CHAPTER - II
CONCEPT OF WOMEN’S REPRODUCTIVE HEALTH

Reproductive health of women has recently become focus of attention due to its implications for women's own health, health of their children, family members, socio-economic development of society and population programmes. The reproductive health status of women, especially in the developing world including India, requires urgent attention. Over one-third of all healthy lives lost among adult women are due to reproductive health problems (WHO, 1995).

At the International Conference on Population and Development in Cairo (ICPD) in 1994, a programme of action shift the focus away from demography and targets towards reproductive health, empowering women, education and choice. It must be viewed as three interconnected domains that include universal rights, women’s empowerment and health service provision. These three concepts must work in unison in order to achieve healthy reproductive and sexual lives. (ICPD; Programme of Action, 7.3).

REPRODUCTIVE HEALTH:

Reproductive Health is a broad and comprehensive concept which is defined by the ICPD at Cairo 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 its functions and processes. Reproductive health therefore 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.” (ICPD1994). Implicit in this last condition are the right of men and women to be informed (about) and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of birth control which are not against the law and the right of access to appropriate health-care services that will enable women to go
safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.¹

Hence, reproductive health means a total well-being in all aspects of reproduction, i.e., physical, emotional, behavioural and social. A society with people having physically and functionally normal reproductive organs and normal emotional and behavioural interactions among themselves in all sex-related aspects might be called reproductively healthy.

The WHO’s definition of reproductive health specifically highlights the importance of an individual’s right to maintain their own sexual health status.

**SEXUAL HEALTH:**

Above comprehensive definition of reproductive health (ICPD 1994) includes sexual health which is defined by the WHO website as "a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."²

Sexual and Reproductive Health (SRH) is the concept of human rights which is applied to sexuality and reproduction. It is a combination of four fields that in some contexts are more or less distinct from each other, but less so or not at all in other contexts. These four fields are: sexual health, sexual rights, reproductive health and reproductive rights².

In the concept of Sexual and Reproductive Health and Rights (SRHR) these four fields are treated as separate but inherently intertwined. The distinctions between these four fields are not always made. Sexual health and reproductive health are sometimes treated as synonymous to each other as are sexual rights and reproductive rights. In some cases, sexual rights

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2. Neeta Tapan: Need for Women Empowerment; Published by Rawat Publication, Jaipur and New Delhi; Page – 91,92; 2000; (Bhatia, S.C. (Ed), Social Justice in Health, IUACE, New Delhi, 1988, P-26 & 114.)
are included in the term sexual health or vice versa.

Sexual Health does not matter who we are, men and women, boys and girls, gays, lesbians, transgender and intersex. They all have an equal right to well-being and sexual well beings. Sexual health is women’s and men’s ability to enjoy and express their sexuality and to do so free from risk of sexually transmitted disease, unwanted pregnancy, coercion, violence and discrimination.

Sexual health also means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one’s sexual identity.

Hence the reproductive health addresses

- The reproductive processes, functions and system at all stages of life.
- Freedom to make decisions regarding a healthy sex life.
- Access to appropriate reproductive health care services

**HISTORICAL BACKGROUND:**

It is helpful to understand the concept and to examine its origins. The term reproductive health was first adopted at the ICPD in 1994 and heralded a major shift in thinking and approach to population issues from population control through family planning. It not only encompassed the fertility control but also the safe sex and pregnancy free from coercion, discrimination and violence.

The concept of reproductive health arose in the 1980s with a growing movement away from population control and demographic targets towards a more holistic approach to women’s health. It gradually gained international acceptance during 1990s. The International Conference on Population and Development (ICPD) at Cairo in September 1994 and the Fourth World Conference on Women (FWCW) in 1995 has been marked as the key event in the history of reproductive health. It was heralded as a turning point for women’s health and also for global population and development initiatives.
The ICPD brought to international recognition two important guiding principles of Sexual and Reproductive Health (SRH):
1) Empowering women and improving their status are important ends in themselves and essential for achieving sustainable development; and
2) Reproductive rights are inextricable from basic human rights, rather than something belonging to the realm of family planning.

The FWCW reaffirmed and strengthened the consensus that had emerged at the ICPD. The ICPD conference was instrumental in formalizing the paradigmatic shift in how women’s health was conceptualized and how services were delivered. The focus became the promotion of healthy reproductive lives rather than the prevention of sexual morbidity.

**Development of Reproductive Health:**
1. Before 1978 Alma-Ata Conference
   - Basic health services in clinics and health centers
2. Primary health care declaration 1978
   - MCH services started with more emphasis on child survival
   - Family planning was the main focus for mothers
3. Safe motherhood initiative in 1987
   - Emphasis on maternal health
   - Emphasis on reduction of maternal mortality
4. Reproductive health, ICPD in 1994
   - Emphasis on quality of services
   - Emphasis on availability and accessibility
   - Emphasis on social injustice
   - Emphasis on individuals woman's needs and rights
5. Millennium development goals and reproductive health in 2000
   - MDGs are directly or indirectly related to health
   - MDG 4, 5 and 6 are directly related to health, while MDG 1,2,3,

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and 7 are indirectly related to health

- World Summit 2005, declared universal access to reproductive health
- “Sexual and reproductive health is fundamental to the social and economic development of communities and nations, and a key component of an equitable society.” (The Lancet 2006)

FEMALE REPRODUCTIVE SYSTEM:

A healthy reproductive system makes the miracle of life possible. A woman has reproductive organs both inside and outside her body.

A healthy reproductive system includes complete healthy conditions of reproductive organs, its functions and processes and not merely the absence of disease or infirmity. The following figure shows the organs of female reproductive systems.

The women’s reproductive system includes the major female reproductive organs inside her and what they do is as follows: 4

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**Ovaries:** These are two small glands contain eggs (ova) and make hormones. One of the ovaries releases an egg about once a month as part of the menstrual cycle. This is called ovulation.

**Fallopian tube:** When an egg is released, it travels through the fallopian tube to the uterus. Woman get pregnant if she has sex with a man and his sperm fertilizes the egg on its way to the uterus.

**Uterus:** The uterus or womb is a hollow, pear-shaped organ. The tissue that lines the uterus is called the endometrium. If a fertilized egg attaches itself to the lining of the uterus it may continue to develop into a fetus. The uterus expands as the fetus grows. The muscular walls of the uterus help to push the mature fetus out during birth. If pregnancy does not occur the egg is shed along with the blood and tissue that lines the uterus. This is menstruation also called getting a period.

**Cervix:** This narrow entryway connects the vagina and uterus. The cervix is flexible so that it can expand to let a baby pass through during birth.

**Vagina:** Also called the birth canal. The vagina stretches during childbirth.

The major female reproductive organs outside her and what they do is as follows:

**Vulva:** It is an external female genital organ which has five parts: labia majora, mons pubis, labia minora, clitoris, bulb of vestibule (urinary opening) and vulval vestibule (vaginal opening). It has sexual functions.

**Breasts:** They contain the mammary gland which secretes milk used to feed infant. Breast health is important to a woman’s sexual health and overall health.

**REPRODUCTIVE HEALTH CARE:**

In line with the ICPD at Cairo definition of reproductive health, the reproductive health care is defined as “the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and
personal relations and not merely counseling and care related to reproduction and sexually transmitted diseases” (Ibid, 1994)\(^5\)

Reproductive health care is the comprehensive reproductive health programme included as part of primary health care (with the appropriate referrals). It will not be possible to ensure reproductive health for all without a functioning primary health care system.

Hence, the concept of reproductive health can be understood, maintained and achieved through the proper reproductive health care techniques or methods which would include certain fundamental and basic components. The following table outlines the Components of Reproductive Health Care.

**Table No – 2.1 Basic Components of Reproductive Health Care**

<table>
<thead>
<tr>
<th>Basic Components of Reproductive Health Care</th>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Family Planning &amp; Contraceptive Methods</td>
<td>Family planning information &amp; services, including counseling and follow-up, aimed at all couples and individuals;</td>
</tr>
<tr>
<td>3. Safe Abortion Facilities</td>
<td>Prevention &amp; management of abortion, Unsafe abortion, Legal Abortion and family planning;</td>
</tr>
<tr>
<td>4. Male Participation &amp; Responsible Behaviour</td>
<td>Participation and Responsibility of good reproductive and sexual health activities and Promotion of Safe motherhood.</td>
</tr>
<tr>
<td>5. Adolescence Reproductive &amp; Sexual Health (ARSH)</td>
<td>Complete information, its Care &amp; Prevention of issues.</td>
</tr>
<tr>
<td>7. Protection from Sexual and Gender-Based Violence (SGBV)</td>
<td>Freedom from unwanted sexual relations and harmful or unwanted sexual practices, including violence &amp; coercion within sexual relationships.</td>
</tr>
</tbody>
</table>

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5. *Neeta Tapan* :“Need for Women Empowerment”; Published by Rawat Publication, Jaipur and New Delhi; Page – 114; 2000

**SAFE MOTHERHOOD:**
Motherhood should be a time of expectation and joy for a woman, her family and her community. Safe motherhood is one of the important primary components the care they need to be safe and healthy throughout pregnancy and childbirth. It is the ability of a mother to have safe & healthy pregnancy & child birth. It begins before conception with proper nutrition and a healthy lifestyle and continues with appropriate prenatal care, prevention of complications when possible and the early and effective treatment of complications.

WHO has recommended four strategic interventions for making safe motherhood. The following figure shows Pillars of Safe Motherhood.

![Figure 2.2: Pillars of Safe Motherhood](image)

1. **Family Planning**: To ensure that individuals and couples have the information and services to plan timing, number and spacing of pregnancies as well as to prevent unwanted pregnancy.

2. **Antenatal Care**: To prevent complications where possible and ensure that complications of pregnancy are detected early & treated appropriately. At least three antenatal visits are recommended, ideally with the first visit early in the pregnancy. Appropriate ANC includes an

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assessment of maternal health, detection and management of complications, observation and recording of clinical data, maintenance of maternal nutrition, health education, prevention of major diseases.

3. **Clean/Safe Delivery:** To ensure that all birth attendants have the knowledge, skills & equipment to perform a clean & safe delivery and provide postpartum care to mother & baby. It includes deliveries outside an equipped health facility, deliveries in equipped health centers. And deliveries at referral hospitals.

4. **Essential Obstetric Care:** To ensure that essential care for high risk pregnancies is made available to all women who need it and complications are dealt appropriately and referred timely.

   Safe motherhood is designed to reduce the high numbers of deaths and illnesses resulting from complications of pregnancy and childbirth. In many countries the most maternal deaths result from hemorrhage, complications of unsafe abortion, pregnancy-induced hypertension, sepsis and obstructed labour. Safe motherhood seek to address these direct medical causes and undertake related activities to ensure women have access to comprehensive reproductive health services and help to improve maternal health.

**LEVELS OF MATERNAL MORTALITY:**

Maternal mortality is defined as the death of a woman while she is pregnant or within 42 days of delivery or 90 days from termination of pregnancy, irrespective of the duration and site of the pregnancy from any cause related to or aggravated by the pregnancy or its management. The MDG Report of the UN Secretary General of 2012 points out that an estimated 2,87,000 maternal deaths occurred in 2010 worldwide. India recorded around 57,000 maternal deaths in 2010, which translate into a whopping six every hour and one every 10 minutes.7

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Maternal mortality rate (MMR) is the annual number of female deaths per 100,000 live births from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes). The MMR includes deaths during pregnancy, childbirth or within 42 days of termination of pregnancy irrespective of the duration and site of the pregnancy for a specified year. The maternal mortality ratio in India is estimated at 400-570 per 100,000 live births which is fifty times higher than several developed countries and six times higher than neighboring Sri Lanka. The maternal mortality ratio ranges from 448 and 397 per 100,000 births in rural & urban areas respectively, in 1992-93. Maternal deaths account for a considerable proportion of all deaths among women of reproductive age, especially in rural areas.

The current MMR of India is 212 deaths per 100,000 live births (2010) according to a World Bank Report published in 2012. India has reduced MMR significantly from 437 per 100,000 live births in 1999 to 212 now, but needs to hasten the pace under NRHM to achieve related MDG.

LEVELS OF MATERNAL MORBIDITY:

Maternal Morbidity (disease/illness) is defined as a complication or illness that arises during pregnancy, birth or the puerperium, which affects woman’s integrity and physical or mental health sometimes permanently. Causes can vary and some examples include obstetric complications, interventions, cultural practices or coercion. The maternal morbidity is the neglected dimension of safe motherhood in developing world due to insufficient attention. Maternal morbidity adversely affects families, communities, societies and poses a severe burden on women’s health.

Maternal morbidity has multiple causes with duration ranging from acute to chronic, severity ranging from transient to permanent and with a

range of diagnosis and treatment options. It is estimated that 15-20 women experience acute or chronic morbidity in the antenatal and postnatal periods for or every woman who dies of pregnancy related causes during delivery. This estimation indicates that an additional 3.75 to 5 million mothers experience impaired health & efficacy as a result of pregnancy or childbirth. Community based assessments of maternal morbidity in India that have addressed all three natal periods indicate high rates of maternal morbidity, 41% in a study of Karnataka and 45% in a study of Tamil Nadu and Pondicherry.⁹

Maternal morbidity and reproductive morbidity in general is an outcome of not just biological factors but of women’s poverty, powerlessness and lack of control over resources as well. Malnutrition, infection, early and repeated childbearing and high fertility also play an important role in poor maternal health conditions in India. Lack of access to health care along with the poor quality of the delivery system and its inadequate responsiveness to women’s needs, exacerbate maternal morbidity.

CAUSES OF MATERNAL MORTALITY & MORBIDITY:

Maternal Mortality & Morbidity are the result of either direct or indirect causes. The direct causes are the diseases or complications that occur during pregnancy or up to six weeks after delivery or termination of pregnancy from any cause related to or aggravated by the pregnancy or its management.

There are five leading major direct obstetric emergencies that can kill a woman within a short period of time. These are - haemorrhage, sepsis, eclampsia, abortion and obstructed labour. (WHO,1991). The indirect causes are those that may be present before pregnancy and aggravated by the pregnancy. These include anaemia, malaria, hepatitis, tuberculosis,

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heart diseases, genito-urinary tract infections and complications of pregnancy and delivery. While death is the most serious of obstetric emergency outcomes those who do survive often suffer serious short or long-term illness. The following graph shows the causes of maternal deaths in percentage.

Graph 2.1: Maternal Deaths - Causes

FAMILY PLANNING:

Family planning plays a crucial role in helping the women to remain healthy by preventing unwanted or untimely pregnancies. Accesses to quality family planning services that provide women with a range of contraceptive options and informed choice can help to reduce the maternal mortality and morbidity by reducing high-risk pregnancies associated with multiple pregnancies. It also helps women to avoid undesired and unsafe abortions.\(^\text{11}\)

Definition:

There are several definitions of family planning.\(^\text{12,13}\)

1) An Expert Committee (1971) of the WHO defined family planning as “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country.”

2) Another Expert Committee (1971) of the WHO defined family planning as a set of practices that help individuals or couples to attain certain objectives such as

1. to avoid unwanted births
2. to bring about wanted births
3. to regulate the intervals between pregnancies
4. to control the time at which births occur in relation to the ages of the parent and
5. to determine the number of children in the family.

\(^\text{11}.\) Sushma Srivatsav :“Women and Family Welfare”; Published by common wealth, 2008; Page – 112 ;
\(^\text{12}.\) K Park :“Park’s Text Book of Preventive and Social Medicine”; Published by M/s Banarsidas Bhanot Publishers, Jabalpur(MP);29th Ed, 2009; Page 421-422
\(^\text{13}.\) N.K. Behura & R.P. Mohanty :” Family Welfare in India – A Cross Cultural Study”; Published by Discovery House, New Delhi, 2005; Page 66-77
CONTRACEPTIVE METHODS: Family Planning Methods

Contraceptive methods are the preventive methods to help women to avoid unwanted pregnancies. In today’s modern world, there are various and wide range of choices of methods available to a couple to plan the family and to prevent unwanted pregnancy. These are also called as fertility regulating methods. The commonly used family planning methods are: 14

1. Natural Methods:
   1. Abstinence
   2. Coitus Interruptus (Withdrawal Method)
   3. Rhythm Method (Calendar Method)
   4. Cervical Mucus method (Billing’s Method)
   5. Symptothermal Method
   6. Breast feeding

2. Artificial Methods:
   1. Barrier methods:
      1. Male Condoms - Nirodha
      2. Female Condoms - Diaphragm
   2. Intra Uterine Devices (IUDs):
      3. Copper T
   3. Hormonal:
      4. Oral Pills
      5. Implants
      6. Injectables

3. Surgical Methods (Permanent):
   1. Vasectomy (Male Sterilization)
   2. Tubectomy (Female Sterilization)

4. Emergency Contraception:
   1. Copper IUD
   2. Levonorgestrel-only or combined estrogen progesterone

14. K Park: “Park’s Text Book of Preventive and Social Medicine”; Published by M/s Banarsidas Bhanot Publishers, Jabalpur(MP); 29th Ed, 2009; Page 421-42
The following table outlines the main advantages/disadvantages and benefits of different contraceptive methods (K Park 2009).

**Table No – 2.2 Short and Long Acting Contraceptives**

<table>
<thead>
<tr>
<th>Short Acting Contraceptives</th>
<th>Long Acting Contraceptives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Contraceptive Vaginal Ring</strong></td>
<td><strong>Contraceptive injection</strong></td>
</tr>
<tr>
<td>Flexible ring which is placed inside the vagina. It releases an oestrogen and a progestogen.</td>
<td>Injection containing progestogen Injected into a muscle every 8 or 12 weeks.</td>
</tr>
<tr>
<td><strong>Contraceptive patch</strong></td>
<td><strong>Implant</strong></td>
</tr>
<tr>
<td>Patch containing oestrogen and progestogen.</td>
<td>Small plastic rod, which is placed just under the skin on the inner side of the upper arm. Contains progestogen.</td>
</tr>
<tr>
<td><strong>Combined Pill</strong></td>
<td><strong>Intra Uterine System (IUS)</strong></td>
</tr>
<tr>
<td>Tablet containing oestrogen and progestogen.</td>
<td>Intrauterine device that is fitted into the womb. Contains progestogen.</td>
</tr>
<tr>
<td><strong>Progestogen-only Pill</strong></td>
<td><strong>Intra Uterine Device (IUDs)</strong></td>
</tr>
<tr>
<td>Tablet containing only progestogen.</td>
<td>Intrauterine device that is fitted into the womb. It does not contain any hormones.</td>
</tr>
<tr>
<td><strong>Male condom</strong></td>
<td><strong>Female Sterilization (Tubal Occlusion)</strong></td>
</tr>
<tr>
<td>Made of thin latex (rubber) or polyurethane (plastic).</td>
<td>Achieved by cutting, sealing or blocking the fallopian tubes.</td>
</tr>
<tr>
<td><strong>Female condom</strong></td>
<td><strong>Male Sterilization (Vasectomy)</strong></td>
</tr>
<tr>
<td>Soft, thin polyurethane sheath loosely lines the vagina and covers the area just outside</td>
<td>The tubes (vas deferens) that carry sperm from the testicles to the penis are cut, sealed or tied.</td>
</tr>
<tr>
<td><strong>Diaphragm /Cap with spermicide</strong></td>
<td></td>
</tr>
<tr>
<td>Barrier methods that you fit inside the vagina to cover the cervix.</td>
<td></td>
</tr>
<tr>
<td><strong>Natural family planning</strong></td>
<td></td>
</tr>
<tr>
<td>Works by observing and recording your body’s different natural signs or fertility each day of your menstrual cycle.</td>
<td></td>
</tr>
</tbody>
</table>
BENEFITS OF FAMILY PLANNING: 15,16

Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. A woman’s ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

Benefits for Women’s Health: Simply by providing contraceptives to women who desire to use it, one can improve reproductive health by reducing maternal deaths and disability by avoiding pregnancy at the extremes of maternal age, preventing high-risk pregnancies & unwanted pregnancy and preventing of STIs and reproductive cancers.

Benefits towards Children’s Health: Family planning indirectly contributes to children’s health, development and survival by reducing the risk of maternal mortality and morbidity. Spacing births at least 2 years apart has to do with their survival. On average babies born less than 2 years after the previous birth in the family are about twice as likely to die in the first year as babies born after at least a 2-year interval. Even older children who are spaced too closely face an increased risk of death during the toddler and childhood years.

Benefits for Women and the Societies: Family planning reduces the health risks of women and gives them more control over their reproductive lives. With better health and greater control over their lives, women can take advantage of education, employment and civic opportunities. If couples have fewer children in the future, the rate of population growth would decrease. As a result, future demands on natural resources such as water and fertile soil will be less. Everyone will have a better opportunity for a better quality of life.

15. K Park :“Park’s Text Book of Preventive and Social Medicine”; Published by M/s Banarsidas Bhanot Publishers, Jabalpur(MP); 29th Ed, 2009; Page 421-422
FAMILY PLANNING STATUS IN INDIA:

India launched a nationwide Family Planning Programme in 1952, which was later, expanded to cover maternal and child health, family welfare and nutrition. Commonly practiced Family Planning methods include birth control pills, condoms, sterilization and IUDs. The efforts of the Government in implementing the family planning programme have significant impact in the country.  

During the period 1965-2009, contraceptive usage was more than tripled (from 13% of married women in 1970 to 48% in 2009) and the fertility rate was more than halved (from 5.7 in 1966 to 2.6 in 2009), but the national fertility rate was still high enough to cause long-term population growth. India adds up to 1,000,000 people to its population every 15 days.

Low female literacy levels and the lack of widespread availability of birth-control methods are hampering the use of contraception in India. Awareness of contraception is near-universal among married women in India. However, the vast majority of married Indians (76% as per 2009 study) reported significant problems in accessing a choice of contraceptive methods. In 2009, 48.3% of married women were estimated to use contraceptive method, on the contrary more than half of all married women did not. About three-fourths of these were using female sterilization, which is by far the most prevalent birth-control method in India. Use of Condoms, at a mere 3% was the next but the most prevalent method. Meghalaya, at 20%, had the lowest usage of contraception among all Indian states. Bihar and Uttar Pradesh were the other two states that reported the usage below 30%.

The year 2010-11 ended with 34.9 million family planning acceptors at national level comprising of 5.0 million Sterilizations, 5.6 million IUD

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17. Family Planning Programme in Indiz- 2011  
http://www.medindia.net/health_statistics/general/family-planning-programme.asp#ixzz3HwDqxDqi (12/08/2011)
Insertions, 16.0 million Condom users and 8.3 million Oral Pill users as against 35.6 million family planning acceptors in 2009-10. The following graph shows the total family planning acceptors during 2010-11.

Graph 2.2: Total Family Planning Acceptors during 2010-11

**IUD Insertions:** During the year 2010-11, 5.6 million IUD insertions were reported as against 5.7 million in 2009-10. Assam, Bihar, Gujarat, Jharkhand, Uttar Pradesh, Arunachal Pradesh, Delhi, Goa, Meghalaya, Mizoram, Sikkim, D&N Haveli reported better performance in 2010-11 than in 2009-10.

**Condom Users and Oral Pill Users:** Based on the distribution figures reported, there were 16.0 million equivalent users of Condoms and 83.07 million equivalent users of Oral Pills during 2010-11.

**Number of Births Prevented:** Implementation of various Family Planning measures prevented 16.335 million births in the country during 2010-11 as compared to 16.605 million in 2009-10. The cumulative total of births avoided in the country up to 2010-11 was 442.75 million.

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19. *Family Planning Programme in Indiz-2011*
   http://www.medindia.net/health_statistics/general/family-planning-programme.asp#ixzz3HwDqxDqi 12/08/2011
FAMILY PLANNING STATUS IN KARNATAKA: 21

In India, Karnataka is the first state to open government sponsored family planning clinics in Bangalore and Mysore as early as in 1930. With the adoption of the family planning programme as a national programme by the Government of India in 1952, the programme became part of the developmental activities of the state with the establishment of several PHCs and Sub Centers. As observed elsewhere in the country, in Karnataka also the fertility has declined significantly at least since the inception of the family planning programme in the state.

For instance, the Crude Birth Rate, which was 42 per 1000 population in 1951, declined to 28 in 1981 and to 22 in 2001. However, in the recent period, the apparent decline in fertility is slower in Karnataka than in Andhra Pradesh and for which the reason is not clearly known. For example, during 1991-2001, the Total Fertility Rate declined by 0.5 in Karnataka while it was 0.8 in Andhra Pradesh.

The decline in the fertility can’t be attributed to family planning programme alone. The change in the fertility levels is not only determined by contraceptive use but also by marriage patterns, fecundity factors, induced abortion, etc, which are called Proximate determinants of fertility.

12/08/2011
SAFE ABORTION:

Safe Abortion is one of the important components of Reproductive Health. It addresses in brief, the clinical care for women undergoing an abortion. The Safe Abortion Services includes termination of an unwanted pregnancy safely, legally and affordably which includes the services such as pre-abortive care (before abortion), abortion methods (during abortion) and post-abortive care (after abortion & follow up).

Safe abortion services are those provided by trained health workers, supported by policies, regulations and a functional health infrastructure, including equipment and supplies which ensure to access to reproductive health services and safe abortion facilities such as addressing unsafe abortion, emphasizing the legalization of abortion, improvements in health care during and after abortion the training of medical personnel.22

Abortion is more than a medical issue, or an ethical issue, or a legal issue. It is above all a human issue, involving women and men as individuals as couples and as the members of the society.

LEGAL ABORTION: (Medical Termination of Pregnancy (MTP))

Abortion in India has been partially legal since 1971. The Indian abortion laws fall under the MTP Act, which was enacted by the Indian Parliament in the year 1971. The MTP Act came into effect from April 1, 1972 and was once amended in 1975. As per India’s abortion laws only certified allopathic doctors under stipulated conditions can perform abortion on a woman in an approved clinic or hospital.23

The MTP Act of India clearly states the conditions under which a pregnancy can be ended or aborted under a qualified physician. The length of the pregnancy must not exceed 20 weeks in order to qualify for an abortion.


Some of these conditions are -
• Women whose physical or mental health was endangered by the pregnancy.
• Women facing the birth of a potentially handicapped or malformed child.
• Rape.
• Pregnancies in unmarried girls under the age of eighteen with the consent of a guardian.
• Pregnancies in "lunatics" with the consent of a guardian.
• Pregnancies that are the result of failure in sterilization.

Legal Abortion Statistics in India:

According to the Consortium on National Consensus for Medical Abortion in India, every year an average of about 11 million pregnancies are medically terminated and 20,000 women die every year due to abortion related complications. Most abortion related maternal deaths are attributable to illegal abortions. The following table 3 suggests year wise number of abortions reported and includes legally reported induced abortions.

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</tr>
</thead>
<tbody>
<tr>
<td>Number of abortions reported</td>
<td>24300</td>
<td>214197</td>
<td>388405</td>
<td>583704</td>
<td>581215</td>
<td>570914</td>
<td>725149</td>
<td>763126</td>
<td>641786</td>
<td>620472</td>
</tr>
</tbody>
</table>


UNSAFE ABORTION:
The WHO defines Unsafe Abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimum medical standards or both. For example, an unsafe abortion may refer to an extremely dangerous life-threatening procedure that is self induced in unhygienic conditions, or it may refer to a much safer abortion performed by a medical practitioner who does not provide appropriate post abortion attention. Performance of abortion outside the safe abortion services and conditions constitutes unsafe abortion. This may lead to severe complications such as incomplete abortion, sepsis, hemorrhage, damage or injury to internal organs, secondary infertility etc which results in maternal morbidity and mortality worldwide.

**Morbidities and Mortalities:**

Unsafe abortion is a global problem. Millions of women around the world risk their lives and health to end an unwanted pregnancy. Every day 55,000 unsafe abortions take place, 95% of them in developing countries and lead to the deaths of more than 200 women daily. Globally, one unsafe abortion takes place for every seven births. Each year, 19-20 million women risk their lives to undergo unsafe abortions, conducted in unsanitary conditions by unqualified practitioner or practitioners who resort to traditional but rudimentary means.

Dr. Gilda Sedgh of the Guttmacher Institute, a U.S. SRH and advocacy center believes that “about half of all abortions worldwide are unsafe”. An appalling number when one considers that abortions are simple procedures when done correctly. It is estimated that approximately 20 million unsafe abortions are performed annually with 97% taking place in developing countries. Unsafe abortions are believed to result in millions of injuries and approximately 37,100 deaths annually as of 2010, accounting

for 13% of all maternal deaths. In addition, a lack of access to effective contraception contributes to unsafe abortion. It has been estimated that the incidence of unsafe abortion could be reduced by up to 75% (from 20 million to 5 million annually) if the modern family planning and maternal health services were readily available globally.26

Reasons of Unsafe Abortion: Most unsafe abortions occur where abortion is illegal or in developing countries where affordable well-trained medical practitioners are not readily available or where modern contraceptives are unavailable. About one in eight pregnancy related deaths worldwide is associated with unsafe abortion.

Why Women Find themselves with Unwanted Pregnancy?

- **Non-use of Contraception:** Majority of unwanted pregnancies occur in non-users of contraceptive methods.
- **Contraceptive Failure:** It results in 8-30 million pregnancies each year either from inconsistent or incorrect use of family planning methods or method related failure.
- **Sexual Coercion or Rape:** 20 to 50 % of women and girls report sexual abuse, rape or sexual coercion which carries about 5% risk of pregnancy in those in reproductive age unless emergency contraceptives given.
- **Other factors include:** Lack of control over contraception; Young age or single marital status; Abandonment or unstable relationship; Mental or physical health problems; Severe malformation of the fetus; and Financial constraints.

Why does Induced Abortion Occur?

Each year women around the world experience 80 million unwanted pregnancies. Out of these mothers nearly 42 million decide to have an abortion and about 20 million of them undergo unsafe abortion.

A woman's decision to get an abortion is not made in a vacuum but is bound up in society's feelings about abortion as well as her feelings about the pregnancy:

- Several social factors influence the emotional decision of obtaining abortion.
- The cultural attitudes toward family size also influence woman’s perception of abortion.
- Religious attitudes strongly affect the decision.
- Personal and interpersonal reasons for continuing the pregnancy can be a great source of conflict. Often, pregnancy is the unwanted byproduct of wanted sexual relations while a pregnancy that is desired to prove her ability as a woman may have little relationship to desire for the actual child.
- Age and marital status are important factors in the decision along with number of other children already born.

Unsafe Abortion Statistics in India:

In India, the problem of unsafe abortions is especially acute. There were 620,472 reported abortions in 2012; experts say the true number of abortions performed in the country could be as high as 7 million with two-thirds of them taking place outside authorized health facilities. Many unsafe abortions are performed on married women unable to obtain contraception and unable to travel to a registered clinic, who for economic or personal reasons do not wish to have another child. A woman in India dies every two hours because an abortion goes wrong.

However, Ipas said that over 40 years after the implementation of a liberal MTP Act, unsafe abortions continue to outnumber safe and legal abortions in India. It is feared that expanding the base of providers for abortion will lead to more sex-selective abortions. However, Ipas said 80-90 % abortions in the country take place in the first trimester and sex determination takes place in the second trimester. Women also delay abortion till the second trimester for reasons other than sex selection. A
Lancet paper in 2007 said there were 6.4 million abortions, of which 3.6 million or 56% were unsafe. Ipas added further that the total number of abortions may have reduced due to higher use of contraception. 27

SEX-SELECTIVE ABORTIONS:

It is the practice of terminating a pregnancy based upon the predicted sex of the baby. The selective abortion of female fetuses is most common in areas where cultural norms value male children over female children, especially in parts of People’s Republic of China, India and Pakistan. Sex-selective abortion can affect the human sex ratio. 28

The selective abortion of female fetuses has increased in India over the past few decades due to increased prenatal sex discernment and has contributed to a widening imbalance in the child sex ratio. Moreover, the high abortion rate of female fetuses has led to a dramatic gender imbalance in India. Over the 50 year period from 1961 to 2011 the number of girls born per 1,000 boys plunged from 976 to 914, according to the census. 29

Graph 2.3: Falling Number of Girls born in India Since 1961

27. The Hindu News Paper dated 6th May 2103 Topic - Unsafe Abortions Killing A Woman Every Two Hours: Ipas India
MALE PARTICIPATION AND RESPONSIBLE BEHAVIOUR:

Traditionally, health care providers and researchers in the field of reproductive health have focused almost exclusively on women when planning programmes and services, especially with regard to family planning, prevention of unwanted pregnancy, unsafe abortion and promotion of safe motherhood. In recent years the efforts have been made in many countries to broaden men’s responsibility for their own reproductive health as well as that of their partners. Measures are also being taken to improve gender relations by promoting men’s understanding of their familial and social roles in family planning and sexual and reproductive health issues.

There was an agreement in Cairo ICPD Programme of Action (1994) that special efforts should be made to promote men's active involvement in such areas. It said, "special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour including family planning; prenatal, maternal child health; prevention of STDs, including HIV; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; recognition and promotion of the equal value of children of both sexes. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children".  

The male involvement, as participation of men in activities which help and facilitate:  
1. Access to information about the SRH of men and women;  
2. Prevention of unwanted consequences of sexual activities - unwanted

pregnancy and transmission of STI/HIV to self and partners;
3. Treatment of the unwanted consequences for self and partners;
4. Ensuring of safe motherhood and
5. Improvement in reproductive health.

The men must adopt a positive behaviour responsibility such as
1. Care of own RSH as well as that of their partners.
2. Education of children from the earliest ages.
3. Behavioural change among men should be promoted where necessary,
   and responsible behaviour among adolescent males should be advocated.
4. Consistent condom use and remaining faithful to a single partner.
5. A measure to improve gender relations by promoting men understands
   of their familial & social roles in family planning & RSH issues.
6. Special emphasis should be placed on the prevention of violence
   against women and children.
7. Involvement and participation in the health policy and reproductive
   health programmes.
8. Accept and indicate support to their partner’s needs, choices and
   rights.

Men who are educated about reproductive health issues are more likely to support their partners in decisions on contraceptive use and family planning; be supportive during pregnancy; and if obstetric complications arise, they will know not to delay in getting appropriate assistance. Men’s education on the protection, testing and treatment of STI, as well as stressing partner notification can assist in reducing HIV transmission.

Hence, the men’s positive behaviour responsibility and active involvement as participation in activities of RSH can help and facilitate to prevent many reproductive and sexual issues.
ADOLESCENT REPRODUCTIVE & SEXUAL HEALTH (ARSH):

Adolescents are the young people between the ages 10-19 years. It is a period of transition from childhood to adulthood. It is a vital stage of growth and development which results in sexual, psychological and behavioural maturation.

ARSH is a healthy condition concerning the system, function and reproductive processes of adolescents. It is affected by pregnancy, unwanted pregnancy, abortion, unsafe abortion, STI including HIV/AIDS, all forms of sexual violence and coercion and by the systems that limit access to information and clinical services.

The ARSH reports that the sexual activity, early pregnancies and STI including HIV infection rates are increasing at unprecedented rates among adolescents. Since the 1994 ICPD in Cairo, Egypt, Youth Friendly Reproductive Health Services (YFRHS) have been recognized as an appropriate and effective strategy to address the SRH needs of adolescents. The YFRHS focused on improving the availability, accessibility and quality of SRH services because YFRHS were developed against the backdrop of inadequacies on the part of health systems to provide SRH services in an efficient, effective and equitable manner to young people.32

ISSUES of ARSH:33

Pregnancy: In many parts of the world, women marry and begin childbearing during their adolescent years. Pregnancy and childbirth carry greater risk of morbidity and mortality for adolescents than for women in their 20s, especially where medical care is scarce. Girls younger than age 18 yrs face two to five times the risk of maternal mortality as women aged 18-25 due to prolonged and obstructed labor, hemorrhage and other factors.

32. Neeta Tapan: Need for Women Empowerment; Published by Rawat Publication, Jaipur and New Delhi; 2000; Page – 114.
Potentially life-threatening pregnancy-related illnesses such as hypertension and anemia also are more common among adolescent mothers, especially where malnutrition is endemic. One in every 10 births worldwide and 1 in 6 births in developing countries is to women aged 15-19 years.

**Unwanted pregnancy:** Every year, approximately 50 million unwanted pregnancies are terminated. Some 20 million of these abortions are unsafe. About 95% of unsafe abortions take place in developing countries, causing the deaths of at least 200 women each day.

**Unsafe abortion:** About one in 10 abortions worldwide occurs among women of the age 15-19 and each year one million to 4.4 million adolescents in developing countries undergo abortion, and most of these procedures are performed under unsafe conditions due to lack of access to safe services, self-induced methods, unskilled or non-medical providers, delay in seeking procedure. Adolescent unwanted pregnancies often end in abortion. Surveys in developing countries show that up to 60% of pregnancies in women below age 20 are mistimed or unwanted. Pregnant students in many developing countries often seek abortions to avoid being expelled from school.

**STIs, including HIV/AIDS:** The highest rates of infection for STIs, including HIV are found among young people aged 20 to 24; the next reproductive health highest rate occurs among adolescents aged 15 to 19. STIs can lead to life-long health problems, including infertility. Worldwide, half of all STIs occur in adolescents. Available data suggest that one-third of STIs infections in developing countries occur among 13-20 year olds, one out of every 20 adolescents contracts STIs. Young people tend to be at higher risk of contracting STIs, including HIV/AIDS, for several reasons i.e., intercourse often is unplanned or unwanted; often do not use contraceptives, little knowledge of STIs, failure to seek treatment, multiple partners, partners with multiple partners and use of drug and alcohol.

**Sexual Violence:** Sexual abuse occurs worldwide. One-third of teenagers experience abuse, with in heterosexual relationships, in United States. Rape and involuntary prostitution can result in physical trauma, unintended
pregnancy, STIs, psychological trauma and increased likelihood of high risk sexual behavior.

**ARSH Issues: A Global Issue**

Adolescents are a diverse group and are in varying situations of risk, status and environments. The breakdown of family, community, social norms, loss of parental supervision, lack of schooling and recreational activities, frustration, boredom, insecurity of refugee life and uncertainty about the future may lead adolescents to experiment with risky behaviours such as engage in smoking, drug abuse, consumption of alcohol, violence and unprotected sex. Some may have gone through traumatic experiences such as armed conflict, sexual abuse, violence and or loss of family members and many have to deal with these issues alone. Thus this age group faces social pressures and expectations that can affect their reproductive health status.  

Adolescents and more so girls, have extra-nutritional requirements that are often ignored, leading to a number of health hazards. This has been a major cause of widely prevalent anaemia among women. Further, girls are forced into early marriage that seriously undermines their health and limits their opportunities for personal development. Unwanted pregnancies, risky abortions, haemorrhage, obstructed deliveries, low birth weight of the baby, anaemia STIs including HIV/AIDS and female genital mutilation are some of the health issues.

Approximately 15 million young females ages 15-19 give birth each year, accounting for more than 10 per cent of all babies born worldwide. Only about 17% of them use contraception. Young mothers, especially those under 16, have increased likelihood of serious health risks.

The risk of death in childbirth is five times higher among 10-14 year-

35. Dr. K Saroja; *Mahile Arogya – Ondu Maruchintane, Published by Prasaranga, Kannada Vishwa Vidyalaya Hampi, Vidyaranya, 2008, PP – 23,24*
olds than among 15-19 year-olds and, in turn, twice as high among 15-19 year-olds as among 20-24 year-olds. Teenagers are over represented among those obtaining abortion and even more so among those needing medical care for complications of unsafe abortion. When adolescents bear children, their offspring also suffer higher levels of morbidity and mortality. The incidence of STDs is also disproportionately high among young people; 1 in 20 adolescents contracts a STDs each year, and half of all cases of HIV infection take place among people under age 25 years.  

ARSH needs to know in order to have correct information about the reproductive process and the various factors that are nearby. With the right information and service programmes for adolescents are expected to have the attitude and responsible behavior on the reproductive process which results in improved health of young people. Since, more than one billion young people are entering their reproductive years. To reach their potential, young people must be empowered with the facts and services they need to make informed reproductive health decisions.

CAUSES OF ARSH ISSUES:

1. Psychological and Socio-economic Consequences of Pregnancy for Unmarried Adolescents:
   - Psychological stress, poor self esteem, lack of hope and social stigma.
   - Disrupted education, poor academic achievement.
   - Leaving home and prostitution.
   - Poor socio-economic future, poor earning capacity: fewer career or job opportunities.
   - Unstable marriage
   - Unwanted child- mistreated, abandoned.
   - Their children face psychological, social and economic obstacles.
2. Early Unprotected Sexual Intercourse in Adolescents:

- Lack of knowledge on physiology of the reproductive system and human sexuality.
- Declining age of menarche.
- Early marriage.
- Urbanization, migration (western cultural influences).
- Sexual violence and coercion.
- Peer influence.
- Lack of knowledge on family planning.
- Unavailability and inaccessibility (including culturally) of services (negative) attitude of the society (including service providers) towards use of family planning services by the adolescents.
- Sense of guilt, fear of discovery, disapproval or rejection.

3. Adolescents Contraceptive Use:

Few married adolescents use contraception before first pregnancy. After becoming sexually active, unmarried adolescents delay use of contraceptives for about a year. Two common reasons for non-use of contraceptives among youths are: did not expect to have sex and lacked knowledge about contraception. Adolescents’ contraceptive use is limited as

- they do not plan ahead or anticipate consequences.
- they don’t think that they are at risk.
- they lack confidence or motive to use.
- they embarrassed or not assertive.
- they lack power and skill to negotiate use.
- the clinics are not friendly to adolescents use.
- the providers are reluctant to serve unmarried adolescents.
- prohibition by law/policy to serve adolescents
- the adolescents are reluctant to use service for fear of judgment or concerned about having pelvic examination.
REALITIES OF ADOLESCENTS IN INDIA TODAY:

1. 30% of India’s population (327 million individuals) is in the age group of 10-24 years (WHO, 2007)

2. Youth are vulnerable to sexually transmitted infections, including HIV, and account for 31% of AIDS burden in the country (NACO, 2007)

3. Though age at marriage is increasing; data from NFHS-3 (National Family Health Survey 3) shows that 27% young women and 3% young men in the age group of 15-19 years were married at the time of the survey (2005-06).

4. 30% women in the age group of 15-19 years have had a live birth by the age of 19 years. 7% married and 9% unmarried girls reported current use of modern contraceptive methods. 60% girls in the age group 15-19 years were found to be anemic (NFHS-3). Anemia is a contributing cause of increased age-specific mortality among female adolescents.

5. The sex ratio in the age group 10-19 years is 882 females per 1000 males, and is lower than the sex ratio of 927 females per 1000 males in the age group of 0-6 years. Among the 15-19 years old, 25% of adolescents in rural areas and 10% in urban areas are illiterate. Gender disparities persist in the education sector despite improved school enrolment rates.

6. Largest proportion of estimated 3 million drug abusers and 0.6 million drug dependents in India are in the age group 16-35 years (UNODC and Ministry of Social Justice and Empowerment, 2004). Among 12,447 children surveyed across 13 states in India, 50% reported some form of sexual abuse. 53% victims were boys (Study on Child Abuse, Ministry of Women and Child Development, 2007). A majority of nonconsensual sexual experiences (eve teasing, abduction) go unreported. Extreme poverty, low status of women and lack of law enforcement has led to an increase in sex work.
WOMEN’S REPRODUCTIVE HEALTH ISSUES

Reproductive health issues remain the leading cause of ill health and death for women of childbearing age worldwide. Although most reproductive health problems arise during the reproductive years, in old age general health continues to reflect earlier reproductive life events. However poor reproductive health becomes a significant cause of disease and death.

The reproductive system either in function or dysfunction or disease, plays the central role in women's health. A major burden of the reproductive issues in females is related to their reproductive system and its function i.e., the uterus, cervix, vagina, fallopian tubes and breasts. The disease patterns of women often differ from those of men because of genetic constitution, hormonal environment or gender-evolved lifestyle behavior which impact on their physical, mental or social health. The way society treats or mistreats them because of their gender.

Women’s Reproductive Morbidity: A reproductive health issue of the women encompasses obstetric and gynecological morbidity.

1. Gyneacological Issues: It includes diseases related to menstruation and gynaecology including RTIs/STIs, HIV/AIDS, breast problems, infertility and cancers. In addition, there is related morbidity like urinary tract infections (UTIs), anemia, high blood pressure etc.

2. Obstetric Issues: It includes diseases related to during pregnancy, delivery and post-partum period.

GYNAECOLOGICAL ISSUES

MENSTRUATION AND ITS PROBLEMS

Menstruation is the periodic discharge of blood and mucosal tissue from the inner lining of the uterus through the vagina. Normal menstrual
cycle is essential for the reproductive health of women for their ability to meet their reproductive goals. Menstrual problems are one of the most common gynecologic issues. The following table outlines the disorders related to Menstruation.

### Table No – 2.4 Menstrual Disorders

<table>
<thead>
<tr>
<th>Menstrual Disorders</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhea (Absence of Menstruation)</td>
<td>An absence of menstruation. Normal causes include delayed puberty, pregnancy, breastfeeding, hormonal contraception and perimenopause. Usually referred to as primary or secondary amenorrhea.</td>
</tr>
<tr>
<td>Dysmenorrhea (Painful Cramps or Periods)</td>
<td>Frequent cramping or pain during menstruation. Pain occurs in the lower abdomen but can spread to the lower back and thighs. It is usually referred to as primary or secondary.</td>
</tr>
<tr>
<td>Menorrhagia (Heavy Bleeding or Periods)</td>
<td>An abnormal menstrual flow that lasts longer and is heavier than normal (about &gt;30ml) at regular intervals. It usually lasts more than 7 days and women lose an excessive (&gt;80ml) amount of blood. It is often accompanied by dysmenorrhea.</td>
</tr>
<tr>
<td>Metrorrhagia (Irregular Periods)</td>
<td>Abnormal bleeding that occurs at irregular intervals occurs between the expected menstrual periods or is unrelated to periods.</td>
</tr>
<tr>
<td>Dysfunctional Uterine Bleeding (DUB)</td>
<td>An abnormal uterine bleeding that usually refers excessive bleeding caused by hormonal problems and tends to occurs at any time during a woman's reproductive life.</td>
</tr>
<tr>
<td>Inter Menstrual Bleeding (IMB)</td>
<td>It refers to vaginal bleeding (that is not post coital) at any time during the menstrual cycle other than during normal menstruation.</td>
</tr>
<tr>
<td>Premenstrual Syndrome (PMS)</td>
<td>It is a set of physical, emotional and behavioral symptoms that occur a week before menstruation in most cycles. The symptoms include irritability, tension, unhappiness, stress, insomnia, headache, mood swings, breast tenderness, changes in libido, emotional sensitivity.</td>
</tr>
<tr>
<td>Menopause</td>
<td>Literally means the end of monthly cycles. It is an event that typically (but not always) occurs in women during their late 40s or early 50s. More accurately...</td>
</tr>
</tbody>
</table>
defined as the permanent cessation of the primary functions of the ovaries.

**GYNAECOLOGICAL ISSUES:**

The following table outlines the disorders related to Gynaecology.³⁹

<table>
<thead>
<tr>
<th>Gynaec Disorders</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leucorrhea (White Discharge)</td>
<td>It is a thick, whitish or yellowish vaginal discharge due to usual cause being estrogen imbalance. The amount of discharge may increase due to vaginal infection or STDs and also it may disappear and reappear from time to time. It is usually a non-pathological symptom secondary to inflammatory conditions of vagina or cervix.</td>
</tr>
<tr>
<td>Poly Cystic Ovarian Syndrome (PCOS) or Ovarian Cyst</td>
<td>Most common hormonal disorder among women of reproductive age. There are multiple small cysts located along the outer edge of each ovary (polycystic appearance). The most common symptoms are Irregular, infrequent periods, no periods, weight gain, thinning hair on the scalp, dandruff and trouble becoming pregnant.</td>
</tr>
<tr>
<td>Uterine Fibroid or Fibroids</td>
<td>These are non cancerous tumors or lumps that grow within the wall of the uterus. Fibroids are the most common and typically found during the middle and later reproductive years. Fibroids, particularly when small may be entirely asymptomatic. Symptoms depend on the location of the lesion and its size.</td>
</tr>
<tr>
<td>Uterine Polyps (Endometrial Polyp)</td>
<td>These are overgrowth of the cells in the lining of the uterus which attached to the inner wall of the uterus that extends into the uterine cavity. The polyps may be round or oval and usually benign (noncancerous). No definitive cause of endometrial polyps is known.</td>
</tr>
<tr>
<td>Uterine Prolapse</td>
<td>It is prolapsed of the uterus. Prolapsed happens when the ligaments supporting the uterus become so weak that the uterus cannot stay in place and slips down from its normal position. The most common cause of uterine prolapsed is trauma during childbirth, multiple or difficult births. It is more common as women get older, particularly in those who have gone through menopause. This condition is surgically correctable through the hysterectomy.</td>
</tr>
</tbody>
</table>

REPRODUCTIVE TRACT INFECTIONS (RTIs):

RTIs are infections of the genital tract of women and men. Absence of 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 RTIs\textsuperscript{40,41}

1. Endogenous Infections: Caused by the multiplying of organisms normally present in the vagina. The below table outlines Endogenous Reproductive Tract Infections.

<table>
<thead>
<tr>
<th>Table No – 2.6 Endogenous Reproductive Tract Infections</th>
</tr>
</thead>
</table>

VAGINITIS: It is an inflammation of the vagina which can result in discharge, itching and pain. It is often associated with an irritation or infection of the vulva. The three main kinds of vaginitis.

- **Bacterial Vaginosis/Vaginal Bacteriosis:** Most common cause of vaginal infection for women of childbearing age due to an imbalance in the normal vaginal flora. It is found more commonly among sexually active women with multiple partners.

- **Vaginal Candidiasis:** Caused by the fungus candida. Some women appear to be naturally more prone to have this type of infection for which reason is not well understood. In addition, recent use of antibiotics, oral contraceptives that contain progesterone or the presence of other conditions such as diabetes, pregnancy, or immune suppression (HIV causes AIDS).

- **Trichomoniasis:** Caused by a parasite that produces effects ranging from no symptoms to irritation, itching, odour, vaginal discharge and or frequent urination in women.

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

\textsuperscript{40.} A Textbook of Gynaecology and Obstetrics - By C S. Dawn, John Howkins. 6\textsuperscript{th} Ed, Published by Dawn Books, 1980.
The below table outlines Iatrogenic Reproductive Tract Infections.

**Table No – 2.7  Iatrogenic Reproductive Tract Infections**

| Pelvic Inflammatory Disease (PID): | It is an infection and inflammation of the uterus, ovaries and other female reproductive organs. It can lead of infertility, ectopic pregnancy, pelvic pain, abscesses and other serious problems. Although a STI is often the cause, many other routes are possible, including lymphatic, postpartum, postabortal (either miscarriage or abortion) and IUDs related. Some women have no symptoms. Others have pain in the lower abdomen, fever, smelly vaginal discharge, irregular bleeding, and pain during intercourse or urination. |

| Endometriosis: | Chronic and often progressive disease that develops when the tissue that normally lines the uterus (endometrium) grows on other areas of the body such as the ovaries, bowels or bladder. It often causes chronic pelvic pain and irregular bleeding. |

| Cervicitis: | Inflammation of the uterine cervix. In many cases caused by STIs and non-infectious causes like IUDs, allergic reaction to spermicides or latex condoms, contraceptive diaphragms. It may be acute or chronic. |

| Salpingitis: | Inflammation of the fallopian tubes. It is often used synonymously with pelvic inflammatory disease (PID). |

| Oophoritis: | Inflammation of the ovaries. It is often seen in combination with Salpingitis. |

3. **Sexually Transmitted Infections (STIs):** They are also referred to as venereal diseases (VD) which are illnesses that have a significant probability of transmission between humans by means of sexual behavior, including vaginal intercourse, anal sex and oral sex. Some STIs can also be contracted by using IV drug needles after their use by an infected person as well as through any incident involving the contact of a wound with contaminated blood or through childbirth or breastfeeding. The following table outlines Sexually Transmitted Infections (STIs).
### Table No – 2.8 STIs Caused By Bacteria and Virus

<table>
<thead>
<tr>
<th>STIs Caused By BACTERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhoea:</strong> It is the common STI caused by bacteria characterized by a pus-like discharge from urethra or cervix and painful urination in both men and women. Women often have no symptoms of infection. It can lead to infertility in both sexes.</td>
</tr>
<tr>
<td><strong>Chlamydia:</strong> Caused by a micro-organism which produce inflammation of the vagina/cervix or urethra. This can also lead to pelvic inflammatory disease in women. It is characterized by a thin mucous discharge in men and cervical discharge in women (can be yellow or green in colour). Women often have no symptoms of infection.</td>
</tr>
<tr>
<td><strong>Syphilis:</strong> Caused by a spirochete which produce a genital ulcer in the early stages (usually painless) and a more general non-itchy skin rash in a secondary stage. If not treated it can also affect the heart and brain in late stages.</td>
</tr>
<tr>
<td><strong>Chancroid:</strong> Most common cause of genital ulcer disease in many parts of the developing world; involves painful, soft sores on the genitals which discharge pus; sometimes causes enlarged lymph nodes in the groin.</td>
</tr>
<tr>
<td><strong>Trichomoniasis:</strong> Caused by a parasite that produces effects ranging from no symptoms to irritation, itching, odour, vaginal discharge and or frequent urination in women. While males rarely display symptoms. They may develop inflammation of the urethra and or skin lesions on the penis.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STIs Caused By VIRUS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genital Herpes:</strong> Caused by a virus producing multiple, shallow ulcers anywhere on the genitalia; lesions usually heal and recur in cycles. Viral shedding can occur during latent periods. There is no known cure.</td>
</tr>
<tr>
<td><strong>Genital Warts:</strong> also called as venereal warts or anal warts caused by Human Papilloma Virus (HPV). Genital warts are small, painless primary lesions occur anywhere in the anal or genital area and are frequently found on external surfaces of the body including the penile shaft, scrotum, labia majora of the vagina or around the anus. It is highly contagious.</td>
</tr>
<tr>
<td><strong>HIV/AIDS:</strong> Human Immunodeficiency Virus causes AIDS (Acquired Immune Deficiency Syndrome). However, the virus destroys the body's immune system and develops number of infections and cancers which ultimately lead to death of an HIV infected person. By the time an individual’s HIV infection</td>
</tr>
</tbody>
</table>
has developed into AIDS, the individual may exhibit following major and or minor signs:

**Major signs:**
- Weight loss of more than 10% body weight
- Diarrhoea for more than one month &
- Fever for more than 1 month.

**Minor signs:**
- Persistent cough for more than one month
- Generalized itching skin rash
- Recurring shingles (herpes zoster)
- Thrush of mouth and throat
- Chronic severe and spreading cold sores (herpes simplex)
- Generalized enlarged lymph nodes
- Loss of memory and intellectual capacity

Although there is no fully effective cure for HIV/AIDS at this time, anti-retroviral medication (ARV) can help to prevent HIV transmission in some cases and can slow AIDS progression and improve the health of those with AIDS.

**BREAST PROBLEMS:**

Breast problems are common health worry in women of all ages. The common Breast problems are
- Mastalgia: Breast pain or tenderness
- Mastitis: Breast infections or abscesses
- Breast Lump: Painless, movable and firm round lumps (Fibroadenomas)
- Sacs filled with fluids (Cysts)
- Growths inside the ducts (Intraductal papillomas)
- Damaged fatty tissue (Fat necrosis)
- Nipple discharge or inversion, changes in the skin of the breast and
- Breast Cancer: are common in women of all ages, from adolescents to older women.

**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.

**REPRODUCTIVE CANCERS:**

Female Reproductive cancers are the cancers of Female reproductive organs. The most common reproductive cancers in women are: Uterine cancer, cervical cancer, ovarian cancer, vaginal cancer, vulvar cancer and Breast cancer is sometimes considered a reproductive cancer too.

**HYSTERECTOMY:**
It is a surgical procedure to remove the uterus. Some common reasons a woman might need a hysterectomy. It includes cancer or a massive hemorrhage from the uterus. Most of the time a hysterectomy is done to relieve heavy, painful or irregular periods (DUB, endometriosis, chronic PID etc) or if there are large fibroids (uterine fibroids in which 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 (uterine or vaginal prolapsed).

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 socioeconomic 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.

**STATISTICAL DATA OF GYNAECOLOGICAL DISORDERS:**
• The prevalence of dysmenorrhea is estimated to be approximately 25% of women. Reports of dysmenorrhea are greatest among individuals in their late teens and 20s, with reports usually declining with age.  

• Endometriosis is typically seen during the reproductive years. It has been estimated that endometriosis occurs in roughly 6–10% of women.  

• Irregular Periods occurs in up to 24% of women aged 40-50 years.  

• Poly Cystic Ovarian Syndrome produces symptoms in approximately 5% to 10% of women of reproductive age (12–45 years old). It is thought to be one of the leading causes of female infertility.  

• Globally approximately 235 million people are affected with uterine fibroids as of 2010 (6.6% of females). About 20–40% of women will be diagnosed with fibroid at some point in their life but only a fraction of those will cause problems or require treatment.  

• STIs cause the second highest burden of disease for women aged 15-44 years in developing countries, after maternal mortality and morbidity. Each day 500 000 young people are infected with an STI. Half of all HIV infections (8000 a day) occur in people under the age of 25 years.  

• The high rates of infection among adolescents are largely due to lack of information or myths about how STIs and HIV are spread, many young people receiving most of their information about these issues from friends, TV, and magazines (Rwenge, 2000).  

• The WHO estimates that each year, there are over 333 million new cases of curable STIs. In addition, UNAIDS calculates that in 2000 alone, 5.3 million people became infected with HIV.

47. www.popcouncil.org/pdfs/RTIFacsheetsRev.pdf; 3/12/2011
Endometrial cancers are the most common gynecologic cancers in developed countries with over 142,200 women diagnosed each year. It appears most frequently between ages of 55 – 65 years and uncommon below 40 years of age.48

Worldwide, breast cancer accounts for 22.9% of all cancers (excluding non-melanoma skin cancers) in women. In 2008, breast cancer caused 458,503 deaths worldwide (13.7% of cancer deaths in women). Breast cancer is more than 100 times more common in women than in men although men tend to have poorer outcomes due to delays in diagnosis.49

Some estimates suggest that worldwide "between three and seven percent of all couples or women have an unresolved problem of infertility. Many more couples, however, experience involuntary childlessness for at least one year: estimates range from 12% to 28%." 50

**OBSTETRICAL ISSUES 47: (Obstetric Morbidity)**

The obstetrical issues or morbidity constitutes

- During Pregnancy (ANC Period)
- During delivery(INC Period)
- After delivery(PNC Period)

The following table outlines common obstetric issues issue.

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51. References: 8/12/2011

2. [http://www.webmd.com/baby/guide/7-pregnancy-warning-signs](http://www.webmd.com/baby/guide/7-pregnancy-warning-signs)
3. [http://www.planababy.com/COMPLICATION%201st%20TRIMISTER.HTM](http://www.planababy.com/COMPLICATION%201st%20TRIMISTER.HTM)

**Table No – 2.9 Common Obstetric Issues**
<table>
<thead>
<tr>
<th>Obstetric Complication</th>
<th>Medical Condition</th>
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<tbody>
<tr>
<td></td>
<td>1. Anemia</td>
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<td></td>
<td>2. Hypertension</td>
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<td></td>
<td>3. Gestational diabetes</td>
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<td>4. Thyroid Disease</td>
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<td></td>
<td>5. Influenza (Flu)</td>
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<td></td>
<td>6. Urinary Tract Infection</td>
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<td></td>
<td>7. STIs</td>
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<td></td>
<td>8. HIV</td>
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<td></td>
<td>9. Hepatitis B &amp; C</td>
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<tr>
<th>Obstetric Complication</th>
<th>I Trimester Obstetric Complication</th>
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<tbody>
<tr>
<td></td>
<td>1. Hyperemesis Gravidarum</td>
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<tr>
<td></td>
<td>2. Spontaneous Abortion (Miscarriage)</td>
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<tr>
<td></td>
<td>3. Recurrent (Habitual) Abortion</td>
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<tr>
<td></td>
<td>4. Ectopic Pregnancy</td>
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<td></td>
<td>5. Molar Pregnancy (Hydatidiform Mole)</td>
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<tr>
<th>Obstetric Complication</th>
<th>II Trimester Obstetric Complication</th>
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<tbody>
<tr>
<td></td>
<td>1. Bleeding (Heavy bleeding)</td>
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<td></td>
<td>2. Incompetent OS (Painless Abortion)</td>
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<th>Obstetric Complication</th>
<th>III Trimester Obstetric Complication</th>
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<tr>
<td></td>
<td>1. Bleeding (APH) due to</td>
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<td></td>
<td>• Placenta Praevia</td>
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<td></td>
<td>• Abruptio Placenta</td>
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<td>• Preterm Labour</td>
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<td>• IUGR</td>
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<td>• Post term Pregnancy</td>
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<td>• Preeclampsia, Eclampsia</td>
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<tr>
<th>Obstetric Complication</th>
<th>Puerperal Obstetric Complication</th>
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<tr>
<td></td>
<td>1. Puerperal Mastitis</td>
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<td>2. Chorioamnionitis</td>
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<td>3. Metritis</td>
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<tr>
<th>Obstetric Complication</th>
<th>Labour or Delivery Complication</th>
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<tbody>
<tr>
<td></td>
<td>1. Preterm labour (premature delivery)</td>
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<td></td>
<td>2. Prolonged labour (failure to progress)</td>
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<td></td>
<td>3. Obstructed Labour</td>
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SEXUAL AND GENDER BASED VIOLENCE
Gender based violence (GBV) is the fate of millions of women all over the world and these are affecting their productivity both in the homes, communities and places of work. There are different types of gender-based violence which occur at different levels like within the family, community and state. Domestic violence typically occurs when a man beats his female partner. It is the most prevalent form of gender-based violence which occurs within the families and inside the homes.

The WHO estimates that at least one in every five of the world’s female population has been physically or sexually abused at some time (Population Reference Bureau, 2001). GBV arises from the patriarchal system which since time immemorial, has exerted control over women’s lives (World March of Women, 2000). It can affect the female psychologically, cognitively and inter-personally.

**Gender Based Violence:**

The UN General Assembly, in adopting the 1993 declaration on the elimination of violence against women defined gender-based violence as any art of violence that results in physical, sexual, or psychological harm or suffering to women; including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life. (Population Reference Bureau, 2001 pg.3).  

Acc. to UNFPA, GBV is defined as a phenomenon that: “…reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations, including sexual abuse of children, rape, domestic violence, sexual assault and harassment, trafficking of women and girls and several harmful traditional practices”. (UNFPA, 2013)

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**Sexual Gender Based Violence (SGBV):**
The term SGBV encompasses a wide variety of abuses that includes physical, mental, sexual, verbal and psychological abuse. Rape and sexual assault are most commonly known. It also includes marital rape, domestic violence, sexual threats, sexual exploitation, sexual harassment, physical assault, confinement, female infanticide, forced labor, socio-economic discrimination and social exclusion, harmful traditional practices such as early and forced marriage, female genital mutilation/cutting, whether occurring in public or private life.

Levels of Gender Based Violence\textsuperscript{53}:

There are three levels of gender-based violence. These are the home or family level, the community level and the state level.

Violence within the Home: Domestic Violence is the most prevalent form of GBV which typically occurs when a man beats his female partner. Violence against women within a couple and in the family consists of spousal battering, sexual abuse of female children, dowry-related violence, rape including marital rape, traditional practices harmful to women and girls like female genital mutilation and incest, non-spousal violence like a son’s violence against his mother. It is difficult to get an accurate information and account on GBV because most of the GBV occur in the private sphere – within families, inside homes and out of sight.

Violence against Women within the General Community: It includes battery, rape, sexual assault, sexual harassment and intimidation in school or work, forced treatments and abusive medication, the exploitation and commercialization of women’s bodies, contraception imposed on women by constraints or force, forced sterilization or abortions, selective abortion of female fetuses and female infanticide (World March of Women, 2000).

\textsuperscript{53}https://www.unilorin.edu.ng/publications/jekayinoluwa/12.%20Types%20and%20Causes%20Original.html
Violence against Women Perpetrated by the State: Physical, sexual and psychological violence are too often perpetrated or tolerated by states that prioritize custom or tradition over the respect of fundamental freedom. In some countries, the rise of religious fundamentalism is extremely disturbing as regards women’s right to their economic autonomy and their freedom of choice. Violence against women is also exercised as a weapon of war in situations of armed conflict. It has many forms including murder, rape, sexual slavery, hostage taking and forced pregnancy (World march of Women, 2000).

Types of Gender Based Violence:
1. **Physical**: Beating, Biting, Kicking, Restraining, Pulling Hair, Choking, Throwing Objects, Using Weapons.
2. **Psychological**: Insulting, Yelling, Recalling Past Mistakes, Constant Criticism, Expressing Negative Expectations, Humiliation, Denying Opportunities, Discriminating.
3. **Sexual**: Harassment (any type of unwanted sexual attention), touching sexual parts of the girl’s/woman’s body, touching in a sexual manner against the will of the girl/woman (e.g. Kissing, grabbing, fondling), Rape (forced sexual intercourse), use of a weapon to force into a sexual act, Forced prostitution, Sexual trafficking.

Causes of Gender Based Violence: The causes of GBV are many and varied depending on the types of violence. Traditional attitudes towards women around the world help perpetuate the violence. Stereotypical roles in which women are seen as subordinate to men constrain a woman’s ability to exercise choices that would enable her end the abuse.

Effects of Gender Based Violence: The effects of GBV can be devastating and long lasting. They pose danger to a woman’s reproductive health and can scar a survivor psychologically, cognitively and interpersonally. A woman who experiences domestic violence and lives in
an abusive relationship with her partner may be forced to become pregnant or have an abortion against her will or her partner may knowingly expose her to a STI’s.

There can be fatal results of SGBV. More common are non-fatal consequences including reproductive ill-health, physical disabilities, emotional and psychosocial disorders and negative social outcomes. The following table shows the Life Cycle of Violence against Women and its Effects on Health.

*The categories of abuse and resulting health effects listed here are representative, not comprehensive. Based on information from Watts and Zimmerman, 2002 and Campbell, 2002.

**Figure No – 2.3 The Life Cycle of Violence Against Women and its Effects on Health**
CONCEPT OF WOMEN’S REPRODUCTIVE RIGHTS

Reproductive rights are the rights relating to sexual reproduction and reproductive health. These are understood as rights of both men and women but are most frequently advanced as women's rights. The UNFPA and the WHO advocate for reproductive rights with a primary emphasis on women’s rights.

Control over reproduction is a basic need and a basic right for all women. Reproductive rights include the basic rights of all couples and individuals regardless of age, gender and other characteristics to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others. It includes the right to access to information and services to support these choices and promote and to attain the highest possible standard of Sexual and Reproductive Health.

The present study is an attempt to understand the women’s reproductive rights and how these reproductive rights will be going to improve the women’s reproductive health and are important means of women’s empowerment.

DEFINITION:

The WHO defines Reproductive Rights as: “Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and to do so and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decision concerning reproduction, coercion and violence.” 54

54. N.K. Behura & R.P. Mohanty: Family Welfare in India – A Cross Cultural Study; Published by Discovery House, New Delhi, 2005; Page 66-77
HISTORICAL BACKGROUND:

Reproductive rights began to develop a subset of human rights at the United Nation’s 1968 International Conference on Human Rights. During the 1990s, a series of important United Nations conferences emphasized that the well-being of individuals and respect for their human rights should be central to all development strategies. Particular emphasis was given to reproductive rights as a cornerstone of development.

Reproductive rights were clarified and endorsed internationally in the Cairo Consensus that emerged from the 1994 ICPD. The ICPD Programme of Action states that women are entitled to make decisions concerning family planning, STDs and ARH free of discrimination, coercion and violence which encompasses gender based that result in sexual harm.

This constellation of rights was reaffirmed in FWCW at the Beijing Conference in 1995. It acknowledged women’s right to have control over their sexuality and articulated concepts of reproductive rights and health. They include the right to voluntarily marry and establish a family, the right to decide the number, timing and spacing of children and the right to the highest attainable standard of health. These two conferences in the 1990s were critical in promoting reproductive rights.

PRINCIPLES:

The Reproductive rights are firmly rooted in the most basic human rights principles. Broadly speaking however reproductive rights encompass two principles. They are

1. Right to Reproductive Health Care: Reproductive health is a fundamental aspect of women’s well-being. Without regular access to safe, high quality services, women become vulnerable to a host of health complications which may include death or injury during childbirth, unwanted pregnancies and STI’s.

2. **Right to Reproductive Self-Determination:** The right to reproductive self-determination has support in the right to plan one’s family freely regarding the number and spacing of one’s children, the right to freedom from interference in reproductive decision-making relates to broader principles of bodily autonomy and the right to be free from all forms of violence and coercion that affect a women’s sexual or reproductive life.

**WOMEN’S REPRODUCTIVE RIGHTS:**

Attaining the goals of sustainable equitable development requires that individuals are able to exercise control over their sexual and reproductive lives. This includes the rights to:

- Reproductive health as a component of overall health throughout the life cycles for both men and women i.e. the right to life.

- Reproductive decision-making, including
  - Voluntary choice in marriage,
  - Right to equality in divorce,
  - Right to family formation and determination of the number, timing and spacing of one's children (family planning),
  - Right to have access to the information and means needed to exercise voluntary choice.

- Equality and equity for men and women to enable individuals to make free and informed choices in all spheres of life i.e. the right to
  - Non-discrimination based on gender.
  - Seek, receive and impart information.
  - Education (to allow full development of sexuality and the self)

- Sexual and reproductive security, including
  - Freedom from sexual violence and coercion and
  - The right to privacy.
  - The right to the benefits of scientific progress (e.g. control of reproduction)
SEXUAL RIGHTS:

The Platform for Action from the 1995 Beijing Conference on Women established that human rights include the right of women freely and without coercion, violence or discrimination to have control over and make decisions concerning their own sexuality including their own sexual and reproductive health. This paragraph has been interpreted by many countries as the applicable definition of women’s sexual rights.

Unlike the other three aspects of SRHR, the struggle for sexual rights includes and focuses on sexual pleasure and emotional sexual expression. One platform for this struggle is the WAS Declaration of Sexual Rights which was adopted the Universal Declaration of Sexual Rights at the 14th World Congress of Sexology. The WAS adopted eleven sexual rights as57:

1. The right to sexual freedom.
2. The right to sexual autonomy, sexual integrity and safety of the sexual body.
3. The right to sexual privacy.
4. The right to sexual equity.
5. The right to sexual pleasure.
6. The right to emotional sexual expression.
7. The right to sexually associate freely.
8. The right to make free and responsible reproductive choices.
9. The right to sexual information based upon scientific inquiry.
10. The right to comprehensive sexuality education.
11. The right to sexual health care.

REPRODUCTIVE RIGHTS AND WOMEN’S EMPOWERMENT:

Empowerment is a strategy that has as a primary goal an equitable redistribution of power and resources. The empowerment of women has been recognized through many international, regional and national conferences as a basic human right and also as imperative for national development, population stabilization and global well-being.

The reproductive rights are the important means of women’s empowerment. The sexual and reproductive rights will provide education and create awareness among the women so that they will handle their own problems in living and use their rights in attaining the highest possible standard of life in general, sexual and reproductive health in particular. Hence the Sexual and Reproductive Rights are essential for the empowerment of women and to all quality of life issues concerning social, economic, political and cultural participation by women.

The neglect or inadequate use of these rights will results in many issues concern to sexual and reproductive health which will be going to increase the maternal mortality and morbidity rate which further have direct impact on the economy of a country.
CONCEPT OF FEMINIST THEORY

Feminism refers to movements aimed at establishing and defending equal political, economic and social rights and equal opportunities for women. Feminism can be defined as “an awareness of women’s oppression and exploitation in society, at work and within the family and conscious action by women and men to change this situation”. Its concepts overlap with those of women’s rights.

Feminist theorists present several diverse perspectives on how best to increase and protect women’s rights. They mainly focus on women’s liberation through the woman’s movement which aspires to the right to control their own bodies, control and reproductive freedom, safe and better motherhood, provision for day-care of children, the right to decide whether a pregnancy should or should not be terminated. All these movements help to maintain healthy reproductive state of women and promote women’s empowerment in the field of health.

The main feminist lines of argumentation regarding motherhood and reproduction sketched since the 1970s and identify the specific shifts in their recurrent issues. The essential contribution of feminism to the understanding of motherhood as a structuring category has been its insistence on the distinction between biological and social motherhood.

Feminist discourse shows how assisted reproductive technology has further decomposed biological motherhood and has altered the meaning of motherhood and reproduction. Feminist analysis maintains that despite the rhetoric of choice surrounding these assisted reproductive technologies have not increased women’s reproductive freedoms. The decomposition of biological motherhood, medical, legal and commercial development of reproduction and the change in the social perception of motherhood have rather established new forms of control over female reproduction.
Motherhood has been one of the issues which have split feminist movements. They have regarded motherhood as a unifying element among women and have based their claims to rights for women on it. On the other hand, the issue of motherhood has also been one of the anchor points for denying women rights and equality and for discriminating against them.

Starting from this observation, the mainstream feminist discourse up to the mid-1980s took a critical approach to motherhood and regarded the rejection of motherhood as a pre-requisite for overcoming women’s subordination and for gaining equality. This position was advocated by Simone de Beauvoir already in her seminal book *The Second Sex*. She stated that “it was fraudulent to maintain that through maternity woman becomes concretely man’s equal” (de Beauvoir 1953, 525). She considered motherhood as the main feature which caused women to be seen as “others” and to tie them to immanence. She felt that women are made to see motherhood as the essence of their life and the fulfillment of their destiny (de Beauvoir 1953, 484ff.).

Motherhood is much worshiped in India. But feminist have a different idea about it. They say, “Because fatherhood is always potentially unknown and always potentially contestable, it is therefore also always a social category. Motherhood on the other hand is always known\(^59\). Feminist considers fatherhood is unknown to them and if known it is contestable. Motherhood is known but immediately after giving birth to the child, the role of mother stops here. The rest is socially constructed, although it may be and often is attributed to biology or maternal instinct. So according to the feminist, the duty and the function of the mother is just give birth to the children and then leave them off to mend their own lives by themselves, while she minds her own business. The children are left to their fate. So, the feminist do not believe in motherhood.
Feminists have regarded women’s acquisition of control over their own reproduction not only as a necessary step to individual freedom and autonomy, but also as a fundamental condition to overcome patriarchal control and to improve the situation of women as a group (Petchesky 1995; Gordon 1976). The struggle for access to free and safe abortion and for the possibility to decide their number of children without outside interference has formed the core of feminist reproductive politics for centuries. Feminists consider reproduction as the cause of women’s oppression.

Shulamith Firestone, Radical Feminists argued that gender inequality originated in patriarchal societal structures imposed upon women through their biology; the physical, social and psychological disadvantages imposed by pregnancy, childbirth and subsequent child bearing. Firestone wrote in “The Dialectic of Sex”, the elimination of sexual classes requires the revolt of the underclass (women) and the seizure of control of reproduction. The reproduction of the species by one sex for the benefit of both would be replaced by artificial reproduction. She advocated the use of cybernetics to carry out human reproduction in laboratories as well as the proliferation of contraception, abortion and support for child-rearing; enabling women to escape their biologically determined positions in society.  

Firestone said that biological reproduction is neither in women’s best interests nor in those of children so produced. The joy of giving birth is evoked so frequently in the society – is a patriarchal myth. She described that in fact, pregnancy is "barbaric" and natural childbirth is “at best necessary and tolerable,” at worst, like "shitting a pumpkin". Among the reproductive technologies she predicted sex selection and in vitro fertilization.

Liberal & Postmodern feminists maintain that Assisted Reproductive Technology (ART) provides the possibility to overcome biological
limitations to conceive and to reproduce. It offers the opportunity of motherhood to previously infertile women and it enlarges women’s choices of voluntary and willed motherhood, i.e., to have as many children as they want at the time when they would like to have them. While most feminists concede that ART may indeed help (some) women to become mothers, many nevertheless question the promise which ART supposedly holds for women’s individual and collective freedom. They argue that ART has changed the practice and the meaning of reproduction, in particular that of reproductive choice and reproductive freedom. Feminist’s view on reproductive choice has been closely linked to their perception of control over their own reproduction and of their body as their own property.  

**FEMINISTS PERSPECTIVES OF ABORTION:**

Feminist claim that the woman has the right to terminate her pregnancy without her husband’s consent as it is she who has to bear the responsibility of the new life within her. In India she has not this right for various reasons such as legal, traditional, social and cultural and M.T.P. Act 1971. As per M.T.P. abortion to be performed, the consent of women is essential except in the case of a minor or a lunatic where the consent of the guardian is required. It should be noted that the M.T.P Act of India, which totally agrees with the women’s views; was emanated at a time when the Indian feminist was not even born.

Although most feminists endorse some right to abortion, the issue of abortion cannot easily be reduced to the interests of men versus the interests of women. Women are represented on both sides of the abortion issue, as leaders, activists and supporters. Even among feminist arguments in favor of abortion there is a diversity of views as to the grounds that serve to justify it.
FEMINISTS PERSPECTIVES OF MARRIAGE:

In Indian society marriage has been regarded as the point of initiation of sexual activity and therefore the beginning of exposure to reproduction. The feminists do not believe in marriage. Acc. to some feminists, marriages is a contract and institution by which unpaid work is exhorted from a particular category of populations. Christine Delphy is to say, that a man marries a woman, just to engage her to do housework which is unpaid. When this work is done by woman outside the house, she earns wages. Hence by marriage, the woman loses her wages. Money and wages are the sole consideration of feminists. Some feminists opine that marriage is a legalized prostitution where as some feminists say that marriage is rape.63

FEMINISTS THEORIES ON REPRODUCTIVE RIGHTS:

The fight for sexual and reproductive rights has been the cornerstone of feminist activism and struggle for many decades. The second wave of feminism saw women’s organizations and feminists mobilizing around (amongst other important struggles for political and social equality) the right to abortion, access to safe contraceptives, better policies and laws to address rape, domestic violence and the eradication of female genital mutilation.64

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63. K A Kunjukkan: Feminism and Indian Realities; Mittal Publications, A-110, Mohan Garden, New Delhi – 110059; PP 136-137
64. Feminism is for everybody, Passionate politics; By Bell hooks, Library of Congress Cataloging-in-Publication Data, South end press, Cambridge, Net PDF Book. Our Bodies, Ourselves: Reproductive Rights