

Reproductive Health Of Women In India During The Last 50 Years

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Reproductive health (RH) is the term which covers all aspects of women's health from childhood and adolescence through reproductive age, menopause and beyond. It is influenced by gender equity, education-including health education, sexual behaviour, fertility control, maternity care, reproductive tract infections and genital cancer. In the last 50 years, population of India has increased 3 fold. Reproductive mortality, both maternal and infant, has not decreased appreciably. Key to RH is education, as better the female literacy and education, better the reproductive health and lower the reproductive mortality, as seen in Kerala. RH can be improved by better fertility control and fewer wanted pregnancies with 100% coverage especially during child birth. In the last 50 years, reproductive tract infections are on the increase, including HIV. The increased incidence of cervical and breast cancer require more facilities for early diagnosis and treatment. It is hoped that with gender equity and education women in India will have better reproductive health in the new millennium.

The World Health Organization defines Reproductive Health (RH) as a state of complete physical, mental and social well-being and not a mere absence of disease in relation to reproductive processes, systems and practices at all stages of life (WHO, 1994). Thus it covers

all aspects of RH across a life span (from the cradle to the grave-childhood to adolescence, reproductive period to menopause and the elderly age) as what happens in adolescence affects her reproductive functions later, and the injuries and infections (e.g. by HPV) occurring in the reproductive epoch may result in genital prolapse and cancer in the postmenopausal age. RH includes human sexuality and fertility control, safe motherhood and child survival, prevention and treatment of reproductive tract infections (RTI), menopausal problems and prevention and treatment of gynaecological cancer. The female illiteracy, gender inequity, malnutrition, uncontrolled fertility, poor maternity care services and RTI all adversely affect RH resulting in high reproductive morbidity and mortality rates often seen in the developing world.

Human sexuality: Human Sexuality influences thoughts, emotional feelings, interactions and actions contributing to the motivation to seek love, contact, warmth, intimacy, peace and happiness. Good sexual health results from responsible sexual behavior by both the partners, when there is no fear of an unwanted pregnancy or any disease. Any unsafe sexual behavior at any age leads to reproductive ill health.

Adolescent health: Adolescents or teenagers form 20% of India's population. Adolescence is the most critical period of life when adequate nutrition, physical activity (sports) and education including sex education are necessary for further development of physical, emotional and mental growth so as to prepare them for professional, social or reproductive life later on. With sexual and reproductive maturation, any sexual misadventure may jeopardize RH as a result of unwanted pregnancy and unsafe abortion or expose her to a risk of STD including HIV. Fifty years ago a conservative society, parental supervision and early marriage might have prevented such temptations. But in the last 2 decades constant bombardment of adolescent sexuality by films and other

media, peer pressure, poverty or employment away from home might have been responsible for the increasing number of unmarried teenagers reporting at the MTP clinics in India (Mukherjee, 1999). Therefore there is an urgent need for sex education in schools and colleges to protect and promote adolescent health. Sex education does not increase sexual promiscuity; on the other hand, it is protective and preventive.

Fertility Control: In the last 50 years uncontrolled fertility with high birth rates and declining death rates have led to a population explosion. The decennial growth exceeded 20% till recently, resulting in the country's population of 360 million 50 years ago, doubling in 3 decades and tripling in less than 2 more decades to surpass 1 billion by 2001 (Table I). This demographic revolution necessitated a contraceptive revolution. Though India was the first country to declare family planning as a national program in 1951, for several well known reasons, it has miserably

Initially, the vasectomies far exceeded tubal ligations reaching a peak of 6 millions in 1975 partly due to mass campaigning but mostly due to coercion leading to numerous complications, including political. Following this the number of vasectomies declined steeply, and in the last 2 decades 90% of sterilisations have been tubal. Fortunately, the advent of laparoscopic tubal sterilisation, has helped to achieve 4 to 5 million sterilisations a year. To ensure recanalisation in those occasional cases who demanded it due to loss of a child or re-marriage, the government has established several centres for microsurgery for recanalisation of the tube or vas. The low dose oral pill was not initially favoured, but is gradually picking up now. The long acting injectables are used in our research centers but their general use as well as that of the implants have been opposed by the women's groups. In 1997, of the 43.5% contraceptive acceptors 30.3% were sterilisations,

Table I.
Reproductive Health In India: Some Parameters 1951 — 2001

	1951	1961	1971	1981	1991	1996	*2001
Popln(in Mil)	361	435.2	548.2	685.2	843.9	934	1012
Contraceptive Prevalence (%)	< 5	—	10.4	22.8	43.5	45.4	51
CBR per 1000	40.8	39.3	37.1	37.2	29.5	27.4	24.0
CDR per 1000	25.1	18.9	17.0	19.0	9.8	8.9	—
TFR	6.0	5.7	5.0	4.5	3.8	3.5	2.9
Life Expectancy at birth (Yrs)	36.7	43.5	50.5	55.4	58.3	59.4	62.3
IMR per 1000 LB	148	138	120	110	80	72	56
MMR per 100 000	2000	—	600	500	500	450	300

* Estimates

Source: Reg. Gen India; Dept of FW, MOH, 1999.

failed to stabilise its population thus upsetting all developmental plans.

In the fifties, perhaps less than 5 percent used contraception. The government promoted sterilisations, in those with 2 or more living children and in others the condom. In the mid sixties, a massive drive of Lippe's loop- insertions with poor screening and follow-up resulted in the loop falling into disrepute and the IUCD program had to be salvaged by CuT-200 in the early seventies. The postpartum program started in 1969 was quite popular,

6.3% IUDs, 2.9% CC and 2% oral pills (Family Welfare Year Book, 1992-93). For the last 6 years the incentive based, target oriented family planning program has been replaced by MCH parameters, with wider choice of contraceptives and better follow up aimed mainly to promote RH and not just to achieve demographic targets. It is hoped that by the year 2002, the number of contraceptive acceptors will exceed 55% and reach 60% by 2011, most of them using effective temporary methods.

Emergency contraception (Norgestrel 750 mg)

taken orally twice at an interval of 12 hours within 72 hours of unprotected coitus is very effective and when introduced in the campaign is likely to eliminate thousands of unwanted pregnancies and unsafe abortions.

Abortions: The MTP Act was passed in 1971 to prevent an estimated 6 to 8 million unsafe abortions per year with the attendant risks. However for the last 20 years, the number of MTPs have been static at 0.6 million per year. Over 85% of these abortions are in parous women and 5-8% in the teenagers. It is tragic to find that despite a very liberal abortion law over 10,000 mothers die annually due to unsafe abortions, supporting the view that a large number of women in the rural areas are either unable to avail of effective FP methods or safe abortion facilities. When RU 486 is introduced into the market, it is hoped that most early abortions will be carried out by this non-invasive method.

Reproductive Period: A woman is most vulnerable during pregnancy, delivery and soon after, so also is her child during the perinatal period and in infancy. The risks are greater when the pregnancies occur too late, too close, too early or too many; or in the absence of prenatal care, a 'skilled attendant' at birth or an organized referral system. 'Skilled' persons include doctors (specialist or not) and persons with formally recognized midwifery skills (nurses and midwives), and excludes traditional birth attendants or TBAs whether trained or not (WHO, 1996). Fifty years ago, the MMR in India was 2000 per 100,000 live births; (Bhore Committee report, 1947) but it declined in the next 2 decades to 800, only to stagnate around 500 in the last 3 decades. In Sri Lanka, the MMR was equally high in 1945, but declined to 550 in 1955 to 239 in 1965 and to 95 by 1980 and finally to 30 by 1994 mainly due to the trained midwives being made available to look after each delivery and supported by a functional referral system for the high risk pregnancies and emergencies in labor (WHO, 1999). Most maternal deaths are preventable. The important causes of these deaths in India are hemorrhages of pregnancy, anemia, toxemia, sepsis, abortion and

obstructed labor (Table II). Besides lack of health education, primary maternity care services are not well organized in the country. Even now almost 50% of the pregnant get no antenatal care, two-thirds of deliveries are not supervised by skilled attendants and 3 out of 4 deliveries occur at home. There is no proper risk screening of pregnant women and a functioning referral system. The Safe Motherhood Program started in 1992 in India with one First Referral Unit (FRU) for every 500,000 population or 4-5 per district and is estimated to cover the whole country by 2000. However we require tens of thousands of trained midwives to have 100% coverage of antenatal care and to supervise each delivery. Our referral system is still not functional as we need thousands of doctors trained in essential obstetric function besides an anaesthetist at the Community Health Centre (CHC) level. In 1996, over 50% of the sanctioned CHCs were not ready, 10% of ANMs and over 50% of nurse midwives and specialists, though sanctioned were not available at the CHC. (RHS Bulletin, 1996).

Table II.

Causes Of Maternal Deaths In India

Causes	1978*	1987*	1997+
Haemorrhages	18.2	27.9	27.6
Anaemia	14.6	17.8	17.3
Abortions	11.0	7.6	7.3
Toxaemia	21.2	6.6	6.6
P. sepsis	12.4	10.7	13.0
Obst. labor	9.5	10.1	10.7
Others	13.1	19.3	17.5
Total	100.0	100.0	100.0

Source: *FW Year Book (1989-90).

+Reg. Gen India, 1999.

Maternal Deaths

1% of total deaths.

2.5% of all deaths in Female.

12.5% of all deaths in Female (15-44) age groups.

Currently, the perinatal mortality rate is about 50 per 1000 and 60% of deaths in the infants occur neonatally. The IMR has decreased from 144 in 1960 and to 69 in 1998, similarly the under 5 mortality rate also has decreased from 236 in 1960 to 105 in 1998 (Unicef, 2000).

III. Indicators Of Reproductive Health In India, Kerala & Uttar Pradesh

	*F.lit (%) (1991)	+CBR (1996)	+TFR (1994)	+Tr.att. at birth (1996)	Instnal deI (1996)	*IMR (1997)	*MMR (1997)
INDIA	39	27.4	3.5	52	40	71.2	408
KERALA	87	17.8	1.7	98	97	12.2	87**
UTTAR PRADESH	25	24.0	5.1	20	12	85.5	707

* Reg. Gen India

** UNFPA, 1999.

+Dept of FW, MOH, 1999.

The low birth weight rate has remained stable at 30% in the last 3 decades despite attempts to reduce it. Important causes of neonatal mortality are birth trauma/ anoxia, tetanus, sepsis, prematurity and pneumonia. The essential neonatal care at the periphery has to be strengthened for the prevention of neonatal anoxia and hypothermia and promotion of breast feeding and immunisation.

A comparison of important RH indicators in India and the states of Kerala and Uttar Pradesh (Table III) shows that the standard of RH is not uniform. It is far from satisfactory in the states like Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar and Orissa. The key to the RH is female literacy or education and a small well-spaced family (TFR of ³ 2). Most important predictor of maternal mortality is the percentage of births attended by "trained or skilled" persons. Every delivery need not be institutional though such deliveries are safer for all primis and high-risk cases. Higher the female literacy rate, smaller the family and better the RH. When every delivery is conducted by a 'trained' person (as defined earlier) the reproductive mortality rates are very low as exemplified by Kerala and Sri Lanka.

Reproductive Tract Infections (RTI) & Infertility:

Permissiveness, pill, promiscuity and multiple partners predispose to RTI/STD. The condom is more protective. The spectrum of STD has changed in the last decades with the Chlamydia as the predominant infective organism leading to infertility, ectopic pregnancy, pelvic

inflammatory disease and pelvic pain. Important sexually transmitted viral infections are Herpes simplex, Hepatitis B Virus, Human Papilloma Virus and in the last 20 years, HIV. The HIV is currently seen in epidemic proportions in India. Over 4 million are now infected with HIV in India. Due to its vertical transmission in the mother, it is estimated that about 40,000 infected infants are born each year (Rao, 1999).

Infertility is seen in 6 to 8% of women in India and is mostly due to salpingitis. Tubal microsurgery which was a popular treatment 25 years ago for tubal block has been now replaced by IVF-ET. The vaccine against Chlamydia when available will certainly be preventive.

Menopausal problems: During the last 50 years besides the rapid growth in population there has been an increase in the longevity of life at birth (Table I), with women outliving their partners by 2 to 3 years. Longevity of life at birth which was 37.2 years for male and 36.2 for female in 1951 has gone up to 55.5 and 59.7 respectively in 1996 and is expected to increase to 67.04 and 69.18 years respectively in male and female in 2016 (Report of Tech Comm pop Proj 1996). Thus when they add 'years to life' it is necessary for us to help them to add 'life to years'. There will be a need for Hormone Replacement Therapy (HRT) in selected cases. There will also be increases in cases of genital prolapse, cardio-vascular and cerebro-vascular diseases and genital cancer.

Cancer in Women: In the Indian female, the commonest site of cancer is the cervix (23.5%), followed by breast (19.3%), and mouth and esophagus (8.3%) (Rao and Ganesh, 1998). According to Murthy et al (1990) there will be an increase of 47,000 cases of cancer cervix and 27000 of breast cancer by 2001 compared to 1986. To detect them early and treat them promptly and adequately we require a lot of infrastructure and manpower.

Gender Inequity: Gender Inequity is against human rights and is known to adversely affect RH. In India, discrimination against women exists from the womb to the tomb — female foeticide, and infanticide, domestic violence, bride burning, gang rape, forced prostitution etc, in spite of stringent laws. The sex ratio (no. of female per 1000 males) at successive censuses reflects the growing problem of gender inequity. The sex ratio of 972 in 1901 had declined to 946 in 1951 and to 927 in 1991. These 'missing millions' of females could be explained by the female infanticides, dowry deaths, maternal deaths and deaths due to domestic violence. In 1998 alone Uttar Pradesh reported over 2000 dowry deaths.

The declaration of the ICPD, Cairo, 1994 provides gender equity, empowerment of women and elimination of all forms of discrimination against women. It assures them the right to sexual health and control of their own fertility, to decide the number and spacing of their children and the right to safe motherhood. The laws must protect the sexual health and RH of women as much as that of men as the human rights law guarantees equality between sexes. As the government of India is a signatory to the ICPD declaration, it is committed to restore gender equity and translate rights in human sexuality and reproduction into laws so that women can enjoy RH as much as men do.

Has the progress in RH been satisfactory in last 50 years?

We have failed to achieve the national health policy goals in RH for the year 2000. In India family planning acceptance has increased 4 to 5 folds in last 5

decades, but it is estimated to reach the TFR of 2.1 only by 2026. But Uttar Pradesh will take well beyond 2100 to reach this level. (Report of Tech Pop Proj, 1996). In 1951 we were having 4 infants dying every minute and 1 mother every 2 minutes compared to 3 infant deaths every minute and 1 maternal death every 5 minutes in 1996. Our tragic situation needs immediate correction by strengthening the community obstetric services including emergency obstetric care besides 100% prenatal coverage.

We hope that with better education, empowerment, gender equity and well organised community RH care services available the women in India will have smaller, healthier families and will enjoy better Reproductive Health than ever before at least by 2050.

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