

## About time: putting family planning back on the development agenda

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Today, 11 July, a Family Planning Summit is being held in London, co-hosted by the UK Government and the Bill and Melinda Gates Foundation. The Australian Government is represented by AusAID Director General, Peter Baxter.

The importance of this Summit was very evident to me last week, when I visited CARE's humanitarian programs in Chad, a country roughly the size of the Northern Territory, with a population of around 10 million. On average, women in Chad have 6.3 children, 60% of girls are pregnant before the age of 18, maternal mortality is estimated at around 1100 per 100,000 births. Just 2% of women of child bearing age are using modern methods of contraception.

CARE recently started a program to address the many barriers to accessing contraception in two regions in Southern Chad. The first barrier is simply access: the program is ensuring a range of modern contraceptive methods were made available in clinics. Given the poor infrastructure in Chad, many parts of the country are inaccessible during the rainy season, so this isn't entirely straightforward, but it is the easiest part of the equation. Women who came to the clinics reported that their husbands weren't supportive of their desire to use contraception and community leaders might not be supportive either. So meetings were held with traditional and religious leaders as well as with groups of men. The doctor managing the program told me that there was a lot of misinformation about contraceptives and in the meetings; the men had wanted to see and touch the various options. They were impressed with the information provided on the health benefits of spacing children. CARE also provided information to the local police who were sometimes drawn into disputes when women started using contraception without their husband's agreement.

In the first 4 months, the program exceeded the expected take-up for the first full year. There was huge pent-up demand by both men and women to space their children. Good information, targeting men, women and community leaders and reliable access to appropriate services has led many more people than anticipated to adopt modern family planning methods in this area.

To give another example, in 2007 CARE surveyed women in rural Uttar Pradesh, India and found that the majority of the respondents believed their husband had a right to beat them if they refused sex. It is not surprising that when this is the prevailing norm, women themselves internalise these social norms and feel unable to challenge them. After a two year community-based intervention designed to promote community and couples' dialogue, reflection and questioning of harmful gender and social norms, the proportion of women who held this belief had decreased by more than 80 per cent, while there was no change in a nearby control district. In addition, the proportion of women in the intervention area who discussed contraception with their husband more than doubled (from 42% to 90%).

The UNFPA estimate that access to contraception reduces maternal mortality by around one third. It also reduces infant and child mortality. When women and men can choose the number of children they have, they generally have fewer, healthier children. Women's health improves and their productivity outside the home increases (for more see this [blog](#) from the CGD).

Despite the obvious advantages of being able to choose if and when to have children, in many low-income countries, contraceptive use has stalled. It is not always a priority in Ministries of Health, there can be religious opposition to contraception (in both donor and developing countries) and while aid donors have, appropriately, significantly increased spending to address HIV and AIDS, funding for other aspects of sexual and reproductive health appears to have flat-lined. Also, as the example above shows, contraceptive use isn't just about access to services, it is also very much limited by social and cultural attitudes.

In 1994, the International Conference on Population and Development held in Cairo, placed women's empowerment and reproductive rights at the centre of development. The Cairo Conference marked an important shift in thinking, away from a focus on population control, to a commitment to a holistic approach to sexual and reproductive health rights. However, in the decades following the Cairo meeting, both aid donors and many developing country governments failed to make the investments necessary to ensure that women and men had access to a range of modern family planning methods and appropriate information about these options. Contraceptive prevalence in Laos it is 29%; in Afghanistan 16%; in Timor-Leste it is 7%. For comparison, in Australia the figures is 71% and Norway is 82% (UNFPA 2010 data).

Lack of transparency around funding for sexual and reproductive health means it is difficult to track how much funding is dedicated specifically to this issue. Donor reporting usually simply indicates funding to the very broad area of maternal and child health. The Guttmacher Institute and UNFPA estimate that meeting the unmet need for modern family planning methods in developing countries would cost about US \$6.7 billion annually. Currently, around US \$3.1 billion is invested, meaning there is a shortfall of US \$3.6 billion.

There has also been quite a lot of controversy around measures of 'unmet need' for family planning. The oft quoted number of 215 million women actually refers only to married women of child bearing age and is an extrapolation from interviews with women in health surveys. Their ability to use contraception may not depend on their preferences alone. In addition, these surveys leave out unmarried women and adolescent girls who nevertheless may wish to use contraception. The 'youth bulge' in many developing countries means that unprecedented numbers of children are entering adolescence and their reproductive years.

Sexual and reproductive health rights are fundamental to women's ability to make choices about their future; fundamental to women's and children's health and fundamental to development. In every society, sexual and reproductive issues are the subject of firmly held social, cultural and religious norms. Issues such as these must be tackled thoughtfully and carefully but with a recognition that access to sexual and reproductive health services is a human right.

To mark the London Family Planning Summit, CARE has released a [report](#) covering our experience in addressing the social and cultural barriers which affect women's ability to claim their rights to sexual and reproductive health services. Harmful social and gender norms which influence family and community attitudes to family planning are often shared by healthcare providers, affecting women's willingness to access services. For Governments attending the Summit, the report is a reminder that technical access to services, while important, is not enough.

I have seen these factors at play in work CARE is doing in the Puno region of Peru where Spanish-speaking healthcare providers did not communicate effectively nor provide services in ways that were culturally appropriate to indigenous Quechua women. Community members identified this as an important barrier to their use of reproductive and maternal health services. CARE is collaborating with local partners to strengthen the capacity of civil society to promote, advocate, monitor and report on the quality of health policies and services. The work is led by indigenous women trained to be 'social monitors', who visit and observe health posts, hospitals and pharmacies and discuss with women their experiences in receiving care. The social monitors regularly prepare reports and analyse them together with the Ombudsman Office, CARE and Forosalud (the main health civil society network). The findings are then shared with healthcare facilities and providers and an action plan is developed to address any concerns raised.

This process creates space for sustained, systematic dialogue on what indigenous women expect from the healthcare system and the achievements and failures of healthcare delivery. It promotes accountability to women's expressed needs and increases awareness of the rights and responsibilities between providers and users of healthcare. An evaluation showed significant increases in utilisation of healthcare services and improvements in reproductive health outcomes. The initiative has contributed to the institutionalisation of citizen-monitoring as part of Peru's national health policy.

In addition to ensuring strategies tackle gender inequality and power imbalances, Governments attending the Summit must also look to address family planning needs in emergency settings. Women are likely to be cut off from their regular source of reproductive health services and are thrust into conditions hostile to pregnancy and child bearing, often with a significantly heightened threat of sexual violence. The successful integration of family planning into emergency humanitarian responses has the power to ensure continuity of services for millions of the world's most vulnerable women. UNFPA has estimated that 25-50% of maternal deaths in refugee settings are due to complications of unsafe abortions.

Organizers are hoping that the Summit will lead to significant new commitments of funding to family planning services, enabling access for an additional 120 million women in developing countries. But, as I've argued above, it's not just about funding. Our new report offers 3 recommendations to ensure that new funding commitments are effective:

- Put reproductive rights, women's empowerment and gender equality at the centre of family planning programming and policy
- Strengthen local accountability mechanisms to promote quality, participation, transparency, equity and local ownership
- Ensure women and girls' reproductive health needs are addressed in emergency and post-conflict responses.

The Family Planning Summit could be a game-changer for poverty – it's about time.

You can find CARE Australia's report *Women's Lives, Women's Voices: Empowering women to ensure family planning coverage, quality and equity* [here](#).

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