

CHAPTER 2

CHAPTER 2

A Review of Relevant Literature

In this chapter, literatures pertinent to the research topic and research setting are reviewed thoroughly. The researcher tries to understand who adolescent groups are and highlight the major issues and problems in worldwide and in India through the available research studies pertaining to adolescent girls' health. The main motto is to highlight the factors that have influenced the adolescent girls' health and the availability of health services through RCH Programme. It also tries to throw light on the studies that have carried out and the conclusion that are being drawn from them, so that it can bring an insight into the research problem and establish a meaningful rationale for the present study.

2.1 WHO ARE ADOLESCENTS?

Adolescence is a time of tremendous opportunity and change. Adolescence is both a transient stage, between childhood and adulthood, and a formative period during which many life patterns are learned and established. The World Health Organization defines adolescents as young people aged 10-19 years. "Adolescence" is often synonymous with the teen years, thus identified as 10-19. "Youth" usually covers the ages 15-24, and "young people" is used for 10-24. "Young adults" are typically considered in the age range 20-24. Adolescence is the period in life that signals a shift from childhood to adulthood (Government of India, 2006).

This is a period of rapid physical, psychological and social maturation. Growth phases can be demarcated as early, mid:

Early adolescence (10-13) is characterised by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.

In *mid-adolescence* (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective. In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions. These changes take place at a different rate for each individual and can be a period of anxiety as well as pride (McIntyre, 2002).

The American psychologist G. Stanley Hall (1916) asserted that adolescence is a period of emotional stress, resulting from the rapid and extensive physiological changes occurring at pubescence.

The French psychologist Jean Piaget determined (1926) that adolescence is the beginning of the stage of formal operational thought, which may be characterized as thinking that involves deductive logic. Piaget assumed that this stage occurs among all people regardless of educational or related experiences. Research evidence, however, does not support this hypothesis; it shows that the ability of adolescents to solve complex problems is a function of accumulated learning and education (Encarta Encyclopedia Deluxe, 2004).

Anna Freud (1946) considered the adolescent years more important for the formation of character. In this period, the basic energy that fuels the sex drive is reawakened and threatens the id-ego balance maintained during the latency years. To avoid being overwhelmed by instinctual urges, adolescents employ ego defense mechanisms.

According to Sigmund Freud (1953), child development consists of five psychosexual stages in which a particular body region is the focus of sensual satisfactions; the focus of pleasure shifts as children progress through the stages. Sigmund Freud developed the theory and techniques of psychoanalysis. In his different stages of life like the genital stage which is considered mature sexuality the keynote of adolescence, individuals develop mature sexual interests. The genital stage is a reawakening of the sexual urges of the phallic stage, which now are directed into socially approved channels-heterosexual relations with people outside the family.

Studies by the American anthropologist Margaret Mead (1961), however, showed that emotional stress is not inevitable, but culturally determined; she found that difficulties in the transition from childhood to adulthood varied from one culture to another.

The German-born American psychologist Erik Erikson (1950; 1965; 1968) saw development as a psychosocial process going on throughout life. Adolescent shares a unique task: to develop from a dependent to an independent person who relates to others in a humane and well-socialized fashion. Erikson's eight stages span the entire life course, and, contrary to Freud's stages, each involves a conflict in the social world with two possible outcomes. He further discussed of adolescence. "Identity Vs Role confusion" defines the teenager's search for self-understanding. The rapid body

growth and new genital maturity emphasize to young people their impending adulthood and they begin to question their roles in adult society. Erikson sees the prime danger of this stage as identity confusion as adolescents may express their confusion by acting impulsively to commit themselves to poorly thought-out courses of action, or regressing into childishness to avoid resolving conflicts. Erikson's theory thus emphasizes the interaction of internal psychological growth and the support of the social world.

2.2 PROBLEMS OF ADOLESCENTS IN WORLDWIDE

Each year, 15 million adolescents aged 15 to 19 years give birth, accounting for up to one-fifth of all births worldwide. In the developing world, an average of 40 percent of women give birth before the age of 20, ranging from a low of 8 percent in East Asia to a high of 56 percent in West Africa (Noble et al., 1996). In many developed regions, only about 10 percent of adolescents begin childbearing as early. In the United States, however, about 19 percent of adolescent women give birth by age 20 (Noble et al. 1996; United Nations, 1995). Each year 1 million to 4.4 million adolescents in developing countries undergo abortion, and most of these procedures are performed under unsafe conditions (PRB/CPO 1994; Noble et al., 1996). Complications of pregnancy, childbirth, and unsafe abortion are major causes of death for women age 15 to 19. According to *Mothercare Matters* (1995), revealed that young women's frequently limited knowledge of or confidence in accessing the health care system results in limited prenatal care, which also contributes significantly to complications STIs also pose significant risk for adolescents. The highest rates of infection for STIs, including HIV, are found among young people age 20 to 24; the next highest rate occurs among adolescents age 15 to 19 (Noble et al., 1996). Each

year. one out of every 20 adolescents contacts an STI, some of which can cause lifelong health problems (such as infertility) if left untreated. WHO estimates that half of all people infected with HIV are younger than age 25 and, in developing countries, up to 60 percent of all new infections occur among 15 to 24 year olds (Shane, 1997). Every day, 7,000 young people worldwide acquire the virus, which amounts to about 2.6 million new infections over one year among youth. Some 1.7 million of these are in Africa and 700,000 in Asia and the Pacific (UNAIDS, 1998). UNAIDS/ WHO 1997 revealed that new infections among females outnumber those among males by a ratio of 2 to 1.

2.3 SURVEY ON DEMOGRAPHIC PROFILE AND SOME IMPORTANT SOCIAL ASPECTS OF ADOLESCENCE IN SOUTH ASIA.

2.3 (i) Demographic profile

There are about 1.2 billion adolescents, a fifth of the world's population, and their numbers are increasing. Four (282 million) out of five live in developing countries. Adolescents aged 10-19 comprise over one-fifth of South Asia's population (Table: 2.1). Within this region, Bangladesh and Pakistan have the greatest proportion of adolescents, while India has the greatest absolute number.

Table: 2.1. Demographic profile of adolescents in South Asia.

Country	Estimated population aged 15-19 circa 2000 (thousands)	Adolescents aged 15-19 (% of total (population))
South Asia	135163	10
Bangladesh	15089	11
India	100963	10
Nepal	2373	10
Pakistan	14841	11
Sri Lanka	1897	10

Source: United Nations, (2001), *World population prospects: The 2000 Revision. Vol.II. The sex and age distribution of the world population*. New York, United Nations.

From the Table: 2.1, it is shown that adolescents aged 10-19 comprise over one-fifth of South Asia's population. Within the region, Bangladesh and Pakistan have the greatest proportion of adolescents, while India has the greatest absolute number.

2.3 (ii) Aspects related to Early Marriage

Gender discrimination in the form of discrimination against women starts at birth and continues until death. The discrimination exists in the spheres of marriage education, employment, dowry, and even violence.

Chowdhury's findings from a study in Bangladesh of women reported that they did not have a choice as to whom or when to marry, or when to begin childbearing. It is

shown from her study that lack of decision making authority permeated all aspects of young women's lives- including food intake, workload, mobility and access to health care.

Table: 2.2. Percent of adolescent girls ever married.

Country and year	Percent of girls aged 15-19 ever married
South Asia	
Bangladesh (1996-1997)	50
India (1998-1999)	34
Nepal (1996)	44
Pakistan (1990-1991)	25
Sri Lanka (1993)	7

Sources: National Demographic and Health Surveys various years as noted.

Surveys from the late 90's suggest that over one-half of adolescents in Bangladesh and two-fifths of adolescent girls in Nepal and nearly one-third of those in India have ever been married. Rashid presents finding that emerged from the focus group discussions in the Nilphamari district of Bangladesh where girls still marry as young as age 11. Mothers explained that the main reason for early marriage was parents' fear that daughters would be raped, become pregnant or elope. The knowledge that a girl has had pre-marital sex can ruin the status and reputation of the entire family. Chowdhury also cites evidence that early marriage of girls in Bangladesh may stem from financial pressures, a father's death or a large of number of daughters.

2.3 (iii) Educational Aspects

Education is called the prime mover of civilization and human development. The gender gap in enrollment in primary as well as secondary levels is seen in world wide. Despite increasing attention given worldwide to education, 121 million children worldwide are out of school, with 9 million more girls than boys (UNICEF, 2003). In the least developed countries, only 22 percent of boys and 13 percent of girls are able to continue their education beyond the primary level.

Differences between the sexes are wide, particularly in Bangladesh and Pakistan where secondary school enrolment ratios for boys are nearly double those for girls (Table: 2.3). It is important to note that geographic disparities are wide within the individual countries.

Table: 2.3 Secondary School enrolment and illiteracy rates among adolescents in South Asia, 1995-1997

Country and year	Secondary school enrolment		Percent of adolescents aged 15-19 who are illiterate.	
	Boys	Girls	Boys	Girls
South Asia				
Bangladesh (1996-1997)	25	13	58	71
India (1998-1999)	59	39	20	44
Nepal (1996)	51	33	26	51
Pakistan (1990-1991)	33	17	56	74
Sri Lanka (1993)	72	78	9	10

Source: Population Reference Bureau, (2000).The World's Youth 2000. Washington, DC. population Reference Bureau, Measure Communication.

2.3 (iv) Health and Nutritional Aspects

Gender disparities in health are particularly significant in South Asia. In terms of food intake, access to health care and growth patterns, girls are worse off than their brothers. Adolescent girls contribute long hours to the household economy, but their activities are largely invisible and undervalued since they draw no income. A sizeable proportion of women in South Asia marry well before 18 years of age and early pregnancy further exacerbates their poor reproductive health and the poor survival chances of the infants they bear. The combination of poor nutrition and early child bearing expose young women to serious health risks during pregnancy and childbirth, including damage to the reproductive tract, maternal mortality and low birth weight.

A large number of adolescent girls suffer from malnutrition. The prevalence of malnutrition is found to be markedly higher among female children compared with male children. The findings of the *Bangladesh National Nutrition Survey, 1998* (relating to adolescents ages 10–17) reveal high levels of both stunting and thinness among adolescent girls. Over one-half of girls ages 10–12 (54 percent) and 13–17 (56 percent) were found to be stunted, with generally higher rates in rural compared with urban areas. A slightly lower proportion of adolescent boys were stunted: 47 and 50 percent for the two age groups, respectively (Bangladesh National Nutritional Survey, 1998).

Mortality rate among adolescents and young people in this region are generally lower than those observed at younger and older ages. However, unlike in other countries, adolescent and young women in the countries of South Asia, with the exception of Srilanka, experience somewhat higher mortality rates than males at the same ages.

From the Table: 2.4. it is seen that disparities are particularly evident among young people aged 15-19 and 20-24.

Table: 2.4 Comparison in countries of mortality among adolescent groups.

Country and Year	Females (%)			Males (%)		
	Aged 10-14	Aged 15-19	Aged 20-24	Aged 10-14	Aged 15-19	Aged 20-24
Bangladesh 1986	1.1	2.3	3.1	1.7	2.0	2.2
India (1997-98)	1.4	2.5	3.8	1.0	1.8	2.7
Pakistan (1996-97)	2.5	1.9	3.9	2.6	1.9	2.9
Sri Lanka (1995)	0.4	0.9	1.0	0.5	1.7	3.6

Source: Bangladesh: United Nations (1997), Demographic Yearbook 1995. Philippines, Sri Lanka, Thailand: United Nations (2000) Demographic Yearbook. India. IIPS 2000, NFHS-2 1998-99. Pakistan: Hakim 1998.

Adolescents in South Asia tend to be poorly informed about their own bodies and matters related to sexuality and health. The information they have is often incomplete and confused. Low rates of schooling, limited access to sex exacerbate their ignorance. Adolescents commonly report that in both rural and urban areas and urban slums, parents often want and expect adolescents particularly daughters to remain uninformed about sex (Bott et al., 2003).

When we look at the communication between adolescents and adults about sexual and reproductive health in south Asia, Qazi (2000) represents data from a pilot survey in Pakistan that explored knowledge about sex and reproduction among adolescents aged

13-21. The survey found that adolescents' knowledge tended to be limited, with many misconceptions regarding pregnancy, contraception and STIs including HIV/AIDS. The study also revealed that although sex and pregnancy were considered taboo topic in discussion, many young people do indeed discuss with peers. The study also revealed that parents are often reluctant to discuss matters of sex and reproductive health with their adolescent children, and at the same time many young people do not ask/talk for such information to their parents. A study in Bangladesh by Bhuiya and colleagues revealed that the communication between parents and children particularly between parents and boys on topics of sexuality and reproduction is limited. The study found that although a majority of girl had discussed reproductive health issues with their mothers, very few boys had discussed such matters with their parents or other family members (2 percent with fathers, 3 percent with mothers and 6 percent with other family members).

In the global view, Mane and Mc Cauley discuss the physiological, behavioural and social risk factors surrounding STIs/HIV among adolescents. They point out that physiologically, adolescents are more vulnerable to STIs than adults, and girls are more vulnerable than the boys. The risks of such disease is also because of the impact of gender power imbalances, societal norms, poverty and economic dependence, poverty, lack of information, illiterate, stigma as well.

2.4 SURVEY ON DEMOGRAPHIC PROFILE AND SOME IMPORTANT SOCIAL ASPECTS OF ADOLESCENCE IN INDIA

2.4 (i) Demographic Profile

In India, there are 225 million adolescents comprising nearly one-fifth (22 percent) of the total population (Census, 2001). Of the total adolescent population, 12 percent

belong to adolescents comprise of almost 47 percent female and 53 percent of male adolescents. The sex ratio among the 10-19 years is 882 females for 1000 males, lower than the overall sex ratio of 933. It is 902 for younger adolescents aged 10-14 years and 858 for older adolescents aged 15-19 years (Government of India, 2006).

India has traditionally been a male dominated society. There is a strong son preference in most parts of India, and girls tend to be discriminated against by their families. Demographic trends indicate deep-rooted gender discrimination. According to Gupta (2003), girl children grow into adulthood without being able to experience the important period of adolescence. They work in the home, look after their siblings, and assist their mothers in the fields. Then they are married off early to soon become mother themselves, still unarmed with knowledge about reproductive needs and rights (Government of Rajasthan, 1995). The situation is similar with other states in the country.

A brief look at the demographic profile of adolescents and young people suggests

- A significant proportion of adolescents' people remain illiterate and wide geographic disparities in school attendance — particularly middle and secondary school enrolment — persist. For example, among adolescents aged 15–17, 63 per cent of those living in urban areas attend school, compared to 44 per cent of those in rural areas. As is well-known, school attendance varies widely by state — while over 90 per cent of those aged 6–17 were in school in such states as Himachal Pradesh and Kerala; only 60 per cent were in school in Bihar (IIPS and ORC Macro, 2000).
- Gender disparities are also stark. While 15 per cent of adolescent boys aged 15–19 are illiterate, about twice this percentage (32 per cent) of girls are illiterate. And while 58 per cent of adolescent boys in the eligible ages are enrolled in middle and

secondary school, only 40 per cent of adolescent girls are (IIPS and ORC Macro, 2000). Even so, the proportion of women aged 20–29 who report seven or more years of education (34 per cent) is dramatically higher than the proportion of older women aged 40–49 who do so (17 percent) (IIPS and ORC Macro, 2000).

- A substantial proportion of young people are economically active. By ages 15–19, large proportions of adolescent boys (44 per cent) and girls (26 per cent) are engaged in economic activity; however these figures may not adequately reflect girls' contributions to household labour. Rural adolescents are more likely to work and less likely to study than their urban counterparts (ILO, 1998).

- Mortality rates among adolescents are generally lower than those observed at younger and older ages, a reflection of the fact that youth is a generally healthy period of life. However, gender disparities are apparent, particularly among young people aged 15–19 (2.5 and 1.8, respectively per 1,000 females and males) and 20–24 (3.8 and 2.7 per 1,000 respectively), and may be explained by the poorer reproductive health of young women at these ages (IIPS and ORC Macro, 2000).

- Crimes against adolescents are prevalent which consists of the range from eve-teasing to abduction, rape, prostitute and violence to sexual harassment. Most rape victims are in the age group of 14-18 years. According to National Crime Reports Bureau (2001), 82 percent of rape cases, the victim knew the offences and 32 percent were neighbour (Government of India, 2001). Unfortunately, social taboos prevent these crimes registered. Even when registered, prosecution rarely takes place. In case of sexual abuse of boys (12-17 years), they are mainly victims of homosexual abuse.

2.4 (ii) Educational and Employment related Aspects

It is visible that there is strong gender discrimination in education. Twenty five percent of 15-19 years age group in rural areas and 10 percent in urban areas are illiterate. The male-female differences grow with each level of education (NSSO 55th Round, 2001). It is also seen that enrollment figures in schools have improved, but gender disparities persist. Girls account for less than 50 percent enrolment at all stages of schooling. The dropout rate from class 1 to 10 is around 68 percent (UNFPA, 2006). Rural girls are most disadvantaged.

Data from the Ministry of Human Resource Development indicate nearly 90 percent of children aged 6-11 are enrolled in school, but enrolment falls to 59 percent among 11-14 years old. An obvious gender bias operates in the education sector. The dropout rate for girls in high school is as high as 72 percent (Government of India, 1999). A study by UNFPA (1998) revealed that while age at marriage among illiterate women is 15 years and age at marriage among girls who have completed high school is significantly higher, at 22 years.

The NFSH-2 data shows that only 33 percent of females and 55 percent males, age 15-17 years are attending school. In rural areas, parents don't prefer to send their daughters to education beyond the primary level. These include lack of access to a school in the vicinity of the village, inadequate facilities of toilets and therefore lack of privacy for girls' students, low proportion of female teachers and fear of sexual abuse reroute to school and within the school. They are often required by their families to attend to household work and take care of their younger siblings, leaving little time to attend school. Even in urban settings in school enrolment show similar

trends. Thus girls' education can be understood in relation to wider economic, social, cultural and ideological factors outside the education field (VHAI, 2002).

According to census 2001, nearly one out of 3 adolescent in 15-19 years is working where 21 percent as main workers and 12 percent as marginal workers. It is also seen that economic compulsions force adolescents to participate in the workforce resulting in high dropout rate for education.

The report of National Sample Survey Organization found that the work participation rate among rural adolescents aged 15-20 years was 77 percent for young men and 31 percent for young women. Many adolescents, including those younger than age 14, work in occupations such as bidi-making, coir-making, paper bag manufacturing, embroidery, glass and carpet industries. It is seen that many adolescents work in the agricultural sector or for local village industries as a part of a family labour force. In urban areas, girls from a large part of the unorganized sector working as domestic help where they get unequal wages, and also were sexual abused and harassments (Nanda, 2002).

2.4 (iii) Marriage related Aspects

According to census 2001 the mean age of marriage for females is 18 years and males 22.6 years. However, more than half (51 percent) of the illiterate currently married females are married below the legal age at marriage. Nearly 20 percent of the 1.5 million girls married under the age of 15 years are already mothers.

A study by Jejeebhoy (1998) about marriage mentioned that in 1996, an average of 38 percent of girls aged 15–19 were married. This rate was significantly higher in rural areas where 46 percent of girls in this age group were married, compared with 22

percent of girls aged 15–19 in urban areas. She compiled that the age at marriage varies from state to state. But early marriages are common in Madhya Pradesh, Andhra Pradesh, Rajasthan and Bihar, where more than 50 percent of girls aged 15–19 is married. In Haryana and Uttar Pradesh, 40–44 percent of girls aged 15–19 are married. It was better in Kerala, Punjab, Goa, Manipur, Mizoram and Nagaland where the girls tend to marry later with fewer than 15 percent of girls aged 15–19 are married. The early age of marriage should be a cause for concern since many younger adolescents are physiologically immature for reproduction that poses greater health risks and can contribute to maternal morbidity and mortality, high incidence of low birth weight babies and neonatal morbidity and mortality.

Unlike most other countries, adolescent fertility in India occurs mainly within the context of marriage. As a result of early marriage, about half of all women are sexually active by the time they are 18, and almost one in five by the time they are 15. Correspondingly, the magnitude of teenage fertility in India is considerable: well over half of all women aged 15-19 have experienced a pregnancy or a birth. Thus their general health and reproductive health are at risks.

It is seen within the age and gender-stratified family structure that characterizes, the average adolescent bride is unlikely to have had a say in the decision about whom or when to marry, whether or not to have sexual relations, and when to bear children. Society places strong pressures on young women on their fertility of bearing sons. This lack of autonomy within their marital homes often means that married girls have limited access to health care or participation in decisions about their own health. Kulkarni (2000) revealed that in some of Indian states such as Maharashtra and Madhya Pradesh, less than one-third of adolescent women surveyed reported any

involvement in decision-making about their own overall health. In many parts of India, early marriage for girls is a religious and social imperative. Despite laws that specify the legal age of marriage for girls as 18 years, cultural pressures often force parents to marry off their daughters at a younger age.

A study done by Kumar (2000) mentioned that approximately 138 million of India's population is between the ages of 15-25 years. About 50% adolescent girls get married at below the age of 20 in U.P, M.P, Bihar and Rajasthan, which contribute to 40 percent of India's population.

2.4 (iv) Health and Nutritional Aspects

Gender discrimination results malnutrition of girls. In terms of food intake, adolescents are worse off than their brothers. A report on NNMB (2001) found that intake of nutrients is less than the recommended daily allowances for adolescents below the age of 18 years both for boys and girls in rural India. Anemia is a widely prevalent health problem among adolescent girls. More than 70 percent girls in the age group 10-19 years suffer from severe or moderate anemia (District Level Health Survey-RCH, 2004). Both the 1992 ICMR study on iron and folic acid supplementation and UNICEF have reported low mean hemoglobin levels and low nutritional intake of proteins, calories, and micro/macronutrients among adolescent girls and pregnant mothers. The 1998-99 NFHS-2 reported that the prevalence of anemia was the highest (56 percent) among adolescents (ages 15-19) compared with other group of women of reproductive age. A collaborative study done in the cities of Hyderabad, Calcutta, and madras showed the prevalence of anemia in girls between the ages of 6 and 14 was 63.8 percent, 65.7 percent and 98.7 percent respectively (Kumar, 2001).

It is also seen according to the report of MISC, 2000 (Government of India, 2001) that Iodine Deficiency Disorders can lead to growth retardation and retard mental development. In India only half of the households are using iodized salt for cooking. According to 2001 census, disability was reported among 1.99 percent of the adolescents in the age group of 10-19 years. Among the disabled adolescents, 40 percent reported visual disability and nearly one third (33 percent) reported movement disability. Males generally reported a higher percentage of the disability than the females (Census, 2001).

2.5 APPRAISAL OF PREVIOUS STUDIES ON REPRODUCTIVE HEALTH OF ADOLESCENCE IN WORLDWIDE

2.5 (i) Studies on Knowledge, Attitude and Behaviour pertinent to Sexuality and Reproductive Health

Agha (2002) in a study in Botswana, Cameroon, Guinea and South Africa examined the impact of mass media, peer education and “youth friendly” and use of contraceptive services. The varied effects of the four programs were attributed to differences both in the way the projects were implemented and in the duration of the interventions. The programs were related to a number of changes in knowledge and attitudes, especially concerning the benefits of condoms and abstinence. It was found that contraceptive use rose, numbers of partners decreased and abstinence increased; however, some negative changes were also detected, such as decreased proportions of young people believing that condoms protect against HIV. This study, and others, has suggested that variations in impact may sometimes arise from the way programs are managed and supervised, rather than from the effectiveness of a model itself (Gallant et al., 2004).

Erulkar et al. (2004) found in the study of Kenyans of 10-24 age groups of their behavioral change in youth programming of Reproductive Health Program that they obtained sexual and reproductive health information and services including skills building from teachers with 38 percent and the project counselors with 16 percent. Since the teachers play an important role in imparting information hence there is a need in improving the teachers' ability to discuss on sexual and reproductive topics with young people.

Koenig et al. (2004) examined in a study of ongoing Rakai surveillance project in rural Uganda during 2001-2002 from a sample of 575 sexually experienced 15-19 year-old women on Coerced First Intercourse and Reproductive Health among adolescent. Fourteen percent of young women reported that their first sexual intercourse had been coerced. A significantly higher percentage of young women who had been coerced into first intercourse than of those who had not been coerced reported having ever been pregnant (81 percent vs. 65 percent). This difference was also significant among unmarried women (57 percent vs. 31 percent) but not among married women, almost all of whom had experienced at least one pregnancy. Overall, the proportion of adolescent women who reported at least one genital tract symptom was twice as high among those who had experienced coerced first sex as among those had not (42 percent vs. 21 percent).

Guidry et al. (2007) assessed among the rural African-American Church leaders on their knowledge, perceptions, and attitudes regarding adolescent sexuality. Church Leader Assessment highlighted an interest and commitment to the prevention of adolescent sexual activity. Eighty-eight percent (88 percent) of church leaders reported that sex education should begin before the age of 13. All responding church

leaders indicated that sex education should be taught in the Church, yet only 58 percent of the leaders reported that their church provided some form of adolescent sex education. The results supported the idea that the development of church-based sex education programs must involve church leadership in rural African-American communities.

2.5 (ii) Studies on Access to Health Services

Rani and Lule (2004) did a survey among the 15-19 years old during 1996 to 2000 on Demographic and Health Survey (DHS) for Bangladesh, India (represented by the state of Rajasthan), Nepal and Turkey in Asia; Chad, Guinea, Kenya, Niger, Nigeria and Tanzania in Sub-Saharan Africa; and Bolivia and Nicaragua in Latin America. The survey found that more than 80 percent of young women had gotten married by age 18. It was found that the poor-to-rich ratio in early marriage was more than 2.0 in half of the 12 countries. Differences were much narrower in the relatively poor South Asian countries like Bangladesh, India and Nepal and in Sub-Saharan African countries like Chad, Guinea and Niger. The study further highlighted that there was a significant differences in using contraceptive methods between socioeconomic groups in all countries as contraceptive use was significantly less common among women in the poorest countries than among those in the richest women with a ratio 0.1 in Turkey to 0.7 in Nigeria. Likewise in case of knowledge of HIV prevention, the poorest young women were significantly less likely to know about the ways to prevent sexual transmission of HIV than were those in the wealthiest with the ratio ranged from 0.02 in India to 0.07 in Guinea.

Jeanpiere (2006) did a study among the mothers and daughters of African American women and girls through the context of mother/daughter communication that

examines how the negative construction of African American women's sexuality impacts upon the women's decisions to seek preventive health care. This study identifies barriers to obstetric/gynecologic health care utilization for African American women and girls. The results indicate that mothers have a significant effect on their daughters' decisions to seek obstetrical/gynecological health care and/or their knowledge about reproductive health care.

2.6 APPRAISAL OF PREVIOUS STUDIES ON REPRODUCTIVE HEALTH OF ADOLESCENCE IN INDIA.

2.6 (i) Studies of Gynaecological Problems of Adolescents

Bang and Bang (1989) made a survey in Gadchiroli district, a backward district of Maharashtra state on high prevalence of gynecological diseases in rural Indian women revealed that the most common non-gynecological conditions found were anemia (91percent), iron deficiency anemia (83 percent), sickle cell disease (7 percent), vitamin A deficiency (58 percent), filariasis (12 percent), pulmonary tuberculosis (2 percent), leprosy (10 percent), and urinary tract infection (4 percent). The very high prevalence of iron deficiency anemia and vitamin A deficiency were due to the poor economic status of women. The survey further revealed that only 7.8 percent of the women had ever had a gynecological examination in the past, even though 55 percent were aware of having gynecological disorders. Obviously there is a large gap between the need and the care. Thus reproductive care to women and adolescent needs are to be broadened beyond maternity care and family planning.

Chakravarty (1989) study in Madras city among the college and school going students shows that a large proportion of adolescent girls suffer from various gynecological problems, particularly menstrual irregularities such as hypermenorrhoea.

hypomenorrhea, menorrhagia, and dysmenorrhea. 40-45 percent of adolescent girls report menstrual problems. The study further revealed that 42 percent of the college and 34 percent of the school-going students reported problems during menstruation. The problems included headache, stomach pain, excessive bleeding, and other vague or non-specific symptoms like lethargy and loss of appetite. Nearly two-thirds of those who had problems sought for medical treatment.

Madhiwalla (1998) studies among women in a district of Maharashtra showed that reproductive problems and weakness together made up 47% of the reported morbidity that include menstruation, itching, white discharge, aches and pains, where 53% reported for fever, respiratory problems, mental stress, injuries, boils and burns.

Gender differentials in mortality rates exist during adolescence. Female mortality rates are higher as compared to males during 15-24 years. Mortality in female adolescents of 15-19 is higher than adolescents 10-14 years. The pervasiveness of discrimination, lower nutritional status, early marriage and complications during pregnancy and childbirth among adolescents contribute to female mortality. (CSO, 2002 and Sample Registration System Statistical Report, 1999). Thus adolescent mothers are at a higher risk of miscarriages, maternal mortality and giving birth to stillborn and underweight babies. According to United Nations Children's Fund 2001 estimated that at the global level that girls aged 15-19 are twice as likely to die from childbirth as are women in their twenties, while girls younger than age 15 face a risk that is five time higher.

2.6 (ii) Studies on Knowledge, Attitude and Behaviour pertinent to Sexuality and Reproductive Health

Studies by Vlassoff (1978); Bhende (1995); Rasheed et al. (1978) found that adolescent girls are generally ignorant of menstruation until it occurs; even then, knowledge is limited to the mechanics of menstruation, and to related behavioral norms like cooking or going too close to the idols of God is not permitted, and not necessarily its link to sex and reproduction.

Gupta (1988) study shows that only one-half of the adolescents were aware of various family planning methods, and young people's knowledge about spacing methods, such as through the use of intrauterine devices or oral contraceptive pills, were very low.

An Indian Council of Medical Research (ICMR) (1992) study showed that knowledge and awareness about puberty, menstruation, physical changes in the body, reproduction, contraception pregnancy, childbearing, reproductive tract infections, sexually transmitted infections (STIs) and HIV was low among boys and girls in younger adolescents. Among the younger adolescents, 40 percent had little knowledge about the sex organs and most girls had not been informed about the menarche prior to its onset. About one-half of the adolescents were not aware of condoms and were confused about the various modes of HIV/AIDS transmission. The study reported, however, that older adolescents ages 15-19 had better knowledge. About 80 percent had knowledge of STI, including HIV. Older adolescents were more aware more than younger adolescent girls of the physical and physiological changes that take place in the body.

Chitale and Das (1992) in Bombay and Solapur college students showed that awareness of sexually transmitted diseases and AIDS varies from 95% and 66% of Bombay and Solapur respectively, but the modes of HIV transmission, and the role of condoms in safe sex were poorly understood by all, irrespective of age and educational status, but particularly by females.

Bhende (1993) studies in Bombay revealed that there is a glaring lack of attention to sex education in the official programme. She further pointed out that what little education exists is imparted largely through the formal school and colleges curriculum and text books which results large segments of out-of school/colleges youth are excluded so ultimately the knowledge and informations are very limited to the youth.

Jejeebhoy (1996) pointed that a formal population education programme exist, in theory, in schools, colleges, universities, there is a glaring lack of responsibility to the sexual information needs of young people in the official programme in practice. NGO's have tried to fill this gap through activities from both the school going youth and those who are not going to school due to drop out and never unattended schools, but their efforts are hardly adequate given the size and cultural diversity of the country, and the magnitude of information needs.

Sodhi and Verma (1997) found on sexual coercion among unmarried adolescents of an urban slum in India. reflected that boys were found outspoken about their desire for sex, while girls speak about romantic and matrimonial aspirations in the relationship. It is also seen that cinema plays a role in perpetuating gender stereotypes

where society perpetuates abuse by tolerating certain kinds of coercion by girls, which emboldens boys to become even more aggressive and violent.

Looking at the HIV/AIDS epidemic in India that India has the second largest population of HIV infected individuals with 5.1 million living with HIV/AIDS. By 2005 over 40 million people are living with HIV. It is estimated that nearly 52.06 lakhs people in the age group of 15-49 years are infective with HIV. Out of this 38.4 percent are females, 57 percent are of the rural background (Government of India, 2006). Over 35 percent of all reported AIDS cases in India occur among young people in the age group of 15-24 years, indicating that young people are highly vulnerable. A national study by NACO/UNICEF (National Behavioural Surveillance Survey, 2001) among the young people (15-24 years) found that there is high level of awareness about HIV especially among urban males. 83 percent respondents knew of at least two correct mode of transmission of HIV/AIDS. However, awareness among rural females was low in Jharkhand, Gujarat, Chattisgarh, Uttar Pradesh and West Bengal. It is also seen that more than half of the respondents were aware that there is no cure for HIV/AIDS. Less than a third reported is being aware of STIs. The awareness was uniformly low across all sub populations. Overall, only one in the five respondents was aware that STI patients had a higher risk of HIV infection.

Sexual awareness appears to be largely superficial, and misconceptions abound. Jejeebhoy (2000) revealed that adolescent in Indian society tends to be extremely poor informed regarding their own physical well-being, their health and physiological changes. Often they have incomplete knowledge and information and are subjected to confusion. Awareness amongst female adolescents about menstruation and other

changes during puberty are poor to patchy at best. Adolescent ignorance about sexual and reproductive behaviour is compounded by reluctance among parents and teachers, health providers to impart relevant information. Teachers find the topic embarrassing and thus avoid it. In both rural and urban areas, mothers expect their adolescent children particularly daughter to remain uninformed about sex and reproduction. Sex and puberty were considered to be embarrassing distasteful and dirty subjects, not to be discussed with their adolescent daughters. Treatment seeking tends to be delayed, presumably out of ignorance and embarrassment. It is seen that school based programme are clearly important in India, many young people who at risk for STIs do not remain in school beyond seventh grade when sex-education classes are somehow given.

Gupta (2003) stated the period of adolescence that begin with the onset of puberty, is a crucial transition into adulthood. Most of the adolescents go through adolescence with little or no knowledge of the body's impending physical and physiological changes. During the transition to adulthood, lack of knowledge and awareness about the reproductive organs, physiological changes, or sexuality can promote psychological stress.

Andrew et al. (2003) made a study of Higher Secondary Schools in south Goa reflected that 95 percent of adolescents had heard about AIDS and nearly 90 percent could say that HIV caused AIDS but more than half the girls and almost third of boys were unable to say whether using a condom could help to prevent HIV infection. A comparable lack of knowledge was shown on matters relating to pregnancy like half of the girls were unsure if condoms could prevent pregnancy.

Andrew et al. (2003) reflected in his study 72 percent of boys and 63 percent of girls shared that the most common person from whom information regarding sex was obtained was a friend. Mothers were the next important person for girls (36 percent) while 26 percent boys cited was doctors.

Fathers were a source for only 6 percent of boys and 25 of girls. It was also seen in the survey that more than half the boys and girls felt they were not able to talk freely to their fathers (in any matter) on the other hand, 75 percent of both boys and girls were able to talk freely to their mothers. However, school going adolescents felt that sex and reproduction were by no means the only, or necessarily the principal, concern of adolescents. Indeed, parental communication and education were important priorities from their perspective. Adolescent concerns covered a broad range of issues which are intimately connected with their developmental and psychological needs: education, relationships with parents and peers. Ramasubban and Jejeebhoy (2000) revealed that the most likely sources of information are peers, who may not be fully informed, or the media, which tends to focus on sexual and gender stereotypes or extremes. Young people indeed recognize the inadequacies of the media as appropriate sources of information.

2.6 (iii) Studies on Access to Health Services for adolescents

Adolescents avoid using existing reproductive health services for a variety of reasons, including policy constraints, operational barriers, lack of information, and feelings of discomfort. According to Senderowity (1999), evidence shows that many young people prefer information. Thus young people tend to remain poorly informed or even misinformed about sexuality. Some of the barriers are because of poor understanding of their changing bodies and needs, insufficient awareness of pregnancy and STD

risks, little knowledge of what services are available, lack of information of RH services locations, belief that the services are not intended for them, concern that the staff will be hostile or judgmental, fear of medical procedures and contraceptive methods, including side effects, concern over lack of privacy and confidentiality, fear that their parents might learn their visit, embarrassment at needing it if the visit follows or wanting RH services, shame, especially coercion or abuse.

Epstein and Chandra (2000) highlighted many obstacles that may discourage young people from seeking any health care. These include an inability to access services independently from their families, fear of discovery by family or community members, inconvenient location and hours, long waits at clinics and providers whom adolescents perceive to be threatening, unwilling to respect their confidentiality.

Women face many barriers to accessing RTI services because laboratory facilities and to treat RTI are mainly available in District hospitals. To access these services, many women would have to go for long distances and they also have to impose an economic and social burden due to the stigma associated with these infections. A study done by Joseph et al. (2003) on health seeking behavior revealed that 78 percent of women who suffered from RTI tried home remedies or sought help from traditional medicine or unqualified private practitioners. Only 9 percent of women had reported symptoms and sought medical care at the government primary health centers.

Joseph et al. (2000) study among the married adolescents in rural Tamil Nadu found that two-third of women with gynecological morbidity symptoms did not seek care, and among those who did, over three in four sought treatment from unqualified sources, such as home treatment or untrained private practitioners.

NFHS-2 revealed that age specific fertility rate in the age group of 15-19 years contributes to 19 percent of the total fertility rate. Amongst currently married women, the unmet need of contraception is the highest in the age group of 15-19 years. Nearly 27 percent of married female adolescents reported unmet need for contraception.

Ganatra and Hirve (2003) revealed that adolescents were significantly less likely to be counseled about contraceptive use and were subsequently less likely than older women to adopt a contraceptive. Unmarried adolescent abortion-seekers reported a markedly higher use of traditional providers than married women, despite the availability of other abortion services. In-depth case studies revealed that providers charged higher prices for unmarried clients. It is seen that nearly 60% of adolescents who had undergone an abortion were unaware that abortions among unmarried women were legal. Thus being unmarried compounds the vulnerability of being young and poses strong culture, provider and legal barriers. The most telling indicator of this vulnerability is the substantial contribution of suicides due to unwanted pregnancies to maternal deaths.

Jejeebhoy et al. (2003) revealed that after marriage adolescents face huge constraints on the autonomy of the marital home. It further adds that sexual negotiation among young married women in India highlights young women's lack of decision making authority in matters relating to sex. Jejeebhoy (1998) has shown that exercise of choice is constrained also by the threat and experience of domestic violence. There is evidence that the threat and experience of violence tends to delay reproductive health decision-making and care seeking and limitation in accessing the health care on the one hand and is associated with adverse pregnancy related outcomes of the other. It is also seen among the married adolescents if the health need relates to child bearing-

whether pregnancy or perceived difficulties in conception then action is prompt whereas for other reproductive health matters-treatment of gynecological symptoms or symptoms of infection. health seeking or counseling may not be as prompt. It was also found that when adolescents experience symptoms of reproductive tract infection or any other gynecological morbidity, they face huge obstacles in seeking treatment because of self limitation-shyness, embarrassment, cost, perceptions.

2.7 STUDIES ON REPRODUCTIVE HEALTH OF ADOLESCENCE IN NORTHEAST INDIA

Some of the studies done by Bhatia and Cleland (1995); Rani and Bonu (2003) suggested that prevalence of RTIs and treatment seeking behaviour could be possibly influenced by a number of socio economic factors such as education, community, and rural and urban residence as well as demographic factors such as age, sex. At the same time the availability of health services is also a main factor. The prevalence of any symptom of RTI/STI is 24.1 percent among currently married women in the age of range 15-44 years in the Northeastern states, slightly lower than the national level, 29.7 percent (IIPS, 2001).

Saikia et al. (2000) examined among the Khasi and Karbi indigenous communities in northeastern on household characteristics and reproduction. It was found that the age of marriage among the two communities almost 60 percent of the Karbi women in the survey married either before or on reaching the age of 18, the minimum legal age at marriage for females in India in contrast to only 28 percent of Khasi women married either before or on reaching the minimum legal age at marriage. The study further examined that ever use of contraception was very low and almost equal in both

communities (28.3 percent and 25.2 percent for Khasi and Karbi respectively). But very interestingly it is seen that High level of female autonomy does empower women in making decisions, especially decisions regarding reproduction and health as Women in the Khasi matrilineal society had a much high fertility than their counterparts in the Karbi society. This is in spite of the fact that Khasi women enjoyed a comparatively higher level of female autonomy in decision-making, a higher degree of freedom of movement, and a greater access to finances.

C. Ramesh (2003) (Unpublished) showed that among women who reported any one or more symptoms of RTI/STI, 60.8 percent did not seek any treatment for symptoms of RTI/STI. This is quite close to the national level 62.4 percent. The data revealed among those who sought treatment for RTI/STI, 30.6 percent go to private /nurse/ pharmacist and 1.0 percent from local Dais. The data further revealed that self-medication is also very much prevalent. It was also seen that women who belong to religions other than Hindu and Christian mainly Muslim are less likely to seek treatment for RTI/STI from public medical sector as well as private medical sector. The study further revealed that caste category does not seem to influence treatment seeking behaviour but those low standard of living show relatively higher reported prevalence level. The study shows that the tendency to obtain treatment is higher among women who are from urban, educated, and has a high standard of living. The RCH-RHS I and II shows among 11603 married women at the age of 15-24 in the northeastern states complaint of any one symptom related to RTI/STI is 26.0 percent and 35.2 percent sought for treatment.

2.8 STUDIES ON REPRODUCTIVE HEALTH OF ADOLESCENCE IN MANIPUR

According to Registrar General of India, 1991 census shows that in Manipur, there are 1,96,842 adolescents in the age group of 15-19 years where 99961 were females and 96881 were males. It is quite interesting to know that girls outnumbered the boys' number in this age group. But it suddenly reduces at the age group of 20-24 where males' number was 92,812 and females' number was 89,755. There is no reason highlighted on this regard. In Manipur, there is no study of adolescents at the age group of 11-19 years but for 15-44 years. According to the survey of Reproductive and Child Health–Rapid Household Survey Phase I and II (RCH-RHS-I and II) conducted in 1998-99 of the awareness level of RTI, STI, and HIV/AIDS in the women age group of 15-44 years 25.64 percent knows about RTI, 14.44 percent know about STI and 78.38 percent know about HIV/AIDS.

In many parts of India, despite laws that specify the legal age of marriage for girls' as 18 years, cultural pressure often force parents to marry off their daughters at a younger age. But in Manipur it has different pictures where girls tend to marry at later age. Looking at Manipur status regarding marriage of girls and boys, Table: 2.5 shows the mean age at marriage by districts.

Table: 2.5. Mean age at Marriage by districts. Manipur, RCH phase I and II

Sl. No.	Districts	Mean age at marriage	
		Boys	Girls
1.	Bishnupur	25.7	22.3
2.	Chandel	24.6	22.0
3.	Churachandpur	25.4	22.2
4.	Imphal	27.8	25.7
5.	Senapati	23.3	21.8
6.	Tamenglong	24.1	20.5
7.	Thoubal	25.2	21.1
8.	Ukhrul	22.2	23.1
	Manipur	26.5	23.8

Source: Ministry of Health and Family Welfare Government of India (2001) report on Manipur-Reproductive and Child Health Programme Project Rapid Household Survey 1998-1999.

The Table: 2.5 indicates that the age at marriage of both the boys and girls in Manipur is relatively higher in comparison with many parts of the country. In all the districts of Manipur, girls and boys tend to get married at later age that gives a better picture for physical well being.

The major needs and problems specific to girls are related to the biological and psychological needs that inherent in the process of growth, development and reproduction. The live of the Manipuri girls and women are governed by certain social

taboos, dos and don'ts in their behaviour, food habits, social outlooks etc. thus affecting their health.

A study done by Laishram (2002) talked about the impact of traditional way of life on the Manipuri girls. The study mentioned that during the period of menstruation a Manipuri girl and a woman are treated as untouchable in most of the families. It is very restricted to the married women but it also happens in most of the girls. She has to remain without taking bath for at least 3-4 days. Sex is not encouraged in this period. She is not allowed to cook, even for the family members. But this taboo is not without any significance in its own way. In the primitive society or in the rural areas, clean tap water was not available. Citizens have to take bath in the water from community ponds. In such conditions, infection during menstrual cycle may occur. To avoid infection, she is debarred from taking bath in such water, or mixing with other clinically unclean persons. However, at many urban areas, relaxations from this taboo can be observed. Such behaviours are not observed among the tribal women folks.

In a report of UNDP (2004) on "Beyond Practical Gender Needs: Women in North Eastern and Hill States" submitted to by Rural Women Upliftment Society (RWUS) found that gynecological and obstetric have been identified as one of the common health problem experiences by rural women and young girls in Manipur. Reasons seems to be heavy workload, sexual harassment by husband, hospitals and dispensaries far away, feeling of shyness to complaint about owns health even to own husband. Above all, health facilities at the community level are poorly equipped to deal with gynecological and obstetric morbidities and lack of female doctors specializing in this field. As per records of Manipur Health Directorates, the

prevalence of anemia in 1999-2000 is 21.7 percent mild, 6.3 percent moderate and 0.8 percent severe.

In Manipur, it was found that the expenditure of IEC is being utilized for the purpose of family planning, mother and child health care and HIV/AIDS. The problem of HIV/AIDS epidemic had become a challenge in Manipur for the health of society. According to NACO, the prevalence rate in Manipur is 92.89/1000 populations as opposed to the national 17.3/1000 (NACO, 1997). According to the study of Singh (2001), one of the basic regions of the epidemic of HIV/AIDS in Manipur is because of the easy access to drugs where Manipur state has a long International border with Myanmar, which is being geographically closed to the Golden Triangle (In South East Asia, Asia, Myanmar, Thailand and Laos are known as the Golden triangle) where 20% of the world's heroin is produced and easily available. There is illegal drug trafficking is prevalent in Manipur since 1970. In the study of Rajeev, I (2001) explained that the spread of HIV/AIDS in Manipur is influenced by socially, politically, economically and cultural context of Manipur. Heroin by intravenous route is the most commonly used drug amongst IDU in Manipur.

Table: 2.6 (below) shows the patterns of HIV cases by risk in Manipur. In Manipur the most important mode of transmission of HIV was injecting drug users (IDU) but the trend had been expanded beyond IDU to heterosexually promiscuous since the last few years. Rajeev (2001) reveal that out of frustration, family problems, pleasure seeking, IDU was a fashion and the lack of social control, political control, poor health service and social unrest lead to increase in the prevalent of IDU. Now, the spread of HIV infection have expanded beyond the IDU to heterosexually. Though there is no red light area in the state, the phenomenon of sex trade has increased. The

data is showing the change of trends from IDU to heterosexually, 415 positive cases compared with IDU cases 451 in 2001.

Table: 2.6 Patterns of HIV cases by risk category in Manipur.

Sl.No	Particulars	2000 (No. of positive)	2001(No. of positive)
1.	Heterosexually promiscuous	238	415
2.	Injecting drug users (IDUs)	509	451
3.	Blood donors	0	0
4.	Blood recipients	20	12
5.	Antenatal mothers	40	0
6.	Suspected ARC/AIDS	110	85
7.	Relatives of AIDS patients	100	122
8.	Others	225	107

Source: Office of the Manipur State AIDS control Society, Imphal, Manipur, 2001.

Looking further at the age-sex proportion of HIV positive cases in Manipur (Table: 2.7). In both the sexes the age group 21-30 is the worst effected by HIV/AIDS. The particular age is most effected; it is because of the increased in unemployment after completing their studies along with the lifestyle of the youth. It further leads to frustration, family problems so they seek for pleasure which ultimately increase in indulging to drug abuse and flesh trade.

Table: 2.7 Age-sex proportion of HIV positive cases in Manipur.

Sl. No	Age-Group	2001(Jan-Dec)			
		Male	Female	Total	Percentage
1.	0-10	116	93	209	2.50
2.	11-20	758	113	871	10.44
3.	21-30	4267	722	4989	59.78
4.	31-40	1586	304	1890	22.65
5.	41 & above	295	92	387	4.64
	Total	820	372	8346	100

Source: Manipur State AIDS control Society report 2001, Imphal. Manipur.

From the above discussion it can be concluded that however, despite adolescents being a huge segment of the population, policies and programmes in India have focused very little effort on the adolescent groups. In India adolescent health is the domain of the Ministry of Health and Family Welfare and the departments of health and Family Welfare of the States. The National Health Policy of 1983 aimed at attaining health for all through primary health care (Government of India, 1983). While the policy did not mention adolescence specifically, it emphasized Safe Motherhood and Child Survival as well as the need for the provision of health care for school-going children through the school health programme. The major thrust to adolescent health, however was given in the National Population Policy-2000, National AIDS Prevention and Control Policy-2000, National Health Policy-2002, National Youth Policy-2003 of Ministry of Youth Affairs and Sports. There was recognizing of the needs of adolescent including the need for protection from

unwanted pregnancies and STIs. The policy also underscored the need for programs that encourage delayed marriage and childbearing and the need for education about the risks of unprotected sex. In fact the commitment of the national government to the reproductive health approach forged at the International Conference on Population and Development reshaped the Family Welfare into RCH. policymakers and planners have now realized that the adolescent population group has specific health and developmental needs. Unfortunately, the special needs of adolescents are rarely addressed by the educational, health, Family Welfare programme in India. Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education and recreation are just some of the factors of civil society that are keys to adolescent development. However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.

In the above context of review of literature, in Northeast India and especially in Manipur, there is not much of study done for adolescent groups but restricted only on HIV/AIDS/RTI/STD. The study done by IIPS (2001) on RCH phase I&II, 1998-1999 are also focused only on reproductive health of women. Further, as our review of literature has not revealed the existence of 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 the study needs to examine the gaps between the RCH Programme and the health care needs of adolescent girls in two Districts of Manipur. The study also needs to explore 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 programmes and policy makers in the study area. The study will make an effort to understand the complexity of adolescent girls' health problems and their association with social, cultural and economic factors. The next chapter deals the rationale and methodology of the proposed study.

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