(IJRSSH) 2013, Vol. No. 3, Issue No. IV, Oct-Dec **ISSN: 2249-4642**

SERVICES OF REPRODUCTIVE HEALTH FOR WOMEN AND GENDER INEQUALITY

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ABSTRACT

In India gender inequality limited access to healthcare facilities and economic resources are greatly facilitating the spread of reproductive tract infections and sexually transmitted diseases for populations living under impoverished conditions. While the focus on women's reproductive health is usually directed towards pregnancy, childbirth and contraception, these issues though important can also divert the attention away from other aspects of women's health, including the way in which gender influences the risk of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs). Recent studies have begun to document the association between gender, impoverished environment and the prevalence of sexually transmitted diseases. Addressing women's reproductive health in totality is important for understanding gender issues as they reveal how gender norms affect reproductive health services, differential exposure to risk, access to services and their benefits, to information, and to resources. In this paper, we discuss approaches for developing suitable gender-sensitive strategies in reproductive healthcare including the impact of RTIs and STDs on women's health, for populations living under impoverished conditions. With the help of primary data and a review of existing literature, we posit that reproductive health services need to address gender biases and obstacles in their healthcare delivery, and recognize that men and women's needs often differ and find ways to meet those needs differentially. The basic source for empowerment of women in a society is to provide them with access to information, education, and skills. We conclude by suggesting strategies that seek to balance the gender equation and encourage women's participation in the decision making process.

INTRODUCTION

Anthropologists use the term sex to refer to biologically based differences between men and women and gender to refer to social, cultural, economic and political differences between the two sexes. Gender is a cultural construct in all human societies we come across two distinct social categories of 'male' or 'female' which are based on specific cultural assumptions regarding different attributes, beliefs and behavior characterizing individuals included within that

category. Gender is also socially ascribed it determines how individuals and society perceive what it means to be male or female, influencing one's roles, attitudes, behaviors and relationships, and relative power and position in a social setting. Gender is relational because gender roles and characteristics do not exist in isolation, but are defined in relation to one another. Sex and gender are both important determinants of health. Biological sex and socially-constructed gender interact to produce differential risks and vulnerability to ill health, and differences in health-seeking behavior and health outcomes for women and men. More significantly, as gender pertains to the roles performed by men and women and the power relationships between them, gender affects most areas of human existence, including health. For example, care work is generally associated with the female gender role and may contribute to significant health problems attributable to the care-giving burden. On the other hand, men in some societies maybe socialized to value risk-taking behaviors and to inhibit support and health seeking activities both of which may be detrimental to men's health, although notably not all men embrace these roles throughout their lifetimes.

In many societies, discrimination against girls and women based on socio cultural norms often relegates them to lower status and value. This often places them at considerable disadvantage in terms of their access to resources and goods decision-making power choices, and opportunities across all spheres of life. Furthermore, the roles, rights, responsibilities and status assigned to women by society may leave more women vulnerable to unwanted and unprotected sexual intercourse, poor nutrition, and physical and mental abuse; they also limit women's access to healthcare. Therefore, gender based inequality have a direct bearing in sexual decision-making and their impact on health. Furthermore, gender discrimination at each stage of the female life cycle contributes to health disparity, sex selective abortions, neglect of girl children, reproductive mortality, and poor access to healthcare for girls and women.

Despite widespread recognition of these differences, and the many reasons for incorporating gender issues in policies and programs, health research has failed to address both and sex and gender adequately. This also includes the lack of attention to gender in the training of health professionals and healthcare workers and the lack of awareness and sensitivity to gender concerns and disparities in the biomedical community.

According to the WHO report, in applied health research, including the social sciences, the problem has often been viewed as one of rendering and interpreting sex differentials in data analysis and exploring the implications for policies and programs. Clearly, examining the gender dimensions of a health issue requires an in-depth understanding of how gender roles and norms, differences in access to resources and power, and gender-based discrimination influence male and female well-being. In this paper, using reproductive healthcare services as an example we posit that a gender sensitive approach is fundamental to health and health care planning. Specifically, we discuss why gender is necessary for understanding all dimensions of health including healthcare and health-seeking behavior and how gender sensitive approaches can

improve reproductive health policies and programming. First, we begin with a brief discussion of some gender concepts relevant to our paper and their application in healthcare services. Next, we discuss the status of reproductive health in India including the social and cultural barriers that exist for accessing reproductive healthcare services. We present our case study to illustrate the reproductive health needs and concerns of women and young adolescent girls living in semi-rural and rural areas of Northern India. Finally, we suggest ways to incorporate gender sensitive strategies to reproductive healthcare services based on the analysis of our case study data.

GENDER AND REPRODUCTIVE HEALTH

Reproductive health is a good starting point for addressing gender issues. The HIV/AIDS epidemic has demonstrated that existing reproductive health programs are having limited impact in helping countries achieve overall reproductive health and development goals. The International Conference on Population and Development and the Fourth World Conference on Women both clearly emphasized the need to promote gender equity and equality in reproductive health policies and programs, and to promote and protect human rights. More recently, these agreements were reinforced in the five-year reviews of both conferences, held in 1999 and 2000 respectively. Furthermore, the United Nations Population Fund (UNFPA) also supports a gender- and rights-based approach to reproductive and sexual health that empowers women throughout their lives. They recognize that reproductive rights become tangible only when reproductive health services offer a high quality of care and are made widely available.

In particular, sexual and reproductive health (SRH) was given an international consensus definition at the International Conference on Population and Development (ICPD) earlier in 1994. Since then, international family planning has expanded from its emphasis on the delivery of clinical services to married women of reproductive age. This emphasis has made important contributions to the health and well being of women and their families. Recently, the ICPD adopted the goal of ensuring universal access to reproductive health by 2015 as part of its framework for a broad set of development objectives. The Millennium Declaration and the subsequent Millennium Development Goals (MDGs) have also set priorities closely related to these objectives. It is understood that progress towards the MDGs depends on attaining the ICPD reproductive health goals.

Currently, family planning programs are expanding beyond their traditional contraceptive focus to address the prevention and treatment of sexually transmitted infections, the reduction of maternal morbidity and mortality and counseling and treatment of sexual problems. Other changes include programs that have a mandate to serve the needs of not only married women, but adolescent boys and girls, men, and unmarried women of all ages. Another important shift had been to move towards a broad, development-oriented concept of health that is not limited to service delivery but includes the social relationships that constrain health more fully. In particular, there has been a formal recognition that more equitable relation between men and women and reproductive rights are important ends in themselves as well as the central means of

reducing fertility and achieving population stabilization. It is clear that intervention programs are needed to improve sexual and reproductive health of both women and men, particularly those that mitigate the impact of gendered values and norms that harm women's and men's health and impede development. Recent understanding of reproductive health has helped to situate sexuality and reproduction within a broader development agenda. Reproductive health therefore goes beyond the health sector, and is now recognized as more than a women's issue.

REPRODUCTIVE HEALTH IN INDIA

India has one of the highest rates of child marriage in the world, which increases reproductive health problems for girls because of early childbearing. The median age at marriage for women (ages 20-24) is 16.7 years. Men are typically older than women when they marry, 72 per cent of men ages 25 to 29 are married. In rural India, 40 percent of girls (ages 15 to 19) are married, compared to 8 percent of boys at the same age. Accordingly, childbearing for women in India is also early; among married women in their reproductive years (ages 20to 49), the median age at which they first gave birth is 19.6 years. The problem with early marriage and childbearing is that young girls are often not adequately prepared with information regarding reproductive and sexual health issues, including sexual intercourse, contraception, sexually transmitted infections and diseases (STIs and STDs), reproductive tract infections (RTIs), pregnancy and childbirth.

In India, more than a million women suffer from RTIs accounting for 25% of the reproductive tract infections between the ages of 15 and 44. Despite their high prevalence and consequences, there exists a "culture of silence" surrounding these diseases, due to the associated stigma and taboos as well as the widespread belief that symptoms of pain and discomfort are a natural part of a women's lifecycle. Women and young girls often do not seek clinical treatment because of fear or embarrassment or a lack of appropriate available care particularly in an impoverished environment. At present there is a growing interest in RTIs and STDs because of the association between STDs and the risk of HIV infection. For instance RTIs produce ulceration and discharge of pus, which all too efficiently facilitates the transmission of HIV virus.

Many women in India are dependent on their husbands and other family members for health related decisions, indicating thereby that the behavior, knowledge and attitudes of men are also integral to the reproductive health status of the couples. More significantly, men's active participation in counselling, testing and safe sexual practices is necessary for the control of STDs and HIV infections. Involving men in reproductive health is crucial to promote gender equality and to improve men's reproductive health. Also, including men as supporting partners for the prevention and control of STDs and HIV/ AIDS is imperative for the success of the intervention programs.

This base-line survey comprised of selected villages from the two respective districts of Stupor and Shahjahanpur in Uttar Pradesh. A total of thirteen villages selected from Sitapur and

eight from Shahjahanpur formed our basic sample. From these villages, 390 households were selected from Sitapur, while 240 households were from Shahjahanpur district. A multistage sampling design was adopted to select the households. These households (630) provided information for the 672 married and 126 unmarried women. In addition, this survey also focused on the reproductive health service providers from the study area. These include 12 medical officers, 14 auxiliary nurse midwife (ANM), 11 traditional birth attendants (TBA), 12 Anganwadi workers (AWW) and 11 private medical practitioners (PMP). Both qualitative and quantitative data were collected from the study areas. For this paper, our discussion focuses only on the analysis of the qualitative data as our emphasis is on developing suitable gender sensitive intervention strategies. The qualitative data were collected with the help of detailed guidelines developed for focus group discussions (FGDs). Ten FGDs were conducted among the study sample, which included married women (15-44 years), unmarried women (15-44 years), married men (30-45 years), older women (45+), ANM and AWW.

Information from the baseline survey revealed that not all villages were covered by the Anganwadi centers. Furthermore, public medical facilities, private medical practitioners and traditional birth attendants are not available in most villages. In addition, access to mass media is also very limited; cooperative societies such as milk and sugarcane cooperatives common in other parts of Uttar Pradesh were practically nonexistent in these villages. Many households (55 per cent) were poor, as majority comprised of landless laborers and some with only marginal lands. More than half the population (55.29 per cent) was illiterate; and Hindus dominated the area.

The qualitative data analyses revealed that both unmarried and married women (15-44 years) were less knowledgeable about male and female reproductive organs. But both groups recognized the physical changes that take place during adolescence. Women were generally aware of the onset of menstruation, and gestation periods including where and how conception and gestation takes place but had incomplete information about the process of conception.

This study also reported a high incidence of untreated menstrual problems among married (57 per cent) and unmarried married (56 percent) women from the study group. Women usually visit their private doctors or clinics for necessary treatment, however, knowledge regarding the necessity and benefit of the antenatal, natal and postnatal care was found to be very limited. Due to cultural inhibitions, women often hide their pregnancies from outsiders until it becomes visible, accounting for delayed registrations of pregnant mothers with nurse practitioners and healthcare workers.

The public health facilities in these study areas were very poorly managed. The primary healthcare workers including Anganwadi workers played a minimal role during antenatal, natal and postnatal phases. Although their work was described to be of advisory nature, many failed to perform these adequately due to their lack of counseling skills. In general, many primary healthcare workers lacked sufficient knowledge concerning reproductive health including prevention, treatment and management of RTIs, STDs and HIV/AIDS. As primary healthcare

workers interact very closely with their respective communities, it would have been more beneficial to strengthen the capacities and train these healthcare workers for their improved functioning and better coordination with doctors and nurses at the village level.

CONCLUSION

It has now been very well established that gender-sensitive approaches are necessary to recognize and respond to different needs and constraints of individuals based on their gender and sexuality, such as counseling women to negotiate condom use or addressing the reluctance of some men to use condoms. By increasing the focus on gender-sensitive services, reproductive health programs can not only respond to the practical gender needs of female and male clients, but also contribute towards meeting the strategic needs. However, gender equity can be brought about only by modifying gender relations and power in a community. Two other very significant approaches have also been identified as long-term tasks for addressing power inequality in gender relations. These include transformative and empowerment strategies. Transformative approaches go beyond gender sensitivity, actually towards changing gender relations in society. Examples include working over the long term with young men and women, or adolescent boys and girls, to redefine gender norms and encourage healthy sexuality. Women's empowerment approaches on the other hand, seek to balance the gender equation by giving women access to information, skills, services, and technology; encouraging their participation in decision making; and creating a group identity that becomes a source of power.

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