

The Transition from Adolescence for Girls in India - Policy Implications;
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July 2007

Introduction

The majority of girls in rural India assume adult responsibilities at an early age and their lives become increasingly restricted as they mature. They become wives and mothers while still very young, thus progressing from childhood to womanhood and skipping the transitional period of adolescence entirely (Rhode; 1993). The problems of early marriage and early child bearing patterns in rural areas are compounded by the fact that adolescent girls are provided with little accurate information about their own bodies. Consequently, adolescent girls are unable to exert control over their reproductive lives and are at increased risk of contracting STDs including HIV (Tinker et al.; 1990). The result is high levels of reproductive morbidity, mortality and poor utilization of health services.

At the International Conference on Population and Development, 1994, and the Fourth World Conference on Women, 1995, recognition was given to the need for addressing the vulnerability of adolescent girls as a consequence of changes resulting from maturation, sexual activity, early marriage and pregnancy. However, till recently, the health community in India ignored youth. In particular, non-pregnant, unmarried adolescent girls were largely ignored because they were considered less vulnerable to disease than young children, and are not at immediate risk of the sequelae associated with pregnancy (WHO; 1989). Consequently, information related to adolescent girls in India is limited (Bahl and Kaushal; 1994), both in terms of their specific needs and context of their lives, and in terms of appropriate interventions to address these needs.

This paper attempts to fill this gap. It is based on several research studies undertaken by the Institute of Health Management, Pachod from 1998 to 2003. The first of these was a study of the reproductive health status of 117 adolescent girls aged 13 to 19 years (IHMP, 1998). The second was an ethno-medical study using qualitative methods. In-depth interviews and focus group discussions were conducted with unmarried adolescent girls and their mothers in an effort to understand the socio-cultural context of adolescence in rural Maharashtra (IHMP, 1997-99). The third was an intervention research study to determine the impact of a life skills education program of one-year duration, on the health and social status of adolescent girls (IHMP, 2001-2002). The fourth was a study of 827 married adolescent girls between the ages of 13 and 19, aimed at examining the levels of reproductive morbidity and treatment seeking behaviours (IHMP, 2003).

This paper is, thus, an ethno-medical overview of the transition that girls experience from adolescence to womanhood in rural Maharashtra, the impact of a life skills program on this transition, and the policy implications implied by this program. The first part of this paper describes the social status of adolescent girls in rural Maharashtra and provides an overview of the transition that they experience from adolescence to womanhood. The second part of the paper deals with the health status of adolescent girls and provides insights into the inter-linkages between their social status and their health. It contends

that the poor health status of these girls is rooted in their low social status. The third section describes a 'Life Skills' intervention that empowered 2500 adolescent girls and resulted in significant adaptive changes in their lives, including their social and health status. Data on the impact of the intervention are presented. The paper concludes with implications for a national policy aimed at adolescent girls.

Social Status of Adolescent Girls

In some parts of rural Maharashtra, the social status of adolescent girls is poor because of historical patriarchal and gender norms, which influence their socialisation into womanhood and marriage practices. Their education, activity, mobility, decision-making ability, and health seeking behaviours are restricted. Dramatic changes are introduced in the every-day life of adolescent girls after they reach menarche. Girls associate these changes with the term 'adolescence', which attests to the impact culture has on the way girls construct knowledge (Koff and Rierdan; 1995).

Cultural beliefs about menstruation are learned and assimilated well before girls actually experience menarche or understand its biological significance (Chaturvedi and Chandra; 1991 and Koff and Rierdan; 1995). Girls are considered to have grown up once they reach menarche (IHMP, 1998). The meaning of menarche to adolescent girls in these villages is linked to culturally prescribed changes which occur in their lives once menarche is attained, such as the end of freedom of mobility, of social interaction and of their education (Koff and Rierdan; 1995).

Women associate menstruation with pollution. This is a traditionally held belief in Hindu religion (Thompson; 1985). When adolescent girls talk about menstruation, their rhetoric is centered on pollution issues. Menstrual hygiene behaviours are reflective of cultural beliefs about the dirtiness of menstruation, and often expose adolescent girls to the risk of reproductive tract infections (IHMP, 1998).

Girls are not informed about the maturation process prior to reaching menarche and must rely on their own experiences to understand what biological changes occur during adolescence (Rhode; 1993 and ICRW, 1996). There is little communication between mothers and daughters regarding menstruation. (IHMP, 1998, ICRW, 1996). Other female relatives and peers are the key sources of information about growing up (IHMP, 1998). The importance of the peer group as an information resource provides an indication of the impact that schooling and education can have on the way information is transmitted in a village setting (Sivaramakrishnan et al.; 1993).

Changes in the behaviours of girls as they mature are symbolic of the socialization process that occurs during this stage of life, and how these changes condition girls for their adulthood roles (Chaturvedi and Chandra; 1991). Socialisation into womanhood cannot be discussed without also discussing patriarchy and its effect. Women living in patriarchal families enjoy much less power, as they remain subservient to their closest male relatives. Few assert their rights in court despite several laws that exist to improve their status, (Wolpert; 1991). Brothers assume an authoritative stance in relation to their

sisters, thus perpetuating the patriarchal tradition. Adolescent girls typically defer to their brothers, and willingly serve them.

The daily lives of adolescent girls are highly structured. Most girls described a sixteen-hour workday both inside and outside the house. This is in sharp contrast to the lives of their brothers. Girls accept these differences, which reflect the social conditioning they encounter at an early age (IHMP, 1998). There is a pronounced difference in the freedom of mobility for an adolescent girl in comparison with her male counterpart. Mothers enforce these restrictions much more stringently after girls reach menarche, when they are considered most vulnerable (IHMP, 1998). Once girls start menstruation, they are often removed from school and are taught to keep quiet and not draw attention to themselves. This is to ensure a good reputation that will impact a girl's marriage prospects, and also help to preserve and protect the honor of the family (Wolpert: 1991).

Married adolescent girls report low decision-making power, especially for health seeking behaviour during pregnancy, for reproductive morbidity, and for the use of contraceptives. Parents-in-law and husbands continue to be the real decision makers after marriage (Ganatra and Hirve; 1995). For the overwhelming majority of unmarried girls, parents and relatives arrange their marriages without consulting them. It is significant to note, however, that girls with higher levels of schooling reported a greater chance of being consulted before their marriages (IHMP, 1998)

Education is known to positively affect the health status of girls in a variety of ways. The cultural barriers to education that girls' experience, however, are detrimental to their overall health (Popkin and Lim-Ybanez; 1982). Beyond the primary level, there is a high dropout rate for rural girls from the formal educational system. Lack of schools beyond the primary level in their own village was stated as one of the main reasons why parents remove daughters from school. They are concerned about the safety and reputation of their daughters if they send them to schools in other villages (IHMP, 1998).

The custom of early marriage is widespread in rural Maharashtra. The baseline study conducted by IHMP in 1998-99 indicates that over 80 percent of girls in the age group 13 to 19 years were married. The median age at the time of marriage was 14.5 years. Mothers who were interviewed emphatically stated that they wanted to wait until their daughters turned 18 before arranging their marriage. The social pressure they encounter, however, compels them to arrange their daughters' marriages before this age. This difference between desired marriage age and the social norm indicates the level of socio-cultural influence on decisions regarding age at marriage.

Reproductive Health and Nutrition of Adolescent Girls

Most of the reproductive morbidity suffered by adolescent girls appears to be related to early age at marriage. Early marriage is followed by early conception. The social pressure on a woman to prove her fertility early on in a marriage is compounded by the additional pressure on her to produce a son (Wolpert; 1991). In IHMP's study, over 72 percent

married adolescent girls aged 13 to 19 years reported having one or more children. Thirty four percent were pregnant at the time of the study. (IHMP, 2003)

This study as well as others conducted in India, indicate that the consequences of early marriage and conception are high levels of reproductive morbidity and mortality. Of the 827 married adolescent girls interviewed in the IHMP study of 2003, a high proportion suffered from reproductive morbidity as shown in Table 1.

Table 1: Reproductive Morbidity in 827 Married Adolescent Girls

| Reproductive Morbidity | Proportion suffering % |
|--|-------------------------------|
| Menstrual problems | 35.0 |
| One or more symptoms indicative of RTI | 50.7 |
| One or more symptoms indicative of UTI | 45.0 |
| One or more symptoms indicative of STI | 4.8 |
| Ante-partum problems such as breathlessness, weakness, swelling on the face and feet, high blood pressure, jaundice | 46.0 |
| Ante-partum problems requiring medical treatment | 65.0 |
| Complications during delivery e.g. in-coordinate uterine contraction, premature rupture of membranes, excessive bleeding, prolonged labour, large perineal tears, retained placenta, severe breathlessness | 68.0 |
| Post natal complication in mother | 50.0 |
| Post natal complications in neonate | 17.0 |
| Married adolescents reporting abortions in last one year | 7.5 |
| Proportion of girls reporting spontaneous abortions in last one year | 72.6 |
| Proportion of girls reporting induced abortion in last one year | 27.4 |
| Of the girls who had abortions, proportion reporting complications | 68.0 |
| Proportion reporting domestic violence | 10.0 |

(Source: IHMP 2003)

As a result of limited opportunities, poor mobility, and an absence of decision making power, the health needs of adolescent girls are not recognized, vocalized or addressed adequately, whether they are married or unmarried. IHMP's data shows that out of 35 percent of married adolescent girls that reported menstrual problems, only 19 percent had sought medical treatment. Of 50.7 percent girls that reported symptoms of RTI, STI or UTI, 85 percent had never sought medical treatment. A relatively higher proportion of married adolescent girls had sought ante-partum care and institutional care during delivery, but less than 10 percent reported having received services during the postnatal period. Only 12 percent reported use of contraceptives, of which 6 percent was to delay first pregnancy and 94 percent after the birth of the first child. (IHMP 2003)

In addition to poor reproductive health status and care-seeking, adolescent girls also suffer from poor nutritional status. A study of haemoglobin levels in over 800 unmarried adolescent girls revealed that 57 percent of girls were anaemic (Hb <12g/dL), and 1.2 percent severely anaemic (Hb <7 g/dL). Logistic regression showed that key

determinants of anaemia include a diet with low iron-rich foods, less than 3 meals daily, heavy household chores, the onset of menstruation, and a severe infection in the past year, (IHMP, 2002).

Ignorance of the increased energy, protein, calcium, and iron requirements associated with adolescence is one of the main reasons why rural adolescent girls do not consume an adequate diet (Kapil et al.; 1993 and Chaturvedi et al.; 1996 and Waslien and Stewart; 1994). Cultural beliefs that too much food will cause a girl to mature faster and hasten the marriage process sustain the prevalent discriminatory food practices. (ICRW; 1994). Heavy workloads assigned to adolescent girls, has a potentially negative impact on their nutritional status (ICRW; 1994 and IHMP, 1999). Chronic nutritional deprivation often results in small stature, reduced pelvic size, and iron-deficiency anaemia, which are independent risk factors for obstetric difficulties and low birth weight babies, (Rhode; 1993 and Merchant and Kurz; 1993).

Adolescence represents a period of rapid growth and, therefore, provides an opportunity to undo the effects of childhood nutritional deprivation and gender discrimination, (Rhode; 1993 and Bahl and Kaushal; 1994). It requires early and effective interventions to improve the nutritional status of girls. Equipping adolescent girls with knowledge and skills to cope with the many physical and emotional changes they experience during this life stage can enhance their lives and prepare them to care for their own families, (Merchant and Kurz; 1993). It is particularly important to do this before they are married. Further, delaying age at marriage and prolonging the time before the first pregnancy would allow girls to complete their development and would limit the risks associated with pregnancy. Finally, there is a need to address the social and health needs of adolescent girls and improve their health utilization behaviors through appropriate and focused health services. IHMP's life skills program was designed to address these needs. The following section describes this intervention and its impact.

The Intervention - Life Skills Education for Unmarried Adolescent Girls

The Institute of Health Management Pachod (IHMP) strives for the health and development of communities through implementation of grassroots programmes, training, research and policy advocacy. The Institute aims at the holistic development of the individual, family and community and is deeply committed to the upliftment of marginalised groups. Within the broad mandate of reaching the most disadvantaged groups, it is committed to the health and development of women, adolescent girls and children. IHMP has been working in the underdeveloped Marathwada region of Maharashtra for the past 25 years. During this period, it has implemented several innovations in the field of public health that have provided policy options at the state and national levels.

IHMP designed a Life Skills course of one-year duration, which has been implemented in 72 villages and 27 slums over the last five years. The course was developed through the active participation of parents and community representatives, and they conceptualised the curriculum and strategy for implementing the programme. Professionals, working

with adolescent girls, developed the educational content. Through this process, the intervention was able to incorporate the larger socio-cultural aspects, which shape the lives of these girls.

The first objective of the 'Life Skills' programme was to delay age at marriage for adolescent girls and improve the social status of adolescent girls by developing skills on a range of issues including gender, legal literacy, and team building. While formal education consistently increases age of marriage, the effect of non-formal education like this life skills course is not established. This program, set up as an intervention research study, was undertaken in an attempt to explore that relationship. Other, related objectives of the programme included improving the health status of adolescent girls by increasing their cognitive and practical skills in health and nutrition, and promoting self-development and increase self-confidence and self-esteem through involvement in individual and community projects as well as in arts and craft.

The course was offered to girls between the ages of 12-18 with a focus on those who were out of school. It was conducted for an hour every evening for a year, and was taught by a village woman with a minimum of an 8th standard education. The course included cognitive and practical skills related to Government institutions and their functions, schemes meant for adolescent girls and women, legal literacy, vocational guidance, health, nutrition, gender, and a variety of other areas. An innovative component of the Life Skills course was education on sexuality and reproductive health through a module conducted as a residential programme.

Over a period of one year, the girls were exposed to a large amount of information and were encouraged to share it with their parents and make informed choices. Over 2500 rural and 700 slum girls have completed the course since its inception. This life skills education was accompanied by monthly orientation and health education for parents and community representatives through house visits and group meetings.

Impact of Life Skills Education on the Health and Social Status of Adolescent Girls

A quasi-experimental design was used to study the impact of the intervention. The determinants of early age at marriage were studied. Adolescent girls from study and control areas were compared for age at the time of enrolment, level of education, school going status, economic status, mother's education and occupation, and father's education and occupation. The cognitive and practical skills of adolescent girls were assessed four times during the year using pre-tested questionnaires.

The findings suggest that it is possible to use a life skills model to effectively and simultaneously address issues related to girls' empowerment, social status, health education and information, and to raise age at marriage, while also engaging parents and the community in the process. The following section describes the findings in more detail.

Results

The evaluation results thus far show that the life skills course positively influenced girls' own skills and self-confidence, as well as delayed age at marriage.

Improvement in skills and self-confidence

The course resulted in an increase in knowledge and self-esteem among participating girls, resulting in their empowerment, all round development, and an improvement in their health and social status. Among other things, this empowerment was manifested in their ability to cope with stressful situations, as illustrated by this brief case study below.

Geetanjali, (name changed) a 14-year-old girl was molested by a man much older than her, while she was walking back to her home. She went to the nearest police station, even before consulting her parents, and asked the police officer to register her complaint and give her a copy of the FIR. The officer was most curious to know where she had learnt to file a police complaint.

Practical and cognitive skills among the girls increased significantly compared to a comparable control group. Participatory group learning enabled the girls to interact and function like a team, providing them with the opportunity to develop communication and negotiation skills. Participating girls' mobility increased. Attending the course every day meant that the girls had to be allowed out of their homes by the parents, thereby increasing their mobility. As a part of the Life Skills course girls were even allowed to travel to nearby towns to attend workshops and to nearby cities for educational tours, and, in the case of two of the girls, allowed to represent the region at the national convention on child rights that was held in Delhi.

In-depth interviews and focus group discussions conducted with parents and community members to identify social changes in the girls attending the life skills course show that parents were aware and approved of these changes in their daughters, particularly the increase in the confidence level of the girls. Parents felt that their daughters had acquired good communication skills and were able to negotiate decisions with family members. Several mothers observed that their daughters never used to open their mouth in front of their fathers, but after this training they have the confidence to state their opinion. Parents perceived that attending the life skills course increased the girls' own recognition of their responsibilities at school and home, and that the girls took these responsibilities more seriously than before.

Raising age at marriage

The Life Skills education resulted in an increase in the age at marriage. A multivariate analysis of determinants of marriage shows that, even after controlling for other key determinants of age at marriage, such as age at the time of enrolment into the life skills course, school-going status, and mother's occupation, participating in the life skills

course was significant (Refer Table 2). Girls in the control area were more than three times more likely to marry early than girls in the intervention area.

Table 2: Determinants of early age at marriage (Logistic regression analysis)

| Characteristics | Number | Percent girls getting married before age 18 years | Adjusted Odds Ratios ⁺ : 1: Girls married before age 18 yrs. 0: Girls not married before 18 yrs. |
|--|--------|---|---|
| Age at the time of enrolment | | | |
| • 11-13 Years | 250 | 15.6 | 1 (reference) |
| • 14-17 Years | 108 | 49.1 | 3.89 ^{**} (2.13 - 7.08) |
| Level of education | | | |
| • Up to Primary | 126 | 29.4 | 1 (reference) |
| • Middle + | 232 | 23.7 | 1.56 ^{NS} (0.71 - 3.39) |
| School going status | | | |
| • School going | 242 | 16.1 | 1 (reference) |
| • Non-school going | 116 | 45.7 | 2.87 ^{**} (1.35 - 6.09) |
| Economic Status | | | |
| • Lower | 126 | 24.6 | 1 |
| • Middle-Lower | 67 | 22.4 | 1.79 ^{NS} (0.79 - 4.04) |
| • Middle-Upper | 93 | 27.9 | 1.78 ^{NS} (0.85 - 3.75) |
| • Upper | 72 | 27.8 | 2.28 ^{NS} (0.97 - 5.33) |
| Mothers education | | | |
| • Illiterate | 238 | 30.3 | 1.67 ^{NS} (0.84 - 3.31) |
| • Literate | 120 | 16.7 | 1 (reference) |
| Mothers occupation | | | |
| • Working | 259 | 31.3 | 2.42* (1.08 - 5.42) |
| • Non-working | 99 | 10.4 | 1 (reference) |
| Girls from | | | |
| • Intervention area | 175 | 10.3 | 1 (reference) |
| • Control area | 183 | 40.4 | 3.96 ^{**} (2.09 - 7.51) |
| Number of observations: 358 Log likelihood: - 154.31952 Pseudo R ² =0.2436 * - P<0.05 ** - p<0.001 NS- Not significant +Adjusted for age, level of education of girl, schooling status of girl, economic status, mothers education & occupation, area | | | |

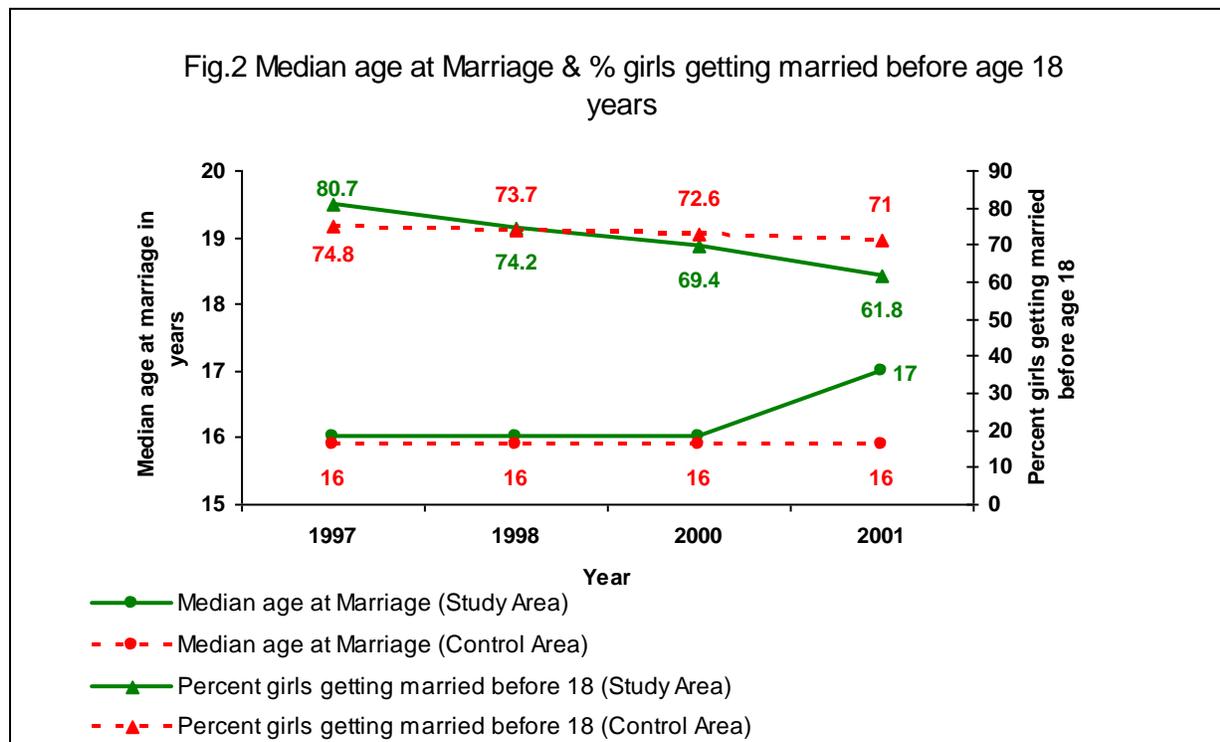
Further analysis showed that the level of exposure mattered as well. After adjusting for age, level of girl's education and schooling, economic status, mother's education and occupation, father's occupation, and type of family, the data indicate that girls who never attended the one-year life skills course were 2.5 times more likely to get married before 18 years than girls who completed the course. These results demonstrate the independent

impact of the intervention on delaying age at marriage, and point to the potential of this one-year intervention in decreasing the proportion of girls getting married before 18 years of age (Refer Table 3).

Table 3: Impact on age at marriage by level of attendance of life skills education (Logistic regression)

| Characteristics | Number | Percent girls married before age 18 years | Adjusted Odds Ratios ⁺ : 1: Girls married before age 18 yrs. 0: Girls not married before 18 yrs. |
|---|--------|---|---|
| Attendance of life skills education | | | |
| • Never attended | 799 | 29.3 | 2.583* (1.433-4.656) |
| • Partially attended | 261 | 22.2 | 2.423* (1.272-4.617) |
| • Fully attended | 179 | 10.1 | 1 (reference) |
| Number of observations: 1146 Log likelihood: - 544.52232 Pseudo R ² =0.1543 | | | |
| * - P<0.05 NS- Not significant | | | |
| +Adjusted for age, level of education of girl, schooling status of girl, economic status, mothers education & occupation, fathers occupation and type of family | | | |

A trend analysis of census data from the intervention and control areas as a whole corroborates the findings above. Between 1997 (before the intervention started) and 2001, the proportion of 13-19 year old girls in the intervention area who got married before the age of 18 steadily decreased, from 80.7 in 1997 to 61.8% in 2001, compared to the control group, which did not change significantly (Figure). Also, of those who did marry, their average age of marriage increased from 16.0 in 1997 to 17.0 in 2001, whereas the control group did not change.



The qualitative data is also consistent with this picture. A substantial number of parents said that their daughters had shared information regarding the negative outcomes of early marriage with them, and had tried to convince the parents to continue with their education and delay their marriages.

"Even if my parents arrange my marriage, I will not agree until I am 18 years old. I will convince my parents about this and I am confident that they will listen to me," said Sheetal Gajwate, 14 yrs.

Several girls whose marriages had been fixed were successful in convincing their parents to let them continue and complete the one-year 'Life Skills' course. A few girls who were not able to convince their parents to delay their marriages came back to their maternal homes specifically to complete the Life Skills education.

Neeta Shitole, 16 years old, said, "We have benefited a great deal from this course. We have learnt how to speak up for ourselves. I feel that our "tai" (teacher) should teach the life skills course to all the girls in our community".

Finally, a significantly large number of girls who had undergone Life Skills education reported that they were consulted when decisions were taken about their education, marriage, health and mobility.

Manjushree Kadam, 18 yrs, demanded a HIV test from her prospective groom prior to giving consent to marriage. Her parents agreed and her demand was fulfilled. Both Manjushree and her groom were tested for HIV prior to their marriage. She had attended IHMP's sexuality module.

Conclusions and Policy Implications

There are over 90 million adolescent girls in India between the ages of 10 and 19, of which about 11 million adolescent girls are in the State of Maharashtra, with approximately 6.5 million living in rural areas. They contribute 27 percent of the total fertility in the state. Studies indicate that in Maharashtra, as in the rest of India, the social and health status of adolescent girls is poor. These girls suffer from a heavy burden of reproductive morbidity. The low social status of adolescent girls contributes to marriage and conception at an early age and to lack of access to resources and services. Thus, while formulating its policy for young adults, the Government of India needs to pay special attention to the health and social status of adolescent girls, and to raising their age at marriage.

Policymakers also need to note that unmarried and married adolescent girls have different health and social vulnerabilities, which need to be taken into account when planning strategic thrust and interventions for these two target populations. Unmarried adolescent girls, who are the focus of this paper, require formal and non-formal educational inputs to improve their health and social status and delay their age at marriage. In order to improve the social status of adolescent girls, interventions are required that will result in their

empowerment, and, to be sustainable, that will go beyond sexual and reproductive health. It is also necessary to simultaneously change societal attitudes by engaging parents and the community, who are the key decision makers in their lives, through effective behaviour change communication.

The study of the impact of Life Skills education indicates that, as a non-formal education process conducted over a substantial period of time of a year, this course was able to achieve these goals for the health and social status of unmarried girls. The results indicate that such a life skills course results in a measurable increase in cognitive and practical skills, self-esteem, decision-making ability, and communication and negotiating skills. It empowers adolescent girls with a wide spectrum of information and knowledge, enabling them to make informed choices (IHMP-ICRW, 2003).

The most significant impact of the Life Skills course was an increase in the median age of marriage in the general population from 14.5 to 17.0 years. This finding has significant demographic and policy implications for Maharashtra: such a delay in median age at marriage will have a significant long-term impact on adolescent girls, as most of the negative health outcomes are related to their age at marriage and first conception. Life Skills education also appears to be an effective means of reaching the adolescent age group with essential nutrition and health related information. This finding, combined with the data presented earlier on girls' poor nutritional status, suggest that nutrition education and dietary change should be considered a vital component of such a programme in an effort to prevent and control anaemia in adolescent girls.

The success of this experience argues for replication elsewhere to improve adolescent girls' lives in the state as a whole. The infrastructure to implement this – or a similar intervention – already exists: the most innovative aspect of this intervention was that women with 8 to 10 years of formal education conducted the 'Life Skills' course at the village level. These women were exactly of the same calibre as ICDS workers in the State. There are over sixty thousand ICDS workers in Maharashtra with the potential to provide Life Skills education to millions of unmarried adolescent girls in the state. With already-existing infrastructure, the only additional costs to expanding such an intervention throughout the state are those required for manuals and training of trainers. With such meagre inputs, and with political will, there is yet a chance that we may redeem the lives of unmarried adolescent girls and give them a better future.

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