International Journal of Multidisciplinary Approach and Studies

ISSN NO:: 2348 – 537X

Women's Reproductive Health- Dismal Reality

Women's Health-A Major Area of Concern

***Prof. Pratibha J. Mishra**

** Dean and Head, Dept. of Social Work School of Social Sciences, Guru Ghasidas Vishwavidayalaya, Koni Bilaspur (CG)*

Some Glaring Facts about the Status of Female Reproductive Health.

1. Every minute, a woman somewhere dies in pregnancy or childbirth. This adds up to 1400 women dying each day- an estimated 529,000 each year- from pregnancy-related causes.
2. For each woman who dies, about 20 women survive, but suffer from serious disease, disability or physical damage caused by complications of pregnancy or childbirth.
3. A million or more children are left motherless each year as a result of maternal mortality. These children are 3 to 10 times more likely to die within two years than children who live with both parents.
4. Almost half- about 3.4 million out of 8 million- of infant deaths per year result from poor maternal health and inadequate delivery care.
5. While many other health indicators have improved over the last two decades, maternal mortality rates have shown little improvement.

The above statistics simply leave us dumbfounded, shocked and reveal the inner truths about the state of affairs regarding the attention paid to female reproductive health. Strident discrimination is pervasive for a woman in all walks of life. Gender stereotypes that are prevalent since birth extend into childhood, adulthood, during the pre and post martial phase of a woman's life. Strong favoritism for male children is reflected in the form of biased and rigid attitudes with regard to a girl's education, training, her overall grooming and socialization. Her physical, mental, emotional well being is not given any heed. Daughters typically have little autonomy, living under the control of first their fathers, then husbands and finally their children. The overall implications of the secondary treatment, unequal access to the resources is that the women grow up maintaining "a culture of silence". The

contribution that they make to families are often overlooked as they themselves end up looking after their family members at the cost of ignoring their own physical and mental health.

Health is considered as a fundamental human right and a World wide social goal. It is essential to the satisfaction of basic human needs and improves the quality of life. From time immemorial. Emphasis has been laid on achievement and maintenance of health. A modern, precise and yet comprehensive definition of health takes into account mental and emotional aspects too, besides physical fitness.

The constitution of the **World Health Organization (WHO)** affirms that-

"Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity. And that the "enjoyment of the highest standard of health is one of the fundamental rights of every human being". **Women's Health**

Within any Community, there are groups that could be termed vulnerable' With regard to their state of health by virtue of their physical, mental, social, spiritual or economic status. It has been recognized that women all over the world are a vulnerable group with regard to their health status.

In India about 15 million girls are born per year but almost one fourth of this number does not see their 15th birthday, despite being considered biologically stronger than boys. Mortality indicators show that up to the age of 35 years more females than males die at every age level. Maternal mortality rate in India is unacceptably high. In the earlier decades of the 20th century when fertility levels were very high, women unsure of child survival rates, bore a heavy burden of repeated pregnancies. Childbirth and child caring started from the early age of 15 years and continued all through the reproductive span of life up to the age of 45 years. Attainment of puberty was traditionally considered the age of marriage for girls in rural areas and in lower and lower middle class families of urban areas. It is common to provide inferior diet to female children. Thus female feticide and female infanticide, malnutrition, neglect for health and medical care on the part of girls and women and early pregnancies are seen as the main areas of concern.

A World Bank Report on Women's Health in India released in 1996 has grimly catalogued the variety of ways in which women are discriminated against. As girls, they get less vaccination, less education and less nutrition than their brothers. When they grow up, they are less healthy than their male counterparts and succumb more easily to sickness and disease.

On the other hand, women are often over worked and undervalued. Their subordination coupled by conditions of alienation, powerlessness and poverty makes it more difficult for them to cope with the many demands made on them, whether of a physical, social or emotional nature. Thus in India, women's health status is very poor due to various reasons. A number of studies indicate that multiple roles and marital status have a sound impact on women's health. But among all the reasons of poor health of women, one leading reason is poverty. There are obstacles, deficits and threats to health inherent in poverty, such as lack of basic necessities, isolation from information, deep rooted customs and religions which give birth to superstitions and many more. Along with poverty, illiteracy among women cannot be put aside, which means due to lack of education there is lack of awareness among women regarding health. Today also women are careless about their health, no matter whether they are literate or illiterate. Hence, it is quite well known that reproductive health dominates women's health problems.

Reproductive Health

Reproductive health is a state of complete well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Implicit to this is the right of women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant.

In this context, the reproductive rights of women and restructuring of health services will pay off through smaller families, which in turn will balance population and development the world over. It is reported that at least 75 million pregnancies each year are unwanted; they result in 45 million abortions, 20 million of which are unsafe resulting in 70,000 women dying and an unknown number of women suffering from infection. With greater investment in education and literacy, individuals will be able to exercise their sexual and reproductive

rights resulting in less pregnancy. Given the choice, women will have fewer children that there parents leading to a balance between population and resources in the country. Health in reproduction in therefore of great importance for the well being of families and communities. Thus, investment in women's health promotes equity in ensures widespread benefits for this generation and the coming generations. Many of the health problems that affect women of reproductive age, begin in childhood and adolescence. Further, improving equity and quality of life could save millions of women and let them lead fully productive lives.

Governmental Interventions

With the broad goals laid down by Five Year Plans, Government has consciously fostered an enabling policy environment in which women's issues are properly reflected, articulated and seriously addressed. It was in 1971 a Committee on 'The Status of Women' in India was appointed by a resolution of the Ministry of Education and Social Welfare to examine the constitutional, legal and administrative provisions that have a bearing on the social status of women, their education and employment and the problems relating to the advancement of women. The recommendations of the Committee have led to a comprehensive Programme for removing economic and social injustice and discrimination against women. International Decade for Women (1976 to 1985) left a lasting impact on the member countries to take up both long term and short term measures in achieving the forward looking strategies for the Advancement of Women up to the year 2000. The most significant documents emerge from this decade was intended to provide a blue print for action to advance the status of women in national and international, economic, social, cultural and legal spheres by the year 2000 A.D.

Development of women and children is at the core of the nation's progress Therefore, a separate Department of Women and Child Development was set up in the year 1985 as part of the Ministry of Human Resource Development to give the much needed impetus to holistic development of women and children. The Department in its nodal capacity formulates policies and programmes; enacts/amends legislations affecting women; and co-ordinates the efforts of both governmental and non-governmental organisations working to improve the lot of women in the country.

The Department also implements certain innovative programmes in the areas of employment and income generation, welfare and support services, gender sensitization and awareness generation. These programmes play both a supplementary and complementary role to the

other general development programmes in the sector of health, education, labour and employment and rural and urban development. The ultimate objective in all these efforts is to make women economically independent and self-reliant. Efforts are being made to bring into force an integrated approach in the development of women through convergence of existing services available under various sectors. Some of the important ongoing interventions toward economic and social empowerment of women are:

- National Perspective Plan for Women (1988).
- Shramshakti- The Report of the National Commission for Self-Employed Women and Women in the Informal Sector (1988).
- Support to Training and Employment Programme for Women (STEP).
- Employment-Cum-Income Generation –Cum-Production Units.
- Condensed Courses of Education and Vocational Training for Adult Women (CCE & VT).
- Rashtriya Mahila Kosh (RMK).
- Mahila Samriddhi Yojana (MSY).
- Indira Mahila Yojana.
- National Commission for Women (NCW).
- National Resource Centre for Women.
- Gender Sensitization and Awareness Generation.
- The National Plan of Action for Children (1992).
- National Plan of Action for Girl Child (1991-2000 A.D.).
- Legal Literary Manuals.

Reservation for Women in Grass-root Level Democratic Institutions (1993).

Reproductive life and secret matter in our society. Due to this culture people often don't discuss matters related to reproductive health problems. Due to the sociocultural taboos attached to reproductive health and ignorant attitudes; women are often the silent sufferers of many reproductive health problems that can be easily detected, cured and prevented. Before understanding the different dimensions of reproductive health, let us first understand what is reproductive health.

Reproductive health is the healthy sexual and reproductive life of individuals right through their life of individuals right through their life cycle not just in the reproductive age group. It addresses the physical, social, emotional and psychological dimensions of sex and reproduction and not just the presence or absence of disease of reproductive organs. It attempts to address the problems originating from irresponsible sexual behavior, myths and misconceptions related to sexual behavior, reproductive health covers the following areas:

- Adolescent health, menstrual care and responsible sexual behavior
- Safe pregnancy, child birth and post natal care
- Rational contraceptive care to prevent unwanted pregnancies and safe abortions
- Control or Reproductive Tract Infections
- Infertility
- Uterine Prolapse
- Tumors and cancer of cervix, uterus and breast
- Prevention of sexual violence and addressing it sensitively

As per this definition, reproductive health orientation means that people have the ability to reproduce as well as to regulate their fertility; that obstetric and gynecological disorders are addressed; that the outcome of pregnancy is successful in terms of maternal and child health and well being; and that couples are able to enjoy martial relations free from the fear of disease. Reproductive health is affectedly a variety of socio cultural and biological factors on the one hand and the quality of the delivery system and its responsiveness to women's needs on the other. A woman-base approach to reproductive health is one which, responds to the needs adult women and adolescent girls in a culturally sensitive manner.

Women's unequal access to resources, including health care, is well known in India, in which stark gender disparities are a reality. While disparities in life expectancy may be narrowing, unequal sex ratios (927 females per 1000 males) 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 life both within the home and outside it. Women's lack of control over economic resources is widespread. While the majority or rural Indian women are economically active, their work goes largely unrecognized and poorly remunerated. These inequalities severely constrain the

ability of women and adolescent girls to acquire good health and woman centered health services. At the household level, these disparities translate into a lack of autonomy and control over household resources- both material and knowledge. Women have little decision-making authority and freedom of movement; few women, including working women, have any control over the household's economic resources. Seclusion practices and other behavioral norms further reinforce women's lack of freedom of movement, self confidence and their acceptance of self denial including in matters relating to health seeking and food intake. Violence against women, rape and incest are all part or women's lives and yet remain invisible in that there are few services that address these issues.

Women in poor health are more likely to give birth to low weight infants. They also are less likely to be able to provide food and adequate care for their children. Let us examine the underlying causes for the dismal state of women's reproductive health.

1. Malnutrition

Maintenance of good nutrition is essential for comprehensive management and prevention of diseases. Eating right and eating nutritious food during childhood and adolescence provides necessary nutrients to meet the physical and intellectual growth, adequate stores particularly for girls incase of pregnancy, prevents the onset of adult diseases related to nutrition. Due to our sociocultural factors that are in favour of boys, girl children are fed less than their brothers and their diet is not given much importance. Disparities in feeding patterns are evident from infancy. Poor adolescent weight and height result is recognized as obstetric risk factors. Underlying reproductive morbidity and exacerbating women's vulnerability to obstetric, gynecological and sexually transmitted morbidity is poor nutrition and such consequences as anemia and physical immaturity. Anemia is known to be a silent epidemic, which is emerging as number one public health problem in most developing countries including India. Anaemia adversely affects reproductive performance of young girls if married. Anaemic women have higher risks of spontaneous abortions, premature labour, low birth weight babies an increase maternal morbidity/mortality. Malnourished mothers give birth to underweight babies who further grow up to having higher incidence of health problems.

2. Lack of Sex Education

Adolescence is a critical phase during one's development. Adolescence is like dusk before dawn and is characterized by a wide range of physical, mental, psychological and social changes, which lay the foundation for a healthy, responsible is a time when due to the physical and psychological changes, attraction towards the opposite sex, curiosity about own bodies, sex and sexuality, changes in the relationship with family and peers are very natural.

There is a glaring lack of attention to sex education in India. What little through the formal school curriculum and textbooks. As a result, large segments of out-of school youth are excluded. Sex education, and even knowledge of menstruation or of AIDS for example, is extremely limited and vague, especially among youth and females, focused on family life education and sex education for both in and out-of –school youth, are hardly adequate given the cultural diversity in the country and the generally limited knowledge of the most basic aspects of reproduction and reproductive health, especially among women. There is also the problem that few people acknowledge that there is much sexual activity among adolescents and young unmarried people or approve of sex education. The latest incident of MMS case where students of a Public School were suspender for sending a MMS depicting a sexual act is a glaring example of the increased sexual activity among of the adolescents and the ignorance observed among the parents and school authorities about it.

3. **Cultural taboos on girls**

In our Indian society virginity is given a lot of importance particularly when it comes to a girl's virginity. A girl is considered "pure" if she does not talk about sex. With the growing curiosity, hormonal changes, attraction towards opposite sex, adolescent girls are indeed a vulnerable and neglected group. Once a girl attains puberty a lot of restrictions are imposed upon her pertaining to her freedom of movement, education, clothing, food patterns etc. Lack of guidance and correct information about sex and sexuality often leads to myths and misconceptions that prevail in their minds.

4. Early marriage

Adolescent's particularly adolescent girls, most of whom are out-of-school, constitute a sizeable proportion of the female population. They are particularly vulnerable and neglected, coming under the purview of government programs only once they are pregnant-the majority are out of school and are neither serviced by educational or school health programs nor by child health and nutrition services. At the family level too, girls are highly vulnerable: son

preference is pervasive, resulting in gender disparities in gender disparities in health care, food intake, school attendance and labor contribution of children, form an early age. Moreover, typically marriage and childbearing are early and universal. There are strong cultural pressures on parents especially in the northern states, to marry their daughters early. Early marriage leads to early onset of childbearing occurring before the female is physically fully developed. Complications of pregnancy, prenatal and neo-natal mortality and low birth weight are much higher among adolescent women than among older women. And not only does early childbearing further deplete the already malnourished adolescent, but it also can result in severe damage to her reproductive tract.

5. Family Planning Methods

The issue of Family Planning Methods brings us to another question if women do have a right to take decisions related to the choice of contraceptives to be used, if they have any say in controlling or spacing births and if they really have correct information about different contraceptive methods, their availability and usage.

Only a very limited number of Indian women have the opportunity to choose whether or when to have a child. Women, particularly women in rural areas, do not have access to safe and self-controlled methods of contraception. The public health system emphasizes on permanent methods like sterilization, or long- term methods like IUD's that do not need follow-up and are thus felt to be more 'fool-proof' than other spacing methods. In fact, sterilization accounts for more than 75% of total contraception, with female sterilization accounting for almost 95% of all sterilizations. (Office of the United Nations Resident Coordinator in India, 2001).

Qualitative availability of reproductive health services comprises of several dimensions like: availability of a wide range of contraceptive, MCH and other services; accessible, complete and accurate information about contraceptive methods, including their health risks and benefits; Safe and affordable services along with high quality supplies; well-trained service providers, with skills in interpersonal communication and counseling; appropriate follow-up care; and regular monitoring and evaluation of performance, incorporating the perspectives fo clients and beneficiaries. To what extent are these really prevalent in India is a question to be dwelled upon.

6. Maternal Mortality

Maternal mortality and morbidity are two health concerns that are related to high levels of fertility. Maternal mortality, or maternal death, refers to "the death of a woman while pregnant or within 42 days of the termination of a pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." (International Classification of Diseases, 10th Revision. World Health Organization, Geneva, 1992).

The high levels of maternal mortality are especially distressing because the majority of these deaths could be prevented if women had adequate health services (either proper prenatal care or referral to appropriate health care facilities). Causes of maternal mortality can be listed as follows:

According to a report by UNFPA, up to 15 percent of pregnant women in all population groups experience potentially fatal complications- 20 million women each year. More than 80 percent of maternal deaths worldwide are due to five direct causes: hemorrhage, sepsis, unsafe abortion, obstructed labour and hypertensive disease of pregnancy. The statistics below gives the details of maternal mortality:

- Unsafe abortion- 14%
- Severe bleeding- 21%
- Infection- 8%
- Eclampsia- 13%
- Obstructed Labor- 8%
- Other direct causes- 11%
- Indirect Causes*- 25%

*Indirect causes include: anaemia, malaria, heart disease.

(Source: Understanding the Causes of Maternal Deaths. Distance Learning Pilot Course. UNFPA, 2001).

Approximately 5 percent of pregnant women- 7 million women-need surgery, most often a Caesarean section and many are without access to emergency obstetric care. This unmet need results in 5, 00,000 to 1 million women living with a painful disability. Only 58 percent of women in developing countries deliver with the assistance of a professional (a midwife or doctor) and only 40 percent give birth in a hospital or health centre. Most maternal deaths (61

per cent) take place during delivery or in the immediate post-partum period. Some 3.4 million neonatal deaths occur within the first week of life.

Maternal mortality affects not only women but also their families and communities. The risk of an infant dying increases significantly with the mother's death. The death of a woman of reproductive age also brings significant economic losses and setbacks to community development. From human rights, economic and public health perspectives, mobilizing resources to combat maternal mortality is imperative.

UNFPA has developed the Three Delays Model to explain the social factors responsible for maternal death. It helps us target interventions and prevent maternal mortality at every stage. In most instances, women who die in childbirth experienced at least one of the following three delays:

The First Delay is the delay in deciding to seek care for and obstetric complication. This may occur for several reasons, including late recognition that there is a problem, fear of the hospital or of the costs that will be incurred there or the lack of an available decision maker.

The Second Delay occurs after the decision to seek care has been made. This is a delay in actually reaching the care facility and is usually caused by difficulty in transport. Many villages have very limited transportation options and poor roads.

The Third Delay is the delay in obtaining care at the facility. This is one of the most tragic issues in maternal mortality. Often Women will wait for many hours at the referral centre because of poor staffing, prepayment policies or difficulties in obtaining blood supplies, equipment or an operating theatre. Programmes designed to address the first two delays are of no use if the facilities themselves are inadequate.

7. Births Taking Place at Home

In India we still have a large majority of births that take place at home with the help of local dai/midwife. Place of birth and type of assistance during birth certainly has an impact on maternal health and mortality. Births that take place in non-hygienic conditions or births that are not attended by trained medical personnel are more likely to have negative outcomes for both the mother and the child.

8. Maternal Morbidity

Maternal morbidity or complications experienced any women, who survive childbirth, are also of great concern. For every woman who dies as a result of pregnancy, some 30 women

live but experience lasting morbidities as a result. An estimated 20 million women suffer from nonfatal complications of pregnancy, including anaemia, infertility, pelvicpain, incontinences and obstetric fistula. Anaemia, which can be treated relatively simply and inexpensively with iron tablets, is another factor related to maternal health and mortality. Severe anaemia also increases the chance of dying from a hemorrhage during labor.

9. **Unsafe Abortions**

Despite the fact that abortion has been legal for over 20 years, limited availability and poor quality have kept safe abortion beyond the reach of most poor women. Lack of awareness about the mal effects of unsafe/incomplete abortions, infections taking place during abortions, calculation about the probable conception time/fetal age leads women to approach untrained dais, RMPs and quacks. A lot of Reproductive Tract Infections (RTIs) are a result of infections that take place during abortions if not done correctly. This can even lead to infertility.

10. **Reproductive Tract Infections (RTIs)**

RTIs as the name suggests are the infections of reproductive organs. There are many kinds of RTIs caused by different germs, which enter the reproductive tract, or due to the overgrowth of organisms normally living in the reproductive tract. Women are more vulnerable to RTIs due to the larger surface area of the female tract as compared to men, methods like Copper T etc. Symptoms of RTIs in women include vaginal discharge, itching/ redness of the genital region, pain in the lower abdomen, pain/burning during intercourse or urination. As mentioned earlier, women are ignorant about the information concerning reproductive health least of all-RTIs. The fact that women suffering from RTIs are most often a symptomatic makes the diagnosis all the more difficult. Even those who do face the symptoms don't approach the doctor. E.g. most women consider 'white discharge' as normal and do not seek medical help. RTIs when untreated can lead to serious complications including infertility.

11. **Women and HIV**

According to the latest UN estimates (2004), out of the 39.4 million persons with HIV/AIDS 47% are females. Women are also 2.5 times deadly infection. Their vulnerability is primarily due to insufficient access to HIV prevention services, inability to negotiate safer sex and a lack of female controlled HIV prevention methods.

12. **Women's Attitudes**

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 behavior. 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 gynecological problem, unless it is very advanced. For example, large numbers of women experience white discharges, dysmenorrhoea etc 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 a health problem has been recognized. 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.

The health delivery system has been largely insensitive to the reproductive health are needs of women and the constraints they face in expressing these-let alone the constraint they face in obtaining service. Doorstep services are essential for secluded women and these are rarely undertaken and where undertaken, focus largely on contraception rather than on reproductive health in general. Health workers themselves are poorly informed about reproductive morbidity (especially gynecological conditions), they can be insensitive in probing and recognizing symptoms and are preoccupied with meeting contraceptive regrets rather than offering a range of reproductive health services. And given women's lack of autonomy and decision-making authority, it is unlikely that sick women will take the initiative in obtaining health care for themselves. In particular there is a tendency to endure obstetric and particularly gynecological morbidity as a fact of life and a shyness to reveal these conditions to or discuss them with health care providers.

Support Services

The national machinery has spread a wide network of support services for women and children belonging to the weaker sections. These support services represent an important plan for the empowerment of women as they reduce the burden of child care and other employment related problems. They include hostels for workingwomen to provide greater mobility to them in the employment market. A National Creche Fund was created in 1993 with a corpus of Rs. 19.90 crores to meet the growing demand for creches. Short Stay Homes for women and girls in difficult circumstances have also been established.

In the field of child development and maternal care, the government administers the world's largest programme called the Integrated Child Development Services Scheme. Apart from caring for children below 6 years the scheme also supports pregnant women and nursing mothers living in rural areas and urban slums. For the first time a special intervention has been devised for adolescent girls using the ICDS infrastructure. The scheme focuses on school drop-outs aged 11 to 18 and attempts to meet their special needs of nutrition, health, education, literacy, recreation and skill development. The scheme has been sanctioned in 507 blocks and when fully implemented will benefit 45,000 girls.

Many efforts are undertaken by government of India and voluntary organisations to improve the health status of women but the following several factors hinder the improvement of health status i.e. Women's Health Status is influenced by:

- Economic status of the family.
- Discriminatory behavior towards the girl child.
- Dietary intake.
- Preference of son in Indian Society.
- Literacy level of Women.
- Exploitation and Violence.
- Occupation of Women.
- Use of Contraceptive by Women.
- Family Planning and Sex Determination.
- Abortion Practices.
- Early Marriage.
- Extra Strain of Work.
- Girl Child Labour.

After independence the government of India developed health facilities and established Primary Health Centres in rural an urban areas. The Family Planning Programme was launched with the aim of reducing birth rate to the extent necessary. During 1975-76, the Government launched a Scheme known as Integrated Child Development Services (ICDS) to benefit children and mother. In 1992-93, a programme called Child Survival and Safe Motherhood (CSSM) was launched in order to improve health status of women and children

and to reduce maternal, infant and child mortality. This entire programme helped in improving the health status of women but it was not as effective as it was planned. Women did not take benefit from the health services. There are many reasons for under utilization of Health Services. Some major reasons are:

- Lack of awareness.
- Ignorance of Women.
- Poverty Stricken families.
- Women do not understand the importance of health.
- Those who are aware do not reach the person concerned.
- Superstitions among low SES families.
- Rigidity- cannot change their behaviour and habits due to which they fail to accept the services.
- High illiteracy among women.
- Women do not give importance to their health. Their first priority is the family members i.e. husband and children.
- Careless attitude of women towards health in particular.
- Customs and traditions- Midwives are usually not trained.
- Health services are too far from their residence or houses.

So in the end we could say that women themselves do not seem very keen to utilize health facilities. They feel their personal health problems are of least priority and importance in comparison to men. They also like to spend on their children's education, health and development, rather than their own health. So there is a great need for bringing about attitudinal change in women themselves, so that they should access existing health facilities. To do this the government should make Health Services better in terms of our reach.

- Creating awareness about their rights for health.
- Explaining the consequences of not looking after their health, e.g. explaining the importance of each food group for proper health growth and disease due to deficiencies of nutrients.
- Bringing understanding about their calorific need especially in conditions like pregnancy, lactation, etc.

- Motivate and encourage them by schemes e.g. giving food packets, free midday meals to their children e.g. SNP, Supplementary Nutrition Programme and Midday Rural Programme.
- By putting attractive banners at public places like water tanks, play grounds, meeting grounds, theatres, restaurants, and cinema halls.
- By providing area wise health services so that women can just visit the health centres at their own leisure time, as it would be near to their places.
- Providing for transport facilities if health centre is far from their homes.
- By giving incentives in terms of promotion in jobs, etc.

Recommendations and Suggestions

- Welcome the birth of a girl child and provide care and support to the mother.
- Provide timely health care, immunization, teaching the importance of breast milk and weaning foods to the mother.
- Enroll the girl in school at the correct age and provide opportunities and support fro education, by reducing her household burden and child care.
- Provide an opportunity to articulate her voice, regarding family planning use of contraceptives etc.
- Provide encouragement and love for her development.
- Do not discriminate between boys and girls during their upbringing.
- Dissuade parents who are stopping the girl's education and prevent child marriages, old and harmful religious rites.
- Enact and implement stringent laws and policies to stop misuse of sex determination tests.
- Provide appropriate activities like play and hobby centres for the development of girls.

Role of Social Worker

1. To identify the problems of the people through face to face contact as an extension worker.

2. The researcher, through research find out the root cause of the problems e.g. related to poor nutrition, low agriculture production, food and water shortage, poverty, etc.
3. The programme planner will plan a programme which will be the solution of the problems e.g. over population, food and water shortage.
4. As a field worker or informer will give information or create awareness among the people about the programmes like medical camps, cleanliness, steps to be taken to prevent diseases etc.
5. As a non- formal educator, teach the people through different teaching methods and materials on different topics like reproductive health, balanced diet, personal cleanliness, etc.
6. As administrator, administrate or control the whole programmes and make maximum use of human and non human resources.
7. As a manager or decision maker take appropriate and judicious decision according to the requirement of the time.
8. As instigator, or motivator motivate people to take part in the programme and take actions for the development e.g.: take part in medical camp and take medicines and act according to the doctor.
9. As an advisor or counselor advise people about certain thing like using family planning methods, importance of balanced diet, etc.

Conclusion

Women's health should be seen as continuum. Healthy babies grow into healthy girls who become healthy women. Invariably women's health is important only when she is carrying out the all-important task of producing a new generation. So, there is a need for changing the perspective of our society and our planners to look at the lives of women, from birth to old age, as a holistic process, which requires care and nurturing all through.

In short, women's poor reproductive health in India is affected by a variety of socio-cultural 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 devalued women on the other. Thus, efforts to improve women's education; raise enrolment and attendance rates of girls in school and reduce the drop-out rate on the one

hand and enhance women's and families health; no less important are improvements in equality and breadth of services catering to reproductive health needs.

"Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light not our darkness that most frightens us. We ask ourselves" who am I to be brilliant, gorgeous, talented and fabulous?" Actually, who are your not to be? You are a child of God. Your playing small doesn't serve the world. There's nothing enlightened about shrinking so that other people won't feel insecure around you..As we let our light shine, we consciously give other people permission to do the same. As we are liberated from our own fear, our presence actually liberated others." By Marianne Williamson, as quoted by Nelson Mandela in a 1994 Inaugural Address.

REFERENCES

i. Women of the world, women's Health in India- By Victoria A. Velkoff and Arjun Adlakha, Issued December 1998.
ii. Addressing Women's Reproductive Health Needs: Priorities for the Family Welfare Program; Economic and Political Weekly. March 1997, 32 (9 & 10). p. 475-484.
iii. 'Hamari Chitthi Aapke Naam'- A Newsletter by 'VHAI' October-December 1997 edition.
iv. Maternal Mortality Update 2002- A Focus on Emergency Obstetric Care by UNFPA; Publication date: 2003
v. 'Hindistan Times Next' dated 1st December 2004, page 6.

****