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Editorial

Why bold policies for family planning are needed now

Last spring at a Technology, Entertainment, Design (TED) talk in Berlin, Melinda Gates used this phrase, "The most transformative thing you can do is to give people access to birth control." She expressed similar sentiments at the London Summit on Family Planning on July 11, 2012, as did the British Prime Minister David Cameron, and Andrew Mitchell who was then Secretary of State for the Department for International Development, the British equivalent of United States Agency for International Development.

The London Summit represented a new focus on international family planning after nearly 20 years of collapsed budgets. It set the goal of halving the number of women with an unmet need for family planning in the world's poor counties in the next 8 years — that is, helping 120 million out of an estimated 222 million women worldwide with an unmet need for family planning. Donor governments and foundations pledged US$2625 million dollars over the next 8 years to reach this goal. Governments of the target countries, especially India, committed another US$2 billion.

This renaissance in international family planning is exceedingly welcome, but if it is to succeed, it must pay particular attention to the least developed countries (LDCs). Melinda Gates herself visited Niger immediately prior to the London Summit. Like the other 48 LDCs, Niger is mired in poverty, has tragically low measures of health, education and nutrition, and it is Number 186 in the Human Development Index — a "United Nations (UN) measure of development based on life expectancy, literacy and income [1]. Since the concept of LDCs was identified in the 1960s, only one country (Botswana) with more than 1 million people has graduated from LDC to the status of a developing country. One way to operationalize the London Summit goal of halving the number of women with an unmet need for family planning will be to link that goal to the imperative of accelerating an increase in contraceptive prevalence rate (CPR) in the world's LDCs. The easiest outcome to measure would be the annual rate of CPR increase. The CPR measures contraceptive use by married women of reproductive age. Every 15% increase in CPR equates to approximately one less birth. The US has a CPR of 78.6%, mostly made up of modern contraceptive use and voluntary sterilization.

Increasing access to family planning has strong and immediate benefits for the individual woman, especially in a low-resource setting. The voluntary control of childbearing accounts for up to one half of the reduction in maternal mortality over the past century in Europe [2]. The World Health Organization recommends an interpregnancy interval of at least 24 months based on evidence that this spacing can significantly improve maternal, perinatal and infant health outcomes [3].

Moreover, the provision of family planning has also contributed to improvements at the country level. LDCs with a low total fertility rate (TFR), such as Bangladesh (2.3 children/woman) or Nepal (2.6), have a plausible chance of graduating from the LDC category in the foreseeable future. There are no examples of any country that maintained a TFR of 5 or more escaping from poverty. In order to sharpen needed policy choices, we generated a scenario comparing population projections for Ethiopia and Niger (see Fig. 1). Ethiopia has begun to invest in family planning, reformed its abortion law and deployed 22,000 health extension workers (HEWs), and it has seen a relatively rapid rise in the CPR. On this trajectory, the population size will stabilize later in this century. There will still be huge problems of food security, education and employment. But there is progress. If pilot projects, such as those that have demonstrated success permitting community volunteers to distribute injectables [4] and HEWs to offer medical abortion [5], are scaled up nationally, then the TFR will continue to fall. We have chosen Niger because, as in many countries in Sub-Saharan Africa, family planning has not been a priority, and until recently, the CPR in Niger rose at a glacial rate. If that lack of attention to family planning were to continue, then the population would reach over 500 million in 2100. In reality, this is unrealistic because death rates will increase long before this level of population is reached, because of malnutrition, starvation and conflict or, alternatively, the birth rates will fall due to improved access to family planning, resulting in a rising CPR. Fortunately, Niger has begun to give some emphasis to family planning. Preliminary results from the 2012 DHS find the CPR has risen from 5% in 1998 to 12% today, but the TFR is higher than originally thought at 7.6. In other countries, such as the Democratic Republic of the Congo, the CPR has fallen instead of rising. The type of unsustainable trajectory set out

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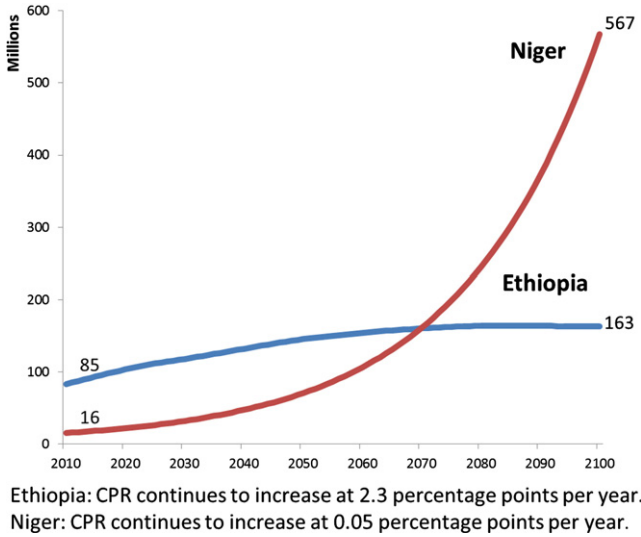

Fig. 1. Population size by 2100 heavily depends on how quickly contraception reaches women.

above could still become a reality in some countries unless policies change.

Even the 11th-h policy change in Niger will leave a severe population challenge. In 1950, the population of the whole Sahel was 30.7 million. The UN Population Division's medium variant projections for 2050 (340 million) and 2100 (605 million) [6] underscore the need for urgent action. On top of this totally unsustainable population growth, climatologists project that the surface air temperature will increase by 2 to 3°C by 2050 and 5 to 8°C by 2100. This collision of rapid population growth and climate change could trigger the largest migration in history. There are likely to be more failed states and, as the *9/11 Commission Report* stated, "…a large, steadily increasing population of young men without any reasonable expectation to suitable or steady employment – a sure prescription for social turbulence" [7]. There is no certainty that the temperate grain-producing countries will have the surplus food needed to feed hundreds of millions of increasingly hungry people.

According to the UN Population Division, the low variant projection for 2100 shows the population of countries with a TFR over 3 (which include all the LDCs) will more than double from 1.2 billion today, which is 18% of the global population, to 2.8 billion, amounting to 39%. According to the high variant projection, the LDCs would grow to a stunning 6.2 billion by 2100, amounting to 45% of the global population. As the current analysis of CPR shows, if the lack of focus on family planning that characterized the last 20 years continues, the division between "haves" and "have-nots" in today's world will deepen. An immediate and significant investment in family planning, along with policies that remove the many unnecessary and unjustified barriers to family planning [8], which includes widespread misinformation about contraception, is imperative.

The London Summit on Family Planning opened the door on new policies and new financial commitments to international family planning — but it is only a beginning. Most professionals outside the field of family planning focus on the medium variant UN population projections. However, as Hania Zlotnik, the recently retired director of the UN Population Division points out, the high variant is based on an assumption of the average woman bearing only half a child more than the medium projection, and it is by no means impossible [9]. The exponential rise in population, especially in countries that will suffer most from global warming, could reverse the welcome declines in infant and maternal mortality that have taken place since the 1950s, unless large-scale and urgent attention is given to making family planning more accessible in the LDCs.

The societies of some of the LDCs also treat women in atrocious ways. We view child marriage as a human rights abuse. In order to move forward, the international community will have to invest heavily in women, both in making family planning easily available to meet the unmet need in the LDCs and to raise the age of the first birth. This dual effort is both a human rights imperative and a demographic necessity. Raising the average age of the first birth by 5 years in a society with teenage marriage reduces the birth rate by 25% [10]. Moreover, a girl who is married in the early teens and has multiple children by age 20 can never develop the autonomy to manage her own fertility.

The philosophy that the most transformative thing we can do is to give people access to family planning is also a philosophy of listening to what women want, not telling them what to do. It is lowering the TFR in a human rights framework. It is offering voluntary family planning even in low-resource settings where reducing average family size is one prerequisite for development. It is an important shift away from some of the misleading assertions made by advocates after the 1994 Cairo Conference that "fertility decline was a consequence of the developmental process and not a catalyst, and that the only way to insure its occurrence was by the indirect route of prompting development" [11]. This belief, which is still influential among some economists and some women's advocacy groups, is unrealistic and counterproductive as the example the Sahel demonstrates.

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