CHAPTER – 1

INTRODUCTION

The Problem and its ramifications

The Problem

This study proposes to examine the socio cultural factors influencing reproductive health behavior of Kerala women. It will be conducted in rural Kerala where traditional behavior still persists and acts as a barrier to the introduction of modern health care practices intended to reduce reproductive health hazards and contribute to better health and wellbeing of women.

Health is a very broad concept and reproductive health is a crucial component of a woman’s general health. Studies on ‘reproductive and child health’ have assumed contemporary relevance after the International Conference on Population and Development (ICPD) in Cairo in 1994. ICPD approach is based on meeting the totality of people’s reproductive health needs particularly those of women and children. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so (United Nations, 1995).

Women’s health involves their emotional, social and physical well-being. This is made complex by the fact that, “apart from the general health needs, women have special health needs related to their role in child bearing
and rearing. It is thus imperative that one looks at women’s health comprehensively, historically and culturally. Women have an inherent biological advantage over men which makes their life expectancy 5-7% longer than that of men. However this biological advantage is negated by the discriminatory treatment towards girls and women and the health risks associated with their reproductive health. Maternal mortality continues to be the major cause of death among women of reproductive age in many countries.

A very simple indication of the level of welfare enjoyed by women in India is that, in large parts of the country, their levels of education are amongst the lowest, and the level of maternal mortality are amongst the highest in the world. Whether in socio-economic indicators such as education, health, and work, or in more subtle processes of decision-making power and self esteem, the inferior position of Indian women has been consistently documented.

When we come to the reproductive health scenario of Kerala women, especially in rural areas, we can see that their poverty-related and socio-cultural factors influence their perception of health and their health seeking behaviour to a great extent. Socio-cultural factors which impinge on reproductive health include women’s lack of awareness of health matters, strong seclusion norms which inhibit health-seeking of adolescent girls, and unmarried women, large family norms and indifference towards family
planning, encouraging frequent and closely spaced pregnancies which frequently result in maternal mortality, morbidity and delivery complications. Above all, their societal devaluation which makes them the last to obtain nutritious food and health care and requires of them long periods of physical strain take a heavy toll on their overall health condition. Gender bias operates at several levels, from womb to tomb and restricts their availability and timely utilization of health services. Women are doubly disadvantaged with regard to their accessibility to health care. Culturally they are not predisposed towards caring for their own selves and socially they are hampered by various taboos and obstacles that prevent them from accessing health care even when it is available. These make the study of the reproductive health of women a very complicated matter. Nonetheless, because of the critical importance of reproductive health to women’s wellbeing, it has to be studied in detail.

**Rationale of the Study**

Healthy population is a pre-requisite for socio-economic and technological development of any country. Kerala, though the most highly literate and long-life-expectancy state in India, is constrained by many ill-health problems. Women here are silent sufferers of ill-health throughout their life course mainly because of their low self-esteem and low perception and negligence of their own health. Researchers in social sciences relate ill-health status of women to their deprived socio-economic and cultural conditions. This is true of Kerala to a large extent. Another fact is that in Kerala, even
though women live longer than men, their quality of life is very poor. They suffer from many health problems during their life time, many of which are very often specific though only to their reproductive processes. Even today maternal mortality in rural areas continues to be the major cause of death among women of reproductive age. Ironically, the women who are dying are in their prime of life and they are crucial to society and economy. Many of these can be prevented or controlled through timely intervention and education. In these circumstances, the present study is most relevant as it will help to identify the social and cultural obstacles that hinder women from improving their maternal health.

**Significance of Reproductive Health**

The current focus on reproductive health marks a global recognition that reproductive health needs have been largely neglected and that the consequences of this neglect have been profound, particularly for women. According to World Health Organization (WHO) health is one of the fundamental human rights. Unfortunately health cannot be given or distributed, but has to be actively acquired and won. Health is a very broad concept and reproductive health is a crucial component of general health. A very simple indication of the level of welfare enjoyed by women in India is that, in large parts of the country, their levels of education are amongst the lowest in the world, and the levels of maternal mortality are amongst the highest in the world.
Indian women, by and large, have poor reproductive health status. One of the reasons why women succumb to reproduction-related complications is lack of timely transportation to the nearest hospital. Experts estimate that 70% of the maternal-related deaths are preventable. Tetanus and anemia claim a large number of women because mothers get very little or no care in the post-natal period. Anemia can be overcome with proper nutrition and supplements. But cultural, social and economic barriers delay or prevent women from seeking reproductive health care at any stage – ante-natal delivery or post-natal. Safe maternity is a vital social indicator which requires immediate attention.

Reproductive health in India is largely influenced by poverty related and socio-cultural factors on one the hand and programme interventions on the other. Socio-cultural factors which impinge on reproductive health include women’s lack of awareness of health practices, strong seclusion norms which inhibit health-seeking, adolescent marriage, large family size norms which encourage frequent and closely spaced pregnancies, and a general devaluation of women which makes them the last to obtain food or health care and which requires them long periods of physical activity. Interventions directed towards reproductive health include maternal and child health, integrated child development services and family planning programmers. The present chapter considers each of these underlying sets of factors and the ways in which they affect reproductive health at various stages of the life cycle.
Reproductive health encompasses a range of health concerns, as indicated in the consensus definition emerging from the 1994 International Conference on Population and Development (ICPD) at Cairo. Specifically, reproductive health is defined as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’ (United Nations, 1994). A reproductive health orientation, drawn from this and other sources, more specifically implies:

- A satisfying and safe sex life free from the fear of disease and free from coercion and violence.

- The capability to reproduce, and the freedom to decide if, when and how often to do so; that is, that women and men have the right to be informed, and have access to, effective, affordable and acceptable methods of family planning of their choice on the one hand, and access to infertility services on the other.

- The ability to go safely through pregnancy and childbirth and have the best chance of having a healthy infant, and the right of access to appropriate health care services.

- Access to safe and affordable abortion facilities
• Access to services for the prevention and care of sexual and reproductive health problems, both gynecological and obstetric, in a culturally sensitive manner.

• The right of all, including women, men, married, and unmarried adolescents, to information and services (including counseling), whether on contraception, pregnancy, disease or the implications of coerced sex, and the freedom to make decisions on the basis of this information.

This implies that although reproductive health problems, per se, are rooted in the biomedical sphere, their origin often lies in human behaviour that is embedded in socially and culturally constructed patterns of gender relations.

The concept further recognizes that women’s needs are different from those of men because biologically and socially women’s bodies and social realities are different from those of men. To that extent, women’s health risks and their health seeking behaviour may also be expected to be different. And since women are generally more disadvantaged than men, their vulnerability to common health risks may be expected to be much greater, with additional implications for their reproductive health. But precisely because unequal gender relations disadvantage women, i.e., man’s culturally conditioned behaviours and roles sustain women’s vulnerability to health risks, the challenge is to investigate how women may be empowered on the one hand
and on the other, how men may be drawn into the process of responding to women’s reproductive health needs.

Reproductive ill health represents an important part of the overall burden of disease, especially for women. From infancy through old age, problems such as female genital mutilation, malnutrition and anemia, unwanted pregnancies, reproductive tract infection including socially transmitted diseases, HIV/AIDS, infertility, sexual and gender violence, unregulated fertility, maternal mortality and morbidity, breast and cervix cancers, osteoporosis and prolapsed of uterus in later years take a toll on women and her healthy life.

- The health consequences of violence against women – rape, sexual abuse and forced prostitution - have been contributing substantially to the burden of disease in women.

- The rapid spread of HIV/AIDS, particularly among young women demonstrates their vulnerability and the need for sensitive and responsive educational messages, technologies and services. It also demonstrates the need to address gender inequalities.

- Women’s desperate burden is a result of the social, economic and political disadvantages that have a detrimental impact on their reproductive health.

Reproductive health is relatively a new field of research; most studies focused on fertility and family planning until recently. Women are the
prominent focus of research in the area of reproductive health. Reproductive health is seen in the programme of action as linked to reproductive rights, which in turns are a part of basic human rights (UN, 1995). Women bear most of the responsibility in sexuality and reproduction through contraceptive use, pregnancy, child birth and breast-feeding. They also bear the greatest burden of reproductive ill health. Their burden starts even at birth. Having a son is like having two eyes, having a daughter is like having only one eye; says an old proverb.

**Dimensions of Reproductive Health**

Reproductive health cannot be fully studied without examining other aspects of a woman’s health. By the time a girl enters the reproductive age (around 15 years) she would have acquired a biological system with either actual morbidity or potential morbidity. For example, stunting during childhood or anemia at any time during prematurity period would impact on the girl’s reproductive health. Hence we have examined all these aspects in great detail so as to leave no stone unturned in our quest for finding the correct and precise factors contributing to reproductive health.

Each year in India, roughly 30 million women experience pregnancy and 27 million have a live birth (MOHFW, 2003c). Of these, over 1,00,000 maternal deaths and one million newborn deaths occur annually. Millions more suffer pregnancy-relate ill health. Although pregnancy-related mortality and morbidity continue to take a huge toll on the lives of women and
newborns, and despite a series of programmatic initiatives, there is little
evidence that maternity has become significantly safer over the last 20 years.
On the positive side, the Tenth Five Year Plan and the Reproductive and
Child Health Programme have set the country on an ambitious course towards
improving pregnancy-related health by the year 2007.

It is generally accepted that maternal mortality is difficult to measure
and even more difficult to track over time. Direct and indirect estimates agree
however that maternal mortality remains unacceptably high in India. For
example, direct measures obtained from NFHS 1 and 2 (covering the period
1992-93 and 1989-99 respectively, available only at the national level) suggest
a ratio of 424 per 100,000 births and 540 per 100,000 live births in the two
years preceding NFHS 1 and NFHS 2 respectively (IIPS, 1995; IIPS and ORC
Macro, 2000).

The neonatal mortality rate currently stands at 43.4 per 1,000 live birth
(for the five years preceding NFHS 2, 1998-99) (IIPS and ORC Macro,
2000). Like maternal mortality ratios, mortality among newborns remains
high but there are signs that it has been steadily declining.

Common causes of maternal death are those seen in most developing
country settings and are largely preventable. Estimates derived from data on
maternal deaths in 1998, collected through the Sample Registration System
may not be entirely accurate because of small sample sizes and difficulties in
ascertaining cause of death from household inquiries. (See Table 1.1).
However, they do provide a useful picture of the causes of death (RGI, 2000). Data on the causes of death were collected through post-death verbal autopsies conducted by non-medical field investigators. Haemorrhage and sepsis were the leading causes of maternal death even as recently as 1998 - 30 per cent and 16 per cent of all maternal deaths respectively; (RGI, 2000). Other identifiable causes of death during pregnancy, childbirth and the postpartum periods were obstructed labour, toxemia and unsafe abortion. In addition, some 25 per cent of maternal deaths were attributed to indirect causes. Leading among these was reportedly anemia (19 per cent); given that the causes of death were assessed by non-medical persons through verbal autopsies, we assume that such causes as “weakness” without indications of bleeding, swelling or fever may have been reported as anemia (Bhatia, 1993; Ganatra, Coyaji and Rao, 1998). Likewise, a study comparing pregnancy-related complications among women who died (through verbal autopsies) and those who survived in three states (Andhra Pradesh, Madhya Pradesh and Orissa) confirms that of the 170 deaths studied, the leading causes were sepsis (“high fever”), obstructed labour and excessive bleeding (Murthy and Barua, 2001).
Deaths of newborns during the first week or month of life are largely the result of inadequate or inappropriate care during pregnancy, childbirth or the first critical hours after birth. Indeed, neonatal mortality (largely dependent on maternal and pregnancy related health) continues to account for almost two-thirds of all infant deaths, and has been declining at a somewhat slower pace than post-neonatal mortality (largely dependent on exogenous factors).

Major causes of neonatal mortality include neonatal infections (tetanus, sepsis, meningitis, pneumonia and congenital syphilis), birth asphyxia and
trauma, pre-term birth and/or low birth weight, and other causes, including congenital anomalies, accounting for some 52 per cent, 20 per cent, 15 per cent and 13 per cent of all deaths nationally (Planning Commission, 2002b). Recent investigations using verbal autopsy highlight the extent to which prematurity, low birth weight, birth asphyxia and neonatal sepsis were leading causes of death of neonates (Gupta and Keyl, 1998; Kapoor et al., 1996; Shrivastava, Kumar and Ojha, 2001).

Maternal and neonatal mortality are undoubtedly influenced by such contextual factors as poverty, access to health care and overall levels of development. Available evidence reiterates the strong association between such socio-demographic factors as women’s education, age and parity and maternal and neonatal mortality.

Indirect estimates suggest for example that maternal mortality among women with a middle school or higher education is lower than among those who are uneducated (Mari Bhat, 2002). Likewise, neonatal mortality for the 10-year period preceding NFHS 2 was 55.3 among illiterate mothers compared to 24.3 among those with a high school or better education, and 55.8 compared to 30.9 per 1,000 live births among those with low and high standards of living, respectively (IIPS and ORC Macro, 2000).

Early onset of marriage and childbearing in India continue to have disturbing consequences for maternal health. The median age at first cohabitation with husband is 17 years among women age 25-49 (IIPS and
ORC Macro, 2000) and cultural pressures make it imperative for a women’s security in her marital home for her to conceive as soon as possible after marriage. This median age of 17 at first child birth of all women who had already experienced pregnancy and childbearing by the time they were 19, often before full physical maturity is attained is alarming. As a result of the combined effects of shorter average maternal height, competition for nutrients between mother’s growth needs and the growth needs of her foetus, and poorer placental functions of adolescent mothers, the pregnant adolescent is particularly at risk (Leslie, 1991). Community and facility level data have reiterated that adolescents are more likely to experience maternal death than adult women.

National-level data suggest that adolescent mothers are considerably more likely than mothers aged 20-29 to experience adverse pregnancy outcomes, notably higher neonatal mortality (63 and 41 respectively) (IIPS and ORC Macro, 2000).

Parity has a similar effect. Mortality is especially high among nulliparous women declines sharply among women at parities 1-3, and rises sharply among higher parity women. The link to previous birth intervals is evident at the national level: neonatal mortality rates fell from 72 per 1,000 live births among women with a birth interval of 24 months or less to 24 among those with an interval of 48 months or more (IIPS and ORC Macro, 2000).
Malnutrition and anaemia, both in adolescence and during pregnancy, are important precursors of complications during pregnancy, childbirth and thereafter, as well as prenatal and neonatal mortality and low birth weight. As the national level, anaemia is widespread. Particularly affected are adolescents, namely, those who have or are about to experience pregnancy, among whom some 20 per cent are moderately or severely anaemic (IIPS and ORC Macro, 2000). Numerous studies confirm the relatively poor health and nutritional status of women, and wide-ranging gender disparities in feeding practices and prompt access to health care from an early age (Das Gupta, 1987; Khan et al., 1988; Srikantia, 1989). During pregnancy, malnourishment can increase. A recent study of pregnant women in Delhi slums reports that 45 per cent of pregnant women were malnourished, that is their caloric intake was less than 60 per cent of the recommended dietary allowance during pregnancy, and 80 per cent consumed less than the recommended daily amount; 40 per cent weighed less than 45 kg and 7 per cent were less than 145 cm in height (Bhandari and Mayank, 1999); two-thirds were anaemic and 12 per cent were severely anaemic (Mayank et al., 2001). A facility-based study concludes that highly anaemic women (Hb <8.9 g per cent) were over four times as likely as those with higher hemoglobin levels (>11 g per cent) to experience prolonged labour and abnormal deliveries (Malhotra et al., 2002).

Other pregnancy-related morbidities are also becoming increasingly apparent. Postnatal depression is observed. A prospective study in Goa of
pregnant women followed up to six months postpartum noted depressive disorders among 23 per cent at 6-8 weeks following delivery and for more than half of these, the symptoms persisted up to six months postpartum (Patel, Rodrigues and DeSouza, 2002).

There appears to be a disturbing trend towards caesarean section delivery in India. Although caesarean section rates nationally are not high - 7 per cent of recently delivered women reported caesarean deliveries in 1998-99. Analysis of NFHS 2 data suggests considerable rural-urban disparity (5 per cent and 15 per cent respectively) (IIPS and ORC Macro, 2000). Moreover, there is considerable state-wide variation: while rates are below 10 per cent in most states, caesarean section deliveries are particularly high in such high literacy states as Goa and Kerala (20 percent and 29 per cent respectively) (IIPS and Macro, 2000). There is also a suggestion that caesarean section deliveries may be increasing over time.

Conditions such as prolapsed and fistulae are infrequently reported in studies of morbidity among recently delivered women, as these are longer-term sequelae of pregnancy. A study in south India that assessed long-term morbidity following delivery found that among 3,844 women who delivered up to 24 months prior to the study, 3 per cent experienced uterine prolapsed and urinary incontinence and two women reported rectovaginal fistulae (Srinivasa et al., 1997). A synthesis of six community-based studies of
gynecological morbidity in India reports prolapsed among 1 to 7 per cent of all women surveyed (Koenig et al., 1998).

While the socio-demographic correlates of maternal and neonatal morbidity are not as well studied as the correlates of mortality, available evidence generally supports a strong association. With regard to age-specific differences in morbidity, for example, NFHS 1 reveals that adolescents were more likely to report morbidity than the West Bengal Report that compared to women aged 20-29, adolescents experienced more problems in the antenatal and intra-natal periods and more anaemia, pregnancy-induced hypertension and pre-term labour (Pachauri and Jamshedji, 1983; Verma and Das, 1997).

The links between pregnancy-related care and maternal mortality are well recognized, and over the last decade national programmers and Plans have stressed the need for universal screening of pregnant women and operationalising essential and emergency obstetric care. Goals set in the Tenth Plan advocate an ambitious agenda to make pregnancy safe, including the achievement of skilled attendance at 80 per cent of all deliveries by 2007, institutional deliveries for 65 per cent of all births, at least three antenatal check-ups for 90 per cent of pregnant women and universal achievement of complete immunization for pregnant women. (Please see Table 1.2)
Table: 1.2. Pregnancy–related care: The current situation and goals for 2007 (%)

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<tr>
<td><strong>Antenatal Care</strong></td>
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<tr>
<td>Women receiving no antenatal check-up</td>
<td>36.8</td>
<td>34.6</td>
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<tr>
<td>Women who received all recommended types of antenatal care</td>
<td>NA</td>
<td>20.0</td>
<td>--</td>
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<tr>
<td>Pregnant women receiving at least three antenatal check-ups</td>
<td>26.9*</td>
<td>43.8</td>
<td>90</td>
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<tr>
<td>Pregnant women receiving two or more doses of tetanus-toxoid</td>
<td>53.8</td>
<td>66.8</td>
<td>100</td>
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<tr>
<td><strong>Intrapartum Care</strong></td>
<td></td>
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<tr>
<td>Women who delivered in a health facility/ institution</td>
<td>25.5</td>
<td>33.6</td>
<td>65</td>
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<td>Women attended by trained health personnel</td>
<td>34.2</td>
<td>42.3</td>
<td>80</td>
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<td><strong>Postpartum Care</strong></td>
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<tr>
<td>Women who received a postpartum check-up within 2 months of birth**</td>
<td>NA</td>
<td>16.5</td>
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<tr>
<td>Women who received a postpartum check-up within 2 days of birth**</td>
<td>NA</td>
<td>2.3</td>
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Source: IIPS, 1995; IIPS and ORC Macro, 2000; Planning Commission, 2002b.

-- no goal

* four or more visits

** among those whose delivery was non-institutional

NA = not applicable

**Care during pregnancy**

No more than two in three pregnant women availed of an antenatal check-up, only 44.0 per cent reported three or more antenatal check-up visits, and only one-third underwent a check-up within the first trimester of
pregnancy (IIPS and ORC Macro, 2000). Some two-third (66.8 per cent) of recently delivered women had obtained two or more tetanus toxoid injections and just less than one half (47.5 per cent) had received a three-month supply of iron and folic acid supplements. In fact, only 20.0 per cent received all the recommended antenatal care services.

Wide state-wide variation is evident (IIPS and ORC Macro, 2000). In such states as Bihar, Nagaland, Rajasthan and Uttar Pradesh, for example, fewer than 10 per cent received all the recommended services. The southern states, in contrast, fared better, and in such states as Goa, Kerala and Tamil Nadu, more than half had received all recommended services. Likewise, variation is observed in the proportions receiving care within the first trimester, ranging from 15 per cent in Bihar to 81 per cent in Kerala.

Antenatal care tends to be perceived as unnecessary and to be availed only in case of health complications. Nationally, for example, of the 35 per cent of recently delivered women who received no antenatal care, the main reason cited by almost two-thirds was that this was unnecessary or not customary. In comparison, some 15 per cent cited cost and 9 per cent cited lack of permission from the family (IIPS and ORC Macro, 2000). A more in-depth case study of pregnancy-related experiences in three states (Andhra Pradesh, Madhya Pradesh and Orissa) reports that 18 per cent of women who suffered complications in pregnancy (and survived) did not seek care: the main reasons cited were that the problem was not serious (27 per cent) or that
“the problem would go away” (16 per cent) Murthy and Baruna, 2001). Other studies suggest that women who experienced morbidity during pregnancy and sought care were considerably more likely to opt for care from the private sector, including unqualified practitioners, rather than access free government services (Bhatia, 1995; Griffiths and Stephenson, 2001).

Smaller studies suggest that among women who received antenatal care, visits tended to be motivated by a perceived health complication rather than as a routine requirement of pregnancy. For example, a study in the slums of Delhi reveals that while 91 per cent of women availed of antenatal care, and an average of three visits were made, a large proportion of these visits were motivated by a health complication; routine monitoring accounted for no more than one-third of all first and second visits and the first contract was typically made in the fifth or sixth month of pregnancy (Bhandari and Mayank, 1999). There are, however, exceptions: studies in rural Karnataka, Tamil Nadu and Pondicherry suggest that large proportions of women did indeed receive timely antenatal care within the first trimester and were not motivated by perceived health problems (Mathews et al., 2001; Srinivasa et al., 1997).

Whatever the motivation for seeking care, there is evidence those women who received no antenatal care were considerably more likely to die of maternal causes than women who had three or more antenatal contacts (Ganatra, Coyaji and Rao, 1998, case control study in Maharashtra). The
stillbirth and per natal mortality rate were reportedly lower and birth weight higher among women who received antenatal care compared to those who did not (Aras, Pai and Purandare, 1990; Kapoor, Reddaiah and Lobo, 1985). Moreover, women who made regular antenatal visits were more likely to initiate breastfeeding promptly and feed colostrums to their infants than other women (Nielsen et al., 1998).

**Skilled attendance at delivery**

As obstetric emergencies are largely unpredictable and can occur during labour, childbirth and the immediate postpartum period, emphasis on early detection of complications, skilled attendance at delivery and referral and treatment in cases of obstetric emergencies are the core of essential obstetric care. Skilled attendance at delivery has been identified as the single most effective measure required reducing maternal mortality. Corroborating this link, one case-control study in rural Maharashtra reports that women who delivered in institutions or who were delivered by a trained attendant were twice as likely to survive as those who delivered at home or were delivered by untrained attendants.

What is clear is that despite ongoing efforts of the family welfare programme, skilled attendance at delivery eludes most women. The situation has improved only modestly over the course of the 1990s; in 1998-99, fewer than half of all recent deliveries (42 per cent) were assisted by a health professional, including 30 per cent by a doctor or nurse, and 11 per cent by an
auxiliary nurse-midwife, a nurse, midwife or lady health visitor compared with 34 per cent of births delivered by trained attendants six years earlier. Over the same period, institutional deliveries increased from one in four births (25.5 per cent) to one in three (34 per cent), (IIPS, 1995; IIPS and ORC Macro, 2000).

While the proportion of births that take place institutionally may have increased, this increase is attributed to the private rather than the public sector. Hence, although there has been an 8 per cent rise in institutional births, the increase in the private sector has been three times greater than in the public sector. This trend marks the failure of the public sector in providing essential health care, but also implies that the poor, who can ill afford private maternity care, are less likely than others to avail of institutional delivery facilities.

State-wise variation is wide. In Assam, Bihar, Meghalaya and Uttar Pradesh, fewer than one quarter of all recent deliveries were assisted by a skilled attendant compared to over 80 per cent so delivered in Tamil Nadu (84 per cent), Goa (91 per cent) and Kerala (94 per cent). Only some eight states reported that 50 per cent or more births were institutionally delivered. Smaller studies suggest that skilled attendance levels are even lower in some settings.

Studies suggest a close correspondence between antenatal care and skilled attendance at delivery. Multivariate analysis of NFHS data from rural Andhra Pradesh, Bihar, Gujarat and Rajasthan suggests that after controlling
for other factors, women who received antenatal care were 2 to 5 times more likely to give birth in a medical institution than those who received no antenatal care (Sugathan, Mishra and Rutherford, 2001). A smaller study of low to middle income women in urban Uttar Pradesh corroborates this link: women who had sought antenatal care were four times more likely than those who did not to seek trained attendance at delivery (Bloom, Lippeveld and Wypij, 1999). These findings suggest that it is possible to encourage skilled attendance at birth through the promotion of antenatal check-ups and related counseling.

**Postpartum care**

In India, where cultural conditions in some settings prohibit both the mother and child from leaving the house in the first 40 days after delivery, it is unlikely that postpartum care will be sought without the active engagement of the health sector by way of home visits and/or efforts at community mobilization. Indeed, until recently, programmers intended to make pregnancy safer paid scant attention to the postpartum period. It is only recently that the Reproductive and Child Health programme recommended three postpartum visits. However, it is notable that while the Tenth Plan goals cover antenatal and intra-partum care, not a single goal refers to the need to ensure adequate postpartum care.

In reality, postpartum care is rarely sought and if sought, is rarely comprehensive. Nationally, among women who underwent a non-institutional
delivery in the three years prior to investigation, only 17 per cent obtained a postpartum check-up within two months, and only 2 per cent obtained a check-up within two days of birth. Of these, just one-third reported an abdominal examination (35 per cent), and around two-fifths reported receiving breast-feeding advice and baby care advice (43 per cent and 46 per cent respectively); even fewer (27 per cent) were counseled about family planning (IIPS and ORC Macro, 2000). In Bihar, Gujarat, Rajasthan and Uttar Pradesh, 10 per cent or fewer women whose births were far from the norm irrespective of whether the woman died of maternal causes or survived with and without complications: indeed, the fact that a somewhat larger percentage of those who died of maternal causes obtained postpartum care than others (42 per cent versus 30 per cent) only suggests that care is sought in case of an emergency and not as a rule (Murthy and Barua, 2001).

Findings from NFHS clearly suggest that women whose non-institutional deliveries were attended by a doctor, nurse, midwife or lady health visitor were substantially more likely to obtain timely postpartum care (42 per cent) than those delivered by a dai (traditional birth attendant) or other untrained attendants (11 and 14 per cent respectively). IIPS study shows that in a rural setting of Maharashtra, while 54 per cent of neonates had symptoms requiring care, only 3 per cent had actually sought care (Bang et al., 2001). Indeed, in view of the fact that many rural women continue to lack skilled
attendance at delivery, home-based care of neonates is as important in the short term as enhancing access to first referral units.

Utilization of pregnancy-related health care services is undoubtedly influenced by such contextual factors as poverty and education. What is clear is that women experiencing symptoms of morbidity do not always avail of services, and many women who seek care do not do so promptly, encounter difficulties in physically accessing services or face serious breakdowns in service at the facility level. Resulting delays in seeking appropriate care have been noted as the critical delays that inhibit safe motherhood (Thaddeus and Maine, 1994). Several obstacles to prompt health care utilization have been identified.

**Lack of awareness of good pregnancy-related practices**

Pregnant women, their families, and indeed the communities in which they live by and large have not yet recognized the need for skilled attendance at delivery or the array of skills that a birth attendant needs. For example, despite the relative proximity to health care facilities, women in rural Karnataka preferred to deliver at home (Ganapathy, Ramakrishna and Matthews 2000). Pregnant women in Delhi similarly preferred to deliver at home and without trained attendants despite the availability of government, private and NGO-run hospitals (Mayank et al., 2001). In studies, calling a nurse or doctor, or going to a hospital were deemed necessary only in case of complications.
Misperceptions abound. For example, as mentioned earlier, the use of pregnancy-related services is considered necessary (IIPS, 1995). Likewise, beliefs and practices regarding food during pregnancy, both on how much and what to eat, tend to encourage “eating down”—reducing women’s already meager average daily food intake and discouraging the intake of such nutritional items as meat and leafy vegetables—during pregnancy (Hutton, 1996; Nag, 1994; Ramachandran, 1989). Postpartum hemorrhage in many parts of western India is perceived to signify cleansing the body of bad blood and hence no cause for alarm (Ganatra and Hirve, 1995).

Danger signals are poorly understood. For example, a study in rural Karnataka concludes that poor understanding of the urgency of many intrapartum complications inhibited timely care seeking (Ganapathy, Ramakrishna and Matthews, 2000). A study of women in the slums of Delhi reports that among women who experienced bleeding during pregnancy, 44 per cent actually recognized it as a danger signal; of those experiencing high blood pressure, and swelling of the hands, face and feet, only 33 per cent and 9 per cent respectively, recognized its severity. Indeed, this study concludes that although the vast majority of pregnant women received antenatal care, fewer than 10 per cent had been informed about danger signals. Correspondingly, care seeking among those experiencing morbidity was far from universal – of those experiencing vaginal bleeding and high blood pressure during pregnancy, as many as 29 per cent and 21 per cent did not seek care; and for
such conditions as anaemia, urinary symptoms, swelling and abnormal vaginal discharge, fewer than one-third actually sought care (Mayank et al., 2001). A comparison of the experiences of women who died in pregnancy (through verbal autopsies) with those who experienced and did not experience complications in three states (Andhra Pradesh, Madhya Pradesh and Orissa) suggests that awareness was largely experience based, and that those who suffered no complications were considerably less likely to be aware of danger signals than others (Murthy and Barua, 2001).

Despite misperceptions and lack of awareness of danger signals, provider-client interactions fail to build awareness, as reported, for example, by women who gave birth in the three years preceding investigation (IIPS and ORC Macro, 2000). Appropriate diet was discussed with just over half of these women; while the danger signals of pregnancy, information on delivery, newborn care and family planning were explained to between one quarter and two-fifths (36, 41, 38, 28 per cent respectively). Small studies suggest an even more disturbing situation. For example, a study of women in the slums of Delhi reports that only 43 per cent were provided information on appropriate diet; far fewer were given information on breastfeeding (5 per cent), subsequent contraception (4 per cent), and the importance of delivering in hospitals and of postnatal check-ups (28 per cent and 4 per cent, respectively). Only 4 per cent were informed of danger signals (Bhandari and Mayank, 1999). A prospective study of pregnant women in rural Karnataka similarly
reports that only 44 per cent were informed about appropriate diet in pregnancy; and even fewer were advised about breastfeeding, danger signals or the need for postpartum check-ups (10 per cent) or informed about contraception (12 per cent) (Matthews et al., 2001). Compliance with antenatal treatment, such as consumption of iron and folic acid supplements, may be considerably influenced by the kind of counseling that women receive on their advantages and disadvantages; a small study cites the failure of health workers to provide regular and detailed counseling on the benefits and mechanisms of these supplements as a key factor underlying women’s lack of compliance (Tuladhar et al., 1997).

As a result of continued misperceptions, where care is sought, it occurs, in all likelihood, as a last resort, among women whose symptoms are particularly severe and unresponsive to home remedies. Lack of information on the location of appropriate facilities can, in these circumstances, exacerbate fatal outcomes: for example, compared to women who survived an obstetric complication, many who died sought emergency care from facilities that were not adequately equipped to provide such care (Ganatra, Coyaji and Rao, 1998).

**Safe Motherhood**

Safe motherhood is a vital, compelling and cost-effective economic and social investment. Promoting women’s health improves not only individual health, but also the health and survival of women’s families, the
labour force and the well being of communities and countries. Making maternal care a priority for a nation’s economic and social health agenda ensures that millions of women and their children escapes from pregnancy related death and disability that are still too common.

For women of reproductive age, pregnancy and childbirth are the leading causes of death, disease and disability, accounting for at least 18% of the global burden of disease in this age group. Recent studies in four developing countries suggest that 58 to 80 percent pregnant woman developed acute health problems; of whom 8 to 29 percent developed chronic health problems as a result of pregnancy.

Poor care of the mother means death of the child; even if the mother survives, poor maternal health jeopardizes a new born’s chances of survival. Prenatal deaths could be avoided with improved maternal health, adequate nutrition during pregnancy and appropriate management of deliveries. Poor maternal health and nutrition contributes to low birth weight infants. Babies born under-weight are at greater risk for infection, malnutrition and long term disabilities, including visual and hearing impairments, learning disabilities and mental retardation. A mother’s death makes survival and education uncertain for her children.

Every minute of every day a woman dies of pregnancy related complications. For every woman who dies, at least thirty develop chronic debilitating problems. Every year, nearly 3.4 million newborn infants die
within the first week of life. And for every new born baby that dies another is still born. These women and babies die for the same reasons: poor health and inadequate care during pregnancy and child birth (WHO, Geneva).

Women’s limited exposure to new ideas and information means that they are socialized to accept pain and suffering as women’s “lot”, and they do not perceive pregnancy as requiring any additional care. As a result, many women do not recognize danger signs during pregnancy and do not know where or when to seek medical services.

In the developing countries, the decision to deliver at home is generally made by the husband or other family members. Many women need permission from their husbands to visit a health centre. Women’s lack of economic resource constraints their ability to make independent health–related choices and to gain access to health and other social services.

Women must have freedom to determine their own health and life choices within families and communities; they must be given opportunities to learn about their rights and their health and to develop a feeling of entitlement to medical care, and other services.

- Women must have access to information on reproductive health and high quality, women centered care.
- Women must have access to education and economic opportunities, and control over economic resources.
• Adolescent girls must be given the opportunity to develop life skills, including self-esteem, so that they can act to protect their own health.

• Men must be sensitized to their role in respect of women within households and communities and in ensuring responsible sexual and family life.

• Women must be supported by policies and laws that promote and ensure safe motherhood, good quality maternal care and gender equality; correspondingly, governments must engage women in planning, implementing, monitoring and evaluating health programs for women.

Gender inequalities and discrimination limit women’s choices, ill-health and death. Legal reform and community mobilization can help women safeguard their reproductive health by enabling them to understand and articulate their health needs and to seek services with confidence and without delay.

Every pregnant woman even if she is well–nourished and well–educated can develop sudden life threatening complications that require high quality obstetric care. Attempts to predict these problems before they occur have not been successful, since most complications are unexpected and the majority of women with poor pregnancy outcomes do not fall into any high–risk categories. Therefore, maternal health programmed must aim to ensure that all women have access to essential health services.
Unsafe abortion is the most neglected and most easily preventable cause of maternal death. These deaths can be reduced by ensuring that safe motherhood programs include client-entered family planning services to prevent unwanted pregnancy, contraceptive counseling for women who have had an induced abortion, the use of appropriate technologies for women who experience abortion complications and safe services for pregnancy termination.

Studies show that some developing countries have dramatically reduced maternal mortality since 1987. There is no disagreement that good nutrition and effective treatment during pregnancy for chronic conditions such as anemia, diabetes, HIV, TB, and Malaria delivery with a skilled attendant, access to timely emergency obstetric care, when required are the best way to avoid unnecessary deaths and morbidity in women and new burns.

At the same time, some 1,400 women die every day from problems related to pregnancy and childbirth. Tens of thousands more experience complications during pregnancy, many of which are life–threatening for the women and their children or leave them with severe disabilities.

The dangers of childbearing can be greatly reduced if a woman is healthy and well nourished before becoming pregnant, if she has a health check-up by a trained health worked at least four times during every pregnancy, and if the birth is assisted by a skilled birth attendant such as a
doctor, nurse or midwife. The woman should also be checked during the 12 hours after delivery and six weeks after giving birth.

Governments have a particular responsibility to make prenatal and postnatal services available, to train health workers to assist at childbirth, and to provide special care and referral services for women who have serious problems during pregnancy and childbirth.

**Aspects of Reproductive Health**

Women’s reproductive health is a vast topic, which makes it difficult to go into all its aspects in detail. Some of the most important and pressing issues are highlighted in the following passages.

**Maternal Mortality**

A maternal death is defined as the death of women while she is pregnant, or within 42 days of delivery, or 90 days from termination of pregnancy, irrespective of the duration and site of pregnancy from any cause related to or aggravated by the pregnancy or its management.

Technically, the main causes of maternal deaths are hemorrhage sepsis (infection), toxemia, obstructed labour and complications of abortion. These are called direct causes. Indirect causes are those that may be present before pregnancy and are aggravated by pregnancy. These include anemia, malaria, hepatitis, tuberculosis and high blood pressure of unknown origins. Among these anemia is the leading indirect cause of maternal death, aggravating other
complications of pregnancy, such as eclampsia, antepartum hemorrhage and genito-urinary tract infections. Anemia accounts for 1 in 5 maternal deaths.

In most of the developing world, post-partum hemorrhage is the leading cause of maternal deaths. In 1993-23% of all maternal deaths in rural India was caused by haemorrhage. Hypertensive disorders of pregnancy, including toxemia and eclampsia, are also a frequent cause of maternal death, especially among the very young mothers and those pregnant for the first time. Eclampsia and toxemia accounted for 13% of all maternal deaths in India. Sepsis accounts for 13% of all maternal deaths in India with community based studies reporting higher figures of up to 35% in rural Andhra Pradesh (Bhatia, 1993). According to the Registrar General of India, abortion accounts for 12% of all maternal deaths. However, several studies indicate that the actual figures may be higher (15-25%) since most abortions are conducted by untrained persons, in unhygienic conditions and are not reported.

However, beneath these immediate causes lie the factors that made these conditions fatal. They are lack of pre-natal care; lack of trained personnel, equipment, blood or transport at the moment the emergency arose, lack of family planning to help women avoid unwanted pregnancies, too many or too closely spaced births, or giving birth when they are too young or too old; pre-existing conditions like anaemia and malnutrition that predispose to obstetrical complications. Going still deeper we find factors like low status
of women, discrimination against them, poverty, and lack of education, local customs and government policies that give low priority to the needs of women.

**Reproductive Morbidity**

Reproductive morbidity encompasses obstetric morbidity including conditions during pregnancy, delivery and post-partum period; and gynecological morbidity including conditions of the reproductive tract not associated with a particular pregnancy such as reproductive tract infections (RTI), cervical cell change, prolapse and infertility. In addition, there is related morbidity like urinary tract infections (UTI), anaemia, high blood pressure sexually transmitted infections (STI) etc.

i) **Obstetric Morbidity**

Conditions constituting obstetric morbidity

a) *During Pregnancy*

Hemorrhage, discharge, fever, head-ache, edema in limbs, burning with urination, high blood pressure, convulsions in third trimester etc.

b) *During delivery*

Hemorrhage, fever, delivery by instrument caesarian section, mal presentation of the foetus, long labour etc.

c) *After delivery*

Hemorrhage, discharge or inflammation, fever, depressions.
ii) Gynecological morbidity

1. Reproductive tract infections (RTI) vaginitis, cervicitis, pelvic inflammatory disease.
2. Cervical ectopy (erosion)
3. Cervical cell changes
4. Prolapse
5. Menstrual problems
6. Problems with intercourse
7. Infertility

Clinical examination and laboratory tests are necessary to diagnose many of the gynecological morbidity, especially reproductive tract infections (RTI), cervical cell changes etc. Since many conditions have no outward symptoms, woman is often unable to recognize morbidity until it reaches its final stage.

A woman’s susceptibility to reproductive morbidity is related to many factors. Malnutrition and other infections can increase susceptibility. A woman’s nutritional and health status in adolescence, pre-pregnancy and during pregnancy are important determinants of complications during pregnancy, childbirth and thereafter as well as of per natal and neonatal mortality and low birth weight. Poor nutrition and health also affects woman’s physical stature and levels of anaemia. Nutritional status and growth levels in
childhood determine age at menarche and adolescent and adult weight and height.

During pregnancy, malnutrition can increase. Beliefs and practices during pregnancy in many parts of India tend to result in the pregnant women having less than the daily average food intake and prevented from taking many nutritional items like green leafy vegetables. Even when women are aware of the need for optimum nutrition, economic and cultural constraints prevent them from achieving it.

Women’s child bearing episodes, the number of pregnancies and birth, her use of health services and her health related practices affect susceptibility. Studies have shown that respective morbidity is higher in the early and late child bearing years and increase with the number of pregnancies and births, and with shorter birth intervals (Dixon – Mueller and Wasserheit 1991).

The extent of a woman’s use of health services during pregnancy, at the time of delivery and in the post partum period is an essential factor in avoiding most of the complications and health problems associated with child bearing, and in treating them quickly when they occur. Her use of services for gynecological and general health care is equally important in controlling reproductive morbidity.
iii) Reproductive Tract Infections and Sexually Transmitted Infections (RTI/STI)

Absence of reproductive tract infections (RTIs) is essential for the reproductive health of both women and men and is critical for their ability to meet their reproductive goals. There are 3 types of reproductive tract infections for women.

1. **Endogenous infections:** that is caused by the multiplying of organisms normally present in the vagina.

2. **Iatrogenic infections:** caused by the introduction of bacteria or other infection causing micro organisms through medical procedures such as an IUD insertion.

3. **Sexually Transmitted Infections:** Endogenous infections and several of iatrogenic and sexually transmitted infections are often easily cured if detected early and given proper treatment. If left untreated, RTIs can cause pregnancy related complications, congenital infections, infertility and chronic pain. They are also a risk factor for pelvic inflammatory disease and HIV.

A number of studies have shown that many Indian women suffer from RTIs. Several researchers have also shown that women in India often bear the symptoms of RTIs silently without seeking health care. RTIs and their sequelae are an important component of programmed for family planning, child survival, women’s health, safe motherhood, and HIV prevention. Studies have demonstrated that RTIs are an important reason for the poor
acceptance and low continuation rates of contraceptive methods such as the IUD. The government of India recognized the importance of RTIs and STIs in undermining the health and welfare of individuals and couples in a policy statement on the reproductive and child health programme, which states that couples should be able to have sexual relations free of fear of pregnancy and contracting diseases.

4. Acquired Immune Deficiency Syndrome (AIDS)

HIV/AIDS is becoming more of a global crisis every day, increasingly affecting young people. Young women are especially vulnerable. The disease so far has no vaccine or cure. Prevention is the only cure. Every person in our country should know how to avoid getting and spreading the disease.

AIDS is an incurable but preventable disease. HIV the virus that causes AIDS, spreads through unprotected sex (intercourse without a condom), transfusions of unscreened blood, contaminated needles and syringes (most often those used for injecting drugs), and from an injected woman to her child during pregnancy, child birth or breastfeeding.

AIDS is caused by the Human Immuno deficiency Virus (HIV), which damages the body’s defence system. People infected with HIV usually live for years without any sign of the disease. They may look and feel healthy, but they can still pass on the virus to others.

AIDS is the late stage of HIV infection. People who have AIDS grow weaker because their bodies lose the ability to fight off illnesses. In adults,
AIDS develops 7 to 10 years after infection, on average. In young children it usually develops much faster. AIDS is not curable, but new medicines can help people with AIDS live healthier for longer periods.

In most cases, HIV is passed from one person to another through unprotected sexual intercourse, during which the semen, vaginal fluid or blood of an infected person passes into the body of another person.

It is not possible to get HIV/AIDS from touching those who are infected. Hugging, shaking hands, coughing and sneezing will not spread the disease. HIV/AIDS cannot be transmitted through toilet seats, telephones, and plates, glasses, eating utensils, towels, swimming pools or public baths. AIDS is not spread by mosquitoes or other insects.

All people, including children, are at risk for HIV/AIDS. Everyone needs information and education about the disease and access to condoms to reduce this risk.

Children living with HIV/AIDS or with families affected by HIV/AIDS may be stigmatized or isolated from their community and denied access to health service and school. Good quality training on HIV/AIDS for teachers and peer educators can increase understanding and compassion and lessen discrimination. Anyone who suspects that he or she might be infected with HIV should contact a health worker or an HIV/AIDS centre to receive confidential counseling and testing.
HIV counseling and testing can help in the early detection of HIV infection and in enabling those who are infected to get the support services they need, manage other infectious diseases they might have and learn about living with HIV/AIDS and how to avoid infecting others. Counseling and testing can also help those not infected to remain uninfected through education about safer sex.

The risk of getting HIV through sex can be reduced if people don’t have sex, if they reduce the number of sex partners, if uninfected partners have sex only with each other or if people have safer sex – sex without penetration or while using a condom. Correct and consistent use of condoms can save lives by preventing the spread of HIV. Girls are especially vulnerable to HIV infection and need support to protect them and be protected against unwanted and unsafe sex.

In many countries, HIV rates are much higher among teenage girls than teenage boys. Teenage girls are more susceptible to HIV infection because young girls may not understand the risk or may be unable to protect themselves from sexual advances. Their vaginal membranes are thinner and more susceptible to infection than those of mature women. They are sometimes targeted by older men who seek young women with little or no sexual experience because they are less likely to be infected.

Girls and women have the right to refuse unwanted and unprotected sex. Parents and teachers should discuss this issue with girls and boys to make
them aware of girls and women’s rights, to teach boys to respect girls as equals and to help girls avoid or defend themselves against unwanted sexual advances.

Empowering women and promoting safer sex, condom use and better detection and treatment of STIs can reduce HIV infection in women. If women discover that she is HIV positive, she needs emotional support and counseling to help her make decisions and plan for her future. Community support groups and NGOs can support women in making these decisions.

People who have a sexually transmitted infection (STI) are at a greater risk of getting HIV and of spreading HIV to others. People with STI should not seek intercourse or practice safer sex (non-penetrative sex).

**Hysterectomy**

Hysterectomy is the removal of the uterus and, in most cases, the cervix (neck of the uterus). The reasons for this would include cancer or a massive hemorrhage from the uterus. Most of the time a hysterectomy is done to relieve heavy, painful or irregular periods, or if there are large fibroids (tumors arising from the uterine wall) present. Sometimes the muscles and ligaments supporting the uterus would have become so weak that the uterus cannot stay in place and it slides down into the vagina. This is called prolapsed and calls for hysterectomy.

A hysterectomy is a major event in a woman’s life and every woman who undergoes this operation should be prepared to handle the physical as
well as psychological changes associated with it. A hysterectomy will result in instant menopause and the woman will experience all physiological changes of menopause after undergoing hysterectomy. Younger women often find it difficult to cope with such changes and sometimes go into depression. Pre-hysterectomy counseling which explains to the woman the changes she can expect after the hysterectomy can be very helpful in coping with the situation better.

Many women fear loss of sex appeal, libido and sexual pleasure after hysterectomy. Counseling can be helpful in dispelling such fears. The health care professionals and the family of the women should be sensitive in handling such fears. Efforts should be made not to trivialize such fears of the women. It is often seen that many women, especially those from a low socio-economic background disregard the doctor’s advice to take proper rest during the post-operative period. Once they are discharged from the hospital they go back to doing heavy housework or even heavy labour outside the house instead of taking the rest prescribed. Such behaviour will later result in chronic back pain and other complaints. It is necessary to counsel not just the patient, but also other members of the family since rest is not always a decision that the women can implement on her own in our social setting.

**Menopausal Problems**

Menopause refers to the cessation of menstruation in older women. The female hormones, oestrogen and progesterone levels start to decline.
Most of the menopausal symptoms are the result of the suddenness of estrogen withdrawal. The symptoms range from palpitation, night sweats, chest pain, breast soreness, aches and pains, muscle soreness, swollen or stiff joints, dry vagina resulting in painful intercourse loss of bladder control, loss of libido, etc.

One of the most important health hazards affecting post-menopausal women is osteoporosis which can be painful, crippling and even life threatening. Osteoporosis is defined as a condition where there is less normal bone density than expected for a woman’s age, with an increased risk of fracture. This happens because estrogen facilitates the uptake of calcium from the blood into the bone and inhibits estrogen levels and thereby leads to bone disintegration.

Post menopausal changes lead to a host of alternations in the skeletal and genito-urinary systems leading not only to osteoporosis, but also genital prolapsed, cervix and the uterus. These often go unnoticed.

**Infertility**

Couples are considered infertile if they do not conceive within one year of marriage in spite of having had unprotected sex two or three times a week. There are two types of infertility.

a) Primary infertility, when the couple has not conceived even once.

b) Secondary infertility, when the couple has conceived at least once but is unable to conceive again for two years. About 5% of infertility is due to
anatomical, genetic endocrinological and immunological problems while the rest is due to preventable conditions like STI, harmful health care practices, abortion and exposure to potentially toxic substances.

WHO estimates there are 60-80 million infertile couples worldwide. Infertility is more prevalent in India (6-7%) than in other developing countries (Bang et al, 1989). The most common causes of infertility in India is infections from STI, followed by complications from unsafe abortions, malnutrition and poor health of women, unhygienic practices during menstruation and delivery etc.

In a society where women are seen as child bearers and little else, a childless woman is an object of pity at the least, and of emotional harassment, condemnation, and social ostracism at the worst, she is seen as a liability, rather than an asset. Males are seldom held responsible for the couple being infertile, even in cases where the man in the one with the medical problem. Not bearing a child is often reason enough to divorce the wife and the husband would soon remarry, only to repeat the whole story again.

Abortion

Abortion can be looked upon as an evil to society and more precisely to women. Abortion can be classified into two - natural abortion and induced abortion. Natural abortion occurs spontaneously and without force. Induced abortion is affected by external force or interference. Induced abortion
becomes criminal when it is done by the insertion of sticks in the uterus done by dais and by non-medical persons.

Medical pregnancy termination is a social, economic as well as demographic reality. Depending upon the legal status of abortion, the health impact of induced abortion can be positive or negative. In contexts where abortion is illegal, and as a result mostly unsafe, it has a strong negative impact on the reproductive well-being and on women’s health affecting, also their chances of survival. Induced abortion also has powerful religious connotations, being condemned by most religious as a sinful act, in fact an attempt against the life of an unborn person. Societies add to the heavy moral stigma imposed by religion by making induced abortion a criminal act punishable by law.

In Hinduism, religious and social practices are often so intertwined that it is difficult to separate the one from the other. In the ancient science of Ayurveda, the scholars and experts would even refuse to discuss the subject of abortion. It is not recognized as a permissible action. Most of the religions also prohibit induced abortion.

Medical termination of pregnancy has a very significant social dimension in that it touches various aspects of the social life. The increasing acceptance of medical termination of pregnancy shows a gradual change in society, its values and organizations. Use of modern technological advancements for denying a female foetus its individual right is of social
relevance. This also is a social problem revealing the declining status of
women.

**Adolescent Reproductive Health**

Adolescence is a phase of fast growth but mental growth does not keep
pace with physical growth. Adolescence is the transition from social,
economic dependence to relative independence; in other words, the transition
from childhood to adulthood (Saroj Pachauri, 1998). Adolescent is a
functional difficulty for a girl as she is neither a child nor a woman.

In many settings, more than half of the adolescents have unprotected
sexual intercourse before the age of 16 and more than 15 million girls 15-19
years old give birth each year. Adolescent females are more prone to
pregnancy related complications and to having low birth weight or premature
infants or still births. Adolescents are confronted with myriad of reproductive
health problems, including early sexual debut, high rates of unwanted
pregnancy and unsafe abortions, increasing rates of STIs including HIV and
gender based violence.

Adolescent pregnancy is accompanied by an increased morbidity to the
child born to the very young mother, psycho social effects on mother, father
and child. Many of the sexually active adolescents fail to use contraceptives
citing several reasons for their non use (McAnarmey, 1978; California, 1978).
Teenage pregnancy has been shown to be associated with an increase in
obstetric complications; gestation associated hypertension and anaemia was found more frequently among these young women (Mahfouz et al, 1995).

Anaemia is wide spread among both pregnant and non-pregnant women in developing countries. Anaemia may increase the risk of dying in childbirth. Severe anaemia is associated with the risk of maternal death during pregnancy. Poor nutrition often worsens later in a woman’s life because of an increasingly heavy work load, the loss of iron stores through menstruation and the combined element of child bearing. Adding to these miseries rituals and superstitions influence their health adversely.

Contraceptive awareness is equally vague, even among married adolescents. Awareness of STD and AIDS is particularly limited among adolescents. As education being more widespread, age at marriage has increased (Singh and Samara, 1996; West off, Blane and Nyblade, 1994) and age at menarche has also declined thus the interval between puberty and marriage has lengthened (Barnes Josiah and Augustin, 1995; Dhlamini and Cameron 1997; Chakravarty, 1994; Jabbar and Wong, 1998; Sharma and Hiramani 1985). As a result, girls in many parts of the world are facing a prolonged risk of pregnancy and reproductive health problems prior to marriage.

**Need for a holistic approach**

In this chapter we have examined the various aspects of reproductive health including maternal morbidity, reproductive morbidity,
obstetric and gynecological issues, reproductive tract and sexually transmitted infections including HIV/AIDS, hysterectomy, menopausal problems, infertility, abortion and the vast area of adolescent reproductive health. These will give the reader some idea about the broad sweep of the problem of reproductive health. Actually they deal with problems around reproductive health but as stated earlier, reproductive health cannot be studied by examining obstetric problems alone. It extends to gynecology and in fact all of a woman’s health problems with reproductive issue in the centre stage. Hence we have attempted a holistic approach to reproductive health. In the next chapter we will deal with the problems within the reproductive health field.

**Chapter arrangement**

Chapter I is an introduction to the study. Here we have described the ramifications of the problem and have brought out the need and relevance of the study and presented the context of the study.

Chapter II deals with factors in reproductive health.

Chapter III constitutes the review of literature

Chapter IV deals with methodology. This chapter also contains the theoretical framework, locale of the study and the social dynamics of the population.

Chapter V deals with the socio cultural dimensions of reproductive health problems
Chapter VI deals with the socio cultural dimensions of reproductive health care.

Chapter VII deals with socio cultural factors in acceptance of family planning methods

Chapter VIII gives the conclusions of the study.

Appendix I: Bibliography

Appendix II: Interview Schedule