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Perspectives of Adolescent Girls on Health Education in Reproductive Health through Anganwadies - A Cross Sectional Study Conducted in the Southern Districts of Kerala

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Abstract

The period of adolescence is peculiar with the loss of identity as a child and the non-acceptance as an adult in social parlance. Thus, those at the cross road of life may be lured to the dark side of life by peer pressure and lack of parental support. The ICDS programme component include the adolescent girl care, covering health and developmental support. The Health Education (HE) sessions conducted at the anganwadi is thus a ray of hope to the adolescent girls in leading a healthy life in all its perspectives. The present study conducted among the Adolescent Girls (AGs) of the four southern districts of Kerala is an effort to bring out the facts about the health education sessions on reproductive health aspects of adolescent health through anganwadies and how the adolescent girls look at it.

Materials and methods: Using a structured interview schedule, data collected from 648 adolescent girls of 16 anganwadies selected from 8 ICDS projects of four southern districts namely Thiruvananthapuram, Kollam, Pathanamthitta and Alappuzha. Two projects each from the four districts were randomly selected at the first stage. Thus, two Anganwadies (AWs) each from these 8 projects were randomly selected. The data collected from 16 AWs were entered in Microsoft Excel and analysed using SPSS ver. 2016.

Results: Nearly 80% of the respondents know their anganwadi worker by name and she is the most accepted source of information. Age at menarche is coming down. The study revealed that 58.97% of the sexually experienced adolescent girls had not regularly attended health education sessions. Knowledge on health issues related to premarital sexual relations is fairly good among AGs. Urinary Tract Infection (UTI) is a common health problem among adolescent girls. Space constrains at the AWs and lack of proper information about the sessions are the important reasons for poor participation of AGs in HE sessions. Nearly 50% of the AGs suggest privacy in the sessions and changes in instructional pattern. It was found that nearly 50% of the sexually exposed AGs are not aware of the health issues associated with premarital sexual relations, suggesting that those AGs were lured or coaxed into sexual relation by the predators. This suggests that an all-round effort to boost the health education sessions to AGs through AWs by improving quality, content and instructional methodology is the need of the hour.

Keywords: Gender bias • Sexual harassment • Age at menarche • Sexual exposure

Introduction

Adolescent period is the transitional period from childhood to adulthood. This is a precarious position that deprives many of her / his childhood rights for caring and loving in the family, even by her/ his own parents. The care craving is more evident among girls, as they naturally are more cared than their male siblings in the family. So, it is natural that they turn to anyone who bestows care or loving, without looking whether it is for good or with malicious interests. That is why adolescent girls easily fall in as preys to sexual exploitations. A serious effort is needed to empower the adolescent girls to say "no" to the luring situations, even from within her neighborhood including relatives and peers and those with whom she acquaints.

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The ministry of Women and Child Development in India is running a programme called Integrated Child Development Services (ICDS) since 1975. It not only covers child development programs but covers all the developmental needs of adolescent girls (AG)1. Government of India (GOI) in 2000 initiated a scheme called Kishori Sakthi Yojana (KSY) for the juvenile girls aged 11 to 18 years under ICDS2. It seeks to provide the AGs with an opportunity to realise their full potential and grow. The ICDS was thus improved with significant content enrichment, improved training component with an objective of skill development, targeting empowerment and enhanced self-perception. The Kishori Sakthi Yojana was later merged in the ICDS to have more fruitful interaction through anganwadies. Anganwadies are the lowermost functioning units under ICDS. It is manned by an anganwadi worker (AWW) and anganwadi helper. Normally an anganwadi caters to one thousand population and the worker and helper are selected from among the population.

The objectives of the AGs scheme were: -

- To improve nutrition and health status of 11- 18 year-old girls
- To provide literacy and numeracy skills through non-formal education.
- To train and equip adolescent girls to improve/ upgrade home-based and vocational skills.
- To promote awareness of
- health,
- hygiene,

- nutrition and family welfare,
- home management and
- childcare,
- iv. and to take all measure as to facilitate their marriage only after attaining the age of 18 years and if possible, even later
- To gain a better understanding of their environment related social issues and the impact on their lives
- To encourage adolescent girls to initiate various activities to be productive and useful members of the society

Anganwadies provide the above services in addition to the preschool education and supplementary feeding of under-fives, immunisation of under-fives, supplementary feeding and nutrition and health education to the pregnant and lactating mothers. Thus, it caters to all sections of the womenfolk. There are separate health education sessions for adolescent girls to attend, wherein adolescent health issues are dealt seriously. Health education aims to have a positive impact on health actions of individuals and communities, as well as on the living and working conditions that affect their health.

Objectives

- The objectives set for this study were:
- To find out the proportion of adolescent girls who are regularly attending healtheducation sessions in the Anganwadi (AW).
- To find out whether sexual and reproductive health was a topic of the HE session
- To assess whether the AGs value this HE session as an empowerment measure
- To study the proportion of AGs affected by sexual exploitation
- To determine the proportion of AGs with a mind set to resist exploitation throughbetter knowledge

Methods and Materials

This study is focusing the sexual and reproductive health component of health education (HE) conducted in the anganwadies to full fill the programme objectives. This studywas conducted in the four southern districts, Thiruvananthapuram, Kollam, Pathanamthitta andAlappuzha of Kerala. The responses of AGs aged 15 – 18 were collected using structured interview schedules prepared in Malayalam directly when they turned up to the health education sessions at anganwadies.

Data entry and analysis

The data obtained through interviews were entered in Microsoft Excel format and analysed using statistical package SPSS (Ver 16). To check the association between categorical variables, chi-Square test was used with p value less than 0.05.

Results and Discussion

The results obtained are presented here in 10 tables.

Distribution of respondents in different icds project area: This table shows the distribution of the adolescent girls in different ICDS projects. It shows an even distribution of adolescent girls from the selected projects (Table 1).

Socio demographic variables: The table above shows the age wise distribution of adolescent girls interviewed. Adolescent girls of age 18 years are only 15.74% while, those having 17 years of age are 34.41%. This may be because those aged 18 and above may go out for employment or studiesand may not be available during working hours of anganwadies. The religious distribution of adolescent girls presented here shows that all the three prominent religions have got ample representations [1].

The split up of the 648 adolescent girls based on the location of their residence given in this table show that those who reside in panchayath area is about 65% and the rest are fromurban areas. The details of siblings give us the structure of the families. It shows that in about 5% of adolescents studied, there are no siblings and for one third there is only one sibling, while 40% had two siblings indicating prevalence of small family norm (Table 2).

The level of education of the adolescent girls interviewed show that over 45% of adolescent girls have schooling up to SSLC and nearly 40% studied or are studying in plus two. A little over 3% have college education. It is a point of concern that, though the education up to plus two level is free, in the state, eleven percent have left schooling after Upper Primary classes. It is a normal practice nowadays to peruse some vocation during studies. Some from low socio-economic family stick to it and stop schooling at some point. Here, nearly 70% of them have no vocation. Only 13.27% have full time job and 17.59% have part time job. Access to mass communication media provides a window to the world around and if anadolescent girl has that advantage, it helps her to learn and adapt to it easily. It is promising tonote that more than 90% of them have access to Radio or TV. Newspapers have got a lesser popularity as

Table 1. Distribution of respondents in different ICDS project area.

Place	Frequency		Percent	
Thiruvananthapuram		170		26.23
Nemom	84		49.41	
Kazhakkoottam	86		50.59	
Kollam		145		22.38
Oachira	73		50.34	
Ithikkara	72		49.66	
Alappuzha		166		25.62
Harippad	85		51.21	
Aryadu	81		48.79	
Pathanamthitta		157		25.77
Pulikeezhu	89		53.29	
Pandalam	78		47.7	
Total	648	648	100	100

Table 2. Socio demographic variables.

Variables	Category	Number	%
Age of Adolescent Girls	15	147	22.7
	16	176	27.2
	17	223	34.4
	18	102	15.7
Religion	Hindu	254	39.2
	Christian	216	33.3
	Muslim	178	27.5
LOCALE	Panchayath	421	65
	Municipality	227	35
Siblings	0	31	4.8
	1	211	32.5
	2	261	40.3
	>3	145	22.4
Level of Education	Upper Primary	74	11.4
	High School	293	45.2
	Plus Two	257	39.7
	College	22	3.3
	Diploma	2	0.4
Vocation	Full time	86	13.3
	Part time	114	17.6
	No vocation	448	69.1
Source of information	Radio	596	91.9
	Newspaper	387	59.7
Total		648	100

only about 60% has access to newspapers. This may be due to the economic condition of their families [2].

Distribution of adolescent girls according to ownership of dwelling house: The ownership of residence of person indicates whether s/he is a permanent resident of the area. Only less than one third dwells in rented houses. Non electrified houses are very less with only 3.2% (Table 3).

Role of anganwadies: Knowing the anganwadi worker by her name shows the popularity of the anganwadi worker as well as her acquaintance with the adolescent girls. Nearly 80% of the adolescent girls know the name of the anganwadi worker in their area. This is a good proportion, and it indicates the acceptance of the anganwadi worker among the community. The table shows that only 6.6% are not regularly attending the health education sessions. Here, the researcher is of the opinion that, the adolescent girls might not have told thetruth. The adolescent girls who were not attending the health education sessions had opined that the timings of the sessions are inappropriate. School going adolescent girls, especially those in SSLC and Plus two classes cannot skip school classes for the health education sessions. Some may have tuitions on weekends and others have it before or after school timings. Thosewho were engaged in vocations may not opt to skip it as they may suffer wage loses. Intimation of sessions including topics covered are not informed in time according to 16.3%, while 11.6% found that there is space constrains at the anganwadi.

There was a notion that attendance in health education sessions can be improved if thetimings of sessions can be changed to holidays. It can be seen that though nearly 60% was in favour, while 40% reject it. It is felt that majority of those studying in schools and colleges were not in favour of health education sessions on holidays, probably due to their preoccupationin tuition classes or other academic engagements. The above table shows that the adolescent girl's suggestions to improve the attendancein health education sessions are sensible. Over 50% suggested increasing the privacy, while 44.4% suggested improvement in instructional pattern. Change in time schedule was prescribed by 42.3%. Usage of aids in teaching make sessions attractive and effective. Chalk and board arethe conventional aid and at the health education sessions conducted at anganwadies, it is being used lavishly. Since aid preparation is included in the training curriculum of anganwadi workers, they prepare posters, flash cards and models depending upon the creativity and mindset of anganwadi workers.

Sexual and reproductive health is an essential component of adolescent health and it was noted that some anganwadi workers are reluctant to handle this topic due to their traditionalapproach. The table above shows that at least in 3.6% of adolescent girls, classes on sexual andreproductive health are not done. These conservative approaches to the topic need to be changed.

Motivation and support by elder women are a must to ensure maximum participation of adolescent girls in health education sessions, especially in rural settings. Nearly 12% of adolescent girls say that elder women are not encouraging their participation. To change the situation, anganwadi workers may take special interest in bringing change to the mindset of elder women. Clarifying doubts in any education settings indicate the manner in which the learner is following what is taught. It is admitted by a minority, say 4.9% that they never try to clarifytheir doubts during health education sessions (Table 4).

Knowledge, attitude and practice: The aim of health education sessions for adolescent girls is to create awareness aboutthe importance of health. It focuses on issues that mar the health and provides opportunities toidentify practices that are harmful to the health of self and the community and it helps to find solutions to overcome such situations. The table above suggests that little more emphasis is required to have a 100% reach for this concept among adolescent girls. Source of information on health can be many in this new age. The table above showsstriking information that anganwadi workers role as adolescent girl's source of information is stronger than mothers. This highlights the credibility of anganwadi workers among adolescentgirls.

This table shows that there are about 8% of adolescent girls who were ignorant aboutmenstruation at the time of their first menstruation. This shows that as the age at menarche is coming down due to various factors, the responsibility of mothers in creating proper awarenesson reproductive matters

Table 3. Distribution of adolescent girls according to ownership of dwelling house.

Ownership	Electrified	Not Electrified	Total	%
Own	459	12	471	72.67
Rented	168	9	177	27.33
Total	627(96.8)	21(3.2)	648	100

Table 4. Role of anganwadies.

Variable	Category	Frequency	Percent
Knowing Anganwadi worker by name	Knowing	516	79.6
	Not knowing	132	20.4
Attending Health Education session in Anganwadi	Attending	605	93.4
	Not attending	43	6.6
	In appropriate timings	9	20.9
	Space constrains at anganwadi	5	11.6
Reasons for not attending Health Education sessions	No interest	11	25.6
	Not considered as worth	5	11.6
	No intimation about session	7	16.3
	No remarks	6	14
Classes on holidays	Support	379	58.5
	Reject	269	41.5
Suggestions to improve attendance in Health Education sessions	Increase Privacy	325	50.2
	Improve the instructional pattern	288	44.4
	Change time schedule	274	42.3
	Board and Chalk	618	95.4
Teaching Aids used in Health Education sessions	Posters	426	65.7
	Flash cards	54	8.3
	Models	23	3.6
	Lecture only	648	100
Classes on sexual and reproductive health	Conducted	625	96.5
	Not conducted	23	3.6
Elder women's encouragement for Health Education sessions	Encouraged	572	88.3
	Not encouraged	76	11.7
Clarifying doubts	Clarified	616	95.1
	Not clarified	32	4. 9
	Total	648	100

to their girl child is increasing as they grow up. In rural areas, it is a customary practice not to take bath during menstrual periods. From the hygienic point of view this is a custom to be done away with. The table shows that there are few still practicing this wrong custom. Unprotected sex leads to two consequences, pregnancy and sexually transmitted diseases. To unmarried adolescent girls, it is important to distance from both. There may be umpteen occasion for an adolescent girl to fall prey to unprotected sex in the present day, whether urban or rural. Empowerment of adolescent girls to say no to such situation certainly demands proper health education on reproductive matters. Hence health issues related to unprotected sex is an integral part of such sessions [3].

The above table shows that at least in some anganwadies this is not done, presumably due to non-availability of seasoned faculty to handle sessions or due to local resistance to include such topic due to too rigid conservative approach.However, it is refreshing to not that around 95% had attended such sessions. It may be shocking to note that 6.02% of the adolescent girls of this study are alreadyexposed to sexual experience. The focus of adolescent health education on sexual health is to bring sexual exposure within marriage. It is true that the adolescent attains sexual capability atthe early stages of her/his adolescent period. But the sexual experimentation had to be restrictedby self-restrain and that needs proper health education. It was found that only a meagre 8% of the AGs said that they will resist intentional touching by males. It is shocking to note that 36% of them opined that they will not respond though they dislike. Another 41% admitted that they will not resist due to fear. This situationwarrants strong and immediate empowerment measures (Table 5).

Distribution of adolescent girls who participated in role playduring health education sessions: Role play is an ideal method in health education in imparting skills and behavioral concepts. It is not impressive to note that a little over 50% had refrained from role play in healtheducation sessions (Table 6).

Distribution of adolescent girls on the basis of age at menarche: Out of 147 adolescent girls aged 15, 18(12.24%) had menarche at the age of 10. Whereas 67 (45.58%) adolescent girls attained menarche at the age of 12. Otherwise, out of 55adolescent girls who attained menarche at the age of ten, 32.73% are now at 15, 27.27% are now at 16, 23.64% are now at 17 and 16.36% are now at 18 years of age. This shows a steadylowering of age at menarche over the span of 3 years.

Out of 147 adolescent girls aged 15, 12.24% had attained menarche at the age 10, 21.77% at the age of 11, 45.58% at the age of 12, 14.97% at the age of 13 and 5.44% after theage of 13. It may be noted that, one third of the adolescent girls attained menarche at the age of 12 and it shows that the age at menarche is coming down (Table 7).

Profile of adolescent girls having sexual exposure: The above table shows that 58.97% of the sexually experienced adolescent girls had not attended health education sessions regularly (Table 8).

Knowledge on health issues of Premarital Sexual Relations (pms) and sexual experience: Knowledge on health issues related to premarital sexual relations is fairly good among Adolescent girls. Only 6.64% are ignorant. This table also refutes the common notion that introduction of sex and sexuality in health education sessions will motivate adolescent girls toexperiment sex. Those adolescent girls who had no knowledge on health issues related to premarital sexual relations are at greater risk of experiencing sex as 41.86% of girls admitted to have had sexual experience (Table 9).

Incidence of uti and sexual exposure: Urinary tract infection (UTI) is a common problem among adolescent girls. Out of 39 sexually active girls, 34(87.2%) had urinary tract infection. Among 609 girls who had no sexual exposure, 523 (85.88%) had urinary tract infection. This is certainly an indication of poor genitalia hygiene. The tables presented above substantiate the relevance of this study and highlights the need for interventions to empower the anganwadi workers' capabilities in conducting health education sessions to adolescent girls (Table 10).

Table 5. Knowledge, attitude and practice.

Variable	Category	Frequency	Percent
Awareness about importance of adolescent health	Aware	603	93.06
	Not aware	45	6.94
Source of information on adolescent health	Mother	328	50.62
	Elder Sister	140	21.6
	Friends	89	13.73
	Lady Teachers	116	17.9
	Jr.PHN	86	13.27
	Anganwadi worker	349	53.86
Knowledge on Menstruation	Received	595	91.82
	Not received	53	8.18
Daily bath during Menstrual period	Taking bath	609	93.98
	Not taking bath	39	6.02
Classes on health issues of unprotected sex	Attended	615	94.91
	Not Attended	33	5.09
Sexual exposure	Exposure	39	6.02
	No exposure	609	93.98
	Pregnancy	621	95.83
Health issues related to premarital sex	Sexual diseases	423	65.28
	HIV / AIDS	238	36.73
	Don't know	27	4.17
	Will resist	52	8
	Will not resist	78	12
Reaction to intentional touching by males	Will not respond though	233	36
	Dislike		
	Will not resist due to fear	266	41
	Need not resist	19	3
	Total	648	100

Table 6. Distribution of adolescent girls who participated in role play during health education sessions.

Role Play	Frequency	Percent
Yes	316	48.77
No	332	51.23
Total	648	100

Table 7. Distribution of adolescent girls on the basis of age at menarche.

Present Age / Age at Menarche	15	16	17	18	Total	%
10	18	15	13	9	55	8.48
11	32	23	16	14	85	13.12
12	67	87	39	32	194	29.94
13	22	11	107	33	204	31.48
After 13	8	40	48	14	110	16.98
Total	147	176	223	102	648	100

Table 8. Profile of adolescent girls having sexual exposure.

Health Education Sessions / Sexual Exposure	Attended Sessions				Total	
	Yes		No			
	Number	%	Number	%	Number	%
Exposed	16	41	23	59	39	100
Not Exposed	589	96.7	20	3.3	609	100
Total	605	93.4	43	6.6	648	100

Table 9. knowledge on health issues of premarital sexual relations (pms) and sexual experience.

Knowledge on Health / Sexual Exposure	Knowledge on Health Issues of PMS				Total	
	Yes		No			
	Number	%	Number	%	Number	%
Exposed	21	53.8	18	46.2	39	100
Not Exposed	584	95.9	25	4.1	609	100
Total	605	93.4	43	6.6	648	100

Table 10. Incidence of uti and sexual exposure.

Sexual Exposure / UTI	UTI				Total	
	Yes		No			
	Number	%	Number	%	Number	%
Exposed	34	87.2	5	12.8	39	100
Not Exposed	423	69.5	186	30.5	609	100
Total	457	70.5	191	29.5	648	100

Conclusion

The Anganwadi worker under the ICDS, acts as a change agent closely working withthe women folk in the country to empower them to take active decision affecting their lives. At the outset an anganwadi is a center for nonformal education to the under-fives with supplementary feeding and the anganwadi worker is fondly addressed by the community as anganwadi teacher. But the fact that their activities percolate more into the social life of the women folk by

giving them nutrition education and health education on child care, pregnancy, breast feeding and family planning. To the adolescent girls she is a friend and mentor giving them the required knowledge and skills for addressing issues related to menarche and menstrual health. They are supposed to give them motivation and support to resist any atrocities against them including attempts for sexual harassments by peers, relatives and the like.

The present study reveals that the anganwadi workers need more effective training to give health education to the adolescent girls to be empowered to meet the challenges against gender bias and gender-based atrocities that are escalating day by day. The rampant access and use of mobile phones and the usage of social media open up many any an avenue to wicked minded people to exploit the adolescents sexually and otherwise. The social acceptance earned by the anganwadi workers through dedicated work can well be utilised through focused training in health education to use them as a change agent in adolescent girl health in the country. The cooperation and support of elder women folk is also required in this mission. To put it in nut shell, the need of the hour is to strengthen the HE sessions through AWs by improving the quality, content and instructional techniques.

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Conflict of Interest

There are no conflicts of interest by author.

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