

## CHAPTER - 5

# SEXUAL & REPRODUCTIVE HEALTH



## 5.1. Literature Review

As a demographic, unmarried women are completely invisible in the domain of sexual and reproductive health and rights in India. Due to societal biases and shame, such women deprioritise their sexual health needs and refrain from accessing services. As a society, we do not acknowledge the fact that unmarried people have sex or are, in any way, sexually active, and that it is important to include them in the conversation on sexual health. Given that India has the second largest population and the largest adolescent population in the world, there are several reproductive health concerns in India including high unwanted fertility. According to the fourth round of the National Family Health Survey (NFHS IV), 9% of pregnancies were unwanted while 4% were mistimed (Welfare, National Family Health Survey (2015-16))<sup>60</sup>. As per the National AIDS Control Organisation's 2018-19 annual report, early diagnosis, appropriate and complete treatment of Sexually Transmitted Infections (STIs) and Reproductive Tract Infections (RTI) reduce the transmission rate of HIV infection by over 40% (Welfare, National AIDS Control Organization (NACO), 2020)<sup>61</sup>. According to an AIIMS report, 10-15% of all married couples in India face fertility issues and require external help (AIIMS, 2014)<sup>62</sup>. However, due to the stigma associated with the subject, people end up experimenting with quacks, tantriks and non-medical practitioners. It is estimated that 11.8 million adolescent pregnancies occurred in 2017 (Roy, 2017)<sup>63</sup>. The NFHS IV reports<sup>1</sup> that one in every 10 women in rural areas in the age group of 15-19 years has begun childbearing (Welfare, National Family Health Survey (2015-16)),<sup>64</sup> while 20% of this age group with no formal schooling has also begun childbearing. This is also the age group with the highest percentage of non-live births. It is estimated that about 26% of the abortions were repeatedly performed by the women themselves at home (Welfare, National Family Health Survey (2015-16))<sup>65</sup>. Pregnancy-related complications are the number one cause of death among girls between 15 and 19 years (UNICEF, n.d.)<sup>66</sup>. Most of the unsuccessful abortions women experience can be traced to the purchase of non-prescriptive drugs that may be falsely advertised by chemists as an alternative and cheaper option to prescriptive abortifacients. According to a survey by NGO Haiyya, as low as 20% of the unmarried women knew about the abortion law in India, and 95% had never visited a gynaecologist to take consultation on sex, pleasure or contraception (Desk, n.d.)<sup>67</sup>.

According to the National Health Survey 2015-16, the contraceptive prevalence rate among currently married women aged 15-49 decreased slightly, from 56% in 2005-06 to 54% in 2015-16, and the use of modern contraceptive methods stands at under 50% (Welfare, Contraceptive knowledge and use)<sup>68</sup>. Additionally, one in seven married women report that they no longer want to get pregnant but are not currently using any form of contraception. According to a Lancet study, 15.6 million abortions occurred in India. 11.5 million (73%) abortions were medication abortions done outside of health facilities, and 0.8 million (5%) abortions were done

outside health facilities using methods other than medication abortion, and only 2.2 million were surgical abortions, 0.8 million took place outside of legalised institutions in private clinics with variable costs and unsafe methods (Susheela Singh, 2018)<sup>69</sup>. On average, women with no schooling have an average 3.1 children, compared with 1.7 children for women with 12 or more years of schooling (Rattanani, 2019)<sup>70</sup>. In the socio-economic context, this translates to women in the lowest wealth quintile having an average of 1.6 more children than women in the highest wealth quintile. In relation to metrics relating to socioeconomic factors, namely levels of poverty and education, illiterate women are 48% more likely to have an unsafe abortion and women in households with minimal asset holdings are 45% more likely to undergo unsafe abortions.

**High maternal mortality rate:** Nearly 45,000 Indian women, accounting for almost 15% of estimated global maternal deaths, die every year due to causes related to pregnancy and childbirth (writer, 2016)<sup>71</sup>. The lifetime risk of maternal mortality is one in 70, i.e., one in every 70 pregnant women is at risk of death, even as she gives birth. Available data also indicates that a significant proportion of women suffer from obstetric morbidities. In fact, women in rural settings have a 26% higher chance of dying from complications than their counterparts in urban settings. The difference is wider in the case of indigenous women; 84% of indigenous women in Jharkhand do not have access to or do not use any form of contraception, whereas this is the case for 59% of non-indigenous women.

**STIs/RTIs:** In a nation-wide community-based study, prevalence was nearly 6% in the 15-50 years age group. The problem is further compounded by the predominant culture of shaming & silencing that discourages women from seeking the required medical treatment.



## 5.2. Common Myths and Misconceptions

**MYTH:**  
**01** | **The hymen is the definitive marker of virginity and, consequently, character.**

**FACT:** Virginity is a social construct. The hymen can break due to physical activities like gymnastics, cycling, using a tampon, intense exercise, etc.

**MYTH:**  
**02** | **You cannot contract an STI if you use a condom.**

**FACT:** While condoms are 98% effective, it is still possible to get an STI while using one.

**MYTH:** | **Douching is necessary to keep the vagina clean.**  
**03**

**FACT:** Douching can change the pH balance of vaginal flora (bacteria that live in the vagina) and natural acidity in a healthy vagina. A healthy vagina maintains both good and harmful bacteria. This balance of bacteria creates an acidic environment within the vagina that helps protect it from infections or irritations (Melissa Conrad Stöppler, 2020) <sup>72</sup>.

**MYTH:** | **Sex can increase the risk of cancer.**  
**04**

**FACT:** Rather, it decreases the risk of cancer. Men who are in a healthy relationship are less likely to receive a prostate cancer diagnosis before age 70. It has also been observed that men who had frequent orgasms (defined as two or more a week) had a 50% lower mortality risk than those who had sex less often.

**MYTH:** | **You cannot get pregnant on your period; sperm can only live a short while after it is released.**  
**05**

**FACT:** While conception is most likely when intercourse occurs a few days before or during ovulation, it is still possible to get pregnant during your Menstrual Cycle. Sperm can live in the female body for up to 5 days after sexual intercourse under the right conditions. So, in some cases, sperm can fertilise an egg a few days after it has been released in ovulation.

**MYTH:** | **The withdrawal method is effective in preventing pregnancy.**  
**06**

**FACT:** A male's pre-ejaculation also contains sperm cells, which leads to the possibility of contraception despite the withdrawal method. So, it is preferable to always use protection (like a condom) during intercourse if pregnancy is not desired.

**MYTH:** | **Masturbation is harmful, especially to women, and it affects the relationship of a husband and wife.**  
**07**

**FACT:** It is very safe; in fact, it increases mental wellbeing along with other advantages including enhanced sex between partners, understanding your own body, and increased ability for orgasms. Pleasure has a positive correlation with better mood and body image.

**MYTH:** | **Doubling condoms means double protection.**  
**08**

**FACT:** Using two condoms can, in fact, offer less protection than using just one. Incorrect use can cause too much friction, weakening the material and increasing the chance of the condom breaking during intercourse. (staff) <sup>73</sup>

**MYTH:** | **STIs can only be transmitted when symptoms are present.**  
**09**

**FACT:** Many STIs do not have symptoms but can be damaging to your body and spread to sexual partners.

**MYTH:** | **STIs cannot be transmitted through oral or anal intercourse and only through multiple partners.**  
**10**

**FACT:** Contracting an STI is a probability given one is sexually active, even if you only have one sexual partner. STIs can be contracted from any kind of intercourse or intimate contact with your partner(s).



### 5.3. Case Study- Mass Hysterectomies, a Way of Livelihood for Women in the Sugarcane Belt

In the drought-stricken interiors of Beed in Maharashtra, October to March are crucial months in the sugarcane belt. Given the good financial returns for the year, contractors employ migrants from nearby districts as sugarcane cutters during these months. However, the contractors faced a bizarre problem to cater to the needs of women on the fields. These cutters, both men and

women, spend up to 16 hours harvesting and loading the cane crop during these six months, with no toilets on the farms. Women, especially, would be penalised with a pay cut or, worse, a replacement if she requested leave during her menstrual cycle/first trimester of pregnancy. Owing to the high demand for work, the labour, especially women, are the most exploited. To counter the problem, the suggested solution was mass hysterectomy, i.e., the surgical removal of the uterus so that they can be gainfully employed on the sugarcane farms. In fact, it had become the norm to such an extent that the contractors refused to hire women who had two or three children and still had their ovaries and uteruses intact. The brazen inequality stands out as these vulnerable women are then made to pay for their own surgeries, which they never wanted in the first place. The exploitation begins when the contractors employ them and give them an advance for the hysterectomy but later recover the money from their wages. These women, who are sometimes as young as 25, undergo hysterectomy because the sugar industry is one of the few providers of employment in the region. The Hindu Business line reports, “you will hardly find women with wombs in these villages (Jadhav, 2019)<sup>74</sup>. These are villages of womb-less women.” According to the report, “State figures say that in three years (2016-2019), as many as 4,605 women have had their uterus removed in Maharashtra. Civil rights organisations allege that the hysterectomy rate in Beed is 14 times more than that for the State or the country” (Shelar, 2019)<sup>75</sup>. In what is a definite labour exploitation, women are robbed of their sexual and reproductive rights over their bodies through systemic injustice. The hardships do not end with the hysterectomies because the removal of the uterus and the back-breaking work on the sugarcane fields give rise to other health problems including severe back and joint pains with no health safety net. Worse, according to the same Hindu report, “There could be a nexus between profit-driven doctors and the hysterectomies. This definitely needs to be investigated, among other things.” When poor hygiene is coupled with gross exploitation and lack of information, the most vulnerable women of the region pay the highest price through unwanted hysterectomies. This is just one the many case studies that is witness to the blatant exploitation of the rights of the women living in the districts, who are uneducated and are, therefore, ill-equipped to make the right health choices.

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*You will hardly find women with wombs in these villages. These are villages of womb-less women owing to the high number of hysterectomies in Maharashtra's Beed district. (Jadhav, 2019)<sup>74</sup>*

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## 5.4. Experts Speak



### MS AISHA LOVELY GEORGE

She is the Executive Coordinator of the Hidden Pockets Collective. She is an award-winning podcaster, and a speaker on reproductive health on various panels nationally and internationally. She is a trained Sexual and Reproductive Health educator and a counsellor.



### MS KARISHMA SWARUP

She is a certified sexuality educator who actively busts myths about sex through social media, among other platforms.



### DR NIVEDITHA MANOKARAN

She is a dermatologist and venereologist from India working as a clinician in sexual and reproductive medicine and HIV medicine in Sydney, Australia.

## 01

What kinds of misinformation (myths and misconceptions) prevail around sexual health in India?

**Ms Aisha:** I would say that the majority of women have no autonomy over their bodies. I mean, everything related to their sexual life and their bodies is decided by someone else. Most often, they are not given a choice as to what kind of contraception can be used or even given the quintessential sexual knowledge on safe and pleasurable intercourse. In case of married women, most often, the mother-in-law takes the decisions and in case she is not married, there is no question of discussion on sexual health. This is clearly because pre-marital sex is taboo in our country. So, the biggest challenge at hand is that women do not see their bodies as their own since it is always other people making decisions for them. Second, there is this stigma about the anatomy, their own body parts—most women do not know what or how their vagina and uterus look like or even the basic differences. It is a sad relationship that women have with their bodies. This is, in fact, not their fault. Owing to the lack of sexual education, these topics are not often discussed while growing up and even in schools, they brush up and skim through these chapters. On the other hand, the internet is full of information (right, mis and disinformation) and most times, women do not have access to the right information. So, most women do not know what to do when they have vaginal discharge or burning sensation and worse, Google search will always render a link to a site suggesting bacterial infection or cancer. Owing to the stigma around the issues, women do not talk about these things, thus worsening their own sexual and reproductive health. Therefore, the biggest challenge is to overcome the stigma and establish a healthy relationship with their bodies. And this is only possible though repeated guided conversations because each problem is unique and has to be dealt with subjectively instead of giving blanket answers. The first step is to understand your own body, listen to its needs and, if needed, seek help accordingly.

02

Given the Indian context and the patriarchal system, any conversation around young women's sexuality is limited and stigmatised. How should we attempt to break this barrier and educate people?

**Ms Aisha:** I would say that it is definitely not going to be that easy to overcome the system and conditioning of patriarchy overnight. Women have been taught to do certain things in their lives and it is not easy to bring about a behavioural change quickly. Therefore, it is important to involve the family members in the conversation because this is a collective societal change, so including the in-laws and parents in the conversation is crucial. Also, it is important to understand where they are coming from and one has to be extremely sensitive in addressing the topic. This is exactly what we do in our workshops. In our experience, I have noticed that sometimes, the men also want to help but were clueless as to where and how to begin. Given the cultural/social norms, most times, our workshops are conducted with men and women sitting in different rooms. Things have to change bottom-up. For that, first, it is important to have a conversation with both the sexes in the community to analyse the gaps in awareness, education and opinions. Sometimes, it is equally or more important to accept their beliefs and values in order to design an intervention and then slowly start building and moulding a conversation around it. It has to be a holistic approach especially targeting the decision-makers of the house including the men and the in-laws for any kind of constructive change to begin because only educating the woman is work half done and it is crucial to understand the dynamics at the grassroot level for any effective intervention.

03

In your research, have you come across any correlation (direct/indirect) between misinformation and miscarriages/abortions (safe and especially unsafe) in both married and unmarried women?

**Ms Aisha:** Yes, in my experience, misinformation plays a critical role, especially in unsafe abortions among adolescents/young women. There is limited understanding of the Medical Termination of Pregnancy Act, given that the language is not straightforward and has a list of criteria for women to be eligible for abortion.

Owing to the lack of understanding of the legal knowledge and their own bodies paired with misinformation on abortion, young women end up seeking help from outside medical institutions including quacks, thus resulting in unsafe abortions. Often, these quacks are not qualified or trained to handle 12-week or 20-week pregnancies, which end up in extreme loss of blood, incomplete abortion and complicated pregnancies. Therefore, there is a direct correlation between misinformation and abortion, but I have not seen any miscarriages till now given that we deal with a lot of unmarried young men and women, and most pregnancies are unintended.

**Ms Swarup:** It's hard because people under 18, if they are engaging in sexual activity, whether they're doing it with a young person or not, it's against the law. And I think that is what makes it really hard for young people to access abortion care or healthcare around their reproductive health because by law, a doctor would have to report if someone under 18 was pregnant, and I think that's a good law because the fact is the age of consent is 18. But it becomes a larger question of are we still creating space for those people to come forward safely and have these conversations and have trusted adults in their lives whom they can talk to about these things. So, there are some newer-age start-ups, for example, and there are crowdsourced lists of gynaecologists who will not be judgmental towards people. And I think that is the first step to help people connect with doctors who will not judge them and who will be able to provide them with care. The second thing is that sometimes, people think that abortion itself might be illegal, which is totally a myth because in India, we do not have that issue. And I think that is another reason why people feel inclined to go to quack doctors because there's just not enough knowledge around the fact that people can go to a legitimate doctor and ask for an abortion.

## 04

What has been the impact of alternative medicines (powders/pills), especially when it comes to infertility issues and abortions?

**Ms Aisha:** Again, this is extremely dangerous, given that young people seek alternatives instead of meeting with a doctor owing to the fear of judgment or getting caught. Therefore, they resort to the simplest alternatives and even if they consult a doctor for abortion, they do not go for follow-up check-ups or even find out if the uterus is clean, i.e., if the abortion is complete. Likewise, a lot of doctors are also not equipped to guide these youngsters or follow up with them and often times, the youngsters face condescending and judgmental behaviour from the doctors. In fact, we had a case where the patient was bleeding continuously for 14 days and it was critical to see a qualified doctor to deal with the complications. In reality, a lot of married/unmarried couples visit quacks, and one can never know what the composition of the medicine/pills is and what is the right dosage to consume. Often, these pills have a lot of side effects/bring about hormonal changes if consumed in higher doses, thus leading to further complications. Even in case of married women, there were a few cases where the women did not want to continue with the pregnancy but they did not wish to inform their husbands. In fact, one of the patients and her sister approached us to seek the easiest way to abort the pregnancy against the wishes of her family. We had to counsel them not to visit a quack and seek necessary medical expertise and connected to a doctor with the help of Hidden Pockets. And we often try to fill this gap of connecting the patients and a qualified doctor through our organisation.

## 05

What are the most affordable types of contraception available for people?

**Dr Niveditha:** Condoms are the safest, cheapest and most easily available form of contraception. There is probably a small percentage of people who could be allergic to latex and there are latex-free condoms available for such people. So, I think that is the most easy and safe thing that you can use, it is the only thing that protects you against STIs, and does fantastic contraception. So, condoms are a go-go for me and that is an easily sold contraception. I think where the problem arises is when a youngster has to walk through a supermarket to the condom aisle and pick a box of condoms or lubricant and go up to the front counter and get it billed standing in line with the other people who are probably giving them looks and talking about them, and I think that is where the problem arises and that is what is the barrier for people to be using condoms. And it's hard for us to change the attitude of the population of one billion. So, it's hard to say don't look at me like this, don't say this, don't see that. So, can we make condoms and lubricants more available in more common places? For example, a lot of our gynaecological clinics and sexual health clinics have bowls of condoms and lubes in the waiting room, in the sitting area, in the coffee area, etc. And we also place plenty of brown bags all over the place, so you don't have to flash your condoms. So, if contraception is easily available and not judged, people will probably use it much more than they use it these days, if they get the relevant education. On the other hand, there are IUDs or Copper-Ts that can be used for contraception for 5-10 years and the copper IUDs can also be used for emergency contraception.

## 06

Men have their challenges too when it comes to sexual health and living up to the stereotypes associated with them. What are some of the issues that they face?

**Ms Swarup:** I find that I get so many direct messages on social media from men, and a lot of them come from a place of insecurity, with questions like is my penis large enough? Am I lasting long in bed? Is my penis the right shape? These are questions that are very personal to them but also, in society, linked to masculinity itself. And these kinds of societal norms translate into the way that people feel about their bodies. And that is a big issue because it makes men feel ashamed of even asking for help when they need it. And they are often afraid to go to or approach a doctor. I have full-blown adults in my direct messages saying things like please help me, I need to speak with a doctor. And my response is always I'm not a doctor! You have to speak with a doctor to get you treatment for whatever issue you're facing. I think it becomes a culture of silence for them, which is ironic because society does afford them more agency and more power when it comes to sex—things like he's a man, so he's going to have sexual feelings; he's going to masturbate; he's going to be attracted to people. Those are stereotypes that exist. But at the same time, there is not as much open conversation around it.

07

Apart from unwanted pregnancies, the lack of knowledge on good contraception also results in STIs. How can people be more aware of STIs if they are sexually active?

**Dr Niveditha:** Most of the time, people approach a sexual health physician only when they start having symptoms, because symptoms tell them that something is wrong. However, I always keep telling people that STIs are mostly asymptomatic; they do not have any symptoms. 70-80% of the time, chlamydia, gonorrhoea and HIV do not show symptoms for a very long time. So, what we have to work and target towards is to get asymptomatic testing, which means that if you are sexually active, you need to get tested at least once or twice a year. If you are having unprotected sex, you probably have to do more STI screening. And if you are having sex with a member of the high-risk population, which includes gay men, sex workers, people who are having sex with sex workers, injecting drug users, people who have sex with trans men and women and then trans men and women themselves, the chances that you could acquire an STI are higher. So, go more frequently for STI testing and that is the only way you pick infections early, prevent complications and prevent life-threatening scenarios. This is something that I really want to encourage people to do but unfortunately, symptoms are the thing that usually make people rush to a doctor.



## 5.5. Conclusion

The stigma around sex leads to several undesirable consequences, from misinformation around the right contraception to people being afraid to seek help, which in turn leads to unsafe abortion and a spread in STIs. Access to information on the full range of acceptable and affordable contraceptives and the accurate methods is essential to both men and women's autonomy and health. The antidote to poor sexual and reproductive health is good sex education. The only weapon to combat misinformation and stigma is through right awareness, accessibility and affordability of sex education, products, and healthcare. Ms Swarup weighs in on the importance of sex education as the way forward:

Many multi-country studies have been done comparing different factors and one of the factors which correlates with a lower rate of misinformation is good sex education. In fact, one of the biggest misconceptions in India is that if you talk to teenagers about sex, they are going to venture out and have more sex but that is not necessarily true. It just means that they are going to be more aware and more informed and make better decisions about their sexual life, and that includes contraception and teenage pregnancy as well. I think there needs to be more awareness around contraceptives because the simple fact is that when someone is young, they are more likely to take risks and engage in risky behaviours without considering the consequences. Second, the lack of access to healthcare is a problem. Say, a young person who has a uterus wants to go and get birth-control pills, it is really difficult if they are under a certain age or I would say even if they're over 18, it is really hard to just go to a gynaecologist and ask for a birth-control prescription or even have a conversation about the appropriate methods of contraception because there's so much stigma around unmarried people having sex, while in reality, young people are sexually active. I think sex education needs to start from kindergarten and needs to go on throughout the entire school period, till class 12, and in college. Given that most of India's population does go through some type of schooling, if we make sex education a mandatory part of school curricula, everyone will have exposure and access to it. We want to also make it accessible in other avenues because if someone is not going to school or does not have access to sex education at school, they should be able to come home, Google it, and find reliable information but unfortunately, that's not the case at the moment. And 50% of the population has smartphones and a lot of young people will access pornography more easily than they'll ever find good sex ed. And that's why making it accessible online, making it accessible within school and college systems, and acknowledging the fact that young people have sexual agency and autonomy is really important. And I'm not saying that people under 18 should be having sex but just saying that they should have the knowledge and have the resources and have access to the education they need.

From the medical system to the education system to families and importantly, the individual—each one of us—there are many stakeholders involved in sexual healthcare. The problem must be approached from both the doctor's and the patient's sides. While attitudes and behaviours of the society are unlikely to change overnight, the primary focus must be to seek the right guidance—consult an expert/doctor to ensure credible information on the problem. One must refrain from consulting quacks or even diagnosing a sexual health problem by reading

about the symptoms online. Similarly, on the medical end, hospitals and medical practitioners must ensure that diagnosis and treatment are evidence-based, and actively bust myths and misconceptions for their patients. Listening attentively and empathising with the patient can go a long way in tackling the misinformation that is widespread in this stigmatised topic of sexual and reproductive health.