Introduction
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Concern for the health of mother and child is both a matter of moral responsibility and a prerequisite for development of the nation in the economic, social and political fields. It used to be thought that economic development led automatically to improved health conditions, but experience has demonstrated that this is not necessarily so.

In spite of the fact that United Nation Organization has given safe motherhood great attention, maternal mortality still remains a matter of great concern in developing countries where it accounts for 25% of all deaths among women of child bearing age as reported by SAARC (1988).

Infant mortality rate is a sensitive indicator of a country's development. The same has declined from 200/1000 live births in the beginning of the century to 90/1000 live births today (UNICEF, 1984). It is also reported by the same organization that out of 22 million low birth weight children born, 21 million are in developing countries.

When the attention is focussed on some common modalities existing in the developed countries for high mortality statistics of early life, it appears that maternal malnutrition is a significant contributor along with other ethnic, genetic and socio-economic differences. The poor environment always coexists.

Population figure for adolescents (10-19 years) in India is at present 22.5 percent. The distribution of rural and urban population of adolescents is 78.4 percent and 21.6 percent respectively. But Raman (1990) has extrapolated the figures and commented, that by 2001, the adolescent population would have increased to 9.72 crores of which atleast 1/3 rd will already be married before the
age of 19. Almost 30-40% of the infants born to them may not even see the external world for more than one month after birth.

The 1981 census figure indicates the mean age at marriage in the country as a whole is 16-17 years. It is estimated that 80% of marriage of rural girls are held between the ages of 10-14 years and 44% of girls in the age 15-19 years age group. Further, about 43% of female deaths are of girls between 15-20 years of age. The immaturity of the reproductive organs before eighteen is the cause for high mortality in this group. Unfortunately, this group has been grossly neglected in the national context and only in recent years there has been surge of interest on this age group.

The younger the woman at the time of marriage, the more are the children she has at the end of reproductive years. It has been reported by SAARC (1988) that by the year 2000, there will be 68% more women in the age group of 15-44 years. This is the population who will get married early under the influence of sociological and psychological factors. Also areas where high female illiteracy is prevalent, early marriage is a rule.

Majority of women in this country enter the conceivable age group undernourished as reflected by their poor body weight for their age. About 10% of girls become mothers even before they have completed the development of their skeletal and reproductive system development. About 50-80% mothers suffer from anaemia due to iron deficiency. Anaemia is found to aggravate the complications of pregnancy. About 30-40% of new borns have low birth weight mainly due to maternal anaemia and malnutrition.

In recent years, the relationship of women’s stature with birth weight of offspring and maternal mortality has been deriving greater attention. In this context, adolescent pregnancy, according to WHO fall into high risk category i.e.
they are likely to suffer obstetric complications and give birth to offsprings of low birth weight. Discrimination against the girl child especially in the distribution of food in the family accompanied by early marriage are also responsible for poor adolescent growth.

With the mandate of "Health for All" by 2000 A.D. and aim of reducing the infant mortality to minimum target, it becomes essential that factors responsible for Infant Mortality Rate are corrected to achieve this goal. Of the nutritional determinants, maternal influences is the most important factor, especially the negative consequences for women who bear children during the adolescent years. Thus it is important to know the health and nutritional status of this group to take up corrective actions in time to prevent high mortality and morbidity. Pregnancies which do not result in live births represent wastage of various resources in terms of food and finance and more importantly the depletion of maternal nutritional stores.

A thorough scan of the available literature reveals that there are evidences for rural and urban differences in the study of adolescent population as a risk factor. There is also some literature available on the differences existing in menarcheal age, age at marriage etc. in different states. But literature is scanty regarding the differences in nutritional status of the adolescent population in north and south and also among migrant and non migrant population. In a cosmopolitan place like Bombay, where there is a mixed population, percentage of migrants is higher. It is not known how the urban slum population compare with a non migratory population as in Bangalore, who are more bound by socio-cultural pressures and traditions and where joint families is the trend and whether any differences exist in the incidence of teenage pregnancy and the outcome in these two areas.
The purpose of the present study therefore was to contribute to the rapidly growing body of knowledge concerning the health and nutritional status of socio-economically disadvantaged pregnant adolescent girls and the outcome of their pregnancies, with the following specific objectives in mind:

1) To study the prevalence of teenage pregnancy in low income group.

2) To study the previous nutritional status of the adolescent girls and its effect on their obstetric performance.

3) To assess the gynaecological and obstetric problems including pregnancy wastage in the adolescents and adults.

4) To assess the dietary and biochemical status of the adolescent mothers and their relationships with the outcome of pregnancy.

5) To plan and conduct nutrition counselling to the target population of adolescent girls.