



Knowledge among Out of School Youth on Sexual and Reproductive Health: A Study in Chittoor District

1. Dr M.SIVAPPA, Guest Faculty, Dept. of Population Studies, S.V.University, Tirupati

2. Dr C.RAMANAIAH, Academic Consultant, Dept. of Sociology, S.V.University, Tirupati

ABSTRACT

Health is a fundamental component of social and economic development, serving as a crucial resource for daily living. The relationship between health and human behaviour has been a significant area of interest in public health research. Adolescence represents a transitional phase between childhood and adulthood, characterized by biological, psychological, and social. According to the Adolescent Reproductive Health Policy of Ghana and the WHO, adolescents are individuals between the ages of 10 and 19 years. In this paper discuss about out of school rural youth socio-economic conditions and knowledge about the sexual behavior and how its implicate the society.

Key Words: Rural Youth, Sexual Behavior, Reproductive Health, Sexual

INTRODUCTION

Sexual and reproductive health is not only about supporting normal physiological functions such as pregnancy and childbirth but also about minimizing adverse health outcomes related to sexual activity and reproduction. It aims to empower individuals of all ages, including adolescents and older adults, by enabling them to engage in safe and satisfying sexual relationships. Achieving this requires addressing critical barriers such as gender discrimination, inequalities in healthcare access, restrictive laws, sexual coercion, exploitation, and gender-based violence. According to the World Health Organization (WHO, 2008), sexual health is defined as a state of physical, emotional, mental, and social well-being concerning sexuality. It is not merely the absence of disease or dysfunction but involves a positive and respectful approach to sexual relationships. For sexual health to be realized, the sexual rights of all individuals must be respected, protected, and fulfilled.

In India, evidence suggests that young people continue to face numerous unmet needs in terms of sexual and reproductive health. Early marriage and childbearing remain prevalent, despite gradual increases in the average age of marriage, particularly among girls. Data indicate that over two-fifths of women aged 20–24 were married by 18, and 16% of girls aged 15–19 have already experienced pregnancy or motherhood. Additionally, access to sexual and reproductive health services among youth remains limited, with many unable to obtain the necessary care and information. Sexual development is a multidimensional process that encompasses physical, psychological, emotional, social, and cultural aspects. It is closely linked to the formation of gender identity and unfolds within specific socio-economic and cultural contexts. The transmission of cultural values across generations plays a crucial role in shaping attitudes toward gender and sexuality. However, young people today are exposed to diverse and often conflicting messages from parents, teachers, media, and peers. Many parents, due to cultural norms, lack of knowledge, or personal discomfort, hesitate to discuss sexual health matters with their children.

Reproductive and Sexual Health Programmes in India

The National Population Policy 2000 recognized adolescents as an underserved group with distinct sexual and reproductive health needs for the first time. It advocated for special programmatic attention to address these concerns (MOHFW, India, 2000). Similarly, the National Youth Policy 2003 focused on individuals aged 13–35, categorizing adolescents (13–19 years) as a special group requiring a different approach from young adults (20–35 years). This policy emphasized strategies to meet youth needs in key areas such as education, training and employment, health, recreation and sports, and good citizenship (Ministry of Youth Affairs and Sports, 2003). Additionally, the Tenth and Eleventh Five-Year Plans highlighted the need to address adolescent and youth-specific health concerns (Planning Commission, 2007). The National Adolescent Reproductive and Sexual Health (ARSH) Strategy provided a framework for adolescent sexual and reproductive health services under the Reproductive and Child Health (RCH) Programme-II (MOHFW, 2006). The National Rural Health Mission (NRHM) (2005–2012) further integrated adolescent health services as part of its health guarantees in sub-centers, primary health centers, and schools (MOHFW, 2005).

These policies and frameworks underscore India's commitment to improving adolescent and youth reproductive health. However, effective implementation remains a challenge due to socio-cultural barriers, lack of awareness, and inadequate access to quality healthcare services. Strengthening these initiatives through better outreach, education, and policy execution is crucial to ensuring the well-being of India's youth population.

Sexual Behaviour Patterns of Youth

The transition into reproductive life is a critical phase in a person's development. The choices and behavioral patterns established during youth shape the trajectory of an individual's life (United Nations, 1998). However, this stage is also characterized by vulnerability, as various risk factors—such as premature entry into sexual relationships, multiple partners, high-risk sexual behavior, and lack of health information

and services—can compromise a young person’s prospects for a healthy reproductive life. Addressing these challenges is crucial, as the health, prosperity, and future population dynamics of the world largely depend on how effectively the educational and reproductive health needs of young people are met.

Challenges in Addressing Youth Reproductive Health

Young people represent the future workforce, parents, and leaders of society. Addressing their reproductive health needs goes beyond solving existing problems it requires investment in their potential, equipping them with knowledge, and 6 empowering them to make informed choices. However, many primary healthcare systems fail to adequately address the sexual and reproductive health needs of youth. A large number of young people lack access to vital health information and services, leaving them unable to make free and responsible choices regarding their reproductive health (United Nations, 1999). Young males, in particular, face reproductive health risks such as sexually transmitted diseases (STDs), including HIV/AIDS, and an increased risk of injury and illness. Many young people hold misconceptions about reproductive health, safe sex, fertility, and contraception, often receiving incorrect or misleading information. Additionally, negative attitudes toward contraception further exacerbate these issues. Therefore, effective youth-focused health programs must address not only service provision but also societal attitudes, community resistance, and widespread misinformation.

Changing Social Norms and Their Impact on Youth Behavior

In contemporary societies, unmarried youth are increasingly engaging in sexual relationships, even in cultures where such behavior is traditionally discouraged. This shift has social, demographic, economic, and health implications. Factors contributing to increased pre-marital sexuality in rural areas include: - Unemployment and economic challenges - Influence of mass media and digital technology - Erosion of traditional customs and social norms → - Improved nutrition and healthcare leading to earlier puberty - Delayed marriage age, extending the gap between sexual maturity and marriage The decline of the joint family system and the necessity for early employment also contribute to increased interactions between young men and women, raising the likelihood of high-risk sexual behavior.

Sexual Behaviour

The initiation of sexual activity, particularly among adolescents, is often unplanned, unguided, and unprotected. With the widespread use of mobile phones, the internet, and social media, adolescents are increasingly exposed to sexual content at an early age, which may lead to risky sexual behaviors, including unprotected sex and engagement in sexual malpractice. Such behaviors elevate the risk of unintended pregnancies and sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) infection. Unintended pregnancies, particularly among adolescent girls, often result in unsafe or illegal abortions, posing significant threats to maternal health.

REVIEW OF LITERATURE

Nunu et.al (2022), Lack of parental knowledge and skills in discussing SRH. Many parents feel unprepared to address these topics accurately, leading to reliance on fear-based messaging rather than factual education

Vincent, R., & Krishnakumar, K. (2022), In India, where cultural taboos restrict open discussions on SRH, digital platforms serve as alternative sources of knowledge

Kågesten, A., & van Reeuwijk, M. (2021), Social media often glamorizes risky sexual behaviors, influencing adolescent attitudes toward casual sex, unprotected intercourse, and multiple partners

Sexual health behavior and decision-making are influenced by a variety of biological, psychological, and sociocultural factors, with gender playing a significant role in shaping these dynamics. Research indicates that men and women often exhibit distinct patterns in sexual health knowledge, attitudes, and practices due to differences in socialization, cultural norms, and access to health services

Objectives of the Study

- To analyze the socio-economic and demographic profile of rural youth
- To explore the knowledge about sexual behaviour

This study adopts a descriptive research design to systematically examine Knowledge among Out of School Youth on Sexual and Reproductive Health: A Study in Chittoor District. The study was conducted in Chittoor characterized by low literacy rates and minimal urbanization. In Chittoor district, Vijayapuram and Yadamarrimandals were selected for each mandal selecting 3 villages i.e in Vijayapurammandal selected villages are Jagannadhapuram, Mangalam, Kaliambakam and in Yadamarrimandalselected villages are Jangalapalle, Patrapalle and Kotalam. To ensure representative and reliable data, the study targeted a total of 180 respondents, from each village selected 30 sample i.e total sample size is 180. Purposively chosen due to their socioeconomic challenges, limited healthcare access and traditional attitudes toward sexual and reproductive health (SRH). A multistage random sampling technique was employed to select the participants.

Table-1

Distribution of respondents by the Socio-Economic Conditions

Age of the respondents		No. of the Respondents	Percentage
1	15-17	55	30.5
2	18-20	56	31.4
3	21-23	69	38.1
	Total	180	100
Caste of the Respondents		No. of the Respondents	Percentage
1	OC	34	18.9
2	BC	73	40.6
3	SC	43	23.7
4	ST	30	17.0
	Total	180	100
Income of the Respondents		No. of the Respondents	Percentage
1	Below 10,000	75	41.7
2	10001-20000	55	30.7
3	20001-30000	35	19.3
4	30001and above	15	8.3
	Total	180	100

The above table shows that socio-economic conditions of the respondents. The age of the respondents i.e majority (38.1%) of the respondents belongs that, 21-23 age group, followed by 31.4% in the 18-20 years 54 category, and 30.5% in the 15-17 years group.

The caste data indicate that the majority of respondents belong to the Backward Classes (BC), comprising 41.0% of the total sample. Scheduled Castes (SC) form the second-largest group at 23.3%, followed by Forward Castes (FC) at 19.2%, while Scheduled Tribes (ST) constitute the smallest proportion at 16.5%.

The distribution of respondents based on their income levels, the findings indicate that a significant proportion (41.5%) of the respondents earn below Rs.10,000 per month, making it the largest income group. This is closely followed by those earning between Rs.10,001 and Rs.20,000, who constitute 31% of the total sample. A smaller proportion of respondents (19.6%) fall within the income bracket of rupees Rs.20,001 to Rs.30,000, while only 7.9% were earning above Rs.30,000 rupees per month.

Table-2

Distribution of Sexual behavior by Age among the out of School Youth

Sexual behaviour	Response	Age of the Respondents			Total
		15 to 17 years	18 to 20 years	21 to 24 years	
Have you ever had premarital sex	Yes	28 40.1%	14 20.9%	27 38.9%	69 38.1%
	No	27 24.4%	42 37.8%	42 37.8%	111 61.9%
If Yes, with whom	Girl Friend	0 0.0%	7 64.2%	4 35.8%	11 6.2%
	Relative	13 81.5%	0 0.0%	3 14.9%	16 8.7%
	Prostitute	3 41.2%	0 0.0%	5 58.8%	8 4.7%
	NA	38 26.3%	50 34.1%	57 39.6%	145 80.4%
Practicing Masturbation	Yes	28 34.1%	28 33.3%	27 32.7%	83 45.9%
	No	27 27.4%	29 29.8%	41 42.8%	97 54.1%
Are you Practicing	Oral Sex	15 21.7%	312 44.1%	24 34.2%	71 39.3%
	Anal Sex	39 36.1%	25 23.2%	45 40.7%	109 60.7%

The above table educates that, a significant proportion (38.1%) of youths reported having engaged in premarital sex, with the highest prevalence among the 15–17 age group (40.1%) and 21–24 age group (38.9%).

A notable having in the (38.1%) are willing to having premarital sex, a few (6.2%) of the respondents are girl friends particularly 21-24 age group, 8.7% are having relatives with premarital sex and very less (4.7%) are having is associate with prostitute.

Among those (45.9%) of the respondents are who had practicing masturbation and remaining (54.1%) are not practicing. It's indicates that nearly half of the respondents are practicing with similar percentage of all age groups.

It is noticed that, above half (60.7%) of the respondents are practicing anal sex, particularly 21-24 age group(40.7%).

Conclusion

This suggests that during late adolescence, there is greater exposure to reproductive health aspects, possibly due to formal education, peer discussions, or media influence.

This pattern suggests that socio-economic advantages linked to caste, such as better education and access to health resources, may contribute to differences in reproductive health awareness.

This indicates that financial status does not necessarily influence youth's awareness of reproductive health rights, suggesting that knowledge dissemination efforts may be reaching all income groups equally or that awareness is shaped more by education and social influences rather than economic background. Younger adolescents (15–17 years) are more vulnerable to coercion in sexual activities, with many experiencing unwanted sex through persuasion or deception. Additionally, risky sexual behaviors, such as multiple sexual partners and unprotected sex, increase with age. These findings emphasize the need for comprehensive sex education and targeted interventions to promote safe sexual practices, consent awareness, and accessible healthcare services for adolescents and young adults.

References

- **Goldman, J. D. (2013)**, International guidelines on sexuality education and their relevance to a contemporary curriculum for children aged 5–8 years. *Educational Review*, 65(4), 447-466.
- **Ivankovich, M. B., Fenton, K. A., & Douglas Jr, J. M. (2013)**. Considerations for national public health leadership in advancing sexual health. *Public Health Reports*, 128(2_suppl1), 102-110.
- **Tseng, Y. H., Hou, W. L., Kuo, S. H., Liu, Y. H., Wang, H. L., Hsiao, R. C., & Yen, C. F. (2021)**, Gender differences in how parents, peers, and exposure to sexually explicit materials influence the intention to engage in casual sex among adolescents and young adults in Taiwan: applying the theory of planned behavior. *International journal of environmental research and public health*, 18(24), 13089.
- **Kågesten, A., & van Reeuwijk, M. (2021)**. Healthy sexuality development in adolescence: proposing a competency-based framework to inform programmes and research. *Sexual and Reproductive Health Matters*, 29(1), 104-120.
- **Vincent, R., & Krishnakumar, K. (2022)**, School-Based Interventions for Promoting Sexual and Reproductive Health of Adolescents in India: A Review. *Journal of Psychosexual Health*, 26318318221089621.