CHAPTER -1

INTRODUCTION

Adolescence is the most dynamic, fascinating, and impressionable period with complex transitions in one’s life. The word “adolescence” is derived from the Latin word meaning ‘to grow in to maturity’. This period is identified with dramatic physical changes with the development in a person’s psychology, cognitive, and social changes (Nair, 2004, www.answers.com, 2006).

WHO (2000) defines adolescent period both in terms of age (spanning the age between 10 and 19 years) and in terms of phase of life marked by special attributes.

The adolescent population is the fastest growing age-group than of any other age groups. One in every five people in the world is an adolescent. Out of 1.5 billion adolescents world-wide about 80 percent live in the industrialized area (The World’s Women, 2000). In India, as per the census (2001) there are 1,027,015,247 persons, out of which 22.5 percent are adolescents. Adolescent girls in India account for 12.1 percent in 10 to 14 years and 10.5 percent in 15.19 years.

The years from 10 to 19 are rich in transition and this critical transitional period characterized the total socio-economic dependence to relative independence as adults. Independence brings responsibility and social pressure, which modifies their life-style drastically. In the rapidly changing urban environment, young people derive most of their information about the world from their peers and mass media. In addition to the impact of growth and development, eating practices affect young people’s risk for a number
of immediate health problems. The family no longer dictates its life-essentials and it has specific needs pertaining to its dietary practices during adolescence and long-term health implications. The problems get compounded for an adolescent who lives in remote rural and tribal area and not pursuing school education (Dhar, 2006).

Due to various social taboos, ignorance, and psycho-social pressures, adolescent girls form a vulnerable group. They are systematically deprived in terms of education, health, food, nutrition, and employment (Dutta, 2004). Social discrimination against women results in systematic neglect of women’s health from womb to tomb. Girls often face discrimination right from the moment they are born in some cases even before they are born. Particularly in India, baby-girls are likely to be breast fed for a shorter time, given less nutritious food, and provided with less health care. During childhood, those girls who are able to attend school may be with-drawn early to help with household tasks, looking after younger children, fetching water, and fire wood, and preparing meals. The heavy loads combined with poor nutrition take a heavy toll on their bodies (Nicol, 1999, Thangamuthu and Rasi, 2002).

Existing literature on adolescent eating patterns showed the faulty food habits with inadequate nutrient intake in terms of less food and food with a lower nutrient density (Allen, 2003). They mainly consume cereal-based food but grossly deficit in legumes, animal foods and green leafy vegetables. As a consequence nutritional deficiencies are wide spread both in low income groups of rural and urban area (Begum, 2001, Gupta and Prithivirajsen, 2000).

Adequate nutrition is an indicator of good health. During adolescence an individual’s total nutrient need reaches the highest point in the life cycle, and, especially, more concern for girls as it is an important determinant of growth-spurt and poor-nutrition is often cited as a major reason for the delay in the onset of puberty of Indian adolescents.
One of the main causes of female under nutrition is gender discrimination. India being the largest incidence of having malnourished girls, high prevalence of anaemia, and other nutritional deficiencies which increases the risk factors during pregnancy and child birth.

Low socio-economic status compounds the problem of under nutrition with consequent effects on height and weight. It is estimated that 35 percent of rural girls of 17 years of age have weight below 38 kgs and 23 percent have heights below 145 cms. The young girls who grow poorly become stunted women and are more like to give low birth weight babies. Since, a smaller pelvis can prolong labour, obstruct delivery, and also pose serious risks leading to injury or death of mothers and their new born (Konje and Ladipo, 2000).

Healthy eating is important at this stage of life due to rapid growth and development. Eating habits are formed early in one’s life will most likely to carry into adulthood. Since, the long-run eating habits are associated with food intake may have implications for the later development of non-communicable diet related diseases like hypertension, diabetes, heart diseases, kidney diseases and cancer during adult phase (Croll, et al., 2001).

Previous studies carried out by nutritional experts during the last 30 years indicate that still the nutritional and health situation today is not much better. Adolescent eating practice and knowledge on healthy foods should be monitored. A study related to nutrition perception and knowledge regarding healthy eating shows that there is a need for providing intensive nutrition education in order to improve their health status. Adolescent health plays an important role in determining the health of future population, since they are considered to be potential mothers, future homemakers, and hold the key to the future (Gopalan, 2000). This discouraging nutritional scenario have direct and indirect negative influence on their health.
Adolescent girls health is not merely a personal or familial challenge, but a social and national challenge. Progress of a nation can be measured by the progress of the women (Bhatia, et al, 2004).

Realizing the situation of adolescent girls, they are being addressed in Government Programme at national level, mainly through the Reproductive and Child Health (RCH) Programme (under the Ministry of Health and Family Welfare) and Integrated Child Development Services (ICDS) (under the Department of Women and Child Development). Both seem to have a tunnel focus, viewing the adolescent girls as future parents or preparing them for adulthood rather than addressing their immediate concerns as adolescents.

ICDS remains the World’s most Unique Early Childhood Development Programme, which has brought about a deserving transition from a welfare orientation to a new challenging perspective (Joshi, 2000).

The emerging profile of ICDS shaped by a quarter of a century of rich experience, signifies a renewed commitment to the Gandhian vision of reaching out to the most deprived in society. It was launched in 33 blocks, today having expanded to 4348 community development blocks, reaching out to 26.85 million young children, 5.07 lakh adolescent girls and 5.3 million pregnant / nursing mothers through network of over 5 lakh Anganwadi centers and more than one lakh Mahila mandals, ICDS is an initiative unparalled in history (Mahajan, 2000).

ICDS plays a nodal role for the advancement of women and children through implementation of certain innovative programmes. All these are directed to ensure that women are empowered both economically, socially, and thus become equal partners in national development along with men (Ramachandran, 2004).
The beneficiaries of this programme are children under 3 years, 3 years to 6 years children, expectant mothers, nursing mothers and adolescent girls. The package of services delivered at Anganwadi centers are growth-promotion, selective supplementary nutrition, early childhood and pre-school education, health services by health personnel, nutrition and health education and referral service.

Component of adolescent health that has been included in ICDS programme in over 2000 ICDS projects since 2000-01 all over the country showed successful results from 507 experimental projects. The present model of adolescent health programme in ICDS needs explicit focus on the communication needs of adolescent girls on vital areas of reproductive health, literacy, behaviour change, and adoption of healthy life styles apart from vocational skills. The beneficiaries of this scheme will receive the services of immunization, referral services, prophylaxis measures against anaemia, goitre, nutrition and health education, and life-skills training.

Anganwadi centre is the focal point for delivering of ICDS package of services. Anganwadi worker at grass root level plays a vital role in delivering the adolescent girl’s scheme. To keep pace with the time and newer developments, the job functions of Anganwadi worker and other functionaries have been redefined to enrich the job and make these more relevant to the needs and aspirations of women and children. The new job responsibilities are strengthening of advocacy, communication, social mobilization of survival protection, health and nutrition education to adolescent girls, and improving quality of service-delivery and management.

Evaluations of the ICDS have found its impact on nutritional status to be limited. Among the reasons for this are inadequate coverage of children under 3 years of age, poor nutrition education of mothers or families, and inadequate training of workers particularly in nutrition, growth monitoring, and communication.
Anganwadi workers are overloaded, and the unsupportive supervision between the ICDS and health system, top-down management and lack of community ownership have resulted in the neglect of crucial nutrition-related tasks.

The services are much in demand and it has substantial budgetary resources, appropriate strategies and inputs should be identified and provided. Extensive studies were carried out in a few important areas like nutritional status of the children, management of severe malnutrition, providing supplementary nutrition etc. But still there is a lack of studies related to nutrition and health-education package delivered to adolescent girls. Further no monitoring, evaluation or strengthening the activities were carried out to support and upgrade the package. Viewing the present scenario, there is an utmost need to focus and find answers to the queries like how the services are delivered to the adolescent girls? What is the role of Anganwadi workers in this scheme, the constraints faced by them, what are the strengths and weaknesses of the programme? Whether it has impact on nutrition and heath status of the beneficiaries through behaviour modification or not? if unmet, identifying the lacunae, which in turn help to rectify the lacunae in a more effective manner.

The findings of the study may pave way to strengthen the programme in terms of its content, methods and aids, frequency etc., Ultimately, it would improve the delivery system. This may indirectly enhance the knowledge, attitude and practice related to health and nutrition among the adolescent beneficiaries of ICDS.

Keeping the present scenario in the mind the investigator has undertaken this study.
CHAPTERISATION

The thesis is presented in five chapters. Chapter I is “Introduction” which gives the need and scope of the study followed by review of literature in Chapter II. Chapter III deals with the methodology of the study. Fourth Chapter focuses on the data analysis and interpretation and finally, Chapter V sums up the study with its key findings, conclusion and recommendations for follow up.