

Conceiving Contraception: Analyzing the Social Barriers to Reproductive Healthcare Access

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Introduction

Beyond economics, beyond creed, and beyond nationality, the one factor that unites us as inhabitants of this Earth is our remarkable origin: the onset of conception. Throughout the course of humanity, between the rises and falls of civilization, the ability to freely reproduce upon one's own discretion has fallen under the confines of varying forms of social and political order. To protect the rights of mothers, those who must carry the physical responsibility of gestation and birthing, fields of healthcare dedicated to reproductive medicine exist today; unfortunately, access to such forms of healthcare are unequally distributed across different parts of the world, allowing harmful practices, such as gender-based discrimination and violence, to exist unchecked.

Defining Reproductive Healthcare

The World Health Organization (WHO) defines reproductive healthcare as complete well-being in “all matters relating to the reproductive system and to its functions and processes.” Furthermore, reproductive healthcare should promote one's “capability to reproduce and the freedom to decide if, when, and how to do so” (Reproductive Health).

Reproductive healthcare can refer to an array of ailments and preventative efforts—contraception, female genital mutilation, infertility, and sexually transmitted diseases—each of which fall under the umbrella of maternal and paternal healthcare (Health Topics). In the past fifty years, healthcare developments have synthesized cures for most sexually-related ailments, effective forms of contraception, and optimal natal care. While these developments have shifted the conversation about women's agency and sexual freedoms significantly, its benefits have yet to reach the corners of the globe that need it most.

Facts and Figures: Trends in Reproductive Healthcare Access

To track levels of access to reproductive healthcare, the WHO has selected maternal mortality ratio¹ as an indicator for the different degrees of access to reproductive healthcare, as it reveals gaps between economic prosperity and scarcity. The WHO's ranking of countries based on maternal mortality rate demonstrates that countries situated in low-resource areas lack necessary reproductive healthcare needs; areas of higher levels of economic development have

¹ Maternal mortality ratio refers to the number of mothers who die per 100,00 live births.

incredibly low levels of maternal mortality, as natal birth is incredibly preventable if the resources are available. The Global Health Observatory of the WHO confirms these trends, stating that “the risk of a woman in a developing country dying a maternal-related cause during her lifetime is about 33 times higher compared to a woman living in a developed country” (Maternal and reproductive health).

As a result of inadequate resources for mothers and those of childbearing age alike, humanitarian tragedy has left millions of women in states of deteriorating health. According to statistics recorded from a meeting I attended with the UNFPA, nearly 800 women die in birth per day; beyond that, 214 million women have unmet contraceptive needs and an added 200 million have undergone genital mutilation. These bits of sobering statistics demand a change quickly; but to combat high levels of health inequality that uniquely target women, it is imperative to first analyze the root causes of meager reproductive healthcare access.

Barriers to Access

To research the barriers to reproductive access that have been manifested in different parts of the world, I analyzed two scholarly articles: one which discusses the theory behind gender-based deficit in healthcare and another that pulls from the direct experiences of thirty women living in Tanzania, a country that has historically lacked sufficient resources for natal and contraceptive care. The first article by C.E. Okojie dates back to 1994, but is still pertinent and referenced in publications by the WHO. Okojie, a researcher from the University of Benin, writes that differential utilization of contraception and natal services are a result of “emphasis on women’s childbearing roles;” that is, viewing women simply as a vector for breeding rather than a sentient and able person. Additionally, there a “sex preference manifested in discrimination against female children” over male children still continues to exist today. Each of these factors has contributed to “excessive childbearing,” posing threats to a woman’s vitality. Okojie concludes with a note explaining that these gender inequalities in health are manifested in “traditional medical practices which attribute women’s illnesses to behavior lapses by women,” signifying a general miseducation about the nature of illness and how their effects on the female anatomy are as a result of poor care, not female inferiority (Okojie). Along with curbing miseducation, however, the research points to the need for a shift in the perception of women.

Published in 2011, the second scholarly article focuses on the role of “gender norms in reproductive decision-making and contraceptive use,” consisting of interviews and a long-term study of thirty married women from Tanzania. The findings suggest that “men’s dominance in decision-making” functions as a barrier to the intervention of modern reproductive healthcare (such as contraception), as well as “fear of side effects by both men and women” (Schuler et al.). These conclusions, even seventeen years after the publication by Okojie, confirm that the experiences women in developing countries have had with childbearing healthcare are directly linked to societal misogyny, as well as a lack of education about the general harmlessness of contraceptive use. Thus, a lasting solution to the problem of reproductive healthcare misutilization must address both root causes: the devaluation of women and miseducation.

Implications of Healthcare Investment

Perhaps the most immediate effect of hypothetically providing adequate access and education in regards to reproductive healthcare is the benefits they provide to women’s health. Well-being is dependent on, not only the absence of illness, but also the ability to enjoy the freedom of choice. A woman able to fully control her reproductive cycles would, as Harvard researcher Jocelyn Finlay notes, most immediately raise the average maternal age at first birth, thus “reducing adolescent childbearing.” Diminishing adolescent childbearing seems to open a Pandora’s Box of multitudinal change for women: doing so would increase the likelihood of school completion, which is necessary for “participation in the formal labor market” (Finlay et al.). These findings corroborate both the conclusions of the research conducted in southern and western Africa, one of the areas in which reproductive healthcare is most needed. If healthcare demands are fulfilled alongside the educational support necessary to optimize utilization of resources, the economic path that would be soon to follow is a beautifully promising one. While reproductive healthcare can be corralled into multiple combinations of the Sustainable Development Goals, it is more fruitful to view it as a topic of humanitarian interest whose connections are complex and far-reaching, transcending categorization.

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