SEXUAL HEALTH AND PSYCHOLOGICAL WELL-BEING OF UNMARRIED ADOLESCENT FEMALES LIVING IN AN URBAN SLUM IN INDIA

AN ABSTRACT

SUBMITTED ON THE 24th DAY OF SEPTEMBER 2014

TO THE DEPARTMENT OF PSYCHOLOGY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

OF THE SCHOOL OF SCIENCE AND ENGINEERING

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BY

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Abstract

In India, ranked 132nd out of 148 countries in the United Nations Gender Inequality Index (2013), females face numerous challenges that pose a threat to their sexual health and psychological well-being. This paper focuses specifically on adolescent unmarried females living in an urban slum, a particularly vulnerable segment of the population that is important to empower in order to effect change. With the ultimate aim to better understand how to design effective and accessible interventions for adolescent females, this paper explores sexual health and its relation to psychological well-being from the perspectives of multiple stakeholders: adolescent girls, mothers of adolescent girls, and service providers who work with adolescent girls. To understand the unique and shared perspectives of the stakeholders regarding the constructs of psychological well-being, gender roles, and sexual health, the author utilized focus group and interview data. Through the use of the deductive-inductive coding process, the author identified overall themes and differences in perspective that elucidated the perspectives of the population. The findings revealed that there is great overlap in the three constructs studied, and each is influenced by and impacts the other. Additionally, the findings showed a trend of girls, mothers, and service providers understanding the importance of girls having access to sexual health information and openness towards mothers potentially sharing this information with daughters. Other implications, future research directions, and limitations are discussed.
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Adolescents (aged 10-19) make up more than one fifth of India’s population. Adolescent girls constitute almost half of this population, with about 113 million currently living in the country (Government of India Ministry of Home Affairs, 2011). Adolescence is a critical period for all individuals throughout the world, involving numerous biological, cognitive, and social transformations. The transition from childhood to maturity is a time of particular vulnerability and presents the possibility of serious challenges. In India, a country ranked 132nd out of 148 countries on the gender inequality index (United Nations Development Programme, 2013), adolescent females face numerous serious challenges that threaten their sexual and reproductive health, and psychological well-being. Gender differences in nutrition, basic health care, education, employment opportunities, household and community roles, and exposure to violence are indicative of a male-dominated society where females continue to be marginalized. In the Millennium Declaration (United Nations General Assembly, 2000), world leaders made a promise to help children and adolescents in all countries to fulfill their potential. Many adolescents throughout India have benefited from their country’s commitment to the Millennium Development Goals in relation to education and labor, health, sexual behavior, childbearing and maternal health, HIV, violence, and gender equality. Despite the country’s efforts, many of the goals still have not been achieved. In order to meet the Millennium Goals, which include the empowerment of women, reduced child mortality, improved maternal health, and eradication of sexual transmitted diseases, it is necessary to effect change within the youth of the country. One major pathway to positive change in
India is the development of informed interventions and policies that address sexual and reproductive health of adolescent females.

The World Health Organization (2006) defines sexual health as,

A state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

In order to conceptualize sexual health, it is necessary to gain an understanding of the many aspects of sexuality which the World Health Organization (2006) describes in the following way,

A central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors.
The World Health Organization definitions elucidate the fact that sexuality and sexual and reproductive health are multi-faceted constructs that need to be examined from numerous angles. Additionally, in order to effect positive change regarding sexual health, it is imperative to consider the many interactions that impact sexuality. One construct that has a particularly intertwined relationship with sexual health and is vital to examine is psychological well-being defined by Nastasi, Maitra, and the RISHTA team (2013) in their Narrative Intervention Model used to inform a sexual health intervention designed for married women and couples living in Mumbai, India as,

Mental health, including emotional well-being (e.g., happiness; satisfaction with self, perceived social support, self-esteem, sense of competence, locus of control); tensions (sources, of tension, coping strategies, body response or reactions to tension, consequences of tension); absence of mental health problems (e.g., symptoms of psychiatric disorders such as depression, anxiety, PTSD) (Nastasi et al. 2013, p. 5).

Globally, females are more likely than males to be afflicted by common mental disorders due in part to risk factors including gender disadvantage, intimate partner violence, and family issues (Das, Das, & Das, 2012). Effective initiatives that address sexual and reproductive health are likely to impact psychological well-being as well. Additionally, in order to improve psychological well-being, particularly in a country with strong gender inequality, it is important to address sexual and reproductive health needs.

The purpose of this research is to increase our understanding of how to create sexual health interventions for adolescent unmarried women in urban India. The study
focuses on adolescent women because they make up a significant segment of the population that is vulnerable to the aforementioned challenges that women face in India. Effectively designed and implemented interventions for unmarried adolescent girls have the potential to empower this population and help them to lead the country in meeting the Millennium Development Goals. In a recent interview addressing why women should be at the center of international development, the executive director of the United Nations Population Fund, Dr. Babatunde Ostimehin, stated, “Women are at the center of people’s lives so being able to provide the enabling environment for them to exercise their rights and make choices in their lives is crucial for us to be able to have the kind of abilities and the kind of vitality we want to have in our communities and nations” (Stephens, 2013, p.1).

The current study focuses particularly on adolescent girls living in urban slums. Many individuals in this population face additional challenges including poverty and lack of education, and do not have access to sexual health educational opportunities that adolescents attending school may have. This population is particularly understudied in India because many girls do not attend school where study measures are typically administered and are unable to complete written measures due to illiteracy. It is important to gain deeper understanding of this marginalized population, and to understand how to design effective interventions that will be accessible to these adolescent girls.

**Literature Review**

The literature review is comprised of numerous research findings from the last two decades that have significantly furthered our understanding of sexuality and
psychological well-being of adolescent girls living in India. In recognition of the multidimensionality of sexual health, this literature review addresses the many factors impacting the sexual health of adolescent females in India. PsychINFO and PubMed provided the basis for the literature search, using the following key terms: adolescents, girls, females, women, unmarried, sexual health, reproductive health, sexuality, psychological well-being, relationships, mental health, psychological disorders, interventions, NGOs, public health, empowerment, education, India, slums, and urban. Based upon this initial search, articles were included in the literature review if the studies added insight pertinent to the understanding of sexual and reproductive health, sexuality, and psychological well-being of unmarried adolescent girls living in slum populations in India. Also, the reference lists from the selected articles provided additional sources.

Although research on sexual and psychological health on urban adolescent girls has increased in recent decades, there is a dearth of published studies. For this reason reports from non-governmental organizations and governmental organizations also were included in the review. For the purpose of this study, the literature reviewed was restricted to that which addressed the specific population of interest, that is, unmarried adolescent females living in urban areas in India. This study does not intend to compare this population to any other populations, but, rather, aims to understand the specific population in depth.

The literature review begins with a general overview of sexual, reproductive, and mental health of adolescent females in India, delving into a wide range of findings within the last decade ranging from information on premarital sexual relationships to information on prevalence of mental health disorders. The findings of the studies discussed in this section provide evidence of the vulnerability of unmarried adolescent
girls in India, and support the need for elevated research attention towards this population. The next section examines the sexual attitudes of adolescent females, as well as attitudes of the general Indian population regarding adolescent female sexuality. Subsequent sections address adolescent girls’ knowledge about sexual health topics and the sources of this knowledge. Next, the review examines literature on stressors and supports that impact psychological well-being of adolescent females in India, specifically individuals living in slum populations. The next section discusses the impact of international, government, and non-governmental associations working to improve the quality of life of adolescent females. Then, specific sexual health interventions that have been implemented with adolescent girls by non-governmental organizations in community settings are examined. Finally, the limitations of existing research and the need for more formative research to understand sexual health and inform interventions are discussed.

**Sexual, Reproductive, and Mental Health of Adolescent Girls**

Progress in the improvement of sexual health of adolescent females in India has been slow. Study findings and statistics within the last decade regarding premarital sexual relationships, contraceptive use, sexual abuse, early marriage, pregnancy, abortion, and sexually transmitted diseases support the need for elevated attention to this vulnerable population. Some underreporting of sexual-related behaviors by women and adolescents is likely, even in studies conducted in a culturally-sensitive manner (Wyatt et al., 2002). This is, in part, due to the difficulty in obtaining accurate data regarding sexual activity of young people, particularly young women, because of the social taboo and stigmatization of adolescent sexual activity prior to marriage.
**Sexual health.** In a study on adolescent sexual behavior in India, Jeejeebhoy (2000) found that up to 10% of all females are sexually active in adolescence. Abraham and Kumar’s (1999) study of young females in the slums of Mumbai and Chakroborty’s (2010) study of unmarried girls in a Muslim slum community in Kolkata found respective estimates of 3% and 5% of young women between the ages of 14 and 22 having sexual intercourse prior to marriage. Studies show that about 20% to 30% of males ages 16-19 have engaged in premarital sexual intercourse (Abraham, 2001; Sathe & Sathe, 2005). Although some adolescent females engage in premarital sexual relationships by choice, mostly while in a romantic relationship they anticipate will lead to marriage (Verma, Pelto, Schensul, & Joshi, 2004); a large number of girls are forced into nonconsensual sex. In a study of nonconsensual experiences of adolescents in urban India, Jaya and Hindin (2007) found that 42% of girls have been touched against their will, most commonly by strangers. A study of 16-year-old adolescents in Goa added to the findings, revealing that 6% of girls were forced into sexual relations (Patel, Andrews, Pierre, & Kamat, 2001). Furthermore, studies of young married adolescents have identified experiences of sexual coercion from husbands particularly in the early years of marriage (Maitra & Schensul, 2004). The 2005-2006 National Family Health Survey found that 40% of a representative sample of women in India had experienced physical, sexual, or emotional violence by their husband; women at the lowest wealth quintile reported even higher levels of violence (International Institute for Population Sciences and Macro International, 2007a.). The majority of nonconsensual sexual experiences ranging from eve-teasing (a widely-used Indian euphemism for public sexual harassment or molestation) to abduction, often go unreported; therefore, the known statistics are likely
underestimates of the actual level of sexual violence (Ministry of Health and Family Welfare, 2000). Adolescent females and women in India often respond to instances of violence or sexual coercion with fear, self-blame, and feelings of humiliation that contribute to reluctance to seek help (Abraham, 2001; Sodhi & Verma, 2003).

Condom use is limited in both unmarried and married sexual relations and perceived as a method to be used mostly with sex workers. The Indian National Family Health Survey 2005-2006 found that 7% of married and 9% of unmarried females reported current use of contraceptive methods (IIPS and Macro International, 2007a.). For young people in premarital sexual relationships, access to condoms and other forms of contraceptives is limited (Jejeebhoy & Sebastian, 2003). Only 28% of adolescent females and 54% of adolescent males in the 15-24 age groups have comprehensive knowledge of HIV/AIDS (IIPS & Macro International, 2007). The serious gap in adolescents’ knowledge of sexual and reproductive health is reflected in unsafe sexual behaviors and the high prevalence of sexually transmitted diseases in India. The NACO National Behavioural Surveillance Survey (2002) reports that over 35% of all reported AIDS cases in India occur among adolescents, and the 15-24 age group accounts for more than 50% of new HIV infections in the country. Sexually transmitted infection testing and care seeking for existing symptoms are not common practices for most individuals (Jejeebhoy & Sebastian, 2003). About one-third of adolescent females, mostly unmarried, with an STI have sought medical attention and less than half of symptomatic males have done so (NACO, 2002). Of the 5 million people aged 15-49 living in with HIV/AIDS in India, women represent an estimated 40%. The rapid rise in
infection of monogamous women has occurred largely as a result of transmission from husbands to wives (Gangakhedkar, Bentely, Divekar, 1997; Maniar, 2000).

Although the minimum legal age for marriage for girls in India is 18 years, many adolescent girls continue to be married at a young age. Almost 50% of women are married by the age of 18 and 18% are married by the time they are 15 years old (IIPS and Macro International, 2007a.). Most adolescent females participate in arranged marriages that are determined by their parents and have little to no input of their own. Early marriage puts women at an increased risk of acquiring a sexually transmitted infection by their husbands and experiencing violence within the marriage (Santhya, Jejeebhoy, & Ghosh, 2008). In addition, women that are married at an early age are less likely to be empowered to make decisions for themselves and their families, and are more likely to have restricted educational opportunities (Lloyd & Mensch, 2006).

**Reproductive health.** Upon marriage many adolescent females have to give up education in order to meet the traditional expectations of maintaining a household and giving birth to children in the early stages of marriage. The National Family Health Survey (2005-2006) reported that 28% of women currently aged 20-49 gave birth by time they were 18 years old, and 24% of 18 year olds had already given birth or were pregnant at the time of the study. In a Public Health Department Study conducted in Mumbai in 2006, around 90% of women in the age group of 15-29 had at least one live birth (Mumbai Human Development Report, 2009). Early childbearing leads to increased risk for mothers and infants. Young mothers are more likely to experience birthing complications and are less likely to receive adequate maternal and child care (Singh & Trapithi, 2013). A little over 10% of adolescent women in India utilize antenatal care,
about 50% utilize safe delivery services, and only about 41% of children of adolescent women receive full immunization (IIPS & Macro International, 2007a). Adolescents living in low income families in urban areas of India experience elevated risk of negative reproductive health outcomes (Jejeebhoy, 1998). In the slum areas of Mumbai only 62% of mothers receive post-natal care within two days of the birth compared to 72% in non-slum areas (Mumbai Human Development Report, 2009). Singh, Rai, and Singh (2012) assessed the utilization of maternal and child health services by adolescent mothers in India and reported that the underuse of these services can lead to high maternal mortality, negative pregnancy outcomes, and worsened maternal health.

Abortion is legal in India under specific situations such as contraceptive failure and rape; however, individuals under the age of 18 are required to have consent from a parent or guardian to undergo the procedure. About two-thirds of all abortions in India take place outside of authorized health services (Population Reference Bureau, 2011). Unmarried adolescent females are more likely than married or older women to undergo abortion procedures from unqualified providers in order to receive prompt and anonymous care. As a result, they are more likely to suffer abortion-related complications (Jejeebhoy, 2000). Although it is illegal, sex-selective abortions, known as female foeticide, have been on the rise in India. In India’s patriarchal society where the birth of a son is preferred, women are often pressured or even forced to abort female fetuses (Nagpal, 2013). The 2011 Census data reveals that child sex ratios have undergone a significant decline from 927 females per 1,000 male children in 2001 to 914 females for a 1,000 male children in 2011 (Government of India Ministry of Home Affairs, 2011). This unnaturally skewed human sex ratio affects gender issues and propagates the continuation
of a male-dominated society where women are discriminated against in many facets of life.

**Mental health.** The aforementioned figures regarding sexual coercion, early marriages, and sex discrimination, provide some insight into the challenges faced by adolescent females living in a society fraught with gender disparities. The numerous stressors related to sexuality and gender discrimination females experience contribute to feelings of helplessness, low self-esteem, and increased psychosocial stress (Kaila, 2001). Researchers in the state of Uttar Pradesh found that adolescent girls had poorer self-image than boys and felt that they were burdens to their families (Jejeebhoy, 1998). Overall, women's risk of having depression or anxiety is two to three times higher than that of men (Vindhya, 2007). Research on psychological disorders in India shows a prevalence of depressive and anxiety disorders of 6-7% in women over the age of 18. Married adolescent females are at a higher risk of developing these disorders compared to single women. This is likely due to the difficult, abrupt transition many females face from childhood to sudden married life (Pillai et al., 2008). Researchers found that suicide is the second most common cause of death among people aged 15 to 29. Of the 72,100 women that committed suicide in India in 2010, 56% were between the ages of 15-29 (Patel, et al., 2012). In a study examining suicide in a slum of Mumbai, researchers found that more women committed suicide than males, and “tension”, a frequently used term which refers to a broad range of subjective distress, was identified as the most common reason for the suicides (Parkar, Fernandes, & Weiss, 2003; Parkar, Nagareskar, & Weiss, 2012). Despite the alarming suicide rates in India and the rising number of cases of depression and anxiety, currently estimated to effect 40 to 60 million
people, mental health services are limited (Weiss, Isaac, Parker, Chowdhury, & Raguram, 2001). In 2011, there were 43 government run mental hospitals with 4000 outpatient facilities, 10,000 psychiatrist beds in general hospital, and 17,900 beds in mental hospitals. The country was reported to have an estimated 37,00 psychiatrists, 2,000 psychiatric nurses and less than 1,000 social workers and psychologists working in the mental health sector for a population of over one billion (WHO, 2011). Research findings show that there is a gender gap in access to health care, and that poor women from city slums receive the least satisfactory services (Vindhya, 2007). For those women that are able to access physical or mental health care, many are treated disrespectfully and are not provided with adequate attention or information from the health care workers (Rama Rao & Andrudh, 2001).

**Sexual Attitudes Regarding Adolescent Girls**

India is largely a patriarchal society with conservative values regarding female sexuality (Sathe & Sathe, 2005; Velma et al., 2004). Expectations of women are strongly driven by social and cultural customs that vary depending on religion, geographic location, caste, and class (Abraham, 2001). An overarching concept, transcending all of these divides, is the idea of izzat- honor. Women are the family keepers of izzat, and family reputations are often dependent on young women’s upholding of izzat. In most Indian societies, in order to maintain the family izzat, young women are expected to behave modestly and should remain virgins before marriage (Chakraborty, 2010; Jejeebhoy, 2006; Sodhi, Verma, & Schensul, 2004). Prior to marriage, girls are not supposed to express any sexuality or interest in the opposite sex and are expected to maintain innocence. Violating these traditional norms may result in loss of
marriageability and ruined family reputations (Mehra, Savithri, & Coutinho, 2002). Double standards that further may prevent girls from engaging in premarital sexual relationships include fear of being labeled as *chulu* (too easy) and other negative names, as well as fear of unwanted pregnancy (Sathe & Sathe, 2005). Oftentimes, upon puberty, adolescent girls become more closely monitored by family members and have their mobility and overall freedom restricted. In contrast, adolescent boys are not treated the same way, but, rather, may even be encouraged to explore their sexualities. Despite the aforementioned risks studies, show that an estimated 10% of adolescent females engage in premarital sexual relations (Jejeebhoy, 2001). In slum communities, such as the one explored in our study, cramped living environments and daily chores often increase the likelihood of interactions and the development of friendships and sexual relationships between males and females (Chakraborty, 2010; Mehra et al., 2002). While increased opportunities sometimes spark consensual relations, they also increase the risk of girls experiencing sexual harassment or being coerced into sex (Mehra et al., 2002; Sodhi & Verma, 2003). A study of adolescents in Goa found that adolescent females have lower perceptions of self-efficacy than males and are less likely to believe that sexual refusal can work. The girls in this study also perceived very high external pressure from males to engage in sex (Patel et al., 2001). A study researching premarital sexual behaviors and attitudes in the slums of New Delhi found that one of the chief coping mechanisms used by adolescent girls in order to maintain izzat is secrecy. Whether they are participating in consensual sex, sexually harassed, or coerced into sex, in order to maintain family izzat, girls are unlikely to share this information with anyone. Partially for this reason, it is
difficult to ascertain accurate figures regarding adolescent sexual activity (Sodhi et al., 2004).

Although attitudes of adolescents are slowly changing towards more liberal perspectives, attitudes towards sexuality are still largely conservative. In a study of 15-19 year olds living in slums in New Delhi, researchers found that the majority of adolescents in the study reported that only married couples should have a sexual relationship (Hindin & Hindin, 2009). When attitudes are studied by gender, it is evident that adolescent females hold more conservative values than males, likely due to the double-standards that allow sex for males and not for females (Ghule, Balaiah, & Joshi, 2007; Sathe & Sathe, 2005). In a study conducted in Pune, half of the male adolescents felt that premarital sex was appropriate if both partners were in love, while only one-fourth of girls endorsed this view. Additionally, 23% of the males in the study thought casual sex was acceptable; only 4% of females felt this way (Sathe & Sathe, 2005). A study of adolescents in Maharashtra had similar findings, with the majority of adolescents deeming casual sex immoral. Researchers found that adolescent females studying commerce/sciences had more liberal attitudes towards sexuality than males (Ghule et al., 2007). Many adolescent females in India have access to very little information regarding sexuality and reproductive health. It is possible that restricted knowledge serves as an additional constraint that helps to maintain conservative attitudes amongst adolescent females, and worse so, contribute further to the vulnerability of this population.
Sexual and Reproductive Health Knowledge of Adolescent Girls

Numerous studies have found that adolescent females living in India, both married and unmarried, have limited knowledge about their bodies, relationships, sex, and reproduction (Bloom & Griffiths, 2007; Bott, Jejeebooy, Shah, & Puri, 2003; Dube & Sharma, 2012; Verma et al., 2004). In a study of 15-19 year old girls assessing knowledge on reproductive health, Dube and Sharma (2012) found that 40% of urban girls considered menstruation as a natural phenomenon, while 39% considered it a disease. In this population, only 33% of the respondents had knowledge of menstruation prior to menarche. Adolescent females also have limited information regarding sexually transmitted infections and diseases. The NACO National Behavioral Surveillance Survey found that 80% of females aged 15-19 had heard of HIV, but only 29% were aware of other sexually transmitted infections. In addition, only 56% of females could identify two prevention methods, and only 58% were aware that HIV is incurable (NACO & UNICEF, 2002). Common misconceptions of adolescent girls about HIV infection include the following: It can be prevented by good personal hygiene; a person with HIV can be identified by their physical appearance; and the HIV infection can be transmitted through everyday activity such as touching hands (Brown, Trujillo, & Macintyre, 2001). The NACO Survey found that only 32% of urban females have no misconceptions about HIV transmission (NACO & UNICEF, 2002). In a study of adolescents living in slum settings in Uttar Pradesh, only 37% of girls compared to 84% of boys were aware that condoms can provide protection against infections (Sebastian et al., 2002). According to the Mumbai Human Development Report 2009, about 50% of women in the slum areas of Mumbai have a comprehensive knowledge about reducing the risk of HIV/AIDS.
Additionally, many adolescent females have little knowledge about sexual intercourse and the biological process of conception. In studies conducted in the slums of Mumbai, two-thirds of adolescent girls and nearly half of adolescent boys reported they knew nothing about married life and its sexual aspects (Sathe & Sathe, 2005). Santhya et al. (2008) found that no more than 43% of young women or men were aware that a woman can get pregnant the first time that she engages in sexual intercourse. Deb’s (2005) cross-sectional study of adolescents in Orissa, found that 39% of males and 51% of females had misconceptions about biological determination of the sex of a baby. Other research shows that only three in ten adolescent girls knew that a male condom can be used only once (IIPS & Macro International, 2007). In this study, researchers also found that perceptions of the risk of acquiring sexually transmitted diseases were low, even among individuals that were involved in risk behaviors such as sexual relations with multiple partners, non-use of condoms, and coercive sex.

Research findings consistently show that males have more knowledge about sexual health (Deb, 2005; Sebastian et al., 2002), likely due to increased educational opportunities and exposure to information. For female adolescents, those that are unmarried and better-educated are more likely to have increased knowledge about sexual and reproductive health (UNICEF, 2002). Overall, the lack of basic understanding and scientific knowledge of most adolescent girls places them at a higher risk for poor sexual and reproductive health outcomes and allows for perpetuation of gender inequality.

**Sources of Knowledge**

The aforementioned findings provide evidence of a society in which many adolescents are largely uninformed in basic information regarding sexual and
reproductive health. The main sources of information for adolescents are the media (television, Internet, pornographic materials, and magazines) and peers (Guilamo-Ramos, Soletti, Burnette, Sharma, Leavitt, & McCarthy, 2012; Sathe & Sathe, 2005).

Globalization has increased access to international media, exposing individuals to media with sexual content from a young age (Verma et al., 2004). Although the media certainly increases exposure, its objective of entertainment and its primarily patriarchal framework, do not provide adequate information. Additionally, peers often are biased and misinformed. Some adolescents are exposed to sexual and reproductive health programming at school; however, these programs are limited and typically HIV/AIDS centered (Gabler, 2011). Despite these pitfalls, Sathe and Sathe (2005) found that about one in three adolescent girls felt that her sexual knowledge was adequate.

Adults, notably parents, are often the least likely source of knowledge for adolescents regarding sexual and reproductive health. Many parents do not communicate with their children about these topics due to embarrassment, traditional norms, and misperceptions that discussions about these topics will lead to sexual activity (Jejeebhoy, Zavier, & Santhya, 2013). Overall, communication with mothers and daughters is closer than communication between fathers and children. Fathers almost never communicate with daughters about topics related to sexual health, and conversations with sons are mostly limited to communication regarding physical changes during puberty. Although mothers are somewhat more likely to discuss “sensitive topics” with daughters, the majority of the communication is focused on the home and other non-sensitive topics (Jejeebhoy & Santhaya, 2011). In Jejeebhoy’s (1998) review of studies on adolescent sexual and reproductive behavior in India, she found that in studies in both rural areas
and urban slums, mothers reported topics of sex and reproduction as distasteful and dirty, and did not feel that they were appropriate topics to discuss with their adolescent daughters. The Youth in India: Situation and Needs 2006-2007 study conducted in-depth interviews with 209 mothers and 213 fathers related to parent and child communication (IIPS, 2008). Mothers reported discomfort and shyness about discussing menstruation with daughters, often not providing any information to daughters about menstruation until it happened, or relegating the task to other women in the family. Both mothers and fathers participating in the study stated that cultural norms prevented them from having conversations with their children on sexual and reproductive topics. Parents reported that young women in particular should not learn about sex until marriage, at which point they would know about it automatically. Many parents held the opinion that discussing sex with their adolescent children would serve as an implicit form of permission for them to experiment with sex. Another reason that parents abstained from discussing such matters with their children was the perception that adolescents learn this information in other, more appropriate settings, such as school, and are too shy to discuss these topics with their own parents (Jejeebhoy & Santhaya, 2011). Yet another reason that parents report not initiating conversations about sex is their own lack of knowledge about such topics (Guilamo et al., 2012).

Participants in a survey of youth in Maharashtan reported that they rarely discussed sexual reproduction, romantic relationships, or contraception with parents (IIPS, 2007). Sathe and Sathe’s (2005) study of adolescents in Pune provides further evidence of the dearth of sexual and reproductive health communication amongst adolescents and parents. Findings showed that less than 20% of parents discussed sexual
intercourse and related topics with daughters, 25% of parents initiated conversations about friendships with a member of the opposite sex, and 9% of girls reported that they did not discuss sex issues with anyone. A study conducted in Andhra Pradesh and Madhya Pradesh had similar findings, with a significant minority of adolescents reporting that they did not discuss sensitive sexual matters with anyone (Jejeebhoy & Gho 2008). Perhaps on a more positive note, over 70% of parents in Sathe and Sathe’s (2005) study discussed physical growth and body image with daughters.

In spite of the cultural barriers that prevent open discussion, parents are concerned negative health consequences for their children such as STIs, STDs, and unwanted pregnancies. In order to protect their children from negative consequences, some parents are showing greater willingness to have direct conversations about sex with their children, whereas others are beginning to recognize the importance of sexuality education in schools and even advocate for it (Jejeebhoy & Santhaya, 2011). Additionally, many adolescents report that they are open to communication with parents and would like to gain knowledge about sexual and reproductive health from them (Guimamo et al., 2012). The step towards communication between parents and children is a positive one as literature from around the world has shown that parents can influence adolescent sexual decisions and limit risk behaviors (Blum & Mamari, 2005; Moore, Miller, Sugland, Morrison, Glei & Blumenthal, 2004). Parents are a key pathway to providing adolescent girls with knowledge that increases the likelihood of sexual and reproductive health and psychological well-being. For this reason, it is vital to conduct further research on parent-adolescent communication in matters of sexuality, and to develop interventions that help to foster positive and informed discussions between parents and adolescents.
Psychological Impact on Adolescent Girls

Living in an environment with traditional norms, rigid expectations, and vast gender disparities, many adolescent girls are uninformed about their bodies and health, have limited ability to make decisions for themselves, face sudden transitions from childhood to marriage, experience sexual harassment or violence, and have poor sexual and reproductive health. Additionally, millions of adolescent girls in India face the challenges of poverty, including hunger, lack of access to running water, and low education (UNICEF, 2012). All of these factors serve as stressors that threaten psychological well-being and increase the risk of poor mental health in the present and future (Vindhya et al., 2007). Worldwide, women face these challenges and are twice as likely to experience depression, anxiety, and somatoform disorders as men (Das, Das, & Das, 2012). Although these issues are faced by women globally, it is important to note that rates of female suicide in India exceed rates in most other countries. Between 1990 and 2010 there has been a 126% rise in suicides among women. Suicide is now the leading cause of death among women between the ages of 15-49 in India (Patel et al., 2012). Given these statistics, it is evident that adolescent females in India are increasingly at risk for poor mental health outcomes and even suicide. In order to work towards improved psychological well-being, it is important that researchers gain a strong understanding of the specific stressors and protective factors for this population.

Studies have begun to examine the specific stressors of adolescent females. In Sarkar’s (2003) qualitative study of mental health status of adolescent school children in Kolkata, India, students identified several stressors, including academic stressors (academic pressure, parental expectations for achievement), family stressors (such as
poverty, financial difficulties, alcoholism, domestic violence, discrimination against girl child), social stressors (e.g., political violence, corruption, lack of infrastructure such as roads, transportation), relationship stressors (e.g., death of loved ones, loss of romantic relationships, peer pressure and ridicule), and personal stressors (losing in a competition, being punished without faults; inability to fight against injustice). Female students particularly emphasized discrimination against females, sexual harassment and molestation, restricted freedom and independence, violence against women, and dowry as major stressors for them. Other research has identified puberty (such as first menstruation) as a frightening and embarrassing stressor for adolescent females (Bott et al., 2003). Additionally, sexual development and romantic feelings serve as stressors, often causing insecurities, anxiety, guilt, and fear among girls (Reeuwijk & Nahar, 2013). Although knowledge about sexual and reproductive health is known to serve as a protective factor (Reeuwijk & Nahar, 2013; Singh et al., 2012), Sathe and Sathe (2005) found that 9% of adolescent girls felt guilty after learning sex-related information, 20% felt dreary after receiving information, and 32% felt tense. With this knowledge, to ensure that information acquisition does not serve as an additional stressor, researchers and intervention developers and facilitators need to carefully consider how they are delivering information to adolescent girls.

Adolescent females in India, particularly those living in slum populations, are exposed to numerous risk factors and stressors, yet protective factors exist that have the ability to improve sexual and reproductive health and psychological well-being and buffer from developing mental health problems. Widely recognized protective factors include sensitive and authoritative parenting, decent educational opportunities,
psychological autonomy and good physical health (Patel, Flisher, Nikapota, & Malhotra, 2008). In the slums of India, strong family systems and close-knit communities form and develop support systems and cultural traditions that help individuals thrive despite the daily hardships and stressors of their environments. In a qualitative study of adolescent females in India conducted by Santhya et al. (2008), the majority of respondents reported access to family or social support. Social support from friends and family increases the likelihood of psychological well-being. As discussed in previous sections, increased knowledge about sexual health through sexual health education and increased supportive communication, serves as a protective factor against psychological stressors and risky sexual behaviors (Guilamo-Ramos et al., 2012; Singh et al., 2012). In Sarkar’s (2003) study, adolescents of both genders identified suppressing their feelings, engaging in reading, drawing, writing, and listening to music as ways of dealing with stressors. Additionally, females reported adjustment and compromising as protective strategies for coping with stressors. Although the statistics are evidence enough that India has a long way to go in improving protections for the country’s adolescent female population, the country has a number of policies and projects in place to improve the deeply intertwined sexual, reproductive, and psychological health of adolescent females.

Impact of International, Government, and Non-Government Organizations

In the Millennium Declaration (United Nations General Assembly, 2000), world leaders made a promise to children to help them fulfill their potential. Many adolescents in India have benefitted from the country’s commitment to the Millennium Development Goals in relation to education and labor, health, sexual behavior, childbearing and maternal health, HIV, violence, and gender equality (UNICEF, 2012). In addition, India
is a signatory of the United Nations Convention on the Rights of a Child, which means the government is legally committed to the four core principles of the Convention: non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of children (UNCRC, 1989). India also has numerous national legal and constitutional provisions committed to the welfare of children and adolescents in the country. The National Youth Policy of 2003 visualizes active participation of adolescents in social enterprise and recommends youth empowerment through education, nutrition, leadership development, and equal opportunity (Government of India, 2003). The National Population Policy of 2000 aims to improve the quality of reproductive and sexual health of adolescent females and emphasizes the importance of educational programming, counseling, and accessible contraceptive services. The National Health Policy of 2000 recognizes adolescents as a vulnerable population with special sexual and reproductive health needs. The National AIDS Prevention and Control Policy of 2000 recommends the inclusion of HIV/AIDS issues in education (Government of India, 2000).

Since 1951, the government has implemented 11 Five-Year Plans and entered the 12th Five-Year plan in 2012. These plans, designed to secure adequate livelihood for all citizens and ensure equitable distribution of wealth, all include provisions that are designed to strengthen child welfare and development (Center for Budget and Governance Accountability, 2012). The Ministry of Women and Child Development implements the government programs allocated by the Five-Year Plans such as the Integrated Child Development Scheme, the world’s largest program for the promotion of maternal and child health and nutrition (Umesh, 2002). In 2009, India passed the Right
of Children to Free and Compulsory Education Act which envisions providing free and compulsory education for all children between 6 and 14 years of age (Government of India, 2012).

Education is a key resource for the empowerment of adolescent females in India. Women with higher levels of education have access to more information, improved cognitive skills, and are more likely to partake in health seeking behaviors (Celik & Hotchkiss, 2000; Raj et al., 2009). In addition, higher levels of education attainment result in increased feelings of self-worth and confidence that serve as protective factors, thus improving the likelihood of psychological well-being; and empower women to make more decisions in their lives. In recent decades, school enrollment and literacy rates have significantly improved; however, many adolescents, particularly females living in impoverished areas, are still not attaining adequate levels of education. Nationally, school enrollment for girls rose from 40% to 91% between 1960 and 1993. Ninety-two percent of the relevant age group is enrolled in primary education and the male-female ratio with regard to primary school enrollment was 100% in 2005 (World Bank, 2012). The youth literacy rate is 74% for females and 88% for males (UNICEF, 2012). In Mumbai, 90% of adolescents have completed some schooling (Mumbai Human Development Report, 2009); however, only 31% of slum dwellers are likely to complete 10 or more years of education (Apnalaya Annual Report, 2012). Due to increasing population pressures, many of the schools in Mumbai are overcrowded and it continues to be difficult for children and adolescents to access education, particularly for those living in poverty (Mumbai Human Development Report, 2009). Many adolescent females in the slums do not have the opportunity to complete their educations because they are
responsible for caring for their siblings and the home while their mothers work, or already have their own families to care for (Apnalaya Annual Report, 2011-2012; Vindhya, 2007). The level of women’s education is perhaps the single most important predictor of a community’s health (Patel & Thara, 2002). In light of this truth, while women’s education opportunities have certainly improved, India still has a long way to go.

Numerous studies have found that school-based sex education programs positively impact the sexual health of adolescents when providing accurate information and encouraging safe sexual behavior (Kirby, Obasi, & Laris, 2006). In India, the Adolescence Education Program, a sex education program created by the National AIDS Control Organization (NACO) and the Ministry of Human Resource Development in 2003 was implemented for 9-12th graders in approximately 150,000 schools across the country. The 16-hour program includes the following four sessions: Growing Up and Adolescence, STIs & HIV/AIDS, Skills for HIV Prevention, Question Box and Activity Session (UNICEF, 2012). In 2007, the program was banned in six Indian states, including Maharashtra, the state with the second highest HIV prevalence in the country (World Bank, 2012). Sex-related discussions are taboo in India, and many teachers and other adults are embarrassed and avoidant when it comes to providing adolescents with sex education (Jejeebhoy, 1998). A study conducted in Mumbai found that 61.6% of students aged 15-17 had some exposure to sex education in school; however, only 45% were satisfied with the quality of education regarding contraception and sexual health. Almost 90% of the students in the study desired more widespread implementation of school-based sex education (Benzaken, Palep, & Gill, 2011). Most schools in Mumbai begin
health education when students are about 13. At this age, only 49% of females are still attending school (UNICEF, 2013). While the aforementioned research findings indicate that many students in India have some exposure to sex education, the majority of these school-based programs do not reach the adolescent girls that may need such education most (Benzaken et al., 2011; Santhya et al., 2008).

Although many adolescent females do not have access to sexual health programming within the education system, some are reached through governmental and nongovernmental organization programs that adhere to the country’s policies to improve the reproductive and sexual health of adolescents and to empower young females. The government’s Reproductive and Child Health Program-Phase II, launched in 2005, has the three main goals of reducing total fertility rate, infant mortality rate, and maternal mortality. To meet these goals the program includes sexual health education initiatives for adolescents, makes available fertility check-ups, and provides immunizations and care for newborns (Ministry of Health and Family Welfare, 2005). Another government initiative, the Rajiv Gandhi Scheme for Empowerment of Adolescent Girls provides aims to empower out-of-school adolescent girls through formal and non-formal educational programming (Ministry of Women and Child Development, 2011). Although these programs are steps in the right direction, they often fall short of their goals and are unable to meet the needs of adolescent girls in India. This is partially due to the fact that, despite growth in India’s public health sector, the government currently spends only 2.5% of GDP on the health sector, far below the recommended World Health Organization Recommendation of 5% (Ministry of Statistics and Programme Implementation, 2012).
Where the public health sector is lacking, hundreds of NGOs make daily contributions and facilitate positive change throughout India. Women’s empowerment has been the basis for a great deal of the NGO actions in India (Patel & Thara, 2002). Major international organizations that provide support and programming include: UNICEF, UNESCO, WHO, World Bank, and UNFPA. In addition to large organizations, numerous religious-based and community-based organizations provide innovative and creative programming throughout the country. Women’s groups (mahila mandals), child caretakers (anganwadi), microfinance groups, and self-help empowerment groups provide systems of care and education within slum communities (Kumar, 2007; Parkar et al., 2012). The adolescent females that are the focus of the current study were recruited after participating in a women’s empowerment group led by a community-based organization. This organization provides multiple services in the slums of Mumbai with the aim, “to empower the disadvantaged to overcome the many social, political and economic barriers they face and to help them access opportunities that lead to a better quality of life” (Apnalaya Annual Report, 2011-2012). Many such organizations provide child care, family counseling, and multiple other initiatives to improve the well-being of individuals within the community. They help empower women and adolescent girls by providing vocational skills classes, savings groups, health education programs, and HIV/AIDS prevention and awareness programs. The next section of this review focuses on specific sexual health interventions for adolescent girls currently being implemented by non-governmental organizations in community settings in India.
Interventions on Sexual Health in India

To date, NGOs have implemented numerous community-based sexual health interventions for unmarried adolescent females. All programs typically cover the topics of pubertal changes, menstrual hygiene, contraception, reproduction, gender rights, and relationship skills. In contrast to past sexual health interventions that were more likely to focus on negative aspects of sexual health, such as risk of disease, maternal mortality, and gender-based violence (Santhya & Jejeebhoy, 2007), many interventions are moving towards a sex-positive emphasis that focuses on sexual well-being and valuing one’s sexuality in addition to understanding the risks involved with sex (Chakrborty, 2010; Gabler, 2012). In addition, current programs for adolescent females are more likely to take on an empowerment framework. These interventions are designed to educate, to build skills and competencies, and to increase self-esteem with the goal of improving gender inequality and helping adolescent females gain control over their lives (Vindhya, 2007). In this section, specific interventions that were implemented and examined for efficacy are examined closely. Many of the interventions implemented for this population are similar to the interventions discussed below; however, few interventions are thoroughly studied. A review of the existing literature on community-based interventions for unmarried adolescent girls living in slums revealed that there is a dearth of studies examining the efficacy of interventions. The following interventions were chosen specifically because they are representative of the types of interventions that are implemented, and because researchers have examined their effectiveness.

The Better Life Options Program (BLP) designed by the Center for Development and Population Activities (CDPA) is a comprehensive, life-skills development program
that has the goal of empowering out-of-school adolescent females between the ages of 12-20 (Levitt-Dayal, Motihar, Kanani, Mishra, 2003). The program components include formal and non-formal education on topics of reproductive health, vocational training, basic living skills, family life, referrals to reproductive health services, and recreation. The program is center-based, run by local women, and allows for flexibility and adaptation based on needs of local girls. CDPA trains alumni of the program as peer educators. The ultimate aim of the BLP is to build self-esteem and self-confidence of adolescent girls, and to expand their overall life choices. Program implementers faced initial challenges in convincing parents to allow their daughters to join the program, but once parents learned about the vocational training component they became more accepting and program participation improved. In a comparative cross-sectional study conducted by the CDPA, using a sample of 835 program alumni and 858 controls, researchers found significant differences between girls who had participated in the program and those in the control group in terms of education measured by literacy and completed secondary education, vocational skills, economic empowerment, autonomy, self-confidence, and reproductive behavior and health-seeking behavior. This study of program effectiveness had a few limitations. First, many of the program’s alumni were not able to participate in the survey because they had moved away. Second, researchers did not have baseline data so the experimental design was post-test-only control group. Third, a gap may have existed between actual behavior and reported behavior (Levitt-Dayal, et al., 2003; Mohajer & Earnest, 2002). Despite these limitations, the intervention evaluation reinforced the strength of multi-faceted and adolescent-friendly programming.
The Action for Slum Dwellers’ Reproductive Health, Allahabad program integrates livelihood training activities and reproductive health programming for adolescent girls (Bott, Jejeebhoy, Shah, & Puri, 2003). The program trains literate 14-19 year olds to become peer educators, after which the peer educators invite adolescent girls between the ages of 14-19 from their neighborhood to meet once a week at their homes. The program components include reproductive health training sessions, vocational counseling, savings formation information, and follow-up support from a peer educator. The reproductive health sessions includes discussions concerning puberty, menstruation, reproductive biology, pregnancy, contraception, sexual transmitted infections, and age at marriage. The vocational training is only available after the reproductive health classes have been completed. Part of the reasoning for this sequence of programming is so that with the incentive of future vocational training, parents will allow their daughters to participate in the sexual health programming. Researchers examined the effectiveness of this combined intervention using a quasi-experimental pre-and post-test longitudinal design. Girls exposed to the intervention were significantly more likely to be informed about reproductive sexual health, have knowledge of safe spaces, self-identify as a group member, score higher on a social skills index, and spend time on leisure activities. No effect was found on gender-role attitudes, mobility, self-esteem, or work expectations. The intervention implementers identified minimal contact with girls’ parents and too short of an intervention period as potential reasons for such a small set of significant effects. In addition to intervention design issues, the study had a number of limitations including difficulty maintaining sample size between baseline and end line resulting in a small study sample size, reporting problems, and measurement error. The intervention
study concluded that the livelihoods program aspect made the program at-large more acceptable to parents from the highly traditional slum community, therefore allowing more girls to participate in it. The researchers stated that in order to effectively reduce gender disparities, future interventions should be more long-term and devote greater effort to developing group cohesion.

An NGO based in New Delhi designed an intervention program to address the individual needs and to create a more supportive environment for unmarried adolescent girls aged 12-19 living an in urban slum (Sodhi, et al., 2004). The ultimate aim of the intervention was to create greater self-determination for young women. The intervention targeted adolescent girls, their mothers, sister-in-laws, elder sisters, and friends directly, and indirectly targeted men and adolescent boys. Prior to developing the intervention, the organization used a mixed qualitative and quantitative approach to study the patterns of sexual behavior, attitudes, and needs of the adolescent population in the community (Sodhi, et al., 2004). The researchers also used techniques to discover the insider (local) perspective and to get better acquainted with members of the community. Local adolescents were included in the research team and all of the fieldworkers involved in the development and implementation of the intervention were from the community. The following techniques were used to gain understanding of the community: social mapping, observation visits, key informant identification and interviewing, adolescent in-depth interviews, focus group discussions, and consensus modeling of adolescent sexual behavior using pile sorts. After gathering and analyzing this comprehensive data, the intervention developers created an intervention model that was context-specific and sustainable for the specific population.
The intervention included the following three components: Skill Building Modules, The Communication Package, and The Social Support Component (Sodhi, et al., 2004). The skill building modules helped to develop adolescent girls’ understanding of self and self-esteem and provided specific skills and capacities to help them become more confident in dealing with life situations. The communications package included both video-based and interpersonal communication providing information on reproductive, sexual health, and legal issues. Finally, the social support component involved groups of older women and adolescent girls meeting regularly at the center to discuss issues of concern, facilitate mutual understanding, and build support for girls. The results of a correlational study using five scales, showed that the intervention achieved much of its’ desired impact. Perceived self-determination was found significantly related to perceptions of social support, knowledge of reproductive and sexual health issues, and scales of knowledge of the law. In addition, there was a large increase in perceived support from adults from the first to the second survey. The primary limitation of the study was that it was cross-sectional rather than longitudinal. Despite the limitation, the success of the intervention provided support for sexual health interventions that address a broad range of knowledge, skills, support, and general development (Sodhi, et al., 2004).

Gabler (2012) investigated 11 non-governmental organization-designed sex education programs in New Delhi. Using qualitative methods of in-depth semi-structured interviews and participatory and non-participatory observation, the researcher found numerous similarities across the interventions being implemented with adolescent females throughout the city. Although only one organization implementing interventions explicitly used the term sexual empowerment in describing intervention goals, all of the
interventions placed great emphasis on developing inner empowerment of adolescent females. The interventions were implemented by professionals and focused on developing empowerment through the acquisition of knowledge and skill development. They created safe spaces, and used highly diverse and creative tools for learning including theater, brainstorming, discussions, role-play, media, and games. The intervention implementers used participatory approaches, allowing the participants to help guide the course of the programming. In addition to focusing on education, the interventions promoted a positive approach, placing emphasis on the importance of the woman’s pleasure and sexual well-being. Gabler found that parents were typically not included in the interventions and often served as barriers to the empowerment of the females participating in the interventions. She advocates for collaboration between NGOs and parents and increased institutional support from other organizations.

Although variety exists in sexual health interventions for adolescent girls, several facets are known to make interventions more effective. First, given the knowledge that adolescents face numerous challenges in addition to sexual health concerns, effective sexual health interventions use an integrative approach by addressing others issues that are salient in adolescents’ lives and help build knowledge and skills in these areas. Also, effective programs are multi-dimensional and use varying methods, such as a combination of education, counseling, and skill building (Mensch, Grant, Sebastian, Hewett, & Huntington, 2004; Sodhi, et al., 2004). In addition, strong interventions are “adolescent-friendly” and participatory. Characteristics that make programs “adolescent-friendly” include ease in accessing intervention, an intervention space that is physically appealing and safe, policies that guarantee confidentiality, and access to intervention
implementers that are knowledgeable, empathetic, non-judgmental, and culturally aware (Mouli, 2003; Epstein, 2003). Interventions that are participatory are guided by the needs and interests of the adolescent participants. Effective interventions typically include a peer education or peer counseling component (Alcock et al., 2009). Also, more effective intervention programs build coalitions with other organizations within the community, thus creating a system of services that are available for adolescents beyond the intervention setting (Epstein, 2003). In addition to community alliance, parental support and inclusion is important for the effectiveness of sexual health interventions; however, this is quite difficult to attain (Levitt-Dayal et al., 2003).

Although up-to-date research on interventions has provided some evidence supporting certain practices and techniques, there is still a great need for continued research and program development in this area. First, although interventions have been shown to successfully influence knowledge and attitudes, ability to change behavior has not been clearly proven. Second, as is evidenced by the aforementioned studies, there are numerous methodological limitations in existing research including small sample sizes, lack of control group, failure to follow up on number of baseline participants in longitudinal studies, and selection bias. Additionally, because there are many interventions being implemented in varying ways, insufficient data exists to replicate study findings (Jejeebhoy, 2006). Given this knowledge, it is important to continue research in order to develop stronger conclusions regarding best program practices.

**Limitations of Existing Research**

Although the numerous research findings from the last two decades discussed in the literature review have furthered our understanding of sexuality and psychological
well-being of adolescent girls living in India, there exist notable limitations to many of these studies. This section addresses the limitations in studies that have incorporated quantitative methods, as well as those that have used qualitative methods. Also, the areas of research that require more exploration are discussed. This section concludes with an explanation of how this study will use the framework of the participatory culture-specific intervention model (PCSIM) to conduct formative research that helps to address some of the limitations in this area of research.

Researchers have primarily used quantitative methods, such as standardized self-report or other-report questionnaires, to gain understanding of overall trends in attitudes and behaviors of this population. Many of the studies integrated in this review are cross-sectional and use self-administered structured questionnaires or surveys (Benzaken, et al., 2011; Sathe & Sathe, 2005; Dube & Sharma, 2012; Patel et al., 2001). A limitation of the use of self-administered questionnaires is the necessity of literacy to complete them, which contributes to poor sample representativeness given that 26% of adolescent girls in India are illiterate and, thus, unable to complete these types of questionnaires (UNICEF, 2012). Although self-administered questionnaires have the strength of maintaining confidentiality, the uniform nature of the questions limits the range of individuals’ responses, creating a simplified understanding of a population. Although less commonly used than quantitative methods, a number of studies have integrated qualitative methods such as interviews and focus groups. These studies also have limitations including underrepresentation of marginalized populations and underdeveloped relationships with research participants prior to use of qualitative techniques to gather sensitive information.
Most studies were conducted in schools or college settings, thus contributing to understanding of educated adolescents while largely neglecting the multitudes of Indian adolescent girls that do not attend school. For example, Dube and Sharma’s (2012) study of knowledge, attitudes, and practices regarding reproductive health among urban and rural girls only surveyed girls attending state government schools. The many adolescent girls that do not attend school due to socio-economic status, lack of access, work responsibilities, early marriage, or forbiddance from parents, likely have different experiences regarding sexuality and psychological well-being than those that are able to attend school. To gain a truly accurate understanding of the entire population adolescent girls in India, it is vital to conduct more studies in community settings and to use measures that do not exclude individuals that cannot read.

Even when studies are conducted in community settings and employ qualitative methods, such as face-to-face interviews, adolescents often need access to the study location and parental permission to participate. In India’s largely traditional culture, many parents may choose to exclude their adolescents from participation in attitude and behavior studies or treatment programs efficacy studies (Jejeebhoy, 1998). In contrast, individuals may have the opportunity to participate in a study because they are already involved with a community organization. Both of these factors contribute to sample bias that may decrease the external validity of study findings. There is still a great need for more research that is conducted with marginalized populations, such as adolescent girls living in slums and not attending school.

In addition to the limitation of study sample populations that are not entirely representative, strong cultural norms may result in hesitation to discuss topics related to
sexuality. As a result, underestimates of rates of sexual activity and inaccurate portrayal of attitudes towards sexuality may be reported by adolescent girls and other members of society. Some researchers have incorporated qualitative methods such as face-to-face interviews in their studies. The Youth Study, India’s first ever sub-nationally representative study, was designed to fill the gaps in evidence about India’s youth, including understanding adolescents’ sexual reproductive health knowledge, attitudes, and life choices (IIPS & Population Council, 2010). The study included a pre-survey qualitative phase using focus group discussions and in-depth interviews with parents and adolescents, and key informant interviews with teachers, health care providers, and community and youth leaders. Based on the information gathered in the first stage, the researchers created household questionnaires and individual questionnaires that were completed by nearly 51,000 adolescents in India in 2007. At the conclusion of the survey interview, in-depth interviews were conducted with a number of consenting survey respondents. The Youth Survey was a great undertaking that undoubtedly contributed to understanding of adolescents in India by incorporating both qualitative methods in addition to quantitative methods. The major limitation of this study was that the researchers conducted face-to-face interviews and focus group meetings only one time with each individual. The researchers acknowledged that oftentimes respondents (e.g., parents, adolescents, and key informants) were not willing to discuss sensitive sexual and reproductive health matters and came up with monosyllabic answers or avoided questions by initiating off-topic conversations (Jejeebhoy & Santhya, 2011). Oftentimes, it is incredibly challenging for an interviewer to establish a level of rapport within a single interview session that truly makes the interviewee comfortable enough to discuss their
attitudes, knowledge, and sexual behavior frankly. In a country where sexuality is often viewed as taboo, particularly the sexuality of adolescent girls, face-to-face interviews are likely to result in a great deal of discomfort and underreporting; thus, leading to further inaccuracies in study results. There is a need for more studies that provide a more in-depth and accurate understanding of individuals by establishing relationships with their participants prior to inquiring about sensitive topics.

The Youth Study and a few other studies have begun to examine how parents and other community members impact adolescent girls’ sexual health and psychological well-being. It is vital to gain further understanding of how these constituents impact adolescent girls’ sexuality (IIPS & Population Council, 2010). Particularly, research is need to explore parent-child communication and how the interactions between these groups and messages from other community members impact transitions into sexual life, the extent of risk-taking, and the extent of informed sexual and reproductive decision making. In a society where adolescent girls are closely monitored by their parents until marriage, and where adult attitudes towards adolescent sexuality are quite rigid, it is vital to establish a level of parental support for interventions to be effective. A few sexual and reproductive health intervention studies have established the importance of parental involvement and support for successful intervention outcomes (Gabler, 2012).

Researchers need to further examine the knowledge and attitudes of adults in regards to female adolescent sexuality. Additionally, in-depth research is needed to gain a greater insight into the protective pathways that contribute to positive sexual and psychological outcomes of adolescent girls. Doing so will allow for more effective intervention designs and will inform future policy.
This study addresses the shortcomings of current research through the utilization of qualitative methods designed to gain the direct perspectives of adolescent females, their mothers, and community members. The study uses Nastasi, Moore, and Varjas’s (2004) participatory culture-specific intervention model (PCSIM), an ecological, participatory model of research that aims to generate culture-specific theory using phenomenological and ethnographic methods, and subsequently use the generated theory in the selection, design, implementation, and evaluation of tailored intervention programs. This study does not aim to complete the entire PCSIM process, but, rather, to analyze formative archival research to inform future decision making. By conducting extended focus groups with adolescent females, their mothers, and community members, the researchers that began this study were able to gain an understanding of the direct, honest perspectives of these individuals on the sensitive and controversial topics of adolescent sexuality and psychological well-being. Taking the time to establish trusting relationships with research participants, increases the possibility of obtaining accurate information. The participatory process, which involves key stakeholders as partners in the theory-research-action process, has the strength of informing interventions and policies that are culture-specific and effective. Given the dearth of research on interventions for adolescent girls living in slums in India, and the great need for effective interventions given the reality of sexual inequality and challenges to this population, taking a participatory approach to research is vital.

**The Current Study**

This study addresses the shortcomings of current research through the utilization of qualitative methods designed to gain the perspectives of adolescent females, their
mothers, and community service providers. The study used Nastasi et al.’s (2004) participatory culture-specific intervention model (PCSIM), an ecological, participatory model of research that aims to generate culture-specific theory using phenomenological and ethnographic methods, and subsequently use the generated theory in the selection, design, implementation, and evaluation of tailored intervention programs. The proposed study does not aim to complete the PCSIM process, but, rather, to analyze formative archival research to inform future decision making. In the original study, researchers sought to gain an understanding of the perspectives of adolescent females, mothers of adolescent females, and community service providers on the sensitive and controversial topics of adolescent sexuality and psychological well-being. Researchers conducted multi-session focus groups with adolescent females and single-session focus groups with mothers and community providers who served the adolescent female population. The purpose of multiple sessions with adolescent females was to provide sufficient time to establish trusting relationships and thereby increases the possibility of obtaining accurate information on sensitive topics. The participatory process, which involves key stakeholders as partners in the theory-research-action process, has the strength of informing interventions and policies that are culture-specific, effective, and sustainable (Nastasi et al., 2004).

**Study Purpose and Research Questions**

The purpose of this study is to explore sexual health and its relation to psychological well-being from the perspectives of multiple stakeholders: adolescent girls, mothers of adolescent girls, and service providers who worked with adolescent girls. The research addresses the following questions:
1. How are sexual health, intimate relationships, and psychological well-being defined as they apply to adolescent girls? Specifically, how are these constructs defined by adolescent girls, mothers of adolescent girls, and service providers?

2. What are the shared and unique perspectives regarding these constructs (sexual health, intimate relationships, and psychological well-being) across adolescent girls, mothers of adolescent girls, and service providers?

**Key Terms**

The following key terms were defined by Nastasi et al. (2013) in their Narrative Intervention Model used to inform a sexual health intervention designed for married women and couples living in Mumbai, India. The exception is Interpersonal Relationships which was adapted to fit the specific study population.

**Sexual Health:** Gynecological and reproductive health, including absence of RTIs and STIs; health (non-risky) sexual knowledge, attitudes, beliefs, behaviors, and practices; sexual competence, defined as engaging in sexual activity that is consensual and non-coercive, with no regret, protected (against STIs and unplanned pregnancy), and based on an autonomous decision.

**Psychological Well-Being:** Mental health, including emotional well-being (e.g., happiness; satisfaction with self, perceived social support, self-esteem, sense of competence, locus of control); tensions (sources of tension, coping strategies, body response or reactions to tension, consequences of tension); absence of mental health problems (e.g., symptoms of psychiatric disorders such as depression, anxiety, PTSD).
**Interpersonal Relationships:** *Family relationships,* including quality of relationships with parents, siblings, family members as source of tension and support, satisfaction with relationships; *social network,* including quality of relationships with individuals, groups, organizations outside of the family, social network as the source of tension and support, satisfaction with relationships in social network (including friends, informal and formal community groups); and *intimate relationships,* including quality of relationships involving physical or emotional intimacy, intimate partners as sources of tension and support, and satisfaction with relationships.

**Method**

The current study uses archival interview and focus group data that were collected for the *Psychological Well-Being and Sexual Health among Adolescent Females in Urban India Study* (also known as the *Adolescent Study*). The participants were a population of unmarried adolescent girls, mothers or unmarried adolescent females, and local service providers (whose client population included unmarried adolescent females) from a slum community in Mumbai, India. The researchers used the Participatory Culture- Specific Intervention Model (Nastasi et al., 2004) as the framework for the project. Qualitative methods were used for data collection. This study was conducted as part of the *Promoting Psychological Well-Being Globally Project* (Nastasi et al., 2008). Data was gathered between in the years 2010 and 2011.

**Background on the Promoting Psychological Well-Being Globally Project**

The *Promoting Psychological Well-Being Globally Project* is a collaborative research initiative chaired by Bonnie Nastasi, and supported by the International
Psychological Association and the Society for the Study of School Psychology. Nastasi (2008) states the purpose of the project is “to develop definitions of psychological well-being and psychologically healthy schools and communities, based on the perspectives of key stakeholders (students, teacher, school, community) within participating countries.” Psychological well-being is defined using an ecological and developmental framework that examines the following individual and cultural factors: culturally-valued competencies, personal vulnerabilities, personal resources, socio-cultural resources, cultural norms, socialization agents, socialization practices, and socio-cultural stressors (Nastasi, 2008). The project is unique in that it focuses on understanding psychological health of individuals from a social-cultural perspective with the subsequent aim of developing culturally-appropriate programs to promote well-being of students through both individual and ecological change.

Fifteen sites in twelve countries spanning five continents- Asia, Africa, Europe, North America, and South America- were included in the study. In order to understand mental health from the perspectives of the international study participants rather than imposing Western-based ideas, the researchers utilize the Participatory Culture-Specific Intervention Model to guide research. The researchers engaged in the process of formative research to gather data from key stakeholders about their conceptions of mental health for children and adolescents, and about school and community contexts. Qualitative methods used to gather data included focus group interviews (students, parents, and teachers), ecomap activities (students), and individual interviews (administrators and physical/mental health support staff). Currently, a book documenting the project’s findings is in publication.
Mumbai Site

Context. Located on west coast of India, Mumbai is the capital city of the Indian state of Maharashtra. With a population of 20.5 million, Mumbai is the largest city in India and the fourth most populous city in the world (Government of India Ministry of Home Affairs, 2011). Similar to the religious make-up of the country at large, the religious affiliations of the residents include Hindu, Muslim, Christians, Sikhs, Buddhists, Jains, and others. The sex ratio in Mumbai is 838 females per 1,000 males (Government of India Ministry of Home Affairs, 2011). Although it is known as the commercial and entertainment capital of India, Mumbai is also a city of great financial disparity. At least 20% of Mumbai residents live below the poverty line, and more than 40% of Mumbai’s residents live in the 108,000 slums distributed throughout Mumbai (Government of India Ministry of Home Affairs, 2011).

“Slum” is a term used for dilapidated areas where residents experience economic hardship and constricted opportunities (Parkar, Fernandes, & Weiss, 2003). UN-HABITAT (2007) defines a slum household as a group of individuals living under the same roof in an urban area who lack one or more of the following: durable housing of a permanent nature that protects against extreme climate condition, sufficient living space which means not more than three people sharing the same room, easy access to safe water in sufficient amounts at an affordable price, access to adequate sanitation in the form of a private or public toilet shared by a reasonable number of people, or security of tenure that prevents forced evictions. In the slums, the average household size is 4.5, and about 13% of households are headed by women. Women and children in slums are
particularly susceptible to extreme poverty due to fewer opportunities for work and

In compliance with India’s Right of Children to Free and Compulsory Education
Bill of 2008, 90% of Mumbai’s adolescents have completed some schooling. Due to
increasing population pressures, many of the schools in Mumbai are overcrowded and it
continues to be difficult for children, particularly those that are living in poverty to access
education (Mumbai Human Development Report, 2009). Despite these challenges, school
enrollment at a primary level is increasing and literacy levels have shown improvement.
According to the 2011 Census, the male literacy rate was 91.5% and the female literacy
rate was 86.5%.

The populations living in slums are often exposed to numerous risk factors, yet
protective factors exist that have the ability to enhance positive psychological well-being
and buffer children and adolescents from developing mental health problems. Stressors
that many slum dwellers experience include migration and displacement, poor
infrastructure, unequal distribution of basic amenities, and ethnic disharmony. In addition
to the aforementioned stressors, many females experience additional stressors such as
domestic violence and sexual exploitation. For children and adolescents living in urban
poverty, risk factors for development of mental health problems include socioeconomic
depprivation, family disruption and psychopathology, early childhood insults,
temperamental difficulties, violence and intellectual impairment. In the slums, strong
family systems and close-knit communities form and develop support systems and
cultural traditions that help individuals thrive despite the daily hardships and stressors of
their environments.
Although traditional Western child and mental health care services are limited in India and not widely recognized, many individuals receive support through religious associations, non-governmental organizations, and community-based organizations (Desouza, Kumar, Shastri, 2009). For women and children in particular, women’s groups (mahila mandals), child caretakers (anganwadi), microfinance groups, and self-help empowerment groups provide systems of care within slum communities (Kumar, 2007; Parkar, Nagareskar, & Weiss, 2012). While much of the humanitarian responsibility falls in the hands of community organizations, there are also international and government provisions in place designed to address the physical and psychological well-being of the citizens of India.

**Participants.** Thirty-seven (37) unmarried adolescent females, ages 12-20 (N=14, ages 12-14; N=23, ages 15-20), participated in the study. The grades completed by the girls ranged from 0-11 grades. Fourteen of the girls were attending school at the time of the study. Twenty-six girls were Muslim and 11 were Hindu. All of the participants spoke Hindi, and several spoke multiple languages including Marathi, Telegu, Kanada, English, Urda, Arabic, and Bhojpuri. Fifteen mothers participated in the study (N=9, daughters in focus groups; N= 6, daughters not in focus groups). The highest reported education level of the mothers was 9th grade. Many of the mothers were illiterate. The study also included 10 service providers. The professions of the service providers were teacher (N=5), doctor (N=3), and social worker (N=2). The service providers’ education level ranged from completion of grade 10 to PhD. Their years of experience working with adolescent girls ranged from 4-27 years.
Table 1.

Characteristics of the Study Participants (n = 62)

<table>
<thead>
<tr>
<th>Girls (n=37)</th>
<th>Mothers (n=15)</th>
<th>Service Providers (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1-12 girls, ages 15-19</td>
<td>Daughters in focus groups-9</td>
<td>Teachers-4</td>
</tr>
<tr>
<td>G2-14 girls, ages 12-15</td>
<td>No daughters in focus groups-6</td>
<td>School Principal-1</td>
</tr>
<tr>
<td>G3-11 girls, ages 15-20</td>
<td></td>
<td>Doctors-3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social workers-2</td>
</tr>
</tbody>
</table>

Procedures

The study uses archival data gathered through qualitative research methods for data collection and analysis. This section includes description of the background and procedures for recruitment, and data collection for the original study; and the data analysis procedures for the current study.

Original adolescent study. The project was guided by the framework of Nastasi et al.’s (2004) participatory-culture-specific intervention model (PCSIM), an ecologically-sensitive participatory model of research with the following primary goals: (a) to generate a culture-specific theory using phenomenological data and ethnography; (b) to use the generated theory in selection, design, implementation, and evaluation of a customized intervention program. PCSIM is a long-term process that includes the following stages: Stage 1, reviewing and understanding existing theory, research, practice, and policy; Stage 2, learning the culture of the participants and their communities; Stage 3, forming partnerships with local key stakeholders, Stage 4, goal and problem identification; Stage 5, conducting formative research; Stage 6, generating a
culture-specific theory; Stage 7, designing a culture-specific program; Stage 8, implementing the program; Stage 9, implementing and evaluating the program; and Stage 10, building capacity and communicating the process and outcomes to the participating communities and scientific bodies. The archival data used in this study comes from formative research conducted at Stage 5 of the process, and informed by Stages 1-4. The data procedures were approved by the Tulane University Institutional Review Board.

**Recruitment and informed consent/assent procedures.** Participants were recruited through a partner organization, Apnalaya, a non-governmental organization, which served the target community. This organization provides multiple services in the slums of Mumbai with the aim, “to empower the disadvantaged to overcome the many social, political and economic barriers they face and to help them access opportunities that lead to a better quality of life” (Apnalaya Annual Report, 2011-2012). The organization provides day care facilities, sponsors education and vocational training for many children whose families cannot afford it, runs a family counseling center, and leads multiple initiatives to improve the well-being of the slum populations throughout Mumbai. The Apnalaya staff shared information about the project with prospective participants (adolescents and their mothers who visited the organization) and provided contact information for the project staff. Upon expressing interest, potential participants were contacted by the project research assistant who explained the project and secured informed consent from the parent/guardian of adolescent participants, mothers and adult participants, and informed assent from adolescent participants. Nominal incentives were provided to study participants for the time they devoted to data collection.
Adolescent focus groups. Data collection with adolescent females involved multi-session semi-structured interview focus groups. The participants were split into three age groups: G1, 12 girls, ages 15-19; G2, 14 girls, ages 12-15; G3, 11 girls, ages 15-20. Six sessions (60-90 minutes each) were conducted with each group. The sessions took place at the cooperating community organization and were scheduled at times to create minimal interference with routine activities and schedules of the participants. Each session began with an introduction to the topic, and all groups were facilitated to encourage open discussion from all the individuals in the group. The sessions took place in a setting that was quiet, comfortable, free of distractions, and private. The sessions were led by the two research assistants, one a trained masters’ level social worker, and the second, an employee of Apnalaya who had extensive experience conducting group sessions with girls. The focus groups were semi-structured interviews, for which the facilitators followed a protocol including introduction scripts, activity instructions, and specific questions to guide discussion. The first session, Social Expectations, was designed to gather adolescents’ perceptions of what is expected of them in their various roles as student, daughter, peer, and citizen. The second session, Feelings/Emotions, included activities that encouraged the participants to talk about the different feelings they have, what these feelings mean, and how participants express them. In the third session, Stressors and Supports, participants generated ecomaps (graphic representation of an individual’s social network) and stories with the purpose of understanding the people and events that serve as stressors and supports for the participants. In the sixth session, Relationships, the participants defined different types of relationships and participated in a discussion about how they learned about relationships, sex, and sexual relationships. In
the fifth session, *Promoting Well-Being and Healthy Relationships*, the participants discussed the differences between healthy and unhealthy relationships and how relationships affect personal well-being. For the final sixth session, *Celebration of Young Women*, the participants shared stories or depictions of who they are as women. See Appendix A for samples of the focus group sessions.

**Focus groups and interviews with adults.** Focus group or individual interviews were conducted with mothers and service providers. Four focus groups were conducted with three mothers in one and two mothers in the other one. In addition, 6 mothers were interviewed individually. Due to scheduling problems, some of the mothers were interviewed individually rather than participating in focus groups as planned. Not all of the parent participants had daughters that participated in the adolescent group. In the first session with mothers, the group leader facilitated discussion about experiences in parenting adolescent girls, parent expectations of their daughters, stressors and supports of adolescent girls, and challenges of parenting adolescent girls. In the second session, mothers discussed adolescent girls’ relationships with boys and girls, how relationships influence psychological well-being of adolescent girls, and how to prepare young women for sexual relationships. The individual interviews covered the same topics, but were conducted in a single session.

Individual interviews were conducted with 10 service providers- 5 teachers, 3 doctors, and 2 social workers. The service providers participated in individual interviews rather than focus groups due to difficulties in scheduling everyone together. The service providers did not necessarily serve the particular students who participated in student data collection activities, but served the population that included unmarried adolescent girls.
In a single individual interview, the service providers were asked to share their views based on their experiences of serving adolescent girls in the community. They were asked to define psychological well-being, healthy relationships, and sexual relationships, to discuss factors that influence psychological well-being for adolescent girls, and to discuss their individual role and the roles of schools, families, and communities, and societies in promoting psychological well-being, healthy relationships, and sexual health in adolescent girls.

**Data analysis.** Following data collection, data were translated to English and entered into text files for data analysis. The archival data constitutes the data set for the current study. To answer the research questions for the current study, a multi-step deductive-inductive coding approach, based in grounded theory of research (Nastasi, 2008), is used. In the first stage, the deductive stage, the deductive codes are applied; these codes were developed based on the research questions and broad definitions of the constructs the research aims to define from the participant’s perspectives. The deductive codes include sexual health, psychological well-being, and interpersonal relationships, as defined in key terms. In addition, a *context* code is used to identify data that provides insight into sociocultural, political, or environmental influences, relevant to other constructs in the study. A code of *not applicable* is used to identify data that are not relevant to the study’s purpose. The process of deductive and inductive coding are applied to each data set (adolescent, mother, provider) separately. All coding is conducted in text (Word) files using procedures consistent with the broader psychological well-being project.
**Deductive and inductive coding.** The researcher trained two undergraduate students to use the deductive scheme. In order to ensure the coders were prepared for deductive coding, the researcher and research assistants independently coded the same sample of data and then discussed any changes needed or questions about code definitions. Once there was complete agreement about the code definitions, each research assistant was assigned a portion of each set of data—adolescents, parents, service providers—so that all coders contributed to coding for all sources. The researcher coded all the data independently. As the researcher and research assistants conducted deductive coding, each individual was encouraged to identify inductive codes that potentially applied to sections that were coded as *not applicable*. Upon completion of coding, the researcher and research assistants met to discuss discrepancies in respective coding through a process of consensus building. In the process of discussing deductive codes, they also discussed potential inductive codes for the statements otherwise identified as non-applicable and came to a consensus about including new inductive codes.

**Theme and pattern analysis.** The purpose of this stage was to identify themes that were reflected in the coded data. Based on individual code categories, the researcher identified consistent and variant themes within and between categories. In this stage, theme analysis was conducted separately for adolescent girl data, mother data, and service provider data. The final step was a higher level of theme and pattern analysis in which consistencies and differences were examined across the three different groups: girls, mothers, and service providers.

**Trustworthiness.** In order to increase the validity of the research, a number of procedures were used in the data collection and analysis to increase trustworthiness,
consistent with established procedures (e.g., Strauss & Corbin, 2008; Lincoln & Guba, 1985; Nastasi & Schensul, 2005):

1. *Prolonged engagement*, through the use of multiple-session focus groups with the adolescent girls over several weeks.

2. *Triangulation*, through the use of multiple sources—adolescents, mothers, providers; and multiple coders.


4. *Thick description*, through detailed description of procedures and quotes from interviews and focus groups included in the results and discussion. *Persistent Observation*, through the in-depth exploration of different topics discussed in multiple-session focus groups.

**Results**

In this section, the results of the analyses are discussed in three subsections: Sexual Health Themes, Gender Role Themes, and Psychological Well-Being.

Supplementing the thick description, tables are included to help summarize the findings.

In the analysis, older adolescents and younger adolescents are distinguished at times. For purposes of this study, younger adolescents are girls ages 12-15, and older adolescents are girls ages 15-20. The following section shares the results of this study.

**Sexual Health Themes**

The following definition of sexual health served as the basis for the deductive code for ‘sexual health’: “Gynecological and reproductive health, including absence of RTIs and STIs; health (non-risky) sexual knowledge, attitudes, beliefs, behaviors, and
practices; sexual competence, defined as engaging in sexual activity that is consensual and non-coercive, with no regret, protected (against STIs and unplanned pregnancy), and based on an autonomous decision” (Nastasi et al., 2013). The following themes were identified by the adolescent girls, mothers, and service providers and explain their understanding of and salient topics regarding sexual health of adolescent girls: Engaging in physical relationships with opposite sex prior to marriage, Sexual Health Risks, Sources of Information, Types of information that should be shared about sexual health, Daughters and mothers discussing sexual health, Barriers to providing sexual health information, and Ways to prevent sexual risks that girls face in the community.

Descriptors of these themes are in Table 2.1. Below, the themes are discussed across groups. Table 2.2 shows the shared and unique perspectives among mothers, daughters, and service providers.

Table 2.1

**Sexual Health Theme Descriptions**

<table>
<thead>
<tr>
<th>Sexual Health Themes</th>
<th>Descriptions</th>
<th>Groups Addressing Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engaging in Physical Relationships with Opposite Sex Prior to Marriage</strong></td>
<td>-Wrong” to have sex prior to marriage&lt;br&gt;-Consequences&lt;br&gt;-Awareness that some girls in community engage in physical relationships prior to marriage</td>
<td>-Girls(early adolescents ,older adolescents )</td>
</tr>
<tr>
<td><strong>Sexual Health Risks</strong></td>
<td>-Rape&lt;br&gt;-Sexual harassment&lt;br&gt;-Eve-teasing&lt;br&gt;-Pregnancy&lt;br&gt;-HIV&lt;br&gt;-Incest&lt;br&gt;-STIs/STDs&lt;br&gt;-Gynecological health problems&lt;br&gt;-Early marriage</td>
<td>-Girls(older adolescents)  &lt;br&gt;-Service Providers</td>
</tr>
</tbody>
</table>
| Sources of Information | -TV/Movies  
-Friends  
-Overhearing adults  
-Books/magazines  
-Older sisters/female relatives  
-Mothers  
-Sex education classes | -Girls (older adolescents)  
-Mothers  
-Service Providers |
| Types of information that should be shared about sexual health | -Education on sexual risk  
-Secondary Changes  
-Physiological changes  
-Body image  
-None- should be taught after marriage | -Girls (older adolescents)  
-Mothers  
-Service Providers |
| Barriers to providing sexual health information | -Attitudes creating taboo  
-Difficulty finding environment to educate girls  
-Challenge to gain accurate information | - Service Providers |
| Ways to prevent sexual risks that girls face in the community | -Education of girls  
-Education of boys  
-Counselling services  
-Group activities  
-Doctor lectures  
-Parents talking to girls openly | -Service Providers |
### Table 2.2

*Shared and Unique Perspectives on Sexual Health among Mothers, Daughters, and Service Providers*

<table>
<thead>
<tr>
<th>Sexual Health Domain</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual Health Risks</strong></td>
<td></td>
<td>-Rape( G, S)</td>
<td>-Incest( SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Pregnancy ( G, SP)</td>
<td>-Undiagnosed/ Untreated Gynecological Problems</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Contracting Sexually Transmitted diseases ( G,SP)</td>
<td>-Early Marriage( SP)</td>
</tr>
<tr>
<td><strong>Sources of Information</strong></td>
<td>-Television( M,G,SP)</td>
<td>-Sex education classes in school or community( SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Friends( M,G,SP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Older sisters/ other female family members( M,G,SP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Daughters and Mothers Discussing Sexual Health</strong></td>
<td>-Never discuss sexual health with one another( M,G)</td>
<td>-Mothers talk to daughters ( M)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Girls sometimes talk to mothers( SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Parents should discuss sexual health topics with daughters( SP)</td>
<td></td>
</tr>
<tr>
<td><strong>Types of information that should be shared about sexual health</strong></td>
<td>-Important for daughters and sons to have access to information ( M,S)</td>
<td>-Secondary changes(SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Education on sexual risk ( G,S)</td>
<td>-Psychological changes(SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Body Image(SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Personal Hygiene(SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Physiological events (SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Wrong to gain knowledge about sexuality prior to marriage(G)</td>
</tr>
<tr>
<td><strong>Barriers to providing sexual health information</strong></td>
<td></td>
<td>-Attitudes creating taboo (SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Difficulty finding environment to educate girls(SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Challenge to gain accurate information( SP)</td>
<td></td>
</tr>
<tr>
<td><strong>Ways to prevent sexual risks that girls face in the community</strong></td>
<td>-Education of girls and boys ( G,M, SP)</td>
<td>-Counselling services( SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Group activities( SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Doctor Lectures( SP)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>-Parents talking to girls (SP)</td>
<td></td>
</tr>
</tbody>
</table>

**Legend**
- G-Girls
- M- Mothers
- SP- Service Providers
Engaging in physical relationships prior to marriage. Both the girls and service providers discussed this theme, while the mothers did not address this topic. This may be due to mothers being unaware of adolescent girls engaging in physical relationships or, more like, is due to the taboo nature of the topic. Across age groups, girls agreed that it is wrong to have physical relationships with males prior to marriage. An older girl further clarified physical relationship stating, “A girl should refrain from kissing and hugging also until marriage”. When asked, “what makes having physical relationships with boys wrong?” the girls in the group of younger adolescents either did not respond or stated that they did not know. Older girls discussed consequences of losing honor, one stated, “she might lose her name and get insulted, if people find out”. A doctor confirmed social consequences stating, “people will talk about her, they will taunt her, humiliate her”. Girls and service providers also brought up consequences of contracting STIs or STDs; however, these were brought up less by the girls than the social consequences, suggesting that social consequences are more salient. The older girls explained that even though the community is strict, the girls knew of young people going out at night, skipping classes to go to faraway places, or engaging in physical relationships in auto-rickshaws. The younger adolescent girls did not share a detailed knowledge about young people going out at night, suggesting that this behavior is more likely to occur in groups of older adolescents.

Sexual health risks. All three groups discussed a number of sexual health risks that girls face. An older girl stated, “It’s safer for men. Women face more risks.” Mother and girls both emphasized the risk of getting harassed on the streets, one older girl stating, “They might follow us, or say bad things. Or sing songs. It’s also embarrassing sometimes.”
Other people who see this might think that I’m a bad girl”. In their responses on sexual health risks in the community, girls provided vague responses indicating a lack of detailed and accurate knowledge on the topic of sexual health. For example, an older girl stated, “If one man has sexual relationships with more than one woman or if a woman has sexual relationships with many men, then there is a risk”. The younger group of girls did not provide any answers on the potential negative impact of sexual relations and did not discuss sexual health risks at all, suggesting that they likely have even less knowledge about these topics than the older adolescent girls. In addition to risks also addressed by adolescent girls such as pregnancy and contracting sexually transmitted diseases, two doctors brought up incest stating, “It is very common in this community” and “They [girls] think incest is normal” has. Also, service providers discussed the risk of undiagnosed and untreated health problems due to mothers not allowing their daughter to have internal examinations. A pediatrician stated, “They [mothers] are concerned about their daughters, there’s no doubt about it. But when it comes to an internal examination…all over India, not just in this community, doing a genital examination, they won’t allow, since virginity is so important and is such a taboo.” Service providers also discussed the risk of early marriage, one social worker stating, “There are girls who get married at 16-17 years. Very few communities wait for the girl to turn 18 before they get married getting them married without their consent and without their feedback, not supporting them after marriage.” In contrast to the detailed accounts of sexual health risks provided by the service providers, mothers and daughters provided more vague answers.

Sources of information on sexual health issues. There was consensus that girls received information from television/movies, friends, reading materials, or older
siblings/other female family members. One older girl stated, “We have small houses. Little girls might even see it happening between parents. Even books, magazines have everything written. Whoever can read, will read”. Another older girl stated, “People talk about it. It spreads from one person to another and even little kids know all about it. You could call all the little kids in our chawl and ask them, they’ll all know. It might also happen that a girl might overhear adults talking about it, because she’ll be right there making food or something. And then she might discuss what she heard with her friends and it just spreads. “A mother of an older girl participating in the study stated, “Now, watching the TV, they all know everything”. A doctor stated, “it is available everywhere you look these days, in the cinema, the TV, in magazines, and most of this information isn’t scientific.” The teacher interviewed stated that sex education classes are conducted at school from Class 7 and that teachers provide information and support regarding sexual health. However, few girls attend school beyond Class 7. These responses suggest that despite the taboo nature of discussing sexual health with girls directly and the dearth of access to accurate information, as one older girl stated, girls often “learn from the environment”.

**Daughters and mothers discussing sexual health.** Mothers, girls, and, service providers gave varying responses addressing the following: Do mothers talk to daughters? What do they share? Who do they refer daughters to (other sources)? What is their comfort level, willingness, and sense of competence when it comes to addressing their daughters? The girls interviewed unanimously stated that their mothers never discussed sexual health topics with them. One older girl stated,” Mothers don’t talk to us,
but if there’s an elder sister, she usually explains some of these things when we get our periods for the first time – she tells us that we should not get involved in these things.”

Half of the mothers expressed that they never discuss sexual health with daughters, but, rather, send their daughters to discuss topics such as menstruation with other women (aunts, sisters-in-law, close friends). These mothers expressed embarrassment over talking about these issues, and some felt it was unnecessary to do so because daughters learn elsewhere. One mother stated, “If they are told about these things in community classes, then there is no need for me to talk to them about it.” The other half of mothers stated that they talked to daughters about menstruation and that mothers need to talk to daughters about what is right and wrong. One expressed, “I do talk to her about her period. And she is free to talk to me about it if she has any trouble at all.” When discussing talking to daughters about physical relationships, a mother said, “Yes, I advise my daughters all the time that this is all just fantasy and not real life. I advise them to concentrate on their studies and their work and not be misled and when talking to young boys, I tell them to be very careful about what they talk and how they talk and about their body language – how they should talk with their voices and “not with their bodies”. Similarly to this mother, other mothers that talked with their daughters often discussed how daughters need to behave around males, rather than providing facts or information pertaining directly to sexual health. Including the mothers that did not directly want to discuss sexual health with their daughters, all of the mothers interviewed supported the idea that their daughters should have access to knowledge. Additionally, some mothers attempted to initiate conversations, but were rejected by daughters. One mother stated,
“Till today, my daughter doesn’t talk to me about it. Even if I ask her something, she asks me if I have no shame to ask her about it.”

Service providers stated that girls sometimes talk to their mothers about sexual health topics. Service providers believed that parents should discuss sexual health topics with daughters rather than treating them as taboo. One social worker stated, “They should talk to their children about it, whether it is a boy or a girl. Information about anything is not bad. Parents should pass on the correct information. And when a boy or a girl has correct knowledge, they wouldn’t make mistakes. Not that they should be told how it is to be done. They should be told more about the hazards of.” In summary, these interviews indicate a push for mothers and daughters to communicate, but a number of barriers including mutual embarrassment, lack of knowledge, and belief that daughters are receiving enough information from other sources.

**Types of information that should be shared with adolescent girls about sexual health.** Girls stated that it is important to be informed about how to protect themselves from sexual risks. In agreement, service providers believe that sexual health education is important. In addition to education on sexual risk that the girls identified, service providers believe that girls need to be taught about secondary changes taking place in the body, psychological changes, body image, personal hygiene, and physiological events. In contrast to the idea of the service providers that sexual education will empower girls and educate them to make good decisions, some girls felt that it was wrong to gain knowledge about sexuality prior to marriage. In response to a question by the focus group leader asking older girls if it was appropriate to gain knowledge about sexual experience through movies or books, the group responded, “That is wrong”. While
some mothers felt it was unnecessary for them to talk about sexual health issues with their daughters because they were learning about the topic through other sources (e.g. media, community classes), mothers agreed that it is important for daughters and sons to have access to information. One mother stated, “If there is any studying or reading they can do at the community center that would be good for them”. Although sexual health is a taboo topic, most of the mothers, daughters, and service providers believe that it is important for daughters to have access to information that will protect them from sexual risks.

**Barriers to providing sexual health information.** The primary barriers identified by service providers are the religious and cultural attitudes that make sexual health a taboo topic in the community. One social worker stated, “In this community, they won’t talk to you about these matters. Even if you talk to them about it, they’ll say ‘you’re talking about such dirty things. Children should not be told about these things.’” Service providers identified that it is both difficult to find opportunities to educate adolescent girls and to gain accurate information about the current sexual health of adolescent girls. One doctor stated, “Because there is so much taboo and inhibition, they would hardly discuss their sexual health or ask questions if they want to know anything about sexuality”.

**Ways to prevent sexual risks that girls face in the community.** While service providers emphasized the importance of education of adolescent girls, One mother stated, “Boys should be taught to respect femininity as such, no matter who the female is. Along with that, dangers of careless sexual practices, differences in male-female anatomy and physiology...all this has to be inculcated into the boys”. A social worker stated,
“Children, when they are young, spend a lot of time with parents. But adolescents spend most of their time with their peers and with teachers in schools/colleges. So schools and colleges should have counselling services. And there should be programmes organized to educate them about these issues. Group activities should be conducted with them.” A school principal added that, “parents should not treat this topic as a taboo. They should talk to their children”. Service providers and mothers agreed that education and counselling services are the ways to prevent sexual risks. The girls did not provide any suggestions for ways to prevent sexual risks.

**Gender Role Themes**

An emergent code that evolved from the data originally coded under “sexual health” was “gender roles” defined as, “social and behavioral norms that are generally considered appropriate by a particular society for males or females.” The following themes were identified by the adolescent girls, mothers, and service providers and explain their understanding of and salient topics regarding sexual health of adolescent girls: Importance of household role, Girls as supporters in the family, Parental Control/Amount of Freedom, Importance of daughters upholding family honor, Differential treatment of brothers and sisters, Societal perspectives on females, Meaning of “woman”. Descriptors of these themes are in Table 3.1. Below, the themes are discussed across groups. Table 3.2 shows the shared and unique perspectives among mothers, daughters, and service providers.
Table 3.1

*Gender Role Themes*

<table>
<thead>
<tr>
<th>Gender Role Themes</th>
<th>Description</th>
<th>Groups Addressing Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of household role</td>
<td>-Girls cooking, washing, and performing other cleaning at home</td>
<td>Girls (early adolescents, older adolescents)</td>
</tr>
<tr>
<td></td>
<td>-Expectation that girls learn to do housework work properly prior to marriage</td>
<td></td>
</tr>
<tr>
<td>Parental control/freedom</td>
<td>-Limitations on when girls can go outside and where they can go</td>
<td>Girls (early adolescents, older adolescents)</td>
</tr>
<tr>
<td></td>
<td>-Restrictions on activities/pursuits parents allow daughters to engage in</td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>-Restrictions on activities/pursuits parents allow daughters to engage in</td>
<td>Service Providers</td>
</tr>
<tr>
<td>Importance of daughters upholding family honor</td>
<td>-Importance of daughters showing respect towards parents</td>
<td>Girls (older adolescents)</td>
</tr>
<tr>
<td></td>
<td>-Girls not talking back</td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>-Girls not showing “loose character”</td>
<td>Service Providers</td>
</tr>
<tr>
<td>Girls as supporters in family</td>
<td>-Sons supporting family</td>
<td>Girls (older adolescents)</td>
</tr>
<tr>
<td></td>
<td>-Daughters marrying and leaving home</td>
<td>Mothers</td>
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<tr>
<td></td>
<td>-New trend of girls helping to support family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Recognition of importance of women supporting themselves if husbands cannot</td>
<td></td>
</tr>
<tr>
<td>Differential treatment of brothers and sisters</td>
<td>-Parents treating children differently by gender</td>
<td>Girls (older adolescents)</td>
</tr>
<tr>
<td></td>
<td>-No differences in some houses</td>
<td>Mothers</td>
</tr>
<tr>
<td></td>
<td>-Service Providers</td>
<td></td>
</tr>
<tr>
<td>Societal perspective on females</td>
<td>-Male-dominated society</td>
<td>Service Providers</td>
</tr>
<tr>
<td></td>
<td>-View that women are inferior sex</td>
<td></td>
</tr>
<tr>
<td>Meaning of being a “woman”</td>
<td>Idea that girl becomes a woman when she has a child</td>
<td>Girls (older adolescents)</td>
</tr>
</tbody>
</table>
Table 3.2

*Shared and Unique Perspectives on Gender Roles among Mothers, Daughters, and Service*

<table>
<thead>
<tr>
<th>Gender Role Domain</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
</table>
| Importance of household role | -Girls cooking, washing, and performing other cleaning at home (M,G)  
-Expectation that girls learn to do housework work properly prior to marriage(G) |                                                                                                           |                                                          |
| Parental Control/Freedom | -Restrictions on activities/ pursuits parents allow daughters to engage in( G,M, SP)  
-Limitations on when girls can go outside and where they can go( G, M,SP) |                                                                                                           | -Maintaining parent’s trust( G)                           |
| Importance of daughters upholding family honor | -Appropriate and inappropriate communication with males- not showing “loose character( G, M, SP) | -Importance of daughters showing respect towards parents( G,SP)                                         |                                                          |
| Daughters as supporters in family |                                                                                                           | -Daughters marrying and leaving home( G, M)  
-New trend of girls helping to support family( G, M)  
-Recognition of importance of women supporting themselves if husbands cannot( G, M) | -Sons supporting family ( G)                             |
| Differential treatment of brothers and sisters | -Parents treating children differently by gender ( M,G,SP)                                                                                        |                                                                                                           | -No differences in some houses( G)                       |
| Societal perspective on females |                                                                                                           |                                                                                                           | -Male-dominated society( SP) Societal view that women are inferior |
Importance of household role. Both older and younger adolescent girls discussed their current responsibilities in their parents’ homes and the expectations of their roles in the house upon marriage. One older girl stated, “At home, my mother tells me to wash the dishes, wash the clothes. I mean, they expect that I will do all these things by the time she gets home.” Girls also discussed the importance of learning how to do housework properly so as not to get in trouble once they are married. One younger girl stated, “My mother also says – Once I get married, I will be in trouble. Because I don’t do work properly. My in-laws might just chase me out.” Additionally, girls expressed that boys are never expected to do housework. In their discussion of expectations of their daughters, mothers confirmed what girls said, emphasizing the importance of their daughters completing household chores.

Girls as supporters in the family. Girls and mothers discussed more traditional roles of girls leaving the home to get married and sons becoming the financial caregivers, as well as more progressive ideas about girls working and gaining skills to stand on their own if necessary. Girls stated “mother thinks that her son will grow up, earn and look after her” (older girl) and that the “daughter will get married and go to another house” (older girl). Expressing another view, an older girl stated, “these days, girls are of more help than boys. Boys sit at home and eat, girls have aspirations, and they want to achieve things, do things. Before, I used to hear that whatever work a man does outside the house,
a girl is not supposed to do, like going out and earning a living. And I used to believe the same. But now, I see that boys stay at home and girls go to work and bring home the income.” A mother supported the idea that females should be able to support themselves and run a household stating, “A girl should be able to stand up on her own feet if later her husband has some problem or some disease. She should be able to take the responsibility of the house, despite being a girl.”

**Parental control/ amount of freedom.** There was a consensus among mothers, daughters, and service providers that, oftentimes, there are restrictions on activities that parents allow daughters to engage in and limitation on where girls can go. Parents place restrictions on girls in order to keep them safe, to maintain the family honor, and to maintain tradition. One older girl stated, “In the community, they always say- ‘Don’t let the girls out at night, the place is bad.’ They might get teased…girls go missing, get raped”. Another younger girl said, “Parents are scared that if they don’t keep their daughters under control they’ll roam around more, they won’t listen to their parents, they’ll act according to their own whims”. A pediatrician confirmed the idea that sometimes parents keep daughters at home and restrict them from continuing with education in order to maintain tradition and ensure that daughters don’t become progressive, stating, “As by this time the girl starts acquiring secondary sexual characteristics, they don’t want to send her out of the house. If they become more educated, they will become more independent and demanding and then, she won’t be able to settle down in the husband’s family. Then, she will come back and will be a burden on them. So, what is the use in educating her, they think. Anyway, she is not going to earn, so there is no need to educate. It is enough for her to look after the family, produce and
bring up children.” While many girls discussed the restrictions placed on them, there was some discussion of girls having freedom to go out of the home. One older girl stated, “If she has the freedom, to go out, and if she is going out, it is her responsibility that she goes and returns properly. I mean, she should keep the trust of her parents.”

**Importance of daughters upholding family honor.** Mothers, girls, and service providers discussed the importance of daughters upholding family honor by not showing “loose character”. One of the major ways community members determine a girl’s character is by watching how and who she interacts with on the street. Oftentimes, when girls are seen talking to boys, whether it is romantic or platonic, this reflects poorly on the girl and, in turn, her family. One older girl stated, “Parents do allow us to talk, but when other people start talking, then our mothers get hurt. The mother feels – how can my daughter do something like that! But when people are talking, parents are bound to get upset, right? We do talk to boys in our neighborhood though”. Another older girl stated, “A lot of girls fall in love with someone, elope with someone, or has an affair with someone in the neighborhood…and then when other people hear about it, her name will be ruined. Her parents’ “head will go down” [in shame], people around will say – ‘see how their daughter is!’ they will say she is [of loose character] or something like that. When she gets a marriage proposal, even they will hear about this and will withdraw their offer. This way, the parents lose their name and respect in front of people, and they become ashamed… In this process, even the girl gets beaten…over why she made these mistakes. If she wants to do something, she should think about it and do it, find a good boy…if it is a bad guy, what will happen in the future? So, parents expect that - our
daughter will never spoil our name, she will like the same things that we like, that she will do only what we approve of.”

**Differential treatment of brothers and sisters.** Mothers, girls, and service providers agreed that most parents treat children differently according to gender. The aforementioned themes discussing the roles of girls in the household, girls as supporter in the family, parental control, and importance of family honor explain some of these differences. Many girls expressed that because boys bring home money, are expected to earn for the family in the future, they are treated differently. One older girl stated, “Boys go out to work. Parents have the trust that they will work and get them money. Girls have to do house-work now, and even after they are married – washing clothes and vessels – before and after marriage. That’s it.” Another older girl stated, “Like they say, the girl is always ‘the other’, an outsider, from the time she is born. She will marry and leave. But the son is their ‘own’, who will stay with them and look after them. They are the ones who will take the family name forward. But my family doesn’t think like that. In my house, the girls are pampered more. If I want something and my brother wants something, they’ll fulfill my desires first. They tell my brothers – ‘You can do these things when you start earning’. But since I am younger, I get my way. If there’s anything I want to do, they let me. Like this here [participating in the research], they said I can do it if I want. And they never take money from me. So, there’s no different treatment at home. But yes, in the community, they always say – ‘Don’t let the girls out at night, the place is bad.’ They might get teased… girls go missing, get raped… But boys have no restrictions regarding their mobility. They can go out any time. Girls
cannot go out alone; people in the neighborhood say ‘don’t stand outside, don’t play outside.”

**Societal perspective on females.** Service providers discussed the attitudes towards women in the society at large. A doctor stated, “It starts with the attitudes towards a female. Forget being the fairer sex, but if they consider them an inferior sex, that is where the behavior starts – not giving the right amount of nutrition to your daughter, providing them less opportunities for education, getting them married without their consent and without their feedback, not supporting them after marriage, because they don’t want their daughters to come back and cry or crib to them. This is a highly male dominated society and we need to start from just telling them that women are at par with men…a shift to gender equality is what we need.”

**Meaning of “woman”**. In response to a question asking what represents a woman, girls explained that a girl feels like a woman when she gets married and has children. One older girl stated, “When a woman gets married and she has children, is when she realizes fully that she is a woman. She feels it in her body...” Another older girl supported her responding, “That’s right. When a woman has children is when she fully becomes a woman. Before, she would have wanted to dress up and put on make-up and admire herself in the mirror...but it is when she has children, that she loses interest in all that and realizes that now, she is a woman. This has happened with a friend of mine. She’s told me.”
Psychological Well-Being

Throughout the course of focus group discussion, girls, mothers, and service providers identified numerous stressors, supports, and reactions to stressors that girls have. The identified stressors and supports explain the way girls perceive their relationships with others. Notably, many of the stressors overlap with the aforementioned sexual health and gender role themes. These are organized into the following subcategories or systems in girl’s lives: family/home, friends, intimate relationships, school, community, self, and others. Tables summarize the consensus and unique perspectives amongst the girls, mothers, and service providers.

Family/Home.

Table 4 presents the findings on Psychological Well-Being within the “Family/home” system. The findings relevant to stressors, reactions to stressors and supports are presented separately.
Table 4

Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls- Family/Home

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family/Home</td>
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</tr>
<tr>
<td>Stressors</td>
<td></td>
<td>-Parents restricting freedom (G, SP)</td>
<td>-Getting caught after laying to parents (G)</td>
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<tr>
<td></td>
<td></td>
<td>-Brothers given more &quot;value&quot; in household by parents (G, SP)</td>
<td>-Parents fighting with each other (G)</td>
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<tr>
<td></td>
<td></td>
<td>-Beatings and scolding from parents and/or siblings (G, SP)</td>
<td>-Mothers not listening or understanding (G)</td>
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<tr>
<td></td>
<td></td>
<td>-Daughters blamed by family for sexual harassment, rape, and/or pregnancy (M, SP)</td>
<td>-Parents expecting too much (G)</td>
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<td></td>
<td></td>
<td></td>
<td>-Lack of support for achieving goals (G)</td>
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<td>-Siblings telling girls what to do/how to behave (G)</td>
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<td></td>
<td>-Beatings and scolding from siblings/ in-laws (G)</td>
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<td>-Siblings acting irritatingly (G)</td>
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<td></td>
<td>-Loved ones passing away (G)</td>
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<td>-Sick parents (M)</td>
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<td>-Girls having to earn their own money (M)</td>
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<td></td>
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<td></td>
<td>-Parents taking daughters out of school after menarche (SP)</td>
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<tr>
<td>Supports</td>
<td></td>
<td>-Family support of ambitions/ education (G, M, SP)</td>
<td>-Family members listening to girls (G)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>-Close relationships with mothers (G, M, SP)</td>
<td>-Families showing love to girls (G)</td>
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<td></td>
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<td></td>
<td>-Parents treating girls like adults (G)</td>
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<td></td>
<td></td>
<td></td>
<td>-Other family members talking to girls (aunts, uncles, sisters) (G)</td>
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<td></td>
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<td></td>
<td>-Mothers doing extra housework to relieve daughters of burden (M)</td>
<td></td>
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<tr>
<td>Reaction to Stressors</td>
<td></td>
<td>-Parents letting daughters do something she wants (G, M)</td>
<td></td>
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<tr>
<td>Emotions</td>
<td></td>
<td>-Sadness (G)</td>
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<tr>
<td>Behavioral</td>
<td></td>
<td>-Fear (G)</td>
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<td></td>
<td></td>
<td>-Anger (G)</td>
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<td></td>
<td></td>
<td>-Resentment (G)</td>
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Legend
- G-Girls
- M-Mothers
- SP-Service Providers
Stressors. Girls across groups repeatedly brought up stressors involving parents and siblings. They discussed high expectations of parents and receiving beatings and scoldings from both parents and siblings. One older girl stated, “They expect a lot of things from me. I get beaten and scolded more. They are after me! I’m tired them being after me.” Girls and service providers both discussed the stress of having their freedom restricted (particularly after reaching menarche) and being told how to behave by parents and siblings. A social worker stated, “Even friendships are chosen by parents. They are not allowed to go very far...I don’t see them going for movies alone or even for a walk...if she expresses the wish to go for a walk, she is asked why she wants and there is no need, just sit at home and help with the work. So, they are denied the pleasure of doing things or being with their peer group in an atmosphere of freedom.” Girls talked about older brothers frequently restricting them from leaving the home, and getting very angry with their sisters if they did not listen to them or if someone from the neighbourhood said something about them.

Service providers also discussed the stress of girls being blamed by families if they are sexually harassed, raped, or become pregnant. Mothers discussed the stress of having sick parents and girls having to earn their own money to help the family. There was no complete consensus among girls, mothers, and service providers about stressors related to family/home.

Reactions to stressors. Girls discussed feeling sad, angry, scared, or resentful in response to family stressors. One younger girl stated, “I feel a little angry when someone scolds me, and most angry when someone beats me.” A behavioral response that multiple
girls and service providers discussed was withdrawal through actions such as putting one’s head down, not talking to parents, or simply keeping whatever happens to oneself. A social worker stated, “It leads to a lot of introversion, a lot of impotent anger that they can’t change their situation. And there is a lot of resentment and depression and very often, they can’t do anything much about it.”

**Supports.** There was complete consensus among girls, mothers, and service providers that close relationships with mothers and family support of girls’ ambitions serve as supports that are likely to improve psychological well-being. Some girls discussed having good relationships with their mothers and talking to their mothers when they were in situations when their friends couldn’t help them. One mother stated, “Whatever it may be, it is only by talking and sharing that solutions can be arrived at when there is a problem and it is mostly the mother who is the best person for that and it is her prime responsibility to ensure that she maintains such a relationship with her child.” A service provider discussed the idea of the mother as the “core strength” of the family that can impact change in her daughter’s life. An older girl stated, “With my parents, I feel loved when they let me do what I want. If I say I want to go to some class or go to the Community Center, and they let me, I feel loved.” Girls and service providers expressed that girls are more likely to be close to, and receive support from, mothers than fathers.

Girls also discussed having the support of other family members such as aunts, uncles, and sisters. Girls talked about older sisters acting like mothers—having expectations of younger siblings, sharing information with them, and being there for them in times of need.
Friends.

Table 5 presents the findings on Psychological Well-Being within the “Friend” system. The findings relevant to stressors, reactions to stressors and supports are presented separately.

Table 5

*Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls' Friends*

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friends</strong></td>
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<td></td>
<td>Fighting with friends(G)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Friendships ending(G)</td>
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<td>-Friends telling secrets to someone else (G)</td>
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<td>-Not having many friends(G)</td>
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<td>-Fear that friends might laugh at them (SP)</td>
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<td>-Concerns about being friends with boys(SP)</td>
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<tr>
<td></td>
<td>Stressors</td>
<td></td>
<td></td>
<td>-Friends providing company and going places with you (G, SP)</td>
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<tr>
<td></td>
<td>Supports</td>
<td></td>
<td>-Talking to friends when happy or sad(G, SP)</td>
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<tr>
<td></td>
<td>Reaction to Stressors</td>
<td></td>
<td></td>
<td><strong>Behavioral</strong></td>
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<td></td>
<td></td>
<td>-Go out and roam around(G)</td>
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<td></td>
<td></td>
<td></td>
<td>-Singing songs/reciting poems(G)</td>
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<td></td>
<td></td>
<td>-Doing housework to distract oneself(G)</td>
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<td></td>
<td></td>
<td>-Throwing things(G)</td>
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<td></td>
<td></td>
<td>-Breaking things(G)</td>
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<td></td>
<td>-Crying(G)</td>
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<td>-Sitting quietly/not talking to others(G)</td>
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<td></td>
<td>-Sleeping(G)</td>
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<td></td>
<td><strong>Physiological Responses</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-Hands get tight(G)</td>
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<td></td>
<td></td>
<td>-Heart beats fast(G)</td>
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<td></td>
<td></td>
<td>-Sweating(G)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-Headaches(G)</td>
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</table>

**Legend**

G-Girls
M- Mothers
SP- Service Providers
Stressors. Across groups, girls discussed the stress of having fights with friends and the possibility of friendships ending. One older girl stated, “When my friends are angry with me and refuse to talk, I feel really upset. Now we are good friends and we go everywhere together and then she stops talking to me, then I’m bound to feel upset, right? And we also feel upset with ourselves – ‘why did I have to fight with her!”’. Whereas girls did not bring this stressor up themselves, service providers identified concern about being friends with boys as a stressor for girls. They brought up the concerns that girls have about parents scolding them, and peers or community members judging them even if they have only platonic friendships with males. One teacher stated, “But parents usually say ‘he is a boy, you can’t talk to him or go around with him’. In that case, the girl also starts thinking ‘if I’m forbidden from meeting boys then why is it so?’…she will think about these things more.”

Reaction to stressors. Girls identified a number of behavioral and physiological reactions to stressors related to friendship. Girls talked about doing things to distract themselves such as “singing songs or reciting poetry”, “doing housework”, “sleeping”, and “making something sweet and eating it”. Girls also discussed more aggressive behaviors such as “throwing things” and “breaking things”. Girls identified physiological reactions including: “hands getting tight”, “heart beating faster”, “sweating”, and “headaches”. Mothers and teachers did not discuss girls’ reactions to stressors pertaining to friends.

Supports. Girls and service providers discussed the support that comes from communicating with friends about feelings, thoughts, problems, etc. A teacher stated, “I
think the main supports are the friends. They mostly share with their friends, and not with their parents. But then, the kind of support that they get would also be such… their friends would understand things just like them.” Beyond communicating, girls talked about friends providing each other with company, hugging, getting in trouble for another friend’s sake, and giving money to friends when in need. A focus group agreed with an older girl after she stated, “A good friend is one who helps us, who tells us not to do bad things…and saves us when we get beatings! Friends should be such that they are there for each other in times of need. Like when we are in trouble – it might be about money or about sharing your thoughts and your feelings.”

Girls talked about having male friends that are like brothers. The girls explained that with their male friends, they are not physically affectionate, but show their affection to each other by helping the other feel happy. One older girl stated, “My best friend (male) helps me out. We enjoy a lot together. He helps me more than my female friends help me. And because of that, I prefer boys as friends more than girls”. While some service providers agreed that girls and boys often have platonic friendships, others explained that it is not acceptable for boys and girls to be good friends.

**Intimate Relationships.**

Table 6 presents the findings on Psychological Well-Being within the “Intimate Relationships” category. The findings relevant to stressors and supports are presented separately. Reactions to Stressors regarding intimate relationships were not addressed by girls, mothers, or service providers.
Table 6

*Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls’ Intimate Relationships*

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intimate Relationships</strong></td>
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<tr>
<td>Stressors</td>
<td>-Rejection by potential husbands (M, SP)</td>
<td>-If someone is having an affair (is romantically involved with someone) and if parents do not accept the relationship (G)</td>
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<tr>
<td></td>
<td>-When a boy likes you and you are not interested in him or the other way (G)</td>
<td>-Risk of contracting STDs or STIs (SP)</td>
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<tr>
<td></td>
<td>-Feeling left out of peer group if a girl doesn’t receive attention from boys or have a boyfriend (SP)</td>
<td>-Being taken advantage of sexually by males (M)</td>
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<td></td>
</tr>
<tr>
<td>Supports</td>
<td>-Regarding male friends as just friends (playing together, studying together, talking to each other) (SP)</td>
<td>-Feeling happy if someone likes them (SP)</td>
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<tr>
<td></td>
<td>-Feeling happy when parents select an appropriate husband (M)</td>
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</table>

**Legend**

G - Girls
M - Mothers
SP - Service Providers

*Stressors.* Girls, mothers, and service providers all identified unique stressors regarding intimate relationships. While the girls did not discuss engaging in romantic relationships themselves, they referred to the stressors that their friends experienced upon engaging in premarital physical relationships. Girls talked about stressful situations involving parents not approving of romantic relationships, and the belief that boys are often deceitful in relationships outside of marriage and are only with girls, “for their bodies and not their hearts”. One older girl stated, “There are so many worries. If
someone has an affair (is romantically involved with someone) and if the parents do not accept the relationship then that causes a lot of tension.”

Mothers and service providers discussed the difficulty of marrying if girls that have already been involved with other males and the stress of rejection by potential husbands. Service providers also discussed the risk of contracting STDs or STIs or getting pregnant. One social worker stated, “I have had to deal with cases where the unmarried girl is 5-6 months pregnant and not even aware of that. I have dealt with girls who don’t even know they have had sex; they don’t know what has happened to them. She will describe the whole act to you and you will wonder what she is up to because she wouldn’t know that it was a sexual act.”

**Supports.** Mothers and service providers both identified girls feeling happy when they were liked by boys. Mothers and girls identified that girls are especially happy when parents select an appropriate husband for them. One mother stated, “My daughter is happy. What more can she want. We’ve chosen a nice boy for her.” Most girls shared the idea that it is ideal for parents to select a husband for their daughter and for a couple to fall in love after marriage. Girls expressed their belief that in an intimate relationship, the couple should provide support for one another by telling each other everything and helping each other out with any problems.

**School.**

Table 7 presents the findings on Psychological Well-Being within the “Friend” system. The findings relevant to stressors, reactions to stressors and supports are presented separately.
Table 7
Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls- School

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School</strong></td>
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<tr>
<td></td>
<td><strong>Stressors</strong></td>
<td></td>
<td></td>
<td>-Poor exam results/ bad grades(G)</td>
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<td>-Having to mind the rest of the class(G)</td>
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<td>-Gang activities in schools(SP)</td>
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<td>-Teachers not being able to pay much individual attention due to large class size(SP)</td>
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<td></td>
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<td></td>
<td>-Parents taking daughters out of school after menarche(SP)</td>
</tr>
<tr>
<td></td>
<td><strong>Supports</strong></td>
<td></td>
<td></td>
<td>-Mothers allowing them to focus on studies when they have exams(M)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Teachers identifying girls that experience psychological distress and referring them to mental health professionals(SP)</td>
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<td></td>
<td></td>
<td></td>
<td>-Teacher working to create environments where students feel safe(SP)</td>
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<td>-Teachers consulting with parents and offering advice for problems with daughters that are happening in the home(SP)</td>
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<td>-Teacher discussing problems and answering questions that students have(SP)</td>
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<td></td>
<td></td>
<td></td>
<td>-Teachers providing moral education and sex education(SP)</td>
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<tr>
<td></td>
<td><strong>Reaction to Stressors</strong></td>
<td></td>
<td></td>
<td><strong>Emotions</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-Fear(G)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-Sadness(G)</td>
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<tr>
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<td></td>
<td><strong>Cognitive Responses</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-Positive thinking (G)</td>
</tr>
</tbody>
</table>

**Legend**
G-Girls
M- Mothers
SP- Service Providers
Stressors. Girls identified receiving bad grades as a stressor related to school. Part of the reason for being stressed about bad grades was the potential of parents scolding girls in response to poor academic performance. One younger girl stated, “I’m scared that my parents might scold me for not doing well.” Teachers that were interviewed as part of the service provider group discussed various stressful aspects of school stating, “The atmosphere is changing. It has changed a lot. Gang activities start in schools – boys at an early age – and girls get targeted in their activities. Teachers don’t share a healthy relationship with the girls. And in municipality schools, the class strength is such that the teacher can’t pay much attention to each student. If the girl has any psychological issues also, then they will not be recognized. Nothing will be done about it.”

Reactions to Stressors. Girls discussed feeling sad and scared in reaction to stressors related to school. Girls agreed and confirmed one girl’s statement, “I feel sad when I get low marks in my exams”. One girl discussed engaging in positive thinking stating, “I just think that I should do better in the next exam.” Mothers and service providers did not discuss reactions to stressors pertaining to school.

Supports. Girls did not identify any school related supports, possibly because they did not recognize having any, or do not feel that the support outweigh the stressors. Mothers discussed how they provide support to daughters by allowing them to focus on studies when they have exams. One mother stated, “Studies is important. If they score less marks, they might even lose a year. That’s why, whenever my health allows me, I do as much of the work myself as possible and let them study.” Teachers that were interviewed identified numerous school supports that teachers provide such as guiding students by discussing problems with students and consulting with parents. Teachers
talked about providing students them with moral education and sex education. One teacher stated, “education, studies, career… we try to guide them in this way.

**Community.**

Table 8 presents the findings on Psychological Well-Being within the “Community” system. The findings relevant to stressors, reactions to stressors and supports are presented separately.

**Table 8**

*Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls*

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/ Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td>Girls not being able to go out if parents hear about them being teased in streets(G,SP)</td>
<td>People in neighborhood fighting( G)</td>
</tr>
<tr>
<td>Stressors</td>
<td>Eve-teasing: boys harassing or assaulting girls in the street(G, M, SP)</td>
<td>-Girls in community gossiping about girls( M, SP)</td>
<td>-Not being able to study due to loud neighbors(G)</td>
<td></td>
</tr>
<tr>
<td>Supports</td>
<td></td>
<td></td>
<td>People in community glossing about girls( M, SP)</td>
<td>-People stealing(G)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Taunts, Rejection, and blame from neighbors if a girl is raped( SP)</td>
<td>-Community disapproval towards discussing topics related to mental health or sexual health (SP)</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td>People in neighborhood fighting( G)</td>
<td>-Group educational lectures at local health centers(SP)</td>
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<td></td>
<td></td>
<td></td>
<td>Not being able to study due to loud neighbors(G)</td>
<td>-Mahila Mandals- self-help groups of women(SP)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>People stealing(G)</td>
<td>-Community programs- tailoring programs, mehendi classes, or beautician classes(Sp)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Taunts, Rejection, and blame from neighbors if a girl is raped( SP)</td>
<td>-Individual social works that take time to know girls and reach out to families(SP)</td>
</tr>
</tbody>
</table>
Stressors. Girls, mothers, and service providers showed consensus in their reports about eve-teasing, the act of girls being harassed in the streets by males, and also discussed the reactions of people in the community. A girl described, “They might follow us, or say bad things. Or sing songs. It’s also embarrassing sometimes. Other people who see this might think that I’m a bad girl. See, people on the road would not know that I’m trying to escape from these guys. They might see them following me and think that they’re coming with me or something.” Girls and service providers specifically discussed stressors of being threatened or grabbed or even sexually assaulted in the streets. Girls also discussed concerns of being forbidden to go out if parents hear about them being teased in the street. Although the girls did not mention the community members as stressors, mothers and service providers discussed the stressor of community members disapproving and gossiping about girls. One mother stated, “It’s time for her to get married. And people start talking. The environment is such. If the girl is see outside too much, or seen talking to people, other people start talking about it. Even if the parents have trust on the child, you can’t stop other people from talking. You and I might not
talk, but others will.” Another confirmed, “When you have a girl child, you’re always worried that someone might say something about them.”

**Reaction to stressors.** Girls discussed feeling anger, fear, and embarrassment in response to stressors within the community. One girl stated, “Both, I feel more angry, that we cannot even walk in peace in our own neighbourhood. But I also feel scared sometimes, that something might happen to me.” Mothers and service providers did not discuss reactions to stressors pertaining to the community.

**Supports.** Girls, mothers and service providers all identified community programs coming from non-governmental organizations or local organizations such as Mahila Mandals (women’s self-help groups) as supports. A mother stated, “I trust XXX organization completely. I’ve been sending my daughter to them ever since she was a little child. All the training programs she has attended and learned things from has been with XXX organization’s support”. Girls and mothers agreed that kind and helpful neighbors provide support within the community context. A mother stated, “Actually, my neighbours are very cooperative and I value their cooperation a lot. When I am not there, if any one touched my children, they take it as their personal issue and will handle the situation as if it is a matter relating to their own household. And, they will remain with my children if there is a problem and tell me as soon as I return in the evening. I should admit that my neighbours are very nice and caring.” Notably, only one group of girls identified supports within the community context.
Self.

Table 9 presents the findings on Psychological Well-Being within the “Self” system. The findings relevant to stressors, reactions to stressors and supports are presented separately.

Table 9

Consensus and Unique Perspectives of Girls, Mothers, and Service Providers on Stressors and Supports of Girls

<table>
<thead>
<tr>
<th>Overall Domain</th>
<th>Stressors/ Supports</th>
<th>Consensus</th>
<th>Some Agreement</th>
<th>Unique Perspectives</th>
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</thead>
<tbody>
<tr>
<td>Self</td>
<td></td>
<td></td>
<td></td>
<td>Loneliness( G)</td>
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<tr>
<td></td>
<td>Stressors</td>
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<td></td>
<td>Reproductive system concerns( SP)</td>
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<td></td>
<td></td>
<td>Studying( G)</td>
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<tr>
<td></td>
<td>Supports</td>
<td></td>
<td></td>
<td>Dancing( G)</td>
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<td></td>
<td></td>
<td>Feeling sense of responsibility at home( G)</td>
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</table>
Stressors. The girls identified loneliness as a stressor, particularly experienced when home alone. A girl stated, “I experience loneliness. When I’m at home. Not here, when I’m with everyone. And I feel suffocated, when I’m alone. Also fear, when I’m alone.” Although girls did not bring up this stressor themselves, service providers identified reproductive system concerns as a stressor. A doctor stated, “I would say psychologically, there will be this fear in her. For them, reproduction is so important. The basic aim…for a woman, all she has to do is that; when she attains a certain age, by 16-17 she has to get married. If she has menstrual or discharge problems, they think she might not bear children in the future…might say that she won’t be happy with her husband or that her in-laws will start troubling her if she doesn’t bear children…so this generates a kind of fear in her own mind…that she has to be at least healthy reproductively. So for them, the main aim revolves around whether they will be fertile or infertile, is it going to affect their future with their husband.”

Reactions to Stressors. Girls identified fear and sadness as reactions to stressors related to oneself. Girls talked about crying or doing nothing as reactions to feeling sad. Girls also identified physiological reactions to stress including “headaches”, “breathing
fast”, “feeling suffocated”, “feeling tired”, “losing appetite”, “getting ear-aches”, and “being unable to sleep”. Mothers and service providers did not identify girls’ reactions to stressors pertaining to the self.

**Supports.** Girls talked about alleviating their stress related to the self by immersing themselves in activities such as studying, dancing, or taking care of the home. One girl stated, “I feel happy when I’m alone at home and I’m responsible for doing everything.” Mothers and service providers did not identify girls’ supports pertaining to the self.

**Discussion**

The present analysis was concerned with the following research questions: (1) How are sexual health, intimate relationships, and psychological well-being defined as they apply to adolescent girls? Specifically, how are these constructs defined by adolescent girls, mothers of adolescent girls, and service providers? (2) What are the shared and unique perspectives regarding these constructs (sexual health, intimate relationships, and psychological well-being) across adolescent girls, mothers of adolescent girls, and service providers? The subsequent sections of the Discussion answer these questions first by defining the constructs, and then by examining the unique and shared perspectives of the various stakeholders. Next, the findings on the integration across constructs are discussed. In addition, implications, future directions, and limitations are included.
The first research question of the study aimed to identify how sexual health, intimate relationships, and psychological well-being are defined as they apply to adolescent girls. In the initial etic stages of research, the three broad constructs of study were identified as sexual health, intimate relationships, and psychological well-being. Through the process of emic analysis, the construct of gender roles, an extension of the sexual health construct, emerged as an important construct for analysis. While still serving as an important construct to understand, intimate relationships became better understood through the lens of the larger constructs of sexual health, gender roles, and psychological-well-being. In many ways, the explanations of the constructs that emerged from the study participants’ accounts support those of the literature reviewed on adolescent girls in India; however, they also provide a more nuanced understanding of the particular population.

The major themes that emerged to define and understand sexual health and the needs of the community pertaining to sexual health were the following: engaging in physical relationships with the opposite sex prior to marriage, sexual health risks, sources of information, types of information that should be shared about sexual health, barriers to providing sexual health information, and ways to prevent sexual risks that girls face in the community. Congruent with Hindin and Hindin’s (2009) research conducted with adolescent girls living in slums in New Delhi, the adolescent girls in the study expressed the belief that it is “wrong” to engage in sexual relationships prior to marriage. None of the girls admitted to engaging in sexual relationships themselves; however, they did express an awareness of some girls in the community engaging in physical relationships...
prior to marriage. Prior research identified that anywhere from 3% to 10% of females in India are sexually active in adolescence (Abraham and Kumar, 1999; Chakroborty, 2010; Jejeebhoy, 2000). The following major sexual health risks that are supported by other literature were identified by study participants: rape, sexual harassment, eve-teasing, pregnancy, STIs/STDs, incest, gynecological health problems, and early marriage. Prior research identifies all of these as major sexual health risks for the population of adolescent girls in India (IIPS and Macro International, 2007a; Jaya & Hindin, 2007; Jejeebhoy & Sebastian, 2003; Patel, Andrews, Pierre, & Kamat, 2001; Maitra & Schensul, 2004; Mumbai Human Development Report, 2009). Notably, the topics of abortion and female foeticide, were not discussed at all (Jejeebhoy, 2000; Nagpal, 2013).

Supported by prior research, the main sources of information that girls learned about sexual health from were media and friends (Guilamo-Ramos, Soletti, Burnette, Sharma, Leavitt, & McCarthy, 2012; Sathe & Sathe, 2005). Somewhat contrasting previous research that shows that parents are often the least likely source of knowledge for adolescents regarding sexual health (Jejeebhoy, Zavier, & Santhya, 2013), some mothers and service providers in this study, identified mothers as sources of knowledge for their adolescent daughters. There was agreement that girls should be provided with education on sexual health risk, and that education of both boys and girls is a major way to prevent sexual risks that girls face in the community; however, a number of girls felt that it was wrong to gain knowledge about sexuality prior to marriage. Service providers identified a number of barriers that exist in the community that prevent girls from learning adequate sexual health information. Notably, in discussing sexual health, girls demonstrated a great absence of knowledge and discomfort with the topic, often remaining silent after
questions or responding with “I don’t know”. This finding is supported by numerous other studies revealing that girls have limited knowledge about their bodies, relationships, sex, and reproduction (Bloom & Griffiths, 2007; Bott, Jejeeboy, Shah, & Puri, 2003; Dube & Sharma, 2012; Verma et al., 2004). Additionally, there was no positive discussion about sexuality, which reflects India’s traditional norms of girls maintaining innocence and not openly expressing any sexuality prior to marriage (Mehra, Savithri, & Coutinho, 2002).

*Gender roles* emerged as a major construct. In defining gender roles, the participants discussed topics that fell into the following themes: importance of household role, parental control/freedom, importance of daughters upholding family honor, girls as supporters in the family, differential treatment of brothers and sisters, societal perspectives on females, and the meaning of being a “woman”. Performing housework correctly, getting married, and having children were described as important in the role of a woman. The participants all discussed the restrictions that are placed on girls in the activities that are allowed to engage in and where and when they can go places. Jejeebhoy’s (2001) research supports the finding by discussing how, oftentimes, upon puberty, adolescent girls become more closely monitored by family members and have their mobility and overall freedom restricted. The theme of parental control/freedom is directly related to the importance of daughters upholding family honor. The study participants discussed the importance of daughters showing respect towards parents and not demonstrating “loose” character. Numerous other researchers have studied the idea of *izzat*, honor, and the role of young women as the family keepers of *izzat* (Chakraborty, 2010; Jejeebhoy, 2006; Sodhi, Verma, & Schensul, 2004). Whereas some of the study
participants defined more traditional gender roles of daughters marrying and leaving the home and sons supporting the family, others discussed the new trend of girls helping to support the family by earning money. Despite the discussion of some new opportunities for girls, participants still described a society that is male-dominated and where women are viewed as the inferior sex.

The third major construct of psychological well-being is defined through the stressors, reactions to stressors, and supports that were discussed in the focus groups. These facets of psychological well-being were discussed in reference to various contexts and relationships. For this reason, they were divided into the following ecological domains: family/home, friends, intimate relationships, schools, community, and self. Multiple stressors were identified in each of the domains, including family/home stressors (e.g., parents and siblings restricting freedom, beatings and scolding from parents and siblings, parents expecting too much, differential treatment of brothers and sisters, and financial difficulties), friend stressors (e.g., fighting with friends, fear of friends laughing at them, and concerns about being friends with boys), intimate relationship stressors (e.g., rejection by potential husbands, feeling left out of peer group if not receiving positive male attention, and being taken advantage of sexually by males), school stressors (e.g., receiving bad grades, not getting quality attention from teachers), community stressors (e.g., eve-teasing/sexual harassment, gossiping about girls, neighborhood fighting), and self-related stressors (e.g., loneliness and reproductive system concerns). Participants in this study identified many of the same stressors as participants in Sarkar’s (2003) qualitative study of mental health status of adolescent children in Kolkata including restricted freedom and independence, sexual harassment,
high parental pressure, and peer ridicule. Similarly to Bott et al.’s (2003) study of adolescent stressors, reproductive system concerns were identified as a stressor for girls. In contrast to Sarkar’s (2003) study, discrimination against females, dowry, and political issues were not identified as major stressors. Both negative and positive responses to stress discussed included emotional responses (e.g., fear, sadness, anger, and embarrassment), cognitive responses (e.g., positive thinking), behavioral responses (e.g., crying, not talking to others, going out and roaming around, singing songs, doing housework to distract oneself), and physiological responses (e.g., hands getting tight, sweating, headaches, and loss of appetite). Similarly to these findings, adolescents in Sarkar’s (2003) study identified suppressing their feelings as a way of dealing with stressors. In addition, participants in the study identified supports in each of the domains including, family/home supports (e.g., family support of ambitions, close relationships with mothers, and family members listening to girls), friend supports (e.g., friends providing company and talking to friends), intimate relationship supports (e.g., feeling happy if someone likes them), school supports (e.g., teachers consulting with parents and teachers providing moral education and sex education), community supports (e.g., helpful neighbors and NGOs that work with girls), and self supports (e.g., studying, dancing, and feeling a sense of responsibility at home). These identified supports are consistent with protective factors that are widely recognized in research including sensitive parenting, access to social support from friends and family, decent educational opportunities, and psychological autonomy (Patel, Flisher, Nikapota, & Malhotra, 2008).
Shared and Unique Perspectives

This section shares the findings of the second research question of the study: What are the shared and unique perspectives across adolescent girls, mothers of adolescent girls, and service providers? First, the differences and similarities between older adolescents and younger adolescent are examined. Next, the shared and unique perspectives among the three stakeholder groups regarding sexual health, gender roles, and psychological well-being are described.

**Older adolescents and younger adolescents.** In discussing sexual health and gender roles, the two groups of older adolescents addressed a number of themes that younger adolescents did not, revealing a deeper understanding of these constructs in their lives. In focus group discussions, older adolescents discussed sexual health risks, sources of information about sexual health, and types of information that should be shared about sexual health. In contrast, the group of younger adolescent girls demonstrated a dearth of knowledge pertaining to sexual health beyond expressing the belief that physical relationships with boys are wrong. Additionally, only older adolescents discussed the following gender role themes: importance of daughters upholding family honor, differential treatment of brother and sisters, and the meaning of being a “woman”. It is not surprising that the younger group of adolescents did not discuss topics that fell under these themes. Numerous other studies support the finding that many adolescent females in India have access to very little information regarding sexuality and reproductive health (Bloom & Griffiths, 2007; Bott, Jejeeboy, Shah, & Puri, 2003; Dube & Sharma, 2012; Verma et al., 2004). Adults, parents in particular, often do not communicate with children about these topics due to embarrassment, traditional norms, and misperceptions that
discussions about these topics will lead to sexual activity (Jejeebhoy, Zavier, & Santhya, 2013). Consequently, younger adolescent girls likely do not have developed opinions on these topics that they are comfortable discussing.

**Perspectives on sexual health.** Discussions pertaining to sexual health revealed that service providers have more detailed knowledge, or at least are more comfortable voicing opinions about sexual health of adolescent girls than mothers and daughters. Service providers named a number of sexual health risks that girls face beyond the ones listed by girls. Mothers did not discuss any sexual health risks that girls face. Additionally, service providers delved beyond the consensual belief of mothers and daughter that it is important for girls to have education, and were the only group that discussed types of information that should be shared with girls about sexual health, specific barriers to providing sexual health information, and concrete ways to prevent sexual risks that girls face in the community. The detailed discussions of these themes by service providers, but not by mothers and girls, is indicative of the heightened awareness and more advanced knowledge of service providers pertaining to sexual health. In contrast, mothers’ not discussing these topics in detail is reflective of their own lack of knowledge on sexual health which is supported by prior research on why parents do not initiate conversations about sex (Guilamo et al., 2012).

Notably, the majority of mothers, girls, and service providers stated that it is important for daughters to have access to information and education pertaining to sexual health. While a few girls stated that it is wrong to gain knowledge about sexuality prior to marriage, none of the mothers made this assertion. This finding contrasts the findings of the Youth in India: Situation and Needs 2006-2007 study (IIPS, 2008) on parent and
child communications in which many parents reported that young women should not learn about sex until marriage, at which time they would know about it automatically. In terms of mothers discussing sexual health with their daughters, there was some discrepancy in responses within groups. A number of girls and mothers stated that mothers and daughters never discuss sexual health. Other mothers and service providers stated that mothers talk to daughters and girls sometime talk to mothers. A study by Sathe and Sathe (2005) found that less than 20% of parents discussed sexual intercourse and related topics with daughters; however, consistent with the finding that some mothers are having discussions with their daughters, Jejeebhoy & Santhaya (2011) found that parents are being show greater willingness to have direct conversations about sex with their children. While there exist differences in opinion about the type of information and who should deliver information to girls, there is consensus among the groups that it is important for both daughters and sons to have access to accurate information.

**Perspectives on gender roles.** There was a great deal of consensus among groups, particularly mothers and daughters, pertaining to gender roles. Girls, mothers, and service providers all discussed the limitations on girls’ freedom, including the activities girls can engage in and limitations and where they can go. Additionally, there was consensus among the groups about the importance of daughters upholding family honor and differential treatment of brothers and sisters. While service providers did not delve into these topics, girls and mothers discussed both the traditional roles of girls (e.g., performing housework, marrying, leaving the home) and new trends for girls (e.g., helping to support their parents financially, supporting themselves if husbands cannot).
The shared awareness and understanding of the groups has the potential to serve as a point of leverage for important discussions between mothers and daughters.

Service providers discussed the societal perspective on females, and explained their views of a male-dominated society where women are treated as the inferior sex. This view aligns with research on the patriarchal society in India (Sathe & Sathe, 2005; Velma et al., 2004), and is further supported by India’s ranking of 132nd out of 148 countries on the gender inequality index (United Nations Development Programme, 2001). While mothers and girls discussed the restricted freedom, importance of upholding honor, and differential treatment of brothers and sisters, they did not directly discuss discrimination against females, a stressor that was emphasized by adolescent girls in Sarkar’s (2003) qualitative study. Future studies on attitudes towards gender inequality might help to understand the views of girls and mothers regarding societal perspectives on females.

**Perspectives on psychological well-being.** In discussion of stressors and supports, a few revealing consensual and unique perspectives of the different groups emerged. In the Family/Home context, all three groups identified “close relationships with mothers” and “family support of ambitions/ education” as supports for adolescent girls. In addition to corresponding with research showing that social support from family increases the likelihood of psychological well-being (Patel, Flisher, Nikapota, & Malhotra, 2008); the consensual agreement about the importance of close relationships with mothers reveals a shared goal of striving to strengthen mother-daughter relationships. In spite of cultural barriers that often prevent mothers and daughters from having open discussions about important issues, including those pertaining to sexual health and gender roles, Guinmamo
et al. (2012) and Jejeebhoy and Santhaya (2011) found that parents and adolescents are both becoming more open to communication about sensitive topics. The participants’ recognition of the importance of daughters having close relationships with mothers aligns with current research showing a trend of both groups striving to be closer to one another.

In the discussion of the School context, girls identified stressors pertaining to school, but did not identify any supports. In contrast, the teachers that participated in focus groups identified a number of supports, including teachers creating safe environments for students, teachers providing moral education and sex education, and teachers discussing problems with students and answering any questions that they may have. Noting that 14 out of the 37 adolescent girl participants were attending school at the time of the study, it is necessary to question why none of the girls identified any school-related supports. Additionally, while service providers listed sex education classes in schools as a source of information for girls, the girls did not list school classes or teachers as sources of information. The lack of discussion in the focus groups about school supports is likely partially attributed to the fact that 62% of the girls were not attending school at the time. This is even higher than the UNICEF (2013) finding that only 49% of girls in Mumbai are still attending school at 13. Considering the girls that were currently enrolled in school, but still did not discuss any supports, a 2011 study conducted in Mumbai found that 61.6% of students aged 15-17 had some exposure to sex education in school, but only 45% of the students were satisfied with the quality of education (Benzaken, Palep, & Gill, 2011). While the teachers participating in the study might feel comfortable providing their students with education and support, many teachers are
embarrassed and avoidant when it comes to providing sex education, leaving students without much adult support on “sensitive topics” (Jejeebhoy, 1998).

In the Community context, there was consensus among all groups on the immense problem of public sexual harassment or molestation known as eve-teasing, and some of the resulting consequences for girls including “not being able to go out if parents hear about them being teased in the streets”, “people in the community gossiping about girls”, and “taunts, rejection, and blame from neighbors if a girl is raped”. In agreement with other studies, girls identified reacting to community stressors with anger, fear, and embarrassment (Abraham, 2001; Sodhi & Verma, 2003). While, service providers and mothers identified NGOs, individual social workers, and Mahila Mandals as community supports for girls, the girls only discussed the support of neighbors. It is imperative for girls to gain more awareness of the supports available to them within their community.

**Integration Across Constructs**

*Figure 1.* Relationship amongst Sexual Health, Gender Roles, and Psychological Well-Being. This figure illustrates the interactional relationship between sexual health, gender roles, and psychological well-being.
For the purpose of analysis, sexual health, gender roles, and psychological well-being were separated into distinct categories; however, in reality, these constructs all overlap significantly. First, to understand the adolescent girls in the study, it is vital to realize the interactional relationship between sexual health and gender roles. In their relationship, gender roles dictated through social, cultural, and economic factors impact sexual health by influencing societal attitudes, behaviors, beliefs, practices, etc. In turn, the many facets of sexual health influence gender roles. In the analysis process, oftentimes, statements made by study participants were relevant for understanding both gender roles and sexual health. For example, in response to a question about talking to boys, a girl stated, “We talk to boys, but those girls roam around with the boys. If we’re just sitting and talking with boys, our parents don’t mind. But going out with them, our parents don’t like. We are expected to stay away from girls like that.” This statement is descriptive of both sexual health and gender roles. In addition to the overlap between these two categories, there exists great overlap between psychological well-being and sexual health and gender roles. Many of the stressors and supports identified, and even the way the girls react to stressors, are related to gender roles and/or sexual health. For example, numerous stressors identified by the girls, mothers, and service providers ranging from “eve-teasing” to “differential treatment from parents” were directly related to sexual health and gender roles in the society. Likewise, a number of identified supports such as “feeling happy when parents select an appropriate husband” are also related to sexual health and gender roles. Additionally, it is important to recognize that an individual’s psychological well-being, including the way she respond to stressors, may impact her sexual health and the way she responds to gender roles prescribed by society.
**Implications and Future Directions**

The overlap and interactional relationships found among sexual health, gender roles, and psychological well-being elucidate the importance of designing interventions that are multi-dimensional and use varying methods (Mensch, Grant, Sebastian, Hewett, & Huntington, 2004; Sodhi, et al., 2004). For interventions to be more successful an integrative approach that addresses multiple, specific issues in girls’ lives and helps to build knowledge and skills across areas is beneficial. Future research might examine common issues that girls grapple with more closely, such as eve-teasing. Based on research that examines such an issue in-depth, interventions should provide girls with concrete steps for addressing these issues in the moment and coping with them productively. Through use of a participatory approach that is guided by the needs and interests of adolescent participants, rather than providing a strictly manualized intervention, interventions have potential to have a more effective impact on girls within a specific community. Additionally, given the differences shown in knowledge and attitudes amongst younger and older adolescent girls, it is important for intervention designers and implementers to create or adapt interventions that are developmentally appropriate. The recommendations for effective interventions do not just apply to girls, but apply to mothers as well. While a number of mothers and daughters in the study do not communicate about sexual health topics, both groups understood the importance of doing so and confirmed a trend in research on parent-child communication of both parties being more receptive towards having these types of conversations with each other (Jejeebhoy & Santhaya, 2011; Guimamo et al., 2012). However, many mothers are uninformed about sexual health themselves and feel embarrassed to talk to daughters. There is a need for interventions designed for mothers (or both parents), that teach them
facts, but also provide them with skills for how to share information and have sensitive discussions with their daughters. If mothers are empowered to provide their children with information, there is potential for a great spread of knowledge. The study findings show that mothers and daughters do not have major discrepancies in attitudes and beliefs pertaining to sexual health and gender roles, and, in fact, could probably discuss these topics with more ease than assumed. In addition to interventions designed specifically to educate mothers, groups that mothers and daughters attend together, led by professionals, and designed to facilitate discussions around topics pertaining to sexual health, gender roles, and psychological well-being, have potential to be beneficial. Future studies might work towards developing and examining the effectiveness of interventions for mothers. Additionally, further research might examine communication on these topics between fathers and daughters, fathers and sons, and mothers and sons.

In order for any kind of services to be effective, first, it is imperative that the community is aware of their availability. The study findings revealed that many girls and mothers were unaware of or did not utilize the resources available to them through non-governmental organizations, community organizations, or individual service providers. Service providers listed sexual education classes as sources of information about sexual health, community resources such as counselling services as ways to prevent sexual risks that girls face, and NGOs and other organizations as supports within the community; in contrast, mothers and girls hardly acknowledged these. It is recommended that service providers and organizations work towards improving their visibility and ensuring that the community members that are most in need of their services are well-aware of how to access them. To be effective, service providers need to be as accessible as possible to the
populations they intend to serve. In addition, individual service providers, such as teachers or doctors, should both be prepared to discuss sensitive topics with girls and mothers themselves and to provide referrals for services pertaining to sexual health and psychological well-being. Future research might further examine the best ways for adolescent girls and mothers to become aware of the existence of services available to them and how to access these services with ease.

**Limitations**

Given the specific population and nature of analysis, the findings of this study may not easily be generalized to other populations. Additionally, the study participants may not entirely reflect the views of the community which they live in because they were willing to participate in this study. At the time of recruitment, the study participants were already receiving services at the community organization. Also, daughters that participated in the study had parents that were willing to consent to it. For these reasons, it is possible that the study participants represent a segment of the community that is less conservative than others. For more generalizable findings, future studies might recruit participants directly from the community.

While the multiple session focus groups with the adolescent females likely helped to establish trusting relationships and gain accurate information, it is possible that some girls felt uncomfortable discussing certain topics around peers. Follow-up individual interviews with girls that expressed interest might have been helpful for gaining more accurate information. Unlike the girls who attended six focus group sessions, mothers and services providers only attended one or two sessions. More sessions might have
improved the comfort level of these individuals and helped researchers to gain more accurate information.

The study analysis was conducted by American researchers that are not personally familiar with the culture of the study participants. While previous literature was reviewed closely, an etic-emic approach was used for the analysis; multiple coders worked together, and peer debriefing were used to ensure the quality of research, the researchers’ Western research lens undoubtedly influenced the findings on some levels. However, while the primary researcher for the paper was not personally familiar with the culture, the project leader from the United States who provided oversight for this research had extensive experience working in this community in Mumbai. To ensure valid research findings that are as unbiased as possible, the process of member checking is suggested for future research (Nastasi & Schensul, 2005).

**Conclusion**

The purpose of this research is to explore sexual health and how it relates to psychological well-being in order to increase understanding of how to create sexual health interventions for adolescent unmarried women in urban India. The study focuses on adolescent girls living in slums because they make up a significant segment of the population that is vulnerable to challenges that women face in India. In order to improve the gender inequality gap in India, it is imperative to empower adolescent girls. Using an etic-emic approach to qualitative analysis, the research aimed to understand psychological well-being, sexual health, and interpersonal relationships as defined by adolescent girls, mothers, and service providers. The author began the inductive-deductive process of analysis using key terms defining by Nastasi et al. (2013) in their
Narrative Intervention Model used to inform a sexual health intervention designed for married women in India. After initial coding, gender roles emerged as a major construct, in addition to psychological well-being and sexual health, while interpersonal relationships were better understood as a context within these major constructs. For the constructs of sexual health and gender roles, themes were generated by observing patterns that emerged from the rich data. Psychological well-being was analyzed through identification of stressors, reactions to stressors, and supports within various contexts. In the next step of analysis, consensus and unique perspectives among adolescent girls, mothers, and service providers were examined. Findings showed that while the three constructs were helpful for analysis, in reality, there is great overlap in sexual health, gender roles, and psychological well-being, and each is influenced by and impacts the other. While the findings were strongly influenced by culture and context, this finding is likely generalizable to most places in the global community where women continue to struggle with gender inequality issues. Additionally, the findings showed a trend of girls, mothers, and service providers understanding the importance of girls having access to sexual health information and openness to mothers potentially disseminating this information to their daughters. Literature around the world is showing that parents can influence adolescent sexual decisions and limit risk behaviors. Now, it is vital for researchers to design and assess interventions that empower parents to speak with their children about topics pertaining to sexual health and psychological well-being.
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Appendix A

Sample Focus Group Questions- Adolescent Girls

Session 1: Social Expectations (Participants discuss their perceptions of what is expected in their various roles as student, daughter, peer and citizen)

Facilitator: First, let’s discuss the roles of a daughter. What is normally expected of you as a daughter? What do your parents expect from you as a daughter?

Girl responses

F: Helping out with the household chores...

Girls responses

F: Are there other things that are expected of you? [pause] Alright, we’ll come back to you in a while.

Girl responses

F: When you talk about not ruining their name, how do you mean a girl can do it? What can a girl do to ruin her family’s name?

Session 2: Feelings/ Emotions (Participants discuss their different feelings, what these feelings mean, and how they express them)

Facilitator: Since we are starting late, let’s not start with a game today. If we find time in between, we’ll have a quick break and do an activity. Is that okay?

Let’s get down to our main topic of discussion for today. Today, we’re going to be talking about emotions. Do all of you understand the term emotions? For instance, we all feel happy or sad or angry...or when we are unsure about something, we feel confused, or we feel disgust and we stay away from it... So we’ll be talking about various emotions today. Before we start, let’s list down the various emotions that we experience. Okay?

Girl responses

F: By emotions here, we mean, what we feel – we feel happiness, happiness is an emotion, we feel sad sometimes, sadness is an emotion, when we feel angry, this anger is an emotion. So I want to hear from you the range of emotions you experience.
Session 3: Stressors and Supports (Participants generate ecomaps and stories with the purpose of understanding the people and events that serve as stressors and supports for the participants)

Facilitator: We’ll be doing some drawing in today’s session. This drawing is going to be about important people and events in your life. I have an example for you [showing sample ecomap]. This is me in the centre, this is my mother, and this here is my father, my brothers and sisters, my teacher... And then, I have drawn the weather as well. I am affected by the weather. When it’s bright and sunny, I feel happy and when it’s raining, it’s dark and gloomy and I can’t go out and I feel upset. This here is my best friend. And this is a wedding, like when there are weddings or other events we have to attend, of friends’ or relatives’. Then here, I’ve depicted violence in the community, like when you said they start fighting with swords.

These are all the people and events that are significant in my life. How they affect me, is what has been depicted by the lines connecting me to them. When I draw a straight, smooth line, it depicts that I share a ‘good’ relationship with that person or event – one that makes me feel happy and safe, and provides me support. And if I use crosses to connect myself with a person/event, it means I share a relationship that makes me feel sad or angry or scared or tense. And if it is a relationship that is both – at some times, it is supportive and makes me happy, but at other times it gives me stress, then I use a smooth line with crosses [giving examples of each of these connections in the sample ecomap].

[sensing apprehension in the group about the drawing] If you don’t want to draw these people and the events, you can just makes circles or squares for each of them and just label them. You do not have to do it just the way I have. Use your creativity, do it the way you like. Just remember to draw the lines the way I asked you to [asking the group to repeat the three different lines representing the three types of relationships].

Each one of us might have different relationships with each one of these events or people. For instance, one person might draw a straight line with an event like a wedding; they might say weddings are times when they get together with their friends and family and have a good time. Someone else might say they don’t like going to weddings because it’s so chaotic and noisy and they just don’t know what to do among so many people. They might draw crosses.

You may put in other events in your life, like coming here to the community center once a week; you can draw your own friends, etc.

Session 4: Relationships (Participants define different types of relationships and participate in a discussion about how they learned about relationships, sex, and sexual relationships)
Facilitators: Let’s all of us stand around in a circle. Each one of us will take turns to come into the centre of the circle and will stand with our eyes closed. The rest of us will, one-by-one, walk to this person and through a gesture show them that we care for them, or appreciate them or that we like them. After each member is done, we’ll open our eyes and share with the group how we felt as we were in the centre of the group, receiving all this love and affection.

F: Today, we are going to talk about relationships...What are the different kinds of relationships among girls your age? Can you name a few?

Girls discuss

F: Okay, by brother-sister relationships, you mean your friends who you consider as close as a brother or a sister?

Girls discuss

F: Let’s make smaller groups and I’ll give you some questions. You’ll discuss among yourselves and write them down and then we’ll discuss them in the bigger group. How many of you write Hindi?

After some discussion, the girls were divided into three groups of three girls each, with each group having at least one girl who knows to write.

F: We talked about three kinds of relationships – 1. friends - who you meet once in a while - like acquaintances - who you casually talk to; 2. good friends – who are like a brother or a sister to you; and 3. “boyfriend- girlfriend” relationships. Each group gets one of these relationships. [Lots of laughter in the group that gets the third type of relationship] We’ll be talking a little about romantic love in today’s session. About boy-girl relationships. We feel shy when we talk about it, don’t we? You might feel shy or hesitant. We know each other now over so many sessions and we’re all girls, right? So, don’t feel too shy. At the same time, if something makes you really uncomfortable, you’re free to not talk about it.

Session 5: Promoting Well-Being and Healthy Relationships (Participants discussed the differences between healthy and unhealthy relationships and how relationships affect personal well-being)

F: Last week we did a drawing of a garden and talked about how if a relationship were a garden what good things we would want in it. Some of you said trust is important, so is being able to share your feelings with them. These strengthen the relationship. When we were talking about things that might affect a relationship badly, you said they were lying and betrayal. And one of you said that what binds a relationship and gives it sanction, is when the family approves of the relationship. This, you said, was in the context of a marriage. Since we ran out of time that day, let’s talk about it a little more today. What are other things that you think are essential in a relationship. R: If there is trust in a relationship, it is good.

Girls discuss
F: It can be any kind of relationship between two people. We’ve spoken about many here, haven’t we? What are things, according to you, that should be there in a relationship, and what should not be?

Girls discuss

F: Mm hmm. What kind of goodness? Like R just said that a relationship should have trust. What do others feel about this?

Girls discuss

F: Could you give me examples where trust has strengthened a relationship you have with someone. And absence of trust has lead to problems in a relationship?

Session 6: Celebration of Young Women (Participants shared stories or depictions of who they are as women)

F: We’d discussed in the last session that today would be a festival...and what would we be celebrating?

Girls discuss

F: A lot of you have come all dressed up, how do you feel having dressed up?

Girls discuss

F: Could you describe “feeling good”?

Girls discuss

Co-F: How do you feel dressing up? As girls, do we like dressing up?

Girls discuss

F: When do you feel like that?

Girls discuss

Co-F: Isn’t this age like this? That when you feel good, you want to dress up and look good. And if you’re feeling sad then you don’t feel like doing anything.

Girls discuss

Co-F: Let’s talk about today. How do you feel today?

Girls discuss
Appendix B

Sample Focus Group Questions- Mothers and Service Providers

Mother Interviews

Facilitator: What are your expectations from a daughter? How would you describe a ‘good daughter’?

Co-F: Does she like doing the house-work?

F: what do children do that might make their parent’s lose their respect?

F: How would you describe a “good man” for your daughter to marry?

F: By what age do you think girls are capable of making a right choice for themselves?

Co-F: What are some of the risks associated with early marriage?

Service Providers Interviews

Interviewer: Based on your experience in the field, how do you see psychological well-being? How do you understand it?

I: You’re saying that mental illness is a concern that people do not take seriously or do not seek timely help for. At the same time, if we look at the other end of the continuum, if we look at well-being, being contented and without stress, how would you describe that? What factors influence it? What factors hinder it?

I: Now like you said that you sometimes see girls in class depressed and you talk to them, what do you think are common problems that girls face, that causes them to be depressed or..?

I: What aspects of the community influence girls and their well-being?

What do you feel, if a girl has started menstruating, is it unsafe for her to go to school, to go out of the home?
Biography

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