

How to Improve Family Planning and Save Lives Using a Stage-of-Life Approach

By Malcolm Potts, Judith Rooks and Bethany Young Holt

Young women who reside in developing countries often face insurmountable challenges when seeking reproductive health care. No developing country has enough medical resources to meet the complete reproductive health care needs of all of its women of fertile age. Most have some family planning clinics, usually situated in large cities, and some have an extensive network of smaller clinics.

These facilities focus primarily on providing care for fertile women in stable sexual partnerships. They tend to focus on services for older, usually married women and are rarely the first choice of young, unmarried persons, who may be involved in the turmoil of early sexual experience and too embarrassed to visit such centers. In addition, the special skills required for diagnosing and treating sexually transmitted diseases (STDs), including HIV, and the cost of laboratory tests have discouraged most family planning clinics from offering these services.

The organization of reproductive health services, including family planning, must be rethought and dramatically altered to give priority to women at the beginning of their reproductive careers, who tend to have the most serious health and social problems. In this viewpoint, we propose a bold strategy to make better use of the limited human and financial resources currently devoted to specialized family planning clinics.

Four Categories of Care

For programs to deliver family planning and other reproductive health services most efficiently and effectively, we propose that they think about the individuals who need these services as being divided into four groups: those who are fertile but not yet sexually active; sexually active women who are childless and do not wish to have children yet; women in

the maternal phase, who are pregnant, are seeking pregnancy or have had a first birth and plan to have additional children; and women who are still fertile, but definitely do not want to ever have a child or another child.

The life situations and reproductive problems and goals of these four groups are different, and so are the services they need and the opportunities to serve them most efficiently. Individuals in the first group, who are not yet sexually active, require education and counseling. These services are likely to be best and most efficiently provided in nonclinical settings.

For those who are sexually active but wish to postpone childbearing, the timing of their first birth and whether they contract any STDs before then will have great bearing on the opportunities and problems that will affect them throughout their lives. They need information and services related to the prevention, diagnosis and treatment of STDs; emergency contraception; pregnancy diagnosis; and education, counseling and support addressing the range of problems that may arise from the sexual aspects of their lives.

Induced abortion is a particularly important issue for this group. According to the local circumstances, services should be available either to provide safe abortions or to treat the consequences of unsafe procedures. Postabortion counseling about contraception is essential in either case.

The lives of women in the maternal phase are structured to accommodate their roles as mothers. These women can be served in the context of maternal and child health services and other, related activities. Family planning information and counseling can be provided in association with prenatal and childbirth care; contraception can be provided in association with postpartum visits (although these are not routine in many countries). In addition, since the majority of infants in most countries

are brought to health care facilities to receive routine immunizations, well-baby visits provide an ideal opportunity to offer contraceptive services to mothers.

During this stage of their lives, women should be offered contraceptive methods that will not interfere with breastfeeding or future fertility. Although these women may be exposed to STDs, the prevalence and incidence of most kinds of genital infections are relatively low in this group.

Finally, those who have completed childbearing may be candidates for contraceptive methods that are contraindicated, or less appropriate, for women in the other three categories. Health care personnel working with this group must be able to educate these women about long-term methods, including voluntary sterilization, and either provide the methods or refer women to facilities that can. In poor communities, the subsidized social marketing of pills, condoms and injectables will meet the needs of many women at this point in their reproductive career.

As in the previous group, the prevalence and incidence of most kinds of genital infections and STDs are relatively low. Although some of these women are mothers of young children, many have moved on to other roles in their society and economy. They need education regarding the health problems that become more common as women age.

An approach to services based on these four categories could make use of the social aspects of obtaining care. Women have much in common with others in the same group but considerably less in common with women from the other reproductive categories. Dealing with each group separately

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Table 1. Characteristics of current and proposed family planning clinics, and of suggested alternative sources of care for women in their later reproductive years

Characteristic	Current	Proposed	Alternative source
Location	Mainly urban	Mainly urban	Mainly urban
Clients	Primarily women in stable partnerships	Young people of both sexes, primarily unmarried, who have not had a first wanted pregnancy	Fertile women of child-bearing age who have reached their desired family size
Services			
Oral contraceptives	Examine users and follow up	Supply	Social marketing, community-based distributors, private sector
Injectables	Examine users and follow up	Supply	Social marketing, community-based distributors, private sector
IUDs	Insert and follow up	Rarely used in this population	Social marketing, private sector, primary health care centers
Condoms	Available	Actively promoted	Social marketing, other retail outlets
Manual vacuum aspiration	Rarely used	Important activity	Rarely used
STD diagnosis, treatment	Uncommon	Major activity	Primary health care clinics, private clinics, hospitals
HIV counseling	Uncommon	Important activity	Public media
Voluntary sterilization	Uncommon	Not offered	Hospitals, private clinics
Pap smears	Common in some places	Rarely used in this population	Hospitals, private clinics
Nonclinical activities	None	Undertaken as resources allow	None

rately should facilitate group education and discussions, the formation of groups to help women support one another in meeting their reproductive health needs, and outreach to naturally occurring networks.

Since each group may tend to prefer particular methods of contraception, the need to provide a wide range of methods in every family planning service setting will be reduced, and programs will be encouraged to link up with other kinds of services offered in their community. Categorizing individuals by need could also allay the fears of some parents and community leaders that sexually inexperienced adolescents will be exposed to inappropriate material in group counseling and education contexts including sexually active women. And this approach could make it easier and more efficient to develop and offer services that are attractive to particular groups of individuals.

This approach should encourage providers to think about the lives, lifestyles and problems of those they serve, and to plan outreach services to meet the needs of those they should be serving but are not. The result would be

an increase in not only the efficiency and effectiveness of care, but also the quality of care from the user's perspective.

Who Needs Help Most?

Half the world's population is younger than 25, and 80% of the 1.5 billion people aged 10–24 live in developing countries.¹ The age of puberty has declined, and the age at marriage is rising.² Adolescence is a time of learning, when mistakes in selecting sexual partners and controlling fertility are common. The effects of such mistakes, especially for women, may be lifelong.

Unintended pregnancy, unsafe abortion and STDs are among the most serious health risks facing women, and biological and social factors interact to make young women especially vulnerable to these risks. The anatomy of the vagina facilitates prolonged exposure to infected secretions following intercourse for all women, but young women may be much more susceptible to HIV infection than older women because of the immaturity of their cervical cells. Furthermore, many STDs are asymptomatic in women (for example, up to 70% percent of chlamydia in-

fections), so infected women are less likely to seek medical help than are men;³ the clinical diagnosis of some STDs, such as chlamydia, is difficult in women, and laboratory tests are expensive and not very sensitive. In addition, young women may be physically and emotionally dominated by older men and thus unable to avoid sexual intercourse with a man who they know is infected.

Data on the reproductive health of young people in developing countries show a serious and worsening situation. Up to 20% of women in some parts of Africa and Latin America are infected with STDs.⁴ In Kenya, the average age at first intercourse is younger than 15 years for girls and younger than 14 for boys, and more than two of every five sexually active girls and three-fourths of sexually active boys have multiple sex partners.⁵ In some metropolitan areas of East Africa, between one-quarter and one-third of women seeking prenatal care are HIV-positive.⁶

Women younger than 25 have the highest rate of unintended pregnancies. Because the provision of abortion is illegal in many developing countries and legal abortion services are inaccessible in many other places, women often obtain abortions from unskilled practitioners working in unsanitary and exploitive conditions. Abortions account for up to 60% of admissions to most gynecology wards in Kenya, where abortion-related mortality rates are 1–6 per 1,000 reported procedures.⁷

Addressing the Crisis

Women and men in the earliest stages of their reproductive lives present the greatest public health challenge. Family planning and STD education and counseling provided to those who are not yet sexually active will reduce morbidity and the need for treatment once they initiate sexual relations. Those who are sexually active but do not yet wish to have children urgently need easier access to both family planning and STD services; immediate improvements are essential if the transmission of HIV is to be slowed. We recommend that countries with scarce medical resources devote most of their resources to meeting the needs of these two groups. Use of the stage-of-life approach can facilitate this shift in priorities, while making services for all women more effective and efficient.

Table 1 shows how the work performed in a typical urban family planning clinic would change under our proposal, and how the needs of women in the two later stages of the reproductive life span would be met. Currently, clinics serve primarily

women in stable partnerships and focus on providing them with contraceptives and, in some places, Pap smears; if clinics shifted their focus to young people who have not yet experienced a wanted pregnancy, they would still supply some methods to their clients, but they would also increase their emphasis on STD diagnosis and treatment, HIV counseling, condom promotion and manual vacuum aspiration provision. The older, fertile women who now often rely on these clinics for their care would instead be served by a mix of social marketing operations and private-sector providers, and would rely on primary health care facilities—both hospitals and private clinics—for Pap smears, STD diagnosis and treatment, and voluntary sterilization.

Successful implementation of our recommendation will require collaboration between vertical family planning programs and other elements of national health programs, especially primary care and maternal and child health services.

It will also require creativity and a willingness to try new approaches. This element of change should not be seen as a negative; it could be used to stimulate new energy and enthusiasm, drawing the most creative people into family planning. Program leaders and staff at all levels will be challenged to understand the lives and circumstances of their clients—and of the women and men who need their services but do not come to the clinic. This cannot help but lead to improvements.

Maternal and child health services should expand the scope of their mission to address the family planning needs of women in the maternal phase. Strategies to meet the family planning needs of women who have completed childbearing would include greater efforts to expand access to voluntary sterilization, increased emphasis on long-acting methods that require minimal follow-up, support for over-the-counter sales of contracep-

tives, and greater reliance on private health professionals and community-based distribution. Use of these strategies should substantially reduce the need to provide clinic-based family planning services to these women, while lowering the cost and raising the effectiveness and convenience of their contraceptive use.

Several factors have made it increasingly easy to provide family planning services. In many developing countries, more than 90% of women are aware of several methods of contraception; older, more experienced women in particular can take advantage of this knowledge and take greater responsibility for their own contraceptive practice. In addition, the services required to provide safe, effective methods to women in the two later stages of the reproductive life span have been reduced, since low-dose combined oral contraceptives are accessible over the counter in some places and there are virtually no contraindications to the use of injectables. Also, vasectomy methods have been simplified.⁸

Conclusions

The increasing demand for family planning and the urgency of combating the spread of HIV are two important items from the long list of needs set out in Cairo at the 1994 International Conference on Population and Development. But since the status quo is inadequate and financial resources are so limited, how can a broader range of services be created? More of the same will not do.

While strong advocacy for increased funding is essential, reallocating existing resources in new ways offers an immediate solution to current problems. Because resources are so constrained, the wide range of reproductive services should be prioritized according to their complexity, cost and impact. In the case of services to limit the spread HIV, which can double its prevalence among women in as little as three years,⁹ no effective change can be

considered too radical.

The existing use of family planning clinic resources is not solving the crisis. Those resources should be switched from their present functions to focus on reproductive health between first intercourse and first wanted pregnancy, and to meet the informational needs of young women who have begun to menstruate but have not experienced intercourse. A commitment to disease prevention intensifies the demand that these women receive high priority. Including STD diagnosis and treatment within existing family planning programs has been advocated, but few approaches suggested to date have been successful.

Our proposal is not limited to giving priority to women who have not yet begun to have sex or to bear children. We believe that use of the conceptual framework offered in this viewpoint will stimulate new, more effective approaches to meeting the needs of women and men throughout their reproductive years.

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