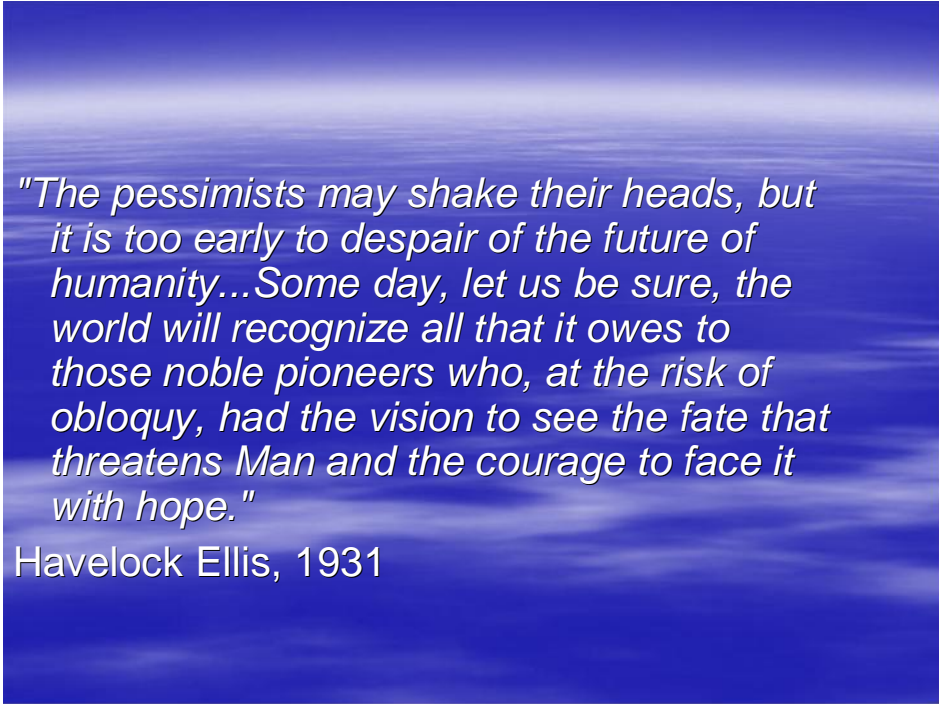


**Family planning
Issues and challenges
Population summit of the world's scientific academies
New Delhi, October 24-27, 1993**

INTRODUCTION



"The pessimists may shake their heads, but it is too early to despair of the future of humanity...Some day, let us be sure, the world will recognize all that it owes to those noble pioneers who, at the risk of obloquy, had the vision to see the fate that threatens Man and the courage to face it with hope."

Havelock Ellis, 1931

Space ship is sending signals of distress loud and clear

Spaceship Earth is sending signals of distress loud and clear

- The globe is warming
- The ozone-layer is being depleted
- Degradation of natural resources, soil erosion, water stress, deforestation and loss of biological diversity are threatening the quality of life.
- As the 20th century draws to a close, the world is confronted by a daunting challenge: to bring growing human numbers and their increasing needs into balance with the natural resource base that underpins any development.

Panic on spaceship earth at this time can only lead to disaster. Apportioning of blame is no good either. This is a time for scientific objectivity and for international cooperation.

Scientific objectivity provides grounds for hope and guarded optimism. A revolution in reproductive behaviour has been taking place in developing countries in the past few decades. Family planning has been a great success story of our time. The optimism, however, is guarded because there are still major challenges ahead.

FAMILY PLANNING TRENDS IN DEVELOPING COUNTRIES

FAMILY PLANNING TRENDS IN DEVELOPING COUNTRIES

The past few decades have witnessed a major change in reproductive behaviour in developing countries.

Family planning issues and challenges

- Family planning in developing countries

The total fertility rate (the average number of children that would be born per woman if all women lived to the end of their child-bearing years and bore children at prevailing levels of fertility) in developing countries, as a whole, has declined from 6.1 in 1965-1970 to 3.9 in

1985-1990 (Ross et al., 1992). Remarkably, the developing world, in just a few decades, has come over half way to the replacement fertility level (the level needed to keep population size constant) of 2.1 children per woman. With an additional decline of 1.8 children per woman, fertility in developing countries would reach the replacement level.

FAMILY PLANNING TRENDS IN DEVELOPING COUNTRIES

The adoption of a smaller family norm, with consequent decline in total fertility, should not be viewed only in demographic terms. It means that people, and particularly women, are empowered to take control of their fertility and to plan their lives; it means that more children are born by choice, not by chance, and that births can be planned to take place at optimal times for childbearing to ensure better health for women and children; and it means that families are able to invest relatively more in a smaller number of beloved children, trying to prepare them for a better future.

FAMILY PLANNING TRENDS IN DEVELOPING COUNTRIES

Family planning should not be looked upon in a narrow perspective as a measure to ease the world population problem. Family planning will be a permanent feature of the way of life of all succeeding generations on this planet. Our reproductive function is being voluntarily adapted to dramatic new realities. What we are witnessing is a major evolutionary jump that is science-mediated, rather than brutally imposed by Nature.

To put the rate of fertility decline in developing countries in perspective, a recent study compared the time taken for fertility to decline from 6.5 to 3.5 in different countries. What took 58 years in the USA took 27 years in Indonesia, 15 years in Colombia, 8 years in Thailand, and merely 7 years in China (UNFPA, 1991a).

In developing countries, the prevalence of contraceptive use- defined as the percentage of married women of reproductive age (or their husbands) using any form of contraception- rose from 9 percent in 1965-1970 to 51 percent in 1985-1990. The total number of contraceptive users in developing countries is estimated to have risen, during this period, from 31 million to 381 million (UNFPA, 1991a).

Between the mid-1960s and the present, 17 countries have had fertility declines of more than 50 percent, and an additional 31 countries have had declines exceeding 25 percent (Ross et al.,1992). Declines are widespread in East Asia and Latin America, are moderately widespread in South and South-east Asia and in North Africa and the Middle East, and have just begun in sub-Saharan Africa (Table I). This reflects variations in the trends for contraceptive prevalence in the different regions.

FAMILY PLANNING TRENDS IN DEVELOPING COUNTRIES

Three major factors have contributed to this revolution in reproductive behaviour.

- Women are looking beyond a domestic and reproductive role, into playing other productive roles in their societies, roles which have been helped by socio-economic progress and change.
- A technological revolution has introduced a range of effective contraceptive methods that are convenient to use.
- Governments and the international community realized that enabling women to control their fertility and to decrease the number of births is critical for checking rapid population growth and for speeding up the stabilization of world population, and are providing the necessary information and services.

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution

THE CONTRACEPTIVE TECHNOLOGY REVOLUTION

THE CONTRACEPTIVE TECHNOLOGY REVOLUTION

A scientific revolution in contraceptive technology in the past few decades has helped hundreds of millions of people to achieve their aspirations to regulate and control their fertility.

The fruits of science have been enjoyed by people living in the most varied circumstances, in the skyscrapers of Manhattan, in peri-urban slums in Latin America, in rural communities of the Indian subcontinent; people in all socio-economic strata; people with different cultures, religious beliefs and value systems; and people postponing a first

pregnancy, spacing their children or putting the limit on childbearing. In the past, contraceptive choice was limited to either coitus-related methods which lacked in effectiveness or permanent methods.

Broadening of contraceptive choice

- Contraception was moved outside the bedroom by the development of systemic methods such as the pill.
- People no longer had to make the choice between a method to be used at every coitus or a permanent method; long-acting reversible methods now offer protection ranging from one month to several years.
- Highly effective but reversible methods became an available option.
- Technical developments have allowed sterilization to be performed as out-patient procedure.
- But perhaps the most significant development brought about by the contraceptive technology revolution, has been the **empowerment of women**. For the first time, women had at their disposal effective methods that they can use to regulate and control their fertility, without being too dependent on cooperation of the male partner.

PREVALENCE OF DIFFERENT CONTRACEPTIVE METHODS

The most striking feature about the prevalence of contraceptive methods worldwide is the diversity of method mix between different countries and regions

There is not, and there probably will never be, an ideal method of contraception for all users, but there can be a variety of "ideal methods" for the needs of different users

PREVALENCE OF DIFFERENT CONTRACEPTIVE METHODS

The second striking feature is the prevalence of modern methods of contraception, particularly in developing countries. The dramatic decline in fertility in developing countries in the past few decades has been largely achieved through the use of modern contraceptive methods. Whatever factors may have influenced people's reproductive behaviour, the availability of convenient, effective, and safe modern methods has helped people to exercise their reproductive choices.

The heavy reliance on modern methods of contraception in developing countries may reflect the more recent adoption of contraceptive practice. Whereas in most developed countries marital fertility reached low levels well before modern contraceptives were invented, in most developing countries contraception did not become widespread until modern methods became available. These tended to be preferred by new users from the start (United Nations, 1989). There is also another rationale for this difference. Modern methods, particularly clinic-based methods are very effective but can be associated with side-effects. Where safe pregnancy termination services are widely available, and where the health risks of continuing with the pregnancy are negligible, a relatively lower efficacy is an acceptable trade-off for freedom from side-effects. The situation in most developing countries, on the other hand, is such that contraceptive failure can be a major health hazard- hence the trend to use more effective methods.

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state

FAMILY PLANNING AND THE STATE

FAMILY PLANNING AND THE STATE

" The basic objective of the State is to promote the economic and social development of the country and to ensure the maximum well-being of its citizens. The objective applies to the future as well as to the present... Avoiding a long-term weakening of a country brought about by a dangerously low birth rate and, inversely, avoiding excessive population growth when it becomes an obstacle to economic development and to the well-being of the population must certainly be among the basic goals of all governments."

Simone Veil, 1978

FAMILY PLANNING AND THE STATE

No society, primitive or advanced, no culture, no religion, and no legal code has been neutral about reproductive life.

The past few decades, however, have witnessed a major development. Governments saw fit to step into people's bedrooms, and for legitimate reasons. Governments began to appraise rates of fertility of their population, and where appropriate to develop policies of intervention to increase or decrease fertility

Governments' perceptions of fertility levels are often translated into policies of intervention, to lower, maintain or increase fertility. The concern of governments is legitimate. But government interventions vary, can sometimes be clumsy and may raise ethical concerns (Fathalla, 1984).

FAMILY PLANNING AND THE STATE

Measurements taken by governments to influence fertility behaviour, whether for an increase or decrease, are either direct or indirect

FAMILY PLANNING AND THE STATE

Indirect measures intended to lower fertility include:

- improving the status of women,
- enhancing child survival so that people will not need to over-reproduce in anticipation of expected child losses, and
- providing care and protection for the aged to make children less needed for old age security.

These indirect measures, apart from any intended effect on fertility, are good on their own, serving worthy social causes.

FAMILY PLANNING AND THE STATE

Social policies specifically directed at increasing or decreasing fertility fall within a wide spectrum, from the **desirable** to the **acceptable** to the **objectionable**.

FAMILY PLANNING AND THE STATE

Provision of family planning services, including education and information, is a desirable social measure on its own. Maternity or paternity benefits and family allowances, as measures intended to increase fertility, can also be justified as desirable social policies on their own.

FAMILY PLANNING AND THE STATE

Promotion of public awareness is acceptable, whether it is intended to decrease or increase fertility. It is, however, at the borderline. It can slip into the potentially objectionable if it results in undue psychological pressure on the individuals.

FAMILY PLANNING AND THE STATE

In another category, are a range of measures including incentives, disincentives and coercion to decrease fertility, and restriction of access to family planning and abortion to increase fertility. These strong handed measures by governments may impact adversely on the health of women, and raise serious concerns whether they are meant to decrease or increase a woman's fertility.

FAMILY PLANNING AND THE STATE

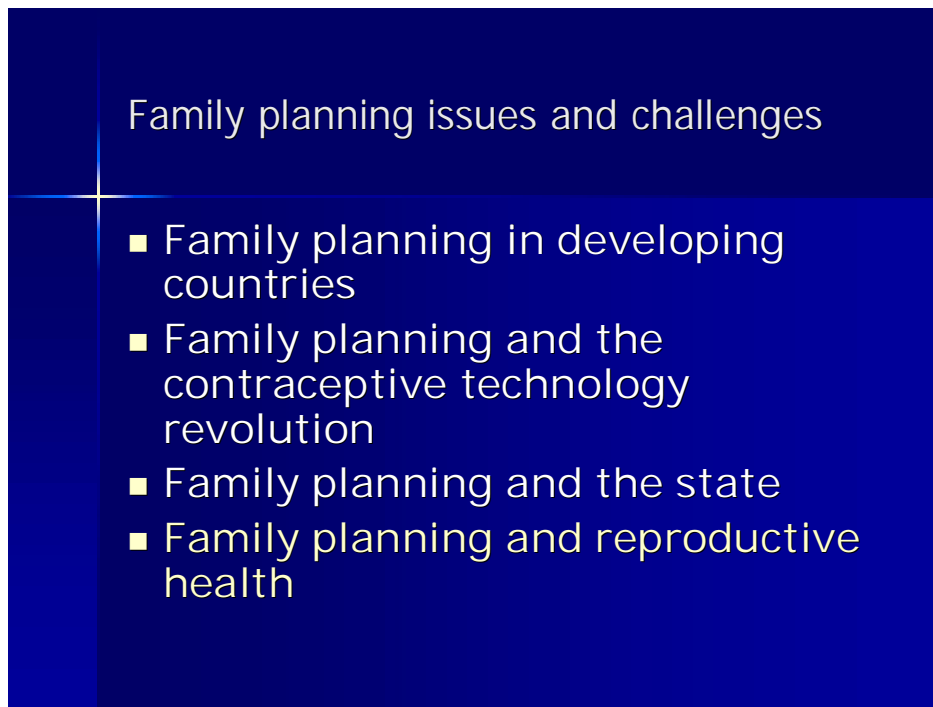
As far as health and human rights are concerned, there is little to choose between coerced contraception, sterilization or abortion, because society does not want the child, and coerced motherhood, because society wants the child. From a health point of view, coerced motherhood may be more serious. It can cost the woman her life.

In 1976, the national population policy of India permitted state legislatures to enact laws for compulsory sterilization. During the following national emergency period, it was reported that several million forced sterilizations were performed (Andorka, 1990).

The opposite side of the same coin is the declaration of Nicolae Ceaucescu that "*the foetus is the socialist property of the whole society. Giving birth is a patriotic duty.... Those who refuse to have children are deserters, escaping the law of natural continuity*" (Hord et

al., 1991). In October 1966, Romania severely restricted the availability of abortion and prohibited the import of contraceptives. The birth rate, 15.6 per 1000 population in 1965, after a transient rise, was down to 14.3 in 1983. Meanwhile, the maternal mortality rate increased from 86 maternal deaths per 100 000 live births in 1966 to 150 in 1984, with 86 percent of these deaths being attributed to induced abortion. In 1988, 505 maternal deaths were linked to abortion. On 25 December 1989, abortion was legalized again.

Romania under Ceaucescu may have been an extreme example of coerced motherhood. But coerced motherhood or compulsory childbearing, broadly defined, is still a problem in the world today. Women are coerced into childbearing when they are denied the choice, when they are denied the means to avoid unwanted pregnancy, and when society makes children the only goods a woman can deliver and is expected to deliver. In many societies in the world today, women are left with no choice in life except to pursue a reproductive career (United Nations, 1990).



Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state
- Family planning and reproductive health

FAMILY PLANNING AND REPRODUCTIVE HEALTH

FAMILY PLANNING AND REPRODUCTIVE HEALTH

In the constitution of the World Health Organization, health is defined as a state of complete physical, mental and social well-being. While this ideal may not be readily attainable, it serves to remind us that health is not merely the absence of disease or infirmity.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

Family planning and reproductive health should be viewed in this broad context of the definition of health. The ability to regulate and control fertility is a basic ingredient in the positive definition of health, particularly for women. A woman who is unable to regulate and control her fertility cannot be considered in a state of complete physical, mental and social well-being. She cannot have the mental joy of a pregnancy that is wanted, avoid the mental distress of a pregnancy that is unwanted, plan her life, pursue her education, and enjoy both a productive and reproductive career.

FAMILY PLANNING AND REPRODUCTIVE HEALTH

The ability of a man and woman to engage in a mutually fulfilling sexual relationship is an important element in reproductive health. Freedom from the risk of unwanted pregnancy helps a woman to fulfill her sexuality and to better enjoy sexual relationships.

FAMILY PLANNING SAVES LIVES

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state
- Family planning and reproductive health
- Family planning saves lives

Family planning saves lives

An unwanted or unplanned pregnancy can have serious physical, mental and social consequences for the woman. These consequences vary widely for different women and in different societies, but they account for a lot of avoidable suffering and avoidable deaths in the world today.

The extent of the physical hazards of unwanted pregnancies depends largely on two factors: the availability of efficient and accessible maternity services to deal with complications of pregnancy and childbirth, and the availability of safe pregnancy termination services.

Although maternal deaths have become rare events in industrialized countries, they are still a major cause of death for women of childbearing age in developing countries. The World Health Organization has recently estimated that over 500 000 women continue to die each year from causes related to pregnancy and childbirth (World Health Organization, 1991).

The maternal mortality ratio in developing countries is estimated to be on average 450 per 100 000 births, i.e. about one maternal death for every 220 births (World Health Organization, 1991). Worldwide, and particularly in developing countries, prevention of unwanted pregnancy is making an impact on safe motherhood (Fathalla, 1992c).

Family planning saves lives

Pregnancies that are too early, too close, too late or too many carry extra hazards not only for the health of the woman but also for the child.

Evidence implying that family planning does indeed help save children's lives is beginning to become more clearly available. A recent study analyzed the impact of fertility patterns upon child survival for 18 countries, based on data from the Demographic and Health Surveys (Hobcraft, 1992). Results were also contrasted with those from earlier World Fertility Surveys. The findings confirmed that children born to teenage mothers, especially those under age 18, experience considerable excess mortality before age 5. More important at the population level is the deleterious effect of short birth intervals for child survival. The study showed that the overall impact of poor timing of births on child survival is substantial in many countries but has been improving over time, probably as a result of increased use of family planning.

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state
- Family planning and reproductive health
- Family planning saves lives
- Family planning and sexually transmitted infections

FAMILY PLANNING AND SEXUALLY TRANSMITTED INFECTIONS

One of the most disappointing aspects of medicine during the past 25 years has been the great increase in the incidence of infections caused by sexually-transmitted agents. STDs are now the most common group of notifiable infectious diseases in most countries. The World Health Organization's minimal estimate for the yearly incidence of bacterial and viral STDs (excluding HIV infection) is 130 million (World Health Organization, 1992).

It may be postulated that the availability of contraception can encourage casual sexual relations. Although the postulate has never been proven, it has been used to justify the restrictive attitudes in some societies toward contraceptive availability to adolescents. It may also be postulated that the availability of the more convenient systemic methods of contraception may have decreased reliance on the coitus-related barrier methods that offer protection against STDs.

In developed countries, there was an apparent time coincidence among the contraceptive revolution, the sexual revolution, and the explosive epidemic of STDs. This may have been a reason for postulating a link. In developing countries, on the other hand, there is no such clear correlation. African countries with high incidence of STDs have the lowest prevalence of contraceptive use. The People's Republic of China, with a very high contraceptive prevalence, does not seem so far to have STDs as a major public health problem.

Family planning and the AIDS pandemic

The pandemic of Human Immunodeficiency virus (HIV) infection, which appears to have commenced in the late 1970s or early 1980s, has been a major set-back for efforts to improve reproductive health. The World Health Organization has estimated, as of early 1992, that some 2 million AIDS cases may have occurred worldwide since the beginning of the pandemic and at least 10-12 million HIV infections (World Health Organization, 1992). For the year 2000, WHO projects a cumulative total of 30-40 million HIV infections and 10 million adult AIDS cases, of which nearly 90 percent will be in developing countries.

The outbreak of the AIDS pandemic, and particularly its potentially devastating impact in Africa, does not in any way decrease the future need for family planning in that continent. Women in Africa and in other parts of the world deserve to have access to services to plan their families and their lives, irrespective of the AIDS situation and the level of population growth. To put the impact of AIDS in perspective, it should be noted that the upwardly revised projections for AIDS deaths for men, women and children in the decade of the 1990s is equivalent to only about one month of global population growth (Potts and Rosenfield, 1990). Also, the number of women who die each year as a result of unsafe abortion is higher than the number known to have died from AIDS through the decade of the 1980s.

On the other hand, the AIDS pandemic has implications for contraceptive technology (Fathalla, 1990b). Contraceptive choices, at the individual and programme level, will have to take the risk and prevalence of HIV infection into consideration. The need for dual protection against unwanted pregnancy and against STDs/HIV poses a challenge to the field of contraceptive research and development.

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state
- Family planning and reproductive health
- Family planning saves lives
- Family planning and sexually transmitted infections
- Family planning and contraceptive safety

In view of the major worldwide expansion in the use of modern methods of contraception by healthy women over prolonged periods of time, contraceptive safety has become an important issue in reproductive health (Fathalla, 1991b).

Contraceptive safety

The past two decades have witnessed a major global research effort on the safety of contraceptives. In fact, no other drugs or devices in the history of medicine have ever been subjected and continue to be subjected to such scrutiny. As a testimony to this scrutiny, no significant public health problem has yet emerged in spite of contraceptive use by hundreds of millions of women.

Family planning issues and challenges

- Family planning in developing countries
- Family planning and the contraceptive technology revolution
- Family planning and the state
- Family planning and reproductive health
- Family planning saves lives
- Family planning and sexually transmitted infections
- Family planning and contraceptive safety
- Family planning and abortion

FAMILY PLANNING AND ABORTION

"Governments are urged to take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and, wherever possible, provide for the humane treatment and counselling of women who have had recourse to abortion;"

International Conference on Population, 1984

Women may not want abortion, but they need it. It is estimated that 36-53 million induced abortions are performed in the world each year, an annual rate of 32-46 abortions per 1000 women of reproductive age (Henshaw, 1990).

The performing of abortions, which in many countries was prohibited or regulated by strict legal constraints, underwent substantial liberalization in the past few decades. A review

of current abortion laws shows that some 52 countries, with about 25 percent of the world's population, fall into the most restrictive category, where abortions are prohibited except when the woman's life would be endangered if the pregnancy were carried to term (Henshaw, 1990). Forty-two countries, comprising 12 percent of the world's population, have statutes authorizing abortion on broader medical grounds- for example to avert a threat to the woman's general health and sometimes for genetic or judicial indications such as incest or rape- but not for social indications alone. Some 23 percent of the world's population lives in 13 countries which allow abortion for social or socio-medical indications. The least restrictive category includes the 25 countries (about 40 percent of the world's population) where abortion is permitted up to a certain point in gestation without requiring that specific indications be present.

FAMILY PLANNING AND ABORTION

Abortion rates do not necessarily correlate with the degree of liberalization of the abortion law. For example, the Netherlands, with a liberal abortion law, has one of the lowest abortion rates. Restrictive laws also do not necessarily mean that safe abortion services are unavailable. Services may exist despite legal constraints because laws are either interpreted with flexibility or are not vigorously enforced. On the other hand, absence of restrictions does not guarantee that safe services are available to all.

Information on clandestine abortions is difficult to document. Combining various estimates yields a total of 15 million clandestine abortions. However, since these figures cannot be fully relied upon, the actual number may be as low as ten million or as high as 22 million (Henshaw, 1990).

It is estimated that out of the 500 000 maternal deaths that occur each year throughout the world, as many as one-quarter to one-third may be a consequence of complications of unsafe abortion procedures (World Health Organization, 1990). Unsafe abortion is one of the great neglected problems of health care in developing countries and a serious concern to women during their reproductive lives. Contrary to common belief, most women seeking abortion are married or living in stable unions and already have several children. However, in all parts of the world, a small but increasing proportion of abortion seekers are unmarried adolescents; in some urban centres in Africa, they represent the majority. WHO estimates that more than half of the deaths caused by induced abortion occur in South and South-East Asia, followed by sub-Saharan Africa.

The magnitude of the problem of unsafe abortion in the world today is a striking testimony to the magnitude of the problem of unwanted pregnancy in the world today.



Significant progress has been made in the field of family planning. Compared to progress in other fields of human development, the achievements have been spectacular. There is, however, no room for complacency. There are still major tasks ahead and major challenges to be faced. The penalties for our failure to act responsibly and collectively as a world community will exempt no one on this planet and will be passed to all future generations.

THE CHALLENGES AHEAD

- **Creating a common ground**

A major challenge facing the family planning movement is the need to create a common ground for all advocates of family planning.

THE CHALLENGES AHEAD

"Family planning could bring more benefits to more people at less cost than any other single 'technology' now available to the human race. But it is not appreciated widely enough that this would still be true even if there were no such thing as a population problem."

UNICEF
(Grant, 1992)

There are three major *rationales* for the organized family planning movement: a demographic rationale, a health rationale, and a human rights rationale. The three rationales have evolved separately, at different times and for different objectives. Although most people are willing to embrace all three, each rationale has strong advocates who sometimes find

themselves in conflict with enthusiastic supporters of another rationale.

THE CHALLENGES AHEAD

Whatever one's concern for family planning may be, be it demographic and development driven, be it health or human rights, the ultimate objective is human welfare. If there is a lesson learnt from the past few decades, it is that there is more common ground between the three rationales for family planning, than what some people realize

THE CHALLENGES AHEAD

The family planning movement started as a movement by women for women.

Dr Marie Stopes, who wrote "Wise Parenthood" in 1918 and opened the first clinic in London in March 1921, was not a demographer and was not a physician. She had a doctorate degree in palaeobotany (McLaren 1990). When Margaret Sanger, her sister Ethel, and a social worker Fania, opened the first clinic in Brooklyn, the clinic was soon raided and the three women arrested. Released on bail, they promptly reopened the clinic and were arrested and

charged with maintaining a public nuisance (Suitters, 1973).

THE CHALLENGES AHEAD

Demographic concerns, serious as they are, should not override the human rights and health rationale of contraception. A reproductive rights and health approach, with women at its centre, can only help to achieve long-term demographic objectives.

Some demographers have clung to the belief that programmes and policies based on voluntary family planning would not bring about substantial reductions in fertility in the foreseeable future. They have argued that the demand for family planning would not be nearly sufficient to produce stabilization of the population in time to avert catastrophic outcomes, including famine and ecological collapse. The very success of voluntary family planning programmes over the past 25 years attests to a high (if not geographically uniform) demand for contraception. The ideational change for a small family norm has permeated even the least developed countries. Bangladesh is a case in point.

Demographers have often used Bangladesh as an example of a society that was unlikely to initiate a transition from higher to lower fertility in the foreseeable future, in contrast to several Asian and Latin American countries that were experiencing spectacular family planning programme successes and rapid fertility declines (Demeny, 1975; Arthur and McNicoll, 1978). It was considered that Bangladesh's social and economic institutions perpetuate high fertility; natural calamities, political upheaval and economic adversity perpetuate these institutional constraints to the modernization of reproductive behaviour. However, the results of two recent independent national surveys show that Bangladesh has achieved a moderate level of contraceptive use. Among currently married women under 50 years old, 31 percent use a contraceptive method and almost 25 percent use a modern method. In addition, 44 percent of ever-married women younger than 50 have used a method at some time (Larson & Mitra, 1992). Reflecting the increase in contraceptive prevalence, the total fertility rate declined from seven during the mid-1970s to about five by the end of the 1980s. Mean desired family size in 1989 was three children, indicating that there may still be considerable unmet need for family planning services.

A recent analysis of data derived from Demographic and Health Surveys, using conservative estimates for the unmet need for limiting fertility and for spacing births, estimated the unmet need to be 24 percent in sub-Saharan Africa, 13 percent in Asia and North Africa, and 16 percent in Latin America. The same study concluded that the total unmet need for contraception could be close to or in excess of 100 million (Bongaarts, 1991).

THE CHALLENGES AHEAD

Meeting the unmet need for family planning will in most cases achieve the desired demographic goals

Twelve of 29 countries included in the Demographic and health Surveys have stated demographic targets. A recent study has estimated that in 10 of the 12 countries, satisfying unmet need would exceed the government established targets by 7.9 to 40.9 percent (Sinding, 1992). The same study concluded that satisfying an unmet need of 12 percent of married women of reproductive age (a very conservative estimate) would result in a decline in total fertility in developing countries from just under four to just over three children.

It should be a responsibility of the whole international community to ensure that women, wherever they are, are given a choice in their lives and are given the means to implement their choice. Even the poorest people in the world should make these choices. There is no justification in denying poor people access to family planning.

THE CHALLENGES AHEAD

- **Creating a common ground**
- **Expanding access and improving quality of family planning services**

A recent study tried to measure access to family planning in 124 developed and developing countries, representing 95 percent of the world population (Population Crisis Committee, 1992). Countries were scored from 0 to 100 on the basis of ten indicators which cover the range of birth control choices available in the country, the competence of those providing family planning services, and the convenience of services and the amount of information available to contraceptive users through various outreach and education efforts. Countries were ranked as having good, fair, poor or very poor access to family planning.

The study assessed access to family planning in 1992 as good for 39 percent of the world population, fair for 36 percent, poor for 16 percent, very poor for 5 percent and not studied in the remaining 5 percent. Some 56 of the 95 developing countries studied and 2 of the 29 developed countries (Japan and Ireland) fell into the poor or very poor category with scores below 50. In the 22 countries in the very poor category, couples still have virtually no access to birth control information or services through either the public or private sector.

THE CHALLENGES AHEAD

Adolescents have special problems in having adequate access to family planning. Providing adolescents with reproductive health services, including family planning, is one of the major challenges.

Demographic concerns have tended to emphasize quantity. Experience of family planning programmes has shown that there is no question of quantity versus quality; on the contrary, quantity will not be achieved and sustained without quality.

Demographic concerns have tended to emphasize quantity. Experience of family planning programmes has shown that there is no question of quantity versus quality; on the contrary, quantity will not be achieved and sustained without quality. If family planning services are perceived as of high quality, couples will be more likely to accept contraceptives and to continue their use; there will be fewer contraceptive failures; resources are more likely to be forthcoming; and opposition can be countered more convincingly (IPPF, 1993).

Quality does not necessarily mean sophisticated facilities. Quality means satisfied customers. A crucial element in quality is proper attention to users perspectives, especially women (Bruce, 1990). Another crucial element in the quality of a family planning service is the freedom to know, the freedom to choose and the freedom to decide. Family planning is a dignified behaviour, and services should be provided with full respect to human dignity.

THE CHALLENGES AHEAD

- **Creating a common ground**
- **Expanding access and improving quality of family planning services**
- **A contraception-21 initiative to launch a second contraceptive technology revolution**

A contraception-21 initiative to launch a second contraceptive technology revolution

In the early days of the contraceptive technology revolution, the scientific community lived through the dream of coming up with the ideal contraceptive that will fit the needs of everyone, everywhere, every time. The field soon matured enough to realize that this magic bullet is a dream that cannot come true.

The needs of different people have to be met by broadening contraceptive choices. There is a need for a wide range of contraceptives tailored to different human needs: for people who are different, for circumstances which are different and for the same individual at different phases of life with different needs

The contraceptive technology revolution has stalled and still has an unfinished agenda. The range of contraceptive choices needs to be broadened to meet the vast expanding and diverse needs for fertility regulation. Moreover, with all its benefits to the quality of life of women, the currently available contraceptive technology has left women with some genuine concerns as well as unmet needs. The qualities of convenience, effectiveness and use by women in modern contraception were not without trade-offs.

The modern contraceptive revolution has been largely demographic driven. Women have benefited in the process but were not in the center of the process. As far as policymakers are concerned, women were often means to an end, objects and not subjects. This has accentuated the suspicions of women's groups and resulted in a feminist critique of the medicalized contraceptive technology (Dixon-Mueller, 1993). Whether justified or unjustified, the critique must be voiced and must be heard, because the concerns are genuine.

To complete the agenda for contraceptive research and development, and to provide the contraceptives of the 21st century, there is a need for a second contraceptive technology revolution, driven by women's needs and women's perspectives. This requires a clear mission, a reinvigorated science and sustainable resources (Fathalla, 1993b).

The first contraceptive technology revolution was goal-driven, with emphasis on methods that could have a demographic impact. When the revolution stalled, the poorly funded field became driven by scientific opportunity. For the second contraceptive technology revolution, the field must again be goal-driven, and the goal should be set right. The field should focus on contraceptive approaches where the needs of women are still unmet by existing methods. The message for all of us, who are concerned about population growth, should be clear: In the words of one feminist, "*What women want for themselves is what the world needs for survival*".

Particular emphasis and priority should be given to methods that coincide with the women's perceived needs and priorities, including among others, methods that are under the user's control and that also protect against STD's, post-ovulatory methods, and safe male methods that enable men to share responsibility for fertility regulation and disease prevention (World Health Organization, 1993).

The agenda for contraceptives of the 21st century will have to be based on the application of new advances in cell and molecular biology and biotechnology to fertility regulation. While these advances have opened new frontiers for medical and biological sciences, the field of contraceptive research and development is yet to benefit from the opportunities provided by these new advances. New frontiers now opening up in science can provide women and men with a broader choice of better and safer state-of-the-art contraceptives. For this, there is a need for a major and sustained investment in human capital to build up a critical mass of scientists active in the field. It was the major investment in the field of reproductive endocrinology which gave most of the leads for the first contraceptive technology revolution. Now, the field is ripe for another major initiative, to provide the leads for a new generation of contraceptive methods.

It may be noted that the global expenditure on contraceptive research and development, from all sources, is less than 3 percent of the global contraceptive sales, estimated to be between \$2.6 billion and \$2.9 billion (PATH, 1993). The funding of public sector programs involved in contraceptive research and development represents about 3 to 4 percent of the international assistance for population and family planning, estimated in 1990 to be \$802 million (UNFPA, 1992). Another figure to note in these budgetary considerations is that about \$230 million is estimated to be required to bring a new chemical entity from research to the market.

Any major infusion of resources in the contraceptive research and development field will have to come from industry. The limited resources available for family planning and reproductive health are badly needed for expanding the access and improving the quality of services (Fathalla, 1992b). The potential of industry, in terms of finance and expertise, is great compared with other resources. The pharmaceutical industry in the developed world invests a substantial amount of money (about 16 to 19 percent of revenues) in research and development of new products (Pharmaceutical Business News, 1992). With U.S. and European companies reporting total revenues of over \$90 billion per year and a projected annual growth of 9 to 10 percent over the next five years, there are significant resources for research activities. The constraints that led to the retrenchment of industry must be addressed, if the vast resources of industry are to be mobilized (Mastroianni et al., 1990; PATH, 1993).

THE CHALLENGES AHEAD

- **Creating a common ground**
- **Expanding access and improving quality of family planning services**
- **A contraception-21 initiative to launch a second contraceptive technology revolution**
- **Mobilization of resources**

The rhetoric about population and family planning is not matched by allocation of resources.

Some developing country governments are not foresighted enough to invest in the future of their population. When they have the will, they also often lack the wallet. It should be clear, however, that of today's total expenditure on population and family planning, about

two thirds is provided by the developing countries themselves (UNFPA, 1991a). India and China pay for over 85 percent of their population programme activities, Indonesia pays 73 percent, Zimbabwe pays 67 percent and five other developing countries contribute more than 50 percent of their national population programme budgets .

As to the international donor community, 1.18 percent of official development assistance in 1990 was allocated for population assistance, of which family planning is only a part (UNFPA, 1992). The total population assistance has remained remarkably stable in constant dollar terms since 1972, hovering around \$US 500 million, in spite of the greatly expanding demand for family planning. Grants for international population assistance reached an all time high of US\$ 801.8 million in 1990. In constant 1985 dollars, this amounts to US\$ 549 million.

Using the United Nations medium-variant population projection of 6.2 billion by the year 2000, it was estimated that about 567 million couples will be using some contraceptive at the end of the century (UNFPA, 1991b). Based on patterns of contraceptive method mix, these couples will need 151 million surgical procedures for male and female sterilization, 8.76 billion cycles of oral pills, 633 million doses of injectables, 310 million IUDs and 44 billion condoms (not taking into consideration condom requirements for prevention of HIV infection). From an annual cost of \$US 416 million in 1991, the bill for contraceptives will rise to \$US 627 million by the year 2000.

The total costs of contraceptive commodity requirements in developing countries are currently shared among developing country governments (61 percent), the private commercial sector (17 percent), and the international donor community (22 percent). In 27 developing countries , production of oral pills, IUDs, condoms and injectables is now going on, or under serious consideration, by local affiliates of multinational companies or by government-owned and private local companies.

The costs of contraceptive commodities are only one component of the total need for family planning services. The total national and international expenditures for family planning and most other major population activities in all developing counties in 1987 amounted to about US\$ 4.5 billion. An additional US\$ 4.5 billion will be needed annually by the year 2000 to meet the expanding needs in family planning (UNFPA, 1989).

"How to mobilize the additional resources is a central challenge facing all of us today, both as members of the international community and as individuals seeking to realize the vision of sustainable development Throughout the world."

Amsterdam Declaration of the International Forum on Population in the twenty-first century, 1989)

This is what it takes. It should not be a question of whether we can afford to do it; the question is: can we afford not to do it.

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