Women and the Reproductive Health

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Abstract

This paper gives the reader a clear idea about the existing health scenario of the women in India. it also gives the reader the reasons for this gap of unequal access to health care.towards the end of the paper it also provides useful information to prevent the same.

Introduction

"All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the universal Declaration of Human Rights, without distinction of any kind, such as race, creed, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person."

—Principle 1, ICPD Programme of Action

Reproductive health is defined as a state of physical, mental, and social well-being in all matters relating to the reproductive system at all stages of life. The International conference on population and development programme of action states that-"reproductive health ….implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in the last condition are the right of men and women to be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and as well as other method of their choice which are not against the law and the right to access to appropriate health care."

To fulfill the above conditions, the requirements are

1. To have disease free, properly functioning reproductive organs.
2. To have sexual intercourse free from discomfort, free of fear.
3. To avoid unwanted pregnancy.

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4. To have pregnancy which is healthy, free from complications and proper growth of baby.
5. The child birth should be normal, free from complication during and after birth.
6. Baby should be delivered normally and free from diseases.

India's national family welfare program has two stated objectives:

1) to address the needs of families, notably women and children, and
2) to reduce population growth rates.

In reality, the Programme has not lived up to its title of "family welfare". The thrust of the programme, as is well known, has been disproportionately focused on achieving demographic targets by Increasing contraceptive prevalence and notably female sterilization. In this process, women's needs have been generally overlooked by the programme and the consequences of this neglect, in terms of poor reproductive health, are disturbing. There is an urgent need to reorient programme priorities to focus more holistically on reproductive health needs and on woman based services, that is, services that respond to women's health needs in ways which are sensitive to the socio-cultural constraints women and adolescent girls face in acquiring services and expressing health needs.

Gender Disparities Underlying Unequal Access to Health Care :

Women's unequal accesses to resources, including health care, are well known in India, in which stark gender disparities are a reality. While disparities in life expectancy may be narrowing, unequal sex ratios and higher female infant and child mortality rates in large parts of the country continue to reflect the general devaluation of women. In other areas also, women remain at a considerable disadvantage in many areas in the quality of that life both within the home and outside it. For one, female literacy and school enrollment rates lag far beyond that of males in most states: enrollment ratios for females are lower and gender disparities in school enrolment are wider in India than in almost every other region of the developing world. Gross enrollment ratios suggest that even in the 1990s, only 88 percent of all girls aged 6 to 10 (compared to over 100% of all boys) are enrolled in school; by the upper primary stages, fewer than half of all girls (47%) compared to three quarters of all boys are enrolled. Of even greater concern is the fact that only about

one in three girls aged 6-14 actually attended school, compared to about three in five similar aged boys. Women's poor reproductive health in India is affected by a variety of sociocultural and biological factors. Underlying poor reproductive health among Indian women is their poor overall status on the one hand and an inadequate delivery system to cater to the needs of secluded, shy and de-valued women on the other.

Thus, efforts to improve women's education, raise enrollment and attendance rates of girls in school and reduce the drop-out rate on the one hand and enhance women's income autonomy on the other are fundamental, in the long run, for improvements in women's and family health; no less important are improvements in the quality and breadth of services catering to reproductive health needs.

Malnutrition affecting poor reproductive health :

Underlying reproductive morbidity and exacerbating women's vulnerability to obstetric, gynecological and sexually transmitted morbidity is poor nutrition, and such consequences as anaemia and physical immaturity. Disparities in feeding patterns are evident from infancy (Das Gupta, 1987; Khan et al., 1988); and studies which have monitored growth and nutritional status among children (Srikantia, 1989; Government of Maharashtra and UNICEF-WHO, 1991) confirm gender disparities in growth and sever malnutrition from an early age. Poor adolescent weight and height result; it is estimated (Gopalan, 1989) that 47 percent of 15 year olds in India have body weights less than 38 kg and 39 percent have heights less than 145 cm., recognized as obstetric risk factors. Another consequence is high levels of anaemia (Chatterjee, 1989): between 40 percent and 50 percent of urban women and between 50 percent and 70 percent of rural women are estimated to suffer from anaemia (UNICEF, 1991; Kapil, 1990; Mathai, 1989).

While nutrition and iron supplementation programmes for pregnant and lactating women do exist, the little available evidence suggests that they neither reach their intended populations, nor have been successful in reducing the prevalence of anaemia among those they do reach (Ministry of Welfare, Department of Women and Child Development, 1991; UNICEF, 1991

At the family level too, girls are highly vulnerable: son preference is pervasive, resulting in gender disparities in health care, food intake,

school attendance and labour contribution of children in childhood, from an early age. The sluggish pace of increase in age at marriage is an important factor underlying both the slow fertility decline and the poor reproductive health situation in the country. Efforts to raise age at marriage have to take a holistic perspective on adolescent girls - their education, enhancement of work oriented skills, as well as measures to delay their marriages and enhance their autonomy and sense of self-worth within their families.

In the 1990s, for the first time, one government programme, the Integrated Child Development Scheme (ICDS), extended its activities, although on a limited scale, to include adolescent girls. The ICDS programme originally intended to provide nutritional supplementation and health and nutrition education for pregnant and lactating women and nutritional supplementation and early childhood education for their pre-school aged children. It has recently expanded its services to incorporate programmes for out-of-school adolescent girls age 11-18. This programme operates through Girls' Clubs (Balika Mandals) and its activities are limited to the provision of nutritional supplementation and health check-ups, along with some health education.

A comprehensive focus on adolescent girls - to improve their nutritional levels, access to health services and increase their ages at marriage - would thus address an important reproductive health need at an early stage in life cycle. Given the particularly constrained situation of out-of-school adolescent girls, such a focus would cater directly to the service and information needs of adolescents and their parents as well as indirectly through measures to enhance literacy, health and reproductive health education and vocational skill development.

Heath, Sexuality and Gender Information, Education and Counseling :

Most government programmes have generally ignored the fact that reproduction takes place through sexual relations, which are conditioned by broader gender relations. A review of conventional demographic and family planning literature illustrates that the population field has neglected issue related to sexuality, gender roles and relationships and has focused largely on outcomes, such as contraceptives safety and effectiveness, unwanted pregnancy, and more recently on infection. Clearly, social constructions of sexuality and gender relations impact on

reproductive health. But because they are generally considered to be politically sensitive, these issues have been neglected.

A proposed approach is to place sexuality and gender relations at the centre of productive health programmes; to empower women to ensure that their health needs are addressed; and to encourage male participation by ensuring that men take responsibility for family planning, family support, and childrearing (Germainet al. 1994). Given that the gender inequalities favour men in most societies in India, it is important to ensure men's involvement in these programmes. To date, most reproductive health programmes have focused on women. Family planning programmes have targeted women to achieve fertility reduction goals.

Maternal and child health programmes have also focused efforts on reaching women. Men have tended to be ex-, eluded and side-lined by these service programmes. In their efforts to improve women's status and empower women, NGOs have also focused exclusively on women. In fact, several women's NGOs have explicitly excluded men from their programmes. While there was a rationale for adopting this approach in the past, there are good reasons to make some changes now. Education and counselling for women and men should form an integral component of all the interventions that are included in the recommended package of reproductive health services. A special effort should be made to strengthen these interventions as they have suffered neglect at the level of implementation in the Health and Family Welfare Programme.

Gender Sensitization of the Health Bureaucracy :

The health care system in India is a bureaucratized, top-down, male dominated hierarchy. To date, women's voices have largely been missing from health policy debate. There is a growing concern among women health advocates that women's views and perspectives must be incorporated in policies and programmes that are designed for them. In order to effectively integrate sexuality information and counselling with reproductive health programmes in a 'gender-sensitive' way, not only is it important to make this an explicit job responsibility of all service providers at the various levels of the health care system, but it is also necessary to sensitize all health planners and service providers to gender issues. Clearly, a long-term process of gender sensitization and training will be needed to effect social change within the present rigid bureaucratic system.

For Effective Implementation of Reproductive Services Women's health seeking behavior while poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision making or movement is also an important constraint on women's health seeking. Women are, by and large, taught self-denial and modesty from an early age and are hence unlikely to acknowledge a health problem, and particularly a gynaecological problem, unless it is very advanced (SEWA-Rural, 1994). For example, large numbers of women experience white discharge but consider it as part of their lives and rarely seek medical care for such a problem. Lack of decision making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognised. Moreover, pelvic examinations are strongly resisted by women. And even if a problem has been diagnosed, treatment is frequently not followed through because it is seen as an unnecessary expense or too demanding.

Often, in addition, the focus on allopathic medicine has tended to alienate women, generally more exposed to traditional medicines; more needs to be known about these traditional treatments, their health benefits and the way they are perceived by women. There is, unfortunately, little rigorous research on women's constraints to health seeking in the area of reproductive health. Moreover, service delivery strategies remain oblivious to the real constraints women face in acquiring good health care Women's organisations and safe motherhood.

The participation of women themselves, as well as families and communities, is essential for the success of safe motherhood initiatives. Women's groups and NGOs can lobby for changes to improve the provision for women's health, as well as for women's rights and legal changes to improve women's status. Community-based research can be carried out by groups and NGOs in order to determine women's own perceptions of problems relating to safe motherhood. Women's groups can also play an important role in educating women about how their bodies work and reproductive health issues, as well as providing information to the community about what services are available and where. Another aspect of this education and communication work may be raising the awareness of men and the rest of the community of maternal death risks. (WHO, 1993)

To translate the reproductive health concept into policies and programmes, two important issues must be addressed: First, a paradigm shift is essential. A change in focus from a top-down, target-driven population control approach to a gender sensitive, client-based approach to address reproductive health needs is necessary. Second, reproductive health programmes must be designed to enhance access and improve the quality of services, particularly from the perspective of the user. There is a need to specially focus on women since they constitute the major client group or users of these programmes and also have the greatest problem of access, both physical and social to health services. On the other hand, it is equally important to promote male responsibility and enhance the involvement of men. As there is tremendous diversity in India among the various regions and states and even within states as well as between urban and rural areas, no single package of services can be recommended.. The Government, NGOs and the private sector must work in partnership to promote reproductive health policies and programmes. Strong advocacy efforts are needed to involve and empower a range of different constituencies, including activists, feminists, NGOs and researchers, to catalyse a process of net-working with a growing number of organizations so that the reproductive health ideology and the ethos is effectively internalized and programmes responsive to clients' needs are designed with the active involvement and participation of all.

Summary : Reproductive Health is a cornerstone of family life and family health. As such it is also an essential ingredient of social cohesion and hence national security. Unsafe abortions contribute to 13 % of maternal deaths, around 68000 per year. Gender based violence is a significant health problem that is prevalent worldwide. one of the important reason of this problem is lack of awareness among the women and the mothers regarding the reproductive health. Initiative should be taken to promote the education of the girl child and awareness and training programmes should be conducted for the females to promote a healthy lifestyle.involving men in this entire process is crucial to prevent gender inequality.

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