Diet quality and nutritional status of rural adolescent girl beneficiaries of ICDS in north India

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This study assessed the diet quality and nutritional status of beneficiaries of Adolescent Girl scheme, a national programme targeted towards their nutrition/health needs. 209 girls (aged 11-21 years) from six rural blocks - Delhi (Alipur, Kanjhawala and Mehrauli), Haryana (Madhosinghana), Rajasthan (Deeg) and Uttar Pradesh (Fatehpur Sikri) comprised the sample. Weight and height were measured and dietary intake data were gathered by one day 24 Hour Recall coupled with Food Frequency approach. Incidence of thinness (‘BMI for age’ <5th percentile) and stunting (‘height for age’ <3rd percentile) was 30.6% and 29.7%. The subjects followed a two-meal pattern and their diets were monotonous and cereal-based. 49.3% of them were found to have energy intake less than 75% of RDA while a substantial proportion of them had inadequate nutrient intake (NAR <0.66) with respect to most of the micronutrients especially iron (84.7%), folic acid (79.4%) and vitamin A (73.2%). The mean daily intake of milk and milk products, pulses, green leafy vegetables, other vegetables and fruits was grossly inadequate meeting only 47%, 36%, 26%, 34% and 3% of the suggested allowances; that of fats/oils and roots/tubers was somewhat adequate meeting 65% and 72% of the allowances while the intake of cereals and sugar was almost adequate revealing a deficit of only 7% and 3%. The study reveals not only a high incidence of under-nutrition but also an inadequate energy/micronutrient intake among the beneficiaries of Adolescent Girl scheme. Therefore, sustained efforts are needed to strengthen the scheme for improving its field-level implementation.

Key Words: dietary intake, diet quality, nutritional status, adolescent girl, rural communities, India

Introduction
World Health Organization (WHO) has defined ‘adolescence’ as the period between 10 and 19 years.¹ Adolescent girls, constituting nearly one tenth of Indian population, form a crucial segment of the society.² Their current nutritional status will decide the well being of the present as well as the future generations. Under-nutrition among these girls is associated with reduced lean body mass, lack of muscular strength and decreased work capacity.³ Moreover, under-fed girls are at risk of being stunted mothers who are likely to suffer obstetric complications and to deliver low birth weight babies.⁴ In the absence of effective nutritional interventions, the low birth weight girls become the next generation of stunted mothers, thus, perpetuating the vicious cycle of malnutrition. Nevertheless, second decade of life is the only time following infancy when the growth rate is very rapid and an individual acquires 35% of adult weight and 11-18% of adult height.⁵ In other words, adolescence provides a second opportunity for girls to attain ‘catch up growth’ and break the intergenerational cycle of malnutrition provided there is a significant increase in their nutrient intake.⁶ However, the state of rural adolescent girls in India is quite dismal. Despite the increased nutritional requirements during adolescence,⁷,⁸ their average nutrient intake is much below the recommended allowances.⁹,¹⁰ It has been estimated that 35% of rural girls, at 17 years of age, are underweight (<38 kg) and 23% are under height (<145 cm) which is recognized as obstetric risk factor.¹¹ Till late, the nutritional needs of these girls had been sadly ignored in our developmental programmes; the focus had rather been only on the preschool children and the mothers.¹² It was in the year 1991 that the Government of India took the initiative of including adolescent girls as the beneficiaries of Adolescent Girl (AG) scheme under the Integrated Child Development Services (ICDS) programme. One of the largest in the world in terms of its reach, ICDS scheme is a comprehensive programme for delivery of an integrated package of services to achieve the overall development of children.¹³ In spite of its shortcomings; it has been quite successful in achieving its objectives.¹⁴ The AG scheme, on the other hand, focuses on out-of-school adolescent girls (ICDS defines 11 to 18 years olds as adolescents) and aims to improve their nutritional status. Under the AG scheme, there are two sub schemes- AG I for 11 to 15 years old girls and AG II for all girls aged 11 to 18 years.¹⁵

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This scheme has now been revised as ‘Kishori Shakti Yojna’ and expanded to two thousand blocks covering 1.3 million girls. The revised scheme provides the states, union territories and districts an option to either continue with the earlier AG scheme or develop their own plan of action to meet their area-specific needs. The present study was undertaken in blocks where AG scheme was in implementation.

While ICDS scheme and its impact on child beneficiaries have been studied extensively, the studies on AG scheme are limited and there is paucity of data on the nutritional status of its beneficiaries. Therefore, this investigation was undertaken to assess the diet quality and nutritional status of adolescent girl beneficiaries of AG scheme.

**Materials and methods**

This cross-sectional study was carried out in the capital of India (Delhi) and its neighbouring states (Rajasthan, Uttar Pradesh and Haryana) where the scheme had been in operation before 1995-96. From Delhi, all the three blocks namely, Alipur, Kanjhawala and Mehrauli where the scheme had been in implementation were included in the study. In case of other states, one block per state i.e. Deeg (Rajasthan), Fatehpur Sikri (Uttar Pradesh) and Madhosinghana (Haryana) were selected. The study area, thus, covered six blocks in four states.

**Sampling**

Purposive sampling was used to identify the blocks; the criteria of selection being the existence of AG scheme for at least five years at the time of data collection and the convenience of visiting the area. On the other hand, random sampling techniques were employed to select the beneficiaries from the identified blocks. Using random sampling, two circle areas per block were selected from which nine Anganwadi Centres (the focal point for delivery of ICDS services) were identified. From each of the identified Anganwadi Centres, 2 or 3 beneficiaries of AG I were selected and in case of AG II, 16 to 20 girls per block were included in the study giving preference to the target beneficiaries (out-of-school adolescent girls belonging to low socio-economic group). The sample comprised of 209 adolescent girl beneficiaries of whom 147 were from AG I and 62 from AG II (while AG I was operational all the six blocks under study, AG II was operating only in Alipur, Kanjhawala, Fatehpur Sikri and Madhosinghana).

Prior to data collection, necessary permission was sought from the Department of Social Welfare in the respective states and the informed oral consent of adolescent girl respondents as well as that of their parents was obtained and their anonymity has been preserved.

**Assessment of dietary intake and diet quality**

The data on dietary intake of the subjects were gathered by one day 24 Hour Recall; Food Frequency Questionnaire was employed for validating the dietary data. Mean daily intake of the subjects was computed and compared with the suggested amounts of various food groups in a balanced diet for Indian girls aged 13 to 15 years. The nutrient intake was calculated using the computerized programme based on food composition tables. Thereafter, mean nutrient intake was assessed and compared with the recommended dietary allowances (RDA) for the respective age groups (10-12 years, 13-15 years, 16-18 years and above 18 years).

In order to assess the diet quality, the adequacy of nutrient intake by each subject was computed in terms of Nutrient Adequacy Ratio (NAR) using

\[
NAR = \frac{\text{Subject’s nutrient intake of a day}}{\text{RDA of the respective nutrient}}
\]

Thereafter, the subjects were categorized as those having an adequate (≥1.00), fairly adequate (0.66−<1.00) or inadequate (<0.66) NAR for various nutrients. Since NAR is not a good indicator for assessing the adequacy or inadequacy of energy intake therefore, energy intake data were expressed as percent of RDA for the particular age group. In the present study, 25% below the RDA has been employed as the cut-off for estimating energy inadequacy while 25% above the RDA has been used to identify subjects with excess energy intake.

**Weight/height measurement and BMI**

Height (to the nearest 0.1 cm) and weight (to the nearest 0.5 kg) were measured using Libra scale and the anthropometric rod. Body Mass Index (BMI) was subsequently computed by dividing the weight in kilograms by the square of height in metres (kg/m²). Mean weight, height and BMI were calculated for different age categories. The anthropometric nutritional status was assessed by ‘BMI for age’ and ‘height for age’ as per National Centre for Health Statistics (NCHS)/WHO standards. The subjects with ‘BMI for age’ less than 5th percentile were categorized as thin and those with ‘BMI for age’ ≥ 5th percentile were considered to be at risk of being overweight while subjects having ‘BMI for age’ between 5th and 85th percentile were categorized as normal. The subjects with ‘height for age’ less than 3rd percentile were considered to be stunted.

**Statistical analysis**

The data were analysed using Statistical Package of Social Sciences (SPSS, version 9). Statistical measures such as frequency, percentage, mean, range, standard deviation and t test were employed to describe and analyse the data.

**Results**

**Profile of the subjects**

Mean age of the subjects was 13.6 years (ranging from 11 to 21 years); the proportion of adolescent beneficiaries (11-18 years) being 95.2%. Younger beneficiaries (11-15 years) constituted 78.5% while 16-18 year old formed 16.7 % of the sample; only 4.8% were aged above 18 years. Of them, 19% were illiterate and 29% school drop-out; only four were married but none had attained motherhood. They were predominantly Hindu (97%) and nearly 60% of them belonged to the scheduled castes, scheduled tribes or other backward classes. 55% reportedly had their family income less than 2000 Rupees per month (45 Rupees = 1 US Dollar) and thus belonged to low socio-economic group as per income categorization.
Nearly half (54%) of the subjects were from the families engaged in agriculture, agricultural labour or non-agricultural labour (Table 1).

**Food intake**

Data indicate that most of the subjects followed a two-meal pattern; their diets were vegetarian, cereal based and monotonous. The mean daily intake of cereals, pulses, milk and milk products, sugar and fats/oils was 250 g, 22 g, 234 g, 20 g and 16 g while that of roots/tubers, green leafy vegetables, other vegetables and fruits was 72 g, 26 g, 34 g and 3 g respectively (Fig 1). Data reveal that the mean daily intake of milk and milk products, pulses, green leafy vegetables, other vegetables and fruits was grossly inadequate meeting only 47%, 36%, 26%, 34% and 3% of the suggested amounts; that of fats/oils and roots/tubers was somewhat adequate meeting 65% and 72% of the allowances while the intake of cereals and sugar was almost adequate revealing a deficit of only 7% and 3%.

**Energy/nutrient intake and diet quality**

Table 2 shows the mean nutrient intake of the subjects by age. In case of 11-18 year old subjects, the mean daily intake of energy was 68.0% to 75.3% of the RDA and that of protein was between 68.3% and 79.8%. Mineral and vitamin intake data indicate that with the exception of calcium and thiamin, the intake of all other nutrients was below the recommended allowances especially, vitamin A, folic acid and iron where the intake was only half to two-third of the RDA. The energy and nutrient gap (particularly for protein, riboflavin and niacin) was found to be more pronounced in case of the younger subjects (10-12 and 13-15 years old) than those aged 16 years and above. However, in case of iron and folic acid, the diets of older subjects were rather deficient.

Energy intake data, expressed as percent of RDA for the particular age group, are presented in Table 3. Data indicate that nearly half of the subjects (52.2%) had inadequate energy intake (<75% of RDA) while only one subject (0.5%) had excessive energy intake (>125% of RDA). Block-wise data reveal that three-fourth of the subjects from Deeg (72.8%) and Mehrauli (73.4%); about half from Alipur (55.5%) and Fatehpur Sikri (52.8%) and less than two-fifth from Kanjhawala (42.2%) and Madhosinghana (30.6%) had inadequate energy intake.

Table 4 reveals nutrient intake data expressed as nutrient adequacy ratio (NAR). Findings indicate that though a large majority of the subjects had adequate or fairly adequate NAR (≥0.66) with respect to protein (83.7%), calcium (94.7%), thiamin (98.1%), riboflavin (60.8%), niacin (87.1%) and vitamin C (56.9%); only a small number had adequate/fairly adequate intake with respect to vitamin A (26.8%), folic acid (15.8%) and iron (15.3%).

**Nutritional status**

The mean weight, height and BMI by age of the subjects are presented in Table 5. Data indicate that the mean weight in all the age groups was below the NCHS stan-
Table 2. Mean nutrient intake of the subjects by age (N=209)

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>10-12 years (n=88)</th>
<th>13-15 years (n=76)</th>
<th>16-18 years (n=35)</th>
<th>&gt; 18 years (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RDA†</td>
<td>Mean ± SD‡</td>
<td>% adequacy</td>
<td>RDA</td>
</tr>
<tr>
<td>Energy (kcal)</td>
<td>1970 (587 – 3129)</td>
<td>1340 ± 350 (9.8 – 67.2)</td>
<td>68.0</td>
<td>2060 (252 – 2139)</td>
</tr>
<tr>
<td>Protein (g)</td>
<td>57 (10.1 – 104.0)</td>
<td>41.3 ± 12.3 (9.8 – 67.2)</td>
<td>72.5</td>
<td>65 (9.8 – 67.2)</td>
</tr>
<tr>
<td>Calcium (mg)</td>
<td>600 (101 – 1656)</td>
<td>563 ± 278 (227 – 1426)</td>
<td>93.8</td>
<td>600 (227 – 1426)</td>
</tr>
<tr>
<td>Iron (mg)</td>
<td>19 (1.6 – 40.0)</td>
<td>13.5 ± 5.4 (1.6 – 34.4)</td>
<td>71.0</td>
<td>28 (1.6 – 34.4)</td>
</tr>
<tr>
<td>Vitamin A (µg RE)</td>
<td>600 (32 – 2626)</td>
<td>399 ± 549 (59 – 2017)</td>
<td>66.5</td>
<td>600 (59 – 2017)</td>
</tr>
<tr>
<td>Thiamin (mg)</td>
<td>1.0 (0.32 – 3.2)</td>
<td>1.33 ± 0.39 (0.18 – 2.28)</td>
<td>133.0</td>
<td>1.0 (0.18 – 2.28)</td>
</tr>
<tr>
<td>Riboflavin (mg)</td>
<td>1.2 (0.20 – 1.7)</td>
<td>0.74 ± 0.25 (0.29 – 1.29)</td>
<td>61.7</td>
<td>1.2 (0.29 – 1.29)</td>
</tr>
<tr>
<td>Niacin (mg)</td>
<td>13 (1.2 – 26.0)</td>
<td>10.7 ± 3.3 (1.3 – 20.2)</td>
<td>82.3</td>
<td>14 (1.3 – 20.2)</td>
</tr>
<tr>
<td>Folic acid (µg)</td>
<td>70 (18.0 – 140.4)</td>
<td>49.5 ± 23.0 (16.2 – 125.3)</td>
<td>70.7</td>
<td>100 (16.2 – 125.3)</td>
</tr>
<tr>
<td>Vitamin C (mg)</td>
<td>40 (1.5 – 133.3)</td>
<td>37.0 ± 26.5 (3.4 – 108.4)</td>
<td>92.5</td>
<td>40 (3.4 – 108.4)</td>
</tr>
</tbody>
</table>

† RDA – Recommended Dietary Allowances; ‡ SD – Standard Deviation. Figures in parenthesis indicate range

Table 3. Block-wise data on the adequacy of energy intake (N=209)

<table>
<thead>
<tr>
<th>Block</th>
<th>N</th>
<th>Distribution of the subjects by energy intake (% RDA†)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>&lt;50</td>
<td>50–60</td>
</tr>
<tr>
<td>Alipur</td>
<td>40 (100)</td>
<td>5 (12.5)</td>
</tr>
<tr>
<td>Kanjhawala</td>
<td>45 (100)</td>
<td>3 (6.7)</td>
</tr>
<tr>
<td>Mehrauli</td>
<td>30 (100)</td>
<td>2 (6.7)</td>
</tr>
<tr>
<td>Deeg</td>
<td>22 (100)</td>
<td>4 (18.3)</td>
</tr>
<tr>
<td>Madhosinghana</td>
<td>36 (100)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>Fatehpur Sikri</td>
<td>36 (100)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Grand total</td>
<td>209 (100)</td>
<td>17 (8.1)</td>
</tr>
</tbody>
</table>

† RDA – Recommended Dietary Allowances. Figures in parenthesis indicate percentages
standard but the subjects aged 13-14 years were significantly (\( p < 0.01 \)) heavier than the preceding age group. The deficit at eleven years of age was below the NCHS standard but the subjects aged 13-14 years as well as 14-15 years were significantly (\( p < 0.01 \)) taller than the preceding age groups. Overall, 67.5% of the subjects were found to have ‘weight for age’ less than the 5th percentile. The mean height in the age groups of 11-14 years was below the NCHS standard but the subjects aged 13-14 years as well as 14-15 years were significantly (\( p < 0.01 \)) taller than the preceding age groups. While the mean BMI of the subjects in all the age groups was higher than the 5th percentile of NCHS standard, 44% of 13-14 year olds and 53% of 14-15 year olds were found to be thin (‘BMI for age’ \( \geq 85\% \) percentile). On the whole, 30.6% of subjects were thin (‘BMI for age’ \( \leq 85\% \) percentile) and 68.9% had normal weight (BMI for age’ 5th–< 85th percentile).

Table 6 presents block-wise data on prevalence of stunting and thinness and it reveals substantial differences in the nutritional status of the subjects from various blocks under study. In contrast to Deeg, Fatehpur Sikri and Mehrauli where the incidence of thinness (63.6%, 38.9% and 33.3%) as well as stunting (40.9%, 55.6% and 30.0%) was quite high, a lower proportion of subjects from Alipur, Kanjhawala and Madhosinghana were found to be thin (27.5%, 15.6% and 22.2%) and stunted (20.0%, 28.9% and 13.9%).

Nearly half (42.6%) of the subjects had attained puberty; the reported mean age at menarche was 13.8 years; though block-wise differences existed. The beneficiaries from Delhi blocks were found to have a lower mean age at menarche (13.3 to 13.9 years) as compared to those from the rural blocks of Madhosinghana, or Fatehpur Sikri (14.0 to 14.6 years). Among the subjects from Deeg, only one had entered puberty. Data further reveal that of the post-menarche girls only 21% had prior knowledge regarding menarche and majority felt scared at its onset (Table 7).

Discussion

The aim of this study was to assess the diet quality and nutritional status of the beneficiaries of Adolescent Girl scheme. The findings indicate that dietary intake met only two-third to three-fourth of the energy and protein requirements. These findings are consistent with the results of a study conducted among poor adolescent girls in rural Rajasthan where the energy and protein intake was 64-74% and 65-77% of the recommended allowances respectively. However, a lower caloric intake (55-64% of the RDA) has been reported by another study carried out on young girls belonging to a low socio-economic group in Delhi.

The food intake, in the present study, was low particularly with respect to pulses, milk and milk products. This could be the possible reason for the energy and protein deficit in the diets. Moreover, the diets were cereal based and vegetarian so, the quality of protein can be expected to be rather low. The intake of fruits and vegetables particularly, that of green leafy vegetables was also found to be grossly inadequate which could possibly have led to the deficient micronutrient intake. Overall, the diets were cereal based as well as vegetarian and lacked in promoters of iron; thus, the bio-availability of iron was probably quite low. It is a well known fact that during adolescence, the iron requirements increase due to the changes in body mass,
### Table 5. Age-wise data on mean weight, height, BMI along with prevalence of stunting and thinness (N=209)

<table>
<thead>
<tr>
<th>Age (yrs)</th>
<th>N</th>
<th>Weight for age (kg)</th>
<th>'Weight for age' &lt; 5th percentile n (%)</th>
<th>Height for age (cm)</th>
<th>'Height for age' &lt; 3rd percentile n (%)</th>
<th>Stunted BMI † for age (kg/m²)</th>
<th>Thin BMI † for age &lt; 5th percentile n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-&lt;12</td>
<td>34</td>
<td>30.5</td>
<td>28.7 ± 5.2 (19.0 – 42.5)</td>
<td>13.4 ± 6.9 (113.5 – 147.5)</td>
<td>10 (29.4)</td>
<td>15.19 ± 1.58 (11.99 – 19.53)</td>
<td>7 (20.6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12-&lt;13</td>
<td>34.1</td>
<td>33 (61.1)</td>
<td>144.2</td>
<td>14.49 ± 1.98 (12.07 – 21.28)</td>
<td>12 (22.2)</td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>37.8</td>
<td>34.8** ± 6.3 (24.5 – 49.5)</td>
<td>146.0** ± 7.1 (131.2 – 159.3)</td>
<td>12 (35.3)</td>
<td>16.69 ± 1.81 (13.48 – 21.21)</td>
<td>15 (44.1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13-&lt;14</td>
<td>41.0</td>
<td>37.0 ± 5.4 (25.5 – 47.0)</td>
<td>149.0</td>
<td>151.8** ± 5.5 (140.9 – 158.9)</td>
<td>15.98 ± 1.70 (12.84 – 16.65)</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>41.0</td>
<td>42.4* ± 6.7 (34.0 – 63.0)</td>
<td>14.62 ± 4.7 (144.2 – 161.2)</td>
<td>9 (36.0)</td>
<td>16.41 ± 2.63 (13.92 – 21.39)</td>
<td>9 (36.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15-&lt;16</td>
<td>43.4</td>
<td>42.5 ± 4.0 (37.0 – 55.0)</td>
<td>151.0</td>
<td>153.2 ± 6.1 (140.2 – 164.0)</td>
<td>18.16 ± 1.76 (15.24 – 23.34)</td>
</tr>
<tr>
<td></td>
<td>25</td>
<td>45.3</td>
<td>43.1 ± 5.2 (36.5 – 54.0)</td>
<td>142.4 ± 6.4 (144.2 – 164.3)</td>
<td>2 (12.5)</td>
<td>18.51 ± 2.04 (15.25 – 21.71)</td>
<td>2 (12.5)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16-&lt;17</td>
<td>45.3</td>
<td>42.0 ± 5.7 (32.0 – 55.0)</td>
<td>152.5</td>
<td>152.0 ± 4.4 (143.5 – 160.5)</td>
<td>18.11 ± 2.15 (15.23 – 22.46)</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>45.3</td>
<td>57.8 ± 8.3 (19.0 – 63.0)</td>
<td>146.7 ± 9.7 (113.5 – 164.3)</td>
<td>62 (29.7)</td>
<td>16.50 ± 2.34 (11.99 – 26.39)</td>
<td>64 (30.6)</td>
</tr>
</tbody>
</table>

† BMI – Body Mass Index; ‡ NCHS – National Center for Health Statistics; § figures in parenthesis indicate range; ¶ figures in parenthesis indicate percentages. *p<0.05; **p<0.01 (comparison with the preceding age group)

### Table 6. Block-wise data on the incidence of thinness and stunting (N=209)

<table>
<thead>
<tr>
<th>Blocks</th>
<th>N</th>
<th>Thin ('BMI † for age' &lt; 5th percentile)</th>
<th>Stunted ('height for age' &lt; 3rd percentile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alipur</td>
<td>40</td>
<td>11 (27.5)</td>
<td>8 (20.0)</td>
</tr>
<tr>
<td>Kanjhawala</td>
<td>45</td>
<td>7 (15.6)</td>
<td>13 (28.9)</td>
</tr>
<tr>
<td>Mehrauli</td>
<td>30</td>
<td>10 (33.3)</td>
<td>9 (30.0)</td>
</tr>
<tr>
<td>Deeg</td>
<td>22</td>
<td>14 (63.6)</td>
<td>9 (40.9)</td>
</tr>
<tr>
<td>Madhosinghna</td>
<td>36</td>
<td>8 (22.2)</td>
<td>3 (13.9)</td>
</tr>
<tr>
<td>Fatehpur Sikri</td>
<td>36</td>
<td>14 (38.9)</td>
<td>20 (55.6)</td>
</tr>
<tr>
<td>Total</td>
<td>209</td>
<td>64 (30.6)</td>
<td>62 (29.7)</td>
</tr>
</tbody>
</table>

† BMI – Body Mass Index. Figures in parenthesis indicate percentages
Implementation for the girls from the adolescent period it-
of these findings, it has been proposed to start iron sup-
demands.33-35 There is also evidence to show that iron and
self to build their stores for present as well as the future
anaemia in women at the time of conception. In the light
reason for this inefficacy could be the prior prevalence of
absence of adequate dietary intake of iron, the girls be-
zymes; the onset of menstruation one year after the peak
expanded blood volume and increased respiratory en-
ances carried on adolescent girls in different parts of In-
ities; the onset of menstruation one year after the peak
mean weight and height of the subjects aged 13-14 years
blocks in our study, may be attributed to socio-
To combat this public health problem of iron defi-
weight than those living in households with higher socio-
living in poorer households are more likely to be under-
weight than those living in households with higher socio-
comparable to other micro-level stud-
Figures in parenthesis indicate the percentages. Only one subject from Deeg had entered puberty
Table 7. Mean age at menarche and related information (N=209)

<table>
<thead>
<tr>
<th>Blocks</th>
<th>N</th>
<th>Pre-pubertal</th>
<th>Post-pubertal</th>
<th>Mean age at menarche</th>
<th>Prior knowledge of menarche</th>
<th>Scared at menarche</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Alipur</td>
<td>40</td>
<td>25 (62.5)</td>
<td>15 (37.5)</td>
<td>13.27</td>
<td>0 (0)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Kanjhawala</td>
<td>45</td>
<td>21 (46.7)</td>
<td>24 (53.3)</td>
<td>13.54</td>
<td>5 (20.8)</td>
<td>19 (79.2)</td>
</tr>
<tr>
<td>Mehrauli</td>
<td>30</td>
<td>19 (63.3)</td>
<td>11 (36.7)</td>
<td>13.91</td>
<td>4 (36.4)</td>
<td>7 (63.6)</td>
</tr>
<tr>
<td>Deeg</td>
<td>22</td>
<td>21 (95.5)</td>
<td>1 (4.5)</td>
<td>14.00</td>
<td>1 (100)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Madhosinghiana</td>
<td>36</td>
<td>9 (25.0)</td>
<td>27 (75.0)</td>
<td>14.00</td>
<td>5 (18.5)</td>
<td>22 (81.5)</td>
</tr>
<tr>
<td>Fatehpur Sikri</td>
<td>36</td>
<td>25 (69.4)</td>
<td>11 (30.6)</td>
<td>14.61</td>
<td>4 (36.4)</td>
<td>7 (63.6)</td>
</tr>
<tr>
<td>Total</td>
<td>209</td>
<td>120 (57.4)</td>
<td>89 (42.6)</td>
<td>13.82</td>
<td>19 (21.3)</td>
<td>70 (78.7)</td>
</tr>
</tbody>
</table>

expanding blood volume and increased respiratory en-
zymes; the onset of menstruation one year after the peak
growth further increases these requirements. But in the
absence of adequate dietary intake of iron, the girls be-
come highly prone to anaemia. In India, the prevalence of
anaemia among adolescent girls has been reported to be
75-90 %.30, 31

To combat this public health problem of iron defi-
cency anaemia, Government of India has launched Na-
tional Nutritional Anaemia Control Programme which
provides iron and folic acid tablets to girls and women
only after they conceive and very often when they reach
the third trimester of pregnancy. This strategy has been
found ineffective in a micro-level study and a possible
reason for this inefficacy could be the prior prevalence of
anaemia in women at the time of conception. In the light
of these findings, it has been proposed to start iron sup-
plementation for the girls from the adolescent period it-
tself to build their stores for present as well as the future
demands.33-35 There is also evidence to show that iron and
folic acid supplementation enhances growth of 10-14 year
old girls in India.36

Nearly 31% of the subjects, in the present study, were
found to be thin and an almost similar proportion stunted.
These findings are comparable to other micro-level stud-
ies conducted on adolescent girls in different parts of In-
dia.37,38 Stunting has important implications for adoles-
cent reproductive health of girls as it can lead to ob-
structed labour during child birth due to a small birth ca-
nal. On the other hand, thinness can result in poor preg-
nancy outcome especially in terms of low birth weight and
increased risk of infant mortality.40 The poor nutri-
tional status, in the present study, could be attributed to
the inadequate food intake as majority of the subjects
belonged to poor families. Lack of access to sufficient
food and inequities in food allocation have been reported
as the key causes of malnutrition in poor households of
India.41 Moreover, there is evidence to prove that subjects
living in poorer households are more likely to be under-
weight than those living in households with higher socio-

economic status.42

Though the study presents a grim picture of the nutri-
tional status of rural poor adolescent girls yet, adoles-
cence provides a unique opportunity to help these girls to
attain their full growth potential. National Nutrition
Monitoring Bureau (NNMB) surveys have indicated that
girls from poor communities gain over 5 centimetre in
height and 6.8 kilogram in weight between the ages of 14
and 18 years.43 Further, a follow up study of rural girls in
Andhra Pradesh aged, 5 to 18 years, has shown that de-
spite continuing poverty, girls who arrive their fifth year
with considerable height deficit register impressive in-
crements in height by the time they are 18 year old.44
This higher rate alone may not be enough to complete the
‘catch-up growth’; nevertheless, additional growth may
be achieved by nutritional interventions during this period.
Therefore, nutritional supplements must be provided to
undernourished girls prior to the onset of menarche so
that they are able to achieve their full growth potential.
In view of the dual burden of malnutrition facing the
country Government of India, in its Tenth Plan, has em-
phasized on screening the adolescent girls for malnutri-
tion (under nutrition or over nutrition) and tackling their
nutritional problems through targeted interventions.45

Age at menarche is also an indicator of nutrition and
health status of the girls as poor nutritional status delays
menarche.46 In the present study, the significantly higher
mean weight and height of the subjects aged 13-14 years
(as compared to those aged 12-13 years) may be indicat-
ing a delayed menarche. It is a known fact that menarche
follows nearly 1.3 years after an increase in height and
weight velocity.47 However, as compared to other blocks
the lower age at menarche, reported by the subjects from
Delhi blocks in our study, may be attributed to socio-
economic factors, dietary intake as well as the exposure
to urban life and television. Similar findings have been

Figures in parenthesis indicate the percentages. Only one subject from Deeg had entered puberty.
reported by other studies where the mean age at menarche was 14 years for rural and 13 years for urban girls/women.\(^{48, 49}\) In the present study, the awareness regarding menstruation was reported to be poor; these findings are consistent with those of a study covering 400 rural girls (aged 10-16 years) in north India.\(^{50}\)

In conclusion, the present study reveals not only a high incidence of under nutrition but also the dietary inadequacy of the subjects particularly in respect of energy, protein and micronutrient intake. If this is the scenario among the ICDS adolescent girl beneficiaries who had been receiving nutritional supplement for almost a period of six months, the status of non-beneficiaries can be expected to be worse. During the course of study, a process evaluation of the scheme was also carried out which revealed that its implementation was rather weak. The functionaries had neither received proper training and nor were they fully aware of the services to be provided. The delivery of services was partial and through inadequate activities.

Therefore, need of the hour is to plan and implement innovative developmental programmes to address the nutrition and health needs of rural adolescent girls in a comprehensive manner. These programmes should include provision of food supplements (particularly for 11 to 14 year olds for ‘catch up growth’), iron-folate as well as nutrition and health education. Some of these interventions, though proposed in the existing Adolescent Girl scheme (now revised as ‘Kishori Shakti Yojna’) are not being implemented adequately. Hence, continuous efforts are needed at the national level to strengthen the scheme by greater involvement of the beneficiaries; capacity building of its functionaries and flexibility in the services, activities and utilization of funds so as to improve its field level implementation. Active participation of the adolescent girl beneficiaries must be sought by engaging them in food production through the establishment of nutrition gardens which may help in increasing the availability of food, green leafy vegetables in particular. They should also be involved in the preparation of low-cost nutritious food using the locally available ingredients and also be encouraged to respect and retain the traditional food knowledge and sustainable food systems. Such a holistic approach shall not only address the nutritional needs of these girls (the would-be-mothers) but shall go a long way in breaking the intergenerational cycle of malnutrition.

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