VIEWPOINT

Whatever Happened to Family Planning And, for That Matter, Reproductive Health?

By Duff G. Gillespie

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In 1994, the nations of the world gathered in Cairo for the International Conference on Population and Development (ICPD) and hammered out the comprehensive Programme of Action to improve women's sexual and reproductive health.[1] Just six years later, the nations of the world agreed on eight Millennium Development Goals (MDGs),[2] and reproductive health was excluded. This exclusion is emblematic of the declining priority placed on reproductive health and is a needed wake-up call. The time has come to reflect on the poor standing of reproductive health as a development issue and to mount efforts to get it back on the agenda.

Like reproductive health more generally, family planning has received declining attention as a development priority and is at a disadvantage in the competition for scarce resources. Steps that would sharpen its competitive edge would also result in significant health benefits.

A TUMULTUOUS HISTORY

Family planning has always been a contentious issue. In the early 1900s, the debate about "birth control" encompassed a volatile mixture of religion, feminism, eugenics, social reform, and neo-Malthusian and pronatalist philosophies. In the United States, debate over abortion has always been a feature of discussion about family planning.[3] The legalization of abortion in the 1973 *Roe v. Wade* decision intensified that debate. In 1984, the Reagan administration unveiled its Mexico City policy, which exported the domestic debate to the rest of the world. The policy prohibits the U.S. Agency for International Development (USAID) from funding foreign nongovernmental organizations that provide abortion services, legal or illegal, or that promote the legalization of abortion, even if those organizations use their own funds for these activities.* Its effectiveness in stifling discourse on and reducing the availability of legal and safe abortion services is recognized by its opponents, who usually refer to it as the global gag rule.[4]

The success of the Mexico City policy is not surprising, given that the United States is the dominant donor in international health, providing 30% of all donor funds devoted to international health in 2001.[5] The U.S. contribution represents 53% of all donor funds for reproductive health; additionally, the United States devotes 8% of its official development assistance to reproductive health, while the average for all donor countries (including the United States) is 3%.[6] The ascendancy of the United States over international and reproductive health resources helps explain the policy's success, and also suggests that we must look elsewhere to understand fully the de-emphasis on family planning in the donor community. It is unproductive to unduly focus on the U.S. government as the major cause of family planning's decline when the U.S. government is the sector's paramount donor.

Other factors worth examining take us back to the 1990s, when two forces converged to lower the priority of family planning: its marginalization at Cairo and the wide acceptance of the view that family planning was unnecessary because of the drop in the global rate of population growth.

FAMILY PLANNING AT CAIRO

Women's groups—many of which have long been uncomfortable with organized family planning—were a powerful force at Cairo. They called for a more complete range of health services for women, correctly pointing out that family planning programs did not serve all of women's reproductive needs. They also proposed major political, social and economic changes to improve women's general well-being. Their efforts paid off, and reproductive health became the core of the Programme of Action.[7]

Unfortunately, the new approach not only developed an expanded agenda, it also downgraded and, in the eyes of some, demonized family planning programs. An undercurrent at Cairo was that family planning programs were an instrument of demographic imperialism used by the rich North to control the behavior of women in the developing world as a means of stemming population growth. This criticism was not directed at family planning per se, but at programs that were considered ill conceived and poorly implemented. For many, the message coming out of Cairo was not that we needed to do more than provide family planning, but that we needed to provide less family planning.

ARE PROGRAMS STILL NEEDED?

One of the most remarkable developments of the 20th century was the dramatic worldwide decline in fertility. In 1965, the average woman could expect to have five children during her lifetime; now she can expect to have about three.[8] The United Nations predicts that we will reach near-replacement-level fertility—2.17 births per woman—by 2050.[9] By that year, many developed countries will have experienced decades of population decline.

While many factors contribute to this massive change in behavior, family planning programs play a critical part

*President Clinton withdrew the policy on his first day in office. President George W. Bush reinstated it on his first day in office.

in the global decline. The spectacular drop in fertility has led widely read pundits, like Ben Wattenberg, to ask if we should not eliminate family planning programs and start worrying about the declining and graying of populations, phenomena not experienced in modern times.[10]

The notion that the job of family planning programs is largely completed is gaining acceptance in the public health community, as evidenced by a 2002 World Health Organization statement that "while some risks to health have diminished, the very successes of the past few decades in infectious disease control and reduced fertility are inexorably generating a 'demographic transition' from traditional societies where almost everyone is young to societies with rapidly increasing numbers of middle aged and elderly people."[11] Even well-known demographers, instrumental in making the case for family planning programs, now believe that organized family planning programs have begun, inescapably, to wither away and will largely disappear by 2050.[12]

These observers do not question the need for family planning in general, but they do question the need for the state to have organized programs to help couples plan their families. They believe the demand for family planning is great enough that market forces alone will satisfy it. Thus, a growing view—not driven by ideology, but assuming that the raison d'être for family planning programs is to reduce rates of population growth—considers organized family planning superfluous.

ADVOCATES FIGHT BACK

Reproductive health and, thus, family planning have failed to gain the political traction and funds required to make the Cairo Programme of Action a reality. Donors have obligated less than half of what they pledged at Cairo,[13] and although many countries have adopted ICPD-inspired policies, few have devoted the political energy and money needed to translate these policies into reality.[14] The reproductive health community has not stood idly by.

Current attempts to raise the priority of reproductive health take two strategic tacks. The first is to reinvigorate the commitment governments made at Cairo and transform rhetoric into budgetary and programmatic reality. Since this effort has been going on for 10 years without much success, it gives little reason for optimism. The second, more recent strategy is to correct the wrongheaded decision not to have a reproductive health MDG by infusing family planning into existing MDGs, especially those for maternal health and child health.[15]

These two interrelated approaches are necessary to ensure that reproductive health does not simply disappear from the high-level discussions surrounding the MDGs; by themselves, however, they are unlikely to increase the financial commitment to reproductive health and family planning. The MDGs are grossly underfunded. Even HIV/AIDS initiatives, which have received a massive increase in funds since 2001, still have only about half the resources needed to reach MDG goals.[16] Understanding that the MDGs are unlikely to attract additional money by themselves, health advocates have mounted targeted campaigns to champion parts of the multifaceted MDG agendas.

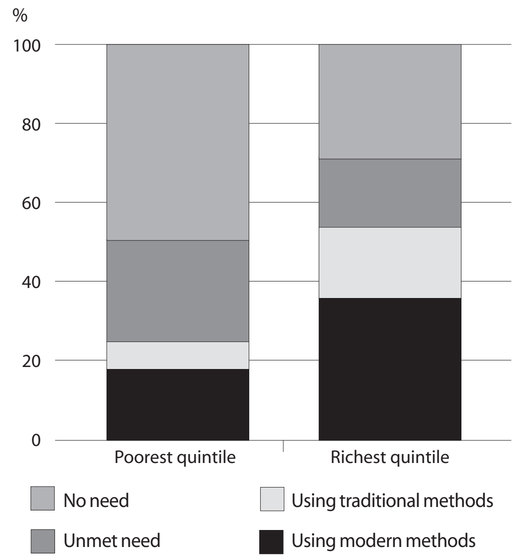
THE COMPETITIVE MARKETPLACE

A prerequisite for improving the marketing position of family planning is shaking off the image that it stands only for population control. Whether this characterization is accurate or fair is beside the point; outside the family planning community, it is a prevalent perception. To distance themselves from this image, some established population advocacy groups have renamed themselves. The first to shed its name was the Population Crisis Committee, which adopted the less shrill appellation Population Action International in 1993. In 2003, the UK-based Population Concern switched to Interact Worldwide, and Zero Population Growth (ZPG) discarded its name for the more politically correct Population Connection. The former ZPG explained that its name was "getting in the way" of its work with newspapers, schools, legislators and opinion leaders.[17] Organizations commonly change their names to reflect changing times. However, to be competitive, they also have to change the products they sell and the missions they promote.

One defining characteristic of international health in the 1990s is the tremendous increase in disease- or problem-specific initiatives and partnerships. There are scores of them—for example, STOP TB, the International AIDS Vaccine Initiative, Rollback Malaria, the Global Alliance for Improved Nutrition, and the Global Fund Against AIDS, TB and Malaria. Each seeks to mobilize political commitment and resources for a problem that policymakers can easily understand and find appealing. ICPD and, for that matter, the MDGs lack this clarity and appeal. The ICPD Programme of Action vaguely defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes."[18] Those most familiar with ICPD may know what this definition encompasses, but others do not. Contrast ICPD's message with that of STOP TB. Instantly, one knows what the TB initiative is about. In an environment in which many champions vie for the attention and support of busy policymakers, a clearly defined message and an appealing product are essential.

Still, having a clear message is not enough. The message must concern a problem that is important to policymakers and must present a clear course of action for resolving or alleviating the problem. Ogden and colleagues describe how a major outbreak of a strain of tuberculosis resistant to multiple drugs in New York catalyzed prevention efforts. Suddenly, tuberculosis was not just a problem for the very poor or the developing world. STOP TB marketed a strategy known as DOTS (directly observed treatment, short course) as the solution to the problem. While the campaign supporting DOTS oversimplified the approach (e.g., the "short" treatment is six months), it was the sound bite that champions needed, and resources for tuberculosis have greatly increased since the late 1990s.[19]

FIGURE 1. Percentage of women in 44 developing countries, by contraceptive status, according to income level



Source: reference 30.

STOP TB deals with a compelling, serious problem that has specific, direct interventions. The Cairo Programme of Action and reproductive health lack an easily understood problem, and no direct interventions or clear courses of action address reproductive health in toto. However, components of reproductive health deal with compelling, serious and actionable problems.

It is important to be programmatically pragmatic in selecting components of the Cairo Programme of Action to promote. Immediately after the ICPD, programs looked for ways to support its spirit and intent. Some areas seemed too abstract to act on (e.g., sexual health). The most frequently chosen of the actionable components was sexually transmitted infection (STI). Donors and governments rushed to integrate the treatment of STIs into family planning programs. However, the difficulty and cost of mounting a major program were greatly underestimated.[20] Results have been so disappointing that USAID, an early supporter of integrated family planning and STI programs, has characterized them as "unimpressive and sometimes even deleterious."[21] Support for a seemingly important and attractive problem may soon wane if progress cannot be documented. Competing problems are always waiting in the wings for more money.

BEST BETS

The Cairo Programme of Action is comprehensive and complex. Promoting and implementing it in its entirety exceeds our existing scientific and programmatic capacity, and potential financial and human resources. Advancing Cairo as an all-or-nothing package may be philosophically comforting, but it will not help the developing world. The Programme is visionary, but not actionable. We must identify the best bets and vigorously promote them.

A best bet must have certain characteristics. It must be important to policymakers, be easy to communicate and understand, be actionable and have direct impact on the problem. Something that initially looks like a best bet may not, on close examination, meet these criteria. For example, a substantial body of literature suggests that unchecked population size and growth adversely affect the environment. But this relationship is not actionable. It is too complex, indirect and poorly understood. Moreover, the organizations and people that implement family planning programs are different from those concerned with the environment. A possible first course of action for an environment minister concerned with biodiversity is to increase the number of game wardens, not to open a family planning clinic. Yet, the population-environment relationship's failure to qualify as a best bet does not mean that it should be completely ignored. Over time, our knowledge of and responses to it could make this a best bet.

Within reproductive health, and the broader Cairo Programme of Action, there are best bets. These can advance the reproductive health agenda, not in its totality, but in significant ways that will save and improve the lives of millions. For illustrative reasons, I have selected three best bets: averting mother-to-child HIV transmission, reducing the incidence of abortion and serving the poor.

Averting Mother-to-Child HIV Transmission

This year, 800,000 infants will contract HIV in the womb, during birth or through breast-feeding; giving mothers and infants a single dose of nevirapine can reduce transmission by 50%.[22] With funding from two major initiatives (the Global Fund Against AIDS, TB and Malaria and the $500 million Presidential International Mother and Child HIV Prevention Initiative), the number of programs aimed at preventing mother-to-child transmission by providing this effective, simple and inexpensive antiretroviral treatment should increase dramatically. However, few such programs actively offer family planning. In those that do, family planning has been well accepted. The potential impact of including family planning in these programs is significant.

King and coauthors found that the one-year incident pregnancy rate among HIV-positive women participating in a voluntary testing and counseling program was 22% before family planning was offered and plummeted to 9% after services were introduced.[23] Stover and colleagues, in a study of programs in 14 countries covered by President Bush's International Mother and Child HIV Prevention Initiative, found that by preventing unplanned pregnancies, family planning services can sharply increase the number of HIV infections averted in infants, and that they do so at relatively low cost: The number of infections averted each year increases from 37,000 to 71,000 when family planning services are added, and the cost of adding these services is only about $660 per HIV infection averted,[24] far lower than the cost of caring for an HIV-positive infant.

Family planning is also effective in averting HIV infection among infants outside treatment programs. Schmid and colleagues found that lowering the pregnancy rate among HIV-

positive women by 6% in Kenya and 7% in Zambia has had the same impact as nevirapine programs in these countries. Of course, as nevirapine programs get larger and more effective, a larger proportion of pregnancies must be prevented to have the same impact as these programs have. A 35% reduction in pregnancies was needed to match the impact of the well-established nevirapine program in Rwanda.[25]

Reducing Abortion

Each year, an estimated 46 million women worldwide have abortions, and 67,000 women die as a result of unsafe abortions.[26] If the number of unplanned pregnancies is reduced, then the number of unwanted pregnancies will be reduced, and the demand for abortion will decrease. The evidence that family planning programs lower the number of abortions is strong.[27] Family planning providers have long known that contraceptive use and abortion are inversely related, yet reduction of abortion remains a by-product of contraceptive practice rather than an explicit program goal. Making it a goal would not only shift the image of family planning, but also result in higher-quality care for women, marked by a greater emphasis on providing emergency contraception and on reducing contraceptive failure, one of the main causes of unplanned pregnancies in the developed world.

The failure of health systems to work toward reducing the incidence of abortion is nowhere more evident than in postabortion care programs. The growth of postabortion care services has been slow, and since these services are not especially difficult to establish, this is hard to understand in the post-ICPD environment. However, what is truly inexplicable is that postabortion care seldom includes family planning counseling and services. If ever there were women in need of family planning information and services, it is those in postabortion care programs. Johnson and colleagues found that two years after leaving postabortion programs that offered family planning, 2% of women had a repeat abortion; by contrast, 5% of women who were in programs without family planning services had a repeat abortion.[28] It is deplorable that women subjected to an unsafe and often life-threatening abortion are not given the information and services they need to avoid having to subject themselves to the procedure again.

Serving the Poor

Reducing poverty and achieving equity are fundamental objectives of the United Nations and all major donors. The relationship between poverty, population and family planning has been vigorously debated for decades; a convincing case can be made that family planning can help reduce poverty at the household and national levels.[29] However, poverty reduction is not a best bet: The indirect relationship is complex, and policymakers have many other levers they can pull to attack poverty indirectly.

A more appealing way to approach poverty is through the equity door. An analysis of Demographic and Health Survey data from 44 countries found large disparities between women in the poorest and richest quintiles in the total fertility rate (6.1 and 3.2 births per woman, respectively) and in the proportions using modern contraceptives (18% and 36%—Figure 1).[30] Such gaps are unfortunate, but not surprising. What is surprising is how much the gap between the rich and poor narrows if women with an unmet need for contraception switch to a modern method. This suggests that poor women want family planning services but are not getting them, an observation supported by ex-