

Chapter-III

HEALTH CONDITIONS OF WOMEN IN INDIA

Women are the most vulnerable group in the family to diseases and the last to be treated. Women have very less control on their own lives. They have limited control on resources and their utilisation. They have very less access to knowledge and information when compared to men. Their decision making choice and power is very poor.

The common self-reported gynaecological symptoms are abnormal vaginal discharge, irregular vaginal bleeding, lower abdominal pain, infertility, menstrual problems, and genital prolapse among women of reproductive age. Self-reports of symptoms have not been found to be good predictors of morbidities, compared with clinical diagnosis. Moreover, a great majority of the women suffering from reproductive tract infections (RTIs) or other reproductive health problems may be asymptomatic. Nevertheless, some perceived gynaecological symptoms, such as vaginal discharge may constitute a heavy social burden in certain cultural settings.¹

Most of the problems, especially RTIs, that contribute to gynaecological morbidity can be cured easily if they are detected early and given proper treatment. Little demand for availability of preventive gynaecological services, such as the PAP smear or regular preventive examinations, exists, however, in most developing countries. Untreated gynaecological conditions such as reproductive tract infections can cause

¹ Sekhar Bonu and Manju Rani (2003). "Rural Indian Women's care seeking behaviour and choice of provider for gynaecological symptoms", *Studies in Family Planning*, Blackwell Publishers, Rajasthan., Vol.34, Issue 3, September, p.173.

pregnancy-related complications, congenital infections, infertility, and chronic pain. Such infections also significantly increase the risk of acquiring pelvic inflammatory disease (PID) and the likelihood of infection with HIV. In Asia, RTIs are responsible for almost 34 percent of hospital admissions for pelvic inflammatory disease.²

Data from the second round of the National Family Health Survey were used to examine the reproductive span--the duration between first marriage and menopause or sterilisation--among 4,032 ever-married women aged 15-49 living in Andhra Pradesh in 1998-1999.³

Between 1992-1993 and 1998-1999, the median age at which women married remained at 15.1, whereas the age at which they adopted sterilisation decreased from 24.5 to 23.6. In life-table analysis, reproductive spans of successive cohorts of women decreased--from 22 years among those who married during the 1960s to 15 years among those who married in the 1970s, 10 years among those who married in the 1980s and five years among those who married in 1990-1996. Proportional hazards regression analyses that controlled for demographic and social characteristics, as well as reproductive attitudes, confirmed this cohort effect. These findings suggest that women are making the decision to end childbearing faster than older generations did. The gradual compression in reproductive spans is attributable mainly to sterilisation acceptance among younger women.⁴

² *Ibid.*

³ Inge Hutter, Sabu S. Padmadas and Frans Willekens (2004). "Compression of women's Reproductive spans in Andhra Pradesh, India", *International Family Planning Perspectives*, USA, Vol.30, Issue 1, pp. 12.

⁴ *Ibid.*

A woman's reproductive span is important in understanding not only the fertility levels of a society but also a woman's or couple's reproductive planning, allocation of time for childbearing and decision to end reproduction. These reproductive decisions are socially and culturally influenced. In many developing countries, sexual relationships are initiated only after marriage, and childbearing out of wedlock is socially forbidden. In India, for example, childbearing is expected to begin soon after marriage. And because marriage used to coincide with the onset of menarche, Indian women had long intervals between marriage and menopause or sterilisation, during which they bore an average of 6-7 children, and the country's total fertility rate (TFR) was high.⁵

To predict the need for contraceptive services, family planning program managers often rely on levels of unmet need derived from measures of childbearing intentions. However, women's intention to use a method has not received as much attention as a measure of contraceptive demand. A survey was conducted in 1999 in rural Madhya Pradesh, India, among a sub sample of women who had participated in the 1992-1993 National Family Health Survey (NFHS). The women's childbearing and contraceptive behaviours were compared with the intentions they had stated in the NFHS, and logistic regression was performed to analyse the association between socio-economic and demographic variables and inconsistent behaviour.⁶

Among women who were married in 1992-1993, 29 per cent of those who intended to have children and 61 per cent of those who intended not to have children

⁵ *Ibid.*

⁶ Nizamuddin Khan, Parveen Nangia, F. Ram, T.K. Roy and Uma Saha (2003). "Can women's childbearing and contraceptive intentions", *International Family Planning Perspectives*, The Alan Guttmacher Institute, Vol. 29, Issue: 1, p.25.

failed to adhere to their intentions by 1999. Furthermore, 51 per cent of women who were not practising contraception at the time of the NFHS but planned to do so acted against their intention by 1999, as did 29 per cent of those who planned not to use a method. NFHS respondents who intended both not to have children and to use a method were more likely than others to have used a method by 1999 (63% vs. 25-41%). Age and history of child death were key factors associated with inconsistency between women's intentions and behaviour.⁷

In India, use of both contraceptive and childbearing intentions predicts contraceptive demand better than use of either indicator alone, and may thus help program planners estimate future demand for contraceptive services. Women often suffer silently with Reproductive Tract Infections (RTIs). Studies of the prevalence of these infections in South Asia have been hindered by low participation rates, and little is known about rates among the youngest married women.⁸

Many women and men suffer from Reproductive Tract Infections (RTIs), including Sexually Transmitted Infections (STIs). An estimated 340 million new cases of curable STIs occur each year, with 151 million of them in South and Southeast Asia. STIs are among the top five disease categories for which adults in developing countries seek health care, and about one-third of STIs globally occur among people younger than 25 years of age. RTIs often cause discomfort and lost economic productivity. The most

⁷ *Ibid.*, p. 25.

⁸ Sulochana Abraham , Valentina George, M.N.R. Jayapaul , Renu John , Abraham Joseph , Kathleen M. Kurz , M.K. Lalitha , Jasmin Helen Prasad & Nandini Shetty., 2005, "Reproductive tract infections among young married women in Tamilnadu, India", International Family Planning Perspectives, Washington DC, Volume: 31, Issue: 2, pp: 73

serious long-term sequelae arise in women: pelvic inflammatory disease (PID), cervical cancer, infertility, spontaneous abortion and ectopic pregnancy, the latter of which may lead to maternal death. The presence of an STI increases the risk of acquiring and transmitting HIV infection by three to five times and bacterial vaginosis may be a cofactor for HIV transmission, especially among younger women⁹

Globally, a disturbing profile has begun to emerge on the prevalence and health consequences of violence against women. For example, the World Bank estimates that rape and domestic violence together account for 5 percent of the healthy years of life lost to a woman of reproductive age in developing countries. At a global level, the health burden from gender-based violence against women aged 15-44 is comparable to that posed, in this age group, by HIV, tuberculosis, sepsis during childbirth, cancer, or cardiovascular disease. Evidence from many countries suggests that pregnant women are no less vulnerable to violence than are other women and that the consequences of violence during pregnancy range from miscarriage to low birth-weight infants to maternal morbidity and mortality.

In India, too, gender-based violence - including wife-beating, rape, sexual abuse, and dowry-related murder - is widespread, but is borne silently. Moreover, data remain limited, and little is known by way of community-based research about the magnitude and patterns of gender-based violence. Even less is known about its consequences for women's lives, health, and pregnancy outcomes.¹⁰

⁹ *Ibid.*

¹⁰ Shireen J. Jejeebhoy (1998). "Associations between wife beating and foetal infant death: Impressions from a survey in Rural India", *Studies in Family Planning*, Washington DC, Vol.29, Issue 3, p. 300.

An ambitious program of action to make reproductive health services universally available was drawn up at the International Conference on Population and Development held at Cairo, Egypt, in September 1994. Reproductive health has been defined by the World Health Organisation as a “state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”¹¹

Such a broad definition does not lend itself readily to the identification of priorities, but many experts would agree that the three main dimensions of reproductive health among adult women are: avoidance of unwanted pregnancies, safe motherhood, and protection against infections and dysfunctions of the reproductive tract, including sexually transmitted diseases. The first dimension has been thoroughly researched, particularly in developing countries, and a growing body of evidence exists on obstetric morbidity and mortality.

However, the third dimension has been badly neglected. Gynaecological morbidity can be defined as structural and functional disorders of the genital tract not related to pregnancy, delivery, or the puerperium. It includes menstrual disorders, reproductive tract infections, cervical cell changes, genital prolapse, and such other conditions as syphilis, urinary tract infections, hypertension, anemia, chronic energy deficiency (CED), and obesity.¹²

¹¹ Leela Bhagavan , Jagdish C. Bhatia, John Cleland, N.S.N. Rao (1997). “Levels and determinants of Gynaecological morbidity in a District of South India”, *Studies in Family Planning*, June, Vol. 28, Issue 2, p. 95.

¹² *Ibid.*

Strong preference for sons in South Asia is well documented, but evidence on female disadvantage in childhood feeding, health care, and nutritional status is inconclusive. Sex differentials are examined in indicators of childhood feeding, health care, and nutritional status of children under age three by birth order and sex composition of older living siblings. As per data from India's 1992-93 and 1998-99 National Family Health Surveys, three reasons are found for inconclusive evidence on female disadvantage in aggregate analyses. First, discrimination against girls is limited to the relatively small fraction of children of certain birth orders and sex compositions of older siblings. Second, discrimination against girls when boys are in short supply and discrimination against boys when girls are in short supply cancel each other to some extent. Third, some discrimination against girls (e.g., in exclusive breastfeeding at 6-9 months) is nutritionally beneficial to girls. Separate analyses for North and South India find that gender discrimination is as common in the South as in the North, where son preference is generally much stronger.¹³

A recent review of 306 child nutrition surveys from developing countries concluded that evidence on sex differentials in under nutrition does not support the notion that anti female bias in intra household food allocation and health care is causing excess female under nutrition. As Marcoux noted, “the statistical evidence tells us that, where detectable differences by sex exist, boys usually fare worse than girls by anthropometric indicators.” Sommerfelt and Arnold reached a similar conclusion after reviewing

¹³ Vinod Mishra, Robert D. Retherford, T.K. Roy (2004). “Discrimination against girls in South Asia less widespread than commonly believed”, *Population and Development Review*, Vol.30, Issue 2, East West Centre, USA, p. 269.

evidence on sex differentials in stunting, underweight, and wasting from Demographic and Health Surveys.¹⁴

Sommerfelt and Piani examined sex differences in immunisation coverage in 28 countries that participated in Demographic and Health Surveys during 1990-94 and found a “slight tendency for vaccination coverage to be somewhat higher among girls than among boys.”

A detailed review of literature on intra household distribution of food found little evidence of discrimination against girls in feeding, drawing on field data from India and a review of literature on household allocation of food in South Asia, where antifemale discrimination is believed to be widespread, found little evidence of discrimination against girls. Analysing data from a national survey in India, Mishra *et al.* (1999) found that boys and girls were about equally likely to be stunted and underweight, but boys were slightly more likely than girls to be wasted. Schoenbaum *et al.* (1995) also found no consistent evidence of differences by sex in feeding or nutritional status among children aged 0-18 months in the Gaza Strip.¹⁵

Women's vulnerability to HIV/ AIDS/ STDs

The majority of HIV cases are in the developing world. India has the greatest number of people infected with HIV - more than 4 million. Men's sexual behaviour puts women at risk. In some countries, including the US and several sub-Saharan African nations, HIV is now spreading faster among women than men. In India a study of married and monogamous women at STD clinics found a high rate of HIV and other STDs in this

¹⁴ *Ibid.*

¹⁵ *Ibid.*

apparently low-risk group .The strongest predictor for HIV infection among these women was having a husband who had been diagnosed with an STD.¹⁶

HIV and other STDs have been described as showing "biological sexism". That is, women are more susceptible physiologically to the viral and bacterial agents that cause them. As a result, men transmit infections to women more efficiently than women do to men. For example, men are eight times more likely to transmit HIV to a female partner through repeated, unprotected sexual intercourse than women are to transmit the virus to men.

STDs are more difficult to detect in women, making accurate diagnosis harder. Women are less likely than men to receive timely treatment because they may have no symptoms at first, they are embarrassed, or they cannot get to a clinic. As a result, sexually transmitted infections can progress to more serious medical conditions before women seek treatment. Thus women suffer more long-term and more painful consequences from STDs, such as ectopic pregnancy, pelvic inflammatory disease, and infertility.¹⁷

Women Are Malnourished

Gender disparities in nutrition are evident from infancy to adulthood. In fact, gender has been the most statistically significant determinant of malnutrition among young children and malnutrition is a frequent direct or underlying cause of death among

¹⁶ Megan Drennan *et al.* (1998). Population Reports published by Population Information Programme, Centre for Communication Programs, The Johns Hopkins School of Public Health, Vol. XXVI, No.2, October, No.46.

¹⁷ *Ibid.*

girls below age 5. Girls are breast-fed less frequently and for shorter durations in infancy; in childhood and adulthood, males are fed first and better. Adult women consume approximately 1,000 fewer calories per day than men according to one estimate from Punjab. Nutritional deprivation has two major consequences for women: they never reach their full growth potential and anaemia. Both are risk factors in pregnancy, with anaemia ranging from 40-50 percent in urban areas to 50-70 percent in rural areas. This condition complicates childbearing and result in maternal and infant deaths, and low birth weight infants. Besides posing risks during pregnancy, anaemia increases women's susceptibility to diseases such as tuberculosis and reduces the energy women have available for daily activities such as household chores, childcare, and agricultural labour. Any severely anaemic individual is taxed by most physical activities, including walking at an ordinary pace.¹⁸

Women Are in Poor Health

A primary way that parents discriminate against their girl children is through neglect during illness. When sick, little girls are not taken to the doctor as frequently as are their brothers. As adults, women get less health care than men. They tend to be less likely to admit that they are sick and they'll wait until their sickness has progressed before they seek help or help is sought for them. Studies on attendance at rural primary health centres reveal that more males than females are treated in almost all parts of the country, with differences greater in northern hospitals than southern ones, pointing to regional differences in the value placed on women. Women's socialisation to tolerate suffering

¹⁸ Carol S. Coonrod (1998). "The Hunger Project Empowering women and men to end their own hunger Chronic Hunger and the Status of Women in India", New York, June, p.8.

and their reluctance to be examined by male personnel are additional constraints in their getting adequate health care.

Anemia continues to be a major public health problem worldwide, particularly among females of reproductive age in developing country settings. In 1992, World Health Organisation global estimates of anemia prevalence averaged 56 per cent, with a range of 35-75 per cent depending on geographic location World Health Organisation 1992 (WHO, 1992). Prevalence of anemia in South Asia is among the highest in the world, mirroring overall high rates of malnutrition.

In India, recent nationality representative data from the National Family Health Survey 1998/1999 (International Institute of Population Sciences and ORC Macro 2000) on anemia of women of reproductive age describe the magnitude of the problem. More than one third of Indian women have a body mass index (BMI) $<18.5 \text{ kg/m}^2$, reflecting chronic energy and micronutrient deficit. The prevalence of anemia among all women in the Indians is 52 per cent.¹⁹

The consequences of anemia for women include increased risk of low birthweight or prematurity, perinatal and neonatal mortality, inadequate iron stores for the newborn, increased risk of maternal morbidity and mortality, and lowered physical activity, mental concentration, and productivity. Government is now establishing Nutritional Rehabilitation centres in some hospitals as there are around 3.22 lakhs of children with malnutrition and anemia.

¹⁹ Bentley, M.E. and Griffiths, P.L. (2003). "The burden of anemia among women in India", *European Journal of Clinical Nutrition*, pp.52-60.

Anemia among women in this large southern Indian state Tamil Nadu cuts across social class, place of residence, and other factors that normally discriminate health status. Rich or poor, fat or thin, urban or rural - the prevalence of anemia is high among women in all these groups and differences are only relative. More than 40 per cent of women in the highest socio-economic group are anemic, as are 62 per cent of urban poor and 54 per cent of rural poor women.

Maternal Mortality

India's maternal mortality rates in rural areas are among the highest in the world. The estimates nationwide are that only 40-50 percent of women receive any antenatal care. It is estimated that pregnancy-related deaths account for one-quarter of all fatalities among women aged 15 to 29, with well over two-thirds of them considered preventable. For every maternal death in India, an estimated 20 more women suffer from impaired health.

“About 24.6 million couples, representing roughly 18 percent of all married women, want no more children but are not using contraception. The causes of this unmet need remain poorly understood, but a qualitative study in Tamil Nadu suggests that women's lack of decision-making power in the family, opportunity costs involved in seeking contraception, fear of child death, and poor quality of contraceptive service all play an important role.”

Some estimates suggest that some 5 million abortions are performed annually in India, with the large majority being illegal. As a result, abortion-related mortality is high. Although abortion has been legal since 1972 in India, “studies suggest that although official policy seeks to make pregnancy-termination services widely available, in practice

guidelines on abortion limit access to services, particularly in rural areas. In 1981, of the 6,200 physicians trained to perform abortions, only 1,600 were working in rural areas.”²⁰

The tasks performed by women are usually those that require them to be in one position for long periods of time, which can adversely affect their reproductive health. A study in a rice-growing belt of coastal Maharashtra found that 40 percent of all infant deaths occurred in the months of July to October. The study also found that a majority of births were either premature or stillbirths. The study attributed this to the squatting position that had to be assumed during July and August, the rice transplanting months.

Selective Abortions

The most extreme expression of the preference for sons is female infanticide and sex-selective abortion. A study of amniocentesis in a Bombay hospital found that 96 percent of female fetuses were aborted compared with only a small percentage of male fetuses. Government officials even suspect that the disproportionate abortion of female fetuses may be a major underlying cause of the recent decline in the nation’s sex ratio.

Sonalda Desai reports that there are posters in Bombay advertising sex-determination tests that read, "It is better to pay Rs.500 now than Rs.50,000 (in dowry) later.”

Government has passed legislation to curb the misuse of amniocentesis for sex selection and abortion of female fetuses. Women activists have been critical of this act

²⁰ Carol S. Coonrod (1998). “The Hunger Project Empowering women and men to end their own hunger Chronic Hunger and the Status of Women in India”, New York, June, p. 7.

because of its provision that calls for punishing the women who seek the procedure. These women may be under pressure to bear a male child.

With globalisation women are over burdened with multi-tasking. They have very less time for taking treatment also. The new role as job maker or bread winner is no way decreasing the burden of household work. Thus they are vulnerable to health ailments.

In rural India, women continue to work on chullahs, which produce smoke and cause drudgery. Many types of cancers are today's threat to women. Especially they are more susceptible to breast cancer and cervical cancer. Changing scenario and increase in pressures are creating cardiac problems too to women.
