THE IMPACT OF REPRODUCTIVE SUBORDINATION ON WOMEN'S HEALTH

FAMILY PLANNING SERVICES

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ABSTRACT

Empowering women with the ability to regulate and control their fertility is a basic requirement for women's health, well-being, and quality of life. It is also a requirement for enjoyment of other social rights. In many societies, the predominant objection to the use of contraception was really an objection to the control of contraception by women, rather than against contraception itself. Male-dominated societies resented giving control of the process of reproduction to women. Patriarchal societies reasoned that if women had control over their reproduction, they would also have the unthinkable—control over their own sexuality.

In terms of maternal health, there is little difference between coerced contraception, sterilization, or abortion, because society does not want the child, and coerced motherhood, because society wants the child. Both interventions deny women the dignity of making a choice in their reproductive life. The negative impact on women's health due to violation of their reproductive rights is also equally pronounced whether it is a result of direct action on the

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part of the State or a result of the State's failure to fulfill its obligations to protect women's reproductive rights.

A dignified informed choice forms the basis of responsible motherhood. When societies allow women only one choice in life, childbearing and childrearing, and make children the only goods they can produce and they are expected to deliver, fertility is not a real choice for women.

The Programme of Action of the Cairo International Conference on Population and Development, 1994, upheld the principles of women's reproductive rights. To hold States accountable for their actions and inactions, there is a need to gather a broad coalition of the legal community, the health community, and women's organizations, under the banner of human rights treaties and the Convention on the Elimination of All Forms of Discrimination Against Women (Women's Convention).

I. A PRESCRIPTION FOR WOMEN'S HEALTH: MORE POWER

A recent world report on women's health issued by the International Federation of Gynecology and Obstetrics emphasized that future improvements in women's health require more than just the efforts of the science and health care professions. Long overdue societal action is needed to correct injustices to women.

Empowering women with the ability to regulate and control their fertility is a basic requirement for women's health, well-being, and quality of life. A woman who does not have the means or the power to regulate and control her fertility cannot be considered in a "state of complete physical, mental and social well-being," the definition of health in the Constitution of the World Health Organization. She cannot have the joy of a pregnancy that is wanted, avoid the distress of a pregnancy that is unwanted, plan her life, pursue her education, undertake a productive career, or plan her births to take place at optimal times for childbearing, ensuring more safety for herself, and better chances for her child's survival and healthy growth and development. Empowering women with the ability to regulate and control their fertility is also a basic requirement for enjoyment of other social rights.

1. Women's Convention, infra doc. biblio.
II. GENDER POWER RELATIONSHIPS AND THE RIGHT TO FAMILY PLANNING

Throughout human history, women have felt a need to regulate and control their fertility. Until the modern era, they had neither the power nor the safe and effective means to do so. As the writings of Hippocrates as early as 400 B.C. indicate, the lack of tools did not prevent them from trying to "doctor themselves," often risking their health, future fertility, and even their lives in the process.5

In almost every culture historians have found ancient, traditional recipes that women have used to regulate and control their fertility. Egyptian papyri dating from 1850 B.C. refer to plugs of honey, gum acacia, and crocodile dung, used by women as a contraceptive vaginal paste.6 Women traditionally had only one genuinely effective biological method at their disposal to postpone pregnancy: prolonged breastfeeding. Whatever the effectiveness of these and other methods, their use by women throughout history demonstrates the serious intent with which women have pursued the control of procreation.

Men, on the other hand, possessed the power and the means very early in human history. The biblical story of O-nan is a case in point:

And Judah said unto O-nan, Go in unto thy brother's wife, and marry her, and raise up seed to thy brother. And O-nan knew that the seed should not be his; and it came to pass, when he went in unto his brother's wife, that he spilled it on the ground, lest that he should give seed to his brother. And the thing which he did displeased the LORD: wherefore he slew him also.7

The actions in the story are those of Judah, O-nan, and the LORD. O-nan's brother's widow, Ta-mar, took no active role in this story.

Withdrawal, or coitus interruptus, one of the most ancient methods, enabled men to exercise control over reproduction. The condom, another effective contraceptive method, has also been available to men for more than three centuries.

In many societies, the predominant objection against contraceptive use was directed at contraceptive control by women, rather than against contraception itself. Male-dominated societies resented giving control of the process of reproduction to women. Patriarchal

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5. POPULATION POLICIES RECONSIDERED: HEALTH, EMPOWERMENT, AND RIGHTS 223-34 (Gita Sen et al. eds., 1994).
6. Id.
societies reasoned that if women had control over their reproduction, they would also have the unthinkable—control over their own sexuality. It is only recently that a contraceptive technology revolution provided women, for the first time, with methods which they can use for the effective regulation and control of their fertility.

III. SOCIETY AND REPRODUCTIVE LIFE

No society—primitive or advanced—no culture, no religion, and no legal code is or has been neutral about reproductive life. Concern for women’s welfare is rarely at the center of society-imposed norms in human reproduction. Women are predominantly considered a means, not an end.

The past few decades, however, bear witness to a major new development: governments are stepping in to address issues concerning female fertility. According to the United Nations Policy Data Bank, in 1988, twenty-two governments considered women’s fertility rates to be too low, and seventy-five considered them to be too high.\(^8\)

Governments’ views of female fertility are often translated into interventions. According to the same U.N. source, only sixty-eight countries out of 170 had no government policies of interventions with respect to levels of fertility; twenty-one countries had government policies to increase fertility; twenty had policies to maintain fertility; and sixty-one had policies to decrease fertility.

The concern of governments is legitimate. But government interventions vary, and can sometimes be clumsy. Measures taken by governments to influence fertility behavior, whether for an increase or decrease, can be classified into two broad categories: indirect and direct.

Indirect measures are intended to lower fertility. They are generally aimed at women, children, and the aged. They are aimed at improving the status of women so that they can pursue a productive career, and not just a reproductive career. They aim to enhance child survival so that people will not need to over-reproduce in anticipation of expected child losses. Providing care and protection for the aged aims at making children less needed as a measure for old age security. These indirect measures, apart from any intended effect on fertility, also serve worthy social causes.

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Social policies specifically directed at increasing or decreasing fertility fall in a wide spectrum, from the desirable, to the acceptable, to the objectionable. Provision of family planning services, including education and information, is a desirable social measure on its own. Maternity or paternity benefits and family allowances, as measures intended to increase fertility, are also desirable social policies on their own. Promotion of public awareness is acceptable, whether it is intended to decrease or increase fertility. It is, however, at the borderline. It can easily slip into the objectionable if it results in undue psychological pressure on individuals. In the category of the objectionable are incentives, disincentives, or coercion to decrease fertility, and restriction of access to family planning or abortion to increase fertility. These strong-handed measures by governments may adversely impact the health of women, and are equally objectionable whether meant to decrease or increase a woman's fertility.

IV. REPRODUCTIVE SUBORDINATION AND WOMEN'S HEALTH

In terms of maternal health, there is little difference between coerced contraception, sterilization, or abortion, because society does not want the child, and coerced motherhood, because society wants the child. Both interventions deny women the dignity of making a choice in their reproductive life and both adversely affect their health.

Let us look first at extreme examples.

In 1976, the national population policy of India permitted state legislatures to enact laws for compulsory sterilization. During the following national emergency period, several million forced sterilizations were performed.9

On the opposite side of the same coin is the declaration of Nicolae Ceausescu that "the fetus is the socialist property of the whole society. Giving birth is a patriotic duty.... Those who refuse to have children are deserters, escaping the law of natural continuity."10 It was reported that in Romania, employed women up to age forty-five were asked to undergo monthly gynecological examinations in their workplaces. Whether or not factory physicians received their full monthly salaries depended on plant employees achieving a State-stipulated monthly quota.11

9. Id. at 132-47.
11. Id.
V. FERTILITY CONTROL BY WOMEN OR CONTROL OF WOMEN

Contraceptives are meant to be used by women to empower themselves, to maximize their choices, to give them control over their fertility, and thus over their lives. The recent contraceptive revolution, however, has been largely driven by demographics. Women have benefited through the process but have not been its center. As far as policymakers are concerned, women often serve as a means to an end, i.e., women are seen as objects and not subjects. Some Governments are short-sighted. They do not see that when women are given both a real choice and the information and means to implement that choice, women will make the most rational decisions for themselves, for their communities, and ultimately for the world at large. The Cairo International Conference on Population and Development (ICPD) has acknowledged as much by asserting in its Programme of Action that:

[T]he aim of family-planning programs must be to enable couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so and to ensure informed choices and make available a full range of safe and effective methods. The success of population education and family-planning programs in a variety of settings demonstrates that informed individuals everywhere can and will act responsibly in the light of their own needs and those of their families and communities. The principle of informed free choice is essential to the long-term success of family-planning programmes. Any form of coercion has no part to play. . . . Governmental goals for family planning should be decided in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients.12

Governments at all levels are urged to institute systems of monitoring and evaluation of user-centered services with a view to detecting, preventing and controlling abuses by family-planning managers and providers and to ensure a continuing improvement in the quality of services. To this end, Governments should secure conformity to human rights, and to ethical and professional standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision.13

12. ICPD Programme of Action, infra doc. biblio., princ. 7.12.

13. ICPD Programme of Action, infra doc. biblio., princ. 7.17.
A government program focused on demographic objectives, rather than on empowering women to control their fertility, possesses the additional features of emphasizing contraceptive methods that may have a demographic impact, and of neglecting other reproductive health needs.

Contraceptives, particularly long-acting and permanent methods, can be used and have been used by governments and others to control rather than to empower women. They have been used where contraceptive health service settings are not optimal, fail to provide adequately for the safe use of contraceptives, and/or fail to guarantee free and informed choice. This situation has, understandably, created a backlash among women's groups against all such methods that are provider-dependent and are not user controlled, in spite of their convenience, effectiveness, and safety in appropriate delivery systems.

Contraceptive use and reduction of fertility are not ends in themselves. They are means to improve the quality of life for people. People, with human faces, are at the center of the process, not numbers. If the ultimate objective is to improve the quality of life for people, it does not make sense to present people with only one component of what is a closely interrelated reproductive health care package. Women need to protect themselves from unwanted pregnancy. Should we not worry also if they are exposed to potentially serious sexually transmitted infections during the same sexual act? Should we worry only about those who do not want to get pregnant and not worry about those who want to get pregnant but experience difficulty in conceiving? What should be our concern for women who get pregnant and lose their life or health in the process of pregnancy and childbirth? Some policymakers tend to forget that the solution for the population problem is not found in government boardrooms, but in people's bedrooms. People would more likely adopt a family planning behavior if they found that their other reproductive health needs are also addressed.

The Cairo ICPD recommended that:

All countries should, over the next several years, assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context . . . and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods

and to related reproductive health services which are not against the law.  

VI. COERCED MOTHERHOOD

Motherhood should be a dignified, informed, responsible choice. When societies allow women only one choice in life, childbearing and childrearing, and make children the only goods they can produce and they are expected to deliver, fertility by choice does not mean much. Only recently has the world started to realize the heavy price it is paying for its failure to empower women to make decisions, including reproductive decisions, in their lives. The Cairo ICPD upheld the principle that "[a]dvancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women’s ability to control their own fertility, are cornerstones of population and development-related programmes."  

Women are coerced into motherhood when governments fail to provide them with the information and means to regulate and control their fertility. In spite of all the rhetoric on population and family planning, not all women expressing a need for fertility regulation have the information and means to fulfill that need. A recent analysis of data derived from demographic and health surveys concluded that the total unmet need for contraception could be close to or in excess of 100 million women. It should be a responsibility of the whole international community to ensure that women, wherever they are, are given a choice in their lives and are given the means to implement their choice. Even the poorest women in the world should have the ability to make these choices. There can be no justification for denying poor people access to family planning.  

A recent study tried to measure access to family planning in 124 developed and developing countries, representing ninety-five percent of the world population. Countries were scored from zero to one hundred on the basis of ten indicators which cover the range of birth control choices available in the country, the competence of those providing family planning services, the convenience of services, and

15. ICPD Programme of Action, infra doc. biblio., princ. 7.16.
16. ICPD Programme of Action, infra doc. biblio., princ. 7.16.
the amount of information available to contraceptive users through various outreach and education efforts. Countries were ranked as having good, fair, poor, or very poor access to family planning. The study assessed access to family planning in 1992 as good for thirty-nine percent of the world’s population, fair for thirty-six percent, poor for sixteen percent, very poor for five percent, and not studied in the remaining five percent. Some fifty-six of the ninety-five developing countries studied, and two of the twenty-nine developed countries (Japan and Ireland), fell into the poor or very poor category with scores below fifty. In the twenty-two countries in the very poor category, couples still have virtually no access to birth control information or services through either the public or private sector.

The extent of the physical hazards of unwanted pregnancies depends largely on two factors: (1) the availability of efficient and accessible maternity services to deal with complications of pregnancy and childbirth; and (2) the availability of safe pregnancy termination services. Although maternal deaths have become rare events in industrialized countries, they are a major cause of death for women of childbearing age in developing countries.

Unsafe abortion exemplifies the magnitude of the problem of coerced motherhood. The moral and religious controversy about abortion tends to obscure its dimension as a health problem. Although unsafe abortion is one of the great neglected problems of health care in developing countries and a serious concern to women during their reproductive lives, it does not get the attention it deserves.\textsuperscript{19} Freedom movements around the world that result in several hundred deaths in a single day, for example, garner worldwide attention and sympathy. On the other hand, women die every day in pursuit of what they consider to be their reproductive freedom. There are those in the world who prefer to close their eyes and ears, rather than to face a problem that exists.

Information on clandestine abortions is difficult to document. Combining various estimates yields a total of fifteen million clandestine abortions.\textsuperscript{20} Because these figures cannot be fully relied upon, however, the actual number may be as low as ten million or as high as twenty-two million.

The magnitude of the problem of unsafe abortion was addressed in the Cairo ICPD Programme of Action, with the recommendation that

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"[a]ll governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services."21

Abortion is an issue of gender inequality. Women may not want abortion, but they need it. A man can walk away from an unwanted pregnancy, and leave the woman to face the consequences. Men can "abort" their children, whose identity as human persons is under no doubt, on the streets and get away with it.

Adolescents are a particularly vulnerable group for unwanted pregnancy. Their health needs have been largely ignored to date by existing reproductive health services. The Cairo ICPD has recommended that "countries with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies."22

VII. INFERTILITY

"And when Rachel saw that she bore Jacob no children, Rachel envied her sister; and said unto Jacob, Give me children, or else I die."23

Responsibility for infertility is commonly shared by the couple. Analysis of data compiled in a large World Health Organization multinational study showed that the situation in which a major factor for infertility existed in the female with no demonstrable factor in the male occurred in only 12.8% of cases; a major factor in the male with no demonstrable cause in the female was diagnosed in only 7.5% of cases.24 The burden of infertility, however, for biological and social reasons, is unequally shared.

Because of their reproductive subordination, the psychological and social burden of infertility in most societies is much heavier on the woman. A woman's status is often identified with her fertility, and failure to have children can be seen as a social disgrace or a cause for divorce. The suffering of the infertile woman can be very real.

22. ICPD Programme of Action, infra doc. biblio., princ. 7.46.
Definitions of infertility widely vary. A conservative estimate is that eight percent of couples "experience some form of infertility problem during their reproductive lives," and that fifty to eighty million people "may be experiencing either primary or secondary infertility" at a given time.\(^25\)

**VIII. BEYOND CAIRO**

The Cairo ICPD has strongly reaffirmed women's reproductive rights. As noted in chapter XVI of the Programme of Action, however, the significance of the Conference will depend on the willingness of governments, local communities, the nongovernmental sector, the international community, and all other concerned organizations and individuals to turn the recommendations of the Conference into action. The Programme of Action calls on the United Nations General Assembly to organize a regular review of the implementation of the Programme, and to consider the timing, format, and organizational aspects of such a review.

To protect and promote women's reproductive rights, and to hold States accountable for their actions and inactions, another review mechanism is needed. A broad coalition comprising the legal community, health professionals, and women's organizations, under the banner of human rights and the Women's Convention, can be the agent for change.

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