MEETING REPRODUCTIVE AND SEXUAL HEALTH INFORMATION NEEDS OF ADOLESCENT GIRLS IN A COMMUNITY SETTING

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I. RATIONALE

Adolescence, the second decade of life, is a powerful formative period of transition from childhood to adulthood. It is one of the most crucial phases in the life of an individual. Between the age of 10-19 years, many key biological, social, economical, demographic and cultural events occur that set the stage for adult life. What happens during adolescence, good or bad, shapes how boys and girls live out their lives as men and women – not only in the sphere of reproduction, but in social and economic realm as well. Yet, in spite of its specific relevance for human development, until recently, the needs of adolescents have not been given due priority in policy and program in several countries.

In India, policy interest in the health and health information needs of adolescents began to grow after ICPD (International Conference on Population and Development) held in Cairo in 1994 called for specific efforts by governments and civic society to understand and meet these needs. Owing to rapid demographic transition, the number of adolescents in the country is increasing fast (though their proportion in total population may decline due to declining fertility level). It is also noted that, today, adolescents are maturing early and are healthier than ever in the past. Further, they are better educated, have a greater access to information, more disposable income. They also have greater freedom to mix with the opposite sex and are keener to live a free life-style than the earlier generations. Their involvement in premarital sexual activities has also increased. It is feared that in most circumstances it has increased their vulnerability to HIV infection, unwanted pregnancies and has led to conflict with the contemporary social values.

Several factors contribute to the adolescents' vulnerability. These range from social, economic, cultural, geographical and political conditions of wider society, to those characterizing living conditions of adolescents including parents to child communication, opportunities to learn/acquire life skills, family education, income, etc. For example, one of the resulting factors is lack of appreciation for the information needs of adolescents on reproductive and sexual health (RSH) matters. In early adolescence (10-15 years), young people experience many physiological changes and need guidance, emotional and social support from parents to cope with these changes. However, parents either do not recognize and appreciate these needs or find themselves ill equipped to provide the guidance. A large number of parents do not even approve of such counseling due to a fear that it may lead to free sex behaviour among adolescents. In wider society, very limited opportunities and space is available to adolescents to acquire learning on these issues. The school-based interventions are just beginning, too limited and too far placed. Social institutions are almost non-existent. On the other hand, westernization has diluted societal hold on taboos governing premarital sex relationship. The consequences are obvious. Studies have indicated that among adolescents the level of awareness for RSH matters is very low, and whatever little they know is largely superficial. It is generally acquired from friends, peers, and pornographic literature, and is full of myth and non-scientific facts (Jeejeebhoy; 1996). On the other side, there is evidence that adolescent indulgence in sexual activities, physical, emotional or social has increased (Goyal; 2004).

Adolescent girls (between 10 and 19 years of age) comprising nearly one tenth of the country’s total population are particularly vulnerable. Discrimination against the girl child in education, nutrition etc., is heightened in adolescence. Poverty forces families to withdraw young girls from schools. Lack of education and employable skills make young girls vulnerable to sexual exploitation as gender bias recognizes

only two productive roles for women-housework and sex. Traditional and pervasive gender inequalities, lack of knowledge and negotiation skills place girls at a particular disadvantage in their ability to choose when, with whom, and under what conditions to have sexual relations and exercise their rights to safer sex.

Apparently, one of the major contributing factors to the vulnerability of adolescents to HIV/AIDS, unwanted pregnancies etc., is lack of scientifically appropriate knowledge on these and related issues. The term, **"lack of knowledge"**, is used here in a wider context incorporating lack of sources of information, enabling environment to seek information and skills to use the information. At policy level in India, these gaps have been recognized only now *(National Rural Health Mission; 2006)*. However, there is a dearth of culturally appropriate gaps in our understanding about sustainability of interventions and taking these (from a project mode) to scale.

The author of this paper has carried out an operations research study to understand the dynamics of premarital sex behaviour among adolescent girls, their vulnerability to HIV/AIDS, unplanned pregnancies and other sexually transmitted infections. This study has also attempted to assess the information and health needs of adolescent girls in relation to sexual and reproductive health matters and to meet these needs through a health education and health promotion programme. This research was sponsored by the Ministry of Health and Family Welfare, Government of India, and was carried out in Ajmer district of Rajasthan (India) during 2001-2004. This paper discusses the process and major findings of this study.

II. OBJECTIVES

The main objectives of this paper are as follows:

1. To examine the perception and attitude of school-going and out-of-school adolescent girls towards issues related to reproductive and sexual health and sexuality.

2. To analyze the premarital sex behaviour among adolescent girls with a focus on its social, psychological and cultural constructs and attributes.
3. To assess the information and health needs of adolescent girls the sphere of reproductive and sexual health, HIV/AIDS.
4. To analyze the process and inputs provided to meet the reproductive and sexual health information needs of adolescent girls.
5. To assess the outcomes of the interventions and their efficacy for scaling-up

The study covers school-going as well as out-of-school adolescent girls in the age group of 13 to 19 years.

As the objectives indicate, the project activities were carried out in three phases: a base line study, an intervention phase, and an assessment of outcomes. The findings are presented in the same sequence.

III. THE BASE LINE STUDY

III.1 Study Methods

This study is based on qualitative and quantitative data collected from rural and urban areas of *Ajmer* district of *Rajasthan (India).* Of the 8 blocks in the district, two blocks, *Ajmer* and *Kishangarh,* were randomly selected for investigation. In these two blocks, the data were collected from 16 localities of which 8 were urban and remaining 8 were rural. Schooling status of adolescents was used as the main stratification variable in the selection of respondents.

The following sampling design was used to draw the sample:

To select the respondents (adolescent girls) on the basis of schooling status, a relevant sampling frame was needed. However, none of the existing data sources provided information on the number of

adolescents in a household, particularly their school-going status. It necessitated development of a sampling frame. As a part of this exercise, in 16 study localities, 4990 households were mapped. This exercise indicated that there were 2142 boys and 1860 adolescent girls in the 16 study units. Of these, 62 percent of boys and nearly half (49.14 percent) of girls were attending schools. To draw a sample large enough for a meaningful analysis, a 33 per cent of these girls (25 from every study unit) were selected for study using a systematic random sampling procedure. Care was taken to select equal number of school-going and non-school going girls. This paper is based on the analysis of responses received from these 614 adolescent girls. For qualitative data, 8 FGDs (focus group discussions) and an equal number of case studies were carried out. Pre-structured study tools were used to collect the data.

III .2 Findings of Baseline Study

A range of socio-economic, cultural and environmental factors could influence the premarital sex behaviour of adolescent girls. In this paper, some of these variables, believed to have a greater significance from the research and programme perspective, are discussed. Further, for drawing the sample of adolescent girls, their schooling status was considered as a stratification variable. Therefore, it is used as the main dichotomization/ intermediate variable for analyzing the interrelationship/influence of other variables on premarital sex behaviour of adolescent girls.

III.2.1 Premarital Sex Relationships: Table 1 presents the trend in premarital sex relationships among adolescent girls with respect to schooling status.

Table 1: Level of premarital sex relationships among unmarried adolescent girls

	School Going			Not Attending School			Total		
	Have sex relations	Did not have sex relations	Total	Have sex relations	Did not have sex relations	Total	Have sex relations	Did not have sex relations	Total
Number	63	298	361	80	173	253	143	471	614
Percent	17.45	82.55	100.0	31.63	68.37	100.0	23.28	76.71	100.0

Table 1 reflects that, of 614 unmarried adolescent girls interviewed, as many as 143 (23.3 percent) had sex relationships. It also indicates that the proportion of girls having premarital sex relationships was significantly larger in out-of-school category than the school-going one. In the context of socio-cultural milieu of contemporary Indian society, particularly when adolescents hails from a relatively less developed region, so many girls conceding about their sex relationships reflects the extent of dilution of social taboo about the premarital sex relationship. It is large enough to match with the pattern observed in large metros of the country. Studies carried in other parts of India supplement these observations.

Survey of school and college students in contemporary India indicates that although among them the extent of premarital sex relationships is not as large as in western countries, it is not as small as perceived by many. Studies indicate that 25 per cent of male students in a Delhi school (Sehgal, Sharma and Bhattacharya; 1992) and 28 percent of male college students in Hyderabad have had premarital sex experience. It is noted that premarital sexual relationships are relatively more common (reported) among men than women, although there could be an element of over-reporting by males and under-reporting by females. Typically, fewer than 10 per cent of young women reported premarital sexual experience, while a higher range (15–30 per cent) was observed among young males (Jejeebhoy 2003; Savara and Sridhar 1993).

III.2.2. Features of Premarital Sex Behaviour: Very few studies have reported about the partners or other features of premarital sex behaviour among girls. In the present study, the sex partner of the sexually active girls was either a friend (58.7 percent) or a relative (37.1 percent). Further, first time it happened incidentally only (63.6). Only 12. 6 percent girls observed that they were coerced into it. However, the periodicity of involvement in sex relationships was relatively low. During a six-month period prior to survey, three-fourths of these girls had had only one or two sex encounters. The extent of multi-partner sex relationship was also low (9.6 percent).

III.2.3. Socio-economic Correlates of Premarital Sex Behaviour: Table 2 analyses interrelationships between certain background characteristics of adolescent girls and premarital sex experience in the context of their schooling status.

Table 2: Premarital sex relationships among adolescent girls with respect to schooling status, age, residence and employment

	School Going			Not Attending School			Total Respondents		
	Have had sexual Relation	Did not have sexual relation	Total	Have had sexual relation	Did not have sexual relation	Total	Have had sexual Relation	Did Not Have sexual relation	Total
Age (in years)									
N	**63**	**298**	**361**	**80**	**173**	**253**	**143**	**471**	**614**
<= 13	00.0	21.8	18.0	00.0	12.7	8.7	00.0	18.5	14.2
14 – 16	22.2	58.1	51.8	22.5	60.1	48.2	22.4	58.8	50.3
17 – 19	77.8	20.1	30.2	77.5	27.2	43.1	77.6	22.7	35.5
Mean Age	**17.5**	**15.0**	**16.0**	**17.5**	**15.6**	**16.2**	**17.5**	**15.3**	**16.1**
Place of residence									
Urban	76.2	52.3	56.5	46.3	55.5	52.6	59.4	53.5	54.9
Rural	23.8	47.7	43.5	53.8	44.5	47.4	40.6	46.5	45.1
Currently working for livelihood									
Yes	4.8	2.0	2.5	30.0	24.3	26.1	18.9	10.2	12.2
No	95.2	98.0	97.5	70.0	75.7	73.9	81.1	89.8	87.8

The analysis shows that girls involved in premarital sex activities were relatively older than other girls. It suggests that among unmarried women, sexual debut occurred in late adolescence. Similar evidence is noted in other studies also (Savara and Sridhar 1993). Schooling status of girls, did not show any association with the age at initiation in to sexual activities. Further, involvement in premarital sex activities was relatively a higher among urban residing girls. Over three-fourths of school-going sexually active girls were urban residing. Among non-school going girls, proportion of sexually active girls was relatively higher (but marginally only) in rural areas. The data also indicate that a larger proportion of employed girls were involvement in sexual activities than other girls. But as only 12 per cent of adolescent girls were gainfully employed, this evidence may not be conclusive.

II.2.4. Gender Discrimination and Premarital Sex Relationship: It has been argued that adverse family circumstances, such as discrimination in the provision of love and affection, access to education, food, health care (in short gender discrimination) etc., could induce several adolescent girls into sexual activities. However, available evidence indicates otherwise.

Table 3. Premarital sex relationships among adolescent girls with respect to schooling status and gender discrimination in the family

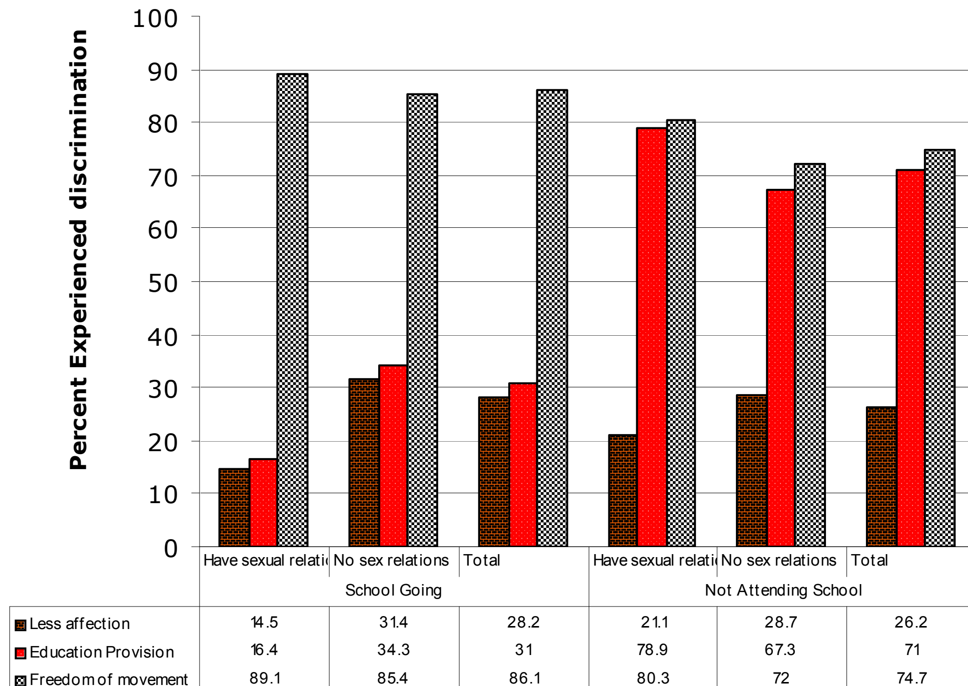
	School Going			Not Attending School			Total Respondents		
	Have had sexual relation	Did not have sexual relation	Total	Have had sexual relation	Did not have sexual relation	Total	Have had sexual relation	Did not have sexual relation	Total
Experienced discrimination in the family									
N	**63**	**298**	**361**	**80**	**173**	**253**	**143**	**471**	**614**
Yes	87.3	80.2	81.4	88.8	86.7	87.4	88.1	82.6	83.9
No	12.7	19.8	18.6	11.3	13.3	12.6	11.9	17.4	16.1
Type of discrimination *									
N	**55**	**239**	**294**	**71**	**150**	**221**	**126**	**389**	**515**
Less affection	14.5	31.4	28.2	21.1	28.7	26.2	18.3	30.3	27.4
Education opportunities	16.4	34.3	31.0	78.9	67.3	71.0	51.6	47.0	48.2
Freedom of movement	89.1	85.4	86.1	80.3	72.0	74.7	84.1	80.2	81.2
Nutrition	3.6	7.9	7.1	4.2	5.3	5.0	4.0	6.9	6.2
Sports and Leisure	3.6	3.8	3.7	1.4	00.0	0.5	2.4	2.3	2.3
Health care	00.0	0.8	0.7	1.4	0.7	0.9	0.8	0.8	0.8

* multiple response

Table 3 shows that a large majority of adolescent girls reportedly experienced discrimination in the access to parental love and affection, education, sport and entertainment opportunities, health and nutrition care. This perception cut across the schooling status also. The proportion of girls reporting experiences of discrimination was almost equal in school going and out of school categories. Further, in general, perception of discrimination did not seem to have any influence over the premarital sex behaviour of adolescent girls. Even though the proportion of girls reporting discrimination was somewhat higher among sexually active girls, it was not statistically significant. However, analysis of the data with respect to specific areas of discrimination indicates that lower access to parental love and affection did cast a shadow over the premarital sex life of adolescent girls. Interestingly it was not in the expected direction. Relatively fewer sexually active girls (than other girls) experienced discrimination in the parental love and affection. It means that premarital sex relationships may not be guided by retaliation motive. However, it is

only a suggestive inference. We do not have enough Indian research to support it.

Gender Discrimination In The Family & Involvement in Premarital Sex Relationships



	Have sexual relati	No sex relations	Total	Have sexual relati	No sex relations	Total
	School Going			Not Attending School		
Less affection	14.5	31.4	28.2	21.1	28.7	26.2
Education Provision	16.4	34.3	31	78.9	67.3	71
Freedom of movement	89.1	85.4	86.1	80.3	72	74.7

II.2.5. Impact of Peer Behaviour: Peer behaviour is known to have a significant influence over the perception and attitude of people. It is particularly more significant in adolescent age group, when boys and girls are relatively more receptive to these influences. Data indicate that a larger number of peers of sexually active girls were also maintaining sex relationships. More one fourth of friends of sexually active girls had physical relationships with boys, whereas among other girls this proportion was 1.5 percent only. It is a classical example of the role of peer influence in promoting premarital sex relationships.

II.2.6. Impact of Exposure to Media: In the present day context, among other things television has increasingly been recognized as a source of inspiration for a carefree life style particularly among youths. It is held that programme and serials shown on TV have a long lasting effect on the behaviour of youths. Table 4 assesses the impact of

exposure to TV and other source of media on premarital sex behaviour of adolescent girls.

Table 4. Premarital sex relationships among adolescent girls with respect to schooling status and exposure to media

	School Going			Not Attending School			Total Respondents		
	Have sexual Relation	Did Not Have sexual relation	Total	Have sexual Relation	Did Not Have sexual relation	Total	Have sexual Relation	Did Not Have sexual relation	Total
Frequency of watching television*									
N	**63**	**298**	**361**	**80**	**173**	**253**	**143**	**471**	**614**
Every Day	87.3	69.5	72.6	48.8	49.7	49.4	65.7	62.2	63.0
Minimum 3 days in a week	7.9	17.8	16.1	20.0	22.0	21.3	14.7	19.3	18.2
<= 1 day in a week	3.2	7.7	6.9	13.8	11.0	11.9	9.1	8.9	9.0
Never	1.6	5.0	4.4	17.5	17.3	17.4	10.5	9.6	9.8
Frequency of reading popular magazines*									
Regularly	46.0	33.6	35.7	8.8	4.6	5.9	25.2	22.9	23.5
Some times	39.7	34.2	35.2	11.3	13.3	12.6	23.8	26.5	25.9
Rarely	6.3	16.8	15.0	6.3	4.0	4.7	6.3	12.1	10.7
Never	7.9	15.4	14.1	73.8	78.0	76.7	44.8	38.4	39.9
Ever scanned any pornographic literature									
Yes	36.5	2.7	8.6	37.5	3.5	14.2	37.1	3.0	10.9
No	63.5	97.3	91.4	62.5	96.5	85.8	62.9	97.0	89.1

* multiple response

Table 4 indicates exposure to television and readership of popular magazines was significantly higher among school going girls than other girls. But it did not have any influence over premarital sex behaviour of adolescent girls. Exposure to pornographic literature however had a significant some influence in this respect. Girls having access to pornographic magazines had a higher involvement in premarital sex relationship. But it could be vice versa also.

II.2.7. Expression of Sexuality and Premarital Sex Relationship:

People express their love, affection and sexuality in different ways. Some people communicate it by holding hands, some express it by kissing, some by touching genital organs and some believe in sex relationship. The level of premarital sex relationship among adolescents could a reflection of their perception about love and sexuality. Table 5 examines this critical inter relationship.

Table 5: Ways of expressing sexuality and Premarital sex relationships among adolescent girls with respect to schooling status

	School Going			Not Attending School			Total Respondents		
	Have sexual Relation	Did Not Have sexual relation	Total	Have sexual Relation	Did Not Have sexual relation	Total	Have sexual Relation	Did Not Have sexual relation	Total
Perception about ways of expressing sexuality *									
N	**63**	**298**	**361**	**80**	**173**	**253**	**143**	**471**	**614**
Holding hands	98.4	95.6	96.1	100.0	93.6	95.7	99.3	94.9	95.9
Kissing	98.4	94.3	95.0	100.0	91.3	94.1	99.3	93.2	94.6
Touching sexual organs	98.4	72.1	76.7	100.0	67.1	77.5	99.3	70.3	77.0
Sexual relation	98.4	54.4	62.0	97.5	43.9	60.9	97.9	50.5	61.6
Others	1.6	3.0	2.5	1.3	1.7	1.2	00.0	2.5	2.0
Have ever expressed sexuality by* …..									
Holding hands	98.4	18.8	32.7	100.0	27.7	50.6	99.3	22.1	40.1
Kissing	98.4	13.4	28.3	100.0	23.7	47.8	99.3	17.2	36.3
Touching sexual organs	98.4	5.0	21.3	98.8	13.9	40.7	98.6	8.3	29.3
Sexual relation	100.0	00.0	17.5	100.0	00.0	31.6	100.0	00.0	23.3

* multiple responses

As Table 5 shows, adolescent girls had a fairly liberal attitude about ways of expressing the sexuality. As many as 95 percent girls would hold hands or kiss their partner, over three-fourths may touch genital organs and nearly 62 percent enter into sex relationships. As expected, this attitude has manifested in their behaviour. This perception and behaviour was so overwhelming that it also cut across the schooling status of adolescents.

I1.2.8. Awareness about Means of Protection against Pregnancy, HIV/AIDS and Involvement in Premarital Sex*:* It is held that if a particular behaviour is perceived as risky, few people may indulge in it. On the other hand, knowledge of means of protection may make people bold. How far do these perceptions hold ground in case of adolescents, particularly when the issue being examined is sex life? Table 6 examines these against the backdrop of schooling status of girls.

Table 6. Premarital sex relationships among adolescent girls with respect to schooling status, and awareness for means of protection against pregnancy, HIV/AIDS.

	School Going			Not Attending School			Total Respondents		
	Have sexual relation	Did not have sexual relation	Total	Have sexual relation	Did not have sexual relation	Total	Have sexual relation	Did not have sexual relation	Total
Awareness for preventive measures for HIV/AIDS*									
N	**63**	**298**	**361**	**80**	**173**	**253**	**143**	**471**	**614**
Abstinence	69.8	41.9	46.8	27.5	13.3	17.8	46.2	31.4	34.9
Use condom	82.5	46.3	52.6	28.8	14.5	19.0	52.4	34.6	38.8
Avoid/ reuse of injection syringe	88.9	57.7	63.2	33.8	24.9	27.7	58.0	45.6	48.5
Use of safe blood	82.5	54.4	59.3	30.0	19.1	22.5	53.1	41.4	44.1
Be faithful	88.9	50.7	57.3	32.5	21.4	24.9	57.3	39.9	44.0
Knowledge about safe sex*									
Abstinence	1.6	1.3	1.4	00.0	0.6	0.4	0.7	1.1	1.0
Use condom	17.5	5.0	7.2	1.3	4.0	3.2	8.4	4.7	5.5
Be faithful	69.8	40.3	45.4	70.0	27.2	40.7	69.9	35.5	43.5
Avoid sex with CSWs	11.1	8.4	8.9	12.5	17.3	15.8	11.9	11.7	11.7

* Multiple response

The table shows that relatively a larger proportion of sexually active girls were aware of HIV/AIDS and its preventive measures. A similar pattern was observed with respect to the knowledge of safe sex practices also. A larger proportion of sexually active girls were aware of the methods of safe sex than the other girls. Here it can be argued that a better understanding of the risk of HIV/AIDS and its preventive measures could have encouraged young girls to indulge in sex relationship. However, available evidence are not large enough to confirm it. As observed earlier, other factors also had a strong influence on the behaviour of adolescents in this respect.

I1.2.9. Observance of safe sex practices*:* Though a large proportion of sexually girls had knowledge of preventive measures of HIV/AIDS, relatively a smaller proportion knew about the condom.

Little more than half of sexually active girls were aware of preventive use of condom against HIV/AIDS (overall it was close to 40 percent). Further, when it comes to adoption, the gap between knowledge and practice was alarmingly large. Only 10.4 percent of sexually active girls reported use of condom during the last sexual act. School-going girls were wiser in this respect with a condom use level of 16.6 percent against 6.4 percent among other girls. Interestingly, in more than 86 percent cases, condom was used as a protection against pregnancy only. Apparently, in spite of a higher level of awareness of HIV/AIDS and its preventive measures, adolescents continue to practice unsafe sex. It shows that either the adolescent girls lacked conviction to adopt safe sex options or were not able to negotiate for its use.

III. CONCLUSIONS OF BASELINE STUDY:

From the above analysis, it can be inferred that premarital sex relationships were no longer a taboo among Indian adolescent girls living even in villages or small towns. The level of premarital sex relationships in these areas is as large as in large cities or metros. Urban residing, out-of-school and employed girls had a larger involvement in premarital sex. It was observed that social pressures for normative behaviour are relatively diluted in these groups. At the micro level, peer image and behaviour emerged as most significant influencing factors in promoting premarital sex relationships. Exposure to television is almost universal. Therefore, its selective influence over premarital sex behaviour could not be established. Though gender discrimination does not seem to have any influence over the level of premarital sex among adolescent girls, there is evidence that girls endowed with parental love, affection and faith are more inclined to have sex relationships.

The level of awareness for safe sex, source of spread of HIV/AIDS and its preventive measures is large. Sexually active girls were particularly better informed about these. But this knowledge was not put to

effective use. Apparently, either the adolescents did not have complete knowledge (as assumed initially of preventive measures against HIV/AIDS or lack conviction to use these. It could also be linked to lack of easy access to condom and ability to negotiate for its use.

This research makes a strong case for bridging the gaps and strengthening the capabilities (of adolescents) for adoption of safe sex practices, particularly the use of condom to reduce the vulnerability to HIV/AIDS and unwanted pregnancies.

IV. HEALTH EDUCATION AND HEALTH PROMOTION INTERVENTIONS

IV.1. On the basis of the findings of base line study an intervention module has been developed. Its main objectives were as follows.

- To create an enabling environment for effective implementations of interventions and to enable adolescents practice the learning acquired

- To undertake health education and health promotion programme to meet information and health needs of adolescents on issues related to reproductive and sexual health

IV.2. The intervention strategy was build with following components:

- Creation of an enabling environment- *dialogue with community leaders, parents, health care providers.*
- Identification of peer leaders of adolescents
- Formation of dialogue groups
- Group /Dialogue meetings- *structured discussion on pre-determined issues with the help of flip charts, video films, experience sharing*
- Diffusion of knowledge through peers
- Individual and group counseling
- Referral to health care facilities
- Exposure visits
- Cultural and sports events

The target group included adolescent girls (13 -19 yrs.), parents of the adolescents, teachers, community leaders and local health care providers.

IV.3. The interventions were designed across the following issues.

- Growing up concerns, problems affecting adolescents
- Physiological and body changes, reproductive system and organs
- Nutrition and personal hygiene
- Gender concern, social values and roles
- Sexuality, high risk behaviour, safe sex
- Planned parenthood and methods of family planning
- Reproductive and sexual health, RTI, STI and HIV/AIDS

A separate module was developed on every issue. It included basic information, discussion points and frequently asked questions. The handout of every module was shared with the participants in the group meeting.

IV.4. The intervention/education tools included: dialogue, experience sharing, reading material, video films, drawing and painting contests, question-answer sessions and debate, cultural programme, exposure visit, exchange visit, individual/group counseling and referral to health care providers.

The interventions activities were carried out four urban and four rural localities.

IV.5. As a part of intervention process the following activities were carried out.

- **Creation of enabling environment-**

1. Interaction with the gate keepers in the community: As a part of this exercise, interactions were held with local leaders, members of panchayats, civic bodies etc. A total of 40 persons were approached for this purpose.
2. Interactions with parents were held in group meetings. Separate meetings were held with fathers and mothers. A total of 160 parents participated in these meetings.

- **Identification and interaction with local health care providers**

For developing a network of user friendly health care services, local public sector health care were oriented with the strategy of the project and expectations from them. A referral system was build to enable easy access of adolescents to these health care services. Twenty health care providers participated in the study.

- **Interaction with school teachers**

  To facilitate interventions among school-going adolescents' teachers of local schools were oriented with the objectives and activities being carried out under the project. A total of 40 teachers participated.

- **Interaction with adolescents-**

  Interactions with adolescents were held in group setting. Independent groups were formed in every locality. The size of a group was restricted to 15 persons. Every group met once a week for 14 weeks. During these meetings discussions were held on the modules developed for bridging knowledge gaps on SRH and related issues. The participants discussed the modules in the interactive mode to facilitate internalization. Project counselors facilitated the dialogue. After completion of one cycle, new groups were formed and the same procedure was repeated. Three cycles of interventions formed were held with the participation of 400 girls.

- **Exposure visits, cultural, religious and sport activities**

  Participants were taken for exposure visits; they also participated in other activities organized for this purpose.

- **Counseling**

  Individual and group counseling was provided to address the specific problems of the adolescents.

- **Referral to health care facilities**

  Adolescents in need of specific health care intervention were identified and referred to pre-identified institutions to seek appropriate care. Involvement of public sector institutions provided sustainability to the interventions.

- **Diffusion of knowledge**

  Issues discussed in the dialogue sessions were widely diffused through peers. Over 2000 girls have indirectly benefited through these interventions.

- **Monitoring and reporting**

  Activities were reviewed at the monthly meetings with the counselors. The performance was reviewed after every cycle of activities.

V. ASSESSMENT OF OUTCOMES

V.1. Objectives: The main objective of this end of project evaluation was to assess the changes in knowledge, attitude and behaviour of adolescent towards reproductive and sexual health matters. It was also aimed at assessing the efficacy of intervention module.

V.2. Sampling Design: A case-control design was adopted for this study. Area covered in the base line survey but not in the interventions was treated as control area. Four intervention and four non-intervention sites were randomly selected for the study purposes. Both quantitative and qualitative data were collected. A systematic random sampling procedure was used to draw the sample for quantitative data and focus group discussion (FGD) and case studies methods were used for collecting qualitative data.

The sample size for different categories of respondents was as follows.

A. Intervention area:

Girls-80; Parents-20; Leaders-20; Teachers-20

B. Non-intervention area:

Girls-80

V.3. Findings: The preliminary findings of this assessment were as follows:

- Interactions with the community leaders and parents helped in creating an enabling environment for interventions with adolescents. Most of parents and leaders had two issues.

Firstly, there was the fear that information provided could be misused by the adolescents and may encourage premarital sex relationships. Secondly, they found themselves poorly equipped with knowledge and vocabulary to educate adolescents

- On the SRH matters. To overcome these concerns, orientation sessions were held with the parents and whatever was to be taught to adolescents was shared with parents. It has not only allayed their concerns but converted them into great supporters of intervention program.

- Creation of an enabling environment for intervention encouraged large participation from girls. Parents, particularly mothers, motivated their daughters to participate in the dialogue sessions. Nearly 400 girls have directly participated in the project activities. Drop out from the program was almost negligible.

- Interventions have greatly facilitated in developing understanding on all the major aspects of reproductive and sexual health.

- A comparison between knowledge for family planning methods in intervention and non-intervention areas reflect large gains in knowledge. Gain in the knowledge on sources of spread and preventive measures against STI and HIV/AIDS was also impressive. There was a greater appreciation of the use of condom as a protection against HIV/AIDS and other sexually transmitted infections.

- Misconceptions about virginity and conception have greatly reduced in the project area.
- There was a very interesting fall out of the intervention in terms of greater closeness between the sexes.

  After the interventions, the level of physical closeness and sex relationships increased among the girls. It baffled the researchers because it was contrary to the assurance given to the parents and gatekeepers in the community. However, on further investigations, it was noted that it was linked to greater confidence among girls to own their physical closeness with boys. (*It may be noted that during the base line survey, a large proportion of adolescents had declined to respond to this question.)*. It is also possible that armed with more knowledge about safe sex methods, indulgence in sex relationship increased. But as increase in extent of sex relationships was very small, this argument does not hold.

- There was a significant improvement in the usage of condom during sex relationships. In intervention areas, n*early half of*

sexually active girls used condom during their last sexual act. In non-intervention areas this proportion was 0 percent.

- Reference to medical care facilities was availed by a small proportion of girls (less than 10 per cent) only. (*To some extent the programme factors could be responsible for the underutilization of this facility. The referral institutions(Government) could not provide appropriate services to the girls referred to them.*

(Note: A DETAILED STATISTICAL ANALYSIS IS BEING CARRIED OUT TO VALIDATE THE RESULTS. THE RESULTS WILL BE MADE AVAILABLE FOR FINAL TEXT OF PAPER.)

Lessons Learned :

- Adolescent boys and girls have a large unmet need for knowledge on issues related to reproductive and sexual health. The extent of physical closeness and sex relationship (with boys) among adolescent girls living in rural and urban areas of Ajmer, is as large as observed in metros or other large cities in India.

- The communication strategy, i.e. group dialogues in a community setting has proved to be effective. It has helped adolescents in internalization of learning and building their negotiation abilities. The community setting has helped in creating a normative environment for adoption of safe sex practices.

- The issues taken up for interaction (along with SRH matters) during group dialogue with adolescents particularly the growing up concerns, nutrition and personal hygiene, social values and roles, gender equality etc., met their information needs in a holistic manner. It has helped in allaying their social and personal concerns to a large extent.

  However, it is noted that interventions would be more beneficial for the adolescents, if the issues like parents to children communication, personality development and stress management are also covered.

- Programme initiatives for adolescents, particularly on sexual and reproductive health issues, have a higher possibility of success, if the community fears are allayed at the beginning and it is actively involved in the program activities.

- Health care system and service providers are less sensitive to the needs of adolescents. Programme inputs are required to build their sensitivity and capacity in this respect. Interventions for adolescents should always attempt to respond to their felt needs. These could be easily woven in the design of the programme.

- Diffusion and adoption of new knowledge is rapid among adolescents. It helps in creating interest in interventions and enabling environment.

- Ownership of programme should rest with adolescents.

References

1. Jejeebhoy, S.J. (1996). Adolescent sexuality and fertility, Seminar, vol.447, pp.16- 23.
2. Jejeebhoy, Shireen J. (1994). Adolescent sexual and reproductive behaviour : a review of the evidence from India. Unpublished report, Mumbai.
3. Jeejeebhoy, Shireen J and Sebastian Mary Philip (2003): "Actions that Protect: Promoting sexual and reproductive health and choice among young people in India", Regional Working Paper ,Population Council, New Delhi.
4. Murthy, M.S.R. (1993). Sex Awareness among Rural Girls. New Delhi: B.R. Publishing Corporation.
5. Nag M, (1995) Sexual behaviour in India with risk of HIV / AIDS transmission, Health transition review, Suppl: 293-305.
6. Nag, Moni. (1996). Sexual Behaviour and AIDS in India. New Delhi: Vikas Publishing House Pvt Ltd.
7. Seghal, Virendra, A.K.Sharma and S.N. Bhattacharya (1992). K.A.B.P, study on AIDS among school.
8. Savara M, Sridhar CR,(1994). Sexual behaviour amongst different occupational groups in Maharashtra, India and the implications for AIDS education, Indian journal of social work., 55(4): 617- 32.