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Reproductive Health and Women: A Review of Literature

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Abstract: *In the last decade or so the subject of reproductive health of women has generated much literature. This review attempts to examine the quality of information in important contributions to the field, providing also a picture of women's reproductive health status, state interventions and their outcomes.*

Historically, the principal duty of women has been viewed as bearing children, particularly sons, and serving as the foundation of families. The cost to the women's health of discharging this duty goes unrecognized. In the discussion on the low status of women, their contribution to the unorganized sector and their invisibility in their productive roles is often discussed. The Government of India therefore appointed a commission to inquire into the conditions of women working in the unorganized sector, which brought out a detailed report describing the conditions of the women [Government of India, 1975]. Several efforts are also made to discuss women's invisibility in data. However greatest invisibility of women prevails in health issues. Health is the basic need of a human being and therefore denying women their health needs has affected seriously their productive and reproductive roles. It has also to be noted that the health and well being of the members of a family is far more dependent on the productive capacities of the woman than that of any other member of the family.

At the Alma Ata conference in USSR, in 1978, primary health care was exclusively discussed by 134 countries and access to family planning, maternal and child care and prevention of common diseases was accepted as a basic human right [WHO 1978][33].

Women play an enormous part in maintaining the health care system through their caring work at home, in the family, in the neighborhood and in the health professions, as nurses, midwives, physicians, etc. At present, more than ever, the health services depend on the caring work of women, and their skills and capacities. Yet the development is not matched by women's participation in the health-care decision making.

Generally there has been medicalisation of women's normal life and bodily functions, such as menstruation, menopause etc., or social issues are seen as medical problems requiring medical solutions. This has resulted in shifting the control from an individual to the medical profession. This means serious of control over and confidence in women's own capacities and in there own bodies [WHO 1985][34].

Reproductive health care strategies to meet women's multiple needs include education for responsible and healthy sexuality, safe and appropriate contraception and services for sexually transmitted diseases, pregnancy, delivery and abortion. [Sai and Nassim 1989][22]. Such an approach accepts that the reproductive health issues of women are inextricably bound with their reproductive rights and freedom. However, even in discussions on primary health care there is hardly any mention of the reproductive health problems of women. In developing countries, currently women are the main targets of the population control policies. This is in keeping with the prevalence of patriarchal attitudes and social structures. It is also in keeping with the interests of the population lobbyists who are more interested in reduction in numbers than protection of quality of life of third world people. USAID's office of population speaks publicly of integrating family planning within a broader health care framework. It argues privately that family planning should not be "held hostage" to strict health requirements and that maximum access to contraceptives should override safety and ethical concerns.

Women's rights and population control are not inherently compatible. The use of targets, incentives and experimental contraceptives in the context of deepening poverty and patriarchy, makes family planning a tool for women's victimization rather than liberation. Financial incentives offered to poor people to accept sterilization, IUD insertions or hormonal contraceptives make genuine reproductive choice a fiction. There is no universal meaning for reproductive rights. The meaning is always contingent upon political and social context. The meaning of reproductive rights has to be integrated with economics, race, gender and class.

In this context it is important to note the WHO definition of reproductive health. Within the framework of WHO's definition of health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, "reproductive health addresses reproductive processes, functions and systems at all stages of life. Reproductive health therefore implies that people are able to have responsible, satisfying, an safe sex life and that they have capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights, of men and women to be informed of, and to have access to safe, effective and affordable and acceptable methods of fertility regulation of their choice; 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" [WHO 1978: 32] [33].

The WHO further adds, "The basic elements of reproductive health are: responsible reproductive/sexual behavior, widely available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infections (including sexually transmitted diseases) prevention and management of infertility, elimination of unsafe abortion, and treatment of malignancies of reproductive organs. Furthermore, reproductive health affects, and is affected by other aspects of health, most particularly HIV infection/acquired immuno deficiency syndrome (AIDS), nutrition, infant and child health, adolescent health and sexuality, lifestyle and environmental factors. Pervading and affecting all aspects of reproductive health are various social and cultural factors, but especially the status of women in society".

Such a definition ignores the reproductive health of women who do not wish to 'accomplish reproduction'. It also makes fertility regulation mandatory as a part of health. Major emphasis of the WHO discussion is on maternity and related situation and very little is said about other conditions that seriously affect women's health.

Women get mentioned in the programs for reducing high infant and child mortality. However they hardly receive attention in matters of their own health. Available data show that the range of infant mortality rates worldwide is between four (in Japan) and 173 (in Mozambique and Angola) for 1000 births. Whereas for maternal mortality it is between four (in Denmark) and 1710 (in Bhutan) for 1,00,000 births [Grant 1991: 102-103, 114-115] [7]. Thus the ratio of the lowest rate to the highest was 1:43.5 for IMR, whereas it was 1:427.5 for maternal mortality. Thus, far greater variation prevails in conditions that govern women than those that govern infants.

Generally the discussion on women's health gets much more attention in the context of illness and death during pregnancy, childbirth and to some extent issues related to contraceptive use. However to concentrate on reproductive health of women who are sexually active is limiting the understanding of the problem. Also, many of the problems arising during the reproductive years or related to reproductive performance of women are rooted in their life before they become sexually active and women suffer beyond their active life. The foundations for the reproductive health of women are laid in childhood and adolescence, and are influenced by factors such as nutrition, education, sexual roles and social status, cultural practices and the socio-economic environment.

Women's health is seen only as means to achieve other social goals rather than end in itself. Women's needs are either unserved or are underserved and women suffer from several problems with the key aspects of sexuality and reproductive health such as reproductive tract infections, infertility, morbidity due to childbirth and violence against girls and women.

[Macklin 1989][16] States that there are three fundamental ethical principles in women's right to reproductive freedom. These are liberty, which guarantees a freedom of action; utility, which defines moral rightness by the greatest for the greatest number; and justice, which requires that everyone has equitable access to necessary goods and services, Under this framework, governments have an obligation to provide information and services for women to exercise their right to reproductive freedom. Feminist argument for reproductive freedom is based on rights to equality, self-determination and human dignity.

Perhaps most important, because it is generally ignored and denied, is the women's right to enjoy sexuality separate from reproduction, and free from fear of negative consequences, on an equal footing with men. The fact that sexual enjoyment, need not lead to procreation is easily accepted for males, but not for females. In framing policies the women's needs are quite often forgotten because by and large, laws and social policies that affect reproductive health and rights have been shaped by men. Women have internalized pain and suffering emanating from sexual and reproductive roles and they are considered to be the very essence of womanhood.

Poverty, unhygienic living conditions and several socio-cultural taboos cause health problems and a 'culture of silence'. Reproductive tract infections (RTIs) are common among the third world women and they have serious consequences for men and children as well. Illnesses and deaths due to complications of pregnancy, childbirth, unsafe abortions, diseases of reproductive tract, effects of harmful contraceptives, are the major causes of ill health of women.

Reproductive Tract Infections (RTIs) include three types of infections. (1) Sexually transmitted diseases (STDs) such as chlamydial infection; gonorrhea, trichomoniasis, syphilis, chanchroid, genital herpes, genital warts and human immuno deficiency virus (HIV) infection. (2) Endogenous infections, which are caused by overgrowth of organisms that can be present in the genital tract of healthy women, such as bacterial vaginosis and vulvovaginal candidiasis; and (3) Iatrogenic infections, which are associated with medical procedures, such as delivery, abortion, IUDs and effects of contraceptives such as oral pills. All these infections are preventable or treatable causes

of infertility, ectopic pregnancy, cervical cancer, foetal wastage, low birth weight, infant blindness, neonatal Pneumonia and mental retardation. They facilitate transmission of HIV. [Wasserheit N and King 1992].

Men also suffer from reproductive health problems, especially the sexually transmitted diseases (STDs). For several reasons however the suffering of women is far greater. [Jacobson (1991, p 6)] [12] says that the reasons for these are:

1] Women alone are at risk of complications of pregnancy and childbirth.

2] Women face higher risk in preventing unwanted pregnancy: they bear the burden of using and potential side effects from most contraceptive methods, and they endure the consequences of unsafe abortion.

3] Women are more vulnerable to contracting and suffering from complications of many STDs. Because the semen is retained in the reproductive tract of the woman, there are greater chances of the woman contracting infection from the infection partner, in contrast to such chances for the man from an infected partner.

Every stage in the complex process of reproduction is vulnerable to damage from environmental factors. The costs of such injuries are often high, and include sub-fertility, intrauterine growth retardation (IUGR), spontaneous abortion, and various birth defects. Moreover, the human reproductive process can be harmed by a tremendous range of complex and multifactorial environmental influences. Infectious diseases, malnutrition and poor living conditions are important causes of reproductive health problems in developing countries. In richer countries chemical pollution, radiation, and stress have become major threats [WHO 1994 p 48][37].

Recently there have been reports of secular declines in sperm concentration and sperm count during the last 50 years, which some scientists have attributed to environmental factors. Analyses reveal that mean sperm density of human semen has fallen from 113 million/ml in 1940 to 66 million/ml in 1990, and mean seminal volume per ejaculate declined from 3.40 ml to 2.75 ml. There is also some concern that this decline in semen quality and quantity has been coupled with an increase in frequency of testicular abnormalities. Although the effect of the environment on human fertility is not directly related to fertility regulation, it would be necessary to study such effects in the next decade, as they would have a bearing on the reproductive health of the coming generations [WHO 1994, p 49][37].

In women most RTIs originate in the lower tract as vaginitis, cervicitis or genital ulcers. If untreated they may ascend into the upper tract to cause pelvic inflammatory disease or PID (endometritis, salpingitis, oophoritis, parameteritis, or pelvic peritonitis). Some types of genital ulcer disease may spread to the blood stream to cause systemic infection. RTIs are also caused by overgrowth of organisms, which are normally present in the reproductive tract (bacterial vaginosis and vulvovaginal candidiasis).

In several developing countries women are the targets of the population control policies and the effort to reduce the infant and child mortality. Consequently the family planning programs as well as the programs for child survival do not attend to the needs of women. Inadequate antenatal care, poor and unhygienic attention at childbirth, and unsafe abortions, continue inspite of known risks. It is reported that the women in Africa have 1:21 chance of dying due to pregnancy related causes, whereas the same for women in Asia is 1:54 and in South America it is 1:73, in North America 1:6366 and in Europe the chance is 1:9850 [Starrs 1987][25].

Cultural restrictions on woman's personal freedom limit dramatically her access to health care. Women's mobility under these conditions is severely restricted. Having male doctors and health care workers limits women's ability to avail of their services. Male dominance in sexual relations and non-access to contraception makes women have no control over their pregnancies and childbirth's and on contracting diseases. Over and above this the government policies and indifference to the health of the women compound the problems for women.

[WHO 1986] [35] Estimates that annually 5,00,000 maternal deaths take place and the largest number of them 3,08,000 takes place in Asia, followed by 1,50,000 in Africa, 34,000 in Latin America, 6,000 in all the developed countries considered together and remaining 2,000 in Oceania. Global incidence of severe maternal disease amounts to 'approximately 7 to 10 million cases per year. This incidence includes only severe chronic or long lasting diseases like fistulae, severe infections, prolapse conditions and lacerations (tissue destruction) in the birth canal. It does not include cases of anemia; transient pregnancy related disorders and curable infections [Bergstrom 1994][3].

Among the causes of maternal mortality are: hemorrhage, sepsis or infection, toxemia, obstructed labor and the complications of an unsafe abortion. About 75 percent of the maternal deaths occur due to these five causes and remaining 25 percent take place due to 'indirect' causes, i.e. complications of pre-existing illness such as malaria, tuberculosis, heart ailment etc. Hepatitis can lead to hemorrhage or liver failure in pregnant women. STDs may be activated due to pregnancy and may harm the pregnant

woman and the foetus, anemia, which is rampant among third world women, also complicates the outcome of the 'pregnancy [Ascadi and Johnso-Ascadi 1990][1]. Anemia may increase the risk of dying in childbirth by a factor of four: severe anemia is associated with an eight-fold risk of death during pregnancy [De-Maeyer and Adiels-Tegman 1985]. Complications of anemia increase with age and repeated pregnancies. Increasing family size reduces the nutrition that the woman receives and with the increasing work burden and blood-loss during menstruation results in higher incidence of anemia. The physical effects of anemia result in debility and lack of resistance, leading to pregnancy-related-problems such as cervical trauma, toxemia, ruptured uterus, infection and hemorrhage [Ascadi and Johnson-Ascadi 1990][1].

A study in India, in the 1970s, found that for every maternal death there were 16.5 cases of illness related to pregnancy, childbirth, and puerperium. [Dutta et al 1980][6]. From one gynecology clinic in northern Nigeria it is reported that 300 young women a month are treated for the repair of vasico-vaginal fistulae, while in other areas the waiting list is said to be 1000 women [Tahzib 1989][26]. A majority of the women, so handicapped are cast out by their husbands, with no support and often turn to prostitution or die a slow, difficult death. In the same area in Nigeria, it has been estimated that for every woman who died as a result of childbirth, about 15 suffered permanent handicap [Harrison 1985][8].

Abortion is widely resorted to and many women take recourse to unsafe abortions at the hands of untrained persons. Mortality in legal abortions that are performed therapeutically is estimated to be 2 per 1,00,000 procedures in Industrialized countries and 6 per 1,00,000 in Developing Countries [Hogbers 1985][9]. But clandestine abortions give rise to very high mortality -- 50 deaths per 1,00,000 procedures in developed countries and about 400 deaths per 1,00,000 procedures in developing countries [Hogbers 1985][9]. Doubts are expressed about the incidence of deaths in the developing countries and the figure of 400 is feared to be a gross underestimate. Khan (1986) reports 10 deaths in 412 procedures, giving a death rate of 2,400 per 1,00,000 procedures. Poor women more often resort to such clandestine abortions. In Latin America it is estimated that about one in three women has had an abortion and upto 50 per cent maternal deaths are due to complications associated with abortions [Hogbers 1985][9]. In Asia, about 20 to 25 per cent maternal deaths are attributed to poorly performed abortions [Khan 1985][14] and [Rochat 1981][21]. In Africa, hospital studies show that abortion-related deaths are reported to be increasing. More than 25 percent in Lusaka, Zambia [Rochat 1985][20] and more than 20 percent in Benin City, Nigeria [Unuigbe 1988] [27] are due to abortion complications. A population-based study conducted in Addis Ababa, Ethiopia, revealed that 50 per cent of the maternal deaths resulted from illegal abortions [Kwast 1986][15].

Reproductive tract infections (RTIs) are syndromes that cause acute physical discomfort, personal embarrassment and marital discord. RTIs compromise women's ability to achieve and sustain pregnancy as well as to produce healthy children. RTIs have a great impact on a woman's status within her family and her community, and more significantly, on her physical comfort. Ironically the current fears of the spread of AIDS has done more to focus attention on the importance of RTIs in reproductive health than all the data linking bacterial cervicitis and vaginitis syndromes with infertility, ectopic pregnancy, chronic pelvic pain, cervical neoplasia and adverse outcomes of pregnancy [Wasserheit 1989a][29]. So even 'safe sex', advised as a measure to avoid AIDS, cannot reduce these problems that women face.

RTIs are caused by a variety of bacteria, viruses and protozoa and they originate in the lower reproductive tract, which begins at the external genitals and extends to the cervix. In the absence of treatment, the infections can spread past the cervix to the upper tract, affecting the uterus, fallopian tubes and overies. AIDS caused by a blood-borne or 'systemic' virus that can enter the body in a variety of ways is not an RTI. It is related in that it too, is often sexually transmitted. Syphilis and herpes are RTIs and may also become 'systemic'.

Women may contract RTIs through sexual intercourse with an infected partner or harmful obstetric and gynecological practice, including unsafe methods of contraception, childbirth and an abortion or an unclean material used to absorb menstrual flow. In Bangladesh village, it was found that the women who used rags prepared at home, to absorb menstrual blood, were almost twice as likely to have bacterial vaginosis as women who used nothing during the menses [Wasserheit et al 1989][31]. Women also contract RTIs due to female genital mutilation, improper use of some contraceptives and unchecked growth of some organisms normally present in the reproductive tract [Dixon-Mueller][5] and Wasserheit 1991.

Among the RTIs is trichomoniasis, a protozoan infection that causes chronic, frequently painful, vaginal infections. Another is chlamydia; a bacterial infection that in women can lead to infertility and even death, and papilloma virus which is the leading cause of cervical cancer worldwide [WHO 1989][36]. 'Though exact figures are not available, it is known that annual incidence of the cancer of the uterine cervix is about the same as the number of maternal deaths. "The pain, horror and suffering in each of these 5,00,000 annual cases should make us feel the challenge to prevent this mortal disease. This is much more important in the light of the fact that the cancer of the cervix is now recognized as a viral disease, presumably transmitted sexually in a way similar to HIV, syphilis, chlamydia and gonorrhea" [Bergstrom 1994][3].

Both bacterial and viral infections remain major health problems in developing countries. Chancroid is the most common genital viral disease throughout much of Africa, Southeast Asia and South America. A study in Maharashtra in India, showed that 92 per cent of the 650 women examined were suffering from one or more gynecological and sexual disease related to RTI. On an average the number of infections suffered by a woman were 3.6. Less than 8 percent of the women in the survey had ever undergone a gynecological examination. Infections were observed to be quite high - bacterial vaginitis, 62 percent, candida vaginitis 34 percent, PID 24 percent, trichomonas vaginitis 14 percent, syphilis 11 percent, cervical erosion 46 percent, cervical dysplasia and metaplasia 2 percent. Overall it was observed that 99 percent of the symptomatic women and 84 percent of the non-symptomatic women, had gynecological diseases [Bang 1989][2].

[Bang (1989)][2] Says that generally the disease that do not kill are neglected. However their consequences include: difficulty in occupational and domestic work because of chronic backache caused by PID and cervical erosion (present in 30 percent of women); foetal wastage due to abortions and stillbirths caused by syphilis or chronic PID (38 percent of the women had bad obstetric histories); neonatal infections from birth canal infections; anemia due to menorrhagia; marital disharmony due to sterility (7 percent) or sexual problems (9 percent to 12 percent) anxiety and stress.

Available data indicate that prevalence of RTIs in both the sexes is about the same. What however needs to be understood is the gender difference in real distribution of many infections and in behavior patterns that affect their prevalence in a population. For example the risk of contracting a sexually transmitted infection from a single episode of intercourse is higher for women in part because infected semen can be retained in the vagina for some time [Jacobson 1991][12].

Once infected, the health threats to women are greater. Typical reproductive tract infections in men cause mild to severe genital or urinary tract problems that are relatively easily treated, in rare cases they can cause sterility and death. Women by contrast, frequently suffer consequences ranging from chronic genital infection to infertility, chronic pain, and death. Infected pregnant women risk higher rates of maternal and infant illnesses and death. Research now indicates that the genital lesions produced by some RTIs increase the risk of transmitting or contracting HIV, the incidence of which is already rising rapidly among women [Dixon-Mueller][5] and Wasserheit 1991 and [Mtimavalye and Belsey 1987][17]

Women face several physical and social obstacles to preventive and curative measures of RTIs. Women also lack obvious symptoms and so the infection is less likely to be accepted. RTIs are also rife with stigmas, taboos and threats of social ostracism. Fear is reinforced by low self-esteem, illiteracy and the fear of violence from or rejection by their partners, thus preventing women from reporting or discussing, so that there will be early diagnosis and treatment. Physical and psychological deterrents to care, including strict mores prescribing even married women from discussing sexual problems, can create virtually insurmountable obstacles to disclosure of RTIs and the gynecological ailments among women [Ascadi and Johnson-Ascadi 1990][1] [Bang 1989][2]. Women are known to accept vaginal discharge, itching, ulcers, bleeding, discomfort during intercourse, or even chronic pelvic pain, painful urination, etc. which accompanies some RTIs, as an inevitable part of their womanhood something to be endured, along with other reproductive health problems such as sexual abuse, menstrual difficulties, contraceptive side-effects, miscarriages, stillbirths and potentially life-threatening clandestine abortions and childbirth's [Dixon-Mueller][5] and Wasserheit 1991.

Five infections - bacterial vaginosis (the most common non-sexually transmitted vaginal infection), chlamydia, gonorrhea, syphilis and the human papilloma virus - can lead to permanent disability and even death. Common outcome of PID - which causes inflammation and scarring of the upper tract - include infertility, ectopic pregnancy, chronic pelvic pain, and recurrent infection. Ectopic pregnancy occurs when, because of scarring and inflammation, a fertilized egg becomes lodged in a fallopian tube instead of in the uterus, dramatically increasing the chances of internal hemorrhage. While infections may move from lower to upper tract, the risk of the disease spreading internally increase greatly when women with untreated lower-tract infections undergo unsafe abortions or gynecological examinations, have IUD inserted or give birth. Rates of such infections, in the developing countries are not known, but they are quite high.

Contraceptive methods also can significantly alter the risk of reproductive tract infections. IUD-users are two five times more likely to develop PIDs than women not using contraceptives. Risks for IUD-users who have never given birth may be twice this level. A number of explanations including a possible increase in the risks of developing bacterial vaginosis - have been offered to explain this link. Oral contraceptives and barrier methods tend to reduce the risk of upper tract infections. Although the oral predispose the user to candidiasis and increase in the risk of chlamydial cervicitis by enlarging the zone of ectopy, which the site for attachment for chlamydia trachomitis, they decrease the risk of upper tract infection by making the cervical mucus plug less penetrable for organisms. Spermicides offer protection against RTIs by killing or immobilizing organisms [Wasserheit 1989].

Clinic-based data indicate that a significant number of women throughout the developing world suffer from lower tract infections related to gonorrhea. As many as 12 percent of women studied in Asia, 18 percent in Latin America, and 40 percent in Africa exhibited evidence of gonorrhea infection [Dixon-Muller][5] and Wasserheit 1991.

In women, chlamydia infections are difficult to trace. Three out of every four women, affected with chlarnydia, will not have any symptoms. In the absence of routine screening, it is the rising incidence of such disabling or fatal conditions as PID, infertility, and ectopic pregnancy that often provides the best measure of where such infections are spreading and how quickly [Dixon-Mueller][5] and Wasserheit 1991.

Village studies in India, Kenya and Uganda. have found rates of PIDs as high as 20 percent. Scarring and blockage of fallopian tubes, from PIDS, is now believed to be a major preventable cause of female infertility in developing countries [Dixon-Muller][5] and Wasserheit 1991.

In the US, though precise data are not available, still research links rising incidence of chlamydia infection with four-fold increase in the ectopic pregnancies between 1970 and 1990. Among the women studied, a history of chlamydia appeared to be more than double the risk of such pregnancies. Acute infection was also found to increase the risks of premature births in normal pregnancies [Cohen et al 1990][10]; [Chow 1990][4] and [Wendy 1991][32]. In the light of the fact, that there is an overwhelming evidence that chlamydial infection is the most common STD and a major cause of infertility in women and that it increases the susceptibility of women to HIV, it is essential that programs of STD control, family planning and maternal and child health provide diagnostic testing for these diseases.

The absence of testing and treatment outlets for the human papilloma virus also condemns each year, hundreds of thousands of women in the developing world, to death. Several strains of human papilloma virus are linked with cervical cancer; approximately 4,50,000 cases worldwide annually, of these potentially fatal reproductive tract cancers are diagnosed. Of these estimated 3,45,000 occur in the third world women, virtually all of whom die due to lack of access to relatively simple early treatment measure [Stanley 1991][24].

For each maternal death several mothers suffer from illnesses. For example in a study in India, it was observed that this number was as high 16 to 17 a woman who suffered pregnancy-related illness. Calculating as from these figures the World Bank estimates that from 3 percent to 12 percent of all pregnancies worldwide result in serious illnesses

among women. Among the pregnancy-related illnesses suffered by women are the vascio-vaginal fistulae-tears between the wall of rectum or the bladder and vagina. This is particularly common among women who experience obstructed labor; a condition usually occurring among adolescents and women who have narrow pelvises. This condition leads to the collection of uncontrolled leakage of urine and feces. The resultant foul smell ostracizes untold thousands of women and young girls. Pregnancy-related illnesses far outnumber pregnancy-related deaths. They affect lives of a very large number of women and need immediate attention.

An increasing incidence of collecting women rejected and abandoned due to their barrenness, for prostitution, is observed in Niger, Uganda, and the Central African Republic. Because of their multiple contacts, prostitutes are more likely to contract and pass RTIs. Chancroid is the most common cause of genital sores in Africa and is strongly linked to prostitution. A 1985 study found genital ulcers, related to chancroid in 42 percent of the prostitutes from slums in Nairobi.[Over and Piot, 1990][18].

Syphilis can go from the genital area into the bloodstream to cause lung and heart damage and meningitis. All of which affect adversely women's health and increase health risks in pregnancies. Syphilis, along with herpes and chancroid, also produces genital lesions that, according to WHO, may increase the risk of contracting HIV by 300 percent [WHO 1989][36]. With the threats of HIV infections, with prevalent RTIs, the possibilities of finding solutions to RTIs among women seems bleak. 'The WHO estimates that more than 8 million adults are currently infected with HIVs including three million women, most of who are in their childbearing years. By the end of 1992, an estimated total of 6,00,000 cases of AIDS will have occurred among women [Petros-Barvazian and Merson 1990][19].

Infection via vaginal intercourse, is the most common route of transmission for HIV in Africa. About 2.5 million Africans are now believed to carry the virus. Nearly 1 million of these are in Uganda alone. Zaire and Zambia have the next highest number of infections, with 2,82,000 and 2,05,000, respectively. In some cities, one-in-five pregnant women, is infected with HIV.

Traditional sexual patterns in Africa also make HIV more likely to spread to women. One such practice, the use of astringent herbs to 'dry' the vagina and give the male more friction, tends to increase the likelihood of transmission through tears in the vaginal wall. Likewise female circumcision also facilitates transmission. As a result, HIV infections among women in Africa are rising exponentially and deaths from AIDS are expected to rise in tandem. WHO estimates that from 1.5 million to 3 million of

reproductive age in central and east Afrira alone will die of AIDS by 2000 [Petros-Barvazian and Merson 1990][19].

In many other regions, the rate of increase in HIV infection among women is now rising rapidly. HIV is increasing rapidly in Asia. In India and Thailand studies of prostitutes in several urban areas found HIV infection between 10 percent to 70 percent of the subjects. In 1986, according to the Thai government, 17 males were infected for every female. By 1990 that ratio had fallen to five males to every female. WHO reports about 2,00,000 women in Asia are now infected [Mtimavalye and Belsey 1987][17]; [Over and Piot 1990][18] and [Smith 1990][23].

As heterosexual transmission of HIV becomes dominant route of infection in most of the regions of the world, [Over and Piot 1990][18] note that "Proportionately more women and more poor people will be among those with HIV infection and AIDS." In other words, HIV is now following the socio-economic pattern of most reproductive tract infections. This is true in North as well as in South America. In many cities of these regions. AIDS is now the leading cause of death among the women between the ages of 20 and 40 [IPPF 1990][11].

Serious note needs to be taken of the evidence that HIV infection may accelerate the development of cervical cancer in women and human papilloma virus and decrease the effectiveness of treatment for chancroid, syphilis and PIDs. In the absence of a concerted campaign to reduce the incidence of both the RTIs and HIV, and to treat existing RTIs, the number of women dying of reproductive tract health causes, will continue to spiral upwards.

While a given death can always be traced back to a medical condition, the real 'causes' of poor maternal health are rooted deeply in social, cultural and economic barriers faced by females in the third world, thoughout their lifetime. Malnutrition is far more prevalent among females than the males in the developing countries and the reasons have more to do with gender than with geography. Gender discrimination in allocation of food - as well as in education and in health care - is widespread and well documented practice in much of south Asia. In conditions of strong son-preference, girls are perceived as risky investment [Ascadi and Johnson-Ascadi 1990][1].

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