.

4.2.2.1 Sex education approaches

Provision of information related to sexuality and reproduction could basically be through two channels, namely the formal education given in the school setting and non-formal education in out-of-school setting. However, the predominant program

strategy in Gujarat seem to be mostly consisting of school or university based sex education approaches. Many of these programmes are initiated by governmental and non-governmental organisations and intergovernmental organisations like the UN agencies and seem to have their origins in population and development issues or curtailing the HIV infection.

Though a strict classification of the various programs in terms of the characteristics is rather difficult, following is an account of the coverage, orientation, SRH component, approach, activities and major drawback of the individual programmes and their linkages with each other. The reported programmes were the Population Education Programs from the Gujarat Council of Educational Research and Training (GCERT) and Gujarat Vidyapeeth, AIDS Education from State AIDS Cell, Family Life Education from the Gujarat Text Book Board and programs from Non-Governmental Organisations and Inter-Governmental Organisations like the UN agencies which are described in the coming sections in some detail.

i Population education programme in schools

- **Actor and coverage**

The Population Education Project at the national level and its state counterpart in Gujarat, the Population Education Cell working under the umbrella of GCERT, seems to be the oldest and nation-wide school based population education program (Population Education Cell, 2000). As the name itself indicates, the program is primarily intended to serve as education about the causes, nature and consequences of population dynamics and related socio-economic problems and is to be viewed different from sex education programme in the true sense of the term. However, owing to its component on adolescence education, it was pointed out by 17 of the respondents (Table 4.2) in the present study as a possible sex education programme.

- **Orientation**

As could be gathered from different sources, the main orientation of the programme is towards introducing awareness on population and development related issues amongst school children. The selection of schools as the venue as justified by some of the respondents including the officials themselves is that nowhere else can such a young, impressionable or captive audience can be found than in schools. Further more, as the

main function of schools and universities is to convey knowledge, they could be ideal settings for educating young people about health matters.

As could be gathered from the officials, initially population education was part of education related to family planning or in other words *curtailing the size of the family*.

As worded by the official,

“as we all know, that was the time of the red triangle and the one child or two child norm and so on” (Official 1, GCERT)

Since 1995, after Cairo conference the population education concept seems to have undergone a change and came out with a reconceptualised format. After reconceptualisation, the population educators are no more talking about curtailing the size of the family. Rather it is more on the lines of population and development education.

“Even, the nomenclature has changed, earlier it was population education, now it is population and development education and this is what we talk about in schools too. We are no more talking about curtailing the size of the family or one child norm or anything like that” (Official 1, GCERT)

The new nomenclature of Population and Development Education in Schools has brought out focus on the new thrust and the adopted strategies. The new thrust is in terms of integration of the elements of post-ICPD reconceptualised population education and introduction of elements of adolescent reproductive health, conceptualised as Adolescence Education

- **SRH component - Adolescence education**

As could be gathered from different sources, the new framework reflects six basic themes focusing on the critical population and developmental issues. These are: i) population and sustainable development ii) gender equality for empowerment of women iii) adolescent reproductive health (Adolescence Education) iv) family: socio-economic factors and quality of life v) health and education: key determinants of population change and vi) population distribution, urbanisation and migration.

With a view of facilitating the introduction of a sensitive area of adolescent reproductive health in school education, it has been conceptualised as Adolescence Education covering three major components: i) process of growing up, ii) HIV/AIDS

and iii) drug abuse. These elements are complementary to each other and aim at attaining the population and development goals envisaged in the Programme of Action of ICPD, 1994.

“In adolescence education, the main topics covered include introduction to the need for the topic; period of adolescence; physical growth and development; mental and emotional development; social and ethical point of view regarding adolescence; gender issues and the discrimination between male and females; AIDS and STIs; drug abuse and the consequences; problems related to adolescence and their answers; Question Box approach; personal counselling and misconceptions related to adolescence” (Official 1, GCERT)

The approach followed by GCERT is to find plug points in the existing course of instruction where in population education concepts and data are included by dovetailing without having to develop separate course of new units.

“A teacher can not teach about sex education or adolescence education in the class just like that, because there will be a lot of *hala-bulu* in the class, so what we have done is, for example, in economics if you have a chapter on population growth and problems, so that means we talk about how population increases or the process of reproduction and the problems associated with that; that means we are finding plug points and is integrating the material (Official 1, GCERT)

Normally the entire material is integrated into the existing curricula of Social Studies, Science, Economics, Geography, History, Civics, Sociology, Biological Sciences, Mathematics and Languages at various school stages. To strengthen the process of integration, a selected number of minimum essential ideas are identified that conveyed the messages of population education comprehensively, effectively and more directly.

- **Activities**

Basically the activities of the Population Education Cell are bifurcated into 6 major categories, training, research, evaluation, advocacy, cocurricular activities, curriculum and material development.

- **General Comments**

Seven of the other stakeholders could comment on the policy and procedure followed by GCERT in the population education programme. All of them opined that the programme is good enough to impart knowledge and awareness on population and development related issues which in turn could facilitate the development of

responsible behaviour towards population issues. However, as noted by some of the respondents, from the point of imparting knowledge on matters relating to sexuality and reproduction, even the post ICPD reconceptualised format of population education does not integrate elements of adolescent reproductive health as they are regarded as very sensitive.

“In GCERT Programme, Reproductive and Child Health in the context of health issues is missing; they are talking about population problems, then physical changes, but the preventive or the care part of reproductive and sexual health is not dealt with. Issues like reproductive rights, contraceptives, teen age pregnancy, safe abortion, are not fully dealt with.” (IGO Official 1)

The reason for this omission as put forward by one of the officials from the Population Cell itself is the sensitivity of the topic and the lack of political will.

“The government is actually scared to introduce reproductive health issues in detail, you see this is a hot issue – like a burning potato – who wants to burn their hands by bringing into the table” (Official 1, GCERT).

Again commenting on their approach, lack of inter-sectoral collaboration was observed as another deficit. The observation was more in terms like they are operating in vacuum without any explicit efforts to collaborate with the health care system.

“It is like something being done in isolation, as it is they do not collaborate with the health care system. If Health care providers like a Medical Officer in a PHC or a ANM working at the village level are not contacted or integrated in to the programme, it is simply in isolation”(IGO Official 1)

Furthermore, some of the respondents also observed that the elements are thinly spread in too many subjects in a *touch-and-go manner* at several points in text books. The other major drawback pointed out is that they do not follow up.

“It will be much better if they can do some follow up. The material is distributed, but what is happening after that they do not know, whether they are using the book, or how it is being used, nobody knows”(Official, Local NGO 3)

ii Population and Development Education in the Higher (University) Education System – Gujarat Vidyapeeth

The UNFPA-funded Population Education Project initiated by the University Grants Commission (UGC) through twelve Population Education Resource Centres (PERCs)

and Population Education Clubs (PECs) is found to be another approach to create awareness regarding various population issues among college students and through them in the community. In Gujarat, the Population Education Resource Centre is functioning in Gujarat Vidyapeeth, a deemed university.

The mode of integration is more or less on the lines of GCERT. Population education concepts in the context of the ICPD Programme of Action are being incorporated in various undergraduate and post-graduate courses. Special courses in population education and appropriate educational and training materials are also being developed. A number of innovative programmes have been reported to be introduced under this project, which includes Helpline counselling, personal counselling, peer-group counselling and referral services.

“Adolescent education is a part of population education, we train college teachers and principals and also people from the community, we prepare literature and distribute material, slides, films and so on. We also prepare the syllabus for the training programme. We have counselling and referral services too. We have a telephonic counselling service that is working really well. It is the biggest counselling hotline for adolescents in India” (PERC Representative, Gujarath Vidyapeeth)

However, the aware on the programme seemed to be very limited (Table: 4.2) and hardly anyone except the representative from Gujarat Vidyapeeth itself could comment in detail about their programme.

Population Education Programs - Highlights

GCERT

- **Oldest and nation-wide school based** population education programs. However awareness is only among one third of the respondents
- Oriented towards introducing **awareness on population and development related issues** amongst school children.
- **Adolescence Education as one of the objectives** in the reconceptualised format. The major aspects covered are: **i) process of growing up, ii) HIV/AIDS and iii) drug abuse.**
- Approach is to **find plug points in the existing course of instruction** where in population education concepts and data are integrated.
- Activities bifurcated into 6 major categories: training, research, evaluation, advocacy, co-curricular activities, curriculum and material development.

Gujarat Vidyapeeth

- Population Education has also been integrated into the higher university education system. In Gujarat it is operated by PERC based at Gujarat Vidyapeeth

Drawbacks

- **does not integrate elements of adolescent reproductive health.** Sensitivity of the topic and the **lack of political will being** pointed out as major reasons.
- **lack of inter-sectoral collaboration.**
- the elements are **thinly spread in** too many subjects at several points in text books.
- **no follow up** after training.

iii **AIDS Education**

The State AIDS Cell working under the auspices of National AIDS Control Organisation (NACO), functioning for more than a decade in the country, has its ultimate objective to slow the spread of HIV by initiating major efforts in the prevention of HIV transmission (National AIDS Control Programme, 1987). Communication by way of Information, Education and Communication (IEC) seems to be one of the most important strategies in the fight against HIV/AIDS adopted by NACO. In the present study, the state counterpart, State AIDS Cell was pointed out by 19 of the respondents as providing sexual and reproductive health information to young people (Table. 4.2)

- **AIDS Awareness among the young – One of the objectives**

As understood by majority of the respondents who are aware of the programme, one of the objectives of NACO is to promote better understanding of HIV infection among people, especially students, youth and other sexually active sections and to promote safe behavioural practices for prevention.

“Young people are one category, most vulnerable to HIV/AIDS. The AIDS Cell as well as the Ahmedabad Municipal Corporation is going to focus on youngsters in the days to come as it looks like the disease has already started penetrating into the low risk zones” (Official, State AIDS Cell)

As was further elaborated, as per the NACO directives, the State AIDS Cell has also set in its policy that AIDS education should be imparted through curricular and extracurricular approach in educational institutions.

“The programme of ‘AIDS education in schools’ and the ‘Universities Talk AIDS’ (UTA) programme should have universal applicability throughout the country in order to mobilise large sections of the student community to bring in awareness among themselves and as peer educators to the rest of the community. Non-student youth should also be addressed through the large network of youth organisations,

sports clubs, National Service Scheme (NSS) and Nehru Yuvak Kendras spread across the country. AIDS prevention education should also be integrated into the programmes of workers education and schemes of social development (National AIDS Control Programme, 1987)

As stated by the State AIDS Cell representative himself, the programme works on the lines of reinforcing family values and respect for the opposite sex.

“Our strategy is to reinforce the traditional Indian moral values among youth and other impressionable groups of population” (Official, State AIDS Cell)

- **Activities**

Under the School Education Programme, the activities include training of teachers and peer educators among students, role playing, debates and discussions, question box and access to referral services.

The University Talk AIDS Project undertakes workshops, seminars and development of written materials especially designed for them.

- **Drawback**

The major drawback pointed out about the programme is in terms of its narrow focus. As pointed by some of the respondents, the focus is only AIDS and Sexually Transmitted Infections and they do not cover the other issues related to Sexual and reproductive health of young people.

“The focus of the State AIDS Cell is only on HIV, Sexually Transmitted Infections and Reproductive Tract Infections. It is only a small part of reproductive health problems and they are focussing only on this”(IGO Official 1)

AIDS Education - Highlights

- Objective is to create **better understanding of HIV** infection among people.
- Strategy of **reinforcing family values and respect for the opposite sex** by means of curricular and extracurricular approach in educational institutions.
- Activities include **training of teachers and peer educators among students, role playing, debates and discussions, question box and access to referral services.**
- The **University Talk AIDS Project** undertakes workshops, seminars and development of written materials especially designed for them.
- Major drawback is that the **focus is only AIDS and Sexually Transmitted Infections.**

iv **Family Life Education through the curricula.**

Another school based approach having components on reproductive health matters is the Family Life Education through the regular syllabus for secondary students for the Biology lessons. This was pointed out by many of the respondents (Table: 4.2) including teachers themselves.

“In the Biology syllabus we have courses on the physiology of reproductive organs as well as reproduction. We also talk about some of the diseases like AIDS and those which get transmitted through sexual contact” (Teacher 2)

Towards preparing the syllabus, it was noted that the syllabus and the content of the text book is decided by the Secondary Education Board, at the national level.

“They have experts on the subject, they are deciding the curriculum, they gives us the syllabus and we just follow it” (Official 1, Education Department)

- **Major comments**

One of the major drawbacks pointed out is that though the name of Family life Education connotes the centrality of training in life skills for young people, the current curriculum seems to be mostly limited to imparting knowledge on reproductive Physiology.

It was noted by more than half of the respondents who expressed awareness about the existence of such lessons that, though the course content is good enough to orient the students, it does not cover all the aspects related to sexual and reproductive health. As is expressed by a local NGO representative, “*it is very little and it is not compulsory too.*” However, as noted, the curriculum is being revised at the time and some more of the things related to young people’s sexuality are being included.

“I think it is going on, there is a Gujarat text book board, I think now they are in the process of reviewing the content and some of this things are already included, for example, gender bias, they are already dealing with it and they have come out with some solutions, it is going on from the education department” (IGO Official 1)

Teachers normally skip

Another frequently reported problem is that the teachers normally skip these lessons as they feel shy to handle it and ask the students to read it at home on their own. Sometimes it also seem to happen that the teacher ask one of the students to read it

aloud in the class with the teacher himself or herself explaining nothing. This is even commented to be possibly creating a negative mindset in the pupils about reproductive health matters.

“I have seen the text book and they are quite OK though they hardly cover much on gender education, gender differences and all that. But the problem is that teachers are not dealing with them properly. My daughter, who is in a reasonably good school in the city, she was also saying that teachers also attach a kind of stigma to those chapters. So what happens is that she feels “Look Papa, see what kind of things have they written, it is all rubbish, bad things” That kind of a mind set is already prepared by the teachers. That is the big problem” (Parent 3, Father)

More or less the same view was also expressed by two of the young people too. While one of them noted that, “*our teacher asked us to read it by ourselves at home*” (Girl, 10th standard) for the second, it was like ;

“Our teacher asked one of us to read it aloud in the class, and we just listened to that, our teacher did not explain anything” (Boy, 12th standard)

However, as expressed by one of the male teachers, it was quite normal for him to teach this chapter too.

“Normally the students giggle when I teach this chapter, but I never skip it. But I have to caution myself not to give too much stress on it, otherwise it might go to the parents and they will get on to my neck” (Teacher 2)

Family Life Education -Highlights

- Family Life Education **through the regular syllabus for secondary students** for the Biology lessons
- **Limited to imparting knowledge on reproductive physiology**
- The **teachers normally skip these lessons** as they feel shy to handle it.

v Non Governmental Organisations (NGOs)

The programmes of NGOs seems to be a commendable source of sexual and reproductive health information for both school as well as out of school youth. Half (25) of the respondents including the 5 local NGO representatives and 1 national NGO representative (Table : 4.2) perceived the significance of NGO programs though they are modest in scale and in early stages of development.

- **Support for sexuality education**

All of the NGO representatives working with adolescent issues expressed that they do support sexuality education both in schools and out of school based and encourage its members to advocate for and participate in such education.

“We have it clearly mentioned in our policy that we support the inclusion of age-appropriate sexuality education from grades 8 through 12 th as an integral part of comprehensive health education in schools and communities” (Official, National NGO 1)

- **Approaches**

Each of the respondent NGOs seem to have a strong component of sexual and reproductive health education either for school going or out of school youth. The approaches varied from directly embarking on school health programmes of which sexuality education is a part, working through peer educators, training teachers and training and other NGOs for capacity building.

School health programmes of which sexuality education is a part

A typical example is the programme of a national NGO as presented by the representative:

“We do have ongoing school health programmes. It is basically five aspects related to health - nutrition, development, puberty, sexuality and contraception. Aspects related to sexual and reproductive health issues, generally we keep it through question-answer sessions. We encourage the students to write down questions without having their names, they sent over the questions in a chit box and we respond to their queries and that way we do it, but then to cover all the messages, we do put in some questions from our side as if they came from the students to cover all the messages. Generally we involve parents in these lessons. We invite them as well. There are many schools where we have already done it and it was real success“ (Official, National NGO1)

Training teachers and peer educators

Training teachers and peer educators is another approach followed by some other NGOs.

“We give training to teachers and some selected students to be peer educators, it is a 5 day training. We call it AIDS education training. But, if I only talk about AIDS, how it is transmitted and how you can protect, it will only take 2 days, but that is not the only thing. First day, I talk about general health and introduction to AIDS, second day reproductive health and adolescent concepts, third and fourth day I talk about communication, the importance of communication in partner relationships, and aspects like gender and communication and fifth day action plan, and then it is conceived as an ongoing programme” (Official, Local NGO 3)

‘Womb to tomb’ approach

Another NGO representative working for out of school youth in slums expressed that they *have a womb to tomb approach* to define the context of adolescent health. In their life cycle approach, they cover issues starting from birth and focus on health issues with a gender perspective. So they talk about issues like early childhood and development, school health, adolescent health, sexual health and maternal health, and thus try to cover all the issues related to different age groups. Their activities include training peer educators from the community, health camps in collaboration with local organisations, capacity building of other NGOs and provision of reproductive health services.

- **Major drawbacks**

The major draw backs pointed out about NGOs is that their sphere of activity is very little compared to government programmes which can not make much impact in the long run and that their objectives are mostly driven by monetary benefit motivations. Some of the respondents seemed to be sincerely doubting the genuineness of NGOs noting by that most of them work without trained personnel, the activities being carried out by so called ‘field workers’ who have no expertise on the subject.

“NGOs and Government if you compare, it is only 1% of the activity that the NGOs do; 99% is done by the Government machinery. Mostly it is kind of business, getting some funds and doing something here and there, the monetary benefits assume great significance. Some of the small NGOs if I talk about, basically they are ‘one-man shows’. Most of them do not have trained people, whatever they have is all field workers. What they know is what they have read somewhere; as far as government policies are concerned and as far new subjects are concerned they are largely ignorant. But if they can do something good, it is ok” (IGO Official 1)

NGO Programs - Highlights

- **Do support sexuality education** for young people both in schools and out of school based.
- The **approaches varied** from directly embarking on school health programmes of which sexuality education is a part, working through peer educators, training teachers and training other NGOs.
- Drawbacks
 - **Sphere of activity could be very little** compared to government programmes which can not make much impact in the long run
 - Objectives may **perhaps be driven by monetary benefit** motivations.
 - May be **working without trained personnel**, the activities carried out by called ‘field workers’ who have no expertise on the subject.

4.2.2.2 SRH Programs with multiple components

In response to the international consensus and as a part of the strategy to implement policies, governmental as well as non-governmental organisations and intergovernmental organisations like the UN agencies seem to have initiated programs, though few, which are more than educative.

i Reproductive and Child Health Programme (RCH)

The RCH programme was launched by the Government of India, in the aftermath of ICPD in 1996 aiming at providing holistic reproductive health services through the existing vast network of the primary health care system. As could be gathered from the reports of the concerned government officials, under the Reproductive and Child Health Programme, special training has been initiated for Health Workers like Auxiliary Nurse Midwives (ANM), Supervisors and Medical Officers with the aim of upgrading their clinical, technical and interpersonal communication skills. During the training, the health personnel are said to be sensitised on issues related to adolescent health in general too. However, in this training the behavioural, social and emotional aspects related to adolescent sexuality seems to be hardly covered. The other initiatives under the RCH programme pointed out as indirectly serving the reproductive health needs of adolescents and youth include the anaemia detection along with the iron - folic acid treatment and the nutritional supplements programme.

“You see earlier, our staff, that is the sub centre staff or in the Primary Health Centre, when they could register a pregnancy in the first trimester they were happy. They thought that it is early registration, but it is not enough. What does it mean to be early if that women who conceive is stunted or malnourished or anaemic? So, there is the need for addressing these issues well in advance or in other words to follow a life cycle approach of RCH. So we took up this issue and now efforts are underway at two levels, iron - folic acid treatment and the nutritional supplements programme. So adolescent health related activity have been taken up under the RCH programme” (Official 2, Department of Health)

“It was seen in Gujarat that almost 70% of adolescents especially women suffer from Blood anaemia which in turn will affect their reproductive health. When they become mothers tomorrow, the amount of danger involved in child birth is high. So either through the Anaemia detection and treatment or through School Health Programme, we are indirectly serving the reproductive health needs of adolescents and youth” (Official 1, Department of Health)

Certain other interventions have also been reported to be initiated to address population issues and social issues like women empowerment, violence against

women and gender issues, though the officials could not furnish the specific information with respect to the interventions.

“The state government developed partnership with international agencies, NGOs and other sectors to work in a much more concentrated way to address certain specific issues relating to adolescent health. The World Bank supported Reproductive and Child Health sub project and the UNFPA supported Integrated Population and Development Project in which all the issues relating to the reproductive health of young people along with population issues and social issues like women empowerment, violence against women and gender issues are addressed in a concentrated way (Official 1, Department of Health)

“Our association has been approached by the government since the last two years. We are conducting Reproductive and Child Health workshops all over India. The govt. is giving us 1.5 Lakhs and we are trying to motivate the doctors in their domicile area to conduct RCH workshops with adolescent issues as a part. I think it has to be ongoing rather than making it as a one time effort. So the entire health department has to get involved.” (Official, National NGO 1)

However, many of the other respondents seemed to be of the opinion that formal primary care settings hardly serve any of the sexual and reproductive health needs of unmarried young people. According to some of the government officials, *there is a big scope* in the integration of the adolescent sexual and reproductive health agenda to which government is committed to and programmes have already been initiated, *but priorities have to be set as well.*

Reproductive and Child Health (RCH) Programme - Highlights

- Aimed at providing **holistic reproductive health services** through the existing vast **network of the primary health care system**
- **Special training** has been initiated for health workers during which they **are sensitised on issues related to adolescent health** in general. However, the behavioural, social and emotional aspects related to adolescent sexuality **seems to be hardly covered** in the training.
- Many were of the opinion that **formal primary care settings hardly serve** any of the sexual and reproductive health needs of **unmarried young people**

ii **Inter - Governmental Organisations / UN Agencies**

Intergovernmental Organisations like the UN agencies also seem to be actively involved in the promotion of adolescent sexual and reproductive health in Gujarat. The major UN agencies reported to be involved are UNICEF and UNFPA.

- **UNICEF**

As could be gathered from the UNICEF official, UNICEF has been playing a advocacy role, undertaking sensitisation of planners and policy makers along with the development of training and other research material.

“We have been advocating adolescent education through the education department and sensitising planners and policy makers. And with the health department we are making a project for the sensitisation of the local policy planners, that is the District Development Officers, Collectors and District Health Officers. We are also planning to go for the training of all of our medical officers on the reproductive health problems of adolescents. It will be done in phases over a period of time. But at the moment it is very much at the planning phase. It has been discussed and has been finalised and could also have been taken off, but for the recent earthquake in Gujarat. In addition, we have been supporting material development, in Gujarat for example, GCERT has developed a book on adolescent education which is being used as training material. The GCERT training programme as well as literature development is also partly sponsored by UNICEF ” (Official, UNICEF)

- **UNFPA funded Integrated population and development (IPD) project**

As per the reports of the concerned official, the UNFPA funded Integrated population and development (IPD) project is working in 5 districts on the lines of an input programme, with the intended output of strengthening reproductive and child health (RCH) services. As detailed by the official, the input from UNFPA is mainly in the form of manpower, funds for quality improvement like infrastructure development, funds for equipment and instruments, funds for training and some funds for advocacy works. Following are the specifics of the programs as presented by the official.

Adolescent health – one of the component

Under the component of adolescent health in RCH, three categories of adolescents seem to be focussed; school going, college going and out of school. Among the school going, those from ninth, tenth, eleventh, twelfth standard students, in secondary and higher secondary are concentrated. In the schools, it is going on as a full swing programme. The major activities undertaken include complementary training to

teachers, supporting cocurricular activities like Quiz, essay completion, exhibition, and drawing competition and organising Mela for school girls.

Under training, two teachers are given one day training, one science and one physical education teacher, on adolescent health issues. The basic things covered are Anatomy, Physiology, physical and mental changes and issues like gender disparity and sexual harassment in school.

“We have selected some 150 schools in each of the two districts. We discuss the issues with the teachers, and it is a complimentary exposure, because they have already taken training from GCERT, and this is just reorientation at some specific points of RCH programme. We have already completed training in two districts” (Official, IPD Project)

After the training is over, some funds are given to the school, normally Rs.1000/- to organise cocurricular activities. Another activity undertaken is the Melas for school girls which is basically meant as a 2 to 3 day programme including 500- 600 girls. The girls stay overnight activities like cultural programmes or exhibitions are organised along with a component of medical examination and counselling for problems they might have. The girls Melas are being organised in 3 districts.

“These are the programme approaches for school going children Whenever there is a programme, a concerned medical officer of the area, a family life educator in our project and the IPD project officer will be informed about the programme and out of three, someone will go to attend and monitor the programme. It is a complementary programme to GCERT programme and is not independent. In GCERT programme, RCH in the context of health issues is missing, so we talk more on the health issues. Nutrition and health aspects are covered in detail. We also talk on how primary health system in the government is able to help these teachers and students as far as family life education for adolescent health is concerned. That brings in collaboration with the public health care system. So whenever adolescents get a problem, they can approach the Medical Officer or Auxiliary Nurse Midwife (ANM) for health related issues” (Official, IPD Project)

College going youth

The IPD Project also cover college going youth with similar programmes which are done through some of the local NGOs. Though some of the activities are already going on, a full fledged programme is yet to be started.

Out of school youth

Out of school youth remains to be the most difficult group to catch. Towards reaching out this target group, combined training for front line workers at the grass root level in villages like Anganwadi Workers and Helpers, trained Dais and Female Health Workers are organised. In this training, issues like women's empowerment, violence against women, gender issues and adolescent health are focussed so that they get exposed on the problems of adolescents. After the training, the workers are asked to organise groups of out of school girls, and will be talking to them in the community about adolescent health problems.

“They will be calling some 10 – 20 girls in one group and it is only for young girls. Boys are not covered. It is not a one time activity and will continue for a time period of six months to one year. However, it is not a regular meeting and we do not do any monitoring too” (Official IPD Project)

Future plans-educational material

As elicited, one of the plans for the future is to develop educational material covering issues which are not tackled so far like sexual harassment or gender issues in local language and context using modern techniques like the use of Compact Disc.

Programs of Intergovernmental Organisations – Highlights

- UNICEF playing **advocacy role**, undertaking sensitisation of planners and policy makers, and the **development of training and other research material**.
- The UNFPA funded Integrated Population and Development (IPD) project
 - Working in 5 districts, with the intended **output of strengthening reproductive and child health (RCH) services**. Support mainly in the form of manpower, support for quality improvement like infrastructure development, equipment and instruments, training and advocacy.
 - Three categories of adolescents; **school going, college going and out of school**
 - In schools, major activities include **complementary training to teachers, supporting co-curricular activities and organising Mela for school girls**.
 - For college going, some of the activities are initiated, a full fledged programme is yet to be started.
 - Under out-of-school, **combined training for front line workers at the grass root level** in the villages. The workers are asked to organise groups of out of school girls, and they will be talking to them in the community about adolescent health problems.
 - Future plan is to develop **educational material** covering issues which are not tackled so far in a local language and context using modern techniques.

“Of course lots of materials are available, pictorial and descriptive, if you talk about Anatomy, Physiology, Puberty and so on. Our plan is to look at some of the issues which are not tackled so far, for instance sexual harassment in schools, in the family or at the work place, or gender issues, such topics are not dealt in a very good manner and not very much highlighted in the local context. May be at the national level they must be talking about it, but in the local village or district level it is not so much focussed yet. Another idea is to prepare Compact Disc. Infact all the materials are available in hard copies or books, but we want to develop Compact Discs and supply to all schools where computer is available. So children are at ease and at freedom to take it and use it on their own. And this has to be in the local language, we do not focus on many pictures, then it may be mistaken as a porn article or something like that, then it is diverted. We want to do more like make it attractive by using bold letters or descriptions or things like that” (Official, IPD Project)

4.2.3 Constraints faced in the planning and implementation of programs

It could also be worthwhile to examine the constraints faced by the various programmers in planning and implementing programmes for young people. Though, the basic idea underlying a change in the existing system may be widely applicable, it is quite possible that an approach that seems perfectly adequate in one setting could be wholly inappropriate in another setting or is difficult to be implemented. This could be due to a number of reasons ranging from the socio-cultural setting, or the fundamental laws or the constitutional systems.

In the current research too, the stakeholders in policy making, planning and implementation of programs seem to be facing a number of constraints in their realm of activity. Following is an account of some of the elicited constraints.

4.2.3.1 Government Officials

- **Social Approval**

In a society which have traditionally frowned upon sexual activity among young people and simply prohibited premarital sex as it violates codes of personal morality, social approval has been perceived as a major constraint in introducing programmes intended to meet the reproductive health needs of unmarried young people. Among the 10 government officials interviewed, 7 of them seemed to be of the opinion that *this is a hot issue*, and seemed to be giving due consideration for society’s approval in the planning and delivery of programmes and services for young people.

“Any programme, unless the society approves it, will end up in a backlash. That means you have to change the basic attitudes. We still have people who have the old frame of mind and it can not be done overnight. It is a long process and will take time“ (Official 1, Department of Health)

However it was also noted by some of the officials that the society has started recognising the need for reproductive health services and programmes for young people and thus setting a more conducive stage for planning and implementing programmes and services for young people.

- **Prevailing myths and misconceptions**

Some of the government officials (5) were of the opinion that the myths and misconceptions in the minds of the public is a major constraint for them to implement programmes starting from sex education or the provision of health care.

“One typical example is the introduction of sex education. People seem to be fearing that talking about sexuality means awakening interest which is more of a misconception. But this still remains as the major impediment in the introduction of sex education” (Official 2, Department of Education)

- **Other priorities**

As put forward by some of the officials they are sincerely concerned about adolescent issues, but the problem is that they have to set priorities in programme planning and implementation which mostly “*goes to other more important issues*”

“Where adolescents and youth are often not even perceived as a distinct group, how can you say that priorities should go to them” (Official 1, Department of Family Welfare)

The same problem was further expressed to be taking other forms too.

“You see Population Education is given a backplace from the ministry, and the deficiency of the staff is not properly taken care of because it is a programme for young people and is not considered very important” (Official 1, GCERT)

Among the 10 government officials interviewed, 5 of them considered other priorities as a constraint towards making programmes and services for young people.

Constraints faced by planners and policy makers – Highlights

- **Social approval**
- **Lack of public support due to myths and misconceptions.**
- **Have to set priorities** in programme planning and implementation to other important issues

4.2.3.2 Non Governmental Organisations

- **Socio-cultural acceptability**

Interestingly most of the non governmental organisations involved in the planning and delivery of services seemed to be very much conscious about the social and cultural factor and of the opinion that whatever they write or whatever they talk, they have to think about the society, and whether it will be accepted. The words of a local NGO representative who is involved in providing AIDS education in schools demonstrate this:

“You know we have to do it in a proper way. Suppose we talk too much about sexual relationships, downright it will be rejected. Otherwise the school will try to hide it. This is the reason behind why many people are scared to do it.” (Official, Local NGO 3)

“We do have ongoing school health programmes, majority of people do like it. And we integrate education on aspects related to sexuality too. But specifically, if we announce that we are going to give a sex education, the problem always has been that, at least 30% of parents are being quite quizzzy about it. So generally we do not explicitly mention it and keep it only through questionnaires. Sex education seems to be the wrong word. Unfortunately they always equate it with the act of sex, that is the problem” (Official, National NGO 1)

The social and cultural factor could be explaining at least partially the reasons for conducting sexuality education in the disguise of family life education or AIDS education.

- **Lack of financial support**

To sustain NGOs work, financial viability is an essential prerequisite. In the present study, some of the NGOs working locally as well as nationally, perceived lack of financial support as a constraint in effectively implementing programmes and services for young people. However, the international organisation representatives were of the opinion that there are enough resources available which are to be channelled in a proper way.

“One big need is finance. If there is money, automatically there will be a flow of people saying that they are interested. We have a group of people who are quite dedicated but the limitation is that we can’t go on a big scale. We work only at the local level with sponsors, that mainly through Pharmaceutical companies, they always look at the affordability of the clients we are targeting. So generally they are not very interested to fund out of school programmes“ (Official, National NGO 1)

Resource limitations seem to be restricting the reach of programs most severely to the poor and marginalised young people.

Furthermore, it was observed that financial constraint is a major reason for the inability of some NGOs to develop certain innovative models of service or programmes. Typical example as put forward by a national NGO representative is that:

“I made a proposal to the Civil hospital superintendent to start a Adolescent Clinic. But, the funds and the mechanics of the system some how could not make it” (official, National NGO)

However, as expressed by UN Agency representatives, lack of financial support is not a major constraint in provision of services and programmes for young people.

“There are enough resources, which need to be channelled in a proper way” (Official, IGO 1)

- **Lack of sensitisation among policy makers**

An important premise behind the success of NGO programmes is a conducive environment with a non-confrontational and supportive attitude from the government. In such an environment, NGOs can work together with the government and this inturn can accelerate the pace of upscaling reproductive health innovations and transforming them into comprehensive reproductive health programmes. This makes it necessary that planners and policy makers from the government are sensitised and they see adolescent reproductive health concerns as important. In the present study it was noted by a few of the NGO representatives that the lack of sensitisation among policy makers and planners is a major constraint for them to implement certain programmes. Again as elicited by some of the respondents, though the paradigm shift arising from ICPD has underscored the need for NGOs to play a greater role, government has to facilitate NGO activities by making a conducive environment and

this could be possible only if the officials are properly sensitised about the problems of young people and the various issues of providing care to them.

- **Lack of a policy framework**

Underlying any explicit action, there should be a certain policy which in turn shape the action. The lack of a reproductive health policy for young people has been perceived as a major constraint by some of the NGO representatives in developing programs and services for young people. As expressed by the respondents, though mention has been made about adolescent health in the National Population Policy, it is only at a primary level and is more on paper without any concrete action being undertaken.

“That is a big problem. Infact, very recently two or three years back, Government of India included adolescent health in the National Population Policy and proclaimed in RCH, but prior to that they were never thinking. And even today, the fact is that it is more on paper than there is hardly anything being done on adolescents. Perhaps, government is very worried about how people would respond that is what the policy makers are very much worried. So they have included on paper, practice, if you ask them, what is the performance that you have envisaged, they do not have anything” (Official, National NGO 1)

Again in the words of a IGO official, NGOs can play an advocacy role in policy formulation which they have already been doing.

“We have been talking about this to the Government of India, there are policies for the old, there are policies for immunisation, there are policies for school health programmes and so on. Taking into account the unique health problems of adolescents and young people compared to other age groups, of course we need a National Policy for young people or adolescents which might come one day. In the National Population Policy, they have mentioned about adolescent reproductive health, but it is only at the very primary level” (IGO Official 2)

Constraints faced by Non-governmental Organisations - Highlights

- **Socio-cultural acceptability**
- **Lack of financial support** as a constraint in effectively implementing programmes and services for young people
- The **lack of sensitisation among policy makers and planners** leading to confrontational and unsupportive attitude from the government.
- The lack of a legal framework in terms of a reproductive health policy for young people

4.2.4 Fit between existing programs and young peoples' needs based on the intervention framework

As summarised in the Table 4.3, though multiple programs are in operation to respond to various issues relating to the sexual and reproductive health of young people, comprehensive and well balanced programs having the potential to reach large numbers of young people seem to be lacking. Furthermore, the programme scene as a whole is characterised by few nation-wide programs and a number of small scale NGO programs. Looking at each of the individual programs, it can be seen that the objectives, orientation, type and quality of education provided vary from programme to programme. Looking at the comprehensiveness of the information given, the nation-wide Population Education programme run by NCERT and the state counterpart GCERT programmes focus on population issues with adolescent health as one component. Though gender issues and sexually transmitted infections seemed to be covered, the preventive or care part of reproductive and sexual health is not dealt with and issues like reproductive rights, contraceptives, teen age pregnancy, safe abortion, are largely left out, the omission being accounted by the sensitiveness of the topics. Their activities are mainly centred around teacher training and the course material is integrated in to the existing curricula. There seems to be no effort at providing care services or attempts at collaborating with the health care system. The National AIDS Control Programme reported to be working with the strategy of 'reinforcing the traditional Indian moral values' is focussed on HIV/AIDS and the information delivered pertains to only part of sexual and reproductive health aspects. The other approach involving family life education through the curricula is also oriented towards giving information on reproductive physiology which is reported to be very little and perhaps be skipped by teachers. Though such public sector programs have the potential to reach large numbers of young people, comprehensiveness of the information itself is limited and this could end up in creating a restricted knowledge base among the learners. However, it is logical to conclude that the availability of programs can contribute to improvements in overall knowledge levels. Some of the NGO seems to be doing a better job in this regard, their coverage seems to be limited except for the professional organisations working at national levels. Another issue is the education in the context of appropriate medical services. Though the importance of a "womb to tomb" approach was specified in the context of the newly conceived

reproductive and child health programme from the Ministry of Health, the only implication aspect going on is with respect to the sensitisation of front liner health workers about the need for providing services within the context of the primary health care system. There are no special programs offering sexual and reproductive health services such as access to a choice of contraception, diagnosis and treatment of sexually transmitted diseases and safe abortion.

Based on the framework described in the previous section, for intended behaviour to occur, the outcome expectancy and self efficacy need to be modified with comprehensive information transfer and skill building. This could be through presenting basic and accurate information about the risks of and avoidance of too early and unprotected intercourse, using a variety of teaching methods, focussing on personalising the information, and providing opportunities to practice communication, negotiation and refusal skills. This inturn would mean the use of methods that involve students directly and include modelling and practice in decision making, self assertiveness and communication skills.

Looking at the program scene against this model framework, it can be seen that some of the core components are missing. Mostly the education programs are based on didactic models of lecture sessions without out much focus on interactive sessions or behaviour modelling or skill building exercises. Learning based on role plays or other methods of modelling seems to be very rare. Furthermore, as the programs are predominantly school based, out of school who constitute a substantial proportion, seem to be largely bypassed. Another important sector are the young people who are out of school. The seems to be largely bypassed. Use of the mass media as well as out reach programmes addressed to young people through radio, television, peer drama groups, posters are hardly reported. Based on the above observations, it can logically be concluded while there is a need for comprehensive programs and services, the existing programmes to be largely devoid of some of the core components of effective risk reduction intervention.

Programme	Actor National/ State	Coverage	Orientation	SRH component	Approach/ Use of modelling	Activities	Major drawbacks pointed out
Population Education in Schools/ Universities	NCERT / GCERT Gujarat Vidyapeeth	Nation-wide /State-wide	Awareness on Population and Development issues	Adolescence Education as one component. Covers 3 aspects: i) process of growing up, ii) HIV/AIDS and iii) drug abuse.	Integration in to the existing course of instruction using minimum essential ideas	Training, research, evaluation, advocacy, co-curricular activities, curriculum and material development	<ul style="list-style-type: none"> Does not integrate all the elements of adolescent reproductive health. Lack of inter-sectoral collaboration. The elements are thinly spread in too many subjects in a <i>touch-and-go manner</i> at several points in text books. No follow up after training.
AIDS Education	NACO/ State AIDS Cell	Nation-wide /State-wide	Awareness on HIV/AIDS	HIV/AIDS	Role playing, debates and discussions, question box and access to referral services.	Training of teachers and peer educators among students,, workshops, seminars and development of written materials	<ul style="list-style-type: none"> Focus is only AIDS and Sexually Transmitted Infections.
Family Life Education through the Curricula	Secondary Education Board	Nation-wide /State-wide	Human Biology	Reproductive Physiology	Class room lectures	Curriculum development	<ul style="list-style-type: none"> Limited to imparting knowledge on reproductive Physiology. Very little and not compulsory Teachers normally skip these lessons as they feel shy to handle it
NGO Programs		Mostly limited to pockets	Sexual and reproductive education	VARIED			<ul style="list-style-type: none"> Sphere of activity is very little which can not make much impact in the long run Objectives driven by monetary benefit motivations. Work without trained personnel, the activities carried out by 'field workers' who have no expertise on the subject.
Programs with more components							
Reproductive and Child Health Programme	Ministry of Health and Family Welfare	Nation-wide	Aimed at providing holistic reproductive health services through the existing vast network of the primary health care system		Special training has been initiated for the upgradation of the clinical, technical and interpersonal communication skills. Sensitisation on issues related to adolescent health in general during the training		<ul style="list-style-type: none"> Behavioural, social and emotional aspects related to adolescent sexuality seems to be hardly covered in the training
UN Agencies	UNFPA, UNICEF	Statewide	Support for sexual and reproductive health programs		Advocacy, sensitisation, material development, support for strengthening RCH infrastructure, school based programmes and teacher training		

Table 4.3 Overview of existing SRH programme

4.3 Access to sexual and reproductive health care - barriers

Translating the ICPD consensus into reality would mean that reproductive health services become equitable to all sectors of the community including large numbers of young people and that services become available, accessible, affordable and acceptable to those who need such care. Furthermore, as young people become sexually active, their access to reproductive health services is vital. Therefore, in addition to the education and information on reproductive health, provision of health care itself is a necessity. As there are no specialised institutions or programmes offering SRH care services to young people, the only possibility for them is to turn to the health care system. So, while thinking of a possible intervention framework, it is imperative to look at the responses of the health care system to the needs of young people.

As Penchansky and Thomas (1981) noted more than 20 years ago, ‘access’ is a major concern in health care policy and is one of the most frequently used words in discussions of the health care delivery. As conceived by Penchansky and Thomas, access reflects the fit between characteristics and expectations of the providers and the clients. They grouped these characteristics into five As of access to care: affordability, availability, accessibility, accommodation, and acceptability. In the current research, though the Penchansky and Thomas framework could not be used to explain all the barriers that young people face in accessing sexual and reproductive health services, some of the As of access assumes significance here too. Following are the access barriers to reproductive health services for adolescents as identified by the key stakeholders. The barriers in accessing services relating to contraception, STI care and safe abortions are discussed.

4.3.1 Availability

Availability measures the extent to which the requisite resources are available to meet the needs of the client (Penchansky and Thomas, 1981). In the present study, almost all of the respondents pointed out that there is enough availability of health care services, both in terms of prevention and cure.

Contraceptive Services

If sexually active young people, be married or unmarried, are to control their fertility, it is essential that they have access to contraceptives. As repeatedly expressed by the respondents, in general the availability of contraceptives is good enough especially in urban areas where contraceptives are reported to be easily available from a number of outlets.

“I think contraceptives are more easily available now, because there are a number of outlets” (Official, Local NGO 1)

There are many public and private clinics as well as drug shops where contraceptives seem to be easily available. Community distribution by health workers was also pointed out by the official from a state government body as another factor making contraceptives easily available.

“Health Workers whenever they move in the field they carry oral pills and Iron tablets, and they provide them during house visits, they also keep condoms in Anganwadis or with pan walas or places like that. But it is mostly married people who go to them.” (Official, State Government Body 2)

The same opinion was expressed by the representative from a international organisation about the provision of contraceptives in rural areas too.

STI Care

As regards the care for Sexually Transmitted Infections too, availability was expressed to be good in urban areas though many of the respondents could not comment about the situation in rural areas. In public hospitals, there is a special clinic for treating STIs, *“in the civil hospital, Ahmedabad, it is known as ‘Vatsyan clinic’ and is running since one and half years. There are 3 doctors and a trained councillor”*. In Ahmedabad city where the study is concentrated, there are also many private practitioners who are specialised in treating skin and venereal diseases (sexually transmitted infections). However, with regard to HIV testing, it was noted that some of the districts in the state do not have any HIV testing facility at all.

Pregnancy Termination

The availability of pregnancy termination services were also reported to be good. This goes well against the ground that abortion is legal in India.

“Services are available, if not all, 40-50% of PHCs have trained doctors and have got the facilities too to perform a legal abortion. Abortion service is also freely available in all government hospitals and medical colleges“(IGO Official 1)

In addition, there are quite a number of private medical practitioners in the city who offer abortion services. However, it was also expressed “*that there are also certain areas where there is no network at all and nobody to take care of such issues*”

Availability of Services - Highlights

- **Availability** of services does **not seem** to be a barrier as such.
- **Contraceptives are available** in many public and private clinics as well drug shops. Community distribution by health workers is also reported.
- **Enough availability of STI** diagnosis and treatment facilities in urban areas.
- **Good availability of pregnancy termination services** in urban and rural areas.

4.3.2 Acceptability

Social and cultural acceptability as presented by the stakeholders captures the extent to which the client is comfortable with seeking services in the particular social and cultural context. Social and cultural acceptability was indicated as an important barrier affecting young people’s access to SRH services by a large number (35) of the respondents. Issues like contraception and family planning often cause embarrassment to young people and the stigma attached to sexual activity outside the context of marriage gets reflected in seeking services too.

“Young people, especially the unmarried cannot seek help easily like a married older women for infections as well as pregnancy as it is not culturally accepted. A married woman can easily go and seek help for infections or pregnancy. An unmarried cannot do so even if needed ” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

The socio-cultural unacceptability also seems to be leading to the fear of being seen, as pointed out by some of the care providers. This in turn cause many youngsters to visit a health centre away from the place where they live and travel to other far off cities to seek treatment for STIs as well as abortion. Sometimes they travel as far as Bombay or Bangalore or sometimes for doing an abortion even the parents themselves take them to far off places. As was mentioned in the previous section, the social stigma also explains partially why large proportions of young people resort to unsafe abortions even when services are available free of cost within the public health system. Seeking care related to STIs is also very stigmatic and this is one reason pointed out for youngsters as well as adults not seeking STI care in public hospitals.

“In the civil hospital, they have this STD clinic, they call it Vatsyan clinic, but the problem is that these are stigmatised, normal people will not go there” (Health Service Provider 1, Teaching Hospital, Obstetrician and Gynaecologist)

Acceptability - Highlights

- **Social and cultural acceptability** and the consequent fear of being seen as an important barrier.
- **Social stigma** also partially explains young people resorting to **unsafe abortions** even when services are available free of cost within the public health system.

4.3.3 Affordability

The ability to pay for the consultation as well as other services was noted as a major barrier for young people especially in private health facilities by more than half of the respondents. In the public health system, the services are available free of cost, but the patients have to buy the medicines from outside. In the case of those with HIV/AIDS, the expense of the medicines go very high and people from low economic background can not afford to buy them.

“The patients who come here are mostly from the low economic strata; after they buy the medicines, they do not have any money left to buy the food” (Health Service Provider 5, Teaching Hospital, STI Clinic)

As perceived by the stakeholders, contraceptives are affordable and the price as such is not a barrier. Condoms are available free of cost in public health facilities and at a very minimal amount in shops as well as pharmacies.

Unwed abortions-high prize

As particularly noted by the respondents, unwed abortions and treatment of those with HIV gets very expensive in private health facilities. The general comment was that it is kind of business, the cost largely depending upon the need of the person.

“Many of the patients coming here for treatment have gone to private doctors outside, and sometimes they have also taken laboratory test. Usually, when private doctors get to know that they are HIV positive, the treatment costs go very very high. Just for stepping into the clinic, they take amounts ranging from RS. 500/ and then for testing 2500-3000 RS, so the expenses become unaffordable for normal people” (Health Service Provider 5, Teaching Hospital, STI Clinic)

Many of the respondents particularly pointed out the high costs involved in performing a termination for a unwed pregnancy in the private sector. “*For unmarried abortions, I have seen doctors simply doubling up the charges*” as pointed out by one of the medical practitioner himself. The comments by some of the medical practitioners clearly indicates the absence of any form of control nor professional norms with regard to this practice.

“What kind of norms do you expect? See all of us know what is fair enough, most of them are doctors only, so doctors are all aware of what is fairness, but as I said, it is business. The focus is more on how needy the person is, isn't it. Forget about abortions in any other service, it is the same” (Health Service Provider- Teaching Hospital, Obstetrician and Gynaecologist)

However, as explained by some of the medical practitioners, generally doctors charge more to perform an unmarried woman's abortion because of the risk involved in it. When it is done for a married woman, there is the support of the husband in the case of some complications. But in the case of unmarried, there will be hardly any support and the risk for the gynaecologist would be much more.

“For instance, you have a girl with apparently wrong name and wrong telephone number and if she dies, what the doctor can do? Ring up the police station and say I have a girl here whom I don't know. What do I do with the body. I know a case where the girl died on the table. The boy found out that something is wrong and he ran away. And the doctor had to go to the police station. This has happened” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

The other reason cited for doctors charging more for unwed pregnancies is the technical difference between abortion done for the first pregnancy and that done after one delivery and the extra costs involved due to this. This is how the charges go up in the case of unmarried pregnancies.

As noted by some of the respondents, by and large the cost could vary from 500-5000 RS, or in a few clinics even higher and the quality of the services would also be different.

“It is available at every level, it is something like you need a cup of tea in the city, you can get it on the pavement shop as well as from a luxurious mountain restaurant. The question is your affordability and your need” (Private Medical Practitioner 2, Obstetrician and Gynaecologist)

Again it was noted that the charge range varies greatly from one clinic to another. This could as well be observed by the researcher. For instance, in a private STI clinic, the cost for first consultation varied from 2-5 \$ where as with a private gynaecologist, it was 4-6 \$ for the first consultation. So the total charges for STI treatment or pregnancy termination could go really high which making the services unaffordable to those with few resources like young people.

However, as expressed by a private medical practitioner it is often the better quality protocol, that takes the cost higher.

Affordability – Highlights

- In the **public health system**, the services are available **free of cost**, but the patients have to **buy the medicines** on their own from outside.
- **Contraceptives are affordable** and the price as such is not a barrier. Condoms are available free of cost in public health facilities and at a very minimal amount in shops as well as pharmacies.
- **Unwed abortions and treatment of those with HIV** gets **very expensive in private** health facilities. The charge **range** seem to **vary** greatly from one clinic to another
- From the doctors’ viewpoint, the high charges are due to the **higher risk in unwed pregnancies, better quality protocol and the technical reasons.**

Table 4.4 - Findings of observation in four Sexual and Reproductive health service facilities

ASPECTS	CLINICS OBSERVED AND MAIN FINDINGS			
	Government Referral and Teaching hospital		Private Clinic for Skin and Venereal diseases in Ahmedabad city	Private Clinic – Obstetrics and Gynec in Ahmedabad City
	STI Clinic	Obstetrics & Gynec OPD		
Available SRH services	- STI and HIV Diagnosis - Treatment prescriptions - STI counselling - Distribution of condoms	- Delivery care - Medical abortion	- STI diagnosis - Referral for HIV diagnosis - Treatment prescriptions - Contraceptive advice	- Obstetric care - Delivery care - Medical abortion
Clinic policies	- Good confidentiality - Name of parent/ spouse required as part of intake registration		- Good confidentiality - Name of parent / spouse not required	- Very good confidentiality - Parent has to accompany
Clinic procedures	- Normally brought by parents /spouse - No prior appointment needed - Follow up after one week, response reported to be not good		- Can come on their own - Mostly with appointment - Simple registration and retrieval system -Follow up and referral system good	- With prior appointment - Very good case registration and retrieval system - Very good follow up and referral system
Cost	- Consultation and diagnosis free of charge - Medicines have to be bought from outside		Out of pocket on the spot payment for consultation (approx \$ 2 – 5 at first consultation)	Out of pocket on the spot payment for consultation (approx \$ 4 – 6 at first consultation)
Clinic staff (Out Patient Department)	1 Assistant Professor, 1 Gynaecologist, 1 doctor from the Skin Department, 1 Counsellor and 1 lab Technician	Full information could not be obtained	1 Doctor, 1 Assistant and 1 Receptionist	2 Doctors, 5 Nurses and 2 Receptionists
Clinic environment	- Convenient location - Poor condition of environment - Non aesthetic infrastructure in poor condition - No waiting room, have to wait in the crowded corridor - No privacy in the rooms - No display of educational materials or handouts - Out-patient opening hours: 9.00 – 12.00 AM		- Convenient location - Good condition of facilities - Good privacy in Consultation room - Common waiting room - Enough display of educational materials - Out-patient opening hours: 12.30 to 5 PM & 6 to 8 PM	- Convenient location - Very good facilities - Very good privacy in rooms and waiting area - Good display of education materials - Out-patient opening hours: 11 AM to 1 PM
Utilisation of the clinic by young people (daily)	Reported to have 2-3 below the age of 25 with complaints of ulcers on genitals, burning urination, discharging lesions	Full information could not be obtained	Reported to have 1- 2 unmarried patients per week	Reported to have around 15 cases a month of unmarried young people coming in for abortion

4.3.4 Service related

4.3.4.1 Information about services

One important barrier for young peoples' access to care as perceived by the stakeholders is the lack of information as to where to get the services from. This barrier was reported by more than half (25) of the respondents.

As noted by many of the respondents, the ignorance about services is more in rural areas compared to the urban regions. One typical example cited was the case of information about contraceptives.

“People in urban areas are mostly informed about where to go and get the services, but in rural areas, many especially adolescents do not have the information. For instance, condoms are available in pan shops, but very few know about it. Normally you see condom advertisements, but you don't see which places it is available. You see if a refrigerator is being advertised, they write about the dealers, such a kind of approach is needed here too” (IGO Official 1)

Normally young people find out about the services mainly through the word of mouth; in some cases it was also reported to be from sources like the telephone directory, state AIDS control programme and hospital display board.

“Some of their friends might have taken treatment from us and they usually try to guide -‘come with me, that doctor is good, he will make you alright’ Then they don't feel shy too. Some people just see the advertisement in Tata Yellow pages or get the address from the state AIDS control programme, or sometimes from the board hanging downstairs in the hospital they find out and come” (Private Medical Practitioner 3, Skin and Venereal Diseases)

Furthermore, as perceived by the stakeholders, mostly young people are informed that they can get such services in private practice but they do not know that the same services can be obtained in Public health facilities free of charge or at a much lower cost.

4.3.4.2 Perceived quality of services

The perceived quality of public health services is another factor hindering their use. As expressed by the respondents, this goes true with respect to all health problems, leave alone sexual and reproductive health, if they can afford, people avoid going to

the government hospital. The typical example as cited by a medical practitioner from the teaching hospital is:

“There is adequate exposure that MTP is safe and it is freely available in the government hospital but in general people they are reluctant to go to there and large majority get it done in private clinics” (Health Service Provider, Teaching Hospital, Obstetrician and Gynaecologist)

While some of the respondents noted that the quality of care is good or better in private clinics, the others were of the opinion that it is only the ‘perceived’ quality and not the ‘actual’ quality.

“And people in need of service for their health problem sometimes prefer to go to private because of the perceived quality, not the actual quality, the perceived quality” (Official 2, Department of Health)

The ground for this argument is that the most experienced and qualified personnel are working in the government sector, and there is also enough equipment and instruments. But people still prefer to go to private practitioners, sometimes even when the practitioner might be a quack and not a qualified person. As expressed what seem to be lacking in the government facilities is the quality in terms of physical infrastructure and certain interpersonal skills of the workers. Most of the public health facilities like Primary Health Centres or Community Health Centres are not so decently maintained, the primary appearance itself is so that people would not like to visit this facility.

“Sometimes the building is there, in the rains it is leaking, or may be the windows are not there, or are broken and this is so off putting to people who want to use the facility” (Official 2, Department of Health)

The other issue pointed out is about the communication skills of the workers which is discussed in detail in the coming sections.

4.3.4.3 Lack of privacy

Lack of privacy in public health facilities was noted as an important barrier hindering young people from using the service.

“Going to a government hospital, people are scared that in a such big hospital, somebody must recognise them as there is no privacy in the waiting area as well as in the consultation room. There are several doctors sitting in the same room and sometimes 2 or 3 patients at the same time in the examination room” (Official, Local NGO 4)

The researcher could herself observe the lack of privacy in a teaching and referral hospital where the patients have to wait for a long time in the crowded corridor. Many times the waiting patients peep in to the examination room too to see what is going on. There is also the long waiting time which increase the likelihood to be seen by a relative or an acquaintance in the health institution. In private clinics, the aspect of privacy was reported to be much more taken care of which could further be confirmed by observation.

“In many of the private clinics, like here, we provide enough privacy and they do not have any inhibitions in revealing the history. But in the general hospital when two three people are standing beside, they have inhibitions. Sometimes when there are elders or some known people they are not willing to reveal their history” (Private Medical Practitioner 3, Skin and Venereal Diseases)

4.3.4.4 Inadequate working hours

Inadequate working hours in public health facilities was also noted as a barrier towards accessing the services. The typical instance as put forward by a medical practitioner from a teaching hospital is that:

“In the STI clinic in the civil hospital, the out- patient services are from 9-12 everyday, I do not think it is a convenient time for school going youngsters. Further more, being a referral hospital, everyday there will be a big queue waiting outside, many of them will have to come back again on the next day” (Private Medical Practitioner 3, Skin and Venereal diseases)

Service related barriers – Highlights

- **Lack of information** as to where to get to the services from.
- **Perceptions regarding the quality** of care.
- **Lack of privacy** in the waiting area as well as consultation rooms in public health facilities. This seems to be better taken care of in private clinics.
- **Inadequate working hours with long waiting time**

4.3.5 Provider-client interface

The ultimate interaction between the health worker and the client seems to be one of the most critical and often neglected dimensions of health services. In the present study, the aspects mentioned in this regard by the respondents include – worker skills and human qualities.

4.3.5.1 Worker skills

Many times the health needs of young people could differ significantly from adults and for the health personnel, it can be very different from performing routine tasks. In such a context, the skills of the health personnel assumes great significance in providing effective services. The typical instance as presented by a respondent is the case of sexual abuse, to deal with it, the health personnel should know, how to interview, how to examine, what investigations need to be done, and how to monitor later on that it does not occur again. As was expressed by many of the respondents, the ignorance of the health personnel both in the private and public systems on such aspects is enormous.

“It is a real fact, many of even our post graduate medical students do not know how to deal with these kinds of problems because it is a medico-legal case generally and students do not handle medico legal cases and hence they do not learn it too” (Health Service Provider 1- Teaching Hospital, Obstetrician and Gynaecologist)

Many of the respondents also pointed that the skills that the health workers mostly lack is the communication skills which is of great importance in interacting with young people. The worker has to be very careful in handling such sensitive issues for young people and need to develop lots of communication skills to be effective.

“The problem is that we hardly ever teach them any communication skills and it will be a disaster if we ask them to handle adolescent clients without teaching them enough communication skills, then the whole purpose may fail” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

“We have to improve the communication skills of the worker. When it comes to public speaking, it is a big problem. If a female health worker has go to a school and deliver a lecture, it is not so easy for her. If it is only girl students then probably she will talk; but if a teacher is there, she will not talk; if boys are there she will not talk, and basically people are hesitant to talk about sexuality aspects too. So communication skills become very important, when it is lacking they fail to deliver the service in a 100 % satisfactory manner” (IGO Official 1)

Again, commenting on the skills of the health workers and auxiliary workers, some of the respondents pointed out that health providers are trying their best to provide the information as well as services in general and are very good at providing information on family planning services. However, they are neither very much sensitised about providing services to unmarried young people nor trained in a way that will equip them with the necessary skills.

“Our Auxiliary nurse Midwives are working in the family planning programme for the last 20 or 30 years, they have good clientele rapport at the village level, and older women come and ask for services. If you go to the village and ask where they got the service 90% of the people will say the first contact was the female health worker, but as far as teen agers are concerned, the information is not much passed” (IGO Official 1)

4.3.5.2 Human qualities

At the heart of the health worker’s performance is the human dimension. Reproductive health workers must address some of the most intimate aspects of sexuality, and life changing, life – giving and sometimes life threatening events. Many of the respondents in the present study noted that the quality of the relationship between the provider and the client is vital to the quality of care especially in the case of providing services to young people.

“Dealing with young people requires a lot of empathy from the part of the health workers. The worker need to be very gentle and very circumventive in their approach to get the real information out and to extend the required services too” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

Further it was expressed that the perceived or real negative, judgmental and unempathetic attitudes of health personnel act as barriers affecting young people’s access to services.

“It is difficult to find people who are empathetic and motivated towards young peoples’ issues. Many of them still feel that sex is bad and are also highly judgmental. They try to enforce their own values” (IGO Official 2)

The reason pointed out for this is the lack of orientation and sensitisation.

“I have often interacted with the personnel who is running routine RCH services, but they are not so sensitised or motivated about issues relating to young people. The entire pressure till now was on family planning, so we are tuned only to family planning, not to do anything else” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

As perceived by a health care provider, in some of the public health facilities, the negative behaviour is much more with the lower grade staff who happen to be the first contact often.

“In a public hospital, if you approach a peon or servant, he would be the worst to be approached, nurses would be slightly better, junior doctors still better and senior doctors are quite OK. But somehow, patients can not often reach upto the higher grade staff, before that that they are so put off and even when it is unaffordable, might spend the money as well and go to a private clinic” (Health Service Provider 1, Teaching Hospital. Obstetrician and Gynaecologist)

Highlights - Provider-client Interface

- **Lack of specific skills to deal** with young people.
- Health workers seem to be **lacking empathy and motivation** towards young peoples' issues.
- Health workers seem to be **neither very much sensitised** about providing services to unmarried young people **nor trained** in a way that will equip them with the necessary skills

4.3.6 Legal – policies and laws

Certain legal statutes regarding the capacity of minors and policies followed by clinics seem to be restricting the access to health care services for young people.

4.3.6.1 Parental consent

It is the law concerning consent to medical treatment of minors that most directly affects the question of whether young people have independent access to health care services in fact. Consent is a key to access. While, requiring parental consent, arguably tend to safeguard adolescents from irrational decisions and poor care in the minds of many observers, it could pragmatically limits the options for health care available to adolescents, particularly where such thorny issues like reproductive health care is concerned. It overlooks as well the process of intellectual development that occurs as the adolescent progresses towards maturity.

As per the laws of the government of India, a minor can not seek health services without the presence of parent or guardian. In the current research, the issue of parental consent was expressed by some of the respondents as a serious barrier for

access to services. When coming to reproductive health issues, the confusion is added as there are separate authorising provisions that gets contradictory often. For instance after 16 years, a girl can indulge in sexual activity on her own volition without attracting any legal hurdles. The law in discussion here is the Indian Penal Code which says that a girl can indulge in sexual activity on her own volition without attracting any legal hurdles in India after 16 years of age. If a girl has indulged in sexual activity before 16 years, then it is considered as a rape and is legally punishable. On the other side, there is the general guideline that any minor (below 18 years) can not seek any health services without the presence of parent or guardian. This would mean that if a sexually active girl seeks contraceptive advice, law debar the medical practitioner to provide it unless she is accompanied by a legal guardian or parent. In short, as per the law, a girl under 16 years indulging in sexual activity on her own volition, she can not seek contraceptive advise without the presence or consent of parents/guardians.

“In effect it means that if a girl indulging in sexual activity at the age of 16 years, seeks contraceptive advice, law debar us to provide it, she has to be accompanied by a legal guardian or parent” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

The right to privacy goes when presence of parents or guardians is insisted by law. Given the fact that many young people do not want their parents to know about their sexual and reproductive health problems, strict adherence to the parental consent rule could be a big obstacle for promoting contraception among young adolescents and would create problems for great numbers of young people in need of health care. However, from the other reports it could be gathered that while most of the practitioners are not aware of this legal position of treating minors, many do not adhere to it too, especially when it comes to the treatment of sexually transmitted infections.

An associated consequence that was brought out is that some of the private practitioners use it for their advantage and charge higher fees for terminations for those who come unaccompanied.

“Now what happens is that some of the Gynaecologists use it for their own advantage and costs very high prizes for those who come unaccompanied by their parents.” (IGO Official 2)

This inturn would mean an additional barrier of paying high fees which makes the services further inaccessible.

4.3.6.2 Medical Termination of Pregnancy Act

Medical Termination of Pregnancy Act, 1971, has been pointed out by a great majority (30) of the respondents as facilitating as well as restricting access to services generally as well as for young people. More than half of those who commented on the Act were of the opinion that generally while all the other acts restrict your functions, MTP act on the contrary facilitates to perform certain things, it enable the practitioners that under such and such circumstances they are allowed to perform MTP.

“You can say it is a different type of act altogether. Generally most of the acts are restricting, like in such and such areas you can not do this, where as the MTP Act says that you can do perform certain things within such and such premises. So it is not restricting and that way act is quite OK, per se” (District Medical Officer 1)

However, a few of the respondents including some of the medical practitioners were of the opinion that the MTP Act is something just on the paper, it is not at all effective in serving the purpose of making abortions safe. The remarks by one of the private practising Gynaecologists, was repeated by some other health service providers too.

“You can forget it altogether, it is just on the paper. In general people are more relaxed that nobody can get on to their neck so easily” (Private Medical Practitioner 1, Obstetrician and Gynaecologist)

In the case of a minors, MTP Act emphasises the consent of the parent or guardian is needed. As worded in the Act itself,

“No Pregnancy of a woman, who has not attended the age of 18 years, or who having the attained the age of 18 years, is a lunatic, shall be terminated except with the consent in writing of her guardian” (Government of India, 1971)

As expressed by some of the stakeholders in the present study in the case of minors such provisions could be rather restricting even for providers who want to extend their services in the best interests of the young person too.

“We cannot offer MTP if they are they are on their own. They need to have their parents or legal guardian, that is very restricting indeed. I think it should increase its provisions to include the adolescents ” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

4.3.6.3 Clinic policies

In addition to legal regulations, policies followed by certain private clinics were also expressed to be affecting the provision of care negatively to unmarried young people by some of the respondents

The following examples reveal clearly how such policies can restrict health care access to young people.

“Generally we have the policy that we refuse if an unmarried girl comes for termination. We have set up this policy because in such cases you never know what complications are involved. For example, if there is any illegal procedure done like a rape or anything like that, there will be police case and we don’t have time for all these” (Private Medical Practitioner 5, Obstetrician and Gynaecologist)

Again in another private clinic, it was noted that even for terminations done for those over 18 years, they insist that they do it only in the presence of a responsible blood relative like mother or sister.

“I will not touch the girl unless there is a blood relative like the mother or elder sister. Even if the boy friend is there, I will not do it. It is my policy, otherwise if something goes wrong, who will be responsible??” (Private Medical Practitioner 1, Obstetrician and Gynaecologist)

Highlights – Barriers from laws and policies

- Legal – Provision of care to minors
 - As per the laws of the government of India, while **minors can indulge in sexual activity after 16 years on own volition**, to seek health services **the presence of parent or guardian** is insisted
 - An associated consequence is that some of the private practitioners charge higher fees for **terminations for those who come unaccompanied**.
- MTP Act
 - Restricting in the case of minors, as the **consent of the parent or guardian** is needed.
- Clinic Policies
 - Some policies followed by clinics like **refusing terminations for unmarried girls and insisting the presence of a blood relative**, even for terminations done for those over 18 years could also restrict access to services for young people

4.3.7 Constraints faced in service delivery by service providers

- **Lack of adequate staff in public health facilities**

One important constraint cited by the health service providers from the public health system is the lack of adequate staff in public health facilities. Most of the public health services were reported to be functioning without adequate staff.

“We do not have adequate staff too, we do not have any peon, so the job of the peon has to be done by the nurse and she gets dissatisfied. We also have a shortage of nurses. Our nurse has to attend other sections too, so she is overloaded”(Health Service Provider 3 - Teaching hospital, STI Clinic)

Another associated issue that has been mentioned is the health worker density in the community. A few of the health service providers were of the opinion that the size of the population that each worker is expected to serve might as well be affecting the effectiveness of services. For example, as was presented, Ahmedabad Municipal Corporation has 43 wards, and in each ward there is one family planning centre which provides family planning services. Some of the family planning centres look after 2 wards and there are altogether 37 centres. Each of the family planning centre has to cover 50000 of the population. There are four workers, one fieldworker, two

Auxiliary Nurse Midwives and 1 Health Visitor in each of the centres and each worker has to serve a population of 12500.

Sustained and repeated provider – client contacts is essential for the effective delivery of reproductive health services in a community. This is possible only with a certain minimal density of health workers.

- **Lack of commitment among the staff**

The lack of concern and commitment among the staff noted to be widely prevalent in public health facilities was pointed out as a major constraint in the effective delivery of services generally and for young people. Among the 13 health service providers interviewed from various levels of the public health system, 8 of them commented on the lines that *“a big problem in public health facilities is the lack of motivated staff”*

“We have too many problems among the staff here, the Gynaecologist does not come often. And there is frequent fight between the staff. The doctors are not regular and they assign their work to the practising residents. Working persons are not co-operative to the work. Non-cooperation of the staff is a major problem ” (Health Service Provider 3 - Teaching hospital STI clinic)

- **Procedural constraints**

Owing to its high incidence in India, Sexually Transmitted Diseases among young people represent a particularly important problem for the health services. However almost half of the service providers were of the opinion that the state of affairs as far as STI treatment is concerned is generally very pathetic. As expressed by one of the health care provider from a teaching hospital, the syndromic approach that is followed at present might not be the right approach in treating patients in the long run.

As cited by the respondent,

“Take the example of civil hospital, Ahemdabad, this is a tertiary care hospital, the biggest one in the state and the state of affairs as far as STIs are concerned is very pathetic. You should ask them, how many varieties of infections have you documented, which one is the most common, was it a clinical suspicion or was it confirmed by laboratory diagnosis, then perhaps you get some picture, I am sure that not even 5% of the infections are diagnosed” (Health Care Provider, Teaching Hospital 1. Obstetrician and Gynaecologist)

- **Legal – Parental consent**

The laws concerning parental consent not only acts as a barrier for young people to get services, but also is a constraint for service providers as well in the provision of health care. In the present study, the issue of consent or presence of parent or guardian for the provision of treatment for minors, was noted as a serious hurdle in providing health care services by some of the service providers. As mentioned before, as per the laws of the government of India, a minor can not seek health services without the presence of parent or guardian. When coming to reproductive health issues, the confusion is added as there are separate authorising provisions that gets contradictory often. For instance after 16 years, a girl can indulge in sexual activity on her own volition without attracting any legal hurdles. However, if she seeks contraceptive advice, law debar the medical practitioner to provide it unless she is accompanied by a legal guardian or parent. For the practitioner this means that he has to ascertain the age of the young patients seeking services own their own.

“Recently, there was a controversial judgement. The girl said that her age is 18 ½ years, infact she was only 17 years, she opted for MTP, the doctor did MTP and then it turned out that she is less than 18 and her parents infact sued the doctor. He was considered liable that he did not ascertain her age, so that it is his fault. There were no physiological complications. This somehow puts the doctors off in treating these patients, even if they are well minded. How could the doctors ascertain the patient’s age? They will have to insist on her birth certificate which is not a practical thing to do. The court opined that the doctor should have adequately checked her age before giving her MTP. This you can say is a fallacy in law itself. So for us, it is a problem” (Health Service Provide 1 - Teaching Hospital, Obstetrician and Gynaecologist)

As was further elaborated by the respondent, many of the practitioners are not aware of this legal stand and that they might be legally liable for what they are doing. Supposing they prescribe something without parent’s accompaniment and consent, and if the parents complain that this doctor has done this, they can be legally liable. In the normal case hardly any of the practitioners takes it up, contraception if a girl comes for advice and it is generally given, but for MTP the doctors emphasise it.

“But if we run a clinic say in the civil hospital, we won’t be able to do it, because the government system would not allow. The problem to be honest is that many may not be aware about their position and could be liable for punishment for what they are doing. That is my worry” (Health Service Provider 1 - Teaching Hospital, Obstetrician and Gynaecologist)

On being asked about the issue of consent, it came obvious that most of the medical practitioners are unaware the legal situation of treating minors except in the case of MTP.

“When a person comes to you for taking some advise, we are bound to give instead of asking for the consent of parent or guardian. If AIDS or other things are there, then we take the consent and inform them before going for investigations and other things, but for simple things, we do not ask” (Health Service Provider 2 - Teaching Hospital, Skin and Venereal Diseases)

Constraints faced by health service providers – Highlights

- **Lack of adequate staff** in public health facilities.
- **Lack of concern and commitment** among the staff in public health facilities
- Laws concerning **parental consent**.

Thus it can be seen that a number of short comings in the health care system can act as barriers to young people to get the required services. Young people who have engaged in sexual intercourse and have experienced unhealthy consequences are the most common group likely to seek health care services. Based on the intervention framework discussed in the previous sections, young people in this group would need access to full range of clinical services as well as to information, training in skills and counselling which could improve self efficacy and outcome expectancies. This in turn could help to promote behaviour change in the direction of abstaining from unwanted sex and to adopt safe practices. Thus the findings raise questions about the appropriateness of current service approaches in the light of the socio-cultural context in which teen age sexual behaviour actually occurs. This could be the same in many developing countries like India, where young people might make up a substantial share of cases of morbidity and mortality, and of hospital admissions for complications of pregnancy, delivery and abortion.

CHAPTER 5

Discussion on sexual risks of young people and programming responses

Describing young people's risky sexual behaviour and the existing programming responses in India towards evolving recommendations for future programming was the major intention behind the present study. The raw data used for deriving conclusions mainly consist of the perspectives of the stakeholders including young people themselves and a circle of adults who influence their health and well being.

Before proceeding with the discussion of the study findings, it is imperative to make a note of the approach followed in the present study to elicit the required information about young people's sexual and reproductive lives. While many of the existing studies are based on first hand reports of own sexual behaviour by young people, the present study used the approach of including adult stakeholders in addition to young people in the main study population. The reliability of such a method in making precise estimates based on secondary reports is yet to be tested as hardly any studies addressing adult stakeholders as the main study population can be traced except for the few studies addressing parents and health service providers. This in turn could possibly be due to the difficulty involved in reaching this target population and asking them about such a sensitive topic. However, in the current investigation, this approach seems to be justified as many of the findings reflect the situation brought out by previous studies done both nationally as well as globally addressing adolescents as the main study population as detailed below.

5.1 Issues of concern in young people's sexual and reproductive health

5.1.1 Context of sexual involvement

5.1.1.1 Too early marriage

In India though the legal age of marriage is set at 18 years, the effect of a legally established minimum age for marriage on sexuality and hence fertility is not entirely understood. It seems that the legal status like other factors interacts with social and cultural influences. The onset of menarche as a sign of social and physical maturity in

traditional orthodox societies, and the existence of practices like too early marriage or formal marriage ceremony has been reported by previous studies from India as well as other countries (Singh and Samara, 1996; UNICEF, 2001; Sharma and Sharma, 1992; Jejeebhoy, 1996; IIPS, 2000). Higher degree of familial control over a woman's choice of marriage partner and the timing of marriage has also been indicated by previous research (Singh and Samara, 1996; Shrestha, 2002; Sharma et al., 2002; Mathur et al., 2001)

It is also striking to note that the respondents who voiced early marriage as of concern are rather few who seemed to have several first hand experience of the situation and those who are rather critical about the practice. Even on prompting great majority of the respondents did not perceive it as a particular issue of concern. This could be explained in three ways; on one hand, there is evidence that nationally adolescent marriages have been declining modestly and the age of marriage is rising (Jejeebhoy, 1996; IIPS, 2000). This might cause many to think that it is a bygone problem and need not be of concern anymore. On the other side, in India like in many other parts of the world, traditionally early marriages have been respected and valued as a desirable and honourable means of assuring virginity at the time of marriage (Mikhail, 2002). Though time has dramatically modified these general attitudes and early marriages in general and child marriage in particular are increasingly frowned upon, there could still be a cross section of people who are in agreement with the traditional outlook and fail to perceive this practice as a essential violation of human rights. The third reason for many to remain silent about this issue could be the cultural, political and religious barriers to their open acknowledgement and above all, to addressing their root causes.

5.1.1.2 Premarital sexual activity /unprotected sexual relations

As depicted in the study, the existence of premarital sexual activity among young people has been brought out by previous researchers too. Several studies from different parts of India have found that adolescents, especially males are sexually active before marriage (Bhende, 1994; Gupta, 1994; Goparaju, 1993; Savara and Sridhar, 1994; Sharma and Sharma, 1994; Sharma and Sharma 1995; Sharma, 1996; Sharma, 1998; Abraham and Kumar, 1999). Furthermore, there have been quite a lot of indications from other cultural settings that today's' young people are more likely

to engage in pre-marital sexual activities than members of their parents' generation (Ajayi, 1991; Population Reference Bureau, 1992; Singh et al., 2000; Starkman and Rajani, 2002; WHO, 2001; Aziken, 2003).

The estimates put forward based on individual experiences goes more or less well in agreement with the findings from previous studies from the region (Goparaju, 1993; Savara and Sridhar, 1994; Sharma and Sharma, 1994; Sharma and Sharma, 1995; Sharma, 1996; Sharma, 1998). However, the estimates presented by a few of the local NGO representatives demonstrate the higher than anticipated extent of the problem. Given that many of them work with specific categories of population which often tend to be high risk groups, these high estimates could be justified. Again, talking about sexual activity among couples who are engaged, similar findings have been reported by Gao (1998) (quoted in WHO, 2001).

To explain the differences in the perception regarding the existence of premarital sexual activity, the lack of reliable data could be pointed out as an explicit reason. Additionally, in a social set up where the timing and context of life transactions are culturally defined, there could be an overwhelming belief that sexually activity should necessarily be taking place within socially approved unions. This can also cause some amount of denial and ambivalence to things happening on the contrary.

As a category, it could be seen that most of the government officials either deny premarital sexual activity or remain ambivalent about it. Though the reason could not be fully understood for them to take such a stance, the situation could be taken as rooting more from assumptions or stereotypes rather than true understanding.

- **Contributing factors to premarital sexual activity**

Changing social context

Changing social context playing a role in shaping the sexual behaviour of young people has been pointed out by studies from India as well as abroad (Speizer et al., 2001; Gardner and Blackburn, 1996; Meekers and Calves, 1997; Mutatkar and Apte, 1999; Abraham and Kumar, 1999). As Speizer et al. (2001) has noted, the society's transition from traditional to modern, occurring throughout the world is generating a radically different culture for sexual and reproductive decision making among today's

adolescents. When most of today's older generation were adolescents themselves, social roles and expectations seemed to be better defined. Individuals authorised by the community (familial or non familial) used to teach adolescents a set of clear and unambiguous rules that governed sexual conduct. With increasing urbanisation, however, pubertal rituals in many societies seem to be giving away and the role originally played by community-appointed teachers has gone non-existent. Furthermore, socio-economic changes with massive urbanisation and migration have lessened the influence of social control mechanisms which formerly discouraged adolescent sexuality prior to marriage. As increasing number of rural families migrate to urban areas, parental control and supervision are weakened, and young people are exposed to modern influences that encourage sexual activity in relationships that may not lead to marriage.

Rising age at marriage coupled with declining age at menarche

An important consequence of a rising age at marriage combined with a decline in the age at menarche is that the number of years between menarche and marriage increases substantially over time. In the most traditional and poorest populations, girls typically marry shortly after menarche. In contrast, some of the more advanced developing countries, the period between menarche and first marriage approaches a decade. This trend results in large increases in the number of sexually mature but unmarried adolescent girls as countries develop thus potentially leading to a higher prevalence of pre marital sexual activity (Senderowitz and Paxman, 1985).

Sexual abuse and coercion

Young women often seems to be pressured into sexual relations by men who see this as their right; the young women may perceive the sexual encounter, or the yielding of her virginity, as a means to her survival especially when they have limited access to financial resources. It has been pointed out that the younger a woman is when she first experiences sexual intercourse, the higher the chances that sexual activity is coercive (Heise et al., 1994). In the present study, the perception of the respondents reveals more or less the same picture as depicted in previous studies. Poverty or financial gains play an important role in women's sexual conduct and is often indicated to be a direct cause of prostitution among the young (Philipson and Posner, 1995; Weiss, 1993; Okpani and Okpani, 2000). Conventional views that do not challenge existing

sex roles and attitudes towards male and female sexuality reinforce prevailing imbalances of power in gender relations coupled with gender inequality in the distribution of resources and mostly young women are in the disadvantaged position (Djamba, 1997) and find themselves powerless to resist pressure to have sex. Unfortunately because of a lack of data, most studies conducted in developing countries do not include a family's economic status among factors influencing causal sex, number of sexual partners and occurrence of pre-marital pregnancy among adolescent girls. This brings into fore how socio-economic aspects and vulnerability are interlinked.

Peer influence

In the present study, though it is not entirely clear how behaviours peer and peer deviance can affect young people's sexual behaviour, the perception of the respondents point out the lack of skills of many young people to repel unwanted pressure or advances. Peer influence as a possible factor of early sexual activity has been indicated by previous studies as well (Rowe et al., 1989; East et al., 1993; Antrobus et al., 1994). Reports of peer pressure could also arise from the feeling that young people could not control what happened to them.

Impact of sexualised media

Though the Indian media is not known to be highly sexualised, explicit sexual material portrayed in various forms starting from advertisements in older media to hard-core pornography on-line seems to be available to young people. Local availability of pornographic material (Mutatkar and Apte, 1999) as well as the proliferation of the western media (Sharma and Sharma, 1996) has been pointed out by earlier researchers, though a precise explanation of how these images and messages translate into attitude or behavioural change for children and teens are largely unknown. Given the fact that we live in a media world, mass media images that portray women as sexual objects, could place severe burdens on both young women and men. Hogan (2000) has pointed out the potential impact of sexualised media on young viewers.

Increase in the availability of contraceptives and other corrective measures

Furstenberg et al. (1997) has indicated prevalent views that provision of reproductive health services like contraceptives and abortion to young people might increase promiscuity is far from new. There has been no scientific indication that punitive approaches or scare tactics help young people to make healthy decisions about sexuality, on the other hand providing teens with accurate information is much more effective than “disease, death and disability” messages (Brindis, 2002). Surprisingly in the present study all of them who expressed this opinion were government officials. Though expressed by a few, it reveals a mind set which could well be carried over in to the planning and implementation of programmes as well, reflecting the view that sexual activity should not occur before marriage.

- **Attitude of the stakeholders towards premarital sexuality**

The ambivalence of the Indian society in matters relating to sexuality is not entirely new. Though there are numerous Indian writings on sex and sexuality, analytic treatise on sex and love called “Kamasutra”, originating from more than 1500 years back, sex is still not a matter of explicit discussion (Sharma and Sharma, 1996; Mutatkar and Apte, 1999). Coming to adolescent sexuality, the images are often stereotypical and extremely negative with adolescent sexuality often being viewed and treated as deviant behaviour in general. Many of the stakeholders seem to be of the opinion that promoting abstinence is the sole means of reliably restraining sexual activity among young people. This attitude seems to be often setting the tone for the kinds of policy options that are promulgated at all levels of society. Studies from other cultural settings have also examined the attitude and viewpoint of parents on reproductive health of young people and the provision of various sexual and reproductive health services to them (Briggs, 1998; Cui et al., 2001). Many adults avoid the topic because they think that it might lead to increased sexual activity, although a number of studies have shown that this is not the case (Grunseit and Kippax, 1993).

The strong negative views such as “putting scare and fear would be a better solution” denotes the unyielding ideological value laden perspective that many of the stakeholders hold about adolescent sexuality. According to them, there is only one set of acceptable values that should dictate sexual life. It is to say that any society that

wishes to delay sexual onset beyond its physical prompting has to hold out strong incentives to resist that which is physiologically normal. Unless the biological normalcy of sexual activity among young people is recognised, implementing approaches that affect it as powerfully as those that controlled it in the past will be difficult.

However, the decriminalising attitude coupled with the realisation that “the average age of sexual debut has gone up over the years” expressed by some of the respondents, is very positive as it indicates a broad and genuine commitment to the health and well being of adolescents along with the recognition of the fact that traditional norms concerning the sexual behaviour of young people are unrealistic and hence invalid in contemporary society. Such an attitude is an essential pre requisite towards finding constructive solutions rather than stamping today’s young people as bad or promiscuous. This inturn could also imply that perceptions of what is “early sexual activity” may change or is already changing resulting in a cultural shift in what is considered on time and off time for such behaviours. As frequency of transitions to adult like behaviours increase, norms involving the acceptability of such behaviours could often change to accommodate the behavioural shift. With the acceptable age of marriage going up, definitions of what is “early” sexual activity may change.

5.1.2 Observed risk pattern

Early sexual onset among young people has been pointed out by a number of previous studies from different cultural settings (McCauley and Salter, 1995; Sedlecki et al., 2001; Okpani and Okpani, 2000; Anochie and Ikpeme, 2001; Kamtchouing et al., 1997; Manzini, 2001; De-Seta et al., 2000; CREPHA, 1996b; Somrongthong, 2003). Typical of many studies of young people’s sexual behaviour are also unsteady relationships with multiple partners (Gorgen et al., 1998; Maswanya et al., 1999; Okpani and Okpani, 2000; De-Seta et al, 2000; CREHPA, 1996a; CREPHA, 1996b). Many of these studies have also noted that sexual intercourse mostly takes place unprotected (Gorgen et al., 1998; Maswanya et al., 1999; Okpani and Okpani, 2000; De-Seta et al., 2000; CREHPA, 1996a; CREPHA, 1996b; NCASC, 1996; Bhatta et al., 1993).

Sexual initiation as well as relations with sex workers by large proportions of unmarried adolescents have been reported from India (Sharma and Sharma, 1995a; Savara and Sridhar, 1991; Goparaju, 1993; Bhende, 1994; Savara and Sridhar, 1994) Watsa, 1993 and Savara and Sridhar, 1991 have indicated various levels of homosexual contacts too.

Failure to use contraception or using them inconsistently has been indicated by many studies (Amazigo et al., 1997; Odimegwu et al., 2002; Aziken, 2003; Gorgen et al., 1998; Alene et al., 2004). As regards the use of condoms which could be the effective method for protection against STIs and HIV, erratic and non regular use with new partners have been reported from among the sexually active girls (Sedlecki et al., 2001). In order to use condoms or contraceptives effectively, one will need greater specificity of knowledge as well as the motivation to use them. Some of the reasons pointed out by the respondents for the non use of condoms like ignorance (Görge et al., 1993; Wilson and Lavelle, 1992); unplanned nature of sex and unavailability of contraceptives at the moment (MacPhail and Campbell, 2001); lack of accurate information as to where to get condoms from (Lewicky and Wheeler, 1996; Araoye and Adegoke, 1996); cultural acceptability or dominant social norms (MacPhail and Campbell, 2001) and feelings of invulnerability (Caraballo and Kenya, 1994) have been previously reported.

5.1.3 Consequences of risky sexual practices

5.1.3.1 Too early pregnancy and child bearing

The view that early marriage which is reported to be widely prevalent in rural areas lead to early pregnancy seems to be of relevance against the context that much of the early child bearing in India involves women who are in a union or marriage (Jeejebhoy, 1996) like in many developing countries (Singh, 1998). After marriage, pregnancies also follow quick succession as marital pregnancy occurring in teen years being considered a normal occurrence establishing a girl in her in-laws' home. Delaying first birth seems to be a socially unaccepted deviation which could be regarded as a sign of the failure to prove fertility as well. Adolescent mothers being married at a comparatively younger age and the age at marriage exposing the women to early pregnancy regardless of who decided the marriage has been pointed from the

neighbouring Nepal too (Shrestha, 2002). From Nigeria, Okonofua (1995) has also pointed out being married as a possible correlate for early pregnancy.

Early pregnancy contributing to long-term poor social, economic, and health outcomes for the mother and child have been noted by a number of researchers (Westall, 1997; Treffers, 2003; Mngadi et al., 2003). In general while motherhood at an early age entails a risk of maternal death much greater than average (Family Care International, 1994), Creatsas and Elsheikh (2002) has pointed out the prevalence of anaemia among adolescent mothers even from developed countries like England.

5.1.3.2 Sexually Transmitted Infections

The recognition that young people in general are less empowered and could subject themselves to high risk of STI infections including HIV is far from new. The view expressed by the stakeholders in the present study that adolescents bear an increased risk of exposure to infection with STIs and STIs are more prevalent among the young rather than adults have been noted by previous researchers from India as well as other parts of the world (Brabin et al., 1995; World Bank, 1989). Significant levels of STI infection among the young has also been reported by studies from different settings as well (Sedlecki et al., 2001; WHO/ SEARO, 1993; CREHPA, 1996; Sieg, 2003).

However, the view that STIs are over reported is to be subjected to evaluation. This goes in contradiction to the previous research indicating reporting of STIs to be poor in many settings; and as a consequence, the actual prevalence among adolescents could be higher than the available inadequate figures indicate (NRC, 1997). But at the same time, myths and misconceptions causing unnecessary anxieties among young people relating to HIV /AIDS and other sexually transmitted diseases is quite well known (Temin et al., 1999; Alene et al., 2004). The observation that many young women seek treatment for discharge is a definite indication in this direction. Obviously, all these complaints could not be taken as a reliable indication of the prevalence of sexually transmitted infections. But at the same time it is to be remembered that at least some of these symptoms could be owing to sexually transmitted infections. Furthermore still to be included are the young people who fail to reach the services. In the absence of any reliable data from community based studies, the expressed view that, the prevalence of STIs among young people seems to

be not high except in high risk groups, can not be cross checked. In this context it is to be noted that very little age and sex specific data seems to be available from India like many of the developing countries (Barbin et al., 2001; NRC, 1997). However, the observation that young people in general are less empowered and therefore could subject themselves to high risk of STI infections including HIV reveals the importance of prevention programs which tackle the social, cultural and economic factors that are fuelling the transmission of HIV/ STIs.

Studies of sexually transmitted disease – related care seeking among adults have reported that men are faster than women in seeking care (Moses et al., 1994). The same goes true with young people too. Delayed health care seeking has also been explained as a possible factor fuelling the transmission of STIs by previous researchers. Many young people especially young women do not know for a long time that they have contracted an STI, because many are asymptomatic (Zabin and Kiragu, 1998) and most initial STD symptoms are associated with annoying but not worrisome local symptoms (Lande, 1993). The difficulty in the distinction of abnormal from normal genital discharges may also partially explain delays in care seeking by symptomatic women. And girls might be more concerned about preventing a pregnancy rather than contracting an infection. This together with the barriers posed by health services lead many young people to seek services delayed. The health service barriers are discussed in detail in later sections.

5.1.3.3 Unwanted pregnancies and unsafe abortions

- **Abortion among young people - magnitude**

It was quite obvious that many of the government officials including medical practitioners from the public health system consciously or unconsciously could not or did not want to comment in detail about medical abortions among young people or unsafe abortions in general. However, many of the private practitioners were quite eloquent and seemed to be getting emotionally charged while talking about abortions in general. All of them have their practising in urban areas and are known to provide abortion services. It was quite striking to note that some of them used abusive terms to refer their own colleagues or the services provided. So the unhealthy competition among private providers was quite evident. Taking into account the role played by

private practitioners in India's health care system, this is definitely an aspect which needs consideration in improving service practices.

The perceptions put forward by the respondents about the magnitude of medical abortions among young people, does not reveal much about the magnitude of the abortion situation relating to young people in India as they base the inferences on clinical experiences. Most of the existing abortion data also seems to be limited to hospital settings, showing only the 'tip of the iceberg' as noted by the respondents, revealing little about women who are unable to obtain abortions from the formal health care system, which goes largely true in the case of unmarried young girls. In the present study, except one, as all the privately practising Obstetricians and Gynaecologists are reported to be doing terminations for unmarried young people too, their views could be considered as a proxy for the actual situation and clarify the point that abortion among young people is not a unusual event. Prevalence of abortions among young people has been noted by previous researchers from India (Ganatra and Hirve, 2002).

In addition, since about two thirds of abortion cases are reported to be handled by private providers in India (Bhatt, 1998), the picture presented by them could be considered more or less accurate. Though the private providers in the study were rather unwilling to talk about specific details like their own charges, their reports reveal other interesting aspects of the abortion situation in general and especially with respect to young people. Furthermore, the magnitude of abortions could also be taken as an indicator of the substantial unmet need for contraception. There have been studies reporting significant rates of abortion among adolescents from other cultural settings too (De-Seta et al., 2000; Anochie and Ikpeme, 2001; Aziken, 2003; Creatsas and Elsheikh, 2002; Treffers, 2003; Lema et al., 2002).

- **Reasons for pregnancy termination**

While the health related consequences of 'mothers too soon' for the married and 'illegitimate pregnancy' for the unmarried remains more or less the same and can essentially be seen as two sides of the same coin, the social acceptance stands on diametrically opposite levels. The expressions like, 'struck by a thunder', 'life is gone', 'no future' put forward by the respondents to explain an unwed pregnancy

itself points to the paramount suffering that a pregnancy could cause to an unwed girl and the extent to which the pregnancy can alter her entire future life. As reflected in the view points of the respondents, an unmarried adolescent mother is likely to experience social ostracism if it comes public. The unwelcome association between adolescent pregnancies and low levels of educational achievement for young women, which in turn can have a negative impact on their position and potential contribution to society has been indicated by previous researches (Caldwell et al., 1998). As Caldwell et al., (1998) has pointed out *“Girls who are exposed as having been sexually active or who become pregnant are not killed as they might once have been, but can be pressured to the point where they commit suicide. If the knowledge of the pregnancy has been confined to the family, an attempt will be made to secure a marriage to the father or, indeed to anyone, or a clandestine abortion may be arranged”*.

All the merits otherwise accrued to pregnancy like the adult status conferred by motherhood or the joy and rewards of having a baby seem to disappear altogether when the act is done outside the context of socially approved unions. There is no noted difference between the perceptions of various categories of respondents in explaining the undesirable consequences of an unwed pregnancy which mostly reflect public opinion. Here it can be seen that the rapid socio-economic changes that have occurred in recent times have not modified much the perception of unwed pregnancy, leave alone the willingness to accept the risks. While noting that young people should abstain from sexual activity to prevent unwed motherhood, none of them seemed to be thinking about oral contraceptive pills which is found to be an efficient method of contraception for sexually active young people in the west. The comment by one of the private medical practitioner that ‘oral contraceptive pills are not suitable for young people as their parents may find it out’ is an important point to consider and to reflect on the vast need for sensitisation among all sections of the society. However, whether unwed pregnancy is probably viewed as greater social problem now than it was in the past is not clear from the views of the respondents.

Fear of social reprisal because of an out-of-wedlock pregnancy has also been cited in the literature as a reason for having an abortion (Adebusoye, 1989; Adebusoye, 1991; Feyisetan and Pebley, 1989; Olukoya et al., 2001) The reasons cited by the respondents for pregnancy termination like victim of rape or incest (Olukoya et al.,

2001; Singh et al., 1997) and being forced to abort the baby has also been cited by previous researches (Olukoya et al., 2001; Caldwell et al., 1998; Ankomah et al., 1997).

- **Health care seeking behaviour**

The health care seeking behaviour of young people in the context of pregnancy termination is often characterised by delay in seeking abortion, resorting to unskilled practitioners and absence of follow up even after complications have been developed. Singh et al. (2002) have noted that teenage pregnancies are a major risk factor for late presentation for abortions. Anate et al. (1995) has noted that teenage abortion seekers are more likely to obtain the procedure late compared to their older counterparts. Resorting to unskilled practitioners is another characteristic of abortion related health care seeking as reported by previous researchers. It has also been pointed out that the younger the adolescent, the more likely that her abortion will be with a non-medical provider, or that it will be self-induced (Archibong, 1991; Family Health International, 1993).

- **Unsafe abortion**

Information from many sources has indicated that non-married adolescent girls often seek unsafe abortion especially in developing country settings (Mundigo and Indriso, 1999). In India, even when the abortion laws are less restrictive, procuring an abortion seems to be difficult for any woman, and more difficult for an unmarried adolescent. Both socio-cultural and financial factors were perceived to be encouraging the practice of unsafe abortions. The major socio-cultural factor in question is the consideration of unwed pregnancy and abortion as highly immoral. As Caldwell et al. (1998) has pointed out, *“The need for great secrecy in this regard is the major explanation for the otherwise extraordinary fact that, although abortion is legal and free in Indian hospitals, 90% of India’s abortions are illegal clandestine ones. If a girl is known to have had premarital birth or abortion, the social standing of her whole family gets affected. Either she will be unmarriageable or her marriage will prove to be possible only with an undesirable man, often an old widower, and she would require a much larger dowry than would normally be expected for such a match. Further more the girl’s unmarried sisters will be treated similarly. When*

families are arranging a marriage, they make sure the family that their son or daughter is marrying into has a “good reputation” meaning more than anything else, no history of premarital pregnancies or of sexual activity” (Caldwell et al., 1998).

Inability to afford a physician’s fee has been cited as a major reason for young people delaying and often resorting to unskilled providers in previous research (Okagbue, 1990). In general, young people have less access to economic resources which can prevent them from getting the service especially when out of pocket payment is used to pay for abortion care. As indicated by Khan (1996), private doctors in India perform legal abortions for a fee not much higher than that charged in the public sector which is in contradiction to the expressed views by the stakeholders in the present study. Though legal abortion care is provided in the public health sector free of cost, those who are in need of services seem to be not going there, which points to important aspects of the quality of care which are described in later sections.

- **Consequences of unsafe abortions**

Reviews of published research on induced abortion have indicated the paucity of available information in most developing countries regarding the consequences for women’s health (Singh, 1998). However, high levels of maternal mortality and other complications from induced abortions has been brought out by studies from different settings (Hyjazi and Diallo, 1996; Gogna et al., 2002 Brabin et al., 1995; Backer and Rich, 1992; Van-den-Broek, 1998). Abortion contributing to infection, infertility and mortality among young women has been widely reported from many sub-Saharan African countries where abortions are illegal and are driven underground (Zabin and Kiragu, 1998; WHO, 1994). Complications including infections and mortality were presented as the major consequence of unsafe abortions in the present study. In India, evidence from a number of consumer grievance cases provides insights into the consequences of unsafe abortions. Examining 172 cases files with the national and state consumer redressal commissions and other state commissions, Bhatt (1998) has shown that 23 % of the complaints relate to Genito urinary cases including abortion and pregnancy related issues.

5.2 Policy strategies and programme interventions to meet the SRH needs of young people

5.2.1 Lack of comprehensive policies for young people

The absence of laws or regulations with respect to the provision of sexual and reproductive health information and services to young people could possibly be due to a number of mutually exclusive causes. First it could be that interest in issues relating to human sexuality and family planning is of such recent origin that the subjects are yet to be dealt with in law. Second it could be that public education on matters of human sexuality may simply be too controversial to be approved in legislation or regulations. The absence of laws, regulations or court decisions could also be a blessing that it pose no legal barriers to the introduction of such measures. Wherever, issues like population pressures or increases in sexuality and fertility related health problems among adolescents pose serious threats, governments are likely to make bold moves to extend reproductive health education to individuals through the school system. Such approaches could flourish without interference from the law and many of the existing educational programmes seem to have such origins too.

Thus the lack of awareness of the respondents about the legal or policy situation seeming to be resulting from a long history of absence of policies and laws. Though the National Population Policy is a step in the right direction, the policy has as of yet not been adequately disseminated to different sectors of the society and awareness among the various stakeholders remains limited. Information about new policies seems to be rarely disseminated in a manner that is likely to catch the attention of the general public. In the present study, the adolescents seem to be grossly unaware of the policy and programme situation. When policies are correctly disseminated, the reality of the sexual and reproductive health behaviour of youth and the need for preventive measures is then increasingly acknowledged by different authorities.

Though the state of Gujarat is reported to be forming a separate population policy, as noted by some of the representatives of state government bodies, in the health sector, policies are mostly set at national or central level and implemented at state, district or subdistrict level. The absence of effective communication and co-ordination between these different layers and sectors also can hamper implementation (Datta and Misra,

1997). Again as remarked by one of the officials from a state government body, in the absence of political will and an unwieldy bureaucracy, translating existing policies is the greater challenge rather than making new policies.

5.2.2 Programmatic approaches

Many researchers world-wide has indicated a widespread need for information for all kinds of young people (Jaccard and Dittus, 1993; Castillo, 1993; Hawkins and Ojaka, 1992). While the need for information has been pointed out, adolescents and youth are noted to receive poor sexuality and contraceptive education, in many settings (Singh and Wulf, 1993; Gage-Brandon and Meekers, 1993; Agyei and Epema, 1992; Adesobuye, 1992). The need for early school-based reproductive health education programmes, incorporating correct information on reproductive biology and the subsequent prevention of reproductive ill health has been pointed out by researchers (Mbizvo et al., 1993). As is the case with many developing countries (Hughes and McCauley, 1998), the largest intervention in adolescent sexual and reproductive health in India also seems to be some version of school based sex education as indicated by the findings. Looking at the programmatic approaches, the school based programs like the population education from GCERT, the AIDS education from State AIDS cell and the curriculum based family life education, all having the potential to reach large numbers of young people. However, though these formal programs have provisions on sexuality education, they seem to be taking a fragmentary appearance failing to take a comprehensive approach. Researchers have indicated that successful sexuality education programmes use a variety of teaching methods, focus on personalising the information, present basic and accurate information about the risks of and avoidance of unprotected intercourse, and provide opportunities to practice communication, negotiation and refusal skills (Kirby, 2001). While many of the existing approaches could have some positive effects upon some outcomes (such as greater knowledge), programs with reasonably strong evidence of delaying sex, increase condom or contraceptive use, seem to be very rare. Again the use of teaching methods, involving students directly and included modelling and practice in communication, negotiation and refusal skills also seem to be very rare.

While it has to be understood and appreciated that sex education is more than knowledge about contraception or population issues or STI/ HIV education, the reasons for the conscious or unconscious omission of the other social, psychological and emotional aspects need to be further evaluated. As Brindis (2002) has noted, in any case expanding, rather than restricting the information available to adolescents (as well as to adults), particularly factually accurate information, is key to the success of many programs.

The role played by the lack of political will in matters of young people's sexual and reproductive health and unwieldy bureaucracy definitely seem to be explaining at least part of it. Although significant improvements have been made in many family life education programmes, the confluence of politics and fear continues to restrict the exposure of these curriculums in all but a limited way to a large proportion of the adolescent population.

While schools provide excellent settings for the provision of sexual and reproductive health information to young people, it is equally obvious that not all adolescents go to school. Out of school youth seem to be often bypassed with respect to formal programmes; but only very few of the respondents seemed to be recognising this population. The reason could be that they are often less accessible than the school population, who may also be less interesting to a developing nation that has made an economic investment in education. Furthermore, as mentioned before, since many of the respondents seemed to perceive pre-marital sexual activity as an urban problem of school and university populations, it is quite logical to think that educating these groups is considered a primary means of intervention.

Though many developing countries seems to be offering some form of Family Life Education or population education or AIDs education in schools, their effectiveness have rarely been measured (Nare et al., 1997). Same goes true with respect to the Indian situation too; the impact of the programs on adolescent's behaviour seems to be less talked about or hardly measured. The lack of evaluation studies seem to be distinct too, with few evaluation studies being conducted so far, research findings can not be used to improve and expand programs. Looking at other regions also it can be seen that evaluation studies are often too inconclusive to yield reliable guidance on

programme effectiveness (Kirby, 1995). Though knowledge can not be expected to alter health outcomes fully and the health implications of many of the educational programmes seem to be only tangential, a number of studies from other regions have indicated that programs are successful in increasing young people's knowledge about reproductive health issues (Kirby, 2001). Some of the problems reported in school based programmes like the unpreparedness of teachers to talk about aspects of sexuality to the students have been reported by other studies as well (Hawkins and Ojaka, 1992; Meekers et al., 1995; Turner, 1994; Miuto, 1993).

Talking about the comprehensiveness of programs, though the Reproductive and Child health programme has specified the need for addressing the SRH needs of young people in a womb to tomb context, the specific measures being adopted seems to be limited to the sensitisation of health workers and to the ongoing programme of iron and folic acid provision in schools. In the absence of any tangible action, it is quite normal for many of those concerned to think that the "initiatives are more on paper".

One of the major expressed constraint, the opposition from parents and other significant adults has been pointed out by previous research. Some adults including parents tend to believe that giving information on sexuality and contraception would lead to increased sexual activity, although a number of studies have found it wrong (Grunseit and Kippax, 1993). Though research has clearly documented that teaching young people about sexuality will not hasten the onset of sexual debut, the opponents of sexuality education continue to argue that teaching abstinence is the sole means of reliably restraining young people from sexual activity. Analysis of studies of sexuality education programmes in schools around the world has concluded that sexuality education do not lead to earlier or increased sexual activity (WHO, 1994). Even in the presence of such findings, the introduction of sex education continues to stir controversy and opposition in many countries where agencies are trying to initiate youth friendly programmes. This point to the need for motivating further research on such lines.

However, studies from different cultural settings have also pointed out that parents do support the inclusion of sex education in school curricula (Briggs, 1998; Orji and

Esimai, 2003) so as students and teachers (Orji and Esimai, 2003). However, opposition to the introduction of sex education by parents is also noted (Orji and Esimai, 2003; CEPED 1997) based on the belief that it would corrupt the students, it might lead to experimentation and that it should be the responsibility of the parents at home (Orji and Esimai, 2003). Cui et al. (2001) have also indicated parents supporting the notion of government establishing educational and service delivery programmes for the unmarried even when they are ambivalent with regard to adolescent sexuality.

Furthermore, there seems to be still a lot of fear of cultural and religious resistance among the majority of institutions working with adolescent development. This points to the grave social sanctions against premarital sexual activity and its consequences. Strong religious and political opposition remains to the acceptance of sex among the young as inevitable, not to say normal. Therefore public discourse remains artificially removed from the reality of the adolescent world. Generations do not seem to be sharing a common view of sexuality, and sex remains a topic of public embarrassment.

5.3 Access to sexual and reproductive health services – Barriers

Several compelling reasons have been offered around the world for why access to sexual and reproductive health services becomes difficult to young people especially to the unmarried. On one hand, many of the factors which affect access to services to adults seem to affect their access to young people too. There seem to be social, psychological and economic barriers to accessing services (Zheng et al., 2001). The Penchansky and Thomas (1981), dimensions of access like availability, affordability, accessibility, accommodation, and acceptability seems to be significant in explaining adolescent's access to reproductive health information and services. Further more, many young people are often not free autonomous individuals being still dependent upon their parents and subjected to the authority of adults. This coupled with the vested interests of many institutions including religious bodies, the family and educational system in shaping the growth behaviors and values of young people can make the social environment of many adolescents qualitatively more restrictive than

that of adults (Langer and Wharheit, 1992) and pose additional legal and social restrictions that in turn can affect their access as well as the freedom to seek services.

5.3.1 Access barriers

- **A's of access**

Availability was not pointed out as a real obstacle in this perhaps because many of the stakeholders seem to be based in the urban area where such services are available. Availability as an access barrier seems to be rarely reported by studies from the region as well. However, equating access with availability of resources will miss other characteristics of the provider and the clients that may be barriers to access. As brought out by the respondents in the present study socio-cultural acceptability seems to be an important factor in defining access to services. Though quantifying and addressing sequel that are taboo or that have causes that are culturally rooted is a rather difficult task, the associated fear of being seen and resorting to unsafe abortions all point to the important role played by the social and cultural factors in seeking services. Furthermore, the fact that a large number of the stakeholders perceive social and cultural acceptability as an important barrier affecting young people's access to SRH services point against premarital sexual activity and its consequences. Previous research has also indicated cultural factor getting reflected in provider's negative attitudes, poor treatment, or refusal to supply contraceptives to young people upon request (Görge et al., 1993; Senderowitz, 1997). Furthermore, because of overt social disapproval of premarital sexual activity, many adolescent girls feel that when they attempt to procure contraceptives, they subject themselves to gossip and to negative attitudes from health personnel (Berglund et al., 1997).

Lack of resources or inability to afford a physician's fee has been cited as a major reason for young people delaying and sometimes not using the services or resorting to unskilled providers in previous research (Okagbue, 1990; Fuglesang, 1997). Financial reasons have been pointed out as a major reason for women resorting to illegal abortions (Koster - Oyekan, 1998). Temin et al. (1999) have reported many going traditional healers because of the high cost of doctors.

- **Service related**

Even when services are available, the lack of information as to its existence could be a serious barrier in hindering use. As perceived by the respondents, young people in India are poorly informed about the place where they can get sexual and reproductive health services and this could affect as a barrier in using the services. Many might still be too young and inexperienced to know how to find services. Furthermore, youngsters in particular adolescent girls, often need to be provided with adult permission and support to receive reproductive health information. Lack of information about existing services has been pointed out as a barrier in other studies as well (Fuglesang, 1997). The typical example that has been pointed out that is the case of contraceptives; many young people seemingly do not use contraceptives because of the lack of knowledge about different contraceptives and where to get them (Fuglesang, 1997). It is surprising to note that though India has one of the oldest family planning programs in the world and the AIDS pandemic has challenged traditional taboos against condom promotion, the information about contraceptives have not gone through the populations especially the younger sections. Given that a reservoir exists of potential interest in contraception among young people whose stake in avoiding pregnancy is rather very high, this lack of information can be crucial in posing obstacles to their health and development

Another point popping up for thought is the role of the media in disseminating messages in a way that imply individuals to assume responsibility for their own actions and inform them about the services. The media typically help to maintain the official line that sex is forbidden activity, all the while showing it to be a common practice. Though contraceptive advertising is taken up in the framework of family planning programs or HIV prevention, very little systematic information is given out by the major radio and television networks for fear of political opposition. Advertising of condoms is becoming more common, but the emphasis remains on encouraging the young to use them to prevent disease rather than pregnancy.

- **Perceived quality of services**

Previous research has reported adolescents giving poor rating to the quality of RH/family planning services at the centres and showing poor interest in RH/family planning service facilities all of which could hinder their use of services (Minh-

Thang, 1999). The narrow focus on reproductive health (Kim et al., 1997) and the de facto illegal nature of some of the services itself (Webb, 2000) also seem to be affecting access to sexual and reproductive health services.

- **Lack of privacy**

Privacy and confidentiality concerns seem to be widely reported as access barriers for young people to use sexual and reproductive health services (Langhaug et al., 2003; Kim et al., 1997; Paxman, 1996; Senderowitz, 1997; Webb, 2000; Temin et al., 1999; Berglund et al., 1997; Fuglesang, 1997; Koster- Oyekan, 1998; Joseph et al., 1997; Leslie and Defo, 1997). Owing to privacy concerns, while the services of nurses are sought outside of the clinic setting by young people in urban Zambia (Webb, 2000), most went to traditional healers for STD treatment in Nigeria (Temin et al., 1999). Associated with the privacy and confidentiality concerns are the reported barriers like fear of being seen by adult family member or neighbours (Paxman, 1996), and the thought that clinic personnel will report them (Senderowitz, 1997).

- **Worker skills**

The inability of current programs and health personnel to reach and assist young people has been noted by previous researchers (Hughes and McCauley, 1998; Kulin, 1988). Research has also shown that the fear of reactions of health service providers (Fuglesang, 1997) and the negative attitude they perceive among the staff at health facilities make adolescents feel alienated when they try to use health facilities (Berglund et al., 1997). In many instances services treat young people seeking sexual and reproductive health services as “promiscuous” or “incorrigible” rather as persons in need of health care and advice (Kim et al., 1997). Adolescents being scolded, refused information or turned away while approaching for help has also been reported (Population council, 1991). There have also been typical examples of family planning providers examining clients as they were sick (Galway, 1992) or denying access to services on the basis of age, number of children and marital status (Askew et al., 1994; Speizer et al., 2000).

5.3.2 Legal – consent of parent / guardian

As noted by Zanele Mfono (1998), although adolescent exposure to the risk of pregnancy creates pressures on service providers to react, their initiatives are likely to be constrained if they lack strong legislative support. Laws and regulations often seem

to be daunting barriers in providing treatment services to young people. Legal restrictions and de facto illegal nature of the services affecting access have been reported by many researchers (CREHPA 1997- 1998; Bennett, 2001; Webb, 2000). The presumption underlying fixing of a minimum age could be that young people lack the maturity to comprehend fully the nature and long term consequences of sexual intercourse. Hence legally they are incapable of “consenting” to treatment. The law may be somewhat arbitrary in the age it selects, but is not concerned with the ability to engage in sex as is reflected in the case of many other regions too.

Given the controversial nature of the issue of parental consent, the dilemma for service providers can often be a complex one with regard to minors. Such issues of consent can hinder their use of formal services and go to informal providers; due to the concerns of privacy and that many young people do not want their parents to know about the termination. This in turn could pose potential barriers to the good health of adolescents especially the very young ones.

5.4 Constraints faced in service delivery

From the expressed constraints, the reluctance to run counter to official or public disapproval of reproductive services for minors is grossly evident. The effect of resource constraints is essential to consider in any programming framework meant to apply to developing countries. Resources are now and will likely to continue to be sharply limited in many program settings, so that the match between available resources and the scale of the program challenge must be assessed. In many developing countries, the assumption can be made that the demand far exceeds the numbers programs currently reach. To reach such large populations in resource limited settings means that cost effectiveness and sustainability are of paramount importance. One approach could be to program for scale, that is to assess the size and characteristics of the target population of young people to design interventions that seem to have good potential to reach large numbers, if such a program proves effective in a pilot version. Also low cost models must be designed and existing public and private resources allocated more efficiently.

As expressed by one of the service providers, too often once a decision is made to expand sexual and reproductive health services, programmer's first impulse is to create special youth clinics or multipurpose centres. This approach has two potential problems. Many young people do not use formal health settings for such services. Evaluation studies have revealed that special youth clinics experience gender imbalance, for instance in Mexico, mostly females attend them, in Africa mostly males – and disappointing levels of use (Townsend et al., 1987; Phiri and Erulkar, 1997; Erulkar and Mensch, 1997). Secondly the operating costs of such facilities are likely to be too high to be sustainable, or to permit their widespread use in resource constraint countries. However, adolescents often need 'safe spaces' where they can meet and socialise with community approval. For this purpose, modest youth centres might be created, and then linked to other settings and providers for sexual and reproductive health information and services.

5.5 Discussion on methodology

The present study is exclusively based on qualitative methods, so the generalisation of findings could be limited and the comparison with quantitative studies is rather difficult. Owing to the labour-intensive and time consuming nature of qualitative methods, the study could be seen more in terms of an initial investigation in limited time and resources using rapid assessment techniques.

Going through studies on sexuality related aspects of young people from different cultural settings, a heavy emphasis on quantitative methodology has been pointed out by Goodson et al. (1997). As noted by Goodson et al. (1997), the absence of qualitative research may be a function of both of non availability of funding, as well as publication bias. It is possible that this type of analysis has lent itself mostly to publication in book format or reports, instead of peer reviewed journal article; it is highly probable that qualitative studies have been denied appropriate funding. Given the importance of personal meaning assigned to sexual activity, qualitative research could contribute substantially to our understanding of adolescents' perspectives on this behaviour. These findings could, in turn help to improve the validity of quantitative research designs.

CHAPTER 6

Recommendations for future programming to meet the sexual and reproductive health needs of young people

India which holds a major share of world's young people, could be taken as the prime example of a region where an uneasy amalgam exists in the sexual and reproductive health arena; too early marriage and youthful marital childbearing on one hand and premarital sexual intercourse on the other. The first pattern, common in the developing world, especially in Asian societies where cultural values strictly prohibit pre-marital sexual activity, seems to exist mostly in rural areas and urban slums. The second and diametrically opposite pattern, seemingly an urban phenomenon, exists primarily in developed countries or more developed regions within developing countries, characterised by the onset of sexual experience, often out of wed lock, in the middle to late teens.

In the current investigation, while declining age at menarche, parental control and socio cultural norms were perceived to be responsible for too early marriages, changing life styles as a result of the process of socio-economic development seem to be responsible for premarital relations in general. With the growth of urban and peri-urban centres, economic and employment opportunities are expanding, especially for women, and age at marriage and child birth is rising. In such a context, increased independence, schooling, later age at marriage, and often economic necessity are combining to break down patterns of premarital abstinence where they once existed, or to change the context of sexual behaviour where premarital patterns existed before.

In addition, the family unit itself seem to be changing drastically. Traditional channels of sex education seem to have disappeared and have not effectively been replaced. Young people are being fed with conflicting media images with no clear guidance on standards of behaviour and little information about matters of sexual and reproductive health. With respect to sexual activity, traditional restraints remain, but are less controlling. All these have resulted in considerable risky sexual behaviour both within the context of marriage as well as outside leading to hazardous

consequences like too early pregnancies, sexually transmitted infections and recourse to unsafe abortions.

As brought out by the respondents in the current investigation, till recently, the sexual and reproductive health programming scene with respect to young people was characterised by a gross neglect of their problems and needs. Population issues and the advent of the HIV epidemic coupled with international agreements like the ICPD declaration in Cairo, has brought some recognition regarding the needs of young people in the past two decades and demand seems to be growing for accelerated programming. Though multiple programs for young people are in operation with implicit sexual and reproductive health components, comprehensive and well balanced programs having the potential to reach large numbers of young people are yet to be designed. In this connection, it is to be remembered that moving beyond policy statements is likely to meet with a number of challenges. The existing extreme disparity in the provision of reproductive health care for young people seems to be resulting from several socio-cultural and structural factors many of which are culturally and politically sensitive too. This would mean quite a revolution in the way programmes and services are planned and managed. In the absence of reliable evidence based answers, as to what kind of programming really work, the need is to develop new and expanded programs that build upon research knowledge concerning young people's needs, the current programming, insights drawn from behavioural theories and the reality of constraints; political, socio-cultural and economic.

In addition to picturing the sexual and reproductive health scenario of young people in India in terms of the risky behaviour patterns and the programming responses, the present research provides insights for future programming based on the application to theoretical framework. The additional contribution would be in terms of breaking the silence surrounding unmarried young people's sexual and reproductive health problems among the various adult stakeholders and initiating a dialogue among them with respect to the fit between young people's needs and current programming.

It can be seen that world-wide, many of the broader sources of young people's risk could be the same. Growing similarities are also developing between adolescents in many large cities of the developing world and those of more developed countries. So,

many of the findings and formulations discussed here might apply outside the region and indeed, might have implications for interventions in other settings too.

6.1 Future directions – improving the fit

Ten programming principles are suggested below to use as guiding markers for programme planners in designing comprehensive sexual and reproductive health programs for young people. Based on these, specific recommendations are given for each of the major actors. These principles as well as the recommendations are drawn based on the results described in previous sections.

6.1.1 Programming principles

- **Recognise the biological normalcy of sexual activity among young people, the consequences and possibilities for intervention:** Risks related to early marriage and child bearing and those related to out-of wedlock sexual activity, sexually transmitted infections and abortions are all likely to increase in the presence of declining age at menarche and the changing life styles. Unless the biological normalcy of sexual activity among young people is recognised, implementing approaches that affect it as powerfully as those that controlled it in the past would be difficult. Because adolescents encompasses years of growth and change, these years may well provide the single best opportunity to intervene. Misreading the sexuality aspects of youth and failing to recognise the consequences or take into account the possibilities could lead to grave disastrous consequences in future.
- **Primary need for information and skills that are non-clinical in nature:** The primary sexual and reproductive health needs of many, perhaps most adolescents are for information and skills that are non-clinical in nature and could be provided through non-clinical services. Many of these can be met in community settings too, provided by well trained and supervised non-medical adults and peers.
- **Acknowledge that sexuality education is neither a new nor a foreign phenomenon:** It is important for all to acknowledge that sexuality education is neither a new nor a foreign phenomenon since traditional societies have long been using its own mechanisms to educate young people in matters

related to sexuality and reproduction and has regulated sexuality among the youth effectively too. Having the correct information increases the chances of making intelligent, responsible choices in matters of sexuality. On a broader front, knowledge about human reproduction and the dynamics about human relationship is an important adjunct to the whole living process. Comprehensive sex education, which emphasizes the benefits of abstinence while also teaching about contraception and disease-prevention methods, might reduce risky behaviour.

- **Programs appealing to young people and acceptable to adults:** Given the potential for differing generational perspectives on sexuality and its expression, programmes that target adolescents may fail to meet their objectives if adults who interact with adolescents act as barriers to adolescent adoption of safe-sex practices. So taking influential adults into confidence and developing programs appealing to young people and acceptable to adults is an important prerequisite for the success of the programs.
- **Centrality of training in skills for young people:** Several factors beyond increased knowledge are necessary for achieving successful changes in behaviour. Intervention programs either school based or community based should have it core as the acquisition of appropriate life skills both generic and specific to sexual and reproductive health in terms of assertiveness, critical thinking and decision making using effective learning exercises like role playing, community visits and other means to teach skills.
- **Build on what exists by linking health programs with non health programs:** One of the promising ways to build on what exists is to incorporate sexual and reproductive health information, training in skills and services into networks and infrastructures that already engage young people. Health programs increase their coverage when they link with non health programs. Some examples could be national youth service programs, scouts and guides, YM/YWCAs, the Red Cross and sport programs and leagues.
- **Address the social context of adolescent sexuality and fertility:** The fact that the problems are social in origin does not make them less critical to adolescent health, but might imply that effective intervention may fall outside

the health sector. Therefore interventions to prevent adverse health consequences must involve an understanding of the social roots too. Broader initiatives such as expanding education and employment opportunities for girls and eliminating harmful traditional practices like child marriage are important over the long term to improve adolescent reproductive health. This approach must go hand in hand with the development of economic opportunities for young women outside the domain of sexual relations; such opportunities would enable them to pay for the items they desire with cash gained from small enterprise opportunities or other non sexual methods of income generation. Such opportunities would go a long way in empowering young people especially young women.

- **Reaching the unreached:** While it is to be noted that many of the intervention efforts are school based, services are also needed for other, even more disadvantaged groups whose sexual mores are also in flux during a period of social and economic change. Groups like young unmarried females and males in the work force may be at even greater risk of dangers of unprotected exposure. Street children or abused adolescents or those from poor urban areas or rural communities could be another group with the least resources. Extending services to such groups is vital to any prevention efforts in the region.
- **Effective co-ordination and networking among the actors:** Two principles can be used for effective collaboration and co-ordination among the various actors. First, each must recognise that other has certain comparative advantages and disadvantages. Second, each must build on the strengths of the other. In formulating such collaboration, it is important to understand the context in its various dimensions: political, social, policy environment, priority accorded to adolescent reproductive health and the status in the civil society.
- **Seek out many different approaches and models and promote careful evaluation of existing programs:** The capacity of single rigid programs incorporating all the elements necessary to match the variety of issues seems very much uncertain. Programs must be flexible if they are to meet, at reasonable cost and sufficient number, the various needs of young people. Communities, planners and programmers should seek out many different

approaches and models using a variety of settings and providers; private and public, clinical and nonclinical and promote careful evaluation to determine which designs or components lead young people to adopt healthy behaviours.

6.1.2 Recommendations

6.1.2.1 Planners and policy makers in government systems

Government has the highest potential for developing sustained and effective intervention programs and has a critical role in leading the way given the financial and human resources at its disposal, the existing infrastructure, and the mechanisms to implement programmes. This would mean that success of programs in general would require great political will and concerted commitment. This in turn implies a change in the political culture surrounding the treatment of sex which bears some responsibility for programmes to be unsuccessful.

Following are some the actions that could be initiated or implemented through the government machinery towards promoting the sexual and reproductive health of young people.

- **Concrete measures to enforce the legal minimum age for marriage:** Many health problems experienced by adolescents do occur within marriage, exacerbated by customs that are culturally linked such as marriage at or close to puberty. Though the issue of early marriage and early pregnancy does not command the attention accorded the health ramifications of out-of-wedlock sexuality, an immense reservoir of suffering is caused by childhood marriage and immediate post-pubertal childbearing among girls given in marriages as young as ten or twelve. This is happening in spite of the laws establishing a minimum age for marriage. Equally law by itself seems to be incapable for the simple reason that such laws are unenforceable where the necessary administrative systems are lacking. Measures like the strengthening of the administrative machinery should go hand in hand with community education to change prevailing attitudes which countenance pregnancy and child bearing at young ages and other empowerment measures like increasing women's

access to education and income generation openings for girls and women in general.

- **Formulation of a national policy on adolescents and adolescent reproductive health:** Policymaking is intended to articulate the vision for the health sector, and to provide a framework for actions. Prevention may depend more upon public policy than upon programs. Policymaking is largely a government function, though considerable inputs are needed from various interest groups for policies to gain acceptance and have a greater chance of success in implementation. Efforts should be made for the formulation of a national policy on adolescents and adolescent reproductive health.
- **Initiation of a dialogue to sharpen the focus on adolescent sexual and reproductive health concepts, programmes and operationalisation:** There are still many gaps in the understanding and operationalisation of the sexual and reproductive concepts, programmes and operationalisation among the various stakeholders. Using the ICPD framework, government can initiate a dialogue to sharpen the focus on reproductive health concepts and introduce more effective operationalisation through collaboration, networking and information sharing among the various actors like the government departments, civil society and the donor community.
- **Explore possibilities of convergence of the different existing school based programs in to a state-wide comprehensive programme intended at addressing all the components of sexual and reproductive health of young people and introduce it as part of the curricula.** Such programs which could be called family life education or life skills education should also be combined with health services or defined contacts with the health care system. Such programs could also include outreach efforts in the surrounding community to reach young people who are out of school. This could be made operational with the collaboration using the services of health workers or front line workers. While the intervention needs to be locally oriented, national government agencies can play other crucial roles such as setting standards, providing training and maintaining quality control.
- **Government systems can take a lead in publicly acknowledging the upward drift in the normative transition of the age at marriage and**

encourage it further towards optimising the age of marriage and childbearing. This would implicitly mean acknowledging premarital sexual activity among young people and introducing programs that ensure that unmarried young people, both boys and girls, receive adequate education, and suitable family planning information and services to promote safe practices.

- **Media policies:** While welcoming the opportunities that increasing modernisation affords through the extension of media and other global information channels, policy makers must be aware of its potentially negative consequences and seek to enable young people to participate in the modern world without being exploited by it.
- **Promotion of programs focussing on vocational training, employment and similar economic or cultural issues:** Even if the specific consequences are health related, responsibility for prevention may fall in the spheres of economics, education or the law. Programs focussing on vocational training, employment, and similar economic or cultural issues contributing to greater financial independence and employment opportunities for adolescents and intended at reducing the biological or social vulnerability need to be promoted.
- **Effective collaboration between the government and nongovernmental organisations:** Given that many NGOs are making pioneering contributions in terms of prevention as well as service provision to young people, government should make active efforts to support NGOs. Many times the existing political, social and policy environment might not allow nongovernmental organisations to grow and contribute to the national reproductive health policy and programmes. Government can create a supportive environment to NGOs by being more transparent, with a non-indicative, unbiased, non-confrontational and supportive attitude. These dimensions are critical in understanding NGO capacity, their needs for further capacity building, extension of their knowledge base and their role in RH innovations.
- **Improving infrastructure of public facilities:** Improving the infrastructure in public health facilities and maintenance of a hygienic environment and provision of adequate equipment would go a long way in improving perceived quality of these services.

6.1.2.2 Service providers

The role of the provider in service delivery is crucial and far ranging. The providers' role as "gate keepers" can profoundly affect how and when clients receive services or even whether clients receive services at all.

- **Introduction of new protocols and standards for reproductive health service delivery:** Precise assessment of service related barriers and introduction of new protocols and standards for reproductive health service delivery address many, if not all, of the restrictive practices. More attention should be given to practices considered important to good quality care that are neglected by providers.
- **Adequate dissemination of new or revised guidelines is necessary, as well as training, close supervision and monitoring:** In addition to changing guidelines, for service providers to offer good quality services to clients, adequate dissemination of new or revised guidelines is necessary, as well as training, close supervision and monitoring to ensure that practices actually change. For better acceptance, it is also to be considered that new or revised guidelines should not unduly increase either provider's workloads or the cost of providing services. Additionally, make sure whether the providers have access to the guidelines and if they actually use them to guide service delivery.
- **Evaluation of basic and refresher training received among service providers:** Most providers get their orientation about adolescent reproductive issues during basic or in-service training, and it is likely that their practices are based primarily on what they were taught then. Strengthening of basic and refresher training on adolescent issues on the lines of the ICPD framework would go a long way in orienting them and enabling them to set goals for practice.
- **Resources:** Service providers may base their practices on the availability of resources for service provision. For example, the availability of equipment, supplies, contraceptive commodities and staffing are likely to influence the choice made in providing reproductive health services to young people who are not considered as a priority group.

- **Reengineering the primary health care services to accommodate the needs of young people:** Reengineering the primary health care services to accommodate the needs of young people through improved training for providers, more flexible program hours and areas dedicated to young people.
- **Comprehensive training for service providers:** The training should include aspects like how to provide information and counselling to young people where to refer them, and how to maintain a basic management information system for use in common.
- **Identify the range of providers used by young people in each area, and design interventions that include those who can offer care of good quality:** To get clinical services, many young people prefer settings that are confidential and informal. Given the fact that many young people turn to private practitioners, program planners should identify the range of providers used by young people in each area, and design interventions that include those who can offer care of good quality. This situation argues for embracing a wider variety of settings and providers in designing new models of service delivery for young people. Programs can identify all types of providers, both public and private, already being sought out by young people, assess the quality of care they offer, and provide training and referral links to upgrade the care of those providers willing to participate. Existing health services can be expanded to serve increased numbers of adolescents by means of referrals. So, an expansion of programming to employ more varied content, settings and providers is essential.

6.1.2.3 Non governmental Organisations/UN Agencies

In collaboration and co-operation with the government, NGOs and UN agencies have a crucial role in actively supporting the development of policy and action in the field of adolescent SRH. The access and effectiveness of NGO programs would depend on deliberate policy choices related to NGO goals; skills and professionalism of staff; resources available and devoted adolescence sexual and reproductive health matters; relationships with the government and other NGOs and independent experts and, in turn, the capacity of the governmental system to respond to the inputs from NGOs.

Some of the specific course of action towards supporting development of policy and action could consist of the following.

- **Effectively communicate the sexual and reproductive health needs of young people with decisionmakers at state, national and international level in a variety of ways**, in relation to the establishment of human rights norms. Armed with precise information and communicated persuasively, NGOs often can set the agendas of the national governments international organisations to address the issues they present.
- **Expose cases of sexual abuse of young people and mobilise shame through public advocacy to end the abuses and ameliorate conditions.** Though this require sensitive information gathering, this could be perhaps be the most efficient tactic that could be adopted to curb sexual harassment which seem to be occurring at large scales.
- **In addition to the provision of broad educational services coupled with health care and training opportunities to high risk groups of adolescents like street children, commercial sex workers in a concentrated way, NGOs can also provide services such as legal aid, training in public advocacy skills etc.** so that such groups will know their rights and how to act upon them.

6.1.2.4 Educators /Parents/ Media/ Young people

- **Educators should actively involve in constant intense dialogue among themselves and with the policy makers about the medium and methods for reaching out to the young people** with sexual and reproductive health information keeping in mind that school based programmes can play a vital role in delivering reproductive health information and care to adolescents. Expanding, rather than restricting the information available to adolescents should be the defined goal guiding their teaching efforts. They should also take active efforts to integrate skill development as a core in the teaching sessions rather than the provision of information alone. Owing to the impact of observational interactive learning, they should make active use of methods like role plays, community visits and other visual teaching aids.

- **Parents should accept and encourage delayed marriage of their children** with an understanding of the possibilities of education, employment and income generation. In the context of such an enlarged gap, it would become imperative to acknowledge and accept premarital sexual activity and should develop the necessary skills and knowledge to act as reliable sources of information to their children in matters concerning sexual and reproductive health services. This in turn points to the importance of fostering good communication and comfort between parents and adolescents about sexual issues. Rather than taking a punitive or judgmental attitude, they should be able to act as promoters of safe sex practices for their children who are perceived to be sexually active.
- **Media - Optimising the mass media for adolescents and young people:** The fact that we live in a media world and the potential of mass media programs to reach large numbers young people, point to the importance of taking into account the prosocial, educational, and positive possibilities offered by this technology and tapping this resource towards making a positive impact. With all the knowledge and intuition about the potential harm posed by media, there is a need for more information about how media can help children learn, amplify experiences, fill gaps in children's lives, provide positive entertainment, and stretch and challenge young minds. Media education or how to analyse media through critical thinking and viewing as a key approach to reducing the health risks associated with the media exposure. Agenda setting for youth and communication media in future is important to improve access to positive educational programming and products, and at the same time protect them from the potential harm of media messages and images.
- **Young people:** Young people themselves should act as the prime advocates for change in their situation. Use their own forums to collectively identify their needs and communicate it effectively to programmers at the local, national and international levels.

6.1.2.5 Researchers

- **Research based on theoretical or conceptual models:** As mentioned before though there have been studies relating to the sexual behaviour and its correlates, most of the studies do not have a theoretical framework or conceptual model guiding data collection and analysis. Given that effective risk reduction programs are those based on prevailing theory, it is important to link empirical evidence to the theoretical framework in programme development.
- **Identification of factors governing risk behaviour:** Owing to the difficulty in establishing causal factors that contribute to the early onset of sexual activity, more precise identification of risk factors, particularly behavioural, environmental, and underlying bio-psycho social determinants, may help to provide a comprehensive picture of the phenomenon and furnish better venues for its prevention. In the Social Cognitive Theory framework, this would mean empirical work involving longitudinal assessments to understand the role of cognitive factors like self-efficacy, outcome expectancies, on both risky and safe sex behaviours of adolescents. Further research could examine relationships between these cognitions and key factors within the domain of behaviour (e.g. multiple partnership) and the social environment (e.g. family support) suggested by Social Cognitive Theory to be proximal influences on sexual risk behaviour. Furthermore, the relative importance of these domains and key factors within each domain is yet to be identified.
- **Research on programme effectiveness:** Though programs are in operation to address the sexual and reproductive health needs of young people, research on programme effectiveness is relatively sparse. Research findings relating to programme effectiveness can be used for future programme development.
- **Service delivery practices:** Understanding provider practices is fundamental to design training, supervision and logistic systems that maximize access and quality of care. Though there are hints on the constellation of factors that influence service providers in delivering services to young people, it has not always been fully clear, why providers impose inappropriate restrictions on young people to obtain the necessary services. Using a variety of research

methods in studies of service practices will produce a more complete picture of the service delivery context in which providers work and young people receive care.

Information on the following factors will help identify root causes of service practices that should be eliminated or emphasised:

1. General trends in specific service delivery practices. Consecutive situation analyses would be useful in detecting general trends in adherence to service practices relating to young people.
 2. Laws and regulations governing reproductive health service provision to young people. Service providers may be constrained in their practices by the laws and policies governing family planning and reproductive health in their country. Studies on service practices should be grounded in an understanding of the legal and policy context in which the providers work.
 3. Studies linking service delivery guidelines and practices with the content of training programs in adolescent issues. Making this link is important for assessing the information given to providers in their training--both basic and refresher--and through service delivery guidelines.
 4. Personal preferences and biases among providers. Personal preferences and biases towards providing family planning to adolescents or unmarried clients, or providing methods to clients without spousal consent. These personal preferences and biases could be most often influenced by sociocultural factors or by prevailing medical conditions in the country.
- **More effective dissemination of study findings:** Researchers must strive to make study results more widely known and together with the parties concerned, translate recommendations to action.

Thus, it can be concluded that effective programmatic and service approaches to meet the needs of young people would involve activities that impinge upon some of the most sensitive issues of human experience, which could be deeply rooted in the value systems of every culture. Only a combined effort by planners, policy makers, health-care providers, educators, parents and young people can enhance the reproductive health of young people who are the most valuable future resource of any country.

By way of conclusion, it would be worth quoting, what Zabin and Kiragu (1998) have noted about the adolescent sexual and fertility behaviour in Sub-Saharan Africa:

“Clearly if concern is directed at many of the primary sources of sex and fertility related risks to adolescents, in and out of union, broader areas of intervention must be defined. Many such areas involve not only adolescents and service providers, but also persons perceived as guardians of the very traditions from which many of the most serious risks to adolescents derive. Enlisting these people in the process of prevention is among the most challenging tasks. Not surprisingly both official and popular confusion makes achieving a rational approach to adolescent sexual behaviour difficult. May be this confusion should, on the contrary, point the way. For example might not family planning centre teach the ritualised forms of sexual contact between young people that formerly helped them avoid pregnancy while acknowledging their post pubertal status? Is it not possible that new levels of economic independence for young women might also free them from exploitative patterns of early sexual liaisons?”

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Acronyms

AIDS.....	Acquired Immune Deficiency Syndrome
AIR.....	All India Radio
ANM.....	Auxiliary Nurse Midwife
CEPED.....	Centre Population et Développement
CHC.....	Community Health Centre
CRC.....	Convention on the Rights of the Child
CREHPA.....	Center for Research on Environment Health and Population Activities
CSE.....	Contraceptive Self-Efficacy
DH.....	District Hospital
DHS.....	Demographic and Health Survey
ECP.....	Emergency Contraceptive Pills
FRHS.....	Foundation for Research in Health Systems
FWCW.....	Fourth World Conference on Women
HBM.....	Health Belief Model
HIV.....	Human Immunodeficiency Virus
ICDS.....	Integrated Child Development Scheme
ICPD.....	International Conference on Population and Development
ICRW.....	International Centre for Research on Women
IIPS.....	International Institute for Population Sciences
ILO.....	International Labour Organisation
IMIFAP.....	Instituto Mexicano de Investigacion de Familia Problacion
IPPF.....	International Planned Parenthood Federation
IRDP.....	Integrated Rural Development Programme
LHV.....	Lady Health Visitor
MCH.....	Maternal and Child Health
NAFCI.....	National Adolescent Friendly Clinic Initiative
NCASC.....	National Centre for AIDS and STD Control
NFHS.....	National Family Health Survey
NGO.....	Non Governmental Organisation
NHP.....	National Health Policy
ORC Macro.....	Opinion Research Corporation Company

ORG.....	Operations Research Group
PHC.....	Primary Health Centre
PRB.....	Population Reference Bureau
RCH.....	Reproductive and Child Health Programme
RCK.....	Reproductive and Contraceptive Knowledge
SAARC.....	South Asia Association of Regional Cooperation
SCT.....	Social Cognitive Theory
SLT.....	Social Learning Theory
SRH.....	Sexual and Reproductive Health
STD.....	Sexually Transmitted Disease
STI.....	Sexually Transmitted Infections
TPB.....	Theory of Planned Behaviour
TRA.....	Theory of Reasoned Action
UN.....	United Nations
UNAIDS.....	Joint United Nations Programme on HIV/AIDS
UNDP.....	United Nations Development Program
UNFPA.....	United Nations Population Fund
UNICEF.....	United Nations Children's Fund
UNPD.....	United Nations Procurement Division
UNPF.....	United Nations Population Fund
WFS.....	World Fertility Survey
WHO.....	World Health Organisation
YARBS.....	Young Adult Reproductive Behaviour Surveys
YARHS	Young adult Reproductive health surveys

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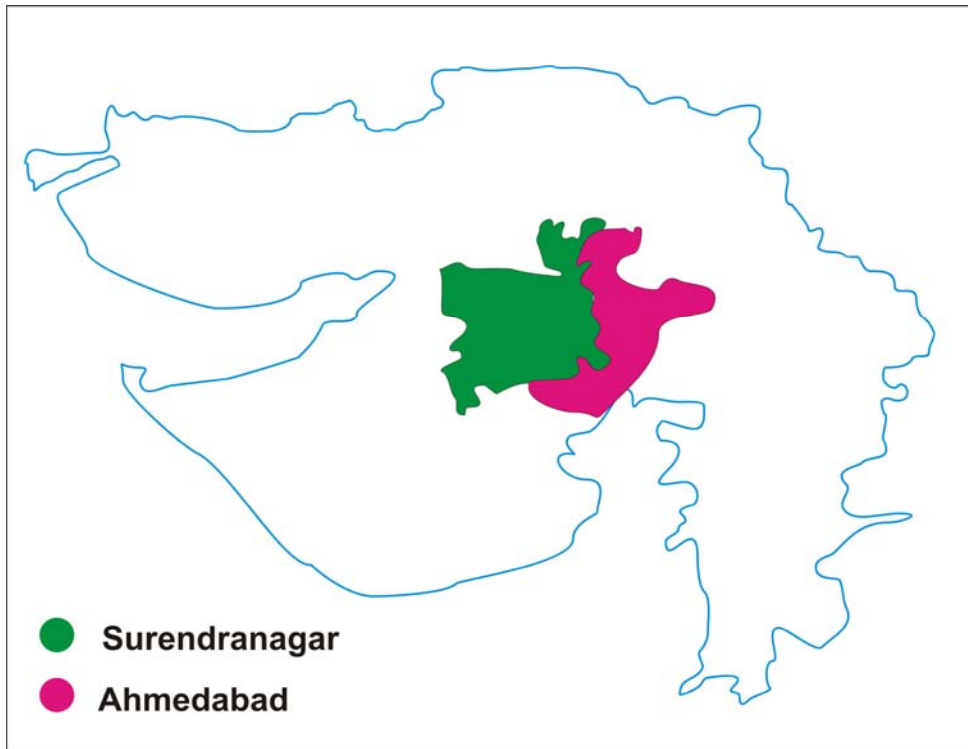
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ANNEXURE

Map of India



Map of Gujarat showing the study areas



Profile of the respondents

3.1. List of government officials

Serial No.	Department/ Institution	Informant's position	Sex
<i>Planners and policy makers from the concerned departments, Government of Gujarat</i>			
1	Department of Health, Government of Gujarat	Additional Chief Secretary (Health)	M
2	Department of Health, Government of Gujarat	Additional Director (Family Welfare) and Director RCH Programme	M
3	Department of Family Welfare, Government of Gujarat	Additional Chief Secretary (Family Welfare)	F
4	Department of Education, Government of Gujarat	Additional Secretary (Education)	M
5	Department of Education, Government of Gujarat	Director (Higher Education)	M
<i>Programme planners / managers of state government bodies</i>			
6	State AIDS Cell	Additional Director	M
7	Population Cell, Gujarat Council for Educational Research and Training (GCERT)	Project Officer	M
8	Population Cell, Gujarat Council for Educational Research and Training (GCERT)	Tutor	F
9	Family Planning Bureau, Ahmedabad Municipal Corporation	Family Welfare Officer	F
10	Women's Cell, Commissionerate of women and child Development, Ahmedabad Municipal Corporation	Deputy director	F

3.2. List of non-governmental and intergovernmental organisation representatives

Serial No.	Department /Institution	Informant's position	Sex
11	Local NGO 1	Director	M
12	Local NGO 2	Director	M
13	Local NGO 3	Director	F
14	Local NGO 4	Representative	F
15	Local NGO 5	Director	M
16	National NGO	Chairperson, Adolescent Committee	M
17	IGO - UNFPA	State Project Officer, UNFPA assisted IPD Project	M
18	IGO – UNICEF	Project Officer, UNICEF	M

3.3. List of health service providers

Serial No.	Department /Institution	Informant's position	Sex
<i>Public Health System</i>			
19	Primary Health Centre	Auxiliary Nurse Midwife 1	F
20	Primary Health Centre	Auxiliary Nurse Midwife 2	F
21	Community Health Centre	Supervisor	F
22	Community Health Centre	Information Education Communication (IEC) Worker	M
23	Community Health Centre	IEC Officer	M
24	District Level	Information Officer	F
25	District Level	District Medical Officer 1	M
26	District Level	District Medical Officer 2 – Training RCH	M
27	District Level	Chief Medical Officer 1	M
28	Teaching Hospital	Head of the Department, Obstetrics and Gynaecology	M
29	Teaching Hospital	Head of the Department, Skin and Venereal Diseases	M
30	Teaching Hospital	Senior Doctor, Skin and Venereal Diseases	F
31	Teaching Hospital	Junior Doctor; Obstetrics and Gynaecology	F
32	Teaching Hospital	Counsellor, Skin and Venereal Diseases	F
<i>Private Medical Practitioners</i>			
33	Private Medical Practitioner 1	Obstetrician and Gynaecologist	M
34	Private Medical Practitioner 2	Obstetrician and Gynaecologist	M
35	Private Medical Practitioner 3	Skin and Venereal Diseases	M
36	Private Medical Practitioner 4	Skin and Venereal Diseases	M
37	Private Medical Practitioner 5	Obstetrician and Gynaecologist (abortion clinic)	M

3.3. List of young people and key informants

Serial No.	Department /Institution	Informant's position	Sex
<i>Young people</i>			
38	Boy 1	Secondary school aged 14 years	M
39	Boy 2	Higher secondary (Pre-university) aged 17 years	M
40	Boy 3	University level aged 22 years	M
41	Girl 1	Secondary school aged 15 years	F
42	Girl 2	Higher secondary (Pre-university) aged 17 years	F
43	Girl 3	University level aged 21 years	F
<i>Key informants</i>			
44	Parent 1	Father	M
45	Parent 2	Mother	F
46	Parent 3	Father	M
47	Teacher 1	Higher secondary	M
48	Teacher 2	Higher secondary	F
49	Teacher 3	University	F
50	Media Representative	Additional Director, Doordharsan	M

Guidelines for interview with planners and programme managers in governmental and non governmental organisations

(Adapted from WHO instrument II)

Interview no:
Place:
Date:
Position of the informant:

What are the most common health problems that young people in Gujarat face today?

Note: if health problems associated with too-early unprotected and unwanted sexual activity are not mentioned prompt on the following lines

What do you think about the prevalence of risky sexual behaviour among young people (in terms of too early marital relationships as well as pre-marital relations) in this area? What is the extent? What are the contributing factors? What is the observed risk pattern in sexual relationships among young people in Gujarat?

What do you believe are the most important SRH problems (like Sexually Transmitted Infections, pre-marital pregnancies, unsafe abortions) arising from risky sexual involvement among young people in this area?

What needs to be done to contribute to the healthy development of adolescents? What can be done to assist them when they have health problems? What is currently being done in Gujarat? What policies and programs exist from your sector? What are the other policies and programs existing towards providing the sexual and reproductive health information and services to young people? What are the concerned policy and legal statements?

Note: in addition to finding out the viewpoints of members of this influential group on what needs to be done, try to draw out information on what is being done (to understand which organisations are active in this area, what they are doing, how they relate to each other and what their interests and concerns are). Also try to obtain a sense what the local sensitivities and tensions are in relation to working with adolescents.

What are your views about the health education programme which addresses matters relating to sexual and reproductive health being conducted in the school? What are the different sex education approaches currently existing ?

Note: 'health education' may have been identified as one of the important things that needs to be done. If not do so yourself and probe to find out their views (and the underlying reasons for the same).

What are your views about the provision of health services in terms of contraception, STIs and safe abortions? What do you think are the barriers young people face in accessing health services for problems relating to sexual and reproductive health?

Note: providing good quality health services may also have been identified as something that needs to be done. If it has not been named do so yourself and probe to find out their views. If they feel this is wrong ask them where in their view adolescents with health problems associated with too early and unwanted sexual activity go for help currently and whether they would be happy if things stayed that way.

What are the constraints faced by people like you in programme planning and implementation?

What are your recommendations for future programming?

Guidelines for interview with health care providers

(Adapted from WHO Instrument VIII)

Interview no:

Place:

Date:

Name of the Health Facility:

What are the most common health problems that young people in Gujarat face today?

Note: if health problems associated with too-early unprotected and unwanted sexual activity are not mentioned prompt on the following lines

What do you think about the prevalence of risky sexual behaviour among young people (in terms of too early marital relationships as well as pre-marital relations) in this area? What is the extent? What are the contributing factors? What is the observed risk pattern in sexual relationships among young people in Gujarat?

What do you believe are the most important SRH problems (like Sexually Transmitted Infections, pre-marital pregnancies, unsafe abortions) arising from risky sexual involvement among young people in this area?

What needs to be done to contribute to the healthy development of adolescents? What can be done to assist them when they have health problems?

Note: in addition to finding out the viewpoints of members of this influential group on what needs to be done, try to draw out information on what is being done (to understand which organisations are active in this area, what they are doing, how they relate to each other and what their interests and concerns are). Also try to obtain a sense what the local sensitivities and tensions are in relation to working with adolescents.

Now, could you please tell me about the health care services provided by your department or clinic to young people:

Note: In all the following aspects, try to find out what the health care provider thinks/feels about the current situation and about what could be done to improve it.

Regarding publicity of the services provided by the clinic: Are adolescents being informed about the services provided by the clinic? If so how is this done? How do you think most adolescents find out about the clinic (and the services it provides)?

Regarding the policies of the clinic: Would you say that the confidentiality of a patient's details/records is maintained by the staff in this clinic? Do you and other health care providers in the clinic insist on the consent of parents/guardians before any medical procedures are carried out? Do you and other health care providers in the

clinic withhold the provision of certain drugs and supplies to patients who are below a certain age or are unmarried?

Regarding the procedures followed by the clinic: Do adolescents usually choose to come to the clinic by themselves or are they sent here by someone? Do adolescents tend to come to the clinic alone or are they generally accompanied by someone? Do patients have to make an appointment in advance or could they drop-in without one? What do patients have to do and approximately how long do they have to wait before they see a health care provider? How much are patients charged for the services provided by the clinic? What systems are in place to accept referrals from other places and to refer patients for services (that are not provided by the clinic)? What systems are in place for following up patients who have been seen/treated at the clinic?

Regarding the clinic staff: Have you received any special training and do you get any periodical support to work with adolescents?

Regarding the clinic environment: In your opinion what impressions do your adolescent patients/clients have about:

- the location
- the displays and handouts
- the ambience (mood)
- the working hours
- the privacy provided?
- the facilities (premises, equipment, drugs and supplies)

Regarding the array of services provided by the clinic: What are the 5 most common reasons for adolescents to come to the clinic? (*for which services they come?*) Does the clinic provide the health and other services needed to solve the health problems that adolescents come to the clinic with? If not are there arrangements in place to refer patients elsewhere for help?

Regarding utilisation of/satisfaction with the clinic: Is this a clinic that is meant for adolescents only? If not what is the proportion of (male and female) adolescents among the patients who come to the clinic? In your opinion are there any obstacles that prevent adolescents from coming to the clinic? In your opinion do your adolescent patients generally leave the clinic feeling that they have got what they wanted? In your opinion do adolescents who have received help come back here if they have the same or another problem/need again?

Note: probe to find out what the reasons underlying a positive or negative response.

Regarding linkages with schools: Are you involved in health education work (on issues relating to SRH and on other issues) in school nearby? If so describe in what way you are involved. Are you aware of any formal arrangement that exists between the clinic and the school: for health care providers from the clinic to visit the school, to conduct education sessions, to carry out check-ups or to provide curative health services; for students to be sent to/brought to the clinic when they need help? If so please describe the arrangements.

What are the constraints faced in service delivery? What are your suggestions for improving the access (accessibility, availability, affordability and acceptability) of adolescents to SRH services?

Guidelines for interview with school going young people

(Adapted from WHO instrument III)

Interview no:

Place:

Date:

Age of the respondent:

What are the most common health problems that young people in Gujarat face today?

Note: if problems resulting from too-early unprotected and/or unwanted sexual activity are not mentioned spontaneously raise them yourself in the following way: are you aware of what health problems can arise from....?

What are the causes of the health problems that you have mentioned?

Note: try to go beyond biological causes to draw out factors in the environment that cause these problems.

Are you aware of any organisations (within or outside your school) which are working to help you avoid the health problems you mentioned? If yes, what are they doing?

Note: try to find out if there are ongoing initiatives within and outside the school setting and what they think of them. Also find out what is actually being done as part of these initiatives.

What are your views about the health education programme which addresses matters relating to sexual and reproductive health being conducted in the school? What are the different sex education approaches currently existing ?

Note: 'health education' may have been identified as one of the important things that needs to be done. If not do so yourself and probe to find out their views (and the underlying reasons for the same).

What do young people like yourselves do when affected by the health problems that you mentioned?

Note: if health problems resulting too-early unprotected and/or unwanted sexual activity such as pregnancy or STD are mentioned in response to question 1, pose the question in as shown below to find out if they can obtain appropriate preventive health products/services such as condoms and contraceptives and curative ones such as STD diagnosis and treatment:

If a young man wants to get some condoms for his use where could he get some?
What is it that young people like yourselves would do if they get a STD? What is it that a girl/young women would do if she discovers that she is pregnant?

If the responses suggest that they would approach a health facility in the area try to find out the following issues:

- Who the providers of such services are?
- Whether they can reach and use clinics with ease (within or outside the school setting)
- If they do experience problems in trying to reach and use the clinics what are them and what in their opinion could be done to improve the situation.

Whom would young people like yourselves like to get help from when affected by the health problems you mentioned?

Note: probe further to get a good description of what they perceive as the ideal situation.

What are the reasons that adolescents or young people here would not want to go to health facilities?

What are your views about the provision of health services in terms of contraception, STIs and safe abortions? What do you think are the barriers young people face in accessing health services for problems relating to sexual and reproductive health? What are your suggestions to improve access to SRH services for adolescents/young people? What way would you like to get involved in activities of clinics?

Guideline for interview with key informants

(Adapted from WHO instrument II, V & VI)

Interview no:

Place:

Date:

Position of the informant:

Sex of the informant:

What are the most common health problems that young people in Gujarat face today?

Note: if health problems associated with too-early unprotected and unwanted sexual activity are not mentioned prompt on the following lines

What do you think about the prevalence of risky sexual behaviour among young people (in terms of too early marital relationships as well as pre-marital relations) in this area? What is the extent? What are the contributing factors? What is the observed risk pattern in sexual relationships among young people in Gujarat?

What do you believe are the most important SRH problems (like Sexually Transmitted Infections, pre-marital pregnancies, unsafe abortions) arising from risky sexual involvement among young people in this area?

What needs to be done to contribute to the healthy development of adolescents? What can be done to assist them when they have health problems? What is currently being done in Gujarat? What policies and programs exist from your sector? What are the other policies and programs existing towards providing the sexual and reproductive health information and services to young people? What are the concerned policy and legal statements?

Note: in addition to finding out the viewpoints of members of this influential group on what needs to be done, try to draw out information on what is being done (to understand which organisations are active in this area, what they are doing, how they relate to each other and what their interests and concerns are). Also try to obtain a sense what the local sensitivities and tensions are in relation to working with adolescents.

What are your views about the health education programme which addresses matters relating to sexual and reproductive health being conducted in the school? What are the different sex education approaches currently existing ?

Note: 'health education' may have been identified as one of the important things that needs to be done. If not do so yourself and probe to find out their views (and the underlying reasons for the same).

For teachers

What activities are conducted as part of the education programme in your school? Which classes in the school are involved in these activities? Are staff members from the school involved in conducting these activities? Do you yourself take part in the programs? Is there a curriculum for the education programme? (topics covered and teaching materials used?) Any problems in conducting these activities?

For parents

As parents, do you feel that you are able to carry out what you believe is your responsibility to help your son/ daughter stay well?

What are your views about the provision of health services in terms of contraception, STIs and safe abortions? What do you think are the barriers young people face in accessing health services for problems relating to sexual and reproductive health?

Note: providing good quality health services may also have been identified as something that needs to be done. If it has not been named do so yourself and probe to find out their views. If they feel this is wrong ask them where in their view adolescents with health problems associated with too early and unwanted sexual activity go for help currently and whether they would be happy if things stayed that way.

What are the constraints faced by people like you in programme planning and implementation?

What are your recommendations for future programming?

Check list for structured observation in health facilities

(Adapted from WHO Instrument IX)

Name of the Health Facility: _____

Date:

Note: when gathering information pay special attention to issues relating to both adolescent males and females.

Policies of the clinic

What is the degree of confidentiality that exists in the clinic?

Do the clinic staff insist on the consent of parents/guardians before any medical procedures are carried out?

Do the clinic staff withhold the provision of certain drugs and supplies based on age and marital status considerations?

Procedures followed by the clinic

Can adolescent patients come to the clinic without being brought/sent to it by an adult?

Can a patient drop-in without an appointment?

Is the case – registration / case – retrieval system a cumbersome and/or time consuming one?

Note: describe what patients have to do and how long they have to wait on average before being attended to?

Do patients have to pay for the services they receive?

If so is there a system for reducing/waiving the charges in needy cases?

What systems are in place to accept referrals from other places and to refer patients for services (that are not provided by the clinic)?

What systems are in place for following up patients who have been seen/treated at the clinic?

The array of services provided by the clinic

Are the SRH services required by patients provided by the clinic?

Are there functional systems for referring them to elsewhere (where these services are being provided?)

The clinic staff

Do they appear to be able and willing to devote adequate time for their consultations with each patient?

Can patients request to see a health care provider whom they have interacted with at a previous visit?

The clinic environment

Is the clinic located in place which is not difficult time consuming or expensive to get to?

Is the clinic open at times when it is convenient for adolescents to reach and use it?

Are the facilities in good condition?

Are educational materials on display and available as handouts for patients to take away?

Is the milieu of the clinic appealing and friendly?

Are the consultation/treatment rooms private and is there privacy in the waiting area and in the entrance/exit?

The utilisation of the clinic

What appears to be the proportion of(male and female) adolescents among the patients who come to the clinic?

Do adolescents who come to the clinic appear to be at ease?

How do the clinic staff and adolescents appear to relate to each other?