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**Knowledge and Adoption of family planning practices among adolescent mothers  
in rural Tamil Nadu.**

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**Abstract:**

*Adolescent pregnancy is a complex issue with many reasons for concern; it is an important public health problem as well as socioeconomic challenge to society. Approximately 15 million young females aged 15-19 give birth each year, accounting for more than 10 per cent of all babies born worldwide. Only about 17 per cent of them use contraception. A large number of adolescent girls are facing the risk of unplanned pregnancies, sexually transmitted infections and unsafe abortions. Most of the sexually active adolescents are frequently unprepared to protect themselves from unwanted pregnancy or infections. The negative health and socioeconomic consequences associated with adolescent pregnancy is worrisome. The high rate of teenage pregnancy in developing countries, has been attributed to factors such as: lack of knowledge of sexuality, peer group influence, lack of knowledge and/or ineffective use of contraceptives, low socioeconomic status, family instability, early age of marriage and cultural permissiveness's*

**Key words:** Adolescents, Knowledge, health problems etc.,

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## **I. Introduction**

In the past few years the issue of adolescent pregnancy has been increasingly perceived as a social problem. Adolescent pregnancy is a complex issue with many reasons for concern; it is an important public health problem as well as socioeconomic challenge to society. Pregnancy in a girl aged between 10 and 19 years is adolescent or teenage pregnancy. The high rate of teenage pregnancy in developing countries, has been attributed to factors such as: lack of knowledge of sexuality, peer group influence, lack of knowledge and/or ineffective use of contraceptives, low socioeconomic status, family instability, early age of marriage and cultural permissiveness's. The negative health and socioeconomic consequences associated with adolescent pregnancy is worrisome (Treffers P.E.2003). Several studies have reported an increase in pregnancy complications associated with adolescent pregnancy, such as: anemia, hypertension, eclampsia, prolonged or premature labour, dysfunctional labour, pregnancy-related infections, postpartum hemorrhage, and premature rupture of membrane and higher rates of premature and/or low birth weight babies. Approximately 15 million young females aged 15-19 give birth each year, accounting for more than 10 per cent of all babies born world wide. Only about 17 per cent of them use contraception. Young mothers, especially those under 16, face increased likelihood of serious health risks. The risk of death in childbirth is five times higher among 10-14 years olds than among 15-19 year olds and in turn, twice as high among 15-19 year-olds as among 20-24 year-olds. Teenagers are over represented among those obtaining abortion and even more so among those needing medical care for complications of unsafe abortion, when adolescents bear children, their offsprings also suffer higher levels of morbidity and mortality. The incidence of Sexually Transmitted Diseases (STDs) is also disproportionately high among young people. One in 20 adolescents contracts a sexually transmitted disease each year, and half of all cases of HIV infection take place among people under age 25 (Arundhati Mishra, 2002).

## **II. Objectives:**

- To assess adolescent mothers knowledge and adoption of family planning methods in rural areas
- To suggest appropriate programme strategies to meet the reproductive health needs of adolescent mothers in rural areas

## **III. Methodology:**

The study was carried out on a sample of 400 adolescent mothers aged 15-19 years selected from two districts of Tamil Nadu. The sample for the study was selected based on the multistage random sampling procedure. After the selection of districts, one Primary Health Centre (PHC) was selected from each of the selected districts. In the next stage, two sub-centres were selected at random from the selected PHC. In the next stage, two villages were selected at random from each sub-centre. All the married adolescent mothers in the age group of 15-19 years with the experience of at least one child birth were listed out from the records and registers maintained by the Anganwadi workers. From the list, a sample of 50 adolescent mothers was selected from each village using systematic random sampling procedure.

## **IV. Result and Discussion**

### **FAMILY PLANNING**

In order to assess the adolescent mothers' knowledge and adoption of family planning methods, informations were collected on various aspects of family planning such as their knowledge, attitude and adoption of family planning methods. The results of the analysis of data on various aspects of family planning methods by selected background characteristics are presented in this section.

#### **Level of autonomy**

The percent distribution of adolescent mothers by level of autonomy is presented in table 4.1 showed that 34 per cent of adolescent mothers had high level of autonomy, followed by medium level (33.5 per cent) and low level of autonomy (32.5 per cent).

**Table 4.1** Percent distribution of adolescent mothers by level of autonomy

<b>Level of autonomy</b>	<b>Number N=400</b>	<b>Percent</b>
Low	130	32.5
Medium	134	33.5
High	136	34.0

#### **4.2 Knowledge about various family planning methods**

The percent distribution of adolescent mothers by their knowledge about various family planning methods and level of autonomy is presented in table 4.2. It is observed that, most of the adolescent mothers (93.0 per cent) reported to have the knowledge of female sterilization which was followed by copper-T/IUD (78.3 per cent), male sterilization (72.8 per cent), condom (59.3 per cent) and oral pill (56.0 per cent). Rhythm and withdrawal methods were reported by only 12.0 per cent and 3.0 per cent of adolescent mothers respectively. It is observed that the knowledge of adolescent mothers on various family planning methods increased with the increase in the level of autonomy.

**Table 4.2 Percent distribution of adolescent mothers by their knowledge of family planning methods and level of autonomy**

Family planning methods	All N=400	Level of autonomy			$\chi^2$	D F	P-value
		Low N=130	Medium N=134	High N=136			
Female sterilization	93.0	89.2	93.3	96.3	5.161	2	<b>0.076***</b>
Male sterilization	72.8	65.4	70.9	81.6	9.184	2	<b>0.010**</b>
Copper T / IUD	78.3	75.4	77.6	81.6	1.565	2	0.457
Oral pill	56.0	63.1	52.2	52.9	3.928	2	0.140
Condom / Nirodh	59.3	65.4	57.5	55.1	3.152	2	0.207
Rhythm / periodic abstinence	12.0	9.2	11.9	14.7	1.887	2	0.387
Withdrawal method	3.0	1.5	1.5	5.9	5.883	2	<b>0.053***</b>

\*P<0.01, \*\*p<0.05, \*\*\*p<0.10

### 4.3 Current use of contraception

The percent distribution of adolescent mothers by current use of contraception presented in table 4.3.revealed that only 19.3 per cent of adolescent mothers had adopted any one of the family planning methods at the time of interview. The adoption of family planning methods increased with the autonomy of adolescent mothers. It has increased from 14.6 per cent for low autonomy to 23.5 per cent for high autonomy of adolescent mothers. However, the differences are not statistically significant.

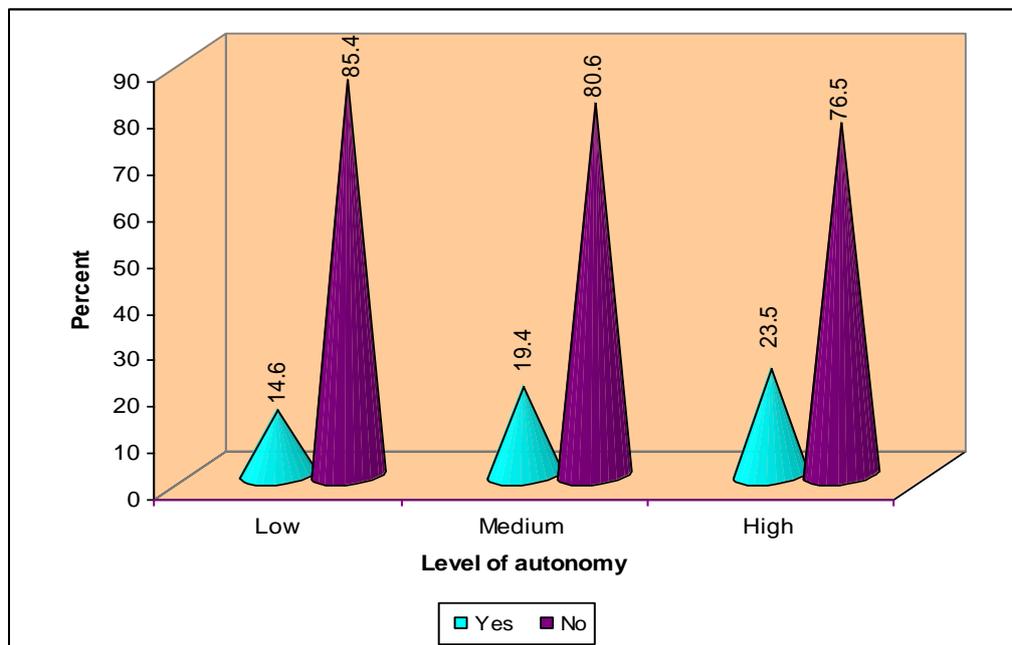
**Table 4.3 Percent distribution of adolescent mothers by current use of contraception and level of autonomy**

Current use of contraception	All N=400	Level of autonomy		
		Low N=130	Medium N=134	High N=136
Yes	19.3	14.6	19.4	23.5
No	80.7	85.4	80.6	76.5

$\chi^2=3.401$  df=2 P<0.183

Figure 4.3

Current use of contraception by level of autonomy



#### 4.4 Type of method adopted

The percent distribution of adolescent mothers by type of method adopted at the time of interview is presented in table 4.4. It is observed that majority of the adopters (53.2 per cent) had adopted permanent method mainly female sterilization followed by copper-T/IUD (33.8 per cent) at the time of interview. The proportion of adolescent mothers who had adopted sterilisation had increased with the increase in their autonomy status. However, the differences are not statistically significant.

Table 4.4 Percent distribution of adolescent mothers by type of contraceptive method adopted and level of autonomy

Current use of contraception	N=77	Level of autonomy		
		Low N=19	Medium N=26	High N=32
Female sterilization	53.2	42.1	50.0	62.5
Copper-T / IUD	33.8	36.8	38.5	28.1
Condom	1.3	21.1	11.5	3.1
Other	11.7	--	--	6.3

$\chi^2=5.175$  df=6 P<0.522

#### 4.5 Age at adoption

The percent distribution of adolescent mothers by their age at the time of adoption of family planning methods presented in table 4.5. revealed that among the adopters 39 per cent were aged 18 years or less and 61 per cent were aged 19 years.

**Table 4.5 Percent distribution of adolescent mothers by age at adoption and level of autonomy**

Age at adoption	N=77	Level of autonomy		
		Low N=19	Medium N=26	High N=32
≤18	39.0	10.5	53.8	43.7
19	61.0	89.5	46.2	56.3

#### 4.6 Reasons for adoption

The reasons for the adoption of family planning methods presented in table 4.6 revealed that the main reason for the adoption of family planning methods was spacing as reported by 53.6 per cent of adopters. To limit family size was the next reason as reported by 34.0 per cent of adopters. Adolescent mothers' autonomy did not make much difference to the reasons for the adoption of family planning methods.

**Table 4.6 Percent distribution of adolescent mothers by reasons for past / current use of contraception and level of autonomy**

Reasons for past/ current use of contraception	N=97	Level of autonomy		
		Low N=25	Medium N=31	High N=41
Spacing	53.6	44.0	61.3	53.7
To limit family size	34.0	44.0	22.6	36.5
Doctors advice / health reason	12.4	12.0	16.1	9.8

#### 4.7 Person who took decision

The percent distribution of adolescent mothers by their level of autonomy and person who took decision for adoption of family planning methods is presented in table 4.7. It is observed that 22.7 per cent of adopters had taken decision to adopt family planning on their own. Joint decision by husband and wife was reported by 53.6 per cent of adolescent mothers. Adolescent mothers autonomy did not make much difference in their decision making process on the adoption of family planning methods

**Table 4.7 Percent distribution of adolescent mothers by person who took decision to adopt family planning methods and level of autonomy**

Person who took decision	N=97	Level of autonomy		
		Low N=25	Medium N=31	High N=41
Husband	19.6	20.0	22.6	17.1
Herself	22.7	24.0	19.4	24.4
Both	53.6	52.0	54.8	53.6
Other family members	4.1	4.0	3.2	4.9

**4.8.Husband-wife communication about family planning and family size desire**

The results of the analysis of data on husband-wife communication about family planning and family size are presented in table 4.8. The proportion of adolescent mothers who had discussion about number of children increased with increase in the level of autonomy. It has increased from 80.0 per cent for low autonomy to 94.1 per cent for high autonomy. The adolescent mothers were also asked in the study whether their husbands desired the same number of children as they desired to have. The results showed that the number of children desired by their husbands was the same as that of their desire for a majority of respondents. The desire to have the same number of children by both husband and wife seemed to be more among adolescent mothers who had high level of autonomy compared to others.

**Table 4.8 Percent distribution of adolescents mothers by husband wife communication about family size and level of autonomy**

Husband wife communication	N=97	Level of autonomy		
		Low N=25	Medium N=31	High N=41
<b><u>Discussion about number of children</u></b>				
Yes	88.5	80.0	91.0	94.1
No	11.5	20.0	9.0	5.9
<b><u>Husband wants the same number</u></b>				
Same number	77.3	68.5	79.8	83.1
More number	12.3	18.5	9.7	8.8
Fewer number	3.2	2.3	4.5	2.9
Don't know	7.2	10.7	6.0	5.2

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## 4.9 Summary

The results of the analysis of data on the knowledge and adoption of family planning methods by adolescent mothers showed that most of the adolescent mothers were aware of female sterilization (93.0 per cent). Copper T/ IUD was the next popular method known to 78.3 per cent of mothers, which was followed by male sterilization (72.8 per cent), Condom/Nirodh (59.3 per cent) and oral pill (56.0 per cent). The knowledge of adolescent mothers on various family planning methods increased with the increase in the level of autonomy. Only 19.3 per cent of adolescent mothers had adopted any one of the family planning methods at the time of interview. Adoption of family planning methods increased with the level of autonomy. Among the adopters, 53.2 per cent had adopted permanent method and 33.8 per cent were using IUD. The proportion of adolescent mothers who had adopted sterilisation had increased with the increase in their autonomy status. Among the adopters, 39 per cent were aged 18 years or less and 61 per cent were aged 19 years. The reasons for adoption of family planning methods were 'spacing' (53.6 per cent) and to 'limit family size' (34.0 per cent). Joint decision by husband and wife was reported by 53.6 per cent of adopters and independent decision was reported by 22.7 per cent. Proportion of adolescent mothers who had discussion about the number of children increased with increase in the level of autonomy. The desire to have the same number of children by both husband and wife seemed to be more among adolescent mothers who had high level of autonomy compared to others. Majority of adolescent mothers desired to have only two children. Most of the adolescent mothers with two children had adopted permanent method. Integrated maternal health, family planning and child health care services should add appropriate personnel and increase referral capacities. Counselling, prevention and treatment services for sexually transmitted infections and HIV should be integrated with other reproductive health services and made available through the primary health care system, which is most likely to reach populations in greatest need, such as adolescents and the poor

## References:

1. **Arundhati Mishra. 2002.** 'Adolescent girls in India Choose a Better Future' at the global perspectives on Adolescent Reproductive Health and Rights panel sponsored by the International Sexual and Reproductive rights coalition.
2. **Treffers P.E.2003.** 'Teenage Pregnancy, worldwide Problem '.Ned Tijdschr Geneeskd; 147:2320-5.
3. **United Nations. 2001a.** 'World Population Monitoring 1996: Selected Aspects of Reproductive Rights and Reproductive Health' (United Nations publication, Sales No.E.97.XIII.5).