ADOLESCENT REPRODUCTIVE HEALTH AND GENDER SENSITIVITY IN TRIBAL AREAS

- An Operation Research -

Submitted to

Ministry of Health and Family Welfare, Government of India

By

MY-HEART

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PROJECT COMPLETION REPORT

TITLE OF THE PROJECT	:	Adolescent reproductive health and gender sensitivity in tribal areas-An operation research
Implementing institutions	:	MY-HEART (Mother NGO), Bhubaneswar
Principal investigator	:	Adait Kumar Pradhan
Co-investigator	:	Jagdish Sahoo
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ACKNOWLEDGMENT

The sexual and reproductive health needs of adolescents differ from those of adults, and remain poorly understood and inadequately served in many parts of the state. Addressing the needs of adolescents, and promoting healthy sexual and reproductive development, maturation and behaviour, undoubtedly represent a considerable challenge. In course of our dialogue with the tribal communities, we work since last 15 years, we found there exists a need to explore in-detail the issues concerning adolescent sexual and reproductive health in its clinical epidemiological and other aspects with vivid investigation to the very special needs, problems, gender roles and common practices on the social, educational, economic, demographic, ecological and cultural aspects of community. The present operational research has then been conducted in 3 GP's of Deogarh district to gather information on present knowledge, practices and behaviour pattern on adolescents' sexual and reproductive health, investigating the determinants of positive behaviour and outcomes in the context of gender roles, community setting and practices specifically focusing on care givers and service providers like parents, elders, AWW's, teachers and health workers and also it identify needs and problems the adolescents face and explores possibilities of new strategies and interventions based on the specific needs identified for improvements. This research was undertaken in 40 villages in the project area covering 480 adolescents, as primary stakeholders and 40 parent groups as secondary stakeholders and 200 service providers as tertiary stakeholders. Pertinent tools and techniques of social-science Research methodology was utilized during field study. The whole process was carried out by the skilled investigators under the principle investigator Mr. Adait Kumar Pradhan and Co-investigator Mr. Jagdish Chandra Sahoo.

Based on the analysis of data collected from field and taking in to consideration the opinions and views of primary, secondary and tertiary stakeholders, suggestions and recommendations have been made based on major findings. I hope the outcome of this operational research especially the findings and recommendations will help in framing future intervention strategies to deal with adolescent sexual health programme. Besides it will be helpful to health policy planners, health administrators, health workers and

researchers in designing plans/programmes and implementing activities on adolescent reproductive health.

I would like to express my sincere thanks to the "Research Team" comprising of Investigator and Co-investigator and field investigators for their relentless endeavors in carrying out the operational research successfully. My special heartfelt thanks to the people of Dholpada, Kansar and Kindeijori GPs of Teleibani Block of Deogarh District and also to the district administration and respondents for their kind help and co-operation during field data collection. The help and cooperation received from State NGO Coordinator Mr. M.R.Mishra and RRC Coordinator Mr. S.M.Dash can not be ignored. I take this great opportunity to extend my sincere thanks for their cooperation and feedback. My Last but not the least, I extend my thanks to Dr. Nabin Kumar Pati for critical inputs in the preparation of final report. Lastly we duly recognize the kind support provided by the Ministry of Health and Family Welfare, Govt. of India and Govt. of Orissa for which the operational research has been a great success.

Shaktidhar Sahoo
Director
MY HEART

ACRONYMS USED

1. RTI : Reproductive Tract Infections
2. STI: : Sexually Transmitted Infections
3. STD's : Sexually Transmitted Diseases
4. AWW : Anganwadi worker
5. WHO : World Health Programme
6. NRHM : National Rural Health Mission
7. AIDS : Acquired Immuno Deficiency Syndrome
8. HIV : Human Immuno Virus
9. NGO : Non-Governmental Organization
10. NFHS : National Family Health Survey
11. SRH : Sexual and Reproductive Health
12. ANM : Auxillary Nurse Midwife
13. FGD : Focussed group discussion
14. ASRH : Adolescent Sexual and Reproductive Health
15. BPL : Below poverty line
16. APL : Above poverty line
17. TBA : Trained birth attendant
18. SBA : Skilled birth attendant
19. IFA : Iron and folic acid
20. TT : Tetanus Toxoid
21. PHC : Primary Health Centre
22. CHC : Community Health Centre
23. AWC : Anganwadi centre
24. MP : Medical practitioner
25. ST : Schedule Tribe
26. SC : Schedule Caste
27. BCC : Behaviour Change Communication
28. ANC : Antenatal care
29. PNC : Post Natal Care
30. ASHA : Accredited Social Health Activist

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1. INTRODUCTION

1.1 Background

Adolescence is times of transition from childhood to adulthood, during which young people experience changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood. Experiences of adolescence vary by age, sex, marital status, class, region and cultural context. Moreover, social, economic and political forces are rapidly changing the ways that young people must prepare for adult life. These changes have enormous implications for adolescents' education, employment, marriage and childbearing, but also for their sexual and reproductive health and behaviour.

As a group, thus, adolescents have sexual and reproductive health needs that differ from those of adults in important ways, and which remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviours during adolescence have far-reaching consequences for people's lives as they develop into adulthood.

Adolescence is a period of increased risk-taking and therefore susceptibility to behavioural problems at the time of puberty and new concerns about reproductive health. Female adolescents, compared to their male counterparts, face disproportionate health concerns following puberty; foremost among these are too-early pregnancy and frequent childbearing. Male adolescents, for their part, often lack a sense of shared responsibility for sexual and reproductive matters and respect for reproductive choices.

With an estimated 1 billion adolescents alive today, the world is experiencing the largest adolescent population in history. As a result, adolescent reproductive health is an increasingly important component of global health. Adolescence is a time of tremendous opportunity and change. It also is a time of heightened vulnerabilities. Programs that can provide information, ensure access to services, and develop life skills are crucial to the future of this population.

Many adolescents in India face reproductive and other health risks. Poor nutrition and lack of information about proper diets increase the risk of iron-deficiency anemia for adolescent girls. Young women and men commonly have reproductive tract infections (RTIs) and sexually transmitted infections (STIs), but do not regularly seek treatment despite concerns about how these infections may affect their fertility. India also has one of the highest rates of early marriage and childbearing, and a very high rate of iron-deficiency anemia. The prevalence of early marriage in India as elsewhere poses serious health problems for girls, including a significant increase of maternal or infant mortality and morbidities during childbirth.

We need to pay attention to the health needs of adolescents to:

- **Reduce death and disease, now and during their future lives.**
- **Deliver on the rights of adolescents to health care, especially reproductive health care;**
- **Ensure that this generation of adolescents will, in turn, safeguard the health of their own children.**

Now-a-days, it is widely acknowledged among public health decision-makers and experts, that adolescents not only have sexual and reproductive needs but likewise rights, including the right to a satisfying and safe sexuality. Adolescents, often termed the "generation of hope", play a vital role for the future health status of any country. Their behaviours, attitudes and beliefs are also shaping the societies of the future.

However, gender-based inequalities put girls and young women at increased risk of acquiring STIs. Gender-based inequalities also affect their access to prevention and care services. In addressing these inequalities, it is important to consider the different needs and constraints of young women and young men, and to design interventions accordingly.

Socio-cultural factors that influence adolescents' views on sexuality, their access to information, and their access to health services affect reproductive health and well-being, including teenagers' ability to protect themselves from unplanned pregnancy or STDs.

The reproductive health of young people has emerged as a priority issue in the last decade, and the Global survey findings demonstrate that countries increasingly recognize its importance. Most countries reported action on this issue since ICPD, including greater efforts to decrease gender disparities in education, to provide comprehensive health care, including reproductive and sexual health and youth friendly services, and to increase life skills education and employment opportunities for young people.

The ICPD review of last ten years by UNESCAP gives an overall scenario of ASRH as follows:

- **With age at menarche declining age at marriage rising;**
- **Sexual relationship outside marriage is on rise;**
- **Sexual relations occur overwhelmingly within the context of marriage;**
- **More than half of females marry as adolescents in Bangaldesh;**
- **Meeting the reproductive health needs of adolescents and unmarried youth is a major challenge;**
- **Asian countries have been taking actions to address these needs but not been evaluated;**
- **Sexual reproductive health needs of young people are firmly highlighted in national agenda;**
- **Much of this knowledge remains superficial and ridden with myths, misconceptions and sense of vulnerability;**
- **Lack of communication with parents and other trusted adults keeps youth ill-informed;**
- **Sexual education remains inadequate and irrelevant;**
- **Services remain inaccessible, unacceptable and unaffordable in meeting needs of youth.**
- **Access to reproductive health services, particularly contraceptives is not available to adolescents and unmarried youth;**
- **Important role played by NGOs in initiating innovative interventions.**

Indeed, in the life cycle of the human being, adolescence period is a transitional, very sensitive and most complicated period of life. Particularly in rural and tribal areas, adolescents are more vulnerable and suffer various from of serious sexual and reproductive health problems due to many factors.

Keeping in view to above, the project is aiming to improve knowledge, skills and capacities of adolescent, parents, elders, teachers, AWW, and health workers in order to promote reproductive health and gender equality in the project area, Deogarh district, Orissa. As part of the operation research project, a Base line survey has been conducted in the project area. The subsequent sections deal with in details about the Baseline survey.

1.1. Concept and definition

Adolescence: In the literature on adolescent health, the terms" adolescent", "young people" and "youth" have been used for some time to describe individuals in the age groups 10-19, 10-24 and 15-24 respectively. The World Health Organization defines "adolescence" as 10-19 years old, "youth" as 15-24 years old, and "young people" as 10-24 years old.

Adolescence is commonly associated with physiological changes occurring with the progression from appearance of secondary sexual characteristics (puberty) to sexual and reproductive maturity (WHO, 1995). It is important to note, however, that even biological markers are subject to change over time, such as the fall in the age at onset of menarche in recent decades, which is attributed to improved health and nutrition (WHO, 1995).

Biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. And as they change, so their needs change with them.

- Early adolescence (10-13) is characterised by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.
- In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective.
- In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions.

- **Adolescents are no longer children but not yet adults.**
- **Adolescents have different needs according to their stage of development and their personal circumstances.**
- **Some adolescents are especially vulnerable or hard to reach, and are in extra need of support.**

Reproductive health: "Reproductive health" is a state of complete physical, mental and social wellbeing and not merely the absence of diseases and infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with best chance of having a healthy child.

Promoting young people's sexual and reproductive health thus means ensuring their physical and emotional well-being and protecting them from: unintended and unwanted pregnancy; abortion; STI, HIV/AIDS, and reproductive tract infections (RTI); maternal mortality; infertility; and all forms of sexual violence and exploitation (*Reproductive health briefing cards. New York, Family Care International, 2005*).

Life Skills: The World Health Organization has defined Life skills as, "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life". UNICEF defines, "life skills based education as behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills.

Gender: "Gender" is a term that can be used to categorize the different roles of men and women, as determined by the society in which they live. While a person's sex -- the biological distinction of being male or female -- determines reproductive health status and reproductive health needs, gender perspectives also play a role.

1.2. Adolescent physical, behavioural and psychological changes:

Adolescence is commonly associated with physiological changes occurring with the progression from appearance of secondary sexual characteristics (puberty) to sexual and reproductive maturity (WHO, 1995). It is important to note, however, that even biological markers are subject to change over time, such as the fall in the age at onset of menarche in recent decades, which is attributed to improved health and nutrition (WHO, 1995).

The period is characterized by a combination of physical changes (puberty), behaviour changes and shifts in social grouping. Broadly, these changes are rapid growth and the development of secondary sexual characteristics making physical changes. There are also psychological changes – the development of a sense of identity distinct from parents and self-worth, the exploration of new relationships with their peer groups, with the opposite sex, families and the community. It is alos a time of exploration (of their own bodies, of one's capabilities and potential) and experimentation (sexual relationships, alcohol and tobacco use). At this stage, media and peers exert a powerful influence. The support and understanding of parents during this phase is critical in enabling them to meet these challenges.

1.3. Socio and demographic profiles of adolescent:

In India, about 23% of population are adolescents aged 10-19 years. Of the total adolescent population, 12% belong to the 10-14 years age group and nearly 10% are in 15-19 years age group. More than half of the currently married illiterate females are married below the legal age at marriage. Nearly 20% of the 1.5 millions girls married under the age of 15 are already mothers (Census 2001).

ADOLESCENTS IN INDIA

- 300 million young people age 10-24 years in India
- Adolescents age 10-19 years represents over one-fifth of population
- 20 per cent of the boys and 44 per cent of girls between age 15 – 19 illiterate
- Two-thirds of married women of reproductive age married by 18 years
- 33 per cent married by age 15
- Among women between 20-24, almost half have given birth by age 20
- Poor reproductive health and high maternal mortality among adolescent girls
- Indian adolescent women have higher mortality risks then adolescent men
- Most adolescent sexual activity takes place within marriage

Adolescent girls living in villages have less access to information, knowledge and learning opportunities as compared to their male counterparts. However, they contributes significantly to their family and the community in the social and economic activities as their male counterparts do.

1.4. Gender norms and adolescent:

Gender" is a term that can be used to categorize the different roles of men and women, as determined by the society in which they live. While a person's sex -- the biological distinction of being male or female -- determines reproductive health status and reproductive health needs, gender perspectives also play a role. Socio-cultural factors that influence adolescents' views on sexuality, their access to information, and their access to health services affect reproductive health and well-being, including teenagers' ability to protect themselves from unplanned pregnancy or STDs.

"A child's sex is determined before birth, but gender is learned," says Dr. Karen Hardee, an FHI principal research scientist. "Throughout childhood, boys and girls receive different messages about behaviors that are expected of them -- messages from parents, society, peers, the media -- messages that some behaviors are acceptable for boys but not for girls, and vice versa. Health workers must be sensitive to how gender norms affect adolescents' decision-making about reproductive health behaviors and how these norms affect access to health services."

"Providers must see reproductive health not only in terms of services but in terms of attitudes and quality of care," says Naana Otoo-Oyortey, an International Planned Parenthood Federation technical officer. "Both boys and girls have a right to basic information and access to resources that will enable them to live a satisfying reproductive and sexual life. Providers must recognize that boys have responsibilities that must not be neglected. They must acknowledge that women's decisions on reproductive matters are directly influenced by their partners, husbands, fathers, etc., and address the need for women to be empowered to make informed decisions."

Many societies place a higher value on males than females. From infancy, girls may receive less food than boys and less medical attention when sick. For adolescent girls, an unplanned pregnancy can mean expulsion from school and, consequently, limited job opportunities.

1.5. Health and nutrition status:

The rapid changes of social, economic and political systems have enormous implications for adolescents' education, employment, marriage, child bearing and health. In addition, gender disparity in terms of food intake, access to health care and growth patterns, girls are worse off than their brothers. Disparities become evident soon after birth, and by adolescence, many girls are grossly underweight.

As per NFHS-II, 1998-99 data, the symptoms of reproductive health problems among adolescent girls are:

- **Abnormal vaginal discharge – 18.2%**
- **Irritation – 8.9**
- **Bad adour – 4.8**
- **Sever lower abdominal pain – 13.4**
- **Urinary tract infections – 11**
- **Other reproductive health problems – 27. 5**

In India, theNFHS-2 found that nearly 15% of ever married women were stunted and about one-fifth had moderate to sever anaemia. The combination of poor nutrition and early child bearing expose young women to serious health risk during pregnancy and childbirth, including damage to the reproductive tract, maternal mortality, pregnancy complications, peri-natal and neonatal mortality and low birth weight. International analysis suggest that, at the global level, girls aged 15-19 are twice as likely to die from child birth as are women in their twenties, while girls younger than age 15 face risk that is five times as great(UNICEF,2001).

1.6. Sexual behaviour and practices of adolescent:

Due to impact modernization, majorities of adolescent girls regardless of their marital status, are sexually experienced and having expose to risky sexual practices including sex for money and also having multi sex partners. A sizeable proportion of women in India marry well before age 18, and early pregnancy further exacerbates their poor reproductive health and poor survival chances of the infants they bear. Few services cater to the needs of adolescents especially for health care, nutrition, vocational skills, economic opportunities of information. However, in India, sexual debut among adolescent girls occurs largely within marriage. One-fourth of women aged 20-24 are married in India.

1.7. Problems, needs and priorities:

Adolescents are not a homogeneous social group and their needs differ according to their age, sex, marital status, class, region and cultural context. There is no clear account of the social and personal heterogeneity of adolescent boys and girls in the target communities with sex-desegregated data to design any appropriate development programme. There is lack of contextual gender analysis of roles and responsibilities of girls and boys.

Some of observations based on MY-HEART's experiences in the field are:

- **The majority of girls of the target area are unaware about the process of growing up because of social restriction of discussing freely about sex and sexuality. Girls are not allowed to share their feelings either with their parents or with their friends.**
- **Lack of adequate knowledge and communication skills among parents and family elders in transferring the information relating to reproductive ill health and sexual problems that arise during adolescent period.**
- **Lack of awareness level among the adolescent girls regarding reproductive and sexual health problems that may occur during adolescent period.**
- **Inaccessibility of appropriate health care to the needs of adolescent gilrs.**
- **Lack of self-confidence and assertiveness among girls, which has a negative influence in developing positive health seeking behaviour.**

Adolescent in India tend to be poorly informed about their own bodies and matters related to sexuality and health. The information they have is often incomplete and confused. Low rates of schooling, limited access to sex education and attitudes that prohibit discussion of sex exacerbate their ignorance. As gate keepers who shold play a central role in enabling adolescents to protect their health, parents often obstruct rather than facilitate informed choice. Adolescent commonly report that discussion with parents about sex or reproduction are taboo. Education systems also tend to be ambivalent about sex education, though this begun to change in wake of the HIV/AIDS pandemic. As a result of adults' reticence to address these issues, adolescent tend to rely on peers and mass media for information about sex, reproduction and STIs including HIV/AIDS.

1.8. Facilities and services for adolescents:

Since the International Conference on Population and Development in Cairo in 1994, recognition of young people's specific sexual and reproductive health needs has gradually increased. Attempts to date to promote the sexual health of young people have tended to focus on prevention, education and counselling for those who are not yet sexually active, while the provision of health services to those who have already engaged in unprotected sexual activity and faced the consequences, including pregnancy, STIs or sexual violence, has lagged behind.

In India, adolescent reproductive and sexual health has been recognized as major focus area under Reproductive and Child Health Programme and NRHM. However, reproductive health needs of adolescent have long been neglected. Govt. of India has recognized the importance of influencing the health seeking behaviour of adolescents. The health situation of this age group will be central in determining India's health, mortality, morbidity, and population growth scenario. Investment in adolescent reproductive and sexual health will yield dividents in terms of delaying age at marriage, reducing the incidence of teenage pregnancy, meeting unmet contraceptives needs, reducing the numbers of maternal deaths, reducing the incidence of sexually transmitted infections and reducing the proportion of HIV positive cases in 10-19 years age group.

The 10th Five Year Plan recognizes adolescents as distinct group for policy and programme attention. The National Population Policy 2000 identifies adolescents as underserved group for which health, specifically reproductive and sexual health interventions are to be designed. The National Youth Policy 2003 recognizes 13-19 years as a distinct age group, which is to be covered in programme of all sectors, including health, education, science and technology etc. In this regard, Youth Ministry has devised special programmes for adolescent health and empowerment.

Equipping adolescents to make informed sexual and reproductive choices requires multi-pronged activities, including efforts to enhance knowledge and awareness, change attitudes and strengthen skills, such as the ability to negotiate with peers, partners and family members. A variety of educational programmes are underway in India, implemented by both the public and NGOs. Nevertheless, these programmes must complement sex education with strategies such a telephone counseling, peers counseling, life skills education, health camps, and efforts to change attitudes and awareness among teachers and parents.

2. REVIEW OF LITERATURE:

There are many studies both at the national and state level indicated the need and importance of further research and studies link with improving access to information and services for adolescents. Many have the opinions to provide sex education and life skills education to adolescent. Several studies revealed various forms of precarious conditions of adolescent especially adolescent girls and its responsible factors. The glimpses of some of the studies are presented below:

- As they matured and become sexually active, more young people face serious health risks. Most face these risks with too little information, too little guidance about their sexual responsibilities, and too little access to health care (Population Report, 1996).

- In at least nine Sub-Sharan African Countries, girls are temporarily of permanently expelled from school if they become pregnant but no punitive action is taken against boys who became fathers. In Kenya, 10000 girls leave annually due to unplanned pregnancy (Nagwana A. Akwy, 1996).

- In Egypt, a demographic and health survey showed that, rarely 32% of women reported being beaten by during pregnancy (EI, Zanty F, Hussien EM, Shawky GA, 1996).

- Gender norms can place girls at risk of sexual violence, including rape and domestic violence.

- In rural Malawi, 55% of 120 adolescent surveys reported they were often forced to have sex (Helitzer, Alen D, 1993).

- A study by the Allan Guttermacher Institute found that 60% of US adolescent girls who had sex before age of 15 did so involuntarily (1994).

- More than, 10% of birth each year are to women age 15-19, according to Washington based Population Reference Bureau. Infant mortality also is greater among the adolescent mother (Allan Guttermacher Institute, 1997).

- In India, of 100 girls who came to hospital seeking abortion, 80% did not know that sexually intercourse could lead to pregnancy or STDs and 90% did not know about contraception (Chhabra S.A, 1992).

- In developing countries 20% to 60% of young women pregnancies and birth are unintended, most coming sooner than planned. Pregnancy puts young women's health at risk, through child bearing or unsafe abortion (Population Report, 1996).

- In India, it has been reported that more young women and men are becoming sexually active during their mid-teens with more than 50% having unprotected penetrative sex before the age of 16 (Dr. A.T.Khan, 1995).

- Traditional norms and the role of the family are losing their importance in governing young people's sexual behaviour in India. School-based sexually programmes are needed that will provide students with accurate information about pregnancy, contraception and sexually transmitted diseases (IFPP, 1999).

- The sexual behaviour among unmarried adolescent is on rise, especially in urban areas, where an estimated 20-25% of unmarried young males and 6-10% of unmarried young females have premarital sex (Rakesh A, 1992).

- NFHS survey suggest that at least half of all young women in India are sexually active by age 18 – mostly within marriage – and almost one in five are pregnant by age of 15. Well over half of all married women aged 15-19 have experienced a pregnancy or given birth (UNPF,1998).

- A multimedia approach increases the reach and impact of reproductive health interventions directed to young people. Building community support for behaviour change also is essential, to ensure that young people find approval for their actions and have access to services (IFPP).

3. RATIONALE FOR THE STUDY:

3.1. Context:

The overall objective of the project is to improve knowledge, skills and capacities of adolescent, parents, elders, teachers, AWW, and health workers in order to promote reproductive health and gender equality in the project area. In the life cycle of the human being, adolescence period is a transitional, very sensitive and most complicated period of life. Particularly in rural and tribal areas, adolescents are more vulnerable and suffer various from of serious sexual and reproductive health problems due to many factors.

Several studies in the worldwide had shown a very precarious and miserable condition of adolescent sexual, reproductive health and gender inequalities. As they matured and become sexually active, more young people face serious health risks, most face these risk with too little information, too little guidance about sexual responsibilities, and too little access to health care. Meeting diverse needs is a great challenge for parents, communities, health care providers and educators.

Further, the situation of adolescent girls in the project area is very vulnerable due to high women illiteracy, gender disparity; early marriage, early pregnancies, unsafe abortions; too close and too many child births, maternal morbidity and mortality; adolescent malnutrition and anemia; high unmet needs for birth spacing and birth control methods; and suffering from RTIs/STIs and many sexual and reproductive health problems. The importance of adolescent reproductive health is one of the most important issues that received national as well as international concern and priorities. The objective of the research is directed to address above context and the application of work will be very much applicable to address national priorities of medical research including reproductive health.

A small study has already conducted in the proposed project area entitled " A study on knowledge and sexual behaviour of unmarried tribal adolescents" under strengthening of health research in NGOs in India, sponsored by TISS, Mumbai. Mr. Jagdish Chandra Sahoo, Programme Officer of MY-HEART and proposed co-investigator of the study was engaged in doing the study.

The main findings of the study are:

- **The high percentages of sexual activities including penetrative form sex have been practiced from early age in the project area.**
- **The most of the adolescents have little knowledge about STI and RTI, its symptom, causes and modes of transmission.**
- **Most of them don't know about safe sex practices. Though they have the knowledge about barrier methods, but use in sexual act is very low which shows the high percentage of high-risk behaviour.**
- **They have knowledge about safe abortion and place of abortion, which clearly implies the high prevalence of unintended pregnancy among the unmarried girls.**

3.2. Rationale:

- In an effort to improve the reproductive health of adolescents and young adults, many organizations that work with youths are incorporating **gender prospective into sex education, service** delivery **and providing training became very effective.** Because gender norms often negatively affect access to reproductive health knowledge, information and services, and promote risky .behaviour for boys and girls.

- Both boys and girls have right to basic information and access to resources that will enable them **live in a satisfying reproductive and sexual life** like adult people, because " today's adolescents are tomorrow's parents".

- Adolescent face many physical and psychological problems related to sexual activities. Adolescents **who became pregnant face** high **risk than older women** of developing following complications, anaemia, pre-eclampsia, premature and low birth weight babies and prolonged labour.

- Because so many adolescents do not understand how their bodies work and because they do not **have access to health and family** planning **services, many teenage pregnancies** are unplanned.

- **Adolescents who are sexually** active **also risk of getting sexually transmitted** diseases. However, they arc less likely to know the symptoms and less likely seek help. Adolescents generally do not have adequate knowledge about their own maturation especially sexuality and little information about what reproductive health services exists and how to use them.

- Persons who could provide such help - doctors, health workers, parents, community leaders, teachers and so on **are rarely trained in issues of adolescent sexuality or how to communicate with adolescent effectively.**

- Existing services are designed with adolescents in mind and almost **never involved adolescent in planning, and evaluating the programmes.** The adolescent reproductive health status and gender inequalities in project area are very alarming which needs urgent attention to achieve the goals of reproductive and child health programme.

- This kind of operation research would be very effective and sustainable because of the programme will be formulated, implemented and evaluated by the beneficiaries and communities and other stakeholders of the project area as per their felt needs.

4. AIMS & OBJECTIVES OF THE STUDY:

4.1. Development objectives:

Changed and improved knowledge, attitude, behaviour and practices of adolescents on sexual and reproductive health; and changed attitude of parents, elders, AWW, teachers, and health workers to promote sexual and reproductive health of adolescent and gender equality in the project area.

4.2. Immediate objectives:

- To identify sexual and reproductive health (SRH) problems and needs of adolescent and to investigate the determinants of positive behaviour and outcomes so as to provide need-based knowledge and life skills, SRH skills, SRH services and referral facilities to improve adolescent reproductive health status.
- To investigate the gender roles and life skills that affects the health situation of adolescent.
- To investigate the ways in which sexually active youth deal with dual risks of unwanted pregnancy, unsafe abortion and STI.
- To adopt and assess the impacts of a combined behavioural theories and models (adolescent development theory and stages of changes), operation research and participatory learning and action (PLA) on sexual and reproductive health and gender status.
- To build the capacity of adolescents for Planned Parenthood and to create demand generation for better reproductive health care services.

5. METHODOLOGY :

5.1. Universe of the study:

The Baseline survey has been conducted in three Grampanchays namely Dholpada, Kansar and Kindeijori under Tileibani Block of Deogarh district, Orissa. It covered 40 villages. Both adolescent boys and girls of these villages are the Universe of study. Besides all care givers (parents/elders) and service providers (AWWs, teachers, and health workers) of the study villages have included as universe of the study. Adolescent will be termed as primary stakeholders. Caregivers will be secondary stakeholders and service providers will be termed as tertiary stakeholders.

5.2. Sampling design:

More emphasis has been given to collect data through qualitative methods as discussed in the tools. For quantitative data, stratified sampling method has been adopted especially for interviewing adolescent. The sampling size has been derived on the basis of following:

- Representative of universe (at least 20% of universe)
- Reliability of results (in relation to study the association among variables)
- Minimum sampling error
- No. of variable to be studies(limited variables)
- Methods and tools of data collection (more qualitative)

The details of sampling size for Baseline survey are given below:

- Villages covered : 40
- No. of Adolescents : 480
- No. of Service Providers : 200

5.3. Tools and Technique of data collection:

The following tools technique was adopted for baseline survey:

- Village Schedule : 40
- Questionnaire for adolescents : 480
- In-depth Interview for Service Providers : 200
- Focus Group Discussion for care givers : 40
- Case Study : 40
- PLA exercise (problems and priority ranking, seasonally, chapatti diagram, gender analysis and trend analysis : 40 villages

5.4. Data analysis, statistical methods used and reporting:

Both primary and secondary data has been analyzed through tabular and graphical forms using different research and statistical techniques. Attempt has been made to derive major findings on key aspect of Baselines Survey. Suggestion and recommendation has been made based on findings study and as per requirement of further operation research as per initial design of project.

6. DATA ANALYSIS, FINDINGS AND DISCUSSION:

6.1. Community profiles:

The Baseline survey has been conducted in 40 villages covering three Gram Panchayats under Tileibani Block of Deogarh district, Orissa. The survey areas is primarily dominated by tribal population. It is under-served and in-accessible area in the context of health care service delivery. The brief profiles of the surveyed villages are given below:

- The population of villages varies from 81 to 851 and average population is 240.
- The adolescent population is ranges from 15 to 183 and average adolescent in a village is 51.
- There is low level of literacy.
- Most of the families belongs to Small farmers category and wage labourers.
- Health institutions are within a distance ranges from 1 km. to 40 kms. for treatment, which are usually not accessible by the community.
- Educational institutions like primary and secondary schools are mostly close to the villages whereas the colleges are far from the locality.
- Safe drinking water facilities exist in villages, whereas nobody owns a toilet in their houses. Most of the villagers depend on tube well for drinking water. Till date hardly any development and informative welfare programmes took place in the interest of for adolescents in the villages.

6.2. Views and opinions of service providers:

Attempt was made to interview service providers like AWWs/ANMs/school teachers/TBAs to ascertain their views and opinions on different aspect gender issues and reproductive health and their attitude towards SRH education for adolescent. The findings of the interview discussed below:

- Gender discrimination exists in the society. Always girls are treated as inferior as regards to physical labour they put in agriculture and other fields is considered as less significance in comparison with boys. Hence, they get lower wage.

- They are not sure whether any sexual reproductive health problems exist among adolescents in their areas but it is felt that there is lack of opportunity and scope to know and update their knowledge about the topic. Some of the sexual and reproductive health problems like premarital and unsafe sex and unwanted pregnancy, were cited by some of the service providers. Due to lack of knowledge and awareness, the adolescents have little knowledge about sexual and reproductive health.

- Events like suitable training programmes would be fruitful to disseminate SRH education among adolescents. Others supportive initiatives like street plays, palas, awareness programmes through audio visuals, literatures and group discussions would help involve community as a whole in the process.

- Although service providers like ANMs/AWWs, teachers, and other care providers are at village and block level, but the capacity and sphere of work is not sufficient to enable people and adolescents to be aware about SRH problems and needs of adolescents. Besides, health institutions are less equipped regarding process, methods and materials for imparting health education.

- Further capacity enhancement of parents and peoples' leaders in the villages does not happen regularly. They also lack of proper education for which they feel as if they are not in any way concerned about the problems of adolescents.

- A few problems like premarital sex and sexual exploitations are noticed by the service providers while dealing with the adolescents.

- In order to promote SRH education properly, few promotional measures like counseling, imparting education to mothers and community sanitations were suggested by the service providers.

6.3. Views and opinions of community on ASRH issues:

Focus group discussion was conducted in all 40 surveyed villages to ascertain the opinions and view of community members on various aspect reproductive health problems and needs of adolescent, gender issues and level of community awareness on ARSH. In each FGD, 10 to 12 members such as village leaders, adolescents, teachers and service providers were participated. The findings of focus group discussion are presented below:

- Participants on their own opined that there is gender discrimination in villages. Male dominance was marked in food intake, wage and preference for having male child. As they grow up, adolescents girls are becoming physically week and suffers from different health problems like STI, RTI and anaemia.

- Periodical health education programmes, counseling should be carried on by adequately trained health personnel and educators, that include reproductive health education, family life health education, Planned Parenthood, etc. Parents being most close to adolescents should be properly sensitized on the said issues. They need to minimize social gaps between them and adolescents. There is a need for friendly environments where boys and girls can share their problems jointly and parents need to suggest for necessary solutions regarding reproductive health.

- Actualization of SRH depends on ability and patience of health service providers. They need to come down to the position of adolescents and talk to them on sexual and reproductive health.

- Most of the respondents mentioned that health education is the priority need of the adolescent. A small proportion of respondents mentioned SRH education, family education, AIDS Education as the priority need of the adolescent while a small proportion of respondents also mentioned that care should be taken by the family member

- Views of respondents were taken after asking some statements. It was seen that almost all the respondents are of the opinion that reproductive health education is required for adolescent who is neglected now-a-days and also mentioned that family life education should be imparted to the adolescent so that they can maintain their family life smoothly. When asked whether parents should disseminate right kind of knowledge to adolescent especially on sexual and reproductive health, only a few of the respondents did not agree on it while almost all the respondents agreed that service providers should educate adolescent on sexual and reproductive health.

6.4. Personal profiles of adolescent:

A structured interview schedule was administered collect information from adolescent in surveyed villages. In total 480 adolescent were interviewed to collect data on socio-economic background of the family; health and nutrition status of adolescent; reproductive health status; knowledge on repordutive abd sexual health; attitude on reproductive and sexual health; and reproductive health practices of both boys and girls. The results of the survey are presented subsequent section of the report.

6.4.1. **Age**: The respondents' age ranges from 10 years to 19 years. The largest groups of respondents (69.2%) were in the range of 15 to 19 years, while only 27.7% of the respondents were in the age range of 13 to 15 years. Only a few respondents (3.1%) were in the 10 -12 years age group.

(In %)

Age	Boys	Girls	Total
10-12 Years	2.7	3.7	3.1
13-15 Years	26.2	29.5	27.7
15-19 Years	71.1	66.8	69.2
Total	**263**	**217**	**480**

6.4.2. **Caste:** Since Deogarh is a tribal dominated district, majority of respondents (79%) belonged to ST category and 14.4% belonged to Other Backward Caste (OBC) category while a small proportion (5.8%) belonged to SC category.

(In %)

Caste	Boys	Girls	Total
SC	2.3	10.1	5.8
ST	77.6	81.1	79.2
OBC	19.0	8.8	14.4
Other Caste	1.1		0.6
Total	**263**	**217**	**480**

6.4.3. **Religion**: A higher proportion of the respondents (88.5%) belonged to Hindu religion. About 11% were Christian and only two respondents belonged to other religion.

(In %)

Religion	Boys	Girls	Total
Hindu	94.3	81.6	88.5
Christian	5.7	17.5	11.0
Others		0.9	0.4
Total	**263**	**217**	**480**

6.4.4. **Education**: Overall, about 13% of the respondents were found to be illiterate. Only 1.9% respondents just knew to read and write, without any formal schooling. More than a quarter (32%) had read up to primary and only 21% had read upto secondary school levels. About 32% were read above secondary level. Across gender, about 20% of the girls were illiterate, compared to only 8% of boys.

(In %)

Education	Boys	Girls	Total
Illiterate	8.0	19.4	13.1
Literate	1.1	2.8	1.9
Primary	30.8	33.2	31.9
Secondary	26.2	15.2	21.3
Above	33.8	29.5	31.9
Total	**263**	**217**	**480**

6.4.5. **Occupation**: About 59% of the respondents were doing household work, while about 10% of them were wage labour and the rest 31% were students.

(In %)

Occupation	Boys	Girls	Total
Student	34.2	28.6	31.7
Wage Labour	9.5	10.1	9.8
HH Work	56.3	61.3	58.8
Total	**263**	**217**	**480**

6.5. Socio-economic background of the family:

The socio-economic background of the family plays a key role shaping adolescent's future. The family size and type, educational status of parents, economic status, occupation of parents and decision maker of family influences behaviour and practices of adolescent much than other factors. Therefore, attempt was made to collect information of above aspect to find association of these factors on sexual and reproductive status of adolescent. The findings are presented below:

6.5.1. Family Size: More than half of the respondents (69.2%) had the family size in the range of 6 to 10 members, whereas about 40% had the family size of less than 5 members. Only a small proportion (5.2%) of the respondents had family size of more than 10 members

(In %)

Family Size	**Boys**	**Girls**	**Total**
Less than 5	50.6	27.6	40.2
6-10	43.0	68.7	54.6
More than 10	6.5	3.7	5.2
Total	**263**	**217**	**480**

6.5.2. Type of Family: A majority of respondents (75%) constitute of a nuclear family, while 14% had extended nuclear family and only 11% of respondents live in a joint family.

(In %)

Type of family	**Boys**	**Girls**	**Total**
Nuclear	76.0	73.3	74.8
Extended nuclear	11.8	17.1	14.2
Joint Family	12.2	9.7	11.0
Total	**263**	**217**	**480**

6.5.3. **Decision Maker of the Family:** While asking about the decision maker of a family, most of the respondents (83%) stated that father is the decision maker of the family, and a small proportion (14%) said that mother is the decision maker and only a small proportion (4%) responded that grand father and other members of the family take the decision in the family.

(In %)

Decision Maker of the family	**Boys**	**Girls**	**Total**
Father	86.3	79.3	83.1
Mother	9.1	16.1	12.3
Grand Parents	3.8	3.7	3.8
Others	0.8	0.9	0.8
Total	**263**	**217**	**480**

6.5.4. **Major Sources of income of the family:** Since the district is tribal in nature, majority of respondents (85%) depends on agriculture for their major source of income, and only 11% depends on wage labour for their livelihood and a small proportion (1.3%) each depends upon business and service, whereas a negligible proportion were rural artisans and dependent upon other source to maintain their livelihood.

(In %)

Major Source of Income	Boys	Girls	Total
Agriculture	85.9	84.8	85.4
Service	0.8	1.8	1.3
Business	2.3		1.3
Wage	9.9	12.4	11.0
Rural Artisans		0.9	0.4
Others	1.1		0.6
Total	263	217	480

6.5.5. **Annual Income of the Family:** Most of the respondents (88%) had an income ranges from Rs. 5000 to Rs. 10,000/-, whereas only 10% were in income range from Rs. 10,000/- to Rs. 20,000/- and only 1% had income above Rs. 20000 and also a negligible proportion(1%) had had income less than Rs. 5000/-.

(In %)

Annual Income of the family	Boys	Girls	Total
Less than 15000	1.10	0.90	1.00
5000-10000	86.30	90.80	88.30
10000-20000	10.60	8.30	9.60
More than 20000	1.90		1.00
Total	**263**	**217**	**480**

6.5.6. **Whether belongs to BPL:** Most of the respondents(88%) were in BPL category and only 12% belonged to APL category.

(In %)

Whether belongs to BPL	Boys	Girls	Total
Yes	84.8	90.8	87.5
No	15.2	9.2	12.5
Total	**263**	**217**	**480**

6.5.7. **Occupation of Parents:** Most of the parents depends on cultivation for their main occupation and about one tenth of parents(9.4%) were wage labourers and only a small proportion (2.5%) were share cultivators and 1.3% were businessmen and a negligible proportion were service holders.

(In %)

Occupation of Parents	Boys	Girls	Total
Cultivator	87.10	83.90	85.60
Share Cultivator	1.90	3.20	2.50
Wage labour	8.00	11.10	9.40
Business	2.30		1.30
Service	0.80	0.90	0.80
Others		0.90	0.40
Total	263	217	480

6.5.8. **Educational Status of Mother:** Majority of mothers (74%) of the respondents were illiterate and rest were literate who have attained education upto secondary level and only a small proportion (2%) have completed their education more than higher secondary level.

(In %)

Educational status of Mother	Boys	Girls	Total
Illiterate	66.50	83.40	74.20
Literate	6.80		3.80
Primary	17.10	11.50	14.60
Secondary	6.10	5.10	5.60
Above Secondary	3.40		1.90
Total	**263**	**217**	**480**

6.5.9. **Educational Status of Father:** Education of the father is slightly more in comparison to the education level of mother. Half of the respondents are illiterate and rest half are literate and majority of fathers have completed primary school (27%) whereas 9% each have completed secondary and above secondary level of education.

(In %)

Educational status of father	Boys	Girls	Total
Illiterate	46.5	54.4	49.6
Literate	5.0	5.5	5.2
Primary	29.9	24.4	27.4
Secondary	8.4	9.2	8.8
Above Secondary	11.1	6.5	9.0
Total	**263**	**217**	**480**

6.6. Health and nutrition status of adolescent:

The good health and nutrition status of adolescent will have lasting effects to promote healthy parenthood. In order to know morbidity and mortality during adolescent will affect physical and mental growth.

6.6.1. **Height:** Only a small proportion (2.7%) were less than 120 Cm in height and majority of the respondents (59%) were in the range of 120 to 150 Cms of height whereas 39% were more than 150 Cms. in the height.

(In %)

Height in Cm.	Boys	Girls	Total
Less than 120 Cm	1.9	3.7	2.7
120-150 cm	45.6	74.2	58.5
More than 150 Cm	52.5	22.1	38.8
Total	**263**	**217**	**480**

6.6.2. **Weight in Kgs. :** More than half of the respondents(61%) had weight in the range of 40 to 50 Kgs and about one fifth of the respondents (21%) were in the range of 31 to 40 Kgs. of weight and only 18% had weight of more then 50 Kgs.

(In %)

Weight in Kg.	Boys	Girls	Total
31- 40 Kg,	18.3	24.4	21.0
40-50 Kg.	54.8	68.2	60.8
More than 50 Kg	27.0	7.4	18.1
Total	**263**	**217**	**480**

6.6.3. **Type of Nutritional disorders:** A slightly more than half of the respondents (53%) had no idea about type of nutritional disorders and only 14% cited "Anaemia" as one of the nutritional disorder and 4.4% cited as "Eye Problem", and only a small proportion (2.3%) cited Angular Stomatitis as a nutritional disorder and a meagre proportion had cited as "Glositis" and "Phrynoderma" as nutritional disorder and one fourth of respondents (25%) had mentioned that there is no symptoms of nutritional disorder.

(In %)

Type of Nutritional disorder	Boys	Girls	Total
Anaemia	15.2	11.5	13.5
Angular Stomatitis	2.7	1.8	2.3
Eye problem	4.6	4.1	4.4
Glositis	1.1	-	0.6
Phrynoderma	0.8		
No symptoms	24.7	25.3	25.0
Others	1.1	-	0.6
Do not know	49.8	57.1	53.1
Total	**263**	**217**	**480**

6.6.4. **Morbidity Status during last 3 months:** When asked about morbidity status during last 3 months, about 35% of the respondents had no idea about it. About one-fourth each (25%) cited Fever and Malaria, and 12% cited skin infection and only a small proportion cited menstrual disorder and peptic disorder.

(In %)

Morbidity Status	Boys	Girls	Total
Fever	18.60	31.30	24.40
Malaria	28.50	20.30	24.80
Menstrual disorder		0.90	0.40
Pebtic disorder		4.10	1.90
Skin infection	11.40	13.40	12.30
Others	3.00		1.70
Do not know	38.40	30.00	34.60
Total	**263**	**217**	**480**

6.6.5. **Food Consumption Pattern:** All the respondents takes cereals daily while only 7% takes Millets daily and majority takes millets once or twice(42%). Only 5% takes pulses / Legumes daily.

(In %)

Food Consumption Pattern

Foods consumed	Daily	Once/ twice	Once in two weeks	Monthly	Seasonally	Occasionally	Don't Know	Total
Cereals	100.0	-	-	-	-	-	-	100.0
Millet	7.3	41.5	26.5	4.0	-	5.0	15.8	100.0
Pulses	4.6	29.6	46.9	12.3	1.9	0.6	4.2	100.0
Green Leafy veg.	7.3	13.1	41.9	14.2	19.0	1.5	3.1	100.0
Other veg.	4.2	3.1	16.7	23.3	48.5	0.4	3.8	100.0
Roots			0.6	1.5	87.9	5.2	4.8	100.0
Milk & milk products	0.4	1.7	6.3	4.0	7.5	76.7	3.5	100.0
Fruits	0.6	0.8	2.3		62.5	30.2	3.5	100.0
Fresh food		4.0	14.0	10.6	5.6	62.1	3.8	100.0
Fat & Oil	0.4	14.8	27.7	8.3	12.7	33.1	3.1	100.0
Sugar & Jaggery	0.6	11.5	26.0	2.5	12.5	39.2	7.7	100.0

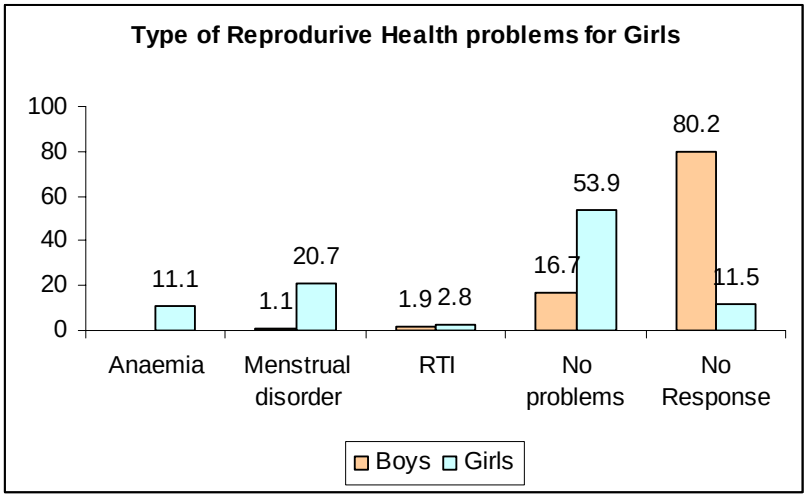
6.7. Reproductive health status of adolescent:

6.7.1. **Age at first Menstrual/semen Discharge**: When asked about the first semen discharge of the boys, a small proportion of the respondents stated that it starts from 13 years or above(1.5%) while almost all(98.5%) had no idea about it. In case of girl, 8.1%of the respondents responded that the first age of menstrual discharge is 10 years, while 15.4% stated that it is 11 years, 12.7% stated 12 years, 1.9% stated 13 years and 4.8% of the responded that it is above 13 years while 57% said that they had no idea about it.

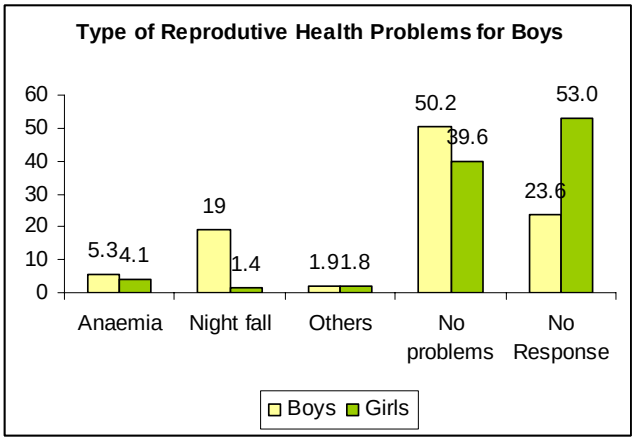
(In %)

Age at first menstrual/semen discharge	Boys	Girls	Total
10 Years	-	18.00	8.10
11 Years	-	34.10	15.40
12 Years	-	28.10	12.70
13 Years	-	4.10	1.90
Above 13 Years	1.50	8.80	4.80
No Response	98.50	6.90	57.10
Total	**263**	**217**	**480**

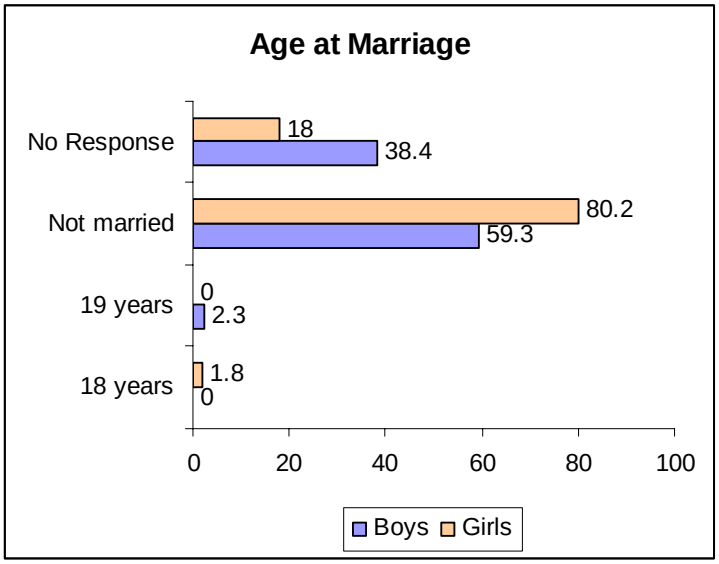
6.7.2. **Type of Reproductive Health Problems for Girls**: When asked about the type of reproductive health problems of girls, 11% of girls stated that Anaemia is one of the health problem for girls, while 20% mentioned menstrual disorder and only 2.8% of girls mentioned RTI majority 54% of girls mentioned that there is no reproductive health problems of girls. In case of boys, only a small proportion(1%) mentioned menstrual disorder, 1.9% mentioned RTI. Majority of boys(80%) stated that there is no reproductive health problems of girls.



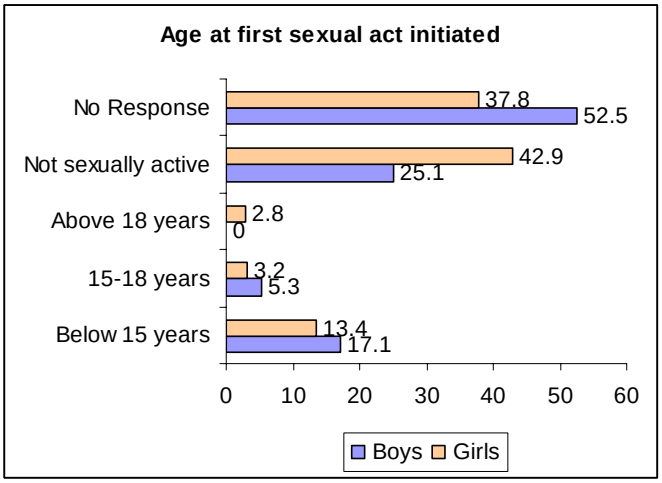
6.7.3. **Type of Reproductive Health Problems for boys**: Similarly, when asked about the type of reproductive health problems of boys, only 4% of girls stated that Anaemia is one of the health problem for boys, while a small proportion (1%) of girls mentioned night fall, majority(40%) of girls mentioned that there is no reproductive health problems of girls. In case of boys, 5% mentioned Anemia, 19% mentioned Night Fall. Majority of boys(50%) stated that there is no reproductive health problems of boys.



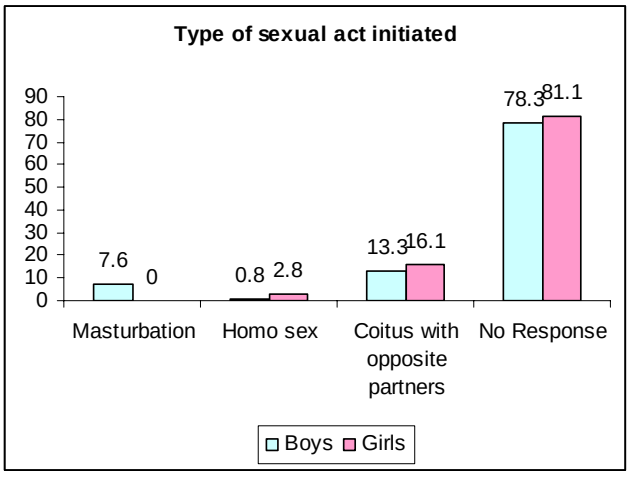
6.7.4. **Age at marriage:** When asked about the age at marriage, about 38% of boys could not answer while only 18% of girls could not answer this question. Only a small proportion 2.3% of boys mentioned that their age at marriage was 19 years and 59% of boys were unmarried. In case of girls the age of marriage was 18 years, 80% of girls were unmarried and 18% of girls could not answer to this question.



6.7.5. **Age at first sexual act initiated:** When asked about the age at which they have initiated their first sexual act, only 17% of boy mentioned that their sexual act initiated below 15 years while 13% of girls mentioned the same. Only 5.3% of boy reported that they initiated it in the age range from 15 to 18 years while 3.2% of girls reported the same. Only the girl respondents mentioned that they have initiated it above 18 years. 25% of boys and 43% of girls reported that they have not sexually active yet while 53% of boy could not respondent the question also 38% of girls could not answer this question.



6.7.6. **Type of sexual act initiated:** When asked this sensitive question, about 78% of boy did not mention anything and also 81% of girls did not mention anything. 13% of boys and 15% of girls mentioned that they had sex with opposite partners a negligible proportion (1%) of boy and 2.8% of girls reported that they had indulged with homo sex while only 7.8% boy did masturbation.



6.7.7. **Age at first pregnancy:** Only 1% of girls mentioned that age at first marriage was 19 and rest of the respondents did not answer anything as they were unmarried and they had no pregnancy at the time of interview.

(In %)

Age at first pregnancy	Boys	Girls	Total
19 years		0.90	0.40
Not married	0.80	6.90	3.50
Not pregnant	20.20	41.00	29.60
No Response	79.10	51.20	66.50
Total	**263**	**217**	**480**

6.7.8. **Outcomes of the pregnancy:** Almost all the respondent, 96% of boys & 92% of girls did not responded this question. Only a small proportion reported they induced abortion.

(In %)

Outcomes of the pregnancy	Boys	Girls	Total
Induced abortion	3.4	8.3	5.6
No Response	96.6	91.7	94.4
Total	**263**	**217**	**480**

6.7.9. **Ever use of contraceptives:** Not a single boy ever used any contraceptives and a meagre proportion (0.9%) of girls used other types of contraceptives and not used condom or Oral pills and 62% of boys and 39% of girls did not mentioned anything.

(In %)

Ever use of contraceptives	Boys	Girls	Total
Others contraceptives	-	0.9	0.4
Not used	38.0	59.9	47.9
No response	62.0	38.2	51.7
Total	**263**	**217**	**480**

6.7.10. **Reasons for not used any contraceptives:** 14% of each boy and girl respondents mentioned that they do not know about the contraceptives and 3% each mentioned that they do not know the use of contraceptives and rest 83% of boys and girls each did not mentioned anything.

(In %)

Reasons for not used any contraceptives	Boys	Girls	Total
Do not know	14.1	14.3	14.2
Do not know how to use	2.7	3.7	3.1
No response	83.3	82.0	82.7
Total	**263**	**217**	**480**

6.8. Knowledge on reproductive and sexual health:

6.8.1. **Legal Age of Marriage for women:** A slightly less than half of the respondents (42% of boys and 46% of girls) mentioned that less than 18 years is the legal age of the marriage. A slightly more than quarter mentioned that legal age of marriage should be between 18 to 20 years while about a tenth responded that 20 years is the legal age of marriage and 9% of each mentioned that it should be above 20 years. About 11% of boys and 4% of girls do not the correct legal age of marriage.

(In %)

Legal Age of Marriage for women	Boys	Girls	Total
Less than 18 years	42.20	46.10	44.00
18-20 years	28.10	29.50	28.80
20 year	9.90	11.50	10.60
Above 20 years	9.10	8.80	9.00
Do not know	10.60	4.10	7.70
Total	**263**	**217**	**480**

6.8.2. **Legal Age of Marriage for men:** About 30% of each respondents mentioned that 21 years is the legal age of marriage. More than half respondents (57% of boys and 61% girls) mentioned that legal age of marriage should be more than 21 years while a small proportion (8% of boys and 6% of girls) do not know the legal age of marriage for men.

(In %)

Legal Age of Marriage for men	Boys	Girls	Total
21 years	34.6	32.7	33.8
Above 21 years	56.7	61.3	58.8
Do not know	8.7	6.8	7.5
Total	**263**	**217**	**480**

6.8.3. **Right Age of First pregnancy:** When asked about the right age of marriage, less than half of the respondents (46% boys and 42% girls) reported that the right age should be between 18 to 20 years. One tenth of respondents reported that right age of marriage should be 18 years. Another one tenth of the respondents said age should be more than 20 years while one fourth of the respondents do not about it. Those who said above 18 years, they were asked to cite the reasons for it but surprisingly not a single respondents could answer any reason for it.

(In %)

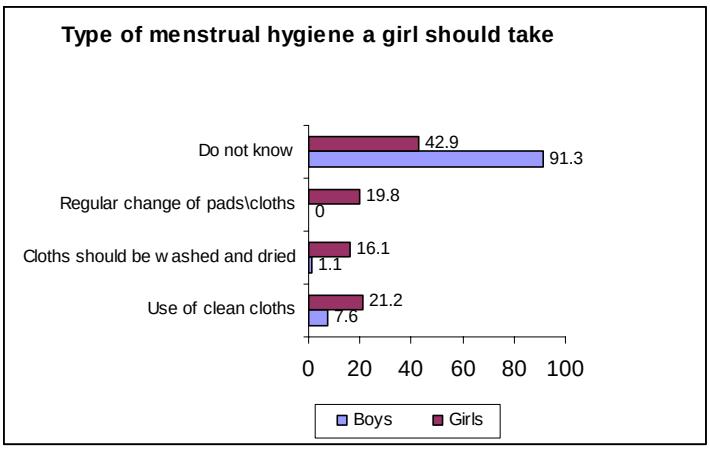
Right Age of First Marriage	Boys	Girls	Total
18 years	9.10	10.60	9.80
18-20 years	45.60	42.40	44.20
20 year	6.10	11.10	8.30
Above 20 years	8.40	15.70	11.70
Do not know	30.80	20.30	26.00
Total	**263**	**217**	**480**
Reasons if said above 18 years	**Boys**	**Girls**	**Total**
No Response	100.0	100.0	100.0
Total	**263**	**217**	**480**

6.8.4. **Knowledge on safe Abortion:** Nobody knows about the safe abortion.

(In %)

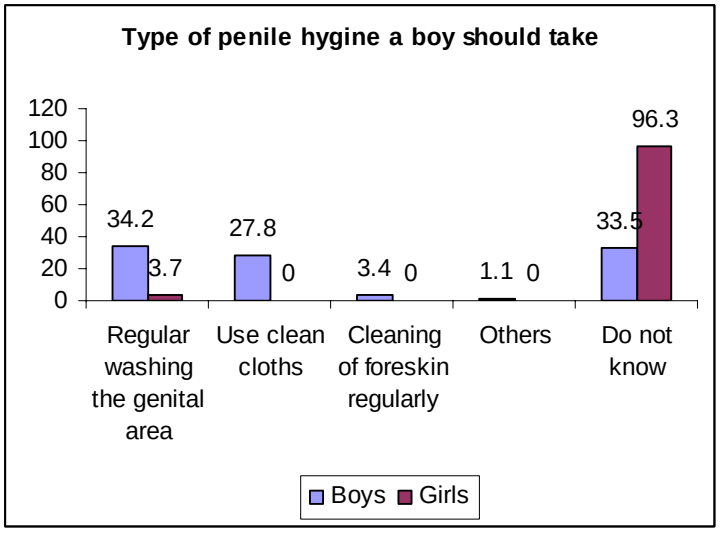
What is safe Abortion	Boys	Girls	Total
Don't know	100.0	100.0	100.0
Total	**263**	**217**	**480**

6.8.5. **Type of menstrual hygiene a girl should take:** There is a little knowledge of boys regarding menstrual hygiene of a girl. A small proportion (7.6%) of boys reported that a girl should use a clean cloth for menstrual hygiene and only 1.1% of boys reported that girls should wash and dry their clothes for menstrual hygiene. Rest 91% of boys does not about the menstrual hygiene. About 21% of girls reported that girls should use clean cloth, 16% of girls reported girls' cloth should be washed and dried for menstrual hygiene. Since girls use pads and cloths, about 20% of girls reported that pads and cloths should be changed regularly for menstrual hygiene. About half of the girl respondents do not know about it.



6.8.6. **Type of Penile hygiene a boy should take:**

When asked about the penile hygiene, a small proportion of girls(3.7%) responded to this questions while 96% of girls did not have any knowledge about it. 34% of boys mentioned that for penile hygiene, regular washing of genital area is required, while 28% mentioned to use clean cloths and only 3.4% mentioned to clear the foreskin regularly is the penile hygiene of boys and 34% of boys did not have any idea about it.



6.8.7. **What are the reproductive organs of female:** About half of the respondents mentioned that vagina is the reproductive organs of female while 46% mentioned "breast" and only a small proportion of respondents 2% mentioned Ovaries is the reproductive organs of female.

(In %)

Reproductive organs of female	Boys	Girls	Total
Vagina	55.5	46.5	51.5
Breast	51.7	38.7	45.8
Ovaries	0.8	3.7	2.1
Don't know	30.4	36.4	33.1
Total	**263**	**217**	**480**

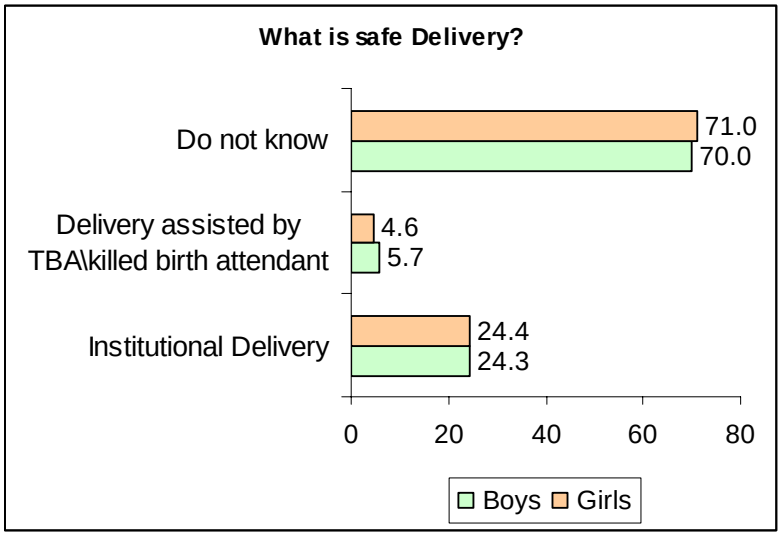
6.8.8. **What are the reproductive organs of male:** When asked about the reproductive organs of male, majority of boys (83%) mentioned "Penis" is the reproductive organs of male while only half of the girl respondents mentioned the same.

6.8.9. **How pregnancy occurs:** Not a single respondent answer this question. It seems that they do not have any knowledge about the occurrence of pregnancy.

(In %)

How pregnancy occurs	Boys	Girls	Total
Don't know	100.0	100.0	100.0
Total	**263**	**217**	**480**

6.8.10. **What is Safe Delivery?:** Only one –fourth of the respondents (24% each) mentioned that institutional delivery is the safe delivery where as only about 5% of respondents mentioned that delivery assisted by TBA/SBA is the safe delivery. About 70% of each do not have any idea about safe delivery.



6.8.11. **Signs of RTI/STI:** Surprisingly, not a single respondent has knowledge about sings of RTI/STI and also they do not about the cause and how to prevent from it.

(In %)

Signs of RTI/STI	Boys	Girls	Total
Don't know	100.0	100.0	100.0
Total	**263**	**217**	**480**

Cause of RTI/STI	Boys	Girls	Total
Don't know	100.0	100.0	100.0
Total	**263**	**217**	**480**

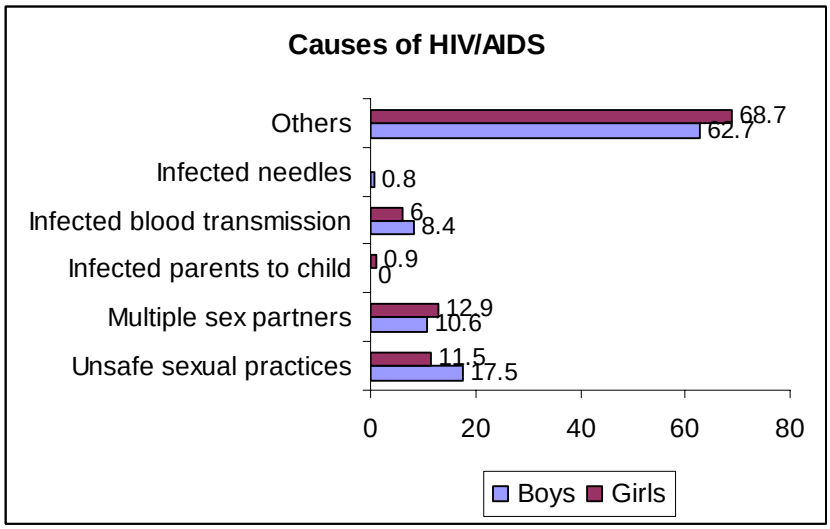
How to prevent it	Boys	Girls	Total
Don't know	100.0	100.0	100.0
Total	**263**	**217**	**480**

6.8.12. **Cause and prevention of STI:** Similarly when asked about STD, nobody mentioned about the cause of STD. However, only a small proportion of boys (2.7%) know that on can prevent from STD by using condom.

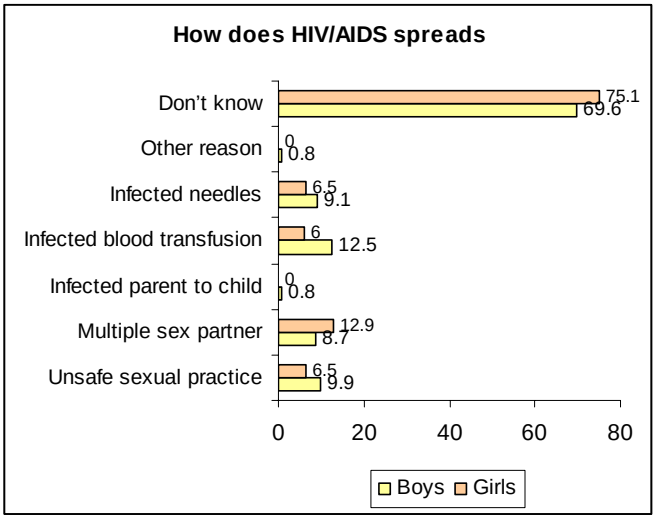
(In %)

Cause of STI	Boys	Girls	Total
Don't know	100.0	100.0	100.0
How to prevent STD			
Use condom	2.7	-	1.5
Don't know	97.3	100.0	98.5
Total	**263**	**217**	**480**

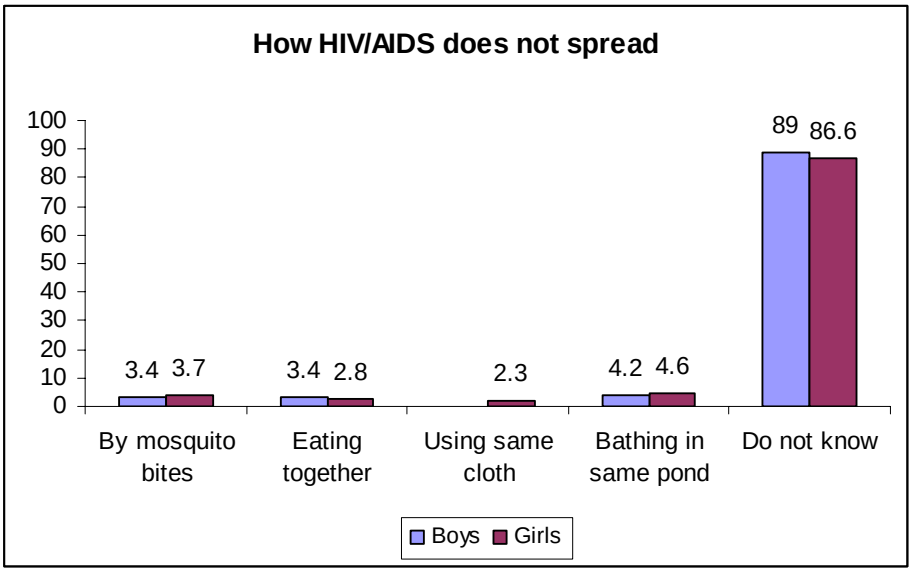
6.8.13. **Cause of HIV/AIDS**: But some of them little knowledge about causes of HIV/AIDS. About 15% of respondents(15%) mentioned unsafe sexual practices whereas only 12% of respondents mentioned multiple sex partners is the cause of HIV/AIDS, only a small proportion mentioned infected parents to child an infected needle is the causes of HIV/AIDS (0.4% each). About 65% of respondents have no knowledge about cause of HIV/AIDS.



6.8.14. **How does HIV/AIDS spreads:** When asked how HIV/AIDS spreads, about three-fourth of respondents did not mentioned anything as they had no knowledge on it whereas only 8% of respondents mentioned unsafe sexual practice, 11% mentioned multiple sex partner, 10% mentioned infected blood transfusion, 8% mentioned infected needles and a small proportion (0.4%) have knowledge that HIV/AIDS spreads from mother to child.



6.8.15. **How does HIV/AIDS does not spread**: Majority of respondents has no knowledge that how HIV/AIDS does not spread. About 88% do not have adequate knowledge on it. Only 3.5% mentioned that HIV/AIDS does not spread by mosquito bite, 5% mentioned "bathing in same pond, 3% mentioned by eating together and a small proportion(1%) mentioned by using same cloth AIDS is not spread.



6.8.16. **How to prevent HIV/AIDS:** When asked how to prevent HIV/AIDS, a majority of respondents (78%) did not have any idea about it. Abstain from sex was mentioned by 2% of respondents and "have only one sex partner" was mentioned by 3% of respondents. Only 16% of respondents mentioned that we can prevent ourselves by using condom.

(In %)

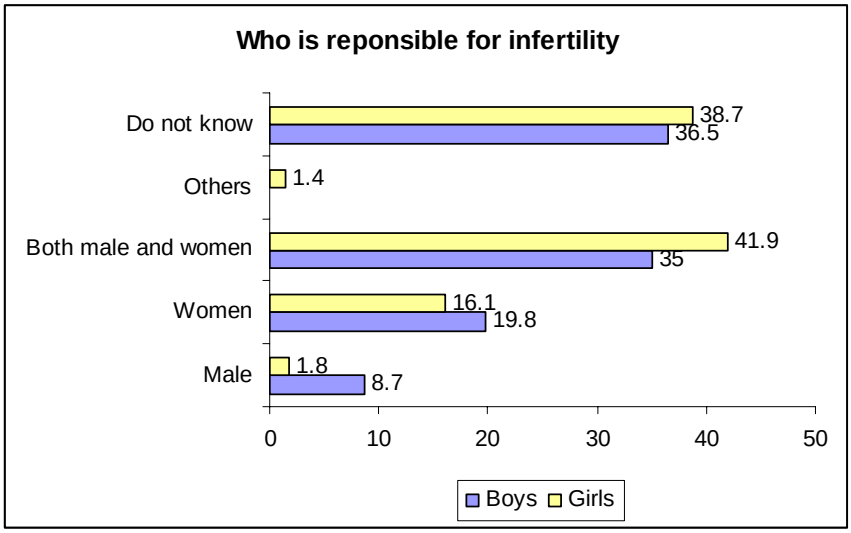
How to prevent HIV/AIDS	Boys	Girls	Total
Abstain from sex	2.30	1.80	2.10
Use condom	20.90	10.60	16.30
Have only one sex partner	3.00	3.20	3.10
Avoid anal sex		1.40	0.60
Do not know	73.80	82.90	77.90
Total	**263**	**217**	**480**

6.8.17. **What is safe sex Practice:** Only 9% of respondents mentioned that sex after using condom is the safe sex, while only 1.7% mentioned one should have only one sex partner to have a safe sex. Majority of respondents (90%) have no knowledge about it.

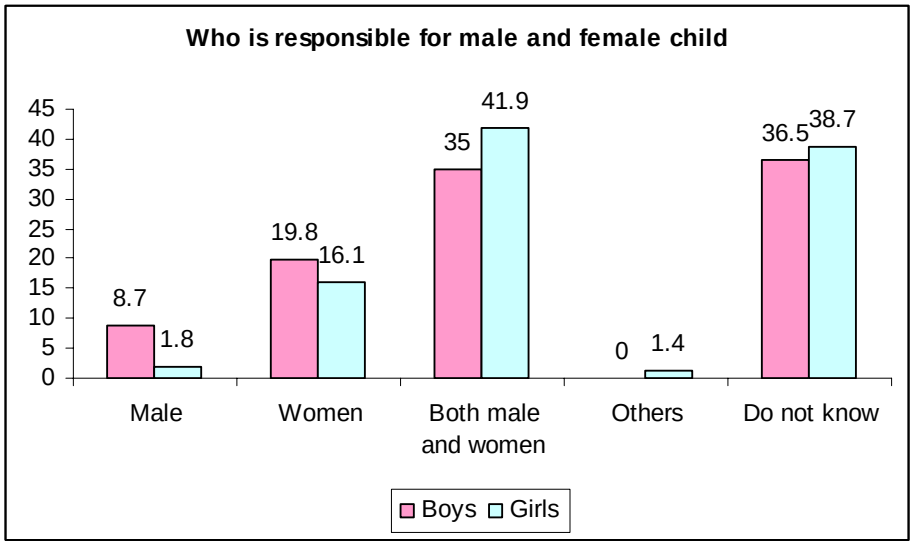
(In %)

What is safe sex Practice	Boys	Girls	Total
Sex with condom	12.20	4.10	8.50
Have only one sex partner	2.30	0.90	1.70
Do not know	85.60	94.90	89.80
Total	**263**	**217**	**480**

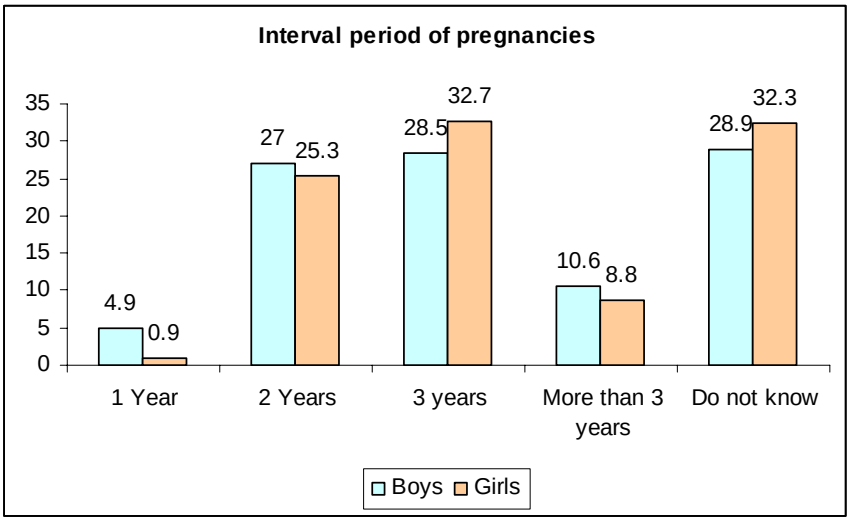
6.8.18. **Who is responsible for infertility:** Only 5% of respondents have idea that male is responsible for fertility, while 13% mentioned that women is responsible for infertility, but about one-fourth of respondents (25%) mentioned that both male and female are responsible for it. 58% of respondents had no idea on it.



6.8.19. **Who is responsible for male and female child:** Similarly when asked about the responsibility of male and female child, only 6% said that male is responsible for it, while 18% of respondent mentioned female and 38% of respondents mentioned that both male and female are responsible for male or female child. 38% of respondents could not answer on it.



6.8.20. **Ideal interval period of pregnancy:** 3% of respondents mentioned that ideal interval period of pregnancy should be one year, while 26% mentioned that it should be 2 yeas, about 30% reported that it should be 3 years. And only 10% reported that it should be more then 10 years, and rest 30% of respondents do not have any idea on it.



6.8.21. **Ideal no. of children a couple should have:** About half of the respondents(53%) reported that a couple should have 2 children, only 2% reported that it should be

one. About 12% mentioned 3 children whereas 6% reported more than 3 children a couple should have.

(In %)

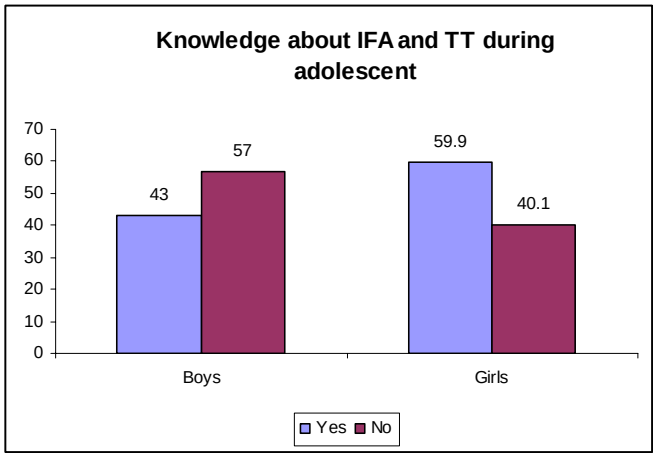
Ideal no. of children a couple should have	Boys	Girls	Total
One	0.80	2.30	1.50
Two	51.00	55.30	52.90
Three	15.60	6.90	11.70
More than 3	8.00	4.60	6.50
Do not know	24.70	30.90	27.50
Total	**263**	**217**	**480**

6.8.22. **Name of the different family planning methods:** When asked about different family planning methods, about 2% each mentioned Condom and Oral Pills, whereas 16% mentioned female sterilization and 3% mentioned male sterilization as the family method. About half of the respondents (45%) did not have any knowledge about it.

(In %)

Name of the different family methods	Boys	Girls	Total
Female sterilization	16.30	15.70	16.00
Male Sterilization	4.60		2.50
Oral pill	3.40		1.90
Condoms	3.80		2.10
Others	3.40	4.60	4.00
Not used	29.30	26.70	28.10
Do not know	39.20	53.00	45.40
Total	**263**	**217**	**480**

6.8.23. **Knowledge about IFA and TT during adolescent:** When asked whether girls should take about IFA tablets and TT during adolescent, about half of the respondents (51%) mentioned “yes” whereas other half mentioned “No”.



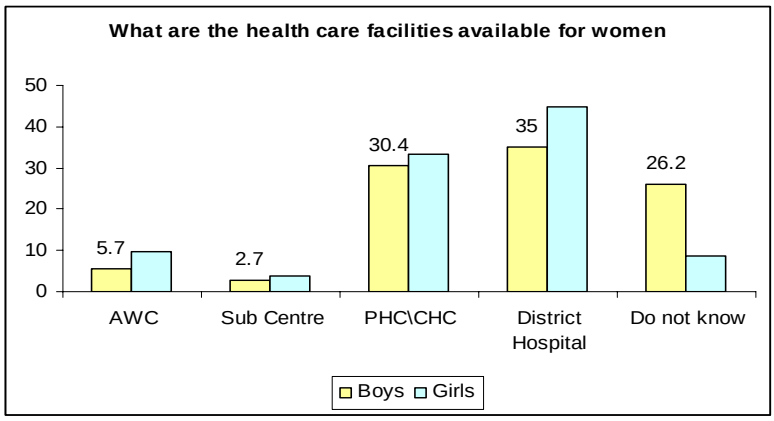
6.8.24. **What are the reproductive rights of couples:** A slightly more than half of the respondents (56%) could not mentioned anything on this question. Right to

equality is mentioned by 5% of the respondents, 16% mentioned that right to life. Right to marriage was mentioned by 13% of respondents and right to education and health care services was reported by 7% of respondents.

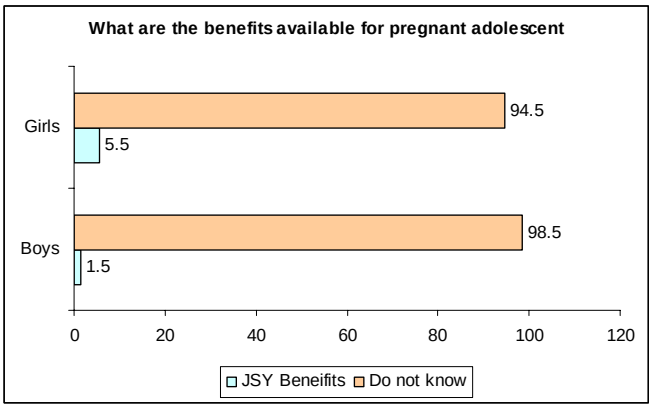
(In %)

What are the reproductive rights of couples	Boys	Girls	Total
Right to equality	6.50	3.70	5.20
Right to life	15.20	16.10	15.60
Right to education & health care services	4.90	8.80	6.70
Right to livelihood	1.10		0.60
Right to development	1.90	0.90	1.50
Right to marriage	11.80	13.40	12.50
Right to decide freely whether or not to have children	1.90	1.40	1.70
Do not know	56.70	55.80	56.30
Total	**263**	**217**	**480**

6.8.25. **What are the health care facilities available for women:** About 40% of respondents mentioned hospital, another 32% mentioned PHC or CHC and only 8% responded AWC and another 3 % respondents Sub Centre is the main health facility available for women. 18% of respondents did not have idea about it.



6.8.26. **What are the benefits available for pregnant adolescent**: When asked about the benefits available for pregnant adolescent, only 3% of respondents are aware about Janani Surakhya Yojana (JSY) benefits where as majority are not aware about the benefits.



6.9. Attitude on reproductive and sexual health:

6.9.1. **Opinion about girl/boy should marry below 18 years/21 years:** Opinion was taken from the respondents that if they are agree or not about the boys or girls should marry below 18 or 21 yeas, only 34% agree on this point while rest 66% did not agree on it. But nobody could cite a single reason behind it.

(In %)

Opinion about girl/boys should marry below 18year/21 years	Boys	Girls	Total
Agree	31.9	37.3	34.4
Disagree	67.3	62.7	65.2
No Response	0.8	-	0.4
Total	**263**	**217**	**480**

6.9.2. **Whether girl should use clean napkins during menstruation:** When opinion was taken about use of clean napkin by girls during menstruation, 91% of respondents was agree on it and only 4% disagree on it and rest 5% could not answer on it.

(In %)

Whether girl should use clean napkins during menstruation	Boys	Girls	Total
Agree	85.2	98.2	91.0
Disagree	6.5	1.8	4.4
No Response	8.4	-	4.6
Total	**263**	**217**	**480**

6.9.3. **Opinion regarding engagement of adolescent in unsafe sex:** A clear majority(90%) agree on the above statement and only 7% disagree on it while ret 3% could not mention anything on this statement.

(In %)

Opinion regarding engagement of adolescent in unsafe sex	Boys	Girls	Total
Agree	82.9	97.7	89.6
Disagree	11.8	2.3	7.5
No Response	5.3	-	2.9
Total	**263**	**217**	**480**

6.9.4. **Agree on Masturbation is normal:** When asked whether masturbation is normal, 67% of respondents was agree on it while only 9% disagreed on this statement, rest 25% did not mentioned anything.

(In %)

Agree on Masturbation is normal	Boys	Girls	Total
Agree	64.3	69.6	66.7
Disagree	10.6	6.5	8.8
No Response	25.1	24.0	24.6
Total	**263**	**217**	**480**

6.9.5. **Whether adolescent should avoid home sex:** Majority of respondent agreed that adolescent should avoid homo sex while only 9% of respondents disagreed on it and rest 6% did not respond anything on it.

(In %)

Whether adolescent should avoid home sex	Boys	Girls	Total
Agree	814	89.4	85.0
Disagree	11.8	5.5	9.0
No Response	6.8	5.1	6.0
Total	**263**	**217**	**480**

6.9.6. **Abortion opt to trained MP:** When respondents were asked to mention whether abortion should be opted to trained MP, 76% of respondents was agree on it while only 3% did not agree on it and rest did not answer on it.

(In %)

Abortion opt to trained MP	Boys	Girls	Total
Agree	73.4	79.7	76.3
Disagree	3.0	3.7	3.3
No Response	23.6	13.8	19.2
Total	**263**	**217**	**480**

6.9.7. **Sexual and reproductive heath education to adolescent:** When asked whether the adolescent should be imparted sexual and reproductive health education, a clear majority(96%) was agree on it, while 2% did not agree on it and 1% did not answer on it.

(In %)

Sexual and reproductive heath education to adolescent	Boys	Girls	Total
Agree	96.2	95.4	95.8
Disagree	1.5	3.2	2.3
No Response	2.3	1.4	1.3
Total	**263**	**217**	**480**

6.9.8. **Sexually active should use condom:** When respondents were asked to answer whether sexually active should use condom, majority (91%) of them was agree on it, while 5% of respondents did not agree on it and rest 4% did not answer anything.

(In %)

Sexually active should use condom	Boys	Girls	Total
Agree	92.8	89.4	91.3
Disagree	3.4	6.5	4.8
No Response	3.8	4.1	4.0
Total	**263**	**217**	**480**

6.9.9. **Adolescent should talk freely:** Opinion was taken from the respondents whether adolescent should talk freely, 93% of them was agree on this statement, while 5% did not agree on it and rest 2% could not answer anything.

(In %)

Adolescent should talk freely	Boys	Girls	Total
Agree	90.5	97.2	93.5
Disagree	6.5	2.8	4.8
No Response	3.0	-	1.7
Total	**263**	**217**	**480**

6.9.10. **Prepared himself for healthy parenthood:** Almost all the respondents (96%) was agree on the above statement, while only 2% was disagree on it.

(In %)

Prepared himself for healthy parenthood	Boys	Girls	Total
Agree	94.7	98.2	96.3
Disagree	1.5	1.8	1.7
No Response	3.8	-	2.1
Total	**263**	**217**	**480**

6.10. Reproductive and sexual health practices:

6.10.1. **Maintenance of menstrual/penile hygiene:** Not a single respondent could answer this sensitive question.

(In %)

Maintain menstrual/ penile hygiene	Boys	Girls	Total
No	44.1	42.9	43.5
No Response	55.9	57.1	56.5
Total	**263**	**217**	**480**

6.10.2. **Nature of reproductive health problems:** Only a small proportion (0.8%) responded this question, but could not specify the nature of reproductive health problems.

(In %)

Nature of reproductive health problems	Boys	Girls	Total
Yes	-	1.4	0.6
No	81.7	78.8	80.4
No Response	18.3	19.8	19.0
Total	**263**	**217**	**480**

6.10.3. **What have you experienced for reproductive health problem:** Only 1% mentioned that they have experienced reproductive health problem but could not specify anything on it.

(In %)

What have you experienced for reproductive health problem	Boys	Girls	Total
Yes	1.1	0.9	1.0
No	77.6	82.5	79.8
No Response	21.3	16.6	19.2
Total	**263**	**217**	**480**

6.10.4 **Whether getting information related to SRH:** About 40% of the respondents reported that they are getting information related to SRH from different sources viz. 81% from friends, 9.3% from TV, 5.2% from Book, 2% each from NGO workers and teachers, and a negligible proportion*0.5%) from health workers.

(In %)

Whether getting information related SRH	Boys	Girls	Total
Yes	28.5	54.4	40.2
No	68.4	45.6	58.1
No Response	3.0	-	1.7
Total	**263**	**217**	**480**
Source	**Boys**	**Girls**	**Total**
Friends	78.7	83.1	81.3
TV	12.0	7.6	9.3
Book	5.3	5.1	5.2
Parent	2.7	4.2	3.6
NGO worker	4.0	0.8	2.1
Teacher	-	4.2	2.6
Health worker	-	0.8	0.5
Total	**75**	**118**	**193**

6.10.5 **Whether taking any type of intoxicants:** When asked whether the respondents are taking any type of intoxicants, 27% of the respondents replied yes. The intoxicants taken by them are Pana(5.4%), Gutaka(51.2%). Liquor. Tadi and Handia(Traditional liquor) were reported to be very high (53.5%). 4% of the adolescents reported "Smoking".

(In %)

Whether taking any type of intoxicants	Boys	Girls	Total
Yes	42.8	7.8	26.9
No	56.7	82.2	72.7
No Response	0.8	-	0.4
Total	**263**	**217**	**480**
Intoxicant taken	**Boys**	**Girls**	**Total**
Pana	6.3	-	5.4
Gutaka	56.3	17.6	51.2
Tadi (Desi)	24.1	70.6	30.2
Liquor	19.6	-	17.1
Handia (Traditional liquor)	5.4	11.8	6.2
Smoking	4.5	-	3.9
Total	**112**	**17**	**129**

6.10.6 **Suggestion for SRH status of adolescents:** Suggestions from the respondents was taken about SRH status of adolescents, but only a negligible proportion (1.3%) responded this question while almost all could not give any suggestion about it.

(In %)

Suggestion for SRH status of adolescents	Boys	Girls	Total
Yes	1.1	1.4	1.3
No	73.4	72.4	72.9
No Response	25.5	26.3	25.8
Total	**263**	**217**	**480**

7. CONCLUSION AND RECOMMENDATIONS:

7.1. Major findings of the survey:

7.1.1. Profiles of adolescent:

- The largest groups of respondents (69.2%) were in the range of 15 to 19 years, while only 27.7% of the respondents were in the age range of 13 to 15 years.
- Majority of respondents (79%) belonged to ST category and 14.4% belonged to Other Backward Caste (OBC) category while a small proportion (5.8%) belonged to SC category.
- Overall, about 13% of the respondents were found to be illiterate.
- Only 31% were continuing education among the respondents.

7.1.2. Socio-economic background of the family:

- Most of the respondents (83%) stated that father is the decision maker of the family.
- Majority of respondents (85%) depends on agriculture for their major source of income.
- Most of the respondents (88%) had an income ranges from Rs. 5000 to Rs. 10,000/- per annum of family.
- Most of the respondents (88%) were in BPL category.
- Most of the parents depend on cultivation for their main occupation and about one tenth of parents (9.4%) were wage labourers.
- Majority of mothers (74%) of the respondents were illiterate.

7.1.3. Health and nutrition status:

- Majority of the respondents (59%) were in the range of 120 to 150 Cms of height.
- More than half of the respondents(61%) had weight in the range of 40 to 50 Kgs.
- About 47% of respondents had experienced some forms of nutritional disorders.
- About 25% of respondents had experienced fever/malaria during last three months.

7.1.4. Reproductive health status:

- About 8.1%of the girls responded that the first age of menstrual discharge is 10 years, while 15.4% stated that it is 11 years, 12.7% stated 12 years, 1.9% stated 13 years and 4.8% of the responded that it is above 13 years while 57% said that they had no idea about it.

- Majorities of adolescent stated anaemia, RTI, menstruation are main reproductive health problems for girls.

- Majorities of adolescent stated that night fall is the main reproductive health problems for boys.

- 59% of boys and 80% of girls were unmarried among the adolescents.

- Only 17% of boy mentioned that their sexual act initiated below 15 years while 13% of girls mentioned the same. Only 5.3% of boy reported that they initiated it in the age range from 15 to 18 years while 3.2% of girls reported the same.

- 25% of boys and 43% of girls reported that they have not sexually active yet.

- 13% of boys and 15% of girls mentioned that they had sex with opposite partners a negligible proportion (1%) of boy and 2.8% of girls reported that they had indulged with homo sex while only 7.8% boy did masturbation.

- Almost all sexually active adolescent were not used contraceptive.

- 14% of each boy and girl respondents mentioned that they do not know about the contraceptives and 3% each mentioned that they do not know the use of contraceptives and rest 83% of boys and girls each did not mentioned anything.

7.1.5. Knowledge on reproductive and sexual health:

- About 44% adolescent stated that legal age for women is 18 years.

- About 30% of each respondents mentioned that 21 years is the legal age of marriage for men.

- Less than half of the respondents (46% boys and 42% girls) reported that the right age of first pregnancy should be between 18 to 20 years.

- Not a single adolescent knows about safe abortion.

- About 91% of boys do not know about the menstrual hygiene of girls.

- About half of the girl respondents do not know about the proper menstrual hygiene.

- About 21% of girls reported that girls should use clean cloth, 16% of girls reported that cloth should be washed and dried for menstrual hygiene, and 20% of girls reported that pads and cloths should be changed regularly for menstrual hygiene.

- 96% of girls did not have any knowledge about the penile hygiene for boys.
- 34% of boys mentioned that for penile hygiene, regular washing of genital area is required, while 28% mentioned to use clean cloths and only 3.4% mentioned to clear the foreskin regularly is the penile hygiene of boys and 34% of boys did not have any idea about it.
- Almost all adolescent do not have clear knowledge about the reproductive organ of female.
- About 32% of adolescent do not know about male reproductive organ of male.
- Almost all adolescent do not have knowledge about the occurrence of pregnancy.
- About 70% of adolescent boys and girls do not have any idea about the safe delivery.
- 24% of adolescent mentioned that institutional delivery is the safe delivery.
- Almost all adolescent do not have knowledge on signs and causes and prevention of RTI/STI.
- About 65% of respondents have no knowledge about causes of HIV/AIDS and three-fourth of respondents do not know how HIV/AIDS spreads.
- Majority of respondents has no knowledge that how HIV/AIDS does not spread and about (78%) do not know how to prevent HIV/AIDS.
- Majority of respondents(90%) have no knowledge about the safe sex practices. Only 9% of respondents mentioned that sex after using condom is the safe sex, while only 1.7% mentioned one should have only one sex partner to have a safe sex.
- About one-fourth of respondents (25%) mentioned that both male and female are responsible for infertility. 58% of respondents had no idea on it.
- 38% of respondents mentioned that both male and female are responsible for male or female child.
- About 30% of respondents do not have any idea about ideal interval period of pregnancy.
- About half of the respondents (53%) reported that a couple should have 2 children as ideal number of children.
- About half of the respondents (45%) do not have any knowledge about the different family planning methods.
- About 2% each mentioned Condom and Oral Pills, whereas 16% mentioned female sterilization and 3% mentioned male sterilization as the family method.

- About half of the respondents (51%) mentioned all girls should take IFA tablets and TT during adolescent period.

- A slightly more than half of the respondents (56%) do not know about the reproductive rights of couples.

- About 40% of respondents mentioned hospital, another 32% mentioned PHC or CHC and only 8% responded AWC and another 3 % respondents Sub Centre is the main health facility available for women. 18% of respondents did not have idea about it.

- Majorities of respondents do not aware about the benefits available for pregnant adolescents.

7.1.6. Attitude on reproductive and sexual health:

- Majorities (66%) of respondents disagreed that girls/boys should marry below 18 years/21 years respective.

- Majorities (91%) of respondents were agreeing that during menstruation, a girl should use clean napkins.

- A clear majority (90%) agreed that adolescent should not be engaged in unsafe sexual practices.

- Majorities (67%) of respondents were agreeing that masturbation is normal.

- Majorities (85%) of respondents agreed that adolescent should avoid homo sex.

- Majorities (76.3%) of respondents agreed that for abortion, all should opt for trained medical practitioners.

- A clear majority (96%) of respondents agreed that the sexual and reproductive health should be imparted to adolescents.

- Majorities (91%) of respondents agreed that sexually active adolescent should use condoms.

- Majorities (93%) of respondents agreed that adolescent should talk freely with parents /peers about sexual and reproductive health problems.

- Almost all the respondents (96%) agreed that adolescents should prepared himself or herself for healthy parenthood.

7.1.7. Reproductive and sexual health practices:

- Not a single respondent could answer about the maintenance of menstrual/penile hygiene practices.

- Only a small proportion (0.8%) respondents stated they have experienced reproductive health problems during last 12 moths. this question, but could not specify the nature of reproductive health problems.

- Majorities (58.1%) of respondents sated they have get any information about sexual and reproductive health issues.

- About 26.5% of respondents taking intoxicants of different types.

- Majorities (80%) of respondents not experienced any types of gender discrimination. It may due lack of knowledge on gender discrimination.

7.2. Recommendation:

- Multi-pronged BCC strategies should be adopted to sensitize and educate parents, caregivers and service providers on adolescent sexual and reproductive health.

- Life skills (problem solving, decision making, goal setting, crtical thinking, communication skills, assertiveness, self-awareness and skills for coping with stress) education need to be imparted to both boys and girls adolescent to promote healthy SRH behaviour and practices among the adolescents.

- At the community level, steps should be taken to create an enabling environment for adolescent to acquire right kind of knowledge and skill for improvement SRH status, especially to address their problems and needs.

- Parents should take sincere efforts to learn more thing about ASRH so that they can provide right kind of information to their adolescent sons and daughters.

- Multi-pronged strategies need to be taken to provide sexual and reproductive health skills (communicating about sex, avoiding unwanted sex, using contraceptive correctly, using condoms correctly, and developing parenting skills) adolescent boys and girls.

- Adolescent friendly health services should be made available at the sub-centers, PHC and Block PHC level to address problems and needs of adolescent with special focus on promotive and preventive services as per need of adolescent.

- Ensure easy access to adolescent to avail sexual and reproductive health services like information on sexuality & reproductive health, individual/group counseling, RTI/STI screening and treatment, providing choice for contraceptives methods, ANC/PNC and abortions.

- Multiple communication channels should be used to create awareness among the adolescent on different aspects of ASRH.

- Appropriate counseling services need to be provided to adolescent by ASHA, AWWs and Health Workers at the community level.

- A further operation research is highly recommended to implement and study the impact of adolescent development theory and stages of change models in order to suggest suitable models for improvement of adolescent sexual and reproductive health status including minimizing gender disparities in tribal and rural areas.

Annexure-1

Reference and Bibliography

1. Rakesh A, 1992: Premarital Sexual Attitudes and Behaviour among Adolescent Girls, Jaipur, India.

2. Divakar SA et al., 1979: Abortion in unmarried girls, Health and Population Perspective and Issues, 2(4).

3. Jejeebhoy SJ, 1996: Adolescent Sexual and Reproductive Behavoiur: A Review of the Evidence from India, Mumbai, International Center for Research on Women.

4. Brabin L et al., 1995: Reproductive tract infections and abortion among adolescent girls in rural Nigeria, Lancet.

5. Beldsoe CH and Cohen B, 1993: Social Dynamics of Adolescent Fertility in Sub-Saharan Africa, National Academy Press, Washington.

6. McDevitt TM et al., 1996: Trends in Adolescent Fertility and contraceptive Use in the Developing World, US Department of Commerce, Washington.

7. Kane TT et al., 1993: Sexual Activity, family life education and contraceptive practice among young adults in Banjul, Studies in Family Planning 24(1), The Gambia.

8. Kirby D, A, 1995: A Review of Educational Programme Designed to Reduce Sexual Risk-Taking Behaviours among School-Aged Youth in the United State, National Technical Information Service, USA.

9. Grunsett A, 1997: Imapact of HIV and Sexual Health Education on the Sexual Behaviour of Young People, A Review Update, UNAIDS, Geneva.

10. Allan Guttmacher Institute, 1995: Sex and America's teenagers, AGI, New York.

11. Allan Guttmacher Institute, 1995: Women, families and the future: sexual relationships and marriage worldwide, AGI, New York.

12. Blum, R.W, 1991: Global trends in adolescent health, Journal of the American Medical Association 265(20).

13. WHO, 1992: Approaches to adolescent health and development: A compendium of projects and programmes, WHO, Geneva.

14. WHO, 1998: The Reproductive health of adolescent: a strategy of action, A joint WHO/UNFPA/UNICEF statement, WHO, Geneva.

15. WHO, 1993: Adolescent sexual behaviour and reproductive health: From research to action, Report of a joint meeting, Darker, Senegal, April 22-26.

16. Mensch BS, Bruce J, Greene ME, 1998: The un-chartered passage – girls' adolescence in the developing world, The Population Council, New York.

17. Alaudin M, MacLaren L, 1999: Reaching newlywed and married adolescents, FOCUS on Young Adults, Washington.

18. Nelson K, MacLaren L, Magnami R, 2000: Assessing and planing for youth-friendly reproductive health services, FOCUS on Young Adults, Washington.

19. FHI: FHI training module on reproductive health for young adults, FHI, USA.

20. FHI: FHI adolescent handbook, FHI, USA.

21. DSE: sex education programmes in Africa, DSE, Germany.

22. Welbourn A, 2000: Gender, sex, and HIV: How to address issues that no one to hear about, Action Aid.

23. Irvin A, 2000: Taking steps to courage: teaching adolescents about sexuality and gender in Nigeria and Cameroon, International Women's Health Coalition, New York.

24. Bharat S, 1998: Adolescent sexuality and vulnerability to HIV infection in Mumbai, Int. Conf. AIDS.

25. WHO: Action for adolescent health towards a common agenda, WHO.

26. Jawaharlal p at el.: Adolescence education in Schools, Part I to V, NCERT, New Delhi.

27. VHAI: Adolescence – to walk through, VHAI, New Delhi.

28. VHAI: Adolescence Kit, VHAI, New Delhi.

Annexure-2

INTERVIEW SCHEDULE FOR ADOLESCENT

Adolescent Reproductive Health and Gender Sensitivity in Tribal Areas
- An Operational Research
Conducted By: MY-HEART, Bhubaneswar

1. Identification

1.1 Name of the Adolescent:……..

1.2 Name of the Village:…….

1.3 GP/Sub-centre:…….

1.4 Block/PHC:……..

1.5 District:…….

2. Personal Profile:

2.1 Age: a) Below 10-12 years b) 13 -15 years c) 15-19 years

2.2 Sex: a) Boys b) Girls

2.3 Caste: a) SC b) ST c) OBC d) OC

2.4 Religion: a) Hindu b) Muslim c) Christian d) others

2.5 Educational Qualification: a) Illiterate b) Literate c) Primary d) secondary e) above

2.6 Occupation/Activity status: a) Student b) wage labour c) helper d) household activities e) others

3. Socio-economic background of the family:

3.1 Family size: a) < 5 b) 6-10 c) >10

3.2 Type of family: a) nuclear b) extended nuclear c) Joint family

3.3 Decision maker of the family: a) Father b) Mother c) Grand parents d) Others (specify)

3.4 Major source of income of the family: a) Agriculture b) Service c) Business d) Wage e) rural artisans
f) Others (specify)

3.5 Annual income of the family: a) < Rs.15,000/- b) Rs.5,000 – 10,000 c) Rs.10,000 – 20,000 d) > Rs.20,000/-

3.6 Whether belongs to BPL: a) Yes b) No

3.7 Occupation of parents: a) Cultivators b) share-cultivators c) wage labour d) business e) service f) others

3.8 Educational status of parents

3.8.1 Mother: a)Illiterate b) Literate c) Primary d) Secondary e) > Above Secondary

3.8.2 Father: a) Illiterate b) Literate c) Primary d) Secondary e) > Above Secondary

4. Health & Nutrition Status:

4.1 Height (in cm): a) < 120 cm b) 121 – 150 c) > 150 cm

4.2 Weight (in kg):a) < 30kg b) 31-40 kg c) 40 -50 kg d) >50kg

4.3 Type of nutritional disorders: a)Anemia b) Angular stomatitis c) Eye problem (night blindness/bitots spot/corneal opacity/karatomalacia) d) Glositis e) Phrynoderma f) No symptoms g) others (specify)

4.4 Morbidity status during last 3 months: a)Fever b) Malaria c) Menstrual disorder d) RTI/STI e) Anemia f) Peptic disorder g) skin infection h) Others (specify)

1

4.5 Who has given more preference to consumed good quantity and quality foods in your family: a) boys b) girls c) others (specify)

4.6 Food consumption pattern:

Food group	Frequency of consumption (code)	Raw amount used per day (Actual)	Most commonly consumed varieties
1. Cereals			
2. Millets			
3. Pulses/Legumes			
4. Green leafy veg			
5. Other veg			
6. Roots/tabers			
7. Milk & Milk products			
8. Fruits			
9. Flesh foods			
10. Fats & oils			
11. Sugar & Jaggery			
12. Others (specify)			
Frequency a) Daily b) Once/twice c) Once in two weeks d) monthly e) seasonally f) occasionally			

5. Reproductive History and Status

5.1 Age at first menstrual/semen discharge: a) 10yrs b) 11yrs c) 12yrs d) 13yrs e) above 13 yrs

5.2 Type of reproductive health problems for girls: a) anemia b) menstrual disorder c) RTI d) no problems e) others (specify)

5.3 Type of reproductive health problems for boys: a) anemia b) night fall c) others d) no problems

5.4 If married, age at marriage: a) below 16yrs b) 17yrs c) 18yrs d) 19yrs e) not married

5.5 Age at first sexual act initiated: a) below 15yrs b) 15-18yrs c) above 18yrs d) not sexually active

5.6 If sexually active, types of sexual act initiated: a) masturbation, b) homosex c) coitus with opposite partners d) others (specify)

5.7 Age at first pregnancy, if girls: a) <16yrs b) 17yrs c) 18yrs d) 19yrs e) not married f) not pregnant

5.8 Outcomes of the pregnancy: a) live birth b) still birth c) miscarriage d) induced abortion

5.9 Do you ever used any contraceptives, if yes types: a) condoms, b) Orall pills, c) IUD, d) others, e) not used

5.10 If sexually active and not used any contraceptives, reasons: a) don't k now, b) don't know how to use, c) fear to collect or purchase d) others (specify)

6. Knowledge on reproductive and sexual health:

6.1 Legal age at marriage for women: a) 18yrs b) 18-20yrs c) 20 yrs d) above 20yrs e) don't know

6.2 Legal age at marriage for men: a) 21yrs b) above 21yrs c) don't know

6.3 Right age of first pregnancy: a) 18yrs b) 18-20yrs c) 20yrs d) above 20yrs e) don't know

6.4 Reasons if said above 18 years:

6.5 What is safe abortion: a) within 10-12 weeks b) performed by trained & recognized medical practitioner c) don't know d) others (specify)

6.6 Type of menstrual hygiene a girl should take: a) use of clean cloths b) cloths should be washed and dried under the sun c) regular change of pads/cloths d) don't know e) others

6.7 Type of penile hygiene a boys should take: a) regular washing the genital area b) use clean cloths/under wear c) cleaning of foreskin regularly d) others (specify) e) don't know

6.8 What are the reproductive organ of female: a) vagina b) breast c) uterus d) ovaries e) fallopian tube f) cervix g) others (specify) h) don't know

6.9 What are reproductive organ of male: a) penis, b) scrotum c) others (specify) d) don't know

6.10 How pregnancy happens:

6.11 What is safe delivery: a) institutional delivery b) delivery with five cleans c) delivery assisted by TBA/skilled birth attendant d) others (specify) e)don't know

6.12 Signs of RTI/STI: a) genital ulcers b) genital discharge c) pain during urination d) lower abdominal pain e) others f) don't know

6.13 Causes of RTI: a) poor menstrual hygiene b) unsafe delivery c) unsafe abortion d) others e) don't know

6.14 How to prevent RTI: a) use clean napkins/maintain menstrual hygiene, b) avoid unsafe delivery c) avoid unsafe abortion d) others e) don't know

6.15 Causes of STD: a) unsafe sexual practices b) multiple sex partners c) others d) don't know

6.16 How to prevent STD: a) abstain from sex b) use condoms c) have only one sex partner d) avoid anal sex e) others f) don't know

6.17 Causes of HIV/AIDS: a) unsafe sexual practices b) multiple sex partners c) mother to child
d) blood transmission e) others f) don't know

6.18 How does HIV/AIDS spread: a) unsafe sexual practices b) multiple sex partners c) infected parent to child d) infected blood transmission e) infected needles f) others g) don't know

6.19 How does HIV/AIDS does not spread: a) by mosquito bites b) eating together c) using same cloth d) kissing/hugging e) bathing in same pond f) don't know

6.20 How to prevent HIV/AIDS: a) abstain from sex b) use condoms c) have only one sex partners d) avoid anal sex e) others f) don't know

6.21 What is safe sex practices: a) sex with condoms b) have only one sex partners c) avoid penetrative sex d) avoid anal sex e) others f) don't know

6.22 Who is responsible for infertility: a) male b) women c) both d) others e) don't know

6.23 Who is responsible for male or female child: a) male b) women c) both d) others e) don't know

6.24 Ideal interval period of pregnancy: a) 1yr b) 2yr c) 3yrs d) more than 3yrs e) don't know

6.25 Ideal no. of children a couples should have: a) 1 b) 2 c) 3 d) more than 3 e) don't know

6.26 Name of the different family methods: a) female sterilization b) male sterilization c) oral pill d) condoms e) IUD) f) others g) not used

6.27 Do you know all girls should take IFA tablets and TT during adolescent: a) yes b) no

6.28 What are the Reproductive rights of couples: a) right to equality b) right to life c) right to education & health care services d) right to livelihood e) right to development f) right to marriage g) right to decide freely whether or not to have children and their numbers and spacing

6.29 What are the health care facilities available for women: a)AWC b) sub-centre c) PHC/CHC d) district hospitals e) others f) don't know

6.30 What are the benefits available for pregnant adolescent : a) JSY benefits b) referral transport funds c) nutrition supplement under ICDS d) others e) don't know

7. Attitude on reproductive and sexual health:

7.1 Do you agree that girl/boys should marry below 18yrs/21 yrs? If agree/disagree, reasons:

7.2 Do you agree that during menstruation, a girl should use clean napkins (washing and drying under the sun)? If agree/disagree, reasons:

7.3 Do you agree that adolescent should not be engaged in unsafe sexual practices? If agree/disagree, reasons:

7.4 Do you agree that masturbation is normal? If agree/disagree, reasons:

7.5 Do you agree that adolescent should avoid homo sex? If agree/disagree, reasons:

7.6 Do you agree that for abortion all should opt for trained medical practitioners? If agree/disagree, reasons:

7.7 Do you agree that sexual and reproductive health education should be provided to adolescent? If agree/disagree, reasons:

7.8 Do you agree that those adolescent are sexually active should use condom? If agree/disagree, reasons:

7.9 Do you agree that adolescent should talk freely with parents/elders about SRH problems? If agree/disagree, reasons:

7.10 Do you agree that adolescent should be prepared himself or herself for healthy parenthood for future? If agree/disagree, reasons:

8. Reproductive and sexual health practices:

8.1 How you are maintaining menstrual/penile hygiene?

8.2 Nature of reproductive health problems experienced during last 12/3 months

8.3 What have you done when you experienced any reproductive health problems:

8.4 Are you getting information related to SRH? If yes, which source:

8.5 Are you taking any type of intoxicants? If yes, types:

8.6 Are you experiencing any types of gender-based discrimination in your family? If yes types of discrimination?

8.7 What do you want to suggest for improvement of SRH status of adolescent?

Verified by Signature of interviewer with date

CHECKLIST FOR FOCUS GROUP DISCUSSION
Adolescent Reproductive Health and Gender Sensitivity in Tribal Areas
- An Operational Research
Conducted By: MY-HEART, Bhubaneswar

1. Name of the village :
2. Name of the GP :
3. No. of key informants :
4. Category of Informants :
5. Date :
6. Venue :
7. Name of the facilitators :
8. Level of knowledge on Reproductive health problems/needs

Sl.No	Reproductive Health problems/needs	Response	Level of knowledge
1	Right age at marriage for girls/Boys		
2	Right age at first pregnancy		
3	Sign of risk pregnancy		
4	Self-care during pregnancy		
5	Safe delivery practices		
6	Care during pregnancy		
7	Care after delivery		
8	Consumptions of colostrums		
9	Exclusive breast feeding		
10	Weaning/child feeding		
11	Immunization of child		
12	Birth spacing		
13	Use of contraceptives among adolescent		
14	Male participation in RCH		
15	Sterilization		
16	Sex of child		
17	No. of child		
18	Safe sex practices		
19	Safe abortions		
20	Menstrual sanitation		
21	Personal hygiene		
22	STD/RTIs		
23	Reproductive Rights		

9. Nature of gender discriminations existed in the village:
10. Bad effects of gender discrimination on adolescent:
11. Nature of health problems faced by adolescent boys and girls:
12. Priority needs of adolescent:
13. Views of Adolescent Reproductive Health:
    - Should Reproductive health education is required for adolescent?
    - Are you feeling that reproductive health of adolescents is neglected?
    - Are you thinking that family life education should be given to adolescent?
    - Do you think that parents should disseminate right kind of knowledge to adolescent especially on sexual and reproductive health?
    - Do you think that service providers should educate adolescent on sexual and reproductive health?

Signature of investigator

INTERVIEW SCHEDULE FOR SERVICE PROVIDERS
Adolescent Reproductive Health and Gender Sensitivity in Tribal Areas
- An Operational Research
Conducted By: MY-HEART, Bhubaneswar

1. Personal Profile:

1.1 Name :

1.2 Designation :

1.3 Institutions :

2. Knowledge /Attitude and views on gender issues and reproductive health education for adolescent:

2.1 Do you ever noticed that there are instances of gender discrimination in your coverage area? Yes/No. If yes please mention nature of gender discrimination:

2.2 Do you think that gender discrimination has affected the sexual /reproductive health of adolescent girls? Yes/No. If yes, How?

2.3 Do you think adolescent have many sexual and reproductive health problems in your area? Yes/No. If yes, Nature of problems?

2.4 Do you think adolescent have adequate and right knowledge on sexual and reproductive health? Yes/No. if no, reasons:

2.5 Do you think SRH education should be given to adolescent? Yes/No. If yes, what information should be disseminated to adolescent?

2.6 How SRH education will be given to adolescent?

2.7 Do you think all service providers (AWW/ANMs/teachers/health care providers) are aware about SRH problems and needs of adolescent? Yes/No.

2.8 Do you aware about SRH services and opportunities for adolescent? Yes/no

2.9 Do you think that the existing health care service delivery institutions are well equipped to provide adolescent friendly services in your area. Yes/no

2.10 Do you think parents/care givers are concerned about reproductive health problems of adolescent? Yes/no. if no reasons:

2.11 Do you think, adolescent have access to reproductive and sexual health information and services? Yes/no

2.12 Did you face any problems as service providers to deal with adolescent problems and needs? Yes/no. if yes nature of problem.

2.13 Did you ever try to educate and solve the problems of adolescent? Yes/no. if no, reasons:

2.14 What is your suggestion for improvement of SRH status of adolescent and reduction of gender discrimination in your area?

Verified by Signature of interviewer with date

VILLAGE SCHEDULE
Adolescent Reproductive Health and Gender Sensitivity in Tribal Areas
- An Operational Research
Conducted By: MY-HEART, Bhubaneswar

1. Identification:

1.1 Name of the village :
1.2 GP :
1.3 Block :
1.4 District :

2. Socio-Demographic Profile

2.1 **No of adolescence** : Boys: ……Girls:……..Total:…….

2.2 Population:

Sex/Caste	SC	ST	OBC	OC	Total
Male					
Female					
Total					

2.3 Profiles of adolescent:

Sex	Age group			Education					Marital status	
	10-12	13-15	16-18	Illiterate	Literate	Pri.	Sec.	>sec.	Married	Un-married
Boys										
Girls										
Total										

2.4 Occupational category of villagers

Occupation	**No. of families**
Small farmers	
Marginal farmers	
Large farmer	
Rural artisans	
Business	
Service	
Wage labour	
Others (specify)	

3. Health facilities & distance in Km

Type of Health facilities	Distance from village in Km	Whether accessible or not
AWC		
Sub-centre		
PHC (N)		
Block PHC		
AYUSH Dispensaries		
Others (specify)		

4. Educational facilities

Type of educational institution	Distance from village	Whether accessible or not
Primary school		
Secondary		
High school		
College		
Others (specify)		

5. Sanitation/Safe drinking water facilities:

5.1 No. of household have own toilets :

5.2 No. of tube-wells in village :

5.3 No. of families used tube-well water for drinking :

6. Development and welfare programme implemented for adolescent in the villages:

Signature of investigator

CHECKLIST FOR CASE STUDY
Adolescent Reproductive Health and Gender Sensitivity in Tribal Areas
- An Operational Research
Conducted By: MY-HEART, Bhubaneswar

1. **Personal Profiles:**
   - i. Name :
   - ii. Village :
   - iii. GP :
   - iv. Parent's Name :
   - v. Sex :
   - vi. Age :
   - vii. Marital Status :
   - viii. Education :
   - ix. Occupation :
   - x. Caste :
   - xi. Religion :

2. **Reproductive and Sexual health knowledge, attitude, behaviour and practices:**

   - i. Right age bad effects of early marriage :
   - ii. Changes during puberty:
   - iii. Pre-marital sex:
   - iv. Menstrual/Penile hygine :
   - v. How pregnancy happens :
   - vi. Child birth/safe delivery practices:
   - vii. Family planning methods/contraception:
   - viii. Abortion/safe abortion:
   - ix. RTI/STI/HIV/AIDS:
   - x. Source of Information:
   - xi. Sexual health:
   - xii. Sexual abuse:

3. Type of reproductive health morbidity/problems ever experienced if any:
4. Action taken/Health care seeking behaviour. Felt needs for better reproductive health:
5. Nature of gender discrimination suffered:
6. Bad effects of gender discrimination:
7. Myths and misconception on sex and sexuality:
8. Suggestion for improvement of SRH of adolescent:
9. Observers remarks:

NB: Please collect the information for case study from sexually active adolescent/married/ adolescent experiencing gender discrimination/anemic/sick adolescent/school drop out adolescent. Write the case study like a story keeping in view to above points.