

Transition from Adolescence to Womanhood - Policy Implications
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Introduction

At the International Conference on Population and Development, 1994, and the Fourth World Conference on Women, 1995, due recognition was given to the need for addressing the vulnerability of adolescent girls, consequent to the changes during maturation, sexual activity, early marriage and pregnancy.

Till recently, non-pregnant adolescent girls were largely ignored by the health care community because they are 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 the adolescent girl in India is limited (Bahl and Kaushal; 1994).

There are about 190 million adolescent girls and boys between 10 and 19 years in India who account for about a fifth of the countries population (IIPS 1995). There is lack of adequate attention to their development, reproductive and sexual health needs in the national programme. The Government of India plans to develop a national policy for young adults in 2004. Among other areas the policy initiative envisages to include health and development issues of adolescent girls including their sexual and reproductive health.

There are about 22 million adolescent boys and girls in Maharashtra, of which approximately 13 million live in rural areas. Adolescent girls constitute a little less than half this population of young adults. Adolescent girls in Maharashtra contribute 27 percent of the total fertility in the state. Their reproductive health is of particular interest to policy makers in the state.

India's interest in the adolescent girl reflects growing concerns about the nation's gender differentials in health indices. But current initiatives are characterised by too little attention to the different needs of boys and girls and the social and cultural context in which adolescent girls lead their lives. Unless attempts are made to put sexual and reproductive health in its socio-cultural context it may not be possible to develop culturally appropriate interventions.

This paper is an overview of the transition that girls experience from adolescence to womanhood in rural Maharashtra, from an ethno-medical perspective. The paper describes the inter-linkages between the social and health status of adolescent girls. It contends that their poor reproductive health is rooted in their low social status.

The first part of the paper describes the social status of adolescent girls in rural Maharashtra. The second part of the paper is on the health status of adolescent girls. The third part describes an intervention undertaken to improve the social and health status of 2500 adolescent girls. Data on the impact of the intervention are presented. The paper concludes with implications for the national policy on young adults.

The paper is based on various research studies undertaken by the Institute of Health Management Pachod, from 1998 to 2003, including an ongoing intervention research study on 'Life Skills' for adolescent girls, in the Marathwada region of Maharashtra.

The first was a study of the reproductive health status of 1609 randomly selected married women 13 to 49 years, of which there were 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 life skills education, of one-year duration, on the health and social status of adolescent girls (IHMP 2001-2002). The fourth study was a survey of 827 married adolescent girls aged 13 to 19 years to study the levels of reproductive morbidity and treatment seeking behaviours (IHMP, 2003).

Definition of Adolescence

WHO has defined adolescence as the progression from the appearance of secondary sex characteristics to sexual and reproductive maturity, the development of adult mental faculties and adult identity and the transition from total socio-economic dependence to relative independence (ICRW; 1996).

WHO recognises that the age range between 10 and 19 encompasses the adolescent time period (ICRW; 1994). These definitions indicate that adolescence is marked by a combination of biological and social changes. However, the perception of adolescence has been found to differ in various cultural contexts, implying that adolescence is shaped by cultural influences (Fabrega; 1995).

Community perceptions of Adolescence

Both mothers and daughters identified the same physical changes during adolescence. Mothers' described adolescent girls as becoming self-conscious and shy, speaking softly and sweetly, characteristics that typify the ideal Indian woman. (IHMP, 1998)

In rural Maharashtra, dramatic changes in the every day life of adolescent girls are introduced after a girl reaches menarche. As a result, 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).

Social Status of Adolescent Girls

The social status of adolescent girls is discussed in terms of the socio-cultural implications of menstruation; socialisation into woman-hood and its implications on the activity, mobility and decision making of adolescent girls; education and finally marriage practices.

1. Menstruation: Cultural and Social Implications for Adolescent Girls

Cultural and social factors have been found to influence the beliefs and behaviours of women regarding menarche (Chaturvedi and Chandra; 1991 and Koff and Rierdan; 1995). Mothers, who were interviewed, said that 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 the culturally prescribed changes, which occur in their lives once menarche is attained. These changes lead girls to interpret the attainment of menarche as the end of freedom of mobility, social interaction and education. (Koff and Rierdan; 1995).

In general, the women associated menstruation with pollution, a traditionally held belief in Hindu religion (Thompson; 1985). They described the menstrual blood as an impure substance, which needs to be excreted on a monthly basis to cleanse the woman's body.

Girls were aware that a relationship exists between menstruation and pregnancy but could not articulate how the two events are connected. The explanations given by adolescent girls for menstruation also centred on pollution issues (IHMP, 1998).

Cultural beliefs about menstruation are learned and assimilated well before girls actually experience menarche or understand its biological significance (Koff and Rierdan; 1995).

Menstruating women sit separately from other household members, refrain from touching religious icons and from participating in religious rituals, do not cook anything or enter the kitchen and avoid touching others. (Thompson; 1985).

The practices women follow during menstruation in these villages to avoid polluting others and angering the gods, illustrate the influence that the socio-cultural context exerts on women's behaviours. (Severy et al.; 1993).

Menstrual hygiene behaviours practiced in the study area are reflective of cultural beliefs about the dirtiness of menstruation. These behaviours expose adolescent girls to the risk of reproductive tract infections (IHMP, 1998).

Sources of Information Regarding Maturation

Girls are not informed about the maturation process prior to reaching menarche and must rely on their own experiences to understand what biological changes happen to girls during adolescence. (Rhode; 1993 and ICRW; 1996).

There is little communication between mothers and daughters regarding menstruation. Both mothers and daughters said that they feel shy discussing menstruation. This shyness is reflective of the secrecy and silence associated with menstruation in traditional Indian culture (IHMP, 1998, ICRW; 1996).

Comments from both the mothers and adolescent girls indicated that other female relatives and peers are the key sources of information for girls about growing up (IHMP, 1998). The importance of the peer group as an information resource is indicative of the impact of schooling and education on the way information is transmitted in a village setting. (Sivaramakrishnan et al.; 1993).

2. Socialisation into woman hood

The changes in the behaviours of girls as they mature, are symbolic of the socialization process that occur during this stage of life and how culturally prescribed behavioural changes, which take place during adolescence serve to condition girls for their adulthood roles (Chaturvedi and Chandra; 1991). Socialisation into womanhood cannot be talked about without discussing patriarchy and its effect.

Women living in patriarchal families enjoy much less power. Most Indian women, especially in rural areas, still remain subservient to their closest male relatives and few assert their rights in court despite several laws that exist to improve their status (Wolpert; 1991). These include laws sanctioning their rights to family property and education, prohibiting dowry and increasing the legal age of marriage for women to 18 years.

Adolescent girls typically defer to their brothers and willingly serve them. Brothers assume an authoritative stance in relation to their sisters. They behave like second fathers, scrutinising their sisters' behaviours to ensure that they act properly, thus perpetuating the socialisation of patriarchy.

Activity & Mobility: Restrictions imposed on adolescent girls after Menarche

The daily lives of adolescent girls are highly structured. Most girls that were interviewed described a sixteen hour work day, inside and outside the house, which is in sharp contrast to the lives of their brother's. The mothers noted that girls express some resentment but tend to accept these differences reflecting the social conditioning they encounter at an early age. (IHMP, 1998)

There is a pronounced difference in the flexibility and freedom of mobility for an adolescent girl in comparison with her male counterpart. The

differential persisted regardless of the education level, caste or socio-economic status of the girl interviewed.

Once girls start menstruation, they are not allowed to move about unescorted. They are instructed to refrain from talking to boys or associating with girls who are 'outgoing'. Girls are often removed from school and are taught to keep quiet and not draw attention to themselves. The mothers said that they begin restricting the movements and activities of their daughters when they first recognize that their daughters are maturing. They enforce these restrictions much more stringently after girls reach menarche, when they are considered most vulnerable. (IHMP, 1998).

The daughter's reputation is so essential because it determines the kind of marriage her parents will be able to arrange for her and is linked to family honour. (Wolpert: 1991).

While mothers in these villages are the main actors responsible for implementing the restrictions placed on maturing girls, they acknowledge that these restrictions have a negative impact on the quality of their daughter's lives. However, their desire to adhere to cultural norms appears to take precedence over their interest in improving the quality of their daughters' lives during adolescence. (IHMP, 1998)

Decision making

Adolescent girls in general, and married adolescents in particular are quite powerless, and constrained in taking decisions relating to their own lives.

For the overwhelming majority of unmarried girls, parents and relatives arranged their marriages without consulting them. However, girls with higher levels of schooling reported a greater chance of being consulted before their marriages (IHMP, 1998).

Married adolescents reported low decision-making power, especially for health seeking behaviour during pregnancy, for reproductive morbidity and use of contraceptives. Parents-in-law and husbands continue to be the real decision makers after marriage. (Ganatra and Hirve 1995).

3. Education

There is a high drop out rate for girls from the formal educational system, beyond the primary level. In general, 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.

Both mothers and adolescents noted that girls in this generation are able to attain a higher level of education than previous generations in their villages, mainly due to the expansion of school facilities in the villages. (IHMP, 1998).

The discussions with adolescent girls and their mothers revealed that the education girls are allowed to receive is closely linked to parental anxieties about the reputation and safety of their daughters (IHMP, 1998).

Several respondents listed poverty as a reason for terminating a girl's education. Other economic reasons for withdrawing girls from school include the girl being needed to work in the fields, to act as a surrogate mother or to help in the household.

Other commonly stated reasons for removing girls from school include the girl reaching menarche, getting married or not performing well in school. However, none of these factors affect the education of boys. Gender discrimination in terms of education is related to culturally informed ideas about the roles of men and women. (IHMP, 1998)

Education is known to positively affect girls' health status through a variety of paths. Hence the cultural barriers to education that girl's experience are detrimental to their overall health (Popkin and Lim-Ybanez; 1982).

4. Marriage practices and age at marriage

The custom of early marriage is largely prevalent in rural Maharashtra. The study conducted in 1998-99 indicates that over 80 percent of girls in the age group 13 to 19 years were married and the median age at the time of marriage was 14.5 years.

The mothers interviewed emphatically stated that they wanted to wait until their daughters turned 18, before arranging their marriage. The social

pressure they encounter 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 related to decisions regarding age at marriage.

Reproductive Health of Adolescent Girls

Child Bearing

The consensus among the mothers interviewed was that a girl should give birth within the first two years of marriage. The social pressure on women to prove their fertility early on in a marriage is compounded by the social norm of producing a son. (Wolpert; 1991).

A large majority, over 72 percent married adolescent girls, aged 13 to 19 years reported having one or more children. A large proportion of adolescent married girls, 34.0 percent, were pregnant at the time of the study. Almost 10 percent reported that they did not want this pregnancy, and about 37 percent reported that they had tried to delay or prevent the current pregnancy. . (IHMP, 2003)

The patterns of early marriage and early child bearing evident in these villages affect the health of adolescent girls. These cultural norms lead to the premature cessation of girls' education and expose them to the risks associated with adolescent pregnancy.

Nutritional status

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). Typically their food is deficient in calories, proteins and iron rich foods.

Cultural beliefs about the nutritional needs of adolescent girls verses boys contribute to discriminatory food practices. Cultural beliefs that too much food will cause a girl to mature faster and hasten the marriage process, sustain the prevalent discriminatory food practices and help legitimate the inferior status of women in this society (ICRW; 1994).

The amount of work girls are required to do plays a determining role in their nutritional status (ICRW; 1994). The heavy workload assigned to adolescent girls in these villages, therefore, has a potentially negative impact on their nutritional status.

Conditions associated with chronic nutritional deprivation such as small stature, reduced pelvic size and iron-deficiency anemia are independent risk factors for obstetric difficulties and low birth weight babies (Rhode; 1993 and Merchant and Kurz; 1993).

Adolescence, because it represents a period of rapid growth, provides an opportunity to undo the effects of childhood nutritional deprivation and gender discrimination and significantly improve the condition of women in India (Rhode; 1993 and Bahl and Kaushal; 1994). It implies the need for early and effective interventions to improve the nutritional status of girls.

Anaemia

India has the highest prevalence of anaemia in the world. The figures among women are staggering “ 87 percent for pregnant women, 68 percent for women in the reproductive age, and 60-70 percent for adolescent girls.

A study of haemoglobin levels in over 800 girls revealed that 57 percent of girls were anaemic (Hb <12g/dL), 1.2 percent severely anaemic (Hb <7 g/dL). The consumption of iron-rich foods was very poor.

Through logistic regression, determinants of anaemia were found to be: diet with low frequency of iron-rich foods, <3 meals daily, doing heavy household chores >2 hours, having started menstruation, and having a severe infection in the past year. (IHMP, 2002)

Anaemia leads to adverse pregnancy outcomes, reduced work productivity, and impaired physical capabilities; and severe anaemia to maternal mortality.

Reproductive Morbidity in Married Adolescent Girls

The mean age at menarche was reported as 13.6 years. Over 62 percent unmarried girls reported problems related to menstruation. Among married adolescent girls about 35 percent reported menstrual problems.

50.7 percent married adolescents reported that they were currently suffering from one or more symptoms indicative of RTI, STI or UTI. Multiple responses were received for these questions, where 20 percent reported suffering from symptoms of UTI, 45 percent were suffering from any one symptom of RTI and 4.8 percent from any one symptom indicative of STI.

46 percent married adolescents reported problems during the ante-partum period such as breathlessness and weakness, swelling over the face and feet, high blood pressure and jaundice. Of these, 65 percent the complications had been severe enough to warrant medical treatment.

Over 68 percent reported complications at the time of delivery, such as incoordinate uterine contraction, premature rupture of membranes, excessive haemorrhage, prolonged labour, large perineal tears, retained placenta and severe breathlessness.

About 50 percent reported postnatal complications in the mother and 17 percent reported some neonatal complication. Majority of these complications required medical treatment by a private doctor or a hospital.

Out of the total 827 married adolescent girls that were interviewed, 7.5 percent girls reported having had an abortion in the last one year; 72.6 percent were spontaneous and 27.4 percent were induced. Of the girls experiencing spontaneous abortions, a large majority reported having the abortion in the 2nd, 3rd or 4th month of pregnancy. Of those who had an abortion, 68 percent reported complications.

About 10 percent adolescent girls reported domestic violence in the form of physical ill treatment. The prevalence of domestic violence appears to be under-reported possibly due to the fact that the interviews were conducted in the home environment of the girls.

The consequences of early age at marriage and first conception

While the age of marriage has been gradually increasing worldwide, median age in Aurangabad District, was still 14.5 years at the time of the baseline study in 1998-99. Over 80 percent adolescent girls got married before reaching the age of 19 years.

This as well as other studies conducted in India indicates that the consequences of early marriage are high levels of reproductive morbidity and mortality as presented below:

Table: Health Needs of Adolescent Girls & Consequences of Early Marriage

Out comes	Adolescent Girls	Women 20+ Years
Maternal Mortality	3	1
Neo-natal mortality	5	1
Anaemia	1.5	1
Abortion	3	1
Post- abortion complications	3	1
Domestic violence (married)	2	1
RTIs	2	1

Health seeking behaviour of married adolescents

Among married adolescent girls about 35 percent reported menstrual problems of which 19 percent had sought medical treatment.

Of the 50.7 percent girls reporting symptoms of RTI STI or UTI, 75 to 95 percent girls reporting different symptoms, had never sought medical treatment.

A relatively high proportion of married adolescent girls (88.0 percent) were registered for ANC, of which 62.0 percent were registered before the 4th month of gestation. The key providers were ANMs either from the Government PHC or the local NGO.

The proportion of married adolescent girls that delivered in a hospital was 62 percent. There was a marked increase in the proportion of institutional deliveries compared to the data collected in 1998. However, of the 38 percent girls that were delivered at home, the majority were still attended by untrained TBAs or relatives.

Less than 10 percent reported having received services during the postnatal period, a time when both the adolescent mother and her newborn are at highest risk of morbidity and mortality.

Out of those who had a post abortion complication 66 percent said it was serious enough to warrant medical treatment from a private doctor or hospital.

About 12 percent married adolescents reported use of contraceptives, of which 6 percent was to delay first pregnancy and 94 percent after the birth of the first child. Majority of adolescent girls reported use of condoms and a small proportion reported use of oral pills.

Access to Information for making informed choices

Equipping adolescent girls with the necessary 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).

Reproductive and other lifestyle behaviours are established during this life stage (Kapil et al.; 1990 and Coats et al.; 1982). Delaying age at marriage, prolonging the time before the first pregnancy would allow girls to complete their development and would limit the number of total pregnancies, and the risks associated with pregnancy.

Life skills Education for Adolescent Girls

The larger socio-cultural and economic aspects, which shape the lives of rural adolescent girls, need to be incorporated in appropriate and relevant interventions in order to bring about a change in their lives. It was assumed that cognitive and practical skills related to health, nutrition, gender, legal literacy, vocational guidance, and a variety of other areas, would increase knowledge and self-esteem in adolescent girls, resulting in all round development and an improvement in their health and social status.

The Institute of Health Management, Pachod, discussed alternatives with parents in 1998, and then designed and offered a life skills course of one-year duration. The objectives of the Life Skills programme were:

1. To delay age at marriage for adolescent girls.
2. To improve the social status of adolescent girls by developing skills related to gender, legal literacy, team building, etc.
3. To improve the health status of adolescent girls by increasing their cognitive and practical skills in health and nutrition.
4. To promote 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, 12-18 years with a focus on out of school, adolescent girls. It was conducted for an hour in the evening, every day, for a year and was taught by a village woman with minimum 8th standard education. Over 2500 rural and about 700 urban slum girls have completed the course, since its inception.

The life skills education for adolescent girls was accompanied by regular, monthly orientation and health education of the parents, through house visits and group meetings.

While formal education consistently increases age of marriage, the effect of informal education like this life skills course is not established. This study attempted to explore that relationship.

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. Comparison was made between 17 study and 18 control villages. Cognitive and practical skills of adolescent girls were assessed four times during the year using pre-tested questionnaires.

Adolescent girls from study and control areas were compared for level of education, school going status, economic status, mother's education and occupation, and father's education and occupation.

As a part of the impact assessment the determinants of early age at marriage were studied. The key determinants were age at the time of enrolment into the life skills course, school-going status, mother's occupation and exposure to the life skills course.

Table: 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			

Table: Impact by level of attendance of life skills education (Logistic regression)

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.
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			

Practical and cognitive skills among the girls increased significantly compared to a comparable control group. This increase in skills was measured through pre-post tests conducted every three months during the course of the life skills education.

The data indicates that the girls who completed the one-year life skills course were 2.5 times less likely to get married before 18 years than girls who never attended the course, after adjusting for age, level of girl's education and schooling status, economic status, mother's education and occupation, father's occupation and type of family. These results demonstrate the independent impact of the intervention on delaying age at marriage. They also point to the potential of this one-year intervention in decreasing the proportion of girls getting married before 18 years of age.

IHMP census data of all girls in the area showed a gradual decrease; starting in 1998, in the proportion of girls married before 18 years (from 80.7 percent to 61.8 percent in 2001), and a more dramatic increase in the median age of marriage from 14.5 years in 1998 to 17.0 years in 2001.

Social Status and Decision Making

In-depth interviews and focus group discussions were conducted with parents and community members to identify social changes in the girls attending the life skills course.

The unanimous perception of parents was that there is an apparent increase in the confidence level of these girls. Parents felt that their daughters have acquired good communication skills and are able to negotiate decisions with family members. Mothers observed, “Girls never used to open their mouth in front of their fathers, after this training they have the confidence to state their opinion”.

Parents perceived that the behaviour of their girls was much more disciplined after they had participated in the life skills course.

There was a measurable increase in the mobility of the girls within their village environment. 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. Two unmarried adolescent girls were nominated to represent the region at the national convention on child rights that was held in Delhi. Parents allowed the girls to travel with institutional staff for this convention.

Mother’s expressed satisfaction at the sexual and reproductive health education given to their daughters.

A substantial number of parents said that their daughters, after attending the life skills course, had shared information regarding the negative outcomes of early marriage with them. The girls 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 who is 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”.

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.

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.

Conclusions

The majority of India’s rural girls assume adult responsibilities at an early age and their lives become increasingly restricted as they mature. Generally, these girls progress immediately from childhood to womanhood, 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.

The response to these health and development problems must not be restricted merely to health interventions. Interventions based on an understanding of the socio-cultural reality of their lives are necessary. Life Skills education is an example of such an intervention, which empowers adolescent girls and can result in an adaptive change in their lives.

Policy Implications

A wide range and variety of interventions are being implemented in the country under the broad definition of life skills education. The range is from education in sexuality and reproductive health, of 3 to 10 days duration, to life skills education of three months to one-year duration.

This study indicates that Life Skills education of a longer duration can have a similar, beneficial impact on the health and development of adolescent girls as formal education.

A life skills course of a longer duration results in a measurable increase in cognitive and practical skills, self esteem, decision making ability, communication and negotiating skills. It empowers adolescent girls with a wide spectrum of information, 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 by 2.5 years, from 14.5 to 17.0 years. Considering the fact that married adolescent girls, contribute 27 percent of the total fertility in the state, this finding has significant demographic and policy implications for Maharashtra. (IHMP-ICRW, 2003)

It is assumed that this 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. Based on the results of this intervention, IHMP is advocating Life Skills education for adolescent girls, of one-year duration.

Information about the beliefs and behaviours regarding the nutritional needs of adolescent girls coupled with discriminatory food practices puts adolescent girls, in this area, at risk of developing nutritional deficiencies. Since nutritional status is known to affect pregnancy outcomes, these beliefs and behaviours also place adolescent girls at risk for future obstetric difficulties and poor birth outcomes.

The cultural patterns of early marriage and early child bearing have negative implications for the nutritional status and reproductive health of adolescent girls. Pregnant adolescents experience additional nutritional stress. (Merchant et al.; 1993 and ICRW; 1994).

The practice of supplementing the diet of women with iron tablets after they have become pregnant needs to be reviewed. Several pregnant women with effective coverage with iron supplements, continue to suffer from iron deficiency anaemia. Supplementing the diet of adolescent girls may result in higher pre-pregnancy haemoglobin levels, so that pregnancy does not have the same depleting effect on their bodies. (IHMP, 2002)

Nutrition interventions should be targeted at unmarried adolescents to overcome micro-nutrient deficiencies. This would benefit, women during their reproductive years, pregnancy and birth outcomes, and their young children. Nutrition education and dietary behavioral change should be considered a viable strategy for the prevention and control of anemia in adolescent girls, in addition to iron supplementation.

The results of this study provide insight into the possible means to improve the awareness levels of adolescent girls and their mothers, in nutrition and reproductive health. Informal education like a Life Skills course appears to be an effective means of reaching the adolescent age group with essential nutrition and health related information. Similarly, the school system needs to be utilised to transmit health related information.

Apart from providing unmarried girls with life skills education and counselling for their parents, policy makers need to seriously consider focussed obstetric and gynaecological services for married adolescent girls. Of particular importance is emergency obstetric care, counselling regarding abortion and post abortion care.

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 adolescent girls in the state. There is yet a chance that we may redeem the lives of adolescent girls and give them a better future.

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