Progress of Social Science Research on Reproductive Health

ANTHOLOGY OF TREATISES OF THE INTERNATIONAL SYMPOSIUM ON SOCIAL SCIENCE RESEARCH IN REPRODUCTIVE HEALTH

Shanghai, People's Republic of China
11 – 14 October 1994

Edited by Gao Ersheng Iqbal Shah

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The International Symposium on Social Science Research in Reproductive Health, which was held on 11 – 14 October 1994 in Shanghai, represents the research of national and international scientists who examined ways to eliminate the existing barries and thereby improve the overall standard of reproductive health in China.

For this symposium, we received more than two hundred research papers both from home and abroad. And we select twenty – four papers which are of representativeness in various aspects of reproductive health for the English version of the Anthology of Treatises, sixteen papers from China and eight from other countries.

Both the symposium and its publications received financial and technical support from the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), with the special technical support from the Social Research Unit of WHO/HRP. The Shanghai Institute of Planned Parenthood Research (SIPPR) hosted the Symposium and took charge of the publication of this Anthology.

We are greatly indebted to many people who made this book possible, especially to Mr LIANG Zhengliu from Shanghai Medical University for his diligence in improving the English version of the papers written by Chinese scholars. We would also like to extend our sincere thanks to Ms LI Weihua for editing the papers and Ms DING Yinqiu for her help in typing.

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Chapter 1 Introduction

Reproductive Health Research: Progress and Policy Implications

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1. INTRODUCTION

Twenty years ago, the world's population experts were divided on the question of how to bring down fertility. Some believed that socio – economic development alone could reduce family sizes, others thought that vigorous promotion of contraception would be effective regardless of levels of development. Many Asian nations acted on this second view, instituting family planning programmes that had a dramatic effect on fertility. Chinese women in 1970 bore an average of 5.8 children each. By 1992, the average had fallen to 2.0.

The success of family planning programmes in reducing family size is incontestable, but critics point out that the cost in terms of individual freedom has sometimes been high. The good of future generations, they say, has been safeguarded at the expense of men, women and children today. Few would doubt that slowing population growth to sustainable levels is a necessary goal. But increasingly the thinking is that the goal will best be achieved by providing for people's needs in the areas of reproductive health, education and income generation, especially for women. Reproductive health services that are comprehensive, high quality and voluntary are likely to improve the timing and spacing of births, reducing sickness and death among mothers and children. They should also contribute to more consistent use of contraception and fewer unnecessary abortions.

In much of the world, fertility research has in the past concentrated on demographic outcomes, ignoring the complex human behaviours that produce those outcomes. China is no exception to this general rule. However, the change in thinking about population programmes has wrought a change in the aims of research. If we believe sustainable fertility falls will best be achieved by meeting people's health needs, we need to know what those needs are. Why do women get pregnant when they don't want to? Who makes fertility decisions? When do young people start having sex and why? How do sexually transmitted diseases spread through a population and how can they be stopped? These are some of the questions which social scientists have been asking in an attempt to identify the needs of different populations.

Chinese social science research in this field has made a strong start in recent years. This re-

port focuses on work presented at the International Symposium on Social Science Research in Reproductive Health, held in Shanghai between the 11th and 14th of October 1994.

In practice, the sheer size of China population and the emphasis placed by policy－makers on slowing the pace of growth means, realistically, that contraceptive services are still at the centre of the research picture. This is not inconsistent with broader reproductive health research. All aspects of reproductive health are inter－related and safe contraception has implications far beyond simply reducing population growth.

Well－spaced children and their mothers are likely to be healthier than those born at short intervals. Planned pregnancies are unlikely to end in abortion, which may endanger a woman's health. The right contraceptive can reduce exposure to sexually transmitted diseases, reproductive tract infections and through them to infertility. Avoiding early pregnancy can also improve women's chances of a staying in education and getting a good job.

The papers presented at the symposium draw many of these threads together and point to the importance of dialogue between researchers and policy－makers in the fields of medicine, public health, sociology and economics. Their findings will be presented as they relate to the different aspects that, interwoven, make up the whole that is reproductive health.

2. REPRODUCTIVE HEALTH

Reproductive health is a term that is much used but frequently ill－defined. Most experts would agree that the three key dimensions are as follows:－

* people have the ability, the information and the means to bear children and to regulate their fertility safely as they choose.
* women go through pregnancy and childbirth safely and have the best chance of having a healthy child.
* people's sexual relationships are not overshadowed by the danger of contracting disease.

2.1 *Fertility Regulation*

The ability to regulate fertility safely is central to reproductive good health. That ability is compromised if people don't know how they can limit births, if contraceptives are not available or if none of the available contraceptives is acceptable. Equally, people cannot choose when to bear children if they are infertile or have been sterilized. Much of the research presented at the symposium was dedicated to ascertaining whether people had access to adequate information and contraceptive choice.

2.1.1 Information

Although the authorities in China have been active in promoting awareness of contraception, it appears that basic physiological knowledge is limited. In 1990, married women of childbearing age in Shanghai were tested on their knowledge of contraceptive methods and their correct use. Although the maximum score possible was 100, nine in ten women scored fewer than 20 points. Less than one percent of respondents scored over 40 points. After a programme of education in reproductive health, contraceptive use rose dramatically. Some 82 percent of respondents could identify contraceptives and used them correctly, up from 32 percent earlier. (Zhou Meirong et al.)

Information about the correct use of effective contraception is especially lacking among young people. In Henan province, over 85 percent of young women who became pregnant before marriage had never spoken about reproduction with their parents, and close to half lacked the most basic physiological information (Yang Shuxia et al.).

Over half of the newly married women using contraceptives in one Shanghai study had been pregnant before marriage. Newly - weds wanting to delay having their first child were little better off: up to 44 percent of them became pregnant through contraceptive failure (Guo Youning et al.).

Comprehensive information about contraceptive options and their effects would do much to correct misconceptions which discourage couples from using suitable methods. In one study, nearly three quarters of newly - weds wanting to delay a first birth were unwilling to take the pill because they believed it would harm the woman or lead to the birth of a deformed child (Guo Youning et al.).

Such information is especially important for those contemplating long - acting or permanent methods. A study in Guandong province showed that 67 percent of women, many of them quite young, were given an IUD before they had any idea that other contraceptive options existed. A worrying 62 percent of the same women had no information at all on potential side - effects of the IUD (He Jialiang et al). Other studies in Hunan, Sichuan and Shandong indicated that counseling before sterilization may reduce the incidence of psychological side effects after the operation (Luo Lin et al.; Liu Poze et al.; Zen Yuming et al.).

2.1.2 Quality Service Provision

Experience in other countries in the region, notably Indonesia, demonstrates that attention to information, counseling and provision of services that meet the needs of specific communities are important ingredients in successful reproductive health programmes (Djuhari Wirakartakasumach). The high rate of abortion in China suggests that both information and contraceptive service provision are inadequate. Around a quarter of married women having an abortion in Shanghai had never used a contraceptive.

Quality service provision depends to a great extent on staff training. Ill - trained staff are unlikely to be able to give people the information about method choice that they need. An evaluation of family planning service stations in Guandong, Shandong and Sichuan provinces showed that training was very poor. Nearly 90 percent of the service stations evaluated scored fewer than 10 points for staff training, out of a possible total of 100 (Cui Nin). Improving training has a phenomenal effect on service quality. In Anhui province, training workshops lasting between four and six days gave family planning workers the opportunity to effectively counsel and serve individuals in need of family planning advice. As a result the discontinuation rate among contraceptors fell from 35 percent to below one percent, while unwanted pregnancies fell too (Yu Guobing et al.).

Services, like information, appear not to be reaching adolescents and the unmarried. One study in Shanghai showed that only one in three young couples having premarital sex used contraceptives (Guo Youning et al.). Other studies calculate that just 15 percent of those who became pregnant before marriage had used any contraception. Over a quarter of all induced abortions in the city are performed on unmarried women. (Ma Gengtian, Yao Bengzhong). Though pre - marital sex is believed to be on the rise, there is little informa-

tion that permits estimation of trends. Female students in Shanghai medical colleges reported more pre－marital sex than male students. Nine percent of unmarried female students reported sexual experience, against seven percent of male students. By the third year of studies, up to one in five unmarried women had had sex. Although they were motivated to avoid pregnancy (every one of the students that became pregnant had an abortion) fewer than half of this highly educated elite group used even a traditional method of contraception. (Zhao Pengfei; Wu Junqing et al.)

A study in Nanjing indicated that as many as half of young couples have premarital sex. The results may be biased upwards by the fact the study was carried out in abortion clinics and marriage registration offices, both settings where people may be disproportionately likely to be as a consequence of premarital sex and pregnancy. Some 59 percent of this group claim to have used contraception at least occasionally.

2.1.3 Method Choice

Different people have different contraceptive needs. A teenager who has sex only occasionally and wants protection against disease as well as pregnancy will not need the same method as a married woman who wishes to stop childbearing. A smoker with hypertension should not be on the pill, while a woman with uterine prolapse should avoid an IUD.

It is fundamental to reproductive health that people have access to the method that suits their health and fertility needs. And yet many research papers confirm the widely－held view that contraceptive choice in China is severely limited and dictated principally by government policy. Little information is given about alternative methods or possible side effects, while screening for contraindications is in many places non－existent (He Daliang; Tu Ping; Gu Danua; Gao Ersheng; Li Mingxiang et al.). Distributing inappropriate contraceptive methods, besides endangering the health and comfort of the user, will increase the likelihood of discontinuation and of method failure. Tu Ping reported that method failure for TCU380 in northern China amounted to five percent a year, far higher than what clinical trials would indicate.

A study of cost－effectiveness concluded that although copper－T IUDs and Norplant hormonal implants were more expensive in the first instance than the more common steel ring IUDs, they lead to lower discontinuation and contraceptive failure rates. Overall, they may represent a net saving in health care provision and productivity (Chao Liwei).

Because it is easier to interfere with one egg a month than with millions of sperm every day, the burden of contraception most often falls on women. Indeed, 35 percent of married Chinese women of reproductive age are sterilized; three times more than men, even though female sterilization is more expensive, more difficult and more dangerous than male sterilization. Focus group discussions in Sichuan, Yunnan and Jiling show that some men feel that sterilization will threaten their sexual health in the future. The problem of post－operation trauma also appears to loom large in people's minds.

Most men participating in focus groups considered condoms to be safe and easy to use, but some felt they decrease sexual pleasure; this may contribute to the low prevalence of condoms, used by just three percent of married men. Many men complain of poor quality products and of difficulties in storage and disposal. These concerns were especially apparent in remote and mountainous regions, where supplies are often erratic.

In general, researchers identified a reluctance on the part of policy－makers to address male contraceptive methods. They pointed out the need for sensitivity to local cultural and environmental conditions (Liu Yunrong; Peng Lin; Liu Wei et al.)

2.1.4 Abortion

If high quality contraceptive services were universally available, then voluntary abortions would be rare. Research shows that this is not yet the case in China. In Shanghai, nearly eight out of ten women undergoing abortions said their contraceptives had failed or service provision was incomplete (Zhou Meirong et al.). Of those who had never used contraception, some 14 percent said they had originally planned to be pregnant, suggesting, perhaps, that not all abortions are voluntary. An epidemiological study in Sichuan investigating contraceptive failure concluded that 62 percent of IUD failure was related to poorly positioned or defective IUDs, and 14 percent to natural expulsion of the device. Among pill takers, 42 percent were pregnant because they forgot to take the pill and 29 percent because they took it only irregularly.

Abortions among married women were more common in younger age groups, a fact which may reflect inadequate provision of contraceptive methods suitable for spacing rather than stopping childbearing. In Shanghai, Shandong and Henan, studies show women between 20 and 24 years of age had twice as many abortions as they did live births. Women in their late twenties had 110 abortions per 100 live births. Once over 35, the proportions were reversed and half as many pregnancies were terminated as were carried to term. The rate was particularly high among the unemployed: 350 abortions per 100 live births (Liu Yunrong; Gui Shixin, Su Xiao).

Childless married women give various reasons for choosing to abort; over half of them say they are too busy in education or work to have a child, 14 percent say they cannot afford a child, often because they are separated from their husband. Some worry that drugs taken during pregnancy may affect the health of the child (Kang Xiaoping).

There is evidence from other quarters that women may be choosing to abort female foetuses identified in pre－natal screening. One study showed that women who already had a girl were far more likely to have a boy next than would be natural. Normally, around 105 boys are born for every 100 girls. In this study, where a family already had a girl, the ratio of boys among second children rose to 120.2; if a family had two girls the sex ratio of the third child was 154.0 (Wang Yan).

A reproductive health education programme reduced the proportion of women undergoing abortions in Shanghai from 32 percent to 20 percent. (Zhou Meirong et al.)

Demographically, induced abortion has contributed 15 percent to the overall fall in China's fertility. (Shi Fan)

2.2 ***Safe Motherhood***

The risks to a mother's health associated with pregnancy and childbirth may be greatly aggravated by malnutrition, anaemia and other diseases of poverty. In poor areas of Sichuan and Yunnan provinces, over 200 women die for every 100,000 children born alive － three times the national average. In Guanxi province, the level was as high as 230.

Maternal mortality risks are highest for women who are very young, who are nearing the

end of their reproductive lifespan, or who bear many children or bear them in quick succession. These behaviours are more likely among ethnic minorities, whose fertility is higher than that of ethnic Han Chinese. Sixty－three percent of Yu women (Butuo county, Yunnan province) aged between 15 and 19 had begun childbearing.

Fertility among ethnic minorities is falling, from 4.2 births per woman in 1981 to 3.0 in 1990 (Qiang Jiangmin). Among the Dai women of Yunnan province, family size norms are coming down to levels common among the Han majority. Eight in ten women say they want only one or two children and the average number of children born by those under 40 is 1.9. But researchers report that women are poorly informed about their reproductive processes (Deng Yongjin). The promotion of long－acting or permanent contraceptive methods may discourage adequate spacing between children among all Chinese women.

Another significant threat to women's ability to bear children safely comes from reproductive tract infections. Little is known about these illnesses anywhere in the world. One study showed high prevalence of lower reproductive tract infection among women in rural areas of Yunan province, with well over a third suffering from candida, trichomonas vaginitis or gonococcal cervicitis (Yan Liqin and Wang Tongyin).

2.3 *A Healthy Infant*

Poverty, poor maternal nutrition, poorly timed and closely spaced births endanger the child as well as the mother. A shocking one in three of the Yu teenagers bearing children in Butuo county saw their babies die before their first birthday (Qiang Fangming; Tian Aiping et al.). In poor rural areas of China, children are three times more likely to die in infancy than in the country as a whole. In Yunnan, nearly one baby in ten will die from neonatal tetanus alone (Jiang Feng). Tetanus toxoid injections given to mothers during pregnancy can all but eliminate the danger of these deaths.

Breastfeeding gives a child the best possible start in life. A mother's milk contains important antibodies which protect an infant from disease, besides providing all the nutrients a child needs for around the first six months of life. It is hygienically packaged, and it is free. Introducing even water to feeding in the first six months will increase the likelihood of infection. And yet breastfeeding levels in both urban and rural areas are low. Just 14 percent of women in Shanghai breastfeed their infants exclusively, with another 23 percent giving breastmilk and water. In rural areas, 19 percent breastfed exclusively while 30 percent added water. Results from a study in poor rural areas of Fujian province are more alarming still －－ not even one of the children in the study was breast fed exclusively to the age of four months (Zhan Shaokang et al.).

The practice of separating mothers and children in maternity wards contributes to these low levels. In Putou maternity unit, where mothers and newborns stay together, breastfeeding was significantly higher than elsewhere. Though schooling and high－status careers appear to be associated with low levels of breastfeeding, education campaigns aimed specifically at mothers can triple the practice. (Yuan Wei et al). Interestingly, ethnic minorities have far higher rates of breastfeeding than Han Chinese. Among the Zhuang, for example, 94% of babies were still breastfed at the age of four months (Shi Yuanli et al.).

The contraceptive effects of breastfeeding appear to account for around eight percent of China's fall in fertility. However it is far from reliable as a contraceptive method after six

months. Over one in five of the married women presenting themselves for abortion in one Shanghai study believed they were protected from pregnancy because they were breastfeeding and among suburban women it was the most common reason given by married women seeking abortions for their pregnancy (Gui Shixun). In Qinghai, 16 percent of women seeking abortions believed they were protected from pregnancy by lactation (Li Chunlian).

2.4 *FREEDOM FROM DISEASE*

Sexually transmitted diseases (STDs) and reproductive tract infections can cause discomfort, sterility and, in the case of HIV/AIDS, death. Common STDs can increase the likelihood of HIV infection. They are more likely to affect people with multiple sex partners and those who never use protective devices such as condoms. Commercial sex workers may act as focal points for the spread of sexual illness.

A study among STD patients in Shanghai confirmed most of these risk factors. Those seeking treatment of STDs tend to have multiple partners – – an average of 4.1 for men and 2.4 for women. They are unlikely to have used protection – – 76 percent had never used a condom at all, and 77 percent said they had had unprotected intercourse while contagious. Sixteen percent of female patients had had sex for commercial purposes, while 54 percent believed they had been infected by their husbands. The majority of men said they had been infected by commercial or casual partners (Zhao Pengfei et al.). Over three quarters of STD patients reported previous infections, and in one study over 90 percent said they had never considered using condoms to prevent transmission, suggesting insufficient counseling to change behaviour among those treated for infection (Liao Mingmin et al.).

High – risk behaviour is by no means confined to STD patients. A quarter of the Shanghai university students who were sexually experienced reported multiple partners, while condom use was fractional. In a household survey in Yunnan, the area of China with the highest known prevalence of HIV infection, one in five respondents said they had had multiple sex partners. Just 10 percent reported using condoms. This is an area of the country with relatively high intravenous drug use – – some 3.4 percent of the urban population in Ruili, Yunnan province are drug users. Although drug injection is thought to account for 60 percent of HIV transmission currently, the high prevalence of other STDs suggests that sexual risk behaviour may be higher than reported. Twenty three percent of sexually active women in rural Yunan suffer from gonococcal cervicitis (Zhu Hua et al).

In other Asian countries the prognosis is no better. A study of prostitutes in Nepal showed that women had been sexually active for an average of five years, and professional sex workers for three. Nearly three – quarters suffered from at least one symptomatic STD, and a quarter tested positive for HIV infection, hepatitis B or syphilis. Yet fewer than a fifth used condoms and some 60 percent had never heard of AIDS. Awareness of the disease was higher in Korea, where 90 percent of young students questioned knew of the disease. However information was often partial or inaccurate – – fewer than half knew that condom use could protect against infection. Over a third of respondents reported more than one sex partner; roughly the same proportion never used condoms. Around 60 percent of those who had contracted an STD used condoms (So Young Cho).

3. COMMON THREADS

The papers presented here covered many areas, but they point in the same direction. Meeting reproductive health needs will depend on more information, more choice and better coordination of inter－related services. And all of these services must be provided to a much broader public.

3.1 *More Information*

Much of the research presented indicates that inadequate information can lead to poor reproductive health. People may not know that their patterns of sexual behaviour put them at risk of disease, of an unsafe or unwanted pregnancy, of bearing an unhealthy infant. They may not know that a certain contraceptive could threaten their own health, or that early bottle feeding could harm their child. These papers show that across China and in all educational and social brackets, people need more information to help them lead healthier lives. The need is greater in some groups than in others; adolescents consistently appear in more need of education and counseling about sex and reproductive health.

3.2 *BETTER SERVICE PROVISION*

Knowledge is useless without the means to act on it. Knowing that IUDs and uterine prolapse add up to high risk is of little value to a woman who wants to use modern contraception but is offered no alternative to an IUD. Knowing that early pregnancy can be dangerous does not help a young newly－wed whose husband opposes delaying the first birth. Knowing that untreated STDs can lead to sterility is nothing but a cause for anguish to an infected woman who has no access to treatment.

In the first decades of China's family planning programme, the emphasis on contraceptive prevalence dwarfed all other aspects of reproductive health provision, and as this research shows, method choice was limited. There is need for provision of a broader range of contraceptive methods to meet the needs of different groups, particularly the young and the poor. More screening for contraindications, information about side－effects and follow－up are needed. Reproductive health is made up of many different behaviours and environmental factors; most are inter－related. There is a need for greater coordination between the different branches of health service provision. This research suggests that more integrated provision of family planning services and STD prevention, screening and treatment would be especially beneficial.

3.3 *MORE RESEARCH*

The Symposium held in Shanghai presented a broad cross－section of research in fertility and reproductive health. It was clear that great strides have been made in recent years, but, as always, good research prompts new questions. If the needs of individuals are to be put at the centre of reproductive health service development, we need to know a great deal more about individual behaviour. Research should focus on the motivations and social context that determine behaviour as much as on quantifying it. An active dialogue between researchers and policy makers will take China towards better reproductive health and a higher quality of life for all its citizens.

Chapter 2 Concept of Reproductive Health

Reproductive Health Research and Its Implications for Policy

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1. INTRODUCTION

Increasingly, during the last five years, reproductive health has been accepted as the central concept to define a wide range of health concerns relating to events that surround or affect human reproduction. The primary aim of reproductive health is to eliminate morbidity and mortality risks from the chain of events leading to the eventual birth of a child and its early growth. Reproductive health includes also aspects of the reproductive process formerly ignored by family planning programmes and by researchers working in this field, for example sexuality and its health implications. Among the services that come under the expanded scope of reproductive health care are: sexual health, including checks for reproductive tract infection and cancer prevention, sexually transmitted diseases, pre－natal and post－natal care, family planning, abortion counseling, and also services for couples who are infertile. Special emphasis is also given to women's and men's access to a wide choice of effective contraceptives provided in quality services and in ways that are appropriate to local culture. Among the goals of reproductive health is that couples enjoy the freedom of starting a pregnancy when a child is desired, therefore reducing unwanted pregnancies as well as unnecessary abortions. In addition to stressing the rights of women to choice and independent decision－making in all aspects relating to the reproductive process, the reproductive health framework recognizes the involvement and preferences of men in reproduction. For both the service and the research community, this expanded concept presents numerous challenges, particularly to design appropriate service models and updated information on needs in order to assist government planners in the development and implementation of improved reproductive health policies.

2. REPRODUCTIVE HEALTH: EVOLUTION OF THE CONCEPT

The concept of reproductive health has evolved in recent years as family planning programmes and research organizations working in human reproduction, have realized that services concentrating only on the provision of contraceptives are insufficient to meet the needs

of couples, particularly of women. Progress in dealing with these needs has not always been rapid nor effective. Less than two decades ago, the World Health Organization, the Alma Ata Conference held in 1978, recognized that maternal and child are services, including family planning, were essential components of primary health care. This expanded view of primary health care implied that WHO should assist countries in the formulation of policies and programmes to ensure that these services became available to the population. As part of this new mandate, efforts were made to assist in the organization and management of services, the training of personnel and the evaluation and research relating to family planning programmes. The many WHO resolutions passed since the Alma Ata Conference have emphasized the need to promote and conduct research, in response to the needs of developing countries, concerning the safety and effectiveness of currently available family planning methods. Emphasis was also given to the development of new contraceptive technologies, the prevention and management of infertility, the behavioral and social determinants of fertility regulation, and the organization and delivery of family planning services. Overall, the main contribution made by WHO was to conceptualize family planning as an integral part of maternal health and to consider reproductive health as a broad set of health - related issues (Kessler and Standley - Kessler, 1993). As new concerns about the scope of human reproduction emerged during the 1980's, WHO realized that strengthening family planning services was not sufficient to meet the concerns women had about their sexual and reproductive well - being.

The first definition of the concept of reproductive health as a new tool for global policy formulation and guidance was first suggested in 1988 when J. Barzellatto (1988), then Director of the WHO Special Programme of Research, Development and Research Training in Human Reproduction, proposed that human reproduction should be approached in a more holistic way, given the resource scarcity affecting many developing countries. He proposed that, at national levels, reproductive health policy, and the corresponding service programmes, should be built on four main cornerstones that should include: a) family planning, b) maternal care, c) infant and child care, and d) control of sexually transmitted diseases. These four areas are by definition inter - dependent and a well integrated reproductive health policy should ensure that all are given full consideration in programme planning.

At about the same time, a similar debate was taking place among women's health advocates led by the International Women's Health Coalition, with the idea of identifying the critical areas that reproductive health should encompass. There was, as a result, a growing agreement between the health community, health scientists and women's advocacy groups on the most important issues to encompassed by future services but a formal definition was also needed, and ideally one that would carry the imprint of WHO (Germin, 1989). From these various events, a new definition was proposed. It was first published under the WHO umbrella although it had not yet been accepted by the higher policy making levels of the organization. This first formal definition of reproductive health was proposed by Dr M. Fathalla (1988), which contained direct references to the always sensitive issues of sexuality, sexual disease and unwanted pregnancy. It read as follows:

Health is defined in the WHO Constitution as a "sate of complete, physical, mental and social well - being and not merely as the absence of infirmity". In the context of this definition, reproductive health would have the following basic elements: a) that people have

the ability to reproduce as well as to regulate their fertility; b) that women are able to go through pregnancy and child - birth safely; c) that the outcome of pregnancy is successful in terms of maternal and infant survival and well being. In addition, couples should be able to have sexual relationships free of the fear of unwanted pregnancy and of contracting disease.

This first definition provided a framework that included a set of clearly stated health goals and a rationale to develop the corresponding services. Its concern with disease, with the psychological dimension of sexuality "free of fear" went well beyond the traditional objectives of family planning programmes. The field of family planning had suffered a serious setback at that time following the 1984 Mexico World Population Conference and this new concept, emerging at the end of the decade, built on family planning and gave it a larger and broader mandate. It also addressed the convictions expressed by a variety of different constituencies, including women's health advocates, feminist groups, and grass roots organizations clamoring for greater gender equity in child rearing and equality in decisions concerning family formation and contraceptive choices. In fact, at the core of this new dialogue has been the status of women, their education, autonomy, access to quality health services and home support facilities.

Simultaneously, at policy levels it became increasingly clear that reproductive health, particularly the reproductive behaviour of the present federation would have a direct impact on the health of the next. This would also mean that taking care of the reproductive health of the population now would mean better chances for improving the future well - being and socioeconomic development of many countries. Population in the 1990s is no longer seen as a development factor that lends itself to easy manipulation, for example to accelerate economic growth. Instead the population factor is conceptualized as one of the many areas of development policy, and as such the concern of policy - makers has shifted to population quality rather than quantity. In this respect reproductive health feeds directly into these new policy concerns since its goals aim directly at the improvement of the well - being of the population.

3. WHAT IS A POLICY?

In any discussion of policy there is concern as to what this term actually means. In general, economic and social development is driven by public policy. Policy is, therefore, an official government statement that identifies areas where improvements are needed and it defines goals and proposes programmes to achieve these aims. Goals are usually set within a defined time frame that includes a planning period to mobilize resources, allocate budgets and generate public support for the programmes that will be launched. In addition, this initial phase of policy planning requires setting activity specific working objectives, including the necessary institutional structures, their organization and staffing (United Nations 1993). Thus matching policy goals with available financial and human resources becomes the most important task for policy - planners to ensure that the proposed programme succeeds. This is true in all fields, including population, reproductive health, or any other area of development that operates under the guidance of public policy.

Policy should be understood as a government effort to meet specific needs of individuals and