1.1 Introduction

India has achieved satisfactory enhancement in social indicators such as life expectancy (63.2), infant mortality 63 per 1000 live births, child mortality (under 5, 73 per 1000 live births) and literacy levels. Women in rural areas are largely disadvantaged due to infections, diseases, malnutrition, and maternal problems. Still, there is no account for the disease burden. India is one of the few countries where males significantly outnumber females and its maternal mortality rates in rural areas are among the world's highest.

According to Ministry of Health and Family Welfare, the Maternal Mortality Ratio (MMR) is 619 per 1, 00,000 live births in 2002. States with high MMR include Rajasthan, MP, Jharkhand, Orissa, UP, and Bihar. Infectious diseases, malnutrition, and maternal and prenatal care 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 labor. Since the turn of the century, India’s sex ratio has become increasingly unfavorable 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 programs 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 ratio 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 unfavorable 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 recognized. 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 unfavorable 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 labor. Ironically, recent agricultural innovations have not benefited rural women, who still perform primarily manual labor. 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. Ninety-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 per cent of Indian females between 15 and 19 are married. Childbearing during adolescence poses a health risk. Poor health during pregnancy is increased during the 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 whereas significantly greater health risks than it do 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.

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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. 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.

1.5 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 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 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: 17.1 per 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 (IIIPS 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.

References