CHAPTER-VI

CONCLUSIONS AND SUGGESTIONS
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Health had always been an important topic in adult education. It very often consiquently featured the curriculum of many adult education courses as well as general education programme. So, also the programmes on health education had been taken up by the Department of Adult Continuing Education of Manipur University in the twelve adopted villages of Total Literacy Campaign. Health related education projects offered course on general health, nutrition, and other issues related with health.

Improving people's knowledge about health was a major component in many literacy and basic education programmes. Many of these programmes were focused on women, drinking water, deforestation, nutrition, hygiene, family planning and other common diseases. Health education was often combined with other measures to improve well being and promote community development. Such programmes usually include micro-credits or skills training for income generating activities.

Education is a major determinant of health. It is well known that those who were most likely to suffer from ill health were not only the poorest, but also those with the lowest level of education. What was more, experience in
both developing and developed countries showed that literacy and non-formal education programmes could lead to significant importance in health and general well-being.

Although there had always been close links between health education and adult education, the relationship between the two had not always been systematic. Recently, however, the two fields had been drawn more closely together. The concept of health education, which now embraced a wider notion of health promotion and a new emphasis on prevention, was increasingly focused on learning and empowerment.

New methods of teaching in health education had gained ground in accordance with concepts of learning in adult education. Within adult education, the major changes reflected the recognition, that the adult education had high relevance to current societal issues. As a consequence, adult education was increasingly taking a central role among diverse policy sectors in which health was one of them.

Health education could be understood as a component of health promotion. Health education aims at improving access to health related information and service to give people much more control over their own health and well-being. The knowledge referred to here dealt not only with the dissemination of simple health facts, but also other information and skills.
Adult learning played an important role in the health promotion strategies. Adult Education increasingly recognised the importance of health, including environment health. There was growing interest among adults to learn more about health issues and this trend was reflected in the growing number of programmes offered in this area.

The closeness between these fields were reflected in the similarity of goals and principles which was characteristic both contemporarily in adult education and health promotion policies. Both are being developed to empower people and encompass individual and societal change.

Just as adult education was a process of enabling people to improve their own living conditions and general welfare, including health status, so also was health education a process of enabling people to take control over their health.

Recent developments in both health and adult learning had brought the two sectors closer together. In the area of health, major changes in policy had taken place after 70's. The Primary Health Care (PHC) strategy based on the integration of social and economic development requires community involvement and emphasised people's own capacity to make decisions and manage their health problems.
In a similar way, adult education in the 70's and 80's developed towards its current focus on participatory learning which starts with people's own knowledge and experience, and puts control of learning into their own hands. Increased recognition of different forms of knowledge, including alternative or local forms of healing and a shift away from the expert or the teacher as the only provision of information, had a strong influence on teaching practice in fields, health and adult education.

In the health sector, the change in the concept of health education and the emergence of the new health promotion strategy has been the most important development in adult learning. Health education has moved from a sole emphasis on transfer of information and individual life-style changes to health promotion that focuses more on the social, economic and environmental factors which are conducive to healthy lifestyle and self-reliance.

With an effort to explore these changes the investigator studied the steps taken up in the state of Manipur and examined the relationship between health education and adult literacy. Since the application of continuing or extension education was not made in the Directorate of Adult Education and also other non-government organizations, the investigation explored the focal point where it was implemented. Before, studying the relationship between health education and neo-literate a brief historical background is required to
be given here as how adult education came up in the International scene and also in the national map and how it reached to Manipur.

Manipur, a small state in the North East with a population of about 22, 93,896 persons had launched the programme of eradication of illiteracy long years back with the establishment of a separate Directorate of Adult Education in 1985. The state like other sister states took up the programme of adult literacy. The programme for eradication of illiteracy had been launched in Manipur University with the establishment of Adult Continuing Education and Extension in 1986.

The Directorate of Adult Education and Non-Government Organizations had not taken up the programme of health education till date. However, the Department of Adult Continuing Education and Extension, M.U had been implementing health programmes for giving awareness and education since 1992. It continued giving its awareness and education to the neo-literates of the 12 adopted TLC villages in the District of Imphal West and Bishnupur. The villages were Langthabal Chingkha, Langthabal Chingthak and Langthabal Kroupum in Imphal West and Leimapokpam, Leimapokpam Khunpham, Wahengkhuman, Kakyai, Pukhrambam, Lourembam, Terapokpi, Sanjenbam, and Maibam Keiren of Bishnupur Districts.

Related literature including books, Journals, pamphlets, theses and related publications published by the established institutions not only of the
national characters but also of the international character were reviewed in order to update the information and facilitate in enhancing to materialise the present study.

The present study had been designed in such a way that it defined and interpreted the terms like Adult Education, neo-literates, TLC, health education, illiterate and adopted villages. A definition of these terms were felt necessary by the investigator before taking up the problem in order to enable to explore and have a clear cut perspective and analysis of the study.

Along with the definition and interpretation of the terms the investigator laid the clear cut objectives of the study. The objectives were to study whether awareness campaign for health care education would be beneficial to the neo-literate and learners; to study whether imparting such education could motivate the illiterates to come out from their houses to the centres and to study the accessibility, acceptability and affordability of health care services to all people through the neoliterate.

The hypothesis framed was to study whether health care education had been an important aspect of the adult education programme and to study whether the programmes of health awareness were useful not only to the adult learners or neo-literates but also to the whole village. The tools employed were to customarise the study.
The tools employed in the present study were Questionnaire Schedule for the Directorate of Adult Education, Questionnaire Schedule for the Department of Adult Continuing Education and Extension. Questionnaire for the Project Officer/Member Secretary, Interview Schedule for the Member Trainer/Pre-rak, Questionnaire Schedule for the Volunteer/Instruction, Information Sheet for the hospital, Interview Schedule for the Drop-out Learner and Interviewed Schedule for the Neo-literate.

The reason for studying the problem was because of the fact that large segments of populations continued to lack access to clean water and sanitation facilities, are forced to live in congested conditions and lack of adequate nutrition. Large numbers of people remain at continued risk of infectious, parasitic and water-borne diseases, such as tuberculosis, malaria and schistosomiasis. In addition, the health effects of environmental degradation and exposure to hazardous substances in the workplace are increasingly a cause of concern in many countries.

Similarly, the growing consumption of tobacco, alcohol and drugs and the increasing number of HIV/AIDS patients of Siro positives will precipitate a marked increase in costly chronic diseases among working age elderly people. The impact of reductions in expenditures for health and other social services which have taken place in many countries as a result of public sector retrenchment, misallocation of available health resources, structural adjustment and the transition to market economics has preempted significant
changes in lifestyle, livelihoods and consumption patterns and is also a factor in increasing morbidity. Although economic reforms are essential to sustained economic growth, it is equally essential that the design and implementation of structural adjustment programmes incorporate the social dimension.

The changing ecological pattern of health and diseases due to increased contact between man and environment was a serious challenge to environment and health planners, particularly in developing countries. There were similarities and differences in the morbidity and mortality pattern in different regions, which was an indication of general levels of community health and well being. There was pronounced awareness of the importance of an interdisciplinary approach in understanding both adult education and medical aspects of the problem of human health.

The recent occurrence of diarrhoea in the Imphal West District of Manipur and malaria in Bishnupur Districts might have been the result of the ecological changes, consumption of untested and unhygienic foods, crowding and insanitary conditions stagnant and polluted water. There would have been roles which an adult educator or functionaries of adult education can play a significant role by imparting awareness programme in relation to health and communicable diseases.

The problem of healthcare was considered seriously and as such it was resolved in its Programme of Action of the UNESCO Conference that
all countries had to re-examine training curricula and the delegation of responsibilities within the health care delivery system in order to reduce frequent, unnecessary and costly reliance on physicians and on secondary and tertiary care facilities, while maintaining effective referral services. Access to health care services for all people and especially for the most underserved and vulnerable groups must be ensured.

The UNESCO Conference had highlighted that it was the adolescents and young adults who faced serious health hazards in recent time. Many of these young people were not yet sexually active. Some of them even suffered or likely to suffer sexual abuse from which they were protected. A large number of them, particularly in urban areas, start sex much before marriage. In rural areas too, sexual activity starts much early in life as a result of early marriage.

Health education makes people aware of the “do’s and “don’ts” that they need to follow in their daily life to keep themselves healthy. It became an established facts that preventive measures were much more effective and purposeful than the curative ones. Recently health education had been recognized as education which had more to offer than just avoiding or preventing from illness. According to W.H.O. technical report, health education like general education was concerned with changes in knowledge, feeling and behavior of people in its most usual forms and concentrated on
developing such health practices as were believed to bring about the best possible state of well being.

It was in 1978 that the health planners from 134 member countries of the United Nations met at Alma Ata in the Soviet Unions drew up a health chart which aimed to bring basic health services within the reach of every community and individual. It was obvious because of the fact that health care in our country conventionally implied only the curative aspect and not preventive. Therefore married women, infants and children who were prone to risks due to diseases, infection etcetera were treated with concern.

And health care provisions included only setting up community health workers, training health workers, setting up immunization programmes for infants, children and pregnant women, dealing with childhood diseases, setting up maternity services and family planning programme. Therefore adolescence and young adult were seldom the recipients of health care in our country.

In India death rate had been brought down from about 27 persons per thousand in 1946 to about nine persons per thousand in 1995. The average life span had increased from 32 years in 1946 to about 58 years in 1995. The infant mortality rate too come down from 134 in 1950 to 74 persons per thousand in 1995. These figures might not be favourable in comparison with those of the achievements on the scores in a poor country like ours was not a meager gain.
In Manipur, the Government was committed to provide health needs of the people to achieve "Health to All". It meant that all the people should have an opportunity to enjoy good health. The Health System Development of the state was based on the concept of Primary Health Care Approach and National Health Policy of 1983. The concepts of three entire system of health system have been accepted as the main frame work of health system. Accordingly the Government of Manipur has taken up a number of health scheme and programme through a network of various types of health institutions to ensure that the health care services are available to the community. The health departments have been special impacts or needs of the population including women and children in the tribal, hilly and remote areas of the state.

The prioritised schemes and programmes as identified by the Health Department were (i) National T.B. Control Programme (NTBCP) (ii) National Anti Malaria Programme (NAMP) (iii) National Leprosy Eradication Programme (NLEP) (iv) National AIDS Control Programme (NACP) (v) National Iodine Deficiency Disorder Control Programme (NIDDCP) (vi) National Programme for control of Blindness (vii) District Mental Health Programme and (vii) Drug De-addiction Programme.

After identification, the Health Department had implemented the National Health Programmes and schemes in the state. The programmes were; (i) Minimum Needs Programme or Basic Minimum services under the
schemes of CHC, PHC, PHSC AND MPW, (ii) National AIDS Control Programme which was under a society (iii) National TB Control Programme (iv) National Leprosy Eradication Programme (v) National Programme for control of Blindness (vi) National Iodine Deficiency Diseases Control Programme and (vii) National Anti Malaria Programme.

Moreover, there were three family welfare clinics in urban and rural areas respectively by 2001 under the Family Welfare scheme. It had been strengthened by two voluntary Organisations and two post partum programme centres in the Imphal West District under the Family Welfare Scheme. In Bishnupur District it had only three rural centres. The number of Family Welfare clinics and centres in these two districts had been increased to four and three for Imphal West and Bishnupur District respectively during 2002-2003.

While studying on health education the perspective of social awareness was one of the important areas to be considered. It required covering the aspects of health awareness, health care and social awareness. All these aspects are interrelated with each other and also with adult education.

Society had been identified as the second major component of Adult Education programmes in India. It aimed at enlightening the learners about existing reality, to overcome the dogmas and to think rationally. It also helped the learners to play an active role in their own development and in the
development of their environment as per the policy statement of Government of India on National Adult Education programme.

The investigator had been making an attempt to study on awareness programme of adult education in promoting the knowledge of health education and health care planning with special emphases on neo-literates and those learners who dropped out of literacy programme due to health problem. The investigation had been made in the programme of health education which had been implemented to the neo-literates and the dropped outs of the Total Literacy Campaign adopted villages under the Department of Adult Continuing Education and Extension of Manipur University.

Other programmes implemented by the Department were Mass Programme for Functional Literacy, literacy programme under Centre Based and Area Based Approach programmes, Population Education Clubs both in the colleges and in Universities and also at the villages; Post Graduate courses, seminars, workshops, lecture-cum-discussions; organising and conducting Research Methodology courses, training, programmes on health and hygiene, Safe drinking water, health care of the pregnant mother, nutritive food, preservation of fruit on the locally available resources and its retentive value, book binding and its preservative technology, tree plantation and social forestry, mushroom cultivation and culture, Dye and Dye, wool knitting and tailoring, blood donation camp, free medical camp HIV/AIDS etc. The
investigator had been making an attempt to concentrate on health related programmes.

These programmes had been taken in view of promoting a meaningful and sustained rapport between the University and the community. In other words, it aimed, to extend knowledge and other institutional resources to the community and vice versa. It also aimed to gain insights from a contact between knowledge resources and socio-cultural realities with a view to reflecting this in the entire curricular system of higher education.

Amongst other programmes implemented by the Department health education and health care was one of the areas which were given priority. These programmes had been implemented in a two pronged approach. First, it had been implemented in the University community by involving post graduate students, Research Scholars, teachers, non-teaching staff and medical experts from the health centre of the University, by inviting medical experts from the Regional Institute of Medical Sciences, Lamphel, and Family Welfare Bureau of the Medical Directorate, Home Scientist of the Government colleges G.P. Women college and experts from Food Nutritive and Extension Unit Department of the Ministry of Human Resource, Manipur Branch and Family Planning Association of India Manipur Branch.

At the village level the Department had taken up the programme on health education at the nine adopted villages of Bishnupur District and three
adopted villages of Langthabal Chingkha, Langthabal Chingthak and Langthabal Khoupum of Imphal West District of Manipur. In these 12 villages Total Literacy Campaign programmes had been launched.

Health education programmes had been implemented by the Department only to the neo-literate persons and to those persons who were learning in the literacy centres. These literacy centres covered a number of populations.

The programmes had been implemented in a two pronged approach, that is, one at the University campus and another at the village level. The villages which were adopted by the Department were at the Imphal West District and the Bishnupur Districts of Manipur. Brief profiles of these 12 villages were grouped into two for the purpose of the present study.

The Bishnupur District which was situated on the Tiddim line of the State Road was a rural based valley district. The District having a population of 2,08,368 included 1,04,550 male and 1,03,818 female. The numbers of literate persons were 1,19,823 including 70,507 male and 49,316 female according to 2001 census.

The nine adopted villages of Bishnupur district consisted of Leimapokpam, Khunpham, Kakyai, Wahengkhuman, Sanjenbam, Pukhrambam, Lourembam, Maibam Kairel and Terapokpi under the Department of Adult
Continuing Education and Extension of Manipur University. These nine villages had been under the three Gram Panchayat; namely, Leimapokpam Gram Panchayat, Sanjenbam Gram Panchayat and Ishok Gram Panchayat.

In order to bring awareness among the villagers of the nine villages, the Department had contacted the local volunteers, clubs, organizations, associations, Pradhans, Panchayat members, Block Development Officers and Deputy Commissioner not only once but twice and thrice as the need arises. After contacting these personnel's, meetings were held frequently at the house of Panchayat members, Niyai and Club Secretaries.

The Department had selected 166 Volunteers for running the Total Literacy Campaign programme. The 166 volunteers were selected from the local clubs and Association of these nine villages with the assistance of the Gram Panchayat Members, Pradhans, Niyai, Pramukh and Upa- Pramukh. These 166 volunteers were given seven days training at the University campus. Out of these 166 volunteers the Department had selected one Pre-rak for looking after the functioning of the literacy centres of the nine adopted villages.

The three adopted villages of Imphal West district of Manipur were Langthabal Chingkha, Langthabal Chingthak and Langthabal Khoupum. These three villages belonging to Kabui community which was one of the recognized scheduled tribes of Manipur had a population of 1013 by 2003 including 298
male and 515 female. The total number of literate persons of these three villages were 765 including 444 male and 321 female. The populations of children of the age group of 0-5 were 83 including 33 male and 50 female. The numbers of illiterate persons of these three villages were 165 including 22 male and 143 female.

These three villages were under Wangoi Gram Panchayat of Imphal West district. Out of the three villages the people of Langthabal Chingkha were mainly cultivators, labourers, weavers. Some of them were engaged in cottage industry running brewing of local wine, piggery, cutting of woods from hills. Some of them were employed in Government and Non-Government sectors. The nearest market of the village called Lairam Keithel Macha of the village had a distance about 2 km.

These three villages had been facilitated by the existence of the University of Manipur at the nearest locality including one Health Centres and 25 teaching faculties library, sports Department, Audiovisual Research Centres, Manipur Studies Centres etcetera. It had also been facilitated by the existence of three Primary Schools and one Junior high School, Primary Health Centre and availability of electric facility. These three villages had one club each. These three villages had one club each. These three villages were four to fives km away from the National Highway No.53 on the western side of the Highway. These three villages maintained the traditional Kabui
religion of Tingkao Rawang and also some of them were converted to Christianity very recently.

Out of these three villages Langthabal Chingkha had a population of 240 including 120 male and 120 female. The numbers of literate persons of the village were 181 including 102 male and 79 female. Total numbers of illiterate person were 37 including five male and 32 female; the total number of children of the age group of 0-5 were 22 including 13 male and 09 female.

The student volunteers made house to house survey. They also motivated the villagers in direct and indirect approach by contacting the village Chief and the local club and association and Langthabal Chingkha Women Society. This process had been done in all these three villages. Out of these three villages the Langthabal Chingkha was declared totally literate on 30th December 2003 by the University. The declaration function was organised in collaboration with the Directorate of Adult Education of the Government of Manipur.

The declaration was made for the first time in Manipur by involving students, volunteers and faculties of the Department of Adult Continuing Education and Extension, Students Organisations of Manipur University, Officials of Manipur University including the Vice-Chancellor, all the Deans of respective schools and the students, Directorate of Adult Education and Panchayats members.
Continuing and Extension Education programme on health education has been made by the Department through medical camp, and health awareness programmes. Particularly on Health Education or Health Awareness or Health Promotion had been implemented by the Department of Adult Continuing Education and Extension to the totally literate developed village and also to other TLC adopted villages under the two Districts of the State. The content of health Education was on safe drinking water, HIV/AIDS, Drug Addiction, family welfare Programmes for the Pregnant mothers, small family norms, health related areas like food and nutrition, aforestration, blood donation, free medical camp water borne diseases, skin diseases etc.

Analyses were made on the basis of the finding through Questionnaire schedule for the Directorate of Adult Education, Questionnaire schedule for the Department of A.C.E.E, Questionnaire schedule for the voluntary organization, Interview schedule for Project Officer or Member Secretary, Interview schedule for the pre-rak, questionnaire schedule for the volunteers or instructors, interview schedule for the Neo-literate, information sheet for Hospital and Information sheet for Directorate of Health and Family Welfare.

Interviews were made with Member Secretary or Project Officer of the Directorate of Adult Education and pre-rak and Project Officer of Adult Continuing Education and Extension, Manipur University. Further, interviews were made with the volunteers and neo-literate of the Department of Adult Continuing Education and Extension. Interview was also made with drop-out learners.
Informations were collected through the 7 information sheet for Hospitals under the management of Regional Institute of Medical Science, Medical Directorate of Health and Family Welfare Bureau. Informations were also collected through personal discussion with the doctors on specific diseases like Eczema and other water borne diseases.

Information were collected from these three sources, namely, the Interview schedule, Questionnaire schedule and Information schedule. The collected informations and data were processed and hypothesis were framed for testing, whenever testing was not applicable percentages were presented. The basic purpose was to get accurate information and data for purpose of analysis of the present study.

All the Project Officers of the Directorate of Adult Education had been utilised in the name of the Member Secretary in the Implementation of Total Literacy Campaign programme in the nine Districts of Manipur under the scheme of District Literacy Society. The Deputy Commissioner concerned of the respective District was the Chairman of the District Literacy Society. It seemed from the record the Directorate's Head Quarter at Imphal was concerned with administrative managements including monitoring, training and MPFL programme while at the District level the Project Officer handled the literacy programme. The Head Quarter also dealt with budget and monitoring. The Directorate received financial assistance from both the State Government and the Central Government.
The Directorate established 212 JSN Centres including 125 Rural Functional Literacy Projects and 87 State Adult Education Projects (SAEP) in the State from 1st April 1989 in pursuance of the instructions received from the State Government. The implementation was also provided in the National Literacy Mission Document.

The immediate purpose of the opening of JSN centres was to ensure retention of literacy skills and also to provide facilities to the learners to continue their learning beyond Elementary Literacy and also to create scope for application of their learning for improvement of their living condition. This was as per their Administrative Report Published in 1980. However, there was no proper report after the crash programme on T.L.C.

The programme of T.L.C was handed over to the District Literacy Society. Till now no particular village was declared totally literate. This might be because of various reasons like untimely sanction of fund, lack of supervision and inspection and lack of comprehensive and tentative schedule for implementation of programmes or reasons known to the Directorate. Further, it might also be because of the lack of coordination between administration and management and long term plan. This might also be because of the lack of political will, a political decision and a collective effort.

It was also found that the Directorate of Adult Education of the Government of Manipur had no Director during the period under study.
However, the Directorate was represented by one Additional Director. All the Additional Directors were not appointed through direct recruitment basis but through promotion. It was very doubtful whether they prescribed recruitment rule through direct policy during the period under study.

In spite of all lacunaes, the Directorate had enough published materials. It included teaching learning materials, annual administrative report, sometimes these materials were also supplied to the Department of ACEE, M.U from 1987 to 1990. The same teaching learning materials were sent to all the Districts of Manipur including the hills Districts. There was no separate teaching learning material prepared for the Hills areas. The teaching learning materials remained same for all the districts including the Hill Districts. This also remained same in developing I.P.C.L. materials.

Till now, during the period under study no step was taken up for continuing education programme which was meant for the neo-literates except organization of few workshops, training, evaluation and monitoring. Further, no programme of extension education had been up by the Directorate till now. Hence, no programme on health education had been taken up by the Directorate.

On the other hand, the voluntary organizations organised programmes in connection with literacy and no steps was taken up for any continuing and extension education programmes till now. It included the Voluntary
Organisation of Wangjing Women and Girls Society of Thoubal District, which was popular for its effort in literacy programme. It had not taken up any continuing and extension programme. Hence, the question for implementation of health education programme did not arise.

The Department of Adult Continuing Education and Extension had taken a multipronged approach. It included literacy programme under Centre Based, Area Based, Total Literacy Campaign, Population Education Club, MPFL, JSN, Continuing Education and Extension programmes in addition to teaching training and research. Training given to the T.L.C. volunteers, programme officers of the colleges both for MPFL and PEC, Principals of the colleges and the pre-rak.

Under Adult Continuing Education and Extension programmes like seminars, workshops, lecture cum discussions, orientation courses, short term certificate courses with demonstration etcetera were organized at different levels. It was organised sometimes independently and sometimes in collaboration with various agencies by involving various resource persons from the University and outside the University. It further included agencies under the Ministry of Human Resources, ICAR, North Eastern Region, Family Planning Association of India, Manipur Branch, Regional Institute of Medical Sciences, Manipur Branch, the Directorate of Family Welfare, Medical Department, experts from G.P. Women's College, North Eastern Hill University, NSS Manipur University itself.
Under the population education club various programmes like spot painting, debate, symposium, essay competition, elocution, etcetera relating to population problem was organised. Lecture series on population issues, population theories, deforestation, and environmental degradation etcetera were organized. The competition was held at the state level and University level. Health related issues like nutritive food, safe drinking water, health and hygiene, health of the pregnant mother etcetera were also organized in different aspects. It also covered the aspects of blood donation camp, free medical camp, small family norms etcetera. Festoons, play cards, charts relating to health aspects were also used utilized in the form of procession.

Under the teaching programme Post Graduate Diploma Course and Post Graduate Course were opened with population education as one of the papers in specialization. Opening of Post Graduate Course in the Department was the first step taken up in the entire eastern region amongst the Universities of the country. Research activities in different areas even leading to Ph.D were taken up by the Department. Implementing the programme under teaching training and research had achieved one of the thrust areas laid down by the U.G.C in their guidelines of higher education.

Implementations of the programme of computer literacy with an objective of eradicating computer illiteracy from the University community
have widened the dimension of the concept of eradication of illiteracy. It signified the meaning of eradication of illiteracy at a very vast and comprehensive way.

To conclude the Department of Adult Continuing Education and Extension of Manipur University was the only agency which had taken up health education programmes amongst other agencies. Although other agencies expressed their desire to implement the programme these were not prepared to launch the programme. The question of drop out and neo-literates was also dealt with in the present study.
SUGGESTIONS

The relative importance of health and literacy for the neoliterates has been studied and examined thoroughly in the present study with reference to national and global context. After studying and analysing the whole problem certain suggestions are full of required for the purpose of future implementation of the programme. Considering the suggestions laid by the Haumberg declaration on health education and health promotion for adults and also the need for implementation in the present study suggests that the first priority be given on providing awareness campaign on health education to the other districts as it was done in the 12 adopted villages of Bishnupur and Imphal West Districts of Manipur where literacy centres opened. Even if it could not reach to all the villages of the two districts attempts should be made for its couragement to all the villages.

Other agencies both government and non-government organizations should also take up the step for implementing health promotion and health awareness programme along with the implementation of the adult education programme. Because of health is a social construct and a social process, medical factors alone cannot explain what makes us sick or how we can be curved. The physical and social environment within which we live is equally, if not more, important. Basic requirements include access to clean water,
housing and food. Other factors, such as economic resources, social situation and political participation are equally important.

Health problems cannot be solved by medical intervention or behavioural changes alone. It is crucial that health education take into account the social, environmental and economic factors that determine people's health. Health education needs to enable people to change these conditions. In this view, health education is essentially a social and political process, and a central component of human development.

Adult learning plays an important role in current health promotion strategies. At the same time adult educators increasingly recognise the importance of health, including environmental health. There is a growing interest among adults to learn more about health issues and this trend is reflected in the growing number of programmes offered in this area.

The closeness between these fields is reflected in the similarity of goals and principles which characterise both contemporary adult education and health promotion policies. Both are being developed to empower people and encompass individual and societal change.

Just as adult education is a process of enabling people to improve their own living conditions and general welfare, including health status, so also is health education a process of enabling people to take control over their health.
More emphasis should be given to the adults who would be the pillars of the nation. They were to be made aware of the problems that would create to various health hazards. It further may extend to population problems.

Community participation and learner involvement are shared principles of health education and adult education. Both health educators and adult educators are aware of the importance of the community setting its own agenda. It is considered extremely important to build on local initiatives and people's own experience by involving local health specialist and community committees. The role of the health educator or the adult educator is facilitator, a resource, a catalyst for action and sometimes a link for communities to approach other structures, such as government services.

"Health Literacy" implies confidence in making one's own decisions relating to health. Health literacy includes knowledge and skills need to participate in joint action for sustainable health in the family, as well as advocacy in local groups and community organizations.

Health literacy implies more than the ability to read health information. It includes the capacity to use this information, thus turning it into knowledge. Better educated people have better access to information about HIV, its treatment and how it can be avoided. Making information and services available and improving health literacy are therefore crucial to any attempt to combat the disease.
The concept of a learning society implies a broad understanding of education; including non-formal and self-directed learning in different places and setting. Learning about health is a process which can take place in a variety of ways over the course of one's life. As living conditions changed and the body became older risk factors keep changing. Thus, this is a continuous need for new health education.

In the field of health, knowledge is changing at a rapid pace. Access to relevant, up to date information is critical for informed decisions and choices. Health literacy also takes the forms of advocacy. It is no longer just the professional teaching the lazy, rather patients and lazy people can equally teach the professionals and decision makers about their health needs.

The most effective education is in helping people to be more confident about their decisions and to widen choices. Being "health literate" includes being autonomous in everyday life, allowing people to be more confident.

Health literacy is a new concept. In order to further the idea as a tool for policy development, it is necessary to identify indicators for the health literacy of individuals and society. Strategies to increase health literacy need to be developed. This is an important area for collaboration between the two sectors.
As recommended by the National Policy on Education 1986 which was also revised in 1992 the present study suggests that programmes of post literacy and continuing education should be planned for neo-literates and youths passing out of primary education system and these programmes should be planned simultaneously with literacy campaign and be made effective as soon as large numbers of persons complete literacy courses.

The Central and State Governments, political parties and their mass organizations, the mass media and educational institutions, teachers, students, youth, voluntary agencies, social activist groups, and employers, must reinforce their commitment to mass literacy campaigns, which include literacy and functional knowledge and skills, and awareness among learners about the socio-economic reality and the possibility to change it.

The critical development issue today is the continuous upgradation of skills so as to produce manpower resources of the kind and the number required by the society. Since participation by beneficiaries in the developmental programmes is of crucial importance, systematic programmes of adult education linked with national goals such as alleviation of poverty, national integration, environmental conservation, energisation of the cultural creativity of the people, observance of small family norms, promotion of women’s equality, etcetera be organized and the existing programmes reviewed and strengthened.
The whole nation must pledge itself to the eradication of illiteracy, not necessarily of the age group of 15-35 but of the whole human span with the changing concept of life long learning. The Central and State Government, political parties and their mass organizations, the mass media and educations must commit themselves to mass literacy programmes of diverse nature. It will also have to involve on a large scale teachers, students, youth, voluntary agencies, employers etc.

Concerted efforts are to be made to harness various research agencies to improve the pedagogical aspects of adult literacy. The mass literacy programme would include, in addition to literacy, functional knowledge and skills, and also awareness among learners about the socio-economic reality and the possibility to change it.

Comprehensive programmes of post-literacy and continuing education is to be provided for neo-literates and youths who have received primary education or 3R's or functional literacy with a view to enabling them to retain and upgrade their literacy skills and to harness it for the improvement of their living and working conditions.

The programmes to be included were: a) establishment of continuing education centres of diverse kind to enable adults to continue their education of their choice; b) workers' education through the employers, trade unions and governments; c) Wider promotion of books, libraries and reading rooms;
d) use of radio, T.V and films-as mass as well as group learning media;  
e) creation of learners groups and organization and f) programmes of distance learning.

Scope for providing health education to the industrial worker should be made after providing them adult education. Literacy for them would be of extreme importance. Adult education for the industrial worker should be designed with utmost care and with the sense of purpose. In this regard health education for the industrial worker who was engaged in public and private sectors should be given after designing it with care.

The industrial workers who had been in those sectors should be made aware of the health hazards affecting from smoking, drinking alcohol, piping and using of drugs. Efforts should be made to promote health to the industrial workers. This could have been arranged by the Regional Workers Education of the Ministry of Labour and Child and Ministry of Human Resource and Development.

Health Education should be given priority in Continuing and Extension Education Programmes. It should not be only for the neo-literates but for the adult learners. This could have been given while literacy programmes were continuing. It meant that health education could also have been given under literacy programme.
Providing health education while implementing literacy programme would rather enhance in motivating the adult learners in coming out from their respective houses and join the literacy classes because, it was really a problem to the volunteers in motivating the learners to attend the literacy class as some of them might hesitate, feeling shy, age complex, non permission by the husband and in laws etcetera.

The investigator would further like to suggest that the health education programmes should be provided in a systematic and well planned way framing its content with demonstrations. This should have been done by the organizing agency for the benefit of the adult learners.

Scope should be given whether government, voluntary agency or the University to implement health education and health awareness programme instead of confining to water tight compartments of teaching the 3R’s or functional literacy only. Accordingly, the funding agency should make provision for implementation of the programme.

The implementation of the programme of health education could also be done while dealing with Population Education as health and family and also literacy are all interrelated to each other. This could have been implemented not only in urban areas but in the rural and hill areas also. It could also have been taken up in the colleges.
Coordination between the Medical Directorate, the medical institution, the government agency, the voluntary agencies and the University Department is felt required while framing its policies and programmes on health education in respect to adult literacy programme. It can also be extended to implement the programme to neo-literates.

Instead of delivering the programme on health education it could have been brought to the main stream of life while framing the curriculum. Even during the programme of NSS lecture-cum-demonstration could be given on health education as an item. This could have been given amongst the lecture series or interaction period which was held normally in a NSS programme to the volunteers.

Health education programme should be made open to both genders. It could be combined with literacy programme and income generating activities taking into account. Although many health education projects focus exclusively on women it could be opened to both genders.