

Editorial

Gender inequality in the control of fertility

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Family planning means exactly what it says, that is, planning when to have each child and how many to have in total. Good-quality family planning is essential to the health and well-being of both mother and baby. For women, particularly those living in developing countries, pregnancy and childbirth pose serious risks, including thrombosis, haemorrhage, pre-eclampsia, sepsis, fistulae and complications during labour (United Nations Children's Fund, 2009). At least 800 women die every day as a result of one or more of these factors because they do not have access to skilled assistance (World Health Organization, 2012). Very young mothers are especially vulnerable. An estimated 10 million girls under 18 years of age, some of whom are as young as 12 years, are married each year and subsequently become pregnant before their bodies are fully mature. For many of these girls, pregnancy and childbirth are likely to result in their death (Save the Children, 2012a). For children, maternal health is essential to their survival. Short intervals between pregnancies, particularly if the mother is already malnourished, mean that children are more likely to suffer developmental delay, permanent physical and intellectual impairment, or death in infancy (World Health Organization, 2005; Save the Children, 2012b). Even if children survive, the demands of further pregnancies on their mother may leave her with little time or energy for her growing family. Consequently, older children, particularly girls, must quickly take on responsibilities for childcare while they themselves are still children, in addition to the work involved in keeping a household running. The result is a life of drudgery and deprivation until it is their turn to marry and have children of their own.

Access to family planning offers women a way out of this cycle, empowering them to take control of their bodies and plan their pregnancies. In societies where early marriage is the norm, family planning and the provision of contraception enable girls to delay their first pregnancy until their bodies are mature, which leaves them free to complete their education. Women

who have completed their secondary education are more likely to know about and access help during pregnancy and labour. They are also more likely to have access to up-to-date information about childcare, and are better able to support themselves financially (United Nations Children's Fund, 2009). Family planning and contraception combined with education lead to an improvement in and in some instances save the lives of women and children. It is therefore pleasing to note that family planning is receiving renewed attention as part of the changes required to achieve the Millennium Development Goals relating to the health of women and children.

These state that mortality among children under 5 years of age should be reduced by two-thirds by 2015. Considerable but uneven progress has been made. In total, 23 developing countries are now on target to achieve this reduction, and 38 have made some progress, although not enough. However, 13 countries have made no progress whatsoever. As a result, child mortality rates remain disproportionately high in parts of sub-Saharan Africa and the Indian subcontinent (World Health Organization, 2010). Less progress has been made in reducing maternal mortality, that is, deaths that occur as a result of complications in pregnancy and/or childbirth. Only nine developing countries are on target to achieve the Millennium Development Goal relating to reducing maternal mortality, and 40 countries are making progress, but a further eight countries have not made any progress at all. Although more women are now receiving some skilled care during pregnancy and labour, there are still serious disparities both between rich and poor nations and between the rich and poor within developing countries, especially in South Asia and parts of sub-Saharan Africa (World Health Organization, 2010).

Considerable commitment is required to achieve reductions in mortality rates in children under 5 years of age and in maternal mortality rates by 2015. Family planning and contraception offer one route to the

achievement of both targets. The 2012 London Summit on Family Planning brought together representatives from the governments of many developing countries, organisations that promote community development, researchers, donors such as the Bill & Melinda Gates Foundation and other bodies to 'revitalise global commitments to family planning and access to contraceptives' and 'remove and reduce barriers' that prevent women from being able to use them (www.londonfamilyplanningsummit.co.uk).

The first barrier is that posed by access to supplies. A reliable supply of appropriate and effective contraceptive devices is essential. The 'pill' that is so popular in western countries is not always suitable for women elsewhere, particularly if they are not able to discuss their preferences for family planning with their husbands. Barrier methods such as diaphragms may not be suitable if there are limited facilities for washing after use. In contrast, long-acting preparations that are administered by injection may be more acceptable and help to maintain confidentiality about their use. A woman who is going to the local clinic 'for an injection' could be going for any kind of treatment, and no one else needs to know what it is really for. Far more research is needed to ascertain women's preferences and to increase the range of contraceptives available.

The second barrier is cost. In the UK, the current price of a long-acting contraceptive such as Noristerat is £4.05 per ampoule, and an implant such as Nexaplanon is priced at £79.46 per rod (BMJ Publishing Group Ltd and Royal Pharmaceutical Society, 2012). Even in such a wealthy country as the UK, these preparations are free at the point of delivery to ensure that all women have equality of access to contraception. However, in the developing world, women whose incomes are below 1 US\$ per day will not be able to afford to pay such prices, and governments that are struggling with very limited resources will not be able to do so either. Accepting money from donors may not be a straightforward option, as there may be 'strings attached', and corruption among local officials is endemic in some societies. The funding of family planning and contraception in an ethically and culturally appropriate manner is therefore a very complex undertaking.

The third barrier is due to conflict and emergency situations such as natural disasters. In 2010 there were 16 new wars in African nations, in addition to ongoing conflict in Somalia and several other countries. Conflicts and emergencies have a negative impact on the availability of resources (Care International, 2012) and clearly disrupt the usual supply chains. However, contraception should be a high priority in these circumstances because of the use of rape as a weapon in war, and the opportunities for rape afforded by the breakdown of normal society in an emergency situation.

The fourth and fifth barriers are due to religious beliefs that are opposed to the use of contraception or family planning in general (Ekeocha, 2012), and cultural traditions in which segregated gender roles are strictly enforced, respectively. In segregated societies, men and women lead quite separate lives and may have little understanding of each other, which may make it difficult for couples to talk about such issues as sex, family planning and contraception (Care International, 2012). Facilitating such dialogue requires sensitivity and education. One example is the social analysis and action approach of Care International (2012, p. 10), which is based on promoting 'a process of dialogue and reflection, leading to actions' about 'gender norms that shape perceptions, expectations, decisions, and behaviors.' This dialogue takes place in several interrelated spheres. Community workers facilitate reflection on what it means to be a man or a woman, so that members of each gender can learn about themselves and the 'other.' This in itself can prove revelatory and extend into educational activities about other topics, such as sex, that are normally regarded as taboo. Increased understanding of the 'other' leads to questioning the way that things are at present, and how change might be helpful. Such discussions enable men and women to develop a vocabulary that they can use to talk about their relationships, household matters and other aspects of their lives together. Thus discussion of family planning and contraception becomes part of a much wider dialogue. Better communication and a shift towards shared decision making help couples to create a shared life in which they do things together, and reduce the risk of gender-based violence. This social analysis and action approach is also a training tool, because community workers are asked to reflect on and discuss their own attitudes and beliefs and how these might influence their work. This is important because the sixth obstacle to family planning and contraception is the negative attitudes of educated professionals towards the poor and underserved.

The two final barriers are gender inequality and the degree to which politicians and leaders are committed to change. The risks inherent in pregnancy and childbirth are largely preventable, and if they do arise they are treatable. Let us be quite clear that 'women are not dying because of a disease we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving' (Fathalla, 2012). In other words, women are dying because men have more interesting and important things to do and on which to spend money. For such men, women are not worth the effort required to keep them alive, as they are perceived as having little or no value. A Zimbabwean tribal leader recently summed up this attitude very well, providing damning evidence that women still lack full human status: 'In the old days, I myself would

settle cases by awarding someone a girl. But, through *Camfed*, (Campaign for Female Education, a charity that pays schools fees for girls) I saw that girls are human beings, too. We were doing the wrong thing and must support them' (Wilce, 2012). To his credit, this man acknowledged that he was wrong to have been thinking in this way, and he had made an effort to change to the extent that he was paying school fees for a girl. Regrettably, many more have yet to learn that women are human beings and that, as such, they are entitled to better treatment.

Perhaps the organisers of the 2012 Family Planning Summit recognised that such attitudes are deeply entrenched, which would explain why they seem to have adopted a business case approach to convince what are still mainly male-dominated governments that investing anything in women might bring rewards: 'Contraceptives are one of the best investments a country can make in its future. Each U.S. dollar spent on family planning can save governments up to 6 dollars on health, housing, water, and other public services' (www.londonfamilyplanningsummit.co.uk). It is clearly not worth bothering with women because they are human beings who should be treated with dignity, but a little investment might free up some cash to spend on more important things (to which a cynic might add 'like guns and bombs'). Nevertheless, if the business case model keeps women and children alive and healthy, change may yet occur even though, at the moment, this seems a long way off.

In this issue

We begin this issue with a focus on the concept of care. Theoretical conceptualisations of care tend to be dominated by western paradigms which are rooted in Christian ideas and influences, even if those responsible for them do not profess to be Christians. These western ideas have been exported around the world through education for health and social care professionals and the migration of workers across the globe. As a result, little attention has been paid to non-western views of care. However, in our guest editorial, Sandy Lovering presents an overview of conceptualisations of care in Chinese, Korean and Native American cultures (Lovering, 2012a). In each case, modern scientific knowledge is blended with particular cultural beliefs and values to create unique perspectives from which care emerges as a way of restoring balance and harmony within an individual affected by illness or disease.

Sandy has been based in Saudi Arabia for a number of years and has developed a sound understanding of cultural differences in the region. Our first paper is taken from her research into conceptualisations of

care among Arab nurses, which has attracted a great deal of positive attention in the region (Lovering, 2012b). This research demonstrates that, for Arab nurses, care is regarded as having five dimensions that are underpinned by Islam and directed towards patients and their families, namely clinical, spiritual, interpersonal, psychosocial and cultural dimensions. Shared understandings and spirituality are essential to the experience of both giving and receiving care. We hope that this paper will encourage others to examine concepts of care in their own localities.

People from Arab backgrounds now form sizable populations in Italy, which raises issues about communication in health and social care settings between patients and professionals who do not share a common language. In our second research paper, Federico Farini presents an analysis of conversations which took place in Arabic and Italian through the medium of an interpreter (Farini, 2012). This analysis reinforces the view that interpreting involves far more than the mere replacement of one set of words with another. Extracts from the transcripts show that the interpreter may be the only person in a conversation who understands what is happening and who has the power to influence how the conversation develops. Where that power is used appropriately, patient and professional are engaged with one another. However, where this does not happen, both parties become frustrated and, more importantly, health problems are not adequately resolved.

Our third research paper addresses methodological issues in researching infertility. Nicky Hudson reflects here on the ways in which insider and outsider perspectives can influence the direction of a project (Hudson, 2012). Nicky is a white woman and is thus clearly an outsider to her research participants in ethnic, linguistic and cultural terms, but an insider in terms of gender. At times her shared experience of being female transcended her outsider status, making her both insider and outsider at the same time. Thus notions about the impact of insider and outsider status cannot be seen in fixed terms and, as in other aspects of qualitative research, what really matters is self-awareness and reflexivity. Maintaining an awareness of the self in an investigation in terms of both how this influences the research and how the research affects the self is clearly crucial for ensuring rigour.

Nicky Hudson's paper links well with our practice paper, in which Dora Bernardes and her colleagues reflect on their experiences of researching mental health issues among asylum seekers (Bernardes *et al*, 2012). What is particularly useful here is their honesty in discussing the many challenges that arose and what might, with hindsight, have been improved. Too often research papers, and particularly research textbooks, give the impression that everything went according to plan, that applying theories is a straightforward matter,

and that research is easy. Dora Bernardes and her colleagues make it very clear that this is not the case. Research design and the real world may at times be quite widely differing realities. The amount of time and effort required to gain people's trust and to recruit an adequate sample can be far greater than anticipated. Language preferences are not predictable, and obtaining informed consent raises multiple questions about what constitutes valid agreement to participate. Perhaps a little more honesty of this kind might help novice researchers to see that conducting research can be a messy business, and that the fact that things do not always go to plan is perfectly normal.

Our final paper presents a discussion of ethnicity and rheumatology. Ash Samanta and colleagues have drawn together an outline of current knowledge about common conditions and the ways in which South Asians perceive and experience them (Samanta *et al*, 2012). In doing so, they reveal some ethnic differences in both the patterns of disease and willingness to seek treatment. The paper then presents an agenda for action based around patient support groups, patient education and research to encourage South Asian people to seek help early, before deformities occur, in order to ensure appropriate disease management. This paper is followed by our CPD feature, which provides guidance on good practice in treating rheumatology patients (Samanta and Shaffu, 2012).

Among our regular features, in our Practitioner's Blog, Mary Dawood reflects on the impact of the economic recession. In the UK, formerly prosperous people who had jobs and futures have suddenly found themselves losing everything and having to access food banks or other sources of help. In the emphasis on diversity, the needs of host populations can often be overlooked as countries strive to accommodate new arrivals who, in some instances, do not appreciate that they have responsibilities in their new homes. It is salutary to contrast the attitudes reflected here with those of Mo Farah at the recent Olympic Games. Alongside years of rigorous training that brought him gold medals, he has set up a charity, the Mo Farah Foundation (www.mofarahfoundation.org.uk), and still found time to attend the Global Hunger Event (www.dfid.gov.uk/News/Latest-news/2012/Global-Hunger-Event). 'This is my country', he said, and he wanted it to be proud of him.

In Did You See? we present Siobhan Champ-Blackwell's review. The argument here is that current research about health inequalities tends to pursue a 'snapshot' approach, reflecting the experience of inequalities at a particular moment in time. Studies that take account of lifespans would provide a better understanding of the cumulative effects of inequalities over the period of a lifetime. Finally, in our KnowledgeShare section, Lorraine Culley presents a range of information and resources for all those

interested in diversity. Contributions to this section should be sent to lac@dmu.ac.uk.

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