Adolescents comprise a major part of reproductive group. They are likely to play a significant role in determining the future size and growth patterns of India’s population. Girls in the stage of adolescence need special care particularly in shaping their health and wellbeing because they face significant risks related to sexual, reproductive health and may lack the knowledge and power to make informed sexual and reproductive choices.

The present study on Reproductive health of adolescent girls in Chittoor district aimed to assess Common Health Problems (CHP), Chronic Health Problems (ChHP) and Reproductive Health Problems (RHP) of adolescent girls. In addition Knowledge of Adolescent Girls on Reproductive Health and Family Welfare Services was examined. The study focussed on the role of demographic variables such as locality, age, residence, religion, caste, ordinal position, type of family, number of children in the family, parent’s education, parent’s occupation, income levels and Socio Economic Status (SES) of the family etc on Reproductive health of Adolescent girls and their Knowledge on Reproductive health issues and Family welfare services.

The following objectives were formulated

1. To explore the Common Health Problems (CHP), Chronic Health Problems (ChHP) and Reproductive Health Problems (RHP) among Rural and Urban Adolescent Girls of 12-17 years residing in Hostels and their Homes.
2. To assess the Knowledge of selected Adolescent Girls (AG) on Reproductive Health (RH) and Family Welfare Services. (FWS)
3. To examine significant difference between selected Rural and Urban Adolescent Girls of different age groups residing in Hostels and their Homes with reference to different Health Problems and Knowledge on Reproductive Health Issues and Family Welfare Services.
4. To explore the impact of demographic variables on Health Problems and Knowledge on Reproductive Health Issues and Family Welfare Services among selected Adolescent Girls.
5. To study the association between Health Problems and Knowledge on Reproductive Health Issues and Family Welfare Services of selected Adolescent Girls.
The null hypotheses formulated for the present study are given below

1. Rural and Urban Adolescent Girls of 12-17 years residing in Hostels and their Homes do not suffer from any Health Problems such as Common Health Problems (CHP), Chronic Health Problems (ChHP) and Reproductive Health Problems (RHP).
2. Adolescent Girls have poor Knowledge on Reproductive Health (KRPH) and Family Welfare Services (KFWS).
3. There is no significant difference between Rural and Urban Adolescent Girls of different age groups residing in Hostels and their Homes with reference to Health Problems and their Knowledge on Reproductive Health Issues and Family Welfare Services.
4. Demographic variables have no impact on Health Problems and Knowledge on Reproductive Health Issues and Family Welfare Services of Adolescent Girls.
5. There is no association between Health Problems and Knowledge on Reproductive Health Issues and Family Welfare Services of selected Adolescent Girls.

Three stage stratified random sampling method was used for selecting the adolescent girls for the present study. In the first stage Ten Mandals consisting of Five rural and Five urban Mandals were selected randomly from 66 Mandals of Chittoor District of Andhra Pradesh. In the second stage one High School and One Junior College were selected randomly from each of the selected 10 Mandals. Therefore, 10 High Schools (5 Rural High Schools and 5 Urban High Schools) and 10 Junior Colleges (5 Rural Junior Colleges and 5 Urban Junior Colleges) were selected from 10 Mandals. In the third stage from each Mandal 100 subjects consisting of 50 Adolescent Girls of 12-14 yrs and 50 Adolescent Girls of 15-17 yrs were randomly selected from each High School and each Junior College respectively (50 + 50 = 100). Thus from 10 High Schools and 10 Junior Colleges selected from 10 Mandals 1000 Adolescent girls in the age group of 12-14 yrs (N=500) and 15-17 yrs (N=500) were randomly selected.
The following research tools were selected to collect relevant information

- Interview Schedule on Reproductive Health of Adolescent Girls (ISRHA)
- Narayana Rao’s Socio Economic Status Rating Scale (SESRS – Revised, 2006)

Thus the above tools were administered to all the selected One thousand Adolescent Girls individually. The collected data was pooled and tabulated and subjected to appropriate statistical techniques viz., Mean, Standard Deviation, Chi Square test, t-test, ANOVA and Co-efficient of Correlation.

5.1 Major findings

1. Majority of the Adolescent Girls (AG) frequently experienced Common Health Problems (CHP) like constipation, dandruff and hairfall and oral health problems such as tooth ache and bleeding gums. Sometimes they suffered from common ailments like fever, body pains and cough and cold. On contrary AG reported that they rarely experienced the problems of acidity, piles, swelling of body parts, knee pain, giddiness etc.

2. Area of living, age and residence had a significant role on Common Health Problems. CHP are mostly found among Rural adolescent girls compared to those from Urban area. It is also observed that girls during Early adolescents (12-14 yrs) reported more CHP than Late adolescents (15-17 yrs). Further adolescent girls residing in Hostels experienced more CHP than adolescent girls residing at Homes with their families.

3. Anaemia was found in 70% of selected Adolescent Girls (AG). This health problem is mostly found among adolescent girls hailed from Urban area, belonging to 15-17 yrs of age group and those who were residing in Hostels.

4. Age of the subjects played a vital role on Reproductive Health Problems (RHP). RHP such as back pain, lower abdominal pain, white discharge, breast pain etc were reported by majority of the subjects. The signs and symptoms of RHP were mostly found among Rural adolescent girls of younger age group (12-14 yrs) and those who were residing in Hostels.
5. Area of living had dominant influence on Knowledge of adolescent girls on Reproductive Health Issues (RHI). Rural adolescent girls were found to have more knowledge on RHI compared to Urban adolescent girls. No significant difference was noticed between AG of different age groups and those residing in Hostels and their Homes. Knowledge on types of contraceptives for men and women was found to be moderate (57%) and high (15%) among adolescent girls. Rural adolescent girls of lower age group residing in Hostels had less knowledge in this area.

6. Regarding Socio Economic Status (SES) it was found that majority of the Rural adolescent girls hailed from Low SES.

5.2 Other Salient findings

7. Majority of the adolescent girls (74%) hailed from nuclear family pattern.
8. Adolescent girls selected for the present study were mostly middle born children (38%).
9. Small family norm was observed among 90% of the subjects. 57% of them had only one sibling.
10. Mothers of adolescent girls (22%) were mostly illiterates compared to fathers (18%).
11. 60% of mothers of adolescent girls were unemployed. Majority of the fathers (71%) and mothers (36%) of the subjects were employed as agricultural labourers on daily wages. Parents employed as job holders on salaried jobs were comparatively low (Father 29%, Mother 4%). Association was found between parents occupation and health status of AG. Reproductive health problems were high among AG whose fathers were employed as agricultural labourers. Better the occupation better the reproductive health status. Regarding knowledge on family welfare services association was found with father’s occupation. Similarly chronic health problems were more among adolescent girls whose mother’s were job holders.
12. Majority of the adolescent girls were found to be from High income group (60%). Rural adolescent girls were lower in this category compared to Urban adolescent girls. 25% of rural adolescent girls were from low and middle income levels (below Rs.20,000/- per month), where as 15% of Urban adolescent girls belonged to this income levels (below Rs.40,000/- per month). Adolescent girls of lower age group
and those who are not residing in Hostels were mostly from High income level. Levels of income had strong association with the Knowledge of adolescent girls on Reproductive health issues and Family welfare services. Adolescent girls from high income group had high level of Knowledge compared to low income group.

13. Observation of heights and weights of adolescent girls revealed that majority of them were normal. 19% of the AG were under weight of which majority of them belonged to Urban area (12%), low age group (14%) and were attending schools and colleges as day scholars (16%). Weight of the adolescent girls had no association with their Knowledge on Reproductive health issues and Family welfare services.

14. Regarding knowledge of adolescent girls on Reproductive health issues it was found that 20% of the subjects were accurately aware of age of Menarche which is between 11-13 yrs. It was evident that most of the adolescent girls (80%) were not aware of exact age of Menarche. 49% of the AG were aware that Sexual maturity is a normal process of growth, Maturation is a normal physiological process (16%) and the main cause of Menstrual bleeding is due to hormonal influence on endometrium (11%).

15. Adolescent girls believed that the blood discharged during Menstrual bleeding was impure (27%) which is a wrong notion. Subjects selected for the present study were well aware of Premenstrual symptoms, Normal duration of menstruation, Care to be taken during menstruation, Ideal age for marriage, Need for treatment for reproductive health problems, Consequence of early marriage etc.

16. Ignorance of AG in the area of Reproductive health issues was noticed with reference to Amount of blood loss during menstruation (53%), Period of release of ovum (85%), Ideal period for conceiving (80%) and Measures of safe pregnancy (77%). 89% of adolescent girls reported that HIV / AIDS was the only Sexually Transmitted Disease.

5.3 Implications

Adolescent girls’ health needs encompass reproductive and general health involving the intricately related aspects of mental, emotional and social wellbeing. Empowering adolescent girls in India requires a systematic programme addressing the different cornerstones that promote empowerment.
Although India has one of the fastest growing youth populations in the world, its gender disparities pose significant barriers for the future of girls. Adolescence represents a critical stage of transition from childhood to maturity. The physical and emotional experiences, knowledge and skills acquired during this phase have important implications during adulthood.

The most obvious recommendation is the need to expand informed choices among girls and women. Short and long term strategies, multisectoral changes and changes at the level of individual women, their families and service providers are required. Short term strategies that have had some success are programmes aimed specifically at mobilizing girls and women, informing them of their rights, enabling them to exert a voice in family affairs and creating in them a feeling of entitlement to health care and other services. They should be encouraged to draw up a clear plan of action in case of an emergency, which will cover health care.

Information campaigns are required that highlight the advantages of appropriate diet, rest and care during adolescence. Greater community involvement is required to identify and screen adolescent girls with reproductive health problems. Community involvement is needed to facilitate physical access to health services and make these services more accountable.

Adolescent girls’ health can be improved through four main actions which are (a) Disseminating sex education- the patterns of sexual behavior and health seeking behavior established during adolescence set the stage for adult health. Healthy sexual behaviors, delaying the start of sexual activity, negotiating within sexual relationships and protecting against unwanted pregnancies, HIV/AIDS and STIs are fundamental to good sexual and reproductive health over many decades. (b) Providing nutritional supplements- anaemia or iron deficiency is a significant burden on young women’s reproductive health leading to lower productivity, complications during childbirth and malnourished children. Given that anaemia is prevalent among girls in India and the young ages at which girls get married, iron supplementation and nutrition education are essential. (c) Fostering menstrual hygiene- the onset of menstruation can be a confusing time in a girls’ life because of hormonal changes, cognizance of the bodies’ reproductive
function as well a shift in day to day behavior. Awareness of menstruation and hygiene are thus crucial to facilitate young women’s understanding of their own bodies. Preventing violence against girls- younger women are at a higher risk of physical or sexual abuse than older ones, making this a critical health challenge for adolescent girls. Gender based violence has a clear link to mental health.

Adolescent girls are also particularly vulnerable in India’s urban slums with their poor infrastructure, breakdown of traditional family structures, increased risk of violence and low access to sexual and reproductive health services.

Several central government policies had themes relating to adolescent girls’ lives in sectors such as education, health and women’s empowerment. However, policies specifically safeguarding the needs of adolescents were largely absent. Adolescent girls have systematically been considered a subset of larger groups such as women or children. Health and nutrition interventions formulated in National Health policy are targeted at adolescent girls as a subsidiary group of women who are mothers or pregnant, without taking into account the specific support needs of adolescent mothers.

Adolescent girls have been considered as sub groups in the formulation of nutrition, education and domestic violence policies. Providing reproductive health services to empower adolescent girls has now received Government attention. Adolescent Girls’ empowerment programs should consider developmental needs such as health education and life skills education as equally important. Efforts to enact legislation safeguarding adolescent girls have also been set back by a shortage of funds and lack of coordination between different government bodies.

Parents as well as teachers should be sensitized on issues of reproductive health, role of personal hygiene and environmental sanitation in maintaining the healthy atmosphere. A holistic approach should be adopted which should focus on broader range of health issues and sexual, reproductive health information.

Rapid population increases and urbanization places pressure on national health education and social infrastructure further reducing access to basic needs. Urbanization and population growth also have dramatically altered traditional cultural and family
structure that in many cases provided clear norms regarding reproductive and sexual behavior.

Advocating increasing awareness of and support for effective programs and policies is essential to the success of any adolescent reproductive health effort. Programs that have partnered with male cultural leaders or traditional indigenous institutions have effectively promoted activities that address adolescent sexual reproductive health and prevention of HIV.

Adolescents can be involved at all the stages of program development, implementation, and evaluation. Reproductive health programs for adolescents girls tend to be most successful when they accurately identify and understand the group to be served, involve adolescents in the design of the program, work with community leader and parents, remove policy barriers and change providers’ prejudices, help adolescent rehearse the interpersonal skills needed to avoid risks, link information and advice to services, offer role models that make safer behavior attractive and invest in long enough time frames and resources.

Youth friendly reproductive health services are ones that are developed and provided in a way that recognizes that the challenges, difficulties, and obstacles facing adolescents are very different than those confronted by adults. Adolescents generally are less informed, less experienced, and less confident about sexual matters and their own abilities than adults. Specialized approaches are needed to attract, serve, and retain adolescents as reproductive health clients. These include having appropriately trained providers who can address adolescents’ specific biological, psychological, and health needs, respect for adolescents’ privacy and confidentiality, accessible facilities and convenient location, reasonably priced services, flexible hours and an environment that feels appropriate and comfortable for all adolescent populations, including groups such as young men or married adolescents.

Adolescent Girls need age-appropriate information about physical and emotional development, the potential risks of unprotected sex, substance abuse, how to access health services, and educational, vocational, and recreational opportunities. Effective programs use multiple approaches to disseminate reproductive health messages including
mass media, interpersonal communication, and community mobilization. Programs have been most successful when information and education are provided interactively and are linked to services.

Educating young adolescents about reproductive health and helping them develop life skills can be especially effective strategies for safeguarding their sexual health and well being. Combining age appropriate sexual health information with activities to help develop communication and negotiation skills can help adolescents who are not already sexually active to delay the onset of sexual activity. Life skills education can develop adolescent girl’s ability to reduce specific health risks and adopt healthy behaviors that improve their lives in general. Bringing services to hard to reach adolescent girls requires special planning and advocacy efforts. Because of adolescents’ cultural, social and geographic diversity, reproductive health programs based in schools and health facilities cannot reach all segments of the adolescent population.

School based sexuality education can be an efficient way to reach young girls and their families with reproductive health education. Age appropriate sexuality education should begin in early elementary school when children are 5-8 yrs old and should continue through adolescence. Courses should be taught by trained teachers.

Programmes need to be aware that adolescents are not a homogeneous group but a very diverse one with needs that differ according to age, religion, socio economic status and gender. The identification of various needs should be done using a participatory approach and must reflect the views of adolescents themselves. Programmes must promote consensual and respectful sexual behavior in adolescent girls while advising them on health risks and consequences of unprotected sex. It should promote accurate and easily comprehensive information in order to enable adolescents to make informed decisions and choices. There has to be an acknowledgement of different sexual behaviors, thereby preventing the creation of a false hierarchy of heterosexuality over homosexuality in adolescents’ minds. Programmes must provide information free from values, morality and judgment thereby enabling them to make choices based on their own decisions. They must promote understanding of gender and sexual diversity and equality.
Regarding the quality of health care from the perspective of individual adolescent girls a number of questions need to be addressed. How do Adolescent Girls perceive the available Reproductive health services and how can these services be delivered in ways that are sensitive to a cultural milieu that inhibits them from expressing reproductive health needs or seeking health services? What is the quality of service provider-client interaction in the area of Reproductive health? How have girls and women’s perceptions of health care services affected their utilization? A multi pronged effort is required: (a) it is important to raise community awareness of the harmful health consequences of early marriage and pregnancy and the legislation prohibiting marriage for girls under 18; (b) given the intractable nature of gender inequities and early marriage and pregnancy, it is important in the short run to address nutritional deficiencies among adolescent girls by providing them iron and folic acid and other nutritional supplementation; (c) equally important are efforts that break the cycle of vulnerability and powerlessness in adolescence itself. Various government and NGO programmes that aim to develop life skills and expand life options among adolescent females need to be strengthened; (d) pregnant adolescents are an extremely vulnerable group, with little power to make decisions or seek care: service providers have to be sensitive to these cultural constraints, on the one hand and their health risks, on the other.

_Investing in an educated, healthy, skilled and empowered girl today means she will have the tools to reinvest back into her family, her community and our world_