

Let's Not Get Carried Away with "Reproductive Health"

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Ironically, 1995's Cairo Conference (the International Conference on Population and Development) may inhibit the family planning movement in some unexpected ways. By emphasizing the importance of "reproductive health", conference resolutions and program policies that echo this emphasis may make pursuing "pure" family planning programs more difficult. If so, less support could be forthcoming for contraceptive services, as funds are drawn away to more comprehensive (and therefore more expensive) programs.

There is a sense of déjà vu here. In the 1970s, partly in response to the Bucharest Conference, integrating family planning into maternal and child health programs was strongly emphasized. Part of this emphasis resulted from political considerations, including fears that governments of developing countries might consider birth-control assistance from the industrialized North to be unwelcome interference or even a form of genocide. Part resulted from the attitude that birth control was – and to some extent still is – controversial anyway. Camouflaging family planning programs as part of maternal and child health was felt to make them more palatable.

Then, as the decade progressed, we began to see the importance of conception control in its own right. Spearheaded by Rei Ravenholt and his team at the United States Agency for International Development, programs emphasizing contraceptive availability – began to show real impact on contraceptive prevalence, fertility rates, and human well-being. As family planning programs succeeded in countries such as Thailand, Indonesia, Colombia, and most recently, Bangladesh, the family planning community came to realize that contraception itself might be the most effective means of improving maternal and child health. Deborah Maine and others documented the astonishing impact of birth spacing on infant mortality (Population Reference Bureau, 1991); social marketing programs took hold in dozens of developing countries and provided inexpensive condoms and pills at convenient locations without being linked other interventions; sterilization camps and clinics were organized in many Asian programs, and they greatly increased the number of surgical contraceptive procedures without, necessarily, addressing a comprehensive health agenda. In short, "pure" family planning gained respectability. Such initiatives came to be seen, by themselves, to have a substantial health impact.

Simultaneously with the recognition that family planning programs need not necessarily concentrate on "health" to be effective came a growing realization that improved levels of education and economic development were not necessary prerequisites for the adoption of family planning, either. "Development is the best contraceptive" was a rallying cry of many developing countries' governments in the early years, no doubt in part to help attract donor nations' investment in other development activities, but surely, too, because assistance provided for economic development was and remains less controversial than support for "pure" family planning. But as fertility control proved its worth, that conviction dissipated too. Considerable publicity surrounded the publication of new Demographic and Health survey data from Bangladesh in the early 1990s, data that demonstrated a dramatic increase in contraceptive prevalence despite stagnant indicators for economic development and the status of women in that country. Observers concluded that "Contraceptives are the best contraceptive", and even "Contraception is the best development" (*Lancet*, 1992:1,155).

But just as this conclusion helped underline the acceptance in the family planning community of the benefits of unalloyed birth-control programs, along comes the Cairo Conference and the new emphasis—on "reproductive health". The Population Council, for example, has gone so far as to assert that in family planning service programs, "the reproductive health concerns of the client [should] be identified and, if possible, resolve" (Population Council, 1995). This statement suggests that simply providing contraceptives (and information about how to use them) is never enough.

Such a policy, if widely adopted, would scuttle many of today's family planning programs and could set back our current ability to bring contraceptive choices to people and save the lives of women and children by doing so. For example, social marketing programs served 12.6 million clients in 42 developing countries in 1994 (DKT International, 1995). Nearly six million of those clients were provided with conveniently available, inexpensive condoms. The couples who used those condoms undoubtedly improved their families' health through birth spacing by using them, and huge numbers of men thereby protected women from STDs and HIV. But, with the exception of instructions for use in the condom box and some education programs for pharmacists, little attempt was made to address issues of "reproductive health" in these programs. Nor, in my view, should it be. While social marketing programs providing oral contraceptives, IUDs, and injectables all bear a higher level of responsibility for client education than do condom programs, these, too, may serve their goals adequately if they provide sufficient education and information about those methods, including proper use, contraindications, and instruction concerning side effects. In other words, for such programs to succeed, they need not go beyond

addressing the issues that directly relate to the contraceptive methods themselves.

Make no mistake, family planning programs and other programs that address reproductive health needs, particularly those of women, are valuable and urgently needed. I soundly applaud such programs. But they are expensive because they require the involvement of trained health workers who must deal with each client face-to-face. Family planning receives just 1 to 2 percent of the total flow of foreign aid. Urgently needed improvement in the comprehensive health status of women can and should be financed from the 98 percent of aid that is not earmarked for family planning. Faced with ever tighter budgets for family planning during the upcoming decades, we must often choose between providing contraceptive services for large numbers of people and providing more comprehensive health services for smaller numbers. This choice is a trade-off that demands thoughtful balancing of the risks and benefits of each approach. It particularly requires recognition of the very substantial reproductive health benefits that mark, as I believe they do, one of the most consider what we are giving up if we insist that all family planning programs address reproductive health issues. If we adopt such a course, we might be depriving many thousands of deserving couples of the one thing that may do most to improve their "reproductive health" contraceptives.

References

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Population Council. 1995. *Population Briefs*. 1,2:7.
Population Reference Bureau. 1991. "Family Planning Saves Lives." Washington, DC: Population Reference Bureau.

Letters: On Turkey

We would like to take issue with tow points made about Turkey in an otherwise interesting article on detecting induced abortions from reports in DHS calendar data by Robert Magnani, Naomi Rutenberg, and H. Gilman McCann (1996).

First, the authors err in stating that Eastern Turkey is predominantly Muslim and Western Turkey is predominantly Christian. In fact, Turkey as a whole is a Muslim country, with Muslims comprising 98 percent of the population. Second, we do not believe that the regional grouping used in the study—which consisted of the East (including East, Central, North, and South regions) and the West—was a rational one. Turkey is a large country with wide regional variation in topography, culture, and social-economic conditions. Some of the regions that the authors included in the East are actually closer to the West in terms of the educational and cultural backgrounds of inhabitants; consequently, one would not expect to find statistically significant differences between the East and the West.

We have raised these issues in the hope that researchers will take into account the specific cultural and social parameters of a country when interpreting DHS data.

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Reference

Magnani, Robert J., Naomi Rutenberg, and H. Gilman McCann. 1996. "Detecting Induced Abortions from Reports of Pregnancy Terminations in DHS Calendar Data." *Studies in Family Planning* 27, 1: 36-43.