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Reproductive Rights and Reproductive Health of Women

Malini Karkal

In the discussion on the low status of women, their invisibility in their productive role is usually given a special attention. To enquire into the condition of women working in the unorganized sector a commission was appointed which brought a detailed report covering various aspects of woryien's problems (Government of India, 1988). Several efforts are also made to discuss women's invisibility in data. However, the greatest invisibility of women perhaps prevails in health issues. Health is the basic need of a human being and denying women their health needs has seriously affected their productive and reproductive roles. At the Alma Ata Conference in the USSR in 1978, wherein primary health care was exclusively discussed by experts from 134 countries, access to family planning, maternal and child health care and prevention of common diseases were accepted as a basic human right (WHO, 1978).

Women play a significant part in maintaining the health care system through their caring work at home, in the family, in. the neighborhood and in the health profession as nurses, midwives, physicians, etc. These days's health services depend on the caring work of women and their skills and capacities more than ever before. Yet the development has not matched the women's participation in the health care decision-making. Generally there has been medicalization of women's normal life and bodily functions. Medicalization occurs when normal biological functions 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 loss of control over and confidence in women's own capacities and in their own bodies (WHO, 1985).

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). Such an approach accepts that the reproductive health issues of women are inextricably bound with their reproductive rights and freedom. However, even in discussion 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 policy. In India, for example, of the total couples, 41.9 per cent are

contraceptive users. Of these 29.8 per cent are sterilized, 5.9 per cent are users of IUD, 10.7 per cent users of oral pills and 4.5 per cent couples use other methods including condoms. It also needs to be noted that among the couples, who have accepted sterilization, over 84 per cent are tubectomies. Thus women not only bear the burden of the sterilization program but also of other methods that are promoted and targeted towards women.

Women sometimes 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 4 (Japan) and 173 (Mozambique and Angola), whereas maternal mortality rate is between 4 (Denmark, and 1710 (Bhutan) (Grant, 1991: 102-103 and 114-115). 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 rate, indicating far greater variations among the conditions that govern women than those that govern the children.

Foundations for the reproductive health of women are laid in childhood and adolescence, and are influenced by such factors as nutrition, education, sexual roles and social status, cultural practices and the socioeconomic environment. Macklin (1989) states that there are three fundamental ethical principles in women's right to reproductive freedom. These are liberty, which guarantees a right to freedom of action; utility, which defines moral rightness by the greatest good for the greatest number, and justice, which requires that everyone has equitable access to necessary goods and services. Under the framework, governments have an obligation to provide the information and services necessary for women to exercise their right to reproductive freedom. The feminist argument for reproductive freedom is based on rights to equality, self-determination and human dignity.

Women's health is seen only as a means to achieve other social goals rather than an end in 'itself. Women's needs remain either unmet or under-served and women suffer from several problems associated with sexuality and reproductive health such as reproductive tract infections (RT1s), infertility, and morbidity due to childbirth and violence against girls and women.

Generally, the discussion on women's health sets relatively much greater 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 are sexually active is limiting the understanding of the problem. Also, many of the problems arising during the reproductive period or related to reproductive performance of women are rooted in their life before they become sexually active and women also suffer beyond the active life.

Perhaps most important, because it is generally ignored and denied, is the women's right to enjoy sexuality free from reproduction and free of fear and negative consequences on an equal footing with men. The fact that sexual enjoyment, need not lead to procreation is easily accepted for the male, but not for the female. 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 (RT1s) 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 abortion, diseases of reproductive tract and effects of harmful contraceptives are the major causes of ill-health of women.

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: 6) says that the reasons for these are: (a) women alone are at risk of complications of pregnancy and childbirth, (b) women face higher risks in preventing unwanted pregnancy, they bear the burden of using and potential side effects from it contraceptive methods and they endure the consequences of unsafe abortions and (c) women are more vulnerable to contracting and suffering from complications of many STDS.

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, parametritis, or pelvic peritonitis). Some types of genital ulcer disease may spread, to the blood stream to cause systemic infection. RTIs are also caused by over-growth 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 efforts to reduce infant and child mortality. In the family planning programs as well as the programs for child survival women's needs are never attended. Inadequate antenatal care poor and unhygienic attention at childbirth and unsafe abortions continue in spite of known risks. It is reported that women in Africa face 1 in 21 chances of dying due to pregnancy related causes whereas the chance of death for women in Asia is 1 in 54, in South

America 1 in 73 in North America 1 in 6,366 and in Europe the chance is 1 in 9,850 (Starrs, 1987).

Male dominance in sexual relations and non-access to contraception makes women have no control over their pregnancies and childbirths and contracting diseases Over and above this, the government policies and indifference to the health of women compound the problems for women. The WHO (1986) estimates that annually 500,000 maternal deaths take place and the largest number of them, 308,000 take place in Asia, followed by 150,000 in Africa, 34,000 in Latin America, 6,000 in all the developed countries taken together and remaining 2,000 in Oceania. Among the causes of maternal mortality are, hemorrhage, sepsis or infection, toxemia, obstructed labor and the complications of unsafe abortions. About 75 per cent of the maternal death's occur due to, these five causes and the remaining 25 percent take place due to "indirect" causes, that is, complications of pre-existing illness such as malaria, tuberculosis ailments' etc. are at risk of complications of pregnancy and childbirth, (b) women face higher risks in preventing unwanted pregnancy, they bear the burden of using and potential side effects from it contraceptive methods and they endure the consequences of unsafe abortions and (c) women are more vulnerable to contracting and suffering from complications of many STDS.

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Cultural restrictions and woman's personal freedom limits dramatically her access to health care. Women's mobility under these conditions is severely restricted. Presence of male doctors and health care workers limits women's ability to avail of their services.

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 (Datta et al., 1980). From one gynecology clinic in northern Nigeria it is reported that 300 young women a month are treated for the repair of vesico-vaginal fistulae, while in other areas the waiting list is said to be 1000 women (Tahzib, 1989). A majority of women so handicapped are cast out by their husbands with no support they often turn to prostitution or die a slow, difficult death. In the same area of Nigeria it has been estimated that for every woman who died as a result of childbirth about 15 suffered permanent handicap (Harrison, 1985).

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 100,000 procedures in industrialized countries and 5 per 100,000 in developing countries (Hogberg, 1985). But clandestine abortions give rise to very high mortality 50 deaths per 1 00,000 procedures in, developed countries and about 400 deaths per 100,000 procedures in developing countries (Hogberg, 1985). Doubts are, however, expressed about the incidence of deaths in developing countries and the figure of 400 is feared to be an underestimate. Khan (1986) reports 10 deaths in 412 procedures, giving a death rate of 2,400 per 100,000 procedures. Such clandestine

abortions are more often resorted to by poor women. In Latin America it is estimated that about 1 in 3 women has had an abortion and upto 50 per cent maternal deaths are due to complications associated with abortions (Hogberg, 1995). In Asia, about 20 to 25 per cent maternal deaths are attributed to poorly performed abortions (Khan 1985 and Rochat et al., 1981). In Africa, hospital studies show that abortion-related deaths are reported to be increasing. More than 25 per cent in Lusaka, Zambia (Rochat, 1985) and more than 20 per cent in Benin City, Nigeria (Unuigbe, 1988) are due to abortion complications. A population-based study conducted in Addis Ababa, Ethiopia, revealed that 50 per cent of maternal deaths resulted from illegal abortions (Kwast et al., 1986).

Reproductive tract infections (RTIs) are syndromes that acutely cause physical discomfort, personal embarrassment and marital discord. RTIs compromise women's ability to achieve and sustain pregnancy as well as 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 fear of the spread of AIDs has done more to focus attention on the importance of RTIs in reproductive health then 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).

RTIs are caused by a variety of bacteria, viruses and protozoa and they originate in the lower reproductive tract, which begin 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 ovaries. 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 to that and it, too, is often sexually transmitted. Syphilis and herpes are RTIs and may also become "systemic".

Women may contact RTIs through sexual intercourse with an infected partner or harmful obstetric and gynecological practice, including unsafe methods of contraception, childbirth, abortion, and the use of unclean material to absorb the menstrual flow. In Bangladesh village 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 menses (Wasserheit, Harris and Chakraborty, 1989). 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 (DixonMueller, 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 human papillomavirus, which is the leading cause of cervical cancer worldwide (WHO, 1989).

In females RTIs originate as vaginitis acid cervicitis. These may be asymptomatic or may result in abnormal vaginal discharge, a burning feeling with urination, abnormal vaginal bleeding, or genital pain or itching. RTIs are often equated with STDs such as chlamydial or gonococcal cervicitis and trichomonal vaginitis. RTIs in women may also be caused by outgrowth of organisms that are normally present in the reproductive tract and that cause syndromes such as bacterial vaginosis and vulvovaginal candidiasis. There are also other etiologies for cervical and vaginal, infections including herpes simpler Virus (HSV), human papilloma virus (HPV) and possibly other viruses, mycoplasmas and enteric bacteria (Wasserheit, 1989a).

Untreated infections such as gonococcal and chlamydial cenlicitis or bacterial vaginosis may ascend into the upper tract to cause severe lower abdominal pain and long-term potentially devastating sequel. Procedures such as insertion of IUD or induction of an abortion generally result in-the ascending of the infection. Upper tract infection may result in damaging the fallopian tube and consequent infertility or ectopic pregnancy.

Both bacterial and viral infections remain major health problems in developing countries. Chancroid is the most common genital-ulcer disease throughout much of Africa, South-East Asia and South America. A study in the state of 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 per cent of the women in the survey had undergone a gynecological examination at some point. Infections were observed to be quite high bacterial vaginitis 62 per cent, candida vaginitis 34 percent, PID 24 percent, trichomonas vaginitis 14 per cent, syphilis 11 per cent, cervical erosion 46 percent, cervical dyspilasia and metaplasia 2 per cent. Overall it was observed that 99 percent of the symptomatic women and 84 percent of the non-symptomatic worsen had gynecological diseases (Bang, 1989). Bang (1989) says that generally the diseases 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 or stillbirths caused by syphilis or chronic PID (38 per cent 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 to 12 per cent) due to 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 behavioral 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). Once infected, the health threats to women are greater. Typical reproductive tract infection in men causes mild to severe genital or urinary tract problems that are relatively easily treated, and in rare cases they can cause sterility and death. Women, by contrast, frequently suffer from serious 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 and Wasserheit, 1991 and Mtimavalye and Belsey, 1987).

Women face several physical and social obstacles towards 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 proscribing 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 and Bang, 1989). Women are known to accept vaginal discharge, itching, vicers, 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 (DixonMueller and Wasserheit, 1991). Five infections-bacterial vaginosis (the most common non-sexually transmitted vaginal infection), chlamydia, gonorrhea, syphilis and the human papillomavirus can lead to permanent disability and even death. Bacterial vaginosis, chlamydia and gonorrhea, if left untreated can spread beyond the cervix to the upper reproductive tract, causing pelvic inflammatory disease (PID), an infection of the uterus, fallopian tubes and ovaries.

Common outcome of PID, which causes inflammation and scarring of the upper tract includes 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 infection may move from lower to the upper tract, the risk of the disease spreading internally increases greatly when women with untreated lower-tract infections undergo unsafe abortions or gynecological examinations, have IUD inserted, or disability in child birth. Rates of such infections in the developing countries are not known, but they are likely to be quite high.

Contraceptive methods also can significantly alter the risk of reproductive tract infections. The IUD users are two to 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 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 orals predispose the user to candidiasis and increase the risk of chlamydial cervicitis by enlarging the zone of ectopy, with the site of attachment for chlamydia trachomitis, they decrease the risk, of upper tract infection by making the cervical mucus less penetrable for organisms. Spermicides offer protection against RTIs by killing or immobilizing organisms (Wasserheit, 1989a).

Clinic-based data indicate significant number of women throughout the developing world suffer from lower tract infections related to gonorrhea. As many as 1-2 per cent of women studied in Asia, 18 per cent in Latin America and 40 per cent in Africa exhibited evidence of gonorrhea infection (Dixon-Mueller and Wasserheit, 1991). In women, chlamydia infections are difficult to trace. Three out of every four women afflicted with chlamydia will not have any symptom. In the absence of routine screening, it is the rising incidence of such debilitating 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 and Wasserheit, 1991).

Village studies in India, Kenya and Uganda have found rates of PIDs as high as 20 per cent. Scarring and blockage of fallopian tubes from PIDs is now believed to be the major preventable cause of female infertility in developing countries (Dixon-Mueller and Wasserheit, 1991).

In the United States, though precise data are not available; research suggests links a rising incidence of chlamydia infection with fourfold increase in the number of 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; Chow, 1990 and Wendy, 1991). 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 this disease. The absence of testing and treatment outlets for the human papillomavirus also condemns hundreds of thousands of women in the developing world to death each year. Several strains of human papillomavirus are now linked with, cervical cancer: approximately 450,000 cases of these potentially fatal reproductive tract cancers are diagnosed annually worldwide. Of these estimated 354,000 occur in the Third World women, virtually all of whom die due to lack of access to relatively simple early treatment measures (Stanley, 1991).

For each maternal death several mothers suffer from illnesses. For example, a study in India observed that this number was as high as 16% women who suffered pregnancy related-illnesses. Calculating from these figures the World Bank estimates that from 3 to 12 per cent of all pregnancies worldwide result in serious illness among women. Among the pregnancy related-illnesses suffered by women are the vasico-vaginal fistulae tears between the wall of the rectum or the bladder and the vagina. This is particularly common among the women who experience obstructed labor a condition usually occurring among adolescents and the women who have narrow pelvises. This condition leads to the collection of uncontrolled leakage of urine and faeces: the resultant foul smell ostracizes an untold thousand of women and young girls. Pregnancy-related-illnesses far outnumber the pregnancy-related-deaths. They affect lives of a very large number of women and need immediate attention.

A large number of women are abandoned and rejected due to their barrenness and they finally take resort to prostitution. This is true not only of India but also of some African countries such as 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 prostitutes from slums in Nairobi (Over and Piot,' 1990).

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 pregnancy. Syphilis along with herpes and chancroid also produces genital lesions that, according to the WHO, may increase the risk of contracting HIV by 300 percent (WHO, 1989). With the threats of HIV infections, with prevalent RTIs, the possibilities of finding solutions to RTIs among women

seem bleak. The WHO estimates that more than 8 million adults are currently infected with HIVs including 3 million women, most of, whom are in their childbearing ages. By the end of 1992, an estimated total of 600,000 cases of AIDs will have occurred among women' (Petro-Barvazian and Merson, 1990).

Infection via vaginal intercourse is the most common route of transmission of HIV in Africa. About 2.5 million Africans are now believed to carry the virus, nearly 1 million of them in Uganda alone, Zaire and Zambia have the next highest number of infections, with 282,000 and 205,000 respectively. In some cities, one-in-five pregnant, women is, infected by HIV. Traditional sexual practices in Africa also make HIV more likely to spread to women. One such practice, the use of astringent herbs to "dry" the vagina which give 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 African women are rising exponentially and deaths from AIDs are expected to rise in tandem. The WHO estimates that from 1.5 million to 3 million women of reproductive age in Central and East Africa alone will die of AIDs by 2000 (Petro-Barvazian and Merson, 1990).

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 in 10 to 70 per cent 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 for every female. The WHO reports about 200,000 women in Asia are now infected (Mtimavalye and Beisey, 1987; Over and Piot, 1990; Smith, 1990).

As heterosexual transmission of HIV becomes the dominant route of infection in most of the regions of the world, Over and Piot (1990) 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 socioeconomic pattern of most reproductive tract infections. This is true in both North and South America; in many cities of these two; regions, AIDs is now the leading cause of death among women between ages 20 and 40 (IPPF, 1990).

A serious note needs to be taken of the evidence that HIV infection may accelerate the development of cervical cancer in women and human papillomavirus -and decrease the effectiveness of treatment for chancroid, syphilis an 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 health causes will continue to spinal 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 throughout their life times. Malnutrition is far more prevalent among females than in males in 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 are a widespread and a well-documented practice in much of South Asia. Under the conditions of a strong son preference, girls are perceived as risky investments (Ascadi and Johnson-Ascadi, 1990).

A brief review of women's health problems, as is presented above, points that women's health has to date received little attention among health policy-makers and program planners. However, cost in terms of pain and suffering as well as the impact on the health of the entire population is quite high and needs immediate attention.

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