Introduction

Reproductive health care is a relatively new concept which is proven to be a significant component of general health. Improving reproductive health is indispensable for improving general health and stabilization of world population (Shanthi, 2017). The Reproductive health of present generation has an impact on the health of the next generation and that both are of crucial importance for socio-economic development. It is a prerequisite for social and economic development and is imperative because human energy and creativity are the driving forces of development (UNDP, 2001; UNFPA, 2000).

According to World Health Organization (2007), Reproductive health is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system at all stages. Reproductive health care is the care that protects the reproductive system from mortality, morbidity and helps in its functioning attributing to the quality of life. The foundation for Reproductive health is laid in adolescence, which is a phase in human life that begins with the onset of puberty and ends with the reproductive maturation of (Adolescence Education Programme, 2008) mostly during the age group of 10-19 years (WHO, 2006).

Adolescent sexual and reproductive health refers to the physical and psychosocial wellbeing of adolescents relating to their sexual development and sexuality which includes their ability to remain free from unwanted pregnancy, unsafe abortion, STIs (including HIV/AIDS), and all forms of sexual violence and coercion. Adolescent sexuality refers to feelings, behavior and development, is a stage of human sexuality and presents the first challenge to healthy growth and development during adolescence. Adolescence being the time of changes, give rise to a mature adult physique and personality. Because of these numerous changes, they become aware of their sexuality and in many cases become sexually active as sexual desire usually begins to intensify along with the onset
of puberty. During this period, rising hormone level contribute to an activation of sexual sensations. They develop intense idealism and feel a new bout in relationships with their friends. Unfortunately these are not very well understood by adolescents. They can be easily influenced by the various factors surrounding them making them vulnerable, resulting in being susceptible towards various reproductive health issues like sexually transmitted infection(s), teenage pregnancy, septic abortion which will affect their future reproductive and sexual lives (Moyosore, 2016; United Nation, Population Fund, UNFPA, 1998).

Adolescents are a demographic and economic force and are the cohort who will determine the future of the country, their contributions being of special interest in the areas of health and economy. Today, 1.2 billion adolescents stand at the crossroads between childhood and the adult world. Around 243 million of them live in India, the largest ever cohort of young people to make a transition to adulthood. As they stand at these crossroads, so do societies at large – the crossroads between losing out on the potential of a generation or nurturing them to transform society. In India adolescents, between the ages of 10 and 19, account for nearly one-quarter of the total population (Hulsof, UNICEF India, 2011). They are of diverse population segment and live in diverse conditions with different circumstances, as stated by UNICEF India, (2011) millions of these adolescents do not have access to quality education, primary sexual and reproductive health care, support for mental health issues, abuse and exploitation, and forums for active participation (Hulsof, UNICEF India, 2011).

Adolescents form a significant portion of the population whose health must be safeguarded to ensure a future healthy population (Moyosore, 2016). International Conference on Population and Development (ICPD) held in 1994 in Cairo for the first time emphasized the need for promoting adolescent reproductive health and rights. ICPD Program of Action 7.46 declares that all countries "should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies". It extended formal recognition and concern for adolescent reproductive and sexual health for the first time. They emphasize
that the parents and other persons responsible for adolescents should provide appropriate direction and guidance in sexual and reproductive health matters. They further highlight that the adolescents need comprehensive information and access to services regarding reproductive health, pregnancy, abortion, child care including STIs, HIV / AIDS (Shirur, 2000).

The commitment of the national government to the reproductive health approach forged at the International Conference on Population and Development (ICPD) in 1994 has reshaped the family welfare program into a broad-based Reproductive and Child Health (RCH) Services Program in India. The Policymakers and planners have now recognized that the adolescent population group has specific health and developmental needs.

The newer focus on RCH also has been invigorated by the continuing realization of Reproductive Health being a public health concern worldwide though it is significant for women specifically of reproductive age. Young women bear by far the greatest burden of reproductive health problems. Women including adolescent girls are at risk of complications from pregnancy, unsafe abortion and childbirth; bear most of the burden in preventing unwanted pregnancy, use of contraception; and are more exposed to contracting the reproductive tract infections and sexually transmitted infections (STIs). Many Biological, Social and Cultural factors influence adolescent girls’ health. Early marriage, early and frequent childbearing and food taboos during menstruation and pregnancies are associated health risks of adolescent girls and they must be given high priority in Indian policy and program development and implementation (Shanthi, 2017; Gupta, 2003).

India ratified International Conference on Population and Development (ICPD) and its Program of Action, the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) highlighting the need for addressing the sexual and reproductive health concerns of young people (Adolescence Education Programme, 2008). The programme of action (POA) of ICPD stated that the
adolescent needs are distinct from adult needs in this regard. Supporting this statement, Gubhaju (2002) emphasized that the adolescent’s reproductive health needs and problems are more distinct than those of young adults aged 20 – 24. According to Shirur (2000), adolescent reproductive health must be a comprehensive approach which comprises of education on human sexuality, de-stereo typing sex-role perceptions, providing free health services and counseling, effective teacher training on physical, psychological and emotional growth and needs, promoting self-reliance in school and college setting and public education of parents for mobilizing support to adolescents education on human sexuality.

The adolescent’s reproductive health is of growing concern today for numerous reasons (Gubhaju, 2002). India has one of the highest rates of child marriage in the world, a practice that often results in reproductive health problems for girls because of early childbearing. 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 (International Center for Research on Women, 2006).

According to the Nutrition Foundation of India, the average age of menarche is 13.4; yet half of the adolescent girls aged 12-15 do not know about menstruation. It is true for rural as well as the urban poor. The lack of information can be attributed to a veil of secrecy that surrounds menstruation (CEDPA, 2001). Many studies found mothers were to be the first source of information regarding menstruation (Jogdand and Yerpude, 2011; Singh et al., 2006; Khanna et al., 2005). Much of this information imparted to young girls is in the form of restriction on her movements and behaviours (Khanna et al., 2005). Large numbers of rural and urban populations in India believe that menstruation contaminates and makes the body unholy. As a consequence, the girl often sees herself as impure, unclean and dirty (Kusuma and Mansoor, 2016). On average, most adolescent girls in India have little knowledge of menstruation, sexuality and reproduction. Menstrual practices are still clouded with socio-cultural restrictions and taboos resulting in adolescent girls remaining ignorant of the
scientific facts about menstruation and hygienic health practices, which lead into adverse health outcomes (Dasgupta and Sarkar, 2008).

The trend of fall in age at menarche has been recorded in recent years, which implies an earlier onset of puberty and sexual maturity that has resulted in young girls becoming sexually active and able to reproduce at an earlier age, though they are emotionally and psychologically immature to perceive the implications. A large number of adolescent girls start sexual activities early much before marriage in urban areas, and the same applies to rural areas due to early marriage. These can endanger not only their physical health but also create long-term emotional, economic and social impairment and losses (Gubhaju, 2002).

Gubhaju (2002) emphasized that it is essential to recognize the growing incidence of premarital sexual activity among adolescents. One-half of all young women in India are thought to be sexually active by the time they are 18 years of age, and almost one in every five are sexually active by the time they are 15 years of age (National AIDS Control Organisation, 2006). As most of the premarital sexual intercourse are unprotected, the adolescents who are sexually active are increasingly at the risk of contracting and transmitting sexually transmitted infections (STIs), including HIV/AIDS. The ignorance about the consequences of unprotected sexual intercourse is typical among the sexually active adolescents often leading them to unwanted pregnancy and abortion.

Adolescents often do not have access to sufficient and correct information and are poorly informed about their physical attributes, sexuality and the consequences of unprotected sex. In fact, the lack of accurate information on reproductive health and conflicting messages in mass media are increasingly posing problems and confusion for adolescents (Shirur, 2000). Due to these reasons, young people during the time of adolescence adopt risky behaviours, and their cognitive distortions and a sense of non-susceptibility leads to uninformed decisions, which may result in unwanted pregnancy and STIs. The notions that the adolescents are "too young to be pregnant" and "unprotected
intercourse just once could not lead to conception or STI transmission" are prevalent among adolescents (Kirby, 2002; Jessor, 2000; Romer et al. 1994). A report by UNFPA (United Nations Fund for Population Activities) on adolescents in India suggests a high level of premarital sexual activity among the adolescents. Also, deteriorating economic conditions in the country places adolescents at risk of abusive, exploitative and unsafe sexual encounters. Moreover, in Indian society adolescent girls are particularly vulnerable to the risks associated with misinformed and unprotected sexual relationships, as well as the adverse consequences of adolescent pregnancy because of the sexual inequality that prevails (Gubhaju 2002).

In developed regions, adolescent mothers tend to be unmarried, and adolescent pregnancy is seen as a social issue whereas, in developing countries, such pregnancies mostly occur in married adolescents, and family and society most often welcome these pregnancies. However, in these societies, early pregnancy may combine with malnutrition and inadequate healthcare to cause health risks (Mukhopadhyay et al., 2010). Risks include haemorrhage, anaemia, delayed or obstructed labour, low birth weight baby, miscarriage, damage to the reproductive tract and in some cases, even death of the mother. A high risk pregnancy and childbirth result in a high level of female mortality, in addition to high morbidity, in the reproductive age groups. Maternal mortality and morbidity of adolescent mothers is a cause for concern. The pervasiveness of discrimination, lower nutritional status, early marriage and complications during pregnancy and childbirth among adolescents contribute to female mortality (CSO, 2002; SRS, 1999).

Needless to say, there is a high proportion of marriage during adolescence in India, although the legal age at marriage is 18 years for females and 21 years for males, resulting in a high rate of adolescent childbearing in India. By the age of 15 years, 26 percent of females are married, and by the age of 18 years, this figure rises to 54 percent. Most reproduction in India occurs within marriage; so, the low age at marriage automatically links to early onset of sexual activity and thereby fertility (WHO, 2004). Adolescent fertility rates are
high, over one in five give birth by age 17 and the median age at first birth is 19 years, suggesting that significant proportions of adolescents undergo pregnancy at ages below which obstetric risks are particularly elevated (Gubhaju, 2002) and a leading cause of mortality among girls aged 15-19 years (Mayor, 2004). Data from the National Family Health Survey (NFHS)-3 revealed that 16 percent of women, aged 15-19 years, have already started childbearing (IIPS, 2007). This proportion is the highest in the state of Jharkhand (28%), followed by West Bengal (25%) and Bihar (25%), all located in eastern India. There are approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. A substantial proportion of young married girls are already malnourished. Nearly 47 percent of adolescent women have body mass index of less than 18.5, 11.4 percent are stunted, and half of them have anaemia (Mukhopadhyay et al., 2010).

Early marriage is associated with a high likelihood of complications in pregnancy and childbirth – among the leading causes of death for girls between the ages of 15 and 19 worldwide. Insufficient control over their own fertility leads many adolescent girls to resort to unsafe abortions, risking serious injury or death and often putting themselves in conflict with the law (UNICEF, 2011). Not only does childbearing occur early among married adolescents, but subsequent pregnancies also tend to be more closely spaced than among adults (Santhya and Jejeebhoy, 2003). Motherhood at a very young age entails a risk of maternal mortality that far exceeds the average, and the children of young mothers tend to have higher levels of morbidity and mortality. Early childbearing continues to be an impediment to improvements in the educational, economic and social status of women (Gubhaju, 2002).

The experience of early and closely spaced childbearing is particularly risky for adolescents because massive proportions are anaemic and may not have reached physical maturity. It is specially true since India has the world's highest prevalence of iron-deficiency anaemia among women, including adolescents (International Center for Research on Women, 2006). Adolescence is the pivotal decade when poverty and inequity often pass to the next
generation as poor adolescent girls give birth to impoverished children (UNICEF, 2012). Girls who marry early are also most at risk of being caught up in the negative cycle of premature childbearing, high rates of maternal mortality and morbidity and high levels of child undernutrition. And there is firm evidence to suggest that undernutrition is among the foremost factors that undermine early childhood development (UNICEF, 2011).

India is in the grip of the HIV/AIDS epidemic, with an increasing number of infections being reported among youth specially women. In India, young people in the age group 15 - 24 years comprise almost 25% of the country's population i.e, a quarter of the population; however, they account for almost one-third (31% ) of the HIV/AIDS burden (NACO; MOHFW, 2007). Out of total cases of HIV/AIDS in India, 35% were in the age group of 15-24 years, and most of them were infected through unprotected sex. One youth is reported to be infected with HIV/AIDS almost every 15 seconds (Population Foundation of India, 2003). Therefore, the information and services catering to the adolescents’ reproductive health is a great need in the present context.

The National Population Policy 2000 gave recognition for the first time, that adolescents constitute an under-served group with special sexual and reproductive health needs, and advocates special programmatic attention to addressing this population (MOHFW 2000). It recommended the need to ensure for adolescents access to sexual and reproductive health information, and counselling and services that are affordable and accessible. The need to "strengthen primary health centres and sub-centres to provide counselling, both to adolescents and newly-weds" was emphasized (MOHFW, 2000).

However, the adolescents’ reproductive health needs have been challenge to the existing health services (Gubhaju, 2002) and the primary sources of information regarding sexual health were pornographic films, magazines and friends which is again uninformed sources. It is not surprising therefore, to find insufficient information available on health and sexuality needs of adolescents, their knowledge on human sexuality and reproductive health, the
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types of physical and emotional problems they face and risks they encounter. Truth to be told, Adolescents' knowledge about any matter relating to reproductive and sexual health is limited or very superficial. According to CEDPA, (2001) 50 percent of adolescent girls have no information or understanding of basic biological process of menstruation. Almost 20 percent were not even aware of the minimum legal age at marriage for females and males in the country. Only one in three young women was aware that a girl could become pregnant the first time she engages in sexual activity (IIPS and Population Council 2007). As far as HIV/AIDS is concerned, the UNICEF statistics (2003-2008) also found that only 20 percent of the adolescent females are aware of the comprehensive knowledge on HIV/AIDS, underlining the vulnerability of female adolescent to HIV/AIDS. Research studies on awareness among adolescent girls reported that adolescent girls were found to be significantly less knowledgeable regarding communicability, modes of transmission and prevention and protective measures of HIV/ AIDS (Naswa and Marfatia, 2010; Chakrovarty et al., 2007; Gaash et al., 2003). In a study conducted by the ICMR (Indian Council of Medical Research) in higher secondary schools in rural areas of 22 districts and 14 states, only 13 percent of adolescent knew that multiple sex partners increased the risk of HIV infection (McManus and Dhar, 2008).

Since the adolescents’ reproductive health needs and problems are more distinct than adults, the efforts are required to educate them about how to protect themselves from various risks like sexual violence, early pregnancy and child bearing with high risk, unintended or unwanted pregnancy leading to unsafe abortion and consequent complications, STI, HIV / AIDS etc (Gubhaju, 2002). However, there is considerable disagreement and controversy. In India, school systems are ambivalent about imparting sex education. Even in some schools where sexual and reproductive health education exists in the curriculum, teachers are often too embarrassed and uncomfortable to effectively instruct and knew a little about what and how to teach various topics and issues, and parents feared that sexual and reproductive health education will encourage sexual
activity among adolescents. It is often argued that giving such information promotes early sexual activity and violates tradition and parental mandates.

From the current scenario and various research findings, we can easily deduce the sexual and reproductive health status of Indian adolescents.

- A large majority of adolescents have poor knowledge and lack of awareness about physical and physiological changes associated with the onset of puberty. Most girls are not informed about menarche and how to maintain menstrual hygiene and manage menstrual problems.

- Adolescents being an age of curiosity, they learn about sexual behaviours primarily from their peer group or media, an unreliable source which leads to adolescent pregnancy, unsafe abortion, RTI, STIs including HIV/AIDS and other social problems.

- Many adolescents are sexually active but lack of information and skill for self-protection. Sexually active adolescents are typically unaware of consequences of unprotected sexual intercourse and means of protecting themselves, often leading to unwanted pregnancy, unsafe abortion and its complications.

- The perpetuate traditions in India encourage early marriage and followed quickly by a first and subsequent births. Adolescent pregnancy has the risk of adverse outcomes (Infant mortality rate, Maternal mortality rate and Low birth weight babies) again is higher.

- Prevailing malnutrition, anaemia, stunting and lack of immunisation have the adverse impact on MMR, IMR, and morbidity; and have intergenerational effects. Stunted adolescents getting married giving rise to a low birth weight baby that too female, again develop into a stunted female and cycle keeps on repeating.

- The family dynamic is still very strong and plays a significant role in the life of adolescents providing support, love and care, but fails to respond to the need for adolescents’ sexual and reproductive health.
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✓ And the existing service delivery system is not catering to the needs of unmarried adolescents. A review of health care system and types of services provided closely reveals profound disparities between different targets. Unmarried growing adolescent girls who are prospective mothers are grossly ignored by the government and even other voluntary health sectors.

✓ So far reproductive and sexual health education has not been a part of the education curriculum in India.

From the various stated facts on status of adolescents, it is clear that the reproductive health needs of adolescents are by necessity, becoming a priority concern. However, adolescent sexuality still being a controversial and sensitive issue, very few countries in the World has set up adequate health care services to cater the needs of adolescents’ reproductive and sexual health (Pati, 2004). The needs of adolescents’ reproductive health care vary with culture, age, marital status. But it is universally agreed that all adolescents need accurate and adequate information about reproductive and sexual health. In the absence of adequate and accurate information, adolescents are at risk of being ill-informed about the matters, which may lead them to make decisions that could have negative effects on their lives. Due to aforesaid reasons, it is felt that there is a need for creating a generation with proper knowledge for good reproductive health status. With regard to the adolescents’ awareness about their reproductive health issues, it is urged that education is major viable medium for this purpose. Also it is acknowledged that adolescents have the right to reproductive health education, partly because it is means by which they are helped to protect themselves against abuse, exploitation, unintended pregnancies, sexually transmitted infections and HIV/AIDS (Goel, 2014).

Thus, the initiatives on reproductive health education are an unavoidable call to address the adolescents’ reproductive health issues. Reproductive health education is the process of acquiring knowledge, encouraging positive attitude and training good behaviour practices on reproductive health issues. Although a
relatively new and sensitive area, there is good evidence that educational intervention programs of adolescents results in improved health of young people, decreased age at marriage and childbearing, decreased alarming rate of married and unmarried adolescent pregnancy and abortion, improved health of young mothers when they bear children, better birth outcomes and health of infants, enhance socio economic potential for young women, and slowed population growth. It is recommended that one of the key actions needed to improve reproductive health is the empowerment of adolescents, mainly through education programmes. Nevertheless, adolescence is the best time to acquire knowledge pertinent to sexual and reproductive health education which provides them a preventive and promotive effort to drive away myths and misconception and acts as a powerful tool which would enable them to blossom into balanced and matured adult in later years. According to Bhave and Prasad (2007) sexual and reproductive health education given in a scientific manner in the early stage for adolescence before they start sexual experimentation has positive effect on their practicing abstinence and delaying initiation of sexual activity. Reproductive health education seeks both to reduce the risks of potentially negative outcomes from sexual behaviour like adolescent pregnancy and abortion, STIs and HIV/AIDS; and to enhance the quality of health status by encouraging positive behaviours, and ability to make responsible decisions (Goel, 2014).

Reproductive and sexual health education as an educational experience aimed at developing capacity of adolescents to understand their sexuality in the context of biological, psychological, socio cultural and reproductive dimensions and to acquire skills in making responsible decisions and actions with regard to sexual and reproductive health behaviour. UNESCO and UNPF (1998), in their ‘Handbook for Educating on Adolescent Reproductive and Sexual Health’ suggested the most comprehensive reproductive health and sexual health education programmes not only cover the biology and anatomy of reproduction and sex, but also provide young people with information about dating, boy-girl relationships, marriage and contraception. They help develop the skills necessary to resist peer pressures, inappropriate sexual advances and to attain a level of maturity required to make responsible decisions. They carry lessons
on goal setting and career planning. Attitudes, behaviour and skills to protect them from unwanted pregnancies, STDs, risky sex, sexual abuse, unsafe abortions, as well as development of respect for the human body, sensitivity and equity in gender relations, including respect of women’s self-determination in matters of sexuality and reproduction are key elements of ARSH education. Contemporary reproductive and sexual health education aims to redress these inadequacies, by exploring a broad range of reproductive and sexual health issues that are the reality of today’s adolescent. The rising incidence of teenage sexual activity and its associated risks of pregnancy and disease require much more than simplistic lectures on anatomy and physiology. Attitudes and behaviours must be understood in the context of social structures and influences such as peer pressure, media influence and changes brought on by increasing urbanization and changing family values to name a few (UNESCO and UNPF, 1998).

It is a recognized fact that efficient way to reach to young people particularly adolescents is through schools. Schools could provide a safe place for adolescents to discuss reproductive health issues, get advice and explore non-stereotypical gender roles. Providing reproductive health education in school is an important public health issue, as it concerns not only addressing the reproductive health and psychosocial issues but also encourage interpersonal relationships. Therefore, providing reproductive health education in school contributes to promote better citizenship (Goel, 2014). Moreover, secondary education enrolment in India is more than two-third from 2012 onwards and 73.97 % in 2015 (World Bank, tradingeconomics.com). Hence, it can be assumed that a good no. of adolescents population attending the secondary education, it is feasible to select school as a suitable place to reach adolescents and provide reproductive health education.

Need of the study

As adolescents are an important resource of any country, investing in the reproductive health of adolescent is critical but profitable to achieve the quality of individual health, family well-being, and improving their economic productivity.
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The adolescents are growing up with lack of opportunities for information, skills, health services and support they need to go through healthy sexual development and to make well informed and responsible reproductive choices. Adolescent reproductive health education despite being an effective approach for improving the sexual and reproductive health status of adolescent girls has not made compulsory and accessible to every adolescents. Therefore, in view of the above facts, an attempt has been made in the present study by the investigator to strengthen the quality of reproductive health care among the selected adolescent girls through an educational intervention programme in schools, with the assumption and concretion that scientific knowledge about sexual and reproductive health if disseminated, will expand the vision of adolescents and enable them to make informed decisions on sexual behaviours and prevent in making trial and error experimentation, entail them to clarify their roles and responsibilities towards a healthy sexual and reproductive society.

Operational Definitions

Reproductive Health Education Programme (RHEP)

Reproductive Health Education Programme, abbreviated as RHEP in the present study developed by the investigator, is an educational intervention programme for adolescent girls aiming to improve their reproductive health status by enhancing the knowledge through correct information, changing the attitude by clarifying myths and misconception, and adopting a strategic management for quality practices. The RHEP intervention covers four major domains of the adolescents’ reproductive health namely (i) Pubertal changes and menstruation, (ii) Sexual behaviour and conduct, (iii) Early marriage and adolescent pregnancy and (iv) HIV/ AIDS.

Adolescents Reproductive Health (ARH)

According to WHO, Reproductive health is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system at all stages. Hence, Adolescents Reproductive Health abbreviated as ARH is a state of complete physical, mental and social well-being and not merely the absence of disease or
infirmitry, in all matters relating to the reproductive system of people in the stage of adolescence.

**Adolescents Reproductive Health Knowledge**

Adolescents Reproductive Health Knowledge is a composite indicator or index measuring adolescents’ theoretical or practical understanding of key reproductive health topics and issues.

**Adolescents Reproductive Health Attitude**

Adolescents Reproductive Health Attitude is a composite indicator or parameter measuring adolescents’ opinion which has a tendency to respond positively or negatively towards the key reproductive health issues. Here the “Positive” attitudes are those logically expected to lead to positive reproductive health outcomes and ‘Negative’ attitudes are those logically expected to lead to negative reproductive health outcomes.

**Adolescents Reproductive Health Practice**

Adolescents Reproductive Health Practice is a composite indicator or a determinant or parameter measuring adolescents’ action which has a tendency to have positive or negative consequences while determining the quality of their reproductive health. Here the practice which is logically expected to lead to positive reproductive health outcomes are considered as good quality practice and actions those logically expected to lead to negative reproductive health outcomes are considered as poor quality practice.

**Objectives of the study**

The present study titled ‘Impact of Reproductive Health Education Programme (RHEP) among adolescent girls – an intervention study’ was carried out with the following objectives.

**General Objective**

Enhance adolescents' knowledge and bring desirable changes in their attitude thus to strengthen the quality of practices on reproductive health care
among the selected adolescent girls through a comprehensive reproductive health education programme.

**Specific Objectives**

1. Investigate the level of Knowledge (K), Attitude (A) and Practices (P) on reproductive health among the selected adolescents with the specific dimensions –
   
   i. Pubertal changes and menstruation
   
   ii. Sexual behaviour and conduct
   
   iii. Early marriage and adolescent pregnancy and
   
   iv. HIV/ AIDS

2. Identify the adolescent girls’ sources of information on reproductive health care.

3. Analyze the influences of the socio-demographic status on adolescent’s reproductive health status.

4. Design and provide an intervention on ‘Reproductive Health Education Programme’ (RHEP) for the selected adolescent girls.

5. Measure the effectiveness of RHEP in improving adolescents’ reproductive health KAP status.

**Hypotheses**

H₀1 – The socio-demographic status of adolescents will not have significant influence on their knowledge on reproductive health aspect- pubertal changes and menstruation.

H₀2 – The socio-demographic status of adolescents will not have significant influence on their attitude on reproductive health aspect- pubertal changes and menstruation.
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_H03_ – The socio-demographic status of adolescents will not have significant influence on their practice on reproductive health aspect- pubertal changes and menstruation.

_H04_ – The socio-demographic status of adolescents will not have significant influence on their knowledge on reproductive health aspect- sexual conduct and behaviour.

_H05_ – The socio-demographic status of adolescents will not have significant influence on their attitude on reproductive health aspect- sexual conduct and behaviour.

_H06_ – The socio-demographic status of adolescents will not have significant influence on their practice on reproductive health aspect- sexual conduct and behaviour.

_H07_ – The socio-demographic status of adolescents will not have significant influence on their knowledge on reproductive health aspect- early marriage and adolescent pregnancy.

_H08_ – The socio-demographic status of adolescents will not have significant influence on their attitude on reproductive health aspect- early marriage and adolescent pregnancy.

_H09_ – The socio-demographic status of adolescents will not have significant influence on their practice on reproductive health aspect- early marriage and adolescent pregnancy.

_H010_ – The socio-demographic status of adolescents will not have significant influence on their knowledge on reproductive health aspect- HIV / AIDS.

_H011_ – The socio-demographic status of adolescents will not have significant influence on their attitude on reproductive health aspect- HIV / AIDS.

_H012_ – The socio-demographic status of adolescents will not have significant influence on their practice on reproductive health aspect- HIV / AIDS.
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$H_0^{13}$ – The RHEP would not have any significant impact on adolescents’ knowledge, attitude and practice on reproductive health aspect - pubertal changes and menstruation.

$H_0^{14}$ – The RHEP would not have significant impact on adolescents’ knowledge, attitude and practice on reproductive health aspect - sexual conduct and behaviour.

$H_0^{15}$ – The RHEP would not have significant impact on adolescents’ knowledge, attitude and practice on reproductive health aspect - early marriage and adolescent pregnancy.

$H_0^{16}$ – The RHEP would not have significant impact on adolescents’ knowledge, attitude and practice on reproductive health aspect - HIV / AIDS.