FAMILY LIFE EDUCATION FOR NON-SCHOOL GOING ADOLESCENTS : AN EXPERIMENT IN AN URBAN SLUM

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Introduction

Adolescence is a vital phase of life. It is one of the most apprehensive stages in which the adolescent is trying to adjust to the various physical, emotional and psychological changes. Many questions emerge in the minds of the adolescent, but very few get access to the right kind of information. In Indian society, talking about sex is taboo. Therefore adolescents are reluctant to approach their parents for guidance. Those who do ask their parents questions are not satisfied with the answers. Many parents avoid answering such questions and try to change the topic. Some even go to the extent of scolding and beating the adolescent. In such circumstances, the only sources of information are friends, films and books. Many a time, the information is either misleading or misinterpreted. The queries that arise in the minds of the adolescent remain as queries forever and they carry these myths and misconceptions throughout their life.

The new concept of reproductive health emphasises the importance of sex education. Family Life Education is an educational process to assist young people to cope with changes during adolescence and to enable them to become responsible parents. Family Life Education is being conducted in India for almost thirty-five years. The pioneer in starting Family Life Education in India has been the Family Planning Association of India. (Israel Sarah : 1967).

The terminology differs, but the ideas and issues are the same : Sex Education, Population Education, Family Life education are the terms used commonly. Any programme that is conducted should take into account the political and sociocultural aspects of the country. A prerequisite for conducting a Family Life Education (FLE) programme is the mental preparation of the population, especially the parents. In India, (Kodagoda : 1986) the discussion about sexuality is disagreeable and the introduction of any such programme is met with hostility. Therefore, there is a need to sensitise the parents, especially the mothers of adolescent girls.

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Materials And Methods

This particular study was conducted in "Malawani" an urban slum situated in North-West Bombay. Seth G.S.Medical College and KEM Hospital have adopted the slum with its population of more than one lakh for providing comprehensive health care services. For many years, various health educational programmes like Child-to-Child Programme, Population Education and AIDS Awareness Programme have been conducted for school children. Non-school going adolescents were not easily accessible for such an extensive health education programme.

Aims and Objectives

The present project was undertaken with the aim of developing an IEC package and assessing its effectiveness in improving the knowledge and attitude regarding sex education, STDs and AIDS and nutrition of non-school going adolescent girls.

Study Design

The study was carried out in four phases to achieve the above mentioned objectives.

Phase 1A

Focus group discussions were held with the mothers to assess their attitude towards imparting sex education to the children and also to formulate the curriculum based on the findings. Three such focus group discussions were held with 29 mothers of adolescent girls (Padma Shetty et al : 1999).

Phase 1B

A single focus group discussion was held with adolescent girls to assess their level of knowledge on various aspects of family life education and gauge their interest in such a programme.

Phase 2

Based on the results of the focus group discussions and review of literature, the curriculum for family life education was developed. Different packages on FLE have been developed by agencies like FPAI, SNDT University and UNESCO. The main focus is on sex education. The curriculum developed by SNDT University includes topics on nutrition, hygiene, mother and childcare and family. The UNESCO module on FLE touches upon various aspects of Family Life (UNESCO : 1988).

The topics included in the present IEC package on FLE were

- Nutrition
- Hygiene
- Family
- Adolescence
- Mother and Child care
- STDs and AIDS

The methodology for imparting FLE included lectures, games, group discussions, role-plays, case situation analysis and question-answer sessions using flash cards. The FLE programme was scheduled for a period of 5 days with a duration of 90-120 minutes every day. A pilot study of the IEC package with a group of 12 girls was undertaken. After making a few changes in the contents of FLE, the IEC package was finalised and used for imparting FLE to the adolescent girls. A brief review of the IEC package is presented in Table 1.

Phase 3

Because the IEC package was comprehensive but time consuming, it was not possible to select the girls randomly from the community and

TABLE 1
IEC PACKAGE ON FAMILY LIFE EDUCATION

Day	Name of Session	Methodology	Materials Required	Duration
1	Getting acquainted	Icebreaker	----------	30 mins
1	Nutrition and Hygiene	Lecture Game	Flash cards	60 mins
2	Family	Lecture Group Discussion Role Play	Index cards Case studies	120 mins
3	Adolescense	Lecture Group Discussion Role Play	Flash cards Index cards Case studies	90 mins
4	Mother and Child Care	Question Answer Session in the form of passing the parcel game	Flash cards Index cards Case studies	90 mins
5	STDs and AIDS	Lecture Group Discussion	Flash cards Index cards Case studies	90 mins

organise their groups. Therefore, adolescent girls attending the vocational training classes in the slum area of 'Malawani' were chosen as the target group. There were 8 batches of adolescent girls. Each batch consisted of 15-20 girls. Majority of the participants had discontinued their education. The participant's knowledge and attitude was tested by administering the schedule prior to starting the session. A total of 135 participants were pre-tested. A 5-day programme was conducted for each batch. The proceedings of each session were documented in writing.

Phase 4

The change in knowledge and attitude after FLE was assessed by administering the schedule, one week after completing the programme on FLE. A total of 112 participants were present for the post-test. Effectiveness can be defined as the positive change in knowledge and attitude of the adolescent girls on the various issues discussed in Family Life Education.

The effectiveness of the IEC package was assessed by

1. Comparing the results of pre-test and post-test schedule :

   a) Qualitative data was analysed using Chi Square and standard error of difference between two proportions.

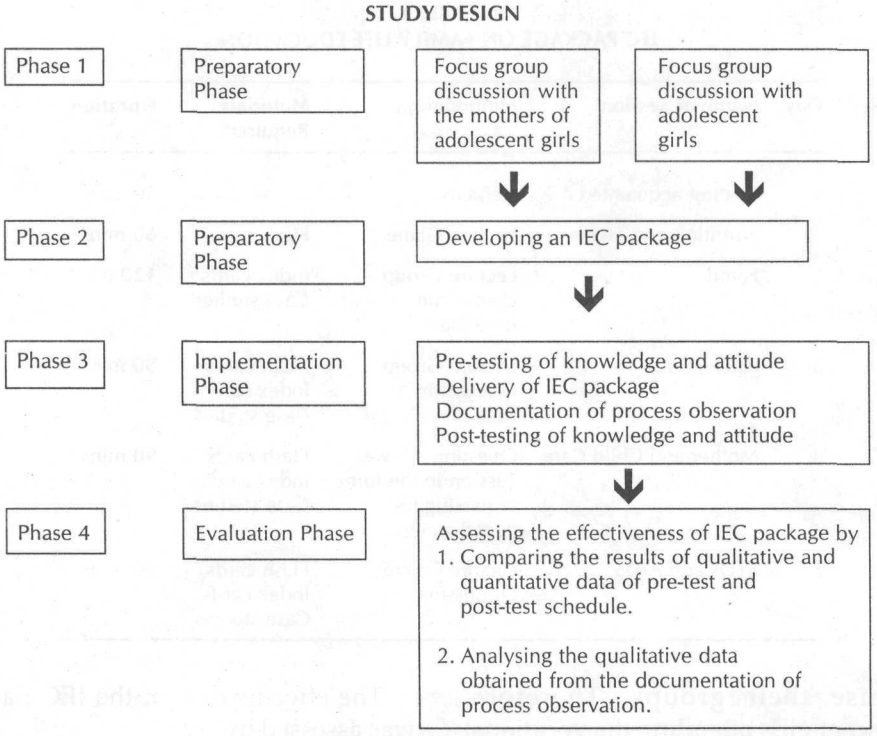
   b) Qualitative data was converted into quantitative data by developing an arbitrary scale of measurement and analysed using standard error of difference between two means.

2. Documentation of process observation.

Results

The total number of girls who participated in the session to begin with were 135. Pre-test was administered to all the 135 participants. The number of girls who were administered post-test was 112.

A significant change in knowledge and attitude of the participants was observed in all the aspects of Family Life Educa-



tion (Table 2 and Graph 1).

Sociodemographic characteristics

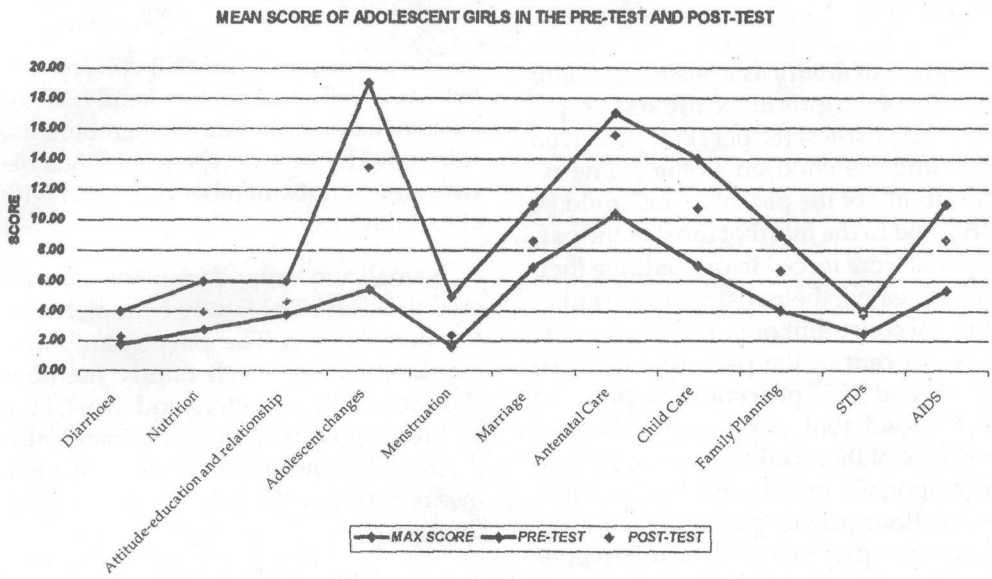
Majority of the participants were in the age group of 14 to 19 years (98.2 per cent) and were equally distributed in the age groups of 14 to 16 years and 17 to 19 years.

The girls predominantly belonged to the Muslim Community (60.7 per cent)

TABLE 2
KNOWLEDGE AND ATTITUDE OF THE PARTICIPANTS REGARDING FAMILY LIFE EDUCATION

Topic	Score		Pre-Test		Post-Test		Z value
	Min	Max	Mean	SD	Mean	SD	
Diarrhoea	0	4	1.76	0.78	2.31	0.72	5.55
Nutrition	0	6	2.79	1.03	3.98	1.07	9.15
Attitude towards education of Girls, Girl–Boy relationship	0	6	3.80	1.34	4.66	1.37	5.06
Adolescent changes	0	19	5.47	1.89	13.45	3.11	23.47
Menstruation	0	5	1.64	0.93	2.37	1.20	5.21
Marriage	0	11	6.89	2.09	8.62	0.98	8.64
Antenatal Care	0	17	10.35	2.61	15.53	2.09	17.27
Child Care	0	14	7.02	3.16	10.79	2.67	10.19
Family Planning	0	9	4.07	1.51	6.71	1.57	13.20
STDs	0	4	2.43	0.84	3.80	0.60	15.22
AIDS	0	11	5.36	1.88	8.73	1.75	14.65
GRAND TOTAL	0	106	49.64	10.64	78.53	9.67	22.33

GRAPH 1



followed by Hindus. This was because the study area was predominantly a Muslim community.

Though 97 per cent of the participants received education above primary level, most of the participants were not studying. During the focus group discussions, the mothers felt that education was important for the girls but expressed dissatisfaction with the school curriculum because it did not give them the necessary skills to become financially independent (Shetty et al : 1999).

Knowledge about management of diarrhoea

Knowledge about management of diarrhoea with home made ORS improved from 58.52 per cent in the pre-test to 65.18 per cent in the post-test. The group discussion with the girls revealed that the girls knew how to prepare ORS at home. The source of knowledge was health education given to them in schools on diarrhoea. Only 20 per cent and 10.37 per cent of the participants were aware about using black tea and rice *kanjee* in the pre-test and this knowledge improved to 66.96 per cent and 37.5 per cent in the post-test. Other fluids available at home like vegetable soups, *dal* water and buttermilk were also mentioned by the participants in the group discussion. A long-term follow-up study after 5 years of intervention among school children conducted by Seth G.S. Medical College showed that 92 per cent knew management of diarrhoea at home (Vidula Patel et al : 1996).

Knowledge about nutrition

Knowledge about dark green leafy vegetables and jaggery as rich sources of iron improved from 67.41 per cent and 11.85 per cent in the pre-test to 90.18 per cent and 44.64 per cent in the post-test respectively. 54.46 per cent of the participants in the post-test as compared to 31.85 per cent in the pre-test knew that vitamin 'A' was important for good eyesight. A few

participants specifically mentioned the role of vitamin 'A' in preventing night blindness.

Perception of family as a basic social unit
Majority of the girls in the pre-test (65 per cent) and post-test (86 per cent) perceived educating the children as the prime responsibility of the parents. This could be attributed to the fact that most of the participants were forced to discontinue their studies against their wishes due to either financial constraint or parental pressure. 60.74 per cent of the participants in the pre-test and 56.25 per cent in the post-test emphasised that parents should take good care of their children. Judging from the responses mentioned above, these observations probably also speak for the gender bias prevailing in the urban poor community.

The participants perceive looking after parents, obeying parents, respecting elders and helping the parents in household chores as the prime responsibility of children towards family. The participants also felt that children should complete their education, become financially independent and take the responsibility of looking after the family.

According to the participants, family is essential as it provides support during times of crisis, fulfils basic needs, gives us love, security and teaches us our cultural norms.

Majority of the participants opted for a nuclear family. The participants expressed their opinion that a lot of misunderstanding and fights occur in the joint family. Less attention is paid to the children because there are many family members and also the women of the house are overburdened with household chores. If there is lack of understanding within the family members one person invariably has the burden of all the household responsibilities. Financial constraint may arise if only one family member is earning.

The participants feel that children are better cared for in a nuclear family; all the basic needs of the family members are fulfilled. The interpersonal relations between the family members are good with close bonding.

A small and happy family was considered to be an ideal family by majority of the participants. The participants also emphasised that each family member should be able to understand, trust, love and respect each other. Participants also discussed the negative influence of arguments between the parents on the children.

Knowledge and attitude regarding growing up, body and bodily processes
51.11 per cent in the pre-test as compared to 18.75 per cent in the post-test replied incorrectly the age of attaining puberty. Such a high percentage of incorrect answers could be due to the fact that puberty is associated with menarche. The percentage of participants who answered correctly in the post-test increased by 52.27 per cent.

Regarding physical changes occurring during adolescence 69.63 per cent of the participants in pre-test as compared to 5.36 per cent in post-test responded as "don't know". The percentage of participants who answered correctly increased by 73.16 per cent in the post-test.

The physical changes in girls mentioned in the post-test are development of breasts (79.46 per cent), growth of axillary hair (45.54 per cent), menstruation (41.96 per cent), growth of pubic hair (38.39 per cent), widening of hip (37.5 per cent) and acne (31.25 per cent). This change in knowledge is probably due to

information provided by the IEC package through lectures and an opportunity to discuss openly.

90.18 per cent in the post-test as compared to 9.63 per cent in the pre-test were able to answer correctly about the physical changes seen in boys. The physical changes mentioned by the participants were growth of moustache (46.43 per cent) growth of axillary hair (44.64 per cent), change in voice (43.75 per cent), growth of beard (30.36), increase in height (27.68 per cent), growth of hair on chest (25 per cent), growth of pubic hair (17.86 per cent) and broadening of shoulders (14.29 per cent).

66.07 per cent of the participants in the post-test as compared to 7.41 per cent in the pre-test referred to emotional changes occurring during adolescence. Emotional changes such as attraction towards the opposite sex, change in thinking and behaviour were discussed by the participants (in two batches) in group discussions. The case situation on emotional changes gave them an opportunity to learn how to deal with these emotional changes and this was reflected in their role-play. 88.39 per cent of the participants in the post-test as compared to 37.04 per cent in the pre-test knew that there were different openings for urine and menstruation.

Bhalerao (1993) in her study on the "Role of Audio Visual programmes in creating awareness about reproductive health in girls" found significant improvements in knowledge about pubertal changes and physiology after intervention. In the pre-test, 45.19 per cent replied that they feel dirty during menstruation and 20.74 per cent expressed fear, 17.78 per cent expressed indifference and 11.11 per cent considered it a nuisance. The percentage of participants who replied as "I feel nice" improved from 2.96 per cent in the pre-test to 11.61 per cent in the post-test which is statistically significant. 46.3 per cent of the participants in the post-test were of the opinion that restrictions should not be imposed on the girls during menstruation. Positive attitude towards girl boy relationship was expressed by 43.75 per cent in the post-test as compared to 15.56 per cent in the pre-test.

Knowledge about Conception, Pregnancy and Delivery

Knowledge amongst the participants regarding how conception occurs, site of development of foetus, duration of pregnancy, signs of pregnancy, route of delivery and ANC improved significantly ($P<0.001$) in the post-test.

49.6 per cent of the participants in the pre-test knew how conception occurs. A study conducted by Chhabra in urban school girls also revealed similar results. (Chhabra et al : 1990). Following Family Life Education, the number of girls who answered correctly increased to 96.4 per cent.

Only 28.9 per cent in the pre-test as compared to 87.5 per cent in the post-test knew that amennorhoea is a sign of pregnancy. Nearly 22 per cent of the girls in the pre-test were of the opinion that vomiting, desire to eat sour food and abdominal pain were signs of pregnancy.

Only 20.7 per cent of the participants in the pre-test knew that the father determined the sex of the child. 45.9 per cent had the misconception that God determines the sex of the child. In the post-test, there was a significant improvement in the knowledge of the participants (81.3 per cent) regarding sex determination.

Knowledge about child care

Only 28.89 per cent of the participants in the pre-test as compared to 94.64 per cent in the post-test knew the correct age for

initiating breastfeeding. The group discussions in FLE programme revealed that the participants had the misconception that colostrum is harmful to the baby and should not be given.

40 per cent of the participants in the pre-test and 85.72 per cent in the post-test knew when to initiate weaning. During the group discussion the participants mentioned *dal* water, rice *kanjee* and commercially available weaning foods. The participants felt that commercially available weaning foods are much better than homemade foods. This was because of the widespread advertisement of commercially available weaning foods.

Knowledge about "BCG" and "Polio" vaccines was higher as compared to that of "Triple" and "Measles" in the pre-test. Awareness about "Polio" vaccine is more because of repeated advertisements on mass media and mop up rounds with "Polio" vaccine in the community. Knowledge about all these four vaccines has improved in the post-test.

Knowledge about family planning methods

92.86 per cent of the participants in the post-test as compared to 29.63 per cent in the pre-test knew that ideal spacing between two children is 3 years. In the group discussion, the girls said that if spacing between two children were less, the health of both the mother and the child suffered and that the children were neglected.

Only 25.19 per cent of the participants in the pre-test knew about family planning methods. Majority of the participants in the pre-test mentioned condoms and oral pills such as Mala D, Choice and Saheli as family planning methods. This could be because of widespread advertisements by mass media. Awareness about Copper 'T', female sterilisation and male sterilisation was poor in the pre-test (4.44%, 4.44% and 0% respectively).

Knowledge about STDs and AIDS

29.62 per cent of the participants in the pre-test and 94.64 per cent in the post-test knew that venereal disease spreads through sexual contact with an infected person.

37.04 per cent of the participants in the pre-test had some knowledge about how AIDS spreads. This is because of the widespread advertisement through mass media. In the pre-test most of the participants said that one gets AIDS by having sexual intercourse with an infected person or by using infected syringes and needles.

14.81 per cent of the participants in the pre-test had the misconception that AIDS was curable but this has decreased to 3.57 per cent in the post-test.

Observations of process

The girls' inhibitions disappeared as the sessions progressed. Mothers of the adolescent girls were relieved of their apprehensions as is evident by the co-operation they extended by sending their daughters for the sessions. The girls liked the participatory method of teaching and responded actively and enthusiastically to methodologies like role – play, games and case study discussions.

Discussion

Many have stressed the importance of importing Family Life Education adolescent girls. International Planned Parenthood Federation, in a seminar held in Lesotho in July 1978, stressed the importance of Family Life Education. Family Life Education (FLE) includes a study of self-awareness, understanding of others, of sexuality, marriage and parenthood. The knowledge and skills gained by the

participants will contribute greatly to the individual's ability to cope, both with the social change and with the relationship in society as a citizen, spouse or parent (IPPF seminar : 1978). FLE would help adolescents adjust dynamically without undue strain in the broad society in which they live, in their intimate relationships with friends in love, marriage and a family of their own (Rao : 1988).

The right age for imparting Family Life Education is the period of adolescence. FLE imparted during adolescence would ensure a safe motherhood and a healthy child, that is, it would help in decreasing infant mortality and maternal mortality rate (Kapil : 1990). As a woman is the caretaker of the family members, she can educate all the family members and inculcate good habits and a positive attitude in them.

Though a broad curriculum for Family Life Education is available, it needs to be adapted based on the felt needs of the community, especially those of mothers and adolescent girls. Participatory teaching methods should be used for educating the girls as it ensures that every participant participates actively. The IEC package utilised various participatory teaching methods such as games, group discussion, role plays and case-situational analysis. Role-plays, case situation analysis and group discussions have enabled the participants to discuss, express their views, opinions and attitude on various issues. The case studies have given the girls an opportunity to think realistically and be prepared for life. It also gave them an opportunity to learn how to deal with various problems in life with optimism. Demonstration of ORS, contraceptives and balanced diet has also contributed significantly to improving the participant's knowledge and attitude of adolescent girls to FLE.

The IEC package has been very effective in changing the knowledge and attitude of the adolescent girls on various issues related to Family Life Education. The change in the knowledge and attitude of the adolescent girls after the Family Life Education was statistically significant (Table 2 and Graph1). This package can be expanded to other urban slums and schools to enlighten the vast majority of adolescent girls who are at the threshold of their adulthood and subsequent motherhood and who will accept the responsibilities of the family. This would support the Safe Motherhood and Reproductive and Child health initiative on a wider scale.

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