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ACRITICAL REVIEW OF LITERATURE ON SEXUAL AND REPRODUCTIVE RIGHTS AND ITS VIOLATION

ANKITA SIDDHANTA

Introduction

The last twenty years witnessed enormous attempts to include the concept of sexual and reproductive health and wellbeing in the arena of human rights. Though this conceptualization of sexual and reproductive rights has been achieved with a fair amount of success but the privileges have not been tasted by women in many circumstances. By 2008, the phrase 'sexual rights' was being used on a regular basis in the international and national scenario.[1]

Sexual health was defined as part of reproductive health in the Programme of Action of the International Conference on Population and Development (ICPD)[2] in 1994. Statements about sexual health were drawn from a WHO Technical Report of 1975,[3] which included the concept of sexual health as something "enriching" and that "enhance[s] personality, communication and love". It went further by stating that "fundamental to this concept are the right to sexual information and the right to pleasure".[4]

Respect for bodily integrity was recognized as a fundamental element of human dignity and freedom as early as 1975 at the World Conference of the International Women's Year in Mexico City. It was further defined and elaborated in the Beijing Platform for Action "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behavior and its consequences." While sexual rights were not specifically

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CHANGE IN BEHAVIOR AND COMMUNICATION REGARDING CHILDBEARING - A STUDY AMONG RURAL MARRIED COUPLES IN INDIA

SHILPA KARVANDE, HEMANT APTE, AXEL HOFFMANN, MARCEL TANNER

Introduction

In India, traditions and values guide the reproductive health behavior of couples in such a way that most of the related issues are assigned to women's domain. Couples are rarely encouraged to have open discussion around childbearing and men seldom perform the role of active and supportive partners of women during childbearing. On the other side, the reproductive health programme aims at involving men to a greater extent. Also, factors such as exposure to the outside world on account of mobility, impact of media and access to resources largely contribute to the process of change.

For more than two decades' researchers from developing countries have studied the role oftraditions, cultures and family network affecting childbearing and the involvement of men. Sich[1] has mentioned about stereotypical assumption of Western clientele that a pregnant woman is entitled to much attention by her husband, family and other public and further states that this assumption is not true in rural Korea except for the early period of first pregnancy. Chowdhury[2] studied the sociology of first birth in rural Bangladesh, and found that food intake and workload does not change with pregnancy; and objection from in-laws and financial concerns are barriers to seeking health care. Waszak, Thapa and Davey[3] in their study conducted in Nepal, about the influence of gender norms on reproductive health, mentioned about traditional beliefs related to motherhood in terms of woman's diet and work, affecting their health. In South Africa, traditionally, men did not accompany their partners for antenatal or postnatal care services and are not expected to attend the birth of their child.[4] In Kenya, cultural barriers and peer pressure acted as barriers to men's participation in reproductive health care.[5]

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A STUDY OF CLINICAL OUTCOMES OF POSTPARTUM INTRAUTERINE CONTRACEPTIVE DEVICE

MAMTA RANI, PARNEET KAUR, KHUSHPREET KAUR, GURDIP KAUR AND ARVINDER KAUR

Introduction

The current population of India is 1.21 billion as per 2011 Census.[1] Approximately 61 percent of births in India occur at intervals that are shorter than recommended birth to birth interval of approximately 36 months.Women in an unplanned pregnancy account for a significant number of inpatients in maternity hospitals. This fact could be explained by lack of information about contraceptive methods and ignorance or even worse, little support provided by governmental agencies to family planning.[2] Recent studies estimate that prevention of unplanned and unwanted pregnancies could help avert 20-35 percent of maternal deaths and as many as 20 percent of child deaths.[3]

The postpartum period is one of the critical times when both women and newborn need a special and integrated package of health services as morbidity and mortality are quite high during this period and also women are vulnerable to unintended pregnancy. Studies show that pregnancies taking place within 24 months of a previous birth have a higher risk of adverse outcomes like abortions, premature labor, postpartum haemorrhage, low birthweight babies, fetal loss and maternal death.[4]

Approximately 27 percent of births in India occur in less than 24 months after a previous birth. Another 34 percent of births occur between 24 and 35 months, 61 percent of births in India occur at intervals that are shorter than the recommended birth-to–birth interval of approximately 36 months.[4]

Contraceptive counselling has become an integral part of antenatal and postpartum

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INSTITUTIONAL DELIVERY AMONG THE TANGKHULS OF MANIPUR

R.K. JEERMISON

Sophisticated tools and technologies are employedto develop programmes and models in recent times, yet, there have been deficiencies for these have failed on many occasions. Even if the programme is insignificant for one percent of the population, considering the size of the country this will affect a largenumber of people. Inresponse to international and national health and population policy, several programmes atthe grassroots level have been implemented to encourage institutional delivery in order to reduce maternal and infant mortality. However, the response to this is insignificant especially among parochial societies who trust traditional healers and traditional birth attendants (TBAs).

Attaining improved maternal health status has been the top most priority of the Government of India since its First Five Year Plan (1951-56) in order to reduce both maternal and child mortality.[1] The target continued to reinforce year after year and it has also been reflected in the Population Policy-2001 within the wider context of reproductive and child health programme, and through the commitment towards achieving Millennium Development Goal i.e. to reduce maternal mortality by three quarters between 1990 and 2015.

Over the last few decades, although India has witnessed success in terms of reducing both maternal and child mortality, the level remains still very high as compared to that of any developed nation. India is still home to 63,000 maternal deaths per year which accounts for almost one-fourth of all maternal deaths of the world, even after the decline of mortality ratio to 230 from 390 from year 1990 to 2008. Similarly, theChild Mortality Rate in India is considered to be very high as compared to developed nations despite the fall to 18 in 2005-06 in 1991-92.[2]

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SOCIO-RELIGIOUS CATEGORIES AND FERTILITY PATTERN - A MICRO LEVEL STUDY OF MALDA DISTRICT, WEST BENGAL

NAZMUL HUSSAIN AND SABA OWAIS

INTRODUCTION

Population scientists claim that the background socio-economic characteristics have important bearing on fertility which shows the reproductive performance of a woman. Demographers describe fertility as the child-bearing activity of a population, where as in biology and medicine this term is generally used for capacity to bear children. The child-bearing period of a woman is usually assumed to exist between the ages 15-49 years. The level of fertility in demography is measured in terms of livebirth performance. Child-bearing is, no doubt, basically a biological function, but child bearing in any society is within the socio-economic and cultural context and is, therefore, influenced by socio-economic factors as well as social customs, values and norms related to various aspects of childbearing.[1] Demographic figures of India suggest that the Total Fertility Rate for Muslims is significantly higher than for Hindus, and that this disparity may outweigh differences in mortality.[2] Age-specific Fertility Rates also indicates that Muslim women are bearing a larger number of children at earlier ages than are Hindu and Christian women. Much of this debate, however, is among religious and political leaders and has masked the fact that while there may be real demographic differences between members of different religious groups in India, these may have more to do with socio-economic disparities than with the content of different religious beliefs per se. Various studies suggest that the fertility difference among the religious groups is particularly in the context of socio-economic differences between members of religious groups.

This paper enquires about the ways in which religion affects demography. Various aspects explored which affect the fertility of women of different religions.The paper studied the SRC (socio-religious categories)

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THE JOURNAL OF FAMILY WELFARE
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The preliminary requirements of an article, before it is processed for review, are the following:

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The review process takes up to three months. When the reports of the two referees do not match, the article is either sent to a third referee or it is reviewed by the Managing Editor (JFW). If the review suggests revision of the article, the authors are given one month time for revision and resubmission. The revised and resubmitted article is sent to the internal referee for checking the revisions.

The paper should be clearly and concisely written. The text, where appropriate should be styled under the usual headings of Introduction, Methodology, Results and Discussion. An original paper should include only sufficient references to indicate the purpose and relevance of investigation. The text, tables and figures should be internally consistent and non-repetitive. Tables and illustrations numbered in Arabic numerals should be typed on separate sheets of paper and headed by brief adequate captions. For the preparation of graphs and figures, good drawings and original photographs should be submitted; negatives cannot be used. The use of too many tables should be avoided. The results should be described briefly and the discussion confined to significant new findings. A Conclusion of

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   Ramachandar L. and Pelto P. J. December 2009. Self-help groups in Bellary: Microfinance and women's empowerment. The Journal of Family Welfare, 55(2), 1-16.

3. A referenced article published in a book should contain the following details. Author's last name, initials, year of publication, name of the article, In: name of book, initials and last name of editors, Ed./s. in parentheses, title of the book, place of publication, name of the publisher and page numbers of the article. For example:

Bang, R. and A. Bang. 1994. Women's perception of white vaginal discharge: Ethnographic data from rural Maharashtra. In: J. Gittleson et al., (eds.), Listening to Women Talk about Their Health:

Issues and Evidence from India. New Delhi: Har-Anand Publications, 79-94.

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   Narayana, M.R. 1994. Selection of PHCs for Evaluation of the Family Welfare Programme in a Developing Country: Alternative Methods and Applications", Artha Vigyana, 34, 79-82.

   1995. Evaluation of Family Welfare Programme in Chitradurga District of Karnataka State: Part II Report (Role of Peoples' Response) Population Research Centre, Institute of Social and Economic Change, Bangalore.

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   Jejeebhoy, Shireen. 1998a. Wife-beating in rural India: A husband's right? Economic and Political Weekly, 33(15):855-62.

   1998b. Association between wife-beating and fetal and infant death: Impressions from a survey in rural India", Studies in Family Planning, 29(3):300-8.

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    Progress in reproductive health research. 2001. HRP, No. 57 part 2, 1-9.

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To create awareness, disseminate knowledge and education, provide counselling and services where appropriate on all aspects of reproductive, child and sexual health including family planning and HIV/AIDS, with free and informed choice, gender equality and equity, the empowerment of women, male involvement, child and adolescent health, and their inter-relationships with social development and environmental concerns in order to advance basic human rights, of all men, women and youth, family and community welfare, the achievement of a balance between population, resources and the environment and the attainment of a higher quality of life for all people.

To place its considered views before government and other agencies when appropriate and assist whenever possible in the formulation of the national programme of reproductive and child health including family planning.

To formulate policies, set priorities and devise programmes in pursuance of the above objectives and to undertake or promote studies and activities for information and education, training, services, and research covering the sociological, psycho-social, economic, medical and other relevant aspects of reproductive, child and sexual health including human fertility and its regulation, methods of contraception, infertility, family life education and counselling, stabilisation of population and environmental concerns, with special reference to the needs of adolescents and young people.

To organise conferences, seminars, training courses and other meetings and events whether local, national or international, in the furtherance of the Aims and Objects and allied subjects of the Association.

To establish Branches, Projects and other types of units to expand the coverage and activities of the Association.

To foster, develop contacts and collaborate or network with other organisations engaged in similar types of work in India and abroad.

To maintain its status as a Founding Member Association of the International Planned Parenthood Federation and to be affiliated to other international bodies as may be deemed fit from time to time.

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