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1.1 Background of the problem

India has witnessed significant industrial and technological development during the post independence era. However the social development indices do not reflect proportionately the same qualitative changes in the lives of people. The lifestyle of the people even today, is largely determined by their traditional socio-cultural practices and mores. Migration, urbanization, access to health services, education and mass media are bringing the masses, specially the young, in contact with global trends of modernization. Consequently, the young people are facing the pressures of conflicting values and life styles.

Though the society is being more open to modern system of education, mobility for occupation and even nuclearisation of family, some of the fundamental behaviors pertaining to marriage, sexuality reproductive health and care, gender roles, inculcation of values, healthy attitudes towards sexuality and interpersonal relationships etc. continue to be governed by cultural norms and beliefs. Early marriage continues to be the norm especially in the rural areas despite legal prohibition, restricting the marriage of girls before 18 years and that of boys before 21 years. Early child bearing too is fostered by the cultural practices inadvertently bringing with it the risks of difficult child birth and high rates of maternal and infant morbidity and mortality. Early marriages are also bringing in psychosocial pressures on young adults demanding coping with the demands of marriage, parenthood and economic responsibilities to sustain the family in sharp contrast witnessed in the urban settings where the period between sexual maturity and marriage is prolonged, as the adolescents are encouraged to pursue education, vocation career etc,

Evidences prove that significant proportions of adolescents are indulging in pre marital sex. Discussions on these matters are not sanctioned by cultural norms. Consequently boys and girls have little information about their own anatomy and reproductive physiology and the risks involved in indulging
in unsafe, sexual activity. Even more alarming is the widespread reporting of sexual abuse of girls within their own families. Statistics reveal that a large proportion of abortion seekers is from adolescent and that incidence of STD including HIV/AIDS has significantly predominant among them. There is an emerging need to create appropriate channels of information for adolescents in order to prepare them for their future roles as men and women and to develop their capacity to make informed choices on life. So there is a need to advocate the cause of family life education for adolescent on reproductive health at all levels, so as to make quality adolescents in India in the near future.

**Concept and components of Family Life Education**

Family Life Education is an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, aging as well as their social relationships in socio cultural context of the family and society (International Planned Parenthood Federation – IPPF)

**Key components**

- Health, growth and development
- Family and inter personal relationship
- Mother and child health
- Gender sensitization
- Personality development

The goal FLE is assist young people in physical, emotional and moral development and also to focus on preparing them for family and parenting responsibilities.

**I.2 Adolescence – Meaning**

The term adolescence comes from a Latin word meaning to grow to maturity. As it is used today, the term adolescence has a broader meaning; it includes mental emotional and social maturity. While all periods in the life span are important effects on attitude and behaviour whereas others are significant because of their long term effects adolescence is one of the periods when both the immediate and long term effects are important. Similarly some
periods are important for their physical and some for their psychological effects, but adolescence is important for both. This period is described by different names such as critical period, awkward age or transitional age. In fact adolescence is an in between transitional stage. The person is no longer a dependent; biologically immature, socially inept and psychologically weak child. He or she is also not yet independent, mature, resolute, strong young adult. The adolescent is really both part adult and part child and hence it is difficult to describe him or her extremely accurately. Because of this confusion many mental health professionals also freely use the word “Adolescent Turmoil” to describe both disturbed adolescents and process of normal development. This century is famous for stress, so today’s youth cannot escape from stress. They face more difficult problem pressures than did youth a decade ago. For example unhealthy competition, parental pressure and peer pressure, influence of western culture through media.

**1.3 Who is an Adolescent**

Adolescence, the second decade of life, is a crucial and dynamic time in the lives of all young people. It is a time when young people are able to empathize with others, start abstract thinking; it is a time when close and dependent relationships with parents and other family members of childhood begin to give way to more intense relationships with peers outside the family. Adolescence is a transition period from childhood to adulthood and is characterized by a spurt in physical, endocrinological, emotional and mental growth with a change from complete dependence to relative independence.

Adolescence is a period of rapid growth and development generally between the ages of 10 to 19 years and marked by physical, social and emotional changes extending from puberty to full reproductive maturity.

These changes occur very rapidly but the rate of growth varies. Depending on heredity and environment some adolescents may mature very fast whereas some adolescents may take a longer period to reach sexual maturity.
Adolescence is a period extending from puberty to full reproductive maturity during which accelerated growth and development occurs.

Adolescence in girls may start as early as 9/10 years and for boys it begins around 12-13 years.

During Adolescence stage marked changes in physical emotional, psychological and social aspect along with changes in attitudes intellect and relationships occur. In human life maximum changes occur during this period.

1.4 Stages of Adolescence

The adolescent stage spans almost 10 years and is divided into two sub stages.

- Early Adolescence
- Late Adolescence

1.5 Early Adolescence (9 to 14 years of Age)

It is a period of rapid physical growth for females accompanied by development of primary and secondary sex characteristics along with the maturation of reproductive functioning. Physical growth in boys begins a little later.

In girls it is marked by the beginning of menarche and in boys the beginning of nocturnal emissions.

Variations in height and development are typical of this stage, within the individuals of the same sex for some it is rapid and for some it is slow. Levels of maturity in males and females vary.

1.6 Changes in Early Adolescence

- Both boys and girls may feel awkward and self conscious due to rapid physical and emotional changes.
- Develop a concept of body image and spend a lot of time looking into the mirror, dressing up in the current style and making themselves attractive especially for the opposite sex.
- Boys and girls may develop crushes (strong attraction) for a person of the same sex or opposite sex who is looked upon as an “idol” or role model. It could be some one of their own age or older.
• Develop social relations with the opposite sex.
• Question authority and become more assertive.
• Try to irritate / annoy the elders. Can be messy, sloppy rude avoid work etc.

1.7 Late Adolescence (14 to 19 years of Age)
• Physical growth continues along with the maturation of reproductive organs.
• Boys now have rather quick growth spurts and out grow girls of the same age.
• Need to be assertive and independent, do not accept authority. Question authority and break rules.
• Preoccupied with themselves and feel that other people’s thoughts are focused on them.
• Try and identify with peer groups and peers exert strong influence on one another.
• Begin to think about the future and are anxious about their educational and vocational goals/future career

1.8 Changes in Late Adolescence

1.8.1 Puberty in Girls
In girls physical changes may begin at around 10 years and may reach their maximum growth around 14 years. Thereafter, growth continues at a slower rate till the age of 18 years. During this period, in female, their sexual characteristics appear and begin to grow. Other changes include accelerated growth and development of genital organs.

1.8.2 Menarche and Menstrual Cycle
Menarche is the onset of first menstruation, which occurs, in young girls at around 12 years. This is often recognized as the maturity in girls. There are variations in age at which menarche occurs. Good nutritional status will lower the age at menarche. i.e., girl will attain menarche earlier, while in malnourished girl menarche is delayed. If menstruation has not started by 16 years, the girl should be referred to a medical person.
Menstruation occurs once a month with a regular rhythmic period. Menstrual cycle is a continuous process. It remains as a normal physiological phenomenon throughout the child bearing years of the young women except during pregnancy and lactation and stops permanently at menopause approximately between the age of 45-55 Years.

I.8.3 Puberty in Boys

Puberty in boys usually appears later than girls. It may begin with changes in voice, growth of hair on chin, under arms, face, chest and pubic region. Development and enlargement of external genital also takes place and sperm production starts. Occasionally penile erection and involuntary ejaculation also occur. The adolescent boys should know that all the changes are normal and natural and there is no need to be ashamed or frightened.

I.8.4 Psychological and Behavioral Changes

During this transition phase from childhood to adulthood due to rapid physical and sexual changes in the body, the adolescent develops anxiety and apprehension. Adolescence is a time for exploration adventure and discovery of one’s own body and one’s capability and potential. Sometimes this can lead to confusion and experimentation with harmful substances like drugs and alcohol, etc. and risky behavior, risky driving.

Sometimes expression of sexual urge by adolescents may lead to anger among adults while among adolescents this may lead to a feeling of guilt and shame. Often adolescents hesitate to make communication about sexual development and other related matters with the elder.

In case they are not given appropriate information and education on these normal physical, sexual and psychological changes they are prone to health risk behavior such as sex experiments and drug abuse leading to teenage pregnancy, contracting RTI/STI, HIV/AIDS, injuries, accidents, violence, rape, homicides, suicides etc.

✓ Try to establish independent and personal identities.
✓ Their emotions are strong and fluctuating.
Concerned about body image, height, body hair, voice change, size of genitals, erection, ejaculation, menstruation, size of breasts etc.

Behave differently with adults and with peers

Boys may have a strong urge to display masculinity and may be somewhat aggressive in their behaviour / demeanor

Are concerned about their career and vocation.

Sexual urges may result in masturbation and viewing pornographic material.

Generally influenced by peers and unfortunately some of them may at times indulge in high risk behavior to gain peer approval and this could be very dangerous.

1.8.5 Health Needs of Adolescence

The nutritional requirement of adolescents is more due to rapid growth spurt and increase in physical activity. The adolescents are encouraged to develop healthy eating habits and lifestyle. Good nutrition is equally important for proper growth of both male and female adolescents.

Adolescents need more of all nutrients particularly calcium, iodine and iron. The need for more iron in adolescents is due to growth spurt and the onset of menstruation. Inadequate iron stored during adolescence before conception is a major cause of iron deficiency anemia during pregnancy, which aggravates the risks during pregnancy. In endemic areas incidence of iodine deficiency disorders is high resulting in retardation of growth, mental retardation and psychomotor development. They should take calcium rich food like milk and milk products, consume iodized salt and iron rich food such as green leafy vegetables, whole pulses, jaggery, meat, poultry fish etc.

Stunted and under nourished girls are more likely to have complications during pregnancy and give birth to low birth weight babies.

1.9 Development of Characteristics of Adolescence

Adolescence, the transition between childhood and adulthood is a stressful period of life characterized by discernible physical, mental, emotional, social behavioral changes.
1.9.1 Physical Development

Rapid and dramatic physical development and growth mark adolescence including development of sexual characteristics. Marked morphological changes in almost all organs and systems of the body are responsible for the accelerated growth and the changes in contours and sexual organs. In case of boys, active acceleration in growth of coarse pubic hair and facial hair usually proceed other signs of puberty such as voice changes. In girls, development of breasts, broadening of hips and rapid growth in height usually begins about two and a half years before menarche.

1.9.2 Emotional Development

Adolescent have to cope, not only with changes in physical appearance, but also with associated emotional changes and emerging and compelling sex urges. Bodily changes cause emotional stress and strain as well as abrupt and rapid mood swings. Getting emotionally disturbed by seemingly small and inconsequential matters is a common characteristics of this age group.

1.9.3 Hormonal Changes

Hormonal changes are likely to result in thoughts pertaining to sex, irritability, restlessness, anger and tension. Attraction towards the opposite sex leads to a desire to mix freely and interact with each other. However, in reality this may not always be possible, partly due to societal restrains on premarital sexual expressions and also because of their priority need in this period, viz education, employment etc. Hence it becomes almost necessary for adolescents to learn how to face and deal patiently with the turbulence they face. It requires development of a sense of balance and self imposition of limits on expression of one’s needs and desires. An inability to express their needs often leads adolescents to fantasize and day dream that helps them to at least partially fulfill their desires. Adolescence is also marked by development of faculty of abstract thinking that enables them to think and evaluate systematically and deduct and question inconsistencies between rules and behaviour. Parents as well as service provider often overlook this development, one of the basic reasons for the popularly known “generation gap”.
Socially, adolescence consists in shifts from dependency to autonomy, social responses to physical maturity, the management of sexuality, the acquisition of skills and changes in peer groupings. The need to be a part of a gang or a large group is replaced by a preference for maintaining fewer, more steady and binding relationship.

I.10 Vulnerability during Adolescent period

- They have specific health related problems
- Their health problems impact National indicators like MMR, IMR
- Have been our past clients (as children) and are likely to remain our future clients (as adults)
- Their ‘bad’ habits can be corrected.
- Their “health care seeking behaviour” can be improved
- Adolescents are vulnerable by virtue of:
  - Normal Development Processes.
  - Family/Peer/Environmental Influences.
  - Life style Patterns; and are “At Risk” because of Certain Behaviors. Some adolescents are more vulnerable and need special attention.

I.10.1 Special Attention Groups of Adolescents are

- “Out of school” adolescents and street adolescents
- Sexually abused adolescents.
- Commercial sex workers.
- Adolescents with mental and physical disabilities.
- Orphan Adolescents, those in foster care and institutions
- Adolescents in conflict with the law
- Working Adolescents.

The adolescents who fall in the special attention groups are more at risk of identity crisis and low self esteem, guilt, frustration and mental problems. They are also the group who can be molded and helped to change their erratic behaviors to more responsible ones to improve their self worth and esteem.
Given the turbulent period and the multiple challenges it is not strange that adolescents have unmet needs in many areas: regarding nutrition, sexuality, reproductive health, managing emotions and stress, mental health, substance abuse, etc. they require appropriate information and skills to negotiate adolescence safely. Adolescents need to be empowered with correct, age appropriate and current information and skills in all these areas to develop and practice responsible behaviors to protect themselves from risks as well as to help them seek appropriate services.

Information for parents, teachers and social workers is equally important as they play key roles in adolescent health and development.

The various issues related to adolescence, growing up, body image etc. have not only a huge socio-economic impact but also impact the National Health Indicators.

**1.11 Importance of Adolescence**

Adolescence is a cross road in the development in life. Young people go through a difficult phase of physical, emotional and psychological stress. Their inquisitive minds oscillate between pornography and peers to know more and more about sexuality. Adolescence is the time when puberty is experienced. Physically adolescents begin to reach their adult size their bodies become more sexually defined and reproductive capability is established.

The period of adolescence is of special significance in the life of an individual and it is marked by many important life transitions on various fronts; there is resurgence of sort in physical, emotional mental and psychological being of the individual frequently leading to conflicts with one’s own self and with the outside world. The characteristics of physical, cognitive and emotional changes and the specific developmental goal of moral, sexual and occupational identity that adolescents have to achieve, result in their having distinct developmental needs. Meeting these needs is a challenge that can result not only in the well being of an individual but that of the community and their entire growth.
This period is very crucial, since these are the formative years in the life of an individual when major physical, psychological and behavioral changes take place. This is also an impressionable period of life. This is also the period of preparation for undertaking greater responsibilities including healthy responsible parenthood. The future of a society depends on adolescents and they form a great human resource for the country.

This is the period in which the adolescent face behavioural and reproductive health problems.

Adolescence is thus a critical period during which significant personality reorganization occurs. The suddenness and rapid pace with which behavior change takes place in the body and mind of adolescents, generate a number of problems. Although they experience the changes occurring in them, they are mostly unable to understand those. So far there is no authentic source through which they can get scientific knowledge regarding these changes.

Since they need information regarding the changes and developments in them, they fall back upon them the peer group or cheap literature, which provides wrong information. Being misinformed they fall prey to myths and misconceptions which adversely affect the process of personality development.

I.12 Adolescent Sexuality

Adolescent sexuality is an important area of study. Teenage pregnancy is a serious health hazard. The majority of illegal abortions occur in adolescent girls. Adolescents are also at a high risk of contracting STDs and AIDS. An understanding of sexual behavior of adolescent as it relates to sexual identity and peer pressures is needed for designing successful strategies to promote safer sexual behaviour for and for combating and controlling the spread of AIDS among the most vulnerable groups in the community.

So far, adolescents in developing countries have been by passed by all reproductive health programmes. The adolescent period is important for several reasons. First, adolescent girls are a high risk group as they are exposed to the hazards of pregnancy when they are not emotionally and physically ready for child bearing. Adolescents constitute a segment of the
population that is potentially important one for targeting health education on
body functions, childbearing child rearing and reproduction. Health services
provided to adolescent girls not only impact on their own health and nutrition
but could reduce the risk of low birth weight and minimize subsequent child
mortality risks and thus have long term intergenerational effects. Programmes
for adolescents should integrate health education, employment and other
related services. As there is a little experience with programmes targeted to
adolescents, considerable experimentation is needed to develop models which
should be carefully evaluated to derive lessons for possible replications.

The reproductive health problems such as early pregnancy, increased pre
marital sexual activity and limited knowledge regarding reproductive health all
result in increased risks of STD infection, including HIV/ AIDS maternal
morbidity and mortality. Unwanted pregnancies leads to unsafe abortions
endangering the physical and reproductive health and productivity of
adolescents.

Adolescents confront problems because of their inability to properly
manage the sudden development of their interest in the opposite sex. The
tendency to distance themselves from their parents and to become deeply
involved with the peer group creates apprehension and anxiety among them. In
the absence of any adult intervention to help them to understand and appreciate
the problems and issues, they turn towards the peer groups. Generally
adolescents are vulnerable to peer group pressure and number of them are
pushed into action without giving any thought to its consequences. They are
found experimenting with smoking, alcohol or drugs for various reasons
including peer group pressure.

Even when adolescence education is not being imparted, children and
adolescents are exposed to sex related issues and that too mostly in a crude
manner, through sources like cinema, film magazines and other periodicals,
video parlors commercial advertisements and certain sensuous programmes on
domestic and foreign channels of television. Even newspapers are devoting
increasing space to sex related stories. Since they need information regarding
the changes and developments in them, they fall back upon the peer group or cheap literature, which provides wrong information. Being misinformed they fall prey to myths and misconceptions which adversely affect the process of personality development. So it will, therefore, be better to impart adolescence education to adolescents, so that they may appreciate such exposures in proper perspective.

1.13 Educational Intervention for Adolescents

The current generation of adolescents is more than a billion strong and will be the largest generation in history to make children to adults. But their health needs, and particularly their reproductive health needs continue to be ignored and neglected. As they stand at the threshold of adulthood, they need authentic reference to their reproductive health needs, so that they are well equipped to cope with the problems which they confront during the transitional phase. They need both guidance, independence, education as well as opportunities to explore life for themselves in order to attain a level of maturity required to make responsible decisions.

It is in this context that the need for an educational intervention is strongly felt. This need is particularly felt in India, because the school curriculum here does not include the crucial elements of reproductive health such as sexual development. There are contents on the biological aspects of the reproduction system but education in these elements can not be complete by giving simple biological information. There is a need to focus on physiological, emotional and socio cultural dimensions of the adolescent reproductive health in a holistic manner. After serious consideration, now a consensus has been reached on the issue of introduction of adolescence education in schools/colleges with a view of providing authentic knowledge to students regarding the process of growing up on HIV/AIDS drug abuse influencing their attitude, behavior and value orientation.

There has been a significant change in the perception of adult members of the society, particularly parents and teachers, towards the introduction of adolescence education in schools/colleges. Although students always felt the
need to get education in sex related matters, parents and teachers had serious apprehensions till very recently. But now a number of studies conducted in different states have found that parents and teachers overwhelmingly favour the introduction of adolescence education in schools/colleges.

The official data do not give information related to psychosocial behavior of adolescents in the context of family and community. However the field experience suggests that adolescents in contemporary Indian society are gradually being drawn to media, consumerism and materialism. Deprived of virtuous (peer groups with proper behavior) role models, they believe in the virtues of capitalism and selfishness. Those in school are scholastically burned. Experience has also shown that even though schools provide a ready setting for integration of education programmes they have not gained much momentum in terms of implementation in India.

Adolescent generation has been denied their right to get scientific knowledge about the changes and developments taking place in their life. They have not been experiencing physical, emotional and social changes but they have been equipped to understand and appropriately, adequately handle the situation. Indian society is also becoming more urban and industrialized and is in a constant state of transformation. There is tremendous impact of mass media, particularly electronic media on the life of an individual. These changes are bringing new pressures the pressures, that require individuals and communities to reexamine the cherished beliefs, question traditional roles and reconsider priorities in adolescence health.

1.14 Adolescent Education

Adolescent education has been conceptualized as an educational response to the specific needs of adolescents in respect of their reproductive health. Since the present school/college curriculum already incorporates a number of elements relating to biology adolescent education focuses only on those aspects of adolescent reproductive health which are not incorporated in the existing school curriculum. The general framework has identified contents
on three major components such as process of growing up, HIV/AIDs and drug abuse etc.,

I.14.1 School System

Content
- Process of growing up – physical, psychological and social aspect of growth; socio-cultural development including self-concept, self-esteem, changing relations with parents, peer group; gender roles
- HIV / AIDS – causes preventive measures, social responsibilities towards people living with HIV / AIDS; RTIs / STIs
- Substance abuse- situations; consequences; preventive measures, treatment, rehabilitation; individual and social responsibilities

Strategies
- Awareness building
- Co curricular activities
- Integration in the school curriculum
- Development of life skills in the context of ARSH

I.14.2 Non Formal System: Life Skill Education for Adolescent Reproductive and sexual Health (ARSH)

Content
- Nutrition, personal hygiene, teenage pregnancy, conception, contraception, adopting safe informed sexual behavior, prevention of RTIs, STIs, HIV / AIDS, caring and supporting people living with HIV / AIDS, addressing sexual harassment and violence, avoiding maternal morbidity and mortality and substance abuse

Strategies
- Environment building
- Capacity building of facilitators and peer educators
- Integration of ARSH in literacy, continuing education, vocational training, self help groups
- Linkages with the health system to provide adolescent friendly health services on pilot basis.
Objectives

➢ To provide authentic and accurate information about physical, psychological and socio-cultural issues related to adolescents reproductive health
➢ To inculcate a healthy attitude towards sex, respect for the opposite sex and responsible sexual behavior
➢ To help adolescents understand the implications of STIs, HIV / AIDS, unsafe abortions, their causes and the means to prevent them
➢ To increase sensitivity to needs of people living with HIV / AIDS
➢ To make adolescents aware of the causes and consequences of drug abuse and ways of preventing it
➢ To enhance life skills of adolescents to make informed and responsible decisions related to ARSH

1.15 Services for Optimum Health among Adolescents

➢ Understand sexuality and adolescent sexuality
➢ Provide accurate information to adolescents, families and media
➢ Address group of adolescents / teachers / parents, schools, colleges and clubs
➢ Provide needed services in a friendly manner (AFHS)
➢ Utilize the media
➢ Facilitate the provision of “life skill education” , help postpone early marriage and early pregnancy

1.16 Family Life Education – Objectives, Content and Meaning

Presently there is much confusion related to content, scope and meaning of family life education programmes for the adolescent. Different programmes that address adolescent education related to sexuality and reproduction use varied terminology. These programmes vary in their goals and content emphasis. The different terms in vogue are: Population education; Family Life Education; Sexuality and Reproductive Health Education; AIDS Education; and Life Skill Education.
FLE programme has had its genesis in population education programmes wherein the emphasis was on generating consciousness on macro-demographic issues among school going children. The related content areas were infused across various subjects in the school curriculum. However, population education programme did not cover issue of reproductive health and sexual identity at the individual level.

Based on the realization that knowledge alone does not lead to change in behavior, there has been a shift in the concept of promoting reproductive and sexual health of adolescents. The theoretical premise is that adolescents should get a platform for value clarification and skill building to enable behavior change that would promote their reproductive and sexual health. Accordingly, the programmes have been translated into family life education programmes and sexual education programmes.

The content of family life education programmes encompasses population growth, personal health and nutrition, family and interpersonal relationships, gender sensitization, personality development etc. Very few FLE programmes address directly to issues of sexuality such as sexual behavior and contraception. They rather aim to avoid controversy by focusing on family and parenting responsibility.

I.17 Advocacy for Family Life Education

It was recommended that to promote FLE in the country there was a need for intensive advocacy effort at National and Regional levels by all the major stakeholders that can take leadership role to influence policies, plans and programmes. The target audience could thus comprise planners, political leaders, key personnel in education and health department, leading NGOs, educationists, health professionals etc.

Advocacy at grass root level for parents, teachers, community leaders and adolescents would be necessary to evoke their active participation in the design, planning and implementation of the programme.

Smt. Rekha Bhargave, Joint secretary in the Department of Women and Child Development. GOI, in her address at the National Convention on Family
Life Education, stressed the need for adolescent literacy through FLE in schools and colleges as this would take care of host of other issues related to adolescent girls and boys. Quoting a few dismal statistics, she particularly drew the attention of the participants towards the problems faced by adolescent girls in terms of their low level of education, gender disparity, early marriage and the entire gamut of problems that were associated with early marriage.

Reproductive health care programmes should be so designed to serve the needs of men and women, including adolescents and should be in sympathy with local cultural responsibilities. These empowerment programmes ought to involve women, in the leadership, planning, decision making, management, implementation, organization and evaluation of services (UN-1974). Such programmes must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for the prevention of STDs. Decentralizing the management of public health programmes by forming a partnership with non governmental organizations including local women groups would improve efficiency outcome.

1.18 Focused Areas for Adolescent Education

1. Biological social and emotional changes during adolescence.
2. Control over ones own body
3. Menstruation (cycle, hygiene)
4. Marriage and concept of child birth
5. Knowing about opposite sex
6. Reproductive organs and their functions.
7. Role of parents in dealing with the grown up boys and girls,
8. Elimination of gender disparity.
9. Understanding the feeling of parents and act accordingly.
11. Masturbation: Myths and facts.
12. Methods of family planning
13. Premarital sex and its ill effects.
14. HIV/AIDS
15. Future building
16. Personality development and empowerment
17. Protection from exploitation and abuse.
18. Inculcation of positive values.
19. Improving interpersonal relationships.
20. Skill building for good reproductive health.
21. Healthy attitudes towards sexuality

### 1.19 Profile of Adolescents in South Asia

Of the estimated 1-2 billion adolescents in the world today, nearly half live in Asia; and nearly one in four (282 million) live in south Asia. Adolescents aged 10-19 comprise over one fifth of South Asia’s population within the region, Bangladesh and Pakistan have the greater proportion of adolescents, while India has the greatest absolute number.

Though the situation of adolescents varied widely within the region and within the individual countries, literacy and school enrolment rates among adolescents have risen in all south Asian countries over the past couple of decades.

Nevertheless according to United Nations estimates secondary school enrollment ratios remain low in most south Asian countries. Except Sri Lanka, and large proportions of teenage girls aged 15-19 remain illiterate. It is important to note that geographic disparities are wide within the individual countries. Differences between the sexes are also wide, particularly in Bangladesh and Pakistan where secondary school enrollment ratios for boys are nearly double to those for girls.

The majority of older south Asian adolescents are not in school, except in Sri Lanka some are unemployed, while others work for pay, or work without remuneration in household’s family farms and businesses. Surveys suggest that labor force participation rates are relatively high both among older adolescents aged 15-19 and among younger adolescents aged 10-14. In Bangladesh, for example a 1995-1996 survey found that over one quarter and
one third of younger adolescent females and males were economically active as were about half and two thirds of older adolescents, respectively. Labor force participation of younger adolescents is also high in other countries among males in Nepal and Pakistan, for example. By ages 15-19 large proportions of South Asian males (36-66%) and females (21-49%) excluding Pakistan are engaged in economic activity. Rural adolescents are more likely to work and less likely to study than their urban counterparts. Caution in interpreting sex specific figures is advised since surveys can underestimate girls' contributions to household labor and consequently economic activity rates.

I.19.1 Health Status of Adolescents in South Asia

As noted in the global overview by Paul van Hook adolescence is generally a period of life free from both childhood diseases and the ravages of ageing. Consequently as in other settings, mortality rates among adolescents and young people in this region are generally lower than those observed at younger and older ages. However, unlike in other countries, adolescents and young women in the countries of South Asia, with the exception of Sri Lanka, experience somewhat higher mortality rates than males at the same ages. Disparities are particularly evident among young people aged 15-19 and 20-24 and this may well be explained by the poorer reproductive health of females in these countries.

Gender disparities in health are particularly significant in South Asia. In terms of food intake, access to health care and growth patterns, girls are worse off than their brothers. Disparities become evident soon after birth, and by adolescence, many girls are grossly underweight (Jejeebhoy 2000). Adolescent girls contribute long hours to the household economy, but their activities are largely invisible and undervalued since they draw no income. Gender roles and expectations have such a profound impact on the lives of adolescents that nearly every author in this connection explores some dimension of the ways in which gender roles affect adolescents lives.
I.19.2 Adolescents Sexual and Reproductive Health in South Asia

There are many factors that undermine adolescents’ ability to make informed sexual and reproductive choices in South Asia. For example, south Asian societies have traditionally placed high priority on preserving young women’s chastity before marriage, a concern that has important implications for their education, age at marriage, autonomy and mobility. Seclusion norms are widespread in the region from puberty onwards. As a result, adolescent girls in many South Asian settings are unlikely to have much exposure or physical access to the outside world. Few services cater to their needs for health care, nutrition, vocational skills, economic opportunities or information. A sizable proportion of women in south Asia marry well before 18, and early pregnancy further exacerbates their poor reproductive health and the poor survival chances of the infants they bear. These papers also highlight the factors that prevent boys from making informed decisions, including lack of knowledge about sex and reproduction, and social pressure to have sex under unsafe conditions placing them at risk of sexually transmitted infections.

Ref: Towards adulthood exploring the sexual and Reproductive health of adolescents in South Asia.

I.20 Profile of Adolescents in India

I.20.1 Adolescent Population

There are 225 million adolescents comprising nearly one-fifth (22 percent) of the total population (census2001)

I.20.2 Variation by Age and Sex

Of the total adolescent population, 12 percent belong to 10-14 age group and nearly 10 percent are in the 15-19 age group. Female adolescents comprise almost 47 percent and male adolescents 53 percent of the total population. The sex ratio is 882 females for 1000 males, lower than the overall sex ratio of 933. It is 902 for younger adolescents aged 10-14 years and 858 for older adolescents aged 15-19 years (census 2001)
1.20.3 Early Marriage

Mean age at marriage for females is 18 years and males 22.6 years. However, more than half (51. percent) of the illiterate currently married females are married below the legal age at marriage. Nearly 20 percent of the 1.5 million girls married under the age of 15 years are already mothers (census 2001). Age at marriage for female is influenced only when the population is matriculate / secondary and above.

1.20.4 Female Mortality – a Cause of Concern

Gender differentials in mortality rates exists during adolescents. Female mortality rates are higher as compared to that of males during 15-24 years. Mortality in female adolescents of 15-19 is higher than adolescents of 10-14 years. The pervasiveness of discrimination, lower nutritional status, early marriage and complications during pregnancy and childbirth among adolescents contribute to female mortality (CSO 2002, SRS 1999).

1.20.5 Educationally Disadvantaged Rural Adolescent Girls

25 percent of the 15-19 years age group in rural areas and 10 percent in urban areas are illiterate. The male-female differences grow with each level of education (NSSO 55th round, 2001). Enrollment figures in schools have improved, but gender disparities persist. Girls account for less than 50 percent enrollment at all stages of schooling. Rural girls are most disadvantaged. The challenge is to keep students in schools. The dropout rate from class 1 to X is around 68 percent.

1.20.6 Work due to Economic Compulsions

Nearly one out of three adolescents in 15-19 years is working – 21 percent as main workers and 12 percent as marginal workers (census 2001). Economic compulsions force adolescents to participate in the work force resulting in high dropout rate for education. Despite adult unemployment, employers like to engage children and adolescents because of cheap labor.

1.20.7 Development affected by Malnutrition

Intake of nutrition is less than recommended daily allowances for adolescents below the age of 18 years both for boys and girls in rural India
More than 70 percent girls in the age group of 10-19 years suffer from severe or moderate anaemia (DLHS-RCH 2004). Adolescent mothers are at a higher risk of miscarriages, maternal mortality and giving birth to still born and underweight babies. Iodine deficiency disorder can lead to growth retardation and retard mental development. Only half of the households are using iodized salt for cooking in India (MICS 2000).

1.20.8 Drug Abuse as an Emerging Problem

24 percent of the drug users were in the age group of 12-18 years. The subjects in the treatment centers reported that about 11 percent were introduced to cannabis before the age of 15 years, and about 26 percent between the age of 16 and 20 years. (UNODC and Ministry of Social Justice and Empowerment 2004). Social factors such as illiteracy, economic background, unemployment and family disharmony increase vulnerability to drug abuse.

1.20.9 Crimes against Adolescence

Crimes against girls range from eve teasing to abduction, rape, prostitution violence and sexual harassment. Most rape victims are in the age group of 14-18 years. In 82 percent of rape cases, the victims knew the offenders and 32 percent were neighbours (NCRB 2001). Unfortunately, social taboos prevent these crimes from being registered. Even when registered, prosecution rarely takes place. In the case of sexual abuse of boys (12-17 years), they are mainly victims of homosexual abuse.

1.20.10 Increasing Delinquent Behavior

Incidences of vagrancy, delinquency, alcoholism, drug addiction, truancy and crime amongst adolescents have seen a sharp increase in the last few years. Boys outnumber girls and most of them are illiterate or have studied up to the primary stage (41 percent primary, 29 percent illiterate); a large number are school dropouts (NCRB 2003)

1.20.11 Unmet Need for Contraceptives

Age specific fertility rate in the age group of 15-19 years contributes to 19 percent of the total fertility rate. Amongst currently married women, the unmet need of contraception is the highest in the age group 15-19 years. Nearly
27 percent of married female adolescents have reported unmet need for contraception (NFHS 2).

1.20.12 Trafficking in Sex Work

Extreme poverty, low status of women and complacency of law enforcing agencies has led to an increase in sex work. Expansion of trafficking and clandestine movement of young girls has also increased across national and international borders.

1.20.13 Premarital Sexual Relations

Most sexually active adolescents are in their late adolescence. Increase in age at marriage, increased mobility and negative peer pressure makes the young people vulnerable to indulging in unsafe sexual behavior.

1.20.14 Recognition of Disability in Adolescents

Disability was reported among 1.99 percent of the adolescents in the 10-19 age group. Among the disabled adolescents, 40 percent reported visual disability and nearly one third (33 percent) reported movement disability. Males generally reported a higher percentage of the disability than the females (Census 2001)

1.21 Adolescent Health Problems

Health problems of adolescence are very different from those of younger children and older adults. Due to lack of accurate information adolescents are prone to various behavioral and reproductive health problems. The period of transition from childhood to adulthood is hazardous for the adolescent health because they develop behavioral problem in the absence of proper guidance and counseling.

Some health problems among adolescents are the consequence of certain respiratory infections repeated diarrhea, poliomyelitis etc and other factors affecting health status like malnutrition etc.,

1.21.1 Irregular Menstrual Cycle

Irregular bleeding in sometimes seen after menarche. In most of the cases the periods get regular within about 2 years of menarche.
1.21.2 under Nutrition

Under nutrition among adolescents girl is a major public health problem in India. Under nutrition during childhood and adolescence leads to impaired growth, anemia, Iodine deficiency etc.

1.21.3 Unprotected Sex and Unwanted Pregnancy

Since adolescent sexuality remains taboo in many societies, there is widespread ignorance among adolescents about risks association with unprotected sexual activity. Unprotected sex may lead to unwanted and unplanned pregnancy which in turn may lead to increased demand for induced abortion. Pregnancy among unmarried adolescent girls may lead them to seek abortion service, from untrained practioners and quacks and become victims of the consequent complications. Termination of unwanted pregnancy through induced abortion among adolescent girls cause greater risk of life than in adult women. Failure in providing proper antenatal care among adolescents may lead to serious complications of pregnancy and child birth.

1.21.4 Risk of Pregnancy in Adolescence

Health of adolescent girls is at high risk if they are married at very young age which leads to consequent early child bearing. The chance of anemia, related fetal growth, pre mature birth and complication during labor are significantly higher for adolescent mother and may even lead to death.

1.21.5 Sexually Transmitted Diseases

A major consequence of unprotected sex among adolescents is the chain of infection from STD’s which include syphilis, gonorrohea and HIV/AIDS. Young adolescents of both sexes who engage in unprotected sexual activities are highly vulnerable to STD’s

Acquiring STDs during adolescence often results in serious consequences in future such as infertility ,pelvic inflammatory diseases, ectopic pregnancy etc.,
1.21.6 Adolescent Pregnancy and STDs

Adolescent pregnancies are high risk pregnancies. Hence for delaying pregnancies there is need to delay the age at marriage. This can be achieved through advocacy, counseling and social as well as legal actions.

Counseling of adolescents can enable them to take proper decisions to prevent pregnancies by adopting abstinence or use of contraceptives for adopting safe abortion services in case of unplanned/unwanted pregnancy.

Use of condom not only provides protection against unwanted pregnancies but also against STD and HIV/AIDS. Counseling and education may be provided to the adolescents regarding the need for practice of safe sex not only to avoid pregnancy but also for protection.

Adolescents have a right to complete correct and detailed knowledge and information relating to their development, physical and psychological changes that take place during adolescence, sexuality in human beings and its implication on their health as well as the means to protect themselves from reproductive health related problem.

1.22 Reproductive Health Status of Adolescents
1.22.1 Girls and Women

The coherence of the role articulation of women, as a wife, mother and an economically mature and productive person is to a large extent conditioned by her adolescence. The onset of adolescence and the associated biological changes makes for a particularly vulnerable phase in the life of women. In a background of poverty, malnutrition, illiteracy and patriarchy, the adolescent girl is deprived of information regarding her reproductive rights. Discrimination of girl child, which begins with her birth, cumulatively and often, organically leads to an adolescence that is characterized by invisibility, malnourishment and deprivation. This impaired access to goods and services by the adolescent is further exacerbated by early marriage and quick pregnancy. At the age of 15-19 28% of women are married. The proportion of marriage at the age of 15-19 is much lower in urban areas (17%) than in rural
areas (30%) (PRC and IIPS 1993) Some of the associated problems are anemia, pre term babies, low birth weight and pregnancy related complications.

1.22.2 Marriage and Fertility Behavior among Adolescent Girls

- 38% of girls in India get married between the age of 15-19 years.
- Mean age of marriage for girls was 19.5 years in 1991.
- 26.1% women were first married by 15 years of age.
- 17% of the total fertility in India is attributed to women in the age group of 15—18 years.
- 8% of India’s 26-27 million annual births are to the mothers under 19 years of age.
- 7.1% of currently married women in the age group 15-19 years are practicing contraception.

The infant mortality rate among live births of adolescent women is about 30% higher, compared to those of older women aged 20-24 years.

1.22.3 Violence against Adolescent Girls

- One rape every 5 minutes.
- One molestation every 26 minutes
- One kidnapped and abduction every 43 minutes
- One act of eve teasing every 51 minutes
- One dowry death every one hour and 42 minutes
- One act of cruelty every 33 minutes and
- One criminal offence against women every 7 minutes

1.23 Crucial Role of Family and Community in Adolescent Health

Family has a crucial role in shaping the adolescent behavior. Parents and adults in the family must ensure a safe and secure and supportive environment for the adolescents during their formative years of growth and development. Family members need to be informed and educated in this regard. A positive and encouraging attitude among parents and family members to interact with adolescents and to give clarification and correct information on their doubts will facilitate better relationship of trust and confidence.
1.24 Educating the Community to Help Adolescents

Adolescents confront a number of problems because of the lack of authentic knowledge regarding their process of growing up, particularly the issues relating to reproductive health. They need accurate information and do not often know from where to obtain this. Educate the community members as well as adolescents about the normal physiological changes with special reference to nutrition and health needs of adolescents. Educate the adolescents about healthy lifestyle and behavior among them. The major health problems of adolescents are stated below:

- Sexual and reproductive health problems
- Nutritional problems
- Mental health problems
- Substance abuse
- Injuries and accidents
- Acute and chronic diseases like (asthma, TB, diabetes etc)

1.25 Adolescent Health Policy

1.25.1 Preamble

This adolescent policy reiterates the commitment to all-round development of adolescents taking into consideration all their needs and rights and gender perspective.

The constitution of India guarantees the right to education of children only up to 14 years and protection against violence and discrimination. Adolescents are covered only partly as adolescents' period extends from 10-19 years in India. Indian government has become the signatory obligation to review all existing legislations for children through the Convention on Right of Children Wisdom. The convention has clearly defined childhood as up to 18 years thus covering adolescents.

1.25.2 The Adolescents Task Force

UNICEF, Chennai responded in a very positive manner to address the needs of adolescent children. UNICEF formed a state level adolescent task force and prepared a comprehensive strategy paper, highlighting the peculiar
needs of adolescent children. The paper also highlighted some of the approaches that can be employed while framing programmes for adolescent children. The strategy paper clearly indicated 5 critical areas for intervention

1. Health and Hygiene and Nutrition
2. Personality development and empowerment
3. Education
4. Protection from exploitation and abuse
5. Improving career and employment potential

I.25.3 Objectives of the Adolescent Policy

The objectives of the Adolescent policy are:

- To provide compulsory, free quality education to all children incorporating academic and skill orientation up to 10th std.
- To create opportunities for formal and non-formal education for boys and girls equally.
- To create access to information and services relevant to integral health of all adolescents such as hygiene, nutrition, mental health etc.
- To provide all adolescents adequate opportunities for acquiring necessary attitude and skills for personality development and empowerment.
- To create awareness among adolescents to resist forms of discrimination and injustice based on gender difference in words and deeds.
- To guide adolescents to prepare for their future employment and career by identifying aptitudes, opportunities and skills.
- To take all possible measures to protect the adolescents against exploitation and abuses.
- To promote legal awareness and understanding of right issues among all adolescents.
- To enable them to have enough opportunities to participate in sports and other recreational activities to make them physically fit and healthy.
• To promote awareness among all adolescents on the importance of protection and preservation of nature including natural resources to maintain good environment.
• To impart training to all adolescent to acquire leadership skills and to be useful citizens in future.
• To provide a special focus on meeting the needs of girl children and most vulnerable children of adivasis, children of commercial sex workers and children of AIDS victims.

1.26 National Policies and Programmes Addressing Adolescent Health

Ministry of Youth Affair and Sports
➢ National youth policy 2003

Ministry of Health and Family Welfare
➢ National health policy 2002
➢ National population policy Year
➢ National AIDS prevention and control policy 2000

Ministry of Human Resource Development
➢ National policy on education, 1996 (As modified in 1992)
➢ National policy for the empowerment of women 2001

Programmes Implemented by the Government

Ministry of Youth Affairs and Sports
➢ Youth affair schemes
➢ Sports schemes
➢ National service scheme
➢ Nehru Yuva Kendra sangethan
➢ Scheme of financial assistance for development and empowerment of adolescents

Ministry of Health and Family Welfare
➢ Reproductive and Child Health (RCH Programme)
➢ National AIDS control programme
Ministry of Human Resource Development

Department of Women and Child Development

- Kishorii shakti yojana
- Swashakti
- Swadhar scheme

Department of Elementary Education and Literacy

- Sarva shiksha abhiyan
- National programme for the education of girls at the elementary level and Kasturba Gandhi swatantra vidyalaya
- Mahila samakya programme
- National population education project
- National adolescents education programme

Ministry of Social Justice and Empowerment

- Scheme for providing coaching to students belonging to SC and ST
- Scheme for educational complex
- Scheme for child help lines
- Services for treatment of drug addicts
- Work place prevention programme

1.27 Constitutional Sexual Reproductive Rights of Women Adolescents

In 1995, the International Planned Parenthood Federation and its 127 member associations approved a charter on sexual and reproductive rights, based on international human rights instruments. They are as follows

- The right to life should be invoked to protect women whose lives are currently endangered by pregnancy.
- The right to liberty and security of the person should be invoked to protect women currently at risk from genital mutilation, or subject to forced pregnancy, sterilization or abortion.
- The right to equality and to be free from all forms of discrimination
I.28 Cairo Conference - International Conference on Population Development

At the International Conference on Population Development in Cairo in 1994, the natives of the world agreed that the focus should be in individual needs instead of demographic targets and that government should give special attention to the education of girls, health of women, the survival of infants and young children, and in general, empowerment of women.

I.28.1 Paradigm Shift

The government has recently adopted this new approach – one that locates family planning services within the target content of reproductive health care. The initiative marks a significant paradigm shift in the Indian context, a change from a population control approach through a top-down target-driven programme, one that provides high quality services that are gender sensitive and responsible to the needs of clients especially women who are major users but have a serious problem of access, both physical and social to health services.

I.28.2 Concept of Reproductive Health

Traditionally, health aspects of human reproduction have been dealt with through the public health approach of “Maternal and Child health” (MCH). Over the past two decades however, important socio demographic changes have taken place that have rendered the MCH approach too narrow to meet all the current concerns in this aspect of health. For example, family planning has increasingly become a way of life, with pregnancies fewer and further between and women claiming their right to have their health needs addressed as women and not merely as mothers. Sexually transmitted bacterial and viral infections have assumed epidemic proportions. Adolescents, a rapidly growing population group – have distinctive reproductive health needs which require special attention. Finally, the reproductive health needs of men also need to be considered.

In response to the changed (and changing) global situation, a new broader concept of “Reproductive and Child Health” has emerged, which offers
a more comprehensive and integrated approach to the current health needs of all in human reproduction.

1.28.3 Definition-Reproductive Health

Health is defined in the constitution of the WHO as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity”. In the context of this positive definition reproductive health is not merely the absence of disease or disorders of the reproductive process, rather it is a condition in which the reproductive process is accomplished in a state of complete physical, mental, social well being. This implies that people have the ability to reproduce, that women can go through pregnancy and child birth safely, and that reproduction is carried to a successful outcome. i.e. infants survive and grow up healthy. It implies further that people are able to regulate their fertility without risks to their health and that they are safe in having sex. The RCH approach is defined as

“People have the ability to reproduce, that women can go through pregnancy and child birth safely, the outcome of the pregnancies is successful in terms of maternal and infant survival and well being and couples are able to have sexual relations free of fear of pregnancy and of contracting the diseases. - International Conference on Population Development in Cairo – 1994”

1.28.4 Reproductive Health care services

Reproductive health care includes the following types of services

> Family planning counseling, information, education, communication and services
> Education and services for prenatal care, safe delivery
> Education and services for post natal care, especially breast feeding and infant and women’s health care
> Prevention and appropriate treatment of infertility
> Abortion including prevention of abortion and management of the consequences of abortion
> Treatment of reproductive tract infections
Information, education and counseling of human sexuality, reproductive health and responsible parenthood.

- Referral for family planning services and further diagnosis and treatment for pregnancy, delivery and abortions etc.
- Active discouragement of harmful practices such as female genital mutilation etc.

According to one estimate, 5,00,000 women die each year in childbirth, 99 percent of whom are in developing countries. Several researches have shown that the major causes of maternal deaths include hemorrhage, obstructed labor, infection, hypertensive disorders of pregnancy and septic abortions. These reasons of maternal deaths are not only similar through out the world, but are for the most part, preventable. What is being realized is that millions of women suffer from morbidities and yet do not seek treatment because of a variety of social, psychological, and cultural factors. These factors operate in very complex manner and leave women in an isolated state of silent suffering. The insensitivity of most population control programmes, particularly in developing countries, was recognized as yet another factor which accentuated women’s health problem.

As a result of these realizations, more than 4000 delegates from 180 nations who met at the International Conference on Population and Development (ICPD), held at Cairo, from 5-13 September 1994, approved a programme of action that reflected a fundamental shift in the attitude of country planners. This document favored promotion of family planning in a broader context of reproductive health care, which included sexual health as well. The concept of reproductive health embodied in ICPD means that

- Every sex act should be free from coercion or infection
- Every pregnancy should be intended and
- Every birth should be healthy

The central theme of the reproductive health revolves around education and empowerment of women. We shall now look at these conceptual issues in
greater detail. It will be better to examine the fact, which have given rise to the need for reproductive health approach.

**1.28.5 Need for Reproductive Health Approach**

How reproductive health approach is different from the various previous approaches such as family planning, mother and child health (MCH) and safe motherhood?. All the previous approaches have so far focused on specific aspects of the reproductive health, for example, family planning programme concentrated on providing information and services on contraception. MCH programmes focused on promoting the health of the mothers and children where as safe motherhood programme has focused on the need to ensure that the pregnant women receive adequate and timely prenatal care, safe delivery and post natal care. Safe motherhood programme also addressed the issues surrounding the high risk that several mothers face during the child birth.

Reproductive health incorporate all of the above aspects in a broad and comprehensive manner. While recognizing the importance of the family planning, the approach emphasizes the reproductive health is not only limited to child bearing ages and that reproductive health concerns both men and as well as women, it also recognizes that there is a need to address the relevant social behavior and cultural practices. Before understanding the essential elements and frame work of the reproductive health, it is important to understand and clarify reproductive health – a bio medical concept. Reproductive health is not simply bio medically determined and is indeed determined behaviorally. Reproductive health problems are routed in a bio medical dimension, but reproductive health seeking behavior are clearly behavioral. Hence, understanding of reproductive health necessitates understanding of the social, cultural and behavioral context by the adolescent population.

**1.29 Need for Investigation**

The investigator as a lecturer for the past 20 years working in Rural Health and Family welfare Training Institute is very much interested in studying the family life Education awareness among adolescent population in
Dindigul district. Dindigul is the head quarter of the Dindigul District. It is one of the most industrially and commercially developed town of Tamilnadu. It has many suburban and semi urban rural areas.

This area of investigation is a long standing thrust area to study the emerging challenges on Family Life Education on Reproductive Health. Adolescents in the country are a heterogeneous group with wide disparities in living, education and health status. Since there is no prototype of a typical Indian adolescent, there can be no uniform Family Life Education programme for them.

So, the investigator shown attention to study the effectiveness of Family Life Education on Reproductive Health among school adolescent population.

An all-out effort in the field of Family Life Education on Reproductive Health is particularly urgent in the context of the policy swing towards reproductive and sexual health.

The World Health Organization defines “Young People” as those between the ages of 10 to 24. This age group is composed of two over lapping sub-groups, namely ‘ Adolescents’ (aged 10-19) and youth (aged 15-24 years) About 20 percent of the India’s population are 1.2 billion are adolescent between the ages of 10 and 19. Their educational and health status, their readiness to take on adult roles and responsibilities and the support they receive from their families, communities and governments will have a profound consequences for the future. Such a large group represents a major resource that can and must contribute to the overall development of the country. Addressing their needs will contribute not only to social and economic development, but also social harmony, gender parity, population stabilization and improved quality of life for all Indians.

Today young people face varied and changing political economic, social and cultural realities. For a many, the certainties of rural tradition and giving way to the complex of city life. Family structures are shifting. Young people are being exposed to new risks and demand. They are deriving more and more information about the world and how to behave from peers and mass media.
Within the framework of human rights established and accepted by the global community, certain rights are particularly relevant to youth. Including gender equality and the rights to education and health. Exercising the rights to health requires access to reproductive and sexual health information and services appropriated their age, capacities and circumstances. Adolescents in the country are a heterogeneous group with wide disparities in living, education and health status. Since there is no prototype of typical Indian adolescent, there can be no uniform Family Life Education programme for them. So there must be specific Family Life Education interventions need to be planned for each location after a systematic analysis of the contexts that affects sexuality in the target group.

There is a need to create appropriate channels of information and value clarification for adolescents on issues related to sexuality and reproductive health. This was felt necessary in view of the growing evidence of increased pre marital sexual activity among adolescents, frequent incidence of early pregnancy due to early marriage that threaten the very health of young girls; and the looming threat of HIV/ AIDS. Extensive coverage of adolescents through Family Life Education programmes is advocated as one of the effective ways of promotion of reproductive health and positive attitudes among adolescents.

The current generation of adolescents is more than a billion strong and will be the largest generation in history to make children to adults. But their health needs, and particularly their reproductive health needs continue to be ignored and neglected and poorly understood and ill served in India. While national strategies and programmes have focused on children and pregnant women, neither services nor research is have focused on adolescents and their unique health and information needs. In a country in which adolescents aged (10-19 years) represent over one fifth of the population the health consequences of their neglect take on enormous proportions.

Health programmes generally have provision for adults and youth and children, but adolescents have largely been over looked. Adolescence is a
period of tremendous opportunity as well as risk, characterized by physical, physiological and social changes while adolescents are not yet adults neither are they completely out of childhood. The 1994, International Conference on Population and Development held in Cairo recommended that governments focus more attention on adolescents through an integrated approach to their health, education and social needs.

There is close association between educational attainment and age at marriage, fertility regulation and health seeking behavior. Studies from India reveal that while age at marriage among illiterate women is 15 years, age at marriage among girls who have completed high school is significantly higher at 22 years. According to National sample survey organization, the work participation rate among rural adolescents aged 15-20 years was 77% for young men and 31% for young women.

Because of early marriage, adolescent fertility in India is very high. Many younger adolescents are physiologically immature for reproduction. Child bearing during adolescence poses greater health risks to both the mother and the new born. Fertility during this period contributes to infant morbidity and mortality, high incidence of low birth weight babies and neonatal mortality and morbidity (Jejeebhoy 1998)

In India, traditionally the transition from childhood to adulthood among females has tended to be sudden. On the other hand as a result of the poor nutritional status of the average Indian adolescent there is evidence that menarche occur 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. Thrusting adolescent females early into adult hood, frequently soon after regular menstruation is established and before physical maturity is attained.
I.29.1 Partners in Reproductive Health – Role of Man

Reproductive health programmes have traditionally focused on women. Increasingly, however we are recognizing men’s influence in reproductive health. Men play key roles in supporting women’s health preventing unwanted pregnancies showing the transmission of STIs, making pregnancy and delivery safer and reducing gender based violence. Further, men themselves need access to clinical services and information on reproductive health a need that must be assessed in context of limited resources.

Many strategies exist to increase men’s constructive participation in reproductive health. Programmes need to promote communication and respect between men and women on reproductive health issues and to help to build the social and negotiating skills of both sexes. Such life skills can influence women’s fertility even without formal education by helping them to make informed decisions and negotiate with their families.

As they stand at the threshold of adulthood, they need authentic reference to their reproductive health needs so that they are well equipped to cope with the problems, which they confront during transitional phase. They need both guidance and independent education as well as opportunities to explore life for themselves in order to attain a level of maturity required to make responsible decisions.

I.29.2 Sexual Behavior and Knowledge among Adolescents

Studies suggest that adolescents have limited knowledge about sexual and reproductive health and know little about the natural process of puberty, sexual health, pregnancy or reproduction. This lack of knowledge about reproductive health including emerging threat of HIV/AIDS may have grave consequences for the country.

Countywide information on adolescent's sexual behavior is not available. The need of the hour is to obtain more culturally and context specific data for formulating interventions that address sexual decision making, gender roles and power relations between the sexes.
1.29.3 Knowledge and Use of Contraception

National family health survey suggests that at least half of all young women in India are sexually active by age 18. Mostly within marriage and almost one in five are pregnant by age 15. Well over half of all married women in the age 15-19 have experienced a pregnancy or given birth (UNPF, 1998). International Institute of Population Sciences conducted National survey on fertility on family planning practices found that adolescents had relatively low levels of knowledge about reversible contraceptive methods.

More opportunities for pre marital sex combined with a lack of knowledge about the body and contraception may be responsible for the increase in the number of unwanted pregnancies and abortion among girls. Because of delays in making a decision or reaching a service provided adolescent abortions are often second trimester, illegal and unsafe. This remains an urgent issue for young people.

Adolescents can face serious physical economic and social consequences from pregnancy and sexually transmitted diseases. Sexual education helps adolescents make responsible choices.

Millions of adolescent world wide are sexually active and at risk of unwanted pregnancy and STDs. Early sexual relationships and reproduction can have a profound effect on health and development of young women and their children (WHO / UNICEF, 1995) For instance unprotected sexual relations among adolescence can result in unwanted and too early pregnancy and child birth, unsafe abortions and STDs including HIV/AIDS and maternal mortality and morbidity thus endangering the physical and reproductive health and productivity of the adolescents.

Adolescents in South Asia often lack reproductive choice such as whether, when and whom to marry, whether and when to have children and how many to have; whether to abort a female fetus; whether to use contraceptives and where to get them. More broadly, adolescents have lot of freedom of choice about where they can study and learn work and earn, keep their own earnings or have to give them to their elders or spouses and whether
they can send their children to school. In many cases, adolescents have dreams and aspirations but little freedom to shape their lives.

The international community has repeatedly agreed to meet young people’s developmental needs, including those relating to reproductive health. Yet young people are too often denied the information and services they need to make healthy, informed decisions about their sexual and reproductive lives.

The social and developmental consequences of reproductive decisions are far reaching. Health education and preparation for the world of work are closely connected. An unintended pregnancy can irrevocably disrupt a young girl’s life, precluding further schooling and training. Contracting HIV is an unprotected sexual encounter can bring young persons prospects for a health and productive future to an end.

Young people have a right to the information and services they need to make healthy decisions about their lives.

The coherence of the role articulation of women, as a wife, mother and an economically mature and productive person is to a large extent conditioned by her adolescence. The onset of adolescence and the associated biological changes makes for a particularly vulnerable phase in the life of women.

So it is in this context that the need for a Family Life Education intervention is strongly felt. The need is particularly felt in India because the school curriculum does not include the crucial elements of reproductive health such as sexual development during the period of adolescence, HIV/AIDS, gender issues, value clarification and promotion of life skills for behavior development. There are the contents on the biological aspects of the reproductive system, but education in these elements cannot complete by giving simply biological information. There is need to focus on physiological, emotional and socio-cultural dimensions of the adolescent reproductive health in a holistic manner. After serious consideration the researcher came to a conclusion on how a consensus has been reached on the issue of introduction of Family Life Education on Reproductive health education in schools with a
view to providing authentic knowledge to students on reproductive health awareness, value clarification and building life skills.

The need of the day is that, the adolescent should be well informed of reproductive health. This study helps to find to what extent the adolescent have known their Reproductive health through Family Life Education.

1.30 Significance of the Study
The researcher has taken up the study of Effectiveness of Family Life Education on Reproductive Health among school adolescent population.

In this experimental study the researcher adopts an active, informal and participatory learning methods so as to create an environment for active involvement of adolescent students in teaching learning process.

There is hope in the evidence that education is the most enabling factor in human being access to income, food, shelter, clear water and health care and over all household welfare. Education might be the magic bullet that will redress the imbalance in power equations and provide Indian with the freedom of choice and autonomy in matters that impinge upon their Social and biological position both within and outside the house hold.

So, the researcher wants to introduce the curricula of Family Life Education among school adolescent population and should therefore encompass information content to promote under standing of reproductive health inculcation of positive values and healthy attitudes towards sexuality improved interpersonal relationships and life skill building for good reproductive health.

The study would promote and improve the capacity building of Higher secondary school population (15-19) mitigating these challenges posed in the promotion of reproductive health in the country. The study would instigate the building up of necessary human resources at all level such as: national, state, and district and block levels among those involved in masters trainers training in Reproductive health education programme.
The study would bring about behavioral and attitudinal changes in the reproductive health of school adolescent population. This study would endorse the adolescence population by

- Giving more life choices (access to get higher education and attain economic prosperity).
- Investing in Reproductive health care and removing the physical, financial and cultural barriers to available services as an important step in the provision of quality care.
- Advocating delays in the onset of sexual activity and first births
- To reach young people, provide them with complete and accurate sexual health information and affordable and youth friendly family planning services and counseling.
- Motivating the parents and teachers to prevent and manage unwanted child bearing. Better access to high quality Family Planning help to prevent unwanted pregnancies, reducing unsafe abortion, involving in promoting hygienic practices where abortion is legal.
- Ensuring universal access to maternal health care.
- Supporting new reproductive health technologies like female condoms, microbicides and emergency contraceptives
- Increasing efforts to address the HIV pandemic
- Involving the parents, teachers and communities in implementing and evaluating programmes.
- Developing partnership so as to broaden support for better reproductive health and
- Measuring progress through monitoring and evaluating the Reproductive health programmes.

This study will identify methods to make the younger generation better adults and healthy adults of the third world countries.

This study would cover the common Family Life Education Programme areas of knowledge of reproductive health, value clarification and life skill
building to enable behavioral change that would promote the reproductive and sexual health of school adolescent population.

The need of the day is that adolescent should be well informed of reproductive health. Schooling and reproductive behavior are closely linked. The adults who are traditional sources of information in sexual and reproductive matters are unavailable also to young people and unfamiliar with current threats of reproductive health.

The girls are more vulnerable to reproductive health problems than boys for both biological and social reasons, and often have little say over the conditions of sexual relations, and child bearing.

1.31 Statement of the Problem

The present research study examines the effectiveness of family life education on reproductive health in school adolescents through an experimental study.

1.32 Title of the Study

“Effectiveness of Family Life Education on Reproductive Health among School Adolescent population.

1.33 Definitions of the Terms

Effectiveness – the extent of achievement of a pre determined objective / goal.

Family Life Education: Family Life Education is an educational process designed to assist young people in their physical, emotional and moral development as they prepare for adulthood, marriage, parenthood, aging as well as their social relationships in socio cultural context of the family and society.

Family- where family is a group of two or more persons joined by ties of marriage, blood or adoption to constitute a single household, who interact with one another in their respective roles and who create and maintain a common culture – Dr. Lucile.

Life – a state of actual existence in the world
Education- education is a learning process or series of learning experiences through which an individual informs and orients himself.

Reproductive health – is a state of complete physical, mental and social well being and not merely the absence of disease and infirmity in all matters related to the reproductive system and its functions and processes.

The pre and post test measurement will be helpful to assess the achievement level of the learners after the experiment of Family life Education on Reproductive Health programmes. .

School – school is the ideal place for learning and cultivating the values of children

Adolescent – the time between puberty and adulthood

Population – population is a group of subjects, one or more characteristics of which the researcher intends to study.

1.34 Objectives of the Study

1. To identify the knowledge level of the students on Reproductive Health in terms of :
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

2. To identify the attitude level of the students on Reproductive Health in terms of :
   a. Area of School
   b. Nature of School
   c. Type of School
d. Sex  
e. Type of residents  
f. Family type  
g. Religion  
h. Parental education  
i. Family income  
j. Media exposure  

3. To identify the significant difference between pre and post test score in terms of:
   a. Reproductive Health knowledge in rural experimental school.
   b. Reproductive Health Attitude in rural experimental school.
   c. Reproductive Health knowledge in urban experimental school.
   d. Reproductive Health Attitude in Urban experimental school.

4. To compare rural and urban adolescent students pre and post test score on knowledge on:
   - Prevention of HIV/AIDS
   - Reproductive Health Issues on Menstruation, Abortion and infertility.

5. To compare Rural and urban students in their attitude on:
   - Importance of Adolescent Stages
   - Sexuality and Sexual Co-ercion.
   - Misconceptions on STI, HIV/AIDS

6. To assess the reproductive health knowledge among the school adolescent population

7. To assess the reproductive health attitude among the school adolescent population.
8. To identify the experimental and control group adolescent boys and girls students on pre and post test score on Family Life Education
   - Parental Education
   - Type of School.

9. To assess the post test score on Family Life Education on reproductive health knowledge among rural experimental and control students of in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

10. To assess the post test score on Family Life Education on reproductive health attitude among rural experimental and control students in terms of:
    a. Area of School
    b. Nature of School
    c. Type of School
    d. Sex
    e. Type of residents
    f. Family type
    g. Religion
    h. Parental education
    i. Family income
    j. Media exposure
11. To assess the post test score on Family Life Education on reproductive health knowledge among urban experimental and control students in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

12. To assess the post test score on Family Life Education on reproductive health attitude among urban experimental and control students in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

13. To develop and validate a module on Family Life Education Programme.

14. To study the effectiveness of the module on Family Life Education on Reproductive Health.

15. To implement the family life education programme on Reproductive
Health through the Reproductive health programme Intervention module.

16. To assess the effectiveness of the programme.

17. To assess the Nutritional status of the school adolescent population.

I.35 Hypotheses

1. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health Knowledge of (rural school) adolescent population in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

2. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of (rural school population in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

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3. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health knowledge of (urban school) adolescent population in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

4. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of (urban school) adolescent population in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

5. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health knowledge of rural experimental students with respect to their level of parental education.
6. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health knowledge of rural control students with respect to their level of parental education.

7. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of rural experimental students with respect to their level of parental education.

8. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of rural control students with respect to their level of parental education.

9. There will be significant difference between the pre and post test score on Family Life Education on Reproductive Health knowledge of urban experimental students with respect to their type of school.

10. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health knowledge of urban control students with respect to their type of school.

11. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of urban experimental students with respect to their type of school.

12. There will be significant mean difference between the pre and post test score on Family Life Education on Reproductive Health attitude of urban control students with respect to their type of school.

13. There will be significant mean difference between the rural and urban experimental and rural and urban control group students post test score on Family Life Education on Reproductive health knowledge in terms of Effectiveness of Module.

14. There will be significant mean difference between the rural and urban experimental and rural and urban control group students post test score on FLE on Reproductive health Attitude in terms of Effectiveness of Module.
15. There will be significant mean difference between the rural experimental and control students post test score on Family Life Education on Reproductive Health Knowledge in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

16. There will be significant mean difference between the rural experimental and control students post test score on Family Life Education on Reproductive Health attitude in terms of:
   a. Area of School
   b. Nature of School
   c. Type of School
   d. Sex
   e. Type of residents
   f. Family type
   g. Religion
   h. Parental education
   i. Family income
   j. Media exposure

17. There will be significant mean difference between the urban experimental and control students post test score on Family Life Education on Reproductive Health Knowledge in terms of:
   a. Area of School
b. Nature of School
c. Type of School
d. Sex
e. Type of residents
f. Family type
g. Religion
h. Parental education
i. Family income
j. Media exposure

18. There will be significant mean difference between the urban experimental and control students post test score on Family Life Education on Reproductive Health attitude in terms of:
   a. Area of School
   b. Nature of School
c. Type of School
d. Sex
e. Type of residents
f. Family type
g. Religion
h. Parental education
i. Family income
j. Media exposure

In this chapter elaborately discussed the adolescent health problems, status condition, policy, programmes, need and significance of the study. In the following chapter is a review of literature of Indian and foreign studies on Adolescence are discussed.