

Adolescent Girls Literacy Initiative for Reproductive Health (A GIFT for RH)



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Abbreviation and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMK	Aaama Milan Kendra
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
CBS	Central Bureau of Statistics
CEDPA	Center for Development and Population Activities
CREHPA	Center for Research on Environment Health and Population Activities
DMPA	Depomedroxyprogesterone Acetate (Depo-provera)
FCHV	Female Community Health Volunteer
FP	Family Planning
HIV	Human Immunodeficiency Virus
HP	Health Post
ICPD	International Conference on Population and Development
IG	Income Generation
IUD	Intra-Uterine Device
MCHW	Maternal and Child Health Worker
NFE	Non Formal Education
NGO	Non-Governmental Organization
PHC	Primary Health Center
RH	Reproductive Health
RTI	Reproductive Tract Infection
SHP	Sub Health Post
SPSS	Statistical Package for Social Science
STD	Sexually Transmitted Disease
TBA	Trained Birth Attendant
TFH	Traditional Faith Healer
TT	Tetanus Toxoid
UNFPA	United Nations Fund for Population Assistance
UNICEF	United Nations Children's Fund
UTI	Urinary Tract Infection
VDC	Village Development Community
WHO	World Health Organization

EXECUTIVE SUMMARY

The goal of the “Gift for RH” (the Adolescent Girls Initiative for Reproductive Health) project was designed to increase the ability of illiterate and out-of-school adolescent girls to make and to act on informed decisions regarding their reproductive health and rights as well as to make the community and their peers aware of the same by continuing participation in Adolescent Girls’ Groups (*Chelibeti Samusa*). This survey was conducted to determine if a nine-month non-formal education program could provide the knowledge needed to do so.

Toward this goal, the *Aamaa Milan Kendra* (AMK or Mothers’ Club), a national non-governmental organization in Nepal in 1999 introduced the Adolescent Girls’ Groups (AGGs) that they had formed to the “Gift for RH” project. The AMK has been supporting activities that help adolescent girls challenge gender inequity and expand their life options. The AMK introduced the *Lalima* literacy program in project areas. Funded by CEDPA and developed by World Education, the program is a health-focused nine-month non-formal education (NFE) literacy class that combines reproductive health knowledge along with literacy training. In addition, the girls have been learning practical subjects such as the importance of planting trees, using smokeless stoves, and building pit latrines. Upon completion of the *Lalima* class, the girls were encouraged to participate in formal schooling and were linked with other educational and economic skill-building opportunities.

Objectives of the Girls’ Classes

The Adolescent Girls’ Groups (AGGs) were founded to improve the self-esteem of illiterate and out-of-school adolescent girls between the ages of 10 and 19. Following the custom set by the Mothers’ Groups, each group has eleven members. The intent was to provide the girls with non-formal literacy education, using a curriculum focused on family life and reproductive health education so that the girls would be able to make educated choices about their own lives. The literacy training was practical, need-based and directly targeted adolescent girls.

The AGGs continued to meet monthly for two hours after the nine-month *Lalima* classes had ended and so continued to provide an atmosphere for open discussion about concerns and questions about adolescent development and reproductive health. In fact, nearly three-fourths of the adolescent girls (74%) felt they could share their own problems in their group.

Purpose of the This Study

The present study attempted to examine the impact of the *Lalima* classes on adolescent girls’ knowledge and attitudes towards reproductive health issues and changes on the following key issues:

- Perception on general health information and services
- Knowledge and attitude to reproductive health issues
- Knowledge about girls' mobility and girl trafficking
- Knowledge about family planning
- Knowledge and attitude to HIV/AIDS/STDs

This study also sought to explore the situation of girl trafficking in the Baglung District and to identify the need for anti-trafficking initiatives.

Methodology of the Study

This is a pre-test/post-test time series study using one pre-intervention survey and two post-intervention surveys. The design of the study was conceptualized by CEDPA and AMK.

The survey was conducted in three phases—

Phase I: Before starting the literacy (*Lalima*) classes (December 1999);

Phase 2: At the completion of the classes (January 2001); and

Phase 3: One year after completion of the classes (February 2002).

In all, almost all of the 891 adolescent girls who were members of the AGG, eleven girls in each of nine classes, were interviewed (861 at the first interview, all 891 at the second and 890 at the third), each time using the same structured questionnaire. Data analysis was descriptive, including frequencies and cross-tabulations for each of the three surveys, with comparisons by age group, caste/ethnicity, and VDC.

Characteristics of the Girls

To participate in the groups, the girls had to be between the ages of 10 and 19, illiterate or barely literate, out-of-school or with less than five years of schooling, preferably of low caste, of low economic status and unmarried. Among the 891 adolescent girls who did participate, younger girls (10-14 years) outnumbered the older ones (15-19 years) in all AGGs in the nine study VDCs. The median age was 13 years. Almost two-thirds (64%) of them were between the ages of 10 and 14. They represented three caste/ethnic groups, namely, Kami/Damai/Sarki (42%), Gurung/Magar (29%), and Brahmin/Chhetri/Thakuri (28%) in the Baglung District of Nepal's Western Development Region.

The Phase I pre-intervention study found that virtually all of the adolescent girls in the AGGs wanted to go to school (95%) but that family responsibilities kept them from attending school. Nevertheless, these girls' families did give them permission to attend the classes, fathers and mothers in almost equal proportion. By the third interview, 93% of the 10-14 year olds and 26% of the 15-19 year olds had begun formal schooling.

Sources of Health Information and Health Care

Along with being better able to assess their own health status, these adolescent girls learned how to get health information and health care when needed. Almost 60 percent said they had not known where to get information before starting the classes. By the third interview, virtually all had gotten information from at least one source, primarily radio, but also health workers and posters and pamphlets as well as the literacy classes themselves.

As with knowing where to get health-related information, knowing where to get healthcare services increased between Phase I and Phase III. By the time of the Phase III interview, virtually all of the girls (98%) knew what health facilities were available in their villages.

Awareness of Adolescent Development

At the time of the Phase I study, almost none of the 10-14 year olds could identify the physical changes that occur in girls or boys during adolescence, although almost 40 percent of the 15-19 year olds were able to. By the third interview, this knowledge was almost universal.

In the Phase I study, only half of the girls knew about menstruation but, by Phase III, 94 percent of even the 10-14 year old girls knew about it even though only one-fourth (20%) had experienced it by that time. At all phases of the study, their mothers were who they preferred to discuss menstruation and menstrual problems with, although the proportion of others increased.

Marriage and Childbearing

Many Nepalese parents have absolute authority as to when and to whom their children marry. However, the proportion of the girls in the AGGs that felt they would be involved in such decisions increased from 37 percent in the Phase I survey to 67 percent at Phase III and there was a similar doubling in the proportion those who felt they could convince their guardians to change their decisions. These results strongly suggest that the *Lalima* classes enhanced the girls' confidence in their ability to negotiate with their families about their marriage.

Most girls are married during their teens and more than one-half begin childbearing by age 19. In fact, the pre-intervention survey found that more than one-quarter of the girls perceived the right age for marriage for girls to be under 20 years. By the Phase III survey, when asked to specify the best age for girls to marry, almost none of the girls still thought it should be before age 20 for either sex. The same applied to when they themselves wanted to marry, with 95% wanting to wait until they were at least 20 years old.

Likewise, the perception of the appropriate age for beginning childbearing was extended. The proportion who thought the first pregnancy should not occur until after age 20 went from 40 percent to 93 percent.

Knowledge about Conception and Family Planning

Knowledge about how women conceive soared by the end of the *Lalima* classes. In the Phase I survey, less than 10 percent knew "how a woman gets pregnant." In the Phase II study, nearly half of the adolescent girls knew how conception could occur; and, by Phase III, knowledge about conception was nearly universal, regardless of age. Ninety-three percent mentioned "sexual intercourse between a boy and girl" and almost 60 percent specifically mentioned "sexual intercourse without using a family planning method" as the cause of conception.

Awareness of family planning increased sharply after the intervention as well. The Phase I study found that almost none (97%) of the girls could name any family planning methods. By the Phase II interview, 33 percent of the younger group and 73 percent of the older group knew at least one and by the third interview, all did, with the three most widely known methods being the condom (96%), oral pills (89%) and Depo-provera (DMPA) (81%). More than 80 percent had learned that these contraceptives could be obtained from health facilities.

Knowledge about Safe Pregnancy and Delivery

Looking toward the time they would begin childbearing, the Phase I study found that 92 percent of the 10-14 year olds and 67 percent of the 15-19 year olds could not name anything specific that a woman should do to keep herself and her baby healthy during pregnancy. By the third interview, the importance of nutritious food, pregnancy check-ups and vaccinations for tetanus were precautions named by 94 percent, 73 percent and 70 percent, respectively.

Similarly, knowledge about the “clean home delivery” kits increased from just seven percent before the class to almost 50 percent by the end of the class and to nearly universal (95%) by the final interview, as did knowledge of at least one source of the kits.

Awareness of STD and HIV/AIDS

Awareness about sexually transmitted infections (STIs) also increased sharply over time. Before the classes, virtually none of the 10-14 year olds and only seven percent of the 15-19 year olds had heard of sexually transmitted infections (STIs). The Phase III study showed that majority of the adolescent girls (96%) were aware of STIs and 99 percent could name at least one symptom.

Likewise, before the classes, knowledge about HIV/AIDS was almost non-existent. Only one in ten of these adolescent girls had heard of AIDS, although a higher proportion of the 15-19 year olds were aware of the disease than those in the younger group. Yet 28 percent of those who did know of AIDS thought it could be cured. By the final survey, almost 100 percent of the girls knew how AIDS was transmitted and that it was incurable and 70 percent named “safer sex practices” as the way of preventing HIV/AIDS, with 55 percent of them specifying condoms as one method of prevention.

Awareness of Girl Trafficking

At the time of Phase I survey, slightly more than one-third of the adolescent girls (35%) reported that girls from their neighborhood traveled outside the VDC for work of some kind. In the Phase II and III surveys, this proportion actually decreased slightly, to below 30 percent. More specifically, however, awareness about girl trafficking increased sharply after the classes. The pre-intervention study found that one-third of these adolescent girls had heard that girls are “trafficked and sold in big cities in India” and this increased with age. By the Phase III survey, the percentage of girls that had heard of girl trafficking was nearly universal (90%). Nevertheless, once aware of the issue, almost all (94%) denied that girls from their village stayed away for extended periods of time to work, which would be the primary indicator of the problem.

Conclusions

The three major finding of this study were that:

- Basic literacy classes were used successfully to teach reproductive health and other health-related topics to illiterate adolescent girls, especially those in the 10-14 age group.
- Knowledge about reproductive health and family planning, as well as sources of health information and health care, all increased quite dramatically by the end of a nine-month non-formal education program and continued to increase throughout the following year.
- The findings of this study strongly suggest that basic literacy classes for illiterate adolescent girls are not only valuable in improving the education and status of women in Nepal, but also in teaching them about their reproductive health and how to care for it, in a context that makes it acceptable to their families and communities.

The dramatic increases in knowledge found in this series of surveys demonstrate that using a health curriculum in classes to teach girls to read and write can provide a highly cost-effective, cost-efficient way to help adolescent girls learn about the general and reproductive health and how to better care for themselves. The literacy classes also built relationships and an atmosphere of trust that fostered informal discussion and learning long after the classes ended. The meetings of the AGG that continued throughout the following year (on a monthly basis for school girls, and weekly for out-of-school girls) provided a means to do that and knowledge continued to grow in large increments during the year after the classes had ended.

Knowledge in and of itself cannot change behavior but it is essential to doing so. Despite the limitations of a study such as this one, its findings demonstrate the value of the Adolescent Girls' Groups and of using literacy classes as vehicles for teaching health-related topics, including adolescent reproductive health.

Programmatic Implications and Recommendations

The implications of these findings for these illiterate girls, their families, and for Nepalese society are demonstrated in two ways. First is the fact that so many of their families gave them permission to go on to formal schooling once they had completed these classes, indicating how much their own perspective about education for girls could change. Second is that these girls will not only be applying what they learned in their own lives but will be sharing what they have learned with their family and friends, thereby spreading the influence of the curriculum.

The fact that the program was initiated by Mothers' Clubs, which already had the respect of the communities they are in, certainly contributed to its acceptability and success in each of the districts. The AMK's far-sightedness in initiating Adolescent Girls' Groups in communities throughout Nepal, and these Girls' Classes in Baglung which incorporated an effective curriculum, serves as a model for the establishment of similar programs elsewhere.

Future Research

The intervention appears to have been very successful in enhancing reproductive health knowledge among disadvantaged adolescent girls, but the study could not document whether the girls were able to translate this knowledge into practice (except for much increased immunization coverage). Further research would be needed to understand changes in the actual reproductive behavior of the adolescent girls based on what they had learned and may be unrealistic.

In the meantime, comparing literacy classes using the standardized health-focused *Lalima* curriculum with literacy classes that have a more general curriculum, based in matched communities, might reduce the potential bias of the girls' maturation process and external influences. Qualitative studies would also be useful to examine how the knowledge gained by these girls affects their own decision-making and their friends, family and community.

Regardless of whether such studies are conducted or not, this program has shown itself to be an extremely cost-efficient step toward improving the status of women and the health and well-being of families and the communities in which they live.

Chapter 1

INTRODUCTION

1. Introduction

The goal of the “Gift for RH” project is to increase the ability of illiterate and out-of-school adolescent girls to make and act on informed decisions regarding reproductive health and rights, as well to make the community and their peers aware of the same, by the girls’ participating in literacy classes given in adolescent girls’ groups.

The objectives of the project were:

- (1) to improve self-esteem of the girls by forming groups and providing nonformal education and family life education to acquire reproductive health knowledge and skills to enable them to make informed decisions on RH;
- (2) to enhance the girls’ communication with their parents and community members about the reproductive health needs and rights of adolescent girls; and
- (3) to assist girls’ groups to transfer what they learn in the non-formal classes onto formal schooling.

This study was conducted to determine if a nine-month non-formal education program for illiterate adolescent girls could be used successfully to teach them how to read and write but also to teach them about their own reproductive health and other subjects related to the health and well-being of themselves and their families.

A separate Endline Study (August, 2002) examined the girls’ perceptions of the effect the classes and the AGG have had on their own lives.

1.1 Background

Following the International Conference on Population and Development (ICPD), adolescent reproductive health has received enormous attention around the world (United Nations, ICPD 1994). The main reason for this was recognition of the vulnerability of adolescents to reproductive health problems.

In 1994, with support from the United Nations Population Fund (UNFPA), *Aamaa Milan Kendra* (AMK), also known as the Mothers’ Club, formed Adolescent Girls’ Groups (AGG), in nine Village Development Committees¹ (VDCs) of Baglung District, namely Kushmishera, Tityang, Dhullu Banskot, Dhamja, Rangkhani, Hugdishir, Bhakunde and Kalika. VDCs. The AGGs, called *Chelibeti Samuha* in Nepali, aimed to improve the self-esteem, knowledge, and communication skills of adolescent girls.

In 1999, with financial support from the Gates Foundation and technical assistance from CEDPA, AMK implemented the *Adolescent Girls Initiative for their Reproductive Health* project—known as “A GIFT for RH” and introduced it to the AGGs. Utilizing CEDPA’s “Better Life Options” program, the project aimed to improve communication about reproductive health between mothers and daughters and to increase the ability of adolescent girls to make and act on informed decisions regarding their social, economic and health needs and rights.

¹ A VDC is an administrative unit. VDCs are composed of nine villages (know as wards).

For the purpose of this study, the term “adolescent” refers to individuals between the ages of 10 and 19 years. Adolescence is the period of transition from childhood to adulthood. During these formative years, a remarkable amount of physical and psychological changes take place. In Nepal, adolescents comprise more than one fifth (22%) of the total population of 23 million. Sixty percent of Nepal’s population is under 25 years of age. The majority of adolescent girls are illiterate. Among adolescent girls between 10 and 14 years of age 49 percent are literate and between 15-19 only 39 percent are literate. Among boys in corresponding age groups 76 and 71 percent are literate (CBS, 1995). In Nepal (as in most developing countries) the rights of adolescent girls are not widely acknowledged or protected, especially with respect to reproductive choice.

In Nepal’s social structure adolescent girls are probably the most vulnerable group. They are victims of early marriage, early and frequent child bearing, and unsafe abortion, all of which lead to high morbidity and mortality among these girls. In addition, their babies are at risk of premature birth, stillbirth, and low birth weight. Pregnancy complications and sexually transmitted diseases during adolescence can permanently affect the future reproductive capacity of the girls as well as the health of the whole family (Tamang & Nepal, 2000). Nepal’s adolescent girls are disadvantaged, neglected, and exploited.

1.2 Adolescent Girls’ Groups (*Chelibeti Samuha*)

Considering the problems facing adolescent girls, a number of government agencies and non-governmental organizations (NGO) have been working to improve their social, economic and health status. In 1999, the AMK (*Aamaa Milan Kendra* or Mothers’ Club), a national NGO, introduced 891 illiterate and out-of-school girls from the Adolescent Girls’ Groups (AGGs) in Baglung District to the “Gift for RH” project.

The AMK has been supporting activities that help adolescent girls challenge gender inequity and expand their life options. AMK introduced the *Lalima* literacy program in project areas. Funded by CEDPA and developed by World Education, the program is a health-focused nine-month non-formal education (NFE) literacy class that combines reproductive health knowledge along with literacy training. In addition, the girls have been learning practical subjects such as the importance of planting trees, using smokeless stoves, and building pit latrines. Upon completion of the *Lalima* class, the girls are encouraged to participate in formal schooling and are also linked with non-formal education opportunities.

1.2.1 Goal of the AGG Program

While the goal of the program has been to increase the ability of illiterate and out-of-school adolescent girls to make and act on informed decisions regarding their reproductive health and rights as well as to make their communities and their peers aware of the same, the key concern has been to prepare these girls for safe motherhood. However, there were other concerns as well. Nepal has been witnessing the exploitation of young girls as sex workers, often with the tragic consequences of their succumbing to STDs / HIV and AIDS.

1.2.2 Objectives of the AGG Program

The AGGs meet monthly under the direction of an AMK facilitator. The objectives of the AGG program have been:

1. To improve the self-esteem of illiterate and out-of-school adolescent girls between the ages of 10 and 19 years by forming 81 girls’ groups. Following the custom set by the Mothers’

Groups, each Girls' Group class has eleven members, for a total of 891 girls. The intent was to provide the girls with non-formal literacy education. The curriculum focused on family life and reproductive health education so that the girls would be able to make educated choices about their own lives.

2. To enhance the girls' communication with their parents and community members about the reproductive health needs and the rights of these adolescent girls, through information, education and communication (IEC) interventions, awareness programs, and community events.
3. To assist the girls participating in the AGGs to transfer the skills they learn to formal schooling through advocacy and networking at local level, by mobilizing parents, communities, schools and non-governmental organizations in collaboration with local government.

1.3 Program Description

1.3.1 Formation of Adolescent Girls' Groups

The AGGs were formed in all nine wards (villages) of the nine project VDCs. Each group was composed of a president, secretary, and nine members. To assist the girls in setting up their AGGs, 27 facilitators received specialized training on how to help the girls organize themselves. There were three AGGs in each VDC at which the girls learned ways of convincing parents and communities to support the groups and to make it possible for them to participate in the program. All group members participated in the literacy program.

1.3.2 Selection Criteria for AGG Membership

The following criteria were used to select adolescent girls for group membership:

- Age between 10 and 19
- Illiterate or barely literate
- Out-of-school or less than five years of schooling
- Low caste (preferable)
- Low economic status
- Unmarried

Mothers' groups and local community volunteers were supportive of the AMK district staff recruitment efforts and were mobilized to identify and motivate prospective participants. Since the villages were small, virtually all of the illiterate girls were able to be enrolled.

1.3.3 Development of the AGG Package

The AMK developed the curriculum based on the Nepali version of the "Choose a Future" program. This program has been running for ten years in some areas of Nepal and had previously been used for the Ministry of Education's literacy program. The effectiveness of the program in increasing literacy was demonstrated by the fact that, after participating in the nine-month program, 50 percent of the girls had been able to advance directly into class two in the public schools, and another 50 percent were literate enough to join class one. Under that program, girls who did go on to formal schooling received a school uniform as an incentive.

The *Lalima* classes focused on basic literacy, but the curriculum included health education (including family planning, reproductive health and STI/HIV/AIDs), and girl trafficking). The literacy training was practical, need-based and directly targeted adolescent girls.

After the nine-month *Lalima* classes had ended, the AGGS continued to meet monthly for two hours and so continued to openly discuss concerns and questions. Those girls who did not go on to be enrolled in formal schooling used to meet twice a week. They learned and did many things, such as community mobilization, participation in special events/days, visits to health facilities (for TT vaccination, anemia tests, etc.).

1.4 Purpose of the Study

The present study attempted to examine the impact of the classes on adolescent girls' knowledge and attitudes towards reproductive health issues and changes on the following key issues:

- Perception on general health information and services
- Knowledge and attitude to reproductive health issues
- Knowledge about girls' mobility and girl trafficking
- Knowledge about family planning
- Knowledge and attitude to HIV/AIDS/STDs

This study also sought to explore the situation of girl trafficking in the Baglung District and to identify the need for anti-trafficking initiatives.

1.5 The Project Area

Baglung District is situated in the Dhaulagiri Zone of Nepal's Western Development Region. It is a hilly district with geo-physical differences ranging from fertile plains in the south to steep, rocky and snowy hills and mountains in the north. The majority of the population is Magar and B.K. (one of the lower castes). Brahmin, Chhetri, Newar, Gurung, Thakali, and Thakuri are also present. According to the preliminary results of 2001 Census, the district has a population of 268,485. It is administratively divided into the municipality of Kalika and 59 VDCs.

The district headquarters is linked to Pokhara (the nearest urban area) by the Pokhara-Baglung Highway, a 68-kilometer black-topped road. This is the only means of transporting goods and services from the district to the main cities of the country. Within the district, there are less than five kilometers of black-topped roads (District Development Profile Nepal, 2001). Spread across the district are one hospital, two primary health care centers, ten health posts and 51 sub health posts.

1.6 Methodology of the Study

1.6.1 Study Design

This is a pre-test/post-test time series study (a quasi-experimental design) using one pre-intervention survey and two post-intervention surveys. The design of the study was conceptualized by CEDPA and AMK.

The study was conducted in three phases—

Phase I: Before starting the literacy (*Lalima*) classes (December 1999);

Phase 2: At the completion of the classes (January 2001); and

Phase 3: One year after completion of the classes (February 2002).

This report presents the results from all three phases of the study.

1.6.2 Sample

This study involved attempting to interview all 891 adolescent girls, eleven girls in each of nine classes, who were members of the AGG using a structured questionnaire. The same respondents were included in all three surveys. No more than 25 replacements (younger and unmarried) were made between the first and third phases, as there was strong follow-up as the program progressed.

Altogether nine wards in nine project VDCs were included in the present study.

1.6.3 Questionnaire Design

The same structured questionnaire was used in all three rounds of the survey. Some questions required closed-ended responses—some forced choice and some allowed multiple responses.

1.6.4 Training of Field Researchers

For the study, eighteen female field researchers (four field supervisors and 14 enumerators) were hired locally. Some of the field researchers were AMK staff, others were volunteers and the rest were recruited by AMK. For the first two rounds of the survey, the field team received two days of intensive training from the core study team. The training was conducted in Baglung and included lectures, role-plays, mock interviews, group work and field practices. For the Phase III data collection, AMK's local Baglung staff trained the field teams.

1.7 Fieldwork

The adolescent girls were interviewed individually in private. Before the beginning of the interview, respondents were briefed about the purpose and nature of the interview. Using the structured questionnaire, interviews solicited knowledge and perception about reproductive health. The fieldwork was monitored and supervised by AMK Baglung project staff.

1.8 Data Management and Analysis

All completed questionnaires were sent to the Center for Research on Environment, Health and Population Activities (CREHPA) immediately after completion of the fieldwork. The questionnaires were manually edited, coded, and entered by CREHPA. The codebook developed during the first phase was used for the second and third phases with minor updating. Data entry validity checks were performed on a randomly selected 10 percent of the questionnaires. After cleaning (consistency checks and corrections), the data were transferred into an SPSS-PC statistical software package for further processing and analysis.

Data analysis was descriptive, including frequencies and cross-tabulations for each of the three surveys, with comparisons by age group, caste/ethnicity, and VDC. The analysis and write-up were reviewed and edited by CEDPA headquarters.

1.9 Organization of the Report

This report begins with the Executive Summary and is divided into eight chapters as follows:

- Chapter 1 presents background, objectives and methodology of the study.
- Chapter 2 provides socio-demographic data about the adolescents and their families.
- Chapter 3 presents the girls' expectations about the *Lalima* classes.

- Chapter 4 looks at the girls' perceptions and knowledge about general health information and services.
- Chapter 5 deals more specifically with girls' knowledge and attitude about reproductive health, family planning, and HIV/AIDS.
- Chapter 6 discusses girls' mobility and girl trafficking.
- Chapter 7 examines girls' involvement in the AGGs and their perceptions of the benefits of AGGs.
- Chapter 8 presents the summary and conclusions.

Chapter 2

CHARACTERISTICS OF ADOLESCENT GIRLS UNDER STUDY

2. Introduction

This chapter analyzes the demographic and socio-economic characteristics of adolescent girls. The variables analyzed were age distribution, caste/ethnicity, sources and control of family income.

2.1 Age Composition

Among the 891 adolescent girls in this study, younger girls (10-14 years) outnumbered the older ones (15-19 years) in all AGGs in the nine study VDCs. The median age was 13 years. Almost two-thirds (64%) of them were between the ages of 10 and 14. The proportion of the younger girls (10-14 years) was as high as 80 percent in Dhullu Banskot VDC. This is probably due to the early marriages of girls in the 15-19 year old bracket.

2.2 Ethnicity

The girls in this study were grouped into three caste/ethnic groups, namely, Kami/Damai/Sarki (42%), Gurung/Magar (29%), and Brahmin/Chhetri/Thakuri (28%). However, there was a wide variation in ethnic composition across the VDCs; for example, almost two-thirds of the girls from Kalika were from the Kami/Damai/Sarki communities, the majority in Rangkhani were from Gurung/Magar communities, and in Kushmishera the majority were from Brahmin and Chhetri families (Table 2.2).

Table 2.2 Percentage distribution of respondents* in nine VDCs, by age group and ethnicity

VDC	Age			Caste/Ethnicity				N
	10-14	15-19	Median Age	Brahmin/ Chhetri/ Thakuri	Gurung/ Magar	Kami/ Damai/ Sarki	Other	
Kusmishera	65.7	34.3	13.0	65.7	18.2	16.2	-	99
Tityang	62.6	37.4	13.0	42.4	3.0	54.5	-	99
Rangkhani	56.6	43.4	14.0	14.1	58.6	27.3	-	99
Dhullu Banskot	80.8	19.2	11.0	18.2	54.5	27.3	-	99
Batakachaur	65.7	34.3	13.0	28.3	16.2	55.6	-	99
Dhamja	53.5	46.5	14.0	23.2	25.3	48.5	3.0	99
Hugdishira	57.6	42.4	14.0	26.3	18.2	55.6	-	99
Bhakunde	72.7	27.3	12.0	11.1	58.6	28.3	2.0	99
Kalika	60.6	39.4	14.0	23.2	10.1	61.6	5.1	99
Total %	64.0	36.0	13.0	28.1	29.2	41.6	1.1	891

*Based on Phase II interviews, in which all 891 AGG members participated.

2.3 Source of Family Income

Farming was reported as the main source of family income by two-thirds (67%) of the girls. Another 22 percent said that day labor was the family's primary income source. This varied by VDC. In Kalika, the district's only municipality, three-fourths of the girls mentioned day labor as the main source of family income (Table 2.3).

Table 2.3 Percentage Distribution of Respondents* According to Family's Main Source of Income

Main source of family income	Phase II
Farming / raising animals	69.0
Day labor	22.4
Foreign Service (abroad)	2.0
Services (e.g., medical and military)	5.4
Other	0.8
Total %	100.0
Total N	891

*Based on Phase II interviews, in which all 891 AGG members participated.

2.4 Control of Family Income

More than three-fourth of the girls from the Brahmin/Chhetri/Thakuri, Gurung/Magar, and Kami/Damai/Sarki communities reported that their fathers were the ones who controlled family income. Among other castes and ethnic groups, 60 percent of the girls mentioned their fathers and 30 percent said their mothers had primary control over family income. (Table 2.4)

Table 2.4 Percentage distribution of respondents according to the person in the family who makes decisions about family income and expenditures, by caste/ethnicity

Who makes the decisions about money	Phase II				
	Brahmin/Chhetri /Thakuri	Gurung/ Magar	Damai/Kami/Sarki	Other Castes	All
Father	74.0	78.5	74.9	60.0	75.5
Mother	22.0	18.1	21.3	30.0	20.7
Grandfather/mother	2.4	2.3	2.2	10.0	2.4
Other relative	1.6	1.2	1.6	0.0	1.5
Total %	100	100	100	100	100
Total N	250	260	371	10	891

*Based on Phase II interviews, in which all 891 AGG members participated.

Chapter 3

EXPECTATIONS ABOUT THE GIRLS' CLASS

3. Introduction

This chapter examines the girls' desire to attend school, reasons for not attending school, sources of information on the literacy class, skills expected to gain from membership in the AGGs the *Lalima* classes, and expected utilization of the skills gained.

3.1 Desire to Attend School vs. Reasons for Not Attending School

The Phase I pre-intervention study found that virtually all of the adolescent girls in the AGGs wanted to go to school (95%). Of the girls who said they did not want to go the reasons varied with age, but the overwhelming proportion said that family responsibilities kept them from attending school. Among the girls aged 15-19, almost three-quarters (71%) said they were not attending school because they had to care for younger children at home. About half of the 10-14 year- old girls also said they had to look after small children. The other half simply said that they had to work at home. More than 10 percent of the girls said their families could not afford the school fee (Table 3.1(a)).

Table 3.1(a) Percentage distribution of respondents according to their desire for formal schooling and main reasons for not attending school, by age

Do you want to go to school?	Phase I		
	10-14	15-19	All ages (10-19)
Yes	94.4	95.0	94.6
No	5.6	5.0	5.4
Total %	100	100	100
Total N	550	319	869
Reasons unable to attend formal school, among those who wanted to attend			
Look after small children	49.9	70.6	55.6
Work at home	46.8	36.0	44.8
Could not afford school fee	11.6	10.6	11.2
Did not like to read	5.0	5.3	5.0
School not accessible	1.9	5.0	3.0
Daughters are not allowed to attend	1.7	1.0	1.6
Other	1.2	1.0	1.1
Don't know	2.3	1.0	1.8
Total N	519	303	822*

Percentage total may exceed 100% due to multiple responses.

Within a year of completing the *Lalima* classes, more than two-thirds of the girls (67%, n=595) enrolled in school, including nearly all of the 10-14 year olds (93%). (Table 3.1(b)). The lower proportion of older girls enrolling in school reflects in part the fact that many had “aged out” (six years of age is the official age for enrollment at Class one), or had married (Table 3.1(b)).

Table 3.1(b) Percentage distribution of respondents enrolling in formal school after taking the literacy class, by age group

Did you enroll in school?	Phase III		
	10-14	15-19	All ages (10-19)
Yes	92.8	26.0	66.9
No	7.2	74.0	33.1
Total %	100.0	100.0	100.0
Total N	544	346	890

Very few of the participants who had begun formal schooling by the Phase III interview reported having any problems at school. Of the 11 percent who did, most said it was because they had difficulty purchasing their uniform. Almost one-quarter (21%) of the 15-19 year olds mentioned that people teased them on the way to school (Table 2.5(c)).

Table 3.1(c) Percentage distribution of respondents who had enrolled in school, according to problems experienced, by age group

Do you have any problems at school?	Phase III		
	10-14	15 -19	All ages (10-19)
Yes	9.7	15.6	10.6
No	90.3	84.4	89.4
Total %	100.0	100.0	100.0
Total N	505	90	595
Type of problems faced			
No uniform	66.7	42.9	61.5
School is too far	33.3	42.9	35.4
People tease on the way of school	2.0	21.4	6.2
Total %	100.0	100.0	100.0
Total N	51	14	65

Percentage total may exceed 100% due to multiple responses.

3.2 Sources of Information about the *Lalima* Classes

More than two-thirds of the girls learned about the AGGs from AMK volunteers. The exceptions were in Batakachaur VDC (39 percent) and in Hugdishir (44%) where they learned about the AGGS through *Sahayogi* (facilitators). Others learned about the class through friends (12%), parents (6%), a sibling (4%), neighbor (4%) or health worker (2%) (Table 3.2(a)).

The girls’ fathers and mothers gave them permission to attend the classes in almost equal proportion. Almost half of the girls were “sent” by their fathers while 43 percent said that their mothers had sent them. Almost 10 percent of the 15-19 year old girls said that they had decided on their own to join the AGGs and attend the *Lalima* classes (Table 3.2(b)). Few girls (6%) reported that they had actually learned about the literacy classes from their parents, but that their parents did give them permission to attend.

3.3 Skills Expected to Gain from the Program

Most of the girls joined the program with the primary hope of becoming literate. As documented in the pre-intervention survey, a large majority of the girls (72%) expressed their desire to learn to read and write. However, 17 percent did not know what they wanted to learn (Table 3.3). This suggests that few of them were aware of the AGG purpose or the *Lalima* curriculum content.

Table 3.2 Percentage distribution of respondents according to what they wanted to learn from the *Lalima* classes

What do you want to learn in this class?	Phase I (All girls, 10-19)	10-14	15-19
Read and write	72.4	63.2	72.7
Vocational skills	6.3	3.7	9.1
Math	5.4	4.4	5.8
Personal or menstrual hygiene	4.7	2.3	7.2
Other *	16.9	18.4	12.5
Don't know	1.8	1.2	2.5
Total N	869	550	319

Percentage total may exceed 100% due to multiple responses

**Includes family planning, AIDS and STDs and adolescent reproductive health among others.*

3.4 Expected Utilization of the Skills Gained

Before starting the classes, one third of the girls (35%) expressed their desire to enroll in formal schooling after completion of the literacy classes. Desire to enroll in school after completion of the classes varied remarkably with age, with almost half of the girls (44%) aged 10-14 saying they wanted to compared with 20 percent of the 15-19 year olds. This variation may be related to age differences.

Almost 15 percent of the girls said they wanted to be able to help their younger siblings learn to read and write while 9 percent would help their friends and 7 percent their parents or other adult family members. An especially high proportion of the girls from Hugdishir (38%) wanted to be able to teach their illiterate parents to read and write (Table 2.5, appendix). Thirty percent of the girls in both age groups were not sure what they wanted to do after completing the classes (Table 3.4).

Table 3.3 Percentage distribution of respondents according to what they want to do after completing the *Lalima* class, by age group

What want to do after completing class	Phase I		
	10-14	15-19	(All) 10-19
Enroll in formal schooling	44.0	20.4	35.3
Help brothers and sisters learn to read and write	11.5	19.7	14.5
Help friends to read and write	9.1	9.7	9.1
Help parents and adult family members learn to read and write	5.6	9.1	7.1
*Work in Home	2.2	5.6	3.2
*Sewing Clothes	2.0	5.3	2.4
*To be a role model	0.5	3.8	2.0
*Engage in Skillful work	0.5	1.6	1.7
Other * including "Nothing"	0.6	1.9	1.0
Don't know	30.2	30.4	30.3
Total N	550	319	869

Percentage total may exceed 100% due to multiple responses

Chapter 4

PERCEPTIONS OF GENERAL HEALTH INFORMATION AND SERVICES

4. Introduction

This chapter examines participants' perception of their own health, the availability of health facilities, participants' utilization of the local health facilities, treatment seeking decision maker, and which area of healthcare information and services were of interest to the participants.

4.1 Participants' Perceptions of Their Own Health

At all three interviews the proportion of girls who described themselves as not feeling well was reassuringly low (5-6%). There were several shifts in their perceptions of their own health over the phases of the study, mostly for the better. Perhaps most telling was that the proportion of those who could not even assess their own health status went down from one out of four of the girls before the classes to almost zero afterwards. This shift pre- to post-intervention from "don't know" to "good" or "okay" may itself be a gauge of their increased understanding of key health indicators.

The pre-intervention (Phase I) survey found that more than 40 percent of them felt "good" and 30 percent felt "okay" about their health before they began the classes. This increased to 65 percent and 30 percent immediately after the class. A 10 percent decline in those describing their status as "good" a year later suggests that their access to care had been significantly higher while they were taking the classes (Table 4.1).

Table 4.1 Percentage distribution of respondents according to their perception about their own health, pre-intervention, immediately after and one year post-intervention

How do you feel about your personal health?	Phase I	Phase II	Phase III
Good	42.6	65.0	54.7
Okay	28.4	29.5	38.4
"Feel sick"	4.9	4.6	6.2
Don't know	24.1	0.9	0.7
Total %	100	100	100
Total N	869	891	890

4.2 Sources of Health Information

Along with being better able to assess their own health status, these adolescent girls now know how to get health information. This ability increased sharply after attending the classes, from 43 percent in Phase I to almost universal in Phases II and III. More specifically, almost 60 percent said they had not known where to get information before starting the classes. Among those who did know, radio was the most common source of information. Less than 10 percent said they got information from friends, family members, or health workers.

At the Phase II interview, the proportion of girls getting information from the radio (39%) almost doubled; and the *Lalima* class itself was cited by the girls as a primary source of health information (22%), along with health worker (23%). By the time of the Phase III interview, health workers had become important sources of health information as well (62%), as had posters and pamphlets (63%). Nearly one-third (30%) of the adolescent girls mentioned the literacy classes as one of their most important sources of health information (Table 4.2). The increase

across all categories suggests that bringing the girls together for the classes opened conversations and resources in many directions.

Table 4.2 Percentage distribution of respondents according to “sources of information” about health before and after the *Lalima* literacy class

How do you get health information?	Phase I	Phase II	Phase III
Radio	19.9	39.3	84.0
Friends	7.5	1.9	28.0
Family members	5.9	10.4	24.4
Health worker	5.1	23.3	61.9
Literacy class	1.0	22.1	29.8
Poster/pamphlet	0.0	3.9	62.9
Nowhere	0.3	0.0	0.0
Other	2.0	2.8	13.3
Don't know how to get information?	58.3	3.8	0.8
Total N	869	891	890

Percentage total may exceed 100% due to multiple responses

4.3 Availability of Health Facilities

As with knowing where to get health-related information, knowing where to get healthcare services increased between Phase I and Phase III. At the time of the pre-intervention survey over two-thirds of the girls knew where to get care. This figure reflects the low level of awareness in Batakachaur (27%) and Dhamja (34%) (Table 3.3 appendix).

By the time of the Phase II interview, virtually all of the girls (98 percent) knew what health facilities were available in their villages. By Phase III all (100%) were aware of the types of healthcare facilities available in their villages. All respondents from Kalika knew there was a hospital in their VDC, 97 percent from Kushmishera were aware of a primary healthcare center in their VDC. Respondents from Rangkhani, Dhamj, and Hugdishira knew their VDCs had health posts, and the majority of the respondents from Tityang, Dhullu Banskot, Batakachaur and Bhakunde VDCs reported the availability of sub health posts in their villages.

Two-thirds of the adolescent girls (64%) mentioned that their usual source of care was a health post or sub health post, with less than 20 percent citing a hospital as the usual source of care. Interestingly, one-fourth of the girls from Rangkhani identified a “traditional faith healer” as the primary source of treatment. This could be because Rangkhani VDC is one of the most remote in Baglung district (Table 3.4, appendix).

Table 4.3 Percentage distribution of respondents’ knowledge about the availability of health facilities in their village

Do you have a health facility in your village?	Phase I	Phase II	Phase III
Yes	61.8	98.2	99.9
No	37.4	1.8	1.0
Don't know	0.8	0.0	0.0
Total %	100.0	100.0	100.0
Total N	869	891	890
If yes, which health facilities do you have?			
Health Post	55.1	75.9	38.8
Sub health post	25.7	4.3	38.1
Hospital	8.2	10.7	11.5
Outreach (Gaun-ghar) clinic	4.7	0.0	0.0
Primary Health Care Center	1.7	9.0	11.6
Don't know	4.7	0.0	0.0
Total %	100.0	100.0	100.0
Total N	537	875	889

4.4 Utilization of the Local Health Facilities

Phase I study showed that less than 20 percent of the girls had visited a healthcare facility for care in the six months preceding the survey. Three-quarters of the girls reported not having experienced any illness in the reference period. Of the girls who had experienced illness but did not visit a health facility, the major reason for not seeking care appeared to be the cost of the services (68%), followed by distance (20%).

The number of adolescent girls making use of local health facilities increased over time. By the *Phase III* study, 70 percent of the girls said they had visited a health facility in the previous six months—primarily for vaccinations. The percentage of girls who had visited a health facility did not vary by age. Only one girl in twenty-five mentioned that she had felt sick during the previous six months but had not visited a healthcare facility. The main reasons were that they could not afford the care or that it was too far away (Table 4.4). None of the participants from Bhakunde had ever visited a health service, due to the cost of care being too high.

Table 4.4 Percentage distribution of respondents who had visited a health facility in the past six months, or their reason for not visiting one if they had been sick

	Phase I	Phase II	Phase III
Have you visited any health facility in the last 6 months?			
Yes	15.5	19.3	70.2
No	10.7	2.7	3.6
Did not get sick during that period	73.8	78.0	26.2
Total %	100	100	100
Total N	869	891	890
Among those who needed treatment but did not go, why not?			
Did not have money	67.7	50.0	43.8
Source far away (inaccessible)	17.2	29.2	21.9
Service not available	0.0	8.3	15.6
Did not know about the services	0.0	12.5	12.5
Other*	3.2	0.0	6.1
Don't know	11.8	0.0	0.0
Total N	93	24	32

Percentage total may exceed 100% due to multiple responses

*Consulted traditional healer or used home remedies.

4.5 Decision on Treatment Seeking

When the interviews took place, girls reported that their fathers were the person in the family who made the decisions whether or not to seek treatment (66% in *Phase I*, 81% in *Phase II*, and 76% in *Phase III*). Less commonly, they mentioned their mothers as the ones who decided on treatment—26 percent, 15 percent, and 20 percent in *Phases I, II and III* respectively (Table 4.5).

Table 4.5 Percentage distribution of respondents according to the person in the family that decides whether and where to seek treatment

In your family who makes the decision?	Phase I	Phase II	Phase III
Father	65.6	81.1	76.0
Mother	25.7	15.0	20.1
Other family member or self	6.3	3.8	4.0
Don't know	2.4	0.0	0.0
Total %	100	100	100
Total N	869	891	890

4.6 Health Information and Services Interested in Learning About

The pre-intervention interview found that less than one-fourth of these adolescent girls could name health issues they wanted to learn about. This percentage varied by age group and VDC. However, the girls (10-14 years) from Kushmishera had the greatest difficulty and those from Bhakunde were the most knowledgeable (not shown). Diarrhea was the greatest concern, with 17 percent of the girls wanting to learn more about it. Only a negligible proportion of the girls expressed an interest in learning about reproductive health issues before the classes began.

By the Phase III interviews, the adolescent girls mentioned several health issues they wanted to learn about. Almost half wanted to learn more about family planning, and a similar proportion about acute respiratory illness (ARI) and STDs/AIDS (Table 4.6).

Table 4.6 Percentage distribution of respondents according to health issues they wanted to learn about

Health issues interested in learning about	Phase I	Phase II	Phase III
Diarrhea	16.7	35.6	62.5
General health information and services	4.4	29.6	51.1
AIDS and STDs	2.4	10.4	41.3
Cleanliness	1.3	0.0	0.0
Acute respiratory infections	0.0	3.3	43.1
Family planning	0.0	6.7	45.1
Immunization services	0.0	9.5	21.8
Other	2.6	2.5	16.1
Don't know	72.6	18.2	0.3
N	869	891	890

Percentage total may exceed 100% due to multiple responses.

Chapter 5

KNOWLEDGE AND ATTITUDE ABOUT REPRODUCTIVE HEALTH

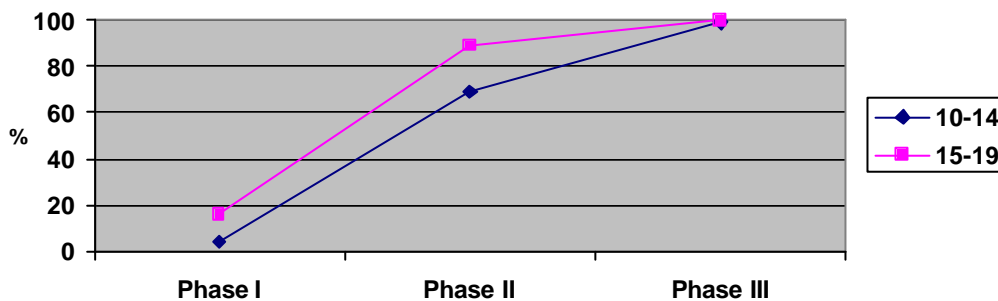
5. Introduction

Adolescence is characterized by physical, psychological, and social changes. Development takes place unevenly, in that physical maturity may well be achieved in advance of psychological or social maturity. In most societies, reproductive capability is now established at an earlier age than in the past (WHO/UNFPA/UNICEF, 1998). The present chapter examines the level of awareness adolescents have about reproductive health, their knowledge of changes that occur during adolescence, awareness of menstruation, perceived types of problems during menstruation, perception of right age for marriage/pregnancy, knowledge about conception, knowledge about family planning methods, and awareness of STD and HIV/AIDS.

5.1 Awareness of Adolescent Reproductive Health

The pre-intervention study showed that adolescent reproductive health was a term rarely heard by adolescent girls. None of the girls aged 10-14 from Tityang and Dhullu Banskot had heard of it. Only one in 25 (4%) of the girls in that age group had heard of adolescent reproductive health. Knowledge of adolescent reproductive health was slightly higher in the age group 15-19. Among all adolescent girls, less than one tenth of them, had heard of adolescent reproductive health, ranging from 3 percent in Tityang to 20 percent in Hugdishir (Table 4.1, Appendix).

Figure 5.1 Awareness of Adolescent RH



After the literacy classes, awareness about adolescent reproductive health had sharply increased. For example, at the time of the Phase I study only 9 percent of the girls had heard of adolescent reproductive health. In Phases II and III that proportion had increased to 76 percent, and 99 percent respectively (see Figure 5.1).

5.2 Knowledge of Changes That Occur During Adolescence

Adolescence is characterized by several physical, social, psychological and behavioral changes. Development is generally uneven; physical maturity may well be achieved in advance of psychological or social maturity. Currently, reproductive capability is taking place at an earlier age than in the past (WHO/UNFPA/UNICEF, 1989).

Different signs and symptoms appear in boys and girls during adolescence. At the time of the Phase I study, most girls (83%) did not know about the changes that occur in girls during

adolescence, although of course, knowledge varied with age. Almost none of the 10-14 year-olds could identify the changes but almost 40 percent of the 15-19 year-olds were able to (Table 4.2, Appendix).

Immediately after the classes, the proportion of girls in both age groups who could identify changes increased. By the Phase III study, all of the adolescent girls could name changes that occur in girls during adolescence, including “pimples” (92%), “oily skin” (86%), “body hair” (70%), and “breasts develop” (68%). It was surprising, that only 63 percent of the girls cited “onset of menstruation” as one of the changes in the girls during adolescence (Table 5.2(a)). The increases during that year probably reflected the girls’ own individual development.

Table 5.2(a) Percentage Distribution of Respondents according to their Perception of Changes/Signs that Appear in Girls During Adolescence

Perceived changes in girls during adolescence	Phase I		Phase II		Phase III	
	10-14 years	15-19 years	10-14 years	15-19 years	10-14 years	15-19 years
Pimples appear	1.3	11.0	38.6	44.3	58.32	96.2
Breasts develop	1.3	8.8	18.6	26.4	29.8	77.2
Menstruation begins	2.4	16.0	40.0	48.8	74.5	63.4
Other*	0.2	1.9	12.2	35.5	70.8	90.0
Don't know	94.9	62.4	36.7	25.5	0.4	0.6
N	890		891		890	

Percentage totals may exceed 100% due to multiple responses.

*"Other" includes oily skin and pubic and underarm hair grows

Adolescent girls were questioned on their knowledge of changes that occur in adolescent boys. In Phase I of the study, 89 percent of the girls had almost no knowledge of the changes that occur in adolescent boys. Knowledge increased over time. By the Phase III study, all girls mentioned some changes that occur in boys during adolescence. A majority of the girls mentioned that 'moustaches and beards become visible' (94%), 'voices deepen' (94%), and 'pimples appear' (77%) (Table 5.2(b)).

5.2(b) Percentage Distribution of Respondents According to their Perception of Changes/Signs that Appear in Boys during Adolescence

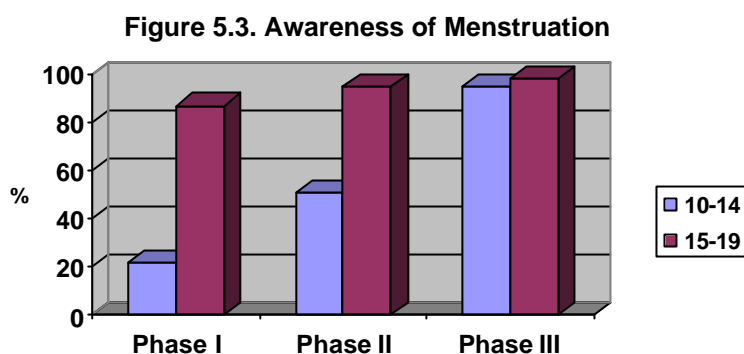
Perceived changes in boys during adolescence	Phase I		Phase II		Phase III	
	10-14	15-19	10-14	15-19	10-14	15-19
Pimples appear	0.2	4.1	29.1	43.0	63.6	98.0
Vocal cord enlarge	1.5	15.4	30.7	59.0	92.8	95.7
Moustache and beard appear	-	-	41.6	54.2	93.4	96.0
Wet Dreams occur	-	-	0.5	0.3	28.3	55.5
Genitals enlarge	-	0.3	0.5	0.9	36.8	51.2
Hair grows in pubic area and underarms	1.8	5.3	-	-	0.6	0.6
Don't know	96.5	74.9	45.6	14.0	0.7	.9
N	550	319	570	321	544	346

Percentage totals may exceed 100% due to multiple responses.

5.3 Awareness of Menstruation

In Phase I of the study, just under one-half of adolescent girls stated they knew about menstruation (Table 5.3). Since 78 percent had already experienced it, there may have been confusion about the wording. Among the 10-14 year-olds, just one-quarter said they knew about menstruation, although this varied by VDC. For example, before the literacy classes began, in Bhakunde none of the 10-14 year-old adolescent girls said that they knew about menstruation.

Knowledge of menstruation increased sharply after the classes. In the Phase II survey, the proportion of those who said they knew about menstruation increased to 67 percent, and by the Phase III survey, the proportion had increased to 96 percent (see Figure 5.3). In fact, by the Phase III study, 100% of the adolescent girls from Tityang, Dhamja and Bhakunde said they knew about menstruation; however, in Kushmishera 11 percent still did not know.



More specifically, by Phase III, 94 percent of the girls 10-14 had knowledge about menstruation although only one-fourth (20%) had experienced it by that time. The range by VDC is demonstrated by the fact that nearly one-half (46%) of the adolescent girls from Kushmishera had learned about menstruation only after having experienced it (Table 4.4, Appendix).

5.4 Perceived Types of Problems during Menstruation

By the conclusion of the study, almost all of the adolescent girls could identify menstrual problems likely to occur. Before beginning the classes, only one in three of the adolescent girls could specify any menstrual problem. Among the one-half who knew about menstruation, 39 percent appropriately cited lower abdominal pain as a possible problem during menstruation; 12 percent mentioned excessive bleeding, and 12 percent mentioned headaches.

By the Phase III survey, virtually all of the girls knew about menstruation and could name at least one health problem associated with it. Ninety percent of the girls mentioned excessive bleeding as a problem, 84% mentioned lower abdominal pain and 60 percent mentioned headaches (Table 5.4).

Table 5.4 Percentage distribution of perceived menstrual problems among respondents who were aware of menstruation

Type of problem	Phase I		Phase II		Phase III	
	10-14	15-19	10-14	15-19	10-14	15-19
Excessive bleeding	5.7	12.2	11.6	34.3	87.5	93.8
Headache	9.8	7.6	6.2	24.2	58.6	61.2
Lower abdominal pain	15.6	34.1	23.3	72.5	82.3	85.6
Other*	0.0	1.5	8.5	0.0	32.2	0.0
Nothing	2.3	7.9	0.0	0.0	0.0	0.0
Don't know	52.5	19.8	37.3	10.5	0.1	0.0
N	397		598		854	

Percentage totals may exceed 100% due to multiple responses

*Including mental tension, sore breasts, and backache.

5.5 Preferred Person to Discuss Menstrual Problems With

The Phase I study showed that among the girls who could name menstrual problems, one-half said they would discuss the problems with their mothers, while 18 percent would prefer discussing it with their friends. Almost one in every five of the girls (19%) did not talk to anyone about their menstrual problems.

By Phase III, mothers continued to be the person most likely to be consulted about menstrual problems, followed by friends. Although not shown, these trends were similar for the two age groups. Perhaps most importantly, the proportion of girls who said they discussed problems with a health worker went from virtually none to 16 percent from Phase I to Phase III.

Nearly 80 percent of the adolescent girls from Rangkhani and 75 percent from Kushmishera had discussed the issue with their mothers. A negligible percentage of the girls (5 percent) did not like to discuss their menstrual problems with anyone. Twenty-four percent of the adolescent girls from Batakachaur still preferred not to discuss menstruation problems with anyone (Table 4.5, Appendix).

Table 5.5 Percentage distribution of respondents according to the person with whom they would prefer to discuss their own menstrual problems, among those who knew about menstruation

With whom do you talk about your menstrual problems?	Phase I	Phase II	Phase III
Mother	50.2	53.9	46.6
Aunt	2.3	2.4	2.4
Sister	4.2	4.5	4.6
Friends	18.2	22.8	24.2
Health Worker	0.7	2.4	16.6
No one	19.2	14.1	5.4
Grandmother	-	-	.2
Don't know	5.2	-	-
Total %	100.0	100.0	100.0
Total N	307	334	427

5.6 Perception on Right Age for Marriage

Marriage marks the onset of socially sanctioned sexual activity and childbearing, an event associated culturally and socially with the end of adolescence. However, many new parents are still adolescents, chronologically, physically, and cognitively. In Nepal, more than one-half of all females begin childbearing by age 19, according to the 1996 Nepal Family Health Survey (MOH 1997). According to a large number of international studies (e.g., McCauley and Salter 1995; Mensch, Bruce, and Greene 1998; Singh and Samara 1996), early marriage reduces girls' access to education and employment.

Perceptions about the right age for girls and boys to marry increased fairly dramatically after the classes. The pre-intervention study found that more than one-quarter of the girls perceived the right age for marriage for both girls and boys is under 20 years (26 percent and 17 percent, respectively). Another quarter of the girls thought age 20 was best for girls. However, more than 20 percent did not state a preferred age of marriage for either sex.

By the Phase III survey, when asked to specify the best age to marry, almost none of the girls still thought it should be before age 20. Almost all of the girls from Kalika (94%) perceived that the right age for a girl to marry was 20. Almost 40% of the girls from Batakachaur suggested that 22 years would be the right age for girls to marry (Table 4.7, Appendix).

All of the adolescent girls (99%) gave 20 years and over as the right age for boys to marry; 32 percent thought they should be at least 24. In fact, more than 60 percent of the girls from Kushmishera and Rangkhani thought boys should be at least 25 to marry Table 4.8, Appendix).

Table 5.6(a) Percentage distribution of respondents according to their perception of the right age for girls and boys to marry

Age	Age for girls to marry			Age for boys to marry		
	Phase I	Phase II	Phase III	Phase I	Phase II	Phase III
Under 20	26.4	9.9	1.7	16.8	3.1	0.1
20	24.1	59.0	69.7	12.9	9.8	2.7
Over 20	27.3	28.9	27.6	47.2	83.1	96.2
Don't know	22.2	2.0	1.0	23.1	3.8	1.0
Total %	100.0	100.0	100.0	100.0	100.0	100.0
N	869	891	890	869	891	890

As for when they themselves wanted to get married, the Phase I study found almost one in four wanted to marry before they were 20 years of age. Another 20 percent mentioned 20 years of age, and one-fourth of the girls did not specify. A year later, in the Phase III study, almost all of the girls (95%) wanted to wait until they were at least 20 to marry. By this time, less than one percent did not know what they thought would be a good age for them to marry (Table 5.6(b)).

At the first interview, almost half of them (47%) already thought that boys should wait until they were already 21 to marry. This increased to 96 percent by the third interview.

Table 5.6(b) Percentage distribution of respondents by age at which they want to get married

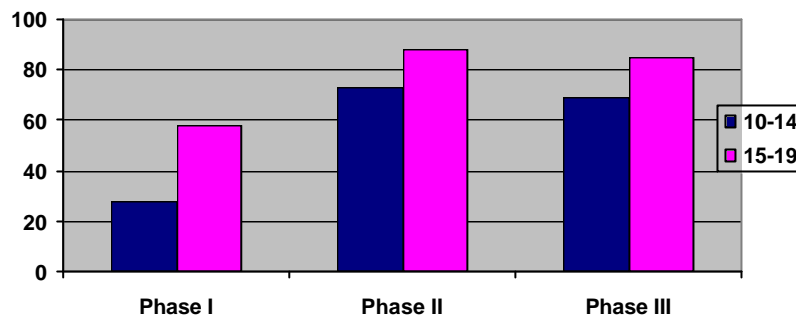
When do you want to get married?	Phase I		Phase II		Phase III	
	10-14	15-19	10-14	15-19	10-14	15-19
Under 20	26.4	15.3	8.4	4.0	5.8	0.3
20	20.4	16.6	47.5	39.6	48.5	33.2
Over 20	19.4	47.0	39.2	53.3	44.0	63.7
Never	1.5	6.0	0.9	1.9	1.1	0.6
Don't know	32.4	15.0	4.2	1.2	1.2	2.3
N	869		891		890	

5.7 Decision on Marriage

Many Nepalese parents have absolute authority as to when and to whom their children marry. Marriages are arranged without discussing marriage plans with their daughters. Arranged marriages are common in much of South Asia (Mensch, Bruce, and Greene 1998). Three-fourths of the girls (75% in Phase I, 84% in Phase II and 82% in Phase III) identified the father as the decision-maker regarding marriage. Nearly one-half of the girls in Bhakunde (45%) and more than one-half in the other eight VDCs said that they are not consulted about marriage choice.

On the other hand, the proportion that said they would be involved in such decisions increased from 37 percent in the Phase I survey to 67 percent at Phase III and there was a similar doubling in the proportion those who felt they could convince their guardians to change their decisions (see Figure 5.7). These results strongly suggest that the *Lalima* classes may have helped to enhance the girls' confidence in their ability to negotiate with their families about their marriage.

Figure 5.7 Percentage of respondents reporting ability to convince their parents to change decisions about marriage



5.8 Perceived Right Age for Beginning Childbearing

Perceptions about the right age to have the first child changed dramatically over the course of the project. Overall, 40 percent of the girls at Phase I did not identify a best age.

By the Phase III survey, 97 percent of the adolescent girls thought the best age to begin childbearing was at least age 20, with almost half recommending waiting until at least age 22 (Table 5.8). By this time, the proportion that felt they could not identify a good age was negligible (Table 5.8).

Table 5.8 Percentage distribution of respondents according to their perception of the right age for childbearing

Perceived right age for childbearing	Phase I	Phase II	Phase III
Under 20	9.1	1.7	1.8
20	10.9	12.0	3.5
Over 20	39.9	77.7	93.1
Don't know	40.0	8.6	1.5
Total %	100.0	100.0	100.0
Total N	869	891	890

5.9 Knowledge about Conception

Knowledge about how women conceive soared by the end of the *Lalima* classes. In the Phase I survey, less than 10 percent knew “how a woman gets pregnant.” In fact, 100 percent of the girls aged 10-14 from Kalika and Tityang and aged 15-19 from Bhakunde responded that they did not know. In the Phase II study, nearly half of the adolescent girls knew how conception could occur; and, by Phase III, knowledge about conception was nearly universal among the adolescent girls, regardless of age. Ninety-three percent mentioned “sexual intercourse between a boy and girl” and almost 60 percent specifically mentioned sexual intercourse “without using a family planning method” as the cause of conception (Table 5.9).

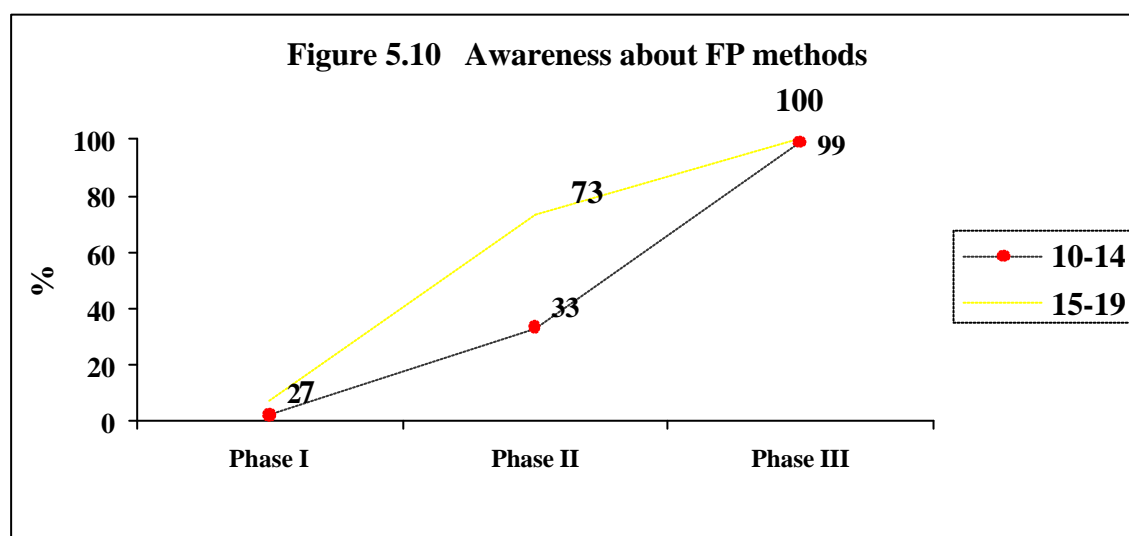
Table 5.9 Percentage distribution of respondents according to their awareness regarding conception (pregnancy) and its prevention

How does a woman get pregnant?	Phase I		Phase II		Phase III	
	10-14	15-19	10-14	15-19	10-14	15-19
Sexual intercourse between a boy and a girl	2.4	12.9	27.9	67.9	91.7	93.9
Sexual intercourse without FP method use	0.6	10.4	2.9	7.7	58.5	39.2
Don't know	92.3	86.2	70.4	25.9	1.3	0.9
Total N	869		891		890	
How does a woman prevent getting pregnant?						
Abstaining from sex	0.9	4.1	17.5	41.1	78.3	73.4
Using contraceptives	1.1	6.9	14.4	36.8	14.4	75.4
Don't know	98.0	89.0	54.3	24.6	0.9	0.9
Total N	869		891		890	

Percentage total may exceed 100% due to multiple responses.

5.10 Knowledge about Family Planning Methods

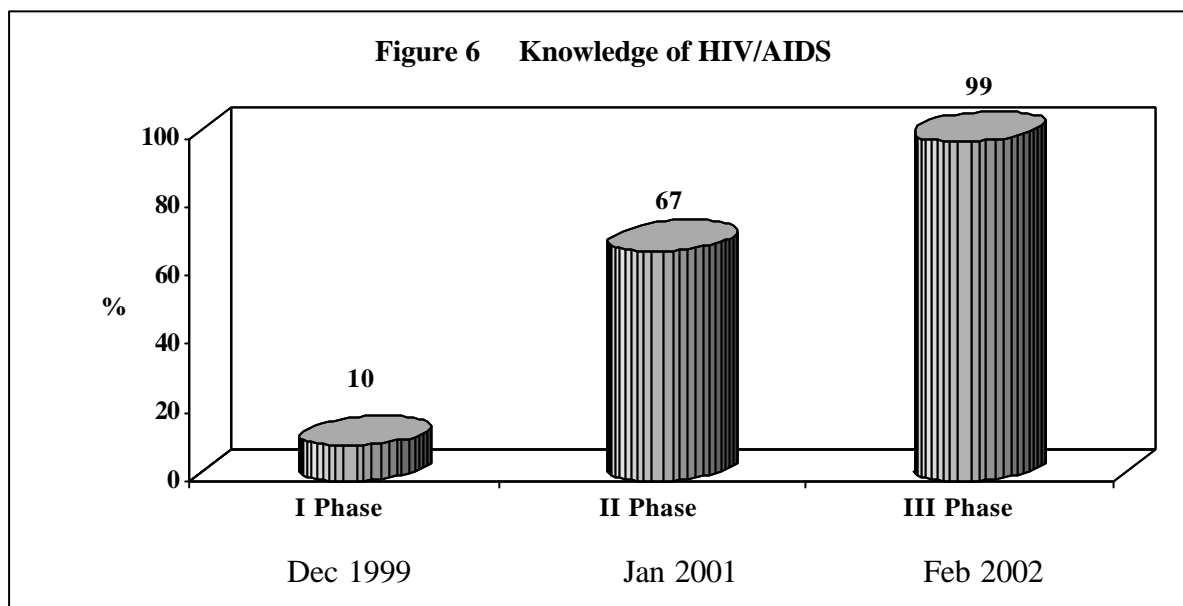
Awareness of family planning increased sharply after the intervention, as shown in Figure 5.10. The Phase I study found that almost none (97%) of the girls had heard of family planning methods. By the Phase II interview, 33 percent of the younger group and 73 percent of the older group knew about them and by the third interview, all were knew about family planning. By Phase III, all of the girls were knowledgeable about family planning methods in general.



As documented in the Phase III survey, the condom (96%), oral pills (89%) and Depo-Provera (DMPA) (81%) were the three methods most widely known among these girls. Nearly one-half knew about Norplant and the Copper-T IUD. Over two-fifths of the girls knew about a permanent family planning method (Table 4.17, Appendix).

5.11 Awareness of STI and HIV/AIDS

Awareness about sexually transmitted infections (STIs) also increased sharply over time. Before the classes, virtually none of the 10-14 year olds and only seven percent of the 15-19 year olds had heard of sexually transmitted infections (STIs). The Phase III study showed that majority of the adolescent girls (96%) are aware of STIs and 99% could name at least one symptom (Table 4.20, appendix).



Likewise, before intervention, knowledge about HIV/AIDS was almost non-existent. Only one in ten of these adolescent girls had heard of AIDS, although a higher proportion of the 15-19 year olds were more aware of the disease than those in the younger group. Yet 28 percent thought that AIDS could be cured (Table 4.20, appendix).

Awareness increased from almost none to universal awareness among the girls who attended the classes. Before the class, only 10 percent of the girls had heard of HIV/AIDS. By the Phase II survey, the proportion increased to 67 percent, and by the Phase III survey, the proportion had increased to 99 percent (Figure 6). In addition, by the last survey, almost 100 percent of the girls knew how AIDS was transmitted and that it was incurable (Table 4.23, appendix).

During Phase III, a high majority of adolescent girls (70%) had mentioned that 'practicing safer sex methods' is a way of preventing HIV/AIDS. Similarly more than three-fifths of the adolescent girls had mentioned that a sexual relationship between husband and wife' and 'abstaining from sex' are the two best ways of preventing HIV/AIDS (Table 4.23(a), appendix). Fifty-five percent specifically mentioned condoms as a method of prevention.

5.12 Perceptions about Care during Pregnancy

The Phase I study found that a large majority of the adolescent girls (82%) lacked knowledge about precautions to be taken during pregnancy. Ninety-two percent of the 10-14 year olds and 67 percent of the 15-19 year olds could not name anything specific that a woman should do to keep herself and her baby healthy during pregnancy. For example, the importance of nutritious food was mentioned by only six percent of the girls aged 10-14 and 25 percent of those aged 15-19. The proportion mentioning any other actions was negligible (Table 5.12).

Knowledge about precautions to be taken during pregnancy increased dramatically by the end of the classes and even more dramatically by Phase III. The importance of pregnancy checks (from none to three-quarters by Phase III) and vaccinations for tetanus (70%). This represents two important changes in knowledge for this population.

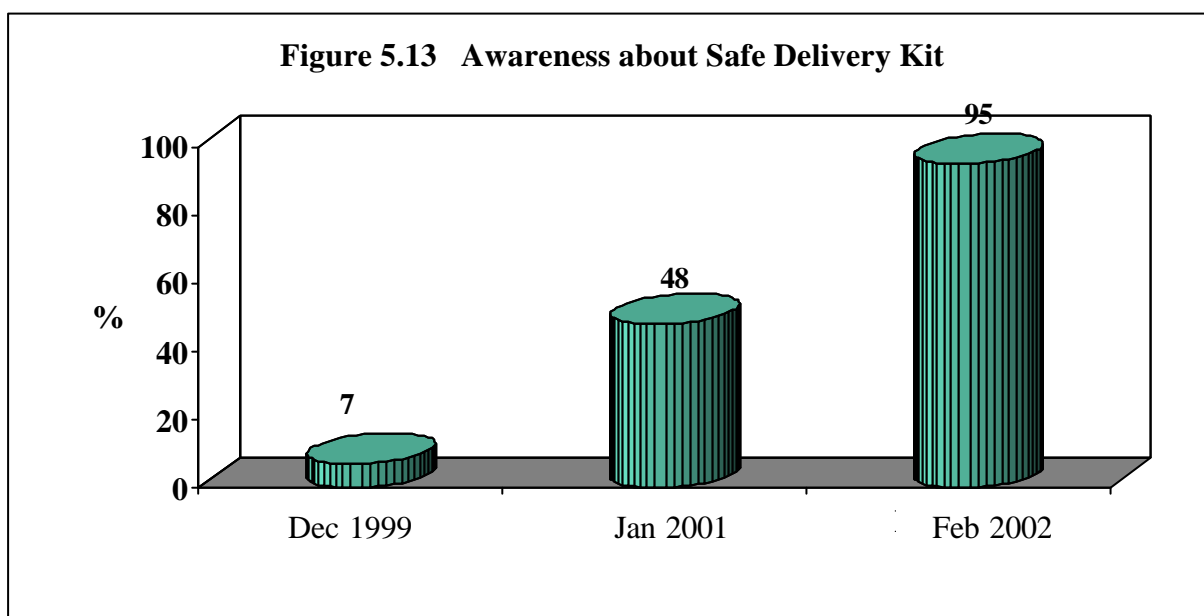
Table 5.12 Percentage distribution of respondents according to their perception of care needed during pregnancy

Precautions to be taken during pregnancy	Phase I	Phase II	Phase III
Nutritious food	12.9	73.3	93.9
Routine pregnancy check-ups	1.2	28.7	73.5
Maintain personal hygienic	1.2	17.5	59.6
Tetanus Vaccine	-	13.2	69.9
Avoid smoking and alcohol	-	4.8	48.5
Light work and sufficient rest	6.0	26.4	22.1
Avoid un-prescribed medicines	-	1.1	10.7
Don't know	82.4	12.7	1.0
N	869	891	890

Percentage totals may exceed 100% due to multiple responses.

5.13 Knowledge about the Safe Delivery Kit

Knowledge about the “clean home delivery” kits increased from just seven percent before the class to almost 50 percent by the end of the class and was nearly universal (95%) by the final interview (Figure 5.13).



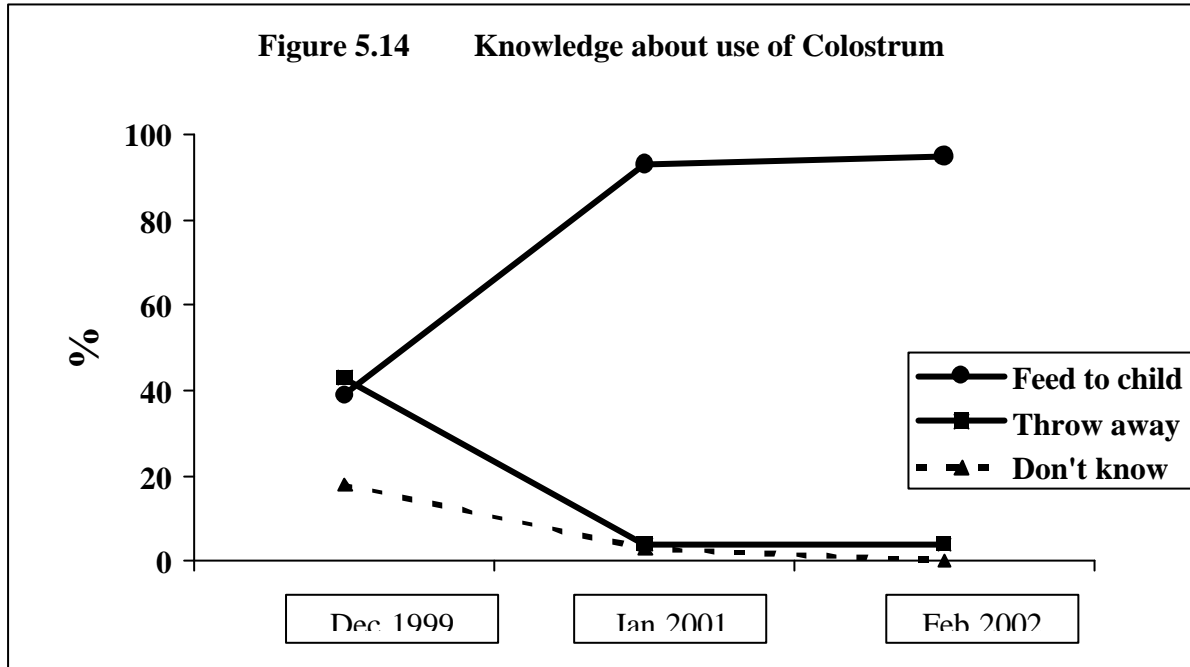
All of the adolescent girls who had knowledge about safe delivery kits were also aware of at least one source for obtaining the kits (83 percent) (Table 4.14, appendix).

At the time of Phase I study, almost none of the adolescent girls were aware of the importance of cleanliness during delivery. By Phase II, 30 percent were aware of the need; and by the Phase III survey, all knew what needed to be done to insure a safe delivery (Table 4.15, appendix).

5.14 Knowledge about the Use of Colostrum

Knowledge that newborns should be given colostrum, the fluid excreted by the breasts in the first few days after delivery, was fairly high before the classes, but increased significantly after the program. At the first interview, almost 40 percent of the adolescent girls said that colostrum should be fed to the newborn. However, almost 20 percent had the misconception that the colostrum should be discarded (Table 4.16, appendix). As would be expected, knowledge about the value of colostrum was substantially higher among the 15-19 year olds than the 10-14 year olds.

The Phase III study showed that almost all the girls knew (95 percent) knew that newborns should be fed colostrum. The percentage increased from 39 percent at Phase I to 93 percent at Phase II and 95 percent at the Phase III survey (Figure 5.14).



Chapter 6

KNOWLEDGE ABOUT GIRLS' MOBILITY AND GIRL TRAFFICKING

6. Introduction

This study made an attempt to explore the knowledge that the adolescent girls had about girls' mobility and girl trafficking in their localities. The present chapter describes girls' travel outside their villages, decision about girls' mobility for work, and awareness of girl trafficking.

6.1 Girls' Travel Outside Their Villages

At the time of Phase I survey, slightly more than one-third of the adolescent girls (35%) reported that girls from their neighborhood travel outside the VDC for work. In the Phase II and III surveys, this proportion actually decreased slightly, to below 30 percent. Belief about girls' mobility varied across the VDCs. Phase III showed that around two-fifths of the adolescent girls from Dhullu Banskot and Bhakunde mentioned that girls travel outside their villages for work (Table 5.1, appendix).

At the time of the Phase III survey, half of the adolescent girls perceived that the district headquarters was the place of the intended destination. As for travel to neighboring villages, nearly one-third of the girls mentioned that girls do travel to neighboring villages (Table 6.1).

More than two-fifths of the girls (41%) perceived that girls from their village who travel outside the village returned within a month (Table 6.1).

Table 6.1 Percentage distribution of respondents according to their perception about girls' migration for work outside the village

Do girls go outside of village for work?	Phase I	Phase II	Phase III
Yes	35.1	29.2	29.3
No	64.0	70.8	70.7
Don't know	0.9	-	-
Total %	100	100	100.0
Total N	869	891	890
Where do they go?			
Neighboring villages	47.2	69.2	29.1
District capital	12.1	17.7	47.9
Kathmandu/Pokhara	14.8	8.5	14.6
Other destinations outside of the district	13.4	1.9	4.6
India	7.2	1.5	-
Don't know	5.6	1.2	3.8
Total %	100	100	100.0
Total N	305	260	261
When do they return?			
One month	30.5	55.0	40.6
6 months	13.4	5.8	21.8
One year	8.2	12.7	7.3
More than one year	10.9	2.3	0.4
Never returned	2.6	-	-
Traveled in morning and returned afternoon	11.8	20.4	28.0
Don't know	25.6	3.8	1.9
Total %	100	100	100.0
Total N	305	260	261

6.2 Decisions About Girls' Mobility for Work

Although few girls reported having traveled outside their villages in search for work, the respondents were asked the question to understand who the family decision-maker had been. Interviews revealed that fathers were found to be the main person taking decisions about girls travel outside their villages for work (66% to 83%) (Table 6.2).

Table 6.2 Percentage distribution of respondents according to the person in the family deciding girls mobility outside the village

In your family who decides whether a girl travels outside village?	Phase I	Phase II	Phase III
Father	66.4	83.1	75.8
Mother	21.4	14.4	18.5
Grandfather/Grandmother	3.5	1.0	2.1
Self	1.2	0.2	0.4
Other*	1.4	0.9	1.3
Don't know	6.2	0.4	1.7
Total %	100.0	100.0	100.0
Total N	869	891	890

6.3 Awareness about Girl Trafficking

Awareness about girl trafficking increased sharply after the classes. The pre-intervention study found that one-third of these adolescent girls had heard that girls are “trafficked and sold in big cities in India” and this increased with age. Less than 25 percent of girls aged 10-14 and slightly more than 50 percent of those aged 15-19 had heard of girl trafficking. By Phase II of the study, over two-thirds of the girls had heard of it, with the proportion of those 10-14 increasing to over 60 percent (Table 5.1, appendix).

By the Phase III survey, the percentage of girls that had heard of girl trafficking was nearly universal (90 percent), although it remained low in Kalika (31%). Nevertheless, once aware of the issue, almost all (94%) denied that girls from their village stayed away for extended periods of time to work. period for work However, it is noteworthy that the girls' awareness of girl trafficking in general was increased but their knowledge about the degree of girl trafficking in their locality decreased. This is probably because of their better understanding of girl trafficking enabled them to differentiate between girls that had actually trafficked and those who had not (Table 6.3).

Table 6.3 Percentage distribution of respondents by their knowledge about girl trafficking

Have you heard of girl trafficking?	Phase I	Phase II	Phase III
Yes	34.4	68.7	90.2
No	65.5	31.3	9.8
Don't know	0.1	-	-
Total %	100.0	100.0	100.0
Total N	869	891	890
Have girls from your neighborhood gone and not returned for a long time?			
Yes	11.7	3.6	4.2
No	46.6	76.9	94.4
Don't know	41.7	19.5	1.5
Total %	100.0	100.0	100.0
Total N	869	891	890
If yes, are they in contact?			
Yes	64.7	87.5	64.9
No	35.3	12.5	35.1
Total %	100.0	100.0	100.0
Total N	102	32	37
Have any girls in your neighborhood been married off to strangers and not returned for a long time?			
Yes	11.4	3.9	0.8
No	43.6	79.1	96.1
Don't know	45.0	16.9	3.1
Total %	100.0	100.0	100.0
Total N	869	891	890
If yes, are they in contact?			
Yes	49.5	77.1	57.1
No	36.4	22.9	42.9
Don't know	14.1	-	-
Total %	100.0	100.0	100.0
Total N	99	35	7

Chapter 7

INVOLVEMENT IN THE ADOLESCENT GIRLS' GROUPS

7. Introduction

The present chapter describes adolescent girls' involvement in community groups, permission to become involved in the Adolescent Girls' Groups, and type of activities learned or performed.

7.1 Involvement in Community Groups

After the literacy classes, participation of adolescent girls in community activities increased in all VDCs. The Phase I study found that involvement of the girls in community groups had been rare (less than 10%) in seven of the nine VDCs, although in Bhakunde it had been 42 percent and in Tityang 29 percent. Among those who had been involved in their communities, most mentioned their membership in the AGGs. By the end of the literacy classes, the 10 percent involvement had grown to 76 percent, almost entirely membership in the Adolescent Girls' Groups. However, the level of involvement varied from almost universal involvement in Dhamja, Bhakunde, Tityang and Hugdishir to about 40 percent in Kalika and Kushmishera.

By the time of the Phase III survey, "belief that community involvement was beneficial" and membership in a group was nearly universal in all VDCs. While girls were primarily members in the AGGs, in some VDCs some of the girls joined other groups as well, with more than 10 percent in Dhullu Banskot VDC joining their village's Forestry Group and five percent from Batakachaur and Dhamja joining their village's Savings and Credit Group (Table 7.1).

Table 7.1 Percentage distribution of respondents by their affiliation to community groups

	Phase I	Phase II	Phase III
Ever involved in any group?			
Yes	10.6	75.9	97.6
No	89.4	24.1	2.4
Total	100.0	100.0	100.0
N	869	891	890
If yes, type of organization			
Girls group (AGG)	85.9	98.7	97.4
Farmers or Forest Group	10.9	1.0	8.9
Saving and credit Group	1.1	0.3	2.1
Youth club	1.1	-	0.5
Mother group	1.1	-	0.1
Total	100.0	100.0	
N	92	676	
If working with the group is beneficial			
Yes	20.1	70.3	98.5
No	79.9	29.7	1.5
Total	100.0	100.0	100.0
N	869	891	890

Nine in ten of the adolescent girls (90%) expressed that they could get to learn something new from their AGG. Nearly three-fourths of the adolescent girls (74%) mentioned that they could share their own problems in their group (not shown).

7.2 Permission to Become Involved in the Adolescent Girls' Groups

According to the pre-intervention survey, most of the girls (83%), regardless of age group, said they needed to obtain permission to participate the Adolescent Girls' Groups). More said they needed permission from their mothers (50%) than from their fathers (42%) (Table 7.2).

Table 7. Percentage distribution of respondents receiving permission to participate in the Girl's Group

Had you sought permission to participate?	Phase I
Yes	82.6
No	13.9
Missing	3.5
Total %	100.0
Total N	869
If yes, from whom?	
Mother	50.1
Father	41.6
Other family member	4.9
Missing	3.4
Total %	100.0
Total N	743

7.3 Perceived Benefits of Participating in the Adolescent Girls' Groups

The Phase I study showed that a majority of the girls perceived that joining the AGGs would be beneficial to them, more than half because they could learn to read and write. However, almost half of the girls were not able to name a specific benefit of joining the group. (Table 7.3)

Table 7.3 Percentage distribution of respondents by expected benefits of participation in the Girls' Group

What do you want to learn in this Girls' Group?	Phase I
Read and write	54.4
Girls' rights	1.0
Adolescent reproductive health	0.6
Other	1.9
Don't know	42.1
N	869

Percentage total may exceed 100% due to multiple responses

7.4 Other Types of Activities Learned in the AGGs

By the time of the Phase III interviews, these adolescent girls reported that they had not only worked on their reading and writing skills, but had learned about maintaining environmental cleanliness (98%), including how to construct an environmentally safe toilet (90%), and how to dispose of household wastes (78%) as part of their membership in the AGG. In Rangkhani one-quarter of the girls mentioned knowing how to make a smokeless oven. (Table 7.4)

Table 7.4 Percentage distribution of respondents according to activities learned in the AGGs

Things learned	Phase III
Environmental cleanliness	98.
How to make toilet	89.
How to make hole for disposing household waste	77.
How to make smokeless oven	8.
How to cultivate plants/flowers	0.
N	890

Percentages total may exceed 100% due to multiple responses.

7.5 Further Activities that Would Interest the Class Members

By the Phase III survey, almost one-half of the adolescent girls wanted further skill development training, with the specific subjects varying across the VDCs. As many as three-fourths of the adolescent girls in Kalika and over one-half in Batakachaur mentioned their desire to participate in skill development training (especially sewing and knitting). Twenty-eight percent wanted to learn more about health and disease in general (Table 7.5). This proportion went up to 40 percent in Dhullu Banskot and Hugdishir (not shown). Just seven percent specified a desire for additional education on adolescent reproductive health.

Table 7.5 Percentage distribution of respondents according to their desire to learn more from AGGs

Desire to learn additional things/skills	Phase III
Skills and income-generation training (sewing/knitting)	45.
General health/diseases, including diarrhea	28.
New subject/activities	22.
Cleanliness	10.
Adolescent reproductive health, including HIV/AIDS	6.
Don't know	1.
N	890

Percentage totals may exceed 100% due to multiple responses

Chapter 8

SUMMARY AND CONCLUSIONS

1. Summary of Findings

This study followed 891 adolescent girls, ages 10-19, who were members of Adolescent Girls' Groups and participate in a non-formal education program (the *Lalima* literacy classes) in nine VDCs in Baglung District. The program was implemented by *Aamaa Milan Kendra* (Mothers' Club) with technical and financial support from CEDPA.

The three major findings of this study were that:

- Basic literacy classes, carried out within the context of girls' clubs (AGGs), were used successfully to teach reproductive health and other health-related topics to illiterate adolescent girls, especially those in the 10-14 age group.
- Knowledge about reproductive health and family planning, as well as sources of health information and health care, all increased quite dramatically by the end of a nine-month non-formal education program and continued to increase throughout the following year.
- Basic literacy classes for illiterate adolescent girls are not only valuable in improving the education and status of women in Nepal, but also in teaching them about their reproductive health and how to care for it, in a context that makes it acceptable to their families and communities.

The following sections look at each of the areas examined in this survey.

2. Characteristics of the Adolescent Girls

The girls in this study represent a special segment of the adolescent population in Nepal. Almost half (41%) were from disadvantaged communities and none had received any formal education. Although participants in these classes ranged from ages 10 to 19, 64 percent were under 15, with a median age of 13 years.

The adolescent girls who enrolled into the AGGs had been deprived of schooling because of the social mores and economic status of their community, with a large proportion reporting that they were needed at home to assist their parents in household chores or to care for younger siblings. Most of the girls were from families in which the father had control over the family income, marriage, decisions about health care and whether the girls would leave their village to work. But once these adolescent girls took the classes, their families' attitudes toward schooling changed and with it the belief that the girls must stay home to help out all of the time.

Although almost all of the adolescent girls enrolled in the classes had themselves expressed a desire to enroll, the level of interest and rates of enrollment decreased as age increased. A high proportion of the 15-19 year olds were already beyond school age when the class began. By the following year, virtually all of the 10-14 year olds had enrolled in formal schooling, but only 26 percent of the older girls (15-19 years) were actually enrolled in formal school a year after the *Lalima* classes.

3. Expectations

Although most of the girls were initially interested only in learning reading and writing or did not know exactly what they would learn, those literacy classes were used to teach them about a

whole range of ways to protect their own health and that of their families. However, many of the older cohort had also hoped for more skill development training.

4. Perceptions About General Health Information and Services

Knowledge about primary sources of health information and services became universal among the adolescent girls and increasing numbers took advantage of those resources, most obviously demonstrated by the increased proportion who said they talked to health workers about menstruation and other reproductive issues.

Almost all of the girls became aware of existence of health facilities in their VDC. However, most of them were likely to share their health problems with their mothers. For example, among those who had experienced menstruation problem, half of them preferred to discuss these with their mothers.

5. Knowledge and Attitudes about Reproductive Health Issues

This longitudinal study found that the *Lalima* literacy classes in all nine VDCs in Baglung District were quite successful in increasing knowledge about adolescent reproductive health. More specifically, knowledge about family planning and reproductive health soared from almost none in the Phase I pre-intervention survey, to three-quarters in the Phase II survey, conducted immediately after they completed the classes, to almost universal in the Phase III survey a year later. For example, awareness of how conception occurs, how it can be prevented and at least one family planning method jumped from well under 10 percent to 99 percent as did knowledge about HIV/AIDS and how to prevent it.

Attitudes toward the timing of marriage and childbearing likewise, with the preferred age of marriage beginning at 20 and childbearing at 23 by the Phase III interview.

Incorporating these lessons into the literacy classes, with a trained adult leader, allowed the girls to discuss questions and concerns among themselves and to do so with accurate information.

6. Knowledge about Girls' Mobility and Girls Trafficking

The girls' awareness about the possibility of girl trafficking was heightened over the course of the study. However, based on their responses to the specific questions, the problem does not appear to be a major one in these particular communities.

7. Involvement in the Adolescent Girls' Groups

The involvement of these 891 girls in the Girls' Groups, which continued after the classes ended, not only allowed them to learn other skills, such as environmental health, but continued their education about the subjects covered in the class.

8. Limitations / Possible Sources of Bias

The results of this study are compelling, even after taking into account the limitations inherent to this kind of three-phased survey. Those limitations are of two kinds, those related to the participants themselves and those related to the study design.

As discussed at the beginning of this report, the girls who participated in these groups are not a representative sample of general adolescent population in the project area. They were not randomly selected but rather mostly illiterate girls who were invited and given permission by their parents to attend these classes to learn to read and write. Therefore, the results cannot be

compared to findings from other studies that have a representative sample of the larger adolescent population.

Even though data are analyzed separately for ages 10-14 and 15-19, those are rough markers of the changes these girls experience as they move from pre-adolescence of a 10 or 11 year old to full adolescence to adulthood in their late teens. The data could not account for what these girls were learning from other sources, from post-literacy class formal education, or as part of their natural maturation process during this year and a half.

The same questions had to be asked at all three interviews as well, which may have caused the girls to pay closer attention to specific points and the terminology used in the questions, inflating positive results attributed to the curriculum. Finally, the researchers could have had difficulty interpreting and reporting some responses because of how they were translated back and forth between English, Nepali and local dialects.

9. General Conclusions

Knowledge in and of itself cannot change behavior but it is essential to doing so. Despite the limitations of a study such as this one, its findings demonstrate the value of the Adolescent Girls' Groups and of using literacy classes as vehicles for teaching health-related topics, including adolescent reproductive health. Put in very rough terms, the proportion of girls knowing about health issues in general, and reproductive health in particular, increased from almost none before the classes, especially among the 10-14 year olds, to more than half at their conclusion, to at least three-quarters a year later.

Using a health curriculum in classes to teach girls to read and write provided a highly cost-effective, cost-efficient way to provide such education. It used the "teachable moment" and built relationships and an atmosphere that would foster informal learning long after the classes had ended. The meetings of the AGGs that continued (monthly for in-school girls and weekly for out-of-school girls) throughout the following year provided a means to do so.

10. Programmatic Implications and Recommendations

The implications of these findings for these girls, their families, and for Nepalese society are demonstrated by the fact that so many of their families gave them permission to go on to formal schooling once they had completed these classes, demonstrating how much their own perspective about education for girls could change.

The fact that the program was initiated by Mothers' Clubs, which already had the respect of the communities they are in, certainly contributed to its acceptability and success in each of the districts. The AMK's far-sightedness in initiating Adolescent Girls' Groups in communities throughout Nepal, and these Girls' Classes in Baglung which incorporated an effective curriculum, serves as a model for the establishment of similar programs elsewhere.

11. Future Research

Although the intervention appears to have been successful in enhancing reproductive health knowledge among disadvantaged adolescent girls, the study could not document whether the girls were able to translate this knowledge into practice (except for much increased immunization coverage). Further research is required to understand changes in the actual reproductive behavior of the adolescent girls.

The findings of this small survey suggest the need for studies of larger networks of such classes, in Nepal and other countries, which could provide sample sizes large enough to measure impact

on such voluntary participants over time. Although they are not fully representative of their communities, a proportion of them are likely to become leaders in those communities, thereby extending the benefits beyond their own families.

Theoretically, experimental studies could be used to “prove” whether the classes are what changes knowledge but, given the cost of doing so, and the fact that the participants are self-selected, makes this unrealistic. On the other hand, studies comparing literacy classes using the standardized health-focused *Lalima* curriculum with literacy classes that have a more general curriculum, based in matched communities, might provide some insight. Qualitative studies would also be useful to examine how the knowledge gained by these girls affects their friends, family and community.

Nevertheless, whether such studies can be conducted or not, this program has shown itself to be an extremely cost-efficient step toward improving the status of rural women and the health and well-being of families and the isolated communities in which they live.

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