REPRODUCTIVE HEALTH AND DIGNITY:
Choices by Third World Women

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Technical background paper prepared for the International Conference on

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FOR WOMEN AND CHILDREN
THROUGH FAMILY PLANNING

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This is one of 13 technical background papers prepared for the International Conference on Better Health for Women and Children through Family Planning, held in Nairobi, Kenya, October 5-9, 1987.

The views expressed in this paper are those of the author and do not necessarily reflect the views in every respect of the Conference's co-sponsoring organizations or of its Technical Consultative Group.

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The Population Council ■ United Nations Children's Fund ■
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United Nations Fund for Population Activities ■
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I wish to acknowledge generous comments and suggestions on earlier versions from Judith Bruce, Elizabeth Coit, Ruth Dixon-Mueller, Joan Dunlop, Janice Jiggins, Barbara Pillsbury, and Gilberte Vansintejan. Any errors are my own.
"Control over reproduction is a basic need and a basic right for all women. Linked as it is to women's health and social status, as well as the powerful social structures of religion, state control and administrative inertia, and private profit, it is from the perspective of poor women that this right can best be understood and affirmed. Women know that child bearing is a social, not a purely personal, phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and institutions by the end of this century. But our bodies have become a pawn in the struggles among states, religions, male heads of households, and private corporations. Programs that do not take the interests of women into account are unlikely to succeed..."

Development Alternatives with Women for a New Era (DAWN)

"... We [the Women's Movement] need to... demand more emphasis on male contraception and media programmes urging men to share the responsibility in family planning; and call for greater promotion of safe barrier methods, unconditional abortion on demand ... adequate counselling and contraception services to meet the needs of the unmarried, demedicalization of family planning and improved availability of safe and humane family planning services to all who need it."

Vimal Balasubrahmanyan
Economic and Political Weekly - India
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INTRODUCTION

It is widely agreed that early entry into reproduction and marriage, and high fertility without access to medical services, endanger Third World women's health and their lives, and curtail their opportunities for education, employment and social and political participation. United Nations documents since 1947 have recognized that reproductive control — defined as the right to "determine freely and responsibly when and how many children to have" — is an essential right. The United Nations Convention on the Elimination of All Forms of Discrimination against Women recognizes as well that access to contraception is essential for women to exercise and maintain good physical and mental health.

Most women in the Third World, however, especially those who are poor and live in rural areas, still face reproduction — including menstruation, sexual relations and STDs, pregnancy, and birth and abortion — without information, trained assistance, or improved technologies. The hazards, though not yet well documented, are severe for women and their children. They are largely preventable. Other papers for this conference (as well as recent analyses by WHO and the World Bank, among others) assess what is known about the role of family planning in reducing these hazards.

This paper analyzes four current program strategies — family planning, maternal and child health, child survival, safe motherhood — to determine the extent to which they might realistically be expected to meet Third World women's reproductive health needs. The paper documents that many women are not yet reached by these programs, and describes many more who are not yet recognized as clientele. It suggests further that current programs have left untreated critical reproductive health problems — unwanted pregnancy, sexually transmitted diseases, and infertility — one or more of which most Third World women face at least once. These problems exacerbate already high rates of maternal and infant morbidity and mortality, and also pregnancy wastage. Were they dealt with, programs might well attract — and keep — more clients both for family planning and for health services.

A "reproductive health approach" is proposed to pull together, conceptually, women's unmet needs and current program strategies. The fact that so many women still face morbidity and mortality — which is preventable — is due to social, economic, and personal factors that prohibit their utilization of services. As important as these factors, however, are limitations in current programs, especially program definitions of women to be served and the attitudes and values that condition
program approaches to women. The paper suggests means to strengthen family planning and health services so that they are not only available, but also accessible and acceptable for all girls and women in need.

Refinement of the basic concepts and values that underlie service delivery are a major challenge. The four types of program strategies under review tend to define their clientele to be women who are mothers or mothers-to-be, or who are fertile and have stable partners. They further assume that providing women full information and choices about contraceptives, delivery, induced abortion, and health strategies is irrelevant ("women cannot make choices"), too costly, or detrimental to the providers' larger social goals of population control or their moral beliefs. Finally, they tend to see women at a particular point in time -- at risk of pregnancy, or pregnant, or the mother of a young child. A "life cycle" view of clients that recognizes that women's needs change over time, and that many needs overlap, would better meet the complex, interrelated reproductive health needs of girls and women throughout their lives.

"Reproductive health" is a long-term goal to be addressed by all health and family planning programs, jointly or separately, depending on the context. It is an umbrella concept that could inspire both incremental changes in the design and management of separate programs, as well as collaboration among them. As such, a reproductive health approach would broaden the range of women served, encourage continuing service utilization by building women's confidence in their ability to make reproductive health decisions, and enhance women's dignity. Such an approach, premised on choice and on a basic commitment to justice and equity, could also garner broader political support than narrower family planning and maternal/child health approaches have yet achieved.
FAMILY PLANNING, MATERNAL AND CHILD HEALTH, 
CHILD SURVIVAL, AND SAFE MOTHERHOOD: 
WHO IS SERVED AND WHO IS NOT?

Women who wish to practice contraception, who are 
pregnant and plan to deliver, or who want to raise 
healthy infants and young children are the clientele 
usually intended to be served by programs in family 
planning (FP), maternal and child health (MCH) child 
survival, and safe motherhood. Increasingly, Third World 
women in all regions except some parts of Africa are 
using modern contraceptives both to space and to limit 
pregnancies. Contraceptive technology, family planning, 
and health services do not yet, however, guarantee that 
all women can do so safely and completely effectively, 
due, among other factors, to the ways in which the 
programs are designed and implemented and to the 
technologies on which they are based.

Millions of women who want to limit or space births do 
not use modern contraceptives because they fear the 
technology; they find services unavailable, inaccessible, 
or unacceptable; they are restrained by partners, family, 
or the community; or they lack information. Many find 
the single (or successive) act(s) of abortion preferable 
to contraceptives that require daily or frequent actions, 
contact with inadequate services, or tolerance of side 
effects. The limits of currently available modern 
contraceptive technologies -- primarily suited to women 
-- do not allow men to share the side effects and risks 
of contraception. Even when sterilization -- available 
to men and women -- is the method of choice, five times 
more women than men are sterilized around the world 
despite the fact that morbidity and mortality associated 
with tubal ligation are four-fold or more than those 
associated with vasectomy (Ross et al., 1985).

Furthermore, as Table 1 suggests, large categories of 
women cannot be served at all or are not served at some 
crucial point in their reproductive lives by existing 
programs. These include:

- women who want to practice contraception but 
  are excluded from services - the young, 
  unmarried (or not in a recognized union), or 
  nullipara; or for whom available contraceptives 
  are unacceptable, contraindicated, or some 
  combination of these;

- women with unwanted pregnancies who want to 
  terminate the pregnancy;

- women with reproductive tract infections, 
  including STDs and AIDS, and/or subfertile or 
  infertile women;
o prepubescent girls aged 5-15 (unless they are married and/or pregnant) whose reproductive systems are developing, and women with other reproductive health problems.

1. Women Who Want to Practice Contraception but Who Are Excluded from Services

Family planning programs have sought to facilitate the practice of effective fertility regulation (primarily modern contraception and sterilization) by the largest possible number of fertile couples. These programs usually measure their accomplishments in numbers of contraceptive "acceptors," "couple years of protection," and "births averted." Some have sought to make services more accessible by reducing costs to users through reimbursement for the costs of obtaining services, through mass education campaigns, or through subsidized commercial sales of oral contraceptives, spermicides and condoms. (See Table 1)

The basic infrastructure for delivery of family planning services (staff, buildings, and logistics systems) has already been developed in most developing countries, especially in Asia and Latin America, although less so in Africa and the Middle East. Of 800 million couples of reproductive age in the world (most of them in the Third World), somewhat more than 40 percent (325 million) are today estimated to use effective modern contraceptives and another 20-40 million couples use abstinence, withdrawal or other traditional methods (Mauldin and Segal, 1987).

Even when combined with MCH services, however, family planning programs do not yet meet the needs of the four major groups of women described above, nor do they yet reach or effectively serve all the women who want to use and are eligible for family planning program services.

At least 60 percent of Third World couples do not practice modern contraception. Surveys suggest that in Latin America and the Caribbean, some 50-60 percent of fertile couples do not practice family planning on average; in developing Asian countries (except China), about 60-80 percent do not; in the Middle East and North Africa, about 75 percent do not; and in Africa south of the Sahara, 90 percent do not practice any form of modern contraception. In most developed countries and China, 70 percent or more couples do practice contraception.

Various factors inhibit use. In many countries, the young, unmarried or nullipara are excluded as a matter of policy, or because of the values of service providers. Many women want to be pregnant, or accept pregnancy as
TABLE 1

I. SERVICE STRATEGIES OF MAJOR HEALTH PROGRAMS IN THE THIRD WORLD

<table>
<thead>
<tr>
<th>PRIMARY PROGRAM</th>
<th>CENTRAL OBJECTIVE</th>
<th>SERVICE FOR WOMEN</th>
<th>WOMEN SERVED</th>
<th>WOMEN NOT SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Planning</td>
<td>Avert pregnancies.</td>
<td>Contraception (usu­ally hormone, IUD, or sterilization).</td>
<td>Fertile women, married or in recognized unions, of higher parity who want to avoid pregnancy.</td>
<td>Not married, young, low parity women; women who seek to terminate an unwanted pregnancy; infertile women; women who seek to become pregnant; women with STIs and reproductive tract infections, girls 0-15.</td>
</tr>
<tr>
<td>MCH</td>
<td>Safe child birth; reduced infant and child mortality.</td>
<td>Prenatal care; &quot;safe delivery,&quot; child spacing.</td>
<td>Pregnant women who have decided to carry to term; mothers of children under five.</td>
<td>Nonpregnant women; women who seek to abort; women who are not mothers of children under 5; women with complicated pregnancies; girls 0-15; infertile women; women with STIs and reproductive tract infections.</td>
</tr>
<tr>
<td>Safe Motherhood</td>
<td>Reduce maternal deaths from 500,000 annually to 250,000 by the year 2000.</td>
<td>MCH as above; emergency obstetric care for complicated deliveries and abortion sequelae; legalization of abortion.</td>
<td>Pregnant women; women with septic or incomplete abortion.</td>
<td>Nonpregnant women; women who seek to abort; infertile women; women with STIs and lower reproductive tract infections; girls 0-15.</td>
</tr>
<tr>
<td>Child Survival*</td>
<td>Reduce infant and child mortality from 18 million to 6 million yearly.</td>
<td>None for women's health under GBDI; food supplements and family planning under FFP.</td>
<td>Mothers of children under 5.</td>
<td>Women who are not mothers of children under 5; girls 0-15.</td>
</tr>
</tbody>
</table>

II. A REPRODUCTIVE HEALTH APPROACH

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>OBJECTIVES</th>
<th>PRIMARY MEANS</th>
<th>CLIENTS</th>
<th>EXPECTED OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproduc­tive Health</td>
<td>Increased and more effective utilization of services, reduced morbidity as well as mortality</td>
<td>Modified strategies for health and family planning staff training and reward systems; expanded services; and enhanced choices of technologies and services.</td>
<td>Girls and women of reproductive age</td>
<td>Improved quality of family planning and health programs; broadened clientele; and continuing use, not simply initial acceptance, of technologies and practices.</td>
</tr>
</tbody>
</table>

*Child survival strategies formulated by UNICEF have advocated "GBO" (growth monitoring, oral rehydration, breastfeeding, and immunization); recently "FFF" (food supplements, Family planning, and female education) has been added.
"natural" or "God-given," not as something for which one plans. Also, women's partners often have veto power in fact as well as in law (Cook and Maine, 1987). Some countries and programs, for example, have begun to change policies and guidelines to reach adolescents at least with information if not with services and to encourage men to take more responsibility for fertility regulation (Gallen et al., 1986).

An important impediment to contraceptive use is the technology itself, as well as the service delivery systems (e.g., Potter et al., 1987). The range of available contraceptive technologies, though expanded in the last two decades, is still too narrow and needs to be broadened to meet the needs and circumstances of more women. The safety, as well as efficacy, of contraceptives needs to be improved (Segal and Mauldin, 1986). Unfortunately, women's voices are not often heard in discussions about contraceptive development, testing and introduction.

The most comprehensive assessment of modern contraception from women's perspectives is Bruce (forthcoming). Her article thoroughly reviews the intrinsic properties of contraceptive methods the balance of male and female responsibility for contraception and for risks entailed in contraceptive use the extent of both physical and social "exposure" required for a woman to gain access to and utilize contraceptives the effects of contraceptives on the user's future fertility the extent to which a contraceptive can be controlled (initiated and/or terminated) by the user or is dependent on intervention by providers and sexuality and sexual relations.

In October 1986, a meeting between women's health advocates and contraceptive researchers to review trends and issues in contraceptive development, sponsored by the International Women's Health Coalition and the Population Council, reviewed common ground between the two groups and issues on which full agreement cannot yet be reached. The meeting was based on a common statement of concern:

"In both the industrialized and developing worlds, we value women's rights to reproductive choice and we are committed to the highest quality and widest range of choice of reproductive health services for all women, without coercion, incentives or undue persuasion. We are equally committed to making available the most complete information about reproductive health and human sexuality, as a matter of human rights and informed consent. Such information includes risks, benefits, and short- and long-term consequences, both intended and unintended. Reproductive rights include the right of refusal of any and all
services or products. We believe these values need to be further explored, elaborated and given more concrete substance."

(International Women's Health Coalition and The Population Council, 1987)

Major points of agreement emerging from the meeting include the following, among others:

We should not expect or look for the "perfect" contraceptive, but should seek instead to expand the range of "good" methods.

The development of new contraceptives necessarily involves clinical trials that entail risks for women study subjects. While some risks may be unforeseeable, volunteers should be judiciously screened and provided with full information on the experimental nature of the drug or device and expected side effects. Trials should be carefully monitored.

Whereas some contraceptive methods are developed with the perceived needs of the Third World as a priority, it is important that contraceptive trials include relatively advantaged First World women as well as women of color and Third World women.

Public education about the risks and unknowns associated with a new method should begin before its broad-scale introduction. Contraceptive surveillance programs that track the experience of large groups of users of newly approved drugs should be encouraged, strengthened, and publicized.

As the range of contraceptive choices is narrowing -- owing to funding, insurance, and political problems, among others -- it is especially important that delivery systems provide the fullest possible range of approved methods.

The past decade's emphasis on "high-tech," provider-dependent methods has reduced family planning providers' knowledge of, and in some cases trust in, user-employed methods. Researchers and service providers, together with women's health advocates, need to help renew support for user-employed methods (condoms, spermicides, diaphragms, etc.) and practices to ensure a full range of birth control choices.
Specific strategies need to be worked out on abortion and on research on methods that act as abortifacients, because US government funding restrictions are already substantial, and various groups worldwide seek to restrict research and services even further.

Issues for further discussion and desirable actions on contraceptive development identified at the meeting include:

Provider-dependence, a characteristic of many "modern" contraceptives (injectables, implants, IUDs), challenges service delivery systems to adequately protect women's health and rights. Provider dependence can be a major drawback where delivery systems are weak, careless, or operate in a coercive context.

Programs for commercial and community based distribution of contraceptives are especially appropriate for barrier methods such as the condom... They increase users' access and freedom to use or not, and often decrease costs. They do not in their current form, however, provide sufficient information about contraindications and management of side effects for such methods as oral contraceptives. Nor do they usually link users to medical services.

... Both women's health advocates and researchers need to work to encourage broader funding guidelines and the generation of resources for relatively neglected methods, such as barrier methods, and for better service delivery mechanisms.

Similar conclusions were reached by primarily Third World feminists at the fifth International Meeting on Women and Health (held in Costa Rica, May 1987) convened by the Global Network for Reproductive Rights and organized by CEFEMINA.

2. Women with Unwanted Pregnancy

"Women in the Third World demand access to all methods of family planning, including abortion as a back-up method, and assert our right to choose for ourselves what is best for us in our situations. By protecting our lives we protect the lives of those children that we genuinely want and can care for. This is our conception of 'Pro-Life.'"
Third World Women at Nairobi

"...the United States does not consider abortion an acceptable element of family planning programs and will no longer contribute to those of which it is a part..."


Though many assert, or would like to believe, otherwise, abortion is an element of women's family planning behavior. Despite access to modern contraceptives, women abort or "induce late menses" through all means and regardless of the law. Women have always and will continue to resort to abortion because contraceptives fail, users fail, contraceptive services are not always available and accessible, or abortion is simply preferable to contraception for some women at some times.

An estimated 30-45 million women -- as many women as use oral contraceptives worldwide -- resort to induced abortion in the Third World each year, fully half of them in countries where the procedure is legally restricted or where safe services, though legal, are not available. In countries as disparate as Bangladesh and Brazil, as in the Third World as a whole, an estimated 20-35 percent of all pregnancies are deliberately terminated. And, in countries where data are available, a high proportion of women resort to abortion at least once in their lives, even when access to contraceptives is relatively easy.

Policymakers today (for example, most of the speakers and panelists at the International "Safe Motherhood" Conference held in Nairobi, February 1987) assert that the best (and by implication the only) means to deal with abortion in the face of legal restrictions is to prevent it through contraception and through changes in timing and frequency of sexual activity (i.e., abstinence, especially by adolescents and outside marriage). It is impossible to estimate how many abortions might be prevented by contraception if it were readily available, but certainly not all would be. In the U.S., for example, where 70 percent of reproductive age couples practice contraception, one quarter or more of all pregnancies are unwanted and eventually aborted.

Current U.S. policy restrictions on the development of safe, nonsurgical contraceptives that may (in some ways or in some circumstances) act as abortifacients, and also restrictions on abortifacients and safe abortion services, are particularly illogical from a health
perspective, given abortion mortality and morbidity rates in the Third World. These restrictions virtually insure that millions of women will continue to risk death and severe morbidity when faced with unwanted pregnancy because many programs fear that their funding will be cut or eliminated if they ignore U.S. policy.

Even a safe, widely applicable, contragestive agent (such as RU486, now under development) would not, however, preclude the need for safe surgical services. Such services will probably always be needed to back up contraceptive failures that are not recognized until later stages of gestation and to serve women who delay seeking abortion until advanced pregnancy.

With regard to sexual behavior, abstinence, though widely practiced in many traditional societies, seems to have been undermined by modernization and Western cultural values, which promote more relaxed norms about sexual relations. Changes in sexual activity, therefore, seem an unlikely means to reduce unwanted pregnancy. Increasing fear of AIDS may, however, reduce sexual encounters; it is too soon to tell.

While legalizing access to safe abortion, as suggested by the Safe Motherhood Conference, might help, two major problems arise with legalization. First, as is clear in countries such as India and Zambia, legalization itself does not assure that safe services are available and accessible. Second, efforts to legalize abortion where safe services are in fact already available, though illicit, can themselves generate active political opposition where none currently exists, jeopardizing the very services legalization would protect (cf. Cook and Dickens, 1978).

Family planning programs offer prevention of unwanted pregnancy through contraception; the Safe Motherhood initiative promises treatment for septic and incomplete abortions, and calls for legalization. Neither FP programs nor Safe Motherhood initiatives currently offers nor proposes safe abortion services as a back-up for contraceptive failure, as a health measure, or as a woman's right, primarily because of U.S. policies and actions, especially since 1984, that would cut off U.S. support for agencies that provide abortion services, counselling, or referral (Dixon-Mueller, forthcoming; Germain, forthcoming).

Yet, early, safe abortions would prevent one quarter to one half of the 500,000 maternal deaths that occur every year, 99 percent of them in the Third World. Safe abortion would save hundreds of thousands, if not millions, of women from severe morbidity, including sterility, due to clandestine abortions. Safe, early services would relieve the tremendous emotional burden
imposed by fear of unwanted pregnancy, and release many women from the physical and mental traumas of carrying an unwanted pregnancy to term and of facing the rigors of delivery when the child is not wanted. Such services would also alleviate rapidly growing problems of child abandonment and abuse, even infanticide, in many countries.

Safe, early abortion would dramatically reduce the drain on health systems -- money, beds, blood, medicines -- currently imposed by septic and incomplete abortion (Winikoff et al., 1987). Early abortion is safe. In general, where appropriate services are available, as in the United States, induced abortion has very low death rates, less than one per 100,000 procedures, and far fewer risks than carrying a pregnancy to term (10 deaths per 100,000 live births in the US, 400-1,000 deaths per 100,000 live births in the Third World).

Early abortion is much more manageable at all levels of the health system and cheaper than other means proposed to reduce maternal mortality (caesarean section, facilities for blood transfusion, emergency obstetrical care). The equipment for early "menstrual regulation," (a plastic, hand-held syringe and cannula) is cheap and simple to operate and maintain. Paramedics as well as physicians have been trained to use M.R. effectively and safely even under extremely limited health service conditions. When it is available, women use it (at least 70-150,000 in Bangladesh annually, one million in India, thousands in major cities of Indonesia and Latin America), and, as important, usually adopt modern contraception after the procedure. The M.R. technique may also be used to treat septic and incomplete abortions at all levels of the health system. Equipment and training for abortion at later stages of pregnancy (eight weeks LMP and more) are somewhat more demanding but also feasible at least at higher levels of the health system, even where human and financial resources are limited.

Excluding China, where abortion is both legal and available on demand, 206 million women aged 15-44 live in Third World countries where abortion is allowed on demand; another 107 million live in countries where abortion is permitted to protect women's health; even the most restrictive countries, where another 252 million women aged 15-44 live, sometimes permit abortion for research or training or other strictly defined purposes (Nortman, personal communication). Important reductions in abortion mortality and morbidity, and by extension maternal mortality and morbidity, could therefore be achieved simply by assuring that safe services are actually available and accessible to women who qualify for them under existing laws.

For example, in India where abortion is legal, only one
million out of an estimated six million abortions annually are performed by trained providers in safe conditions; most of these are urban. In Bangladesh, where menstrual regulation is allowed, services reach only 10-20 percent of the estimated 780,000 women who attempt to terminate unwanted pregnancy every year (Dixon-Mueller, 1987). In Zambia, where abortion is permitted on social grounds, only one in ten procedures in the Lusaka teaching hospital is considered a legal abortion because three doctors' signatures are required and these are difficult to obtain; nine in ten procedures are treatments for the consequences of illegal abortion (Coeytaux et al., 1986). In Brazil, where access is very restricted legally, even those women who qualify -- because the pregnancy is due to rape or incest or endangers the life of the mother -- have often not been able to get the required doctors' recommendations. In Indonesia, where abortion is legally restricted, more women need to know that teaching hospitals will perform M.R. and abortion for purposes of research and medical training.

Wherever abortion is legally restricted -- especially in fundamentalist Islamic countries, much of Africa, and virtually all of Latin America -- women with money can often obtain relatively safe services. The risk of mortality and morbidity due to clandestine abortion thus falls primarily on poor women and, increasingly, on adolescents. From both health and equity perspectives, this situation is unacceptable.

3. Women with Reproductive Tract Infections and/or Infertility

Very little is known about the prevalence, etiology and consequences of reproductive tract infections in Third World women. One of the few population-based studies showed that, among 3,000 village women interviewed in Matlab, Bangladesh, 22 percent reported symptoms consistent with genital tract infections; of those examined, more than two-thirds actually had infections (Wasserheit, 1986). Anecdotal evidence and anthropological, hospital, and clinic-based studies suggest that reproductive tract infections are probably endemic in the Third World, are definitely debilitating for women and men, can have very adverse consequences for marital relations, and lead to subfertility, infertility, pregnancy wastage and low birth weights as well as other congenital defects (Brunham et al.; Muir and Belsey, 1980; Rosero, 1987).

Reproductive tract infections can be important contributing factors to mortality as well as morbidity when they lead to cervical cancer or ectopic pregnancy. In the case of AIDS, morbidity is severe and mortality is apparently the inevitable outcome. Finally, although
reproductive tract infections are a contraindication for IUD insertion, in many Third World settings, many women requesting IUDs are not screened and treated for infection, putting them at risk of pelvic inflammatory disease (PID), a major cause of infertility.

Although cost-effective, transferable technologies exist (see, e.g., Rosenbert et al., 1986), virtually nowhere in the Third World have health services been available -- except for a few, higher income women -- to screen for and treat reproductive tract infections, to help women who are subfertile or infertile, or even to educate both men and women on how to avoid sexually transmitted diseases and the fertility problems they cause in the first place. It is a sad irony, especially in the face of the AIDS epidemic, that family planning programs have generally not provided condoms or instructions for their use even though they say they will, tending to prefer the "more secure" contraceptives (IUD, sterilization, or hormonal methods). Some family planning programs provide sex education, including facts on the efficacy of condoms in preventing disease transmission, but those that do are too few and generally give it too little attention. Condom sales through "social marketing programs" have been increasing and are important in some countries.

Screening and treatment for sexually transmitted diseases have been the province of health agencies, often separated from other health care, stigmatized, and especially unapproachable for women. STDs are associated with women who are not "decent" or with men who are "vulnerable" because they visit prostitutes. Although the chaste wife or lover has been recognized as a social victim, she has not been recognized as the chief physical victim of her partner's philandering, though the AIDS epidemic may soon change this.

4. Girls and Women with Other Health Problems

Programs that focus on reducing births and/or deaths tend to downplay the role of morbidity both as a contributing factor to maternal mortality, pregnancy wastage, and poor pregnancy outcomes, and also in its own right. Many maternal deaths are probably the result of repeated "insults accumulated over time" (see Chen, 1986, for an analogous argument on infant and child mortality, and Fathalla, 1987).

The young woman who dies in first childbirth at age 15 or 16 is likely to have died from causes, such as obstructed labor or hemorrhage, associated with malnutrition and chronic anemia from childhood. Chances are that she received less food and health care than did her brothers in most societies. Few child survival or MCH programs even define such gender differentials as a problem, let alone actively seek to combat them. Furthermore, they
generally treat only children under 5 years of age, leaving the girl aged 6-15 unattended in her formative and some of her most vulnerable years.

The older, higher parity woman who dies in childbirth has not only the disadvantages accumulated from her girlhood, but she may also have been injured in or depleted by previous pregnancies. Women of parity five or more have a significantly higher risk of death than those of lower parity (Fathalla, 1987).

Morbidity includes not only physical but also emotional ill health. Lack of information and education about their bodies, sex and sexuality leaves women vulnerable to both physical and emotional abuse by men. Equity and a strong sense of dignity are virtually impossible without an understanding of sexuality. Lack of education can make it more difficult for women to use certain methods of contraception, to avoid sexually transmitted diseases (through hygiene as well as sexual and contraceptive practices), to recognize pregnancy, and to seek help. As sexual mores, family structures, and social norms change, adolescent women are an increasingly vulnerable group, though women of all ages suffer from lack of knowledge.

Finally, in virtually all societies at all income levels, many women are subject not simply to sexual abuse, but also to generalized violence, even when they are pregnant, because they are women. Drunk or angry husbands, rejected suitors, or in-laws abuse women with little censure in most countries, including the U.S. Except for small experimental projects, these women generally have no recourse and no support. Health workers and others need to be trained to watch for indications of abuse and to offer counselling. (I am grateful to Ruth Dixon-Mueller for raising this point.)

Some women may also be subject to traditional practices (such as infibulation) and to occupational hazards that impair their reproductive health, often seriously. For example, agricultural field labor, especially in deep water, can contribute to vaginal infections and heavy manual labor can be dangerous for some women during pregnancy.

WHAT DO THIRD WORLD WOMEN WANT?

All women want to be healthy, and most want to regulate their reproduction, that is, to have as many children as they want, when they want them, and without risk to their own or their child's health. They want health services for themselves and their children, and for the safe delivery of healthy infants.
Women want contraceptives that are easily available, accessible (i.e., low in cost both financially and socially) and acceptable, to postpone, to space, or to limit their childbearing. They want more methods for men, and male cooperation.

Many women now excluded from contraceptive services want access -- the young, the unmarried, and those who do not yet have a child or do not want any.

Many women need better access. Those who are employed or face multiple demands on their time find access restricted because clinic hours conflict with their work schedules; they have to wait for hours or make repeated visits for service; there may be a shortage of supplies; or they may have to travel long distances just to reach a clinic or contraceptive dispenser. In some countries, laws and policies restrict access to some or all contraceptives, including sterilization.

Pregnant women determined to avoid another birth want safe abortion services.

Women want services that treat them with respect, provide full information, supportive counselling, choice among contraceptive methods, the choice to terminate pregnancy safely, and follow up care to cope with side effects or to enable them to switch contraceptive methods. Most family planning delivery systems -- clinic based, community based, or commercial -- do not meet this ideal.

Finally, women want services to meet their multiple reproductive health needs. As it is, many women faced with the time and other costs of seeking health care for their families as well as themselves, often from different sources, frequently give priority to their children's health care over their own.

REPRODUCTIVE HEALTH: REDEFINITION OF THE PROBLEM AND ALTERNATIVE APPROACHES

For poor Third World women to exercise their right to health care and to regulate their fertility safely and effectively, family planning and health technologies and services must be made available -- and strengthened so that they are both accessible and acceptable. The resources required must be sustained, preferably increased, which in turn requires broadening the base of political and social support in donor countries as well as in the Third World countries themselves. Strengthening services and also broadening support for these services require a redefinition of the problem.
1. Redefining the Problem

As noted above, virtually nowhere are contraceptives physically available to all the women and men who need them. Some argue, therefore, that priority should continue to be given to contraceptive supply and acceptance. It is not sufficient, however, simply to make commodities available. The delivery systems are as important as the technologies. As Bruce suggests (1987), "whatever the intrinsic properties of a given contraceptive [or health] technology, ... the service delivery mechanisms that encircle it ... may determine the acceptability of contraception [or health care] itself as well as the individual method ... women do not choose simply to use a specific method, they choose or accept interaction with a ... service apparatus."

Maternal and child health programs, which have tended to approach women primarily as the means to achieve child health and to neglect the "M" in MCH, need to give more attention to emergency obstetrical and postnatal care for the mother as recommended by "Safe Motherhood" proponents; to safe termination of unwanted pregnancy; and also to underlying factors in high maternal mortality rates such as anemia, malnutrition, and the all too common tendency to give girls less access than boys to health care, food, and other family resources. "Child survival" programs, which seem to eliminate the "M" altogether in name and in fact, need to recognize and help alleviate the heavy demands they place on mothers' time, financial resources and skills (Leslie, 1987).

The solution is not to drastically alter but to modify family planning and related programs to make women's well-being and reproductive choice the central objectives. A reproductive health approach would build on the base already established by population and maternal and child health programs. The "reproductive health" concept provides an underlying set of values, premised on choice, and an overarching standard for collaboration among programs now perceived to compete for scarce resources.

Reproductive health programming, as distinct from more narrowly conceived family planning or MCH programs, has as its basic objectives both reproductive choice and reduction of ill health and death among women due to their sexuality and their reproductive function (see lower section of Table 1). Recognizing as well that women's health status has direct effects on infant and child survival, a reproductive health approach would seek to enable Third World women to:

- Regulate their own fertility safely and effectively by conceiving when desired, by
terminating unwanted pregnancies, and by carrying wanted pregnancies to term;

- Remain free of disease, disability or death associated with reproduction and sexuality;
- Bear and raise healthy children.

Ideally, reproductive health care would include not only contraception but also infertility prevention, counseling and treatment, safe menstrual regulation and induced abortion services, prenatal care, supervised delivery and postpartum care, education, screening and treatment for reproductive tract infections and gynecological problems resulting from age, repeated births and birth trauma, and infant and child health services. Such services would give priority attention to providing full information, treating clients with respect, and establishing follow-up procedures. They would emphasize continuing use of contraceptive and other services, rather than simply initial acceptance. (See Table 2, which presents conclusions similar to those reached in the 1986 meeting between women's health advocates and contraceptive researchers, International Women's Health Coalition and The Population Council).

2. Alternative Approaches

Many of the basic means to achieve reproductive health objectives have been previously recognized as beneficial, for example, improved program and clinic management and logistics systems to assure the regular flow of supplies, and expanded research to develop safer, more easily used contraceptives — for both women and men (e.g., UNFPA et al., 1981). The problem is that these aspects of programs have been accorded relatively low priority and not enough progress has yet been made.

Other on-going family planning activities and procedures require more substantive modifications. Training materials for staff and information materials for clients need to be revised to emphasize contraceptive choice and include other reproductive health needs (e.g. Edmunds et al., 1987). Reward systems for staff and program evaluation criteria need to give more weight to continuing use of services rather than simply initial acceptance, as well as to encourage respectful treatment of clients (e.g., Crowley et al., 1987; Lapham and Simmons, 1987; Phillips et al., 1986; Simmons et al., 1986). Record systems must be modified so that each client, not just the particular service or contraceptive method delivered, can be followed over time (see Kay, 1987 for Bangladesh experience in revising record systems). Much more needs to be done to encourage men to take responsibility for contraception (including
TABLE 2
THE REPRODUCTIVE HEALTH APPROACH

I. CHARACTERISTICS OF REPRODUCTIVE HEALTH CARE

Comprehensive
- Gynaecological screening and treatment (for infections, cancer)
- Counselling about sexuality, contraception, abortion, infertility
- Choice of contraceptive methods, and attention to contraceptive safety
- Abortion for contraceptive failure or non-use
- Pregnancy, delivery, and post-natal care (more and better maternal health intervention at primary and secondary levels)

High quality
- Provides full information
- Treats clients with respect
- Follows them up

Premised on informed choice

II. REQUIREMENTS FOR IMPLEMENTATION

Build on existing programs through:
- Revised staff training content and procedures
- Intensified staff supervision and modified reward systems
- Additional services

Expand available resources through:
- Collaboration among programs
- Broadened political support
development of more male contraceptive methods) and to support their partners in doing so (Gallen et al., 1986).

No one strategy to achieve reproductive health care of high quality exists, given differences among countries in resources, cultural beliefs and practices, and attitudes of key actors (policymakers, physicians, donors, clients, and others). Furthermore, care must be exercised to assess women's specific needs and perspectives in each country (or section of a country). It is imperative to involve women's health advocates from the country in the process, as well as service providers who know what the problems, prospects, and limitations are (cf. Joffe, 1986; International Women's Health Coalition and The Population Council, 1986).

Throughout the Third World, where competition for scarce public resources (human and financial) is intense and political commitment to women's reproductive health may not yet be strong, comprehensive reproductive health programs may not be feasible in the short run. Much can be done, nonetheless, by modifying and augmenting existing family planning and health -- especially child health -- programs. Even a modest increase in health service coverage, for delivery and also for incomplete abortion and its sequelae, could reduce deaths by as much as 25 to 50 percent in the next decade (Winikoff et al., 1986; Herz and Measham, 1987). If all unwanted pregnancies were avoided through effective contraception, and the need for induced abortion reduced, as many as 25 percent of maternal deaths could be avoided. If safe abortion services were provided, 25-50 percent of maternal deaths in many countries could be eliminated.

The potential scope of innovation is broad. In setting program priorities, it is essential to recognize the woman as important in her own right, as well as the key actor in fertility regulation and in infant and child health. Account must be taken of her needs and constraints, not just of the needs of her children, family, and society. Competing or conflicting claims on scarce resources require explicit assessment. The tendency of population programs to give priority to fertility regulation over related health problems, and the tendency of health programs to give priority to child health over maternal health need modification. Examples of how choices have been made or might be made in particular countries demonstrate what might be done.

3. Country Examples

In Bangladesh, maternal, infant, and child mortality rates are among the highest in the world. The population is growing at 2.7 percent per year, and only one quarter of reproductive age couples as yet practice modern contraception. Priority has recently been given to
reducing the birth rate as rapidly as possible. The government emphasizes "more secure" contraceptive methods -- the IUD and sterilization -- and facilitates access to menstrual regulation services to reduce the very high number (perhaps 780,000 per year) of clandestine abortions. Relatively less attention and fewer resources have been given to MCH services, although recognition of their importance is increasing. Broader contraceptive choice, management of contraceptive side effects, and continuity and effectiveness of contraceptive practice have received little emphasis.

In deciding what more can be done, Bangladesh policymakers face major resource constraints -- both at the level of individual households, most of which are simply too poor to pay for family planning or MCH services, and also at the national level where infrastructure, transport, logistical systems and personnel are extremely limited. Reallocation of existing resources and strategies to strengthen their utilization, as described below, could enhance achievement of both reproductive health and population control objectives.

Higher priority needs to be given in Bangladesh to the basic logistics systems that determine whether family planning and MCH services are actually available and accessible at the village level. Many women in Bangladesh cannot reach clinics because their movement outside the home is constrained by traditions of "seclusion" and by demands on their time from work, child care, and household management responsibilities. Mobile units could, for example, provide contraceptive pills and immunization as well as sterilization and IUD services. If regular enough, they could also provide prenatal and follow-up care.

A reproductive health approach in Bangladesh would seek to improve the acceptability of family planning by modifying training, work plans, record systems, and supervision of fieldworkers to expand contraceptive choices; improve client follow-up and thereby continuity and effectiveness of contraceptive use; and provide information and support to women to utilize MCH and menstrual regulation services early in pregnancy. Such a strategy has been shown to be effective and of reasonable cost -- for both health and demographic objectives -- in a large experimental project and several smaller ones (Koenig et al., 1987; Phillips et al.; Simmons). Furthermore, large scale programs that reach women with other resources, such as credit (e.g., the Grameen Bank), could provide health information and referral and also mobilize women to demand improvements in services.

Carefully targeted research on other aspects of acceptability in Bangladesh should investigate
contraceptive safety and side effects, reproductive tract infections, and reasons for non-use or late use of menstrual regulation services. Research on pregnancy outcomes -- for both the mother and the infant -- is needed to determine prenatal, birth or postnatal practices that are harmful, and also to describe patterns of clandestine abortion as a basis for determining training curricula and public information needs.

Indonesia, in contrast to Bangladesh, has one of the strongest and most extensive family planning programs in the Third World. Perhaps 55 percent of couples practice contraception. Family planning practice is encouraged by every level of government, emphasis on the IUD and, more recently, NORPLANT\textsuperscript{R} (capsules containing hormones implanted under a woman's skin to prevent conception for up to five years). Recognizing that contraceptive discontinuation and failure rates might be reduced by expanding the range of contraceptives available, the government has recently also allowed commercial sale of condoms.

Logistical systems for service delivery down to the local level are stronger than in Bangladesh. Program improvements could, therefore, emphasize encouraging women to switch contraceptive methods rather than stop use altogether, screening and treatment for reproductive tract infections in women requesting IUDs, proper fitting of IUDs to reduce failures, and client follow-up to manage side effects. Furthermore, research to closely monitor contraceptive safety and side effects, discouraged until recently, should be pursued on a priority basis along with research on and services for reproductive tract infections. Because clandestine abortion is thought to be rising, at least in urban areas, and traditional means of "inducing menses" are widespread but ineffectual or dangerous, introduction of menstrual regulation services would be very beneficial. Family planning practice might also be enhanced by strengthening child health services that bring women of reproductive age into the health and family planning system.

Little systematic, program oriented research has been done on practices (including induced abortion) during pregnancy, birth, and the postpartum period that affect women's health in Indonesia. Rural surveillance systems for child health are being established, into which should be incorporated procedures to monitor the condition of mothers and pregnant women as well. Such research could identify other means to serve women effectively.

Finally, research is needed to examine women's responses to contraceptive choices and the best ways to serve them. The IPPF affiliate in Indonesia is experimenting with a model of high quality, comprehensive reproductive health
care that emphasizes counselling, choice, and follow up. Their family planning and health materials for staff and clients could also be applied in the government program.

In Brazil, birth rates have fallen substantially in the last decade, except among teenagers and in some regions of the country. About 65 percent of couples use some form of contraception, despite the fact that contraceptive choices are limited not only by government policy but also by public criticism of the IUD and hormonal methods, and by the fact that sterilization is illegal though widely practiced. In the absence of a government family planning program, pills and sterilization have been provided primarily by non-government organizations and private doctors, while pills, spermicides and condoms are sold commercially. Induced abortion rates are very high (perhaps one million annually as against four million births).

Feminist health advocates and progressive doctors have recently persuaded the government to adopt a comprehensive women's health policy that includes family planning as a basic component of women's health care. The policy emphasizes quality of service and patient involvement, seeks to reduce excessive medicalization of health services -- especially for childbirth, and recognizes induced abortion as a public health problem.

In this favorable environment, reproductive health advocates are seeking implementation of the policy and extension of coverage to teenagers. They could also pursue several low cost activities to improve available technologies and modes of service delivery. For example, a process could be designed for dialogue between contraceptive researchers and women's health advocates to assure that women have full information on contraceptives and a voice in contraceptive development. Furthermore, the role of women's health advocacy groups in informing and counselling women about contraceptive choices, broader reproductive health, and sexuality should be strengthened so that women can make fully informed choices.

Evaluations are needed of the ways in which the two most widely available methods in Brazil, the pill and sterilization, are currently delivered to recommend means of ensuring safety and reducing side effects. For example, contraceptive pills sold over the counter (the usual source for most women) should have an informational insert suitable for semi-literate or illiterate women that describes contraindications and instructions on proper use.

Research and seminars on induced abortion (incidence and consequences for the woman and for the health care system) are also needed to educate the public and to
support efforts to decriminalize abortion and make safe, low cost services available. Finally, approaches to the treatment of reproductive tract infections need to be developed to determine the extent, nature, and consequences of these infections and to design information campaigns to promote use of the condom as a protective measure, to screen and treat both women and men, and to provide information on infertility services.

In sub-Saharan Africa, contraceptive use is exceedingly low, maternal and infant mortality very high, and sexually transmitted diseases and infertility widespread. Male dominance and various cultural norms encourage early and repeated pregnancies. Family planning services, usually integrated with MCH, cannot meet even the small existing demand for contraceptives in some countries, and in others services are virtually nonexistent. Almost everywhere, family planning and health programs are understaffed and short of supplies. These patterns, along with changing social norms and economic circumstances have led, among other things, to increasing rates of abortion, especially in urban areas and among young, unmarried women (e.g., Nichols et al., 1986), usually under very dangerous conditions.

Many agencies, including some African governments, are working to expand services. A reproductive health approach would encourage, in these broader efforts, attention to infertility -- especially prevention through sex education, screening and treatment for sexually transmitted diseases -- as well as contraceptive choice. Given the large number of hospital beds and blood supplies required to treat septic abortion cases, attention should be paid to the introduction of safe abortion services.

Contraceptive services should be based on research to determine women's perceptions of their reproductive health needs, their views about services, and their knowledge about contraceptives. Promotion must include full information and counselling about various methods, their disadvantages, and their benefits. Fear of contraceptive side effects is widespread in sub-Saharan Africa, as elsewhere. Some women, fearing that modern contraceptives will damage their future fertility, choose abortion rather than contraception, not realizing that clandestine abortion is highly likely to cause infection or physical damage that will make them sterile (Coeytaux et al., 1986).

Another important initiative would be with teenagers, especially in urban areas where social norms and family structures are undergoing rapid change. Programs would seek to educate these new generations not just about contraception and prevention of STDs, but also about broader gender roles, safe sexual behavior that respects
women as equal partners, and ways that teenage women can protect themselves from exploitation.

BUILDING ALLIANCES

Women-centered reproductive health approaches that emphasize options and quality of care -- widely accepted as a woman's right -- could appeal to more constituencies than have traditional family planning programs. These several constituencies include, among others:

- Population professionals who want both to increase the number of contraceptive users and to support their continuing use for substantial enough periods to have both demographic and health effects;

- Child survival and primary health care professionals, as well as women's health advocates, who recognize family planning as an essential health service for women and children;

- Those concerned with "women in development," who seek to enable women to make choices about their lives and to more effectively and safely manage their productive, reproductive and household management roles;

- Proponents of social justice and human rights who recognize that women cannot exercise their basic rights fully unless they have effective access to comprehensive reproductive health care;

- Other professionals and organizations, including the U.S. Congress and a wider public, who are (or can be encouraged to be) concerned about economic development and the reduction of poverty in the Third World.

To date these various constituencies have at best ignored each other and at worst, have come into conflict (see, e.g., Connell, 1987; Rooks, 1985), largely because of their divergent values and perceptions about the benefits or drawbacks of population control (Dixon-Mueller, forthcoming; Hartman, 1987). A reproductive health approach health services, with women's health and reproductive choice as its central concerns, would do much to lessen the conflict and to generate a coalition in support of sustained, preferably increased resource allocation. At the same time, each of these various interest groups could do more in its own sphere to assure Third World women's access to services.

*   *   *
These problems are fundamentally human problems. The solutions must be both humane and responsive to the complexities of human behavior. For both humanitarian and political reasons, those concerned must reaffirm their commitment to reproductive choice, modify program approaches to emphasize choices and quality of care, and broaden their mandate to embrace women's multiple reproductive health needs. In so doing, alliances with other actors will be possible, for the benefit of women, their families, and their societies around the world.
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