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REPRODUCTIVE HEALTH STATUS OF WOMEN IN INDIA: AN OVERVIEW

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ABSTRACT

The largest gap between the rich and poor nations is seen in maternal mortality levels amongst all the social indicators. Developed countries have achieved a Maternal Mortality Ratio (MMR) as low as 10 whereas India reports 407 deaths per 1, 00,000 women. Nine in ten maternal deaths occur in developing countries and India shares one fourth of such deaths worldwide. MMR is an indicator for general socio-economic status, nutrition level as well as maternal health care in the community. Therefore, this paper examines women's reproductive health status in India.

1.1Introduction

India has achieved satisfactory enhancement in social indicators such as life expectancy (63.2), infant mortality 63 per 1000live births, child mortality(under five, 73 per 1000 live births) and literacy levels women in rural areas are largely at disadvantage as infections, diseases, malnutrition and maternal problems still account for most of the disease burden. India is one of the few countries where males significantly out number females and its maternal mortality rates in rural areas are among the worlds highest.

According to Ministry of Health and Family Welfare, the MMR is 619 per 1, 00,000 live births in 2002. States with high MMR include Rajasthan, M.P, Jharkand, Orissa, U.P, and Bihar. Infectious diseases, malnutrition, and maternal and prenatal causes account for most of the disease burden. Females experience more episodes of illness than males and are less likely to receive medical treatment before the illness is well advanced. Because the nutritional status of women and girls is compromised by unequal access to food, heavy work demands, and deprivation of special nutritional needs, females are susceptible to illness, particularly anemia.

Women, especially poor women, are often trapped in a cycle of ill health exacerbated by child bearing and hard physical labour. Since the turn of the century, India's sex ratio has become increasingly favourable to males, sex ratio (females per thousand males) measure the balance, between males and females in human population. Large imbalances in this aspect affect the social, economic and community life in many ways. In a population, the sex ratio is an indicator of the sex differential in mortality. A higher or lower sex ratio reflects the status of the social – cultural, maternal and child health care programmes existing in the population.

Female disadvantage in mortality is attributed as the cause for the low sex ratio in India. Over the last decade, the fall in the ration of girls to boys has been greatest in the richest states of the north and west. According to 2001 census in Punjab, the ratio is 793 girls to 1000 boys, down from 875 in the previous census. In Gujarat, the figure is now 878 girls to 1000 boys compared to 928 girls ten years ago.

1.2 Status of Women in India

The position of women in traditional Indian society can be measured by their autonomy in decision making and by the degree of access they have to the outside world. By these measures, Indian women particularly those in the north, fare poorly. Girls are typically married as adolescents and are taken from their natal homes to live in their husband's households. There they are dominated not only by the men they have married, but also by their new in laws, especially the older females. The consequences of women's unfavourable status in India include discrimination in the allocation of household resources, such as food, and inaccessibility to health care and education, as well as marriage at young age. The loss of a husband usually results in a significant decline in household income, in social marginalization, and in poor health and nutrition.

Education: The female disadvantage in India is also evident in education, although significant gains have been made in female literacy since independence and the benefits of educating females are widely recognised. According to the 1991 census, only 39 percent of Indian females above age 7 are literate, compared with 60 per cent of males. In some northern states, the percentage of literate females is as low as 21 to 26 per cent. A variety of socio-economic factors are responsible for women's lower educational attainment including direct costs, the need for female labour, the low expected returns, and social restrictions. Because women's educational level and improvements in their health status are closely linked, increasing female education is key to improving their health.

Poverty: Poverty underlies the poor health status of most of the Indian population and women represent a disproportionate share of the poor. Women's relatively low status and the risks associated with reproduction exacerbate what is already an unfavourable overall health situation. Women in rural India live in lower status (except in a few states) and experience more episodes of illness than males and also are less likely to access health care facilities before the illness is well advanced due to poverty. A vast majority of the poor women who are caught in the vicious circle are young women in the reproductive age, who are deprived of their basic right to be healthy.

Women and work: Beginning in childhood, most rural – women fulfill multiple agricultural productive functions in addition to bearing children and performing household labour. Ironically, recent agricultural innovations have not benefited rural women, who still perform primarily manual labour. The strenuous physical tasks allocated to women, combined with limited food intake, exacerbate malnutrition among Indian women. Productive responsibilities are hardest on child bearing women, who typically work until late in their pregnancies without needed rest or additional food. Mothers resume work before they have fully recovered from childbirth and have their children in relatively close succession resulting in a cycle of maternal depletion that saps their physical strength and undermines their ability to function effectively.

Poverty: Poverty increases the risks inherent in childbearing and maternal mortality and morbidity. Ninty - nine per cent of maternal deaths occur in developing countries, in which Africa and Asia alone accounts for 95 per cent. Two thirds of maternal deaths in 2000 occurred in 13 of the world's poorest countries, and one quarter of these were in India alone. With in countries the wealthiest women have much better access to skilled obstetric care than the poor.

Morbidity: Reliable data on mortality and morbidity in pregnancy are scarce, and for female morbidity in general they are almost nonexistent. The limited studies available report high morbidity and malnutrition among girls and women. Emerging evidence indicates that the prevalence of reproductive tract infection is considerably higher and that the spread of HIV/AIDS is a concern. Iron – deficiency anemia is widespread among Indian girls and women and affects 50 to 90 per cent of pregnant women.

Fertility: Female mortality and morbidity rates are linked to overall fertility levels – in India. Child bearing closely follows marriage, which tends to occur at a young age: 30 percent of Indian females between 15 and 19 are married. Childbearing during adolescence poses significantly greater health risks than it does during the peak reproductive years and contributes to high rates of population growth; Indian women also tend to have closely spaced pregnancies. Some 37 per cent of births occur within two years of the previous birth, endangering both the health of the mother and the survival of the infant and older siblings.

Maternal Mortality Rate: Maternal mortality in India, estimated at 437 maternal deaths per 1, 00,000 live births, results primarily from infection, hemorrhage, eclampsia, obstructed labour, abortion, and anemia. Lack of appropriate care during pregnancy and childbirth, and especially the inadequacy of services for detecting and managing complications, explain most of the maternal deaths. There are wide disparities in fertility and mortality among states and, within states, between rural and urban areas. The substantially unfavorable levels of these indicators in the northern states Bihar, Madhya pradesh, Rajasthan, and Uttar pradesh in relation to most southern states reflect marked social and demographic contrasts between the Hindi belt and the rest of India.

The southern state of Kerala, for instance, has achieved fertility and mortality level approaching those of industrial countries. India accounts for more than 20 per cent of the global maternal and child deaths, and also records 20 per cent of births worldwide. Approximately 30 million women in India experience pregnancy annually, and 27 million have live births. Of these, nearly 1, 36,000 maternal deaths occur annually, most of which can be prevented.

1.3 Causes for Maternal Deaths

The major causes of maternal deaths are excessive bleeding during childbirth generally among home deliveries, obstructed and prolonged labour, infection, unsafe abortion, disorders related to high blood pressure and anemia. Forty seven per cent maternal deaths in rural India are attributed to excess bleeding and anemia resulting from poor nutritional practices. Intermediate causes, which are the first and second delays in care – seeking include the low social status of women, lack of awareness and knowledge at the household level, inadequate resources to seek care and poor access to quality health care. Causes of third delay are untimely diagnosis and treatment, poor skills and training of care providers and prolonged waiting time at the facility due to lack of trained personal, equipment and blood.

There are insufficient facilities for antenatal care and 65 per cent of deliveries are still conducted at home, very often by untrained helpers. Every woman, rich or poor, faces a 15 per cent risk of complication almost every time of the delivery, but maternal deaths are practically nonexistent in developed regions. The lack of progress in reducing maternal mortality in many countries highlights the low value placed on the lives of women and testifies to their limited voice in setting public priorities. The lives of many women in developing countries could be saved with reproductive health intervention that people in rich countries take for granted.

Health care especially maternal health care is poor in developing countries. Poor health services contribute significantly to maternal deaths .For example, a study of 152 maternal deaths in Dakar and Senegal showed that the following major risk factors were associated with health system failures: medical equipment breakdown, late referral, lack of antenatal care and , most importantly , non – availability of health personnel at the time of admission. Indeed the lack of a skilled attendant at the time of childbirth is the most serious risk factor for maternal death and yet the percentage of births attended by a trained person can be as low as 5per cent in some developing countries. Similarly, family planning services can be poor and erratic, contributing to the lack of interest among potential clients. But behind this health system, obstacle to the health of women in developing countries lays a plethora of other factors: social, cultural and political.

Social Factors: The correlation between lack of education and high risk of maternal mortality has been demonstrated in several studies and reports (e.g. Harrison, 1996; World Bank, 1993). It applies equally to child health, which depends very much on parental schooling, especially the mothers (World Bank, 1993). It has also been shown to determine the level of use of contraception.

Cultural Factors: Some cultural practices are detrimental to reproductive health. For example, in some societies pregnant women are prohibited from eating certain foods, thus contributing to poor nutritional status and anemia. It is well known that anemia is a risk factor for maternal morbidity and mortality. In other societies, the practice of female genital mutilation (FGM) causes pain and difficulties in childbirth. This practice is common in South-East Asia and Africa.

Political Factors: Political stability is essential to the sustainability of health programmes. Civil wars and the refugees resulting from them are not and cannot be conducive to the delivery of health care. Moreover, when comparing the percentage of central government spending in such countries on defense, education and health, it is clear that defense is given priority.

1.4 Infant and Young Child Mortality

Good reproductive health care and the exercise of women's reproductive rights can help ensure that every infant is wanted, loved and has a chance to thrive conversely. A mother's poor reproductive health can undermine the health and well – being of her children. Maternal and infant mortality are closely linked, when a mother dies giving birth, her infant often dies as well. Motherless new -borne are three to ten times more likely to die than those with mothers. Mothers are usually the primary guardians of the health, education and nutrition of their children, and in many cases, also a contributing source of income. Every year up to two million children lose their mothers for lack of services that are readily available in wealthier nations.

Birth spacing significantly reduces infant mortality; a two to three year interval between births reduces the chances of premature birth and low infant birth weight. Birth spacing is credited with reducing child mortality by close to 20 per cent in India, and 10 per cent in Nigeria. Unwanted children in general are more vulnerable than others to illness and premature death.

1.5 Maternal Death and Disability

Maternal death and injury rates throw into sharp relief the impact of poverty and gender inequity on reproductive health. Every minute one woman dies needlessly of pregnancy related causes. This adds up to more than a half million mothers lost each year – a figure that has hardly improved over the past few decades. Another eight million or more suffer lifelong health consequences from the complications of pregnancy. Every woman, rich or poor, faces a 15 per cent risk of complications around the time of delivery, but maternal death is practically nonexistent in developed regions. The lack of progress in reducing maternal mortality in many countries highlights the low value placed on the lives of women and testifies to their limited voice in setting public priorities. The lives of many women in developing countries could be saved with reproductive health interventions that people in rich countries take for granted.

1.6 India's Reproductive Health at a Glance

1. Estimated population of India by the year 2025: 1.36 billion;

2. Estimated percentage of births to women aged 15-19: 17.1per cent
3. Estimated percentage of induced and spontaneous abortions to women aged 15-19:11.4 per cent,
4. Maternal death rate per 1, 00,000 births 540.

According to National Aids Control Organisation India had 4.58 million people living with HIV/ AIDS at the end of December 2002 (Second only to South Africa). These and other health risks are pervasive and deadly. Not surprisingly, reproductive health care challenges figure heavily in the health of a nation. Access to family planning is limited and in some regions complicated by low acceptance of reversible contraception, although this is changing.

Although abortion is legal in India, safe abortion services are not always easily accessible to women, especially poor women from rural areas. Unsafe abortion is a leading cause of maternal mortality. A significant number of maternal deaths occur due to unsafe procedures performed by untrained providers. Up to 80 per cent of abortions are performed by untrained personal in unhygienic environment; cultural barriers play a role in women's choices as well. Almost 48 per cent of women have no say in decision regarding their own health care.

1.7 Reproductive Health Problem

Reproductive health problems are the leading causes of women's ill health and death worldwide. When both women and men are taken into account, reproductive health conditions are the second highest cause of ill health globally, after communicable diseases. Universal access to reproductive health care is achievable, which could prevent most reproductive health problems and could also spur progress across various areas of social and economic development

1.8 Early Pregnancy And Child Bearing

Early pregnancy and child bearing characterize the experience of a large proportion of young women in India, Adolescent fertility rates are high, roughly 107 births take place per 1,000 girls aged 15-19 and the fertility of this age group makes up 19 percent of the nation's total fertility rates. NFHS (National Family Health Survey)-2 findings suggest that in many cases pregnancy and child bearing occur even before adolescents are physically developed, and may expose young girls to particularly acute health risks during pregnancy and childbirth.

Over one in five give birth by age 17 and the median age at first birth is 19 years, suggesting that significant proportions of women undergo pregnancy at ages below which obstetric risk are particularly elevated (IIPS and ORC Macro 2000) Not only does child bearing occur early among married adolescents, but subsequent pregnancies also tend to be more closely spaced than among adults. The experience of early and closely spaced child bearing is particularly risky for adolescents because a large proportion is anemic and may not have reached physical maturity. Nearly 15 per cent of ever married adolescent women were stunted and about one fifth had moderate to severe anemia.

Induced abortion: It is estimated, that between one in 10 per cent of abortion – seekers in India are adolescents, though a few facility – based studies report that the proportion of adolescent abortion – seekers is as high as one in three. An analysis of data from NFHS 1998-99 shows a life time induced abortion ratio of 1.1 among married adolescents nationally. Among unmarried abortion – seekers adolescents constitute a disproportionately large percentage. At least one – half of unmarried women seeking abortions at facilities are adolescents many of whom are below 15 years.

Lack of Contraceptive or Condom use: Lack of contraceptive or condom use characterizes vast majority of sexual encounters among youth. Adolescents worldwide are less likely than adults to use contraception, either in or out of marriage, and this appears to be equally true in India.

Reproductive Tract and Sexually Transmitted Infections, Including

HIV/AIDS: Globally, nearly 45 percent of all new HIV infections (about 2.4 million per year) occur among 15-24 year olds, and the rate is equal to or more than that estimated among adults. In India, for example, the estimated percentage of young females aged 14 - 24 living with HIV/AIDS (0.96 and 0.46 per cent in high and low prevalence sites, respectively); exceeds the rate for young men (0.46 and 0.20 per cent in high and low prevalence sites, respectively - this compares with a corresponding percentage of 0.80 among adults.

Unintended Pregnancy and Unsafe Abortion: Unsafe abortion is a leading cause of maternal mortality and can result in permanent injuries; Lack of access to family planning results in some 76 million unintended pregnancies every year in the developing world alone. Each year, 19 million abortions are carried out under unsanitary or medically unsound conditions. These result in some 6, 80,000 deaths. Many women who seek abortions are married. They are usually poor and struggling to provide for children they already have. Research suggests that one in 10 pregnancies will end in an unsafe abortion, with Asia, Africa and Latin America accounting for the highest numbers.

1.9 Conclusion

Therefore it could be concluded from above discussion that the only a very limited number of Indian women have the opportunity to choose whether or when to have a child. Women, particularly women in rural areas do not have access to safe and controlled methods of contraception. The Public health system emphasizes permanent methods like sterilization or long-term methods like IUDS that too not needing follow – up and are thus felt to be more fool– proof than other spacing methods. In fact, sterilization, accounts for more than 75 per cent of total contraception, with female sterilization accounting for almost 95 per cent percent of all sterilization.

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