YOUTH IN TRANSITION

SEXUAL HEALTH RISKS AMONG UNMARRIED YOUTH

Youth in Transition

Sexual Health Risks among Unmarried Youth

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Citation

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About Youth in Transition Study

India is one of the youngest countries in the world with around 28% of its population in the age group of 15-29. In recent years, the context of life of many young people especially in urban India is changing very rapidly. Urbanization, globalization and technological revolutions are leading to diverse impacts on people. Many young people are moving to cities in the pursuit of higher education and jobs and leading a relatively independent life. The age at marriage is increasing, especially in urban areas providing the youth more time and freedom to explore their sexuality. Increasing age at marriage, widespread availability of internet and social media, availability of spaces that are not under family surveillance and the desire to lead independent life are important aspects of social context of youth in neo-liberal urban India. In this changing context, it is essential to examine the choices young people make about their relationships and sexual intimacy, how these choices evolve over a period and how these choices are interdependent with other life domains. In order to address these issues, the Youth in Transition study was conducted, adopting a life course perspective.

The primary focus of the study was to understand the sexual health needs of never married youth.

The study focused on never married youth because, in Indian context, sex is often linked with marriage. The sexual health needs of unmarried youth remain unaddressed. We have taken a broader perspective of sexual health, beyond mere absence of diseases. We refer to sexual health as a state of physical, emotional, mental and social wellbeing in relationship to sexuality. Improvement in sexual health would require developing a positive and respectful approach to sexuality and sexual relationships as well as possibility of having pleasurable and safe sexual experiences free of coercion, discrimination and violence.

While premarital relationship is the commonly used term in the literature to indicate relationships before marriage, the term 'non-marital relationship' is preferred in this report because the participants do not consider many of these relationships as precursor to marriage. Non-marital relationships in the context of the study refers to relationships among never married youth.

Why life course perspective?

The current research literature on sexual intimacy before marriage in India is limited. The available literature mainly focuses on understanding 'proportion' of men and women who are sexually active (mostly defined as experiencing penetrative sex) and does not explain the context in which young people make their decisions and how these decisions evolve over a period of time. The Youth in Transition study adopted the life course approach to understand the dynamic process of decision-making of young people. A life course is defined as "a sequence of socially defined events (completing education, migrating to another place, starting a relationship, break-up, etc.) and

roles that the individual enacts over time". Life-course approach views developmental processes as a trajectory, which is shaped by multiple interacting factors, the interrelation of which is likely to change based on timing and sequences of life experiences and transitions. This approach enables understanding the continuity of life pathways by analyzing how behavior and experiences encountered during childhood and adolescence period may affect adult behavior and experiences. Such a diachronic understanding is essential to identify the patterns of behavior and for planning age and context appropriate interventions for improving sexual health of youth.

How was the study conducted?

The study was conducted among never married, educated youth living in Pune for at least 6 months prior to interview, and were between 20-29 years of age. Being in a relationship or being sexually active was not a criterion for participating in the study. Given the focus on understanding the trajectories and the difficulties of recruiting a random sample, a non-probability sample of participants who self-nominated themselves for the study and were fulfilling the eligibility criteria was included in the study. An appeal was made to young people living in diverse socio-economic and educational backgrounds to participate in the study. [please see **this link** for details of the study methodology].

The data on timing and sequencing of different events in the life of a participant was collected in the Relationship History Calendar (RHC). The RHC gathered quantitative information on monthly changes in the status with respect to various life events such as education, work experience, history of migration, staying arrangement, relationships, sexual behavior, substance use, mental health, etc. A separate form was prepared to collect data of each relationship to understand details of sexual behavior, contraception use and abusive experiences in that relationship. Data were retrospectively collected from age 10 until current age. Narrative interview technique, which encourages participants to share their story, was used to collect information on different events. The RCH with narrative interview technique has been shown to follow the process of memory recall and reduce recall bias. The participant and the interviewer had a side-by-side sitting arrangement so that the participant was able to see the calendar and could participate in filling it and ensure the correctness of the information collected. The study tools were prepared in Marathi and English language. Data were collected between July 2017 and Jan 2019. Data were analyzed using the principles of event history analysis, sequence analysis and group based trajectory modelling in SAS and R statistical software. After each interview, the interviewer noted down important details of the participant's story including some quotes that were felt essential to provide the context. The quotes used in the briefs are based on these notes.

The findings of Youth in Transition study are shared through research briefs focusing on specific thematic issues.

Sexual Health Risks among Unmarried Youth

"We (me and my boyfriend) met on a dating app. We both have been in previous relationships. I used to like him but he was not ready (for a serious relationship). We have clearly discussed that we will have a relationship without any emotional involvement. He does not like to use condoms. I also do not feel the need … I feel he is a safe guy. We have never really seriously discussed this topic (risk of HIV) as such." (A 24-year-old, heterosexual woman)

Background

One of the important aspects of sexual health is to have absence of sexually transmitted infections including HIV/AIDS. Higher vulnerability of young people in this context is well established[1]. Until now, however, the studies on risk taking sexual behaviors among Indian youth have largely been cross sectional in nature. The focus has been on questions such as how many young people engage in unsafe behavior (and therefore are at risk of acquiring HIV or STIs) and who they are (in terms of socio-demographic correlates). While this information is useful to make estimations about the size of at-risk population, it does not throw light on how these behaviors shape from adolescence to adulthood and the different behavioral patterns that affect the risk. This information is important to build appropriate behavioral interventions.

There is emerging global literature highlighting the importance of studying trajectories of sexual behavior over a period, as the risk is not static [1,2]. Those at risk at a certain time point can move into a 'not at risk' category and vice versa. Information on longitudinal patterns of risk taking behavior can improve our understanding about sexual health needs of youth. However, India specific information on this subject is very limited.

The present section seeks to understand the sexual health risks with specific emphasis on the risk of acquiring sexually transmitted infections/diseases including HIV. It describes the patterns of sexual behavior among unmarried youth - from adolescence through adulthood. It also describes the preparedness level of youth in terms of knowledge, risk perceptions and access to health care. The issues related to contraception, pregnancy and abortion are dealt with separately, in a subsequent chapter.

Methodology

Retrospective data about relationships and sexual behavior in each relationship was collected through a one-time interview. During the interview, the participants were asked to recollect their relationships sequentially starting from age 10 onwards until current age or other way round based on the participant's preference. Relationships that lasted for less than a month and more than one month were defined as short term and long term relations respectively. Timeline of each relationship was plotted separately on a time event calendar. A month was marked if a sexual encounter happened at least once in that month and frequency of condom use for that month was noted. If condom was not used every time, data on reasons for not using condoms was collected. HIV risk scores were calculated for each month, based on condom use and concurrent sexual partners. A risk score was assigned ranging from 1 to 4, as per the consistency of condom use ranging from 'always', 'most of the times', 'sometimes' and 'never', respectively. A score of 1 was added for each risky partner (defined as a partner with whom condom was not used always). Thus, the lowest risk score was 1 which meant in a given month there was only one partner and condom was always used. Data were analyzed using group based trajectory (GBT) technique, which is a statistical methodology [3] for analyzing developmental trajectories - the evolution of an outcome over age or time. The aim was to identify clusters of individuals with similar or distinct trajectories, and understand what factors account for their distinctiveness.

Using a separate set of questions, information on current level of knowledge about HIV/STI and protection self-efficacy was obtained. Participants were asked about HIV testing done in the past. Further, they were explained about self-testing of HIV and asked which choice they would take between self-testing and testing at a health care facility, if they were to do an HIV test. Further details about study recruitment, data collection and overall profile of the participants are provided in a separate document and can be accessed through [this link](#).

Participant profile

Total 1240 participants were enrolled in the study out of which 653 were men, 584 were women, and 3 participants marked their gender as 'other'. One of them mentioned that she (her preferred pronoun) is still questioning her gender identity and for the purpose of the research, her identity can be marked as woman. While we completely understand and support collection and analysis of gender identity data to reflect the diversity, because of the very small number of participants with other gender identity in the research, it was not possible to include a separate gender category in analysis. There was no apparent difference in the trajectories of participants with other gender identities compared to men and women. Therefore, an analytical category of gender with 655 men and 585 women was created.

The median age of the participants was 23 years. Majority of the participants reported to belong to the middle/upper middle class (81% men, 91% women). Average monthly family income between 21000-75000 was reported by 46% men and 41% women whereas above 75000 was reported by 28% men and 43% women. Majority of the participants had completed or were studying for graduation (55% men, 47% women) or post-graduation (21% men, 23% women) degree. Almost half of the participants (57% men, 50% women) were involved in remunerative work at the time of interview. Majority of the participants were born and lived in the city during their childhood whereas 38% of the men and 23% of women were born and at least had schooling (up to 10th) in village or town and later migrated to the city for higher education or work.
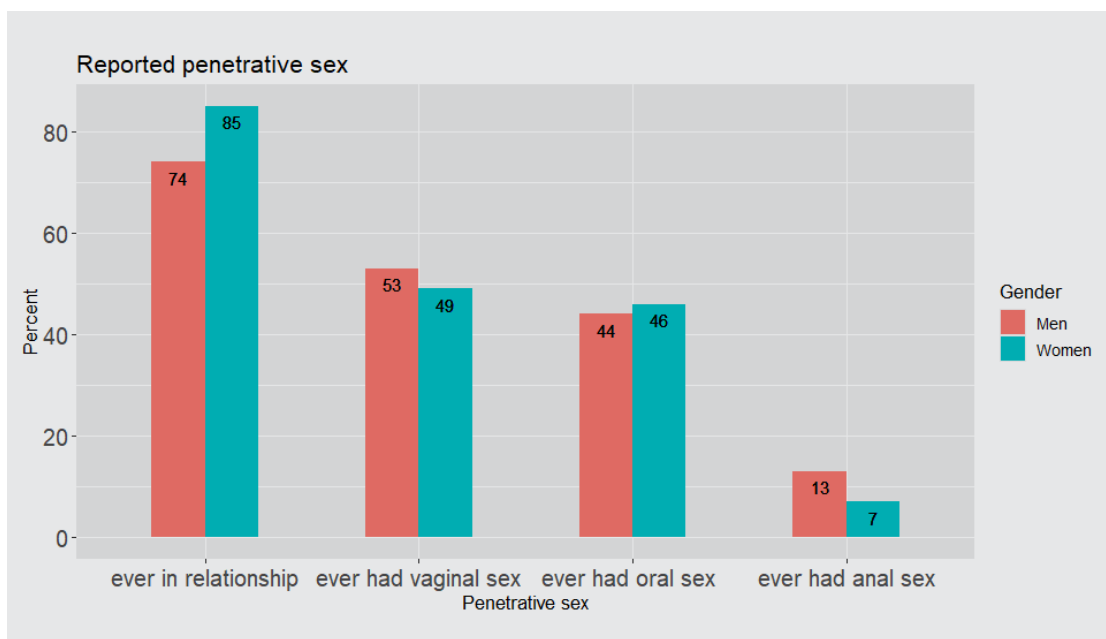
Of the 1240 (655 men and 585 women) participants recruited in the study, 271 (41%) men and 246 (42%) women reported to have ever engaged in vaginal and/or anal sex. Of these 65 men and 34 women reported having anal sex. Data of participants (n=517) who reported to have ever engaged in vaginal or anal sex was analyzed to assess HIV risk. To analyze for risk of STIs all three forms of penetrative sex (vaginal, anal, oral) were considered.

Descriptive and inferential statistics was used for data analysis. Data were analyzed using a SAS version 9.4. As these interviews adopted a biographical style of interviewing, we had encouraged interviewers to keep brief qualitative notes of each interview. We also referred to these notes, to interpret the quantitative data.

Findings

Young people had engaged in diverse sexual practices.
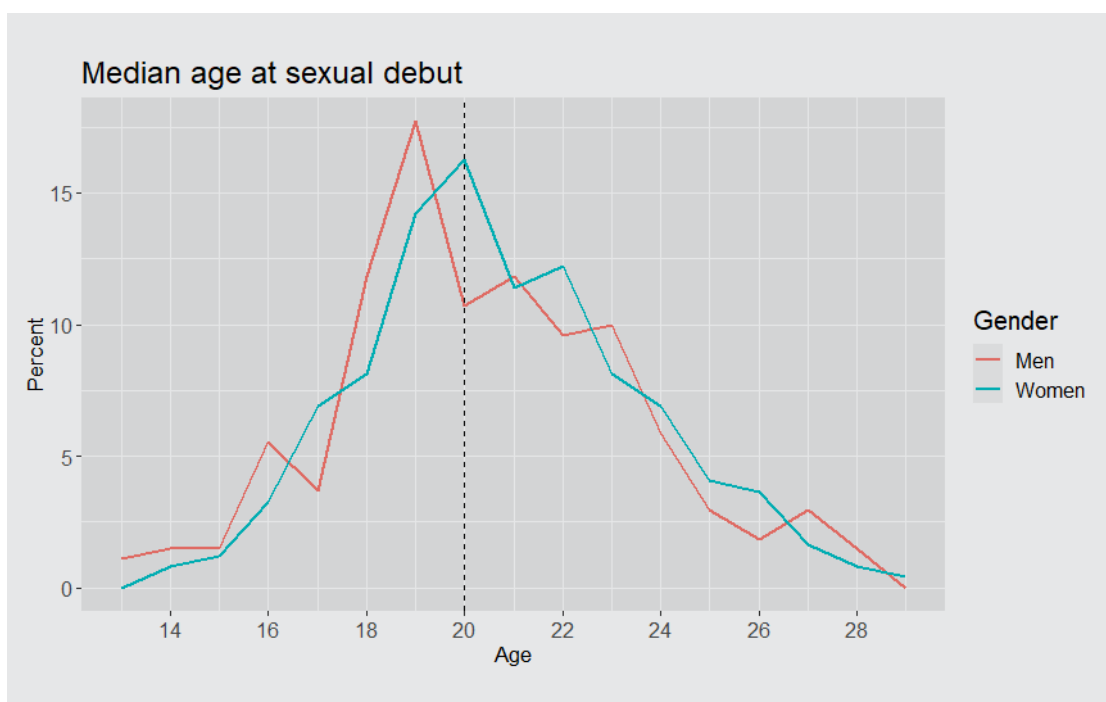
Figure 1: Reported penetrative sex

Majority of the young people who participated in the study (n=1240) reported heterosexual orientation (91%).

- A total of 984 participants (487 men and 497 women) ever had a relationship. Of these, almost half reported to ever have engaged in vaginal sex. Almost similar proportions were observed to engage in oral sex. (Figure 1)

- Around 9% men in heterosexual relations and 7% women reported to ever engage in anal sex.

Younger cohorts were more likely to have earlier sexual debut
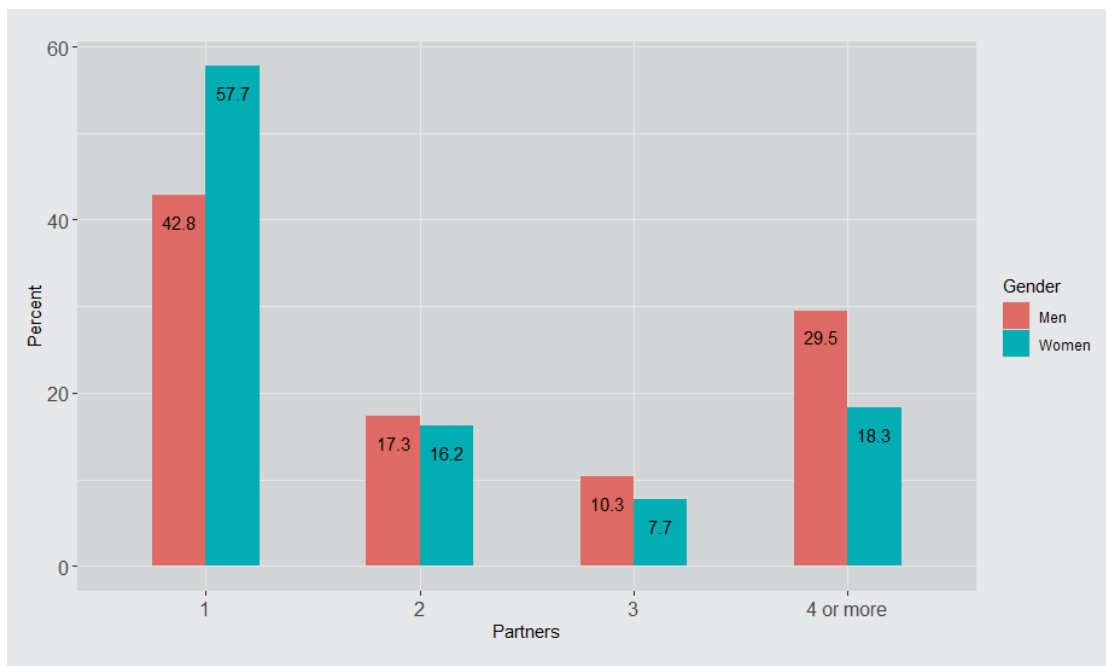
Figure 2: Median age at sexual debut

Summary of the analysis from the cohort of 517 sexually active participants:

- Thirteen percent of men and women were sexually active before the age of 18 years. These were not reported as abusive or forceful encounters.

- Ten percent of men and women had sexual debut at the age of 16 -17 years and a small minority (4% men and 2% women) had their first sexual encounter before 16 years of age.

- The median age at sexual debut was 20 years. The interquartile range was 19 to 23 years, i.e. 50% of the participants had sexual debut in this age range.

- The age at sexual debut was more likely to be below 18 years for the younger cohort (below 22 years at the time of interview). (21.6% vs 10.7%, p=0.003)

Sequential multiple sexual partnerships were common

Figure 3: Number of sexual partners over lifetime

- Fifty-seven percent men and 42% women had more than one sexual partner in their lifetime. These were mostly consecutive relationships.

- At least a quarter reported 4 or more partners over life-time.

- Higher proportion (50%) of people with non-heterosexual orientation reported 4 or more partners over life-time.

- More men (49%) had at least one short term sexual partner (relationship that lasted for less than a month) compared to women (27%). Among men who had short term sexual partner/s, 35.6% reported partner/s being a commercial sex worker.

The sexual encounters were intermittent in nature and happened in a context of secrecy

- The median age at sexual debut was 20 years. The median age at the time of interview was 24 years (IQR=22-26 years).

- The sexual encounters mostly happened intermittently, with long gaps in between.

- Majority of the participants did not disclose their sexual behaviors to family or friends. The behaviors happened in a context of secrecy. Lack of safe spaces to meet each other was a commonly spelled out concern by the participants.

The risk taking behaviors were dynamic, changing with time.
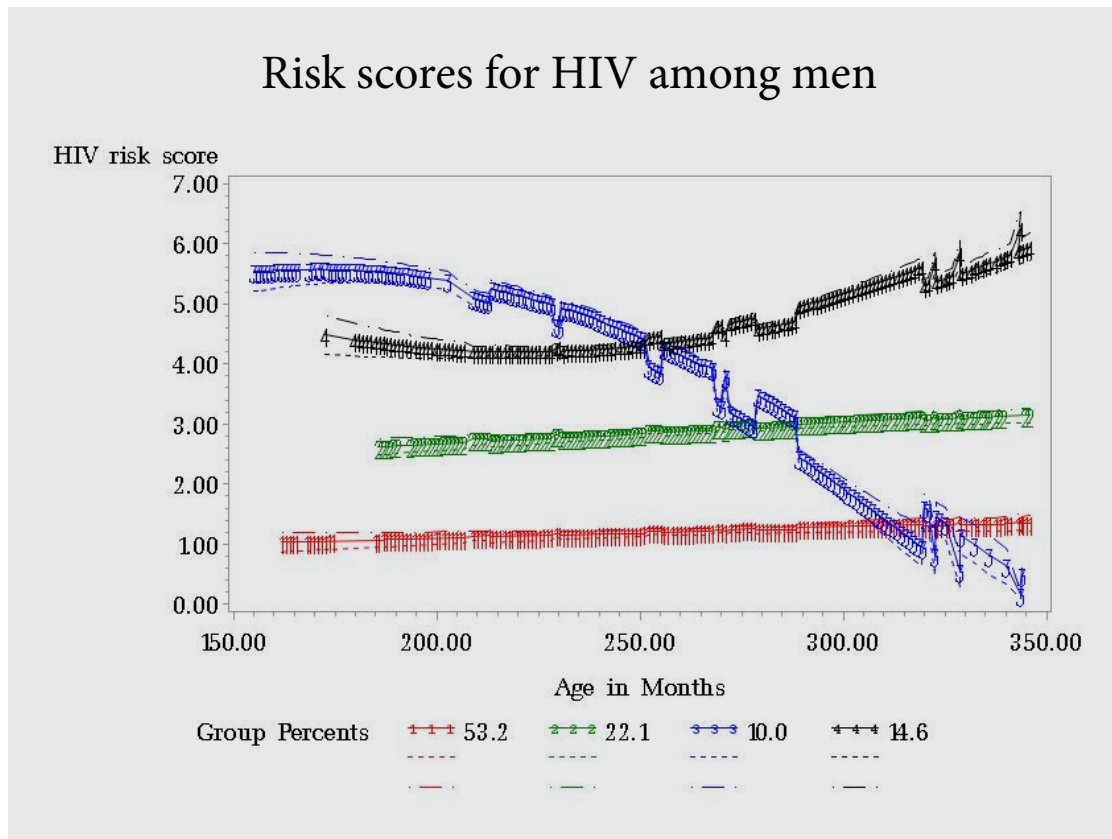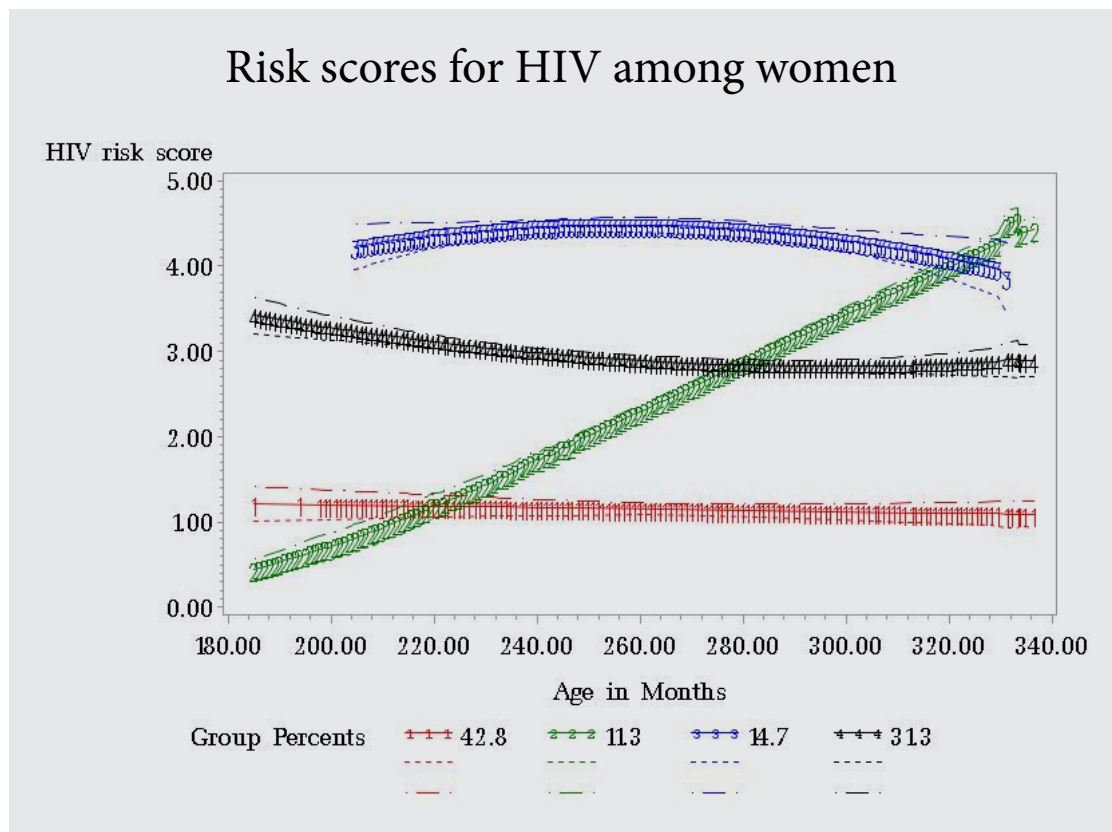
Figure 4: Risk scores for HIV among men

Figure 5: Risk scores for HIV among women

- Figure 4 and Figure 5 shows different trajectories of how HIV risk scores evolved from adolescence to adulthood in men and women. Each trajectory (denoted by a different color) is made up of clusters of individuals following similar sexual behaviors, in terms of the HIV risk associated with the behavior. Individuals engaging in safer sexual behaviors have lower HIV risk score (=1). Engaging in unsafe sexual behaviors (such as inconsistent condom use or no condom use, more than one concurrent partner) result in higher risk score.

- 53% men and 43% women had low HIV risk scores throughout. 22% men and 31% women had moderate level risk scores consistently.

- There were two trajectories each in men and women that indicated higher risk; however, the way the risk evolved differed across gender.

- 10% men had a very high risk score during adolescence but the risk declined during later ages (Declining risk – high to low); while 15% men had consistent high risk scores.

- Of the two high risk trajectories in women, in 11% the risk scores were low in early years but sharply inclined in later ages (Late rising high risk). And 15% had consistent higher risk scores.

The condom use was inconsistent, raising concerns about health risks

Table 1 – Relationship type and condom use pattern

		Long term relations	Short term relations
Total months during which sex was reported with one or more partner (n=11253)		9967	1549
Consistency of condom use	Always	4195 (42.09)	1037 (66.95)
	Most of the times	2787 (27.96)	340 (21.95)
	Some times	1415 (14.2)	63 (4.07)
	Never	1395 (14)	109 (7.04)
	Mixed pattern*	175 (1.7)	0

*   If for a particular period there was more than one partner and condom use pattern was different across concurrent partners, it was defined as mixed pattern

- Condom use was inconsistent in a substantial proportion of monthly observations.

- The pattern changed as per the length of relationship. The use was consistent for short relations that lasted for less than a month. In longer relationships, only 40% monthly observations accounted for consistent condom use.

- Similar pattern was seen in both genders.

- In majority of cases, condom was not used during oral sex. The risk of HIV is extremely low through oral sex. But the risk of transmission of other sexually transmitted infections (such as gonorrhea, syphilis) is high.
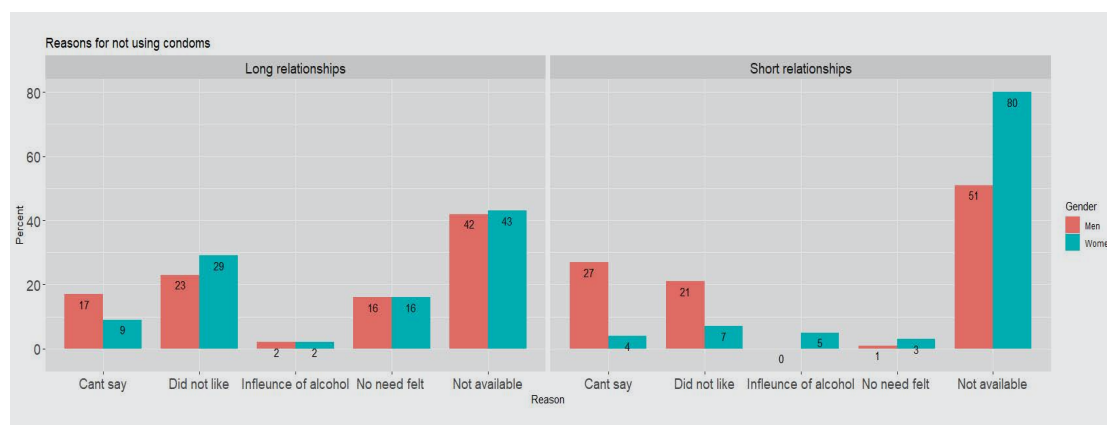
The inconsistent condom use was driven by lack of preparedness given the unplanned nature of sexual encounters, norms around pleasure and perceived low risk of HIV.

The inconsistent use of condoms could not be explained by level of knowledge alone. A number of factors contributed to unsafe behaviors.

Knowledge about HIV, receipt of sexuality education in school had no impact. More than 80% participants in the study cohort had adequate knowledge about HIV transmission through vaginal sex. It is likely that this has contributed to high proportions of 'ever use of condom' observed in the study cohort. However, it did not correlate with consistent use.

'Unavailability of condoms at the time of act' was reported as a dominant reason for inconsistent use. The accompanying graph provides the understanding of the various reasons reported, when condom was inconsistently used / never used. In the area where this study was conducted, condoms are widely available through public health facilities as well as many other outlets such as pharmacies, 'pan or cigarette' shops. Despite this, one of the prominent reasons for condom non-use was 'unavailability of condoms'. The unplanned nature of the acts is one of the likely explanations. A person is less likely to be prepared to carry condom when possibility of sex is not anticipated or cannot be discussed upfront.

Figure 6: Reasons for not using condoms

- Prevailing norms about condom use played an important role. It was commonly felt that condoms reduce pleasure, which affected condom use.

- Poor risk perception was another factor that led to inconsistent use of condoms. The risk perception of HIV was very low in this cohort. Only 20.6% men and 13% women had ever thought that they could be at risk

of HIV (p=0.005). People with non-heterosexual orientation had higher risk perception. The risk perception appeared to have links with group identities rather than risk behaviors.

- The fear of contracting HIV/ STI did not figure in the narratives; however, there was considerable fear about pregnancy. Young people assessed the risk of the partner based on his/her educational background, occupation, family background etc. The perceived risk was high if partner was a sex worker and that reflected in consistent condom use. However, the same was not necessarily true, if the partner was a friend or a known person. For example, a participant said,

> *"I met this guy only once, through a friend. I generally use condoms with my partners, but this one time I did not use it. He was a handsome guy from a good educated family. I thought he must be safe."*
> *(A 27-year-old homosexual man)*

Stigma and secrecy limited the abilities of youth to adopt protective behaviors.

The access to condoms was further hampered by perceived challenges in accessing condoms.

- 35.4% women and 10.3% men found it difficult to procure condoms from a chemist or health care provider (p=<0.01).

- Similarly, a third of participants (32.8% men and 34.14% women, p=0.45) found it difficult to carry condoms.

- The disadvantage was further exaggerated for people coming from a rural background. The gender gap was evident, with women being at a higher disadvantage.

The uptake of HIV testing was poor

- Only 33% men and 16% women had ever got themselves tested for HIV. Men reporting non-heterosexual orientation (76%) were more likely to have tested themselves, compared to those with heterosexual orientation. The uptake was low, despite risky behaviors in the past.

- The willingness to test for HIV was asked at the end of interviews. The testing was made available at the study site at subsidized cost. A total of 262 (57% women and 44% men) people showed willingness to test. Of these 9.9% women and 6.6% men availed HIV testing services on the day of their interviews.

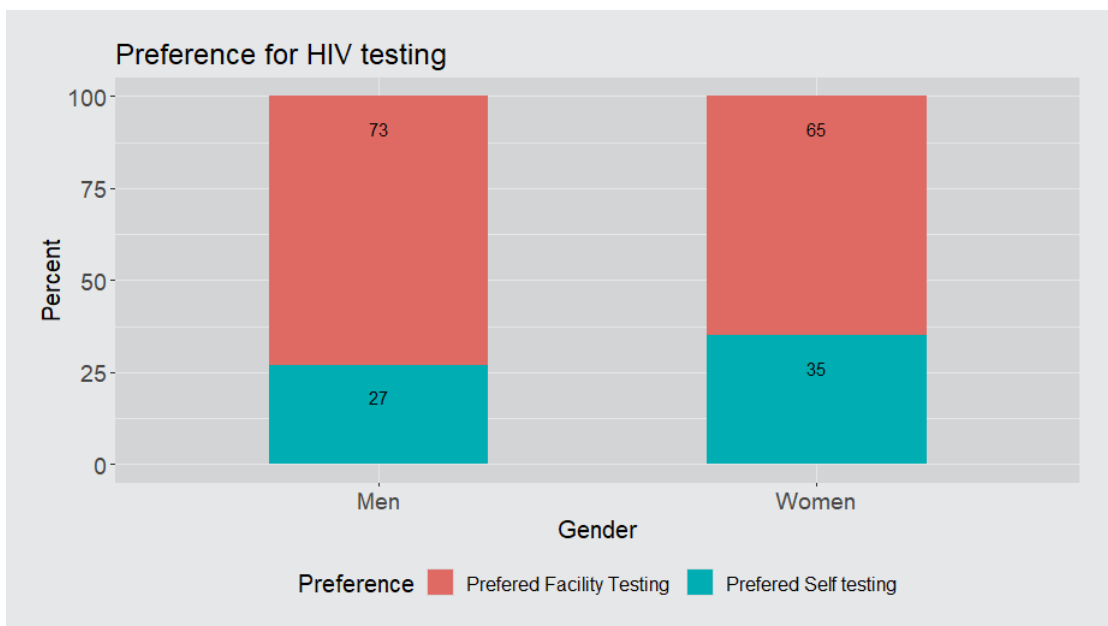**The acceptability of self-testing was higher in women compared to men**

A third of participants preferred for self-testing over testing at a health care facility.

- Women (35.2%) were more likely to opt for self-testing compared to men (26.6%) (p value- 0.04).

- The acceptability was higher (although not statistically significant) among gay people and those who reported to have perceived themselves at risk of HIV.

The most common reason why participants preferred self-testing over testing at a health care facility was fear of stigma and breach of confidentiality by health care providers. Self-testing was perceived to be more convenient. The reason for not opting self-testing was low confidence of performing the test and concerns about accuracy. They felt that the guidance from health care providers is essential to interpret the results.

Figure 7: Preference for HIV testing

Summary

The present study was done in a homogenous group consisting of urban, educated, middle class. Majority reported heterosexual orientation. Sequential multiple sexual partnerships was a norm in this cohort. Younger age people were more likely to have early sexual debut. A subsection engaged in 'high risk' behaviors. Within this subsection, the way the risk behaviors evolved from adolescence to adulthood was not homogenous. There were stark gender differences. The higher risk taking was seen during early age (adolescence) among men. As against, in women, the period of higher risk was marked during later ages (25 onwards). A smaller subsection of both genders had higher risk over the entire age spectrum.

The HIV risk was mainly driven by inconsistent use of condoms. Concurrent partnerships were uncommon in this cohort. The secretive context in which sexual behaviors happened led to unplanned sexual acts which negatively impacted condom use. The HIV related risk was assessed based on identity (eg. socio-economic status) rather than behaviors. Stigma and secrecy limited the abilities to procure condoms or

carry condoms. Owing to 'low risk' perception, motivation to get tested for HIV was poor. Self-testing was perceived to be more convenient and preferred for fear of stigma and breach of confidentiality by health care providers. The reason for not opting for self-testing was low confidence of performing the test and concerns about accuracy.

The study cannot comment on size or proportions of at-risk populations, as it is purposive in nature. Also, the findings are applicable mainly to middle class educated urban unmarried youth. However, it indicates their possible vulnerability to acquire HIV/STI. The primary focus of the study was to understand more about the nature of risk-taking sexual behaviors among unmarried urban youth. It brings out a nuanced, longitudinal understanding of HIV related risks among youth.

Implications and way forward

There are early indications of emergence of at-risk subgroups within the conventionally defined low risk general population.

The Indian HIV epidemic is concentrated in nature. The infections are concentrated in conventionally defined high risk groups (men having sex with men, sex workers, transgenders, migrants etc.). Youth from the general population are typically considered to be a 'low risk' population. However, recent evidence from India points at a changing picture. For example, trend data of PMTCT (prevention of mother to child transmission) program from western Maharashtra shows increasing sero-discordancy (woman HIV infected, husband HIV uninfected) in young married pregnant women during the last decade. It indicates changed HIV transmission dynamics and increased vulnerability of young women from the general population to acquire HIV[4]. In another study, it was observed that districts with attributes such as urbanization, population size and density, higher levels of literacy, better socio-economic status, late marriages had positive correlation with consistent high HIV prevalence[5]. The study raises concerns about increased vulnerability of urban youth to HIV and STI. The heterogeneous patterns observed in the current study echo these concerns. It highlights that youth from the general population is not a homogenous entity. There are subgroups that have heightened HIV risks which must be reached out to.

Young unmarried people from general population is an important group that needs to be reached by HIV prevention programs

The national HIV program considers adolescents and young adults as one of the priority populations[6]. The program focuses on young people from 'high risk' groups. However, educated unmarried youth from the general population remains less attended to in current HIV programs. The HIV programs need to devise appropriate strategies to reach the at-risk subgroups within the larger general population of youth. Looking at the mere size of youth population, rapidly scalable low cost options need to be considered. Use of technology can be very useful in this regard. Sexuality

education needs to be expanded beyond schools at varied platforms such as colleges, workplaces, youth groups etc. Its content needs to be more comprehensive. Beyond information, it also needs to focus on improving abilities.

The HIV / STI prevention efforts need to focus on increasing self-efficacy to adopt safe sex practices

The study findings show that improving knowledge is a necessary but not sufficient step towards HIV/STI prevention. There are difficulties in interpreting and applying scientific knowledge in real life. HIV preventive behaviors can be better interpreted through 'motivation-opportunity-ability' framework. The youngsters need supportive interventions that will help them assess their risk, build their skills to negotiate safer sex and take an informed choice. The motivation and ability to negotiate are crucial, especially in the given context of stigma and unequal gender norms. The interventions to promote condom use as well as HIV testing need to incorporate these elements.

Stigma is a major hurdle in accessing sexual health services, especially for unmarried youth and needs to be addressed

The national health program is committed to providing equitable, non-discriminatory SRHR services to all, irrespective of their marital status and sexual orientation. However, the larger social unacceptance of premarital and non-hetero sexual behaviors impedes access to services. The societal attitudes get reflected in attitudes of care providers resulting in stigma and discrimination, be it healthcare providers or providers from other sectors such as police, legal aid systems. The efforts to reduce stigma and discrimination in health care systems need to be embedded in larger efforts aimed at society in general.

Self-testing can be a promising option for strengthening linkage of youth to HIV cascade of services.

The HIV testing uptake remains low despite wider availability of HIV counseling and testing services in the country. As per recent national family health survey, among sexually active never married youth, only 6.6% women and 3.3% men had tested for HIV[7]. The major reasons are low risk perception and fear of stigma & discrimination by healthcare providers. The acceptability of self-testing was found to be fairly good in current study. The groups bearing highest burden of stigma, such as unmarried women or people with non-heterosexual orientation, show higher acceptance. The option of self-testing can be explored for these groups. Improving risk perceptions of youth would be essential to improve their access to self-testing. Experts from the field have often expressed concerns about negative implications of self-testing (such as suicide, self-harm etc.) Such adversities can be minimized by providing immediate access to support mechanisms. Digital technology can play an important role in this.

Increasing trend of early sexual debut has implications for POCSO

In the present study, the majority of the sexual encounters happening before age 18 were consensual. However, in a setting where age at sexual consent is 18 and above, these behaviors become unlawful. The requirement of mandatory reporting by service providers can have devastating consequences for youngsters. It can greatly impede the timely access to psycho-social and medical services. The legal and care and support systems need to take cognizance of these nuances.

Acknowledgements

References

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List of research briefs from the Youth in Transition Study

1. Relationship Patterns and Dynamics among Unmarried Youth
2. Sexual Health Risks among Unmarried Youth
3. Contraceptive Use and Unwanted Pregnancies among Unmarried Youth
4. Abuse in Non-Marital Relationships
5. Experiences and Impact of Childhood Sexual Abuse among Unmarried Youth
6. Sexuality and Mental Health Issues among Unmarried Youth

All the research briefs and detailed methodology of the Youth in Transition study is compiled in a report, which can be accessed through [this link](#).

Publications and resources based on insights from the Youth in Transition Study

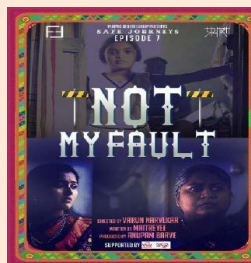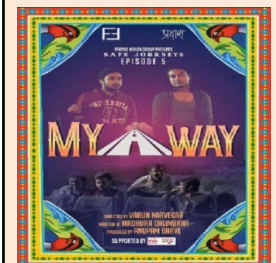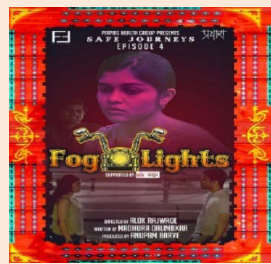*The Wire Marathi Article Series*

The findings of Youth in Transition Study were shared through a series of articles written in a Marathi news portal, The Wire Marathi. Click the title of the articles to read more.

1. युवकांना स्थित्यंतरात समजून घेण्याचा 'प्रयास'
2. 'सिरीयस', 'कॅज्युअल' आणि जातीची जाणीव
3. नाती, नात्यांच्या कल्पना आणि अदृश्य दबाव
4. लैंगिक अत्याचार आणि आपण सर्व
5. लैंगिक अत्याचाराचा लपलेला चेहरा
6. लैंगिकता आणि नैराश्य
7. संमतीची जाणीव- नेणीव
8. सेक्स आणि इज्जत का सवाल
9. सेक्स आणि जोखमींचे जोखड

Safe Journeys- A Web Series

The web series is based on the insights from the Youth in Transition study and is created with the aim of increasing young people's ability to deal with issues related to sexuality. The series of eight videos can be accessed from Safe Journeys web page and through Prayas Health Group's You Tube channel