



## Reproductive Health and Health Care Practices of the Oraon Tribal Women of Nadia, West Bengal

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### KEYWORDS

Oraon, Reproductive Health, Antenatal Care, Obstetric Morbidity.

### ABSTRACT

*The present study was undertaken to envisage the reproductive health and health-care practices and also find its association with the socio-demographic characteristics among the Oraon tribal women of Nadia district of West Bengal, India. A total of 100 Oraon women were included in this study who were presently in wedlock and aged between 15 to 49 years. Thus, it is evident from the present study that the reproductive health and health care facilities of the Oraon women needs augmentation by enhancing their socio-economic status through improved education and employment opportunities. The present study reinforces to understand the pragmatic depiction of the nutritional status of the Oraon tribal women, since it has an direct impact on their reproductive health.*

### Introduction

India is the second largest country in the world, with a large population of Scheduled Tribes. The tribal populations of India constitute a significant proportion of India's total population. According to the 2011 census, India has more than 104 millions tribals who constitute 8.6 % of the total population. India probably has the largest number of tribal communities in the world (Topal and Samal, 2001). The vast majority of tribal populations reside in the rural areas of the country. The tribal populations of India are recognized as socially and economically vulnerable (Ghosh and Bharati, 2006). These tribal populations are facing various types of health problems like undernutrition, communicable (infectious) diseases, on one hand, and obesity and noncommunicable diseases like diabetes, hypertension, cardiovascular diseases and cancer, on the other hand (ICMR, 2010).

Reproductive health is defined by the World Health Organization (WHO, 1991) as a state of physical, mental and social well-being in all matters relating to the reproductive system and is not merely the absence of disease or disorders associated with the reproductive process. Reproductive health further implies that reproduction is carried to a successful outcome in the form of infant and child survival, through growth and healthy child development. It also implies that women can pass safely through pregnancy and childbirth and that fertility regulation can be achieved without health hazards.

A 1991 report by the World Health Organization (WHO) suggest that improvements in women's reproductive health inevitably involves empowering women to have control over their own fertility

and sexuality with maximum choice and minimum health problems. The term “Women’s reproductive health” is thus most often equated with their capacity to reproduce, abortion/miscarriage status, pregnancy related complications, use of contraception and availability and accessibility to health care services. Women’s reproductive health is influenced by social and economic conditions (Cook, 1993; Garcia-Mereno and Claro, 1994). Thus, reproductive health care is defined as the constellation of methods, techniques and services that contribute to the reproductive health and well-being by preventing and solving reproductive health problems.

Fertility, the reproductive behaviour of women, is a biological and universal phenomenon which is influenced by the socio-cultural norms and practices and physical environmental condition. In the recent years, increasingly more attention has been paid to the demographic and fertility problems of the communities, since it is found that co-linearity of one or more particular cultural variables with biological variable(s) have some amount of additive or interactive impact on fertility

The status of women in a society is a significant reflection of the level of social health in terms of the level of social justice in that society. Women’s status is often described in terms of their level of income, employment, education, health and child bearing capacity as well as the roles they play within the family, the community and society. A tribal woman occupies an important place in the socio-economic as well as the health structure of her own family as well as society. The status of tribal women has gone from bad to worse as a result of the impact of social change which has affected the social structure of the tribal society (Chauhan, 1990).

Women are more vulnerable in the society, especially the poor tribal women who are more prone to reproductive health problems such as pregnancy, delivery and post delivery complications, contraceptive use side effects and other reproductive health problems. To avoid these health problems, women should have health checkup like ante-natal check-up during pregnancy, natal and post natal check-up at the time of delivery and after delivery which would protect the health condition of the future born babies of women.

In order to assess the achievements of goals and targets of reproductive health it is necessary to establish a system for monitoring and evaluation. This is possible because of the essential reproductive indicators and guidelines. The indicators of reproductive health enable policy makers and program managers to assess and improve reproductive health services so that clients can achieve their reproductive health intentions. Reproductive health includes the age at marriage, reproductive performance and fertility regulation, care during pre-natal, natal and post-natal period, breast feeding and infant care practices.

Research evidence from India also shows that utilization of the safe motherhood services plays a pivotal role in influencing maternal, peri-natal, neo-natal, infant and child mortality (Srinivasa and Venkatesh, 1982; Mahadevan, 1985; Jain and Visaria, 1988; Ramachandran, 1989). Age at marriage affects the fertility of tribal women and thus the reproductive health behavior in tribal groups differs from non-tribal groups.

There is a general agreement that the health status of the tribal population in India is very poor. Different studies (Choudhury and Kumar, 1976; Rizvi, 1986; Roy Burman, 1986, 1990; Basu, 1987, 1990; Basu et al., 1990, 1993; Basu and Kshatriya, 1989, 1997; Bardhan et al., 1989; Mukherjee, 1990; Mahapatra, 1990; Haque, 1990) have tried to establish this with the help of morbidity, mortality and health statistics. In West Bengal, Santal and Munda tribal women shows a high prevalence

of underweight, which is still a major problem (Ghosh, 2016). Another study among the Lodha tribal women of West Bengal reveals that the prevalence of hypotensive and anemia was very high, approximately five times higher than that in the mainstream communities (Bepari et al, 2015).

Keeping these facts and observations in view an attempt has been made to understand some relevant aspects of reproductive health and health care practices of the Oraon tribal women and to find out an association between the socio-demographic characteristics and reproductive health care practices of the Oraon tribal women of West Bengal.

## Materials and Methods

The present study was conducted in two villages namely Madna and Hatibandha which are situated in the Nadia district of West Bengal. The study included 100 Oraon tribal women who are presently in wedlock and are aged between 15 to 49 years. Data on socio-demographic characteristics, reproductive performance and reproductive health care practices and obstetric morbidities were collected by using a pretested structured schedule. Various statistical tools were used to analyze the data.

## Results

*Table:1- Socio-economic characteristics of the Oraon tribal women.*

Variables	Categories	Percentages
Age Group (In Years)	15-24	13
	25-34	46
	35-44	23
	≥45	18
Educational Status	Non Literate	30
	Literate (Can Sign)	11
	Primary School	28
	Secondary School & above	31
Occupation	1.Skilled Labour	33
	2. Unskilled Labour	63
	3.Service	1
	4.Home Maker	3
Monthly Family Expenditure (Rs)	<2500	0
	2500-5000	88
	>5000	12

Table-1 reveals that most women (46%) belongs to the age group 25-34 years and 30% of them are non-literate, 11% women can only sign and the rest 59% went to either primary school or secondary school and above. Most women (63%) were engaged as unskilled labour. The monthly family expenditure among most of them (88%) are between Rs 2500 to 5000 per month.

*Table:2 Distribution of the Ever Married Women (EMW) by Age at first marriage.*

Present age group	Number of respondent	Age at first marriage			Mean age of marriage in years
		Below 14 years	14-17 years	18-21 years	
15-24	13	0(0.00%)	3 (23.08%)	10 (76.92%)	18.46
25-34	46	1 (2.17%)	14(30.43%)	31(67.39%)	18.40
35-44	23	0 (0.00%)	15 (65.22%)	8 (17.39%)	16.33
≥45	18	3(16.67%)	15(83.33%)	0 (0.00%)	15.22
Total	100	4 (4.00%)	47(47.00%)	49(49.00%)	17.10

Table-2 shows that the mean age at marriage of the Oraon women is 17.10 years which is low compared to the legally permitted female age at marriage in India that is 18 years. The lowest mean age at marriage is 15.22 years which has been observed among the women of the age group greater than equal to 45 years. The mean age at marriage decreases as the age group increases.

*Table:3 Distribution of the EMW by Age at marriage and Age at first child birth*

Age at marriage in years	No of ever married women	Age at first child birth			Mean age at 1 <sup>st</sup> child birth
		15-17 (years)	18-21 (years)	22-25 (years)	
<14	4	4 (100.00%)	0 (0.00%)	0 (0.00%)	15.5
14-17	47	45(95.74%)	1(2.13%)	1(2.13%)	16.13
18-21	49	0(0.00%)	24(48.98%)	25(51.02%)	21.0
Total	100	49(49.00%)	25(25.00%)	26(26.00%)	18.53

The above table-3 reveals that the mean age at first child birth of the Oraon woman is found to be 18.53 years. The gap between the mean age at first marriage and the mean age at first child birth is 1.43. The mean age of first child birth of the woman who got married below 14 years of age is 15.5 years.

*Table:4 Distribution of the EMW by Age group and number of children ever born*

Age group	No of children ever born					Total		Average children per women
	1	2	3	4	5	Women	Children	
15-24	10(76.92%)	3(23.08%)	0(0.00%)	0(0.00%)	0(0.00%)	13	16	1.23
25-34	6(13.04%)	25(54.35%)	10(21.74%)	5(10.87%)	0(0.00%)	46	106	2.3
35-44	5(21.74%)	10(43.49%)	5(21.74%)	3(13.04%)	0(0.00%)	23	52	2.26
≥45	0(0.00%)	5(27.78%)	10(55.56%)	2(11.11%)	1(5.56%)	18	53	2.94
total	21(21.00%)	43(43.00%)	25(25.00%)	10(10.00%)	1(1.00%)	100	2.27	2.18

Table-4 shows that women of the youngest age group (15-24 years) delivered the least number of children as compared to women of the higher age group. It is observed from the table that the average number of children born per woman increases steadily with age.

*Table:5 Distribution of EMW by duration between two successive live births*

Present age group	No. of ever married women	1 (years)		2 (years)		3 (years)		4 (years)		5 (years)		6 (years)		7 (years)		No. of women having one child	
		No.	%	No.	%	No.	%	No.	%	No..	%	No.	%	No.	%	No.	%
15-24	13	0	0.00	4	30.80	0	0.00	0	0.00	0	0.00	1	7.7	0	0.00	8	61.60
25-34	46	1	2.19	31	67.27	8	17.36	1	2.17	1	2.17	0	0.00	1	2.17	3	6.51
35-44	23	1	4.34	8	34.72	9	39.06	0	0.00	2	8.68	0	0.00	0	0.00	3	13.02
≥45	18	0	0.00	9	49.95	7	38.85	1	5.56	1	5.56	0	0.00	0	0.00	0	0.00
Total	100	2	2.00	52	52.00	24	24.00	2	2.00	4	4.00	1	1.00	1	1.00	14	14.00

The above table-5 highlights that maximum percentage (52%) of the Oraon tribal women maintains 2 years of gap between two successive life births. It is also observed from the table that maximum percentage of the women of age group 25-34 years (67.30%) and ≥ 45 years (49.95%) maintains 2 years gap while a considerable percentage of women maintain a gap of 3 years.

*Table: 6 Percentage of women who receive at least one antenatal check-up, Age group-wise distribution of the women not going for antenatal check-up, antenatal check-up*

Antenatal Care		No.	%				
	Received	46	46.00				
	Not Received	54	54.00				
Antenatal Care not received	Age group	Total women N=100	No. N=54	%			
	15-24	13	5	38.46			
	25-34	46	15	32.61			
	35-44	23	16	69.57			
	≥45	18	18	100.00			
At least one antenatal check-up	Age Group	Total women N=100	Yes (n=46)		No (n=54)		Chi-square (X <sup>2</sup> )
			No.	%	No.	%	
	15-24	13	8	61.54	5	38.46	0.013*
	25-34	46	31	67.39	15	32.61	
	35-44	23	7	30.43	16	69.57	
≥45	18	0	0.00	18	100.00		
Iron Folic Acid (IFA)	Age Group	Total women N=100	Yes (n=40)		No (n=60)		x2
			No.	%	No.	%	
	15-24	13	7	53.85	6	46.15	0.0084**
	25-34	46	28	60.87	18	39.13	
	35-44	23	5	21.74	18	78.26	
≥45	18	0	0.00	18	100.00		

At least one Tetanus – Toxoid(TT) taken	Age Group	Total women N=100	Yes (n=44)		No (n=56)		x2
			No.	%	No.	%	
	15-24	13	8	61.54	5	38.46	0.0073**
25-34	46	30	65.22	16	34.78		
35-44	23	6	26.09	17	73.91		
≥45	18	0	0.00	18	100.00		

\*p<0.05 ; \*\*p<0.01

Table-6 reveals that 46% of the Oraon women received antenatal check up where as 54% did not receive any antenatal check up. A significant difference was observed between the acceptances of antenatal care with age-group. It is interesting to note that around cent percent of the women aged above 45 years do not avail themselves of the antenatal care provided by the Government, whereas fewer percentages of the women of 35-44 years accept antenatal care, when compared to the women of the younger generation. Maximum percentage of women in the age groups 25 to 34 years received antenatal checkup (67.39%), T.T. vaccines (65.21%) and consumed IFA (60.86%).

Table:7 Distribution of Women by Educational status and acceptance of Antenatal check-up

Age group (in years)	Total women	Educational status of the women								At least one antenatal check up	Educational status of the women								x2		
		Non- literate		Literate (Can Sign)		Primary (1-5)		Secondary (6-10)			No.	%	Non- literate (n=30)		Literate (Can Sign) (n=11)		Primary (1-5) (n=28)			Secondary (6-10) (n=31)	
		No.	%	No.	%	No.	%	No.	%				No.	%	No.	%	No.	%		No.	%
		15-24	13	2	15.38	3	23.08	1	7.69				7	53.85	8	61.53	–	–		–	–
25-34	46	1	2.17	3	6.52	22	47.83	20	43.48	31	67.39	–	–	1	17.39	10	32.26	20	64.52		
35-44	23	15	65.22	2	8.7	3	13.04	3	13.04	7	30.43	–	–	1	22.22	3	42.86	3	42.86		
≥45	18	12	66.67	3	16.67	2	11.11	1	5.56	0	0.00	–	–	–	–	–	–	–	–		
Total	100	30	30	11	11	28	28	31	31	46	46.00	0	0.00	2	4.35	14	30.43	30	65.22		

The above table-7 shows that maximum percentage of the women of younger generation were educated up to the primary and secondary levels in comparison to the women of the older generation, which is also reflected in their acceptance of antenatal care.

Table:8 Distribution of the EMW with pregnancy complications

Present Age group	Total no. of EMW	Mother with no pregnancy complication		Mother with any pregnancy complication		x2	Type of pregnancy complications							
		No.	%	No.	%		Nauseas		Severe vomiting		Indigestion		Loss of appetite	
							No.	%	No.	%	No.	%	No.	%
							15-24	13	7	53.80	6	46.15	0	0.00
25-34	46	29	63.00	17	36.90	2	4.30	9	19.56	9	19.50	2	4.34	
35-44	23	16	69.30	7	30.43	0	0.00	4	17.39	5	21.70	0	0.00	
≥45	18	11	61.10	7	38.80	0	0.00	3	16.66	7	38.90	2	11.11	
Total	100	63	63.00	37	37.00	2	2.00	18	18.00	24	24.00	5	5.00	

It is observed from table -8 that women of age group 15 to 24 years have more complication than the women of other age groups. The common pregnancy complications prevalent among the women

of all the age-groups include indigestion and vomiting.

*Table: 9 Birth Assisted by Doctors/ Other health professional/ Elderly women*

Age group	Total women	Doctor/LHV/ANM		Dhai/Elderly women	
		No.	%	No.	%
15-24	13	8	61.54	5	38.46
25-34	46	31	67.39	15	28.26
35-44	23	7	30.43	16	69.56
≥45	18	0	0.00	18	100.00
Total	100	46	46.00	54	54.00

From the above table 9 it is observed that the dependency on the Dhai or an elderly woman for delivery is around 54% and is more prevalent among the women of the older age group. It also reveals that the maximum number of institutional delivery is from the age group of 25-34 years (67.39%) and 15-34 years(61.54%). This development in the acceptance of the health care provision is due to the financial incentives provided by the Government for institutional delivery.

*Table: 10 Distribution of the EMW with Postnatal complications*

Present Age group	Total no. of EMW	Mother with no post natal complication		Mother with any post natal complication		x2	Type of post natal complications							
		No.	%	No.	%		Fever		Lower abdominal pain		Pelvic pain		Severe headache	
							No.	%	No.	%	No.	%	No.	%
15-24	13	9	69.20	4	30.76	0.9857	1	7.69	11	84.60	0	0.00	0	69.20
25-34	46	31	67.39	15	32.60		2	4.76	30	65.20	4	8.69	17	36.90
35-44	23	16	69.56	7	30.43		3	13.00	16	69.56	0	0.00	9	39.13
≥45	18	13	72.20	5	27.70		1	5.50	12	66.60	0	0.00	9	50.00
total	100	69	69.00	31	31.00		7	7.00	69	69.00	4	4.00	44	44.00

Table-10 shows that 31% of the women faced any kind of problems during the first six weeks after the delivery or postnatal complication. The most common problem reported by the majority of women is lower abdominal pain (69%) and severe headache (44%).

## Discussion

Age at marriage is an important social as well as demographic factor which influences the child bearing period and also determines the fertility of the community. The relationship between age at marriage and fertility is well known (Maudlin and Berelson, 1978; Nag, 1982; Pandey and Talwar, 1987). In tribal societies, the prevalence of the practice of girls getting married generally after puberty results in early age at marriage. It is found that a later age at marriage reduces fertility (Agarwala, 1967; Durch, 1980; Yadav and Badari, 1997).

In the present study mean age at marriage of the Oraon woman is 17.10 years which is low compared to the legally permitted female age at marriage in India that is 18 years.

The lowest mean age at marriage (is 15.22 years) has been observed in the age group greater than equal to 45 years. The mean age at marriage decreases as the age group increases. Thus, it can be told that the younger generation Oraon girls prefer to marry slightly late. The findings of the present study are in accordance with the other individual tribes of India. For example the female age at marriage for Naga (16 to 20 years), Bhil (16 years), Khasi (13 to 18 years), Koli (12 to 16 years) Bosh (19 years), Gond (18 years), Munda (18 years as) are referred by Sinha (1986). Singh (2006) in his study among the four communities of Manipur observed that age of marriage of Meitei (19.9 years) and Kabui (20.0 years) women is very close to the all India average (20.0 years). He further observed that age at marriage is occurring much earlier among the Nepalese (17.3 years) and Pangals (17.5 years). It has been observed that majority number (67.55%) of respondents among Santal, Lodha and Munda tribal women of West Bengal whose age at marriage occurs between the age group 15-17 years (Manna and Sarkar, 2016).

Present study also reveals the mean age at first child birth of the Oraon woman is 18.53 years. The gap between the mean age at first marriage and the mean age at first child birth is 1.43. Singh (2006) in his study highlights that the age at first childbirth is associated with the age at first marriage which occurs early or late. This is in accordance with the findings of the present study. Further table reveal that the mean age of first child birth of the women who get married below 14 years of age is 15.5 years. The women who marry below 14 years of age are of the older generation.

Present study shows that the duration between two successive births among the Oraon women is 2-3 years. This may be due to the effect of postpartum amenorrhea which is a natural method of fertility regulation. The duration of postpartum amenorrhea varies from women to women (Knodel and Lewis, 1984; Jones, 1988). On the basis of data from 13 studies in 8 countries, the Bellagio consensus statement concluded that breast feeding provides more than 98 percent protection from pregnancy during the first 6 months postpartum if the mother is fully breast feeding (Howie, 1993).

The present study reflects that mothers of the youngest age-group (15-19 years) delivered least number of children as compared to mothers of the higher age group. It is observed that the average number of children ever born per woman increases steadily with age. This is in agreement with the findings of Singh (2006) who has also reported that there is a tendency of increasing number of live births with increasing chronological age of mother due to exposure to longer period of married life.

The antenatal care coverage of Oraon women (46%) is comparatively lower than the Khasi tribe of Meghalaya (Deb, 2008). According to NFHS-3 2005 to 2006 72% women in rural India received antenatal care which is higher than the Oraon woman. It is observed that percentage of women receiving antenatal checkup is slightly lower in the age group of 15 to 24 years than the next age groups 25 to 34 years. This is in agreement with Bhatia and Cleland (1995 a).

Maiti et al. (2005) reported that 25.7 percent tribal women have received antenatal check-up and 24.3 percent was given IFA tablets and 43.7 percent were given TT vaccine which is still lower than the findings of the present study. In the study of Deb (2008), 83.3 percent women of the Khasi tribes of Meghalaya have received the TT vaccine and 79.3 percent have consumed Iron Folic Acid tablets. Suman and Asari (2001) have observed that 58.6 percent tribals have received antenatal care and 87.8 percent women have utilized the immunization services provided by the PHC. It is interesting to note that among the women who received antenatal checkup (95.1%) received at least one tetanus toxoid vaccine and consumed IFA supplement. Similar findings were also revealed by Pallikadavath et



al., 2004 where among all women who received antenatal care 89.3 percent women have received TT and only 60.2 percent have consumed IFA. The finding of the present study is in accordance with the findings of NFHS-2 (1998-99), IIPS-ORC-MACRO (2000), where also the percentages of women with no antenatal checkup increases with chronological increase in age group. The women receiving the TT and consuming IFA also shows a similar trend. El-Gilany and Aref (2000) have also reported that utilization of antenatal care might depend on the enthusiasm or anxiety of the mother, which is greater among young women than older women.

The present study also reveals that the younger women are more educated than the oldest woman which has direct impact on the acceptance of antenatal care during pregnancy. Thus it is evident that education plays a significant role in improving the health status of the women moreover maximum percentage of women who never receive antenatal check up are more likely to be illiterate. Several studies have found a significant association between maternal education and the use of maternity services (Obermeyer and Potter, 1991; Bhatia and Cleland, 1995 a).

In this study it is observed that women of age group 15 to 24 years have more complications than the next age groups. This is due to first pregnancy and early age of childbirth, when their reproductive system is not mature enough to carry forward the entire process of pregnancy. Anandalakshmy et al. (1993) and Miller et al. (1996) have also stated that very young and older mothers have increased risk for both the mother and the baby.

The dependency on the Dhai or an elderly woman for delivery is more among the older women ( $\geq 45$  years). It is thus distressing to know that maximum percentages of women depend upon the Dhai or elderly women for delivery. This is in accordance with Pandey et al. (1997), who have reported that the primitive tribes of Madhya Pradesh (Hill Korwas, Pando etc) considered delivery as a natural phenomenon and usually the elderly woman or traditional Dhai conduct delivery. In this study women of higher age group suffer more from post delivery complications this is due to more illiteracy and for no antenatal care and more home deliveries in these age groups. Younger women aged 15 to 24 years into have more complications due to their first pregnancy and early age of childbirth. Complications of pregnancy and childbirth are still the leading causes of death and disability among women of reproductive age in developing countries (Maine and Rosenfield, 1999). Bhatia and Cleland (1995 b) describes that in India 18 percent of the women have reported problems during pregnancy period and an equal proportion during delivery. In another study conducted in South India, it is found that 33% of the women have reported at least one problem like anemia/paleness and lower abdominal pain (Bhatia and Cleland, 1995 b) and is slightly lower than the present study (37%).

Salam and Maksuda (2007) have reported that postnatal complications like hemorrhage, pelvic pain, fever more than three days, headache etc are significantly associated with the delivery attendance. Goswami (2012) shows that 32.7% of the Bhumija women of northern Odisha reported of any postnatal complications. Similarly, Maiti et al. (2005) revealed that 23.2 percent women have any postpartum complication which is slightly lower than the findings of the present study (31%).

## **Conclusion**

Reproductive health of women, though biological, is influenced by several socio-cultural norms and practices and also physical environmental condition. The cultural norms that particularly affect women's reproductive performance is age at marriage, age at first child birth etc. The present study

shows that the mean age at marriage of the Oraon women is 17.1 years which is lower than the legally permitted female age at marriage in India i.e. 18 years. It further shows that the mean age at marriage decreases with age-group which implies that the younger generation Oraon girls prefer to marry slightly late. The mean age at first child birth is 18.53 years. Results of the study also indicates that the older women have higher fertility than younger women which is due to multiple reasons like early age at marriage, post-natal loss is more, preference of male child, lack of awareness of family planning methods etc.

Among all the Oraon women 46 percent of the women receive antenatal care. It is to be noted that the acceptance of the antenatal care is more in the women of younger age-group which reflects the impact of the maternal health services provided by the Government. Similar trend is noticed in the consumption of Iron-Folic Acid supplement and availing at least one tetanus-toxoid vaccine. The effect of educational status is also observed in the acceptance of antenatal care. It is distressing to note that, in spite of the existing health facilities, maximum percentage of women (54%) even today depend upon the elderly women for delivery. It is observed that 37% of the Oraon women experience at least one complication during delivery and 31% women have faced any one complication during the first six weeks after delivery. Thus, it is evident from the present study that the reproductive health and health care facilities of the Oraon women needs augmentation by enhancing their socio-economic status through improved education and employment opportunities. Further, the present study reinforces to understand the pragmatic depiction of the nutritional status of the Oraon tribal women, since it has an direct impact on the reproductive health of the women.

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