INTRODUCTION

Everyone has the right to enjoy the reproductive health, which is a basis for having intimate relationships, healthy children and happy families. Reproductive health is a relatively new concept recognizes that especially a young girl has special reproductive health needs before, during and beyond the child bearing age. It also recognizes that reproductive health of the present generation has an impact on the health of the next generation and that both are of crucial importance for socio economic development.

Reproductive health refers to mortality, morbidity and quality of life attributable to the reproductive system, process and events experienced by men and women at all ages (Mahapatra and Latha, 2002). World Health Organization (WHO) has defined reproductive health as a “state of complete, physical, mental and social wellbeing and not merely the absence of reproductive disease or infirmity. Reproductive health addresses the reproductive processes, functions and system at all stages of life. Reproductive health therefore, implies that people are able to have a responsible satisfying safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access of safe, effective, affordable and acceptable methods of fertility regulation of their choice and right of access to appropriate health care services that enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant” (WHO, 2011).

Reproductive health includes sexual health, a condition defined by the World Health Organization as freedom from sexual diseases or disorders and a capacity to enjoy and control sexual behavior without fear, shame, or guilt (Law Carol, 2001). The sexual and reproductive health of women is also related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination (OHCHR, 2015). Thus reproductive health is a crucial part of general health and central feature of human development. It is a reflection of health during childhood and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men and affects the health of the next generation (Kotwal, et.al. 2008). The health of the newborn is largely a function of the mother’s reproductive
health and of her access to reproductive health care. Reproductive health is a universal concern but is of special importance for young girls and women particularly during the reproductive years.

Young people are distinct population group with particular needs and capacities. World Health Organization defines adolescence as 10-19 years old, “Youth” as 15-24 years old and young people as 10-24 years old (WHO SEARO, 2015; Singh and Gururaj, 2014; Shahani Rajiya, 2014). Their numbers have steadily increased in last few decades. According to UNFPA (2014), for the first time, nearly 1.8 billion young people in a world population of 7.3 billion are alive today, than at any other time in human history. According to United Nations Report, with 356 million tend to be in the age of 10 to 24 years old, India has the world’s largest young population despite having small population than China (The Economic Times, 2014). The emergence of a huge population of young people in unprecedented size can have a profound effect on development of the country. Since they represent the well-being of a society and its development potential, this in turn ensures productivity across the life course.

Adolescence is a period of transition through which young people acquire not only new capacities for progress towards adulthood but it is also a time during which rapid physical growth, physiological and psychosocial changes, the development of secondary sexual characteristics and reproductive maturation (Shahani Rajiya, 2014).

The transition from childhood to adulthood is a critical stage of human development during which young people leave childhood behind and take on new roles and responsibilities of adulthood. It is a period of social, psychological, economic, and biological transitions, and for many young people it involves demanding emotional challenges and important choices. Unfortunately, young people worldwide face social, economic and health challenges that was unimaginable (Shahani Rajiya, 2014). To a large degree, the nature and quality of young people’s future lives depend on how successfully they negotiate through this critical period (National Research Council and Institute of Medicine, 2005). Young people become less dependent on parents and more involved with peers. They begin to form self identity and develop further capacity for managing interpersonal relationships. But knowledge and understanding of choices and how young people manage their choices
or relationships are limited. During the time of transition, whatever the decisions that are made by young people affect not only the individual wellbeing, but also the wellbeing of entire societies at large (UNFPA, 2012).

Adolescence in girls has been recognized as a turbulent period which signifies the transition from girlhood to womanhood and considered as a landmark of female puberty. Menarche is the first menstrual period occurs during the period of adolescence and it is a physiological and developmental phenomenon significant in the life of a female. It occurs between the ages of 10 to 16 years with the average age in India being about 12 years (Dambhare, et.al. 2012). It occurs earlier than it once did in many parts of the world. The age at menarche shows many socio-economic, environmental, nutritional and geographical differences in the societies (Dambhare, et.al. 2012). It is a part of the complex process of growing up and further it calls for special attention because of the problems that are associated (Sharma, et.al. 2008). During this phase of growth, the girls first experience menstruation and related problems which is marked by feeling of anxiety and eagerness to know about this natural phenomenon (Singh, et.al. 1999; Tarhane and Kasulkar, 2015). Unfortunately, adolescents are deprived from receiving adequate education, guidance and services that would help them to make smooth transition to adulthood. Additionally, the traditional Indian society discourages open discussion on sexual and reproductive health issues, leading to repression of feelings which can cause intense mental stress and seek health advice from quacks and persons who do not have adequate knowledge on the subject (Singh, et.al. 1999).

Good menstrual hygiene is crucial for the health, education, and dignity of girls and women. This is an important sanitation issue which has long been in the closet and still there is a long standing need to openly discuss it. Most of the time adolescent girls are unprepared – in terms of knowledge, skills and attitudes, for managing the menstrual cycle (Juyal, et.al. 2014).

Menstruation is regarded as unclean or dirty in developing countries like India. Although it is a natural process, is linked with several misconceptions and practices which sometimes results into adverse health outcomes in terms of increased vulnerability to reproductive tract infections (Bobhate and Shrivastava, 2012). The limited knowledge about reproductive health issues make them vulnerable to various diseases and infections including HIV/AIDS/STDs, substance abuse, sexual
violence and exploitation. As a result young people’s reproductive health is an increasingly important component of global health.

Young people are not a homogenous group. They are living in diverse circumstances and have diverse health needs. A large number of them are out of school, get married early, work in vulnerable situations, are sexually active, and are exposed to peer pressure. These factors have serious social, economic and public health implications (Bobhate and Shrivastava, 2011). According to UNICEF global data base 2014, worldwide, more than 700 million women alive today were married before their age of 18 years and more than one in three (about 250 million) entered into union before age of 15 years. Child marriage among girls is most common in South Asia and Sub-Saharan African regions. The 10 countries with the highest rates of child marriage are found in these two regions. Nigeria has the highest overall prevalence of child marriage in the world. However, Bangladesh has the highest rate of child marriage involving girls under age 15. South Asia is home to almost half (42 per cent) of all child brides worldwide. India alone accounts for one third of the global total child marriage (33 percent) and it is in 6th position among the 10 countries with the highest prevalence of child marriage (58 percent) where women aged 20 to 49 years who were married or in union before ages 15 and 18 (UNICEF, 2014). In India, there are nearly half (45%) of women aged 20–24 married before their 18th birthday where as in Karnataka State, there are more than 40% of women aged 20–24 married before the age of 18 years. The proportion of marrying that early is as high as 60–61% in the states of Bihar and Jharkhand, but as low as 12% in the states of Himachal Pradesh and Goa (Moore et.al. 2009). In Karnataka state, North Karnataka regions lead in the percentage of child marriage. According to core committee report on prevention of child marriages in the state of Karnataka (2011), an alarming 45% to 68% of children were being married off before they attain the age of 18 years in nine districts of North Karnataka; Belgaum, Bidar, Bijapur, Bagalkot, Bellary, Gadag, Dharwad, Raichur and Koppal.

Along with child marriage, onset of sexual activity before the age of 18 years indicates that there is growing evidence of premarital sexual activity among adolescents and youth. Consequent to early marriage and sexual acts, childbearing is initiated early and multiple pregnancies characterise the life of many young girls and women (Jejeebhoy and Santhya, 2011).
Early childbearing or teenage pregnancy rates vary between countries because of differences in the levels of sexual activity, general sex education provided and access to affordable contraceptive options. Worldwide, teenage pregnancy rates range from 143 per 1000 in some sub-Saharan African countries to 2.9 per 1000 in South Korea (Saba et.al. 2013). Most of the World’s births to teenagers i.e. 95 percent occur in the developing world and the overwhelming majority of these births i.e. 90 percent occur within marriage or a union. About 19 per cent of young women in developing countries become pregnant before age 18. Girls under 15 account for 2 million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries (UNFPA, 2013). In India, One in five young women aged 20–24 had their first baby before they were 18 years of age (Jejeebhoy and Santhya, 2011). Data on childbearing by an adolescent’s 18th birthday shows that 22% of all Indian young women have already given birth by 18 years of age and it is 12% in urban areas, but it is double (26%) in rural areas. The ten states of India i.e. Jharkhand, Bihar, Andhra Pradesh, West Bengal, Arunachal Pradesh, Uttar Pradesh, Chhattisgarh, Assam, Madhya Pradesh and Karnataka already stood out for having higher-than-average levels (22%) of childbearing before the age of 18 years, ranging from 23% in Karnataka State to 37% in Jharkhand State (Moore, et.al. 2009).

The factors that contribute to teenage pregnancies may include customs and traditions that lead to early marriage, adolescent sexual behaviour which may also be influenced by alcohol and drugs, lack of education and information about reproductive sexual health including lack of access to tools that prevent pregnancies, peer pressure to engage in sexual activity, incorrect use of contraception, sexual abuse that leads to rape, poverty, exposure to abuse, violence and family friction at home, low self esteem and low educational ambitions and goals (UNICEF, 2008). In developed countries, teenage pregnancies are associated with social issues including lower educational levels, higher rates of poverty, and other poorer life outcomes in children of teenage mothers (Saba et.al. 2013). In developing countries, teenage pregnancies are often within marriage and their pregnancies are welcomed by family and society. There is also a social expectation to have a child soon after marriage (Acharya, et.al. 2010).

Girls bearing their first baby between the ages of 14-18 are at obstetric risk and the subsequent result is low birth weight babies and prenatal complication
common among teenage girls (Patel, 2007). Young girls are vulnerable due to their lower educational status and inability to negotiate on issues related to reproductive and sexual health (Kumar and Kumar, 2009; Patel, 2007). Reproductive health problems remain the leading cause of ill health and death for women of childbearing age worldwide. Impoverished women, especially those living in developing countries, suffer disproportionately from unintended pregnancies, maternal death and disability, sexually transmitted infections including HIV, gender-based violence and other problems related to their reproductive system and sexual behaviour. Because young people often face barriers in trying to get the information or care they need (UNFPA, 2012).

According to UNICEF (2011), approximately five million young people aged 15-24 in the world are living with HIV. Young people aged 15-24 represent 41 percent of all new HIV diagnoses, and 890,000 acquire HIV each year and at least 95 percent of all new HIV cases occur in low and middle income countries. Sub-Saharan Africa region is badly affected with HIV where nearly 76 percent of young people are living with HIV. Young women are more vulnerable to the HIV epidemic than are men; young women comprise 60 percent of all young people with HIV (Edwards and Peterson, 2013; UNICEF, 2011). Between 2001 and 2011, HIV prevalence fell by nearly 27 percent among young people aged 15-24 globally. The decline was driven by changes in sexual behavior patterns, including increased use of condoms (Edwards and Peterson, 2013; UNAIDS Outlook Report, 2010). In India, 11 percent of young men and 5 percent of young women aged 15–24 had engaged in pre-marital sex during adolescence, that is, before age 20. The disproportion is noticeable between rural and urban young women. The rural young women are twice as likely (6% versus 3%) to have experienced pre-marital sex during adolescence as compared to their urban counterparts. Where sexual relations take place, they are often unsafe and for many young women, unwanted or forced. According to Youth Study report, 25 percent and 21 percent of sexually experienced unmarried young men and women respectively had engaged in sex with more than one partner. With regard to condom usage, 27 percent of young men and 7 percent of young women had ever used a condom, and even fewer, 13 percent young of men and 3 percent of young women had used a condom consistently. Moreover, 18 percent of the young women and (3% of the young men) had been forced to engage in sex (Jejeebhoy and Santhya, 2011).
Reproductive morbidities are the major causes for maternal death. Reproductive morbidity has defined as any condition or dysfunction of the reproductive tract, or any morbidity which is a consequence of reproductive behaviour including pregnancy, abortion, childbirth, or sexual behaviour (Tehrani et.al. 2011). It normally affects the quality of life of girls and women. There are three categories of reproductive morbidities such as obstetric, gynecological and contraceptive morbidity. Gynecological morbidity has been defined as 'any condition, disease or dysfunction of the reproductive system that is not related to pregnancy, abortion or childbirth but may be related to sexual behaviour (Mbu et.al. 2008; Rahman et.al. 2004). Obstetric morbidity is defined as “morbidity in a woman who has been pregnant (regardless of site or duration of the pregnancy) resulting from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (Sontakke et.al. 2009). Contraceptive morbidity refers to health problems caused by use of specific contraceptive methods such as intrauterine device (IUD) insertion and unhygienic sterilization (Chellan, 2015).

A majority of girls in India are suffering from either general or reproductive morbidities due to socio-economic and environmental conditions. These factors make them more vulnerable to health risks especially of reproductive morbidities. If reproductive problems are not treated early, these could lead to various disabilities and consequently, affect their valuable lives (Balasubramanian, 2005). Varying proportion of reproductive morbidity was reported by different studies ranging from 22.0 percent to 92.0 percent (Rahman et.al. 2004; Wasscher et.al. 1989; Bang et.al. 1989; Kambo et.al. 2003). The vast majority of the adolescents have been suffering from either one or the other reproductive morbidity. This high prevalence of reproductive morbidity is certainly disabling young women in the community under study, who are mostly less literate having low socio-economic status. This high prevalence of morbidity raises great concern about women’s physical and social well being which causes physical discomfort, personal embarrassment, marital discord and also problems of women’s ability to achieve a sustained marital satisfaction (Rahman et.al. 2004; Wasscher et.al. 1989). There has been increased recognition of the scope and significance of gynaecological problems experienced by women in recent years. The first and perhaps the most compelling evidence on the importance of gynaecological morbidity came from a community-based study undertaken in rural
Maharashtra, India in the mid-1980s (Latha et al. 1997). A study was conducted by Bang et al. (1989) in rural India surprisingly found a high prevalence of gynaecological morbidity of 92 per cent. Both men and women in developing countries with low level of education and lack of health information, especially about personal hygiene promote misconceptions about many illnesses and limit preventive practices that lead to increased reproductive morbidity. Women of these areas tend to internalize their health problems because of their status in the family, they may not be allowed to seek health care, or they may feel shy about reporting such sort of reproductive problems causing them to be stigmatized by the community (Bang, et al. 1989; Ola et al. 2011). A recent study revealed that even today there is high prevalence of gynaecologic morbidity among young girls and women. Prasad et al. (2005) revealed a surprisingly high prevalence of gynaecologic morbidity among married women of 16–22 years old, including a high prevalence of RTIs, urinary tract infections and uterine prolapsed, and of primary infertility among married couples. Women tend to consider many symptoms as normal, do not seek treatment until discomfort is quite high and so apparently remain infected for a long time. Analysis of the study revealed that the older adolescents with rural background, joint or extended family and non-hygienic practice during menstruation are the causes of high prevalence of reproductive morbidity (Rahman, 2004).

There are several other gynaecological problems faced by young female adolescents. These problems arise primarily as a result of changing hormone pattern, emotional, psychological and physical changes associated with adolescence. The age of menarche among Indian girls, which is reported to be declining, ranges from 11.5 - 14.5 years, with the current average age being 13.5 years. This has resulted in earlier onset of puberty, development of secondary sex characteristics and increased reproductive exposure (Gupta, 2003).

The reproductive tract infections and sexually transmitted infections are not uncommon among young people. In India STIs rank third among the major communicable diseases. Approximately 12-25 percent of all STI cases are among teenage boys. The STIs go undetected or untreated among young women who are embarrassed or stigmatized by the presence of an STI are reluctant to seek help. These STI agents can have dire consequences such as infertility, cervical cancer and facilitate the transmission of HIV (Gupta, 2003).
Maternal mortality ratio (MMR) is the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births. According to WHO (2014), globally, there were an estimated 289,000 maternal deaths in 2013. At the country level, the two countries that accounted for one third of all global maternal deaths are India at 17% (50,000) and Nigeria at 14% (40,000). The major causes of maternal deaths are bleeding, severe anaemia of various origin, puerperal sepsis and obstructed labour and toxaemia of pregnancy. Early marriages, early pregnancies and short spaced pregnancies are also some of the factors underlying such high rates of maternal deaths. Lack of awareness, guidance, low literacy level, low knowledge on reproductive health, health care, nutrition and under utilization of health services have further aggravated the problem. Therefore, the safety of the life of women in her reproductive age depends on a number of factors such as number of pregnancies, number of miscarriages, abortions, still birth, reproductive health problems, the antenatal, pre-natal and post-natal care a girl receives during her young age, adolescence pregnancy and child birth (Ramana and Rani, 2014).

Reproductive health need of young people especially for young girls and women includes needs for reproductive health care, family planning, HIV/AIDS information, safer sex, unwanted pregnancy, early pregnancy, sexually transmitted diseases (STDs), safe abortion and safe motherhood. For many years, the health of young people has been neglected. The unmet need of adolescent for reproductive health information and service is huge and diverse both in terms of quality as well as quantity (Haque, 2010). To enable adolescents to enjoy their reproductive and sexual rights, including their rights to information, education and services and to ensure that young girls gain self-esteem and confidence it is important to generate an awareness and appreciation of crucial skills to help adolescents negotiate life's more difficult passages. This calls for interventions that are flexible and responsive to their disparate needs (UNFPA, 2001).

A study showed that knowledge and awareness about puberty, menstruation, physical changes in the body, reproduction, contraception, pregnancy, child bearing, reproductive tract infections, sexually transmitted infections (STI) and HIV was low among the younger adolescents, 40 percent had little knowledge about the sex organs and most girls had not been informed about menarche prior to its onset. About a half
of the adolescents were not aware of condoms and were confused about the various modes of HIV/AIDS transmission. The study reported however that older adolescents (ages 15-19) have better knowledge. About 80 percent had knowledge of STI, including HIV. Older adolescent girls than younger adolescent girls were more aware of the physical and psychological changes that take place in the body (Gupta, 2003).

The national population policy 2000 has recognized adolescents especially girls as an underserved, vulnerable group that need to be served especially by providing reproductive health information and services (Joshi, et.al.2006). The period between the ages of 10-24 years needs special attention because of the turmoil a youth faces due to different stages of development, different circumstances, different needs and diverse problems. So, young people face numerous reproductive health challenges worldwide. Cardinal among these challenges includes unsafe sex, unwanted pregnancies, unsafe abortion, HIV/AIDS, sexually transmitted diseases and increased vulnerability to sexual abuse and lack of access to reproductive health services (Gichangi, 2003).

Recently a number of programs for school going adolescent in India have focused on information, education and communication with a limited focus on provision of clinical and counselling services on reproductive health. Educational programmes can increase awareness about reproductive health but this awareness may not always translate into appropriate help seeking behaviour by adolescents. Moreover most of the adolescent reproductive health programmes focus on the 15-19 years old age group. There is an increasing need to recognize the 10-14 age group that comprises 12% of India’s total population (Joshi, et.al.2006). This group is different from the older group as it is difficult for them to understand their problems, the consequences of their behaviour and effects of their action. Very little is known about their unmet needs making it difficult to mobilize resources and development program strategies for this group.

Adolescent girls who are fortunate enough to be given relevant textbooks and health education materials by their teachers gain some information about reproductive functioning and reproductive health problems from school sources. But many studies of Indian women have found that young girls are generally told nothing about menstruation until their first personal experience of it (George, 1994). After menarche a large proportion of adolescent girls suffer from various gynaecological problems,
particularly menstrual irregularities such as dysmenorrhea, polymenorrhea, leucorrhoea, etc. Of the total, 40-45 percent of adolescent girls reported menstrual problems (Gupta, 2003). These are mainly due to psychosocial stress and emotional changes associated with physical changes during adolescence. So Adolescence in girls has been recognized as a special period in their life cycle that requires specific and special attention. There are direct linkages between poverty and adolescent girls’ health and vast majority of poor girls caught in this vicious circle are the young mothers of 21st century, deprived of their basic rights to health, education, development and independence.

As the girls are going to be mothers of future generation, nation needs to have girls who are free from reproductive health problems is very important. The girls’ good health free from any menstrual problems is a pre-requisite for the good future of their reproductive life and safe motherhood.

1.1 Rationale for the study

• Reproductive health is a relatively new concept recognizes that especially a young girl has special reproductive health needs before, during and beyond the childbearing age. It is a reflection of health during childhood and crucial during adolescence and adulthood, sets the stage for health beyond the reproductive years for both women and men and affects the health of the next generation.

• Reproductive health is a universal concern but is of special importance for young girls and women particularly during the reproductive years. Young people are distinct population group with particular needs and capacities. World Health Organization defines young people as 10-24 years old. Their numbers have steadily increased in last few decades.

• For the first time, nearly 1.8 billion young people in a world population of 7.3 billion are alive today, than at any other time in human history. India has the world’s largest young population. The emergence of a huge population of young people in unprecedented size can have a profound effect on development of the country.

• Menarche occurs earlier than it once did in Indian population. The girls first experience menstruation and related problems which is marked by feeling of
anxiety and eagerness to know about this natural phenomenon. Good menstrual hygiene is crucial for the health, education, and dignity of girls and women. This is an important sanitation issue which has long been in the closet and still there is a long standing need to openly discuss it. Unfortunately, adolescents are deprived from receiving adequate education, guidance and services that would help them to make smooth transition to adulthood.

- Menstruation is regarded as unclean or dirty in India. Although it is a natural process, is linked with several misconceptions and practices which sometimes results into adverse health outcomes in terms of increased vulnerability to reproductive tract infections.

- The limited knowledge about reproductive health issues make young girls vulnerable to various diseases and infections including HIV/AIDS/STDs, substance abuse, sexual violence and exploitation.

- India alone accounts for one third of the global total child marriage (33 percent). In India, there are nearly half (45%) of women aged 20–24 married before their 18th birthday where as in Karnataka State, there are more than 40% of women aged 20–24 married before the age of 18 years. In Karnataka state, North Karnataka regions lead in the percentage of child marriage. According to core committee report on prevention of child marriages in the state of Karnataka (2011), an alarming 45% to 68% of children were being married off before they attain the age of 18 years in nine districts of North Karnataka; Belgaum, Bidar, Bijapur, Bagalkot, Bellary, Gadag, Dharwad, Raichur and Koppal.

- Gadag district is one of the 30 districts of Karnataka state located in western part of Northern Karnataka. The Gadag district has five taluks namely Gadag, Mundargi, Nargund, Ron and Shirahatti. According to Comprehensive Composite Development Index (CCDI) report, Gadag district is one of the backward and not so progressive districts in the state. Urbanization is not uniform across the taluks. Per capita income of the district is quite less and the standard of living in most of the parameters is relatively poor in Gadag district as compared to the state average. The situation is quite worse in rural than in urban areas (Gadag District Human Development Report, 2014).
• According to the 2011 census, the Gadag district had a population of 1,065,235 of which male and female were 537,147 and 527,423 respectively. Among the total population, 35.63 percent of population lives in urban regions while 64.37% population lives in rural areas of the Gadag district (Gadag District Human Development Report, 2014).

• The child sex ratio is quite lower than the overall sex ratio, implying greater gender discrimination against girls in Gadag district. Gender discrimination against girl child continues to be persistent and hence, there is a need for effective policy intervention and mass awareness to improve the child sex ratio. The average literacy rate of Gadag in 2011 according to gender wise male and female literacy was 84.66 and 65.44 respectively. Although there has been an impressive improvement in female literacy rates both in rural and urban areas, gender gap is still quite high, especially in rural areas (Gadag District Human Development Report, 2014).

• The problem of malnutrition and underweight of the children is persistent and worsening in Gadag district. The Infant Mortality Rate (IMR), Child Mortality Rate (CMR) and Maternal Mortality Rate (MMR) were estimated to be significantly high in rural areas than in urban areas of Gadag District in 2011-12.

• Gadag taluk has more people suffering from HIV/AIDS and dengue as compared to other taluks in the district during 2011. In the district 107.1 people were affected with reproductive health infections per lakh population in 2011-2012 (Gadag District Human Development Report, 2014).

• Hence the study on attitude, awareness and reproductive health problems among young girls of reproductive years is necessary. Such studies shed light on the information which will be highly useful for health policy makers, planners, implementers to plan the various programmes to young girls at an early age.

In this backdrop, the study was planned to conduct in Gadag district on young girls in the age group of 10 to 24 years, involving both married young adults and unmarried young girls to study their awareness and attitude on reproductive health and related problems. Further educational intervention for sub group of population was planned to check its impact on awareness and attitude of young girls.
towards reproductive health. The study was planned with following aim and objectives.

**1.2: Aim and Objectives**

**Aim:** A study on reproductive health and related problems among young girls (10-24 years of age) of Gadag district.

**Objectives:**

1. To study the socio demographic conditions of young girls.
2. To assess the physical growth and nutritional status of young girls.
3. To assess the attitudes and awareness of young girls towards reproductive health.
4. To study the reproductive morbidity among young girls.
5. To know the age at menarche and its association with reproductive health and related problems.
6. To understand the cultural rituals at menarche and its association with reproductive health and problems.
7. To know the association of various socio-demographic factors with reproductive health and problems.
8. To know the parental involvement in dealing the reproductive issues and problems of young girls.
9. To study the impact of intervention programme on attitudes of young girls dealing with reproductive health and related problems.