CHAPTER 1

INTRODUCTION

Adolescence is a fascinating period of life that marks the transition from being a dependent child to becoming an independently functioning adult. It is a period in which an individual undergoes enormous physical and psychological changes. In addition, the adolescent experiences changes in social expectations and perceptions. Physical growth and development are accompanied by sexual maturation, often leading to intimate relationships (Dagathambal and Nalini Devi, 2002).

Of the world's 6.1 billion population in 2000, over one billion people (19.1 per cent) belonged to 10-19 age group. The Asian region comprises 712 million people in this age group. According to United Nations Medium Variant Projections, the number of persons in the 10-19 age group will continue to grow worldwide reaching 1,253 million by the year 2025, while in Asia this number will decline to 698 million by the year 2025 (United Nations, 2001a).

According to 2001 census of India, the population of adolescents (10-19 years) constitutes nearly 22 per cent of the total population of India. The adolescent girls constitute more than 21 per cent of total female in India. Among the adolescent girls in India, rural adolescent girls constitute 72 per cent. In TamilNadu, the adolescents constitute nearly 19.5 per cent of the total population. Among the female population, the adolescent girls constitute 19.3 per cent. The rural adolescent girls constitute 56.8 per cent to the total adolescent girls of TamilNadu (Census, 2001).

In India, traditionally the transition from childhood to adulthood among females has tended to be sudden. On the one hand, as a result of the poor nutritional status of the average Indian adolescent, there is evidence that menarche occurs later than in other regions of the world, particularly in developed nations; therefore, the biological onset of adolescence may be later in India than elsewhere. On the other hand, marriage and consequently the
onset of sexual activity and fertility occur far earlier in India than in other regions of the world, thrusting adolescent females early into adulthood, frequently soon after regular menstruation is established and before physical maturity is attained (Shrireen and Jejeebhoy, 1996).

In India, marriage at an early age is still common and unfortunately institutions do not provide any education regarding safe motherhood and child care. Adolescent girls are trained in different vocations and remain ignorant about mother and child care. Factors like illiteracy, early marriage, socio-economic disparities also add to this. Women account for almost 49 per cent of the total population and about 46 per cent of this comprise girls under 20 years. The young would-be mothers have little knowledge about reproduction, safe motherhood and child care. They acquire little knowledge from friends, relatives and sometimes from books. They are not able to have dialogue with their parents because of inhibitions and social taboos. So with this little knowledge they become mothers and may face problems like early pregnancy, spacing problem, birth control measures, health, nutrition, immunisation and other aspects of maternal and child care (Subhanga et al., 2003).

Reproductive health problems are particularly acute for adolescent girls, because they have the highest levels of unmet need for contraception and are the most vulnerable to unwanted pregnancy and sexually transmitted infections, including HIV. Many sexually active adolescents do not use contraception. Of the roughly 260 million women aged 15-19 worldwide, both married and unmarried, about 11 per cent (29 million) are sexually active and do not want to become pregnant but are not using a modem method of birth control. Every year some 14 million young women become mothers (Alan Guttmacher Institute, 1998) and an estimated 1-4 million young women aged 15-19 have induced abortions, many of them unsafe (Family Care International and the safe motherhood Inter-agency group, 1998).
Female adolescents suffer from a variety of poverty-ridden village life conditions: caste oppression, lack of facilities, malnutrition, educational backwardness, early marriage, domestic burden, and gender neglect. Girls carry a heavy work burden. Adolescence in rural areas is marked by the onset of puberty and the thrust into adulthood. Girls have no independent authority to control their sexuality or reproduction. Girls are expected to get married and produce children. Control of female sexuality is shifted from the father to the husband. There is a strong push to marry girls soon after menstruation, due to the burden of strict restrictions on female sexuality, the desire to reduce the burden of financial support and the need to ensure social security for daughters. Girls are not allowed to go out alone or stay outside after dark. Many rural parents fear that education and freedom would ruin their daughters. Girls develop a low self-image added to this rural villages have poor sanitation, toilet facilities, and drainage systems. Girls are ignorant of health and sex education and lack access to education (Kumari, 1995).

The situation of adolescent women is particularly precarious, as they tend to have limited education, skills and opportunities for employment. They have relatively poor health and limited access to good nutrition, and many are caught in a cycle of early marriage and child-bearing. Marriage adds dramatic changes to their lives that involve their bodies, emotions, and daily life experiences. These changes often occur in unfamiliar surroundings among virtual strangers, as a large proportion of marriages in India are patrilocal and arranged by family elders (George, 2003).

In the past few years the issue of adolescent pregnancy has been increasingly perceived as a social problem. The International Conference on Population and Development (ICPD, 1994) has identified adolescents as a distinct target group in need of ad hoc reproductive health programmes and services. It takes on a different dimension in the developed world and various steps have been taken in terms of policy orientation, to try and curb adolescent fertility. In many developing countries, government officials working in the social sectors readily identify it as one of the pressing social issues. However, this
perception is rarely translated into programmes intended for adolescents, or into programmes, which, although intended for them, effectively reach them. As a group, they have been overlooked due to a lack of awareness of their needs and cultural specificity of these needs. Moreover, there are methodological issues that hinder the setting up of appropriate programmes, such as obtaining appropriate data, given that the data available-usually grouped in five-year age groups-hides enormous heterogeneity and widely differing needs (Suresh Sharma, 2003).

In the Indian cultural setting, an increase in the age at marriage to limited extent has certain repercussions. Raising the age at marriage for girls to 18 years has caused the waiting time between marriage and pregnancy (Gaufna or effective marriage) to almost disappear, and at the same time, social pressure combined with scant knowledge of and desire to plan a family have given a boost to adolescent fertility. Therefore, an increase in the marriage from a very low level to around 16 or 17 years, have, in reality, hardly had any impact on fertility. The negligible contribution to fertility of girls below the age of 15 years is another reason for this lack of impact (Suresh Sharma, 2003).

Approximately 15 million young females aged 15-19 give birth each year, accounting for more than 10 per cent of all babies born worldwide. Only about 17 per cent of them use contraception. Young mothers, especially those under 16, face increased likelihood of serious health risks. The risk of death in childbirth is five times higher among 10-14 years olds than among 15-19 year olds and in turn, twice as high among 15-19 year-olds as among 20-24 year-olds. Teenagers are over represented among those obtaining abortion and even more so among those needing medical care for complications of unsafe abortion, when adolescents bear children, their offsprings also suffer higher levels of morbidity and mortality. The incidence of Sexually Transmitted Diseases (STDs) is also disproportionately high among young people, one in 20 adolescents contracts a sexually transmitted disease each year, and half of all cases of HIV infection take place among people under age 25 (Arundhati Mishra, 2002).
The health and well being of adolescents is closely interlinked with their physical, psychological and social development, but this is put at risk by sexual and reproductive health hazards which are increasing in the world (Fassbander, 1994). In India, almost forty per cent of girls are married and have their first child before eighteen years of age. This adolescent pregnancy is often associated with premature birth, low birth weight, prenatal mortality, increased infant mortality and maltreatment of children (Kamet, 1994).

Adolescent pregnancy and childbearing have significant effects on maternal and child health. Children born to adolescent mothers are highly likely to have a low birth weight and to be premature, injured at birth or stillborn, and are associated with delivery complications resulting in higher mortality. The increased risk of infant death to adolescent mothers is also associated with immaturity at early childbearing and inexperience in child-rearing. Studies have invariably shown that infant mortality rates are generally higher for babies born to adolescent mothers than for those born to women in their 20s or 30s (United Nations, 1989; Devitt et al., 1996).

Because adolescents are physiologically and socially immature, health risks associated with their pregnancies and childbearing are more pronounced than are those among older women (United Nations, 1989; Royston and Armstrong, 1989). Studies reviewed by the Population Reference Bureau found that adolescent women were especially vulnerable to reproductive health problem and were more likely than older women to die from problems related to pregnancy and childbirth. Most importantly, adolescent women faced increased risks during pregnancy and childbirth because they had less information and access to prenatal, delivery and postpartum care as compared with older women (Ashford, 2001). Studies reviewed by UNESCO suggest that in Bangladesh high incidences of teenage pregnancies have contributed to high maternal mortality: among adolescent girls under 18, the maternal mortality rate is three to four times higher than among older women (Uddin, 1999).
As concern grows over adolescent’s reproductive health risks and spread of HIV and other sexually transmitted diseases, there is a need to study the adolescents socio-demographic characteristics, their reproductive behaviour, knowledge and use of contraceptives and sources of information on reproductive health in order to plan programmes to address their sexual and reproductive health needs. In this context, the present study has been undertaken in the rural areas of Tamilnadu.

**Chapterization of the thesis**

The present thesis contains the following five chapters

1. Introduction
2. Review of literature
3. Objectives and methodology
4. Results
   4.1 Background characteristics of respondents
   4.2 Puberty and menstruation
   4.3 Maternal and child care practices
   4.4 Gynecological problems
   4.5 Fertility behaviour
   4.6 Family planning practices
   4.7 Sexually transmitted diseases
5. Summary and conclusion

In chapter two, available literature on the adolescents has been reviewed. Findings of studies related to other countries have also been cited wherever relevant. The review of literature mainly focused on adolescent mothers' reproductive and sexual behaviour, puberty and menstruation, maternal and child care practices, gynecological problems, experience of post partum complications, fertility behaviour, family planning practices and awareness about sexually transmitted diseases and HIV/AIDS.
Chapter three focuses on the methodology of the study. In this chapter objectives, study area, study design, variables included in the study, data collection and methods of data analysis are presented in detail.

Chapter four discusses the results of the survey. The survey findings are presented in seven sections. In the first section of chapter four, the background characteristics of adolescent mothers which include social, economic demographic and marital characteristics of the respondents, their level of exposure to mass media and autonomy status have been explored. The topics covered under the socio-economic characteristics of the respondents are childhood residence, education of respondent, education of husband, religion, community, standard of living, involvement in income generation activities and type of family.

Demographic characteristics of adolescent mothers include age, age at puberty, age at marriage, husband wife age difference, number of male children, number of female children and total number of children.

The marital characteristics of adolescent mothers such as type of marriage, consanguineous type, kind of marriage, inter-caste / inter-religious marriage are included in this part.

The level of exposure of adolescent mothers to mass media such as listening to radio, watching television, going to movies, reading newspapers/magazines is also covered in this section.

Adolescent mothers' autonomy measured in eight different dimensions such as sex-segregated interaction, freedom of movement, freedom to participate in social and political activities, household decisions, freedom of choice, violence against women, financial management and decision about contraception and fertility is discussed in this section.
Section two of chapter four focuses on puberty and menstruation and deals with knowledge about menstruation, menstrual cycle, duration of menstrual cycle, practices followed by adolescent mothers during menstruation period such as type of absorbent used and number of times the absorbent changed, etc. Experience of physiological discomforts during menstruation, type of physiological problems and place of treatment for physiological problems are also studied in detail.

Section three of chapter four deals with maternal and child care practices of adolescent mothers in rural areas. The topics covered in this section include time of registration of pregnancy, place of registration, number of antenatal check-ups, immunization, health problems during pregnancy, outcome of pregnancy, nature of delivery, abortion, place of delivery, experience of delivery complications, birth weight of baby, breast feeding behaviour and post partum complications.

Section four of chapter four focuses on the gynecological problems of adolescent mothers, treatment seeking behaviour and place of treatment.

Section five of chapter four deals with fertility behaviour of adolescent mothers like number of children born alive and surviving, sex composition of children, number of still births, experience of abortion, sex-preference and birth interval.

Section six of chapter four deals with adolescent mothers' knowledge about contraception, adoption status, reasons for use of contraception, age at the time of adoption, number of children at the time of adoption, person who took decision to adopt family planning methods, reasons for adoption of family planning methods, experience of side effects, etc.

Section seven of chapter four deals with adolescent mothers' awareness on sexually transmitted diseases, cure for STD, signs and symptoms of STD, knowledge about HIV/AIDS, mode of transmission, prevention of HIV/AIDS, cure for HIV/AIDS and availability of vaccine for HIV/AIDS.
In chapter five, results observed in chapter four are summarized and the significant findings are highlighted. Based on the findings, recommendations are made and policy implications are suggested for a comprehensive measure to meet the adolescent mothers sexual and reproductive health needs in rural areas.

List of references quoted in the text, district wise Human Development Index, sample area, standard of living index, women's autonomy score and a copy of interview schedule are annexed.