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THE JOURNAL OF FAMILY WELFARE

INSTITUTIONAL STRUCTURE AND COMMUNITISATION OF HEALTH CARE SERVICES UNDER NRHM: AN ASSESSMENT

R. B. BHAGAT

Introduction

The Health Survey and Development Committee, popularly known as the Bhore Committee, was constituted in 1943 which submitted its report in 1946 to the British Government. It was a milestone report which provided a solid foundation for the evolution of India's health policy in independent India. The Committee emphasized that ill health of India's population was mostly preventable, and recommended that no one should be denied access to health care because of the inability to pay. The report was path breaking in the sense that it pleaded for access to health care to be universal and free even during the time of colonial rule.[1] After independence, another Committee known as Health Survey and Planning Committee, popularly known as Mudaliar Committee, was constituted in 1959 which submitted its report in 1961 to the then Union Minister of Health also found recommendations of Bhore Committee valid, and reemphasized strengthening of the public health infrastructure, improving water supply and sanitation and medical education in the country.[2] In spite of two monumental reports on health, India announced its first health policy as late as in 1983 which was later revised in 2002. The Health Policy of 1983 remained largely vertical focusing on selected diseases. The resource allocation was inadequate accompanied by lack of decentralization and having no framework to restrain the unregulated growth of the private sector. The new Health Policy 2002 addressed some of these issues, but was partially implemented.[3]

Enormous concern was on maternal and child health in both the Bhore and Mudaliar Committee reports which took cognizance of a very high maternal and infant mortality in the country, but it was the newly created

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COMMUNICATING HEALTH: AWARENESS AND KNOWLEDGE AMONG RURAL WOMEN FROM NUCLEAR AND JOINT FAMILIES OF AHMEDABAD DISTRICT, GUJARAT

SANTOSH K. PATRA AND RAKHI MAKHIJA

Introduction

To improve maternal health and child health status in developing countries, women's demand for health services and associated health seeking behaviour must be increased and encouraged, in addition to improving physical access to health services. There are various determinants which highly affect the health seeking behaviour. Social support, especially from spouses and other family members could be one of those determinants, and improving social support could have the potential to improve maternal health.

As we know the country, India is full of dichotomies and diversities, where culture not only plays a significant role but also is one of the key determinants of the paradigms of development. As defined by E.B.Taylor[1] "Culture ... is that complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society". Essentially this encapsulates everything an individual learns as a member of society. So, broadly when we get a sense of what is culture, the major question is how it is being practiced and what the key agencies that facilitate for cultural enforcements are. While identifying some of the key cultural agencies which are being studied in literature of sociology, any social institution that play the role of imparting values, morals and beliefs to the individual need to be considered as cultural agencies in the society. Amongst the entire first social unit from where a child is not only born but also being nurtured with all societal values is the family. Gerald Laslie[2] defined family as a group of two adults of opposite sex, living in a socially approved sex relationship and their own or adopted children. Though family is being

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TREATMENT SEEKING BEHAVIOUR AMONG WOMEN WITH PERCEIVED REPRODUCTIVE HEALTH PROBLEMS IN URBAN INDIA

ANJALI RADKAR AND TARA KANITKAR

Introduction

A number of studies in India have documented a high prevalence of reproductive health problems, such as, abnormal vaginal discharge accompanied by itching and bad odour, urinary tract infections, menstrual problems, acute pelvic inflammatory diseases, severe abdominal pain, intercourse related pain and bleeding.[1-5] It is known that consequences of the reproductive tract infections (RTIs) are grave. Untreated RTIs and sexually transmitted infections (STIs) can cause considerable physical, emotional, and social damage to the women and their children. Besides, the presence of RTIs increases the risk of acquiring HIV infections.[6] Thus, RTIs are a heavy burden on the public health system and it is one of the priority areas in public health action programmes.[7] It is also true that many RTIs and STIs such as endogenous infections and several iatrogenic and sexually transmitted infections (syphilis, gonorrhea, chalmydal infections and chancroid) are curable provided detected early and treated properly.[7,8] In such situations early detection and proper treatment is of paramount importance for improving the reproductive health of women. However, in developing countries including India hardly any preventive gynecological service facility exists.[9]

A review of studies on treatment seeking behaviour with respect to reproductive health problems revealed a range of actions such as no treatment, self-treatment or home remedies, visit to traditional healer and allopathic provider.[4] According to Apte and Trasi,[10] seriousness of symptoms as perceived by the woman herself, determines her treatment seeking behaviour. They also invited attention to the fact that few researchers have tried to study the

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UNWANTED PREGNANCY AND AWARENESS ABOUT MTP: A SOCIAL PRESPECTIVE, MADHYA PRADESH, INDIA

ANIL K AGARWAL, PREETI GUPTA, RAKESH K MAHORE AND AKSHAT PATHAK

Introduction

Abortions are usually categorized as spontaneous and induced. Spontaneous abortions occur once in every 15 pregnancies. Induced abortions, on the other hand, are deliberately induced-they may be legal or illegal.[1] It is estimated that of the 210 million pregnancies which occur each year, about 80 million are unintended. In 2008, 21.6 million unsafe abortions were estimated to have occurred, causing about 47,000 deaths. Almost 14 unsafe abortions per 1000 women aged 15-44 years takes place. In developing countries the rate is 16 per 1000 women and least developed countries about 27 per 1000 women in the age group 15-44 years.[2] Unsafe abortion is defined by W.H.O as a procedure carried out to terminate an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both as those performed by unskilled individuals, with hazardous equipment, or in unsanitary facilities carry a high risk of maternal death and other complications.[3]

For unsafe procedures, the mortality rate has been estimated at 367 per 100,000 (70,000 women per year worldwide).[4] Although the global rate of abortion declined from 45.6 million in 1995 to 41.6 million in 2003, unsafe procedures still accounted for 48 percent of all abortions performed in 2003.[5] WHO estimates that at least 33 percent of all women seeking hospital care for abortion, complications occurred among adolescents aged less than 20 years. Furthermore, of the 50 million abortions induced annually, 33 percent were illegal and almost 50 percent were performed outside the health care system.[6] Many women are not aware of the legal

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UNMET NEED OF CONTRACEPTION AND ASSOCIATED FACTORS IN AN URBAN SLUM

RUPALI A. PATLE AND GAUTAM M. KHAKSE

INTRODUCTION

Family Planning today is no longer about controlling numbers. Instead, it is a basic human right closely linked to the empowerment of women, whose availability can avert thousands of maternal deaths, improve the health of mothers and their babies, and pull communities out of poverty.[1,2] The 5th Millennium Development Goal is to reduce maternal mortality and India's National Health Policy 2000 goal is to achieve a target of Total Fertility Rate of 2.1.[2] Limited access to family planning results in high rates of unintended pregnancies, millions of unsafe abortions and thousands of maternal deaths.[3] Women with an unmet need are those who are fecund and sexually active but are not using any method of contraception, they report not wanting any more children or wanting to delay the next child.[2] The concept of unmet need points to the gap between women's reproductive health care intentions and their contraceptive behaviour. If measured accurately it can indicate the potential demand for family planning services and the likely impact on fertility if the demand is met effectively. Thus, the unmet need for family planning is a discrepancy between expressed fertility goals and contraceptive use.

Unmet need includes both women who state that they want no more children in the near term (spacers) and women who have reached their desired family size and are not using any method of contraception (limiters).[1] Unmet need is especially high among adolescents, migrant, urban slum dwellers, refugees, women in the postpartum period.[2] Different nationwide surveys have estimated unmet need of family planning. Many studies found higher percentage of total unmet need among rural women, illiterate women, women whose husbands are illiterate and women not exposed to media messages on family planning.[4] Meeting the family planning needs of all women means reducing inequities in knowledge, overcoming social and cultural barriers, and ensuring access to high-quality services.

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MARITAL RELATIONSHIP AND CHILDHOOD DEATHS: SUBSTANTIATION FROM INDIA

ATREYEE SINHA AND APARAJITA CHATTOPADHYAY

INTRODUCTION

Marriage is the base of the family system; the most important social institution in the Indian culture, which permits two persons legally and socially to cohabit and procreate. The strength of marital relationship lies not only on the love between the two, but depends a lot on the level of understanding and communication between them, on trust and respect for each other. But in reality, throughout the world, this sacred relation is characterized by excessive control exerted by the husband, denial of freedom and occurrence of violence against the women within marriage. This is especially so in the global culture of discrimination which denies women's rights and is deeply rooted in societies with very strong patrilineal-patrilocal-patriarchal foundation with non-egalitarian gender relations, where women are literally powerless in every sphere of their lives and live on the mercy of their male counterparts. It is the manifestation of gender inequality, as an outcome of the patriarchal 'socialisation process,'[1] where girls, right from the beginning of life learn to grow up as subordinate to the male authority and accept submissiveness as their destiny. These particular cases of abusive marital relations cut across the barriers of region, religion, caste, education and income groups, prevalent both in the developed and developing countries, many a time silently and very carefully kept behind the closed doors. In many instances, women in general cannot escape – for the sake of their children, maintaining status in society and extreme powerlessness as a result of not having a strong ground for self-support, continue to bear with the ill-fated relationship. The violent turn up of a

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PUBERTY AND MENSTRUATION AMONG SCHEDULE CASTE GIRLS

A. K. RAVISANKAR AND V. VENKATESWARULU

INTRODUCTION

Since the 1994 International Conference on Population and Development (ICPD) placed Adolescent Sexual and Reproductive Health (ASRH) on the global policy agenda many governments have pursued strategies to address the specific sexual and reproductive health needs of adolescents.[1] However, the large relative proportion of young people in low and middle-income countries have relatively high rates of teenage pregnancy, unwanted pregnancy, maternal mortality, unsafe abortion and STIs/RTIs and HIV/AIDS which indicates the need for greater improvement in service usage.[2,3] Many adolescents underuse sexual and reproductive health (SRH) services due to barriers such as lack of or incorrect knowledge on SRH issues, service costs and distance, lack of awareness about where to get contraceptives and STI treatment, embarrassment, lack of confidentiality and privacy, and negative provider attitudes.[4]

On the other side, in India the stratification of social class (caste) is one of the strongest social determinants of health.[5] In India, the term 'socially backward classes' is commonly used to describe some of the most socially disadvantaged groups, which includes the scheduled castes (SC) and scheduled tribes (ST). Furthermore, caste has been shown to be the most appropriate household characteristic for identifying poor and disadvantaged households. They are not only distinguished by economic poverty but also by their marginalization and seclusion from the rest of the society, having different traditions and living in the most economically disadvantaged areas.[5] Besides, they have less knowledge, poor information and lack of awareness about physical and physiological changes associated with the

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Footnotes: should be avoided. If essential, it should appear at the bottom of the respective page and must be indicated with an asterisk(*).

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Each statement may be supported by the author with a logical explanation, the author's opinion, illustration, or citation/paraphrasing of another author's work. Without citing the source, use of other's written **work** amounts to plagiarism and, thereby, fraud.

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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.

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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.

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