IMPACT AND IMPLICATIONS OF INDIAN OCEAN TSUNAMI ON THE INDIAN GOVERNMENT'S PLANNING AND POLICIES OF REPRODUCTIVE HEALTH DURING DISASTERS

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Abstract: The status of reproductive health of women in India is not very satisfying as Human Development Report of 2015 ranks India at 130th position out of 185 countries in its human development report. It has been also testified by India Health Report (IHR): Nutrition 2015. According to IHR the 55.3% of total women aged between 15 to 49 years are suffering from anemia. The 30.3% of total women aged between 20 to 24 years, were married before the legal age of marriage in India, which is 18 and also the 44.7% of total adolescent girls aged between 15-18 years are having a low body mass index. These data clearly indicate the alarming situation of reproductive health of women in India in normal situations. So, it is automatically understood that the situation during the disasters is also not very satisfying and needs immediate attention. During Indian Ocean Tsunami of 2004, it was the first time when the issue of reproductive health during disasters got the attention of South Asian Countries. In 2004 and preceding years, a large number of studies have been conducted on the issue of gendered nature of disasters and also became the basis for many structural changes in disaster management policies of affected countries. But the current status of the problem suggests that the steps taken for the remedy of the problem is not sufficient and therefore need re-examination.

Keywords: Reproductive health, Disaster Management, Gender, Vulnerability

Introduction: The maintenance of reproductive health of women is not a luxury; even it is the call of the hour. For better future of a country, it is necessary to provide appropriate condition to women for safe, secure and healthy motherhood, which itself is a precondition for safe, secure and healthy childhood. This phenomenon got recognition at International level in 1994 during the International Conference on Population and Development (ICPD). As a result, many efforts in this field have been started such as Inter- Agency working group on reproductive health in crisis situations (IAWG) established 1995, and Introduction of MISP (Minimum Initial services package,). In India, It started with the Introduction of National Population Policy (2000) and the National Health Policy (2002). But this process got Momentum only after the occurrence of Indian Ocean Tsunami in 2004, which made Indian government to realize the large scale need of reproductive health issues especially during disasters. Therefore, The Impact of Indian Ocean Tsunami and its Impact on Government of India's planning and policies of reproductive health is a relevant issue of discussion. This study is content specific. Therefore, it will use the case study method of qualitative research to demystify the research problem. The study will refer both primary and secondary sources of information and data by using deductive method.

Reproductive Health: Before getting into the major debate, it is necessary to answer two important questions for the basic understanding of the problem. First, what is the meaning and emergence of the term "Reproductive Health" and second, why it is necessary to study the impact of disasters on the reproductive health of women separately from men and other sections of society?

During the 1970s and 80s, there was an ongoing struggle of women in industrialised countries for the recognition of the right of safe and legal abortion and it was the first time when the issue of reproductive health came into notice. But it got global acceptance only after the ICPD, 1994 and Fourth World Conference on Women, 1995. The concept of Reproductive Health has been developed during ICPD 1994 [1]. As per this conceptualisation:

"Reproductive Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive Health therefore implies that people are able to have a satisfying and safe sex life and they have the capacity to reproduce and the freedom to decide if, when and how often to do so [1]."

As far as the second question concerned, it is important to understand that in every society, there is a hierarchal social structure exists. This social structure also determines the capacity and vulnerability of each and every section of society by itself. Therefore, a disaster affects the different sections of a society differently and accordingly to their position in the social hierarchy. In patriarchal social structure which most of the South Asian Countries observe, women are always considered as the secondary members of the society, which made their position more vulnerable and less capable in the context of disasters and its management. Most of the

burdens of disasters have been burnt by women due to their central role in the family. After the occurrence of a disaster, women are responsible for caring and well being of elderly, children and sometimes the male members of the family as well. In this process, women generally ignore her needs in terms of health, nutrition and sometimes safety also [2][3][12]. Added to this, women have unequal access to employment opportunities and earning capacities which aggravate the vulnerability of women further. It is also important to mention here that analyses of real situations have proved that women are not just the helpless victims of disasters as generally portrayed, even though they are more vulnerable to disasters than men due to the gender construction of society. But women have valuable knowledge and experience of disaster management because women have to live with the regular and seasonal disaster cycle, which made them to learn the methods of management of the risks associated with these disasters. So, they have a different approach towards disaster management [12]. But due to the patriarchal nature of society, the policy making comes under the realm of the public sphere which is dominated by men only. As a result, the experiences, vulnerabilities and capacities of women of disasters are largely ignored. As a consequence, women become more vulnerable to disasters due to the exclusion from policy making and implementation and they get affected by disasters at very large scale [2][3][4][12].

Impact of Indian Ocean Tsunami of 2004 on the reproductive health of women: Early pregnancy loss, premature delivery, still births, complications related to delivery and Infertility were some of the major adverse reproductive health outcomes Indian Ocean Tsunami. Forced marriages, reversal of sterilization operations and forced pregnancies to compensate dead children, which were sometimes at the risk of mother's life were some more examples of violation of reproductive rights of women observed during the Indian Ocean Tsunami [5].

In another severe impact of Indian Ocean Tsunami were the sexual and other forms of violence against women by intimate partners and unknown men as well. The risk of such violence was further provoked by the lack of safety and privacy in shelters or camps, coercion to provide sex in exchange for goods and services and a counterattack against those women who have taken the leadership roles during and after Indian Ocean Tsunami [8].

Due to the lack of privacy and other sanitation needs, young girls and women helplessly started avoiding their menstrual hygiene and many times reuses the dirty clothes also. Women could not get the full benefit of government health services provided in their villages during the Tsunami as they were feeling uncomfortable to discuss women related issues with male health workers. Consequently, most of their problems left untold and unnoticed. In addition, the social taboos related to menstruation and norms about the apt behavior for women were also responsible for the health problems in young girls and women as an effect of Indian Ocean Tsunami [9]. Although Government of Tamil Nadu and Kerala had stationed many female fire officers, Police Officers and doctors to address these problems, but it was insufficient at large level [7].

In South Asian and African countries, women are still subjected to household food hierarchies, which support the idea of higher calorie need of men. On the contrary, women have unique nutritional demand, especially during the time of pregnancy and breastfeeding. Therefore, at the time of Indian Ocean Tsunami, the women of these countries were suffering from nutritional deficiencies. The 80%of women were suffering from Iron deficiencies and 45-50% of women of reproductive age were underweight. With this nutritional standard, the state of women's reproductive health during the Indian Ocean Tsunami could easily predicted [6].

Large scale displacement is another consequence of Indian Ocean Tsunami which exposed women to increased gender based violence and other form of abuses in the lack of structural and organizational measures to protect them [11].

Indian Government's planning and Policies of Reproductive Health during disasters: One of the striking impacts of Indian Ocean Tsunami on Government of India's policy of disaster management was the emergence of a structural body of disaster management in a form of Disaster Management Act 2005. But this act gave very little attention to the issue of women during a disaster [13].

But, As far as the Reproductive health issues are concerned, the Government of India has given a large attention to this. Indian government launched National Rural Health Mission [2005-12] to combat the issues of reproductive health in India. The primary aim of this scheme was to provide the facilities of public health at all levels via a decentralized, community driven and functional service delivery system. It also aimed the fulfillment of health needs of the urban poor by its district level heath plans. Reduction of number of maternal deaths and increment in the facilities of institutional deliveries, especially for the pregnant women of below poverty line was one of the main objectives of this scheme. It had also ensured the free maternal free health care services for all women belonging to below poverty line. Four antenatal checkups and two post natal home checkups, 24 hour access to emergency obstetric care, contraceptives and family planning were also included in this mission. NRHM also assured about the standard of services given

under this scheme which were in compliance with Indian Public Health Standard [12]

Indian Government also started two cash incentive schemes to promote the institutional deliveries, which is an integral part of reproductive health of women. First is, Janani Suraksha Yajana and the second is National Maternity Benefit Scheme. In Janani Suraksha Yojana, women get the cash incentive of Rs. 600 to Rs 1400. This incentive is accessible to all women living below the poverty line and at least 19 years old. But this incentive is limited to only first two live births in high performing state based women and three live births in the case of low performing state. The performance of state is judged by the public health indicators and infrastructures available in a particular state. The second incentive scheme provides the cash incentive of Rs 500 to all women living below poverty line irrespective of age and the number of prior births. The objective of this scheme is to ensure the necessary nutritional standard of pregnant women living below the poverty line. Therefore, the money is expectedly paid before the 8 to 12 weeks of delivery [15]. Indian Government also included the reproductive health issues in its 12th Five year plan.

But these efforts have many inherent loopholes. One of the major shortcoming of above discussed policies and schemes is lack of structural measures in these initiatives. The above discussed issues of reproductive health during disasters are majorly the result of age-old beliefs and practices which resulted in the marginalization of women especially young and adolescent women. Therefore, it needs some structural remedy of this problem which is missing in these initiatives. Second shortcomings of these policies are that they are created for the needs of reproductive health of women during normal times, which largely goes ineffective when a disaster occurs because of its differential needs. When a disaster occurs, it affects the local health services and providers as well. This has not been dealt with above discussed measures.

Conclusion: After the reexamination of plans and policies of government of India to combat the reproductive health issues of women during disasters, it has been observed that after the occurrence of a major disaster like Indian Ocean Tsunami Indian Government is still not serious about dealing with it. After many years of emergence of disaster management's organizational structure, the country still lacks an appropriate structural mechanism to deal with the reproductive health of women during disasters.

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