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HEALTH EDUCATION FOR WOMEN

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You can tell the condition of a nation by looking at the status of its women. - Jawaharlal Nehru

Women, the word sounds so powerful. Since eternity, women have played a role more important than men and that is no exaggeration. The world would not have been the same lovely adorable and livable place without wonderful contribution so selflessly made by women. It has been said that, you teach a female and you build up a nation and truth can't be closer than that. Women have always carried the burden of being a wife, mother, sister all on their own and we need not to explain how magnificently they have carried this position.

Men and women complement each other. If men were supposed to handle outside stuff then women were more responsible for internal affairs. The only difference in this notion is, today women are equally competent behind the veils and outside world. They are more confident and one can find them in every possible sphere of human's life. No male bastion is untouched by females and that's a wonderful sign of strides made by women.

Urban women in India always had more advantages and opportunities than women residing in rural places. In India,

we still face the grim reality that health is the second largest cause for indebtedness among the rural poor. Majority of the communities borrow money on seeking health care: mainly for men folk. Even though women suffer from various mental, physical and psychological disabilities, they still do not have access to diagnosis, cure and treatment from the Primary Health Care System due to existing socio-cultural and economic constraints.

Health Status of Women in India

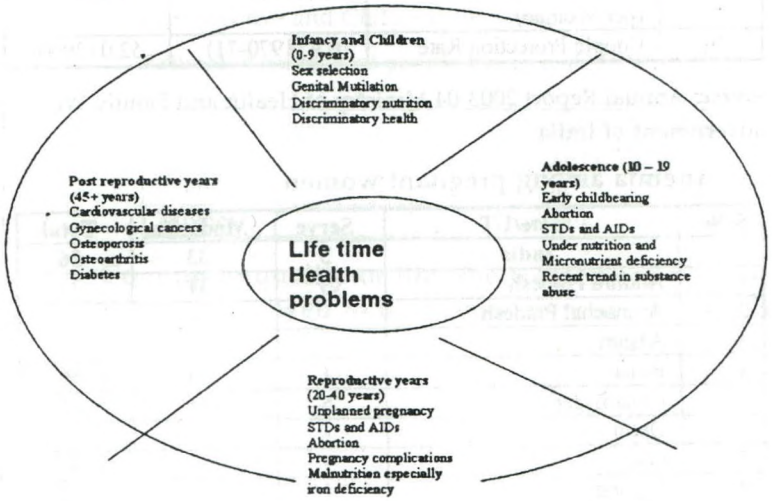
The health of women and men is determined not merely by biological factors or by factors related to individual lifestyles. In order to attain a state of "physical, mental and social well-being" all human beings need access to a range of basic resources. These consist of resources essential for survival, such as food, clothing and shelter, as well as capabilities such as literacy and access to information and the power to make decisions concerning their lives.

A country's overall level of development affects the health status of its people. The poorer a country is the fewer are the resources available to ensure the well-being of its population. Within countries, inequalities in health status across population groups are associated with socioeconomic status.

Women's position in the family and society in India presents a complex picture of modernity and tradition, and of strivings for gender equity amidst pressures to maintain the status quo. On the other hand, there is evidence of their growing awareness and assertiveness of rights, educational advancement, and increased participation in the economy and in the public arena. At the same time, there is continuing domination of patriarchal values and traditions reflected in son preferences, seclusion of women among some populations, and restriction of their mobility among others. Laws that restrict women's inheritance and make them unequal partners in marriage infringe on women's sexual and reproductive rights. All these have serious negative consequences on women's health and quality of life.

Women's Hhealth status varies widely both within and among countries because of such factors as local disease prevalence, health-related behaviors, and women's educational attainment, exposure to health information, influence on decision-making, and access to health care. Poverty, environmental degradation, civil conflict, and migration also influence women's health.

Health and Nutrition Problems Affecting Women Exclusively or Predominantly During the Life Cycle



Health Indicators

S.No.	*Indicators*	*Female*	*Male*	*Total*
1	Birth Rate (per 1000)			25.0
2	Death Rate (per 1000)	7.7	8.4	8.1
3	Infant Mortality Rate (per 1000 live births)	65	62	64
4	Child Mortality Rate (per 1000 live births under 5yrs of age)	71.6	70.5	71.1
5	Maternal Mortality Rate (per 1,00,000 live births)	407		

Source: Sample Registration Survey 2002, Sample Registration Survey 2001 - 1998

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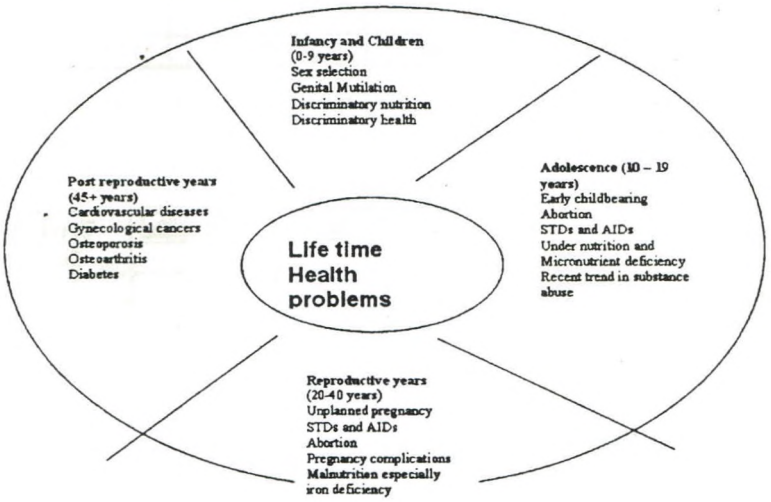

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S.No.	Health indicators	Past performance	Latest findings
1	Crude Birth Rate (per thousand population)	40.8 (1951)	25.0 (2002)
2	Crude Death Rate (per Thousand population)	25.1 (1951)	8.1 (2002)
3	Infant Mortality Rate (per 1000 live births)	146 (1951-61)	64 (2002)
4	Maternal Mortality (per 100000 live births)	437 (1992-93)	407 (1998)
5	Total Fertility Rate (per Woman)	6.0 (1951)	3.2 (1999)
6	Couple Protection Rate	10.4 (1970-71)	52.0 (2000)

Source: Annual Report 2003-04 Ministry of Health and Family Welfare, Government of India

Anemia among pregnant women

S.No.	State/UT	Serve	Moderate	Total
	India	**3**	**33**	**36**
1	Andhra Pradesh	3	31	34
2	Arunachal Pradesh	-	-	
3	Assam	-	-	-
4	Bihar	1	35	36
5	Chhattisgarh	5	41	46
6	Delhi	-	-	-
7	Goa	-	-	-
8	Gujarat	1	39	40
9	Haryana	3	52	55
10	Himachal Pradesh	2	32	31
11	Jammu & Kashmir	-	-	-
12	Jharkhand	0	31	31
13	Karnataka	2	24	26
14	Kerala	1	3	4
15	Madhya Pradesh	2	38	40
16	Maharashtra	2	56	58
17	Manipur	-	-	-
18	Meghalaya	-	-	-
19	Mizoram-	-	-	-
20	Nagaland	-	-	-
21	Orissa	4	30	34
22	Punjab	4	50	54
23	Rajasthan	3	36	39
24	Sikkim	-	-	-

25	Tamil Nadu	1	24	25
26	Tripura	-	-	-
27	Uttar Pradesh	3	37	40
28	Uttaranchal	1	26	27
29	West Bengal	8	16	24
30	Andaman & Nicobar Island	-	-	-

Source: International Institute For Population Sciences. (2004). National Dissemination Seminar on Reproductive and Child Health Project (Phase 1, Round 2, 2002) Results, New Delhi, 2004 Jan. 27-28. Fifth Session: Reproductive and Child Health Services, Mumbai. p.145

Estimated number of people living with HIV/AIDS

Group	Living with HIV/AIDS
Adults and children	5,700,000
Adults	5,600,000
Women	1,600,000

Coming to quality of life, the women are exposed to poverty, even in well to do homes, they are denied food, adequate in quantity and appropriate in quality. They are denied immunization and health care. They don't get medical treatment at the time of need. They do not get full opportunity for education, career planning, and security at work place, besides the abuse of every kind and every degree. Their legal rights remain jeopardized.

In addition, due to lack of health information, women spend scarce resources seeking health care from expensive and exploitative private practitioners. If women are empowered with appropriate information they will become better equipped to take care of their own, their families' and their communities' health. So Basic health education for women is the need of the hour.

Basic Health Education

1. ***Community Health***: Characteristics of a healthy community; roles of community agencies, organizations, and staff; skills for advocacy and collaboration; overcoming racism and prejudice;

2. *Disease Prevention and Control:* Factors contributing to the development of chronic, degenerative, and communicable diseases; methods for detection and strategies for prevention;
3. *Environmental Health:* Ways to conserve natural resources and prevent pollution; relationship between the environment and physical, mental and social health;
4. *Family Life:* Development of healthy roles and interactions between family members; physical, mental and social growth and development through the life cycle, from birth to death;
5. *Health Relationships:* The importance of healthy relationships with family, friends, and workplace and community members; communication skills and other skills to build such relationships; concepts and skills for conflict resolution and violence prevention;
6. *Mental and Emotional Health:* Issues related to attitudes, stress, self-acceptance, and social awareness; relationship to physical health; understanding and managing emotions; dealing with loss and grief; preventing suicide;
7. *Nutrition:* Skills, knowledge, and attitudes that help in selecting a healthy diet; nutritional requirements throughout the life cycle; factors that influence food choices; sports nutrition; eating disorders;
8. *Personal Health:* Structure and function of body systems, including their interdependence and overall contribution to healthy functioning;
9. *Personal Safety:* Factors contributing to intentional and unintentional injury, including motor vehicle crashes, guns, homicide, and suicide; first aid and emergency procedures; verbal, physical, emotional, and sexual harassment and abuse; rape; homophobia;
10. *Physical activity and fitness:* Manipulative, locomotors, and non-locomotors movement skills; concepts of biomechanics and exercise physiology; principles of

training and conditioning; role of regular physical activity in lifelong health and well-being;

11. *Resource Management:* Obtaining and evaluating health - related information, services, and products; managing home, consumer, workplace, and environmental resources;
12. *Sexuality:* Reproductive physiology; interpersonal skills for responsible sexual behavior and choices, including abstinence and protection; gender and sexual orientation; prevention of unintended pregnancy and sexually transmitted diseases, including HIV infection;
13. *Tobacco, Alcohol, and Other Drug Use:* Risks and consequences of using these substances; skills and strategies for prevention; appropriate uses of drugs and medication.

Legislative Measures

There are areas in which legal provisions could help considerably in improving the health status of women and children. In what follows, some of these areas are highlighted:

(i) *Medical Termination of Pregnancy Act 1971:* The Act has been envisaged as a health measure for women to protect them from the dangers inherent in getting unwanted pregnancy terminated stealthily by unqualified practitioners. There is a need to disseminate information regarding the provisions under this Act among women.

(ii) *Age at Marriage of Women:* The present statutory minimum age of marriage of girls under the Child Marriage Restraint Act is 15; there are instances of girls being married younger. Early marriage and early pregnancies lead to greater pregnancy wastage, higher incidence of infant as well as maternal mortality. Though the age at marriage has been rising over the decades it has been very slow and there are regional differences. The age at marriage of women in several developed as well as developing countries has been above 20.

(iii) *Curb Advertisement of Baby Foods:* The manufacturers of baby foods put forth grossly exaggerated claims for their products in their advertisements through the mass media. They often mislead mothers belonging to the middle and lower income groups who can ill afford such high priced commercial foods. Yet, they go after them because of the advertisements, and on account of frivolous prestige and social status implied. This leads to neglect of breast feeding and use of traditional home-made foods for babies. The cumulative results of this is very often, faulty feeding of infants leading to malnutrition and diarrhea contributing to illness and death among infants. The provisions of the Prevention of Food Adulteration Act should be evoked, to prevent manufacturers of commercial baby foods from making exaggerated, unwarranted and misleading claims for their products.

(iv) *Provision of Maternal and Child Health Services in Municipalities and Local Bodies:* Women living in urban towns have special problems on account of the congested poor housing, unclear families, working status etc. Provision of maternity and child health services should be made obligatory for Municipalities/Local Bodies.

(v) *Regulation of the Practice of Midwifery by Unqualified Traditional Birth Attendants:* The Nurses and Midwives Act requires that all those who practice midwifery should be registered. However, the provisions of the Act are not strictly enforced to cover unqualified midwives.

Role of Voluntary Organizations

Women voluntary organizations are best suited for motivation in the field of health family planning and nutrition. There is, therefore, every need for creating a conducive climate for the functioning of such institutions, so that they can render the needed service effectively. The following measures are suggested in this regard:

(i) Women organizations working with a missionary zeal in the field of maternity care and child health should

be given all legitimate assistance by the Central and the State Governments for carrying on the work, both in the shape of grants-in-aid and MCH supplies.

(ii) Voluntary organizations are also involved in the training of health manpower, particularly women workers. Such programmes should be further encouraged and regularized.

(iii) Voluntary organizations are currently involved in providing school health. Such services should be encouraged by providing the necessary assistance in terms of resources-men and materials.

(iv) The women in slum areas in cities form a significant segment of the urban population. Women voluntary organizations should be assisted in rendering proper motivational and health services in this type of population.

Policy Guidelines for Health Care for Women

Health care has been accepted as an important intervention for women's development since the First Five Year Plan. It was recognized that the high infant and maternal mortality would have to be reduced through the provision of maternal and child health services and family planning. The basic strategy for providing health care to the general population as well as women, in the 1950s during the first and second plan periods. Included

(i) Expansion of physical infrastructure for health (including opening MCH centers)

(ii) Initiating the family planning programme

(iii) Communicable disease control(for malaria, filarial, tuberculosis, leprosy and venereal diseases)

(iv) Establishing facilities for training (attention was given to training female health personnel including nurses, auxiliary nurse midwives, health visitors and dais) and having more manpower. The need to link hospitals at different levels into an effective "coordinated hospital

system", and correlate their functions with those of "clinics, domiciliary care services and public health activities", was recognized.

The basic strategies for health care in terms of expansion of physical infrastructure, training more female health personnel, communicable disease control and family planning, were continued during the Third and Fourth Plan periods. Specific prophylaxis programmes were initiated to prevent anemia in pregnant women and vitamin A deficiency in children 1-5 years of age during this period. Also, programmes were started to control smallpox, cholera and goiter. School health services were also formulated, which included a component for instruction of school teachers.

The primary objective of the Fifth Five Year Plan was to provide 'minimum public health facilities integrated with family planning and nutrition for vulnerable groups – children, pregnant women and lactating mothers, the accent during this period was similar to previous plan periods – increasing the accessibility of health services to rural areas; correcting regional imbalances; development of referral systems for health care; and communicable disease control. The need for qualitative improvement in the education and training of health personnel was also recognized. Several schemes were initiated during this period to give increased emphasis to the health of mothers. The Integrated Child Development Services Scheme was accepted for country-wide application in 1977. Though primarily for child development, this scheme provides for a package of health, nutrition and family planning services for pregnant women and nursing mothers who are socio-economically deprived.

During the Sixth and Seventh Plans, the major strategies for health care, including that for women, continued to be (I) expansion of physical infrastructure, (ii) increasing the availability of trained manpower, (iii) strengthening services for communicable diseases control, as well as other diseases, and (iv) provision of family planning as well as MCH services.

During the Sixth Five Year Plan period, in 1983, the National Health Policy was formulated and accepted for implementation. The policy for the first time, defined goals for women's health; reduction in maternal mortality, crude death rate and crude birth rate; coverage with antenatal care and immunization of pregnant mothers; and the control of leprosy, tuberculosis and blindness (form which women also suffer), were specified.

The Seventh Five Year Plan clearly states that primary health care will be the main sphere of action in health. It was stated that "women would be organized around available economic activities to enable them to actively participate in the entire process of socio-economic development, including health." Care of pregnant and nursing mothers, young children and school-age children (both in and out of school) was stated to be a priority.

The Eighth Five Year Plan (1992-97), which was launched in 1992, promises to ensure that the benefits of development from different sectors do not bypass women and special programmes will be implemented to complement the general development programmes. Therefore, the flow of benefits to women in the three core sectors of education, health and employment will be monitored with a greater vigil. Women must be enabled to function as equal partners and participants in the developmental process. This approach to the Eighth Plan marks a further shift from 'development' to 'empowerment' of women.

During the Ninth Plan efforts further intensified to improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents and drugs. Efforts are directed to improve functional efficiency of the health care system.

During the Eleventh Five Year Plan efforts is taken to ensure that pregnant women would get at least four ante-natal checkups during the pregnancy to give more attention on the pregnant women and children.

- Learn to resolve disagreements, reduce conflict, and prevent violence; and
- Treat others with respect and understand similarities and differences among people.

All women should have access to material and services for their own personal sense of empowerment and self-esteem, as well as advancing the social and health status of women worldwide. The aim is to increase women's awareness and understanding of issues that affect them and in so doing, broaden our horizons by knowing that they have some choice in the way we live their lives. They have to be provided full opportunities in the area of education and health at all stages of their lives.

Health Education Career Opportunities

Health Care Settings: these include hospitals (for-profit and public), medical care clinics, home health agencies, HMOs and PPOs. Here, a health educator teaches employees how to be healthy. Patient education positions are far and few between because insurance companies do not cover the costs. Public Health Agencies: are official, tax funded, and government agencies.

They provide police protection, educational systems, as well as clean air and water. Public health departments provide health services and are organized by a city, county, state, or federal government.

School Health Education: involves all strategies, activities, and services offered by, in, or in association with schools that are designed to promote students' physical, emotional, and social development. School health involves teaching students about health and health-related behaviors. Curriculum and programs are based on the school's expectations and health.

Non Profit Voluntary Health Agencies: are created by concerned citizens to deal with health needs not met by

Guidelines for Ensuring Gender Equity in Health Education

- select and use resources that reflect the current an evolving roles of women and men in society;
- instruct on how to recognize gender inequities in what they read, hear, view, say or write;
- seek a balance of male and female role models in activities and resources;
- encourage and respect the interests and abilities of both genders;
- model gender-fair language in all classroom interactions;
- instruct the use of gender-fair language;
- have equally high expectations for both male and female;
- Provide opportunities for both male and female to assume leadership roles.

A comprehensive health education programme will enable all women to:

- Know basic concepts of human development, mental health, sexuality, parenting, physical education and fitness, nutrition, and disease prevention, and understand the implications of health habits for self and society;
- Make informed and responsible judgments regarding personal health, including avoidance of violence, tobacco, alcohol, drugs, teen pregnancy, and sexually transmitted diseases;
- Develop skills and participate in physical activities for personal growth, fitness, and enjoyment;
- Manage money, balance competing priorities and interests, and allocate time among study, work, and recreation;
- Know career options and the academic and occupational; requirements needed for employment and economic independence;

- Learn to resolve disagreements, reduce conflict, and prevent violence; and
- Treat others with respect and understand similarities and differences among people.

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Non Profit Voluntary Health Agencies: are created by concerned citizens to deal with health needs not met by

governmental agencies. Missions include public education, professional education, patient education, research, direct services and support to or for people directly affected by a specific health or medical problem. Usually funded by such means as private donations, grants, and fund-raisers.

Higher Education: typically two types of positions health educators hold including academic, or faculty or health educator in a student health service or wellness center. As a faculty member, the health educator typically has three major responsibilities: teaching, community and professional service, and scholarly research.

As a health educator in a university health service or wellness center, the major responsibility is to plan, implement, and evaluate health promotion and education programs for program participants.

Work site Health Promotion: is a combination of educational, organizational and environmental activities designed to improve the health and safety of employees and their families. These work site wellness programs offer an additional setting for health educators and allow them to reach segments of the population that are not easily reached through traditional community health programs. Some work site health promotion some work site health promotion activities include; smoking cessation, stress management, bulletin boards, newsletters, and much more.

Independent Consulting and Government Contracting: international, national, regional, state, and local organizations contract with independent consultants for many reasons. They may be hired to assess individual and community needs for health education; plan, implement, administer and evaluate health education strategies; conduct research; serve as health education resource person; and or communicate about and advocate for health and health education.