Population Control and Women's Health: Balancing the Scales

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At least half a million women die annually in the Third World due to pregnancy, birth, and unsafe abortion; uncounted millions suffer chronic, severe health problems or infertility. Most illness and death due to reproduction and sexuality is, however, preventable.

IWHC seeks to generate practical experience, leadership, alliances, and the political will required to ensure reproductive health and dignity for girls and women throughout the Third World.

Introduction

To most people, the "population problem" means "overpopulation"— primarily in the Third World, where three-quarters of the world's five billion people live. "Overpopulation" conjures up images of malnourished and dying children, burgeoning slums, deforestation and desertification, an unending cycle of poverty, disease, illiteracy, and social and political chaos. Population growth, along with poorly planned industrialization and environmental destruction, are seen as threats to sustaining life at acceptable levels in the future.

Hoping to change this devastating prospect, family planning and related programs have supplied millions of women in the Third World with contraceptives which would otherwise be unavailable to them. Most such programs have viewed women as producers of too many babies and as potential contraceptive "acceptors." The tendency to neglect other aspects of women's reproductive health has often undermined or negated the achievement of effective and widespread contraceptive use, however. For example, inappropriate contraceptive use due to poor counselling, and high discontinuation rates due to side effects or infection, among other causes, are common in the Third World.

The "population problem" and possible solutions need careful review and redefinition. A "reproductive health" approach, with women at its center, could considerably strengthen the achievements of existing family planning and health programs, while helping women to attain health, dignity, and basic rights.

A reproductive health approach requires:

- Reallocation of resources among existing programs;
- Attention to currently neglected reproductive health issues;
- Changes in training and reward systems to enable and encourage service providers to offer choices and to treat women with respect;
- Services for girls and women currently excluded from programs;
- Commitment, not only to improving contraceptive understanding and use, but also to empowering women to manage their overall health and sexuality; and
- Increased participation by women in reproductive health policy and program decisions to build political will and institutional impetus for program changes.

The "Population Problem" Defined

Since 1965, population growth rates have slowed almost everywhere except in Africa (and recently, possibly, in China). Nonetheless, the world's population will continue to grow rapidly at least until the turn of the century. In Africa alone, the population will probably grow by over 300 million. In the next 20 years, the current world population of 5.1 billion is likely to increase by one third. The populations of developing countries, if they continue growing at 2 percent annually on average, will double in 34 years.

Since the 1950s, scholars, policy makers and others have debated, without resolution, whether or not such increases are irreparably destructive of natural resources and whether they inhibit or enhance economic development. Most agree, nonetheless, that rapid population growth in poor countries makes it more difficult, or even impossible, for all people to attain a reasonable quality of life. In Bangladesh, for example, where unemployment or underemployment already affect 50 percent of the labor force, it is hard to envision how jobs can be found for the additional one million people entering the labor force each year. In Kenya, 300,000 enter the labor market annually, but only 18,000 new jobs are created. By the year 2000, countries such as Kenya face a doubling or tripling of their school age population; estimates are that, in Nairobi alone, 44,000 primary school students will not find a place in school by that year.

Use of Contraception Globally

Of 800 million couples of reproductive age in the world (most of them in the Third World), only 40 percent are today estimated to use modern contraception. Approximately 2.5-5.0 percent say they use abstinence, withdrawal, or other traditional methods. In most developed countries, and China, 70 percent or more couples use contraception.

Surveys suggest that in Latin America and the Caribbean, some 50-60 percent of fertile couples do not contracept on average; in most 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 use any form of contraception.

Why Birth Rates Are High

Populations grow rapidly for many reasons. First, because of declining mortality and rapid population growth in the past 20 years, the number of women entering the reproductive ages (15-49 years) is increasing in the Third World. This produces a built-in "demographic momentum" for rapid future growth.

Second, from the perspective of individual couples in the Third World, high fertility is often beneficial. Children can be important sources of labor and income, old age security, social status, and enjoyment. Many couples know that some of their children are likely to die before the age of five, as infant mortality rates in many countries remain tragically high. People therefore have many children to ensure that some survive.

Third, the means of reproductive choice are often not available to women and men who want them. Lack of sex education and contraceptive services, together with tradition and the wider social environment, mean that many women in the Third World spend most of their lives pregnant or lactating,

recovering from pregnancy and birth, or coping with the effects of clandestine abortion.

Even when services are available, women often do not have a choice in the matter. Preference for sons over daughters, pressures from men and in-laws, and male dominance of sexual relations may force women to have more pregnancies than they otherwise would.

Strategies to Date

Population growth in the Third World was first recognized as a severe problem by the United States and by some Third World countries in the early 1960s. The primary strategy launched to reduce birth rates was development and distribution of modern means of contraception through family planning programs. Initially financed primarily by the United States and other Western governments, and more recently by Third World governments and major international development organizations, family planning programs have sought to facilitate contraception by the largest possible number of fertile couples. Generally, these programs have measured their accomplishments in numbers of contraceptive or sterilization "acceptors" and statistical estimates of "births averted."

Major institutions such as the United Nations Fund for Population Activities (UNFPA) and the International Planned Parenthood Federation (IPPF) were established in the late 1960s and early 1970s to provide family planning services and technical assistance. Within the same decade, universities and other institutions set up population centers to study both the biological and the social science aspects of fertility control and contraceptive development.

Additional related programs have included maternal and child health (MCH), Child Survival, and the recent Safe Motherhood Initiative, all of which, at least in theory, recognize family planning as a key to achieving their own goals. But MCH programs have tended to emphasize child health, attending to women's health as a means to that end rather than an end in itself. Similarly, the newer "Child Survival"

Salma and Zarina of Bangladesh

For Salma and Zarina, as for most of the approximately 40 million girls and women who live in rural Bangladesh, health services are not readily available. Their ability to travel to clinics or other service providers is limited by the time demands of their daily struggles to survive, and frequently by the opposition of their husbands, in-laws or community leaders.

Married at fifteen, Salma has already given birth to four children, although she is only twenty-two years old. Her third child, a boy, died at one month from diarrhea and malnutrition, and Salma is pregnant again. Like other women in her family, Salma works fourteen to sixteen hours a day. In addition to caring for her children, husband and in-laws, she processes rice in a neighbor's house to earn much-needed cash. Salma depends on her older daughter, who is only five, to care for the baby; and on her son to graze the cow whose milk Salma's husband sells in the local market.

Zarina, who is thirty-three, has had eight children. Six have survived— one died at birth and the other died of measles. Desperate to avoid another birth, Zarina recently turned to the local, traditional midwife for an abortion. She hemorrhaged and nearly died; now she is unable to perform the hard labor required for her own and for her family's sustenance.

programs focus on children's immunization, growth monitoring, and oral rehydration (a treatment to prevent death due to diarrhea). These programs provide few if any services for the woman herself, and tend to place heavy demands on the mothers' time, financial resources, and skills.

Since 1987, attention has been drawn to the mother herself through the Safe Motherhood Initiative (SMI), which seeks to reduce pregnancy-related mortality through prenatal care, emergency obstetrical services and postnatal care. Contraception is recognized as an important means to prevent the highest risk pregnancies. Although SMI recognizes that botched abortions are a major cause of maternal mortality, provision of safe abortion services is not an explicit component of SMI.

Today, most Third World countries have national population or family planning programs as a population control measure or as a health measure. Several new contraceptives and improved sterilization techniques have been developed in the last two decades. The accomplishments of population and other related health programs have been substantial. However, their effectiveness has varied considerably both within and across countries. Much remains to be done to enhance their achievements and extend their services.

Few, if any, of these programs yet recognize or provide services for major reproductive health problems that affect fertility decisions directly and indirectly, such as infertility, sexually transmitted diseases (STDs), or violence. Nor do they attend to the health of girls in their formative years (ages 5-15) when health, nutrition and sex education could prepare them for safe sexual relations and childbearing as adults. Few family planning and related programs effectively include men.

More than a Problem of Contraception

Solving the "population problem" requires more than simply provision of contraceptives. Fertility control involves the most intimate of human relations, complex behaviors, and substantial risks. To control their own reproduction, therefore, women must also be able to achieve social status and dignity, to manage their own health and sexuality, and to exercise their basic rights in society and in partnerships with men.

Early sexual relations and pregnancy, however, curtail education, employment, and other social and political opportunities for millions of young women in the Third World, just as they do for one million teenage women in the United States every year. Prevention of adolescent pregnancy will require social acceptance of sex education and contraceptive services for teens, wide-ranging support for development of young women's self esteem, and other interventions that are politically or otherwise challenging.

A Matter of Needs and Rights

"Control over reproduction is a basic need and a basic right for all women . . . . . Programmes that do not take the interests of women into account are unlikely to succeed. More important, the requirements of a genuine, people-oriented development necessitates the acknowledgement of this fundamental need and right."

From *Development, Crises and Alternative Visions: Third World Women's Perspectives* by Gita Sen and Caren Grown for the project Development Alternatives with Women for a New Era (DAWN). Monthly Review Press, New York, 1987.

Third World women who become pregnant face a risk of death due to pregnancy that is 50 to 200 times higher than women in industrial countries. Pregnant adolescents frequently face obstructed labor that culminates in death or serious physical damage. Sixty percent of pregnant women in the Third World are anemic, which makes them especially vulnerable to problems in pregnancy and labor that result in death. Over half, in some countries 80-90 percent, of pregnant women give birth without trained assistance or emergency care. As many as 250-375,000 women are estimated to die annually when giving birth. This tragedy is intensified many-fold by its impacts on the families left behind.

Fears about the safety of modern contraceptives are strong deterrents to contraceptive use. Women must bear most of the social and health risks of modern contraception, partly because contraceptive methods available to men are extremely limited in number and appeal. Condoms have no side effects and can be very useful in preventing spread of disease, but men are often reluctant to use them and women are not in a position to persuade them to. Similarly, vasectomy, safer and simpler than female sterilization, is practiced far less in the Third World. Thus, population control requires development of new and improved contraceptive methods.

Increasingly, women in the Third World who do not want to be pregnant avoid pregnancy by using contraception effectively. But millions of women have unwanted pregnancies. Many of these carry their pregnancies to term and end up with one to three more children than they want. Every year an estimated 30-45 million pregnant Third World women who cannot accept a birth resort to abortion. And every year, at least 125,000 of them— and quite possibly at least twice that many— die in the process. Uncounted others are rendered sterile or suffer severe chronic health consequences. Those who survive abortion often face greatly increased risk of death in subsequent pregnancies.

Sexuality and sexual relationships are fraught with other dangers for girls and women that also affect their views about fertility and contraception. First, millions suffer sexually transmitted diseases, including AIDS, transmitted by men. As a result of STDs, botched abortion, harmful surgical practices, or their

Reproductive Dilemmas in Nigeria

In many parts of sub-Saharan Africa, malnutrition and anemia are particularly severe. This, together with other circumstances of women's lives— long hours of hard physical work, lack of reproductive health services, and traditional health practices, among others— make African girls and women highly vulnerable to ill health and death. In fact, maternal mortality rates are the highest in the world (800-900/100,000 births), 100-200 times higher than in the West. Widespread sexually transmitted diseases, and infections from unsafe abortions or unnecessary surgical procedures, have resulted in high rates of infertility and also pregnancy wastage.

Mrs. Alabi's situation is not uncommon in Nigeria. The second wife of a truck driver, Mrs. Alabi has only one child, a four year-old girl. Concerned that she had not been able to conceive in over three years, she sought help from a nurse-midwife. The lower back pain and discharges Mrs. Alabi had suffered for years and thought normal turned out to be symptoms of pelvic inflammatory disease. Left untreated, the disease has caused scarring which means Mrs. Alabi probably will never become pregnant again. Already shamed by the lack of a son, Mrs. Alabi now must live with the fact that her husband has taken another wife, leaving her alone to care for her child, with no prospects of economic support, except what she earns herself.

partners' infertility, among other causes, millions of women are subfertile or infertile. They live in dread of divorce and social ostracism because they cannot bear children. Second, millions are subject to violence due to their gender— rape, incest, and emotional and physical battering by husbands or relatives.

Contraceptive Practice in Brazil

Approximately 70 percent of couples in Brazil use contraception, despite the fact that contraceptive choices are limited by government policy and by public criticism of the IUD and hormonal methods. Oral contraceptives are widely available through nongovernmental providers and private doctors, and are sold commercially, without prescription. Sterilization, although legally restricted, is widely practiced. Demand for sterilization is one reason for the unnecessarily high rate of caesarean births in Brazil — approximately 40-60 percent of all deliveries.

Few choices among contraceptive methods, lack of screening for contraindications, and lack of counselling or follow-up for women experiencing side effects are common problems. Women often use a method improperly, or stop using it, or use the rhythm method. Consequently, clandestine abortion rates are very high, with at least one million, perhaps as many as four million, performed annually, as against four million births.

Jurema's situation is typical. At age 24, she has two children and a third is on the way. She and her husband are having difficulty keeping up with inflation and are worried about how they will support their family. She wants no more children after she gives birth, but oral contraceptives make her sick, and abortions are expensive and dangerous. Jurema therefore plans to be sterilized when she gives birth by caesarean.

What Do Third World Women Want?

Women want to be healthy, and to have as many children as they want, when they want them, without risk to their own or their children's health. They want services for their own health, for safe delivery of healthy infants and for child health. They want means to space or to limit their childbearing that are easily available. Why, then, do so many not use modern contraception effectively or at all? Reasons include the following:

- Contraceptives are not always available; or they may cost more than people can pay.
- Contraceptives may not be socially acceptable to husbands, in-laws, or the community at large, or access to them may be legally or administratively restricted.
- No contraceptives are perfect— they have side effects and they sometimes fail even when properly used.
- Women fear that contraceptive methods may cause serious discomfort or health problems, including infertility.
- Some contraceptives are not easy to use (e.g., the pill must be remembered every day, condom use requires cooperation from the partner).

Many women now excluded as a matter of policy from contraceptive services want access. In many countries, these include the young, the unmarried, and those who do not yet have a child. Many women need easier access to services. Those who are employed or have multiple demands on their time often face major obstacles in obtaining services, including inconvenient clinic hours; travel over long distances just to reach a clinic or contraceptive

dispenser; hours of waiting in the clinic or repeated visits for service because of shortage of supplies or personnel, among other reasons.

Women determined to avoid birth want safe services for terminating an unwanted pregnancy. Unlike women in most Western countries and in China, most Third World women face highly restricted access to such services due to legal restrictions or to failure to make services available, even where legal, as in India. One third of Third World women live in countries where abortion is prohibited altogether or is permitted only to save a woman's life. Even women who qualify for safe abortion under the law may often not be able to reach a hospital, or obtain enough money to pay for the procedure, or persuade a medical committee that they are eligible for pregnancy termination.

Women want to be treated with respect. They want full information, supportive counselling, the choice to terminate pregnancy safely, choices among contraceptive methods, and follow-up care to cope with side effects or to enable them to switch contraceptive methods.

Women also want services to meet their multiple reproductive health needs. Millions of Third World women face the discomforts and consequences of reproductive tract infections, including the personal and social trauma of infertility. Little or no counselling or treatment is available to women suffering from infertility or sexually transmitted diseases, often a consequence of their partners' sexual behavior rather than of their own. Where the services do exist, they frequently are not all available from the same source, but must be sought (more conspicuously, expensively, and inconveniently) at diverse locations.

Sex education for boys and girls, and support for girls and women who are the victims of violence are very rarely available. Women themselves may be reluctant to demand such services because of social and other taboos.

Faced with the time and costs of seeking health care, women frequently give priority to their children's health care over their own. To avoid the death, sterility, chronic health problems and unwanted children that are the consequences of unwanted or mistimed pregnancies, family planning services, including safe abortion, must be made convenient, their quality improved, and their scope expanded. More and better contraceptives, for both men and women, must be developed, along with programs to enable women (and men) to undertake sexual relations safely.

What Third World Women Want

At the NGO Forum of the U.N. Conference on Women in Kenya, marking the close of the U.N. Decade for Women, in 1985, Third World women from 26 countries declared:

"... 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.' "

For Two Women in Peru: No Way Out

Women's experience with health and family planning service providers in Peru, as in other countries, are often unhelpful.

Maria (not her real name) has five children, the first one delivered at a doctor's office, the next three at home, and the last one in a hospital. She had no prenatal care and little contraceptive choice. Maria said in a recent interview:

"The midwife told me that I could use an IUD, pills or an injectable. I didn't check into it any further because I was afraid and embarrassed to ask about this. I thought that if I asked the midwife for further information she would take it badly, and that she would judge me . . . Some people told me that one has to take care of oneself through natural methods because contraceptives are harmful. I now live alone."

Another woman, who has four children and has had one abortion told interviewers:

"They have never explained family planning to me. In the Maternity they told me that I could not have any more children and that I should go to the Loayza Hospital to have my tubes tied. They didn't tell me how to take care of myself. My husband took care of himself, . . . (by having sex with another woman)."

Quotes translated from Peru Mujer's *Calidad de Atención en los Servicios de Salud Reproductiva: Las Perspectivas de las Usuarias*, 1987.

Public Policy and the Politics of Population

Since it became the leading proponent of family planning in the 1960s, the United States Government has allocated millions of dollars in foreign aid annually to population programs. The U.S. allocation for fiscal year 1988 was approximately $235 million. These funds are distributed primarily by the U.S. Agency for International Development (USAID) to government and to nongovernmental organizations conducting research and administering family planning and population programs internationally.

In 1973, the year when abortion was legalized in the United States, the Helms amendment to the U.S. Foreign Assistance Act barred the use of U.S. government funds for abortion services overseas. Since 1983, the "Right-to-Life" lobby in the United States has campaigned to curtail further both public and private support for abortion services. They also are working to restrict contraceptive services and research both in the United States and in the Third World.

In 1984, at the World Population Conference in Mexico City, the Reagan Administration reversed the U.S. position on international family planning policy. The U.S. delegation declared that growing numbers of people are an absolute good, that economic development can be enhanced by population growth, and that technological innovations can extend natural resources infinitely. At that same conference, most Third World countries, in a reversal of their position at the 1974 World Conference, defended their need to adopt population policies and provide family planning services.

Although the U.S. delegation indicated that the U.S. Government would continue funding international family planning on health and humanitarian grounds, their "Mexico City" policy restricted basic principles of "voluntarism" and "informed choice." Extending the restrictions imposed by the Helms Amendment, the policy prohibits U.S. funding of international organizations that use money from other sources for abortion services, counselling, or referral. In addition, to implement the "Mexico City" policy, restrictive conditions on U.S. aid have since been formulated: American nongovernmental organizations (NGOs) that receive funds from USAID must agree not to support any foreign NGO that, with its own money, performs, counsels or refers for abortion.

This restrictive policy has dealt a blow to family planning and population agencies such as the International Planned Parenthood Federation (IPPF), which provides contraceptive services (rarely abortion services) in 123 countries, and the United Nations Fund for Population Activities (UNFPA) which works in 144 countries. The "Mexico City" policy is currently the subject of lawsuits by the Planned Parenthood Federation of America (PPFA) and other organizations that argue that the operating requirements violate rights of free speech and privacy. If the lawsuits fail, the international arm of the PPFA, Family Planning International Assistance (FPIA), with 140 projects in 35 Third World countries, could lose its USAID funds.

Despite negative political pressure from "Right-to-Life" proponents, among others, contributions to these programs from other donors have increased, partially compensating for the loss of U.S. support.

Pro-choice advocates and the family planning lobby have kept the overall allocation for population programs in the U.S. foreign aid appropriation constant. According to opinion polls, the U.S. public also recognizes population growth as a problem and favors continued U.S. assistance to overseas family planning programs.

Pressure continues, nonetheless, from the Right, to reduce U.S. support for family planning programs, to reallocate family planning funds to programs promoting only "natural family planning" or to non-family planning uses, and to reduce funds for contraceptive research in general, and abortifacients in particular. One particularly effective strategy of the Right has been to attack family planning programs where they have been most vulnerable — quality of services, informed choice, and use of incentives — while at the same time downplaying the individuals' and couples' right to services. In doing so, they have effectively used criticisms of population programs made by proponents of reproductive freedom and family planning services.

Building Blocks for Reproductive Health Care

PROGRAMS	OBJECTIVES	MEANS	CLIENTS	EXPECTATIONS
Family Planning	Contraception by largest possible number of "acceptors."	■ Delivery of modern contraceptives and sterilization.	Married women, or those in socially recognized unions, with at least one child.	Population growth control.
Child Survival	Adoption of technologies and practices to improve child health.	■ Training of mothers and traditional birth attendants, ■ Immunization, ■ Oral rehydration.	Children under 5 years.	Reduction of infant and child death and illness.
Maternal-Child Health (MCH), "Primary Health for all by the Year 2000," "Safe Motherhood"	Adoption of technologies and practices to improve maternal and child health.	■ Safe child birth, ■ Immunization of pregnant women and children, ■ Child survival interventions, ■ Broader health and sanitation measures.	Pregnant women who want to give birth; children under 5 years old.	Reduction of infant, child, and maternal deaths and illness.
Women in Development Programs	Improvement in women's productivity, opportunities, and choices.	■ Health information and referral to appropriate services, ■ Child care, ■ Advocacy.	Girls and women, age 15 years and older.	Improved social and economic status for girls and women.
Reproductive Health	Reduction of ill health and death through comprehensive family planning and health services; high quality care; informed choice; continuing use of technologies; personal empowerment.	■ Modified strategies for staff training and reward systems, ■ Sex and health education, ■ Expanded services, ■ Enhanced choices through existing programs.	Girls, single and married women of reproductive age.	Improved health of women and children and reduction in deaths; personal empowerment; increased and more effective use of health and family planning services.

The Challenge Ahead

Virtually nowhere in the Third World are contraceptives available to all the women — and men — who want them. Some argue, therefore, that programmatic priority should continue to emphasize contraceptive supply and acceptance. It is not enough simply to make commodities available, however. To serve women well, and to reduce attacks from both the Right and the Left, contraceptives must be made available in settings where quality of services, counselling, choices among methods, and respect for reproductive freedom are prominent.

At the urging of women's health advocates and others, population professionals now recognize that the earlier focus on contraceptive acceptance rates needs to be broadened. Women in the Third World are calling for more comprehensive services that provide them with reproductive choices and that reduce ill health and death resulting from their sexual and reproductive roles. The central objectives of "reproductive health" programming are therefore 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 danger of death due to reproduction and sexuality;
- Bear and raise healthy children.

Reproductive health approaches seek to provide comprehensive services, emphasize high quality care, and are premised on fully informed choices. They build on the base established by family planning, MCH, child survival and related programs. They seek modifications in current programs to make

What is Reproductive Health Care?

It is comprehensive, providing:

- Education on sexuality and hygiene;
- Education, screening and treatment for reproductive tract infections, and gynaecological problems resulting from sexuality, age, multiple births and birth trauma;
- Counselling about sexuality, contraception, abortion, infertility, infection and disease;
- Infertility prevention and treatment;
- Choices among contraceptive methods, with systematic attention to contraceptive safety;
- Safe menstrual regulation and abortion for contraceptive failure or non-use;
- Prenatal care, supervised delivery and postpartum care;
- Infant and child health services.

It is high quality:

- Treating clients with respect and compassion;
- Following them up.

It is premised on informed choice:

- Providing full information;
- Encouraging continued use of services, rather than just initial acceptance.

How Can it be Implemented?

By building on existing programs through:

- Revised staff training content and procedures;
- Intensified staff supervision and modified reward systems;
- Additional services to ensure choices, safety and effectiveness.

By expanding available resources through:

- Collaboration among programs;
- Public education and advocacy to broaden political support.

women's well-being and reproductive choices the central objectives. Demographic goals are important, but they are not primary.

Reproductive Health Care in Indonesia

In Indonesia family planning is encouraged by the government, but limited to dispensing contraceptives, with emphasis on oral contraceptives, the IUD (inter-uterine device), Norplant® (capsules containing hormones implanted under a women's skin to prevent conception for up to 5 years) and, more recently, condoms. Approximately 55 percent of couples nationwide practice contraception, and the government's infrastructure for service delivery is comparatively strong.

The Indonesian Planned Parenthood Association (IPPA), seeking means to address important gaps, is experimenting with an approach to high quality, comprehensive reproductive health care in 7 of its approximately 50 clinics. The approach includes:

- Counselling to help women manage sexuality, help them choose among contraceptive methods, and switch methods rather than discontinue use;
- Design and testing of procedures for routine screening and treatment of reproductive tract infections;
- Careful follow-up of IUD and Norplant® users;
- Improved systems of client data collection and analysis;
- Development of informational materials for clients and staff;
- Support and services for women who have unwanted pregnancies.

Such approaches imply a long-term strategy of collaboration among programs now competing for scarce resources. If this collaboration is rooted in a common, humane concern for girls and women in Third World countries, support for international population assistance is likely to be strengthened and criticisms deflected. Although currently accorded relatively low priority in the delivery of services, several basic means of achieving the objectives of reproductive health care are already widely recognized as beneficial, such as:

- Improved program and clinic management;
- Improved logistical systems to assure a reliable flow of supplies;
- Expanded research to develop safer, more effective contraceptives for both women and men.

In addition, family planning and health programs need substantial modifications. For example:

- Training materials for staff need to emphasize contraceptive choices and address other aspects of reproductive health and sexuality.
- Similar informational materials need to be developed for women.
- Reward systems for staff and program evaluation criteria need to give more weight to respectful treatment of women and to continuing use of services rather than simply initial acceptance.
- Record systems need to be modified so that each woman, not just the particular service or contraceptive method delivered, can be followed over time.
- Much more needs to be done to encourage men to take responsibility for contraception and safe sexuality, and to support their partners in doing so.

Bangladesh Women's Health Coalition: A Decade of Experience

In Bangladesh, maternal, infant, and child mortality rates are among the highest in the world. Less than 30 percent of reproductive age couples as yet have effective access to modern contraception. Broader provision of MCH services, enhanced contraceptive choices, and continuity and effectiveness of contraceptive practice are major challenges.

The Bangladesh Women's Health Coalition (BWHC) provides high quality, comprehensive reproductive health care at reasonable cost. Founded in 1980, the BWHC operates six clinics in low-income neighborhoods in urban and rural Bangladesh and serves 75,000 women and their children annually. Services include counselling, contraception, menstrual regulation (simple, vacuum aspiration of the uterus, usually performed within ten weeks after the last menstrual period), basic child and women's health care, prenatal and postpartum care.

The primary service providers, almost all women, are recruited from the community for their interest in serving other women and for their professional skills. They have up to ten years of formal education, and eighteen months of government training, are supervised by physicians and supported by nurses' aides and administrative staff, all of whom are trained to provide health and family planning information to clients. Because the BWHC's policy is to treat clients with kindness and respect, and provide them with the full information necessary to make choices about their health and family planning needs, salary increases and promotion depend on providing quality care, not only quantity.

Each client has a registration card and file that are used every time she or her children visit the clinic, so that staff can keep track of her and her family. A counselor answers all the client's questions to ascertain that she has full information and carefully considers her options and choices. Once the client has decided on the services she wants, staff accompany her through the clinic to reassure and comfort her, to remind her how to care for herself so that no complications develop, and to tell her when to return for a follow-up visit.

Low overhead, high volume, and multiple services make BWHC's high quality care inexpensive. For example, the cost to provide a woman menstrual regulation, contraceptive information and services, and follow-up care is US$6.00. BWHC clinics, however, can serve only a small fraction of the women in need. So the Coalition also trains others, especially government health and family planning workers.

- Services need to be expanded to encompass currently neglected problems such as reproductive tract infections, infertility, safe abortion, and violence.

In most of the Third World, competition for scarce human and financial resources is intense and political commitment to women's reproductive health not yet strong. This may mean that comprehensive reproductive health programs will not be considered feasible in the short run. But competing or conflicting claims require explicit assessment, not unexamined assumption, to determine the likely benefits of alternative resource allocations. For example, maternal deaths could be reduced by as much as 25-50 percent in the next decade by even a modest increase in health service coverage for childbirth and for

safe medical termination of pregnancy. Expanding the number of contraceptive choices available would be cost-effective by encouraging sustained use rather than short-term acceptance.

Conclusion

Woman-centered reproductive health approaches that emphasize options and quality of care — widely accepted as a woman's right in the United States — could appeal to more constituencies than have conventional family planning programs to date. These several constituencies include, among others:

- 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 responsibilities;
- Proponents of social justice and human rights who recognize that women cannot exercise their basic rights fully unless they have effective access to reproductive health care and choice;
- Population professionals who want not only to increase the number of contraceptive users but also to encourage longer continuation rates for both demographic and health effects;
- Other professionals and organizations, the U.S. Congress, and a wider public 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 come into conflict or competition because they have different perceptions about the benefits or drawbacks of "population control." Reproductive health approaches, with women's health and reproductive choices as their central concern, would provide a firmer base for coalition building. Such collaboration could lead to sustained and preferably increased resource allocation, especially in the U.S. foreign assistance program.

"Population" is a fundamentally human problem. The solutions must be both humane and responsive to the complexities of people's behavior. For both humanitarian and political reasons, those concerned about population growth need also to reaffirm their commitment to individual well-being. That commitment can be enacted by making reproductive choices possible, by modifying program approaches to emphasize quality of care, and by recognizing and seeking to meet women's multiple reproductive health needs. The potential scope for innovation is broad. In setting program priorities, it is essential to recognize that the woman is important in her own right, as well as the key actor in fertility regulation and in infant and child health. Her needs, not just those of her children, family, and society, must be central. Alliances for this purpose will be to the benefit of all.

An International Call for Action

Two hundred women's health advocates and health professionals from 34 countries, primarily in the Third World, attended The Christopher Tietze International Symposium "Women's Health in the Third World: The Impact of Unwanted Pregnancy," held in Brazil in October, 1988, and sponsored by IWHC. The Symposium issued the following statement:

Reproductive rights are fundamental to women's achievement of a just status in society. Reproductive health care services are essential for the exercise of these rights. Achieving total health for women demands their full participation in defining their health needs, and in designing and implementing health policies.

The overwhelming medical evidence presented at The Christopher Tietze International Symposium clearly shows the adverse consequences of poor reproductive health care services for women in general, and for Third World women in particular. These consequences include extremely high levels of maternal mortality and morbidity, due importantly to clandestine abortion where abortion is legally restricted, and to the lack of adequate abortion services where legal. The situation is exacerbated by the disparity in health resources between and within countries.

We deplore the current restrictive policies and pressures, dictated by cultural and religious beliefs and political interests, that are being applied globally and locally to reduce women's access to health services and to reproductive choices — in particular the right to terminate an unwanted pregnancy safely.

The Symposium calls on governments to acknowledge the appalling wastage of women's lives; to eliminate legal constraints on voluntary abortion; and to generate necessary health policies and resource allocations.

Efforts should be made to increase the health profession's sensitivity and commitment to women's need for and right to high quality reproductive health care.

Our mutually held commitment to women's reproductive health and rights, premised on fundamental ethical principles of justice, liberty and tolerance, provides the basis for a continuing alliance of doctors, health care providers, women's groups and activists, and women and men from North and South alike.

Suggested Reading

T. A. Abdullah, and S. A. Zeidenstein, *Village Women of Bangladesh: Prospects for Change,* Oxford: Pergammon Press, 1982.

Judith Bruce, "Users' Perspectives on Contraceptive Technology and Delivery Systems: Highlighting Some Feminist Issues," *Technology in Society,* Vol. 9, 1987, pp. 359-383.

Francine M. Coeytaux, "Induced Abortion in sub-Saharan Africa: What We Do and Do Not Know," *Studies in Family Planning,* Vol. 19, No. 3, May/June 1988, pp. 186-190.

Development Alternatives with Women for a New Era (DAWN), *Development Crisis and Alternative Visions: Third World Women's Perspectives,* Olden, Norway: Media-Redakjonen, June, 1985.

Ruth Dixon-Mueller, "Redefining Family Planning: Feminist Perspectives on Service Delivery." Unpublished paper delivered at the 1988 Annual Meeting of the Population Association of America. Copies available from IWHC.

Oscar Harkavey, "Birthspacing: A Common Cause," *International Family Planning Perspectives,* Vol. 12, No. 3, Sept. 1986, pp. 67-68.

Other Publications from IWHC

Adrienne Germain, *Reproductive Health and Dignity: Choices by Third World Women,* The Population Council, New York. Technical background paper prepared for the International Conference on Better Health for Women and Children through Family Planning (Kenya, Oct. 1987).

"Women's Health in the Third World: The Impact of Unwanted Pregnancy," a special supplement of the *International Journal of Gynaecology & Obstetrics,* Amsterdam: Elsevier. Containing 20 papers commissioned for The Christopher Tietze International Symposium, Brazil, 1988; edited by A. Rosenfield, M. Fathalla, A. Germain, and C. Indriso. Forthcoming, Fall 1989.

Report of The Christopher Tietze International Symposium, "Women's Health in the Third World: The Impact of Unwanted Pregnancy." Forthcoming, Fall 1989.

Resources for Women's Reproductive Health in the Third World. Report of a meeting co-sponsored by IWHC and the Women and Development Unit (Extra Mural Department, University of the West Indies, Pineland, St. Michaels, Barbados), Miami, 1989.

The Bangladesh Women's Health Coalition, Adrienne Germain and Bonnie Kay. To be published in collaboration with The Population Council as part of their "Qualité" Series. Forthcoming, Fall 1989.

Bonnie J. Kay and Sandra M. Kabir, "A Study of Costs and Behavioural Outcomes of Menstrual Regulation Services in Bangladesh," *Social Science Medicine,* Vol. 26, No. 6, 1988, pp. 597-604.

Reproductive Choice in Jeopardy: International Policy Perspectives. Panel presentations given at the Biennial Conference of the Association for Women in Development (AWID), April, 1987.

The Contraceptive Development Process and Quality of Care in Reproductive Health Services. Rapporteur's report of a meeting sponsored by the International Women's Health Coalition and The Population Council, New York City, October 8-9, 1986, between women's health advocates and contraceptive developers.

This paper was originally commissioned to provide new insights into the "population problem." Much of the substance has been drawn from a longer paper with complete references, *"Reproductive Health and Dignity: Choices by Third World Women,"* by Adrienne Germain, commissioned for the International Conference on Better Health for Women and Children through Family Planning and available from IWHC.