Chapter 1

Introduction
Women have been around since ‘Eve’. But there was little recognition, documentation or even concern about the roles women play in social and economic development, nor of the relationship between these roles and women’s health and status until the International Women’s year Conference in 1975 at Mexico city which launched the Women’s Decade 1975-1985. Many studies were then instituted all over the world, including India, which revealed gross discrimination against women in all spheres of their lives. It is less than two decades, in the long span of history, that women and their status have evolved interest (Pati, 2003).

Then came 1978 and Alma Ata, where the nations of the world committed themselves to achieving the attainment by all citizens by the year 2000, of a level of health that will permit them to lead a socially and economically productive life—“Health For All”—the emphasis being on all. This goal is impossible to reach without giving priority to women’s health’s needs, not only because women form half of the population, but also because their health and well-being is the key to the health of their families and the health of today’s and future generations.

1.1 Status of Women

Many factors influence woman’s health. The genetic constitution, exposure to disease producing organisms, imbalanced or inadequate nutrition, and low resistance to infection all determine health. In addition, social, cultural, economic, political and environmental factors, as well as the availability of health services, greatly influence the health of individuals. Attitudes to marriage, age of marriage, value attached to fertility, and sex of the child, the pattern of family organization and the ideal role demanded of women by social conventions- are all cultural norms that affect the woman’s health.
The reproductive role of women all through the processes of gestation, birth, breast-feeding and child-bearing places additional demands on her. Though many diseases place a heavy burden of morbidity and mortality on both men and women in developing countries, women are more seriously affected due to the synergistic interaction and effects of infection, malnutrition and uncontrolled fertility. Maternal mortality accounts for the largest or near largest proportion of deaths among women in developing countries and it is estimated that where the problem is most acute, the maternal mortality rate is as much as 200 times higher than the lowest rates on industrialized countries (Pati, 2003).

Violence affects the lives of millions of women worldwide, in all socio-economic and educational classes. It cuts across cultural and religious barriers, impeding the right of women to participate fully in society. Violence against women takes a dismaying variety of forms, from domestic abuse and rape, to child marriages and ‘female foeticide’. In 1993 the United National General Assembly adopted a declaration, which for the first time gave an official United Nations (UN) definition of gender-based abuse. According to Article 1 of declaration, violence against women includes (Information Booklet, 2003).

Violence includes “any act of gender-based violence that results in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life” (Summary Report, 2000).

In India, women fall victim to traditional practices that violate their human rights. The persistence of the problem has much to do with the fact that most of these physically and psychologically harmful customs are deeply rooted in the tradition and culture of the society. Women have a low status and are considered as inferior and there is a strong belief that men are superior to them and even own them (UNICEF, 2002).
The National Commission for Women (NCW) set up as a statutory body under the National Commission for Women Act of 1990, was the culmination of the relentless struggle of the women’s movement to ensure that an apex body was created to advise the Government on policy decisions and legal safeguards concerning women. The Commission was given a very large mandate and has taken great strides in championing the cause of the women and striven relentlessly to address the various problems faced by the largest minority of India’s citizens in the social, economic and political fields (Information Booklet, 2003).

International Conference on Population and Development (ICPD) which was held in Cairo, Egypt from 5th to 13th September 1994 has earned a place in history as one of the most significant global conferences ever. It drastically transformed the views and perceptions of thousand of policy makers and programme managers as how population policies and programme should be formulated and implemented in future. At the same time, the unparallel exposure it received through newspapers, radios, television and internet helping to bring issues relating to reproductive health, reproductive rights and women's empowerment to attention of millions of women and men around the world, and may indeed have enhanced their understanding and apprehension of those 3 issues in a positive manner (Singh, 1998).

The concept of reproductive health was adopted at the ICPD for the first time in a UN setting. The acceptance by the international community of this concept linking family planning with the treatment and provision of sexually transmitted diseases (STDs), the reduction of maternal mortality and the promotion of maternal health, and sexual and reproductive health both men and women, must be seen as one of the landmark achievement of the ICPD.

Well before the Cairo conference—at least a decade earlier—several NGOs, researches, women’s group, and donors in India, had sought to change programme direction by moving away from demographic targets and
numbers and focussing on how to address the needs of clients, especially women.

The hallmark of India’s new National population policy is its emphasis on improving the quality of reproductive health care by working more closely with community based organization and women’s group.

1.2 Definitions of Reproductive Health

Bucharest conference outlines that “all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so; the responsibility of couples and individuals in the exercise of this right takes into account the need of their living and future children, and the responsibilities towards the community (UN, 1975).”

World Health Organisation (WHO) has used, for years, what it calls a ‘working definition’ of reproductive health. Mahmood Fathalla, who served as the director of the WHO Programme on Human Reproductive (HRP) from 1986 until 1992, wrote and lectured extensively on the linkages between safe motherhood, maternal and child health (MCH) services and family planning programmes (FPP), and on the evolving concept of reproductive health, arguing that it offers a more comprehensive approach to current health needs in human reproduction (Fathalla, 1989, 1991).

During the third session of the ICPD Prep Com III in 1994, WHO was asked by several delegations to explain what the term ‘reproductive health’ meant. This was the definition provided:

WHO defined reproductive health in ICPD, “as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Reproductive health addresses the reproductive process, functions and system at all stages of life. Reproductive health implies that people able to have a responsible, satisfying and safe sex life, and that they have the capability to reproduce and decide, if when and how often to do so. Implicit
in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy family” (ICPD, 1994).

WHO went on to say that ‘the content of this definition of reproductive health [is] derived from nearly 30 years of policy established by WHO which enables the organization to respond to the needs of, and demands for support by, Member States’. Implicit in this statement was the acknowledgement that this working definition was never brought to the attention of WHO’s principal organ – the World Health Assembly- which meets once a year with the attendance of health ministers and senior health officials to define and update WHO’s policies and strategies. One of the reasons given at the time by several former WHO officials was that a debate on the definition would have brought up such potentially divisive issues as reproductive rights, adolescent health and prenatal responsibilities, and abortion (Singh, 1998).

**Protecting Reproductive rights**

During the 1990s, a series of important United Nations conferences emphasized that the well being of individuals and respect for human rights should be central to all development strategies. Particular emphasis was given to reproductive Rights as a cornerstone of development, and to the empowerment of women as being as important element in ensuring the exercise of these rights.

All major human rights treaties and consensus statements obligate countries to protect and promote rights that relate to Reproductive Health. Of all human rights documents, the Convention on Elimination of all Forms of Discrimination Against Women (CEDAW), provide the strongest legal
support for the right to reproductive health per se. In Article 12, CEDAW guarantees non-discrimination in access to health care, including affordable services and information relating to family planning, and the post-natal period.

**Reproductive Rights Provision in CEDAW**

Articles 10 (a) and 10 (h) require state parties to take all necessary steps to eliminate discriminations against women in education, and to provide women equal access to educational materials and advice on family planning.

Article 11 (2) requires state parties to undertake appropriate measures to prohibit dismissal of women workers on the grounds of pregnancy, to introduce maternity leave, to promote the development of a network of childcare and to provide pregnant women with special protection from work that may be harmful.

Article 12 requires state parties to undertake appropriate services where necessary during ante and post-natal stages of pregnancy.

Article 12 (1) requires state parties to eliminate discrimination against women in the area of health care and to ensure that men and women have equal access to health services, including family planning services.

Article 16 requires state parties to eliminate discrimination against women in all matters with regard to marriage and family relations.

Although non-binding, the international conference on Population and Development, Programme of Action and the 1995 World Conference of Women (Beijing) platform for action are highly persuasive consensus statement that confirms the centrality of reproductive rights in advancing the health of populations and the status of women. Beijing document in particular recognizes women’s right to control their own sexuality and sexual relations and to decide upon these matters on an equal basis with men.
Similarly the IPPF (International Planned Parental Federation) Charter and Reproductive Rights (content.ippf.org) is based on twelve rights that are grounded in core international human rights instruments and additional rights that IPPF believes are implied by them. The standards section draws heavily on documents that won international consensus at four key UN conferences, which took place between 1993 and 1995, namely the UN world Conference on Human Rights (Veinna, 1993); the UN International Conference on Population and Development (Cairo, 1994); the UN World Summit for Social Development (Copenhagen, 1995); and the UN Fourth World Conference on Women (Beijing, 1995). The charter represents IPPF’s response to the challenge of interpreting human rights language and applying it to sexual and reproductive health care issues.

1.3 Aspects of Women’s Health

1.3.1 Fertility and women’s health

Many of the health problems of Indian women are related to or exacerbated by high levels of fertility. Overall fertility has been declining in India; the total fertility rate was 3.4 in 1992-93 (NFHS-1 National Family Health Survey); 2.9 in 1998-99 (NFHS-2); and 2.7 in 2005-06 (NFHS-3). However there are large differences by state, education, religion, caste, and place of residence. Uttar Pradesh the most populous state in India has a total fertility rate of over 3.8 children per woman.

High rate of infant mortality combined with the strong son preferences motivated women to bear high number of children in an attempt to have one or two sons to survive to adulthood. Numerous pregnancies and closely spaced births erode a mother’s nutrition status, which can negatively affect the pregnancy outcome (Jejeebhoy and Rao, 1995). Unwanted pregnancies terminated by unsafe abortions also have negative consequences on women’s health. Therefore, reducing fertility is an important element in improving the overall health of Indian women.
Increasing the use of contraceptives is one way to reduce fertility. NFHS data shows trends in contraceptive use in percentage (currently married women 15-49 Years of age). According to NFHS-1 it was 41%; NFHS-2, 48%; and NFHS-3, 56%. Though differences have been marked between Urban and rural but the gap is not very wide. In urban areas contraceptive use was 51% in NFHS-1; 58% in NFHS-2, and 64 in NFHS-3, while in rural areas 37% was in NFHS-1; 45% in NFHS-2; and 53% was in NFHS-3.

Place of residence, education and religion are strongly related to both fertility and contraceptive use. More than half of married women with a high school education or above use contraceptives, compared to only one third of illiterate women. Differentials among the religious groups are also noticed e.g., Muslims have the highest total fertility rate and the lowest contraceptive use (IIPS, 1995). Despite a large increase in the number of women using contraceptives, (41% in NFHS-1; 48% in NFHS-2; and 56% in NFHS-3) and limiting their fertility, there is still unmet need for contraceptive use in India. What is most needed among younger women is for spacing births rather than limiting them. This implies that methods of limiting pregnancies other than female sterilization (the method strongly promoted by India’s family planning programme), need to be considered and promoted. (US Census Bureau, 1998).

Maternal mortality and morbidity are two main health concerns that are related to high level of fertility. In India, maternal mortality rate is very high. Complications of pregnancy and childbirth are the leading cause of death and disability for childbearing women in India. Comprehensive, high-quality maternity care can help prevent infant and maternal death and disability. No matter where they live, women should have access to the information and care that keeps them healthy and safe (Engender Health).
1.3.2 Prenatal care and women’s health

National family health surveys found that in spite of a lot of improvement, still a large percentage of Indian women received no prenatal care during their pregnancies. Most women who did not receive health care during pregnancy, thought prenatal care as a wastage of time and just a show-off. Thus, there is a definite need to educate women about the importance of health care for ensuring healthy pregnancies and safe childbirths. Another reason for the low levels of prenatal care is lack of adequate health care centres (Bhalla, 1995).

1.3.3 Antenatal care and women’s health

National family health surveys show increase in antenatal care, but the target is not achieved according to NFHS-1, 65%; NFHS-2, 66%; and NFHS-3, 77%; women were getting any type of antenatal care. In access to antenatal care rural urban gap is also very wide. In urban areas (84% in NFHS-1; 86% in NFHS-2; and 91% in NFHS-3) on the contrary in rural areas (59% in NFHS-1; 60% in NFHS-2; and 72% in NFHS-3) women were having access to any type of antenatal care.

Figures of NFHS-3 (2005-06) reveals that mothers who had at least three antenatal care visits for their last births were as a whole 50.7%, in which 73.8% were urban and only 42.8% were rural. It is also clearly indicated in the findings of NFHS that there is a direct relation between education of mother and in access to antenatal care. National Family Health Survey-3 statistics show that mothers who have complete ten years of education are 85.3%; mothers with 8-9 years of education 67.3%; mothers with less than 8 years of education 59% and with no education 29.8% receiving antenatal care.

Most women who do not receive health care during and after pregnancy thought that it was unnecessary. Thus there is definite need to educate
women about the importance of health care for ensuring better reproductive life of women.

1.3.4 Social structure and women’s health

Social scientists are increasingly recognizing that reproductive behaviour is strongly related to gender inequality, especially the way inequality is rooted in a society’s kinship structure and cultural context (Ravichandran and Rajashree, 2005).

Dyson and Moore (1983) studied the organization of the patterns of gender equality along the cultural and demographic divide running from India’s south-east to north-west, the kinship pattern favouring greater female autonomy and use of contraceptive in the south, and lower female autonomy and higher fertility in the north.

Sopher (1980) and Miller (1981) stated that the variation is most pronounced with regard to kinship structure as it relates women’s status and can be delineated along geographic lines; areas in the north are culturally less favourable to female autonomy than areas in south and east.

1.4 Proximate Determinants of Reproductive Health

1.4.1 Religion and fertility

In many developing countries, particularly in India, religious and other cultural diversities have contributed to definite fertility differences. There is also definite evidence of religious differences in fertility since the beginning of this century as well. The Hindu tradition for example demands that every family should have a son. The traditional Hindu blessing to an Indian bride is “be the mother of eight sons” (Reddy, 1996). In Hindu society, depending upon the pattern of their internal variations in culture, preference of son or daughter varies. Nevertheless, Hindu doctrines do not suggest open resistance to the scientific methods of family planning. Hindu customs like universal marriage, early age at marriage, strong desire for sons to continue
the family line and to perform rituals for the salvation of the departed souls have a strong pro-nationalist orientation. The traditional Hindu way of life, however, facilitate reduction in the duration of effective period of married life through culturally prescribed sexual abstinence during early and later parts of marital life and also on different in-auspicious occasions during reproductive period (Mahadevan, 1979).

Although among Muslims there is no organized opposition to any fertility regulating methods, the fertility rate of Muslims in many countries is higher compared to the Hindus and Christians in India. Kirk (1968) points out that it would seem that Muslim institutions, more than those of other world religions favour generally a high natality.

The Mysore population study (U.N 1961) indicated that religion is associated with fertility, married Muslim women have born on an average a larger number of children than Hindu women. The average for Christians is less than the Hindus. Driver (1963) found in central India that the average number of children born to Hindu and Muslim wives (standardised for age) was 4.5 and 4.6 respectively. In the erstwhile Travancore-Cochin state, the average number of children born to wives who had completed their fertility, was 6.4 for Hindus and 7 for Muslims (Kurup and George, 1965). In the Lucknow area Mukerjee and Singh (1961) found that the number of pregnancies per wife is 3.9 for Muslims and 3.4 for Hindus and that the proportion of pregnancies resulting in live births is higher among Muslims than among Hindus. In Bombay, Brady (1967) found that the Muslim wives have a significant higher average parity than the Hindu wives.

The effect of caste on fertility has been noted by a number of researchers. In a survey conducted in the rural areas of Banaras revealed that the upper caste Hindus had lowest fertility and lower caste Hindus had higher fertility. Saxena found that both the cumulative fertility and age specific fertility were higher for the low castes, lowest for the upper castes and intermediate for the intermediate castes. Study found that in the rural Punjab, the predominantly
agricultural jats have lower fertility compared to the lower proportion of chamars having higher fertility. Driver also observed that the forward castes are having lower standardized average children compared to the backward castes having higher average children and the scheduled castes and tribes having still higher average children.

However in Etawah district of Uttar Pradesh, rural women of high castes and agriculturists preferred larger families (4 to 7 children) for security in old age whereas those of middle and low caste non-agriculturists and labourers preferred smaller families (less than 4 children) because of economic burden in arranging marriage of their daughters, strife, adverse effects on health, etc.

The number of studies conducted in various parts of India has shown significant caste differentials in attitudes towards family planning, knowledge of contraception and practice of family planning methods. It is inferred that caste does exert an influence in the acceptance of contraception. So the segmental division of society basing on religion, race, caste, class, region, language and colour is influencing the fertility and family planning differentials particular in the rural areas. The following extracts also gives a brief idea on the role of castes in the Indian society and its influence on the fertility and family planning variations with special reference to the rural communities in south India.

1.4.2 Economic condition and fertility

Children can be regarded as special commodity, in the economic parlance, a feasible relationship between income and fertility is not difficult to visualize.

A rise in income is likely to be associated with higher fertility. The relationship behind this positive income-fertility relationship is that, holding everything else constant, higher income implies greater resources available to support a large family, and if children are assumed to be consumer durables with positive income elasticity, higher income will lead to the consumption of more children (Becker, 1960). Early research on this
suggested such a possibility (Glass, 1968; Stys 1957; Driver, 1963; UN, 1961).

But the value or utility of children has not been invariant over time and space. With a rise in income, a greater concern for the quality of children rather than their quantity may become the dominant concern. And quality children usually require greater investment than return, a rise in income might lead to reduction in fertility. In fact, a majority of the later studies tend to support this negative association (Easterlin, 1975; Bulatao and Lee, 1983; Registrar general, 1979). However, in some cases, this negative relationship is interrupted at the top end of the economic scale, that is, couples with very high incomes have a larger fertility than those with high incomes (Bernhardt, 1972). Undoubtedly, how children are valued in a society will be a dominant determinant of the fertility of the desire of the couples. The form of the utility function, as indicated by Becker who propounded the positive relationship, is determined by tastes which in turn depend on social characteristics like education, religion, ethnicity etc, (Becker, 1960). Thus the economic ends are largely determined by the socio-cultural ends of a society.

1.4.3 Marriage

The age of marriage (or entry into sexual union) and the proportion of women remaining single determine the number of women exposed to the risk of pregnancy and the duration of time for which they would be exposed to the risk of pregnancy. In India, marriage continues to be both early and nearly universal, but there are significant interstate variations in the mean age at marriage. Therefore, marriage is a very strong determinant of reproductive health of women in a country like India, where mostly sexual life starts after marriage.

For most women in India, sexual activity starts in adolescence and within marriage (UNICEF, 1990; IIPS, 1995). Early marriage was perpetuated in the
past by tradition, beliefs about preservation of a girl’s chastity, family honour and the need to reduce expenditure.

Present laws prohibited early marriage: the legal minimum age of marriage for girls is 18 and 21 for boys. Regardless, many girls continue to be married off at an early age and are expected to prove their fertility well before they attain full biological and emotional maturity.

Data from the 1992-93 National Family Health Survey, provides some insight into marriage patterns and fertility behaviour of adolescent girls in India. There is some evidence of a modest increase in the average age for marriage; the singular mean age at marriage for females has gone up by 4.1 years, from 15.9 years in 1961 to 20 years in 1992-93. In all, as many as 6 percent of 10-14 years olds are currently married. Further, 58 percent of ever married adolescent girls between the ages of 13 and 19 years have begun childbearing. This corresponds to 17 percent of all females aged 13-19 years.

1.4.4 The role of infant and child mortality

Fertility decline observed during the last 20 years has been accompanied by substantial decline in infant mortality. The overall IMR (Infant Mortality Rate) in India, according to SRS estimates, has declined from 132 to 80 deaths per 1,000 births between 1970-72 and 1990-92, while Total Fertility Rate (TFR) declined from 5.7 to 3.7 births per woman. The overall relationship between state-level IMR and TFR is reflected by the correlation coefficient of 0.619 between the two, which suggests that states with high infant mortality also have high fertility.

The implication of high infant and child mortality for fertility behaviour by a gap between the average number of surviving children and the average number of live births per woman. For example, the average number of children born and surviving among women aged to years, according to the NFHS, were births and children, respectively. The difference between them
in Uttar Pradesh with high infant mortality, however, was much higher than that in Kerala with low infant mortality versus births. The number of births a woman has is included in the numerator for estimating indices of fertility such as TFR and Crude Birth Rate (CBR). However, when a woman says that she wants a certain number of children she refers to surviving children and not to live births. This means that a reduction in infant and child mortality would reduce the number of surviving children, which in turn would reduce TFR without reducing the desired family size.

This connection between IMR and TFR reflects both the biological and behavioural effects of high infant mortality on fertility. For example, the duration of breast feeding for a child who dies in infancy is considerably shorter than for the child who survives for a longer period. Thus, the birth interval in the absence of contraceptive use following an infant death is usually shorter than that following the child who survives for more than one year. Moreover, a desire to replace a lost child in the subsequent birth interval may be implemented by adjusting the timing and frequency of coitus.

The relationship between IMR and TFR also reflects the fact that high fertility in a community means a higher proportion of high parity births and the fact that IMR is also high among births of high parity. Hence, a reduction in TFR achieved through a reduction of high parity births would also reduce infant mortality. However, direct interventions to reduce infant mortality at all parities, and especially at the first parity, are most likely to reduce TFR. Such policies need special attention in Assam, Bihar, Madhya Pradesh, Orissa and Uttar Pradesh where the level of IMR is estimated to be as high as 85 deaths or more per 1,000 births.

1.4.5 The role of female education

Female education in many societies have been found to be associated with a desire in decrease in indicators of fertility and mortality. India is no
exception. The assumption about the fertility reduction effect of education is based on the observation that advancement in female education leads: (i) a decrease in demand (ideal or desired) for children; (ii) an increase in age at marriage; (iii) an increase in the use of contraception; and (iv) a decrease in the incidence and duration of breast feeding and postpartum abstinence.

Improvement in girl education will reduce fertility as they move through their reproductive period. There are two reasons for not expecting a feedback loop of children’s education for parental fertility. The first reason is based on demographic realities and the second on the belief that parents in high fertility societies tend to maximize their own welfare rather than their children’s.

In high fertility societies, by the time the eldest child is likely to complete primary education; the mother would be about 30 years of age and, on an average, would have completed about 70 percent of her marital fertility. If the effect of child’s education on parent’s fertility is postponed until she/he completes secondary school, the mother will be close to completing her childbearing process.

If benefits to parents from their children’s education are higher than the corresponding costs, they are unlikely to reduce their fertility because more children would mean higher benefits. On the other hand, if benefits from their children’s education are lower than the corresponding costs, the outcome is likely to be no education for children and low fertility for parents. In brief, children’s education is unlikely to have a negative feedback effect on parent’s fertility unless parents are assumed to maximize the welfare of their children at an early stage of childbearing. But if that were the case, parents would already have small families (Jain, 1982).

1.5 Use of Contraception

Contraceptive use is one of the major determinants of fertility in modern times. India has officially accepted a nationwide family planning programme
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since 1952, but the use of contraceptives did not spread widely. The
programme has since 1960s, been collecting statistics on the distribution and
acceptance of four methods provided by the programme (condoms, IUD,
oral pill, sterilisation ) and has been converting them into couple protection
rates (CPR) on a yearly basis for all the major states of India (Visaria,
1999).

1.5.1 Duration of breastfeeding and length of postpartum amenorrhoea

It is reasonably well established that breastfeeding is the principal
determinants of postpartum amenorrhoea and with the increase in the
duration of breastfeeding, the duration of amenorrhoea rises. In a survey of
four districts undertaken in Gujarat in 1989, the estimated mean duration of
breastfeeding ranged between 21 and 26 months (Visaria et al, 1995). It is
often said that compared to rural women, Urban women tended to breastfeed
their children for a shorter period.

1.6 Strategies to Improve Reproductive Care and Health (RCH)
Services

The goals of the population policy in India are ambitious and can not be met
by the efforts of the government alone. A multi pronged approach is needed
in partnership with different stakeholders. Opinion leaders, non-government
organizations, cooperatives, private health sector, and other agencies have to
play a major role in achieving the policy objectives.

1.6.1 Strategies for Community Involvement

1.6.1.1 Age at marriage

Though a lot of decreased have been marked in legal age at marriage since
last 10 years. But still a very high (more than 50%) girls in India marry
before reaching the legal age of marriage. Low age at marriage not only
contributes to the high fertility rate but also to the risks associated with early
childbearing. Childbearing at a young age also contributes significantly to
the infant mortality rate. An increase in the age at marriage is possible only when there is a major change in social values and attitudes towards the girl child. And to bring about these changes, the understated points are proposed.

- Services of advocacy groups such as religious leaders and women's groups will be used to bring about changes in the values and attitudes of people, particularly in rural areas.

- Electronic media will be used to disseminate information on the legal age at marriage and also on the adverse consequences of early marriage on the health of adolescent girls.

- Those marrying before the legal age will not be eligible for any job in government marriage organizations.

- Registration of marriage will be made compulsory and panchayats and urban local bodies will be entrusted with the responsibility for registering marriages.

1.6.1.2 Adolescent education and family life education

Family life education (FLE) will be provided to adolescent boys and girls. Family life education will cover planning for one's future and the importance of education, gender roles and responsible parenthood.

- The department of health and family welfare in consultation with the department of education and other stakeholders will develop curricula appropriate to the cultural milieu and introduce a FLE programme in secondary schools and colleges.

- NGOs will be involved in FLE programme implementation for girls not attending schools, particularly in urban and rural areas. Pathfinder international has done a lot of work in this direction in India.

- Parents and community leaders will be involved from the beginning and throughout the implementation of any adolescent FLE initiative to
ensure social support. Orientation programmes will be organized to encourage parents to send their adolescents to the programme.

- Learning material appropriate for adolescent boys and girls on key topics will be generated and made widely available.

1.6.1.3 Empowerment of women

Women bear the entire burden of child bearing and child rearing. Yet, in most cases, they have very little say in decisions about their own childbearing, when to have children, how many children to have, and whether to use contraceptives. If women had the choice, many would prefer to have fewer children than what they actually have. There is a need for reform to eliminate gender inequalities and a multi-pronged approach to empower women.

The Government of India has already initiated a series of measures in this direction. In several development programmes such as the Integral Rural Development Programme (IRDP), Training Rural Youth for Self-Employment (TRYSE), Jawahar Rozgar Yojna (JRY), Jawahar Gram Samridhi Yojana (JGSY) and several other schemes. It has been made compulsory to have 30 to 40 percent women as beneficiaries.

- 33 percent of all new jobs in the government sector or in organizations owned and controlled by the government will be reserved for women.

- 33 percent of all commercial establishments such as ration shops, which require government licenses will be reserved for women.

- Education, particularly girl’s education, is important to empower women. Special awareness campaigns on the importance of female education.

- Milk cooperatives run by women, currently in operation in 12 districts, will be extended to all districts, and exclusive women cooperatives will
be formed to encourage participation of women in different economic activities.

- The strong bias of the society against girls is manifest in the preference for sons, and the extreme form of bias is reflected in the rising tendency of couples to opt for termination of pregnancies if the foetus is known to be female. A law has already been enacted to prevent such heinous practices, and all provisions of this law will be rigorously and strictly enforced.

- All forms of gender bias in the provision of services to women will be eliminated by sensitizing personnel in different departments, particularly in the health and family welfare department.

1.6.1.4 Role of panchayats in programme implementation

Panchayats have a constitutional responsibility for health, family welfare and education activities. Last year, the state government took active steps to devolve financial and administrative powers to the panchayats. The state government recognizes the overarching role that the panchayats can play in the implementation of the family welfare programme by converging services from a host of developments and by using their influence to advocate the small family norm and create demand for services by mobilizing the community. However, panchayats need to be further strengthened and empowered to fulfil their role with respect to programme implementation, supervision and monitoring.

- Panchayat meetings at all levels will begin with the review of reproductive and child health programme performance.

- Health and welfare committees of the panchayats would identify area specific unmet needs for reproductive health services and develop village level plans to provide these services.

- Of the total financial resources allocated to Panchayati Raj institutions, 10 percent will be earmarked for the performance in the areas of reproductive and child health services and female education.
• Every year each district, block, and gram panchayat would be appraised for its contribution to meeting reproductive, child health and family planning needs and for recording marriages, births and deaths.

1.6.2 Strategies to Involve Private Sector

1.6.2.1 Non-government organizations (NGOs)

The government of India will encourage non-government organizations to implement innovative reproductive health programmes. Ability to mobilize and involve communities in development programmes is the major strength of non-government organizations. India has several hundred non-government organizations. By providing financial and material resources and capacity-building opportunities to NGOs, community-based counseling and service delivery can be expanded rapidly to underserved rural areas and urban slums. The Society for Innovations in Family Planning Services (SIFPSA) has supported several innovative NGO projects in the past five years and many of these NGOs have made impressive contributions to the RCH programme.

**Pathfinder international**

Pathfinder international has been working in India since 1999. Current programs are located in urban slums and rural areas of five states across India, including Delhi, Bihar, Rajasthan, Maharashtra, and Karnataka (Pathfinder, 2006).

• In a culture with long-standing traditions of early marriage and childbearing, Pathfinder works to promote knowledge and understanding of the dangers of adolescent childbirth, the personal health benefits of delaying the first birth until a woman reaches age 21, and spacing subsequent children by at least 3 years.

Pathfinder international integrates HIV/AIDS and sexually-transmitted infection (STI) prevention, care, and support with its reproductive health programs in India.
Pathfinder worked to improve access to safe abortion services, primary care practitioners were trained in the use of manual vacuum aspiration and medical methods for first trimester abortions. Community-based communication activities for women increased their awareness of issues related to safe abortion and enabled them to seek services early on from qualified providers with quality counseling on family planning methods (Pathfinder, 2006).

**Engender Health**

Engender Health’s approach to maternal health is holistic, addressing women’s sexual and reproductive health needs throughout their lives, including adolescence. Ensuring the availability of quality services helps pave the path for appropriate, specialized care during pregnancy, labour and delivery. Still, for many women, pregnancy marks their first contact with a health care system, which provides an unmatched opportunity to not only help make pregnancy and delivery safe for both mother and child, but also to address broader aspects of women’s health including family planning, and HIV and other sexually transmitted infections.

Engender Health has worked in India since 1998. **Reproductive Health and Family Planning Programme**, part of the innovations in family planning services (IFPS) programme, focused on Uttar Pradesh and Uttarakhand. Engender Health’s programs ensure that health facilities are equipped with supplies and well-trained staff to provide high-quality services support.

Engender Health manages the following major projects worldwide:

**The Acquire Project** (access, quality, and use in Reproductive Health) works globally to advance and support the availability, quality, and use of facility-based reproductive health and family planning services at every level of the health care system and to strengthen links between facilities and communities.
QHP (Quality health partners) works to ensure high-quality reproductive and child health services in Ghana. AWARE_RH in China, R3M in Ghana, APHIA Nyanza in western Kenya (Engender Health, 2007).

1.6.2.2 Cooperatives

The government of India has many cooperative societies. Among these societies UP has 20,311 primary cooperatives with 22.48 million members spread over sectors as diverse as agriculture, credit, handloom, dairy and sugarcane. Being economic platforms, with organizational strengths in rural areas and good understanding of rural markets, these cooperatives offer an opportunity for involving large networks of volunteers in the promotion of family planning and RCH services

- Milk cooperatives will be used for service delivery using the model developed by SIFPSA.
- Primarily agriculture credit societies will be used as depots for both free and subsidised brands of contraceptives and as points for promoting RCH services.

1.6.2.3 Organized sector

As part of SIFPSA facilitated initiatives, individual industrial units and organized chambers of commerce have started providing RCH services to employees and their families and the community around them. These efforts by the corporate sector will be further expanded and strengthened.

Large industrial units in both the private and public sectors will be involved in the delivery of RCH services. These industrial units have management strengths and excellent captive hospital facilities that could be used to provide clinical services to the rural and urban communities.

1.6.2.4 Indigenous system of medical practitioners

India has many registered indigenous system of medical (ISM) practitioners belonging to the ayurvedic, unani, and homeopathic schools of medicine.
Chapter 1 Introduction

There are perhaps an equal number of non-registered medical practitioners. A large proportion of rural population seeks health services from ISM practitioners to provide family planning services is immense.

- ISM practitioners, who are the first point of contact for health care in rural areas, will be trained to provide counseling and services related to family planning through district level training projects.

They would be promoted as trained family planning counselors and used as depots for free and priced oral contraceptives, condoms and other reproductive health products. (Population Policy of Uttar Pradesh, 2000).

1.6.2.5 Private health sector

Given the huge task of providing services to a large number of eligible couples every year to reach replacement-level fertility, the public health sector alone will not be able to cater to the needs of all. Partnership with the private sector is essential. In India, the private health sector is in its early stages of development. Government will initiate steps to expand the private health sector and also to utilize the facilities in existing health institutions.

- Private health institutions, meeting quality standards to provide sterilization and IUCD services, will be identified in each district.

- Private medical practitioners will be trained in providing quality family planning services.

- Wide publicity will be given to recognized institutions, and people will be encouraged to utilize services at these institutions.

For private recognized health institutions and people will be extended in the form of supply of equipment and other resources. (Population Policy of Uttar Pradesh, 2000).

1.6.2.6 Contraceptive marketing

Use of spacing methods in the country is very low. Of the total number of currently married women in reproductive age, very few use spacing
methods. A large proportion of users of spacing methods depend on the private sector for fully priced or subsidized products. Contraceptive marketing has to play a major role in promoting the use of spacing methods, particularly condoms and oral contraceptives (Population Policy of Uttar Pradesh, 2000).

1.6.3 Strategies to Improve Access to and Quality of RCH services

1.6.3.1 Maternal health services

Maternal health services, particularly antenatal care and postnatal care services, require special attention to reduce both maternal and infant mortality. A large proportion of women in both urban and rural areas are anaemic and are not protected against tetanus. The proportion availing of postnatal care services are also very low. Prophylaxis against nutritional deficiency would be able to save many lives.

- ANMs will register all pregnant women in rural areas in the first trimester with the help of periodic surveys.
- Pregnant women would be given at least two doses of tetanus (TT) injections and 100 tablets of iron and folic acid (IFA) twice a year, following the special campaign approach in addition to the regular services at all services delivery points.
- Antenatal check-ups will be conducted to identify pregnant women at risk and the referral system will be strengthened to serve these women.
- Supplementary nutrition will be provided to all pregnant and lactating women and an IEC campaign will be launched to promote healthy food habits.
- Postnatal check-ups will be done by ANMs at both sub centers and also during home visits.
- Infertility clinics will be opened in all district hospitals and services will be provided to couples having infertility problems.
• Maternal health care services will be set up in all villages with more than thousand people, initially by involving community members and mobilizing resources from the community.

Facilities and trained personnel will be made available at the CHC level to treat women with reproductive tract infections (Population Policy of Uttar Pradesh, 2000).

1.6.3.2 Deliveries by trained personnel

Deliveries conducted by trained personnel are extremely low in Uttar Pradesh (UP). Most of the deliveries take place at home and are attended by untrained personnel.

This has led to high infant mortality, particularly neo natal mortality and also maternal mortality. To reduce infant and maternal mortality, added emphasis will be placed on increasing institutional deliveries and the proportion of deliveries attended by trained personnel.

• The proportion of institutional deliveries will be increased substantially by encouraging women to avail of the facilities available at block PHC, CHC, and health institutions above the CHC level.

• In a phased manner, round-the-clock service centers will be opened in all health institutions with facilities to conduct deliveries.

• Panchayats will be provided funds to provide transport and other facilities for emergency delivery.

• Traditional birth attendants will be trained in all villages in conducting safe deliveries, and innovative approaches will be initiated to provide safe delivery kits to trained dais.

Refresher training programmes will be conducted for trained traditional birth attendants on a regular basis (Population Policy of Uttar Pradesh, 2000).
1.6.3.3 Sterilization services

Sterilization services have a major role to play in the reduction of fertility. Demand for sterilization services is very high and has increased over time. Health worker’s visits to villages and their contacts with women to promote informed choice have also declined. There is an urgent need to streamline service delivery systems to provide services to voluntary acceptors of sterilization methods (Population Policy of Uttar Pradesh, 2000).

1.6.4 Strategies to Improve Service Delivery Systems

India has unmet need for contraceptive services. This is primarily gaps in the existing health infrastructure and services and the lack of out-reach to remote areas and under served groups. One of the main challenges for the family welfare programme in UP is to expand coverage of services by increasing their reach and improving their quality. The government will endeavour to identify the strengths of the programme and build on them while at the same time removing weaknesses that impede its acceptance. At the village level, efforts would be made to identify specific unmet needs in the reproductive and child health programme and focus efforts of all departments to provide quality services. The service delivery system would have operational strategies geared to cater to the needs of rural as well as urban expanding areas. These strategies would be reviewed regular intervals to ensure that they are implemented in an efficient manner and are continuously focused to meet client needs (Population Policy of Uttar Pradesh, 2000).

1.7 Chapter Plan

The thesis comprises of six main chapters followed by bibliography and appendices.

First chapter deals with definition of reproductive health, variables, proximate determinants, strategies for the improvement of Reproductive
health, and role of NGOs in improving the health of the women. It also presents the objectives, methodology, and limitations of the present study. It explains the rationale for carrying out the present study. Second chapter highlights historical background, geography and socio-economic conditions of Dibai Town. The third chapter presents the literature review. Relevant findings and excerpts of the literature reviewed are classified and presented with the aim of identifying the research gap. The analysis of the surveyed data, interpretation, and discussion are presented in chapter fourth and fifth. The fourth chapter deals with the impact of society and culture on reproductive health. Chapter five deals with the problems of reproductive health and use of various method of fertility control in Dibai town. The six chapter draws results and conclusions of the study.

The thesis ends with the bibliography followed by the appendices.

Research Methodology

1.7.1 Scope of the study

The scope of the study defined in terms of subject coverage, area coverage and period coverage-

1.7.1.1 subject coverage

In terms of subject coverage, the present study is related to an inquiry into the broad area of society, culture and reproductive health. In doing so the coverage includes issues related to Historical and Geographical aspects of the town in study, Economics and Trade, Education, Religion, Culture and Caste system of the study area. So far as the reproductive health aspects is concerned, the coverage extends to social attitudes towards reproductive health dimensions of fertility, problem of reproductive health and use of contraceptive etc.

1.7.1.2 Area coverage

In order to achieve the objectives of the study, the town of Dibai in district Bulandshahr of Uttar Pradesh was concerned. No such study has ever been
conducted in this area and therefore there need was as to partake a study on the reproductive health, attitude and problem among women of this area.

1.7.2 Research design

The present study is based on the objectives as mentioned in the previous section. In the light of these objectives the technique of investigation to be adopted, tools to be used and pattern of analysis to be followed were to be determined.

In order to achieve the objectives of the study, exploratory research design was used as it provides a wide scope to understand the problem in depth. The present research consisted of structured and unstructured interview (interview schedule was prepared in advanced and some additions were made after few interviews.) The field work was conducted between April 2004-2005. The information gathered through interviews was used to prepare case studies. Some representative cases have been included in chapter four and five. The technique of in-depth qualitative interview was used to solicit detailed information. Each respondent was visited more than once.

**Convenience sample technique** was used to conduct interviews. The target was to conduct more than 150 interviews equally divided between Hindu and Muslim women. It was further divided into upper and lower caste families; having the lowest proportion in the total population of Dibai, therefore only a few cases could be covered.

Interview of women and sometimes their families were conducted in their houses, doctor’s nursing homes and government hospitals. These interviews were recorded with notes taken on site. I also interviewed a range of medical practitioners, including doctors, nurses hospital & local midwives (Dai). In addition to discussing child birth in homes and hospital, I also had the opportunity to observe postpartum rituals and rites such as bathing and dietary practices, in variety of setting.
1.7.3 Design and content of interview schedule

In order to get the necessary primary data, interview schedule was prepared through identifying issues related to research topic (refer to appendix- 1). After a few interviews, some additions were also made in the schedule.

Data analysis technique

The collected primary data have been processed and developed into case studies. The case studies were analyzed, and content analysis was done. On the basis of the information, major themes were categorized and discussed.

1.7.4 Objectives of the study

The general objective of the study is to analyse reproductive health of women in relation to society and culture in Dibai.

The Present research work is split up as per the following specific objectives.

1. To identify the socio-economic conditions of Dibai town affecting the reproductive health of women.

2. To determine the extent to which formal and informal education is helpful in reducing the fertility rate, and to take pre-natal, post-natal and post-abortion care.

3. To see the role and attitude of society and the family members of a woman in high fertility rate.

4. To determine the role of NGOs and government health workers in improving the reproductive health of women.