Chapter I

INTRODUCTION

Adolescence is the developmental period of transition from dependent childhood to self-sufficient adulthood. While the early adolescence is characterized by the onset of puberty, it is the middle adolescence, which is considered as the most stressful period. Adolescence in girls is truly one of life’s journeys that are more challenging. Demands for personal recognition are intensified and the adolescent girl, although not ready for the responsibility of being an adult, resents being treated like a child. In the middle adolescence, adjustment problems peak up. The adolescence problems are associated with the heightened struggle for independence and identity (Connell et al 1975).

In a rapidly changing society, the adolescents face many developmental tasks and decisions (Collins & Harper, 1981).

The Characteristics of an adolescent are:

A - Aggressive, Anaemic, Abortion.

D - Dynamic, Developing, Depressed.

O - Overconfident, Overindulging, Obese.

L - Loved but lonely and lack information.
E - Enthusiastic, Explorative, and Experimenting.

S – Spiritual, Social, and Sexual.

C - Courageous, Cheerful, and Concern

E - Emotional, Eager, Emulating.

N - Nervous, never say no to Peers and Naughty/Notorious.

T - Temperamental, Teenage Pregnancy.

The meaning of the word adolescence is "to emerge". The adolescents are (emerging) developing rapidly and having an extreme degree of pressure from the peers, parents, society and their own self. They lack knowledge and skills to cope up with the pressure.

Adolescence (from the Latin word *adolescere* meaning "to grow up") is a transitional stage of physical and mental human development generally occurring between puberty and legal adulthood (age of majority) but largely characterized as beginning and ending with the teenage stage. According to Erickson's stages of development, a young adult is generally a person between the ages of 20 and 40 years, whereas an adolescent is a person between the ages of 13 and 19 years. Historically, puberty has been heavily associated with teenagers and the onset of adolescent development. However, the start of puberty has had an increase in
pressure of a preadolescence (particularly females, as seen with early and precocious puberty).

Adolescence has had an occasional extension beyond the teenage years (typically males) compared to previous generations. These changes have made it more difficult to define rigidly the time frame in which adolescence occurs.

The evolutionary theorists demonstrate that the natural laws of evolution, which are applicable to plants and animals, are also applicable to humans. The law also emphasizes the power of the natural forces to direct and modify the growth of adolescent girls.

**Stanley Hall, G. [1904]** the father of Adolescent Psychology, viewed in his Recapitulation Theory that the adolescence is the time of psychosocial development, when the transition is in-between the more primitive child and the truly human adult. Human development is a recapitulation of human evolution. It is the period, capable of changing the course of their lives. Behavior is a function of the life with awareness of the environment [Kurt Lewin 1951]. The environmental influences and the related problems are responsible for making up the adolescent girl’s emotional instability, value conflicts, hostility and changes in ideology.
Harry Stack Sullivan in his Interpersonal theory [1953] explains three phases of adolescence.

1. **Pre adolescence** brings in the development of need for specific close personal relationship with another person, of the same sex.

2. **Early adolescence** is the period, which seeks for interpersonal interest. The puberty initiates with lust - the stage of interpersonal derivative and the sexual drive. This phase works with collisions and conflicts of the need for intimacy and lust.

3. **Late adolescence** is the phase where major intellectual events occur. The increasing development of a sense of oneself and a sense of the other would determine the amount of intellectual development.

   Personality is learned self [Orville Brim, 1965] where an adolescent girl plays a number of roles, which require complex skills. It involves role-play, role differentiation and role integration. Thus, an adolescent girl plays her role as a student, member of a family and peers each with its own challenges.

   Adolescent period is the time of increased libidinal energy [Anna Freud 1969], which is associated with biological maturation,
and leads to impulsiveness, low tolerance or frustration and continuous demands for self-gratification.

**Jean Piaget [1971]** notes that the adolescent stage is the formal thought operational stage. The conceptual skills are the ability to manipulate more than two categories at the same time, able to hypothesize about a logical sequence of events that might occur, ability to think about the things, which leads to failure, ability to anticipate the consequences of their actions, capability of detecting consistency and inconsistency and ability to think realistically.

Human development is a process, and the individual attempts to learn the tasks that are required by the society, into which the individual is born. There are sensitive periods for learning developmental tasks i.e. the teachable moments, specifically the pubertal period of the adolescent. If a specific task was not learned, the task will be difficult to learn later [Robert-Havighwist, 1972].

Adolescence is a vital period in the development of personal morality (Lawrence Kohlberg [1973]).

Sigmund Freud, (1968) states that adolescence is the final stage of personality development. It is the period of psychological
conflict, which an adolescent experiences, due to failure to satisfy or express the specific needs during childhood.

From infancy, development occurs in eight stages [Erick Erickson, 1977]. Personal identity is seen during the adolescence, which evolves through a time of search, experimentation and introspection. Identity is a creative integration of past identification and personal competencies and future aspirations.

The present scenario of the adolescents in the developing countries clearly shows that the health condition of the adolescents has significantly deteriorated. Rise in problems is seen among the adolescents. Anaemia is more prevalent among the adolescent girls. In addition, there are marked differences observed in gender discrimination in their functioning. The socio-cultural context encourages gender discrimination; a predominant feature of the Indian patriarchal society is that it does not give much importance to an adolescent girl child; although, the Government on its part gives much importance to the girl children.

The adolescent girls acquire knowledge from many sources; the family and the school play a major role. Nevertheless, they fail to help the girls to shape their growing self about adolescence conceptualizations.
The adolescent health is more important to be preserved. Health is a complete physical, mental, and social well-being and not merely an absence of disease or infirmity according to the WHO. Thus, health has to be viewed in a holistic manner and to be promoted by all means and ways.

One of the most memorable and defining moments of adolescence is menarche, the first menstrual period. It is a meaningful, dramatic, and concrete event, which marks puberty. Unlike pubic hair growth and breast development, which are prolonged pubertal changes, menarche is unique in that, its onset is abrupt. As the most distinct event of female puberty, menarche is a sign of physical maturity and fertility. It represents a transition from childhood to biological sexual maturity of a girl child. This transition can be full of anxiety for the early adolescent. It adds more to the anxiety if she is proposed for marriage. The onset of menstruation is often met with a variety of reactions. In several studies, feelings of anxiety have been associated with menarche. Mixed feelings, such as being “excited but scared” and “happy and embarrassed”, are common (Chrisler and Zittel, 1998; Koff, 44 Rierdan, and Jacobson, 1981; Petersen, 1983; Woods, Dery, and Most, 1983). In a study of pre- and post-menarcheal girls, Stubbs, Rierdan, and Koff (1989) found that the pre-menarcheal girls tended to describe feelings of excitement and positive anticipation.
about menstruation, whereas girls of new post-menarcheal expressed negative feelings and reactions, being “grossed out”, and feeling sick.

In the United States, girls will often have a “Sweet Sixteen” party to celebrate turning the aforementioned age, a tradition similar to the quinceañera in Latin culture. In the modern western society, events such as getting one’s first driving license, high school education and later on college graduation and first career related job are thought of as being more significant markers in the transition to adulthood.

The first menstruation is often a traumatic and very negative experience for young girls in most parts of India (George, 1994). In Tamil Nadu the event is marked with a festival celebration. Bhattacharyya (1980, 1996) has described the menstrual rites widely prevalent in ancient India.

In South India, female puberty rites are followed with the ritual actions. But the knowledge and hygienic practices were inadequate (Naranyan, K.A. et al., 2001, Singh, S.P. et al., 2006). The belief, conception and hygiene was low (Dasgupta, A., Sankar, M. 2008, Khanna, A.R.S., Goyal and Bhawsar, R. 2005 ).

Psychoanalysts Thompson and Deutsch were among the first to focus on menarche as a key milestone in girls’ development.
Thompson (1942) maintained that menarche is a traumatic event, during which the girl experiences a loss of freedom, power, and spontaneity. There is a cultural denial of menarche and menstruation, which manifests itself as a decrease in girls' self-esteem.

The Latin word for menstruation is “sacer”, meaning both pure and impure (Walker, 1983). Words used in other early cultures to describe menstruation and menstruating women carried such meanings as supernatural, mysterious, incomprehensible, spirit, deity, and holy (Walker, 1983).

The Romans called a menstruating woman sacra, sacred and accursed (Delaney et al., 1988). The meaning of these words indicates the reverence and fear. It has been inferred that the fear of menstrual blood held by early cultures resulted in an evolution that led to the alienation and tabooed state of the menstrual woman.

Deutsch (1944) believed that girls’ psychological reactions to menarche have a common root of anxiety “in which the approaching adulthood and sexuality are experienced as a threatening danger”. Deutsch argued that such an anxiety is, in part, the result of a menstrual taboo that exists in our culture. A look into the history of menstruation supports these theorists’
notions of a menstrual taboo. In fact, the history of menstruation reveals that the women’s periods, since primitive times, had been considered taboo in many cultures.

This taboo which played an awe-inspiring role in earlier civilizations becomes a highly negative event, in recent times. For a young girl, embarking on the journey of puberty, living in a culture that endorses a taboo of something that is so pivotal to what it means to be female may make the transition into womanhood, much more trying and confusing. Such difficulties may ultimately lead a young girl to a negative outlook about herself. Because culture dictates the beliefs, values, and behaviours that a person holds (Delaney et al., 1988), exploring menstruation within this framework will lead to an insight into how negative views of menstruation are established.

In fact, the word “taboo” is believed to originate from the Polynesian word ‘tupua’, which means menstruation (Delaney et al., 1988; Golub, 1992; Novak, 1916; Walker, 1983). For menarcheal girls, this period of seclusion represents a rite of passage from childhood to womanhood. Among the more extreme devotees of the practice were the Carrier Indians of British Columbia, who forced a menarcheal girl to live alone in the wilderness, where she remained secluded from her tribe and had to spend for herself for several years (Benedict, 1944).
Natives of New Ireland, a large Island in Papua New Guinea, kept their girls at home for some period of time, but in cages, where they would get fat and pale, in accordance with the tribe’s standards of beauty (Frazer, 1951).

The Kolosh Indians of Alaska locked away newly menstruating girls in tiny huts for one year, during which time they were allowed no fire, exercise, or company (Frazer, 1951). In all these cultures, once the period of seclusion was complete, the girl emerged as a woman and was ready for marriage.

In South India, the girl is secluded during the first menarche. During the seclusion, the girl is instructed not to look at birds, not to go out alone, prevented from entering the pooja rooms, warned not to leave over food. Further, she was not allowed to touch the flowering plants, and stored food and so on.

The WHO insists upon the holistic health of the individual. Holistic health cannot be achieved only by physical health, but must include mental health. Mental health is nothing but, the psychological health. As Erickson had rightly stated, ‘the adolescent period is the identity period’, where the adolescent girl also seeks for identity. If the adolescent girl has not obtained the identity, she reaches the state of confusion. Identity boosts up the
self-esteem. Physical health is important and psychological health is even more essential.

The matter of self-concept is so prominent a feature of adolescence, that it is preferred by the social scientists to make all the developmental issues associated with identity formation.

Many psychologists and researchers have defined self-esteem. Self-esteem is a positive or negative attitude towards an object usually referring to the self (Rosenberg, 1965). Self-esteem can have two different meanings. In one meaning, a girl might have high self-esteem if she thinks, she is “very good”; on the other hand, she may think she is “good enough” (Rosenberg 1965: p.30). Rosenberg believes, high self-esteem means, the individual respects herself, considers herself worthy; she does not necessarily consider herself better than others, but she definitely does not consider herself worse, she does not feel that she is the ultimate in perfection, but, on the contrary, recognizes her limitations and expects to improve and grow. Low self-esteem, on the other hand, implies self-rejection, self-dissatisfaction, and self-contempt. The individual lacks respect for the self. The self-picture is disagreeable, and she wishes it were otherwise (Rosenberg 1965: p.31). It is the global appraisal of her positive or negative value, based on the scores a girl gives herself in different roles and domains of life (Rogers, 1981).
Self-esteem is theorized as a central component of personality and identity. Maslow’s self-esteem is the core or base for human development and motive [Maslow 1970].

We are born “to succeed not to fail” is a motivating factor for the low self-concept individuals. Self-esteem is part of everyday language and at an intuitive level. Self-esteem refers to the personality, which is the way people feel about themselves. Global or trait self-esteem is enduring across time and situation [Kernberg, 1975].

High self-esteem is characterized by general fondlesness or love and low self-esteem is characterized with mild positive or ambivalent feelings towards the self. Trait self-esteem is related to cognitive, emotional, and behaviour phenomena.

The self is social product, carrying out of symbolic interactions and prerequisite cognitive capacity for role making, which enables to see the self as others see i.e. the ‘looking glass self’ or reflected appraisal (Cookey 1902, Rosenberg 1979). In the family, the girl expects the reflected appraisal of the parents to be particularly significant for the girls’ self-conception.

Self-esteem is how you see yourself and how you want to see yourself [Tary Higgins, 1989]. It guides the self as actual self,
ought self and ideal self. Nobody is perfect in coping but with some degree of self-discrepancy, better coping may be obtained.

Self-esteem is the sum of an individual's belief and knowledge about her personal attributes and qualities. It is classified as a cognitive schema that organizes the abstract and concrete views about the self. It controls the processing of self-relevant information (Markus, 1977, Kihlstrom and Cantor, 1983). Self-esteem is the evaluative and affective dimension of the self-concept, and is considered as equivalent to self-regard, self-estimation and self worth (Harter, 1999).

Everyone is motivated by a need for self-esteem and satisfying the need is critical to the entire life. People with high self-esteem tend to be happy, healthy, productive and successful. There is mere acceptance of others and less likely to confirm to the peer pressure. On the other hand, low self-esteem leads to more anxiety, depression, pessimism about the future and failure [Brown1991]. Lack of self-esteem leads to lack of self-confidence.

According to Orenstein (1994), self-esteem originates from two different avenues. That is how a girl sees or views her performance areas in which success is important to her (so if appearance is more important to a girl than academic success, gaining a few pounds may damage her self-esteem more than an
“F” in maths) and how a girl believes others perceive her such as parents, teachers, and peers. Girls learn to look outward for their sense of value, putting their self-esteem in the hands of others to confer their worth.

There are two important aspects of how self-esteem is built up or torn down. Girls with a healthy self-esteem have an appropriate sense of their potential, their competence, and their innate value as individuals. They feel a sense of entitlement or the right to take up space in the world because they feel they are contributing—their right to be heard and feelings to be accepted. It gives feeling a sense of value. Our culture tends to be unsure when women are successful, independent, and have the right to fulfill equal opportunities. Our culture devalues women and their qualities that they often portray such as nurturance, cooperation, and intuition (Orenstein, 1994). Our culture has taught women to undervalue their existence as unimportant. Girls, plain and simple, tend not to give themselves enough credit or the ability to achieve and degrade themselves and their abilities (Orenstein, 1994).

The transition from girlhood to womanhood usually begins around the time of middle school and is the time where the greatest amount of self-esteem is lost (Orenstein, 1994). Gilligan and her colleagues (1992) at the Harvard Project of the psychology
of Women and the Development of Girls found that, before puberty girls feel strong, secure, and wise but when they undergo the transformation to puberty, they emerge as adolescents with less confidence and more negative views about themselves (Phillips, 1998). Dissatisfaction with their body image is associated with low self-esteem (President’s Council, 1997).

Many women identify themselves through their body. The reflection of their body gives them positive or negative feelings about themselves resulting in positive or negative self-esteem. According to West and Sweeting (1997), low self-esteem is more characteristic in women than men because of their greater concern about their body and appearance. Their study concluded that those who worry about their weight, looks, and being popular will more likely have “low self-esteem” issues.

Girls are often portrayed as a unified group of individuals, who have lack self-confidence and a sense of entitlement. In the last two decades, girls have struggled to maintain a strong sense of self and they have experienced a decrease of self-confidence and positive feelings about themselves as they have gone through adolescence (Phillips, 1998).

Harter, (1999) found that there is a common dominant link between self-appraisals of physical appearance and self-esteem.
She has found that individuals who favour their appearance through positive feedback tend to report high global self-esteem. For both boys and girls, poor body image has been associated with poor self-esteem (Eklund and Bianco, 2000)

The time spent by an adolescent girl in class, work, leisure activities, social interactions, school pressure, and household assistance, meals and so on varies accordingly from culture to culture. It is surprising to see that the time actually and truly spent to think about the self is very less than the time that she spares for others. The self-awareness is just a mental trap and it is not a way to escape.

Positive feeling about the self during development has been posited to promote psychological well being and stability [Harter, 1993].

Positive self-esteem is always indispensable to a normal and healthy adolescent girl’s development, since it provides her resistance to stand on the problem, strength to decide and resolve the problems and a capacity to regenerate. A high level of self-esteem, not only gives her positive thinking and feelings, but act as a protective factor in increasing resilience on the emergence of disorder. It is a good indicator of social health or social well being, to get along with other people. It is how another
person reacts to her, and how she interacts with others [Mc Dowell and Newell, 1996].

Self-esteem is the core component in restoring and maintaining mental and physical health [Demo, 1987, Miller, 1985, Over Beurgh, and Savin, 1992]. Self-esteem is an evaluation that an individual makes and maintains with regard to herself [Coopersmith, 1947].

A girl’s perception and feelings about her abilities and efforts have the greatest importance in shaping self-esteem (Sieving and Danisch 1990). Self-esteem is a learned phenomenon involving a lifelong process (Coopersmith, 1967, Shanwyck, 1983). The learning process includes the interaction of the girl with her social environment, referring primarily to the immediate family, and significant others as they vary across the individuals’ life span. Interaction with significant others is a major contributor to self-esteem [Coopersmith 1967, Rosenberg 1965].

The individual’s self-esteem is dependent upon how significant others view them and their interactions are interpreted [Miller 1985].

The school has primary influence in developing the adolescent’s self-esteem. Looking different from others can evoke
feelings of inadequacy, that may lead to avoidance of peer activity, isolation, loss of self-esteem and loneliness [Ellis 1991].

Self-esteem is the overall image or awareness one has towards oneself. It includes the perception of “I” and “Me” together with the feelings, beliefs and values associated with them. Self-esteem is a cluster of selves. It is in turn, the way one perceives, judges and behaves.

Self-esteem provides the personal identity or sense of self-realization. It gives coherence to thought and action and reassures the self, without changing even the environmental pressures (Cervone and Shoda 1999). Self-image is more real than anything including the body image. Identity and a sense of self are more important even if the situation/person threatens.

A positive view on self maintains the self-esteem. Thus, it seeks only the positive information neglecting the negative one, even the information is ambiguous (Sedikidest 1993). Self serving attributions glorify the self, for the good outcome as taking the personal credits for the success and blaming the external force for the failure.

The most important aspect of self-esteem is the personal evaluation and the resulting feelings of self worth. The self-esteem is affected by a variety of influences ranging from formative
childhood experience in relation to child rearing, standard of life or ideal self-related culture (Miller 1999).

The self-esteem is influenced by not only the parenting style, over strict, permissiveness or inconsistency but also success and failure (Brrin & Gallagher 1992).

Self-esteem continues to change. Indeed, there is growing recognition that the cluster of selves comprised by the self-esteem can and does change to a greater extent than previous realization.

The change occurs with maturity, with age and experiences. It comes from adapting from different people and situation, different jobs, new friends and change in responsibilities. The stable core of self is retained with self-perception.

Physical and psychological well-being may be attained by health promotion. In turn, health promotion is deliberate and efficient management of the physical, psychological and social inputs to health. Health promotion is attained by many ways. One such way is using life skill approaches to health and thus well-being may be attained.

Life skills are those abilities, which help human beings to adjust with the changing situations in everyday life. They stimulate positive behaviour, which enables them to deal with the demands
and challenges in life. Life skills are the psychological competencies needed to be distinguished from other important skills that the adolescent need to acquire. Life skills are necessary for promoting the physical and mental health. They also train human beings to achieve emotional balance.

For the adolescents in their young age, the mind is normally flying in an imaginary world. However, life skills help them to understand the realities in life. They teach how to live in the real world. These skills include problem solving, critical thinking, decision-making, creative thinking, interpersonal relationship, communication skills, self-awareness, management of stress and emotions and so on.

Life skills are used in different ways in different situations. Youth and adolescents should be encouraged to develop such skills. Some situations in life are critical and challenging. Hence, it is important to provide opportunities to the young adolescent girls and the young generation for adopting such skills in their life. Following life skills in life may result in valuable outcomes.

These outcomes may increase self-esteem, assertiveness, the ability to plan, interest in acquisition of knowledge, self-confidence, social sensitivity, ability to establish relationships, learning ability etc.
Life skills can influence the way we feel about ourselves and the way others perceive us. Individuals can have the courage to face the conflicts and are able to solve them without stress. Today every activity in life includes negotiation and adjustment. Life skills help to develop effective negotiation skills for personal as well as social interests. Risk situations are also very common in this competitive world. Life skills promote and protect the life and health of human beings in risk situations.

Life skills help the youth to strengthen their overall development and contribute to the motivation and skills to develop and maintain healthy behaviour. It also helps to make healthy choices and avoid high-risk behaviour, which may lead to negative health in life.

Health promotion is the process of enabling people to increase control over problems and improve their health (WHO, 1986). Subjective control as well as subjective health each aspects of the self are considered as significant elements of the health concept.

Health promotion is a strategy for improving the health of the population especially the adolescents, by providing individual, group and community support as a tool to make informed decision about health and well beings (Lucas and Lloyd 2005)
BACKGROUND OF THE STUDY

Life is undergoing significant changes in the 21st century. Among the most affected are the adolescents. The behavioral pattern followed by the adolescents, during adolescence will last for the entire lifetime. They influence the health and the wellbeing of any adolescent.

Health and well-being are strongly interrelated with the development. Apart from bio-psycho social changes and technological advancements, an adolescent undergoes many other changes. These changes make them dependent on their parents economically for a longer period, than the previous years. They get more information related to cultural alternatives, which lead to change in life styles.

India is a big country with diverse conditions, such as

- 5,000-year-old civilization,
- 325 languages spoken - 1,652 dialects
- 18 official languages,
- 29 States, 5 Union Territories,
- 3.28 million square km - area,
- 7,516 km – coastline,
- 1 billion people in the year 2000 and
- 207 million of adolescents.
The end of adolescence and the beginning of adulthood vary from country to country and by function.

In many societies, adolescence was not recognized as a phase of life, especially the girls were not brought into the limelight at all. Culture, religion and family no longer control, but rather act as buffer. When external controls no longer are effective, internal controls have to be strengthened. However, adolescent girls are rather neglected till recently. It is the fact that in the field of education, we have achieved a lot i.e. rise in the literacy rate, decrease in school dropouts, encouragement of girl child education, empowerment of adolescent girls, etc. Despite all this, girls are always neglected.

Certain in-built buffers of the family, as support and control are no longer available to the present day adolescent girls and they do not like to follow it. This is because of extended family, smaller, closed community and the peer pressure. Additionally the industrialization, migration, urbanization, poverty, single parent family, and alcoholism pressurize the adolescents, especially the girls in particular.

It is the time the adolescent’s need to be helped before they sink into stress. The Indian society expects and demands more
from the adolescent girl. These expectations make them, to be, a challenge for an adolescent girl.

**NEED FOR THE STUDY**

Adolescence is the developmental period marked by rapid maturational changes, shifting societal expectations, conflicting role demands and increasingly complex relations [Block & Robins 1993]. It brings with it developmental maturity and certain new problems that center around the biological, emotional and social aspects of the adolescent personality. Adolescence is characterized by rapid changes, when events and experiences have significant implications and consequences for later life. As they develop, the adolescents adopt new roles of social responsibility; acquire skills and access opportunities necessary for functioning in adult life. The health and, even more importantly, the knowledge, attitudes and practices of the adolescents are regarded as essential factors when predicting the process of epidemiological transition of a population.

The current lifestyles of the adolescents, such as eating habits and reproductive behaviour, are crucial for the health and disease patterns that will endanger the adolescent health. The adolescents are subject to many influences dominating their internal and external environment. These include parents, teachers, peer groups, health care providers, media, and religious
and cultural norms in the community. Knowledge acquisition is the significant in the adolescent period rapid. The physical, mental and social changes occurring during this critical stage of life helps the adolescents to absorb and adapt to these changes and enables them to avoid becoming victims of many serious illnesses.

Adolescence is the critical period in human development, that is, the fork on the road that shapes an adolescent girl’s destiny. Social scientists argue that the society ultimately mirrors the results of the adolescent girls in her developmental process.

Technology has made education and training necessary. This in turn has made the adolescents depend on their parents economically for a longer period, more than in their earlier agricultural era. At the same time, today the adolescents are exposed to more information and cultural alternatives than in earlier periods. This provides the adolescents with culturally diverse choices, which cannot be easily exercised due to economic dependence. Ironically, the adolescent has to prepare for a global life of competitions, comparison and independent functioning in a dependent environment.

Rapidly changing social, moral, ethical and religious values have ushered in certain “Life styles” in the present society
especially among the youth/adolescents. These affect their health significantly.

Adolescent period is the critical and dynamic stage of development. The adolescent girls face challenges and demands in everyday life. The adolescent girls need psycho-social competencies to deal with the challenges and demands effectively.

Menstruation is a phenomenon unique to the females. The onset of menstruation is one of the most important changes occurring among the girls during the adolescent years.

Adolescent girls constitute a vulnerable group particularly in the Indian society. The reaction and the manner, which the girl learns about menstruation and its associated changes, may have an impact on her response to the event of menarche. Although menstruation is a natural process, it is linked with several misconceptions and practices, which have in adverse health outcomes.

Knowledge related to the menstruation is important. Hygienic practices are very much necessary. However, it is not given much importance merely because of the misconceptions, religious practices and related cultural and religious issues. The knowledge of the adolescents regarding sexual and reproductive health is very much limited. Most of the adolescent girls do not
have adequate knowledge on puberty and menstruation, particularly in developing countries like India, where very little attention is being paid to the reproductive health of the adolescent girls.

A majority of the school going adolescent girls are not aware of the fundamental facts of menstruation and puberty. Negative perception and misinformation, which they gather continue through their reproductive years and act as barriers for a healthy reproductive life. Unhygienic practices during menstruation endanger the reproductive health and the wellbeing of the adolescent girls and expose them to reproductive tract infections (RTI) and other related complications. Therefore, adolescence is often seen as a stage of both opportunities and risks, since their behaviour including sexual and reproductive health have generational and intergenerational consequences.

Positive feelings about the self, during the development have been argued to promote psychological well-being and stability (Harter 1993), behavioral adaptation (Kaplan1982) and success in school (Beane and Lipka 1983). High levels of self-esteem also may function as a protective factor increasing resilience to the emergence of disorder (Garmezy, 1985; Rutter, 1987; Werner and Smith, 1982). These considerations suggest the importance of enhancement of self-esteem as an aim for community and school
based interventions for the adolescents, that seek either to prevent disorder (Albee, 1980), or to promote mental health and psychological wellness more generally (Cowen, 1994). In the recent significant development of the literature a greater attention being given to a multidimensional conceptualization of self-esteem (Harter, 1993) compared to prior studies, which focused primarily on global or overall feelings of self worth (Hater1983; Wylie, 1979). The conceptualization of child and adolescents’ self-esteem (DuBois, Felner, Brand, Phillips and Lease 1996) is based on the family context.

Parental attitude and behaviour acceptance of their adolescents, clear and well-enforced demands, and respect for actions within well-defined limits- were the primary antecedents of self-worth (Pervin, 1993).

The study done by Juliet F (1991) on adolescent problems and their relationship to self-esteem revealed that girls reported more problems in interpersonal relationship, personal adjustment and that leads to a low level of self-esteem than the boys.

Adhikaari, P. et al. (2007) found that adolescent girls were not properly maintaining the menstrual hygiene and they lack knowledge.
Adolescents face crises. This is because they are unaware of their “physical and psychological development”. The silence surrounding menstruation burdens the young girls by keeping them ignorant of this biological function. The first menstruation was often a traumatic and very negative experience for young girls in most parts of India (George 1994). The adolescent girls constitute a vulnerable group, particularly in India where female children are neglected. Menstruation is still regarded as something unclean or dirty in the Indian society (Dasgupta.A, Sankar. M 2008).

Narayan. K.A et al., (2001) in his study Puberty Rituals, Reproductive Knowledge and health of adolescent school girls in South India done at JIPMER, Puducherry noted that adolescent girls are not prepared in any way for their first menstruation. Two-third of the girls described the onset of menarche, as a shocking or a fearful event. The adolescent girl’s knowledge of anatomy is very weak. The little information given were “keeping the cloth” and in the form of restrictions and caution about behaviour towards males. Majority of the girls are unprepared for the trauma of first menses.

The study done by Sindhu Devi M (2007) revealed that 83% of the respondents advocated education on reproductive health
either by teaching in classes or by providing books which had the necessary information.

**WHO (1997)** has specified ten Life Skills for promotion of psycho-social competency of the adolescents. They are Critical and Creative Thinking, Decision making and Problem Solving, Interpersonal relationship and Effective Communication, Coping with Emotion and Stress, and Self Awareness (it includes self-esteem) and Empathy.

**Rekha (2006)** conducted a study in Kerala and Karnataka on enhancing practice skills of professional social work trainees through short-term participatory training programme, and found that the programme enhanced student’s skill in respect of verbal communication, creative thinking, critical thinking, interpersonal relationship, stress management, decision-making and problem solving.

A one year study done by **Srikala B and Kishore KK (2007)** on 605 adolescents on life skills education programme revealed that adolescents had significantly better self-esteem, perceived adequate coping, and better adjustment generally, specifically with teachers, in school, and pro-social behavior. A randomly selected group of 100 Life-Skill teacher-educators also perceived the positive changes in the peers in the program, in classroom
behaviour and interaction. Life Skill Education integrated into the school mental health program using available resources of schools and teachers was seen as an effective way of empowering adolescents’ peers.

Susan Anand et al., (2008) in their study on Life Skill for the adolescents found out that there is very high significant gain in the scores on Life Skills among the students.

Thus, the school-based interventions are critical for enhancing the health of the youth, especially the adolescent girls who are most affected due to many reasons. The Goals For Health (GFH), school-based project was a goal setting and Life-Skills intervention programme conducted in rural areas to increase self-efficacy, knowledge, and positive behavior related to a healthy lifestyle and the health promotion of the adolescents.

Paradoxically, self-esteem is an ongoing developmental process that is influenced by new situations and events. Positive or confirming experiences, individual skills, interests, and talents within the context of family, economic status, community and culture lead to higher evolutions of self-esteem (Murk, 1995).

It is essential to prevent today’s youth from the pressure and problems with a set of ways and skills to deal with the demands and challenges of an adolescents’ life. The “individual” rather than
the “system” is recognized as the basic unit of the society. It is essential and a must to help the adolescents to develop the skills to handle a wide variety of choices, challenges and stressors in themselves and work towards better health.

Many health problems prevail among the adolescents. The attention given to the health problems of the adolescent girls is still meager, even though adolescence is a time during which looking after health and nutrition, can help to build a buffer against the heavy physical demands of the reproductive years. High rates of gynecological morbidity have been reported in rural population (Bang and others, 1989; Koenig and other, 1998). However, the knowledge and problems of adolescents have so far received only minimal attention (Koblinsky, 1993).

The adolescent girls who are fortunate enough to be given relevant books and health education materials by their teachers gain some information about reproductive functioning and reproductive health problems from the school sources. But a great deal of their scarce knowledge is dependent on informal communications with peers and family members. Some studies of the Indian women have found that young girls are generally told nothing about menstruation until their first personal experience of it. George, (1994) in his study of women in Mumbai noted, “The silence surrounding menstruation burdens the young girls by
keeping them ignorant of this biological function” (George, 1994). The events and experiences surrounding menarche can be a significant influence on the young girls’ view as on their understanding of reproductive health issues, and on appropriate behaviour for hygienic management of menstruation.

The problems related to reproductive health affects the self-esteem of the growing adolescents. The lower the self-esteem the higher the problem. It leads to depression among the young adolescents.

Hence, there is an urgent need to provide today’s youth with a set of ways and skills to deal with the demands and challenges of life. On the health side, more emphasis is on the prevention side than on the curative side. The values of a stable society and the family have to be replaced with the skills of the individual that would enable the girl child to be stable amidst the rapid transition in the environment. It is the responsibility to incorporate scientific methods to help the adolescents to develop the required skills. Life Skill education is such a method. Empirical studies over the past 15 years indicate that self-esteem is an important psychological factor contributing to health and the quality of life (Evans 1997).

The responsibilities which the adolescent girl shoulders, is much more and countless. Thus, the present study has been
initiated to promote health of the school going adolescent girls using some skills. So that, the adolescent girls will gather some knowledge. They grow according to the society’s expectations. Health promotion module using life skill will help the adolescent, especially the girls to grow, to face the critical situations in life and to solve the problems.

Hence, the investigator incorporated the selected Life skills, which are advocated by the WHO to enhance the self-esteem and to create awareness on menstrual health in order to promote the health of the school going adolescent girls. Health promotion using Life skills helps her to achieve the high self-esteem and to solve the problems that she faces in day-to-day life.

**STATEMENT OF THE PROBLEM**

A study to assess the effectiveness of teaching module on selected Life Skill approaches in promoting health of the school going adolescent girls in Puducherry.

**OBJECTIVES**

1. To evaluate the knowledge of adolescent girls towards reproductive health.

2. To elicit the attitude of the adolescent girls towards reproductive health.
3. To assess the level of self-esteem of the school going adolescent girls.

4. To assess the effectiveness of teaching module using selected life skill approaches.

5. To associate self-esteem, knowledge and attitude towards reproductive health with selected socio-demographic variables (Type of school, medium of instruction, and parental education).

**HYPOTHESES**

1. The Adolescent girls after receiving the teaching module based on life skills approaches will demonstrate a significantly better level of knowledge on reproductive health in the posttest.

2. The Adolescent girls after receiving teaching module based on life skills approaches will demonstrate a significantly positive attitude towards reproductive health in the posttest.

3. The Adolescent girls after receiving teaching module based on life skills approaches will demonstrate a significantly higher level of perceived self-esteem in the posttest.

4. The Adolescent girls after receiving structured teaching module based on life skills approaches will demonstrate a significantly higher level of the perceived self-esteem related to the domain of Personal Self-esteem in the posttest.
5. The Adolescent girls after receiving structured teaching module based on life skills approaches will demonstrate a significantly higher level of perceived self-esteem in the domain related to the Family self-esteem in the posttest.

6. The Adolescent girls after receiving structured teaching module based on life skills approaches will demonstrate a significantly higher level of perceived self-esteem in the domain social self-esteem in the posttest.

7. The Adolescent girls after receiving structured teaching module based on life skills approaches will demonstrate a significantly higher level of perceived self-esteem in the domain Self-concept in the posttest.

**OPERATIONAL DEFINITION**

**Life Skills Approaches:** Life skills approaches advocated by the WHO are living skills or abilities for adaptive and positive behavior that enables the adolescent girls to deal effectively with the demands and challenges of everyday life.

In this study, the life skill approaches are applied to educate the subjects and it includes small group approaches, interactions with peer, participatory activities, education on menstrual health in-turn to enhance the self-esteem and to educate the parents to rear their adolescent daughter.
**Teaching module:** Teaching module is a conceptualized self-contained units of content or technique. In this study, the strategy adopted by the Investigator as recommended by the WHO is to enhance the knowledge and create a favourable attitude towards reproductive health. It also aims to increase the level of perceived self-esteem of the subjects, which includes the various domains of personal, social, family and self-concept as a tool to make informed decisions about their health and well-being of the subjects in this study. Reproductive health and menstrual health are invariably used.

**Promoting health:** Promoting health the process of enabling people to increase control over their health and in determinants, and there be improve their health. In this study, it is to enhance the knowledge and create a favourable attitude towards reproductive health and raising the level of perceived self-esteem in various domains as personal, social, family and self-concept and thus attain the health and well being of the subjects.

**Effectiveness:** Effectiveness is the attainment of objectives. In this study, it is the improvement in the knowledge and attitude towards menstrual health and improvement in the level of perceived self-esteem of the subjects in the domains of personal,
social, family and self-concept as recommended by the WHO based on the Life Skill approaches is aimed in this study.

LIMITATIONS

1. Previous exposure of the subjects in the similar programme was not considered in this study.

2. The socio-economic condition, lifestyle and habits of the subjects were not taken into consideration.

DELIMITATIONS

1. The study was delimited only to the school going adolescent girls in the age group of 13 years to 15 years studying in 9th standard.

2. The study intervention was limited to create knowledge and a favourable attitude on menstrual health.

3. Self-esteem was confined to boost up only in the areas of Personal, Family, Social and Self-concept.

4. The study was delimited up to 6 sessions with equal intervals for all the subjects.

5. The data was collected before and after interventions.

CONCEPTUAL FRAMEWORK - PENDER’S HEALTH PROMOTION MODEL

Conceptual framework is a theoretical approach to study the problems that are scientifically based which emphasizes the selection, arrangements and classification of the concepts.
Conceptual framework is the inter-related concepts or abstractions that assembled together in some rational scheme by virtue of their relevance to a common theme \cite{PolitHungler1999}.

The Theoretical Framework selected for this study was based on Nola J. Pender- Health Promotion Model.

The Health Promotion Model (HPM) proposed by Nola J Pender (1982; revised, 1996) was designed to be a “complementary counterpart to models of health protection.” It defines health as a positive dynamic state not merely the absence of disease. Health promotion is directed at increasing a client’s level of wellbeing. The health promotion model describes the multi dimensional nature of persons as they interact within their environment to pursue health. The model focuses on following three areas:

- Individual characteristics and experiences.
- Behavior-specific cognitions and affect.
- Behavioral outcomes.

The health promotion model notes that each person has unique personal characteristics and experiences that affect subsequent actions. The set of variables for behavioral specific knowledge and affect have important motivational significance. These variables can be modified through nursing actions. Health
promoting behavior is the desired behavioral outcome and is the end point in the Health Promotion Model. Health promoting behaviors should result in improved health, enhanced functional ability and better quality of life at all stages of development. The final behavioral demand is also influenced by the immediate competing demand and preferences, which can derail an intended health promoting actions.

**The major concepts of the theory are:**

- Enhance perceived self-esteem and self-perceived development of competency, coping and practice life skills.
- Create a healthy living condition.
- Assess the individual’s own potential.
- Make them to be stable along with the change.
- Promote the health of the adolescent girl with the available / self-psychosocial competency.

As per the Pender’s health promotion model the individual’s experiences and characteristics plays the role in the adolescent health promotion. The socio-demographic variables such as the age of onset of puberty of the subjects parental education, socio-economic status of the parents, plays a role in the acquisition of the knowledge on reproductive health, and enhancement of self-esteem in the areas of personal, family, social and self-concept of the adolescent girls.
The personal factors such as body-image, hormonal changes resulting in regular/irregular period, low self-esteem, level of parental education leading to misconception, beliefs, cultural practices and the taboos adds to the enhancement of the perceived self-esteem.

The behavioural specific cognition and the affect influence the change in the behaviour and well-being of the adolescent girls.

As the positive perception increases, the barriers decrease. Positive perception increases the self-potency, self-efficacy and decreases the perceived barriers.

The adolescent girls wrongly perceive the family that it is not supporting for her health promotion. Lack of family support, cultural belief runs in the family, unhygienic practices followed during menstrual periods due misconceptions and the level of education of the mothers’ acts as the barriers for the adolescent girls’ health promotion.

The life style followed by the Indian society, mother–child communication to transmit the knowledge related to reproductive health and some of the environmental factors influences the enhancement of the self-esteem in all the domains of personal, family, social and self-concept.
The interventional strategies based on the participatory activity module using selected life-skills increased the self-esteem and acquisition of the knowledge on reproductive health.

The participatory activity module was planned in six sessions to improve the perceived self-esteem in the areas of personal, family, social and self-concept. The intervention also made the adolescent girls to acquire knowledge on reproductive health thus complete self-awareness was achieved.

The committed plan of action as parental education, income, type (management) of the school and the medium of instruction that the adolescent girls study had some influences. Mother’s meet and an interactive session with the mothers was conducted to reduced the gap.

The six interventional sessions on reproductive health and the self-esteem on personal, family, social and the self-concept enhanced the knowledge and the self-esteem as the behavioural outcome.

Thus, Pender’s Health Promotion Model brought out behavioural outcome of the adolescent as enhanced perceived self-esteem and increase in the knowledge and attitude towards the reproductive health by commitment in plan of action of the participatory activity module using the life-skill approaches.