CHAPTER 1
INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Adolescence is often described as a phase of life that begins in biology and ends in society. The word adolescence is derived from a Latin verb "adolescere" which means to grow into maturity. It also means "to emerge". Adolescence is a formative and the most fascinating period of human life that marks the transition from childhood to adulthood and during this period, new adjustments in life situations will have to be made. Stanley Hall (1904) had characterized adolescence as a period of "storm and stress". Adolescence is also described as a period of sexual development (Barber, 2004).

World Health Organization (WHO) defines adolescence as the period of life between 10-19 years, youth as between 15-24 years and young people as those between 10-24 years. Though the age group is defined as 10-19 years, it is recommended by WHO that the adolescent programs be targeted to the age group of 13-19 years (WHO, 2004). One out of every five people in the world is an adolescent. Of the estimated 1.2 billion adolescents in the world today, 85% live in developing countries, nearly half live in Asia and nearly one in four – 282 million live in South Asia. Bangladesh and Pakistan have the greatest proportion of adolescents while India has the greatest absolute number (United Nations, 2001).

India is a home for more than one billion people, of which one fifth are adolescents in the age group of 10-19 years of age. It is estimated that there are
around 190 million adolescents (10-19 years) in India. Further, it is expected that this age group will continue to grow, reaching over 214 million by 2020. However, growth for this age group will peak at 223 million in 2015 and will then slow down (Registrar General and Census Commissioner, 2001). At present, there are 207 million adolescents in the age group of 10-19 years in India (Chopra, 2007).

Adolescence is a period of sexual maturity that transforms a child into a biologically mature adult, capable of sexual reproduction. It starts with a period of very rapid physical growth, accompanied by the gradual development of reproductive organs, secondary sexual characteristics and menarche in girls. The rapid growth of the entire body, enlargement and maturation of pelvic organs are not complete and still continues in adolescent girls. In other words, an adolescent girl is still a child, and is not yet prepared for pregnancy and motherhood. This is a period during which the adolescent is in the second genital stage of psychosexual development. An adolescent is in the stage of identity versus confusion before entering into the stage of intimacy versus isolation as stated in Erikson’s life cycle. Personality development too continues and is almost completed by 16 years of age (Whaley and Wong, 1998).

The health and wellbeing of adolescents is closely related to their physical, psychological and social development. Good health during the adolescent period enables them to enjoy, at the same time provides the foundation for their adult life. They very soon bear the future generation. They are also the breeding grounds for new ideas, talents, energy, languages, and values. The new ideas that adolescents acquire from school and other strong social forces may have significant impact on the society too. In many ways, a nation’s fate lies on the
strength and aspirations of its youth. One of the most important commitments a country can make for future economic, social and political progress and stability is to address the health and developmental needs of adolescents. Research from the World Bank also shows that investments in adolescent health and development translate into significant long term benefits for entire societies as reported by UNICEF (2004).

Adolescents are generally thought to be healthy and death seems so far removed or almost unthinkable. Yet, many adolescents die prematurely. Every year an estimated 1.7 million young men and women between the ages of 10-19 lose their lives globally – mostly through accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable (WHO, 2004). Therefore adolescents should be considered as a distinct group with special needs. Healthy growth of adolescents is of great concern today. It has become an increasingly important focus for governments, foundations, and behavioural researchers. Health promoting attitudes and practices during adolescence have a great influence on the health of the adolescents.

Habits formed and choices made during adolescent period have long lasting implications for individuals and public health, which will determine the health of this generation as adults, as well as, the health and future of the nations. Adolescents may not have established their sexual habits and if safer behaviours can become their norm, then there is an opportunity to limit the health risks. They are put at risk by sexual and reproductive health hazards, which are increasing in many countries in the world. Young persons are becoming sexually active at earlier ages than ever before. Attitude towards sex among adolescents
in India is conservative. Responsible sexual behaviour in the opinion of adolescents is to stay away from opposite sex. But, the rise of tele-communication, decline in communication among family members, early onset of menarche and exposure to mass media are contributing to an increase in unprotected sexual relations before marriage.

The Chennai study by Sathiyanathan (2007) among school students reported that 13% of male and 10% of female school going adolescents clearly approved premarital sex. A Delhi study by Mehra and Agarwal (2004) found that 15% of male and 6% of female adolescents reported premarital sexual activity. Trikha (2001) reported that despite the general censure of premarital sex, 14-16% of adolescent boys and 1-10% of adolescent girls engage in premarital sexual activity in Haryana. The author also stated that premarital sexual relations tend to occur among Indian adolescents secretly, without full information and without protection. Abraham and Kumar (1999) also found that 26% of boys and 3% of girls in selected colleges of Mumbai city were involved in premarital sexual activity. This early sexual activity is not often accompanied by appropriate knowledge which has been reported by many studies (WHO, 2003).

India has been traditionally a male dominated society. There is a strong son preference in most parts of India and girls tend to be discriminated by their families. It is not enough therefore to highlight adolescents in general, and a larger focus on the adolescent girls is needed. Gender discrimination starts with female feticide. Sex pre selection is popular in many States in India, like Maharastra, Rajasthan, Punjab, Haryana and Tamilnadu. There is an unfavourable sex ratio of 927 females to 1000 males in the country. As reported
by the Registrar General and Census Commissioner (2001), the child mortality rate is also considerably higher for girls (37 deaths per 1000) than boys (25 deaths per 1000) and the adolescent girls continue to be a vulnerable group, particularly in developing countries, where they are traditionally married at an early age. Then they become mothers soon, still unarmed with knowledge about reproductive needs and rights.

Adolescent girls are generally expected to enjoy good health, but this does not seem true in the rural areas of a developing country where poverty, malnutrition and repeated infections exist. Studies have shown poor general health of rural adolescent girls. Having survived with various hazards of infancy and childhood, these girls continue to suffer from the after effects of poor nutrition and adverse socioeconomic conditions (Joseph, Bhattacharji, Joseph & Rao, 1997). A good number of adolescent girls are deprived of nutrition, access to health care, and opportunities for education and employment. They suffer mostly from anemia and malnutrition. In many parts of India, adolescent girl’s food intake is more likely to be inadequate in all nutrients and it results in morbidity and mortality. According to WHO (2003), as high as 42% and 55% of adolescent girls are found to be anemic in Nepal and India respectively. Observations from India indicate that the growth stunting among adolescent females (45%) is greater than adolescent males (20%).

Majority of the adolescent girls in rural areas of India are taken out of schools when they attain menarche. This is evident in the study by Kurz and Johnson-Welch (1994). The author reported that in rural areas, 32.7% of female adolescents aged 15-17 attended the school compared to 60.5% of female
adolescents in urban areas. Therefore the adolescent girls grow into adulthood without being able to experience the important period of adolescence. The non-school going adolescent girls in rural areas seemed to be reserved and inhibited about voicing their opinions. The predominant feelings of rural adolescent girls are fear and apprehension, fear of society, fear of parents and family members since they have lot of restrictions especially in relation to their behaviours.

The adolescent girls’ lives are busy with overwhelming responsibilities of earning income through casual agricultural labour. They work in the homes, look after siblings and assist their mothers in the fields. Their social life is very much restricted and there are limited opportunities for going out and getting an exposure to the outside world. They are very sensitive but non-vocal about son-daughter discrimination. Adolescent girls in rural areas live under severe restrictions of cash even for small necessities as well as luxuries. They have no privacy at home and are hesitant to ask questions and share their problems especially with parents. They feel free with their friends who are also in a similar stage. Their ways of coping with stress and conflicts are also subdued since expression of emotions by girls are not encouraged in our country.

Presumably, urban girls have better education and this leads to delayed marriages because a girl generally does not marry while she is studying. Better education leads to paid employment in formal sector by increasing opportunities in the service sector that provides clear alternative to the early marriage. On the other hand, rural girls have lesser opportunities for higher education which lead to dropping out from schools. They have no other alternatives, and so enter into
early marriage and exposed to a greater risk of reproductive morbidity and mortality. Many rural adolescent girls marry before the completion of their overall growth leading to many reproductive health problems in their future lives. Early onset of sexual activity results in early marriage, which pressurizes the adolescent girls in rural areas to prove their fertility immediately after marriage. Therefore for a large number of girls, adolescence can be best defined as the period, which starts with premature end of education and ends with the premature start of pregnancy and child bearing or even death. For many girls, it can also be a stressful period.

A large proportion of adolescent girls suffer from various gynaecological problems particularly menstrual irregularities. As many as 40-45% of adolescent girls report menstrual problems in India. They are mainly due to psychological stress and emotional changes because of lack of appropriate information as reported by International Institute of Population Sciences (IIPS, 2000). Although most of their symptoms are normal among adolescents, these need to be mentioned particularly in the Indian context because most of the girls are not aware of this natural phenomenon. Reproductive tract infections are of special importance for sexually active adolescent girls. This is because their symptoms are less obvious, they don't share their problems with caregivers, and so the treatment is more likely to be delayed. AIDS and other Sexually Transmitted Infections (STIs) are a growing problem today among adolescents but, many do not understand about these diseases and their prevention. Undoubtedly, hazardous child labour in India largely resulted in physical and sexual abuse of adolescent girls that has been linked to the current and future risks for STIs and AIDS (Heise, 1994).
Social and economic changes like urbanization and industrialization have eliminated many of the traditional restraints on early sexual activity outside marriage and have exposed many adolescent girls to the risks of unwanted pregnancy and abortion. This in turn increases the risks to their reproductive health and well being. Data compiled by Alan Guttmacher Institute (1998) revealed that between 33% and 66% of births among teenagers are unplanned in many countries in the world. The phenomenon of unwed mothers is quite common in Europe, Africa and America, and is also now reported in India which may cause maternal mortality as well as morbidity.

Many adolescents who experience an unplanned pregnancy resort to abortion. A high number of abortions occur in countries with very restrictive abortion laws like India and USA. Abortions among adolescent girls in India are estimated to be up to 4.4 million per year, most of which are unsafe, performed illegally and under hazardous circumstances by unskilled practitioners. And also, there is hardly any official data or authentic research based information regarding incidence of abortions among unmarried adolescents in India (Trikha, 2001). Statistics reveal that abortions among unmarried adolescents in the Government Hospital, Chennai in the year 2004 was 165 and it was 599 in a private hospital. Among them, 22.1% were in the age group of 13-15 years, 21.8% were aged 16-17 years and 55.2% were between 18 and 19 years. It was surprising to note that majority of the abortion seekers among unmarried adolescents (62.6%) were from rural areas (Gowri, 2006).

In India, the family system in olden days was the joint family system where the parents, in laws and children were living together in the same house
especially in the rural areas. The change in the family system from joint family to nuclear family had led to absence of elders in the family especially, the grandmothers who usually taught the adolescent girls about family life and had a control over the behaviour of adolescent girls. At the same time, traditional and conservative societies are still more common in the rural areas of Tamilnadu where sex is still considered as taboo and sexual matters are not discussed freely in the family.

As adolescents mature and become sexually active, more young people face serious health risks due to inadequate factual information or too little information about their sexual responsibility. Most adolescents tend to be extremely unaware of their own bodies, their health, physical wellbeing and sexuality. Kamble (2001) reported that half of the adolescent girls aged 12-15 years residing in rural areas do not know about menstruation until its onset. The great majority of adolescents are poorly informed about sexuality and reproduction. Parents believe that withholding information about sexuality and reproduction from young people will dissuade them from becoming sexually active. As a result, they get information about sexuality from their friends, whose views are often inaccurate, based on rumors as well as from the sensationalized mass media messages. This results in a lot of anxieties and confusions among adolescents.

In the midst of the above situations, the emergence of AIDS has focused everybody’s attention towards the role of family life education. The growing incidence of sexual relationship among adolescents and increasing number of premarital pregnancies coupled with the gradual erosion of the institutions of
marriage and family have impelled educational and health care planners to start the process of imparting education about family life. Adolescent Family Life Education (AFLE) is a process that informs, motivates and helps people develop healthy sexual practices and lifestyles. Researchers have found that good quality family life education can delay sexual activity among adolescents and protect them from Sexually Transmitted Infections (STIs) including AIDS. It can also clarify their values, avoid risk behaviours and improve negotiation skills (Barnett, 2007). But in India, school systems are ambivalent about imparting sex education. Even though in some schools in Andhra Pradesh and Karnataka, where sexual and reproductive health education exists in the curriculum, teachers are too often embarrassed and uncomfortable to effectively teach on family life education. In Tamilnadu, family life education is not included in the school curriculum.

Health promotion in adolescents is “the process of enabling adolescents to increase control over and to improve health”. It includes family life education, environmental modifications and lifestyle/behavioural changes (Butler, 2001). The young people of today are the greatest investment in the future. Therefore, health promotion and disease prevention should be the major focus of adolescent health efforts. The life style patterns adopted during adolescence often continue thereby influencing long term prospects for good health and in reducing the risk of chronic diseases.

A study done by Ackard and Neumark-sztainer (2001) in Minnesota, USA on Health care information sources for adolescents reported that parents and the health care providers were the key sources of health related information.
Although adolescents may be embarrassed having discussions with the health care providers initially, adolescents do believe that these topics should be addressed by the health care providers. It also concludes the importance of health care providers to initiate and facilitate discussions on these topics. As a key health care provider in the community, the nurse can facilitate health promoting behaviours among adolescents (Synder, 1989). As community health nurses, the care and nurturing we offer to the adolescent is just as important as what we offer to children and the elderly. Nurses being the key members in the public health team, they play an important role in helping adolescents to cope with their sexual development and risk behaviour. Community health nurses are in a unique position to promote the adolescent health in relation to family life through purposeful interventions. They should understand the situation of adolescent girls and respond effectively to their sexual and reproductive health needs. It is the responsibility of the community health nurses to create a positive attitude among adolescent girls about family life which will enable them to make informed choices in their life.

Health promotion in adolescents represents, “a mediating strategy between the adolescents and their environments, synthesizing personal choices and social responsibility in health” as stated by WHO (Butler, 2001). AFLE can be the mediating strategy in the promotion of sexual health and prevention of risk behaviours. Adolescents are receptive to new ideas. They are keen to make the most of their growing capacity for making decisions. Their curiosity and interest are a tremendous opening to foster personal responsibility to health. Therefore, a comprehensive study is needed to find out the existing knowledge of adolescent girls, the prevalent practices and their attitude about reproductive health. A
research mechanism is also needed for tracking the changes in knowledge, attitude and practice as a result of family life education program and is urgently required in terms of its specificity, social relevance and impact.

1.2. SIGNIFICANCE AND NEED FOR THE STUDY

Adolescence is the second decade of life, marking the transition from childhood to adulthood during which, the adolescents experience maximum amount of physical, psychological and behavioural changes following puberty. Adolescence offers unique opportunities for investment in health and well-being. First of all, good mental health and physical health enable young people to make the most of these precious years, which provide the foundation for adult life. Secondly, the behaviours adopted by the adolescents influence the health of their adulthood and the risk of chronic diseases. Finally, while the death rate among young people is low, most of these deaths are preventable.

The Planning commission of India estimates that adolescents aged 10-19 years comprise 23% of the Indian population. According to the Census India (2001), there are 120 million adolescent girls in the age group of 10-19 years in Tamilnadu, of which 33,90,844 live in rural areas. There are 2,16,539 adolescent girls who live in the rural areas of Vellore District (Registrar General and Census Commissioner, 2001). Such large group represents major human resource that can and must contribute to the overall development of the country. Addressing the needs of adolescents will definitely contribute not only to social and economic development of the country but also to the social harmony, health status, population stabilization and improved quality of life for all Indians.
The blossoming of adolescence in each generation is as fascinating a sight as an unfolding of spring each year predictable and repetitive. Yet, for millions of young people worldwide, adolescence is one of the most dangerous cross roads. Although most adolescents have preoccupation with their bodies, they are not always engaged with activities that will protect and develop them. Adolescents are often exposed to peer pressure, the effects of which may impact negatively on their behaviour and health. They are hormonally fully charged and adolescent sexuality can have enormous effects on their future physical, psychosocial, moral and sexual development. Before they reach adulthood, their relative powerlessness and emerging sexuality leave them vulnerable to exploitation and at risk for many forms of discrimination, violence and ill health.

Adolescents are at a crucial phase because of many facts. Studies suggest that the adolescents have limited knowledge about sexual and reproductive health and know little about the natural process of puberty, sexual health, pregnancy and Sexually Transmitted Infections (STIs). Mukerjee et al. (2001) conducted a survey on knowledge of reproductive health issues among school going teenagers of rural Bengal. This survey revealed that though the teenagers had a satisfactory knowledge about legal age at marriage, they lacked information about the various issues of reproductive health. This study reflected on the real picture about the ignorance of reproductive health issues among school going teenagers especially the female teens who are the future mothers of the society. Much of their knowledge remains superficial and ridden with myths, misconceptions and beliefs, based on inaccurate or incomplete information. According to Jejeebhoy (2000), lack of knowledge about reproductive health, the
emerging threat of unsafe abortions, Sexually Transmitted Infections including HIV/AIDS may have grave consequences on the country.

Yet, in India, as in many parts of the world, talking about sexuality is not welcomed and is shrouded in secrecy. Unfortunately, in spite of the occurrence of Sexually Transmitted Infections (STIs) including HIV/AIDS, unwanted pregnancies, unsafe abortions and countless unhealthy practices, there is still a large unmet demand for adequate reproductive and sexual health information, culminating in various risky practices. Though it is the largest unmet need for adolescents after their academic and career concern today, adolescent sexuality is denied, reproductive health is ignored and queries go unanswered (Family Planning Association of India (FPAI), 2004). Adolescent Family Life Education (AFLE) is one of the strategies for promotion of reproductive health. Adolescents are curious about their reproductive biology and hence they would be more receptive to the family life education. It is an ideal time to provide family life education before responsibilities begin.

“Basic information on reproductive health is important for youth just as basic information about other types of health issues is important, says Dr. Cynthia Waszak, a Family Health International researcher who is an expert in adolescent health. Family life education programs may be the only place where young people can learn accurate information about reproductive health. Family life education programs may offer the only setting in which young people can practice the skills necessary to maintain good reproductive health” (Barnett, 2007).
The importance of adolescent family life education has been recognized at the global level by the 2001 UN General Assembly Special Session. It was decided to ensure that by 2010 at least, 95% of young men and women have access to the information, education including youth specific education on family life to reduce their vulnerability to sexual health problems (WHO, 2004). The school health program implemented by the Government of India, since 1960’s seems to be the only existing outreach education program for adolescents. In spite of these efforts, the school health services provided are inadequate because of administrative, managerial and logistic problems. India, the youngest nation in the world did not have a specific policy for protection of the sexual and reproductive health of unmarried adolescent girls. Realizing this need, the National Health Policy (2002) has defined adolescents as an underserved vulnerable group that needs to be addressed especially by the provision of reproductive health information and services. The Government of India in its Reproductive Child Health Program – Phase II insists on the importance of reproductive health of adolescents (Nair, 2002).

An extensive education related to reproductive health issues should be considered as a preventive measure. Keller (1995) described a good family life education as “a program that includes the right to regulate one’s own fertility with full knowledge of reproductive biology, menstruation, conception, contraceptive choices, the ability to control sexuality and freedom from infections / sexual diseases”. Handa (1995) stated that proper dissemination of information on sexual matters is essential to help adolescents to develop a correct and healthy attitude towards sex and to enter into adult life with a wholesome attitude towards reproductive health. The author also recommends that AFLE to be undertaken in
different settings especially in rural areas and that experimental studies to be undertaken to validate and standardize AFLE program. Nurses have an important role in ensuring that the adolescents learn the correct information related to the consequences of unhealthy behaviours and life styles. Nurses also should encourage the parents to be role models and they need to reinforce good health practices in adolescents.

It is evident that, the education on reproductive health is important to develop mature and healthy sexual attitudes and sexual responsibility among adolescents to prevent behaviors that place them at risks of adolescent pregnancy, Sexually Transmitted Infections and AIDS. Literature review reveals that only limited number of studies are available on adolescent reproductive health in South India especially in Tamilnadu. Most of the studies are done in cities and towns focusing on the married adolescents. The sexual health needs of unmarried adolescent girls are not addressed much. The available studies too do not provide sufficient information, since they are done on a small sample and many are unpublished reports. Therefore there is a limitation in generalizing the study findings.

The sexual and reproductive health problems among unmarried adolescent girls are increasing day by day. Early marriages, premarital sexual activity, unmarried adolescent pregnancy, unsafe abortions, menstrual problems and reproductive tract infections are the common problems found among adolescent girls. The adolescent girls are unaware of the dangers of these problems and they do not have adequate knowledge about the sexual and reproductive health. Adolescent Family Life Education (AFLE) Program is
therefore essential to bring about reduction in age at marriage, teenage pregnancy, maternal mortality and morbidity, delay in first intercourse, protect sexually active adolescents from unwanted pregnancy/abortion by use of contraceptives and protect them from Sexually Transmitted Infections (STIs) including HIV/AIDS. As a key person in providing the family health services in the community, nurses need to assess the current knowledge, attitude and practice of adolescent girls about family life and understand the impact of AFLE program on adolescent reproductive health. The study findings would be instrumental in formulating strategies for adolescent health services in the community at large using AFLE as one of the inbuilt program.

1.3. STATEMENT OF THE PROBLEM

Literature review reveals that adolescent girls tend to be poorly informed about their own bodies and matters related to sexuality and health. The information they have is often incomplete and confused. The vulnerability to various risks/health problems and the gender inequalities limit the abilities of adolescent girls to contribute effectively to the society’s social and economic growth and development, especially in developing countries. Limited access to family life education and attitudes that prohibit discussion of sexual health exacerbate their ignorance. Further they lack appropriate family life skills that are needed in future to promote the health of mothers and children. As gate keepers, nurses should play a central role in enabling adolescents to protect their health and promote healthy behaviours.

In the CONCH program area, it was observed that unmarried adolescent girls became pregnant and resorted abortions indicating their involvement in
premarital sexual activity. Problems related to menstruation and reproductive tract infections were seen in large numbers. Media reports too highlight the increase in sex crimes, sexual abuse and exploitation of young girls in the Vellore District. The investigator through her community health field experience in the CONCH program area as well as in the areas around Vellore Town, felt that the sexual and reproductive health needs of adolescents especially the rural girls are not addressed adequately.

Considering the above, an experimental study was undertaken to assess the effectiveness of Adolescent Family Life Education (AFLE) program on adolescent girls' knowledge, attitude and practice about family life in a rural community of Vellore District, Tamil Nadu, South India

1.4. OBJECTIVES OF THE STUDY

The objectives of this study were to:

1. Develop an instrument to assess the knowledge, attitude and practice of adolescent girls about family life.

2. Assess the knowledge, attitude and practice of adolescent girls about family life before AFLE (Pretest) both in the control and experimental groups.

3. Assess the knowledge, attitude and practice of adolescent girls about family life after AFLE (Posttest) both in the control and experimental groups.

4. Determine the effectiveness of Adolescent Family Life Education (AFLE) program on the knowledge, attitude and practice of adolescent girls.
5. Determine the relationship between knowledge, attitude and practice of adolescent girls about family life before and after AFLE (Pretest and Posttest).

6. Determine the association between knowledge, attitude and practice of adolescent girls about family life before AFLE (Pretest) and selected socio-demographic and personal characteristics of adolescent girls (age, religion, education, occupation, type of family, family income, attainment of menarche, age at menarche, information received about menarche and sexuality, sharing information about sexuality and presence of menstrual problems) and selected socio demographic characteristics (education and occupation) of their parents.

1.5. OPERATIONAL DEFINITIONS

**Effectiveness** in this study refers to the significant increase in the level of knowledge, attitude and practice of adolescent girls of experimental group who had participated in the AFLE program, compared to the girls in the control group who did not participate in the AFLE program, as measured by the instrument prepared by the investigator on knowledge, attitude and practice about family life.

**Adolescent Family Life Education (AFLE)** addresses the biological, socio-cultural, psychological and moral dimensions of sexuality from the cognitive, affective and psychomotor domains including skills to communicate and make responsible decisions (WHO, 2004).

**AFLE** in this study refers to a planned structured teaching program on selected aspects of family life which includes

- Human reproductive system including puberty
- Menstruation and menstrual hygiene
- Responsible sexual behaviour
- Pregnancy / Conception
- Contraceptives
- Sexually Transmitted Infections including HIV / AIDS

Adolescent girls in this study refer to unmarried girls in the age group of 13-19 years.

Knowledge is the information and understanding that is gained through education or experience. In this study, it refers to the awareness of adolescent girls about selected aspects of family life which is given as verbal responses as measured by Part II of the AFLE Instrument prepared by the investigator.

Attitude is the way that we think and feel. In this study, it refers to the expressed beliefs and feelings of adolescent girls, towards family life as measured by Part IV of the AFLE Instrument prepared by the investigator.

Practice is the way of doing something which is the usual or expected way. In this study, it refers to the behaviour of the adolescent girls, related to menstrual hygiene as measured by Part III of the AFLE Instrument prepared by the investigator.

Rural community refers to the 21 villages served by the College of Nursing Community Health Nursing Department (CONCH), Christian Medical College, Vellore.

Socio-demographic characteristics of adolescent girls include age, religion, education, occupation, family income and type of family.

Personal characteristics of adolescent girls include attainment of menarche, age at menarche, information received about menarche and sexuality, source of
information, sharing information about sexuality and presence of menstrual problems.

**Socio-demographic characteristics** of the parents of adolescent girls in this study include the educational and occupational status of the mothers and fathers of adolescent girls.

1.6. RESEARCH HYPOTHESES

H1. There is a significant increase in the level of knowledge, attitude and practice about family life among the adolescent girls who participate in the AFLE program, compared to those who do not participate in it.

H2. There is a significant relationship between knowledge, attitude and practice of adolescent girls about family life

H3. There is a significant association between knowledge, attitude and practice of adolescent girls and selected socio-demographic and personal characteristics of adolescent girls (age, religion, education, occupation, type of family, family income, attainment of menarche, age at menarche, information received about menarche and sexuality, sharing information about sexuality, presence of menstrual problems and selected socio-demographic characteristics of their parents (education and occupation).

1.7. ASSUMPTIONS

1. There is a dismal lack of information about sexuality among rural adolescent girls.

2. In Indian culture, young people receive knowledge about family life within marriage alone.
3. Information, Education and Communication (IEC) activities promote health, prevent diseases and enhance early health seeking behaviours.

4. Knowledge and attitude of people have a strong influence on the adoption of healthy behaviour.

5. Parents lack knowledge and are embarrassed to talk about family life, and the adolescent girls are not provided with adequate information about family life.

1.8. LIMITATIONS OF THE STUDY

1. Selected aspects of family life education only were included in the AFLE.

2. While assessing the practice of adolescent girls, only menstrual hygienic practices were assessed through self reporting.

3. Self reporting has its own limitations due to its element of subjectivity.

4. The personal nature of the questions may make the adolescents reluctant to answer truthfully

5. It is very difficult to isolate the effect of AFLE from those of other sources of information, such as mass media, parents, teachers, peers etc.

1.9. PROJECTED OUTCOME

The study helped to find a reliable, suitable and culture specific instrument to assess the knowledge, attitude and practice of adolescents about family life in the South Indian context. The study also enabled to evaluate the impact of adolescent family life education program on rural adolescent girls. Knowledge about the adolescent behaviour can help nurses understand, interpret, and promote healthy behaviours among adolescents. Good quality AFLE program can help delay first intercourse, and protect from Sexual Transmitted Infections,
including HIV/AIDS. Adolescents who participate in AFLE program before becoming sexually active are more likely to delay initiation of sexual activity and learn about responsible and safe sexual behaviors. The long term effectiveness of this study would help in the improvement of the adolescent’s quality of life in terms of marriage at an ideal age, safe and responsible sexual behaviors, reduction in teenage pregnancy, unwanted pregnancy/unsafe abortions, reduction in maternal morbidity and mortality freedom from fear of conception, myths related to family life and freedom from STIs/including HIV/AIDS.

The study findings would provide a framework necessary for culturally specific design of effective health promotion and intervention programs. It would also assist the nurses to prepare themselves to give effective family life education based on the social and cultural background of people. The community health nurses would benefit from the current findings while including adolescent health services in providing family health services in the community and use the AFLE program - teaching module. It would provide guidelines to prepare a specialized training on Adolescent Health Nursing for nurses. The study is hoped to provide an empirical basis to plan an ongoing Information Education and Communication (IEC) activities for school going and non school going adolescent girls in the area of family life as well as to establish strategies and principles that can support programs for improving adolescent health. The study findings would provide a basis for the modification of community health program models and approaches. They would also lead to modifications in the interventions, developing future modules for parents, teachers and communities in order to create a more supportive environment for adolescent girls in the promotion of sexual and reproductive health.