

CHAPTER 8

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Discussion and Conclusion

World Health Organization uses to define “adolescence” as 10-19 years old, “youth” as 15-24 years old, and “young people” as 10-24 years old (United Nations, 1999). Adolescence, the second decade of life is a period when young people acquire not only new capacities for progress, but also a time during which rapid physical growth, physiological and psychosocial changes, the development of secondary sexual characteristics and reproductive maturation occur. Nevertheless, adolescence should be considered as a phase rather than a fixed age group, with physical, psychological, social and cultural dimensions. Adolescence is thus a transition phase through which a child becomes an adult.

It is estimated that there are almost 200 million adolescents in India (ages 15-24). (Registrar General and Census Commissioner, 1991). However, despite adolescents being a huge segment of the population, policies and programmes in India have focused very little on the adolescent group.

In a woman’s lifetime her health status during any phase of life impinges upon the next phase. The life cycle approach includes the health of the girl child right from birth, adolescent group through the reproductive years and into menopause and

geriatric health. Thus health is from “womb to the tomb”. Adolescents are the period of pre-womanhood. If their general health, reproductive health and the cultural and societal attitudes are taken care of, there will be less effort needed at the stage of womanhood. Therefore, one should not separate adolescents’ health from the overall development of a girl to the womanhood.

The International Conference on Population and Development (ICPD), 1994 marked the start of a global rhetoric on reproductive well-being. In India, in 1995, the ministry of health and Family Welfare (MoHFW) introduced the Reproductive and Child Health Programme (RCH) as part of a paradigmatic shift in its on going Family Welfare programmes (Rachel, 2002). Reproductive and Child Health Programme draws the same principles of the ICPD. RCH Programme has two separate packages, the Comprehensive (expanded package) and the Essential package. But neither the Comprehensive package nor the Essential package considers the general health of the adolescents. Their emphasis is on reproductive health services, prevention and treatment of reproductive tract infections and sexually transmitted infections, health sexuality and gender information, education and counseling. Thus RCH Programme does not seem to recognise the general health of the adolescents where reproductive health is a part of the general health and the social and cultural factors that are associated with it. Review of literature has revealed different issues that the reproductive health, reproductive rights and freedom are linked to empowerment and socio-economic status. Thus, the reproductive health concept goes beyond the narrow confines of family planning to encompass all aspects of general health and reproductive health needs during the various stages of life cycle. As a result, the general health and reproductive health of the adolescents should come within the

gamut of the RCH Programme. According to Jejeebhoy (2000), adolescents in Indian society tend to be extremely poorly informed regarding their own sexuality and physical well-being, their health and physiological changes. Adolescents' ignorance about sexual and reproductive behaviour is compounded by reluctance among parents, teachers and health providers to impart relevant information. As a result, adolescents tend to get their information from peers and the media. Often the adolescents have incomplete knowledge and information and are subject to confusion. Treatment seeking also tends to be delayed, presumably out of ignorance and embarrassment. Jejeebhoy (1996) has also pointed, though a formal Reproductive and Child Health Programme and an education programme exist in theory in schools, colleges and universities, in reality there is a lack of responsibility among officials to implement the programme in giving education and information to young people. NGOs have tried to fill this gap through education of both, the school going adolescent students and those who have dropped out and those who had not attended any schools. But, NGOs' efforts are hardly adequate considering the large number of adolescents, the cultural diversity of the country, and the magnitude of information needs. As our review of literature has not revealed the existence of such services in practical for adolescents in India, in this situation in Manipur, the health care providers rarely touches upon the needs of adolescent girls in providing the services. Thus in the present study, the researcher has tried to examine the gaps between the RCH Programme and the health care needs of adolescent girls in two Districts of Manipur. The study has explored the issues to provide not only the reproductive and sexual health but also the whole other factors that are associated with adolescents health that have not been seen by policy makers and programmes in the study area. The study has

also made an effort to understand the complexity of adolescent girls' health problems and their association with social, cultural and economic factors.

An exploratory research design has been used in the present study. The study is carried out in five phases. In the first phase, secondary data pertaining social, cultural, economical and political factors that influenced the concept of reproductive rights and reproductive freedoms in Western and South East Asian countries and its impact in paradigm shift in the health services by bringing Reproductive and Child Health Programme in India after independence were gathered through literature review. In the second phase, pilot study was done where addresses of schools, hospitals, and NGOs for the study of two districts in Manipur were collected based on certain criteria by using purposive sampling technique and listed accordingly. District wise distribution of schools, hospitals and NGOs were analyzed from the list. In the third phase, focus group discussion and interview were conducted for 128 girls with the help of interview schedule. Likewise 64 couple parents were also interviewed by using interview schedule to collect the necessary data in order to analyze the factors that influenced the adolescent girls, their health seeking behaviors and distribution of health services towards the girls. In the fourth phase, 32 teachers, 12 doctors, 12 nurses, 8 health workers, 12 NGO workers were selected purposively as key informants and they were interviewed accordingly to gather the information on the curriculum: services available in the schools, hospitals, and NGOs: types of training programmes undertaken to deal with the health problems of adolescent groups: etc. In the last phase i.e. fifth phase, from both two districts, 2 district hospitals, 4 CHCs, 2 PHCs and 4 NGOs (2 MNGOs and 2 FNGOs) were selected purposively based on certain criteria and studied in details. Efforts were made to explore the historical

background, administrative set-up, present activities, nature of programme available, staff members and the influence of socio-political factors on providing the health care service to adolescent girls.

In the present study, data for fulfilling all the objectives were discussed both qualitatively and quantitatively. Some of the important findings of the study have been discussed below. The discussions have taken place at three levels.

8.1 GLOBAL LEVEL

The global society at large that provides a background of reproductive health elevated the issues suddenly at center stage by International agencies when the International Conference on Population and Development (ICPD) Programme of Action focused centrally on the issues of reproductive health and population. The ICPD held in Cairo, Egypt from 5-13 September 1994 was organized principally by the United Nations Population Fund (UNFPA) and the Population Division of the UN department for Economic and Social Information and Policy Analysis. Chapter 2 while articulated the relevant literature, has discussed that ICPD talked about gender equality and equity and the empowerment of women, elimination of all kinds of violence against women and the need to deal with adolescents sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion (as defined by WHO), STDs and HIV/AIDS through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counseling. However the final emphasis was only on the cornerstone of population and development by control over women's fertility.

8.2 NATIONAL LEVEL

India is the first country that adopted Family Planning Programme. Since the First Five-Year plan, the percentage of total outlay on family planning has increased from 0.01 to 1.76 in the Ninth Five-Year Plan. The Reproductive and Child Health Programme came to India in 1997. Again Reproductive and Child Health Programme has clubbed with the National Rural Health Mission in 2005. The National Rural Health Mission (NRHM) is being operationalised from April 2005 throughout the country, with special focus on 18 states which includes 8 Empowered Action Group (EAG) states, 8 North east states, Himachal Pradesh and Jammu & Kashmir, where the infrastructure is weak. There are at present two separate packages of reproductive health services in the RCH Programme; Comprehensive (expanded package) and Essential packages. In both the packages, RCH Programme emphasizes only on reproductive health services including abortion, prevention and treatment of reproductive tract infections and sexually transmitted infections, health sexuality and gender information, education and counseling. As a result, adolescent health is broken into fractions since the RCH Programme does not tackle reproductive health as a part of general health.

8.3 LOCAL LEVEL

8.3 (i) Health Programme in Manipur

Manipur represents 0.23 percent of the total population of India. The sex ratio of Manipur is 978 females per 1000 males. For the last two decades, the state is facing socio-political and economic instability. Thus it is economically in a bad shape without much development in both public and private sectors. Within the situation of instability in every aspect of life, the health services available in Manipur are very

poor. The patients treated in both indoor and outdoor have reduced overtime. When the number of nurses and midwives were already less, now the numbers are drastically reduced to 1064 in 2001, which is less than 1073 during 1996. In addition, the problem of HIV/AIDS epidemic had become a challenge in Manipur society. According to NACO (1997), the prevalence rate of AIDS in Manipur is 92.89/1000 population as opposed to the national 17.3/1000.

In Manipur, the same principle of implementing approach of RCH as in India is followed. The NRHM was also launched in the Northeast states including Manipur in November 2005 but started implementing in 2006. The RCH Programme is now fully concentrated on the assigned task of reproductive health of mothers and child care. In the programme of RCH, the coverage of immunization is 90 percent, family planning programme is 60-70 percent and awareness of HIV/AIDS is 90 percent. Regarding the budget expenditure of the programme the fund is solely released by Ministry of Health and Family Welfare, Government of India. The different sets of people that responsible for the implementation of RCH Programme are the health personnel, teachers, parents, and NGO's workers.

8.3 (a) Health Personnel

The work profile of the doctors has been changed after the RCH clubbed with NRHM. The workload of doctors have increased as survey of the work, meetings, training, workshops, selecting of ASHA workers, etc need to be done within the time frame. But among the nurses and community health workers there is no change in the work profiles as NRHM has not operationalised practically. Regarding training programme among nurses and health workers, they attended the training programme

like leprosy programme, malaria programme, HIV/AIDS, post partum programme, antenatal examination, handling of delivery cases, and immunization programme for children. The main work of nurses are to attend in-door patients and out-door patients mainly on immunization of children and pregnant mothers and assist doctors in conducting any minor surgery, operation of tubectomy cases. They had never come across any specific training programme for adolescent's health.

Doctors have further mentioned that there are no specific medical services offered for adolescent groups within RCH Programme in both the districts. There is no separate counseling center for adolescent groups. There is no particular programme implemented for adolescent groups besides providing awareness on HIV/AIDS in schools and colleges. There were hardly any cases of adolescent coming to the hospital. Even if they come, the cases are of fever, poisoning, diarrhea and sometimes for abortion, etc. So there is no specific importance given to this section but according to NRHM, there are programme components for adolescents especially on behaviour change modification and so on.

(b) NGOs

It is found in chapter 7. NGOs are facing constraints in networking with community as there have not been any efforts made to include other stakeholders such as local leaders, Municipal counselors, teachers and parents. All the NGOs including Family Planning Association of India, Landing Cherapur Homeopathy and Unani Association, Christian Volunteers for Social & Rural Development Organization and Socio Economic Development Organization are mainly based on service organization, developmental organization, religious organization and educational promoter in the

state. All the four NGOs has shown concern for adolescent groups but unfortunately only one NGO i.e. LACHUA has medical services for adolescent groups which is given through homeopathy medicines.

In all the four NGOs, IEC plays a very important role in providing information at schools and colleges but they are inadequate. Only two NGOs namely FPAI and LACHUA focus on awareness programme based on gender issues and behavioral change modification. Otherwise they mainly focus on family planning, immunization and HIV/AIDS. They do not undergo research activity and proper documentation. They also do not go for follow up after have conducting the awareness programme. Thus the above cited NGOs do not have any specific programme for adolescents' health besides the awareness programme they conducted in the schools, colleges, clubs and community on HIV/AIDS. The strategies that are used for campaigning or publicity are mainly cable TV channel, radio, posters and pamphlets. Very interestingly, it can be noted that they provided incentives like books, pen for teachers and eatable stuffs for students to get support from the schools. They sometimes even whitewashed and provided some other help in the school for making the programme more effective. Thus, practically there was no consulted effort from NGOs for proper implementation of RCH Programme for adolescent groups.

(c) Teachers

Discussed in chapter 6 that in all the 8 (eight) Higher Secondary Schools there were no counseling centers and no health centers but in two schools i.e. Kakching Khunou Navodaya Vidyalaya and Chandel Navodaya Vidyalaya there were two nurses each to look after the minor ailments of students. It is found that only in two schools, there are

common rooms for boys and girls whereas the remaining six schools do not have common rooms thus they used to conduct and organize programmes at birandah or in the ground or inside the classrooms. In all the schools they have separate toilet facilities for both girls and boys. But the maintenance is quite poor in some of the schools. Interestingly it is observed that all the schools have NSS units. It is also evident that most of the schools used to conduct cleanliness programme, literacy programme, science subjects matters through NSS camp. But according to teachers, girl students hardly participate in the camp as they are being stopped by their parents and relatives. It was also found that 7 (seven) schools have already conducted awareness programme on HIV/AIDS in last two years (2006 and 2007). Only Moreh School has not conducted so far. It is found that the awareness programme on HIV/AIDS was mainly conducted through different NGOs in collaboration with District hospitals and Community Health Centers. Unfortunately besides HIV/AIDS programme, there is no specific programme conducted specially for adolescent groups.

All the teachers have shown concern and importance of sex education for young people. Teachers felt that all the teen age group of girls and boys should acquaint the physical changes and other emotional changes happening to them. They have also felt that this period of age is a curious time where they will try to explore new things. They may indulge in unwanted experiences like sex and drugs, etc. Therefore, it is necessary to guide the young girls and boys in right direction for their better health and better thinking.

Out of 32 teachers only 7 teachers have heard of RCH Programme. But these 7 teachers are not fully aware of the same programme. According to them, they have heard the programme through family members for immunization of children, mothers' health and family planning. Otherwise they are not sure for any specific programme for the adolescent groups.

The data further reveal that 40.6 percent of teachers have already undergone training programme on HIV/AIDS through different NGOs [like Rapid Intervention And Care (RIAC) and Continuum of Care Project (COCP)] and Manipur AIDS Control Society (MACS) in collaboration with District hospital, Drug and Rehabilitation Unit, etc. Thus it further reveals that the importance of overall development of girls and boys are mainly neglected but unfortunately the programme of HIV/AIDS look the adolescent groups as a promiscuous group.

Some of the teachers also mentioned that they tried to start sex education in classrooms after the training programme. But they are not so convinced to teach the students as the students themselves are not comfortable to listen, mainly the girl students are not ready to digest. This statement is somehow opposite to the information given by the girls. FPAI (1993-1994) found the similar finding among the urban educated Indian adolescents and youth with the present study that they were shy to ask their teachers to clear their doubts on sex, sexuality and reproduction. At the same time, teachers are ill equipped to explain these matters. The need for sex education has been clearly expressed by the respondents.

(d) Parents

It is discussed in chapter 5, majority of the parents 71.9 percent have expressed of having very good relationship with their daughters. It is also evident that there are different views among the parents both father and mother for their daughters. The image of good daughter is very much seen among the parents as parents want their daughters to be responsible within and outside the family. They want their daughters to help mothers in the household chores, good in studies, respect elders, dress up properly, do not mix with boys, etc. Culturally it is also seen that in Manipur eloping system is still prevailing. So parents are worried about their daughters if they run away from family before completing their studies.

Regarding decision making of careers, some of the parents reveal that they help their daughters in choosing the subjects which can be useful in their life. It is found that fathers are more conserved than the mothers in terms of restricting the girls in choosing their careers. They often do not want and stop their daughters going out of the state for higher studies. Parents feel, in Manipur, the problems of corruption are highly prevalent. Without money and friendship it is very difficult to get jobs. Therefore, parents are worried about their children's future and they stop them from choosing their own career by themselves.

Regarding physical changes among the girls it is seen that very minimal parents can explain to their daughters the reason of menstruation and other physiological changes on the onset of puberty. It can also be noted that often girls were told how to maintain themselves during the periods and also told to maintain the secrecy of their periods to others. It reveals that parents especially mothers do not explain the girls before their

puberty and even after the puberty. but only the managing of themselves during periods.

Majority of the mothers have revealed that girls do not share their health problems and personal problems with their fathers but health problems and sometimes personal problems were shared to their mothers. It is also revealed that girls do not disclose their problems but parents come to know on observing the attitudes and behaviours of girls. Many of the mothers added that they were the mediator between their husbands and daughters. If their daughters want money or any permission to go out, they will tell their mothers to tell fathers and get the permissions. Often girls take support of their mothers in solving their problems in negotiating with fathers. Sometimes fathers scold mothers instead of scolding directly to daughters so that mother can pass on to their daughters. It is interesting to note that some of the findings of the present study have similarity with the study conducted in Gao. For instance, Andrew et al. (2003) show that sex and reproductive were by no means the only or necessary principal concern of adolescents. Indeed parental communication and education are important from adolescents' perspectives.

Regarding sex education among the girls, the parents who are not in the favour of sex education have expressed that if girls are being taught about sex education then they will try to practice that knowledge somewhere or other thus it should not be discussed in the open arena. Girls will tend to ask embarrassing questions even in front of us. Thus the RCH Programmes need to focus on clearing the mindset and the myths in providing sex education. So it should also target on the primary group which is very close to adolescent groups. Thus it is necessary for the programme planners to

provide safe and supportive environment for the safety of adolescent group. FPAI (1993-1994) has also found that there is a need not only for introducing sex education in schools, but also for parents specially the mothers who can induce a sense of confident among the adolescents.

Very few parents reflected of awareness of RCH Programme. Parents especially mothers revealed that they were aware of family planning programme, mothers' health and immunization which was a part of RCH Programme but they did not know any programme for adolescent groups. They received these awareness through radio, television, posters and hospital itself.

Majority of parents 73.4 percent have preferred private doctors along with chemist, homemade medicines, pastor whereas very few parents 6.2 percent opt for government doctors (hospital). They say that in private clinic they do not need to wait for long and they will be treated properly with good advice. They have added that doctors who work in the government hospitals are the same doctors. They always prefer nearby private doctor who is easily accessible though they pay higher price compared to government hospital. They have expressed that the cost is not very less in the government hospital. According to them they do not find the government hospital favourable because doctors come quite late, attitudes of nurses and other health workers' towards patients are not firm and medicines are not available in the hospital. At the same time the environment is not at all healthy, the cleanliness of the surroundings is in the worst shape. If the condition of the patient is severe, doctors in government hospital will keep delaying for the treatment as doctors are not there, medicines are not available and instruments are not sufficient. After much delay, the

patient will be referred to other medical hospitals. Therefore, if the case is serious, parents take their children straight at private clinic or State medical hospital. It shows that they always bypass the community health centers and district hospitals for poor quality of services.

For reproductive health related illness like dysmenorrhea mothers expressed that the girls themselves did not want to consult doctors and they wanted to manage with painkillers from chemist shop and homemade medicines. They also expressed that homemade medicines were quite effective for cold, cough, fever, vomiting and even stomach upset. It thus helped the girls in solving their problems. Therefore, we cannot ignore the traditional medicines in overall health programme.

8.3 (ii) Adolescents

(a) Profile

It is within the above scenario that we have studied the health needs of adolescent girls and the ways in which RCH Programme do not meet them. The sample of adolescents is from school going girls of 10+1 and 10+2 at the age group of 15-19 years who reside in both Thoubal and Chandel districts. All the respondents are unmarried. Regarding the population composition of the study area, both the districts, Meitei community are dominant in Thoubal district with 87.5 percent, Naga community with 6.25 percent and Meitei-pangal with 6.25 percent whereas in Chandel district, Naga and Kuki communities have a larger population with 46.9 percent and 18.8 percent respectively and no Muslim community is found. Majority of the respondents under the study area are Hindu with 60.93 percent, 35.94 percent Christian and 3.13 percent Muslim. It is observed that the Meiteis of both General

Caste and Other Backward Classes follow Hindu religion, while all the Scheduled Tribe follows Christian religion. It is gratifying to note that unlike other parts of India, caste system is less intense in this region. The respondents constitute 37.5 percent to Scheduled Caste, 35.9 percent to Scheduled Tribe, and 21.9 percent of Other Backward Classes with 4.7 percent of general category. It can also be highlighted that Scheduled Caste population of Manipur, named as Lois recognized by the Constitution of India under the Article 341 is mainly inhabited in Thoubal district with a population of 9.3 percent and less population of Scheduled Tribe with 1.2 percent. But in Chandel district, almost all the populations belong to Scheduled Tribe with of 91.9 percent with 0.2 percent of population of Scheduled Caste.

It is also found that the average earning members among the families of respondents is 2.06. It is seen that in both the districts across the caste group, agriculture is the main source of income with 46.1 percent followed by combination of agricultural job and governmental job with 12.5 percent and private job with 12.5 percent. It is found that almost all the respondents have their own agricultural land where there is equal work participation of male and female. Right from the beginning of sowing upto harvesting the female provides a helping hand beside her household duties. The female work participation in Manipur is 40.51 percent compared to the male counterpart with 51.93 percent.

Majority of the households with 30.5 percent live in a poor economic condition having a monthly family income of less than 3000 and closely followed by 28.9 percent whose income ranges from 3001 to 5000. There is less number of respondents, 3.2 percent who belong to the income group of above 10000. It is

evident that the maximum number of respondents resides in mud floor houses with 69.5 percent followed by 23.4 percent of cement floor houses. It is also noted that type of household is very much associated with the type of geographical area of one lives. Majority of the respondents 96.7 percent have latrine followed by pit 27.3 percent and very less of flush with 4.7 percent. The data show that the respondents who belong to different caste and class, the majority of the respondents are in the low economic conditions. Hence, policy planners need to take positive steps to look into the prevailing situation in order to uplift their economic condition thereby bringing the community at least to the national level of economic status.

It is also evident that 32.8 percent of the respondents are not only using tap water but also associating with hand pump, ponds and river water. It shows that the availability of tap water is not adequate. It is seen that majority of the people have piped connection but the water does not come and when it comes it is not at all sufficient enough. The water comes once in a day, in the morning for one hour or less than that. The speed of water flow has low pressure of flow. As the water flow is slow, there are many localities that cannot avail the facility. It can further highlight that the infrastructure of water supply is not adequate for the population. Therefore, most of the people use pond water, river water and hand pump according to the availability at their locality.

Looking at the electric facility, the per capita consumption of electricity during 2002-2003 in the region is only about 166 units against the country's average of 330 units, so the infrastructure of electricity is also very poor to reach the people. It is also seen that during the rainy days, there will not be any light for the whole day due to burnt

off the powerhouse due to problems of lightening and connection of posts. This will ultimately hamper in everyone's life especially in health sector as in case of emergency time most of the CHCs, PHCs and even in district hospital they cannot do any minor and major operation thus they have to refer the case to state level hospital. This will delay in all the treatment procedures in dealing with the serious cases.

(b) Social Problems faced by the Adolescents.

All the adolescents under the study have experienced restriction comes not only from society but also from parents in many ways. Many of the girls respond that there is not much safe and supportive environment for them starting from family, schools, and hospitals and at large in society. They are often neglected and restricted by the parents and society in their mobility, mixing up with friends, not allowed in kitchen and puja during periods, parents often neglect girls' participation in decision making. They find that they are being neglected their potentials and abilities. They are often teased by classmate boys in schools, strangers in market areas, and even by relatives at their locality. It is evident that 24.2 percent of the respondents felt they became care takers and were subordinate in the family. They also have to help especially their mothers in the household chores and in their earning activities. The data reveal that girls and women continue to be victims of social humiliation with social evils and practices. Girls and women are always being treated as impurity. The physiological changes occurring among the girls are not taken as their becoming of maturity rather they are treated as impurity. It is also shown that girls always remain the center of subordinate and inferiority. They are physically, emotionally and culturally deprived. Andrew et al. (2003) have found the similarity that many of adolescents reported strained

relationships with parents over restriction placed on them, which were often gender-specific and also source of stress because of high parental expectations.

It is seen that girls got eve teasing and sexual harassments from friends and the relatives with 35 percent. It shows that the girls are also often exploited from their near ones who are closed and known to them. There is 27.3 percent who is unknown to the respondents. Thus it can reveal that society at large is not gender sensitized even if we believe that the status of girls and women in Manipur are much higher compared to other states.

(c) Health Problems faced by the Adolescents

The natures of the problems faced by adolescent girls are seen in the light of physical, medical, social and psychological aspects. The most common health complaints mentioned by girls were general health problems of 75.8 percent that includes fever, cold, cough, bodyache, headache, diarrhea, stomach problems, skin problems, eye problems, dizziness, weakness, etc. than the reproductive health problems of 24.2 percent including the cases of itching, white discharge, dysmenorrhea and irregular menstruation. It can be noted that girls may be shy to disclose reproductive health related information or they are not aware that they have got the problems until it has become serious. Thus it can be revealed that the need for general health has to be given more importance along with reproductive health. It can also conclude that the data bring a total different picture on the current Reproductive and Child Health Programme that the programme has to check from womb to tomb instead of giving priorities only on reproductive health than the overall general health in their plan of action.

It was seen that for treatment of their general illness, the number of treatment seeking behaviour is very less in government hospitals but more in private doctors with 57 percent along with homemade medicine, pastor, government doctor (hospital) and chemist. But it is seen that girls with 24.2 percent rely more on self medication (homemade medicine). Regarding reproductive health related treatment only 4.7 percent of the girl respondents sought medical advice from private doctors and government doctors (hospital). Majority of the girls 75 percent do not reveal their reproductive health problems if they have any and accordingly they do not attend any treatment. This reveals that majority of the girls do not go to doctors for their reproductive health problems thus reproductive health problems remain within self or in peer circles. It is also seen from the data that 13.2 percent of girls prefer for homemade medicine and 5.5 percent of girls take medicine from chemist. The significance of this data is that if people are not accessing the public health services how will the programme reach to the people where majority of the people are going to private doctors, self medication and chemists. Thus the health systems should not be always medicalised and it is worth studying the traditional medicines as well the cultural aspects behind it. Thus health service needs to be sensitive of access and available but other systems of medications need to be appreciated. It is important that social structures, stigma associated and health cultures cannot be ignored.

(d) Health Care Needs of Adolescent Girls

Looking at the health care needs of girls, it has been identified that safe and supportive environment are not there within the family, schools, hospitals and society at large. There is no safety in the society because of the current social violence and conflicting situations in Manipur. On the top adolescents are often being discussed in

their dresses, restricted from mixing up with friends especially boys, talking to others, food habits, eating patterns and even in decision making of choosing careers etc. Mutual attraction between boys and girls is common but societal pressures do not allow them to meet members of the opposite sex freely and establish healthy relationships based on respect and understanding. It is seen that adults do not respect their right to choose and dignity and participate in decision-making processes. Girls in fact need social skills for building positive relationships with others.

Very often, they are unable to understand the emotional turmoil. Unfortunately they do not have a supportive environment in order to share their concerns with others. It can also be noted that myths and misconceptions related to menstruation affect the social behaviour of girls and also the importance of genital hygiene is not emphasized leading to reproductive tract infection (RTI). In schools, the girls do not even approach the teachers for their any health related problems. They do go to the teachers only on academic related problems. Girl respondents have expressed their uneasiness to share their health problems to the teachers. At the same time teachers feel inhibited to discuss issues frankly, sensitively and interestingly.

(e) Perception and Awareness Level among Adolescent Girls

For understanding the perception and awareness level of adolescent girls pertaining to health care services available it was evident to understand the perception on sex education, health services and awareness level among the girls on physical changes, family planning methods, HIV/AIDS and the knowledge of RTI/STD and their source of information.

It is found that majority of the respondents 93.8 percent wanted sex education to be given to them. The girls want sex education should be put as a proper course in the syllabus. Though they read magazines, books and get information from the peers circle, it is not sufficient for them they need to know more on overall reproductive health system. They also said that there should be both the male and female teachers who are trained and could teach on the subject matters of sex education. They also felt that in coeducation system of school, sex education should be taught separately for girls and boys.

Regarding awareness on reproductive organs the data reveal that the awareness level among the girls on reproductive organs are quite high with 98.4 percent of girls could list down one or other of the reproductive organs. Majority of the girls 75.8 percent learn about the reproductive organs from books, peers and magazine, only 10.2 percent mentioned teachers and books. Thus, it is found that the most likely source of information is from peers who may not be fully informed and books and magazine, which tends to focus on sexual and gender stereotypes or extremes. The educational system is also ambivalent about imparting sex education. Teachers, by a large, find the topic embarrassing and try to avoid it. Hence, both the teachers and parents as seen in the above are generally reluctant in addressing these issues.

The awareness levels of different methods of contraceptives are quite high among the girls with 93.7 percent. All the girls, 100 percent are aware of HIV/AIDS but it is evident that even if Manipur has the highest prevalence rate of HIV/AIDS by injecting drug users with 451 cases in 2001, a large proportion 80.5 percent of the adolescents responded that the mode of transmission of HIV/AIDS were through

sexual contact and blood transfusion from infected persons. There were only 19.5 percent adolescents who had awareness on the mode of transmission by injecting drug users along with blood transfusion and sexual contact. Again, girls of 79.7 percent are aware of the methods of prevention through condoms, screening of blood before transfusion but only 27.3 percent of adolescents are aware of sterilization of needles. It further reveals that the awareness levels of mode of transmission of HIV/AIDS among the adolescent girls are very high. However the knowledge is general and not specific to the condition and situations of the Manipur state.

Majority of girl respondents with 89.1 percent have not even heard of RTI/STD. There are very less number of girls 3.9 percent aware of RTI/AIDS and 7 percent of girls have heard of RTI/STD through friends and magazines but not aware of it. Data show that the information provided by mass media, NGOs, department of health services, etc. was totally confined only on HIV/AIDS, immunization and family planning programme. It further reveals that the reproductive health related problems are totally neglected especially for adolescent girls and women at large. It can also conclude that RCH Programme is not at all touching the main issues of girls and women health problems and their rights over body. They are mainly focused on the areas of family planning programme, immunization and HIV/AIDS. As the girls are not aware of reproductive health related problems; they do not disclose the problems and thus their health seeking behaviour will also differ as they tend to manage by themselves instead of utilizing the health services.

Regarding RCH Programme majority of the girls 96.1 percent have not heard of the Programme whereas very few girls 3.9 percent are aware of it. . But no one knows

what RCH Programme is all about. Those girls who have heard and got the information are mainly from mass media and seen in posters.

The present study has given many new insights. It has confirmed following two hypotheses. The first as well as second hypothesis was developed in the study of Goa (Andrew et al., 2003) and was confirmed by the study of Maharashtra (Bhende, 1994 and 1995) and the study of four zones of India of SECRT Centers (Family Planning Association of India, 1993-1994).

- i There is a relation between attitudes, perception and awareness level of the adolescents and the availability of services especially health care aspects.
- ii The gender perspective plays an important role in shaping the RCH Programme.

The present study has developed two new hypotheses. These are:

- i There is an influence of socio-economic, cultural, and political factors on the health of adolescents.
- ii Instability of the state politics directly and indirectly has impact on overall social welfare programme including health.

8.4 SOCIAL WORK THEORY AND INTERVENTIONS

8.4 (i) Social Work Theory

The major findings and observations of the present study reflect the relevance of 'Feminist Social Work' perspective in bringing gender-based equality as it is based on premise that people's material and emotional well-being can only be enhanced if gender is taken into account, applying equally to girls, women, men and children.

The findings of the study propose the crucial need for a Social Work practice for bringing a social change. The study illustrates that the adolescent girls are oppressed or inferior and snatched away their identity and power in all context within and outside the family because of different aspects including their gender, lack of knowledge, dominant by patriarchal norms, insensitive of the policies and programmes, especially health services that by-passed their health care needs. Adolescent girls are at large being deprived and neglected of their potentials and abilities. There is always a shift in the power base on gender-related issues for girls that include eve teasing, sexual harassment, etc and there is also a growing trend to ignore adolescent girls especially when it comes to the decision-making. Therefore, adolescent girls' needs are not met socially, economically and politically in all spheres.

Thus, the present study articulates that the importance of Feminist Social Work for empowering girls. There are four broad approaches to feminist theory such as liberal feminist, Marxist feminist, radical feminist and socialist feminist for bringing a gender-based equality. Feminist Social Work seeks opportunities for the education, knowledge, information and professional advancement of girls and women, equal to boys and men within the existing social structures. It exerts liberation of girls when a classless society is achieved. Girls should not always be treated as subordinate and care taker at home; their emotions, feelings and voices should be heard by parents in families, teachers in schools, NGOs and hospitals in health care institutions and society at large.

Thus, the successful operationalising of Feminist Social Work by family at primary level, educators and health policy planners at secondary level for empowering girls by meeting their health care needs will inspire the social worker and civil society around the world to take initiatives against gender-based discrimination and so on. It will help in developing faith among social work students and professional practitioners that the Feminist Social Work is not merely ideology but a statutory setting that aims to channel resources into tackling issues of gender, health and social injustice, with advocacy for the development of female-specific services.

Therefore, in social work education, the Feminist Social Work perspective can be adopted as a model to address the issues of gender-based discrimination. From this model we suggest some of the areas of intervention.

8.4 (ii) Social Work interventions

1. As adolescents need family support, Social Worker can encourage parents in the following areas:

- Parents' involvements in planning policy are necessary for ensuring a safe and secure environment for growth during the formative years of their children.
- Providing information, education and counseling and clinical services to parents.
- Support sexual and reproductive health education programmes and courses in schools and in non-formal centers. And also to find out what is being taught about sexuality, who is teaching it, and what their children think about it.
- Support the setting up and functioning of school and community-based adolescent health centers.
- Work with adolescents to and books and websites that offer accurate information on sexual and reproductive issues.

2. School Environment Promotes learning therefore. Social Worker needs to work with teachers in the following areas:

- Teachers can make a successful adolescence education. thus teachers involvement are important. Teachers should be given proper training for adolescence education.
- Encourage students to identify their personal, family, community, and religious values on sexual health.
- Provide medically accurate information on reproductive and sexual health. including information about contraception and disease prevention.
- Encourage participation of students in planning, designing and implementing a comprehensive adolescence education programme.
- Creating a supportive school environment is important thus there should be counseling center and common rooms for students in schools and hospital.

3. Community Leaders can advocate on Reproductive Health Programme. thus Social Worker needs to work with community leaders in the following ways:

- Issues related to adolescent reproductive and sexual health require a supportive community environment and also encouraging open discussion and conversations on sexual and reproductive health in public spaces like panchayat meetings.
- Talking of the importance of educating young people and how it can empower them to look after themselves and take care of their families.
- Creating and distributing pamphlets on powerful messages related to the issue on adolescent health.
- Mobilizing the media, including local and folk media, to produce in-depth news stories, article and features on issues for younger person or a radio

- Peer educators can become change makers: form network to encourage, support and promote healthy living. This will empower them and enhance their life skills.

8.5 CONCLUSION

The study concludes that there is a gap between the health care needs of adolescent girls and RCH Programme in the context of socio-economic and cultural set up of Manipur. Thus there is a need in formulating the methods of delivery of the health services: the government should take an approach from “womb to tomb” that includes the health of the girl child right from birth, adolescence, reproductive age, menopause to old age, etc. It has to be cyclical in nature because at all points in a girls’ life, her health status impinges upon the next phase. If adolescents’ general health is not taken care of, it will be hard for the RCH Programme to succeed as one should not separate adolescents’ health from the overall development of a girls merging towards the womanhood. We have given the main needs of adolescent girls’ in the above section. It is seen that in RCH Programme there are components for adolescents’ health but it is not at all meeting the health needs of girls. It is quite obvious that RCH Programme is concentrating on Family Planning, Immunization Programme as well as HIV/AIDS. These are not the needs of adolescent girls. The present study suggests that there is a need to initiate further research in the following areas: (a) Importance of social and cultural factors in health seeking behaviour. (b) Interface between Government, NGOs and indigenous medicines for addressing the health care needs of adolescent girls with regard to health care in Manipur.

station to make an announcement on these issues particularly on days like the World AIDS Day, International Youth Day and Women's day.

4. Service Provider can make a difference in the health status of adolescents where Social Worker needs to work with health providers in the following areas:

➤ The programme should not be target oriented focusing only on women and children.

➤ The programme should not be generalized with other states.

i. as societal and cultural play a very important role in the development of a child and

ii. Problems of the state need to be dealt.

➤ Involve adolescents in setting up the services to enhance their sense of ownership.

➤ Ensure that Programme are relevant to adolescents' actual needs

➤ Seek their help to identify messages and communication channels and activities popular with their subculture.

➤ Equip adolescents to participate in devising evaluation mechanisms to get feedback.

➤ Service providers like hospitals and NGOs can make a difference in the health status of adolescents. so adolescents need a friendly environment to access freely these services. so attitudes of service providers. locations of service is very important.

➤ Involvement of adolescent in planning and development of health services is necessary so that there will be ensured that programme are relevant to adolescents' actual needs.

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