Chapter 1
Introduction and Review of Literature

Women have internalized the ethic of nobility in suffering such that pain and discomfort emanating from their reproductive and sexual roles are accepted as the very essence of womanhood. Social stigma and hence the culture of silence [are] attached to sexual and reproductive problems, the genesis of which is invariably perceived to be women.

(Kisekka, 1989)

Introduction

There has been a broad acknowledgment of the enormity of health problems confronting women in and there is an endorsement that women in their normal roles as mothers, wives and daughters have been the prime source and distributors of good health to their families and therefore to the community as a whole. Yet when it comes to their own health needs, women in India experience low preference. Attempts to address the requirements of women in developing countries, and particularly in India, have engaged mainly on their roles as mothers and child care givers. Any effort to assess the problems of Indian women and to eradicate impediments to their development is unfinished without a look at their social status, culture, tradition, health seeking and dietary behaviour. Social and behavioral dimensions have received scant attention in the recent past as a means of filling the gaps of program addressing the health needs of women. In view of the physical, geographical, ecological and social diversities in India, reaching these goals within the shortest time is a challenging task.

Exigency for public services is constantly disseminated across space, broadly in accordance with the distribution of population, but unfortunately these services are only provided at secluded settings. Predictably therefore, there will be disparities of access in terms of the utility of using services, transport costs, travel time and so on. Geographical factors, such as physical proximity, travel time etc. are not the only aspects which influence access to healthcare. Other dimensions are social, financial and functional. *Social* accessibility to healthcare may generally depend on race, age, sex and other social characteristics of individuals as well as relationship between

patient and the doctor. *Financial* accessibility depends upon the price of a particular healthcare and *functional* accessibility reflects the amount and structure of provided services. This can vary among different countries or regions of the world, but the one thing that is common in almost all part of the globe is the widening gap between the periphery and its centre. Hence the present study is focused in an area which located in the periphery (Manipur) of the centre (India), to realize the status of one of the most neglected and underexplored field for both academicians and policy makers i.e. reproductive health of one of the most deprived section of the society i.e. women in one of the most destitute settings of the globe.

Statement of Research problem

Health is fundamental to the national progress in any sphere. The health conditions in one phase of a woman's life affect other phases of her life as well as the health and well-being of future generations. WHO has advocated strongly for a lifespan approach to women's health from conception to old age. It has also emphasised on multicultural action for women's health, particularly in the areas of raising female literacy, creating opportunities for income generation, increasing the participation of women in national development and in short, empowering women to make decisions on matters that impact their health. Reproductive and sexual health and rights are essential for the empowerment of women and to all quality of life issues concerning social, economic, political and cultural participation by women.

Empowerment has its impact on the all round development of women, particularly their health. Increased empowerment of women is likely to increase their awareness of the health problems faced by them, their symptoms and facilities available to cure them, and it also encourages the ability to seek out and use health services better to meet their own reproductive health goals, including the goal of safe motherhood.

It is well recognised that in patriarchal settings such as in India, hierarchical gender relations and unequal gender norms impact women's sexual and reproductive health and choice and act as significant obstacles to access of services and facilities. Equally, the achievement of good sexual and reproductive health may be inhibited by structural factors such as poverty and malnutrition, early marriage and inadequate educational and health systems. Gender roles have significant implications for sexual and reproductive health and choice. Gender norms condone early onset of sexual activity,

pre-marital and extra-marital casual sexual relations and sex worker contacts among young males while severely prescribing even the hint of sexual misconduct among young females, as lack of awareness, lack of spousal intimacy and communication on sexual matters, and widespread gender-based violence compound women's inability to negotiate safe sex, seek appropriate health care or experience a healthy pregnancy. Finally, gender roles that perpetuate the 'culture of silence' inhibit women from communicating a health problem or seeking prompt treatment unless it inhibits them from carrying out their daily chores. This 'culture of silence' is even more exaggerated for gynecological and reproductive morbidity that are so closely linked with sexuality.

Since the 1990's women have been identified as key agents of sustainable development and women's equality and empowerment are seen as central to a more holistic approach towards establishing new patterns and processes of development that are sustainable. The World Bank has suggested that empowerment of women should be a key aspect of all social development programs (World Bank, 2001). Although a considerable debate on what constitutes empowerment exists Kabeer's (2001) definition: "The expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them." For women in India, this suggests empowerment in several realms: personal, familial, economic and political. Hence, empowerment has its impact on the all round development of women, particularly their health. Increased empowerment of women is likely to increase their awareness of the health problems faced by them, their symptoms and facilities available to cure them, and it also encourages the ability to seek out and use health services to better meet their own reproductive health goals, including the goal of safe motherhood.

In Manipur, in spite of the several attempts by the government to uplift the status of women through different projects seems not reaching the expected outcome as the society and the culture with their unscientific beliefs and rituals are creating an atmosphere that is not encouraging these changes to reach its desired outcome. Hence the proposed study is aimed to unearth the patterns of reproductive health emerging under impact of education, economy, decision making among women. It is of prime interest to discover the actual reasons behind the backwardness of women's health in

one of the most backward part of the country, what we call the north east region and particularly Manipur as there is dearth of serious research work on this issue.

Theoretical framework of health and medicine

Given the extensive and diverse nature of the sociology of health and medicine, any explanation needs to attend to the substantive research topics as well as the theoretical frameworks that have justified the approach to research. The problem-solving orientation and fusion disciplinary nature of much research relevant to medical sociology, with its strong empirical tradition, means that a theoretical position is not always overtly described in published research. Researchers have often taken a very practical approach to theory, picking elements that serve specific purposes. Despite its sometimes implicit and frequently fragmentary nature, social theory is nonetheless a key attribute of the sociology of health and medicine, and seen as distinguishing it from other social sciences approaches. Here we are focusing on the theoretical developments of the discipline from functionalism to realism, via interactionism.

Parsons and functionalism

The beginnings of medical sociology are contested and there is dispute as to who were the key figures. Do we start with the mid-nineteenth-century reformers who recognized the statistical link between social positions and rates of morbidity and mortality? Do we follow Foucault's suggestion and tie the origins of sociology to those of modern medicine and the emergence of anatomical, sociological and demographic bodies as objects of interest? Whether or not he is regarded as the founding father, there's no denying the significance of Talcott Parson's work for the subsequent development of medical sociology as a body of research recognized by other disciplines. Parsons offered medical sociology an 'academic respectability by providing its inaugural theoretical orientation' in the shape of structural functionalism, calling attention to its potential as an area of sociological inquiry. Parsons recognized the doctor-patient relationship as a social system built upon Emile Durkheim's interest in the societal norms, structures and processes which were beyond individuals and whose effect is social cohesion

Like Durkheim's explanations of suicide in terms of social facts, Parsons sought to analyze individual behavior in the context of large-scale social systems and the link

between the two was ‘pattern variables’ which structure any system of interaction. His interest in ill health was in terms of its influence on the wider functioning of society: high levels of illness and low levels of health being dysfunctional for society, preventing people from fulfilling their social roles. A certain level of good health in the population was, in Parsons’ view, a key social resource for the efficient functioning of society, with medicine working to maintain this favorable level of health. The onset of illness was of interest to Parsons because it prevented the fulfillment of social rules, such as paid employment and parental duties, and he also conceptualized disease as motivated in some measure. The motivation to withdraw from social roles and to be cared for as a sick person is, in this model, countered by the medical practitioner. Where a person’s ill health requires a relinquishing of normal social roles, he or she is expected to visit a doctor and this encounter involves a reciprocal set of obligations and privileges. The incapacitated person is offered a niche, termed ‘the sick role’, where expectations are lifted and he or she is permitted time off to recover. The sick role offers the privilege of bed rest and the suspension of domestic and employment duties, on condition that professional help is sought out and full cooperation is ceded to the physician. In return, the physician is reciprocally obliged to act in the patient’s best interests and to offer technically competent care in an objective fashion. Writing in the USA, Parsons underlined that the patient’s welfare, rather than personal or commercial gains through the profit motive, must inform the physician’s actions towards the patient. Where doctors achieve the required affect, neutrality and technical competence in the skilful application of medical knowledge to their patients’ problems, they are granted the freedom to behave as autonomous professionals, and have privileged access to patients’ bodies in ways that would be taboo under other circumstances.

Parsons described an ideal type, delineating institutionalized roles of doctor and patient that were reciprocal, consensual and functioned to reduce the social costs of deviant illness behavior, such as hypochondria and malingering. The doctor’s official sanctioning of a state of illness discourages illegitimate claims to the privileges of the sick role and means that doctors and the medical diagnoses they make regulate access to sickness benefit, sick leave and treatment. Parsons saw the reciprocal obligation on the patient to make an effort to recover as the means whereby people were returned to the performance of their normal social roles as rapidly as possible, thereby reducing

the harm done to the social consensus by illness. Blaxter describes Parsons' theoretical proposition as: 'if the function of institutions is to maintain social stability, then these are the rules which are necessarily followed in the case of medicine'.

Theories of conflict and political economy

While Talcott Parsons' (1951) work on the sick role gave medical sociology a place in mainstream sociology, it was the work of Eliot Freidson (1952-2005) that gave medical sociology its critical dimension. *Profession of medicine* published in 1970 defined the boundaries of medical sociology, suggesting how sociological perspectives on the practice and profession of medicine as well as on health an illness could be examined. By introducing a conflict perspective to the study of medicine and taking patients' perspectives seriously, the claims of the then powerful medical profession were interrogated. Freidson advocated a distinctive kind of medical sociology that applied structural perspectives to medical institutions and yet remained 'detached from medicine's own viewpoints and assumptions'.

Blaxter (2004: 95) points out that conflict theory focuses attention on sources of ill health in the economic environment and on the competition of rival interests in the health care sector, and hence are preoccupied with the relationship between medicine and society. She suggests that this preoccupation has distracted research interest from the broader issue of the relationship between health and society. Political economy approaches to health have the class struggle for resources at the centre of analysis, and the influence of the approach has informed understandings of other social divisions as similarly conflict-driven. Conflict theory has shaped feminist medical sociological analyses of the sexist treatment of women by physicians and the disadvantaged position of women within the medical profession. Analysis of the medical division of labor and iniquitous patients' outcomes in racialized groups interrogates another system of privilege and power. While analyses that include class, gender and racism in a single analytic framework are an ideal, the tendency to collapse all systems of inequality derives from the influence of the political economy approach to health.

A political economy approach emphasizes that under capitalism person's relationship to the means of production is central to understanding not only their position in the hierarchy, but also their prospects of wealth and health. Research by Fredrich Engels (1820-1895) showed that the etiology and distribution of the main diseases

(communicable and incommunicable) are directly associated with the means of production (Engels, 1971 [1845]). This early social class mapping of disease incidence, pointed up the centrality of socio-economic structures to understanding people's living conditions, including their experiences of illness, and indicated that individual medical intervention could not, of itself hope to eradicate disease. The central insight of the political economy approach is to understand disease as socially produced or not, as the medical model would suggest a result of the random occurrence of infection and environmental and congenital misfortune to luckless individuals.

Political economists of health describe how capitalism's relentless pursuit of pursuit of profit is regularly in direct contradiction to workers' health and how medicine is entangled in the capitalist system through its statutory roles and its relationships with a range of industries. Under highly developed capitalism, where all dimensions of life are dominated

by the unregulated market, the welfare state and National Health Service is left with the unenviable and, by definition, impossible job of solving the health problems created by the pursuit of profit. In view of the failure of state socialism in the former Soviet Union and its modification towards capitalist forms of trade in China, there seems to be no serious alternative economic system to rival capitalism (Waitzkin, 2000). Thus, any system of healthcare apparently serves to maintain the workforce for ongoing employment in a capitalist system. Physicians have been criticized on grounds of the professional dominance (for which they have campaigned) within the division of healthcare and the statutory responsibility that they hold to keep the workforce healthy for the smooth-running of the economy. However, the political economy view suggests it is unfair to hold the medical profession responsible for medicine's complicity in the capitalist oppression of workers. Physicians are merely the lackeys of capitalism, rather than the main authors of disaster. In this view, health is simply another arena in which capital can operate in pursuit of profit and the multiplicity of ways in which this can be done is breath-taking; from the big business of servicing clinical settings with personnel and equipment for cleaning and catering to pharmacogenetic products at the forefront of big science.

Inequalities and social stratification

The observation that one's experience of illness and chances of premature death are related to one's position in the socio-economic hierarchy is central to the study of health inequalities. Marx saw a social class as a group of individuals who shared similar conditions and circumstances which might have an environmental impact on health, but also as a collectivity that shared a similar history and identified its common interests to some extent. An identification of group interests facilities a class-consciousness which may lead to collective negotiation and hence action to ameliorate class interests.

The Marxist classification of people into workers and owners, while highlighting important historical changes arising from the industrial revolution, is too crude to be useful for the ongoing study of health inequalities. A materialist emphasis persists in the ongoing interest in class-based health inequalities, but it has been modified by a Weberian insistence that forms of status other than economic superiority should be considered in the measurement of social status. The main index of social stratification used by the UK's national statistics office is the 'National Statistics – Socioeconomic Classification' (NS-SEC) which considers the characteristics of a person's employment as well as their position in the labor market. This index seeks to capture whether or not the job is routine, skilled or professional and the extent to which it involves power over other employees, and in these respects is an improvement on its predecessor, the 'Registrar General Social Class classification', which relied on individual referees' rankings given to particular occupations of their 'general standing'. Despite the somewhat subjective nature of the Registrar General classification, throughout the twentieth century it nonetheless consistently demonstrated the inverse relationship between high social class and low rates of morbidity and premature mortality that Engels and Chadwick had identified in the nineteenth century. Alternative indices of socio-economic class, such as the Erikson-Goldthrope scheme and the Cambridge scale of occupations, rely on different weightings for aspects of social, occupational and economic life. The ongoing research into the relationship between socio-economic differentials and health outcomes has not settled the issue of the extent to which aspects of income or of lifestyle associated with absolute or with relative poverty are responsible.

Recent controversies have centered on how relative poverty, that is, having basic requirements for food, clothing and shelter met but living near the bottom rung of a wealthy society characterized by inequality, potentially damages health through psycho-social influences on the immune system. The persistence of inequalities in mortality and morbidity, even as life expectancy in wealthy nations has consistently risen, suggests that competition for scarce resources is a better model of human society than the value-consensus cooperation imagined by structural functionalism. In a competitive environment, a key resource is the possibility of an extended and disease-free life. Measurement of inequality in mortality rates has been shown to be sensitive to the degree to which equality of opportunity characterizes a society: social democracies with redistributive central taxation and high quality provision of social services have smaller disparities in mortality rates between rich and poor compared with countries without policies of reallocating social resources through education, health and social care services. The importance of equality of opportunity and social cohesion for the well-being of individuals seems to go beyond an individual's interest in the functioning of social institutions such as hospitals and schools and has been described in terms of social capital.

Turner (2004: 13) defines social capital as the social investments of individuals in society in terms of membership in groups, networks and institutions, which serves to measure the extent of reciprocity in a society and the degree of trust. A high level of income inequality reduces social trust between citizens and thereby degrades the social environment and, hence, individuals' health. The mechanisms that cause high social capital to be translated into good measures of individual health are controversial, with various models of the appropriate role of state and citizen in contention. A materialist view suggests that high levels of income inequality relate to poor health outcomes because of consistent under-investment in infrastructure (including schools, libraries, hospitals, parks, housing) that sustains the population's well-being. An individualist psycho-social interpretation contends that the trust and cohesion that typifies an equitable society provokes a good psychological response from individuals which translates into good health (Kawachi and Kennedy, 1997).

Interactionism

As with the rise of political economy approaches, interactionism developed as a means of interrogating vested interests. While interactionism is recognizable as a widespread practice in sociology, it is not a coherent theoretical position in the same sense as the structural functionalism against which early interactionists were reacting. Developed from the work of George Herbert Mead (1865-1931), the central proposition of interactionism is that the self is a social product, dependent on interactions with and responses from other people. As creative and thinking beings, people can choose their own behavior to a great extent. Annandale (1998: 22) pinpoints the contradiction inherent in any interactionist encounter: how the individual both modifies and is modified by the social relations of health and illness in which she or he participates. This theoretical paradox is central to any interactionist encounter where that encounter constitutes both the location where human agency occurs but also the main impediment to its growth. While the tension of apprehending human agency within a structural context is not confined to interactionism, a focus on constraints on patient agency in medical encounters in interactionist research has shown how little power patients often wield. Much qualitative medical sociological research has promoted the patient's point of view in the patient-carer interaction, with a particular interest in exploring the turn-taking, negotiation and blocking that occurs during the course of medical work, and the means whereby professionals' priorities are asserted.

Gerhadt distinguishes two forms of interactionist model in medical sociology: crisis and negotiation models (1989: 89). The crisis model is associated with labeling theory as exemplified by the anti-psychiatry movement which sees medicine as a dominant profession in the process of ascribing and validating a status such as 'mentally ill' (Scambler, 2002: 17). Gerhardt's negotiation model sees the interaction between healthcare professional and patient as more open in the process of creating meaning: while professionals may dominate in defining the meaning of an interaction, the possibility of a consensual negotiated definition is at least mooted(1989: 90).

Goffman (1922-1982) offered a dramaturgical analysis of rule-governed encounters between healthcare professionals and patients, and the ways that these performances played out in a constrained but not entirely scripted fashion (Scambler, 2002:18). While Goffman's work cannot easily be subsumed under a single theoretical

perspective, influential aspects are close to Gerhardt's view of a negotiated version of interactionism. Interactionism is commonly criticized for having little to say with regard to social structures and as better able to analyzed agency than structure: there is more capacity to analyzed the life-world than the convert constraints of the structural features of systems.

Phenomenology

Phenomenology offers another means of apprehending the social world, and therefore the world of illness, by interrogating how social reality is maintained. Harold Garfinkel (1971-2011) developed theories about how we constitute the everyday knowledge on which we rely into the practice of ethnomethodolgy, which concentrates on how we create and share social order but does not seek to validate these methods of production against an external benchmark. Garfinkel paid particular attention to what happens when the everyday routines of life which constitute reality are disrupted, noting that people's strong attachment to the rules that govern daily routine lead to a designation of rule-breakers as deviants. The analysis of talk between health professional and patient to ascertain how meaning is negotiated, resisted and achieved through interaction and speech has been an important contribution to medical sociology.

Gerhardt (1989: 196) points out that the phenomenological view only conceptualizes illness as trouble, which, arguably, elicits one of two possible responses. First, the ill person can neutralize their environment and reduce their participation to avoid 'deviant' encounters with others or, second, the trouble can be diagnosed and dealt with by an expert. This view allows for consideration of how the clinical encounter is achieved, but does not offer space for consideration of how medical dominance happens, nor how it might be resisted. More generally, and in common with interactionism, phenomenology stands accused of paying insufficient attention to power, to hierarchy and, crucially, to diagnosing how current social structures might be overthrown or otherwise transformed.

Social constructionism

Social constructionism is arguably the most pervasive and influential legacy of post-modern theory. A constructionist view holds that knowledge or practice that is normal and taken for granted can be understood as a result of the particular power relations pertaining in that historical and social context. Understanding disciplinary knowledge as socially constructed in the context of a particular regime of authority has been the basis of a powerful critique of medicine, as exemplified by the work of Foucault. Foucault provided a means of analyzing the medicalization of society by seeing the exercise of medical power as operating via diffuse and diverse local factors, rather than through a central or unified power structure. Focault's work shows that power and knowledge ('savoir') are key to understanding medical institutions medical institutions and how the moral character of disease categories operates in quotidian settings. Foucault's interest in medicalization was part of a wider survey of 'the institution of normative coercion' including the law and religion as well as medicine (Turner, 1992). Foucault's analysis of institutional discipline over individual behavior through medical systems of surveillance placed medical sociology as less marginal to the concerns of a broader sociological project.

Of course, the work of sociology itself can also be understood as a construction, or interpretation of signs and symbols, against which there is no external measure of intrinsic, fixed validity. The deconstruction of the truths of sociology has been taken up enthusiastically by feminist scholars analyzing binary divisions between male-female and masculine-feminine as a powerful construction that defines a class of women apart from men. The binary social construction of gender creates an expectation of false opposition, such that men are assumed to have more in common with other men than with women, and features that are associated with masculinity cannot then be associated with women and the feminine. Feminism has built on this insight across all areas of sociology, including medical sociology, such that gender has become an almost routine dimension of sociological enquiry. Taken-for-granted norms around sexuality, race, disability and age have been successfully and convincingly exploded by taking a social constructionist approach to understanding marginalized groups as constructed through highly partial value judgments being promoted as neutral, often with the support of medical authority.

Health is generally defined as a state of well-being (physical and/or psychological), but sociological theories differ in their interpretation of the social meaning of illness. For example, as Gerhardt (1989) pointed out, structural-functionalism assigns responsibility for one's health to the individual; symbolic interaction theory sees illness in terms of stigmatization and proposes that societal and cultural influences impinge upon individuals' perception of health, self-determination, and ability to negotiate their situation; phenomenology sees the situation as ''trouble-trust dialectics''; and conflict theory addresses the questions of power and domination and associates illness with a surfacing of the everyday conflict that results from social, ''political, and economic inequity,'' an argument also pursued by Marxist and neo-Marxist approaches.

Ultimately, the interest of the theoretical positions outlined here lies in their ability to offer critical perspectives on the relationship between people's experience of illness, seeking healthcare and their place in wider social structures. The biggest factors in seeking to understand these social processes hitherto have been the inequalities in social position and the institution of medicine. Despite enormous changes since medical sociology emerged as a distinct area of sociology, in terms of the configuration of social and economic hierarchies and the statutory and commercial roles played by medicine, in many ways its core interests remain unchanged. Ever since Parsons' time, sociologists have sought to understand the regulation of health and illness in terms of the individual and the wider social order.

Questions of balance between developing theoretical frameworks and pursuing empirical enquiry crystallized in the accusation that medical sociology is a theoretical and empiricist. Such a challenge, issued from a comparative perspective, should not, perhaps, provoke an absolute response. Strident assertions that 'Medical sociology has become a theoretical discipline' and 'The notion that medical sociology is a theoretical is wrong', suggest an over-sensitivity about medical sociology's image in the academic world. While medical sociology indubitably debates and tests theoretical ideas, compared with some branches of sociology, it retains, by definition, an interest in questions that relate to policy, practice and lived experience. The interest in practice and policy has kept medical sociology abreast of the world of science and technology and of government, in terms of imagining possible futures and the ways in which they might alter our humanity with both social and individual terms of

reference. Medical sociology's merit should lie in understanding the excitement of scientific and technological innovation without being dazzled by its salutary potential and keeping sight of its implications in terms of social justice.

A Healthy Lifestyle Theory

William Cockerham health lifestyle theory combines the ideas of agency and structure to demonstrate that in modern society, not all individuals are provided equal opportunity to be healthy. Cockerham uses *agency* to refer to an individual's ability to choose a behavior (or action), and notes that there must be alternative options that the individual does not choose. *Structure* is defined as "sets of mutually sustaining schemas and resources that empower or constrain social action and tend to be reproduced by that social action."

According to Cockerham there are four categories of structural variables that have the capacity to shape health lifestyles: (1) class circumstances, (2) age, gender, and race/ethnicity, (3) collectivities, and (4) living conditions."

Class circumstances work to shape health lifestyles, unhealthy eating habits are a reality for the low class people, not by their own agency, but instead because of a structural disadvantage.

Less information is available for the effects of age, gender, and race/ethnicity shapes lifestyles, however, studies consistently show that there are significant differences in health for each of these categories.

Collectivities are defined by Cockerham as "collections of people linked together through particular social relationships, such as kinship, work, religion, and politics. These shared norms, values, ideals, and social perspectives constitute intersubjective thought communities." Religion serves as a strong example of how these thought communities affect health as those who are more invested in religion will, in most cases, be less inclined to partake in unhealthy behaviors such as drinking or smoking.

His final structural component is living situation. Differences in the quality of housing and access to basic utilities (such as electricity, gas, heating, sewers, indoor plumbing, hot water), as well as neighborhood facilities including grocery stores, parks,

recreation, and personal safety no doubt account for disparities in access to health for different people.

These four variables are responsible for creating the opportunities that an individual will have in their lifetime, and due to the varying circumstances that different people are born into, the opportunities one person encounters will not be the same as someone else.

In regard to the agency aspect of his agency-structure theory, Cockerham “maintains that individuals have the capacity to interpret their situation, make deliberate choices, and attach subjective meaning to their actions.” This is true, people do make their own decisions, however as Cockerham also points out, “all social action takes place in contexts that imply both constraints and opportunities.”

With the realization that a person’s experiences and socialization essentially molds them to be who they are, it can be assumed that these experiences (which are no doubt affected by the four variables above) are partially responsible for the choices that person makes, revealing that even the agency component of being healthy is not completely under individual control.

Reproductive Health: Issues, Development and Definition

According to the United Nations (1995), reproductive health is defined as "a state of complete physical, mental and social 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". This definition implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. The definition encompasses the rights of both men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law. In addition, the definition includes the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Thus, the major components of reproductive health include an individual's informed ability to be involved in sexual relationship, to make effective, acceptable, and affordable contraceptive

choices, and to avail oneself of safe and appropriate healthcare services during pregnancy. These three major components relate to the three proximate determinants of fertility defined by Davis and Blake (1956), namely, intercourse variables, conception or contraception variables and gestation variables.

The concept of reproductive health rights is rooted in the modern human rights system developed under the auspices of the United Nations. In the 1990s, women's reproductive rights were recognized globally and nationally, with a focus on political, economic, social, and cultural rights at both individual and collective levels at the International Conference on Population and Development (ICPD) in 1994 (UNFPA, 1995). Reproductive health rights of women usually indicate the individual rights of women over her reproductive power. The ICPD outlined the right to reproductive autonomy, including the right to privacy and the right to decide the number and spacing of one's children, which ideally should obligate governments that are signatories to ensure that men and women have equal access to a full range of contraceptive choices and reproductive health services; they have access to information and that their decisions pertaining to their reproductive choices are fully respected by the government and third parties (Cabal et al, 2003).

Global Strategy on Reproductive Health

More than a couple of decade ago, at the ICPD, held in Cairo, 179 countries agreed that:

(a) All couples and individuals have the right to decide freely and responsibly the number, spacing and timing of their children, and to have the information and means to do so;

(b) Decisions concerning reproduction should be made free from discrimination, coercion and violence.

A major breakthrough at the ICPD, reaffirmed repeatedly since, is that these services are essential for all people, married and unmarried, including adolescents and youth. For people to realize their reproductive rights, the ICPD Program of Action calls for and defines reproductive and sexual health care in the context of primary health care to include

(a) Family planning;

(b) Antenatal, safe delivery and post-natal care;

(c) Prevention and appropriate treatment of infertility;

(d) Prevention of abortion and management of the consequences of abortion;

(e) Treatment of reproductive tract infections;

(f) Prevention, care and treatment of STIs and HIV/ AIDS;

(g) Information, education and counseling, as appropriate, on human sexuality and reproductive health;

(h) Prevention and surveillance of violence against women care for survivors of violence and other actions to eliminate traditional harmful practices, such as FGM/C;

(i) Appropriate referrals for further diagnosis and management of the above.

At the Fourth World Conference on Women, held in Beijing (1995), governments recognized that entrenched patterns of social and cultural discrimination are major contributors to sexual and reproductive ill health, along with the lack of information and services. SRH efforts are to be coordinated with interventions that address the patterns of social discrimination, gender inequalities and exclusion that hinder women, men and adolescents from exercising their reproductive rights.

In 2000, world leaders met at the United Nations in New York to commit their countries to achieving the Millennium Development Goals (MDGs). In 2005, the World Summit reaffirmed that universal access to reproductive health is critical to achieving the MDGs. In October 2007, of the target of universal access to reproductive health was added to MDGs, for improving maternal health. By this action, countries validated once more the critical importance of SRH program to meeting the MDGs. The inclusion of the target on universal access to reproductive health is an opportunity for a renewed commitment to further advance the SRH agenda.

In May 2004, the 57th World Health Assembly adopted the World Health Organization's first strategy on reproductive health. The aim is to accelerate progress towards meeting the Millennium Development Goals and reproductive health goals of the ICPD and its five-year follow-up. The strategy identifies five priority aspects of reproductive and sexual health:

(1) Improving antenatal, delivery, postpartum and newborn care;

(2) Improving high-quality services for family planning, including infertility services;

(3) Eliminating unsafe abortion;

(4) Combating STIs, including HIV, reproductive tract infections, cervic cancer and other gynecological morbidities;

(5) Promoting sexual health

The Assembly recognized the ICDP Program of Action, and urged countries to:

(1) Adopt and implement the new strategy as part of national efforts to achieve the MDGs;

(2) Make reproductive and sexual health an integral part of planning and budgeting;

(3) Strengthen health systems' capacities to provide universal access to reproductive and sexual healthcare, particularly maternal and neonatal health, with the participation of communities and NGOs

(4) Ensure that implementation benefits the poor and other marginalized groups including adolescents and men;

(5) Including all aspects of reproductive and sexual health in national monitoring and reporting on progress towards the MDGs.

Indian scenario

India was the first country to have a national government supported family planning/ welfare program beginning from 1952 and till the late 1990s, ie post ICPD, the Indian government has focused on sexual and reproductive health mainly through the population control policies (Visaria, et.al, 1999). As a commitment towards the ICPD , the Government of India introduced a number of changes in the national population and family welfare program. Removal of method specific targets, and formulation of the National Population Policy (NPP 2000) (Ministry of Health and Family Welfare, India. 2000) based on the principles of the ICPD and introduction of a program dedicated to improvement of reproductive and sexual health – the Reproductive and Child Health Program are some of the milestones. The second phase of the Reproductive and Child Health Program RCH II (Ministry of health and Family

Welfare, India, 2004) – was launched in 2005 with a vision to bring about outcomes as envisioned in the Millennium Development Goals.

Maternal Health Situation in India

While a state wise disaggregation and analysis has been done of states with high and low MMRs (Special Bulletin of Maternal Mortality in India, 2009), an analysis of who are the women who die has not been included in this report. The decreasing maternal mortality ratio for India as a whole hides wide discrepancies between states and different communities in the area of maternal health.

Data from the National Family Health Survey (NFHS) 3 shows that women from poorer wealth quintiles and scheduled castes and tribes have poorer health indicators including in receiving antenatal care and skilled birth attendance, having an institutional delivery, and in levels of anemia. Social grouping, education and economic class are thus important social determinants of maternal health in India.

Skilled Birth Attendance, Institutional Deliveries, or Safe Deliveries

The National Family Health Survey states that 47% of births in the five years preceding the survey are assisted by health personnel. 37% are assisted by a traditional birth attendant (TBA) and 16% are assisted by only friends, relatives, or other persons (NFHS-3, India, 2005-06). According to the GOI, the unsatisfactory increase in skilled attendance at birth is due to poor progress in institutional deliveries (MDGs – India, Report 2011).

In an effort to promote institutional deliveries, the Government of India launched a conditional cash transfer scheme called the Janani Suraksha Yojana (JSY) (Ministry of Health and Family Welfare, Janani Suraksha Yojana, 2006). The scheme gives a cash benefit – different across different states – to Below Poverty Line women who deliver in accredited private institutions. There is evidence that JSY has resulted in increasing the number of institutional deliveries and probably contributed to reducing neonatal deaths (Hunt Paul, 2010), (Kumar Satish, 2010), (Special Bulletin of Maternal Mortality in India, 2009)

Contraceptive Prevalence Rates

This is a globally accepted indicator of health, population, development and women's empowerment and a proxy indicator of access to reproductive health services. Reducing Total Fertility Rate to 2.1 by 2012 is an important goal of the GOI – and the government acknowledges that both increase in the Contraceptive Prevalence Rate and reduction in the Unmet Need for Family Planning can contribute towards this (Planning Commission of India. Mid-Term Appraisal, 2011). The contraceptive Prevalence Rate among currently married women is 56 percent, up from 48 percent in NFHS-2 (Iyengar K, et.al, 2009). Contraceptive use in India is characterized by:

- The predominance of non-reversible methods, particularly female sterilization - 66% of all contraception use is female sterilisation (NFHS-3, 2005-2006).
- Limited use of male methods – condoms 5.3%, male sterilization 1% (NFHS-3, 2005-2006).
- High discontinuation rates among those who use temporary methods (NFHS-3, 2005-2006) and
- Negligible use of contraceptives among both married and unmarried adolescents (Santhya, KG, 2003).

Antenatal Care

Three Antenatal care checkups, a sensitive indicator of access to outreach care in pregnancy has improved in rural areas from 36.7% in 2005 to 63.3% in 2009, according to a recent NRHM review (Planning Commission of India, 2011). The NFHS 3 points out the usual inequities in ante natal care - women not receiving antenatal care tend disproportionately to be older women, women having children of higher birth orders, scheduled tribe women, women with no education, and women in households with a low wealth index (Iyengar K, et.al, 2009).

Quality of ANC is a serious issue. Complete ANC is hardly provided. Skills of measuring blood pressure, assessing anemia amongst Auxiliary Nurse Midwives are woefully deficient (Nair, Harish, Rajmohan Panda, 2011),(Dr.Sri Subha, 2011).

Unmet Need for Family Planning

The accepted definition of unmet need for contraception is the percentage of fertile married women in reproductive age group who do not want to become pregnant and are not using contraceptives. The concept of unmet need however should assess the need for contraception based on whether and when a woman wants a child.

Unmet need for family planning is an important indicator for assessing the potential demand for contraceptive services. According to NFHS 3 (Iyengar K, et.al, 2009), 13% of currently married women in India have an unmet need for Family Planning. Unmet need for spacing is highest between 15 and 24 years. Unmet need for limiting is highest between 25 and 34 years (almost 20%).

Postnatal Care

Considering that 60% of deaths occur after delivery, only 1 in 6 women receives postnatal care (UNICEF, 2001-2003). Urban, literate, women living in households with higher standards of living, those who delivered with the assistance of a health professional rather than a traditional birth attendant were more likely to be followed up with a post partum check up (Iyengar K, et.al, 2009).

Access to safe abortions

As mentioned above, abortion accounts for 8 % of maternal deaths. Yet access to safe abortion services is not an indicator for Universal Access to Reproductive Health. Access to services for Medical Termination of Pregnancy (MTP) is still limited at peripheral levels due to a various factors including lack of fully equipped facilities, trained staff and drugs. (Reproductive & Child Health Program II, 2009)

A related issue is the effect of the deteriorating sex ratio on access to safe abortions. Census of India 2011 shows that the existing child sex ratio (0 to 6 years) has further deteriorated (from 927 females per 1000 males in 2001 to 914 females per 1000 males in 2011) (Census of India, 2011). Fears of sex selection and sex determination and the ineffective implementation of the Pre Conception Pre Natal Diagnostics Techniques Act (1994), are causing a knee jerk reactions in the highest government circles and there are moves to tighten access to safe abortions, like ‘mandatory counselling of women seeking abortion’, and restricting second trimester abortions (Nandan Jha Durgesh , 2011).

Infertility

Childlessness has serious demographic, social and health consequences. Motherhood is important in India for socio cultural reasons and continuity of marriage.

Analysis of the NFHS and DLHS data shows infertility rates are high among women in urban areas, maybe because of higher educational attainment and later age of marriage. Among population groups, scheduled tribes have higher infertility rates (Ganguly, Unisa Sayeed, 2010). Half the women belonging to low socio economic group used allopathic infertility treatment, probably because infertility treatment is limited or unavailable in public health sector. Basic low cost diagnostic and treatment services including health education are required at community level health facilities (Unisa Sayeed, 2010)

Nutritional status of women and girls

Anemia and Malnutrition are not tracked as part of MDG monitoring. These are cross cutting issues between MDG 1 on Poverty and Hunger and MDG 5 on Maternal Health and are discussed below in the section on determinants of Maternal Health.

Although India's health policies were somewhat progressive with respect to SRHR and after the ICPD at Cairo, became even more progressive, the main problem has been in the implementation of well conceived programs. The National Rural Health Mission has attempted to bridge some of the implementation gaps by attempting to strengthen the public health system. Even so, the progress on the MDGs is slow in India (MDGs, India, 2011), (Jan Swasthya Abhiyan. MDG 5, 2010).

Review of Literature

The review of literature has been done thematically and discussed on the basis of following themes and subthemes.

Cultural construction of fertility and childbirth

Nitcher (1989), in his South Asian case studies examined the cultural notions of fertility in Sri lanka and its impact on family planning practices. He also wrote about findings on ethno-physiology and food consumption practices during pregnancy. Nitcher (1981) demonstrated that South Indian Women eat less during pregnancy so they will deliver small babies, not just to ease the birth process but rather to give their bodies more space inside their womb while they are growing. Women in this study reported that if they ate a lot during pregnancy, the food would occupy the "baby space" inside them preventing a baby from growing.

Adetunji (1996), describes the traditional conceptualization of parental care in a Nigerian community and draws its implication for effective delivery of reproductive health services in the area. The findings highlights a local metaphor that linked the risks of pregnancy and childbirth to a group of women that trekked to a local brook to fetch water with their earthen pots, some fell, broke their pots, some missed steps and split their water but kept their pots and others returned without any mishap.

Laishram (2002) in the study of the impact of traditional way of life on the Manipuri girls finds that during the period of menstruation a Manipuri girl and a woman are treated as untouchable in most of the families. During the period taking bath and sex is restricted; cooking is prohibited, even for the family members. However, at many urban areas, relaxations from this taboo can be observed. Such behaviours are not observed among the tribal women folks.

Krisnakumari Pebam (2012), In her study on reproductive health of women in Manipur comparing two areas (Andro & Kwakeithel) reveals that belief and practices like not taking bath during menstruation for fear of polluting the surrounding with menstrual blood which may be affect their reproductive health. Almost all the respondents of Andro and nearly half of the respondents of Kwakeithel were not using sanitary napkin for soaking the menstrual blood. Most commonly reported symptoms

among the respondents are vaginal discharge, menstrual problem, prolapsed, digestive problem, circulatory/respiratory, infertility and weakness problem during intercourse but majority of the respondents were not given treatment for this problem, they remain silent and bear the brunt of illness because of fear of being stigmatized or encroaching tabooed. She suggests that there is a need to make the women aware on the consequences and effect of hiding and prolonging such illness. More over in her study she found that a good number of respondents delivery were handling by the untrained dais (maibees) and belief of cutting the umbilical cord with *wakthou* (a kind of bamboo) so that the child grow tall and sturdy like the bamboo tree can be risky as it is not sterilized.

In his attempt to find out the fertility performance of the Anal women of Lambung Village, Chandel District, Manipur, ***L. Khiloni (2009)*** found that early age at marriage, lower educational status and lower economic status are the main reasons of higher fertility amongst the Anal Naga Tribe (4.3) in comparison to the population of Chandel District (2.8) and Manipur (2.6).

Gynaecological Problems

A survey on high prevalence of gynecological diseases in Gadchiroli district, Maharashtra shows that the most common problem found were anemia, iron deficiency anemia, sickle cell disease, vitamin A deficiency, filariasis, leprosy, urinary tract infection, pulmonary tuberculosis. The survey shows that due to the poor economic condition of women, iron deficiency anemia and vitamin A deficiency were high. The survey further reveals that 55 percent of the women were aware of having gynecological disorders even though, only 7.8 percent of the women ever had a gynecological examination in the past ***(Bang and Bang's ,1989)***.

A study in Madras city among the school and college going student found that a large proportion of adolescent girls suffer from various gynecological problems like menstrual irregularities, headache, stomach pain, excessive bleeding during menstruation and other vague or non –specific symptoms like lethargy and loss of appetite. Nearly two-thirds of those who had problems sought for medical treatment (***Chakravarty's 1989)***.

Shatrugna et al. (1993), studied on the effect of women's work on their reproductive morbidity in a large urban slum showed that in a sample of ill women workers, almost

30 percent complains of gynecological morbidity, the highest category among all other complaints which include "general feelings of ill health", urinal problems, fevers and pregnancy and operation related problems. More women who worked for wages and women who are self employed reported gynecological complaints and general feeling of ill health compared to women who worked with their husband or families and women who are housewives.

A survey of 370 female sex workers in West Bengal revealed that 58.8 percent of these women were suffering from syphilis, 23.2 percent from candidiasis, 13.2 percent from gonorrhoea and 11.1 percent from trichomoniasis. In all, 80.6 percent of these women were infected with single or multiple RTI pathogens (***Singh, 1995***).

***Bhatia and Cleland (1995*)** in their study among the rural women in Karnataka states that one third of all women reported at least one symptom of gynecological morbidity and one tenth of women having sexually transmitted disease comprising of trichomonas vaginalis (75 percent), candidiasis (5.2 percent), syphilis (1.5 percent),and gonorrhoea (0.8 percent). According to their findings, sterilized women are more likely to report morbidity as compared to users of contraceptive methods. Reporting of symptoms was also less among women who delivered in private institutes as compared to those who delivered in government hospitals

Oomman's (1996) study of gynecological morbidity among women in Alipur by the Department of Community Medicine, Maulana Azad Medical College found that 77 percent of women had gynecological complaints. Cytological smears revealed presence of inflammation (62 percent), trichomonas vaginalis (7 percent), condyloma (0.7percent) and candida (0.4 percent). The prevalence of moderate dysplasia or malignancy in this setting was 0.2 percent

Nandini Oomman (2000) shifts attention to another dimension of reproductive ill health among women-one that is endured silently or considered a normal part of Womanhood. These are RTIs and other gynecological morbidities, and include a range of conditions such as menstrual problems, white discharge, infertility, cancer, prolapsed, and problems of intercourse. She highlights the surprisingly widespread experience of morbidities- clinically and laboratory detected, as well as self-reported- as noted in a diverse set of studies conducted in various parts of the country.

Shireen Jejeebhoy (2000) presents what is known about the sexual and reproductive health of adolescents. Her review cautions that adolescents are rarely considered a distinct group with special needs apart from those of children and adults, and that much of the available information is recent and exploratory. The situation depicted by available studies confirms the vulnerability of adolescents, both female and male, and married and unmarried.

Pertti Pelto (2000) focuses on studies of sexual behaviour among adults and youths conducted during the decade of the 1990s. His review provides key findings that advance our understanding of patterns of sexual behaviour in Indian society and provide insights into approaches towards targeting safe sex messages given the rapid spread of HIV.

Jejeebhoy (2000) emphasized the need to address the background factors that are ultimately responsible for maternal ill health and the fore mentioned risk factors. Predominant among these is the situation of women and unequal gender relations. There is widespread misinformation concerning feeding practices, the need of care, and the identification of danger signals and awareness of appropriate facilities in case of any complications.

Bela Ganatra (2000) reviews what we know and what we need to know about induced abortion and its context in India. Despite the fact that the Medical Termination of Pregnancy Act has been in place since 1971, data on the magnitude and patterns of induced abortion in India remain incomplete

Radhika Ramasubban (2000) conducts a more focused investigation of what women and men in India know about STIs. She points out that an estimated 40 million new STIs occur annually in India; the high incidence of untreated STIs would appear to be the principal factor fuelling the HIV epidemic in the country.

Pimawun Boonmongkon et al., (2001) documented from North East Thailand women's experiences of gynecological complaint which broadly encompass symptoms commonly associated with RTI's and pelvic, lower abdominal and back pain associated with hard manual labour, childbearing, menstruation, etc. as well as other symptoms linked to the ''uterus'' (*mot luuk*) through cultural reasoning. In North East Thailand, women suffer from *mot luuk* problems, regardless of whether or not they have a disease that doctors classify as significant and worthy of treatment.

Women's experiences of *mot luuk* problems are influenced by a complex of factors, including the burden of women's work, perception of illness causality that carry social significance, fears that sexual relations will aggravate symptoms and lead to cervical cancer, additional fears that they will lose their husbands to other women if sexual relations are suspended

Lubma Ishaq Bhatti et al. (2002), explores the contextual factors influencing health seeking behaviour of women in Karachi regarding RTI. Cause of RTI reported were "melting bones"consuming food with perceived hot composition, poor personal hygienic and procedures like dilatation and curettage, delivery and induced abortion. Interference with religious activities, sexual relationship or socializing was reported as a consequence of RTI in addition to lower abdominal pain, menstrual irregularities, backache and weakness.

Maha Talaat et.al., (2004) conducted a interdisciplinary study to identify female genital schistosomiasis in an Egyptian hamlet. Clinical assessment was combined with an in-depth study of the social context of reproductive health. Along with 16.7 percent of women having Schistosomia baebatobuim other reproductive tract morbidities were also identified. Clinical examination revealed that 39.5 percent of women suffered from virginities and more than half i.e. 53.3 percent from prolapsed. Laboratory investigations showed an extremely high prevalence of chronic cervictis, 75.6 percent syphilis was detected in 13.1 percent of women. The study identified a number of factors that would affect the reproductive health care in general. It was found that women were unwilling to complain to their husband if they are unwell for fear that they will take another wife or divorce them nor do they discuss these problems with female kin's and friends for fear of stigmatization and shame. Another profound finding is that many women regarded uterine prolapsed as normal so long as it does not interfere with delivery or intercourse. Another finding from this study is misconceptions about family planning and revelation of limited access and use of health care.

In a report of UNDP (2004) on "Beyond Practical Gender Needs: Women in North Eastern and Hill States" submitted by Rural Women Upliftment Society (RWUS) found gynecological and obstetric as one of the common health problems experienced by rural women and young girls in Manipur. Causes of which is identified as heavy workload , sexual harassment by husband, distance of hospitals and dispensaries from

the house, feeling of shyness to complaint about owns health even to own husband. Above all, the poorly equipped health facilities at the community level to deal with gynecological and obstetric morbidities and lack of female doctors specializing in this field is found as the major reason for the rise of patent complaining the particular health problem.

Contraception

In several developing countries women are the targets of the population control policies and the effort to reduce the infant and child mortality. Consequently the family planning programs as well as the programs for child survival do not attend to the needs of women. Inadequate antenatal care, poor and unhygienic attention at childbirth, and unsafe abortions, continue in spite of known risks. It is reported that the women in Africa have 1:21 chance of dying due to pregnancy related causes, whereas the same for women in Asia is 1:54 and in South America it is 1:73, in North America 1:6366 and in Europe the chance is 1:9850 ***Starrs (1987)***

Leela Visaria (2000) focused on the changing profile of contraceptive use dynamics in India and the transition from meeting targets to meeting client needs and expanding their choices. She points out that contraceptive use rates have increased from about 10% in 1970 to an impressive 45.8% in 1997-98, with considerable regional variation.

Gillian Foo and Michael Koenig (2000) describe the Indian family planning program at the ground level with respect to services access and availability, quality and actual implementation. Findings collectively suggest that quality has been severely compromised in the Indian program. At the level of the client, contraceptive choices offered are limited, counselling and information provided inadequate, client provider relation threatening, follow-up and continuity of care largely overlooked and frequent lapses observed in the technical quality of care and the rigor of infection control.

Women Empowerment and Health

Macklin (1989), states that there are three fundamental ethical principles in women's right to reproductive freedom. These are liberty, which guarantees a freedom of action; utility, which defines moral rightness by the greatest for the greatest number; and justice, which requires that everyone has equitable access to necessary goods and services, under this framework, governments have an obligation to provide

information and services for women to exercise their right to reproductive freedom. Feminist argument for reproductive freedom is based on rights to equality, self determination and human dignity.

Bhanwar Rishyasringa (2000) addresses the social processes that influence the situation of women and their ability to make choices. He stresses on macro-level policies and strategies designed to address women's needs, ranging from programs on family planning and more recently, reproductive and child health and women's welfare, to programs designed to create enabling conditions for women to achieve economic freedom.

The edited volume of ***Aparna Mahanta (2002)*** sought to explain the question of women's access to or deprivation of basic human rights as the right to health, education and work, legal rights, rights of working women's, besides issues like domestic violence, all the while keeping the peculiar socio-cultural situation of the North East in mind.

Findings of ***Sunita Kishor and Kamla Gupta (2004*)** revealed that average women in India were disempowered absolutely relative to men, and there had been little change in her empowerment over time. The authors viewed that there were several cogent and pressing reasons for evaluating, promoting and monitoring the level of women's empowerment in India, not the least of which was that household health and nutrition was generally in the hands of women and their empowerment was necessary for ensuring not just their own welfare, but the wellbeing of households. They also asserted that empowerment was critical for the very development of India, as it enhanced the quality and quantity of human resources available for development

Falendra K. Sudan (2005) investigates the relationship between status of women and fertility decisions in rural and urban context in Jammu district of Jammu and Kashmir. The study reveals that the fertility levels are influenced by community access, household level, individual women level and individual child level variables in potent way. However, the individual women level characteristics have more influence on fertility than community access, household level and child level characteristics in both rural and urban areas. At the same time, the influence of individual women level characteristics such as women age, educational and work status along with exposure

to media have more influence in urban context than in the rural, as these are comparatively more pervasive in urban areas than rural areas.

S. Latha (2007) states that the poor reproductive health in India is affected by a variety of socio cultural and biological factors, together with the poor status of the health care delivery system. Thus efforts to improve women's education, by raising enrolment and attendance rate of the girls in school and reducing the dropout rate together with enhancing women's income autonomy are fundamental in the long run, for the improvement of the status of women's health particularly reproductive health in India.

Ainon Nahar Mizan (2000) explains the importance of the demographic, socioeconomic and cultural patterns, to evaluate the status of women in Bangladesh. He asserts that some of these conditions have direct bearing on women's decision-making in the family while others may indirectly influence such power.

Gulati S.C & Rana Patnaik, study of four slums of Delhi reveals that due to lack of education and limited access to relevant pre-natal care services in hospitals and other medical institution amongst women in Delhi slums, only 424 (33 percent) of the total of 1273 full time pregnancies or deliveries the pre natal health care services were utilised. And it further reveals that 86 percent deliveries were taking places in houses with unhygienic conditions. Significantly awareness of at least one family method was very high among the respondents.

M.Tineshowri **(2010)** finds female adolescents continue to be victims of social humiliation with social evils and practices. They are deprived in their understanding, perception and awareness level as the focus of government programs are least touched upon the needs of adolescents groups, but the focus are much more given to HIV/AIDS, family planning program. Finally her findings highlighted the lack of facilities and services available for adolescent groups in RCH programs of both government and NGO health centres, together with the lack of proper training to the health care providers to deal with adolescent population.

In their study to find out the impact of education on the health of rural women in Hanapurna and Kherla ka baas villages of Rajasthan, ***T. Majumdar, M. Das and Nirupama Prakash (2011)*** states that education, has a strong effect on prevalence of RTI and its treatment seeking behaviour. The more women get educated at higher

level the more she becomes aware of her own health problems and consequently she starts taking care and treatment of her health.

B.Pant and others (2008) in their study to assess the magnitude of the problem of RTIs and its social correlates, among the rural women (600 married respondents) aged 15-44 in Meerut. The study concluded that 35.3% of the respondents reported symptoms suggestive of RTI. The study also highlighted the higher prevalence of RTI among the women with lower literacy and poor hygiene. Notably higher prevalence of RTI (40.9%) are among women who are married at an age below 18 years.

Beyond the contributions reviewed above, medical sociologists are also active in international comparative research studying health systems or specific health care sectors within them. They are involved in health policy research both at the federal and at the local community level; they are studying alternative health care providers and their clients as well as various forms of folk medicine and lay care; and they are doing research on informal caregivers and the process of care work. Even these additions do not exhaust the parameters of the field. Medical sociology has enriched and continues to enrich the discipline of sociology, as well as making unique and valuable contributions to important policy issues and to the needs of health care professionals, managers, and patients. Similarly, with the same cause the present study is also an attempt to add to the body of established knowledge on the status of reproductive health of women in both urban and rural setting in a state (Manipur) where we can still discern paucity of literature on the topic.

Taking the aid of phenomenological perspective to identify the perception of the individual (women) on their health (reproductive health) and functionalism to study the status of both traditional and modern heath services in the functioning of the society as a whole, the study promises to unearth many answers to the present crisis of poor status of women health and their empowerment in the state.

Objectives

- To explore the perception and awareness level of the respondents about the reproductive health of women.
- To inquire about the use of contraceptive methods and husband-wife communication on reproduction.
- To inquire about the status of women's reproductive health.
- To find out the relationship between socio-economic background and reproductive health of women.

Methodology:

The research work is descriptive and analytical. It is based on both primary and secondary data. Secondary data are collected from books, journals periodicals and census and primary data are collected through field study. The study is focused on Meitei women of Nagamapal area under Lamphel subdivision of Imphal west district and Heinoubok village under Nambol Sub-Division of Bishnupur district of Manipur. It is focused on 300 Meitei women respondents which are further sub-divided into three age groups viz, a) 16-25 years, b) 26-35 years, c) 36-45 years. The respondents are selected by stratified random sampling. The total 300 respondents are also categories into married and unmarried group. Entire list of the population (who are stratified into marital status and age groups) that is to be covered is prepared from the electoral roll prepared by the election commission and the samples of 300 respondents are selected randomly from the study area. The tools of data collection are interview schedule, field notes, camera and voice recorder and the data is collected with the help of a structured interview schedule covering particularly their status of socio-economic, health, education, nutrition, decision making, cultural factors, their perception and awareness about the health care services. For analysing the data software name statistical packages for social sciences (SPSS 17 version) is used.

Significance of the Study

In a typical patriarchal setting as in Manipur, in spite of the several attempts by the government to uplift the status of women through different projects seems not reaching the expected outcome as the society and the culture with their unscientific beliefs and rituals are creating an atmosphere that is not encouraging these changes to reach its desired outcome. In these scenarios it is of prime interest to find out if women of this area can change their socio-economic status with the help of education and employment which is improving in the area in the past decade. Moreover, if there is any impact of the rising education and employment of the women in their reproductive health status and knowledge about their reproductive rights than in the past. Furthermore the conclusion of the study can help to understand the problem of health and particularly of reproductive health of women in Manipur and it can further provide the direction to improve the status of women's health and encourage awareness among women about their reproductive rights of the area.