

EMPOWERMENT OF ADOLESCENT GIRLS FOR REPRODUCTIVE HEALTH BASED LIFE SKILLS THROUGH PARTICIPATORY LEARNING ACTIVITY METHOD

DR. MANJULA VISHWAS, DR.MUNIRA M. HUSSAIN

Abstract: Adolescents are faced with a number of critical issues unique to their age group, such as changes in the body brought on by puberty-peer pressure, experimentation, sexual abuse, premarital physical relation, emotional blackmailing and the implications of teen pregnancy. Actions taken during adolescence can affect a person's life opportunities, behavior patterns and health. Present study aimed to assess the impact of the life skills reproductive health education program on experimental regarding Self-esteem, Communication, Decision Making and Coping abilities of the selected adolescent girls. Through purposive random sampling method 635 unmarried adolescent aged girls (AGs) between age group of 15-20 years who were from Bhopal and Raisen Cities. The experimental received a reproductive health based Life Skill training program for empowerment and improvement of quality of Life on studied domains. Obtained results revealed that initially majority girls knew poorly about basic aspects of reproductive health. However the difference in pre to post test level scores on knowledge menarche, family planning, STDs, HIV and AIDS improved significantly among the experimental group. So the study indicated that there is a need proper reproductive health care and awareness program in adolescent aged girls.

Key words: Life skills, reproductive health, adolescent girls

Introduction: It is important to understand adolescent sexual and reproductive health in the context of the individual's overall life situation. Sexual and reproductive health is part of physical and emotional well-being. A holistic approach is essential if adolescent sexual and reproductive health needs are to be addressed successfully. Adolescents are faced with a number of critical issues unique to their age group, such as changes in the body brought on by puberty-peer pressure, experimentation, sexual abuse, premarital physical relation, emotional blackmailing and the implications of teen pregnancy. As we move into the next millennium, some 17.5 per cent of the estimated world population of 6.09 billion in the year 2000 will be aged 15 through 24. Today, births to teenage women account for a little over 10 per cent of all births worldwide. While the global birth rate for women under age 20 is declining, the number of adolescents worldwide is increasing, so that the total number of births to young women is growing. Moreover, fertility rates are declining more rapidly among women of other age groups, which mean that births to adolescents account for an increasing proportion of overall births in many countries.

The educational philosophy in ancient India was one of guru-chela/shisya parampara and stressed on the teacher being responsible both for literacy/knowledge and personality development of the ward. However, education, which is currently prevalent in our country, is achievement oriented than child oriented. It does not address the needs of all the children who in spite of various levels of scholastic competence are capable of learning and need to develop those skills, and become empowered to live effectively in this world. This empowerment is very essential in today's context in India as there is rapid globalization and urbanization with a breaking up of joint families and the traditional support systems.

Actions taken during adolescence can affect a person's life opportunities, behavior patterns and health. For physical, socio-cultural, economic and psychological reasons, young people are typically poorly informed about how to protect them sexually and are thus particularly susceptible to unwanted pregnancies and sexually transmitted diseases, including HIV/AIDS.

Research demonstrates that possessing life skills may be critical to young people's ability to positively adapt to and deal with the demands and challenges of life. Some programs effectively teach and promote life skills. This paper briefly reviews some of these programs and presents lessons learned from the life skills approach to HIV prevention education. These lessons are also applicable to a wide range of sexual and reproductive health programs for youth.[1]

A review by UNICEF found that approaches relying on life skills have been effective in educating youth about health-related issues—such as alcohol, tobacco, and other drug use; nutrition; pregnancy prevention; and preventing HIV/AIDS and other sexually transmitted infections (STIs). Life skills education programs can also be effective in preventing school dropout and violence among young people. Finally, these programs can lay the foundation for skills demanded in today's job market.[2] Present study aimed to assess the impact of the life skills reproductive health education program on experimental regarding Self-esteem, Communication, Decision Making and Coping abilities of the selected adolescent girls.

Methodology:

Sampling: Through purposive random sampling method unmarried adolescent aged girls (AGs) between age group of 15-20 years who were studying in class 11th to 12th and in under graduate courses were enrolled for the study from Bhopal and Raisen Cities. In all 635 adolescent girls were studied who were divided as 95 control and 540 experimental as per their choice.

The experimental group gave consent to join a reproductive health based Life Skill training program named as "Kishori Chetana". This title was finalized by adolescent girls themselves unanimously after discussion. They also selected program's motto and logo as:



Logo had three happy girls together holding hands representing love and togetherness with right side girl indicated as peer leader directing at the goal. Their slanting legs showed their dynamism. Motto kept as "Organize your life yourselves".

Since Kishori Chetana was based on participatory learning activity method. Active learning by girls was the only objective. For this purpose activities were designed in such a way which encouraged them to open up and talk about their issues and ask questions. The role of the investigator was just a facilitator and expert, who steered the discussion in right direction and answered their queries and made them to believe in you, take that right decision and adapt positive behaviour to change and modify their behaviour in right direction.

For Pre and Post Study Knowledge assessment of AGs: dates and time for contact were adjusted according to the convenience of school authority and availability of subject girls.

The Achievement Test was prepared to assess the knowledge of adolescent girls on reproductive health issues. The questionnaire was pre tested for reliability and validity and after correction the assessment tool was finalized. Same test was used for asses Pre and Post Study knowledge of adolescent girls on reproductive

health issues. It included questions regarding reproductive organs, menses and reproduction, family planning, STD, HIV and AIDS. This had a total of 38 questions included question regarding reproductive organs, menarche and reproduction – question 1 to 23, Family Planning – question 24 to 29, STD, HIV and AIDS – question 30 to 38.

Life skill education program: An education tool was designed on the basis of available latest recommendations by the agencies like GOI, NACO, NCERT, UNICEF, UNESCO and UNFP.

5 to 8 contact visits were planned to experimental group and at least 1 hour time was spent with them for the purpose of empowerment for better health today and safe womanhood tomorrow. 2 contact visits were done for control group for data collection only

Empowerment included Enlightening of experimental group on the issues related to reproductive health – Menses, reproductive systems (male & female), family planning, STDs HIV and prevention of HIV/AIDS under study through brain storming session, awareness and self esteem was enhanced. Viewing Charts to understand anatomy and physiology, lectures to enhance knowledge and clear the concept, put question in question box without writing names to facilitate communication on a less discussed topic in home as well as in school/college, answering all questions in class, giving different case studies to different groups and finding solution through group discussion for decision making, do role plays to communicate it and coping with others reactions.

Quality of Life which is a sense of being pleased (happy) or satisfied with those life elements that are most important to a person as social being. In addition, quality is the sense of being pleased with what one has. Although satisfaction, happiness, or pleasure is the central element in this definition, it should not be seen as a momentary state of happiness. May be it is best expressed as a sense of fullness or a completeness of life.

Statistical analysis: On the basis of the frequencies of comparative groups in percent of responses Chi square test was applied to test significance in difference minimum at level .05 levels.

Results:

Response	Pre Study		Post Study	
	Control (N=96)	Expt. (N=538)	Control (N=96)	Expt. (N=538)
Ignorant	54.2%	49.1%	55.2%	23.8%
Correct	33.3%	35.1%	33.3%	66.7%
Wrong	12.5%	15.8%	11.5%	9.5%
χ^2 & inference	$\chi^2 = 1.0795$ P > 0.01		$\chi^2 = 43.2215$ P < 0.01	

The table 1 reveals the pre and post study knowledge of AGs regarding menses. Pre study knowledge of AGs

were very poor i.e. 54.2% were ignorant & 12.5% gave wrong responses in control group whereas 49.1% were

ignorant & 15.8% gave wrong responses in experimental group. The χ^2 value shows that knowledge difference among both groups is insignificant at 0.01 level df is 2. This table clearly reveals the improvement in knowledge of AGs of experimental group after empowerment.

66.7% AGs of experimental group in the post study gave correct response as compared to 33.3% in control group, 23.8% and 55.2% remained ignorant about this fact of feminine life. χ^2 showed the significant difference at 0.01 level.

Response	Pre Study		Post Study	
	Control (N=96)	Expt (N=538)	Control (N=96)	Expt. (N=538)
Ignorant	45.8%	46.3%	42.7%	28.3%
Correct	19.8%	19.9%	20.8%	18.8%
Wrong	21.9%	22.3%	27.1%	48.0%
χ^2 & inference	$\chi^2 = 0.0772$ P > 0.01		$\chi^2 = 16.4184$ P < 0.01	

The table 2 revealed the pre and post study knowledge of AGs regarding family planning. It clearly shows pre study knowledge was very poor in control as well as experimental group, 45.8% and 46.3 showed ignorance respectively. 12.5% from control and 11.5% from experimental gave wrong responses and 19.8% from control & 19.9% from experimental gave partially correct responses. Furthermore χ^2 value reveals the difference among control and experimental group is insignificant at 0.01 levels.

Table clearly indicate the improvement in the knowledge of AGs of experimental group after empowerment. 48% AGs of experimental group gave correct responses, 18.8% gave partially correct responses and 28.3% were ignorant as compared to their counter parts of control group 27.1%, 20.8% and 42.7%. χ^2 value further clarifies that the difference among control and experimental group is significant at 0.01 level.

Response	Pre Study		Post Study	
	Control (N=96)	Expt. (N=538)	Control (N=96)	Expt. (N=538)
Ignorant	60.4%	60.0%	60.4%	36.6%
Partially Correct	12.5%	12.5%	12.5%	16.0%
Correct	11.5%	11.3%	13.5%	39.0%
Wrong	15.6%	16.2%	13.5%	8.4%
χ^2 & inference	$\chi^2 = 0.0182$ P > 0.01		$\chi^2 = 29.5498$ P < 0.01	

The table 2.3 shows the pre and post study knowledge of AGs regarding STDs, HIV and AIDS. Above table indicates that at pre study 60.4% AGs from control and 60% experimental group are ignorant about STDs, HIV and AIDS. This ignorance is an alarming sign. 15.6% from control group & 16.2% from experimental group gave wrong responses whereas 12.5% from both groups both gave partially correct responses. Only 11.5% from control & 11.3% from experimental group gave correct responses. χ^2 further clarifies that difference among control and experimental group is insignificant at 0.01 level.

Table clearly shows that after empowerment there is improvement in knowledge of AGs of experimental group. 39% gave correct responses, 16.0% gave partially correct, 36.6% remain ignorant only 8.4% gave wrong responses as compared to 13.5% correct responses, 12.5% partially correct responses, 60.4% remain ignorant and 13.5% gave wrong responses from control group. This shows that AGs need further empowerment on this

issue. χ^2 value reveals that the difference among control and experimental groups is significant at 0.01 level.

Discussion and conclusion: Menses though is a natural phenomenon of female's life 49% to 55.2% ignorance was there. Very high level of ignorance 51% and 49.1% was found regarding reproductive system and reproduction. Regarding family planning ignorance found was 42.7% to 46.3%, girls could not name the male & female reproductive organs correctly, they did not know about ovulation and when it occurs. They knew that union of male and female sex cells was must for conception but they were confused about unsafe sex, development of breasts, number of chromosomes and father being responsible for determination of the sex of baby. Most of them said that two kids make happy family and the ideal gap between two births is more than two years. Most of them have some knowledge of contraception and they could write two names of contraceptives condom and oral pills i.e. Mala D. A few wrote about IUD and operation.

Girls did not know that close location of vagina, urethra and anus is the main cause UTI (Urinary Tract Infections). Aids was the only STD they could name before study. They could not right full names of HIV and AIDS. But they knew that how HIV spreads. In Govt. Girls H.S. School Raisen two teachers who were trained on Adolescent Education by SCERT but they never talked on these issue with the AGs of this school. Govt. In Bhopal also there was no interaction on reproductive health among students as well as teachers. Life Skill Education is a novel promotional program. In this participatory and activity based learning is done by students. "Didactic methodology" or "advice" was not part of Kishori Chetana at any level. In India, education has become institutionalized. Schools need to be recognized as the single most important and recognized forum to reach out to the young population. Any program to reach the adolescents/youth has to be incorporated into the educational system to be feasible, effective, and cost-effective. In a country like ours, where resources and trained professionals are sparse and few, it is more be practical to involve and work with the teachers.

Original resource material was in English and we translated resource materials in Hindi evaluated and modified both by professionals and investigator. Using the above tools the present comparative study indicated that at the end of KISHORI CHETNA, there was a significant positive change in the way the adolescent girls perceived themselves in the school/college, with the teachers, and the confidence level of their ability to deal with developmental challenges. Though it was a short term intervention in institutes; however the treatment tool was focused on specific issues related to reproductive health to increase the ability of the AGs to understand feminine as well as masculine body facts, learned to carry their body with grace ,learned to communicate on less discussed issues confidently and improved self-esteem and coping. This was also perceived by the facilitator that better classroom behaviour and interaction among the students in Experimental group of Kishori Chetana, Improved knowledge was reported regarding reproductive system and reproduction, TDs, HIV and AIDS.

The program probably by its facilitative and interactive nature made the adolescents more aware of their

behavioural changes with themselves i.e. Positive self image as young women, with teachers and friends too with whom they probably felt that they had always interacted well. This is evident in their reporting a difference in the prosocial behavior generally but not specifically with peers. The positive effect of program in student--teacher interaction, academic performance, and peer interaction has been established by others.[9-12] Parents were involved in the initial focus group discussions and later were aware of the implementation of the program. However they were not active partners in the implementation of the program. This was probably the reason for the absence of difference ($P=0.088$) in the home adjustment between the two groups. Perceived self-efficacy ($P=0.000$), better self-esteem ($P=0.001$), and better general adjustment ($P=0.000$) were important aspects which were significantly different between the two groups, indicating that the program prepares the adolescent to be a 'competent' and 'empowered' person in a changing, competitive, globalized world.[7- 9]

Review indicates that most preventive program with adolescents have been specific addressing specific issues of substance abuse, teen pregnancy, violence, bullying, etc.[3,4,8] However generic programs with multiple outcomes have also been present and found to be more effective [10-12] The current study confirms that absence of pre- and post-evaluation of the same students apart from a comparative group, feedback of the teachers who specifically handled the sample children, assessment of a longer nature are some of the limitations of the study.

Conclusions:The present study named Kishori Chetna is a suitable and an effective reproductive health program. The highlights are as follows

1. Comprehensive health including reproductive health through psychosocial competence in AGs is the goal to empower the reachable young women.
2. Using life skills as the medium/process.
3. Providing a structure to the program by combination of visuals, lectures, case studies, group discussion, role-plays as participatory activities.
4. Investigator as life skills educators became facilitator to otivate all AGs for active participation and expressing their own feelings.

References:

1. Kapur M. New Delhi: Sage; 1997. Mental Health in Indian Schools.
2. Patel T. New Delhi: Sage; 2005. The Family in India: Structure and Practice.
3. Botwin GJ, Eng A, Williams CL. Preventing the onset of cigarette smoking through
4. WHO Programme on Mental Health: Life Skills in Schools. WHO/MNH/PSF/93.7A
5. Rosenberg M. Princeton: University Press; 1965. Society and the adolescent self-image.
6. Pareek U, Rao TV, Ramalingaswamy P, Sharma BR. Varanasi: Rupa Psychological Center; 1975. Manual for the battery of preadolescent personlity tests.
7. Schwarzer R, Jerusalem M. Generalized self-efficacy scale. In: Weinman J, Wright S, Johnston M, editors. Measures in health psychology: A user's portfolio. Causal and control beliefs. Windsor, UK: NFER-NELSON; 1995. pp. 35-7.
8. Goodman R, Meltzer H, Bailey V. The strengths and difficulties questionnaire: A pilot study on the

- validity of the self-report version. *Eur Child Adolesc Psychiatry*. 1998;7:125-30.
9. Weissberg RP, Kumpfer KL, Seligman ME. Prevention that works for children and youth. *Am Psychol*. 2003;58:425-32.
 10. Parsons C, Hunter D, Wayne Y. Canterbury, UK: Christ Church College, Evaluation Unit; 1988. Skills for adolescence: An analysis of project material, training and implementation.
 11. Nation M, Crusto C, Wandersman A, Kumpfer KL, Seybolt D, Kane EM, et al. What works in prevention: Principles of effective prevention programs. *Am Psychol*. 2003;58:449-56.
 12. Greenberg MT, Weissberg R, O'Brien MU, Zins JE, Fredicks L, Resnik H, et al. Enhancing school-based prevention and youth development through coordinated social, emotional and academic learning. *Am Psychol*. 2003;58:466-74.

* * *

Asst. Professor, Sarojni Naidu, Govt. Girls PG College, Bhopal (MP) manjula.vishwas@gmail.com
Professor (Food & Nutrition), Govt. Girls P.G. College Moti Tabela, Indore (M.P) India,
muneerahasain@hotmail.com