CHAPTER II

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This chapter presents a brief historical background of women and the present situation of women's social position in order to have clear idea about the health and developmental needs of adolescent girls and women. Attempt is also made to look in detail, the government of India’s effort relating to the health needs of adolescent girls and women.

Women in India: An overview

First, it may be helpful to provide a brief historical perspective on the status of Indian women in general in order to effectively deal with the various problems faced by them. Different sociological perspectives have identified different factors as being responsible for the status or positioning of an individual in any given society. The Indian social system with a few exceptions is characterised by Patriarchy. Patriarchy recognises male dominance and female subordination in the Hindu society. In India, women have always lived dependent lives firstly through their fathers and brothers and later through their husbands and sons.

The traditional roles associated with the home such as cooking, cleaning, washing, caring of children etc are allocated to women thereby rendering a less prominent status in society. Women are expected to play these traditional roles and they continued to do so. As they lived a dependent life, they cannot take decisions independently. Thus, their male counterparts continuously exploited them. Contrary to this, men are required to fulfill their role as the maintainer and the protector of the family. A man's world is outside the home, where he earns his living, interacts in the public sphere, and makes all the important decisions. Women are largely absent from public life. This shows clearly the difference in the status between men and women.
Some early writers are of the view that the low status of women is biologically determined and is a universal and immutable fact. George Peter Murdock, in his cross-cultural survey of 250 societies ranging from hunting and gathering bands to modern nation states give the idea that women, because of her biological function of childbearing and nursing is tied to the home base; because of her physique she is limited to less strenuous tasks such as cooking, gathering wild vegetable products, water carrying and making and repairing clothes etc. While man with his superior physical strength undertake the more strenuous tasks, such as lumbering, mining, quarrying land clearance and house building, etc. Murdock concluded that, “The advantages inherent in a division of labour by sex presumably account for its universality”. Social status has been reckoned in terms of the degree to which a person possesses qualities or attributes that are considered valuable in a particular society and performs his role accordingly¹.

To Talcott Parsons, for a family to operate efficiently as a social system, a women’s expressive role is essential. This means she provides warmth, security and emotional support for effective socialisation of the young and to her husband with love, consideration and understanding².

John Bowlby examines the role of women from a psychological perspective and gives a similar argument like Parsons. Bowlby concludes that it is essential for mental health that the infant and young child should experience warm, intimate and continuous relationship with his mother³.

Some, who argue that gentler roles are culturally determined and socially transmitted, oppose such view. Ann Oakley⁴, a British sociologist and a supporter of the Women’s Liberation Movement attack all the above assumptions that biology largely determines that sexual division of labour. She argues that gender roles are culturally rather than biologically determined and is not universal. She regards as a myth the incapacity to carry out heavy and demanding work. Studies from large
number of different societies indicate that the mother role is a cultural construction and children do not require a close, intimate and continuous relationship with her.

Ernestine Friedl\(^1\) supports the cultural explanation and shows that male dominance and gender roles are culturally determined. She observes that in some societies, activities that are regarded, as men’s were women’s in some other societies for example, weaving, pottery making and tailoring. However, men carry higher prestige than women do. This Friedl sees as a reflection of male dominance, which exists, to some degree in all societies. She opines that men are dominant because they control the exchange of valued goods beyond the family group, which brings prestige and power. The greater their control over the exchange of valued goods outside the family the greater their dominance.

Every society has allocated different statuses to men and women that have resulted in the creation of a social order, which is not only gender unequal but also gender unjust. An attempt has been made to examine the status of women in India during different periods of time, which will provide an insight into different factors that have led to their low status and thus ultimately restricted women (50 per cent of the total population) from the opportunities to take part in the developmental activities of the country.

Not all women in India have a common status. Status is closely affected by considerations of caste, class, religion, and region and so on. The attempt here is not to go into the details of periodisation and its controversies but to provide a general overview. However, it is crucial to have a brief look at the part society, because some of the norms and values affecting women today have their roots in the past.

A women’s life has been moulded for ages. In the past the women was a slave and nowadays she has been reduced to the situation of a doll in a showcase. Our women are the frogs in the well, constricted in their conduct by tradition\(^6\). A review of the past and present is necessary to look into the position or status of women in India.
The Rig Veda, a religious text is the oldest source of information available on the ancient period. Many scholars observed that during the period of the Rig Veda there was near equality between men and women in various areas of social life.

Women have better situation in terms of access to education, religious rights, freedom of movement, etc in the Vedic Period. Woman could marry a man of her own choice. They could also remain unmarried and remain Brahma Vadinis devoted to the pursuit of knowledge and self-realisation. Love marriage was also reported during this period. Marriage was based on truth and duty. During the marriage ceremony, woman promises in the Saptpadi (seven steps taken around the fire), that she will look after her husband and his family, and the husband endows her with his wealth, grain and eatables, which are her managerial responsibility. She thus has equal rights as a partner.

The most important role of woman besides being a wife is that of motherhood which was recognised as a fundamental right of a woman. Sons were instructed to respect and care for their mothers. There was no difference between children of different sexes. There was no objection to the birth of girl child instead special mantras had been prescribed for the birth of a girl child. The Rig Veda praises the woman who has undergone the Upanayan ceremony. There is a reference in Rig Veda to a system in which the husband’s brother or a close male relative could invite a widow from her husband’s funeral pyre to marry him. This indicates that widow remarriage was not banned during this period.

In the epics, the Ramayana and the Mahabharata, Sita and Draupadi can be mentioned. In the Ramayana, Sita is more often regarded as the ideal Hindu woman who always portrays the character of a self-sacrificing and obedient wife. Sita’s accompanying her husband to the forest on her own will clearly shows her loyalty towards her husband. However, in the Mahabharata, we can see Draupadi as the stronger female character, which was not only beautiful and capable but was determined to do the right thing by her to preserve her honour and her dignity. Here
one example can be mentioned when Dushasan on command of Duryodhana, she being well versed in the legal system of the time, appealed to the laws of the lord. The above-mentioned characters are strong women embodying the ideal of chastity who married men of their choice.

The position of women began to decline from the period of Manusmriti, i.e. 500 B.C. to 1800 A.D. The Manav code paid down a pattern of hierarchical caste structure, Patriarchal joint family and the subordinate status for the Shudras and women. Generally, women are treated and equated with the Shudras. Even the Bhagavad Gita places women, Vaishyas and Shudras in one category and describes them all as being of sinful birth.

Out of all, the laws of Manu have influenced women largely. Manu viewed that woman, as a daughter should live under the control of her father as a wife of her husband and as a window of her son. As per the laws of Manu, a devoted wife should serve even a bad and adulterous husband as a God. Women have to preserve her chastity and her responsibility was to manage the household as well as to care every member of the family and guests. In a marital relation, a man had absolute control over his wife. The husband had the right to award punishment to his wife if she committed crimes. She was not expected to remarry after widowhood but is fit for Niyoga i.e. intercourse only with husband's near relatives for begetting children. This was to keep up the line of her husband. The Manusmriti is entirely silent about the widow burning (Sati). The Rama says that the greatest suffering that a woman can have is widowhood. A widow did not receive much sympathy from society. Whether she lived in the family of her husband or separately, she was always look down upon in the society. Her very right was regarded as most inauspicious so was generally treated as an outcaste on festive occasions. The case is hot the same for the husband. He could remarry after the death of wife. The man is also entitled to remarry if the wife cannot beget him a son. It was stated that a woman should never be independent
for she would abuse it. According to Manu, man and woman are unequal in strength, stamina and psychology\textsuperscript{13}.

The Smriti writer held that when a girl reached the age of 10, she should be regarded as having attained puberty so her marriage should not be postponed any further. However, for inheritance of property is concerned, woman could inherit property and wealth if unmarried or no male issues of their family were left. Women could also keep their stridhan (money given to them by parents or in-law)\textsuperscript{14}.

It may be summed up that the entire concept of the Smriti writers was to keep women inferior to men. Throughout her life, a woman did not have a life of her own but was always controlled by somebody else as if she was a commodity. The poor situation of women continues even today in many Indian families.

During the Muslim rule, women of the middle and the lower classes had a tougher time than the princesses, queens and begams of the aristocrats\textsuperscript{15}. They were married at young age, have many children and work as domestic servants, singers, and dancers. The Mughal class and middle class women received education whereas the poor remained illiterate. The system of Purdah began to be practiced by all high-class Muslim women as well as Hindus. Even Sati continued to be practiced by the ruling class and higher castes though some rulers banned this custom. However, this practice was rare among the lower classes and castes.

Thus, it appears that early marriage, the Purdah, the Sati, the prohibition of widow remarriage etc., contributed to the degradation in the status of women.

During the British rule, there were political and social movements, which greatly affected the position of women. These were the Social Reform Movement of the 19\textsuperscript{th} century and the Nationalist Movement of the 20\textsuperscript{th} century. Efforts began to be made by the 19\textsuperscript{th} century social reformers to counter the social evils such as Sati, female infanticide, child marriage, ban on widow marriage, denial of access to education and health care which are the real blocks to women’s development. The
social reformers laid great stress on the education of women and the enactment of progressive legislation, through which the women’s condition will be improved. Due to the efforts of the committed reformers, many laws were enacted which tried to eradicate certain social evils. It was because of the great effort of Raja Ram Mohan Rai (1774-1833) which strengthened the hands of Lord William Bentinck the Governor-General of India at that time, that in 1829 Sati was abolished and made it a crime. Iswarchandra Vidhyasagar (1820-1871) with his untiring efforts made widow remarriage legal with the enactment of the Widow Remarriage Act of 1856. Another credit goes to Keshab Chandra Sen (1838-1884) for the Civil Marriage Act 1872, which was a great landmark of the 19th century. This act made marriage a secular ceremony and provided for the registration of the marriage. It rose the age at marriage of girls to 14 years, made widow remarriage, and inter-caste marriage legal. The most significant feature of the Act was the enforcement of monogamy.

Another attempt of the social reformers is to educate Indian girls and they do succeed in opening few schools for girls. Major impetus came from the Christian missionaries. Because of their efforts, great progress was made in girl’s education in the last quarter of the 19th century. By 1902 there were over 256,000 girls in the various institutions and as many as 169 in the liberal arts colleges. Women started entering into the professions of teaching and medicine.

The 20th century Nationalist Movement particularly during the Gandhian phase not only helped in changing the status of women but also the attitude towards women. The Nationalist Movement not only drew a large number of women to political activity but it also generated strength and confidence among women which helped them to organised and to fight for their own cause, rather than depend upon the benevolent men in society to promote their cause. Gandhiji apart from being a political leader, work hard for the equality of women and for their rights. He asserted that woman has the same right of freedom and liberty as man. He vehemently condemned the custom of child marriage, prohibition of widow remarriage,
prostitution and the custom of Purdah. Gandhiji also continuously urged the women to think independently by themselves and make decisions of their own without depending on the male members or blindly following the custom. He showed the importance of the participation of women (who constitute 50 percent of the population) in the developmental activities of the country. Child marriage was banned by an Act of 1929 that the minimum age at marriage was 18 years for girls and 21 years for boys.

After independence, the social, economic and political structures and the cultural milieu are dominated by patriarchal ideology. There has been a differential impact of factors of change in different sections of women, which is hazardous. After independence, we can see a change in the public opinion regarding the education of girls, age at marriage and employment of women specially in the urban areas. There also women who are able to break the traditional barriers and started working in non-traditional jobs and are also holding decision making posts and move freely. Some are of the view that the status of Indian women has improved. In reality, women are still facing numerous problems. In small towns and rural areas, the long hours, women spent in activities of kitchen, bearing and rearing of children, fetching water and bringing firewood etc. is because of the patriarchal system that has confined women to such homebound specific areas, which are unpaid. There are strong differences between the women of urban and rural areas. Women generally are confined to domestic roles, which restricted their mobility and opportunities to benefit equally from the resources of society, which kept them subordinate to men.

Women often internalise their role as natural, thus inflicting an injustice upon them. Bhatia points out that woman still have to take invariably the responsibility of home and family cares, consequently sacrificing their leisure and personal care time. Thus, women in India are still having a very low status in the family as well as the society. The low status of women has an adverse affect on their health condition.
Health and developmental needs of adolescent girls and women

As mentioned before, the health of Indian women is said to be related to the socio-economic status of the households to which they belong and their age and marital status within the household. There is discrimination against girls resulting from son preference, as sons are expected to care for parents in their old age. Further, Indian women have low levels of education, limited power over their own sexual and reproductive lives and lack of influence in decision-making. They have been living under the control of first their fathers, then their husbands, and finally their sons. Women thus starting from their childhood days are less likely to get good care, food and necessary nutrition, excess to health care and education, which later on may have reproductive health consequences.

In India, generally women marry at a very young age with no knowledge of reproductive and sexual health. Poor nutrition leading to anaemia combined with lack of knowledge of reproductive health and family planning services often force women to too many or too closely closed births. This is said to be one of the reason for the high Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), low-birth weight babies, high fertility rate etc that occurred during the reproductive age of women in India. The Tenth Five Year Plan reported that MMR has been declining from 468 in 1980 to 407 in 1998, which is still very high so it is a matter of great concern. The incidences of MMR, IMR along with educational backwardness of women results in low socio-economic status of women and limit their access to education, good nutrition, family planning and health care services.

All these conditions adversely affect not only the health of women themselves but also the well-being of their children. This is because the health of women plays an important role in determining the health of the future population. Women in poor health are also most likely to pass on the same health condition to their children. Women’s poor health also affects the economic well-being of the household, as they will be less productive in the labour force. Therefore, to look into the health problems
of women, it would be worth to look equally into the health needs of adolescent girls as adolescence is one of the crucial periods in a women's life.

The period of adolescence is regarded as a gateway to the promotion of health. To have a clear view of the health and developmental needs of adolescent girls, an attempt is made here, to examine the meaning, various definitions, different views and perceptions about adolescence in general. Attempts are also made to look into the many changes — the physiological, psychological and social changes that have taken place during adolescence. The health, nutrition and developmental needs of adolescent girls in relation to their socio-cultural environment is also be dealt with.

The word adolescence is Latin in origin, derived from the verb ‘adolescere’, which means ‘to grow’ or ‘to grow to maturity’\(^\text{17}\). It is very difficult to define the period of adolescence. Adolescence is a modern cultural and social phenomenon and therefore the ages of adolescents vary by culture. There is still a debate going on the age of adolescence that is what age adolescence begins and when it emerges into adulthood as the time span is not the same for every person. Therefore, there are different assumptions and views on adolescent age.

The World Health Organisation (WHO) defines adolescence both in terms of age between 10 and 19 years and in terms of a phase of life marked by special developmental attributes such as rapid physical growth and development, physical, social and psychological maturity, but not all at same time, sexual maturity and the onset of sexual activity, experimentation, development of adult identity, transition from total socio-independence\(^\text{18}\). The United Nations Population Fund (UNFPA) has also given the age of adolescents as 10 to 19 years. In contrast, in the United States, adolescence is generally considered to begin between ages 12 and 14, and end at 19 or 20\(^\text{19}\). As distinct from adolescence, the word teenager is more easily defined as a person who is thirteen to nineteen years of age. In the Report of the Working Group, Government of India, Planning Commission, June 2001, the working group for the Tenth Five Year Plan has accepted age of adolescents from age 10 to 19 years\(^\text{20}\).
The Government of India in its document on Youth Policy (2003) defines adolescence as 13 to 19 years age group.\textsuperscript{21}

The National Council for Educational Training and Research (NCERT) has divided the period of adolescence as\textsuperscript{22}.

I. Early adolescence (9-13 years)-characterised by a spurt of growth and the development of secondary sexual characteristics.

II. Mid adolescence (14-15 years) – this stage is distinguished by the development of a separate identity from parents, of new relationships with peer groups and the opposite sex, and of experimentation.

III. Late adolescence (16-19 years) - at this stage, adolescents has fully developed physical characteristics and has distinct identity and well-formed opinions and ideas.

In the light of the above mentioned meaning and definitions of adolescence, the only universal definition of adolescence is to mark it as a period in which a person is no longer a child and not yet an adult.

Adolescence is a period of rapid growth, development and change. Numerous changes take place, which are of vital importance in conditioning the behaviour and thinking of adolescents. This period of transition is characterised by a combination of physical, psychological and social changes. Generally, adolescence is a period of transition from puberty to adulthood. Puberty refers to the period of physical growth and the development of secondary sexual characteristics.

It is a known fact that girls began their pubertal development and attain full growth at an earlier age than boys attain. Girls grow faster in height and weight at approximately 12 years of ages, while it is approximately at 14 years for boys.\textsuperscript{23} Young girls became aware of the physical changes taking place and this deeply
affected their thinking. Most of them develop some new feelings, which are very hard for them to understand. Menstruation may be very upsetting event for some girls who are not prepared for it. Young girls became self-conscious about their development if they believe their growth is not normal. This happens with those girls who mature late and when they are not growing as their friends. This is also true of those girls who mature early. They are taller and more developed sexually. This makes them feel awkward and self-conscious about her appearance because she is different from her pubertal friends\textsuperscript{24}.

Most researchers have pointed out that girls are more concerned than boys about their physical appearance. They are concerned about the size and shape of their breast, the dress they wear and other accessories. Tallness, pressure to remain thin, menstruation, underweight, defective teeth, defective speech and shortness are some of the major problems of concern for adolescent girls\textsuperscript{25}. Because of this, early maturing girl are known to have more problems that are emotional, a lower self-image and higher rates of depression, anxiety and disordered eating\textsuperscript{26}. This deeply affected their interests, their social behaviour and the quality of their affective life\textsuperscript{27}. The evidence suggests that bodily changes play an important role in the overall development of adolescents.

This period of transition is also regarded as very crucial. Some young girls are unaware about the physical changes that have taken place. She is not informed about it, thus she lack knowledge on the biological processes of maturation and normal physiology. As discussion on sexuality is absent in Indian society, young girls are not prepared mentally for the physical changes. Thus, they began to have psychological problems, which may deteriorate their health condition. This is true more in case of young girls in a socially and economically backward family where discrimination is high. She is deprived of the attention and care; she needed most, so they are a burden on their families and has poor self-image as compared to their brothers.
Another important factor for psychological stress among adolescent girls is the onset of menstruation. Those young girls, who are not given information about menstruation prior to its onset, were frightened at the sight of blood for the first time. They are also vulnerable to infections if prior information about hygienic practices regarding menstruation is not given. In western societies, ‘it is argued that menarche conveys conflicting societal messages, it represents the beginning of womanhood and sexuality, but girls of this age are seen as too young to be sexually active’\textsuperscript{28}. In the Indian society, menstruation is considered a polluting factor among Hindus\textsuperscript{29}. There are certain myths and taboos associated with menstruation. A menstruating girl/woman is restricted from cooking food, from touching anything in the kitchen or visit temple. While the girls/women are very knowledgeable about the myths and taboos, they have little knowledge about the biological processes of maturation and normal physiology.

Thus, young girls lack information on hygienic practice during menstruation, which consequently may increase susceptibility to various infections. A study showed that knowledge and awareness about puberty, menstruation, physical changes, reproduction, contraception, pregnancy, childbearing, reproductive tract infections (RTIs), sexually transmitted infections (STIs) and HIV was low among young adolescents in the age group 10-14 year\textsuperscript{30}. Young girls in this age group are unaware and are not informed about menstruation prior to its onset. However, the study showed that among the older age group 15-19 year had better knowledge.

From a sociological point of view, the process of maturation during adolescence is the process of becoming socialised. Davis defines socialisation as the process by which individuals learn and adopt the ways, ideas, beliefs, values and norms of their culture and make them part of their personalities\textsuperscript{31}. Each society defines the goals, values and behaviours it desires for its members. Socially acceptable behaviour is rewarded while unacceptable behaviour is
punished. Most of the factors that underlie the unhealthy development in adolescents result from the social environment in which they live as poverty and unemployment, gender and ethnic discrimination and the impact of social change on family and communities. Adolescents occupy an important position in the family as well as in the society.

The relationship of adolescents with their parents began to change at the early adolescent years as their life outside the family develops. Most parents are not as perfect as their adolescents would like them to be nor do most young people live up to all the expectations of parents. These results in some tension and conflict arise between an adolescent and his parents on matters that may seem unimportant to the parent although they are very important for the growing adolescent. The conflicts are on such matters concerning home chores, spending money, and apparent criticism of one child over another, dates, selection of friends, vocational choice and parental rejection or over protectiveness, and youthful impatience with parental opinion. The changes in the relationship between adolescents and parents are found to become a factor of anxiety for parents and adversely affect the psychological development of adolescents. As children matured, parents in a good family have become friends with their children rather than the controllers of their children.

In a poor socially disadvantage family the period of adolescence for a young girl is for a limited period. This is because of the prevalence of gender discrimination and low socio-economic status where preference for son is high. Discrimination starts right from the birth of a female child. From lineage to religion and from appropriating a hefty dowry to earning for the family, everything points towards begetting a son, which leads to practice of female foeticide.

The health and well-being of adolescents - the future parents are very important. However, the importance of adolescents’ health and of nutrition is
recognised recently. Adolescents make roughly 20 per cent of the total world population, of whom 85 per cent live in developing countries. India has an estimated 200 million adolescents’ population. About one-fifth of India’s population is in the adolescent age group 10-19 years. Girls below 19 years of age comprised one quarter of the total rapid growing population of India. Despite the huge growing adolescents’ population, policies and programmes in India focused little on the health of adolescents as they are basically considered a healthy group having the lowest mortality and morbidity compared with other age groups.

In a family where discrimination is high, young girl receives inferior health care and nutritional needs. They are breastfed for shorter periods, have lower rates of immunisation and receive less nurturing than their brothers. During adolescence, the actual need for food is great. Nutritional health during adolescence is important for supporting the growing body and for preventing future health problems. Adolescent girls need additional calories, protein, calcium and iron. It is said that during adolescence, the attainment of maximum height, strength, other growth of the body and physical well-being depends upon good nutrition. Young girls need additional nutrients from age 13 to 15, need more calories than the average woman, 2,800 calories as compared with 2,500, but from age 16 to 18, the needs decrease and 2,400 calories are enough. They also have a higher calcium requirement of 1500 mg daily. They also need 10 per cent more iron as a result of menstrual blood loss, but their consumption is much less. Nutritional deficiency compounds the problem of malnutrition resulting in poor physical growth and may affect the whole life of the young girl. Poor nutrition is a major reason for the delayed onset of puberty in Indian adolescents. It also reduces the reproductive, physical and mental capacities of girls in consequence resulting in low birth rates and high infant mortality.
Another visible health problem because of nutritional deficiency is the widely prevalent anaemia among adolescent girls of age group 15-19 years, compared with other age groups of women of reproductive age. Both the 1992 ICMR study on iron and folic acid supplementation and UNICEF have also reported low mean hemoglobin levels and low nutritional intake of proteins, calories, and macro/micronutrients among adolescent girls and pregnant mothers. Thus, we can see the importance of nutritional needs during adolescence period, which is necessary for healthy living.

The young girl is not only deprived of nutritional needs but also opportunities for education and employment. It is estimated that in developing countries, at any point in time, up to three-fourths of the children not attending school are girls. Nearly twice the percentage of girls, 46.6 per cent are illiterate compared with males 25.5 per cent. According to a report, 67 per cent adolescent girls in the age group 10-14 years attended school compared with 80.2 per cent of male adolescent. Though there has been some improvement in the education of young girls, the probability that adolescent girls will drop out of school is still significantly high. Very few of adolescent girls attend and complete secondary school. Only 40.3 per cent of adolescent girls ages 15-17 attended school compared to 57.7 per cent of their male counterparts. On average, by the age of 18, girls have received 4.4 years less education than boys have. Discrimination and increasing responsibilities of girls at home are the reason for girls dropping out of school.

A young girl always assists her mother in the household work and look after siblings. She is taught from the beginning to accommodate the male-dominated patriarchal society. She is married off early with no knowledge of reproductive health, increases the prevalence of early child bearing, and repeated pregnancy to beget a son. This makes the situation risky for both the child as well as the young mother. Premature marriages begin the vicious circle of malnutrition.
where under-weight mothers have underweight babies who are at risk of suffering from nutrition and educational deprivation. This should be a cause for serious concern since many young girls are not physiologically mature for reproduction and they know little about the sexual and reproductive health. As a result, they are at a higher risk of unwanted pregnancies and various nutritional complications often leading to maternal death. Their offspring also suffer higher levels of morbidity and mortality. The Government of India 2000 Report says that 45 per cent of adolescent girls are under-nourished. It states that nutritional anaemia combined with early child bearing, puts adolescent girls at risk of maternal mortality and morbidity. It also reports that 40 per cent of young girls are married before the legal age of marriage i.e., 18 years. The Tenth Five-Year Plan also subsequently highlights that 47.8 per cent of adolescent married girls suffer from moderate to severe anaemia.

Therefore, with lack of nutrition, health care, and support from elders, the young girl suffers from various health problems. Moreover, inferior education lowers the young girl’s self-esteem, her employment opportunities and her ability to take part in the world around her and later in life; she is likely to pass on her disadvantages to her children. Consequently, she is left with no future whereas an educated girl tends to delay marriage and childbirth and have fewer children. Thus, there is a close relation between educational attainment and age at marriage, fertility regulation and health seeking behaviour.

Even in a well-off family, because of influence of peers, media, widespread availability of information, and lack of parental care, young girls are no better than girls are in a poor family. As adolescence is a time of exploration and experimentation, their behaviour is guided by intense desire for independence and identity. They began to have serious interest in interacting with the opposite sex, in sexual relationships and may indulge in more readily available harmful substances such as tobacco, alcohol and other drug use which without timely
intervention may lead to risky behavioural pattern and other health risk that last a lifetime. Another serious problem is that adolescents lack information on sexual and reproductive health and use of contraception.

Thus, there is the threat of spreading of STDs, RTIs and HIV/AIDS. 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 years old. There are also reports of approximately 10 million pregnant adolescents and adolescent mothers throughout India at any given time. In a study, it was revealed that a large percentage of adolescent boys and girls engaged themselves in non-penetrative sexual experiences such as kissing, hugging, touching sexual organs, etc. but only 26 per cent of boys and 3 per cent of girls reported that they had experience sexual intercourse. It was also revealed that 50 per cent of the boys have knowledge about contraception.

Thus, Reproductive health, Sexually Transmitted Diseases (STDs), Reproductive Tract Infections (RTIs), Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and early pregnancy is understandably a major concern, which required special needs and concerns of adolescents. Increasing the age at marriage and providing adolescents their health and developmental needs will help in determining the future size and growth pattern of India’s population.

As mentioned before, in the past decade, the United Nations major global conferences and conventions such as the World Conference on Population and Development (ICPD), Convention on Rights of the Child (CRC) and Fourth World conference on Women (FWCW) have given higher emphasis on health issues particularly the reproductive health and have initiated and supported a number of programmes of the needs and rights of adolescent girls and women. Since then, India has signed and ratified all major conferences and conventions, which helps in increasing policy attention towards adolescent girls and women for improving their
health status, which will in future enable them to make good choices for themselves and their communities. For this to happen adolescent girls and women must be provided free legal access to information and their rights must be guaranteed and protected by law.

Women in Manipur: An overview

In the early period of history, women in Manipur held a very high social position and status. This can be traced back to the mythological figures like Imoinu, Panthoibi, Phouoibi, Ima Leimaren etc and legendary figures like Thoibi, Tonu Laijinglembi, Pidoinu etc. Imoinu is still worshipped as the Goddess of wealth in every house of the *meitei* (the dominant community inhabiting in the valley). Once she falls in love with a man to whom she finds out to be a married man. After knowing this, she is determined not to see that man again and spent all her life by rendering help to the people of *meitei* society. She prescribes certain norms and behaviours, which are followed by the housewife; the family would be happy and prosperous. Panthoibi is worshipped as the Goddess of war. She was found to be assertive and independent. She falls in love with a man but her parents gave her in marriage to another man against her wishes. Later on, she succeeds in running away with the man she loves.

This shows that women during those days exercised her right of choosing her life partner. Another legendary figure Thoibi also makes her own decision in choosing her life partner. Overall, women in the mythology of Manipur were bold, courageous, and independent, enjoyed their due rights and had a honourable place in society. There are also eminent women figures in the history of Manipur like Lingthoinganbi, Kuranga Nayani, Kumudini etc who contributed a lot in protecting the territorial integrity as well as the throne of Manipur by fighting against enemies. During the Pre-British period, women had to bear the burden of household responsibilities along with earning for the family. This is because all
adult male members of a family were engaged in warfare activities along with the king, against the neighbouring enemies. In normal days also, the male members had to attend the “Lallup” or military training in the palace. Many men were killed and many were taken away as war prisoners. As a result, many women became widows and thus had to shoulder social responsibilities in the absence of their husbands. They started selling and buying of essential commodities, which in course of time developed into a market, where women in large numbers congregate and share their views relating to the socio-economic as well as political matter.

E.W Dun made a comparative study on the characteristics of both men and women of Manipur and he stated that Manipuri women are very industrious while men are described as lazy and indolent. During the British rule, two women’s movements emerged in 1904 and 1939, due to women’s presence as collective force in the market place. The first, 1904 movement known as “Nupilan Ahanba” (first women’s war) was against the British authority to review the Lallup system in Manipur. This movement forced the British to review its policies. The 1939 women’s movement also known as “Anisuba Nupilan” (second women’s war) was also against the British authority to stop the export of rice from the Manipur. This was due to the scarcity of rice in Manipur. Because of the movement, the British discontinued the export of rice. Some of the prominent leaders who played vital role in the women’s movement were A. Rajani. R.K. Sanatombi, T. Shabi, M. Indumukhi and L. Ibemhal etc.

After Independence in 1975, another women’s movement known as Nisha Bandh (Anti liquor movement) was engineered. This women’s movement fought against the selling, buying and drinking of liquor and anti-social activities that disturbed the peace and social order in Manipur. In the late 70s due to the political instability in the state, a series of political problems emerged such as the emergence of insurgency. A clash between the insurgency groups and the security
forces resulted into the death of innocent people, physical injury and mental torture. Women became the worst sufferers. Thus to protect the innocent persons, women's movement called Meira Paibis (torchbearers) was formed in the 80s. They also resolved family conflict, checked immoral trafficking, drug trafficking etc. The Meira Paibis from time to time organised rallies; sit in protest, etc. to highlight their feelings.

Politically, women of Manipur lagged behind in comparison to other states of India. Although women voters outnumbered male voters, very few women are elected since the assembly election, 1972. The selected women candidates belong to political families who are supported by their husbands. This shows that the decision-making is still in the hands of men where common women will take time to come to the forefront in political sphere of the state.

Quite interestingly, the NFHS-3 reveals that Manipuri women account for 85 per cent in the family decision-making50. There is a consensus among men that women who participate fully in the decision-making would not face any problem of domestic violence against themselves. Contrary to the above NFHS-3(2005-2006) further reveals that 42 per cent of women of Manipur faced spousal violence and Manipur stand 4th rank in India. There are various causes of violence viz.; poverty, divorce, judicial separation, conflict, status quo, alcoholism, drug abuse, economic disparity, unequal power equations HIV/AIDS etc. All these problems would have an adverse impact on the health of women, as women’s health is intimately tied with the health of the children and that of the family as a whole.

Health needs adolescent girls and women in Manipur

In the Meitei society since the time immemorial, there has been a trend of preference for a male child at first birth. This preference for a son is in tune with the patrilineal principal of their social organisation. Therefore, a male child is always welcomed, as he is the protector of the lineage line and also gives in old
age. Moreover, the mother who has given birth to an eldest son has a highest ritual status than the mother who has given birth to an eldest daughter. Generally, a mother with an eldest son is regarded as a symbol of goodness and welfare. A girl child faces less discrimination in the meitei society and she is never considered a burden to the parents. She also faces less pressure to marry early. However, a daughter is always expected to assist her mother in household activities, to take care of her younger siblings and to attend on the elderly members of the family, while it is not a compulsion on boys. This unequal treatment of parents will certainly lead to the girl child receiving less care, food and education from their parents, which will in turn bring health problems in their later life. Again, in meitei society, talking about sex is taboo, so young girls are not given the required physical, sexual and reproductive health information. As a result, they are at a higher risk to suffer from depression and various other health problems associated with it. As young girls attain puberty, they go through a stage where their bodies grow much more rapidly to prepare them for childbearing. Nevertheless, due to the poor economic situation of the state and their urge to remain slim, to rate better in marriage market, they consumed less food.

Thus, they are deprived of various nutritional needs that increased her vulnerability to the risks of growth retardation and particularly risk in childrearing as well as for the child to be born. Their nutritional needs are further deprived by the culturally prescribed dos and don'ts for a menstruating girl. She is refrain from eating all types of fruits and vegetables peruk (Centella asiatica), nongmangkha (Adhatoda visica), Yongchak (Parkia roxburghii), Banana flower (Musa paradisiaca), brinjal (Solanum melongena) and particular curry known as Utti [a curry prepared by mixing pulse, vegetables and soda (sodium carbonate)] for six days. It is believed in the meitei society that if one consumed all those said food; she would become unhealthy and blackish in complexion. Young girls also suffered from mental tensions when they are treated like untouchable during those
six days. She is restricted from touching any family members, from cooking and serving food, and is not allowed to dine with others. She is prohibited from performing any ritual and from entering sacred places like temples.

The same rule is for married women also. In addition to the above mention restrictions, a married woman is not allowed to perform any ritual and religious ceremonies as they are regarded as polluted for a whole three months after delivery of child. The ritualistic belief is so strong in meitei society that women in Manipur continue to observe this food taboos and rituals even at the expense of their health.\footnote{51}

Many young adolescent girls enter into sexual life and childbearing with no knowledge about sex and the reproduction processes. Thus, gave birth to low weight babies and run a high risk of life. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment. Therefore, they are also very vulnerable to STDs, RTIs and HIV/AIDS etc. Manipur being a border area drugs like Heroin is easily brought from Myanmar. The numbers of injecting drug users are therefore increasing in Manipur that is why there is high prevalence of HIV/AIDS in the state. Because of it, the number of widows is increasing in Manipur, which affects the health of not only themselves but also of their children and the family as a whole. The consequences of HIV/AIDS reach beyond women’s health to their role as mother and caregivers and their contribution to the economic support of their families. Some of the greatest or main challenges that the Manipuri women faced at present which adversely affect their health are the increasing socio-economic problem; drugs; HIV/AIDS; ethnic crisis; armed conflict where women faces many serious problems such as sexual abuse, rape, killing etc.; low political participation of women in the state etc. Thus, women of Manipur are the one to be worst affected from these above-mentioned problems in the present days Manipur.
It will be appropriate to elucidate here the demographic and health profile of Manipur. According to the 2001 census, the total population of the state is 23,886,34. The decadal growth rate of the state is 30.02 per cent as against the all India level of 21.34 per cent. The density of population is 107 persons per square kilometers, much lower than that of all India 324. The process of urbanisation in the state is found to be very slow but Manipur ranks second among the northeastern state of India in respect to urbanisation. The urban population has increased from 5.06 lakhs in 1991 to 5.76 lakhs in 2001. The literacy rate is 68.87 per cent and male percentage is 77.87 percent whereas female is 59.70 per cent.

Historically, Manipur has had a higher sex ratio at birth than the all India figure. The sex ratio which represents the survival scene of women, registered an improvement from 958 (females per 1000 males) in 1991 to 978 (females per 1000 males in 2001) much higher than the all India level of 933, but we can still see the imbalance in the sex ratio. Life expectancy is another indicator of how healthy one can expect to be. Inequalities in this area have the most fundamental bearing on well-being and opportunities. Life expectancy rates of Manipur and India have increased over the years, however most recent data available for life expectancy for Manipur are for 1991. Therefore, comparisons with the all India figures are not possible. In 1991, the life expectancy of females in Manipur was greater than that of males. It was 58 for males and 61.50 for females while it was 58.1 and 58.6 (for India). According to Sample Registration System Bulletin, the birth rates in Manipur declined from 20.1 in 1991 to 18.3 in 2001 and death rate from 5.4 in 1991 to 5.2 in 2001 all India birth rate is 20.20 and death rate is 8.40.

According to the NFHS (National Family Health Survey) -3, the IMR per 1000 live births in Manipur has a steady decline from 42 (NFHS-1) to 37 (NFHS-2) and at present comes down to 30. However, the IMR of Goa and Kerala is at 15 each. This shows that the health status of Manipuri women is lower than Goans.
and Keralites women. The NFHS-3 (2005-06) also reveals that 42 per cent women of Manipur faced spousal violence and is in the fourth rank in India. This shows that domestic violence is highly rampant in Manipur, which may have a significant public health consequence including effects on unwanted fertility and contraceptive use, rates of HIV and other health care. All these may adversely affect the mental and physical well being of women and consequently their children.

**Government policies and programmes for adolescent girls and women**

The Government of India had ushered in the new millennium by declaring the year 2001 as ‘Women's Empowerment Year’ to focus on a vision ‘where women are equal partners like men’. The most common explanation of ‘women's empowerment’ is the ability to exercise full control over one’s actions. The last decades have witnessed some basic changes in the status and role of women in our society. There has been shift in policy approaches from the concept of ‘welfare’ in the seventies to ‘development’ in the eighties and now to ‘empowerment’ in the nineties.

Several legislative provisions have been introduced that directly or indirectly protect the rights of adolescents. Some Constitutional Provisions affecting adolescents are such as Article 15, Article 16, Article 21, Article 23, Article 24, Article 39 (c), Article 39 (d), Article 39 (e), Article 39 (f), Article 40, Article 42, Article 45, Article 46 and Article 47. Besides, the constitutional provisions, legislative Acts have also been promulgated to safeguard the health and social protection of children (including adolescents) such as the Immoral Traffic Prevention Act, 1956; the Child Marriage Restraint Act, 1976; Child Labour Prevention and Regulation Act, 1986; the juvenile Justice Act, 1986; Pre-natal Diagnostic Technique (Regulation and Misuse) Act, 1994; Persons with Disability/Equal opportunities, Protection of Rights and Full Participation Act, 1996.
All round development of women has been one of the focal points of planning process in the various Five Year Plans of the Government of India. Within the development plans, improving the health of women and children has been given special attention. After independence, we have had ten Five Year Plans, which are as described below.

The Government of India (GOI) has framed and announced its development strategies through Five-Year Plans. The Government of India right from the very first plan (1951-56) had recognised the importance of the role of women in development. The First Five Year Plan (1951-56) was mainly welfare oriented. This Plan envisaged a number of welfare measures for women such as the establishment of the Central Social Welfare Board (CSWB) in 1953 that served as an apex body at the national level to promote voluntary action at various levels, especially at the grassroots, to take up the welfare-related activities for women and children. The Plan further recognised women in the reproductive age groups and children as especially vulnerable groups. Under the section on health, maternity and child health service is kept at the forefront in the planning of health programmes. The First Plan also stated that protecting the health of the expectant mother and her child is the most important way for building a sound and healthy nation. The Plan aimed at developing maternity and child health centres, which are properly equipped with adequate number of staff to provide them the health services.

There were no philosophical or conceptual changes in the Second to Fifth Plans (1956-79), as the same welfare approach is continued besides giving priority to women’s education, and various measures were taken up to improve maternal and child health services, supplementary feeding for children and expectant and nursing mothers. Women’s Welfare and Development Bureau was set up under the Ministry of Social Welfare. The Fifth Five Year Plan (1974-78) is considered very crucial from the point of view of women development with 1975 being declared as ‘International Year of Women’. The plan identified areas of health, family planning, nutrition,
education, employment, legislation, and social welfare for formulating and implementing action programmes for women and called for planned intervention to improve the condition of women in India.

The Sixth Five Year Plan (1980-85) saw a definite shift from welfare approach to development approach. The Plan recognised women’s lack of access to resources as one of the important factor impending their growth. The strategies for women’s employment and economic independence, education, health care and family planning and the creation of a supportive legal and institutional environment were conceived. It was in the Sixth Plan document that women were recognised as a separate group by including a separate chapter on ‘Women and Development’. Accordingly, the Sixth Plan adopted a multi-disciplinary approach with a special thrust on the three core sectors of health, education and employment. Since then all efforts of the Government of India have been directed towards bringing women into the mainstream of the national development process by raising their overall status—social, economic, political and legal.

Development approach is continued in the Seventh Five Year Plan (1985-90) which aimed at raising the economic and social status of women and bringing them into the mainstream of development of the country. A significant step in this direction was the identification and promotion of the ‘Beneficiary-Oriented schemes’ (BOS) in various developmental sectors, which extended direct benefits to women. The Seventh Plan emphasised the need for gender equality and empowerment. The Plan also recognised that the health and nutrition status of women are important factors, which affect child survival and development. Thus, for improving the health and nutrition status of women, maternal and child services were strengthened in the Seventh Five Year Plan. The Universal Immunisation Programme, which aims at universal coverage of pregnant women and infants, was extended to all districts in the country. Increasing the age of marriage, adoption of two-child norm and spacing of births was
vigorously promoted, to project family planning as a programme for the well-being of the mother and her child.

In the year 1985, the Department of Women and Child Development was set up as part of the Ministry of Human Resource Development. For the advancement of women and children, the Department formulates plans, policies and programmes; enacts/amends legislation, guides and coordinates the efforts of both Government and Non-Governmental Organisations (NGOs) working for women and child development. The Department has also been implementing the Integrated Child Development Scheme (ICDS), providing a package of services comprising supplementary nutrition, immunisation, health check-up and referral services, preschool non-formal education. The major policy initiatives undertaken by the Department includes the establishment of the National Commission for Women (NCW), Rashtriya Mahila Kosh (RMK), adoption of National Nutrition Policy (NNP), universalising and strengthening of ICDS, setting up of National Crèche Fund (NCF), launching of Indira Mahila Yojana (IMY), Balika Samridhi Yojana (BSY) and Rural Women's Development and Empowerment Project (RWDEP).

The Eight Five Year Plan (1992-97) focused on human development. The Plan marked a shift from development to empowerment. It focused on empowering women, especially at the grassroots level, through Panchayati Raj Institutions. Efforts would be made to facilitate women's access to, and control over and use of locally available foods to ensure adequate nutrition, particularly iron and iodine intake. Nutrition Programmes will lay emphasis on nutrition education, particularly increasing the awareness about the nutritional needs of women especially during infancy, adolescence, pregnancy and breastfeeding of the newborn. The Eight Plan contemplated universalisation of Integrated Child Development Services Scheme.

In the Ninth Five Year Plan (1997-2002), empowerment of women became one of the nine primary objectives. The Plan also attempted convergence of existing services in both women-specific and women related sectors. To this effect, the Plan
adopted a Women's Component Plan (WCP), under which not less than 30 per cent of funds/benefits are earmarked for women-specific programmes. The Ninth Five Year Plan recognises the special health needs of women, the girl child, and the importance of enhancing easy access to primary health care. There is specific mention of adolescents in the Ninth Plan, which emphasises its commitments towards the child, to universalise supplementary feeding with a special emphasis on adolescent girls, to expand the adolescent girls' scheme and to assess the health needs of adolescents in the RCH programme. Nevertheless, adolescents continue to be a sub-group of women, children or youth. The year 2001 is declared as 'women’s Empowerment Year' which saw various activities and programmes specially aimed at women including the much talked about women’s self-help groups (SHGs).

The neglect in the health needs of women viz., the pregnant women, adolescent girls and girl-babies, is responsible for the present high rates of Infant Mortality Rate/Child Mortality Rate/Maternal Mortality Rate. Therefore, a holistic approach with RCH measures is to be adopted in improving health status of women by focusing on their age specific needs. ICDS continues to be the major intervention for the overall development of children. It caters to the pre-school children below six years and expectant mothers with a package services viz., immunisation, health check-ups, referral services, supplementary nutrition, pre-school education, and health and nutrition education. During the Ninth Plan period, several new initiatives are taken as part of the Reproductive Child Health Programme (1997), in order to make it broad-based and client-friendly.

The Tenth Five Year Plan (2002-2007), is different from the earlier plans as it borrows from the Platform for Action with definite goals, targets and a time-frame and expects to continue the process of empowering women initiated during the Ninth Plan. The plan aims at the operational strategy in terms of a time-bound action plan; responsibilities of the executing agencies, both government and non-government; built-in mechanism for coordination, monitoring, and evaluation of impact through
measurable indices, etc. The plan also promotes SHG mode to act as agents of social change, development and empowerment of women.

Thus, the Tenth Plan (2002-2007), aims at empowering women through the National Policy for Empowerment of Women (2001) and ensuring Survival, Protection and Development of Women and Children through Rights Based Approach. The focus shifted from the individualised vertical interventions to a more holistic integrated life-cycle approach to women’s health with more attention to reproductive health care.

However, in the Tenth Five Year Plan (2002-2007), there is still no more to consider adolescents as a separate group/category but they continue to be a sub-group of women, children or youth. The 10th Five-Year Plan states that adolescent girls (15-19 years) are very sensitive from the point of view of planning because of the preparatory stage for their future production and reproductive roles in the society as well as the family. The 10th Five Year Plan is committed to improve the accessibility and utilisation of services of primary health care and family welfare particularly, the undeserved and underprivileged sections through universalising reproductive and child health services and reiterates to achieve the goals set by the National Health and Population Policies to reduce Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). The commitment to adolescent girls also include universalisation of Integrated Child Development Services (ICDS) Scheme and nutrition supplementary feeding programmes for tackling nutritional deficiencies, to increase enrolment/retention rate and reducing drop-outs, to strengthen and expand the schemes for adolescent girls and encouraging media to project positive images of women and girl child.

The Plan stated that women in the reproductive age group 15-44 years need special care and attention because of their reproductive needs. The commitment of Tenth Five Year Plan includes universalisation of Reproductive and Child Health services to achieve the goals set by the National Health and Population Policies,
especially with regard to women and child. Other effective measures includes obstetric care through early registration of pregnancy and screening of all pregnant women at least thrice during this period to detect risk factors; identification and management of anaemia and hypertension disorders; providing referral care to ‘at-risk’ mothers and to ensure safe delivery. Services for the prevention and management of RTIs, and STIs are also continued as part of RCH care.

The Government in different Five Year Plans has enunciated the policies advocating women’s issues including women’s health. The Government has also consciously fostered on enabling environment in which women’s issues can be properly reflected, articulated and seriously addressed. It was in the year 1951, where India’s Family Planning Programme was initiated for the first time, in an effort to stabilise the huge growing population of the country. Since then, the policy, approach, and implementation of the Family Welfare Programme has undergone a number of changes and has embraced six major approaches viz., the clinical approach (1951-61), extension and education approach-low intensity HITTS (Health department operated, Incentive based, Target-oriented, Time-bound, and sterilisation-focused Programme) approach (1962-69), high intensity HITTS approach (1969-75), coercive approach (1976-77).

Under the clinical approach (1951-61), the family planning coverage was negligible, with the couple protection rate (CPR) remaining at about 0.2 per cent. The CPR rose to 15 per cent in 1975 with the introduction of the extension and education approach (1962-69). The programme suffered a setback during the coercive approach (1976-77). During the recovery phase, the family planning programme was integrated with maternal and child services. Since then, variety of services has been provided to mothers and children, including antenatal, delivery, and postnatal care, immunisation of children against various vaccine-preventable diseases, and counseling on maternal and child health problems and nutrition. The CPR increased from 24 per cent in 1977 to 45 per cent in 1992-93. The Government of India as part of the family planning
programme launched the Child Survival and Safe Motherhood (CSSM) Programme. The component of this programme includes an integrated package of interventions for improving the health status of mothers and children. The programme also includes treatment of diarrhoea and acute respiratory infections, essential newborn care, and strengthening of emergency obstetric care services.

In response to the International Conference on Population and Development (ICPD), the Government of India launched the Reproductive and Child Health (RCH) Programme in 1997 incorporating new approach to population and development issues, as exposed in the ICPD. The Programme integrated and strengthened Child Survival and Safe Motherhood Programme and Family Planning Services and the treatment of Reproductive Tract Infections (RTIs) and Sexually Transmitted Diseases (STDs) was added to the existing services.

In the last couple of years, the Government of India has not yet formulated specific policies for adolescents; however, several plans and policies have components that address adolescent health and needs. Some of the policies and programmes for adolescent girls and women are listed as follows: The National Nutrition Policy 1993, the National Plan of Action on Children, 1992 and 2005, the National Education Policy, 1986 (modified in 1992), the National Policy for the Empowerment of Women, 2001, the National Population Policy, 2000, the National AIDS Policy, 2000, the National Youth Policy, 2003, The National Rural Health Mission, 2005-2012, etc.


In summary, there is no doubt about the fact that development of women has always been the central focus of planning since Independence. However, gender issues continued to be framed by dominant patriarchal ideologies and discourses even as institutionalised attempts were being brought in place for expanding spaces for women in a greater equity paradigm. Empowerment is a major step in this direction but it has to be seen in a relational context. A clear vision is needed to remove the obstacles to the path of women's emancipation both from the government and women themselves. Efforts should be directed towards all round development of each and every section of Indian women by giving them their due share.
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