ARSH BASELINE STUDY OF ADOLESCENT GIRLS BY ABSSS, CHITRAKOOT (UP)

April 2017

ABSSS-CHILDFUND India project: Bargarh (Chitrakoot, UP) By Akhil Bhartiya Samaj Sewa Sansthan (ABSSS)
Bharat Janani Parisar
Village & GP- Ranipur Bhatt,
Post Office- Chitrakoot Dham (Sitapur);
District- Chitrakoot (U.P.)
INDIA 210204
E-mail:
absss2883pm@gmail.com;
abssckt@gmail.com
Website: www.absss.in;
www.bundelkhandinfo.org.in
Tele.No. - 05198-224025;
Mob. No: +91-9415310662

Introduction

This document is a report of a baseline study of adolescent girls in select villages of 11 gram panchayats (GPs) of Bargarh cluster of Chitrakoot district, in the Bundelkhand region of Uttar Pradesh (UP). The girls and the villages are covered under a multidimensional development project initiated by **Akhil Bhartiya Samaj Sewa Sansthan (ABSSS), a reputed NGO headquartered in Chitrakoot, with support from ChildFund India (CFI).**

One of the project dimensions is improving the health and self-confidence of adolescent girls. This objective is sought to be achieved through an initiative called ARSH (adolescent reproductive sexual health), which covers girls who are 'enrolled' under the CFI project in the Bargarh cluster and are in life-stage 2 (LS-2) and LS-3.

The specific expected outcomes of ARSH are:

- Adolescent girls are confident on menstrual hygiene management (MHM) and sexual reproductive health (SRH) issues.
- Adolescent girls become change agents in a supportive environment for adoption of MHM, SRH and hygiene practices.
- Adolescent girls adopt use of sanitary napkins.
- Adolescent girls have improved SRH status.

A study was undertaken in December 2016-February 2017, to understand the baseline knowledge, perceptions, and practices of adolescent girls in relation to the above-mentioned outcomes. The present report is the output of this study.

Objective

The objective of the study was to generate baseline data related to ARSH outcomes, so that:

- Planned activities of the initiative can be given appropriate direction and focus; and
- The impact of the ARSH initiative could be measured and analyzed at appropriate stages.

Scope

The study covered 312 adolescent girls who are enrolled under the project. Information was gathered from the girls on the following broad heads:

- Age, religion
- Puberty status
- Literacy and schooling status
- Working status

- Participation in youth groups
- Knowledge about physical changes that occur during adolescence
- Knowledge about menstruation before attaining puberty
- Following of traditional practices during menstruation
- Problems faced during menstruation
- Basic hygiene practices
- Knowledge about reproductive tract infection (RTI), sexually transmitted diseases (STD) and HIV/AIDS
- Exposure to information about contraception
- Sources of health services used, and purpose and nature of services used.

Methodology

Data was generated by administering a detailed questionnaire in Hindi. The questionnaire was pilot tested before it was finalized. Female field investigators were given proper orientation to administration of the questionnaire. Respondents were given the option of not answering any or all of the questions. The data was collated, checked and analyzed using basic statistical tools. Findings were reviewed against findings of comparable studies.

Limitations

The study covered 'sensitive' topics which are not discussed openly in the target community, and across India generally. Hence, a significant percentage of respondents chose not to answer some questions, or they reported that they did not know the answer.

Profile of respondents

The respondents live in 40 villages of 11 GPs of Bargarh cluster. The distribution of respondents by GP is given in the table below. (Distribution of respondents by village is according to number of enrolled girls in each village).

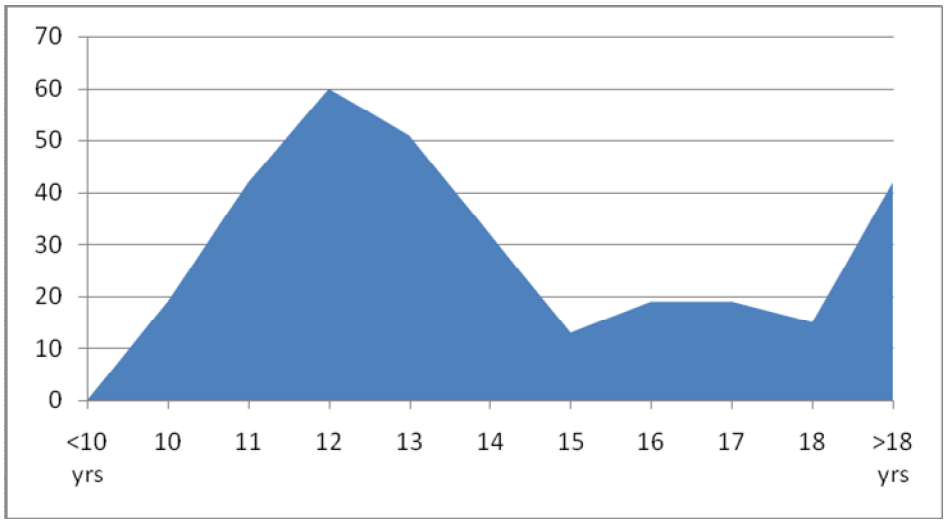
Table 1: Distribution of villages by GP and respondents by GP

No	Gram panchayat	No of villages	No of respondents
1	Dondiya	2	19
2	Kolmajara	5	30
3	Kalchiha	3	7
4	Koniya	3	25
5	Bojh	7	42
6	Semra	2	18
7	Gahur	2	15
8	Bargarh	7	55
9	Goiya Kala	5	56
10	Turgawan	2	18
11	Khohar	2	27
Total		40	312

Almost all the respondents (95.5%) are Hindus; the remaining are Muslims.

The distribution of respondents by age is shown in figure 1. As can be seen, most respondents (around 60%) were 11 to 14 years old. Nearly 15% were above the age of 18 years.

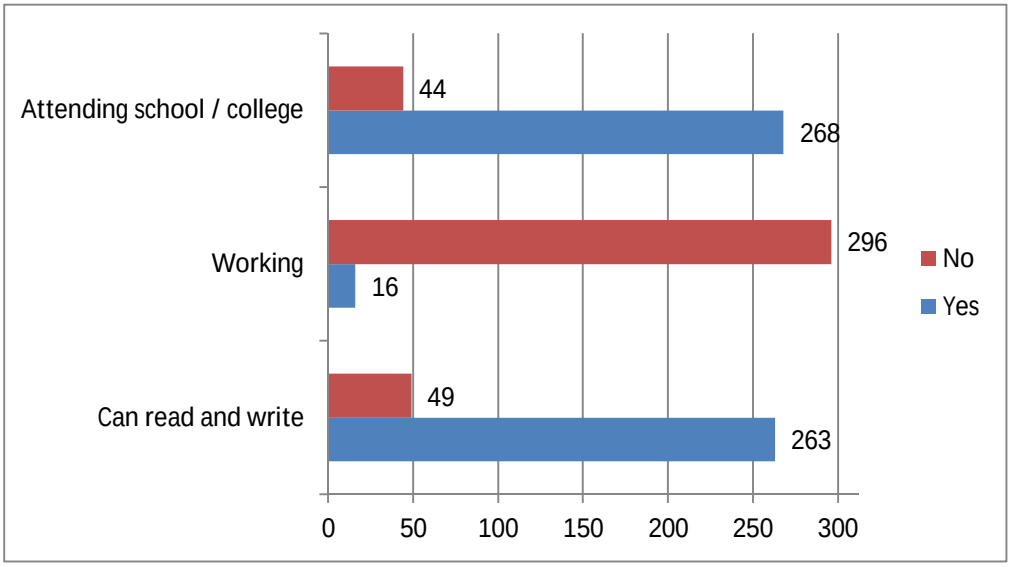
Figure 1: Distribution of 312 respondents by age



Education and working status

As figure 2 shows, 268 (85%) respondents are attending school, but around 49 (15%) cannot read or write and probably for this reason, around the same number of respondents do not currently attend school or college. Almost all the other respondents are in upper-primary school. Only 16 (5%) respondents are working.

Figure 2: Education and working status of 312 respondents



The ability of the 15% girls, who have dropped out of formal education, to access and use health information, is severely constrained, and unless remedial measures are taken to build their basic literary and numeracy skills, the disadvantage would be long-lasting and severe.

Respondents' knowledge and practices: key findings

Before discussing the key findings related to respondents' knowledge and practices related to ARSH outcomes, it would be useful to consider the findings of comparable studies.

Findings of comparable studies

From a national perspective, relevant findings are available under the head of 'Awareness of sexual and reproductive health matters' in the *Youth in India: Situation and Needs 2006-2007* report of the International Institute for Population Sciences, Mumbai (2010). The data, collected from urban and rural areas of six states (other than Uttar Pradesh), indicates that (Chapter 8):

- Only 46% of rural women in the age group of 15-24 years had correct, specific knowledge of at least one modern method of contraception.
- Only 14.4% of above category of women had heard of STIs.
- While 65% of women of this category had heard of HIV/AIDS, only 22.3% had 'comprehensive knowledge' on this topic.
- Less than 10% of women of this category had correct knowledge on all the conditions under which abortion is legal.
- Nearly 50% of women of this category had never received information on sexual matters from any source. Among those who had received information, the most common sources of information were a friend/neighbour or the mass media.
- However, 75% of women of this category perceived education on family-life/sex to be important.

A significant observation made in the report is that health-care providers, teachers and family-members were "infrequently and inconsistently" cited by respondents as sources of information on sexual matters, though it is assumed that these are more reliable sources of information on these matters than peers or the media.

Another relevant study is *growing up in rural India: An exploration into the lives of younger and older adolescents in Madhya Pradesh and Uttar Pradesh* by K.G. Santhya, Shireen J. Jejeebhoy, Iram Saeed and Archana Sarkar (The Population Council, 2013). The study covered married and unmarried girls aged 10–19 years from poor households or households belonging to socially excluded groups (scheduled castes, scheduled tribes, Muslim) in selected villages of Rewa and Satna districts of Madhya Pradesh (eight villages), and Allahabad and Banda districts in Uttar Pradesh (eight villages). The researchers reported that:

- Trusted mentors with whom girls could discuss personal problems were largely restricted to family members, and even so, the extent to which girls had been able to discuss personal matters with a family member was uncertain. Access of girls to non-family, trusted mentors was considerably more limited than access of boys. Membership in any organised group was nonexistent among girls and boys, and married adolescent girls were far more socially isolated than their unmarried counterparts.
- Only one-third and two-fifths of older (15 to 19-year-old) adolescent girls had the main say in decisions on personal matters.
- Young adolescents unanimously reported that they were not informed about the physical changes that occur during adolescence. Awareness of sex and pregnancy matters among older adolescents, likewise, was limited. The fact that a woman can get pregnant at first sex was known only to 19% of girls aged 13–14, and 53% of girls aged 15–19.
- Awareness of contraceptives was more widespread than awareness of sex and pregnancy matters; even so, it was far from universal.
- Awareness of HIV/AIDS was also limited particularly among girls: only one-quarter (27%) of girls reported that they had heard of HIV/ AIDS. Further, what they knew about HIV/AIDS was far from comprehensive.

The above findings suggest that awareness-levels among respondents of the present study can be expected to be low, particularly as the study area falls in a 'backward' region. The findings of the present study are briefly presented below.

Reported puberty status

While girls generally attain puberty at the age of 10-11 years, and 94% of respondent girls are 11 years old or older, nearly 45% of them reported that they had not yet attained puberty. It is possible that as many respondents are unwilling to discuss physiological changes undergone during adolescence (discussed below), they are unwilling or unable to identify signs of puberty.

Knowledge about physiological changes at adolescence

Respondents were given the option of identifying one or more physiological changes that occur at adolescence. Significantly, two-thirds of the respondents chose not to answer this question, and none identified growth of pubic hair or attraction towards the opposite sex as signs of puberty. Only around one-fourth identified beginning of menstruation and growth of breasts as signs of puberty. The poor knowledge-level is related to access to information on SRH issues, discussed below.

Access to information on SRH issues

Nearly two-thirds (62%) of respondents said that they had not discussed SRH issues with anyone. The most common source of information, reported by around one-fifth of the respondents was 'friends', which is, in the context of the general education and awareness level in the study area, an unreliable source. Only around one-tenth of respondents (9%) had discussed SRH issues with their mother and less than 1% had discussed the issues with a health worker. Nearly 80% of respondents said that it was difficult for them to talk on SRH issues with family members, and the most common reason attributed for the difficulty (by 84% of respondents) was 'shyness'.

MHM knowledge and practices

Not surprisingly, 85% respondents reported that they did not know about menstruation before puberty, and the common source of information (reported by 40% of respondents) was a friend rather than the mother (21%). Notably, only 17% of the respondents got the information from a school teacher.

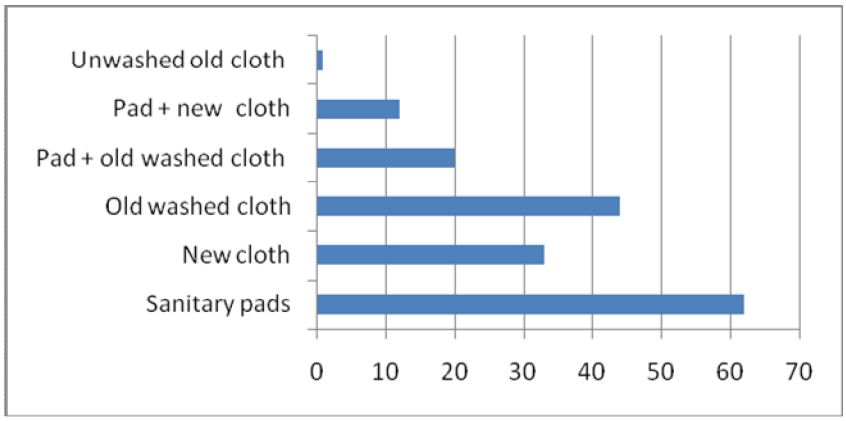
Around 40% of respondents chose not to answer a question on traditional practices followed during periods, and the remaining mentioned several traditional practices including:

- Not going out of the house (24%)
- Not attending auspicious events (39%)
- Not visiting holy places (24%)
- Maintaining a distance from food items (13%)

The 172 respondents (55% of total respondents) who reported that they have menstrual periods deal with it in a variety of ways, as shown in Figure 3.

- While use of sanitary pads was reported by 62 respondents (36% of girls having periods),
- Around 35 respondents (56% of girls using pads) reported facing difficulty in procuring or disposing the pads.
- Of the 172 girls who have menstrual periods, 22 (13%) said that they skip school during periods.

Figure 3: Absorbent items used during menstruation (172 respondents)

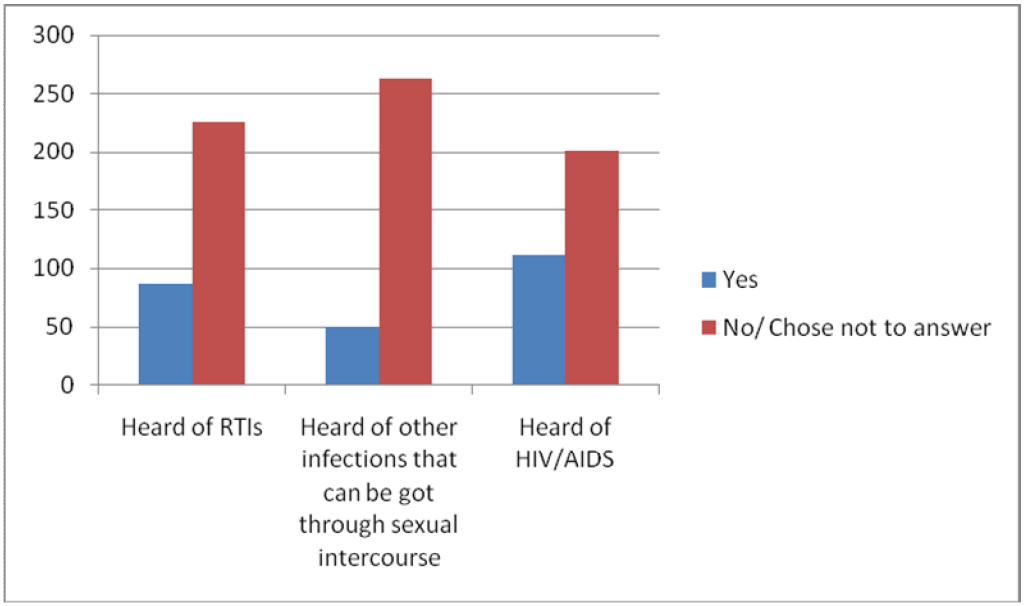


Knowledge about RTI, STI/ HIV/AIDS

Considering respondents' poor access to information on SRH issues, it is not surprising that most of them either chose not to answer questions on RTI, STI and HIV/AIDS or reported that they did not have knowledge on these matters. In fact, as figure 4 shows:

- The majority of respondents reported no knowledge on these matters.
- Only around one-third of the girls (36%) had heard of HIV/AIDS despite the massive government and non-government efforts taken to create awareness on this issue.

Figure 4: Primary knowledge about RTI, STI, HIV/AIDS (312 respondents)



Even among those who claimed to have some knowledge, the knowledge was far from comprehensive:

- Less than 4% knew that RTIs can be prevented by using condoms during sexual intercourse.
- Less than 10% could name any STI.
- Less than 5% could identify genital sores/ulcers or swellings as symptoms of STI.
- Less than 15% knew that HIV/AIDS can be transmitted through infected blood or from a mother to a child, and less than 10% knew that it can be transmitted through heterosexual or homosexual intercourse.
- Only 17% knew that HIV/AIDS is curable and only 8% knew that it can be detected through a medical test.

Hygiene practices

Poor knowledge about sexual health issues is compounded by poor hygiene practices. While nearly all respondents reported taking a bath daily, and 96% reported that they washed their hands before eating food, and 90% reported using soap and water, a large number of respondents were not following many other routine hygiene practices:

- Around 30% respondents report that they did not wash their hands before preparing food.
- Only 91 (41%) of the 172 respondents who reported that they menstrual periods said they washed their hands after changing a sanitary pad or other absorbent material.
- Around one-fourth said they had never washed external genitalia.
- Around one-third (35%) said that they did not take a bath when they had fever.

Access to health services

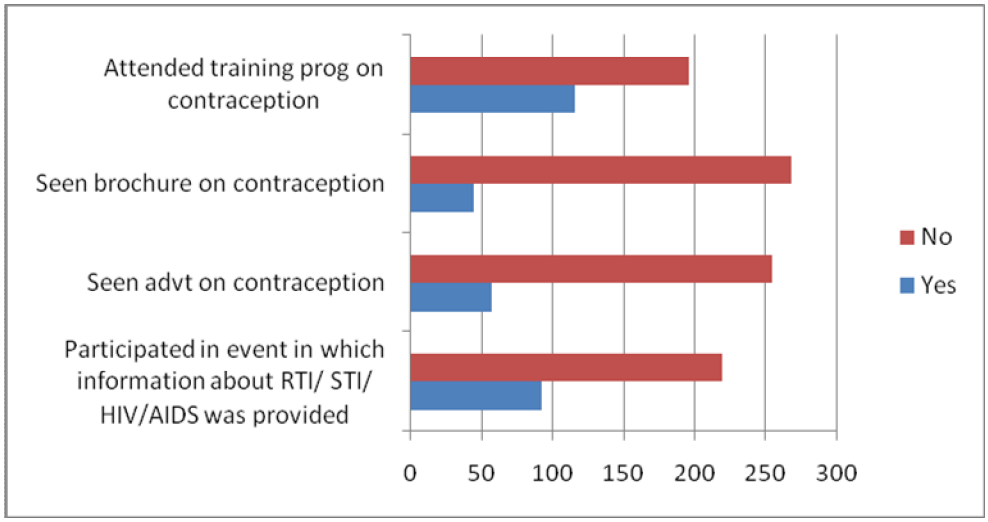
Respondents have poor access to health services provided by qualified personnel. While three-fourths had used the services of non-qualified medical salesmen, who move around villages and are known as *jhola-chaap doctors*, only 15% had ever visited a qualified private doctor and less than 1% had gone to the government health centre. Around 8% had obtained a health service directly from a medical shop. The most common reason for accessing any kind of health service was to seek treatment for common ailments like fever. Less than 10% of respondents had used a health service to deal with STI or to obtain contraceptives, and less than 2% had spoken to a qualified doctor or nurse about contraception or STI.

Access to other sources of health information

Respondents also reported poor access to other sources of health information (figure 5). Around 80% had not seen an advertisement or brochure on contraception, and only 30-38% had attended a training programme on contraception or RTI/STI/HIV/AIDS. These events were organized by an NGO (not ABSSS) and the effectiveness of information delivery can be judged by the poor

knowledge reported by respondents even on basic matters, such as awareness of a health condition called HIV/AIDS (discussed above).

Figure 5: Access to other sources of health information (312 respondents)



Participation in youth clubs

The general ignorance level of the respondents is aggravated by considerable social isolation: While almost respondents reported to have friends, their participation in youth-group activity is low. While Kishori manchs or girls' clubs were supposed to have been formed under a previous CFI project in the area, less than half the respondents (46% of total) reported knowledge of any such organization in their area, and only one-third (34%) reported attending club meetings. Amongst those who attend meetings, 99 (94%) attend only once a month.

Summing up

Knowledge about sexual health issues among adolescent girls in the Bargarh cluster is terribly low. The low level of awareness can be judged from the following findings:

- Around half the respondents were unwilling or unable to identify signs of puberty.
- 85% respondents reported that they did not know about menstruation before puberty
- The majority of respondents reported *no* knowledge on RTI, STI and HIV/AIDS.

The main reasons for low level of awareness are: (i) Silence is maintained on sexual-health issues in the community (ii) Girls have low access to reliable sources of information on these issues. These reasons are reflected in the following findings:

- Two-thirds of the respondents chose not to answer the question on physiological changes that occur at adolescence.
- Nearly two-thirds of respondents said that they had not discussed SRH issues with *anyone*.

- Only around one-tenth of respondents had discussed SRH issues with their mother and less than 1% had discussed the issues with a health worker.
- Only 2% had spoken to a qualified doctor or nurse about contraception or STI.

The overall low level of awareness is reflected in unhygienic practices: Around one-fourth of the respondents said they had never washed external genitalia and only 41% of the respondents who reported that they have menstrual periods said that they washed their hands after changing a sanitary pad or other absorbent material.

These findings point to following specific directions for ARSH initiatives:

- Girls' *basic* knowledge of SRH issues should be built up, starting from elementary topics like: What changes take place during adolescence? How is onset of puberty to be recognized? What is menstruation? From what age and how can a girl get pregnant? What are the main kinds of reproductive tract and sexually transmitted infections? How they can be prevented and detected? What is HIV/AIDS? How can it be contracted?
- The culture of silence on sexual health issues in the community has to be broken. Particularly, girls' mothers have to be made aware that
    - Menstruation is a biological process to which no taboo should be attached
    - SRH issues should be discussed with girls.

Other key issues that need to be addressed by ARSH are:

- Around 15% of respondent girls have dropped out of the formal education process and cannot even read or write.
- Local health workers and doctors hardly impart any information on SRH issues.
- Two-thirds of girls do not participate in any youth club activities and most of the rest have low level of participation.