Complacency, Abortion Politics Obstacles to Improved Health Of Pregnant Women and Children

By Lisa Kaeser

Persistent high rates of maternal mortality and morbidity worldwide, but especially in developing countries, are focusing the world health community's attention on the pregnancy-related needs of women. Recognizing that maternal health—or "safe motherhood" as it is often called in the international context—has benefits not only for individual women but also for families and societies at large, international health leaders are creating, under the maternal health aegis, new linkages among a broad range of preventive health services and education activities. Chief among them is the provision of family planning (see *For the Record*, page 14).

In the United States, by contrast, maternal health as a policy issue is largely off the radar screen. Lulled, perhaps, by favorable comparisons to the shockingly high rates of maternal deaths in other countries, policymakers and the maternal and child health (MCH) advocacy community are focusing almost entirely on meeting the critical health needs of children, primarily through expanded insurance coverage (*TGR*, Vol. 1, No. 2, April 1998). Dwarfed by abortion politics, meanwhile, the critical role of family planning in facilitating the health of both pregnant women *and* children is almost entirely ignored. Yet, maintaining a focus on the "M" in MCH is of critical importance—in the United States as well as in the developing world. Equally important is recognition of the fact that—by helping women to time and space their pregnancies and be as healthy as possible prior to becoming pregnant, and by facilitating their early entry into prenatal care—family planning is an integral maternal health service (see box).

Family Planning and Maternal Health

Few would argue with the notion that a woman having a baby should be as healthy as possible prior to conception and be able to conceive and carry a pregnancy to term without adverse health effects for herself or her child. To achieve these goals—for individual women and society at large—family planning counseling and services must be recognized as integral components of the maternal health care continuum. Family planning entails both the prevention of unintended pregnancies and the achievement of planned, wanted pregnancies

By helping women prevent unintended and high-risk pregnancies—particularly those at either end of the reproductive age span—family planning reduces maternal and infant mortality and morbidity.

By helping women plan for their pregnancies, family planning is also a prerequisite for "preconception care"—counseling and medical services designed to enable a woman to be as healthy as possible at the time she gets pregnant. For example, withdrawal from addictive substances—such as illicit drugs, alcohol or tobacco—before pregnancy can reduce their deleterious effects on a woman's overall health, as well as prevent severe harm to a fetus. Likewise, some birth defects, such as spina bifida, can be prevented if a woman takes supplements (folic acid, in this case), but the protective effect is stronger if begun prior to conception.

Family planning is also critical in facilitating early entry into prenatal care—during which serious problems such as gestational diabetes and hypertension can be diagnosed—since a women who is trying to become pregnant is more likely to recognize the signs of pregnancy early on than is a woman whose pregnancy is unintended.

International Developments

Over the last two decades, numerous studies conducted throughout the world have found that maternal mortality and morbidity are far more serious problems than had previously been realized. One of the most recent studies, published by UNICEF, estimated that in 1996 almost 600,000 women died in pregnancy and childbirth. Moreover, for every woman who died, the report states, approximately 30 more incurred debilitating injuries, infections and disabilities that may have effects well beyond pregnancy and delivery.

These reports have prompted increasingly more insistent calls for new and better-coordinated initiatives to bolster maternal health care, including the provision of family planning services. In 1987, the United Nations (UN) launched its safe motherhood initiative in conjunction with the First Conference on Safe Motherhood held in Nairobi, Kenya, issuing a call for action to reduce both maternal mortality and the risks of pregnancy for all women. This message was echoed at subsequent international meetings, including the 1994 UN-sponsored International Conference on Population and Development in Cairo (ICPD). Among the key objectives in the ICPD Programme of Action, agreed to by 180 participating nations, is the provision of fam-

ily planning services "to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality."

Most recently, the World Health Organization designated "safe motherhood" as the topic for its World Health Day 1998, held on April 8. The international publicity surrounding World Health Day included a charge that all nations come to terms with the magnitude of maternal mortality and morbidity, which is probably far greater, even in the United States, than had been previously acknowledged. Speaking that day from the World Bank, First Lady Hillary Rodham Clinton drew a stark connection between access to family planning and improved maternal health. Stating baldly that "no women should ever die in childbirth," she urged the world community to "invest in family planning—which improves maternal health."

On the Domestic Front

In the United States, meanwhile, new research shows that maternal mortality, while low compared to the rest of the world's (about 1,000 deaths per year nationwide), may be seriously underreported. Further, about one in five pregnant women (800,000 annually) in the United States experience a serious health problem before they begin labor, and about one in four (one million each year) have a significant complication during delivery, including excessive bleeding, high blood pressure or infection. Significant racial and ethnic disparities persist, with black women having far higher rates of maternal mortality and morbidity, even when socioeconomic factors have been taken into account.

Moreover, sexually transmitted diseases (STDs) continue to exact a steep toll. As recently as the early 1990s, more than 3,000 U.S. infants were born annually with congenital syphilis, an entirely preventable condition. Women of reproductive age continue to be one of the fastest growing groups of individuals infected with HIV.

Despite these continuing problems, the MCH-related focus, at present, appears to be mainly on children, rather than the women who bear them. To some extent, this may be an unintended result of the unprecedented level of attention to MCH issues in the 1980s, when the massive federal-state Medicaid program

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was revamped to encourage expanded coverage of pregnant women and infants. Driven by a strong desire to reduce U.S. infant mortality rates, the critical role of the woman's health was nonetheless recognized; accordingly, a large number of new low- and marginal-income women were added to the Medicaid rolls for the duration of their pregnancies and through a 60-day postpartum period.

The primary focus of the Medicaid expansions was on expanding access to prenatal care and increasing the number of Medicaid-funded deliveries (which, in fact, more than doubled between 1985 and 1991, from 15% to 32% of all U.S. births). To the extent that family planning was included, it was in the context of care provided during the postpartum period.

Building on that first step, however, several states have received federal permission to develop demonstration programs to extend this postpartum coverage of family planning for as long as five years following a Medicaid-funded birth. These expansions have been promoted because of their cost-efficiency *and* the benefits to both a woman and her children of a longer interval between births. More recently, a handful of states have received permission to expand Medicaid-funded family planning to *all* women in the state below a specified income level, regardless of whether they have recently given birth—once again, because of both the cost and health implications of helping women time and space their pregnancies.

Enter Abortion Politics

The emerging consensus in the United States around the importance of family planning to improved maternal and child health is gratifying. The fact remains, however, that when family planning is considered *as a political matter*, outside the context of an avowedly MCH-related program, that consensus is too easily forgotten. Seen almost exclusively as an issue of women's reproductive rights, family planning is regarded almost entirely in terms of its relationship to abortion—either as a service that promotes abortion by encouraging promiscuity or one that reduces the need for abortion by preventing unintended pregnancy.

Once the abortion controversy is raised, efforts to achieve an adequate level of support for publicly funded family planning programs, such as Title X, are effectively doomed. A major challenge facing supporters of family planning programs, then, is to present family planning in *all* its dimensions, including its relationship to improved maternal and child health. Ironically, efforts to do so seem to be faring better internationally these days than they are in Washington, D.C., or many state capitals throughout the United States.