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## **A Reproductive Health Approach to the Population Problem**

### **Challenges and Problems of Developing Countries**

**W**ORLD population in mid-1992 will be 5.48 billion. It will reach 6 billion in 1998. Annual additions to world population in the next decade will average 97 million, the highest in history. And nearly all of this population growth will be in Africa, Asia and Latin America with over half in Africa and South Asia. This growth in human numbers is compounded by widespread poverty and deprivation and presents a serious threat to local and global environments. The past three decades of development have seen undeniable economic progress and the proportions of the poor have declined in most parts of the world. However, their absolute numbers have increased in developing countries, in every region but most steeply in Africa with Asia having the biggest share of the world's poor (United Nations 1990).

India's population of 844 million constitutes 15 percent of the world's people. The 1991 census has shown an increase of 160 million during the past decade. A particularly disquieting feature of this census is the decline in the sex ratio. While birth rates and death rates in India have been declining, the pace and distribution have been slow and uneven. There are significant regional, class, caste and gender differentials. For example, the crude birth rate (19.9 per 1000) and infant mortality rate (29 per 1000 live births) in socially advanced Kerala compare favorably with developed country figures but provide a stark contrast to the corresponding statistics (birth rate 37.9 per 1000 and infant mortality rate 127 per 1000 live births) for Uttar Pradesh, (Government of India, 1990). Stagnant fertility rates, particularly in the four major northern states which account for about 40 percent of the country's population, are currently a major concern among policy planners. These states also depict gloomy statistics for other socio-economic and health indicators including literacy, child mortality and maternal mortality.

While concern for curbing the country's rapidly growing population has never been stronger, India's family planning programme, which has a heavy emphasis on sterilization, is not achieving the desired demographic impact. Spacing methods are more likely to affect birth rates but require complementary attention to improving the quality of health services

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and addressing women's reproductive health needs. Considerable discussion on these issues has been underway among health planners, researchers and NGOs. This debate has more recently been fuelled by women activist groups who are attempting to introduce the perspective of the client, which has so far been neglected in the design and implementation of family planning programmes in developing countries. Their argument is that the lack of strong client-oriented programmes and the poor quality of services have operated as major impediments to contraceptive acceptance.

### **Socio-Economic Development, Mortality, and Fertility**

A growing recognition among policy planners of the important linkages between socio-economic development, health improvement and fertility reduction has further broadened the contours of the population debate in recent years. These linkages are particularly explicit in relation to population programmes where reproductive health, women's education and women's social status are seen as necessary correlates to future progress in fertility reduction. Several research studies in developing countries have documented the relationship between child mortality and fertility (Hobcraft 1992) and between socio-economic development, particularly enhancement of economic opportunities and education for women and the improvement in reproductive health, fertility reduction (Cochrane 1979) and child survival (Cleland 1988). It is estimated that in developing countries each extra year of education for a woman reduces the mortality risk of her children by 7 to 9 per cent (Cleland 1988).

Some of these research findings are beginning to be reflected in the formulation of national programmes. For example, while the National Family Planning Programme has been implemented in India since 1952, during the 1980s, National Child Survival Programmes gained significant momentum and vigorous efforts were made to achieve universal immunization. During the latter part of the 1980s there was also a clearer articulation of the need to improve women's reproductive health and the Eighth Five Year Plan has incorporated a Safe Motherhood Programme for lowering maternal mortality.

These government programmes, however, are vertically organized and are implemented with insufficient investment in developing critically needed problem-solving capacities within the health service system. Access to health care, particularly for poor women and children, therefore, remains problematic and there is a widening gap between the problems and the institutional capacities to address these problems. On the other hand, India's vigorous and highly professional voluntary sector has played a key role in providing models of successful health and family planning programmes (Ford Foundation, 1988). And in recent years there has been a productive and growing dialogue between the government and non-government organization (NGOs) in an effort to work as partners in development.

Recent years have also witnessed a clearer articulation by NGOs, activists and researchers, of the diverse problems facing women in developing countries. India now has a National Perspective Plan for Women. Current national debate is focussed on how to operationalize this plan so that disadvantaged women are benefitted. The chapter on 'Women and Development' of the Eighth Five Year Plan has also been widely discussed

through countrywide consultations. Initiatives launched during 1990, the Year of the Girl Child, stimulated the design of experimental health, education and development programmes to address the needs of adolescent girls. These initiatives have generated considerable discussion and debate on women's issues and have been successful in drawing the attention of policy planners on the diverse problems facing poor, disadvantaged women including health, education, employment and legal rights. The challenge, however, is to translate these ideals and concepts into coherent strategies within national programmes.

### **Past Lessons : A Historical Perspective**

A review of past experiences of developing countries that have formulated policies and programmes to control population growth can provide some lessons for planning future strategies. Since the 1950s, several developing countries have participated in the evolution of programmes designed to address the twin problems of population pressure and the health and welfare of women. In the 1950s several countries asked the question "Is population growth a problem of national and global significance?". During the 1960s, efforts were made to develop fertility control technologies to address the problem and in the 1970s clinical trials were conducted to evaluate their safety and effectiveness in different field settings. During the 1970s and 1980s, the international population community focussed on the production and dissemination of these technologies to reduce birth rates. Recognizing the urgent need to control population growth, several developing countries organized family planning programmes aimed at achieving demographic targets. Thus, during these years, efforts were mainly focussed on demographic research and contraceptive development along with the organization of programmes to provide family planning services, particularly to women in developing countries.

In the 1980s however, we learnt that modern fertility control methods are at best only a partial solution to the population problem. And so, the questions now being raised are : "How can we develop the political will to improve the quality of care in order to enhance the use of contraceptive technologies?" "How can we empower women to control their own fertility and sexuality while making informed choices about their fertility?" These issues have begun to surface in policy debates and will be areas of common concern during the 1990s.

### **Moral Dilemmas and Ethical Issues**

Although the need for family planning has been recognized both at the national as well as at the individual level, societal goals and strategies have frequently conflicted with the goals and needs of the individual. The population community has primarily focussed at the societal level, and while emphasizing the need for providing services to the largest number of people has often sacrificed service quality and neglected the client's needs. Over the past 40 years, most population-related investment, particularly from the public sector, has gone to providing contraceptive supplies and information through family planning programmes. On the other hand, those who have been concerned with the reproductive health and rights of the individual have viewed service quality and informed method choice as paramount. The latter constituency is now arguing for a re-examination of service delivery paradigms

that have been taken for granted for many years on the grounds that these strategies have yielded mixed results. There are still marked regional differentials in contraceptive use and there is a stagnation of birth rates in large parts of the world, especially in Asia and Africa.

These divergent perspectives have also raised serious moral and ethical questions: Is it ethical, for example, to provide fertility regulation methods for women without at the same time addressing other equally critical aspects of reproductive health such as pregnancy care, sexuality or reproductive tract infections? Is it ethical and responsible to introduce contraceptive methods that are heavily dependent on skilled health personnel in countries where health services are generally poor? Is it morally acceptable to restrict access to safe abortion services and simply promote contraception when contraceptive technologies are imperfect? Is it ethical for developed and developing countries to use different criteria and standards for the regulation and monitoring of technologies and services? Do precarious health conditions in resource poor settings place women at a higher risk of side-effects from certain contraceptives and, if so, is it ethical to introduce these methods where general health is poor? At a meeting recently convened by the World Health Organization to bring together women's health advocates and health scientists, several of these ethical issues were discussed (WHO, 1991).

Many of these questions raise profound dilemmas that are not easily resolved. However, these debates do highlight the importance of recognizing the contextual factors in developing programmes. In any setting, factors such as the quality of the existing health care system; social and cultural attitudes, norms and values about sexuality, fertility, and gender roles; and political and economic factors do play critical roles in how programmes are implemented and how services are utilized by communities, families, and individuals.

Experience with past programmes has shown that the health and family planning infrastructure has significant impact on the safety, effectiveness and acceptability of fertility control methods. Some critical questions that should be addressed are: Are trained staff available who have both the skills and the time required to deliver the various methods safely? Can the programmes ensure informed choice and provide counselling and follow up services for clients? Are services readily available to deal with method complications, side-effects and unwanted pregnancies?

There is a concern, for example, regarding the safety of particular contraceptive methods in settings where women suffer from high levels of reproductive morbidity and malnutrition. A community-based epidemiological study in rural India showed that 92 percent women had one or more gynaecological problems, 91 percent suffered from iron deficiency anaemia, and infections constituted 50 percent of the disease burden (Bang, *et al.* 1989). A study in Bangladesh showed that users of intrauterine devices (IUDs) and women who had been sterilized were seven times more likely to develop reproductive tract infections than women who did not use contraceptive methods (Wasserheit, *et al.* 1989). These studies highlight the need to examine the interactions between fertility regulation methods, reproductive tract infections and sexually transmitted diseases, especially AIDS. For example, should IUDs be used in settings where women have a high incidence of reproductive tract infections and where these problems cannot be diagnosed and treated?

The bias towards provider-dependent methods such as IUDs and subdermal implants that have a lower likelihood of user failure but can result in significant dissatisfaction is

another concern of women's groups. These methods require careful follow up since the devices must be removed after a recommended period. Many women do not return for routine follow-up visits and special outreach efforts are, therefore, needed. Experience with the Norplant in Indonesia and Bangladesh shows high rates of 'loss- to-follow up'. There are, therefore, questions regarding these methods: Can women be found five years later for removal of implants? Will those who remember that removal is necessary find properly trained personnel to remove the device? What are the programmatic implications for introducing these methods into national programmes with inadequate facilities for counselling and follow up?

In India, feminist groups have gone to court and have brought about a court stay order against contraceptive injectables and implants. There is clearly a need to initiate a dialogue between programme planners, service providers and the users of family planning services. Two-way communications must be fostered so that information is effectively disseminated at all levels and women's views on health and family planning, which have thus far been neglected from policy debates, are incorporated in the design and implementation of programmes.

### **A Framework for Reproductive Health**

Recognition of the context in which reproductive decisions are made highlights the importance of improving the lives of disadvantaged women through a broader approach to population and reproductive health. Such an approach seeks to link concerns about fertility and mortality at the macro and micro level, and to incorporate the socio-cultural as well as biomedical aspects of reproductive health (Ford Foundation 1991). In this context, reproductive health means that people have the ability to reproduce and to regulate their fertility; that women are able to go through pregnancy and childbirth safely; that the outcome of pregnancy is successful in terms of maternal and infant survival and well-being; and that couples are able to have sexual relations free of the fear of pregnancy and of contracting disease (Fathalla 1987).

The proponents of the reproductive health framework believe that reproductive health is inextricably linked to the subject of reproductive rights and freedom, and therefore, to women's status. The reproductive health framework goes beyond the narrow confines of family planning to encompass all aspects of human sexuality and reproductive health needs during the various stages of women's lives (Sai and Nasim 1988). In addressing the needs of poor women, such an approach places an emphasis on developing programmes that enable women to make informed choices, provide screening and counselling services and education for responsible and healthy sexuality, and services for safe abortion as well as maternity care and treatment of reproductive tract infections (Germain 1987).

### **Quality of Life**

The last couple of decades have witnessed an increasing concern for what is referred to as 'quality of life'. This concern draws attention to reducing inequity and discrimination and promoting ethics and human rights, including reproductive rights (Barzelatto 1989). The concern for 'quality of life' has highlighted the inequity of focussing merely on numbers of births without giving equal attention to the well-being of children born. Recognition of the

longstanding discrimination against women has led to a better understanding of women's status as a key factor determining fertility. In much of the developing world, women are more likely than men to be malnourished; they are less likely to be educated and have fewer opportunities to earn income and have access to health care (UNFPA 1992). Although it is difficult to isolate the effects of education, income-earning opportunities, and improved health status for women, all of these factors are associated with declining fertility rates. The most constant correlations are between women's education and smaller family size and between women's education and child survival. There is considerable evidence to show that improvements in the status of women exert negative effects on fertility over the course of the demographic transition (Jejeebhoy 1991).

While progress in improving the quality of life in India has been slower than what might have been expected, there are significant differentials between national trends and outcomes at the state level because of the tremendous diversity among India's regions and states. Kerala, for example, has achieved universal literacy when only 10-20 percent of women in the northern states can read. Infant mortality in the north is four times higher than in Kerala. Kerala's fertility rate of 23 children per woman is lower than that of Thailand and China, the former USSR and Ireland. Contraceptive prevalence in Kerala is three times the national rate (Government of India 1990).

Two important factors explain Kerala's success in human development. First, the state government's priority to invest in education and health has been a continuing tradition that reaches far back into colonial times. Spending has also been equitably distributed. Kerala is the only state in India (and one of the few in the developing world) where the rural death rate is lower than the urban. A far-reaching land reform from the 1960s has benefitted three million tenants and landless. The second factor, whose roots reach even further into history, relates to the status of women. In Kerala, unlike the north, women inherit land. The husband's family pays a brideprice to the wife's family at the time of marriage and women are considered an asset. Thus, women's education and women's autonomy have had an important impact on the use of health and family planning services in Kerala (Kabir and Krishnan, 1992).

The case of Kerala effectively demonstrates that gender equality can have important demographic repercussions. And, in fact, some recent studies suggest that the status of women may be the single most important element in explaining the fertility transition in India (Mitra, 1978 and Dyson and Moore, 1983). The history and experience of Kerala's health and demographic transition offers several lessons for India as well as for other developing countries.

A growing recognition that population dynamics, quality of life, and women's status are closely related highlights the need for developing new approaches to the population problem, but how these concepts can be translated into coherent policies and programmes remains to be explored. A strategy of human-centered development must form the core of policies leading to sustainable, balanced development. Population policies should ensure equitable development, protection of the environment and improved quality of life.

### **Concluding Comments**

Population and reproductive health concerns have been articulated by three separate constituencies in somewhat different ways. First, the population community, concerned

primarily with reducing birth rates, has used family planning programmes as a means for achieving demographic objectives. Most family planning programmes have, however, been dominated with the supply approach and a lack of attention to the demand for services has limited programme effectiveness. Second, the health community has focussed attention on maternal and child health problems and several programmes to improve child survival, and more recently to promote safe motherhood, have been implemented in developing countries. And, third, a growing community of women activists, voluntary agencies and researchers concerned with women's issues have drawn attention to the importance of women's empowerment and reproductive rights for improving reproductive health. They believe that since poor health is a reflection of the disadvantage and discrimination suffered by women from birth, through childhood, adolescence and adult life, the deep-rooted causes of illhealth, such as poverty, illiteracy, high fertility, poor nutrition, and lack of access to health care must be addressed (Pachauri 1992).

The high burden of reproductive morbidity that women in developing countries suffer is an outcome of poverty, malnutrition, infection, low status, and lack of access to health care. These determinants operate synergistically throughout the life cycle of poor, disadvantaged women resulting in high levels of mortality and fertility. To understand how these multiple factors operate to undermine women's health, researchers must examine the biomedical factors within varying socio-economic and cultural contexts (Pachauri 1992).

For most programmes in developing countries, 'reproductive health' has been equated with 'family planning'. Some countries have implemented integrated maternal and child health and family planning services. But should the scope of these programmes not be broadened to address the underlying and interrelated problems of infection and malnutrition? Reproductive tract infections are an important reason for the poor acceptance and low continuation rates of contraceptive methods such as the IUD and yet no provision is made for their diagnosis and treatment in family planning programmes.

The impact of sexually-transmitted diseases (STDs) on reproductive health is particularly serious in developing countries where weak or non-existent systems make their diagnosis and treatment difficult. The emergence of the fatal Acquired Immuno-Deficiency Syndrome (AIDS) has brought about a renewed concern for the prevention and control of STDs which are an important risk factor for acquiring AIDS. There are strong epidemiological and programmatic reasons for considering a broader reproductive health approach for the prevention and control of STDs and AIDS.

As there is a growing concern with population and reproductive health among researchers, voluntary agencies, policy planners and women's groups, there is a need for coordination and networking among these constituencies to better understand their different perspectives and concerns and to develop a more comprehensive framework for developing programmes that are relevant to the needs of poor communities.

Programmes designed to improve reproductive health should empower women to better understand and articulate their health needs and to make informed choices. Women's views on health care have been largely missing from policy debates and should be incorporated in the design and implementation of programmes. Interaction and exchange between researchers, policy planners, service providers, women's organizations and legal rights groups should be encouraged so that there is better informed public debate on population issues.

## References

- Bang, R.A., Baituk, M., Sarmukaddam, S., Bang, AT., Choudhary, Y. and Tale, O. 1989, High prevalence of gynecological disease in rural Indian women, *The Lancet*, 85-87, January 14. Barzelatto, J. 1989, Reflections about Ethics and Human Reproduction and the Sense of the Conference. In : Z. Bankowski, J. Barzelatto and A. M. Capron (eds.), *Ethics and Human Values in Family Planning*. CIOMS, Geneva. Cleland, J. C. and Van Ginneken, J. K. 1988, Maternal education and child survival in developing countries, *Social Science and Medicine* 27(12): 1357-1368. Cochrane, Susan H. 1979, Fertility and Education : What Do We Really Know? World Bank Staff Occasional Papers. Washington D.C., World Bank. Dyson, Tim and Moore, Mick 1983, Kinship structure, female autonomy and demographic behaviour in India, *Population and Development Review*, 9(1): 35-36. Fathalla, M. 1988, Research Needs in Human Reproduction. In: E. Diczfalusy, P. D. Griffin and J. Khanna, (eds), *Biennial Report (1986-1987)*. Geneva, World Health Organisation.
- Ford Foundation 1988, *Anubhav Series: Experiences in Community Health*. Thomson Press (India) Ltd., New Delhi. Ford Foundation 1991, *Reproductive Health: A Strategy for the 1990s*. A programme paper of the Ford Foundation, New York, June. Germain, Adrienne 1987, Reproductive Health and Dignity: Choices by Third World Women. International Women's Coalition, New York. Paper prepared for the International Conference on Better Health for Women and Children through Family Planning, Nairobi, Kenya, October 5-9. Hobcraft, John 1992, Child Spacing and Child Mortality. Proceedings of the Demographic Health Surveys. World Conference, Washington D.C., August 1991. IRO/Macro International, Columbia, Md., 1992 (in press).
- Jejeebhoy, Shireen J. 1991, Women's status and fertility: Successive cross-sectional evidence from Tamil Nadu, India, 1970-80. *Studies in Family Planning*, 22(4), 217-230, July/August. Kabir, M. and Krishnan, T. N. 1992, Social Intermediation and Health Transition: Lessons from Kerala. Paper presented at the Workshop on the Future of Health Development in India: Health and Development Transitions in India; Public Policies and Action, organized by the National Council of Applied Economic Research and the Harvard University, Center for Population and Development Studies, New Delhi, January. Government of India 1990. *Family Welfare Yearbook 1988-89*, Ministry of Health and Family Welfare, New Delhi. Mitra, A. 1978, *India's Population : Aspects of Quality and Control*, Abhinav Publications, New Delhi. Pachauri, S. 1992, Women's Reproductive Health: Research Needs and Priorities for Developing Countries. Paper presented at the South East Asia Regional Seminar on Social Dimensions of Health Care and Health Policy, National Institute of Health and Family Welfare, New Delhi, March 1992. Sai, Fred T. and Nassim, Janet 1988, The Need for a Reproductive Health Framework. Paper presented at the Christopher Tietze International Symposium, Rio de Janeiro, Brazil, October 29-30, 1988. United Nations 1989, *Report on the World Social Situation*, United Nations, New York. United Nations Population Fund 1992, *The State of World Population 1992*, UNFPA, New York. Wasserheit, Judith N., Jeffrey, Harris, Chakraborty, R., Kay, Bradford, A. and Mason, Karen J. 1989, Reproductive tract infections in a family planning population in rural Bangladesh, *Studies in Family Planning*, 20(2), March/April. World Health Organization 1991, Creating Common Ground: Women's Perspectives on the Selection and Introduction of Fertility Regulation Technologies. Report of a meeting between women's health advocates and scientists organized by the Special Programme of Research, Development and Research Training in Human Reproduction and the International Women's Health Coalition. WHO, Geneva.