REPRODUCTIVE HEALTH matters

FEATURE

Effects of reproductive morbidity on women's lives and costs of accessing treatment in Yemen

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Abstract: *Research on the consequences of reproductive morbidity for women's lives and their economic and social roles is relatively under-developed. There is also a lack of consensus on appropriate conceptual frameworks to understand the social determinants of reproductive morbidity as well as their social and economic implications. We report here on an exploratory study in Yemen using quantitative (n=72 women) and qualitative methods (n=35 women), in 2005 and 2007 respectively, with women suffering from uterine prolapse, infertility or pelvic inflammatory disease (PID). It explored women's views on how reproductive morbidity affected their lives, marital security and their households, and the burden of paying for treatment. We also interviewed six health professionals about women's health care-seeking for these conditions. Sixty per cent of women reported that treatment was not affordable, and 43% had to sell assets or take out a loan to pay for care. Prolapse and PID interfered particularly in subsistence and household activities while infertility created social pressure. Reproductive morbidity is not a priority in Yemen, given its multiple public health needs and low resources, but by failing to provide comprehensive and affordable services for women, the country incurs developmental losses.*
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There have been relatively few community-based studies in developing countries of reproductive morbidity, with the exception of South Asia,[1,2] and data on prevalence are typically lacking.[3] While population-based surveys in many countries, including Yemen, include questions about women's reported symptoms of some reproductive morbidities, these are unlikely to be valid measures of prevalence without clinical examination, which is costly and difficult to conduct in field settings.[4] Even less is known about the consequences of reproductive morbidity for women's lives and their economic and social roles.[1,2,5] One early qualitative study of women's experiences of utero-vaginal prolapse in India documented the negative consequences for women's lives.[6] More recently longitudinal follow-up of women who experienced major obstetric complications has shown an increased risk of mortality and depression among them and impoverishment of their households.[7,8]

There is also a lack of consensus on appropriate conceptual frameworks for understanding the social determinants of reproductive morbidity as well as the social and economic implications, which could raise the visibility of these problems and their consequences, as advocacy tools to motivate health policy.[3] DALYs for measuring health are useful both as a tool for priority setting among competing health needs and for international comparability, but researchers have criticised their omission of the social and non-medical implications of ill-health.[9,10] Difficulties in accessing care and paying for treatment mean that reproductive morbidities remain untreated, with potentially serious sequelae. Compounding their physical impact (discomfort or pain) are their social implications, such as stigma and shame. Such effects may impede treatment-seeking and involvement in daily activities, with economic implications for households.

An alternative conceptual framework of potential relevance is the capabilities approach,[11–14]

which sees poverty as capability deprivation and argues that policies should be evaluated for how well they improve the objective features of how people actually live and the aspects they value (e.g. being free from unacceptable deprivation). This may be more useful than DALYs because it can help to frame the determinants as well as the consequences of morbidity and because it takes into consideration both women's "agency" and enabling opportunities ("social arrangements"). There has been increasing application of the capabilities approach across education, disability and social development and more recently, public health, but with as yet limited application to reproductive health.[15–17]

In the Middle East, there is evidence that women bear a high level of untreated reproductive morbidity. The Giza study in Egypt provided the first evidence that women often bear these conditions within a "culture of silence" and rarely report them to health service providers.[18] Reproductive morbidity thus becomes an area described by Amartya Sen[13] as one where individuals in unfavourable or deprived circumstances adapt to the adversity and do not indicate that it affects their actual well-being. Confirming international findings,[1,4] clinic-based prevalence estimates of morbidity in the region may under-estimate their true prevalence. Community-based studies on reproductive morbidity have subsequently been conducted on reproductive tract infections (RTIs) and prolapse in Lebanon[19] and Jordan.[20] Oman is the only Arab country to have published national data that includes both women's reports and clinical diagnosis.[21]

As no data are available for Yemen, we decided to conduct an exploratory study in the capital Sana'a, using quantitative and qualitative methods among women suffering from uterine prolapse, infertility and pelvic inflammatory disease (PID). The objectives of the study were: 1) to explore constraints to health care-seeking and women's perceptions of the implications of the three conditions for their own lives and the economic implications of seeking care for their households; 2) to understand women's perspectives about the determinants of these conditions; 3) to investigate selected providers' views about health-seeking for these conditions; and 4) to test the empirical application of the capabilities approach to reproductive morbidity.

Reproductive morbidity includes a wide range of conditions. We chose these three conditions because they represent a range of both gynaecological and obstetric morbidity, with both physical and social implications; one (infertility) does not feature prominently in DALYs*; and they have received little policy attention in Yemen.

The Republic of Yemen was formed in 1990 following the unification of the (capitalist) North and the (socialist) South, and has had a turbulent political history. It is a low-income country which relies heavily on oil, labour migrant remittances from the Gulf States (reduced due to regional politics), and the production of *qat* (leaves that are chewed to achieve a euphoric sensation, widely used in Yemen). In 2003, 42% of the population were living below the poverty line and 19% in absolute poverty.[22] The situation is likely to have worsened since then. Yemen ranks 133 out of 169 countries on the 2010 Human Development Index. It has very low school enrolment ratios for girls and high rates of illiteracy among women. Yemeni women are almost absent from parliament and local councils and have limited legal rights.[23]

Yemen also has extremely poor indicators of women's health, with female life expectancy at birth of only 63.[24] On the Mother's Index, Yemen ranks 90th out of 94 ranked countries,[24] has the highest fertility rate in the region (5.6 in 2006[24]) and a life-time risk of maternal death of one in 19.[24] According to the Yemen Family Health Survey of 2003, the most recent nationally representative data available, 51% of Yemeni women reported complications during pregnancy, delivery (30%) and the puerperium (32%). Female genital mutilation is practised in the coastal areas with a national prevalence of 38% among ever-married women, while 22% of ever-married women of reproductive age and 10% aged 15–19 reported symptoms of genital prolapse. More than half of those reporting prolapse had been affected by it for five years or more. Overall 14% of urban and 16% of rural ever-married women reported symptoms of vaginal discharge indicative of a reproductive tract infection (RTI). Yet women reported major barriers to the utilisation of services, which was low, including cost and perceptions of poor quality of care. Poverty, limited mobility and the low status of women and the country's hilly topography have all contributed to Yemeni women's low health care

*DALYs measure disability, interpreted as individual physical suffering, and since infertility is often asymptomatic, it is only included in DALYs as a disabling outcome of sexually transmitted diseases.[9]

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