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Promotion of Reproductive Healthcare Services among Adolescent Girls in Rural Bihar: A Social Work Perspective

–Kheyali Roy*, Shaurya Prakash*

Abstract

An effective healthcare system specialising in reproductive healthcare improves the health and well-being of the populace. The creation of smart cities depends on making high-quality healthcare accessible and affordable for everyone. The current study aims to ascertain how reproductive healthcare is provided in rural Bihar. According to the WHO (World Health Organization), reproductive health is the whole state of health and proper operation of the reproductive organs throughout all stages of reproduction. This includes an entire condition of mental, bodily, and social well-being. The analysis showed that although Bihar's adolescent health status has improved somewhat, it is still below the national average. Bihar has made progress in reproductive healthcare services, yet promoting reproductive healthcare services among adolescents in rural Bihar is the need of time.

Keywords: *Reproductive Healthcare, Adolescent, Rural Bihar*

INTRODUCTION

Adolescent girls' health status in rural Bihar is below the national average. The nutritional state of Bihar is poor; more than half of pregnant and lactating women are anaemic, the second-highest percentage of women in India has below-normal BMIs, and the proportion of fat women doubled over the study period. Even though Bihar has improved antenatal care, postnatal care, iron and folic acid consumption, and institutional births, the

* Assistant Professor, Gopal Narayan Singh University, Jamuhar, Sasaram, Bihar, India; Research Scholar, Department of Social Work, Visva-Bharati (A Central University and An Institution of National Importance), Santiniketan, West Bengal, India. Email: sauryap75@gmail.com

state still has lower maternal health rates than other states and the country. Across the nation, the rising trend of caesarean deliveries is causing a lot of anxiety. Controlled contraceptives have decreased in several states, including Bihar, increasing women's literacy, child marriages, and cigarette use. The IMR, which is thought to be a summary indicator of general health, has dramatically reduced both in Bihar and nationally, indicating that women are now more mindful of their health. Overall, it was shown that Bihar's current health situation for women is worse than that of other places, and they need to receive sufficient care. Therefore, the government must effectively carry out ongoing health programs, paying particular attention to Bihar, to improve women's nutritional and maternal health status, which is closely tied to the family and society. In India's Bihar state, where few people use family planning services, clinical reproductive health treatments are chronically inadequate for women. According to a yearlong assessment by the International Centre for Research on Women, public and private health clinic issues included a lack of sanitary health facilities, insufficient beds for post-surgery recuperation, and a lack of fundamental tools like scissors (ICRW, 2020).

Sexuality, sexuality education, and public discussion of sexuality are stigmatised and taboo in the Indian cultural environment. It is crucial to change the course of future generations to achieve the global development goals linked to gender equality, poverty, education, and reproductive health. India has the world's most significant teenage population, with adolescents making up one-quarter of the country's total population. The World Health Organization classifies teenagers as between 10 and 19. Access to reliable reproductive health information and services is essential for teenagers' health and well-being because this stage of life is when a person begins to explore their sexuality. Only a respectful and upbeat attitude about sexuality, sexual rights, and sexual relationships free from violence, prejudice, and compulsion, makes it possible to have good reproductive health. Studies showed that adolescents' understanding of Reproductive Health is generally limited. In India, where the rate of early marriage is high, women's reproductive health is negatively impacted. Menstrual hygiene has been identified as a potential risk factor for Reproductive health among adolescent girls in India, mainly in rural areas. Menstrual hygiene is essential in predicting the prevalence of reproductive tract infections (Vincent & Krishnakumar, 2022). The Indian government is aware of the significance of influencing adolescents' health-seeking behaviour. An important factor affecting India's general health, mortality, morbidity, and population growth is the health of this age group. There

is a need for investment in reproductive healthcare services, therefore, pay off in the form of later marriage age, a decrease in the prevalence of teenage pregnancies, the provision of unmet contraceptive needs, a decrease in maternal mortality, a reduction in the incidence of STIs, and a decrease in the prevalence of HIV. It will also assist India in achieving its demographic dividends, as young people in good health are a valuable economic resource (NHM).

RURAL BIHAR

As per 2011 stats, Bihar has a population of 10,40,99,452 people, out of which the urban population is 1,17,58,016 while the rural population is 9,23,41,436. Like most other regions of India, the state inherited a rural, underdeveloped economy after its Independence. While many peasants were emancipated from the most blatantly exploitative agrarian system once the zamindari system was abolished, it also resulted in massive evictions of peasants. While the nature of land relations changed somewhat under the new system, it was still mostly semi-feudal. According to the National Sample Survey, the state has a shallow work participation rate (WPR), mainly because women have a lower WPR than men. Over the past thirty years or so, Bihar has undergone substantial social, economic, and political development. Even though progress has been unequal, there has been some social and political empowerment of the poor, particularly among those from middle castes, and a significant decrease in poverty, even if the poverty population is more. The villagers still depend on agriculture for their livelihood, but Bihar is infamous for its weather-related problems.

Regular droughts and floods can damage people, animals, and the local economy. An expanding population has not been able to find enough work due to agriculture's relative stagnation in Bihar. Through migration or commuting from the hamlet, there has been an increase in people looking for jobs outside of agriculture. The frequency of migration varies significantly between localities. Between 26 and 86 per cent of homes are classified as "migrant households", meaning at least one household member worked outside the village (UNDP, 2020).

Bihar's rural areas are generally plagued by high mortality rates, malnutrition, especially in women and children, and various diseases. Yet, unfortunately, despite a growth in the number of health sub-centres, there is a severe lack of health infrastructure. However, along with chemist

stores and quackery, private hospitals and qualified allopathic doctors in private practice have significantly impacted the medical landscape. The current facilities' services, except those offered by low-level specialists, are not only subpar but also exceedingly unsatisfactory (nurses and Anganwadi workers). Even though nearly a third of pregnant women still visit private doctors for check-ups, the Janani Suraksha Yojana under NRHM has performed somewhat better. Even if house deliveries have decreased and institutional (both government and private) deliveries have increased over the past few decades, Bihar still has a low institutional delivery rate compared to other states. Only 38% of the children eligible for the food supplement program for young children (ICDS) saw any benefit (MoWCD, 2021).

Open defecation is common in rural Bihar because there are few sanitary services. Ironically, just 6% of homes have benefited from TSC funding to construct toilets. Drainage is a severe issue concerning cleanliness, with only 7% of village hamlets having pucca drainage, despite advancements made over time due to recent public works programs. In rural settings, disputes over drainage are frequent (WASH Report, 2018).

REPRODUCTIVE HEALTHCARE SCHEMES AND SERVICES FOR ADOLESCENT GIRLS IN BIHAR

India's family planning program is the first of its type worldwide and is exceptional. The program has altered in terms of policy goals and stated approach to actual program implementation from its historical beginning in 1951. From the clinic approach mode used from 1952 to 1961 to the current reproductive and child health (RCH) approach, the program has changed several systems. The RCH technique was first implemented experimentally in 1995 and then formally introduced in 1997 (Kumar A, 2014). India introduced a national program for family planning in 1952 as the first nation. The program has changed over the years regarding policy and actual execution. It is currently being repositioned to meet goals for population stabilization, reproductive health promotion, and a decrease in maternal, newborn, and child mortality and morbidity (NHM).

- *Rashtriya Kishor Swasthya Karyakram (RKSK):* The Ministry of Health and Family Welfare launched Rashtriya Kishor Swasthya Karyakram (RKSK) on January 7, 2014, intending to reach 253 million adolescents, including male and female rural and urban, married and unmarried, in-school and out-of-school youth, with

a focus on underserved and marginalised groups. Including nutrition, injuries and violence (including gender-based violence), non-communicable diseases, mental health issues, and substance abuse, the program broadens the scope of adolescent health programming in India, which had previously been restricted to sexual and reproductive health. Teenagers frequently lack the agency or autonomy necessary to make their own decisions. RKSK is aware of this and includes the community and parents. The current public health system must be reorganised to serve adolescent service demands better. Teenagers, married and unmarried, boys and girls, receive routine check-ups at primary, secondary, and tertiary levels of care during clinic sessions under this core package of services, which includes preventative, promotive, curative, and counselling treatments.

- *Adolescent-Friendly Health Clinics (AFHCS):* Under the facility-based approach, Rashtriya Kishor Swasthya Karyakram (RKSK) emphasizes the necessity of establishing adolescent-friendly health clinics (AFHC). The adolescent reproductive sexual health (ARSH) clinic was established under RCH II in 2006 to offer counsel on sexual & reproductive health issues. Under RKSK, AFHC includes a wide range of clinical and advising services on various adolescent health issues, including nutrition, substance abuse, injuries, violence (including gender-based violence), non-communicable diseases, and mental health. These issues range from sexual and reproductive health (SRH) to nutrition, injuries, and violence. Adolescent-friendly health centres (AFHCs) are found at primary health centres (PHCs), community health centres (CHCs), district hospitals (DHs), and medical colleges. These facilities provide adolescent-friendly health services through trained service professionals, including MO, ANM, and Counsellors.
- *Weekly Iron-Folic Acid Supplementation (WIFS):* The weekly Folic Acid Supplementation Programme (WIFS) program was introduced by the Ministry of Health and Family Welfare to address the problem of the high prevalence and incidence of anaemia in adolescent girls and boys. WIFS is an evidence-based programmatic solution to the prevalent anaemia problem in teenage boys and girls that involves biannual helminthic control and supervised weekly ingestion of IFA supplementation. The long-term objective is to end the intergenerational cycle of anaemia, while the immediate advantages are enhanced human capital in nutrition. The program is being implemented nationwide in both urban and rural regions.

- *Menstrual Hygiene Scheme (MHS):* The program was started in 2011 in 107 selected districts across 17 states, where rural adolescent girls were given a pack of six sanitary towels named "freeways" for a cost of Rs 6. Since 2014, funds under the national health mission have been given to states and UTs for the decentralized purchase of sanitary napkin packs for distribution to rural teenage girls at a discounted rate of Rs 6 for a multitude of 6 napkins. The ASHA will continue to be in charge of distribution and will be compensated with Rs 1 for each package sold, in addition to receiving a free collection of napkins each month for her use. ASHA organizes monthly gatherings in Aanganwadi Centers or other similar venues for teenage girls to focus on menstrual hygiene issues and act as a forum for talking about other pertinent SRH topics. To educate adolescent girls about safe and hygienic menstrual health practices, various IEC materials have been developed around MHS. These materials include audio, video, reading materials for adolescent girls, job-aids for ASHAs, and other field-level functionaries for communicating with teenage girls.
- *Peer Education Programme:* The peer education (PE) program serves teenagers in the neighbourhood. The chosen peer educator, Saathiya, ensures that teenagers receive consistent peer education that covers all six RKSK themes. This strategy is expected to make it easier to protect teenagers who do not attend school in addition to those who do. Through this intervention, the states may consider the districts with a high number of teenagers who are not in school. Peer Educators are chosen from every village/1000 inhabitants/ASHA dwelling under the PE program to interact with teenagers. Asha works with the village health sanitation and nutrition committee to facilitate the selection of *Saathiya.* Each *Saathiya* gathers a group of 15 to 20 kids from their neighbourhood, and they use PE supplies to lead weekly, one- to two-hour interactive sessions. Saathiya also keeps a diary in which she notes the number of attendees and a summary of each session. For all teenagers to make the most use of the available adolescent-friendly health services, they will educate and increase their awareness of the importance of their health. *Saathiya* participates in the Adolescent Friendly Club (AFC) meetings and helps organize the quarterly Adolescent Health Days (AHD). ASHA oversees the proper operation of the peer education programs at the village level in its capacity as the Saathiya coordinator. Male health

workers and ANMs preside over the monthly AFC.

NEED FOR PROMOTION OF REPRODUCTIVE HEALTHCARE SERVICES

The International Conference on Human Rights Declaration and the 1994 International Conference on Population and Development have steadily acknowledged reproductive rights as human rights. United Nations, 1996 International Covenant on Economic, Social, and Cultural Rights (ICESCR) and Against Women discrimination further highlighted the significance of reproductive to achieving women's human rights. The SDGs, or Sustainable Development Goals, are Prior Millennium Development Goals (MDGs), which include some objectives that formally and informally acknowledge the right to an abortion. The Indian public health system is also troubled by problems, such as limited public investment, inadequate infrastructure, including drugs and diagnostics, and a lack of qualified human resources. The problem of corporatisation and privatisation of healthcare and a lack of strict control has been prominent over the past few decades. These all contribute to the decline in healthcare access, cost, and quality, including for needs related to reproductive health, resulting in increased social, economic, and geographic distances, especially for girls, women, and marginalised communities. For vulnerable populations and within and within states, disparities in access to reproductive healthcare are evident in India, as are differences in health outcomes. Poorer economic quintiles of the population, particularly adolescent girls and marginalised people, even in states where overall averages are increasing. A review of government programs and schemes about reproductive health revealed many initiatives covering family planning, maternal and child health, adolescent health, etc. An examination of these programs, however, repeatedly demonstrates the absence of a rights framework in place; a variety of people are discriminated against and excluded, which presents persistent obstacles.

Additionally, it worsens the marginalisation of reproductive health by limiting access and care quality. Analysis of programs and policies concerning the relevant rights and reproductive health problems also indicated a lack of comprehensive programs. Reproductive Health has only been partially implemented through health and other Auxiliary services. The government continues to show egregious neglect of reproductive morbidities plans and regulations.

EFFECTIVE STRATEGIES

- Evaluation in light of enhanced laws, policies, and programmes.
- Better access to accurate information and high-quality healthcare.
- Improved human resource capabilities in the areas of health and complaint procedures for quality and accountability.
- Through the accounts of essential stakeholders, specialists, civil society actors who deal with the affected demographic groups, and government statistics, the implementation, accessibility, and quality of each health care service should have been evaluated.
- The status of reproductive rights and health rights concerning vulnerable and marginalised population groups, mainly the adolescent age group, has received particular attention, as has the identification of barriers that prevent or restrict access to thorough, high-quality information and services.
- Teachers and healthcare professionals need education and sensitisation about Reproductive Health.
- Need for convergence in the functioning of various government ministries to effectively carry out the knowledge of Reproductive Health.

SOCIAL WORK PERSPECTIVE

A significant factor determining a woman's general health and well-being is her reproductive health. The study of reproductive health and the obstacles to treatment is relevant to social work and should be the subject of social work practice, instruction, research, and advocacy (Wright, Bird & Frost, 2015). Every person needs to have access to family planning, abortion, and other reproductive health care within the framework of their value system (NASW, 2015). The social work ethical principle of client self-determination, as well as the foundation and practice values of social work and the dignity and worth of a person, all strongly support the rights of people to receive education and services related to sexual and reproductive health (NASW, 2008). Social workers have numerous possibilities to benefit the communities we serve since we are informed about family and community resources. We should be proud of our professional duty to assist clients in obtaining the knowledge and assistance they require for efficient learning and attitude of reproductive health and reproductive health care services. We can use the strengths perspective, which emphasizes people's and environments' strengths. This also focuses

on people's dignity and resilience. We all know that every adolescent girl has powers, and we must bring their strengths to the upbringing of their knowledge and attitude. Social workers need to collaborate with that particular age group and create an environment that should have resources for the well-being of reproductive health. Although not considered a goal in and of itself, maternal health is crucial to achieving children's health. Despite differences across ethnic groups in maternal and infant morbidity and mortality, policy problems, lobbying, and community knowledge of health inequalities in mother and child health are uncommon in a social work environment.

CONCLUSIONS

Regarding reproductive health, men and women have the right to timely, accurate information, access to contraceptive methods, and good pregnancy, delivery, and postpartum health care services. All treatments, techniques, and services required in matters relating to reproductive health are included in reproductive health care. Social workers have access to the necessary resources, context, guidelines, and philosophical underpinnings through various international conferences, resolutions, and conventions that numerous nations and the IFSW have ratified. It follows that to perceive people holistically following typical social work methods like the social systems, empowerment, and feminist views, sexuality and reproduction should be integrated within a human rights framework. The IFSW's ethical principles and policy statements point to similar values and principles that unify the profession, notwithstanding national variations in social work areas of practice and educational requirements. These principles and assertions reflect social workers worldwide who contribute information, skills, and experience obtained through local practices. In addition to being aware of and comprehending international declarations relating to sexual and reproductive health and rights, social workers' abilities are improved by determining how these declarations square with their profession's ethical values. Indian women's and young people's sexual and reproductive health has significantly improved. Adolescents who are stigmatised because of their sexual orientation, gender identity, or marital status have additional challenges in accessing information and assistance. All adolescents must have equitable access to comprehensive sexual and reproductive health care to exercise their right to bodily autonomy and lead healthy lives. To provide high-quality and

complete treatment, private channels must be reinforced, especially for contraceptive services for spacing births, as teenagers frequently seek this care from non-public providers. According to WHO recommendations for sexual and reproductive health self-care, adolescent women must get knowledge, supplies, and support. Adolescents who want to self-administer contraceptives such as oral contraceptives, injectables, and medication abortion must have access to sexual and reproductive health care. All teenagers must have access to comprehensive, stigma-free contraception and abortion services. Through community- and school-based initiatives, comprehensive sexuality education that is age-appropriate and recognises young people's rights, including their right to pleasure, must be made available. These programs should include contraception, pregnancy, and fertility awareness alternatives. Government family planning initiatives like Mission Parivaar Vikaas should use more inclusive language so that everyone may benefit from preventing unplanned pregnancies, regardless of their marital status.

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