Reaching the hard to reach

The draft plan of action, prepared for the International Conference on Population and Development, says the number of couples using contraception in the developing world must rise from 550 million in 1995 to 880 million in 2015 if the envisaged reduction in unmet need is to take place. If this is to be done, alongside other improvements in reproductive health care, including measures to prevent the spread of HIV and other sexually transmitted diseases, the total cost of national population programmes is likely to rise to $17 billion in the year 2000 and $21.7 billion in 2015. But how are governments going to serve these additional users of family planning, many of them hard to reach in remote rural areas or in crowded shanty towns? Here three highly experienced experts give their own personal view.

by Pouru Bhiwandi, Martha Campbell and Malcolm Potts

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Above: *Panama poster promotes use of condoms to avoid AIDS.*

The problem is not so much reaching people as allowing them to access the services they want. All over the world couples want smaller families. The percentage of married women who say they want no more children varies from under 20 in Senegal to almost 80 per cent in Peru. In addition vast numbers of women want to delay the next birth. The crowded wards in the hospitals that treat botched abortions in so many parts of the world add reality to the statistics from social surveys.

In 30 years of organized family planning programmes a great deal has been learned about the acceptability of various contraceptive methods and how to make them available. In countries as diverse as Buddhist Thailand, Catholic Colombia and Islamic Indonesia fertility has fallen two to four times as rapidly as it did in the West at a comparable stage in the transition from large to small families.

Until recently sociologists overestimated the socio-economic variables in fertility decline and underestimated the role of family planning services. So ingrained was the conviction that increases in wealth and improvements in education were required for fertility decline that in 1967 Kingsley Davis of the University of California at Berkeley called the family planning programmes that were beginning at that time "either quackery or wishful thinking". He was wrong: wherever realistic contraceptive choices (including voluntary sterilization) have been offered, and some effort has been made to face the problem of unsafe abortion, fertility has plummeted despite cultural and religious barriers. In 1959 women in East Asia were having an average of 5.9 children; today, it is 2.3 – or near biological replacement.

This is not to say that development and family planning are not synergistic. In nearly all countries, educated urban families have fewer children than rural illiterate families. But experience has shown that socio-economic development is not a *prerequisite* of fertility change and good family planning services, of themselves, can reduce fertility. The effects work both ways. Studies from Thailand show that even when all other social and economic variables are fixed (e.g., income, land holding, parental education) children from small families are more likely to enter school and stay in school than children from large families.

Of course, in many parts of the world women do not call the shots: they are discriminated against and have little autonomy. All those interested in development and gender equality must do their utmost to ensure better access to female education and strive for greater female autonomy. But from the perspective of those designing family planning services, these problems simply reinforce the basic strategy to improve access to meet existing demand.

The more disadvantaged or ambivalent an individual person is about family planning the more convenience plays a role in contraceptive use. If a woman is a new and uncertain user, or of her husband disapproves of her decisions, then she may find the fact the family planning clinic is open only certain hours an excuse for not going; while if the same contraceptive is available in the local store, she may use it. Simplifying access to family planning services can remove as a barrier the absence of spousal consent.

The demand for family planning also seems to be a moving target. This has been demonstrated aptly in Bangladesh, where the per capita income is less than a dollar a day, over one in 10 babies die before their first birthday and the status of women is low. Contraceptive prevalence has risen in Bangladesh from one in 20 in 1975 to

40 per cent today and completed family size has fallen from 7.0 to 4.8 in 20 years. Even more impressive is that desired family size has fallen during this period from 4.1 15 years ago, to 2.9 today, 30 per cent lower than the government's own most ambitious demographic target. These changes have occurred through the introduction of accessible family planning choices, programmes still imperfect but much better than, for example, Pakistan's, where contraceptive prevalence has not risen and family size remains stubbornly at 7.0.

Family planning is now a well understood, extensively studied and highly predictable undertaking. For every 15 per cent increase in contraceptive prevalence, completed family size will fall by approximately one child. A realistic programme provides contraceptives at numerous locations, sells contraceptives at acceptable prices, delivers oral contraceptives without a prescription, tries to involve private as well as government doctors, offers voluntary sterilization without limits of age or the number of children a woman has, promotes long intervals of breast feeding and deals with the public health problems associated with unsafe abortion.

The secret to good family planning is to make a variety of well promoted choices available through a range of complementary distribution channels. Family planning is not a medical treatment but a service for consumers, not necessarily tied to health care systems. Low dose contraceptive pills are now so safe that there are suggestions even in the United States and Britain to remove them from prescription. Tying family planning to medical practice often does women a disservice by reducing their choices and accessibility. Consumers must be allowed to orchestrate their own services as much as possible. Most people end up using use different methods at different stages of their journey through their fertile lives: they may buy their condoms from a pavement vendor, get their pills from the corner pharmacy, their IUD from a private doctor, and their sterilization at a government health clinic.

Free programmes that employ armies of poorly supervised field workers are often inefficient. Community-based distribution (CBD) systems are often more cost-effective. CBD programmes use volunteers and

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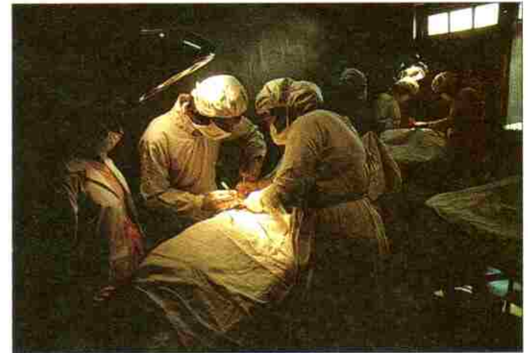

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Top right: *Community agent provides family planning in Bangladesh.*
Top: *Selling contraceptives in a Sri Lankan chemist shop.*
Above: *Tubectomy teams at a Bangladesh health centre.*
Below: *Maasai women in Kenya. Family planning can reduce maternal mortality among the very poor and the hard-to-reach.*

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MARK EDWARDS/IPPF

train people such as shopkeepers or village headmen's wives to distribute condoms and birth control Pills, charging the consumer a small amount and making a small profit, as in Thailand or Mexico. Payment may not cover the whole cost but it gives the consumer a lever on quality assurance. Patient payment is also a guarantee of freedom of choice, particularly in the all-important area of sterilization: people rarely pay for what they do not want, especially poor people.

In many parts of the world the most direct way to reach burgeoning numbers of underprivileged groups is to focus on robust, easy to manage projects that can be replicated rapidly. Is it better to reach 500 teenagers through a structured outreach programme at $50 a couple year of protection (CYP), or to serve 3,000 at $8 per CYP, through a less labour-intensive project? It is estimated that for about 360 million couples in the developing world, even the choice of family planning is not there. One of the problems is that individual agencies often expect the 'other agency' to do the work: the IPPF affiliate focuses on sex education for young people because it believes there are other sources of large-scale service – but can the young people really get the Pill or an abortion when they need it? UNFPA focuses on communications because it believes the government should provide large scale services – but are they really providing condoms and can any woman who wants one get a tubal ligation? Often not.

For the poorest of the world's families, such as those in the rural areas of much of sub-Saharan Africa or South Asia, the only practical way of reducing maternal mortality (the majority of the half million women dying each year from pregnancy, childbirth and abortion come from exactly these areas) is to make family planning choices available. Improvements in primary health care and obstetrics are urgently needed but could take a generation to put in place. Social marketing programmes, which sell subsidized contraceptives through small shops or kiosks and use local promotional skills, can get life saving contraceptives to the farthest corner of any country in three to five years.

As a result of continued high fertility, more women than ever before are entering the fertile years. As a consequence, while the rate of global population growth is falling, the absolute increase in human numbers each year continues to rise. The bad news is that whatever we do, global population is going to grow hugely before it stabilizes; the good news is that rapid action today can have a considerable impact on that stable final population. If we fail to take action now, many countries will face the same predicament as China, requiring forceful implementation of the one child family.

The demand for family planning is so strong that universal access to family planning could well shift population projections much below the 8.5 billion currently quoted as the median UN projection for 2025. We have an opportunity to double the number of couples using contraception in the developing world in a decade. If we meet this challenge, then the final stable population of the world will be several billion lower than if we allow innumerate people to continue to de-emphasize large scale family planning services.

The aggregate effect of hundreds of millions of individual choices about family size gives the planet as a whole a choice. If we have the wisdom and humanity to make family planning universally available by the end of the century, then we will improve the health of millions of families, enhance the status of women around the globe, decrease human suffering and tragedy, and set the world on a significantly lower population trajectory. The technology, experience and demand exist: do we have the insight and the political will to put the necessary policies in place? ■

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Ingredients of family planning success

by Jay Parsons

■ Widespread recognition and acceptance by governments, especially ministries of health and/or national family planning coordinating agencies, that high levels of contraceptive prevalence cannot be achieved in the absence of the provision of adequate family planning information and services. But programmes must be culturally sensitive, offer a range of services, be voluntary and tailored to the needs of acceptors.

■ Commitment by governments – measured primarily in terms of allocation of domestic financial and manpower resources – to make such information and services available to all sectors of society regardless of economic or social status or geographical location.

■ Recognition by programme managers, both government and non- government, that satisfying existing demand for family planning is far easier and has a greater multiplier effect than tackling the more difficult issue of setting out, in situations of low prevalence or widespread resistance to family planning, to gain rapid and widespread acceptance of "the small family norm" or "the two child family".

■ Flexibility and sensitivity of governments with regard to the need for different family planning strategies to fit particular local needs and conditions.

■ Ability of governments to obtain international donor support for family planning by demonstrating commitment, ability to plan and implement national family planning programmes and strategies, and to co-ordinate – not be co-ordinated by – international donor agencies.

■ Allocating national and donor resources to concrete programmes which empower women – from education for girls, literacy and skills development programmes for school dropouts to the full involvement of women in all aspects of development. ■

The author has served as Country Director for UNFPA in Indonesia, Thailand and Bangladesh. He is presently serving as Deputy Director of the Asia and Pacific Division in UNFPA headquarters in New York. The opinions expressed in this article are solely those of the author.