REPRODUCTIVE HEALTH SEEKING BEHAVIOR AND SOCIAL SUPPORT OF ADOLESCENT GIRLS IN LUNGLEI, MIZORAM

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DECLARATION

I, C.Lalrempuii, hereby declare that the subject matter of this dissertation titled "*Reproductive Health Seeking Behavior and social support of Adolescent girls in Lunglei, Mizoram*" is the record of work done by me, under the supervision of Dr Kalpana Sarathy, Associate Professor, Department Social Work, Mizoram University. The contents of this work did not form the basis of award of any previous degree to me or to the best of my knowledge to anybody else, and that the dissertation has not been submitted for any research degree to any other University or Institute.

This is being submitted to the Mizoram University for the Degree of Master of Philosophy in Social Work.

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CERTIFICATE

This is to certify that the dissertation "Reproductive health seeking behavior and social support of adolescent girls in Lunglei, Mizoram" submitted by C.Lalrempuii, for the award of Master of Philosophy in Social Work is carried out under my guidance and incorporate the student's bonafide research.

The scholar has fulfilled all the required norms laid down for the M Phil regulations by the Mizoram University. The dissertation has not previously formed the basis for award of any degree of this university or any other and this work is a record of the scholars personal effort carried out under my guidance.

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18th December, 2014 (C.LALREMPUII)

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LIST OF ABBREVIATIONS

AIDS: Acquired Immuno Deficiency Syndrome

ARH: Adolescent Reproductive Health

ARSH: Adolescent Reproductive Sexual Health

BCC: Behavior Change Communication

CHC: Community Health Clinic

DH: District Hospital

ESCAP: Economic and Social Commission for Asia and the Pacific

HIV: Human Immuno Deficiency Virus

ICDS: Integrated Child Development Services

ICPD: International Conference on Population and Development

ICTC: Integrated Counseling and Testing Centre

IEC: Information, Education, Communication

ICMR: Indian Council of Medical Research

IUDs: Intra Uterine Devices

IIPS: International Institute of Population Sciences

GoI: Government of India

GoM: Government of Mizoram

KAP: Knowledge Attitude Practice

MSACS: Mizoram State AIDS Control Society

NFHS: National Family Health Survey

PHC: Public Health Centre

RBSK: Rashtriya Bal Swasthya Karyakram

RCH: Reproductive and Child Health

RTI: Reproductive Tract Infection

SAARC: South Asian Association for Regional Cooperation

SDH: Social Determinants of Health

SERC: State Education Resource Centre

SHAHN: Safdarjung Hospital Adolescent Health Network

STIs: Sexually Transmitted Infections

TFR: Total Fertility Rate

UNAIDS: United Nations Agency for International Development

UNICEF: United Nations Children's Fund

UNFPA: United Nations Population Fund

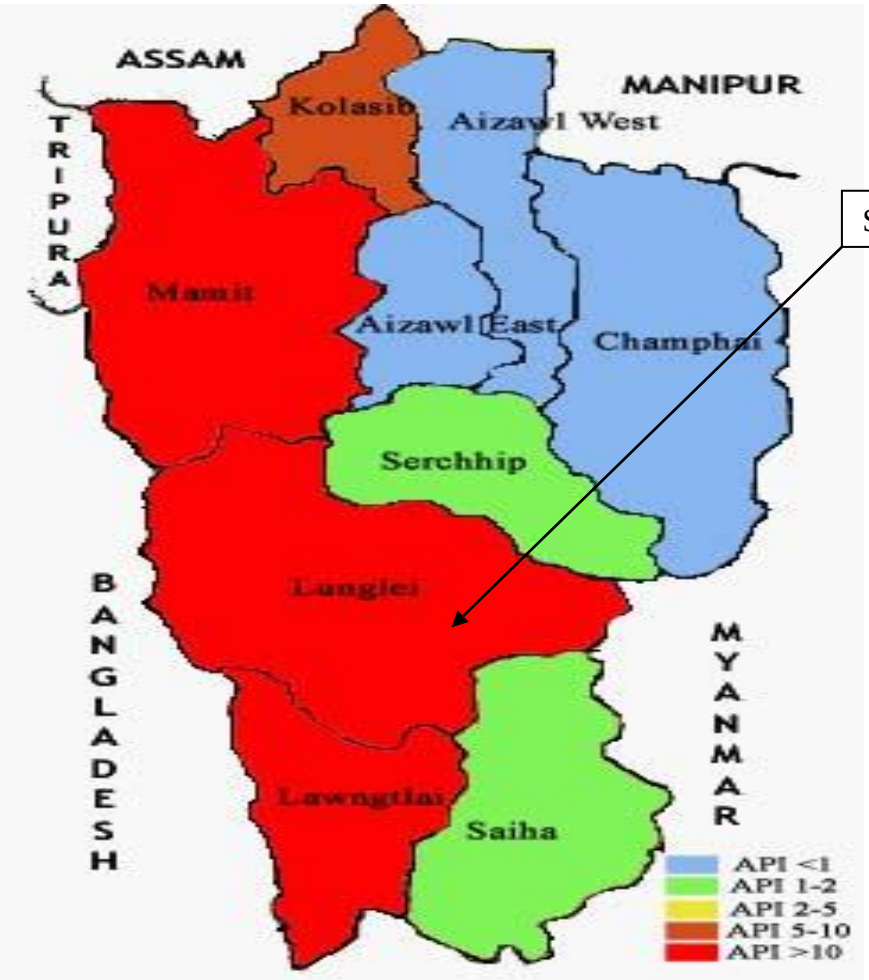
WIFS: Weekly Iron Folic Acid Supplementation

WHO: World Health Organization

CHAPTER - I

INTRODUCTION

The present study attempts to understand the repr13oductive health seeking behavior and social support of adolescent girls in Lunglei, Mizoram. Adolescence is the period of transition, a distinct and dynamic phase of development in the life of an individual because during this period an individual is neither a child nor an adult. The inability to cope with the changes has a direct impact on adolescents' psychosocial health and development on interpersonal relationships.



Lunglei (situated in the south-central part of the state of Mizoram) is a hilly district covered by forest throughout the year. There are no plain areas. The climate of the region is tropical and has a population of 1,61,428, of which female were 78,537(Census 2011, GoI). More than half of the population constitute youth group with an average literacy rate of 86.86% of which males and females are 92.04% and 85.49% literates respectively. In actual number 59,008 people are literate in urban region, Lunglei of which males and females are 30,448 and 28,560 respectively (2011 census).

The reproductive health of adolescents is of growing concern today. The Programme of Action adopted at the International Conference on Population and Development, held at Cairo in 1994, stressed the importance of addressing adolescent sexual and reproductive health issues and promoting responsible sexual and reproductive behavior (United Nations, 1994). The reproductive health needs of adolescents have been largely ignored by the existing health services. Therefore, there is a need to provide such services and to undertake research in understanding adolescent sexual behavior and reproductive health (Bhakta B. G., 2002).

Of the world's 6.1 billion population in 2000, over one billion people (19.1 per cent) belonged to the age group 10-19 years. The Asian region comprises 712 million people in this age group. According to United Nations medium-variant projections, in the world as a whole the number of persons in the age group 10-19 will continue to grow, reaching 1,253 million by the year 2025, while in Asia this number will decline to 698 million by the year 2025 (United Nations, 2001a).

1.1 Adolescence

Those aged 10-19 years are referred to as adolescents by the World Health Organization (WHO) which has also emphasized that 'adolescence is neither merely a social classification nor merely a specific age limitation, rather the combination of the two'. Adolescence is the period between the ages of 10 and 19 years, which is generally when puberty occurs (IN Hurlock E., 2002).

The Government of India Reproductive and Child Health Programme declares 10-19 year olds as adolescents. However, the Government's Integrated Child Development Services (ICDS) state that adolescent girls are those between 11 and 18 years old. *In this study adolescents are those girls who are between the ages of 10-19years*.

1.2 Types of Adolescence

The period, which a child grows and develops into an adult, is called adolescence. WHO (1998) considers "adolescence" to be the period between 10 and 19 years of age. It generally encompasses the time from the onset of puberty to the full legal age which begins with a biological event – puberty, and ends with psychological event like adulthood. According to Mehta and others, the period of adolescence can be

divided into early, middle and late period.

1) Early adolescence (10-13years) is characterized by a spurt of growth, and the beginnings of sexual maturation, they start to think abstractly.
2) In mid-adolescence (14-15years) main physical changes remain completed, they develop a stronger sense of identity, and thinking becomes more reflective, relates strongly to their peers, though families usually remain of primary importance.
3) In later adolescence (16-19years) the body turns to adult form, while they like to get identified noticeably with advanced ideas and opinions (IN Karalam, S.R., 2010).

1.3 Reproductive Health

The most widely accepted definition of reproductive health was adopted at the International Conference on Population and Development (ICPD) in 1994 at Cairo. The ICPD Programme of Action describes reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in al l matters relating to reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Reproductive health therefore subsumes the concept of sexual health and in earlier studies it was not uncommon to see the term reproductive and sexual health. The ICPD Programme of Action cans on all the countries to make reproductive health services and infrastructure available through their primary health care systems for all individuals by 2015 (UNFPA, 1995).

Talking about sex is generally taboo in many cultures. Consequently, little information is provided to adolescents about sexual health. Instead, young people learn more about sexual and reproductive health from uninformed sources, which results in the perpetuation of myths and misconceptions about puberty, menstruation, secondary sex characteristics, physiological and body changes, masturbation, night emissions, sexual intercourse, and STIs. (IN Nembiakkim.R.,2008).

1.4 Magnitude of Reproductive Health – International

Globally, 16 million adolescent girls aged 15-19 years and two million girls under age 15 give birth every year. In the poorest regions of the world, this translates to roughly one in three girls bearing children by the age of 18. Adolescent girls are at the highest risk of maternal mortality: the risk of pregnancy-related death is twice as high for girls aged 15-19 and five times higher for girls aged 10- 14 compared to women in their twenties. Further, pregnant adolescents are more likely than adults to pursue unsafe abortions; an estimated three million unsafe abortions occur every year among girls aged 15-19(Save the Children & UNFPA, 2012).

It has been estimated that at the end of 2001, approximately 40 million people worldwide were living with HIV/AIDS. *Nearly one third of those currently living with HIV/AIDS are aged 1 5-24years*. Adolescents are more vulnerable than adults to unplanned pregnancies, sexually transmitted diseases and HIV/AIDS. It has been observed that when adolescents become sexually active, they tend to have multiple partners and use condoms and other contraceptives inconsistently. Furthermore, younger women are more vulnerable to forced sex and sex in exchange for gifts and money, with increased risks of contracting sexually transmitted diseases, including HIV/AIDS (Ashford, 2001).

Lack of knowledge, skills, and access to contraception and vulnerability to sexual abuse put adolescents at highest risk of unwanted pregnancy, early childbirth, unsafe abortion and RTI including HIV /AIDS. More than half of all new HIV infections, reported globally are from the age group of 15-24 years (WHO, 2002).

1.5 Magnitude of Reproductive Health – Asia

Of the world's 6.1 billion population in 2000, over one billion people (19.1 per cent) belonged to the age group 10-19. The Asian region comprises 712 million people in this age group. According to United Nations medium-variant projections, in the world as a whole the number of persons in the age group 10-19 will continue to grow, reaching 1,253 million by the year 2025, while in Asia this number will decline to 698 million by the year 2025 (United Nations, 2001a).

Several countries in Asia have witnessed a substantial decline in the total fertility rate over the past few decades and a subsequent fall in adolescent fertility.

However, there are still a number of countries in the region with fairly high adolescent fertility rates. According to the 2001 ESCAP Population Data Sheet, the adolescent fertility rate in Asia is 36 births per 1,000 females aged 15-19 (United Nations, 2001b). Bangladesh has one of the highest levels of adolescent childbearing, followed by Nepal and India; all these countries are characterized by early age at marriage for females. It is interesting to note that in Bangladesh about 15 per cent of women aged 20-24years had a child before they reached the age of 15. By the time they were 18 years of age about 47 per cent had had a child and over three fifths (63.3 per cent) had had a child before age 20. Similarly, over half the women aged 20-24years in Nepal and almost half the women in this age group in India have had a child before reaching age 20(ESCAP Population Data Sheet, 2001).

1.6 Magnitude of Reproductive Health – National

In India, **one-half of all young women are thought to be sexually active** by the time they are 18 years of age, and almost one in five are sexually active by the time they are 15 years. A study in 2000 in Madras found that 13 percent of male school-going adolescents and 10 percent of female school-going adolescents clearly approved of premarital sex. The study also revealed that 14 percent of the students, both boys and girls, stated that premarital sex is allowable for males only (IN Nembiakkim.R., 2008).

It is the interplay of biological, cultural and economic factors that make young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV, including their own biological vulnerability to infection if they start having sex very young. Girls are also far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer. In the era of AID S, the consequences for young girls can be disastrous (UNAIDS, 2001).

Adolescents' knowledge of contraception is relatively lower as compared with women aged 20-24years and women aged 15-49years. It is also evident that in countries where the knowledge level is very high, there is only a small difference in contraceptive knowledge between females in the age groups 15-19years and 20-24years.A higher level of knowledge about contraception, however, does not always

translate into a higher level of contraceptive use (Bhakta, B. G., 2002).

Adolescents are considered to be physiologically and socially immature and health risks associated with their pregnancies and childbearing are more pronounced than are those among older women (IN United Nations, 1989). Studies reviewed by the Population Reference Bureau found that adolescent women are especially vulnerable to reproductive health problems, and they are more likely than older women to die from problems related to pregnancy and childbirth. Most important, adolescents face increased risks during pregnancy and childbirth because they have less information and access to prenatal, delivery and postpartum care as compared with older women (Ashford, 2001). Research in many settings finds that in the case of STIs many adolescents and adults opt first for self-treatment or some non-professional service (local healers, patent medicine sellers, etc.) and only subsequently turn to public health clinics or other professional health providers. For example, research from Bangladesh has found that in the case of STIs, the preferred place of treatment for female adolescents (both married and unmarried) was pharmacies, followed by local healers (Barkat et al., 2000).

According to a poll by Durex (2005), 42% 'and 60% of school-going Indian girls and boys respectively have had sexual encounter before age 19, with a quarter having experienced sex before 19 age. Changing social and economic conditions have brought risks as well as opportunities for the adolescents. While early marriage and some harmful traditional practices are diminishing, measures to prevent unwanted pregnancy and sexually transmitted diseases (STDs) among adolescents remain inadequate. In addition to these reproductive health issues, which are beginning to be better documented, there remain areas of special concern which need more research and policy consideration. (Singh and Darroch, 2000).

1.7 Magnitude of the Study – Mizoram

Reproductive and Child Health (RCH) program has been implemented in the state since 1998. Adolescents are critical to the success of any reproductive and sexual health. A severe shortage of services for adolescent anemia among adolescent girl is very common in Mizoram. IEC/BCC activities towards knowledge of RTI/STI, HIV/AIDS and harmfulness of marriage during teenage is required. Adolescent

friendly services also need to be improved in order to motivate them to access health services. Adolescent clinics also need to be identified. *The Reproductive and Child Health status in Mizoram as on April 2012 is depicted in Annexure V.*

Youth clinic under ARSH has been made functional in 27 District Hospital /Sub Divisional Hospital/CHC/PHC across the state. The clinic is operationalised with ICTC, MSACS. The clinic is opened to adolescents in need of counseling - psychological as well as physical. Awareness campaigns are also held across the state among adolescents. State resources and other sources of funds are depicted in *Annexure III.*

Achievement under adolescent health, NRHM during FY 2013-14: Rashtriya Bal Swasthya Kryakram (RBSK) - Being an important health initiative under NRHM, RBSK involves health screening and early intervention services, covering children from birth to 18 years of age and was launched in July, 2013 in the State of Mizoram. Under RBSK, apart from regular health screening of children enrolled in Anganwadi Centres and students in Govt. and Govt. Aided Primary Schools, the latter are administered IFA and Albendazole tablets. Presently, 18 RBSK Mobile Health Teams carry out extensive health screening across the State. Mizoram State Wise Budget allocation of funds for **RCH** and other health sectors are also depicted in Annexure IV.

The following is the health infrastructure in the state:

Medical College Hospital	0
State Hospital	1
Government Hospital	6
District Hospital	6
Referral Hospital	0(1 as on 2014)
Mobile Medical Units	9
City Family Welfare Centre	0
Rural Dispensaries	0
Ayurvedic Hospitals	0
Ayurvedic Dispensaries	1
Unani Hospital	0
Unani Dispensaries	0
Homeopathic Hospital	8
Private Hospital	14
Homeopathic Dispensaries	13

Source: Mizoram PIP: 2011-2012

ARSH: Under ARSH, steps are being taken for upgrading and strengthening 27 Youth Clinics which caters to adolescents in need of psychological and physical counseling services *(Refer Annexure IIa for ARSH).*

Weekly Iron and Folic Acid Supplementation (WIFS): Under WIFS, approximately one Lakh forty seven thousand adolescent boys and girls in the age group of 10-19 years are administered IFA (WIFS) and Albendazole tablets with the aim of reducing anemia prevalence among target groups*(refer Annexure IIb for WIFS)*. (Source: Health.mizoram.gov.in/sh.htm).

1.8 Health - Seeking Behaviour

Health-seeking behavior studies acknowledge that health control tools, where they exist, remain greatly under or inadequately used. Understanding human behavior is prerequisite to change behavior and improve health practices. Experts in health interventions and health policy became increasingly aware of human behavioral factors in quality health care provision. In order to respond to community perspectives and needs, health systems need to adapt their strategies, taking into account the findings from behavioral studies (Muela,S.H.,Ribera,J.M.,Nyamongo,I.,2003).

Knowledge, attitudes and practices (KAP) surveys are possibly the most frequently used studies in health-seeking behavior research. Knowledge is usually assessed in order to see how far community knowledge corresponds to biomedical concepts. (Good, 1994).

There are several tested and tried ways of understanding health seeking among various populations. Some models have outlined the process of health seeking.

1)The Health Care Utilisation Model - This model groups in a logic sequence three clusters or categories of factors (predisposing, enabling and need factors) which can influence health behavior and was specifically developed to investigate the use of biomedical health services (see Weller et al. 1997).

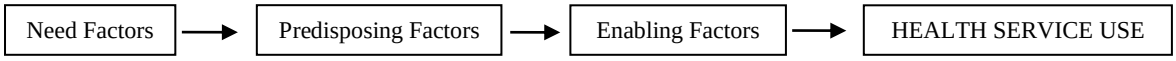


Figure 1: Health Care Utilization Model

Need factors include perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, help from outside for caring etc. *Predisposing factors* include age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc. *Enabling factors* include availability of services, financial resources to purchase services, health insurance, social network support etc. *Health service Use* includes all activities that are done by way of treatment- seeking in response to health problems.

It has become popular among researchers to use different categories which group key factors for health-seeking behaviour. The best known is the grouping into the "four As": -

Availability: refers to the geographic distribution of health facilities, pharmaceutical products etc. **Accessibility**: includes transport, roads, etc. **Affordability**: includes treatment costs for the individual, household or family. A distinction is made between direct, indirect and opportunity costs. **Acceptability**: relates to cultural and social distance. This mainly refers to the characteristics of the health providers – health workers' behaviour, gender aspects (non acceptance of being treated by the opposite sex, in particular women who refuse to be seen by male nurses/doctors), excessive bureaucracy etc. The 'model' of the "four As" has been widely used by medical geographers, anthropologists and epidemiologists who mainly emphasised distance (both social and geographical) and economic aspects as key factors for access to treatment (e.g. Good, 1987). The advantage of the "four As" is the easy identification of key potential 'barriers' for adequate treatment.

1.9 Social Support

Social support, like help-seeking, is a term that does not have a widely agreed-upon definition in the adolescent health and development literature. Social support is generally defined as a range of interpersonal relationships or connections that have an impact on the individual's functioning, and generally includes support provided by individuals and by social institutions. Reid (1989, cited in *Costello, Pickens & Fenton, 2001*) offers a broad definition of social support that includes four specific kinds of support:

1. *Instrumental support*, which is direct support to an individual in the form of financial assistance, skills training, health services, transportation, etc.;

2. *Informational support*, which includes providing information about a need or referrals for help, including health-related information;

3. *Affiliative support*, which means simply, being with other individuals who have mutual interests; and

4. *Emotional support*, which includes close friends or family members, or professionals, who provide help for emotional needs or personal crises.

Social support enhances quality of life and provides a buffer against adverse life events. The source of support may influence which kind of support is effective. There is some evidence that among the four different types of support *informational support shows the strongest relation to quality of life among the adolescent girls. Informational support is helpful if it comes from family and friends, social media, educationist and health professionals such as doctors, nurses, physicians, professors etc to educate them about reproductive health behavior in relation to their illness and problems(Helgeson, 2003).*

The range of programs varies because of organizations' varying experiences and capacities to undertake adolescent- related issues. There is a need to scale up these efforts in order to have a larger impact. The different programmes include *Reproductive and Child Health Services Program,Adolescent Girl Scheme,State Plans of Action for the Girl Child ,District Primary Education Program,Baika Samriddhi Yojana, 1997,National Plan of Action for the SAARC Decade of the Girl Child (1991–2000),* National Rural Health Mission(NRHM).

1.10 Statement of the Problem

Adolescence is a period marked by changes in the physiological and psychological aspects. Adolescent girls in particular go through a series of changes in reproductive health and the beginning of menstruation also brings with it several psychological changes. However, studies assessing the relationship between reproductive health communication and awareness of health seeking behavior among adolescent girls are lacking. The complexity of the period of adolescence, and the accompanying changes in physical and social characteristics is usually emphasized, but it is not very well understood by adolescents or adults. A poor understanding of

reproductive health seeking issues is the main cause for the absence of focus on services, information and research on unique features of adolescent reproductive health (ARH). In recent years, the trends of globalization and liberalization, the rapid spread of communication and information technology, and shifting social and moral norms maybe said to have eroded the traditional bases and defining points for adolescent reproductive behavior, leading to a host of changes in reproductive health concerns. It is acknowledge that adolescents seek informational, emotional, instrumental and affiliative support from their peers, family and other sources. Research is still lacking on the nature and quality of the support offered. These require immediate attention and appropriate interventions. Therefore, this study will focus on information on reproductive health, practices related to reproductive health, and examine social support among adolescent girls. The study will offer suggestions that are likely to have policy and programme implications.

1.11 Objectives

1. To assess the socio-demographic (pre-disposing and enabling factors) particulars of adolescent girls in Lunglei, Mizoram.

2. To understand sources of information and the level of the awareness of adolescent girls on reproductive health behaviour.

3. To understand availability, accessibility and affordability of reproductive health services and opportunities of the adolescents.

4. To examine the social support available to adolescent girls in relation to health-seeking behavior.

1.12 Chapterization

The study is organised in the following chapters**.**

Chapter I Introduction

Chapter II Review of Literature

Chapter III Methodology

Chapter IV Results and Discussions

Chapter V Conclusion and Suggestions

CHAPTER - II

REVIEW OF LITERATURE

"This world demands the qualities of youth: not a time of life but a state of mind, a temper of the will, a quality of imagination, a predominance of courage over timidity, of the appetite for adventure over the love of ease." - Robert Kennedy

A review of the existing literature on Adolescent and Reproductive Health is attempted and the review is organized in the following sub-sections. The first section deals with a study related to the concept of adolescents.

2.1 Adolescence

The word adolescent is derived from the Latin verb *adolescere* meaning 'to grow up '. The term 'adolescence' has been associated with the transition from childhood to adulthood, encompassing the interval between puberty and marriage, and it has been evolved into a distinct period of biological clock.

Adolescent refers to the period of life after the development of secondary sex characteristics, usually between childhood and adulthood representing the period of time during which a person is biologically adult but emotionally not at full maturity. The ages, which are considered to be part of adolescence, vary by culture.

According to UNFPA, people in 15-24 year age group are considered 'youth'. Those aged 10-19 years are referred to as adolescents (WHO 1989). UNICEF however, refers to all age 5-19 years as "children". WHO also emphasized that adolescence is neither merely a social classification nor merely a specific age limitation, rather the combination of the two' (WHO, 1989).

Pachuri (1998, p.118-ll9) states 'puberty marks the biological beginning of adolescence, but of its completion is varied and ill defined. Thus, age and puberty are important defining criteria for adolescence ... the only universal definition of adolescence appears to be that, although no longer considered a child, the young person is not yet considered an adult.' Thus, defining adolescence within a social construct is not possible as it varies across cultures. Adolescence therefore, cannot be defined only by age, puberty, sexual intercourse or marriage so, to have a clear understanding of the meaning of adolescents across cultures, events need to be viewed within the context of gender relations, age hierarchies and social class as well. 'Variation in social and cultural settings between countries and biological differences

concerning age of physical maturation render different connotations to the meaning of adolescence in different settings. In India, traditionally the transition from childhood to adulthood among females has tended to be sudden' (Jejeebhoy, 1996).

2.2 Adolescent health

Adolescence is a time of opportunity and change. It is a period that sees the decision making process that exists between the parents and the child. The major concern during this period is adolescent health. Adolescent health is of high public health concern, particularly reproductive and sexual health. Programs that can provide information, ensure access to services, and develop life skills are crucial to the future of the adolescents. Adolescence is also a time of heightened vulnerabilities. During adolescence an intense sexual drive develops and adolescents typically start exploring relationships with the opposite sex. Adolescents start defining social relationships outside the family (Naseem, 2004). Adolescents experience several changes that include forging of new relationships; challenges related to identity and heightened sense of awareness regarding sexual matters. Most adolescents go through these changes. Nonetheless, all adolescents need support and care during this transition to adulthood. The lives of millions of adolescents worldwide are at risk because they do not have adequate *information, skills, health services and support* they need to go through sexual development during adolescence and postpone sex until they are physically and socially mature, and able to make well-informed, responsible decisions.

Limited access to information creates its own problems for adolescents. Sex is often with coercion, violence and abuse - sometimes even by family members or adults with privileged relations. In patriarchal societies, women are conditioned to be submissive to men, and they find it difficult or impossible to refuse early marriage, to space births, or to refuse to have unprotected sex with an unfaithful spouse or partner. The social environment is critical to healthy adolescent development. Current literature reflects that there are key aspects of this environment, which can prevent adolescents from engaging in unsafe/unwanted sexual behaviour, for example, a strong relationship with parents, a connection to school and open communication with sexual partners. In traditional Mizo society, families do not engage in discourse regarding sexual matters and therefore adolescents grow up regarding all such matters

as taboo. Further, they rarely feel comfortable or have access to counselors who may be able to guide them better. Often policy makers, public opinion leaders and parents believe that withholding information about sexuality and reproduction from the adolescents' will dissuade them from becoming sexually active.

Adolescents need life skills in order to face the challenges of adulthood. Most adolescent boys and girls, married and unmarried become sexually active before the age of 20, but generally lack access to family planning services (including appropriate contraceptives), prevention and care of sexually transmitted diseases, or pregnancy care. Cultural taboos surrounding communication about sexual matters persist in the parent-child relationship, and adolescent have few opportunities outside their peer group to talk about their feelings and anxieties. Providing adolescent reproductive health as a separate service is not feasible in conservative societies as many health care facilities require the consent of parents or spouses (ICPD programme of Action Plan, 1995).

For many adolescents in this study, the opening times or location of services make them inaccessible, or the care is too expensive. In addition, the judgmental attitudes of many health care professionals often discourage adolescents from seeking advice and treatment related to sexual and reproductive health. However, when provided within the umbrella of general health services, the adolescent reproductive health services are readily acceptable by the parents and the society at large. Hence, it is important to consider adolescence as a phase having needs and desires rather than a fixed age group, with physical, psychological, social and cultural dimensions, perceived differently by different cultures.

As a group, adolescents include nearly 1.2 billion people; about 85% of who live in developing countries (United Nations, 1999) therefore providing the adolescent with the reproductive health services now will prevent them from indulging in high-risk activities. According to this report, the needs of adolescents remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviors during adolescence have far reaching consequences for people's lives as they develop into adulthood. Leading a healthy and productive life given the challenges that many

adolescent face, require access to appropriate information, counseling and services in the health and other sector as well as the development of a broad range of decision-making and interpersonal skills.

Most adolescents' in different part of the country tend to marry early, and experience high fertility rates, levels of contraceptive use, high abortion rates, and high levels of violence and sexual coercion (IIPS, 2000).

2.3 Reproductive and Sexual Health

"Reproductive health, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are rights of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning and the right of access to appropriate health care services that will enable the women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant". (ICPD Programme of Action, 1994)

The ICPD report states that the origins of reproductive health often lie in human behavior- the practices in which individuals are engaged, the choices they make and can make, their awareness of healthy practices, and their perceptions of what constitutes acceptable behavior for women or men-that determine the extent to which women and men can attain 'a state of complete physical, mental and social well-being'. Adolescents' needs for reproductive health services are often misunderstood, unrecognized or underestimated. This may be because the information about the adolescent health services is not available or the attentions of the health care provider have not seen a shift towards adolescent health care. In spite of the lackadaisical approach towards the adolescents reproductive health needs it is important to focus on them because: o Adolescents have a right to quality reproductive health services. o Adolescents need reproductive health services.

"Sexual health is a state of physical, emotional, mental and social well being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (WHO, 2002). Further WHO has mentioned that there should be a positive and

respectful approach to sexuality and sexual relationship along with pleasurable and safe sexual experiences free from any kind of discrimination or ill treatment. In order to attain as well as maintain sexual health, it is important to respect the sexual rights of every individual in terms of its protection and fulfillment.

Sex education for adolescents is a controversial issue in India. The controversy, however, is slowly shifting from whether sex education should be there or not to the topics to be covered in such education, and whether the emphasis should be on anatomic and physiologic facts or on norms and morality. In many cases the name itself is unacceptable and a more sanitized name of Family Life Education is being used (Narayan et aI, 2000). Another report states that in Indian schools, sex education is all too often taught by embarrassed teachers who rarely mention homosexuality or condoms. It further states that this is a strange paradox because it is everywhere in the media but no one wants to talk about it. It is the onset of AIDS and the special vulnerability of adolescents and young people that has ensured that we now talk about sexual matters. Nevertheless, the Supreme Court on 16 November 2005 decided that sex education in schools cannot be brought under the ambit of fundamental rights by making it a part of the right to education (www.indiatogether.orgl2005/dec/edu-notaboo.htm), leaving it therefore as an option for many educational administrators to decide.

There is therefore no consensus in India over introducing sex and reproductive health education in the school and college syllabus. Meanwhile, the reality is that a large population of adolescent is in the age group 12-24, and studies are showing their growing preference for pre-marital sex. In a survey in 2002 by The Week magazine, of unmarried young Indians, 69 per cent of men admitted to pre-marital sex compared to 38 per cent of women. In the 16-19 group, forty-five per cent had pre-marital sex, while 27 per cent were 15 years or under and 28 per cent were 20 years or older. At present, information regarding sexuality education is gaining prominence not only in the schools but also in the society, among family or within the workplace. Safdarjung Hospital Adolescent Health Network (SHAHN) operational in New Delhi since 2nd August 2001 undertook a study regarding the needs of adolescent who are between the age group of 15-19 years, in Delhi in the year 2002.

2.4 Adolescents and Contraceptive Use

Adolescents knowledge of contraception is relatively lower as compared with women aged 20-24 and women aged 15-49. It is also evident that in countries where the knowledge level is very high, there is only a small difference in contraceptive knowledge between females in the age groups 15-19 and 20-24.(Bhakta B.G.,2002)

2.5 Maternal and Child Health

Adolescent pregnancy and childbearing have significant effects on maternal and child health. Children born to adolescent mothers are highly likely to have a low birth weight and to be premature, injured at birth or stillborn, and are associated with delivery complications resulting in higher mortality. The increased risk of infant death to adolescent mothers is also associated with immaturity of early childbearing and inexperience in child- rearing. Studies have invariably shown that infant mortality rates are generally higher for babies born to adolescent mothers than for babies born to women in their twenties or thirties(IN ICPD, 1995)

Because adolescents are physiologically and socially immature, health risks associated with their pregnancies and childbearing are more pronounced than are those among older women (IN ICPD, 1995).

2.6 Vulnerability of Young Girls in the Transmission of HIV Infection

It is the interplay of biological, cultural and economic factors that make young girls particularly vulnerable to the sexual transmission of HIV. While both girls and boys engage in consensual sex, girls are more likely than boys to be uninformed about HIV, including their own biological vulnerability to infection if they start having sex very young. Girls are also far more likely than boys to be coerced or raped or to be enticed into sex by someone older, stronger or richer. Sometimes the power held over them is mainly that of greater physical strength. Sometimes it is social pressure to acquiesce to elders. Sometimes it is a combination of factors, as may be the case with older sugar daddies who offer schoolgirls gifts or money for school fees in return for sex. In the era of AIDS, the consequences for young girls can be disastrous (UNAIDS, 2001).

2.7 Programme and Policies of Adolescent Girls - The range of programs varies because of organizations' varying experiences and capacities to undertake adolescent-related issues. There is a need to scale up these efforts in order to have a larger impact.

RCH Services Program: The RCH Program was launched nationwide in 1996 to provide holistic reproductive and child health care through the existing, vast network of the primary health care system.

Adolescent Girl Scheme: This special intervention for girls ages 11–18 started in 1991–92 to meet their special nutrition, education, and skill development needs. This scheme has been extended to 3.9 million adolescent girls in 507 blocks throughout the country, which were selected through the ICDS scheme.

State Plans of Action for the Girl Child: The governments of Karnataka, Madhya Pradesh, Tamil Nadu, and Goa have formulated state plans of action.

District Primary Education Program: This Department of Education program provides a special thrust to achieve universal coverage of primary education through decentralized planning and management, decentralized target setting, community mobilization, and district- and population-specific planning.

Baika Samriddhi Yojana, 1997: This scheme works to raise the status of girl children born in families below the poverty line by providing financial help to these families.

National Plan of Action for the SAARC Decade of the Girl Child (1991–2000): The heads of the government of the SAARC region declared 1991–2000 as the "SAARC Decade for Girl Child" and developed this plan of action.51 In fulfillment of this commitment, the government of India identified "Survival, Protection, and Development" as a major theme, focusing on gender-specific needs and requirements to the fullest possible extent. This was a conscious effort to ensure equitable rights, opportunities, benefits, and status to girl children.

ARHM and NRHM - Government of India has positioned Adolescent Reproductive and Sexual Health (ARSH) Strategy as one of the key technical strategies in RCH II Programme under National Rural Health Mission (NRHM). This strategy focuses on reorganizing the existing public health system in order to meet the service needs of adolescents. Steps are being taken to ensure improved service delivery for adolescents

during routine hours as well as in the dedicated clinics on fixed days and timings at the Sub-Centre, Primary Health Centre, Community Health Centre and District Hospitals and also through the outreach activities. A core package of services would include preventive, promotive, curative and counselling services for adolescents. The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure. The 18 States are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh (http://mohfw.nic.in, accessed on 27th March, 2008).

2.8 Adolescent Sexuality

2.8.1 Sexual behaviour

The ICPD reports are exhaustive and report that although national-level surveys tend to suggest that premarital sex is less common in Asia, more focused in depth studies on adolescent sexual and reproductive health undertaken in some countries of Asia have revealed that it is clearly on the rise. Survey results on sexual behaviors of adolescents in Asia suggest that a noticeable percentage of adolescents are sexually experienced. The report cites that in Korea, for example, 24 per cent of male and 11 per cent of female secondary school student are reported to have had pre-marital sexual intercourse. Among sexually experienced adolescents, a majority of women had their first sexual intercourse with a steady boyfriend with marriage in mind, while a significant proportion of men had the first experience with a commercial sex worker or a casual friend. In the Republic of Korea, Nepal, Thailand, and Viet Nam, over half of the adolescent men had sexual intercourse with sex workers. A large number of sexually-experienced young men have also reported having multiple sexual partners; close to 70 per cent of male students in the Republic of Korea and about 30 per cent of young men in Thailand had more than two partners. (ICPD, 1995)

In India, although traditional norms oppose premarital sex, some studies indicate a growing trend towards premarital sexual activities among adolescents.

However Uddin, in his study had stated that Bangladesh has a very high incidence of premarital sex: 61 per cent of males as compared with 24 per cent of females had had premarital sexual activity among adolescents, and this percentage was much higher in urban than in rural area. A study of Rai in 2001 revealed that from a 1991 study conducted in nine districts of Nepal it has found out that 20 per cent of young people were engaged in premarital sex.On pre-marital sexual behaviour among adolescents, ICPD reports have presented in detail (refer Annexure I)

2.8.2 Factors that lead to risk behaviour among adolescents

ICPD report outlines factors and barriers that can lead to risky reproductive health-related behaviour among adolescents in general, particularly among unmarried adolescents as falling into four main categories, which are reproduced below (ICPD,1995).

(a) Limited access to information

First, adolescents often do not have access to sufficient and correct information. Cognitive distortions and a sense of non-susceptibility lead to uninformed decisions, which may result in unwanted pregnancy and STDs. The notions that they are too young to be pregnant and unprotected intercourse just once could not lead to conception or STD transmission are prevalent among teenagers. There is a great need for reproductive health information and services targeted at adolescents. Information on the risks and prevention of pregnancy, STDs and HIV/AIDS, as well as on the consequences of unplanned pregnancy and abortion, is particularly needed.

(b) Peer pressure

A second factor in risky reproductive health-related behaviour concerns the increasing significance of peer pressure. Growing social acceptance of premarital sex plays a major role in reproductive health-related decision-making among adolescents and other young people. As adolescence is a developmental period of physical transition and identity formation, the struggle for individual autonomy and the social construct of masculinity or femininity, render teenagers susceptible to peer pressure. According to Gage in this report, the influence of peer pressure is increasing in the context of the erosion of traditional parental control over premarital sexual behaviour

and the declining role of family members, especially grandmothers, in providing adolescent girls with premarital instruction and advice on appropriate sexual and marital behaviour . A study by Isarabhakdi on sexual experience of rural Thai youth is also quoted which found that peers influence was one of the main motivations for engaging in first premarital intercourse.

2.8.3 Inadequate access to youth-friendly health services

Third, inadequate access to youth-friendly health services is a major barrier for young people and adolescents often fall between the cracks. Since they no longer qualify for paediatric services and their health problems are not like those of adults, they require specially trained health personnel. Health systems in most countries, particularly in Asia, generally do not specifically address adolescent needs and adolescents often do not feel comfortable visiting clinics designed for adults.

Moreover, the report states that health-care providers in those clinics seem unprepared to discuss sexuality issues with adolescents and many fear that the provision of contraceptives will condone premarital sexual activity. Especially in countries with conservative values and traditions, many parents and policy makers have held strong views that providing contraceptive information and services will promote promiscuity among unmarried adolescents. However, reviews of sex education programmes in several countries conclude that sex education does not encourage early sexual activity, but can delay first sexual intercourse and lead to more responsive behaviour (UNAIDS, 1997).

Hence, the lack of knowledge of contraceptives on one hand and access to contraceptive services and supplies on the other may prevent adolescents from using contraceptives even when they want to protect themselves from pregnancy.

2.8.4 Economic constraints

Finally, quoting Podhisita and others, it is reported that economic constraints can influence the behaviour of young people in some cases. Resource constraints affect the ability to buy contraceptives or seek medical services. Another economic dimension is manifested through youth involvement in sexual relations for economic gain. Economic exchanges are made with persons who are perceived to be in a position to provide economic remuneration for sexual favours. Adolescents are more

likely than adults to engage in such sexual behaviour as offering sex for money or having coercive sex. Adolescent girls are more vulnerable than adult women to being involved in exploitative sexual practices because of compelling reasons to earn money for their own needs or for their families.

2.9 Reproductive Health: Some Specific Issues

Adolescents constitute perhaps the healthiest group in the population, having the lowest mortality and morbidity compared with other population age groups. However, the period of adolescence, beginning with the onset of puberty, is a crucial transition into adulthood. Most adolescents go through adolescence with little or no knowledge of the body's impending physical and physiological changes. In a country like India, where discussion about sexuality with young children is almost absent, adolescents are not prepared mentally or psychologically to cope with these changes.

2.9.1 Psychosocial health

During the transition to adulthood, lack of knowledge and awareness about reproductive organs, physiological changes, or sexuality can promote psychosocial stress. Adolescent girls and boys experience psychosocial stress. A study conducted by the State Education Resource Centre (SERC) in Uttar Pradesh established that gender equality was unknown and adolescent girls felt that they were a burden on their families and had poorer self-image while their counterparts felt superior (SERC, 1998). A recent study by SERC revealed that 14 percent of boys and 8 percent of girls had trouble with sexual thoughts, and nearly 9 percent of the boys and girls perceived premarital stress(Kaila, 2001). The study is particularly true for girls given that the majority of them have no knowledge of menstruation. In most cases, the mothers are the only source of information. Most girls perceive menstruation as disgusting and as a curse. Adolescent girls are also at higher risk of psychosocial stress because of gender discrimination(Government of Rajasthan, 1995).There is a lack of knowledge and awareness among adolescents about health issues and problems.

An Indian Council of Medical Research (ICMR) 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, especially in younger adolescents (ages 10–14). Among the younger adolescents, 40 percent had little knowledge about the sex organs and most girls had not been informed about 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 STIs, including HIV. Older adolescent girls were more aware than younger adolescent girls of the physical and physiological changes that take place in the body. 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 (IUDs) or oral contraceptive pills, was very low(Gupta, 1988).

2.9.2 Reproductive health

The National Family Health Survey has states that high fertility rates, high rates of teenage pregnancy, high risk of STI/HIV, and poor nutritional status are the main health problems among the adolescent population in India. High fertility is related to early marriage. The NFHS-2 showed that over one-third of married adolescents (ages 15–19) had given birth to their first child and another one-tenth to their second child. The average age of women at the birth of their first child was 19.2 years. Births to teens in states such as Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar, Maharashtra, Karnataka, and Andhra Pradesh are more common than in other states in India, with many women younger at first birth less than the national average. (Sabu, et al.,1999)

NFHS-2 also revealed that only 8 percent of married adolescents were currently using a method of contraception to avoid pregnancy. The use of contraceptives was lower in rural areas compared with urban areas, at 7.7 percent and 9.9 percent, respectively. Eighty-six percent of adolescents had never used contraceptives and only 7 percent used contraceptives before having any children. The remaining, ever users, 7 percent, only gave birth to one or more children before starting contraceptive use. Over one- quarter (27.1 percent) of married adolescents have an unmet need for family planning services—primarily for spacing methods (25.6 percent. (IIPS,2000)

Teenage pregnancy, almost all of which takes place within marriage, is the major cause of poor reproductive health and health outcomes among adolescents. About 15 percent of pregnancies are among teenage girls under age 18 who have a two to five times higher risk of maternal death. Adolescent pregnant mothers, who are often already poorly nourished before becoming pregnant, run a high obstetric risk for premature delivery, giving birth to a low birth weight baby, prolonged and obstructed labor, and severe intrapartum and postpartum hemorrhage. Early pregnancy has shown an association with high neonatal mortality, and infant and child mortality. (Jejeebhoy, 2000a. and Verma and Das, 1997).

The NFHS-2 results has been shown that mothers who are younger than 20 years old at the time of first birth were associated with a 1.7 times higher neonatal mortality rate and a 1.6 times greater infant mortality rate than were mothers giving birth between ages 20–29. Induced abortions are yet another important reason for the poor reproductive health of women in general and adolescents specifically. An estimated six million induced abortions are performed in India, and anecdotal evidence suggests that a fairly large proportion of them are performed for adolescent mothers and unmarried teenage girls. While no realistic or accurate data are available, the enormity of the problem may be judged by the fact that 8–10 percent of those who seek medical terminations of pregnancy are teenage mothers and unmarried girls. The real percentage may be far larger. While induced abortion was legalized in India under the Medical Termination of Pregnancy (MTP) Act, a major proportion (approximately 80 percent) of all induced abortions is still performed illegally by private and untrained persons in unhygienic conditions. Induced abortions account for more than 11 percent of maternal deaths and significantly influence women's reproductive health (Registrar General, India, 1993 and Jejeebhoy, 2000b).

A large proportion of adolescent girls suffer from various gynecological problems, particularly menstrual irregularities such as hypermenorrhea, hypomenorrhea, menorrhagia, and dysmenorrhea. As many as 40–45 percent of adolescent girls report menstrual problems. These are mainly due to psychosocial stress and emotional changes. Vesico-vaginal fistula and urinary incontinence are not uncommon. A study conducted in Madras city 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 medical treatment. Although most of these are normal symptoms of menstruation among adolescents, these need to be mentioned particularly in the Indian context because most of the girls are not aware of this natural phenomenon (Chakravarty, 1989).

There are several gynecological problems among female adolescents. These problems arise primarily as a result of changing hormone patterns (due to changes in endocrine activity during the transition from pre- puberty to puberty) and emotional, psychological, and physical changes associated with adolescence (although puberty is a normal physiological process, menstrual irregularities and dysmenorrhea may frighten young adolescents). The age of menarche among Indian girls, which is reported to be declining, ranges from 11.5–14.5 years, with the current average age being 13.5 years. (Bhatia, 1993) This has resulted in earlier onset of puberty and secondary sex characteristics, and increased reproductive exposure. This has special significance in the Indian cultural context because early marriage and indeed, child marriage, is commonly practiced in many of the states' rural areas (Bhatia, 1993).

A cross sectional study was carried out among adolescent and pre-adolescent girls (10-19 years) in the rural district of Karimnagar, AP,with a total sample size of 181using a predesigned, structured interview based questionnaire which contained questions related to puberty, hygiene and urinary tract infection. Association was seen between Urinary Tract Infections and use of unsanitary practices such as use of Cloth during periods , repetitive use of same cloth etc.(Ahmed and Avasarala, 2009).

Reproductive tract infections (RTIs) and STIs are not uncommon. In India, STIs rank third among the major communicable diseases. Of concern, however, is that approximately 12–25 percent of all STI cases are among teenage boys. (Ramasubban, 1995). STIs often go undetected or untreated among young women, who, embarrassed or stigmatized by the presence of an STI, are reluctant to seek help. Yet STI agents, such as chlamydia and human papilloma virus, can have dire consequences, such as infertility or cervical cancer. STIs also facilitate the transmission of HIV. There is very little information on the female sex partners of unmarried male students.33 Increased sero-positivity has been reported in Mumbai,

rising from 2 percent to 30 percent in two years among commercial sex workers (CSWs), the primary makeup of whom are adolescents. (Ramasubban, 1995)

Anemia is a widely prevalent health problem among adolescent girls. Both the 1992 Indian Council of Medical Research(ICMR) study on iron and folic acid supplementation and UNICEF have reported low mean hemoglobin levels and low nutritional intake of proteins, calories, and macro/micronutrients among adolescent girls and pregnant mothers. (ICMR, 1992) Poor physical growth and stunting are the primary outcomes of poor nutrition. The 1998–99 NFHS-2 reported that the prevalence of anemia was the highest (56 percent) among adolescents (ages 15– 19) compared with other groups of women of reproductive age. Even in the prosperous state of Gujarat, over 61 percent of adolescent girls were found to be anemic with mean hemoglobin levels of 11.4 g/dl.(Sheshadri, 1997) The serum ferritin levels were less than 20 mcg/l among 58 percent of girls, indicating a severe depletion of iron. A series of studies during 1992–97 in urban areas in different parts of the country reported that 64 percent of adolescent girls were anemic (Kanani, 1997).

2.9.3 Sexual health

Adolescence is shrouded in myths and misconceptions about sexual health and sexuality. In Indian culture, talking about sex is taboo. Consequently, little information is provided to adolescents about sexual health. Instead, young people learn more about sexual and reproductive health from uninformed sources, which results in the perpetuation of myths and misconceptions about puberty, menstruation, secondary sex characteristics, physiological and body changes, masturbation, night emissions, sexual intercourse, and STIs. In India, one-half of all young women are thought to be sexually active by the time they are 18, and almost one in five are sexually active by the time they are 15. There are approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. A study conducted in 1997 of boys and girls from the selected colleges of Mumbai revealed that a large percentage of boys and girls reported engaging in non-penetrative sexual experiences (e.g., kissing, hugging, touching sexual organs), but only 26 percent of boys and 3 percent of girls reported that they had experienced sexual intercourse. (Leena Abraham, 2001).

The study also revealed that less than 50 percent of the boys who reported that they had experienced sexual intercourse had used a condom, although all of them said they knew about condoms and their function. Another study on sexual behavior and attitudes among urban college students reported that 28 percent of males and 6 percent of females were sexually active (Watsa,1993). A study in 2000 in Madras found that 13 percent of male school-going adolescents and 10 percent of female school-going adolescents clearly approved of premarital sex. The study also revealed that 14 percent of the students, both boys and girls, stated that premarital sex is allowable for males only (Sirur, 2000).

A study conducted in Rajasthan on adolescent boys' and girls' knowledge and awareness of sexual behavior revealed that more than half of the adolescent boys (ages 15–21 years) reported that they masturbated, and the practice was reported more often among rural and older boys(Gupta, 1998). More than one-third of the adolescents said they touched their body in some sexual manner, and about 20 percent had touched their genitals. The study also revealed that 15 percent of the adolescents had experienced sexual intercourse and 21 percent of those reported having had a homosexual relationship.

Thus, we can list out some important problems specific to adolescence regardless of any boundaries, these include:

- Early pregnancy
- Abortion
- STDs including HIV AND AIDS
- Substance abuse (including abuse of alcohol and tobacco with or without addiction)
- Risk-taking, impulsive behavior leasing 0 accidents, suicides, and homicides
- School dropout or truancy and unemployment
- Juvenile delinquency
- Prostitution

2.10 Health seeking behavior (HSB)

Health seeking behavior (HSB) denotes visiting the health-care facility, which

includes privately owned hospitals, public hospital, clinic, ayurvedic hospitals, nursing homes or home medicine. The desired HSB has been related to visiting official channels in a formally recognized health-care. However, public hospitals in India are known for low quality treatment, long waiting period, long distance, inconvenient location and inadequate facilities in public hospitals. So, private care was preferred due to easy accessibility even in the night, quick relief and individual attention.

2.10.1 Health seeking behaviour models

Health- and treatment-seeking behaviour models from social psychology, medical sociology and medical anthropology allow for considerable extention of the determinant factors for behaviour of KAP and FES studies. In public health, probably the most utilised models from social psychology are the Health Belief Model, the Theory of Reasoned Action and its later development to the Theory of Planned Behaviour. Most known from medical sociology and medical anthropology are, respectively, the Health Care Utilization or Socio-Behavioural Model by Andersen and its diverse posterior variations, and the Decision Making Model. All models contain associations of variables which are considered relevant for explaining or predicting health-seeking behaviours. On the whole, health-seeking behaviour models as applied to public health mostly serve as catalogues of relevant variables that need to be considered in research design, rather than as behavioural models themselves (IN Muela,S.H et.al, 2003).

2.10.1.1 The Health Belief Model (HBM)

This is possibly the most known model in public health, and also the oldest one from social psychology, developed in the 1950s. Action in the HBM is guided by:

(1) Beliefs about the impact of illness and its consequences (threat perception) which depend on: - Perceived susceptibility, or the beliefs about how vulnerable a person considers him- or herself in relation to a certain illness or health problem. - Perceived severity of illness or health problems and its consequences;

(2) Health motivation, or readiness to be concerned about health matters. (This factor has been included later in the HBM, in the 1970s).

(3) Beliefs about the consequences of health practices and about the possibilities and the effort to put them into practice. The behavioural evaluation depends on: - Perceived benefits of preventive or therapeutic health practices; - Perceived barriers, both material and psychological (for example 'will-power'), with regard to a certain health practice.

(4) Cues to action, which includes different, internal and external factors, which influence action. For example, the nature and intensity (organic and symbolic) of illness symptoms, mass media campaigns, advice from relevant other (family, friends, health staff, etc.). (5) Beliefs and health motivation are conditioned by socio-demographic variables (class, age, gender, religion, etc.) and by the psychological characteristics of the interviewed person (Sheeran and Abraham, 1995).

2.10.1.2 The Theory of Reasoned Action and the Theory of Planned Behaviour

The Theory of Planned Behaviour (TPB) is an extension of the earlier Theory of Reasoned Action (TRA). Both have been developed and amply used in HIV/AIDS research. An outstanding aspect of the TPB is the central role of social network support. Health promotion among sex workers, with the collaboration of committed sex workers who were trained to distribute information and to offer support to their colleagues, provided positive results in a South African mining community (Campbell & Mzaidume, 2001).

2.10.1.3 The Health Care Utilisation Model

The socio-behavioural or Andersen model (Andersen & Newman, 1973) groups in a logic sequence three clusters or categories of factors (predisposing, enabling and need factors) which can influence health behaviour. The model was specifically developed to investigate the use of biomedical health services. Later versions have extended the model to include other health care sectors, i.e. traditional medicine and domestic treatments (Weller et al. 1997).

2.10.1.4 The "four As"

It has become popular among researchers to use different categories which group key factors for health-seeking behaviour. The best known is the grouping into

the "four As": - **Availability:** refers to the geographic distribution of health facilities, pharmaceutical products etc. - **Accessibility**: includes transport, roads, etc. - **Affordability:** includes treatment costs for the individual, household or family. A distinction is made between direct, indirect and opportunity costs. - **Acceptability**: relates to cultural and social distance. This mainly refers to the characteristics of the health providers – health workers' behaviour, gender aspects (non acceptance of being treated by the opposite sex, in particular women who refuse to be seen by male nurses/doctors), excessive bureaucracy etc (Good, 1987).

2.10.1.5 Pathway models

The strength of pathway models is that they depict health seeking as a dynamic process. Factors are sequentially organized, according to the different key steps (i.e. recognition of symptoms, decision making, medical encounter, evaluation of outcomes, re-interpretation of illness) which determine the course of the therapy path. Pathway models acknowledge the dynamics of illness and decision-making (Good 1987).

2.10.1.6 Ethnographic decision-making models

Ethnographic decision-making models attempt to predict health-seeking behaviour. The methodology they use in order to identify key factors involved in therapy choice follows several steps. In a first ethnographic assessment, the key factors as pointed out by the community are enquired. Combining these factors, the researcher will creates different hypothetical scenarios or vignettes. A typical vignette would be: If illness is perceived as serious, and you have economic resources, what would you do? These vignettes are then presented to interviewees, and answers are quantified in percentages. Finally, a series of rules is elaborated, for example: "if a family has money and a severe illness they would consult a doctor" (Weller et al. 1997).

2.11 Interventions and policy making

Health-care-seeking behaviour studies range across many different health care programmes – from malaria studies to reproductive health. These studies are important because they provide relevant information on what patients, or caretakers,

do when faced with a health problem. The primary question is, to what extent have health- seeking behaviour studies been useful in determining the type of intervention programmes that can be put in place to alleviate the myriad of health problems?

1) IEC campaigns

Information, education and communication (IEC) campaigns combine strategies, approaches and methods that enable individuals, families, groups, organisations and communities to play active roles in achieving, protecting and sustaining their own health (UNHCR, 1999).

2) Improving home treatment practices

Kleinman (1980) stressed that most decisions about health care and treatments occur in what he called the popular sector – as differentiated from the 'folk' and the professional sectors. Numerous studies have documented the importance of home treatments. Ryan (1995) found that in a Kom village of Cameroon, 83% of the illnesses were treated at home, with 22.5% of the 454 illness episodes seeking treatment outside the home. Kroeger (1983) reported that 80% of illnesses are managed within the household, further pointing to the importance of looking at the home as a major player in the management of health problems. In Guatemala, Weller and colleagues (1997) have shown that up to 90% of the initial treatment actions take place at home and they may involve use of home remedies or remedies obtained from a pharmacy. Of the remaining 10%, 8% of the initial actions involved seeing a physician or a nurse while about 2% of the people visited a folk healer. The importance of home treatment with a particular emphasis on malaria has been shown in a variety of studies (Foster, 1995; Hamel et al., 2001; Nyamongo 2002). In developing countries, constrained access to health care facilities reinforces the need to focus on local solutions in the management of illnesses. Particularly in the field of malaria, interventions have been designed to improve access to drugs and treatment compliance.

3) Collaboration with traditional healers

Traditional medicine is one of the most ambiguous and controversial topics in the ambit of national and international agencies involved in the development of Primary Health Care in developing countries. As a medical recourse utilised by the population,

its interest as a study object is unquestionable, but its position in the design of health planning is a constant motive for polemic among experts. Although without outstanding results, the World Health Organization has promoted since 1978 (WHO, 1978; Akerele, 1984; WHO, 1991; WHO, 1995; WHO, 1996; WHO, 2002) a search for strategies which, at least, make possible a certain collaboration between the generically called 'traditional healers' and health professionals linked to biomedical institutions.

4) Social marketing

Population Services International (PSI) uses social marketing techniques in pricing and selling of nets, condoms and other family planning methods. These techniques are aimed at making products accessible to the poor who are also more likely to be affected. Coupled with segmentation of the client market, one can achieve higher sales while reaching the widest market at affordable rates (PSI, 2003).

5) Gender-sensitive approaches

The number of health care alternatives for each gender has changed significantly over the past years. The classical approach of Women in Development (WID) emphasized campaigns designed to improve women's health, mainly through education. The more recent approach of Gender and Development (GAD) moves explicitly away from considering women as passive subjects whose life and health circumstances need to be improved towards seeing women as protagonists in the health programmes (WHO, 1997).

2.12 Social Support and Adolescent Girls

It has been studied that for other minority adolescent groups (e.g., racial minorities), family is a significant source of social support, in part because family members commonly share minority back- grounds. This is not true of sexual minorities, however. Parents' attitudes toward their children's sexual orientation vary considerably and exert a strong influence on adolescents' psychological state. Although parents do not always respond negatively, disclosure of sex- ual orientation to parents is one of the most stressful developmental tasks for sexual minority adolescents (D'Augelli and Hershberger 1993).

Adolescents who anticipate negative responses from parents are less likely to disclose their sexual orientation; to avoid disclosure; they may become emotion- ally distant from their parents, as with their friends (Savin-Williams 1998). It has been envisage that many past studies documenting sexual minorities' conflicts with parents or emotional distance from parents tended to focus on parents' initial responses to disclosure of sexual orientation, but the existing evidence shows that the over- all relationship with parents is not necessarily bad (Savin Williams 1998). To cope with the noxious social environment at school, sexual minority adolescents may develop friendships with each other. This argument also is consistent with the general tendency of friendships to develop among people who share social positions (e.g., in sex, race, or socioeconomic status).

In this study, attachment to parents, friends and boyfriend included five items each for mother and for father: "whom can you really count on when you need to talk?"; "whose live do you feel that you are an important part of?"; "In the case of failed relationships, whose is most likely to be of help to you?"; "Who is most understanding when you have monthly periods?"; and "Who is least understanding when you have monthly periods?" Attachment to mother and father were highly prevalent.

It has been reviewed that skills, attitudes, perceived social norms, and self-efficacy have all been related to parent-adolescent sexual communication behavior. Skills are the abilities an individual needs to carry out the behavior. We assessed two skills: parent knowledge and parent comfort. Multiple studies indicate that parents' perceptions of being more knowledgeable about sexual health and more comfortable talking to their children about sexuality are associated with more frequent and more extensive parent- child sexual communication (Byers et al., 2008; Guilamo-Ramos, Jaccard, Dittus, & Collins, 2008; Jaccard, Dittus, & Gordon, 2000; Jerman & Constantine, 2010).

It is evident that attitudes consist of positive and negative evaluations of the likely outcomes of performing the behavior. Parents identify a number of outcomes that serve as barriers to communicating with their children about sexuality, including feeling embarrassed, believing that their child is too young for such discussions, and fearing that talking about sex will encourage their child to engage in sexual activity

(Wilson et al., 2010). Parents who expect fewer negative and more positive outcomes from sexual communication tend to talk more to their children about sexuality (DiIorio et al., 2000; Guilamo-Ramos et al., 2008; Jaccard et al., 2000). Perceived social norms refer to perceptions that important others think one should or should not perform the behavior. *Guilamo-Ramos et al*. found that mothers who saw important others as approving of them talking about sexual intercourse engaged in more frequent discussions of the topic with their young adolescents. Self- efficacy is the confidence one has to perform the behavior. Mothers with higher self- efficacy for parent-child sexual communication engage in more frequent and more extensive sexual communication with their children (DiIorio et al., 2000; Guilamo-Ramos et al., 2008).

It has been therefore suggested by Macbeth and Weaver that mother in the intender group, changing their perceptions of social norms may be particularly important for helping them enact their intentions.Mothers in the non intender group, these mothers may be more likely to enact their intentions if they were aware that there is widespread support among parents for providing sexual health information to adolescents. Findings by Byers and others suggest that mothers require more help talking about some topics than others. In keeping with previous research (Byers et al., 2008; Rosenthal & Feldman, 1999), mothers were particularly likely to have engaged in discussions on topics relevant to their adolescent's developmental level including puberty, abstinence, sexual coercion, and sexuality in the media and on the Internet. Fewer mothers, however, had discussed topics that would prepare their adolescent for future sexual experiences such as birth control and safer sex, STDs/STIs, and sexual decision making.

According to Salovey, Social support, whether from a trusted group or valued individual, has been shown to reduce the psychological and physiological consequences of stress, and may enhance immune function. Social networks, whether formal (such as church or social club) or informal (meeting with friends) provide a sense of belonging, security and community. In fact, social support is now proven to be a literal life-saver. People that are supported by close relationship with friends, family, or fellow members of church, work, or other support groups are less vulnerable to ill health and premature death. There is also a strong tie between social

support and measures of wellbeing. Those who have close personal relationships cope better with various stressors, including bereavement, job loss, rape, and illness.

CHAPTER - III

METHODOLOGY

3.1 Pilot study

A pilot study was conducted among the key informants(Chief Medical Officer, Child Development Programme Officer, Gynaecologist, Counsellor and community leaders) in Lunglei to understand the issues and challenges faced by adolescent girls in respect to their sexual and reproductive health since there has been very little data available.

The pilot study revealed the following data which guided the designing of the present study. Secondary data was also collected at this stage in reference to achievement of family welfare, Adolescent Reproductive and Sexual Health, Reproductive and Child Health Programme. Details are appended at the end.

3.2 Methodology

This study was conducted among 70 adolescent girls between the ages of 10-19years, residing in Lunglei district of Mizoram.

3.2.1 Research Design

This study employs an exploratory design and is cross - sectional in nature. Mixed methods research was applied which involves the philosophical assumption and an approach to enquiry that contains qualitative and quantitative forms. Both qualitative and quantitative data was thus collected.

3.2.2 Sources of Data

Data was collected from both primary and secondary sources. Primary sources included data that was collected from Key Informant Interviews (with CMO Lunglei, District Social Welfare Officer, Lunglei, CDPO Lunglei, Gynaecologist, Counsellor, and community leaders), Focus Group Discussions(one each in each area of study) with adolescents added to the primary data. A semi-structured interview schedule for the adolescent girls in rural and urban communities was administered for collecting the information on reproductive health awareness, health seeking and social support.

Secondary sources included information collected from the Health Department (Aizawl), CMO (Chief Medical Officer) Office and Social Welfare Department, GoM.

3.2.3 Universe of the Study

Adolescent girls in Lunglei, Mizoram formed the universe of the study.

3.2.4 Sampling

a) Multi-stage sampling was used. In the first stage, Lunglei was chosen using purposive sampling as the researcher is from this district and further, since there are very few studies from Lunglei on reproductive health. In the second stage, Lunglei town was selected purposively. In the third stage, one core and one peripheral area in Lunglei town were selected based on objective criteria such as literacy and sex ratio (2011 census). 'Chanmari' was identified as the core area and is the central area housing the market and all other amenities and facilities. 'Thuampui', which is located 22kms away from the core area was the selected peripheral location. In the fourth stage, a list of all adolescent girls between the ages of 10-19 years was obtained from the community leaders. In the final stage, the sample was drawn using systematic random sampling. A final sample of 70 respondents was thus obtained (35 from the core area and 35 from the peripheral area).
b) Sampling for key informant interviews with CMO Lunglei, District Social Welfare Officer, Lunglei, CDPO Lunglei, Gynaecologist, Counsellor, Nurse (GNM) and community leaders was done purposively.
c) Two focus group discussions (one in each locality with a group of 8-10 members) among adolescent girls were conducted to assess social support perceived by adolescent girls in relation to reproductive health. Sampling for this was done purposively. A group was mobilised after explaining the objectives and obtaining consent through voluntary participation.

3.2.5 Tools of Data Collection

Three tools were used to collect data from different groups of people in order to arrive at an understanding of the topic.

a) Guide for KIIs – to collect information on help seeking behaviour, problems and challenges faced by adolescent girls, magnitude of the problem, services and opportunities faced by the adolescent girls.

b) Guide for FGDs – to document challenges and issues faced by the adolescent girls.

c) Semi-structured interview Schedule – which included information related to demographic profile, sources of information, awareness level of the adolescent girls, accessibility, affordability, availability and social support.

3.2.6 Data Processing and Analysis

Data from the interview schedule with respondents was processed through Microsoft excel and with the help of computer software SPSS package. Data is presented in simple percentages. FGDs and KIIs were analyzed through manual coding and is presented in narrative form.

CHAPTER - IV

RESULTS AND DISCUSSIONS

This study was conducted with the objective of understanding reproductive health and social support of adolescent girls in Lunglei. This chapter presents the results and discussions in two parts. The Part I is data collected through quantitative means. Part II consists of data from qualitative means. Part I consists of six sections. Part II consists of two sections. The chapter is organized keeping the objectives of the study in the following manner.

PART I

Section I: Socio-demographic particulars

Section II: Personal Information

Section III: Reproductive Health History

Section IV: Marital and Sexual History

Section V: Perceptions Related to Sexual and Reproductive Health

Section VI: Awareness on Reproductive Health

Section VII: Accessibility, Availability and Affordability

Section VIII: Coping and Social Support

PART II

Section I: Data from Key Informants

Section II: Data from Focus Group Discussions

Section I: Socio-demographic Particulars

There are few studies that have been done that document reproductive health of adolescents in Mizoram. It is important to understand the socio-economic particulars of adolescent girls as we have little data in Mizoram. Age, Marital status, Nature of intimate relationship, etc are of great importance. Social work intervention also has to take into consideration the social and demographic particulars. Social work intervention is the practice of working in a variety of ways with individuals and families in need.

Figure1. Age of Respondents

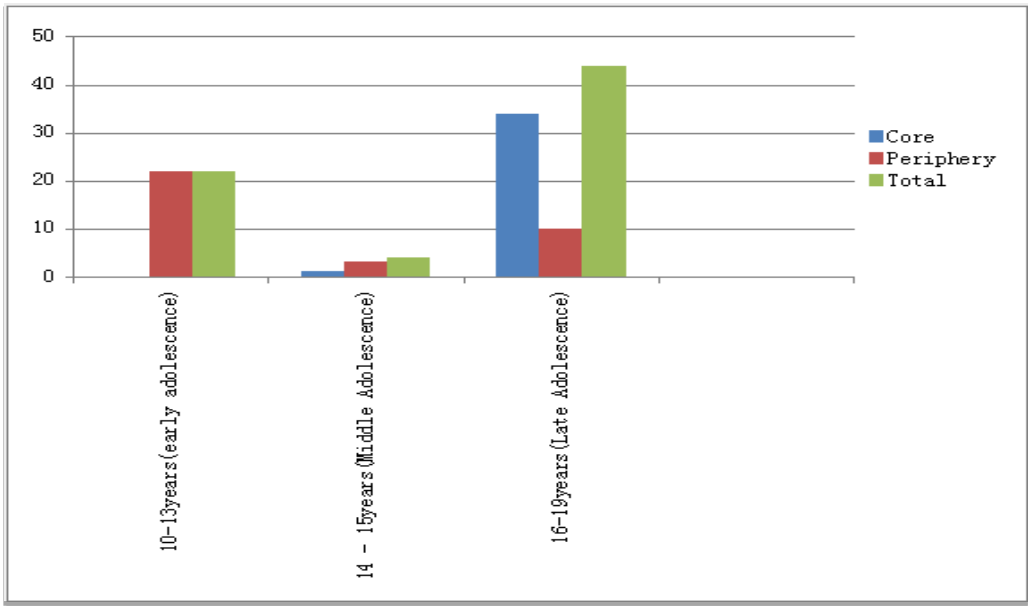


Figure 1 shows the age group of respondents i.e adolescent girls. The age group is therefore classified as *Early adolescence, Middle Adolescence and Late Adolescence.*

With regards to gender, the respondents are adolescent girls of the age group 10-19 years.

With respect to the age of the respondents, there are three categories of age group i.e *early adolescence (10-13 years), middle (14-15years) and late adolescence (16-19years).* Less than a third of the respondents are between 10-13 years, an insignificant minority between 14-15 years and less than two-thirds of the respondents are within 16-19 years of age. From the total sample drawn, there were no respondents from the core area who were between 10- 13 years.

Table 1: Educational Status of the Respondents

Sl. No	Educational Status	Location		Total N=75
		Core n=35	Periphery n=35	
1	Class V	0	19	19
		(0.0)	(54.3)	(27.1)
2	Class VI	0	6	6
		(0.0)	(17.1)	(8.6)
3	Class VII	0	4	4
		(0.0)	(11.4)	(5.7)
4	Class IX	0	2	2
		(0.0)	(5.7)	(2.9)
5	Class X	0	4	
		(0.0)	(11.4)	(5.7)
6	Class XII	35	0	35
		(100.0)	(0.0)	(50.0)

Source: Computed Figures in parentheses are percentages.

Qualification comprises of *class V, Class VI, Class VII, Class IX, Class X and Class XII.* In the core areas, all the respondents falls under *Class XII* i.e. half of the respondents. In the peripheral areas, more than half of the respondents (54.30%) have studied up to *Class V* standard, more than a fifth(17.10%) are *Class VI*, slightly more than a tenth(11.40%) are C*lass VII*, an insignificant minority in *Class X* and no respondents from *Class XII.* Interestingly, all respondents in the core area had studied upto Class XII while not a single person from the peripheral area had done the same indicating that respondents from the core area were able to study in higher classes as compared to their counter parts in the peripheral area.

Table 2: Marital Status of the Respondents

Sl.No	Marital Status	Location		Total N=70
		Core n=35	Periphery n=35	
1	Unmarried	31	34	65
		(88.6)	(97.1)	(92.9)
2	Married	0	1	1
		(0.0)	(2.9)	(1.4)
3	Others	4	0	4
		(11.4)	(0.0)	(5.7)

Source: Computed Figures in parentheses are percentages.

Marital status comprises of three categories viz., *unmarried, married and widow*. Majority of the respondents (92.90%) are *unmarried* and an insignificant minority are *married* (1.40%), out of which it was from the periphery(2.9%) and *widowed*(5.70%), out of which it was from core(11.4%). Only one respondent had been married at the time of interview and she is from the peripheral area. *More than a tenth from the core area were categorized as others since they reported having had sexual experience and bearing children out of wedlock although they remained unmarried.*

Table 3: Number of children, if any

Sl.No	Number of Children	Location		Total N=70
		Core n=35	Periphery n=35	
1	No children	31	32	63
		(88.6)	(91.4)	(90.0)
2	One child	4	3	7
		(11.4)	(8.6)	(10.0)

Source: Computed Figures in parentheses are percentages.

Majority of the respondents (90.0%) did not have any children. In the core areas, more than a tenth (11.40%) have had at least one child and less than a tenth in peripheral areas (8.60%). *Overall, the results signify that one in ten adolescents have already borne a child before reaching 19years of age.*

Table 4: Nature of Intimate Relationship

Sl. No	Nature of Intimate Relationship	Location		Total N=70
		Core n=35	Periphery n=35	
1	Boyfriend	13	14	27
		(37.1)	(40.0)	(38.6)
2	Any other (flirt)	0	20	20
		(0.0)	(57.1)	(28.6)
3	NA	22	1	23
		(62.9)	(2.9)	(32.9)

Source: Computed Figures in parentheses are percentages.

Nature of intimate relationship is classified into three categories i.e, spouse, boyfriend, any other and NA (not applicable). A third of the respondents (32.40%) in the core area and nearly two-thirds in the peripheral did not have any kind of intimate relationship. More than a third (38.60%) of adolescents however, have had intimate relationships with a boyfriend. More than a quarter (28.60%) in peripheral area has an intimate relationship and state that such relationships were casual involving flirting with others other than their spouse and boyfriend.

Table 5: Type of Family

Sl.No	Type of Family	Location		Total N=70
		Core n=35	Periphery n=35	
1	Nuclear	21	30	51
		(60.0)	(85.7)	(72.9)
2	Joint	14	4	18
		(40.0)	(11.4)	(25.7)
3	Extended	0	1	1
		(0.0)	(2.9)	(1.4)

Source: Computed Figures in parentheses are percentages.

Type of family is classified into *Nuclear, Joint and Extended family*. Nearly three - quarters (72.90%) had *nuclear family* pattern. A quarter (25.70%) of the respondents lived in *Joint family* system. An insignificant minority (1.40%) are *extended family*. Nearly an overwhelming majority (85.70%) in peripheral areas is living in nuclear family system and nearly two-thirds (60.0%) from core area. More

than a third (40%) are following the J*oint family* system in core area and an insignificant minority (4%) in peripheral area. An insignificant minority (2.90%) has an *extended family* among adolescents in peripheral area.

Table 6: Form of Family

Sl. No	Form of family, if nuclear	Location		Total N=70
		Core n=35	Periphery n=35	
1	Single Parent Family (father headed)	4	5	9
		(11.4)	(14.3)	(12.9)
2	Single Parent Family (mother headed)	5	4	9
		(14.3)	(11.4)	(12.9)
3	NA	26	26	52
		(74.3)	(74.3)	(74.3)

Source: Computed Figures in parentheses are percentages.

More than a tenth (12.9%) belong to *single parent family with either* mother headed or father headed family in core and peripheral areas. Nearly three quarters of the respondents (74.3%) are *living with their own parents* and not a single parent family.

Table 7: Denomination

Sl.No.	Characteristics	Location		Total N=70
	Denomination	Core n= 35	Periphery n=35	
1	Baptist	24	24	48
		(68.6)	(68.6)	(68.6)
2	Presbyterian	2	0	2
		(5.7)	0.0	(2.9)
3	UPC	9	10	19
		(25.7)	(28.6)	(27.1)
4	Hindu	0	1	1
		0.0	(2.9)	(1.4)

Source: Computed Figures in parentheses are percentages.

Social characteristics consist *of religion, denomination and socio-economic* category. An overwhelming majority (97.10%) of the respondents are *Christian*. An insignificant minority are *Hindu* (only 1.4%). There are four denominations among the respondents viz *Baptist, Presbyterian, UPC and Hindu.Baptist* dominated more than two thirds (68.6%) of the respondents. *UPC* dominated more than a quarter (27.1%) of the respondents. An insignificant minority are *Presbyterian* (2.9%). Among the respondents, 1.4% is *Hindu,* out of which it was from the periphery (2.9%).

Table 8: Socio- economic category

Sl. No	Socio-economic category	Location		Total N=70
		Core n= 35	Periphery n=35	
1	APL	31	7	38
		(88.6)	(20.0)	(54.3)
2	BPL	4	28	32
		(11.4)	(80.0)	(45.7)

Source: Computed Figures in parentheses are percentages.

Majority (88.6%) of the respondents from urban areas falls under *APL category* where only a fifth (20%) of the rural areas falls under *APL category*. However, majority (80%) of the rural areas falls with *BPL category* compared to only more than a tenth (11.4%) of the urban areas. So, there is more than a half (54.3%) of the respondents which falls under *APL category* and less than a half (45.7%) falls under *BPL category*.

Section II: Childhood History and Academic Performance

Information was sought on childhood history and academic performance. This section also includes number of siblings, traits in childhood and works that contributes to family income. The personal information consisted of awareness level with reference to birth, health in childhood, traits in childhood, academic performance, number of closed friend in schools, contribution to family income and number of siblings.

Table 9: Awareness level of respondents on kind of delivery system

Sl.No.	Delivery	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Normal Delivery	35	35	70
		(100)	(100)	(100)
2	Premature Birth	30	24	54
		(85.7)	(68.6)	(77.1)
3	Section Delivery	14	16	30
		(40.0)	(45.7)	(42.9)

Source: Computed Figures in parentheses are percentages.

An overwhelming majority (100%) of the respondents were aware of Normal delivery at birth. More than three – quarters (77.1%) were aware of pre-mature birth. Almost half (42.9%) of the respondents were aware of section delivery. It is clear from the table that the all respondents have adequate information about the types of delivery. Nearly a sixth (14.9%) in urban areas is not aware of pre-mature birth when nearly a third (31.4%) is not aware of pre-mature birth. Almost two-thirds (60.1%) of the urban areas are not aware of section delivery. More than a half (54.3%) of the rural areas are not aware of section delivery as well.

Table 10: Perceived health in childhood

Sl. No.	Perceive Health in childhood	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very good	1	21	22
		(2.9)	(60.0)	(31.4)
2	Good	24	9	33
		(68.6)	(25.7)	(47.1)
3	Poor	8	5	13
		(22.9)	(14.3)	(18.6)
4	Very poor	2	0	2
		(5.7)	0.0	(2.9)

Source: Computed Figures in parentheses are percentages.

Nearly a third (31.4%) of the respondents' health condition is *very good* in their childhood. Nearly half (47.1%) of the respondents' had a *good* health condition. More than a sixth (18.6%) reported health condition as *poor* and an insignificant minority (2.9%) of the respondents had a *very poor* health condition. This has shown that the respondents' health condition is quite *good* in their childhood. Nearly two-thirds of the respondents from rural areas have *very good* health condition and more than two-thirds of the respondents from urban areas have *good* health condition. It is then clear than respondents from rural areas are *healthier in childhood* than those in urban areas. This shows that an overwhelming majority rated their health in childhood as ranging *from good to very good* while a fifth rated it between *poor and very poor.*

Table 11: Traits in Childhood

Sl.No	Traits in Childhood	Location		Total N=70
		Core n=35	Periphery n=35	
1	Nail Biting	15	23	38
		(42.9)	(65.7)	(54.3)
2	Temper Tantrums	17	13	30
		(48.6)	(37.1)	(42.9)
3	Sleeping excessively	15	14	29
		(42.9)	(40.0)	(41.4)
4	Bedwetting	22	24	46
		(62.9)	(68.6)	(65.7)

Source: Computed Figures in parentheses are percentages.

As adolescence is a very troubled phase, information were sought on certain traits that are typical during this phase. Less than half (42.9%) reported having *'temper tantrums'* with more in the core than in peripheral areas. More than a third (41.4%) reported *'excessive sleep'* during childhood and less than two-thirds (65.7%) reported *'bed wetting'* with more in the peripheral areas (68.6%) as compared to core areas (62.9%).

Table 12: Academic performance

Sl.No	How good are you in studies?	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very good	0	3	3
		(0.0)	(8.6)	(4.3)
2	Good	28	22	50
		(80.0)	(62.9)	(71.4)
3	Poor	7	9	16
		(20.0)	(25.7)	(22.9)
4	Very poor	0	1	1
		(0.0)	(2.9)	(1.4)

Source: Computed Figures in parentheses are percentages

Nearly three quarters (71.4%) of the respondents have a *good academic performance* in school and an insignificant minority (1.4%) reported being *very poor* in academic performance. Nearly a tenth (8.6%) of the respondents from the rural areas have *very good performance* in school. An insignificant minority (2.9%) have *very poor* academic performance in school. A fifth (20%) and a quarter (25%) of the respondents in core and peripheral areas have a *poor* academic performance in school. Perceptions related to academic performance revealed that over three quarters reported being *good* or *very good* in their studies, while a quarter reported being *poor or very poor* in studies.

Table 13: Close friends in school

Sl.No	In school, did you have a lot of close friends?	Location		Total N=70
		Core n=35	Periphery n=35	
1	Yes, only one	0	3	3
		(0.0)	(8.6)	(4.3)
2	Yes, 2 to 4	16	17	33
		(45.7)	(48.6)	(47.1)
3	Yes, more than 4	19	15	34
		(54.3)	(42.9)	(48.6)

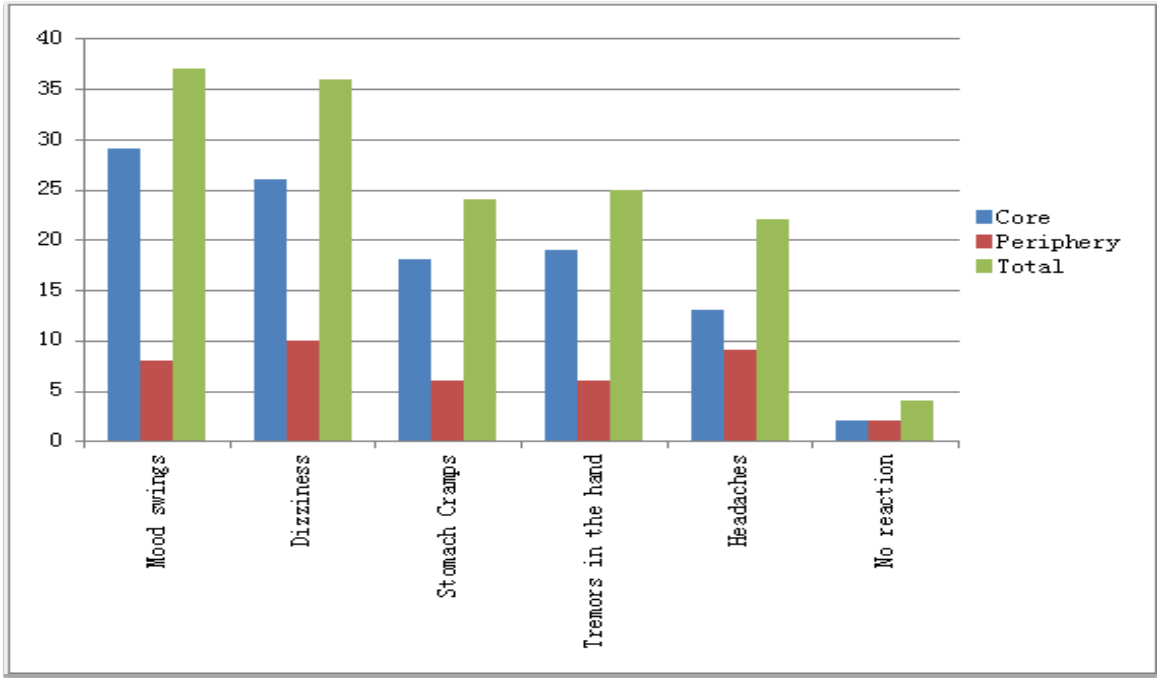
Source: Computed Figures in parentheses are percentages

Peer groups are an important influence during adolescence. Nearly half (47.1% and 48.6%) of the respondents have more than *two or more close friends* in school. An insignificant minority (4.3%) of the respondents had only *one close friend* in school, all of whom belonged to the peripheral area.

Section III: Reproductive Health History

Adolescent health invariably brings questions regarding reproductive health when we are referring to girls. In this section, information was sought on reaction to menstruation – initial reaction, regularity of cycles, menstrual flow, menstrual cycle, duration of an average period, association with menstruation(physical and mental), material used during menstruation and financial involvement during menstruation.

Figure 2. Physical and Mental reaction to Menstruation



Reactions to menstruation are often extreme and may have long term impact on adolescents therefore information on this was sought. **Figure 2** describes the *physical and mental reactions* to menstruation. More than a third report frequent *stomach cramps*. Less than a third (31.4%) report *headache* with more respondents in the core areas (37.1%) than peripheral areas (25.7%) reporting the same. *Mood swings* are reported by more than half the respondents (52.9%) with more than an overwhelming majority in the core areas (82.9%) reporting the same while more than

a fifth (22.9%) in the corresponding figures in the peripheral areas. *Dizziness* comes the next with a quarter (26%) of the respondents from core area and a tenth from peripheral area. Nearly a fifth (19%) from core area experience *tremors in their hand* and only an insignificant minority(6%) from the peripheral area. An insignificant minority from both the areas do *not experience* any reaction due to menstruation.

Table 14: Age at Menarche

Sl. No.	Reaction	Location		Total
	Age at menarche	Core n= 35	Periphery n=35	N=70
1	10 - 15	35	14	49
		(100)	(40.0)	(70.0)
2	not experienced	0	21	21
		0.0	(60.0)	(30.0)

Source: Computed Figures in parentheses are percentages

Age at menarche is an important determinant in understanding adolescent health of girls. Nearly three - quarters (70%) of the respondents had their menarche at age between *10-15 years* and nearly a third (30%) did *not yet experience* menarche. Nearly two-thirds (60%) of the respondents from rural areas have not yet experienced menarche and an overwhelming majority of the respondents from urban areas have experienced menarche.

Figure 3: Source of First Information about Menstruation

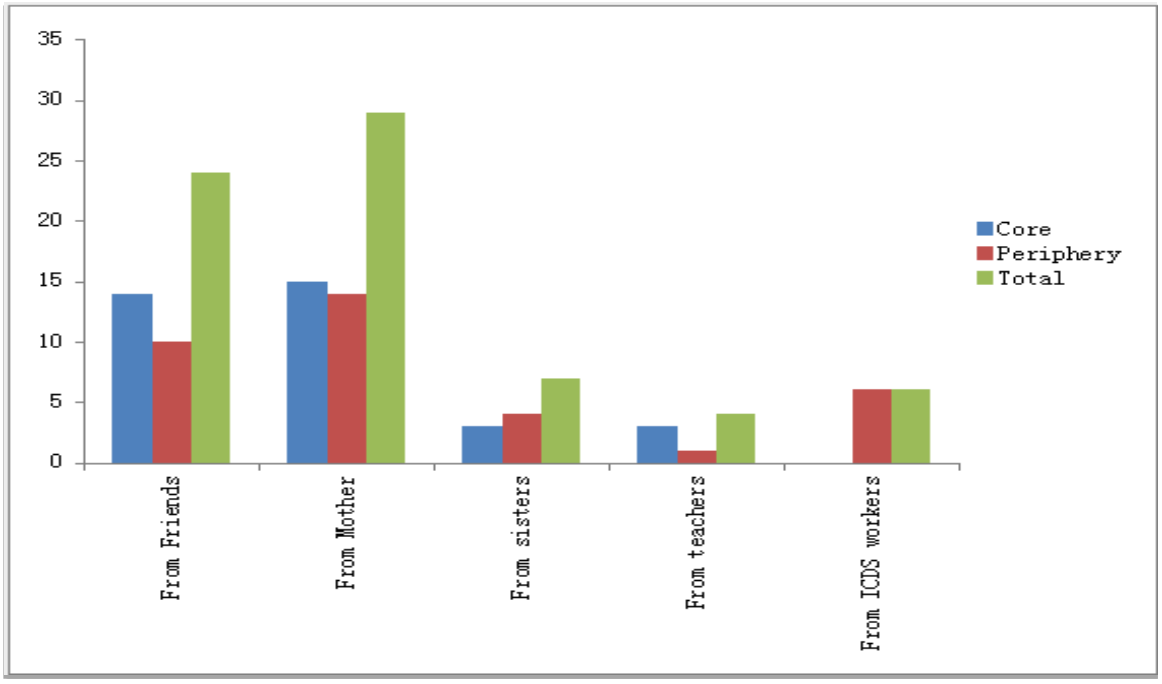


Figure 3 has shown that, more than a third(34.3%) gained information *from friends* while less than half(41.4%) gained such information *from mother* and the tenth *from sisters* while a small number gained such information from *teachers and ICDS workers*.

Table 15: Initial reaction to menstruation

Sl. No.	Initial reaction to menstruation	Location		Total N=70
		Core n=35	Periphery n=35	
1	Sadness	25	35	60
		(71.4)	(100)	(85.7)
2	Comfortable	24	32	56
		(68.6)	(91.4)	(80.0)
3	Shock	21	32	53
		(60.0)	(91.4)	(75.7)
4	Irritation	7	13	20
		(20.0)	(37.1)	(28.6)
5	No reaction	1	1	2
		(2.9)	(2.9)	(2.9)

Source: Computed Figures in parentheses are percentages

Half of the respondents (50%) have experienced *sadness* in their initial menstruation. Less than half (45.7%) of the respondents were *shocked* while an equal

number were comfortable. Nearly a fifth (18.6%) reported *irritation* in their initial menstruation. An insignificant minority (1.4%) had *no reaction* prior to their initial menstruation.

Table 16: Initial stages to menstruation

Sl. No.	Initial stages of menstruation	Location		Total N=70
		Core n= 35	Periphery n=35	
1	No problem at all	13	8	21
		(37.1)	(22.9)	(30.0)
2	Very Difficult	7	4	11
		(20.0)	(11.4)	(15.7)
3	Difficult	15	2	17
		(42.9)	(5.7)	(24.3)
4	Not Applicable	0	21	21
		0.0	(60.0)	(30.0)

Source: Computed Figures in parentheses are percentages

Menstruation difficulties were reported by more than a fifth (24.3%) who said it was *very difficult.* Nearly a third (30%) did *not face any problems* in their initial stages of menstruation, out of which there was more in core (37.1%) than periphery (22.9%). Nearly a third (30%) of the respondents did *not experience menarche yet*, out of which there was more in periphery (60%) than core (0%).

Table 17: Regularity of Menstrual cycles

Sl.No	Regularity of menstrual cycles	Location		Total N=70
		Core n=35	Periphery n = 35	
1	Regular	11	5	16
		(31.4)	(14.3)	(22.9)
2	Irregular	4	2	6
		(11.4)	(5.7)	(8.6)
3	Can't say	17	6	23
		(48.6)	(17.1)	(32.9)
4	NA	3	22	25
		(8.6)	(62.9)	(35.7)

Source: Computed Figures in parentheses are percentages

On regularity of the menstrual cycle, more than a fifth reported *irregular* menstrual cycles(22.9%) with more people in the core areas(31.4%) than peripheral areas(14.3%) reporting the same.

Table 18: Extent of menstrual flow

Sl. No	Extent of menstrual flow	Location		Total N=70
		Core n=35	Periphery n = 35	
1	Very heavy	3	6	9
		(8.6)	(17.1)	(12.9)
2	Heavy	13	4	17
		(37.1)	(11.4)	(24.3)
3	Not too heavy	17	3	20
		(48.6)	(8.6)	(28.6)
4	Not heavy at all	2	1	3
		(5.7)	(2.9)	(4.3)
5	NA	0	21	21
		0.0	(60.0)	(30.0)

Source: Computed Figures in parentheses are percentages

Very heavy menstrual flow was reported by more than a tenth (12.9%) of the respondents, out of which there was more in periphery (17.1%) than core (8.6%). An insignificant minority (4.3%) reported *not heavy at all*, out of which there was more in core (5.7%) than periphery (2.9%). Nearly a quarter (24.3%) reported *heavy menstrual flow*, out of which there was more in core (37.1%) than periphery (11.4%) while nearly a third (28.6%) reported *not too heavy*, out of which there was more in core (48.6%) than periphery (8.6%).

Table 19: Duration of an average period

Sl.No	Duration of an average period	Location		Total N=70
		Core n=35	Periphery n = 35	
1	Less than 2 days	0	1	1
		0.0	(2.9)	(1.4)
2	2-4 days	19	4	23
		(54.3)	(11.4)	(32.9)
3	5 days or more	11	8	19
		(31.4)	(22.9)	(27.1)
4	Can't say	5	1	6
		(14.3)	(2.9)	(8.6)
5	NA	0	21	21
		0.0	(60.0)	(30.0)

Source: Computed Figures in parentheses are percentages

In understanding menstruation, it is also important to know the average duration of a cycle. In this study, more than a quarter reported an average duration of more than 5 days in their menstrual period and there were more in the core (31.4%) as compared to the peripheral (22.9%) who reported the same.

Table 20: Duration of Amenorrhea

Sl. No	Duration when periods did not occur	Location		Total N=70
		Core n=35	Periphery n = 35	
1	Few days	4	10	14
		(11.4)	(28.6)	(20.0)
2	Fortnight	1	1	2
		(2.9)	(2.9)	(2.9)
3	A month	13	2	15
		(37.1)	(5.7)	(21.4)
4	More than a year	4	1	5
		(11.4)	(2.9)	(7.1)
5	NA	13	21	34
		(37.1)	(60.0)	(48.6)

Source: Computed Figures in parentheses are percentages

Amenorrhea is a condition when menses stops for a period of few weeks to few months and this could be attributed to several reasons including nutrition and diet,

stress, hormonal imbalances, etc. A small number (2.9%) reported an amenorrhea as occurring for *fortnight.Amenorrhea* was reported by less than half of the respondent with a fifth (28%) reporting it for a few days while a small number did not have it for fortnight and over a fifth (21.4%) did not have a period for *a month* at a stretch.

Table 21: Sanitary Practices during Menstruation

Sl.No.	Sanitary Practices during menstruation	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Sanitary pads	34	4	38
		(97.1)	(11.4)	(54.2)
2	Tampons	1	0	1
		(2.9)	(0.0)	(1.4)
3	Cloth	0	10	10
		(0.0)	(28.57)	(14.28)
4	NA	0	21	21
		(0.0)	(60)	(30)

Source: Computed Figures in parentheses are percentages

Management of menstruation was discussed and more than half (54.2%) *used sanitary pads* with almost all but one in the core areas reporting the same. However, most interestingly, almost the third in the peripheral areas (28.57%) reported using *cloth.*

Table 22 : Frequency of changing sanitary pads/cloth

Sl. No	Frequency of changing sanitary pads/cloth	Location		Total N=70
		Core n=35	Periphery n= 35	
1	3-4 times	19	1	20
		(54.3)	(1.4)	(28.6)
2	1-2 times	15	13	28
		(42.9)	(37.1)	(40.0)
3	NA	1	21	22
		(2.9)	(60)	(31.42)

Source: Computed Figures in parentheses are percentages

Nearly a half(40%) change their sanitary pads/cloth *1-2 times a day*, out of which there was more in core(42.9%) than periphery(37.1%) while more than a

quarter (28.6%) change it *3-4times a day*, out of which there was more in core(54.3%) than periphery(1.4%). Less than two-thirds (60%) from the peripheral area *did not experience menarche yet*.

Table 23: Expenses during menstruation

Sl. No	Expenses during menstruation	Location		Total N=70
		Core n=35	Periphery n=35	
1	Rs 20	1	1	2
		(2.9)	(2.9)	(2.9)
2	Rs 21-50	14	3	17
		(40.0)	(8.6)	(24.3)
3	Rs 51 or more	20	3	23
		(57.1)	(8.6)	(32.9)
4	NA	0	28	28
		(0.0)	(80.0)	(40.0)

Source: Computed Figures in parentheses are percentages

The average expenditure during menstruation per month is *Rs 21 to 50* for almost a quarter of the respondents (24.3%), out of which there was more in core (40%) than periphery (8.6%). However, nearly half of the respondents (40%) did *not spend any money* to buy their sanitary pads since they have a *cloth* during their menstrual period, out of which all were from the periphery.

Section IV: Marital and Sexual History

In this section, information on marital and sexual history was sought. This section therefore includes marital status, awareness on matters related to sex, sexual experiences, person responsible for indulge in sexual activity, STIs and treatment for STIs.

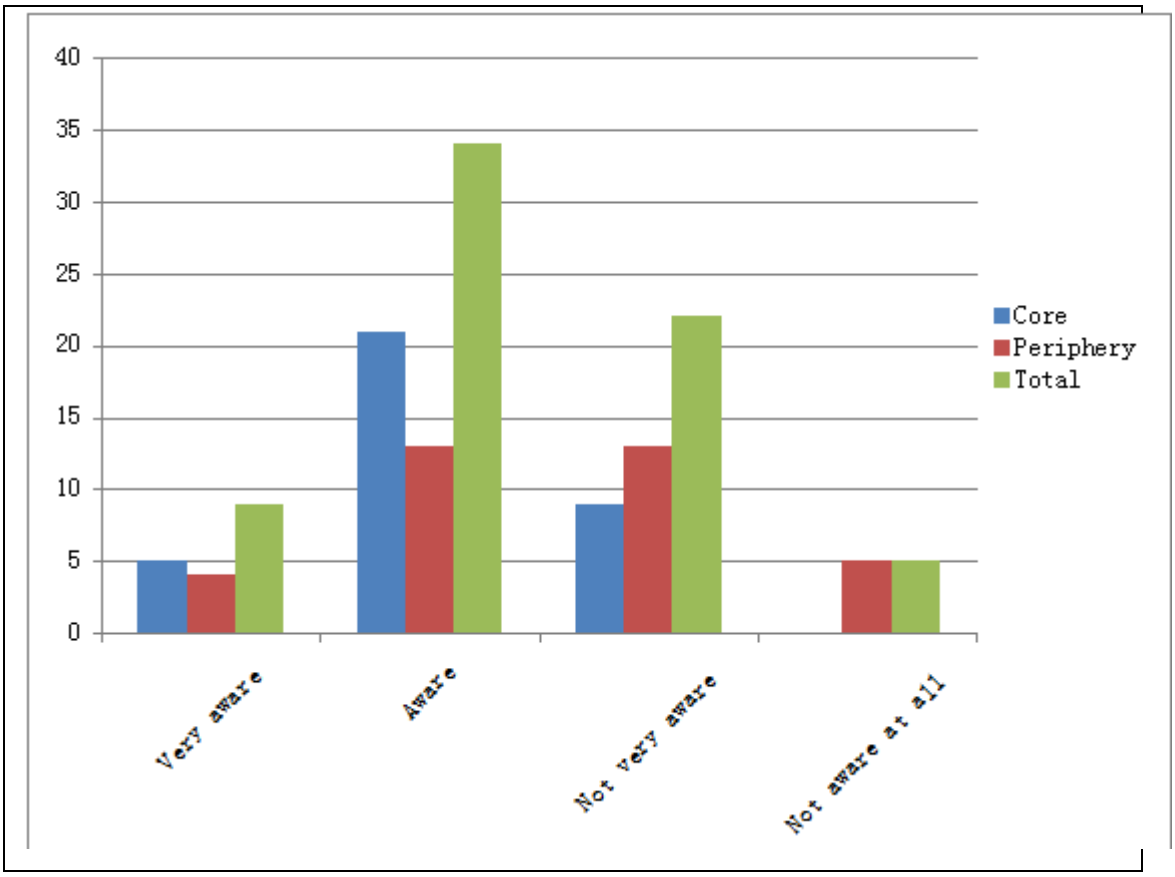
Table 24: Marital status

Sl. No.	Married	Village		Total N=70
		Core n= 35	Periphery n=35	
1	No	34	33	67
		(97.1)	(94.3)	(95.7)
2	NA	1	2	2
		(2.9)	(5.7)	(2.9)

Source: Computed Figures in parentheses are percentages

All the respondents are not yet married though they have had children on their own. An overwhelming majority (95.7%) of the respondents are not married, out of which it was more in core (97.1%) than periphery (94.3%). An insignificant minority (2.9%) has not been answered with the questions.

Figure 4: Awareness level on matters related to sex



Awareness regarding sexual information was sought and more than a tenth reported being very aware. This is crucial information for policy planners and service providers.

Table 25: Sexual Experience

Sl. No	Sexual experience	Location		Total N=70
		Core n=35	Periphery n=35	
1	Yes	4	3	7
		(11.4)	(8.6)	(10.0)
2	No	29	31	60
		(82.9)	(88.6)	(85.7)
3	No Response	2	1	3
		(5.7)	(2.9)	(4.3)

Source: Computed Figures in parentheses are percentages

Sexual experience was reported by a tenth (10%) of the respondents, out of which there was more in core (11.4%) than periphery (8.6%). More than a majority (85.7%) had *never had sexual experiences,* out of which there was more in periphery (88.6%) than core (82.9%) and an insignificant minority (4.3%) did not respond, out of which there was more in core (5.7%) than periphery (2.9%).

Table 26: Current sexual activity

Sl. No	Current sexual activity	Location		Total N=70
		Core n=35	Periphery n=35	
1	Yes	1	1	2
		(2.9)	(2.9)	(2.9)
2	No	2	16	18
		(5.7)	(45.7)	(25.7)
3	No Response	32	18	50
		(91.4)	(51.4)	(71.4)

Source: Computed Figures in parentheses are percentages

More than half did not respond to this question. When asked about their current sexual activity, an insignificant minority (2.9%), one each from the core and peripheral areas were *currently sexually active.*

Table 27: Protective measures during sex

Sl. No	Protective measures during sex	Location		Total N=70
		Core n=35	Periphery n=35	
1	Yes	0	1	1
		(0.0)	(2.9)	(1.4)
2	No	5	9	14
		(14.3)	(25.7)	(20.0)
3	No Response	30	25	55
		(85.7)	(71.4)	(78.6)

Source: Computed Figures in parentheses are percentages

An insignificant minority (1.4%) among the respondents have had used *protective measures during sex, and this was only in the peripheral area.*

Table 28: Sexually Transmitted Infections

Sl. No	Any sexually transmitted infection	Location		Total N=70
		Core n=35	Periphery n=35	
1	No	33	19	52
		(94.3)	(54.3)	(74.3)
2	NA	2	16	18
		(5.7)	(45.7)	(25.7)

Source: Computed Figures in parentheses are percentages

None of the respondents have experienced any STIs so far. It is difficult to understand whether the information given here is accurate since many of the respondents were uncomfortable in answering this question.

Table 29: Experience of Sexual Violence

Sl. No.	Having had encountered with the following	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Inappropriate touching			
	Yes	4	8	12
		(11.4)	(22.9)	(17.1)
	No	31	27	58
		(88.6)	(77.1)	(82.9)
2	Compelled to have sex under force			
	Yes	1	6	7
		(2.9)	(17.1)	(10.0)
	No	34	29	63
		(97.1)	(82.9)	(90.0)
3	Raped			
	No	35	35	70
		(100)	(100)	(100)
4	Compelled to have sex when man under influence of alcohol/drugs			
	Yes	0	4	4
		0.0	(11.4)	(5.7)
	No	35	31	66
		(100.0)	(88.6)	(94.3)
5	Have been exposed to verbal sexual advances			
	Yes	0	5	5
		0.0	(14.3)	(7.1)
	No	35	30	65
		(100.0)	(85.7)	(92.9)
6	Compelled to have sex after being given alcohol/drugs;	0	0	0
	No	35	35	70
		(100.0)	(100.0)	(100.0)

Source: Computed Figures in parentheses are percentages

A tenth reported having had *sex under force* and in the peripheral areas this is almost a fifth of the respondents. A small number reported *having sex with a man who is under the influence of Alcohol/Drugs* with a similar number reporting verbal sexual advances.

Table 30: Perpetrator of Violence

Sl. No	Person responsible for compelling	Location		Total N=70
		Core n=35	Periphery n = 35	
1	Father	0	1	1
		0.0	(2.9)	(1.4)
2	Cousin	0	1	1
		0.0	(2.9)	(1.4)
3	Boyfriend	1	7	8
		(2.9)	(20.0)	(11.4)
4	No Response	34	26	60
		(97.1)	(74.3)	(85.7)

Source: Computed Figures in parentheses are percentages

When asked about the person responsible for *compelling to have sex under force, inappropriate touching, compelled to have sex when men under influence of alcohol/drugs,* more than a tenth (11.4%) reported it was due to their *boyfriend*, out of which there was more in periphery (20%) than in core (2.9%). An insignificant minority (1.4%) reported it was their *father* and *cousin*, out of which there was more in periphery (2.9%) than core (0%). More than a majority (85.7%) reported that they *had not experienced at all*, out of which it was more in core (97.1%) than in periphery (74.3%).

Section V: Perceptions on sexual and reproductive Health

This section includes perceptions about sex, whether a girl is seen as a problem by the society or not, perception whether young women can become sexually active when they attain 15 years, pre-marital sex and whether girls are more prone to sexual abuse than boys or not.

Table 31: Perception 1-Talking about sex is a taboo

Sl. No.	Talking about sex is a taboo	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Strongly agree	0	2	2
		(0.0)	(5.7)	(2.9)
2	Agree	4	7	11
		(11.4)	(20.0)	(15.7)
3	Disagree	27	15	42
		(77.1)	(42.9)	(60.0)
4	Strongly disagree	4	11	15
		(11.4)	(31.4)	(21.4)

Source: Computed Figures in parentheses are percentages

Perceptions related to sexual and reproductive health were interesting with almost a fifth (21.4%) reporting that talking about *sex is a Taboo*. This perception is likely to lead to inhibitions regarding sexual matters, lack of assertiveness on the part of adolescents and poor confidence in sexual matters.

Table 32: Perception 2-A girl is a problem for the society

Sl. No	Being a girl is itself a problem for the society	Location		Total N=70
		Core n=35	Periphery n=35	
1	Agree	1	1	2
		(2.9)	(2.9)	(2.9)
2	Disagree	11	11	22
		(31.4)	(31.4)	(31.4)
3	Strongly disagree	23	23	46
		(65.7)	(65.7)	(65.7)

Source: Computed Figures in parentheses are percentages

Nearly two-thirds (65.7%) *strongly disagree* that *being a girl is itself a problem for the society*. An insignificant minority (2.9%) *agree* to the statement while nearly a third (31.4%) *disagrees* with the statement. This is a perception that is not commonly shared by the respondents.

Table 33: Perception 3-Young Women can become sexually active when they attain 15 years

Sl. No	Young Women can become sexually active when they attain 15 years	Location		Total N=70
		Core n=35	Periphery n=35	
1	Agree	10	14	24
		(28.6)	(40.0)	(34.3)
2	Disagree	17	15	32
		(48.6)	(42.9)	(45.7)
3	Strongly disagree	8	6	14
		(22.9)	(17.1)	(20.0)

Source: Computed Figures in parentheses are percentages

Nearly half (45.7%) of the respondents *disagree* that *young people can become sexually active when they attain 15 years of age* while a fifth (20%) of the respondents *strongly disagree* to it. More than a third (34.3%) however *agreed* that women can *become sexually active at the age of 15 years. This perception is likely to influence sexual behavior among adolescents.*

Table 34: Perception 4 - Pre-marital sex is more common among school going girls than school going boys

Sl.No	Pre-marital sex is more common among school going girls than school going boys	Location		Total N=70
		Core n=35	Periphery n=35	
1	Strongly agree	0	1	1
		(0.0)	(2.9)	(1.4)
2	Agree	14	15	29
		(40.0)	(42.9)	(41.4)
3	Disagree	15	17	32
		(42.9)	(48.6)	(45.7)
4	Strongly disagree	6	2	8
		(17.1)	(5.7)	(11.4)

Source: Computed Figures in parentheses are percentages

When asked whether *pre-marital sex is more common among school going girls than school going boys*, nearly half of the respondents (41.4%) agreed to the statement, out of which there was more in peripheral areas (42.9%) than core (40%) while an insignificant minority (1%) strongly agreed to the statement. More than a tenth (11.4%) strongly disagreed to the statement, out of which there was more in core (17.1%) than periphery (5.7%).

Table 35: Perception 5 - Girls are more prone to sexual abuse than boys

Sl. No	Girls are more prone to sexual abuse than boys	Location		Total N=70
		Core n=35	Periphery n=35	
1	Strongly agree	13	5	18
		(37.1)	(14.3)	(25.7)
2	Agree	17	21	38
		(48.6)	(60.0)	(54.3)
3	Disagree	4	8	12
		(11.4)	(22.9)	(17.1)
4	Strongly disagree	1	1	2
		(2.9)	(2.9)	(2.9)

Source: Computed Figures in parentheses are percentages

More than a half (54.3%) had agreed to the fact that *girls are more prone to sexual abuse than boys*, out of which there was more in peripheral area (60%) than core (48.6%) while only an insignificant minority (2.9%) were *against the statement*. A quarter (25.7%) strongly agreed to the statement, where there was more in core (37.1%) than periphery (14.3%) and more than a sixth (17.1%) disagree to the said statement.

Section VI: Awareness on Reproductive Health

In this section, information was sought about menstruation prior to actually getting it. It also brings information on reasons for irregularity in periods, from where the respondents acquire information on reproductive health, etc.

Table 36: Knowledge on menstruation prior to actually getting it

Sl.No.	Knowledge on menstruation prior to actually getting it	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Yes	26	18	44
		(74.3)	(51.4)	(62.9)
2	No	8	11	19
		(22.9)	(31.4)	(27.1)
3	NA	1	6	7
		(2.9)	(17.1)	(10.0)

Source: Computed Figures in parentheses are percentages

Nearly two-thirds (62.9%) of the respondents had said *'yes'* when asked about knowing their menstruation prior to actually getting it, out of which there was more in core (74.3%) than periphery (51.4%). More than a quarter (27.1%) had said *'no'*, out of which there was more in periphery (31.4%) than core (22.9%).

Table 37: Advance prior to information on menstrual period

Sl. No.	Advance prior to information on menstrual period	Location		Total N=70
		Core n= 35	Periphery n=35	
1	one day	16	15	31
		(45.7)	(42.9)	(44.3)
2	one week	10	7	17
		(28.6)	(20.0)	(24.3)
3	two weeks	0	2	2
		0.0	(5.7)	(2.9)
4	Never	7	9	16
		(20.0)	(25.7)	(22.9)
5	any other	2	2	4
		(5.7)	(5.7)	(5.7)

Source: Computed Figures in parentheses are percentages

Nearly half (44.3%) of the respondents had known their menstrual period *one day* in advance prior to actually having it, out of which it was more in core than in

periphery. While nearly a quarter (24.3%) knew it before *one week*, out of which there was more in core (28.6%) than in periphery (20%). More than a fifth (22.9%) *never knew* of their advance prior to information on menstrual periods, out of which there was more in periphery (25.7%) than core (20%). An insignificant minority (2.9%) knew it before *two weeks* ahead, out of which it was more in periphery (5.7%) than core (0%).

Table 38: Reasons for irregularity in periods

Sl.No	Reasons for irregularity in periods	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Lack of nutritional diet	11	8	19
		(31.4)	(22.9)	(27.1)
2	Stress	6	2	8
		(17.1)	(5.7)	(11.4)
3	Health complications	2	2	4
		(5.7)	(5.7)	(5.7)
4	NA	16	23	39
		(45.7)	(65.7)	(55.7)

Source: Computed Figures in parentheses are percentages

When asked reasons for irregularity in periods, more than a half (55.7%) do not have any idea regarding their *irregularity in periods*, out of which it was more in peripheral area (65.7%) than in the core area (45.7%). While more than a quarter (27.1%) believes it was due *to lack of nutritional diet*, out of which it was more in core (31.4%) than the peripheral area (22.9%). More than a tenth (11.4%) thinks that it was due to *stress*, out of which it was more in core (17.1%) than in periphery (5.7%). An insignificant minority (5.7%) thinks it was due to their *health complications* from both the areas.

Table 39: Requirement on reproductive health

Sl.No.	Awareness on reproductive health is required	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Yes	34	28	62
		(97.1)	(80.0)	(88.6)
2	No	1	2	3
		(2.9)	(5.7)	(4.3)
3	NA	0	4	4
		(0.0)	(11.4)	(5.7)

Source: Computed Figures in parentheses are percentages

More than a majority of the respondents (88.6%) has revealed that there is a need for awareness on reproductive health issues while an insignificant minority (4%).

Table 40: Source of Awareness on Reproductive Health

Sl. No	Source of Awareness on Reproductive Health	Location		Total N=70
		Core n= 35	Periphery n=35	
1	Parents	20	18	38
		(57.1)	(51.4)	(54.3)
2	Friends	26	24	50
		(74.3)	(68.6)	(71.4)
3	Teachers	10	24	34
		(28.6)	(68.6)	(48.6)
4	Uninformed Sources	5	13	18
		(14.3)	(37.1)	(25.7)

Source: Computed Figures in parentheses are percentages

Awareness on health care services revealed that less than half (48.6%) gained information on health from *teachers*, out of which there was more in peripheral areas (68.6%) than in core (28.6%). More than a half (54.3%) gained information from *parents*, out of which there was more in core (57.1%) than in periphery (51.4%). A half received information from their *friends*, out of which there was more in core

(74.3%) than in periphery (68.6%). Nearly a fifth (18%) gained information from *uninformed sources*, out of which there was more in peripheral area (37.1%) than the core (14.3%).

Table 41: Requirement of awareness on reproductive health

Sl.No	Awareness Required on	Location		Total N=70
		Core n= 35	Periphery n=35	
1	On menstruation	23	20	43
		(65.7)	(57.1)	(61.4)
2	On Contraception	18	21	39
		(51.4)	(60.0)	(55.7)
3	On health care and services	35	35	70
		(100.0)	(100.0)	(100.0)
4	On STI's	13	9	22
		(37.1)	(25.7)	(31.4)
5	On abortions	13	11	24
		(37.1)	(31.4)	(34.3)

Source: Computed Figures in parentheses are percentages

More than a third (34.3%) wanted information on *abortions* and on *STIs* (31.4%), out of which there were more in core area (37.1%) than in peripheral area (25.7%) who wanted information on STI's. Nearly two – thirds (61.4%) wanted information on *menstruation*, out of which it was more in core (65.7%) than in periphery (57.1%). While more than a half (55.7%) wanted on *contraception*, out of which it was more in periphery (60%) than in core (51.4%). An overwhelming majority (100%) wanted information on *healthcare and services* from both the areas.

Section VII: Accessibility, Availability and Affordability

This section comprises of accessibility, affordability and availability of reproductive health care services.

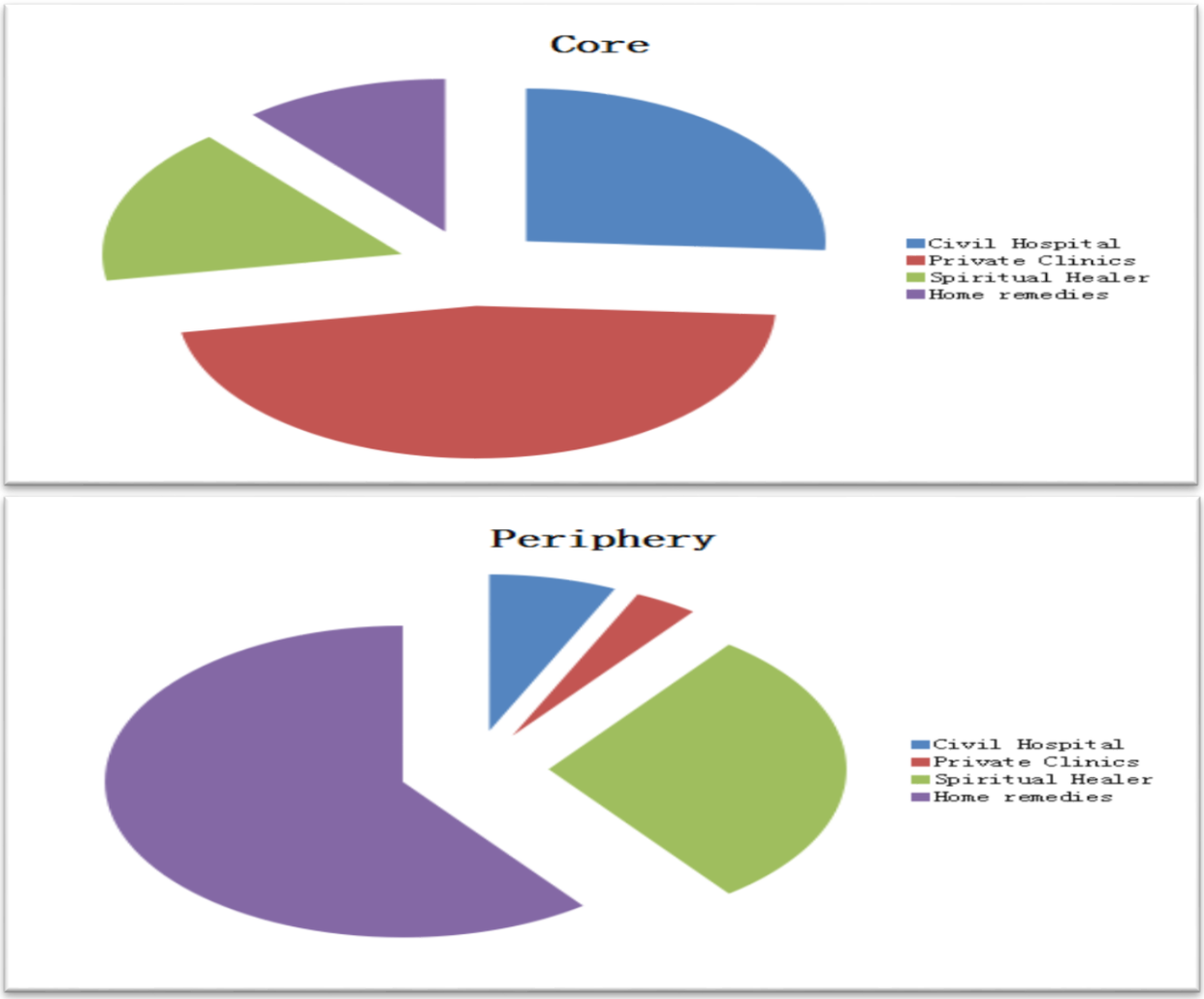


Figure 5: *Accessibility, affordability and adequacy.*

A quarter of the respondent (25.7%) found C*ivil hospital* as *affordable, accessible and adequate.* Private clinic was rated by more than a third of the adolescence with more in the core areas (71.4%) and fewer in the peripheral area (5.7%) finding it *affordable*. Spiritual healers were accessed by more than a third of girls in the areas with more than half in the peripheral areas reporting it. Home remedies were used by more than half of the respondents in both the categories. All the girls in the peripheral areas interestingly used *home remedies*.

Table 42: Availability of facilities

Sl. No	Availability of facilities	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very available	11	5	16
		(31.4)	(14.3)	(22.9)
2	Available	23	24	47
		(65.7)	(68.6)	(67.1)
3	Somewhat available	0	4	4
		(0.0)	(11.4)	(5.7)

Source: Computed Figures in parentheses are percentages

More than two-thirds(67.1%) reported that reproductive health facilities are *available* in their areas, out of which there is slightly higher percentage in peripheral area(68.6%) than in core area(65.7%). An insignificant minority(5.7%) find it *somewhat available*, out of which there is more in peripheral area(11.4%) as compared to core(0%). More than a fifth(22.9%) had find it *very available*, out of which there is more in core area(31.4%) than in peripheral area(14.3%).

Table 43: Quality of health care for reproductive health

Sl. No	Quality of health care for reproductive health	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very adequate	2	7	9
		(5.7)	(20.0)	(12.9)
2	Adequate	32	24	56
		(91.4)	(68.6)	(80.0)
3	Somewhat adequate	1	2	3
		(2.9)	(5.7)	(4.3)
4	NA	0	2	2
		(0.0)	(5.7)	(2.9)

Source: Computed Figures in parentheses are percentages

An overwhelming majority (80%) of the respondents reported that the *quality of health care is adequate* for the adolescent girls with a high percentage (91.4%) of

the core areas. More than a tenth (12.9%) find it *very adequate*, out of which there is more in peripheral area (20%) than in the core area (5.7%).An insignificant minority (4.3%) find it *somewhat adequate*, out of which there is more in peripheral area (5.7%) than in core area (2.9%).

Table 44: Accessibility of services for reproductive health

Sl. No	Accessibility of services for reproductive health	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very accessible	2	1	3
		(5.7)	(2.9)	(4.3)
2	Accessible	8	26	34
		(22.9)	(74.3)	(48.6)
3	Somewhat accessible	25	7	32
		(71.4)	(20.0)	(45.7)
4	NA	0	1	1
		(0.0)	(2.9)	(1.4)

Source: Computed Figures in parentheses are percentages

Nearly a half (48.6%) find the services *accessible* with a peripheral area reporting it *somewhat accessible* (22.9%) with more in the peripheral area reporting it *accessible (*74.3%).

Table 45: Adequacy for utilization of health care facilities

Sl. No.	Adequacy for utilization of health care facilities	Location		Total N=70
		Core n=35	Periphery n=35	
1	Very adequate	2	2	4
		(5.7)	(5.7)	(5.7)
2	Adequate	31	27	58
		(88.6)	(77.1)	(82.9)
3	Somewhat adequate	2	5	7
		(5.7)	(14.3)	(10.0)
4	NA	0	1	1
		(0.0)	(2.9)	(1.4)

Source: Computed Figures in parentheses are percentages

Majority (82.9%) of the respondents reported that utilization of health care facilities is adequate. A tenth reported somewhat adequate.

Table 46: Problems related to Accessibility

Sl. No	Problems related to accessibility	Location		Total N=70
		Core n=35	Periphery n=35	
1	Too far	8	24	32
		(22.9)	(68.6)	(45.7)
2	Very Costly	14	27	41
		(40.0)	(77.1)	(58.6)
3	Workers are not approachable	4	10	14
		(11.4)	(28.6)	(20.0)

Source: Computed Figures in parentheses are percentages

More than two-thirds (68.6%) of the peripheral areas has reported that they *cannot access the services* of reproductive health since it was *too far* for them to reach in time of problems. Also, more than three-quarters (77.1%) reported very *costly*.

However, in the core area nearly half (40%) of the respondents reported *very costly* and there *is not much a problem* regarding the place of accessibility.

Section VII: Coping and Social Support

In this section, information was sought on the coping and social support of adolescent girls. Respondents were asked information regarding the nature and quality of social support received by them in relation to their reproductive health. Further, they were also asked on how they cope with their reproductive health.

Table 47: Social Support

The social support for reproductive health issues in ranked below:

Sl.No	Perceived Social Support (most supportive)	Location		Total
		Core	Periphery	
1	Family	1	1	1
2	Relatives	2	2	2
3	Friends/Neighbors	3	3	3
4	Doctor	4	4	4
5	Church Elders	5	5	5
6	NGOs	6	5	6
	Test Statistics			
	Kendall's W	0.96	0.75	0.83
	Chi-Square	168.08	130.49	291.58
	df	5	5	5
	Asymp. Sig.	2E-34	2E-26	6E-61

Kendall's Coefficient of Concordance

Source: Computed Figures in parentheses are percentages

All the girls reported *"Very Supportive"* families while more than a quarter reported "*Supportive"* friends, neighbors (68.6%) and relatives 62.9%. Tertiary support included information on *NGO's, Doctors, Church elders,* and they were found to be '*Somewhat Supportive'.*

Table 48: Coping Mechanism During Menstrual Flow

Sl. No	Coping Strategy	Location		Total N = 70
		Core n = 35	Periphery n = 35	
1	Sleeping	30	25	55
		(85.7)	(71.4)	(78.6)
2	Don't feel like doing anything	21	21	42
		(60.0)	(60.0)	(60.0)
3	Pray	26	16	42
		(74.3)	(45.7)	(60.0)
4	Listening to Music	26	15	41
		(74.3)	(42.9)	(58.6)
5	Go out with friends	15	19	34
		(42.9)	(54.3)	(48.6)

Source: Computed Figures in parentheses are percentages

Table 51 shows the coping strategies of adolescent girls. Their coping strategy in their stressful situation would include *sleeping, don't feel like doing anything, pray, listening to music and go out with friends*. Nearly majority (78.6%) of the respondents cope by *sleeping*, out of which there are more in core (85.7%) than periphery (71.4%). Nearly two-thirds (60%) cope by *praying* and *don't feel like doing anything* out of which three-quarters (74.3%) cope with *praying* in core and nearly half (45.7%) cope in periphery. More than a half (58.6%) copes by *listening to music*, out of which there are more in core-nearly three-quarters (74.3%) than periphery (42.9%). Nearly half (48.6%) cope by *go out with friends*, out of which there are more in periphery (54.3%) than in core (42.9%).

Part II

Section I: Data from Key Informants

Interview 1: CMO, Lunglei

Place: Office Duration : 30 minutes Date : 28th October, 2013

Interview an interview with CMO, Lunglei, topics on challenges of adolescent girls, support and suggestions on reproductive health were mentioned. He said that " Hmeichhe tleirawl te hian harsatna tun hma aiin an tawk nasa emaw tih tur ania,mahse tunah chuan support system lo awm zel avangin an dinhmun a kang chho ve mek zel a. Amaherawhchu, nurse(ANM) te nurse(GNM) te pawh kan nei tha lo a. Doctor(Gynaecologist leh Ostriaticians) te pawh thingtlang lamah kan nei tha lo hle in an indaih lo a. Khawpui chhungah pawh gynaecologist pahnih chiah(pakhat ve ve) kan nei a(Civil Hospital leh Christian Hospital,Serkawn). Thingtlang atanga inkalpawhna tha leh rang zawk te pawh kan mamawh hle ani. Mahni in luma neih mai te thingtlangah chuan kan la hrat hle a, hetiang atan hian mi thiam bik te pawh kan mamawh a nurse leh doctor kan indaihlo em em hi pawi ka ti khawp mai."

(There have been improvements in the maternal health outcomes due various RCH interventions. However, continuous focus is needed because of the following deficiencies - Non availability of adequate ANM to provide timely and quality ANC and PNC services, lack of public health facilities providing obstetric and gynecological care at district and sub-district levels, shortage of gynecologists and obstetricians to provide maternal health services in peripheral areas, lack of skilled birth attendants to assist home deliveries, referral problem-there is no proper arrangement, limited BCC/IEC activities – target groups are not well aware about the services available, poor transport and communication facilities.)

Interview 2 : Counsellor, ICTC(MSACS)

Place: Residence Duration: 30 minutes Date: 16th October, 2014

Interview an interview with counselor, ICTC (MSACS), Lunglei, topics related to HIV/AIDS and safe sex of adolescent girls, their situation, challenges, social support and knowledge they faced. She said that " Lunglei ah hian sex in zirtirna leh humhalh dan kawng hi kan la uar lo em em a. inchhung ah leh sikul ah te sawi uar theih ni se a lawmawm ang. Tam tak ten STI treatment an rawn lak na chhan hi chu thian te atanga drugs leh a kaihnhoih an zirchhawn ani ber a, chhungkaw kehchhia leh nu leh pa ten a an duat lutuk vanga lo thleng a tam ber awm e. Treatment rawn la te hi sex lama lo inhnamhnawih tawh deuh vek an ni a, tin zuk leh hmuam pawh lo ti vek tawh an ni tlangpui. Chuvang chuan an nungchang an lo thlak theih nan leh zawimuanga an sim theih nan nasa takin kan bei ve mek a. ARSH orientation Training prograame te hi awm tam thei se, hmeichhe tleirawl bik tan a clinic tha leh changtlung zawk te hi awm thei se duhthusam ani. Tleirawl local tam be rte hi an tleirawl pui te avanga harsatna tawk an ni ber a, chhungkaw inrelbawl dan fello tang pawh in a ni bawk. Sucide attempt pawh a sang hle".

(To educate and change behaviour amongst adolescent – especially regulating safe sex, prevention of RTI/STI and HIV/AIDS is not an easy task. This form of regulating information and giving awareness on adolescent girls is not so familiar in the family as well as in schools in Lunglei district since many young people are reluctant to disclose their problems and hide their identity in public(esp in core areas). The most popular dominants of STI is from peer pressure and a dependent child. So, to reduce adolescent marriage/pregnancy, to educate adolescent boys and girls about human physiology ,RTI/STI, HIV/AIDS, risk of early pregnancy of adolescent, more adolescent health clinics, IEC/BCC activities, ARSH Orientation Training to State must be organized and maintained. There is a lot of incidence due peer pressure and family relationships. There is also high level of suicidal attempt".

Interview 3: District Social Welfare Officer, Lunglei

Place: Office Duration: 40 minutes Date: 15th October, 2014

Interview an interview with District Social Welfare Officer, topics related to family planning, adolescent health issues and challenges. She said that " sawrkar in ruangam kan siam vet e hi khawtlang hruaitu leh kohhran a rawngbawltu tam tak ten an zawm tha duh lo em em a. kan hna thawk tur pawh hian hmanrua leh hnathawh pawh kan nei tha tawk lo ve bawk a. Thingtlang leh khaw chengreng kilkhawr tak tak ah inhrilh hriat kim te hi a harsa em em a,entirnan chakma ramah te awareness zuk pe dawn pawh ni ila an tawng kan thiam vet e a ngai a, bru hnamah lah an tawng kan thiam ve zel a ngai a,kawng a lo chhe thin bawk nen a harsa em em ani".

(The major issues affecting the implementation of the Family Planning program are anti family planning campaign initiated by some prominent NGO/Church leaders who used to convinced a number of target group not to accept family planning. Lack of health facilities, both in terms of physical infrastructure and skilled human resources to deliver quality family planning services is prone in the area. Difficulties to access of family planning services lead to high level of unmet needs particularly in hard to reach areas. There is low percentage of male sterilization due to social factor. There is a weak public-private partnership to promote the health conditions and delivering of family planning services and lack of adequate IEC/BCC Activities is the main factor.)

Interview 4: CDPO, Lunglei

Place: Office and telephonic communication Duration : 1 hour

Date: 17th November, 2014 & 11th December, 2014

An interview with CMO, subjects related to services, challenges and life skills education for adolescent girls under SABLA were discussed. He said that "Khawpui mi te aiin thingtlang lamin SABLA hi chu an hlut a. Lifeskill education lam leh hriselna atana taksa in a mamawh iron leh folic acid te, mahni intundin theihna tura atana thiamthil chi hrang hrang- dakin a account siam dan, ATM hman dan,la phiar, sam siam, thingzai, electrician, etc te hi an in zirtir thin a. Khawpui lam pawhin an hlut em em a, thingtlang lam tan phei chuan a hlawkpui awm em em ani. Kishori

Shakti Yojana hi kalpui mek ani a, thla thum danah vawikhat neih thin ani. He tah hian hmeichhe chhungte pawh koh khawm thin an ni a, feedback kan dawng tha thei hle. Mahse khawpui lamah chuan mahni a ding thei tawka inhriatna leh a tangkaina ngai pawimawh lo an tam zawk mah. Inrinni tinah hmeichhe tleirawl te hi an veng chhung a anganwadi worker te hian zirtirna chi hrang hrang an pek bak ah damdawi tha tak te an sem thin."

(Rajiv Gandhi Scheme for empowerment of adolescent girls (SABLA) with the objective to give adolescent girls adequate health facilities as well as life skills education is valued both in the areas but is largely valued by the peripheral areas as compared to core areas. The Kishori Shakti Yojana is held once in every three months in which the parents (either the mother or father preferably mother) were asked to join the meeting. There is always a good feedback from the parents saying that their girls become more responsive and interactive within the family as well as with the community participation at large. The core adolescents were not necessarily sent by their parents for vocational training since they find themselves a better off to practice on their own efforts in private settings.)

Interview 5 : Gynaecologist(MBBS)

Place: Residence Duration: 30 minutes Date: 28th October, 2013

In an interview with Gynaecologist, the specific issues affecting the adolescent reproductive health was discussed. She said that " Thingtlang tleirawl aiin khawpui tleirawl te hin UTI hi an nei tam zawk a,hei hi chhan berah chuan ei te a tha tawh a, taksa insawizawi lam an la uar lo deuhin a lang. Thingtlang lamah naupang taka rai hi a la hluar zawk a, a that lohna leh a changkan lohna inhrilhhriat tam a la ngai zual hle. Condom hman dan te, nau tih tlak dan te, zunkawng thalo chhuah dan leh enkawl dan te, HIV/AIDS chungchang te, rilru lam hriselna inzirtir kan la ngai nasa hle khawpuiah leh thingtlangah pawh."

(The specific issues affecting adolescent reproductive health in the state are that vulnerable groups are not well aware about the necessity of spacing births which lead to complication among child. There is a high levels of child pregnancy, particularly in rural areas and in adolescent belonging to disadvantaged groups. There are also high levels of urinary tract infection among the core areas. Lack of adolescent

health facilities, both infrastructure and human resource, to provide curative services for common adolescence ailments such as UTI, abortions, condom practices, HIV/AIDS, mental health, etc, lack of knowledge of basic reproductive health care practices amongst health care providers also affect the reproductive health of adolescent girls. There is also a failure to generate community awareness regarding essential reproductive systems and hygiene practices that impact on the health of adolescent reproductive health.)

Interview 6: Nurse (GNM)

Place : Residence Duration: 40 minutes Date : 15th October, 2014

In an interview, ideas and challenges faced by adolescent girls in Lunglei were asked. She said that " Nau tihtlak kan la pun zel tho avangin a tihtlak dan him zawk leh tha zawk hi awm se. Khawtlang pawh hian pasal neih hmaa sex lo hman pawi zia te hi uar deuh deuh in tlangau pui ta se, zahna chang kan hriat theih nan hian hma la lehxual se ka duh. Damdawiin ah nau tit la tur hi an local reng tho a hei vang hian condom hman te hi in zirtir uar ila, sex kan hmang dawn tho tho a nih chuan."

(To promote RTI/STI services, to improve safe abortion and reduce unsafe abortion, to enhance inter- Sectoral Co-ordination and Community Support and to improve post natal care, we need to be aware of safe sex and how to use condoms. The community has also played a large role in awaring the communities the shamefulness and illegal practices which the adolescent of our generation has been adopted.)

Interview 7 : Community Leaders(Core and Periphery - Village Council Chairman, MHIP President, MUP President, YMA President)

Place: Office Duration : One hour each from core and periphery

Date: 23rd August, 2014 & 24th August, 2014

In an interview with Community Leaders a discussion was held on topics related to perception regarding the reproductive health of adolescent girls. The Interview held with leaders show that community role and participation with regards to adolescent reproductive health is not very much appreciated. It was perceived by them that community action alone is inadequate to generate information on the mentioned issues. It was further perceived by the leaders that family plays a vital role

in this regard and that the communities do not make any contribution and effort to improve adolescent reproductive health. This is due to the belief they had that many programmes have been implemented by the Government which effectively influence the community members and which are likely to be of benefitted.

Section II: Data from Focus Group Discussion(FGDs)

Qualitative tool of Focus Group Discussion (FGD) was used to explore the adolescent's help seeking behaviour, the type of service facilities they approached, constraints faced by them and the facilitating factors in approaching the adolescent girls school based and the views of elders on their health problems. A focus group discussion was held with eight adolescent girls (core) between the age group of 10-19years. Topics on their perceptions and awareness level on reproductive health were discussed.

Sl. No	Marital Status	Age	Qualification	Have had sexual experience	Age at Menarche	Compelled to have sex under force
1	Unmarried	18	Class XII	Yes	14years	Yes
2	Unmarried	19	Class XII	No	14years	No
3	Unmarried	18	Class XII	No	13years	No
4	Unmarried	18	Class XII	No	15years	No
5	Unmarried	18	Class XII	No	14years	No
6	Unmarried	17	Class XII	No	12years	No
7	Unmarried	19	Class XII	Yes	13years	No
8	Unmarried	16	Class XII	No	13years	No

Source: Compiled

It may be concluded accordingly:

- Many adolescents' girls are unaware of reproductive health and it was perceived by them that awareness and information generation is very much required especially on menstruation, contraception, and availability of health care and services, STI and abortions.

- Many respondents disagree that pre marital sex is more common among school going girls than school going boys.
- It was also believed by them that girls are more prone to sexual abuse than boys that certain steps needs to be taken to tackle this problem.
- Many respondents from core area are aware of reproductive health of adolescent and had known about what sex is all about.
- The group members from core area reported that services are availed by and make use of private clinics and civil hospital as well which they also find it costly.
- It was believed by them that talking about sexual health is not shameful and it must be made aware among adolescent girls.
- The main coping mechanism used by members from core area during the menstruation was "Adaptive Mechanism".

FGD with adolescent girls from peripheral area

Sl. No	Marital status	Age	Qualification	Have had sexual experience	Age at menarche	Compelled to have sex under force
1	Unmarried	12	Class VI	No	12 years	No
2	Unmarried	14	Class VII	No	13years	Yes
3	Unmarried	15	Class VII	Yes	12years	Yes
4	Unmarried	13	Class VI	No	12years	No
5	Unmarried	12	Class VI	No	NA	No
6	Unmarried	10	Class V	No	NA	No
7	Unmarried	16	School drop out	Yes	13years	Yes
8	Unmarried	18	School drop out	Yes	14years	Yes

Source: Compiled

It may be concluded accordingly:

- Many adolescents' girls are unaware of reproductive health and it was perceived by them that awareness and information generation is very much required especially on menstruation, contraception, and availability of health care and services, STI and abortions.

- The group members from peripheral area reported that services are not availed by them due to inadequate services and financial problem of their families.
- It was believed by them that talking about sexual health is shameful which result in "Passive endurance" as a coping mechanism.
- Some respondents from peripheral area are not aware of reproductive health of adolescent and had not known about what sex is all about.

From both the Focus Group Discussion, it may be concluded that –

1) Many adolescents' girls are unaware of reproductive health and it was perceived by them that awareness and information generation is very much required especially on menstruation, contraception, and availability of health care and services, STI and abortions.
2) Accessibility and availability of services should be provided more in the peripheral areas.
3) Focus group discussions with adolescents revealed many underlying factors that influenced the adolescent's visit to the center. Some adolescents went to private practitioners or municipal dispensaries as they always felt better going to these places and many of them preferred home remedies. Very few of them mentioned that they were shy to approach the ICTC counseling centre.
4) Most adolescent girls did not consider their problems important enough to seek care. Few said that problems subsided on their own. Mothers or senior female members of the family and neighborhood felt that menstrual problems such as pain and discomfort during menses were very common for girls and they must learn to bear the pain. Thus girls only sought care when the pain was unbearable or during exams or when they had to miss school.
5) Similarly white discharge and itching of genitals was taken on a very casual note. They used home remedies such as applying coconut oil or drinking some herbal remedies for cooling the body as they attributed itching to excess heat in the body. Majority of these girls practiced improper washing technique after defecation.

Overall, it was found that adolescents attended the Counseling Centre and visited Gynecologists' for information and health problems mainly related

to mental rhealth and family problems, general health and menstruation followed by problems related to height and weight, vaginal discharge, itching of genitals. Acne, urinary complaints, and psychological complaints were among the sought services. Most of the complaints needed only reassurance and counseling. It was surprising to note that some of the parents were not aware of the conditions of their children, as it was never detected during childhood and those that were aware were not advised properly by the doctors whom they had consulted. The mean age of menarche among girls was much earlier as against the earlier reported age of 12-14 years.

CHAPTER - V

CONCLUSIONS AND SUGGESTIONS

4.1 Conclusion

This study titled 'Reproductive Health Seeking Behavior and social support of adolescent girls in Lunglei, Mizoram' is one that included a sample of seventy adolescent girls between the ages of 10-19 years and was conducted using a mixed-methods design in Lunglei. The study had the objectives of profiling adolescent girls, understanding sources of information and levels of awareness regarding reproductive health among adolescents. Further it sought to understand availability, accessibility and affordability of reproductive health services and to explore social support of these girls for the same. The study drew its sample of adolescents from one core area and one peripheral area of Lunglei, Mizoram.

Adolescence is an important stage in the life span and comprises of children between the ages of 10-19 years, roughly divided into three categories that include early, middle and late adolescence. Adolescents currently make up 18% of the world's population .It is a stage of life that brings with it marked physical changes, significant psychological changes and is likely to be filled with dramatic reactions to the several stressors faced by adolescents.

While all adolescents generally face marked challenges in their life, girls are likely to have some very specific challenges in relation to reproductive health in particular. Reproductive cycles begin at this stage of a girl's life with the onset of menarche averaging at 12 years of age across countries (UNICEF, 2011). A study done by Eswi, Helal and Elarousy on 200 adolescent girls in Egypt, using a self administered tool observed that menstruation is seen as a debilitating, bothersome event although it was considered a natural event.

The UNICEF State of World's Children, 2011 discusses that puberty for girls occurs earlier (12 -18months) than it does for boys. It goes on to state that puberty is occurring at earlier ages than it has been with some girls attaining menarche by even 8 years of age. Among various reasons offered for this, better health and nutrition has been attributed in several studies. This trend outlines the importance of understanding issues related to menarche and subsequent reproductive health issues among adolescents since menstruation begins in many cases even before adolescence has been attained, heralding and spearheading several changes in young girls.

This study had respondents between 10-19 years, mostly unmarried but a tenth have had children already indicating that early pregnancy is not uncommon. A number of them confess also to being in intimate relationships currently. More than a tenth from the core area was categorized as others since they reported having had sexual experience and bearing children out of wedlock. Interestingly, a tenth had at least one child with more in the core area than peripheral area. The state of the World's children also records that many adolescents in South Asia or in Sub -Saharan Africa are married between the ages of 15-18 years. The study also quotes that a neighbouring country like Bangladesh too sees that a lot of women who were currently married and between 20-24 years of age, were married at the age of 15 years. The report quotes that the government has been offering incentives since 1994 to girls who postpone the marriage until later, a practice that is common even in some Indian states .This finding is significant as the present study in Mizoram is in the same region and shares international boundaries with Bangladesh. An overwhelming majority of adolescents in Lunglei rated their health in childhood as ranging from good to very good while a fifth rated it between poor and very poor.

Majority of the girls in this study in Lunglei had awareness on menstruation that was gained from mother but a few also have had information from teachers and ICDS workers indicating primary and tertiary support as important sources. The role of a mother in imparting information is undeniably significant but for adolescent girls who are vulnerable and in marginalised existences, the need to strengthen secondary and tertiary supports , in the absence of a mother , becomes crucial.

The study also reports a small number of adolescents experiencing irregualr menstrual cycles, with a menstrual cycle of once in a fortnight while more than a tenth particularly in the core area could not describe the menstrual cycle suggesting gross irregularity of periods. Regarding sanitary practices, interestingly less than half of the respondents in the peripheral areas are still using cloth while this is not practiced in the core areas. Sanitary practices among adolescents are a major area of concern as insanitary practices can lead to several health challenges including Urinary tract infections.

There was a significant association observed in a study in rural Andhra Pradesh between prevalence of UTI and use of unsanitary pads during menses (CI = 95%, p<

0.001). Misconceptions included not taking bath during periods and not eating certain foods. Low socioeconomic status was chiefly responsible for frequent use of same piece of cloth as sanitary pads during menstrual bleeding leading to urinary tract infection (Ahmed and Avasarala, 2009).

Any discourse on adolescent girls in developing countries always emphasizes the need for protection in the context of violence. Sexual violence is of particular significance as many young adolescents find themselves in situations that violate the sense of dignity and self. In this study too, violence had been a part of their lived experience and the main perpetrators for violence were *'boyfriend'*. Probing techniques suggested that girls were compelled to have sex under force by their boyfriend.

Health care services and health seeking behaviour is an integral component on any study that deals with reproductive health. Most of the girls in this study find health care services accessible, available and affordable. However, probing revealed that almost all the respondents in peripheral areas go for home remedies and find private clinics difficult to access and afford. A quarter of the respondents found Civil Hospital as affordable, accessible and adequate. Private Clinic was rated by more than a third of the adolescents as satisfactory, particularly adolescents from core area. This is important to understand as intervention needs to be targeted in peripheral areas more. Home remedies were used by more than half of the respondents in both the categories. All the girls in the peripheral areas interestingly used home remedies. What is noteworthy is that self-prescription also passes off as home remedies.

With reference to social support, more supportive are members of the family with mother being rated the highest. This has policy implications as they could be included in intervention efforts. Tertiary support is seen as on "*somewhat supportive"* and tertiary support included information on NGO's, Doctors, Church Elders.

A multi – stage sampling for key informant interviews included interviews with CMO Lunglei, District Social Welfare Officer, Lunglei, Child Development Programme Officer, Lunglei, Gynaecologist, Counsellor, Nurse(GNM) and community leaders . These interviews revealed that there is a need for policy makers and contributors to stress health related issues more with the peripheral areas since they have less access to health services than those in the core areas. Moreover, the key

informants agreed to the fact that community leaders could play an instrumental role in helping gain better access to health services for their community members.

Focus group discussions among adolescent girls recorded views that suggest that girls would like to receive more awareness on reproductive health related issues and the kind of services available and affordable for them. The adolescent girls visited Gynecologists' for information and health problems mainly related to mental health and family problems. Most of the complaints needed only reassurance and counseling. Therefore, it can be concluded accordingly that the adolescent girls in Lunglei are still lacking the awareness related to their reproductive health conditions and that more research should be conducted in order to find out the problems and challenges faced by the adolescent girls.

Taking home remedies for their problems, self-medicating, preference to go to private practitioners because of presumed better services and poor knowledge on reproductive health along with lot of myths and misconceptions could be clubbed under *predisposing factors*. Seeking care only when symptoms become unbearable and severe so as to miss school or that the problems are self-limiting fits into the category of the severity or *need factor* as described in both the models. Lack of support from parents, their casual attitude to adolescent problems, the psychological barriers and health motivation or readiness to be concerned about health matters, feeling shy to approach the health facility fall under the preview of l*ack of enabling factor or barriers to accessing care* as described in both the models. Addressing some of the predisposing factors, actively diagnosing their health problems through medical checkups and informing them about them and creating an enabling environment by parental involvement helped in improving the help seeking behaviour.

Based on the above findings, the study recommends the following suggestions that may be categorised as Policy related, Programme related and Research related. All suggestions are given within a social work perspective.

4.2 Suggestions

1. Policy suggestions include better networks between Government and NGOs to promote adolescent reproductive health and their help-seeking behavior to avoid dilemma and stress. School adolescent health programs and community health delivery system can directly address risk behavior, depression, anxiety,

2. stress and early sexual contact/intercourse.
3. Program implication of the study include-
    a) Life skill workshop for adolescents to cope with challenges they faced in school, family and community. Such workshops need to address issues related to assertive skills of adolescents, refusal skills to withstand the pressures related to them in sexual risks and other challenges. Further, communication skills are also required to help them learn better style of communication with family, among peers and in the community.

    b) It is also suggested that in the peripheral area, more networking between NGOs and Private clinics to ensure easy accessibility and affordability.

4. Research implications of this study suggest that more studies are required on issues related to perceived social support, sexual risk behavior, awareness on sexual and reproductive health, importance of family relationship and causes of early pregnancy.

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APPENDICES

APPENDIX I

Reproductive Health Seeking Behavior and Social Support of Adolescent Girls

(Confidential and for Research Purpose Only)

Interview Schedule (English)

Research Investigator:
Ms. C.Lalrempuii
Research Scholar
Dept of Social Work
Mizoram University

Research Supervisor:
Dr. Kalpana Sarathy
Associate Professor
Dept of Social Work
Mizoram University

I.Identification Information

1. Schedule No. 2.Location: 3. Locality:

4.Date: 5.Time:

II. Socio Demographic Profile

Sl. No		**1**	**2**	**3**	**4**	**5**
1.	Sex*	Male	Female			
2.	Age*					
3.	Qualification*	0-V	VI-XII	Any other		
4.	Clan					
5.	Marital Status	Unmarried	Married	Divorced	Widowed	Remarried
6.	No.of children	No children	1 child	2 or more		
7.	Nature of Intimate relationship	Spouse	Boyfriend	Any other	NA	
8.	Type of Family	Nuclear	Joint	Extended		
9.	Form of Family if nuclear	Single parent family(father headed)	Single parent family(mother headed)	Reconstituted	Any other	
10.	Religion*	Christian	Hindu	Buddhist	Muslim	Any other
11.	Denomination if Christian	Baptist	Presbyterian	Roman Catholic	Salvation	Any Other
12.	Socio-economic category	APL	BPL	AAY	No category	

- **Predisposing factors**

III. Family Particulars

Sl. No	Relationship to respondent	Age	Sex	Educational Status	Occupation	Monthly Income

***1.Father 2.Mother 3.Brother 4.Sister 5.Uncle 6.Aunty 7.Grandmother 8.Grandfather 9.Any other.

***0None 1.Gov't Officer 2.Gov't workers 3.Cultivators 4.Wage Labourer 5.Skilled Labourer 6.Petty Business 7.Large Business.

***1Less than thousand 2.Rs 2000-5000 3.Rs5000-10,000 4.Rs10,000-20,000 5.Rs20,000-50,000 6. Rs 50,000 and above.

IV. Personal Information

13. Are you aware of any of the following in reference to your birth as a child?

1.Normal Delivery	2.Premature birth	3.Section delivery	4.Any other

14. How do you rate your health in childhood?

1.Very Good	2.Good	3.Poor	4.Very Poor

15. Were you possessing any of the following traits in childhood?

1.Nail biting	2.Temper tantrums	3.Sleeping excessively	4.Bedwetting

16. How good are you in studies?

1.Very Good	2.Good	3.Poor	4.Very Poor

17. In school, did you have a lot of close friends?

Yes only one	Yes, 2 to 4	Yes,more than 4	No

18. Are you involved in any work that contributes to the family income?

Yes	No	No response	

19. Which of the following applies to you?

1.Only Child	2.Have older sisters	3.Have older brothers	4.Have younger siblings	5.Have both brothers and sisters

V(a). Reproductive Health History

20. Age at menarche -

21. Where did you learn about menstruation first

1.From friends	2.From mother	3.From sisters	4.Any other(specify)

22. What were your initial reactions to menstruation?

1.Shock	2.Irritation	3.Sadness	4.Happiness	5.No reaction

23. Which of the following applies to you in the initial stages of menstruation?

1.No problems at all	2.Very difficult	3.Not Difficult at	4.Any other

		all	

24. How would you describe the regularity of your cycles?

1.Regular	2.Irregular	3.Can't say	4.No response

25. How would you describe your menstrual flow?

1.Very heavy	2.Heavy	3.Not too heavy	4.Not heavy at all

26. What is the frequency of your menstrual cycle?

1.Once in 15days	2.Once in 28days	3.Once in 30 days	4.Any other

27. What is the duration of an average period?

1.Less than 2days	2.2-4days	3.5days or more	4.Can't say

28. Have you ever had a time when your periods did not occur? Yes,No

If Yes,For what duration

1.Few Days	2.Fortnight	3.A month	4.More than a year	5.One year

29. Which of the following do you associate with your menstruation?

1.Stomach cramps	2.Headaches	3.Dizziness	4.Tremors in the hand	5.Any other

30. Which of the following do you associate with your menstruation?

1.Mood swings	2.Anxiety	3.Sadness	4.Irritability	5.No response

31. Which of the following do you used during menstruation?

1.Sanitary pads	2.Tampons	3.Cloth	4.Any other

32. How often in the day do you change sanitary pads/cloth?

1.3-4 times	2.1-2 times	3.Once a day	4.Once in two days

33. On an average, how much do you spend per cycle on your menstruation?

1.Rs 20/-	2.Rs 21- 50	3.51 or more	4.No response

V(b).Marital and Sexual History

34. Are you married?

1.Yes	2.No

35. How aware are you on matters related to sex?

1.Very aware	2.Aware	3.Not very aware	4.Not aware at all

36. Have you had sexual experience?

1.Yes	2.No	3.No response

36(a).If Yes, at what age?

_____

36(b).Are you currently sexually active?

1.Yes	2.No	3.No response

37. Have you had any of the following happen to you?

Inappropriate touching	Compelled to have sex under force	Raped	Have been exposed to verbal sexual advances	Compelled to have sex when man under influence of alcohol/drugs	Compelled to have sex after being given alcohol/drugs

37(a). If Yes to any of the above, who was responsible?

1.Uncle	2.Father	3.Cousin	4.Boyfriend	5.Father	6.Any other

38. Do you use protective measures during sex?

1.Yes	2.No

If Yes,Specify_____

39. Have you had any sexually transmitted infection?

1.Yes	2.No

If Yes,Specify:_____

40. Have you received treatment for STI?

1.Yes	2.No

If Yes,Specify:_____

VI(a). Perceptions on sexual and reproductive health

41. Talking about sex is a taboo.

1.Strongly Agree	2.Agree	3.Disagree	4.Strongly Disagree

42. Being a girl is itself a problem for the society.

1.Strongly Agree	2.Agree	3.Disagree	4.Strongly Disagree

43. Young women can become sexually active when they attain 15years.

1.Strongly Agree	2.Agree	3.Disagree	4.Strongly Disagree

44. Pre-marital sex is more common among school going girls than school going boys.

1.Strongly Agree	2.Agree	3.Disagree	4.Strongly Disagree

45. Girls are more prone to sexual abuse than boys.

1.Strongly Agree	2.Agree	3.Disagree	4.Strongly Disagree

VI(b). Awareness on Reproductive Health

46. Do you get to know of your menstruation prior to actually getting it?

1.Yes	2.No

46(a).If Yes, how many days in advance do you know?

1.One day	2.One week	3.Two weeks	4.Never	5.Any other

47. Do you find that awareness on sexual and reproductive health is required among adolescent girls?

1.Yes	2.No

48.From where did you receive awareness on reproductive health?

1.Parents	2.Friends	3.ICDS workers	4.Uninformed sources	5.Any other

49. What information do you require on reproductive health?

1.On menstruation	2.On contraception	3.On health care and services	4. On STI's	5. On abortions

50. What are the reasons for irregularity in periods?

1.Lack of nutritional diet	2. Stress	3. Health complications	4.Any other

VII. ACCESIBILITY, AVAILABILITY AND AFFORDABILITY

51.What services are available if you had health complications?

1)Gov't Clinic	2) Civil Hospital	3)Spiritual Healer	4)Home remedies/any other

52. Are the above facilities available when you need?

1)Very available	2)Available	3)Somewhat available	4)NA

53. How adequate is the quality of health care for reproductive health in your locality?

1)Very adequate	2) Adequate	3)Somewhat adequate	4)NA

54. How accessible are the services for Reproductive Health?

1)Very accesible	2) Accessible	3)Somewhat accessible	4)NA

55. Do the utilization of health care improve your health condition?

1)Very adequate	2) Adequate	3)Somewhat adequate	4)NA

56.What are the problems related to accessibility of health care?

1) Too far	2) Very Costly	3) workers are not approachable	4)Any other

VIII. Coping and Social Support

57. Which of the following do you do when you have heavy menstrual flow

1. Sleeping	2.Listening to Music	3.Pray	4.Go out with friends	5.Any other

58.Whom can you really count on to listen to you when you need to talk?

1.Mother	2.Father	3. Friend	4. Sister/Brother	5.Boyfriend	6.Any other

59. Whose lives do you feel that you are an important part of?

1.Mother	2.Father	3. Friend	4. Sister/Brother	5.Boyfriend	6.Any other

60. In the case of failed relationships, who is most likely to be of help to you?

1.Mother	2.Father	3. Friend	4. Sister/Brother	5.Boyfriend	6.Any other

61. Who is most understanding when you have monthly period?

1.Mother	2.Father	3. Friend	4. Sister/Brother	5.Boyfriend	6.Any other

62. Who is least understanding when you have your periods?

1.Mother	2.Father	3. Friend	4.	5.Boyfriend	6.Any

			Sister/Brother		other

63. Rank the following in terms of social support for reproductive health issues?

1.Family	2.Friends/Neighbours	3.Relatives	4.NGO's	5.Doctor	6.Church Elders

1.

2.

3.

4.

5.

6

APPENDIX II

Reproductive Health Seeking Behavior and Social Support of Adolescent Girls

(Confidential and for Research Purpose Only)

Interview Schedule(Mizo)

Research Investigator:

Ms. C.Lalrempuii

Research Scholar

Dept of Social Work

Mizoram University

Research Supervisor:

Dr. Kalpana Sarathy

Associate Professor

Dept of Social Work

Mizoram University

I. Identification Information

1. Schedule No. 2.Khua :Lunglei/Thuampui 3. Veng:

4.Date: 5.Time:

II.Mahni Dinhmun Chungchang

Sl. No.		1	2	3	4	5
1.	Nihna*	Mipa	Hmeichhia			
2.	Kumzat*					
3.	Zirna	0-V	VI-XII	Thildang		
4.	Hnam hming					
5.	Nupui/Pasal	Neilo	Nei tawh	Inthen	Nuthlawi	Nei leh
6.	Fa neih tawh zat	Neilo	Pakhat	Pahnih	Pahnih aia tam	
7.	Tuna I kawppui	Pasal	Bialpa	Neilo	Thildang	
8.	Tut e nen nge in chen ho?	Chhungkaw bil	Pi leh put e nena cheng ho	Thildang		
9.	Chhungkaw bil te a cheng in nih chuan eng ang nge	Pa enkawlna(N u tello)	Nu enkawlna(P a tello)	Inthen tawh in zawm khawm leh		

10.	Sakhuana	Christian	Hindu	Buddhist	Muslim	Thildang
11.	Kohhran	Baptist	Presbyterian	Roman Catholic	Salvation	Thildangh
12.	Chhungkaw Nihna	APL	BPL	POP	AAY	Engamah

III.Chhungkaw Dinhmun tlangpui

Sl. No	**Chhangtu nena inlaichinna**	**Kum**	**Mipa/ Hmeichhia**	**Zirna**	**Hnathawh**	**Thlatina lakluh zat**
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

***1.Father 2.Mother 3.Brother 4.Sister 5.Uncle 6.Aunty 7.Grandmother 8.Grandfather 9.Any other

***0None 1.Gov't Officer 2.Gov't workers 3.Cultivators 4.Wage Labourer 5.Skilled Labourer 6.Petty Business 7.Large Business

***1Less than thousand 2.Rs 2000-5000 3.Rs5000-10,000 4.Rs10,000-20,000 5.Rs20,000-50,000 6. Rs 50,000 and above

IV. Mimal Chanchin

13. Heng te hi I pian dan milin hriat theih I nei em?

1.Thla kima piang	2.Thla kimlo a piang	3.Khingbai deuha piang	4. Thildang

14. I naupan laia I hriselna dinhmun enge?

1.Tha lutuk	2.Tha pangai	3.Hrisel vak lo	4.Hrisel lo lutuk

15. I naupan laiin tih zawngchhang I nei thin em?

1.Kut tin seh	2.Thinchhe tawp/ thil paih ching	3.Mut duh tak	4.Zun cheh ching

16.Zirna kawngah enge I an?

1.Thiamthei lutuk	2.Thiam pangai	3.Thiam theilo	4.Thiamlo lutuk

17. School ah thian engzat nge I kawm thin?

1.Pakhat	2.Pahnih-pali	3. Pali aia tam	4. Nei lo

18. I chhungkaw tan sum I hai lut ve tawh em?

1.Aw	2.Aih		

19. Eng te hi nge I nih?

1.Fa mal	2.Hmeichhia aia upa nei	3.Mipa aia upa nei	4. Aia naupang nei

V(a). Hmeichhiatna lama Hriselna Dinhmun

20. Thi I neih tan kum:_____

21. Tu hnen atangin nge thi neih chungchang I hriat hmasak ber?

1.Thiante	2.Nu	3.Unaunu	4.Midangte_____

22. I thi neih tan tirh in engtin nge I dawnsawn?

1.Hlauthawng	2.Thak/Tisa kham	3.Nguai	4.Hlim	5.Engtinmah

23. Hengte hi I thi neih tantirhin I tawk em?

1.Buaina awmlo	2.Harsatna tam	3.Harsatnha awmlo	5.Thildang_____

24. I thi neih hunbi a pangai em?

1.Hunbi zat zat a nei	2.Hunbi lo takin	3.Sawi theilo	4.Thildang_____

25. I thi neih tam dan dinhmun?

1.Tam lutuk	2.tam	3.Pangai	4.Tlem te in

26. Engtiangin nge thi I neih thin?

1.Ni 15 danah	2.Ni 28 danah	3.Ni 30 danah	4.Thildang_____

27. Engtia rei nge?

1. Ni hnih aia tam	2.Ni hnih – Ni li	3. Ni nga aia tam	4.Sawi theilo

28. Thi I neih miahloh hun a awm em? Awm chuan engtia rei nge?

1. Ni engemaw zat	2.Chawlhkar hnih chhung	3.Thlakhat	4.Thlakhat aia tam	5.Kum khat

29. Hengte hi thi I neih laiin I nei thin em?

1.Pumna	2.Lu na	3.Luhai	4.Kut khur	5.Thildang_____

30. Heng lamah hian thi I neih dawnah harsatna I nei ngai em?

1.Rilru puthmang thlak thut thut	2. Ngaih that lohna	3.Lungngai	4.Thinur	5.Engmah awmlo

31. Eng hmanrua te nge thi I neih laiin I hman thin?

1.Sanitary pads	2.Tampons	3.Puan	4.Thildang_____

32.Engtia zingin nge ni khatah I thlak thin?

1. Vawi 3-4	2.Vawi 1-2	3.Vawikhat	4.Ni hnihah vawikhat	5.Thildang_____

33. A chawhrualin thalkhatah engzat vel nge pawisa I sen ang?

1.Rs 20/-	2. Rs 21-Rs 50/-	3. Rs 51 aia tam	4. Engmah senglo

V(b). Kawppui leh inpawlna chungchanga zawhna.

34. Pasal I nei tawh em?

1. Aw	2. Aih

35. Inpawlna/Nupa nun(sex) chungchang hi I lo hr eve tawh ngai em?

1.Hre tawh lutuk	2.hre ve	3.Hre lutuk lo	4.Engmah hrelo

36. Sex chungchang hi I lo tem ve chin(experience) tawh em?

1.Aw	2.Aih	3.Thildang(no response) _____

36(a). Kum engzat I nih in nge inpawlna(sex) I hman?

_____

36(b). Tunah I la hmang reng em?

1.Aw	2.Aih	3.Response awmlo

37. Heng a hnuai ami te hi I lo tawng ve tawh ngai em?

1.Mawilo taka khoih/zut	2.Sex hmang tura tih luih	3.Pawngsual	4.Tawngkam a a ruka sex hman(phone atang te pawn)	5.Zu rui/Damdawi rui in sex hmang tura sawmna	6. Zu/Damdawi a hrai ruih hnua sex hamn puia sawmtu

37(a). A chunga mi I lo tawn tawh ah tunge mawhphurtu ber?

1.Patea	2.Cousin	3.Bialpa	4.Hmelhriatloh	5.Pa	6. Midang _____

38. Sex hman laiin invenna(e.g.condom) I hmang ngai em?

1.Aw	2.Aih	3.A chang changin

Aw nih cuan enge I hman thin?_____

39. STI I nei taw hem?

1.Aw	2.Aih	3.Hrelo

40.STI laka Invenna/inenkawlna I la em?

1.Aw	2.Aih

Aw nih cuan enge I lak?_____

VI(a). Mimal Ngaihdan (sex leh inthlahchhawnna lakah)

41. Inpawlna(sex) lam sawi hi thil thianglo tak ani?

1.Dik tawp	2.A dik reng	3.Diklo	4.Diklo bur

42. Hmeichhe nih hi khawtlang tana hnawksak nihna ani?

1.Dik tawp	2.A dik reng	3.Diklo	4.Diklo bur

43.Hmeichhia te kum15 kan tlin hian kan sex hman chak na a sang thin?

1.Dik tawp	2.A dik reng	3.Diklo	4.Diklo bur

44. Nupa a inseam hmaa sex hman hi sikul kal mipa aiin hmeichhia ah a tam zawk?

1.Dik tawp	2.A dik reng	3.Diklo	4.Diklo bur

45. Mipa te aiin hmeichhia ah in[pawlna(sex) lama intih luihna hi a hluar zawk?

1.Dik tawp	2.A dik reng	3.Diklo	4.Diklo bur

VI(b). Inthlahchhawnna chungchanga kan lo hriat tawh dan.

46. I thi neih hma in I nei dawn tawh tih I inhre lawk thin em?

1.Aw	2.Aih

46(a).Aw nih chuan ni engzata hmain nge I hriat lawk thin?

1.Ni khat naah	2.Kar khat naah	3.Karhinh naah	4.Awmlo

47. Hmeichhe tleiawl te hnena inpawlna(sex) lama inhrilhhriatna(awareness) neih hi tul I ti em?

1.Aw	2.Aih	3.Hre lo

48.Tu hnen atangin nge inhrilhriatna I dawn ve?

1.Chhungte	2.Thiante	3.Zirtirtu_____	4.T.V/Radio/Internet etc	5.La hrelo

49. Eng lamah hian nge chinchang hriat duhna I neih?

1.Thi neih vel chungchang ah	2.Nau tih tlak dan chungchang ah	3.Hriselna lama sawrkarin chhawmdawlna a pek theih te ah	4.STIs(HIV/AIDS) lamah	5.Naupai theihlohna hmanruaah

50. I thi neih hun bi taka I neih loh chhan engte nge niag?

1. Taksa insawizawi loh vang	2.Rilru sen nasat lutuk vang	3.Damdawi thaei loh vang	4.Thildang _____

VII. Inkalpawhna, Remchanna leh Senso chungchang

51. Hriselna lama harsatna I tawh in khonge I pan thin?

1.Civil Hospital	2.Private Clinic	3.Tawngtai Dam thei	4.Sub-Centre	5.In lama in enkawl

52. A chunga mite khi I mamawh hun apiang ah an puin remchang thei che em?

1.Remchang lutuk	2.Remchang ve tho	3. Remchang lo zeuh zeuh	4.Remchang ngailo

53. In veng chhunga hriselna lama hmalakna hi tha tawk I ti em?

1. Ti lutuk	2. Ti ve tho	3.Ti vak lo	4. Ti lo lutuk

54. Engtiang takin nge inthlahna kawnga hriselna hi a remchan?

1.Remchang lutuk	2.Remchang ve tho	3.Remchang vak lo	4.Remchang lo

55.Health-care(sub-centre) I tan a tangkai em?

1.Tangkai lutuk	2. Tangtai ve tho	3. Tangkai vak lo	4. Tangkai lo

56. Damlohna I tawh chang in inkalpawhna chungchangin eng harsatna nge I tawh thin?

1.Hla lutuk.	2.To lutuk	3.Thawktute biak pawh an harsa	4.Thildang _____

VIII. Khawtlang Inpuihna leh In chhawmdawlna

57. I thi neih laiin engtia awm nge nuam I tih ber?

1.Mut	2.Hla ngaihthlak	3.Tawngtai	4.Thian te nena chhuah ho	5.Thildang _____

58. Harsatna I tawh chang in tunge hrilh tlaka I rin ber?

1.Ka Nu	2.Ka Pa	3. Thiante	4.Unaunu/Unaupa	5.Bialpa	6.Midang _____

59. Tu nunah hian nge pawimawh ve a I inhriat?

1.Ka Nu	2.Ka pa	3.Thiante	4.Unaunu/Unaupa	5.Bialpa	6.Midang

60. In inlaichinna a lo chhiat in,tu hi nge nagmah tanpui thei tur ni awm a lang ber?

1.Ka Nu	2.Ka pa	3.Thiante	4.Unaunu/Unaupa	5.Bialpa	6.Midang

61. I thlatin thi neih ah tuinge nagmah hrethiam tu ber che?

1.Ka Nu	2.Ka pa	3.Thiante	4.Unaunu/Unaupa	5.Bialpa	6.Midang

62. Tu hi nge thi I neih in hriatthiamna nei tlem ber che?

1.Ka Nu	2.Ka pa	3.Thiante	4.Unaunu/Unaupa	5.Bialpa	6.Midang

63. Inthlahna kawnga puibawm tu ber che anga I ngaih a pawimawh dan indawt in dah rawh?

1.Chhungkua	2.Thiante	3.Chhungte	4.Khawtlang hruaitu	5.Doctor	6.Kohhran hruaitu

1.

2.

3.

4.

5.

6.

APPENDIX III

REPRODUCTIVE HEALTH SEEKING BEHAVIOR AND SOCIAL SUPPORT OF ADOLESCENT GIRLS IN LUNGLEI,MIZORAM

(Confidential and for Research Purpose Only)

Key Informant Interview

Research Investigator:	Research Supervisor:
Ms. C.Lalrempuii	Dr. KalpanaSarathy
Research Scholar	Associate Professor
Dept. of Social Work	Dept. of Social Work
Mizoram University	Mizoram University

Key informant interview.

PART A

Name:	Marital status:
Age:	Designation:
Date:	Place of KII:

PART B

KI interview schedule:

1. What are the common reasons for which reproductive help is sought?
2. Is there any relation between adolescent reproductive health problem and health seeking behaviour?
3. What problems are adolescent prone to in their reproductive transition?
4. In your opinion what is the relationship between adolescent girls and reproductive health?
5. What in your opinion are the key issues and challenges of adolescent girls in Lunglei?
6. As a community leader, what are the challenges that you faced in treating them?
7. How do you rate the social support of adolescent girls in their reproductive transition?
8. What are the coping mechanisms used by adolescent girls?

APPENDIX IV

REPRODUCTIVE HEALTH SEEKING BEHAVIOR AND SOCIAL SUPPORT OF ADOLESCENT GIRLS IN LUNGLEI,MIZORAM

(Confidential and for Research Purpose Only)

Focus Group Discussion

Research Investigator:

Ms. C.Lalrempuii
Research Scholar
Dept. of Social Work
Mizoram University

Research Supervisor:

Dr. KalpanaSarathy
Associate Professor
Dept. of Social Work
Mizoram University

(*Focus Group Discussion(FGD) is a unique method of qualitative research that involves discussing a specific set of issues with a pre-determined group of people. The essential purpose of FGD is to identify a range of different views around the research topic, and to gain an understanding of the issues from the perspective of the participants themselves.*

PART A

Place : **Time :**

Date : **Duration:**

Topic :

Group Members

Sl. No	Marital status	Age	Qualification	Have had sexual experience	Age at menarche	Compelled to have sex under force

PART B
Discussions

1) Group Leader :
2) Group Facilitator :
3) Recorder :
4) Issues discussed :

a)_____

b)_____

c)_____

d)_____

5) Name and Signature of Candidates:

Name	**Signature**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

ANNEXURE I

Premarital sexual behaviour among adolescents

Cambodia: A study of garment workers revealed that only 2 per cent of unmarried female garment workers had had any form of sexual experience and that these sexual encounters had been with their boyfriends. These young women were on the average 18 years of age at the time of their first sexual experience. However, male garment workers were less likely to have had their first sexual experience with their marriage partners. Some 40 per cent had had their first sexual experience with their girlfriends or sweethearts and another 40 per cent with commercial sex workers (Ampornsuwanna and others, 2000: 6).

Malaysia: A study on the reproductive health of adolescents (aged 13-19) revealed that 40 per cent of respondents had begun dating from age 13. By the age of 18, 84 per cent had started holding hands, 85 per cent kissing and necking and 83 per cent petting. In the household survey, 1 per cent admitted to having had sexual experience, while 24 per cent confirmed that in the media survey. Of these, 18.4 per cent had had their first sexual intercourse between 15 and 18 years. Yet another study showed that 45 per cent of respondents aged 15-21 had dated and 9 per cent reported having had premarital sexual intercourse. As in most studies, more boys than girls reported having had sexual intercourse, confirming the belief that there is less pressure for boys to remain virgins or that they are more aggressive when it comes to having sex (Lee, 1999: 4-5).

Philippines: The 1994 young adult fertility and sexuality study showed that some 18 per cent of youth were engaged in premarital sex, with a higher level of premarital sex at 26 per cent among males as compared with 10 per cent among females. This study also revealed that there had been very little change in the level of premarital sex among females over the previous 12 years, declining slightly from 11.5 per cent in 1982 to 10.2 per cent in 1994. The average age at sexual debut is 18 years for girls and 18.3 years for boys (Berja, 2000: 5).

Thailand: Sexual activity is found to be much more common among male than female adolescents. In a study conducted in 21 private and government secondary schools, it was found that nearly one third of male students in grade 12 were sexually active. In another study from schools, community centres and organizations in

provincial cities, two thirds of single males aged 15-24 reported having had sexual intercourse. Surveys have also indicated that between 36 and 45 per cent of males had their first sexual experience with a commercial sex worker. In comparison with males, fewer female adolescents were engaged in premarital sex, ranging from only 1 per cent of single females in the school-based study to about 10 per cent of young females drawn from the broad catchment area (Soonthorndhada, 1996: 1-2). Yet another study conducted among final-year secondary school students in Suphanburi province found that 40.6 per cent of male and 6.6 per cent of female respondents had experienced sexual intercourse (Gray and Sartsara, 1999: 7). The above studies also found that the average age at first sexual intercourse was around 16 years for boys and 18 years for girls.

Source: ICPD Programme Implementation Plan, 1995

ANNEXURE II

(a) Background Information Required for Approval of State PIPs for 2013-14 - Adolescent Health

ARSH Clinics

Name of District	DH				CHC				PHC			
	Cumulative Number of AFHCs Approved till 2012-13	**No. of AFHCs operational as on 30th October 2012**	**No. of AFHCs proposed (2013-2014)**	**Average Case Load per AFHC**	**Cumulative Number of AFHCs Approved till 2012-13**	**No. of AFHCs operational as on 30th October 2012**	**No. of AFHCs proposed (2013-2014)**	**Average Case Load per AFHC**	**Cumulative Number of AFHCs Approved till 2012-13**	**No. of AFHCs operational as on 30th October 2012**	**No. of AFHCs proposed (2013-2014)**	**Average Case Load per AFHC**
Mizoram	**5 (existing)+ 3 @ DH & 2 @ SDH**	**10 DH/ SDH**	**0**	Reports yet to be submitted.	**17 CHC/PHC**	**11**	**0**	Reports yet to be submitted.	**17 CHC/PHC**	**6**	**0**	Reports yet to be submitted.

***Actual Reports expected from 3rd Quarter onwards. Delay in release of fund resulted in delay of establishing/operating clinics. Fund for establishing new clinics/operating existing clinics released only towards end of 2nd Quarter. Hence clinics officially operated from 3rd Quarter onwards.**

(b) WIFS

Total No. of Districts	No. of Districts covered	No. of School going girls and boys covered (10 to 19 years)	No. of out of schools girls covered	No. of IFA tablets required	No. of Albendazole tablets required
9	9	1,10,000	32271	97,19,986	3,42,692

***Source: School Education Annual Publication 2011-2012 & ICDS, Social Welfare Deptt, Mizoram.**

ANNEXURE III

STATE RESOURCES AND OTHER SOURCES OF FUNDS FOR HEALTH SECTOR

In order to get a complete picture of the resources available for the Health sector, the State of Mizoram clearly indicates the resources available from the State Government and from other sources for the Health Sector and the details of the activities for which these funds would be utilized.

S. No	Source of Fund / Name of Development Partner	Activity for which funds expected to be received	Amount expected in 2013 – 14
	Nil	Nil	Nil

Part	Head	Budget (Rs in lakhs)
A	**RCH Flexible Pool**	**4816.32**
B	**NRHM Flexible Pool**	**6406.56**
C	**Immunisation (from RCH Flexible Pool)**	**223.31**
D	**NIDDCP**	**79.20**
E	**IDSP**	**300.04**
F	**NVBDCP**	**1228.84**
G	**NLEP**	**106.94**
H	**NPCB**	**367.06**
I	**RNTCP**	**714.13**
J	**Director & Administration**	**2731.52**
K	**PPI Operation Cost**	**45.00**
	TOTAL	**17018.92**

ANNEXURE IV

MIZORAM : DISTRICT WISE BUDGET ALLOCATION 2013-14

District	RCH	NRHM Flexipool	Immu	NIDDCP	IDSP	NVBDCP	NLEP	NPCB	RNTCP	Direction & Adm	PPI Operational Cost	Total (Rs in lakhs)
Aizawl East	529.80	704.72	24.56	8.71	33.00	135.17	11.76	44.05	78.55	328.00	5.40	**1903.72**
Aizawl West	481.63	640.66	22.33	7.92	30.00	122.88	10.7	36.71	71.41	273.00	4.50	**1701.74**
Champhai	433.47	576.60	20.10	7.13	27.00	110.6	9.62	36.71	64.27	273.00	4.50	**1563.00**
Kolasib	337.14	448.46	15.63	5.54	21.00	86.02	7.49	25.69	49.10	191.00	3.15	**1190.22**
Lawngtlai	481.63	640.66	22.33	7.92	30.00	122.88	10.70	44.05	71.41	328.00	5.40	**1764.98**
Lunglei	626.12	832.85	29.03	10.30	39.00	159.75	11.76	40.38	92.84	300.00	4.95	**2146.98**
Mamit	433.47	576.59	20.10	7.13	27.00	110.6	9.62	25.69	64.27	191.00	3.15	**1468.62**
Saiha	337.14	448.46	15.63	5.54	21.00	86.02	7.49	22.02	49.10	164.00	2.70	**1159.10**
Serchhip	288.97	384.39	13.40	4.75	18.00	73.73	6.62	18.35	42.85	137.00	2.25	**990.31**

State	866.95	1153.17	40.20	14.26	54.04	221.19	21.18	73.41	130.33	546.52	9.00	**3130.25**
Total	***4816.30***	***6406.60***	***223.31***	***79.20***	***300.00***	***1228.8***	***106.94***	***367.06***	***714.13***	***2731.50***	***45.00***	***17019.00***

ANNEXURE V - Reproductive & Child Health (As on April 2012)

S/N	Name of Services	2006-07	2007-08	2008-09	2009-10	2010-11
1	No. of ANC	**22610**	**26006**	**26067**	**32438**	**18342**
2	No. of ANC (within 1st trimester)	9115(40%)	9043(35%)	11032(42%)	13637(42%)	8327(45%)
3	No. of 3 ANC	19315(85%)	18800(72%)	18863(73%)	22863(73%)	13296(72%)
4	IFA 100 tab. given to pregnant	15112(67%)	18639(72%)	20124(77%)	22587(70%)	13470(73%)
5	TT2 + Booster	20134(89%)	20763(80%)	21035(81%)	22792(70%)	13128(72%)
6	Total Delivery	**20309**	**25813**	**20244**	**23834**	**13232**
7	Institutional Delivery	14418(71%)	18922(73%)	15176(75%)	18134(76%)	10740(82%)
8	Safe Delivery	17376(86%)	21592(84%)	17215(85%)	20518(86%)	11776 (89%)
9	No of JSY Beneficiaries	NA	NA	NA	NA	13953 (32%)
10	PPC within 48 hrs of delivery	NA	3542(22%)	7120(35%)	13272(56%)	10212 (77%)
11	PPC within 2 - 14 days of delivery	NA	6927(28%)	9183(45%)	13962(59%)	8007 (61%)
12	No. of Maternal Death	4(MMR 20)	15(MMR 60)	6(MMR 30)	12(MMR 50)	9 (MMR 55)
13	No. of Child death (below 1 yr.)	426(IMR 21)	608(IMR 25)	600(IMR 30)	701(IMR 29)	276 (IMR 36)
14	No of Child death < 5 yrs	222	738	790	876	340
15	Children below 1yr fully Immunised against Annual Plan Target of EPI	19440(93%)	18788(91%)	19111(85%)	22005(89%)	13048 (50%)

Source: RHS Bulletin,March 2012,Ministry of Health & Family Welfare

Note: The IMR and MMR of Mizoram appears to have been increasing due to the following reasons.

1) The high incidence IMR was mainly in the rural areas and occurrence of famine during 2006 – 2008 due to bamboo flowering. As a result, nutrition supply to mothers and children were greatly emphasized by Health Department and deeply involved in monitoring and helping the State Nutritional Programme due to famine this year. Moreover, acute shortage of area utilization for Jhum Cultivation was so high and decrease of Jhum Cultivation so resulted decrease of food production which further resulted low nutritional status amongst mother and infant.

2) Even though not proved, there was infant death due to outbreak of epidemics in the State. This is one of the main reasons resulting increase of IMR.

PARTICULARS OF THE CANDIDATE

NAME OF THE CANDIDATE	: C.LALREMPUII
DEGREE	: M.PHIL
DEPARTMENT	: SOCIAL WORK
TITLE OF DISSERTATION	: Reproductive Health Seeking Behavior and Social support of Adolescent Girls in Lunglei, Mizoram
DATE OF PAYMENT OF ADMISSION	: 2nd August, 2013
COMMENCEMENT OF SECOND SEMESTER	: 18th February, 2014

APPROVAL OF RESEARCH PROPOSAL

1. Board of Professional Studies : 15thApril, 2014
2. SCHOOL BOARD : 16th May, 2014
3. REGISTRATION NO. & DATE : MZU/M.Phil/161 of 16.05.2014
4. DUE DATE OF SUBMISSION : 31st January, 2015

(Dr. KALPANA SARATHY)	(Dr. KANAGARAJ EASWARAN)
Associate Professor	Head, Department of Social Work
Mizoram University	Mizoram University

BIO – DATA

Bio-data of the candidate is shown below:

Sl.No	EXAMINATION	UNIVERSITY	YEAR OF PASSING	DIVISION
1.	MATRICULATION	MBSE	2003	I
2.	HIGHER SECONDARY(SCIENCE)	MBSE	2005	II
3.	BACHELOR (BSW)	NEHU	2010	II
4.	MASTER(MSW)- JRF No.F.15-6(December,2011)/2012(NET)	MZU	2012	I
5.	M Phil Completion of Course Work	MZU	2013	I

The candidate has also experienced in certain fields of social work in which the following are some of the experiences of the candidate:

1) Project Coordinator at Mission Foundation Movement – August 2012 to May 2013
2) Work as a volunteer in Bethel Centre, Lunglei a children's home(abandoned, neglected and destitute children) – June 2013
3) Awareness campaign on Juvenile Justice(Care and Protection of Children) Act, 2005 in collaboration with DCPO(District Child Protection Officer), Lunglei District, Lunglei on celebration of MHIP Day – 6th July, 2014
4) ConductAwareness Programme to mobilise and Sensitized the children with the need and protection of Children at Middle and High School going students(Bethel Centre School) -30th September,2014