On Women's Health and Rights
Lectures, Speeches and Statements
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Health and being a woman

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HEALTH AND BEING A WOMAN

Being a woman has implications for health. Health needs of women can be broadly classified under four categories[1]. First, women have specific health needs related to the sexual and reproductive function. Second, women have an elaborate reproductive system that is vulnerable to dysfunction or disease, even before it is put to function or after it has been put out of function. Third, women are subject to the same diseases of other body systems that can affect men. The disease patterns often differ from those of men because of genetic constitution, hormonal environment or gender-evolved lifestyle behavior. Also, diseases of other body systems or their treatments may interact with conditions of the reproductive system or function. Fourth, because women are women, they are subject to social diseases which impact on their physical, mental or social health. Examples include female genital mutilation, sexual abuse and domestic violence.

The reproductive system, in function, dysfunction and disease, plays a central role in women's health. This is different from the case with men. A major burden of the disease in females is related to their reproductive function and reproductive system, and the way society treats or mistreats them because of their gender. While more men die because of what one may call their "vices", women often suffer because of their nature-assigned physiological duty for the survival of the species, and the tasks related to it. In a study on investing in health, reported by the World Bank, ranking of the five main causes of the disease burden in young adults (15 to 44 years) in developing countries showed the following gender differential[2] :

	Females	Males
1.	Maternal	HIV infection
2.	Sexually-transmitted diseases	Tuberculosis
3.	Tuberculosis	Motor vehicle injuries
4.	HIV infection	Homicide and violence
5.	Depressive disorders	War

WOMEN AS ENDS AND NOT MEANS

Women, healthy women, need health care in order to be able to carry their sexual/ reproductive functions, and to carry them safely and successfully. During the second half of this century, there

has been a vast expansion of health technologies and of health services to provide women with certain elements of reproductive health care. The services were not, however, without shortcomings.

Apart from inadequate allocation of resources, the major shortcoming was in the philosophy with which these services were provided. Women were considered as means in the process of reproduction and as targets in the process of fertility control. The services were not provided to women as ends in themselves. Women benefited from the process but were not at the center of the process.

The needs of women have been traditionally addressed within the concept of maternal and child health (MCH). The needs of the woman were submerged in the needs of the mother. MCH programs and services have played and continue to play an important role in promotive, preventive and curative health care of mothers and children. MCH services tend to focus on the healthy child as the successful outcome. While mothers care very much for this successful outcome because of the investment they make in the process of reproduction, this focus resulted in less emphasis being put on caring for the health risks to which mothers are liable during pregnancy and childbirth, and on putting in place the essential obstetric functions and facilities to deal with them. As a result, the tragedy of maternal mortality in developing countries has now reached dimensions that can no longer be ignored.

With all their benefits to the quality of life of women, family planning programs have left women with some genuine concerns as well as unmet needs[3]. Women have more at stake in fertility control than anyone else. Contraceptives are meant to be used by women to empower themselves by maximizing their choices, and controlling their fertility, their sexuality, their health and thus their lives. Family planning, however, can be used and has been used by governments and others to control rather than to empower women[4]. The family planning movement has been largely demographic driven. As far as policymakers are concerned, women were often objects and not subjects. Some governments were short-sighted, not to see that when women are given a real choice, and the information and means to implement their choice, they will make the most rational decision for themselves, for their communities and ultimately for the world at large.

With women as means and not ends, important health needs in the reproductive process have been left unmet. Infertility may not be a serious hazard as far as physical health is concerned, but can be a major cause of mental and social ill-health. It is not fair that society should provide care to reproducing women, but should neglect the suffering of those who are unable to conceive. Sexual intercourse exposes women to the risk of unwanted pregnancy. It exposes many women also to another serious or more serious risk, that of sexually-transmitted infections, including HIV infection. Family planning programs, with an exclusive demographic focus, may not see the point of this important need for women.

The concept of MCH focuses special attention on women when and if they are reproducing, to ensure that society gets a healthy child, but often neglects their other reproduction-related health needs. Women's reproduction-related health needs are not limited to the reproductive years of

their life. The girl child, the adolescent girl, and the mature adult and older woman have health needs related to their future or past reproductive function.

The societal attitude of looking at women as means and not ends is even more pervasive. Services offered to women often have something of a veterinary quality about it. Proponents of the education of girls cite the advantages that such education will have for the survival and health of the children, and the impact it will have on reducing birth rates. Nutrition of women is justified because of the needs of the foetus and the lactating infant. Even with the tragedy of maternal mortality,
A justification put forward for investment in keeping mothers alive is that their survival is critical for the survival of the children.

The concept of reproductive health has emerged in response to the fragmentation of the existing services and their orientation. The broader concept of "reproductive health" offers a comprehensive, and integrated approach to the health needs related to reproduction. It puts women at the center of the process, as subjects and not objects, as ends and not means. It recognizes, respects and responds to the need of the woman behind the mother.

WOMEN AND THE HEALTH CARE SYSTEM

In spite of major expansions and improvements in health care and development, the health care system has been unable to meet the needs for large segments of the world population, and particularly women. Inadequacies of the health care system vary from country to country and even within the same country. Basically, however, one can differentiate three patterns of inadequacy: deficiency, under-utilization, and over-medicalization[5]. These patterns of inadequacy apply to the whole field of health care, but they are particularly prominent in the areas of women's health.

The coverage of health care services in developing countries is deficient, with a distinct urban bias. Levels of coverage of maternal health care remain inadequate in most developing countries. In developed market economies and economies in transition, well over 90% of pregnant women receive antenatal care and are assisted by a person trained in midwifery during childbirth[6]. In the least developed countries only 50% receive antenatal care, and only 30% deliver with the help of a skilled birth attendant. In other developing countries the figures are about 70% and 60% respectively. Levels of postpartum coverage are particularly low: below 30% for many developing countries.

In 1965, only about 9% of all married women of reproductive age in developing countries, or their partners, were using a reliable method of contraception. Today this figure is approaching 60%[6]. In spite of this increase in the ability of women to regulate their fertility over the past 30 years worldwide, there remain marked differences between the developed and developing parts of the world and among regions within the developing part. There are still large segments of the world's population whose fertility regulation needs are not met by the currently available methods and services. In 1990 it was estimated that 200 million couples were using methods of family

planning that they considered unsatisfactory or unreliable, contributing to the estimated 30 million unintended pregnancies that occur each year among people practicing contraception[6]. In addition, at least another 100-120 million couples were not using any method of contraception even though they wanted to space their pregnancies or limit their fertility. Finally, contraceptive choices available to couples in developing countries are often very limited, with heavy reliance on permanent methods (male and female sterilization) which account for nearly 50% of use.

The *under-utilization* of the health care system is a distressing phenomenon in some developing countries. Grafted, socially non-relevant, culturally inappropriate health care services are bound to be rejected. Where different societies have their own traditions of disease prevention and sickness care, the introduction of the concepts and technologies of modern scientific medicine will be most effective only through adaptation and accommodation to these existing systems. Health care professionals find it easy to blame it on patients when they do not utilize the service and advocate better education. It is less palatable to health professionals, but more true, to blame it on the system. The question should not be why do patients not accept the services we offer, but rather why we do not offer patients the services they will accept.

Over-medicalization of the health care system is becoming typical of affluent societies, and is infecting developing countries[7]. Technology utilization is lurching from appropriate use into indiscriminate use. The "lust" for technology and medical over-consumption or “gluttony” are escalating the costs of health care to staggering heights. Women are also voicing their concerns about the over-medicalization of physiological events in their lives.

The health care system needs a change in psychology, and not only in anatomy (structure) and physiology (function). Throughout human history, medicine has been recognized as a profession for both care and cure. This was the way it was when the medical man or woman was also the priest and/or the magician. This was also how it continued to be when the medical profession diverged from religion and from magic. A reader of the history of medicine would realize that our physician ancestors, for the major part of human history, had really so little in their hands to influence the process of disease or to prevent deaths. Their treatment had an equal chance, in many cases more than an equal chance, of being more harmful than useful. In spite of the clumsy performance of our ancestor physicians in the function of cure, they continued to command respect and prestige in the societies they served, and the societies continued to invest in their activities. This was because they did so well in the function of care. This pastoral/ supportive function may be described as the provision of psychological help and "tender loving care" to the anxious patient. The wide application of scientific knowledge and biomedical technology is now creating an "emotional gap" in the care of patients. Machines now stand between the doctors and their patients[7]. The loss of the caring function is no more evident than in the field of reproductive health. Women in exercising normal functions are often in need of more care than cure. They are getting instead a depersonalized, mechanized, mystery-clouded medical service. Women are objecting to being objectified in one of their fundamental physiological roles, and they are right.

There is a need to look at the health care system with a woman’s lens, and for the system to change from being Hyper-medicalized, Impersonal, and Sub-specialized (HIS) to being Humane, Equitable and Rational (HER).

WOMEN'S RIGHT TO LIFE- THE NEGLECTED TRAGEDY OF MATERNAL MORTALITY

The neglected tragedy of maternal mortality is the health scandal of our time[8]. The World Health Organization estimates that about 585 000 women die each year, for causes related to pregnancy and childbirth, that is a woman every minute. This mortality is only the tip of an iceberg of morbidity, suffering and ill-health. For us obstetricians and midwives who have practiced in developing countries, maternal mortality is not about numbers and statistics. It is about women who have names. It is about human faces seen in the throes of agony, distress, and despair, faces which continue to live in our memories and continue to haunt our dreams. This is not simply because these are young women in the prime of their lives who die at a time of expectation and joy. It is not simply because a maternal death is one of the most terrible ways to die, be it bleeding to death, unbearable bangs of obstructed labor, convulsive fits of eclampsia, or the agony of puerperal sepsis. It is not simply because of all this that maternal mortality is such a human tragedy. It is because, in retrospect, almost each and every case of maternal death is an event that could have been avoided and should not have been allowed to happen.

We learned a hard lesson in the past decade of efforts for safe motherhood. Motherhood cannot be made safe without access to essential and emergency obstetric care. Pregnancy and childbirth are a risky business. Unfortunately, the risks are generally neither predictable nor preventable. It is a risk that unites women, all women, and does not discriminate between the rich and the poor. While the risks are not predictable or preventable, they are all manageable. To make motherhood safe, essential and emergency obstetric care should and can be made available and accessible to all mothers when and if the need arises. For this, there is no alternative.

We know how to make motherhood safe and the world affords to make motherhood safe. What is then hindering the will to make it safe and to commit the resources necessary to make it safe? I submit that it is a question of how much the life of a woman is considered worth. A painful lesson I learnt from colleagues in economics is that, consciously or subconsciously, society sets a monetary value for each human life, and this will in turn decide how much society is willing to spend to save that life, in other word, deciding who shall live and who shall die. My colleagues in economics taught me further that the invisible price tag on human life is set on the basis of two considerations: how much society has invested in you and how much society expects from you and values your product. Applying this cold and cruel logic to the reality of women's lives in the world today, it is clear that the investment in girls is very much lagging behind, and that the product of women's work, much that it counts, goes mostly uncounted.

I submit also that an additional factor not helping in getting the will and the wallet for safe motherhood is that few women are in the position of decision making about the allocation of resources, particularly in countries where these resources are scarce.

Women, worldwide, should mobilize for the right to safe motherhood, basically the woman's right to life. It is true that women in the North have mostly forgotten what maternal mortality is. But for their sisters in the South, the journey of pregnancy and childbirth is still dangerous and many do not return.

The tragedy of maternal mortality in developing countries is not just a health problem; it should be recognized also as a human rights issue[9]. The theme for World Health Day in 1998 was: "Pregnancy is Special; let's make it safe". When the World Health Assembly adopted this theme, it was setting a principle in health policy. Pregnancy is not a disease. Pregnancy is special. Pregnancy, a woman's privilege, is the means for survival of our species. Women have a right to safe motherhood, when they risk their life and health in order to give us life. Pregnancy should not compete for resources with disease conditions. Pregnancy is special.

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