



WOMEN'S REPRODUCTIVE HEALTH AND MATTERS OF POLICY

At each developmental stage a woman's health can be effected by a policy world which she rarely controls. Policies can have a devastating or constructive effect. Sometimes it is the absence of policy which causes negative results, other times it is the continuation of restrictive policies which directly influence health outcomes. Progressive national policies, like those which delay age at first marriage, can save the child bride from death in early childbirth. National policies which ensure family planning programs are voluntary and safe, can greatly enhance a woman's opportunity to control her fertility. Conversely, abortion policies which limit its safe availability, consign women to unnecessary mortality and morbidity as they either bear children they cannot care for or resort to the unhealthful practices of illegal abortions.

Using examples from Asia, this **Policy Dialogue** focuses on the stages of a woman's life and the policies which effect it. Further, it examines these in the light of societal or family attitudes, those which are difficult to influence but which policy makers must understand if they are to create an environment where women's health issues can be at the center of concern and action. Too often policy makers, particularly at national levels, after concentrating their energies on changing policies believe that their work is done and that lives will change simply because of progressive policy work. Unfortunately, changing policy is only the first critical step. Once adopted these require dissemination, education, vigilance and enforcement before becoming part of the culture.

The prenatal period -- a risky time for a female fetus

While it has long been known that many cultures do not greet the birth of a female child with unmitigated joy, historically these babies were born as Nature planned. Once born, their chances of survival depended on their family and culture. Though not as welcomed as the birth of a son, practices of female infanticide or infant neglect were not the general rule in most societies. However, in recent years Nature's balance has been changed by the readily available opportunity for sex selection of the unborn fetus. With the advent of these medical tests, a girl child is less likely to be born, especially in countries where male preference is strong or national population policies encourage a limited number of children.

In the absence of policy, an identified female fetus is easily aborted. The practice of aborting a female fetus after testing is common in China, India, and Korea particularly, where couples desire small families and demand for a son is strong. It has become so common that the Asian popular press features articles which highlight the issue. These articles present male concerns as their viewpoint rather than focussing their editorial comment on the continued second class status of women reflected by female fetal destruction. They write about the impending frustrated bachelor or the "bachelor boom" which looms particularly in China, India and Korea (ASIAWEEK, 1995).

All three countries have recently tried to ban the use of tests for sex determination. But, it is reported that doctors still routinely use them, with as many as 100,000 scanners being used in China alone, in both urban and rural areas. More work needs to be done to develop effective policies which can avoid sex selection yet continue to offer fetus testing for necessary medical reasons.

Birth of a girl child

When a girl child is born, it is not unusual for the birth to be greeted with concern or outright disdain. This culturally-based rejection is age-old. Daughters are considered investments without return as they will go with education or skills, which their parents provide for them, into another household at the time of marriage. They thus enrich that household rather than their parents.

In spite of policy reform, as well as societal upheaval due to rapid urbanization which changes the extended family structure or universal education which influences the outlook on the potential value of daughters, prejudice against female births continue.

Policies which make daughters economically less burdensome have been developed to ameliorate gender bias. In some countries, policies have been enacted to eliminate the dowry system since the provision of dowries has beggared families for centuries. The outlawing of the custom was welcomed in India, and its neighboring countries. But, the policy has not become the practice and even though such payments are illegal, families that don't offer them usually can't find many suitors for their daughters. Today dowries (in India) range from a couple of cows to millions of dollars in gold, consumer goods and property. So while too many daughters can mean financial hardship -- if not ruin -- for a poor or even middle-class family, sons are like money in the bank (ASIAWEEK, 1995). Other policies have changed inheritance rights to allow girls to equally inherit family property. But, policies cannot eliminate the tightly held beliefs that girls are "not worth investing in" because they will marry and take the investment with them to enrich another family.

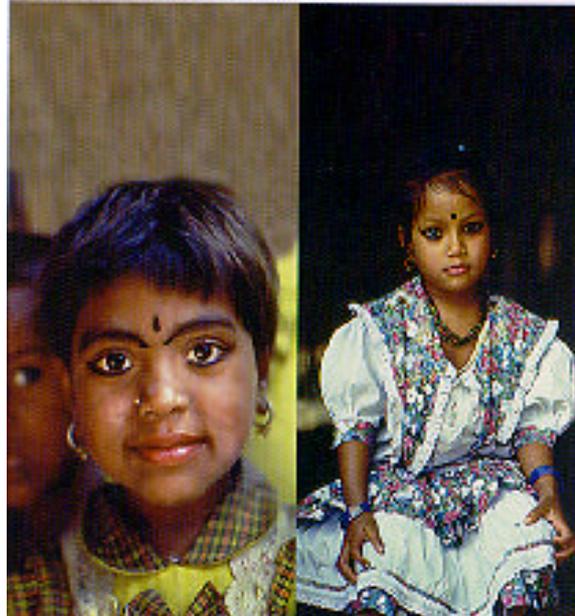
Potentially the greatest health risk for the female infant is the immediate family or cultural encouragement, often unrelenting pressure, for her mother to produce another child in the hope of getting the desired son. This pressure puts both mother and infant daughter at risk. When birth intervals are shortened, the outcomes are less likely to be positive as shortened birth intervals put the mother's health in danger, as well as affecting the fetus. As for the daughter already born, she is too soon denied the best source of nourishment, her mother's milk. If the mother dies in the birth of another child, statistics show that the survival for her remaining children under-five is jeopardized.

While early care of infant daughters is influenced more by family and culture norms than national policy, there are initiatives which are essential to change that. Most important is the

development of vital registration systems, with accountability, which record all births and deaths. Only in this way will the magnitude of infant deaths be determined and anecdotal reporting of the neglect of daughters confirmed.

Care of the infant daughter and under-five girl

If a girl's birth is not welcomed, what initial care does she receive from her family? In extreme cases in the modern world, infanticide is still practiced. More likely the death of an infant daughter is from simple neglect. Disappointed mothers, particularly when their personal disappointment is exaggerated by family censure, have a difficult time effectively nurturing their infant. Evidence from Nepal indicates that son preference influences the care of daughters. Certain cultural factors suggest that girls may be more susceptible to illness than boys. Nepal has the second highest index of son-preference in the world (UNICEF, 1987). While it is unlikely that girls really are "more susceptible to disease than boys," the kind of care that they receive compared to their brothers does influence the outcome of any illness.



Right from the welcome the infant girl receives in the family, there are sex differences which affect health. The boy is welcomed and loved simply because he is a boy. He is accorded pride of place and all that goes with the male's special status in the culture. The girl must earn her place in the family. Like her mother and sisters, she eats after the men of the family, no matter what her nutritional need is. In Nepal, food distribution within families tends to favor boys more than girls, and women usually eat after everyone else. Poor nutrition in childhood resulting in inadequate skeletal development, may affect their capacity to give birth to their own children, and add to the risk of premature, complicated or prolonged deliveries (UNICEF, 1987).

Early childhood care is also determined by the national policies regarding the availability of health care services. If the nation has encouraged the development of health care facilities, particularly those which cater to Mother and Child Health (MCH) care, it is possible for any child to have the opportunity for life saving immunizations and primary health care. National programs which have policy to educate families about health services at the household level will greatly enhance access to care for all children, especially if the home visitors are women. When MCH services are offered free of cost at the community level, access increases further. Thus the combination of national policies to promote primary health care, using community-based service delivery systems, female workers and free services combine synergistically to provide care to all who seek it.

However, even the most enlightened national policies cannot always change the social or family practices which commonly effect health. In general, female children are less likely to be taken to clinic at the time of illness. If a girl is taken to a clinic, it is only when her illness is critical. This lack of attention may lead to unnecessarily negative outcomes. Immunizations may or may not be provided for girl children even in situations where there is easy access to well-baby clinics.

Data should be collected at the health center or immunization post level to determine whether infant daughters are less likely to be immunized. Until statistics at the service delivery level are disaggregated by gender, the magnitude of the lack of care of infant daughters will remain an issue which policy makers can ignore.

Puberty and its companion -- early marriage and child bearing

If a girl survives to puberty, her health is directly effected by policies and customs regarding marriage. In countries where there are no laws and conservative cultures, child marriage is common. In those where civil marriage laws have been enacted, raising the age of marriage for women has a direct effect on their health. If marriage can be delayed until the late teen years, problem pregnancies can be minimized though not completely averted.



In fact, many countries have enacted delayed marriage laws. The effect of these laws is mixed. In Bangladesh, though age at first marriage has increased over the past 25 years, 60 percent of women are still married by the age of 15. In Nepal, the National Code of 1963 raised the legal age of marriage for women to sixteen, as well as banning polygamy, child marriage and broadening other women's rights. Still nearly 40 percent of currently married women are married before the legal marital age of sixteen.

Policy regarding marriage does little good without enforcement. When traditional religious leaders can ignore civil laws governing marriage, as is a common occurrence in Bangladesh, or where families can simply lie about the age of a prospective bride in the absence of an accountable vital registration system, flagrant violation of the law can result. Though social workers, especially those which specialize in advocacy for the rights of women work tirelessly to educate women on civil marriage laws, their's is an uphill struggle without accountability imbedded in policy reforms.

Maternal Care

There are two aspects of maternal care which require special attention. One is pregnancy and child birth and the second is the care of women for reproductive tract infections (RTIs) and other reproductive health problems which arise during the childbearing years. This is certainly one of the most difficult areas to ensure that policy reform can change health status. Women die during pregnancy and child birth in great numbers both from misplaced beliefs as well as lack of appropriate policy. Often women neglect presenting their own health problems on the assumption that it is a "woman's lot to suffer."

There is no question that maternal care is still inadequate but even where countries have accepted the Safe Motherhood Initiative and invested in facilities and training of service providers for obstetrical care, society's norms interfere with the use of these facilities. Pakistan is a good example. Though accessible government and private facilities for attended child birth exist, UNFPA figures rank Pakistan with the dubious distinction of having the highest maternal mortality rate of any of its South Asian neighbors.

"...at least 28,000 women [are] dying from pregnancy-related causes each year. In a country where the virtues of motherhood are consistently extolled, it is ironic that motherhood is more dangerous than anywhere else in the world. Each time a woman becomes pregnant in Pakistan, the risk of death is 31 times higher than in the developed world...It is estimated that 85 percent of all deliveries in Pakistan are carried out at home, usually by female relatives or traditional birth attendants who do not have adequate training to deal with complications or maintain hygienic standards" (Karim, 1994).

While the Pakistan story is dramatic, it is not a new tale. Either because of cultural beliefs or limited understanding of other possibilities, most women in the developing world still deliver their children at home with limited medical assistance. What makes this practice critical is that with the combination of early marriage and high parity, many women will be child bearing and lactating most of their adult lives. Thus, they are at perpetual rather than only occasional risk, of morbidity and mortality.

The Safe Motherhood Initiative has helped countries focus their MCH programs more effectively in recent years. Previous criticism was that the M was left out of most MCH programs, as



providers concentrated on children for primary health care. At the policy level, efforts have been made to change that by policy reform that gives equal emphasis to care of pregnant and lactating mothers. Services are being established exclusively to reach women. However, long-held cultural beliefs are not easily changed. Women themselves do not believe that pregnancy is an "illness" which requires clinic visits. Rather it is a natural process that demands only rudimentary care. Thus, even when services are set up for them, it takes a sustained educational effort to

encourage the use of modern health care facilities. A program which combines trained traditional birth attendants and accessible back up referral for emergency obstetrical care is one that many countries are working to establish.

Women's attitudes to other reproductive health issues, like RTIs, defy simple policy solutions. A compilation of recent studies on reproductive health issues from Indian rural and slum populations clearly show that women recognize the signs and symptoms of RTIs and related problems. In fact, RTIs are widely prevalent. But, their care seeking behavior is governed by their perception of these infections being a woman's "lot in life" or a simple lack of power in making decisions about their own health care. Pauchauri and Gittelshon (1994) observed

"The fact that most, if not all women, suffer from these illnesses, coupled with their inability to address them has resulted in the belief that these problems are an inevitable part of women's lives for which they must suffer in silence because there is no recourse. This fatalistic attitude is further reinforced by the lack of women's decision-making power within the household to take remedial action."

As a result of the International Population Conference in Cairo in 1994, many policy makers have turned their attention to these aspects of women's health. It is essential that policies are developed that are sensitive to traditional behaviors surrounding maternal and reproductive health. The policies must articulate the establishment of programs which are appropriately designed at the service delivery site and also provide the necessary information and education to women and their partners which make access to the services possible.

Family planning as a life saver

Following marriage, women's health is potentially safeguarded by government policies on family planning. Most countries in the world now have active family planning programs which provide contraceptives freely, or at nominal cost, to married women of reproductive age. Governments are more hesitant to provide contraceptives to adolescents or unmarried women, even when these women may be sexually active.

While national policies can be written to ensure that family planning is a safe and voluntary choice for all couples, policies at a program or service delivery facility can negatively impact on national goals by limiting access to services or erecting medical barriers. Some country programs have policies which limit access to certain family planning methods, usually for cost reasons. For example, the Indonesian national policy offers free family planning services to all couples. However, the injectable contraceptive is offered freely for only two years to a client. If the client would like to have subsequent doses, she has to pay for these, switch to another method, or drop out and risk an unwanted pregnancy.

Policy also effects who can provide contraceptive methods. Indonesia's primary family planning service provider is the nurse-midwife. She can serve clients who require pills, injectable, IUDs and natural family planning methods. She is also allowed to insert the hormonal implants (Norplant) but not allowed to remove it. For removal, policy demands a physician. In a country where approximately two million women are using implants and, more important, where numerous studies have highlighted that the midwife is the most trusted care giver, this limitation negatively effects implant removal process.

Policy can be also demark territory. In Bangladesh, couples seeking family planning services must attend the facility in their neighborhood (thana or ward). Many couples want to have a sterilization service but would prefer that their neighbors remain ignorant to their decision. If they may only use their neighborhood service point, true access to services is denied.

Informed consent, as part of the sterilization services of national programs, is an important quality indicator. However, many national policies require that both the woman who chooses to undergo the sterilization, and her spouse, must sign the consent form. Most women who avail themselves of sterilization services in the Philippines do so immediately after child birth. By custom, husbands do not accompany wives at the time of delivery. As long as this program policy exists, women who desire sterilization may not receive it. This policy reflects a double standard too because it only effects the decision of women. If men request vasectomies, their wives do not have to consent.

At the service delivery point, many policies effect services. Positive policies like serving clients when they come, without prior appointment and without charge, have a positive effect. Policies which put limitations on services cause negative effects. Scheduling sterilization services is a case in point. In some service delivery points in the Philippines, women who request a sterilization service are required to check into the hospital the evening before the procedure so the hospital staff can monitor the pre-procedure care. They are operated on in the morning but not allowed to check out until the following day. Basically, a short procedure [done on an outpatient basis in most countries] becomes an elongated process, eliminating many who would like to avail the service.



When policies regarding program and service delivery constrict the availability of services, as in the case of the Philippines policies on sterilization, women's access to services is curtailed and an individual woman's health is directly effected. In the Philippines, it takes such an effort to obtain services that women who are finally sterilized admit that they do so after having two more children than they wanted. It is essential to review policy at all levels to ensure that the essences of the positive national ones are implemented at the service delivery level. Only in this way women will be assured of the timely and appropriate services which their national programs promulgate.

Abortion

Access to safe abortion, while a political anathema in many countries, is a life saver directly influencing women's health. Ross and Frankenberg (1993) noted that induced abortion is widely resorted to, whether under legal or illegal conditions. Where it is safe and legal it prevents some unwanted births, depresses fertility rates, and reduces the maternal mortality rate. Where it is illegal and unsafe, however, it increases maternal morbidity and mortality.

Controversy surrounds abortion and, no doubt, it will always remain an emotionally charged topic in all countries both developed and emerging ones. Everyone, especially politicians, is forced to have an opinion and to work to make their opinion into policy. Unfortunately, while controversy continues, women require safe abortion services. Abortions are needed for many reasons. Even where family planning programs provide excellent coverage and are successful, abortion is needed to back up contraceptive failures. It is also needed where a family planning program does not yet have national coverage, where method choice is limited, or where women do not have access to methods which work for them and drop out for reasons of side effects or incompatibility. In some countries, family planning programs have failed to reach women in need of services. These women require abortion services when the limited knowledge they may have for birth spacing fails them.

Where nations do have abortion programs, the policies which govern those can impact the service. The extent to which abortion is legal differs greatly from country to country. Common restrictions include parental notification for minors, gestational period, husbands' permission, waiting periods, and counseling (Ross and Frankenberg, 1993). Some of the policies appear to both give permission but remove it simultaneously. Where abortion is legal yet spousal consent is required, a woman may be unable to obtain that consent from her husband. Thus, she has as little access to safe abortion care as a woman who lives in a country where abortion is completely illegal.

One area where policy needs review is in post-abortion care. In countries like Bangladesh, the menstrual regulation services were originally established to serve as a back up to contraceptive failures in the family planning program. Now however, many of the MR services fail to meet the family planning needs of clients who accepted MR services. Results indicate that many women leave an MR clinic without a family planning method. Service providers have built up barriers to post-MR family planning methods, especially IUDs which they will not insert because the "MR causes too much bleeding already."

Women also leave MR services facilities without any information on their rapid return to fertility. They erroneously assume that they are protected from pregnancy because they equate induced fetal wastage to a normal post partum period. This lack of information directly causes the repeat MRs, as women quickly become pregnant again and need the second MR for the same reason they needed the first.

Policy makers need to review post-abortion policy to ensure that family planning counseling and service is an integral part of every abortion service. Evidence suggests that positive abortion policy can influence women's health. The absence of positive policy, however, has a negative effect. Estimates suggest that abortion-related deaths account for a minimum of 23 percent of all maternal deaths. The numbers will continue to increase as long as national policies restrict abortion. In countries where abortion is not restricted, care must be taken to ensure that access is not limited by policies at the service delivery point level.

Conclusion

If the reproductive health status of women is to significantly change, policy makers must ensure that there is legislation in all areas which effect women's health. This includes policies on sex determination and fetal wastage; universal MCH care with equal and free access for all citizens; civil marriage laws which set minimum marriage age, as well as the laws which accompany it of banning polygamy and obtaining of a divorce a more equal situation; policy guaranteeing access to family planning and abortion services, making it a law that all methods must be available to all women in need of those, regardless of marital status or age. Abortion available on demand for all women is another law which is required to be set at national levels, with assurance of family planning as part of that service.

At the same time, it is essential to recognize that positive policies will not automatically change practice. Words which exist in the books of law do little to effect women's reproductive health if these are ignored by social customs or by those service providers who are supposed to enact them. While ensuring positive policies is essential, the next steps of making that policy, the real "law of a land" is equally critical to changing women's health status.

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