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EMPOWERMENT OF WOMEN THROUGH REPRODUCTIVE HEALTH CARE MEASURES

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ABSTRACT

According to Kofi Annan "There is no tool for development more effective than the empowerment of women." Development programs to empower women are unproductive if population and reproductive health care programs are not taken at the same time. Reproductive health includes a wide range of issues including the health and function of structures and system involved in reproduction, pregnancy, childbirth and child rearing, including antenatal and prenatal care. It also implies that people are able to have an enjoyable and safe sex life and the freedom to decide when to have the child. Reproductive health problems represent a major cause of death and disability for women even in developed countries despite advances in obstetrical science and practice. Maternal death is the main problem in the global health and is the major aspect in judging the value of health care systems. Child marriage is a major contributor worldwide though legally abolished. Efforts have been made globally, nationally and regionally to raise the reproductive health status of women. In Tamilnadu, maternity and child welfare centres have been started. Family planning and welfare schemes have been implemented. Maternity leave and other provisions were created. The latest amendments to the maternity act passed in 2017 by the government of India have the provision for compulsory crèche enabling woman to take care of her child even during work. A male employee can also

take his child to a crèche, if it is far away from the woman's work place. It is a revolutionary step and leads to a healthy and secure mother and a child. Adoptions are also facilitated. These steps ensure the economic independence of women and create a conducive environment for them to work. Healthy people only can give productivity to the economic development of the nation on the whole. Without improvement in their health status, empowerment and autonomy of women are unsuccessful.

Key Words: Contraception, Empowerment, Family Planning, Family Welfare, Maternal Mortality, Reproduction, Sterilisation, Vasectomy.

I. Introduction

Health is a crucial component of all developmental activities. "The health status of women and the disparities in health between the sexes are often critical indicators of equity in society" (WHO, 1986). Women's health differs from men in many unique ways. Pregnancy results in major changes in a girl's life physically, emotionally, socially and economically and jeopardises her transition into adulthood. The fundamental right to the highest achievable quality of health has been acknowledged in many international, national and regional announcements and acts. Healthy population is a foundation for sustainable social, economic and environmental development and for peace and security, and vice versa. Though there are many works on women empowerment, there is no work relating to health aspect and its relationship with empowerment. This article aims to bring out the various measures taken by the Government of Tamilnadu in line with the national policy such as starting of sufficient maternity and health care centres, implementation of family planning and welfare programs and increased maternity leave to raise the health status of women there by empowering them to contribute towards national development.

II. Methods and Materials

Historical method is followed. Data have been collected from the Tamilnadu Archives, Chennai, and official websites of the Government and other relevant cyber sources.

III. Empowerment and Health

The empowerment of women is one of the main subjects in the process of development of countries globally. It refers to the creation of an enabling environment for women where they can make decisions of their own for their personal benefits as well as for the society as equal partners along with men. It is a process in which women get greater share of control over resources - material, human and intellectual, financial and control over decision-making in the home, community, society and nation, and to gain power. Country Report of Government of India defines empowerment as moving from a position of enforced powerlessness to one of power. In order to achieve the status of a developed country, India needs to transform its colossal women force into a useful human resource and this is possible only through the empowerment of women. It is vital to sustainable development and the recognition of human rights for all. Empowerment of women is possible only if women have control over their life both within and outside of their home and workplace. Ability of women to control her fertility is absolutely fundamental to empowerment and equality. When a woman is healthy she can be more productive. When her reproductive rights are promoted, she can participate more fully and equally in society and in the nation building. The International Conference on Population and Development held at Cairo in Egypt in Sept. 1994 acknowledged that freely deciding the number, spacing and timing of their children is their basic right. It is the responsibility of the states to take necessary steps to ensure universal access to health care services including reproductive health-care programs. The Government of India in the Ninth Five Year Plan has made 'Empowerment of Women' as one of its principal objectives and as an agent of socio-economic change and development. In order to realise this, the National Policy for Empowerment of Women, along with a well-defined Gender Development Index to monitor the impact of its implementation was developed. To emphasise on empowerment, the year 2001 was announced as Empowerment of Women year. In order to achieve this, one of the strategies identified was to accord high priority to reproductive health services and thus ensured easy access to maternal and child health services. National Policy for Women 2016 (draft) has also an objective for a holistic and life cycle approach to women's health for appropriate, affordable and quality health care. It identified maternal and pre-natal mortality as priority to bring down the maternal mortality(MMR) and infant mortality rate (IMR). A gender transformation health strategy which recognises women's reproductive rights with shifts such as family planning focus from female sterilization to male sterilisation will be implemented. For achieving sustainable

development, both women and men have to participate fully in productive and reproductive life, including sharing of the household responsibilities and caring and nurturing of children.

IV. Maternity and Child welfare services in Tamilnadu

Tamilnadu is the southernmost state in India. It has the splendid practice of recognizing the importance of empowering women from the ancient period. There were women administrators, poetesses, writers, freedom fighters and doctors. Siddha and Ayurvedic medicines were practiced in every home. With the introduction of Allopathy medicine women were admitted in the medical schools and colleges. Medical education for women was given priority much earlier to the introduction of female education. Madras Medical College had opened its portals to women as early as 1875. It resulted in the emergence of many women pioneers in the field of medical service; notable among them was Dr.S.Muthulakshmi Reddy. The Government Maternity Hospital was opened in 1844 at Chennai to provide accommodation for women in confinement. Royal Victoria Gosha Hospital for Women (Govt. Kasturba Gandhi Hospital) was founded in 1885 at Chennai to provide medical aid to the caste Hindu purdah women who were unwilling to go to a hospital under the management of men doctors. Christian Medical College and Hospital, Vellore originated in 1900 as a one bed clinic by Dr Ida Sophia Scudder, a young American Missionary, in response to a dramatic encounter with the suffering of Indian women is now world fame. When India attained independence there were 318 maternity and child welfare centres in Tamilnadu; in 1951 the number increased to 461. Every year a lot of such centres have been added and schemes for the purpose constituted a regular feature of the annual health budget. These measures, including the number of trained midwives and of additional maternity wards in hospitals had contributed to the decline in maternal mortality which was eight per thousand births in 1946 to less than six and infant mortality from 147 to 117 per thousand live births in 1951. Under Backward Area Scheme and Primary Health Centres and Community Development Programme of the Second Five-Year Plan, the maternity and child welfare services in rural areas were further augmented considerably by opening 439 such centres proposed for Tamilnadu. This scheme benefited a population of 1,14, 000 in a short span. Various programs were also launched during the first three five year plans. There were 1,945 maternity and child welfare centres in 1960 and it increased to 3840 in 1972.

V. Family Planning

Population growth was a matter of concern not only for the development of the country but also for the welfare of women. In 1951 Government of India implemented a National Family Planning program to help slow their booming population. The national family welfare program was implemented in Tamilnadu in 1956 on voluntary basis. It is viewed and implemented as people's program aimed to raise the standard of living of the people and improve the maternal and child health and thereby reduce population growth. Family planning is recognized as a basic human right by the United Nations in 1968. It is a key to every individual and every family's betterment. Family planning is not the same with birth control. World Health Organisation (1971) defined Family planning as "practices that helps individuals and couples to attain certain objectives they are, to avoid unwanted births, to bring about wanted births, to regulate the intervals between pregnancies, to control the time of which births occur in relation to the ages of the parent, and to determine the number of children in the family." The fewer children they have, the more freedom and free time they can have. They can use their spare time to pursue higher things of life and for social purpose. It is also part of the right of women to be in full health and to bring up healthier, better looked after children, to have more attractive homes and find deeper fulfilment in their lives.

E. V. RamasamyNaicker, better known as Periyar (Great Man) a social reformer of Tamilnadu advocated birth control not only for the health of women and population control, but for the liberation of women. Periyar and the followers of Self-Respect Movement spoke about family planning even from 1930s. In all the Self-respect marriages, the need for birth control formed an essential part of their talk. He spoke about the under-nourished, poorly clothed and illiterate boys and girls due to the low income of their parents. Periyar used to tell that if God granted children, then he should have provided a cow to give them milk, some land to grow food to feed them and enough means to bring them up with sufficient clothing, proper education and other essential facilities. If God granted only children and not the means for their proper growth, he was an irresponsible person. Such arguments by Periyar convinced even simple people of their responsibility to limit the number of children and to bring them up properly. Women empowerment was the primary aim of Periyar in advocating birth control. Periyar said that contraception is necessary for women to gain freedom. Others advocated contraception taking into consideration many problems like the health of women, the health and energy of the

children, the poverty of the country and the maintenance of the family property. He also recommended that women should stop delivering children altogether because conception stands in the way of women enjoying personal freedom.

Studies prove that in Tamilnadu the knowledge of contraceptive methods is universal with 100 per cent of currently married women recognizing at least one modern method of contraception. Statistics show that the number of women performed sterilisation in the Chennai city was 33,471 in 2008.Family planning objectives are achieved mainly because of the support of women. The methods followed by the family welfare acceptors are 29% Sterilisation, 36% IUCD(Intra-Uterine Contraceptive Device),19% OP (Oral Pills) and 16% CC during the year 2015-16.

The following table shows the details of sterilization performed in Tamilnadu from 1997-98 to 2015-16**.**

Table-1

Year	Sterilization performance	Year	Sterilization performance
1997-98	332991	2007-08	353436
1998-99	336760	2008-09	346266
1999-00	374195	2009-10	346456
2000-01	375654	2010-11	327262
2001-02	391062	2011-12	339845
2002-03	418017	2012-13	316990
2003-04	430312	2013-14	323310
2004-05	417027	2014-15	311322
2005-06	380655	2015-16	289432
2006-07	357568	-	-

Source: Directorate of Family Welfare, Health and Family Welfare Department, Government of Tamilnadu.

The highest number of 4, 30,312 sterilisation was performed during the year 2003-04 and there was a marginal drop next year with 4,17027 women underwent sterilisation and there was a fall for the year 2015-06 with 289432 cases only. Despite awareness campaigns and incentives to promote male sterilisation, men are reluctant to undergo the simple procedure of vasectomy. According to Union Health Ministry statistics, the number of vasectomy procedures in Tamil Nadu dropped from 3,024 in 2008-09 to 1,524 in 2012-13.Statistics of Madurai district during 2011-12 and 2012-13 show that the share of men in birth control procedures was only 0.5 per cent, that is out of the 28,000 family planning surgeries performed in the district in the two years, there were only 150 vasectomies and even these were possible only because of motivational camps conducted by doctors and health workers. In the case of women in the high-risk category who may suffer complications during delivery, health department always motivates men to undergo the family planning procedure. But female sterilization is the most widely known and practised method of contraception in Tamil Nadu. In fact female sterilization requires a woman to take rest for one month. Vasectomy will take only a few minutes and it does not require hospitalisation. Sterilisation procedures are painful and put women at a lot of infection risk while vasectomy is relatively painless. In many cases men forced their wives to undergo sterilisation even if they had pre-existing health conditions. In rural areas women do not allow their men to do *v*asectomy thinking it would affect them physically. It will be appreciable and a great help to their life partners if men volunteer to undergo the family planning practice. The No-Scalpel Vasectomy project is aimed at helping men to do vasectomy and thus promote male participation in the family welfare program.

The State Commission on Population was constituted to supervise and review State Population Policy 2007. The state now follows the Community Needs Assessment Approach to implement the family welfare and maternal &child health programs in the state. Family welfare program is intended to provide maternal and child health care and thereby to bring down the birth rate. It is also aimed at avoiding higher order of birth (i.e. third and above order of birth in a family) and prevention of female foeticide and female infanticide. It persuades women to deliver in a hospital or, if at home, with assistance from a trained health person and to receive at least three check-ups after delivery. Thanks to all these efforts 99.8 percent of all deliveries in the state are conducted in institutions by qualified and trained personnel. Higher birth order is slowly falling. It was 25.1 in 1998, and 18.9 in 2003, 12.5 in 2008, 8.7 in 2013 and 7.9 for 2015. Infant mortality rate is

getting reduced annually. It was 113/1000 in 1971,91 in 1981, 57 in 1991,49 in 2001 , 22 in 2011, 21 in 2013 and 20 in 2014.The maternal mortality rate ratio is 97 / 100000 live births during 2007-2009 and was 79 in 2014. Health and Family Welfare Department - Government of Tamil Nadu targets to achieve maternal mortality rate of 44/100000 live births and infant mortality rate of 13/1000 live births by the end of the 2017.

A milestone in women's health is the Medical Termination of Pregnancy Act. Pregnancies that are a result of failure in sterilization and in certain other cases can also be terminated.

VI. Medical Termination of Pregnancy (MTP) Act, 1972

The Indian Penal Code enacted in 1860 declared induced abortion as illegal. Countless women died attempting illegal abortions. This, combined with the idea that abortion could be a mode of population control, caused the government to reconsider the law. In 1964, the Central Family Planning Board of the Government of India met and formed a committee designed to examine the subject of abortion from medical, legal, social, and moral standpoints and enacted the MTP Act in 1971 with the intention of reducing the incidence of illegal abortion and consequent maternal mortality and morbidity. This act came into effect from 1 April 1972 and was amended in the years 1975 and 2003. Pregnancies not exceeding 12 weeks may be terminated based on a single opinion formed in good faith. In case of pregnancies exceeding 12 weeks but less than 20 weeks, termination needs opinion of two doctors. This act clearly stated the conditions under which a pregnancy can be ended or aborted like women whose physical and/or mental health were endangered by the pregnancy; Women facing the birth of a potentially handicapped or malformed child; rape; pregnancies in unmarried girls under the age of eighteen with the consent of a guardian; pregnancies in lunatics with the consent of a guardian and pregnancies that are a result of failure in sterilisation. This act enabled women to undergo abortions with specific conditions. It was amended in 2003 to facilitate better implementation and increase access for women, especially in the private health sector. Immediately after the passing of this act, awareness programmes were started all over India. Through these programmes, abortions were conducted by trained doctors in well equipped approved medical institutions. There were 140 medical termination program centres in Tamilnadu at the end of 1979-80. From March1972 to November 1988, there were 5, 56,762 legal abortions performed in Tamilnadu. Year after year the number of institutions and the pregnancies terminated increased.

Medical termination of pregnancies performed in Tamilnadu since 1997-8 is given in the table

Table-2

Year	Number	Year	Number
1997-98	49954	2007-08	63875
1998-99	56206	2008-09	59759
1999-00	61282	2009-10	60743
2000-01	60999	2010-11	57893
2001-02	68659	2011-12	58867
2002-03	73335	2012-13	59470
2003-04	73372	2013-14	62499
2004-05	72710	2014-15	62991
2005-06	71128	2015-16	63166
2006-07	64742	-	-

Source: http://www.tnhealth.org/dfw/dfwstat.php

The Tamilnadu State Health Mission formed in 2006 has a Sub Committee for Maternal Child Health and Family Welfare to implement a State Specific Safe Abortion Policy. Its activities cover availability of safe abortion services and emergency contraception at all levels of health care. Since daughters are not preferred sex-selective abortion has been commonly practised. It affected the sex ratio. It is prohibited by the Pre-Natal Diagnostic Techniques (regulation and prevention of Misuse) Amendment Act 2002. The sex ratio in the state as per census 2011 is 995 as compared to 940 for the country.

VII. Maternity Leave Rules for Women Employees

The Maternity Benefit Act, 1961 regulated the employment of women in factories, mines, the circus industry, plantations and shops or establishments employing ten or more persons except the employees who are covered under the Employees' State Insurance (ESI) for certain periods before and after child-birth. Under this act, women employees are entitled to maternity benefit at the rate of average daily wage for the period of their actual absence up to 12 weeks due to the delivery. They are also entitled to six weeks maternity benefit in case of miscarriage. They can also receive medical bonus of Rs. 250, if no pre-natal confinement and post-natal care is

provided for by the employer free of charge. In the year 1980, maternity leave for married women government servant was raised to 90 days with full pay in Tamilnadu which may be spread over from the pre-confinement rest to post confinement recuperation at the option of the government employee for three children. In 1983 the leave applicable was limited to only two surviving children. In 2011 it was raised to 180 days for two surviving children. It was raised to 270 days in 2016.This will lead to improved health and well-being of infants by making nursing easier. It will also lead to reduced stress and improved psychological health and well-being of the mother. Tamilnadu provides more benefits over and above what is mandated in the central statutes. It definitely is improving their work life balance. It would ensure that full maternal care is provided during the full bloom period and will encourage more women to join the workforce in organised sector. It is a progressive, long-overdue accomplishment that indicates social and economic advancement, holding tremendous benefits for the working women in India's job market.

Central Government also amended the Maternity Benefit Act 1961 in 2016 and became act in March 2017. Now women working in the organised sector are entitled to maternity leave of 26 weeks, up from 12 weeks for two children. For third child, the entitlement will be for only 12 weeks. As per the bill every organization with 50 or more employees has to provide crèche facilities within a prescribed distance. The mother will be permitted to visit the crèche four times in a day. It also allows employers to permit woman to work from home if it is possible to do so. Three months leave is eligible for adoption or surrogacy. India is now among the 16 countries having the longest paid leave for new mothers. It is a momentous step and a real empowerment.

VIII. Conclusion

The impact of various developmental policies and programmes and the efforts put in by both governmental and non-governmental organisations over a period of time in empowering women and development of children have brought forth a perceptible improvement in the status of women. Strict implementation of family planning along with the passing of the Medical Termination of Pregnancy Act and maternity leave are really a boost to women's health and thereby an empowerment. Now women's activities outside the home will not necessarilybe a stop gap. It can be a serious career, part of plan for the whole life and of real value to society.

The practical problems involved in combining a family with a serious career are reduced. Family must be conceived and considered as part of her life plan of which a major part is the career. Babies can be planned accordingly. Reliable birth control frees women from biological limitations. Quality of life and development can be achieved only with healthy mind and body.

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