Reproductive Health including Family Planning

The integration of family planning into expanded reproductive health programmes that provide women and men with choice in planning their reproductive lives, while still incomplete, has not led to reversals in fertility decline

By Philip Guest

Despite occasional efforts to reverse the consensus articulated in the Programme of Action of the International Conference on Population and Development (ICPD), for almost a decade the recommendations contained in this Programme of Action have provided the guiding framework for expanding and reorienting reproductive health programmes in the Asian and Pacific region. Reproductive health in the above-mentioned Programme is defined 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" (para. 7.2). Reproductive health services are viewed as a basic right through which women and men can express their reproductive choices.

The High-level Meeting to Review the Implementation of the Programme of Action of the International Conference on Population and Development and the Bali Declaration on Population and Sustainable Development and to Make Recommendations for Further Action, which was held at Bangkok in 1998, highlighted the progress that many countries in the region had made in integrating family planning with other reproductive health services and improving the quality of care provided in their family planning programmes. However, the Meeting also noted that major obstacles remained in implementing the recommendations contained in the Programme of Action. Some of the obstacles related to the capacity of the service system to provide expanded services, some to cultural barriers, particularly those related to gender inequality, that limited the reproductive health options of women and some to weak government commitment. The Meeting made a number of recommendations that were designed to manifest further commitment to the ICPD goals and remove obstacles to attaining the goals (ESCAP 1998).

In Asia, there has been continuing debate over the role of national family planning programmes in reproductive health programmes. While national family programmes have undoubtedly contributed to rapidly declining fertility in many Asian countries through allowing couples to achieve their desired family size, the very success of the programmes has resulted in a diminishing interest in using public moneys to fund them. However, the changes in orientation towards family planning and reproductive health that have existed since the late 1980s and that were legitimated by ICPD have provided family planning programmes with new roles and a new purpose.

In this paper several issues are examined. In the first section of the paper, the author summarizes selected aspects of family planning programmes in the region. In the second section, the linkages between family planning and other aspects of reproductive health are examined. The third section of the paper focuses on quality-of-care issues related to reproductive health, while in the final section of the paper new roles for reproductive health programmes are examined.

Family planning programmes in the Asian and Pacific region

Caldwell and others (2002: 10) state that the twenty-first century started with "the greatest number of national family planning programs in position that had ever existed". Asian countries have been leaders in the establishment of family planning programmes and despite the remarkable fertility declines that occurred in most of East and South-East Asia over the preceding decades, the number of programmes continues to grow rather than diminish.

Table 1. Percentage of currently married women aged 15-49 using contraceptives by type of method: nine selected populous countries

Country and year	Percentage using contraceptive method			
	Any method	Sterilization	Any modern temporary method	Any traditional method
China, 1997	84	41	42	1
India, 1998/99	48	36	7	5
Indonesia, 1997	57	3	51	3
Pakistan, 1995/95	18	5	8	5
Bangladesh, 1999/2000	54	7	36	10
Viet Nam, 1994	65	4	39	21
Philippines, 1998	47	10	18	18
Iran (Islamic Republic of), 1992	65	9	37	20
Thailand, 1993	74	23	50	2

Source: East-West Center (2002).

For the entire Asian region, by the year 2000 the total fertility rate (TFR) had dropped to levels that are intermediate between 2 and 3. Well over one half of currently married women in reproductive ages were using contraception, and population growth had slowed appreciably. These changes have been facilitated by the presence of national family planning programmes in most of the countries of the region. There remains, however, significant diversity in the levels and methods of contraceptive use among countries in the region.

In table 1, the contraceptive prevalence rates for nine populous countries in Asia are shown. In several of the countries approximately two thirds or more of currently married reproductive-aged women were using contraceptives. For Pakistan the contraceptive prevalence rate was below 20 per cent. In India there is a particularly high reliance on sterilization, while in countries such as Indonesia and Viet Nam sterilization comprises a small proportion of methods used. Meanwhile, in other countries, traditional methods, primarily the calendar method and withdrawal, contribute a large proportion to overall levels of contraceptive use.

Many of the differences among countries in the levels of contraceptive use and contraceptive method mix can be linked to the evolution of national family planning programmes in the region. Jones and Leete (2002: 117) characterize the 1970s as the "heyday of family planning programmes in Asia." It was during this

decade that many countries established their family planning programmes in a context of growing international and domestic concern over the need to reduce fertility. International funding was available for family planning programmes, and a focus on the measurable outcome of achieving targeted lower levels of population growth helped motivate programmes.

The emphasis on achieving fertility decline resulted in family planning programmes in several countries, particularly in South Asia, focusing on permanent methods. Pakistan, a country with a long-established family planning programme, has had difficulty in achieving political support and commitment and this is reflected in low levels of use, and a relatively high proportion of use consisting of non-modern methods. The Philippines is another country where political commitment to family planning has waxed and waned and where the use of non-modern methods is high. In Viet Nam, political commitment to family planning has not been a problem. However, despite recent efforts to broaden contraceptive choice and improve quality of care, it appears that concerns about the quality of services have contributed to relatively high levels of use of non-modern contraceptives.

In many countries with newly established programmes, success was quick in coming. In Thailand, TFR, which had already been declining before the national family planning programme commenced in 1970, declined from over 6 during the latter half of the 1960s to below 4 by the end of the 1970s. Although fertility decline in Thailand has been ascribed to a number of factors (Knodel and others 1987), the flexible approach of the family planning programme and its willingness to respond to interventions successfully piloted by an active non-governmental organizational (NGO) community, helped to facilitate the decline.

Harbison and Robinson (2002) argue that the main reason for the success of family planning programmes in reducing fertility was that they were able to convince the public of the benefits of a small family. In turn, other societal forces contributing to the ideational change favouring fewer children helped to contribute to some family planning programmes being considered as very successful. This argument implies that where family programmes have been able to cater for the emerging needs of women for effective contraception, and where they have in some way been able to help to legitimize those needs, programmes have been successful in attaining the policy objective of lower fertility. The extent to which reproductive health programmes, including family planning, can address the

reproductive health needs of women and men will continue to determine their success.

The role of family planning in reproductive health

The centrality of family planning to reproductive health in the post-Cairo era has been reiterated in several international population forums (see Khan and others 1998). The provision of quality family planning services provides couples with the ability to choose the timing and number of children they will have. Family planning services undertaken in isolation from other aspects of reproductive health weaken the commitment to providing couples, and particularly women, with the full range of reproductive health services that they require to lead healthy lives. Family planning is a crucial aspect of services since it provides couples with the ability to make choices about their reproductive goals and it is these choices that have implications for health. In much of the region, family planning programmes are the primary organizational structure for implementing policies designed to affect non-contraceptive aspects of reproductive health, so the role of family planning programmes must be recognized and adapted to help to solve reproductive health concerns. Finally, and a fact not recognized by many family planning programmes, women themselves make a link between family planning and their reproductive health. Often this is in terms of the perceived health risk that they feel they will be exposed to if they adopt family planning.

Family planning and mortality reduction

The links between family planning and infant and child mortality are now well established, even if the magnitude of the effect continues to be debated. Over the past decade a number of studies in several Asian countries have demonstrated how the use of contraception, resulting in few children and longer spacing between children, has contributed to improved maternal and child health (see Greenspan 1993; Luther and others 1999; Miller and others 1992; Popkin and others 1993). There are a series of interrelated factors that affect the probability of an infant dying. The shorter the interval between births, the higher the parity of the child, and births occurring at the extremes of a woman's reproductive career are all associated with higher probabilities of infant deaths. Estimates of the differentials in mortality associated with each of these effects give some indication of the potential for infant mortality decline if contraception was more widely used to

space or limit fertility. For example, probabilities of death are up to 2.5 times higher where the birth interval is less than 2 years compared with birth intervals of more than 2 years; the probability of death of an infant of parity 7 or more can be up to 2 times higher than for parities 1 to 3, and women giving birth from age 18 to 34 may be up to 50 per cent less likely to have their infant die compared with mothers aged less than 18, and about 25 per cent less likely compared with mothers aged 35 and over.

Many of the issues that relate infant and child mortality to fertility can also be applied to maternal mortality. Without there being any changes in socio-economic conditions or access to health services, a reduction in fertility would result in a reduction in maternal mortality. This would occur in an absolute sense, with the number of mothers dying declining, and in a relative sense, with the probability of maternal death associated with each birth declining. This latter effect would occur because fertility decline results in a reduction of births occurring to high-risk groups. Based on data from the Matlab in Bangladesh, Fortney (1987) demonstrates that if births at ages of mothers less than 20 and greater than 39 and births of parities greater than 5 were eliminated, the maternal mortality ratio would decrease by 25 per cent while the number of women dying in the age group 15 to 49 would decrease by 56 per cent.

International commitment to Safe Motherhood has increased over the last decade, primarily as a result of the ICPD Programme of Action. There is now a much better appreciation of what are priority interventions and how and where these interventions might be integrated into family planning programmes (Berer and Ravindran 1999).

The indirect effects of family planning on improved morbidity and mortality of mothers and children are harder to document than the direct effects but are probably equally strong. At the societal level, fertility decline can reduce the overall levels of dependency and hence increase the per capita level of resources available for investment in health services for the dependent population. This can also occur at the household level: small families have greater wealth than larger families and hence can devote more resources to improving the health of family members. Access to family planning programmes can also be an entry point for women into the wider health system. This can lead to better health for women and their families.

A contentious issue that many family planning programmes prefer to avoid is the issue of abortion. Ahman and Shah (2002) estimate that in the year 2000, there were 19 million unsafe abortions and of these, over 50 per cent (10.5 million) occurred in Asia. Unsafe abortion is a major contributor to maternal mortality, with annually over 80,000 deaths of women, the vast majority in developing countries, attributed to unsafe abortions (WHO 1998). The presence of a high level of abortion is one indication of difficulties of women obtaining access to appropriate methods of effective contraception. In many fertility transitions, initial declines in fertility were associated with increases in the incidence of induced abortion. As effective contraception became available, the level of abortion was reduced. In many developing societies, abortion-related deaths are most likely to occur for women in their twenties; therefore, family planning can have a major impact on reducing the risk of maternal mortality at ages where, in the absence of abortion, the risk of maternal mortality is very low. Increases in premarital sexual activity, the difficulty of unmarried women obtaining access to contraception and/or social factors which tend to discourage the use of contraception for the unmarried are also related to increased levels of abortion and attendant mortality risks for young women.

In those areas of the Asian and Pacific region where son preference of children is strong, there continues to be the problems of sex-selective abortions (East-West Center 2002). Bairagi (2001), in a study of the effects of son preference in Bangladesh, notes that the effect of son preference on abortion has increased over time and that if foetal sex identification becomes more widely available, the number of abortions of female foetuses may increase. Other countries in the region where sex- selective abortion has been a concern include China, India and the Republic of Korea. While these countries have combated the problems through legislation banning foetal sex identification, change in the underlying societal values that result in son preference requires more programmatic attention.

Some of the issues not discussed here, but which deserve fuller treatment, are the effects of family planning on other aspects of a family's life. There is a growing body of evidence that families who limit fertility are able to invest more resources in improving the human capital of their children (better health and education) and in increasing the economic resources of the family. Of course these outcomes are not only a result of the adoption of family planning, but can also be seen as a major motivation for the acceptance of family planning. It is notable that

the presence of these relationships is most evident in societies in which the fertility transition is well advanced, suggesting that when couples realize the benefits to their family from limiting fertility, they are quick to practise contraception.

Family planning and reproductive morbidities

In the years leading up to ICPD at Cairo in 1994, evidence emerged of the high levels of reproductive tract infections (RTIs) in developing countries. Bang and others (1989) reported high level of both endogenous RTIs and sexually transmitted infections (STIs) in rural India. Other studies in India have also reported high levels of RTIs (Bhatia and Cleland 1995). Similar results have been reported in other Asian countries such as China and Viet Nam (Kaufman and others 1999; Lien and others 2002).

Since Cairo the provision of RTI/STI services have been seen as an important area of integration with family planning services (Walker 1998). In part this is because methods such as the IUD should not be provided unless it has been determined that the client does not suffer from an RTI. Also, women often see symptoms of RTIs as an outcome of their contraceptive use and hence seek assistance from family planning services when they experience possible RTI symptoms such as vaginal discharge.

The ability of family planning clinics in resource-poor settings to effectively diagnose and treat RTIs requires further investigation. Lien and others (2002), based on their study in Viet Nam, argue that investing in establishing and maintaining diagnostic facilities may not be the most efficient use of resources at the local level. Instead, they provide several alternative options that involve more simplified procedures for diagnosis of RTIs. Kaufman and others (1999) came to similar conclusions based on their study in China. What is clear is that any treatment strategy adopted for RTIs within family planning programmes needs to be based on knowledge of the levels and composition of RTIs within each area.

Even in situations where it is not possible to integrate diagnosis and treatment of RTIs into the operations of family planning programme service delivery points, it is possible to include prevention in programmes. For areas where STIs/HIV are a concern, this could include promotion and distribution of condoms, HIV pre- and post-test counselling and referral. For RTIs, education on recognizing RTIs and appropriate care-seeking behaviour could be provided.

Quality of care in reproductive health services

As part of the demographic argument, and also as a recognition of the human rights and dignity of clients, programmes are now stressing the quality of care provided to clients. It has been shown that where a variety of methods are available, where communication between service provider and client is open and two-way and where service providers are well trained, current users are more likely to continue using contraceptives and to use their chosen method of contraception more effectively. The quality of care framework (see Bruce 1990), provides a set of guidelines that programme managers can use to reorient their activities to make them more consistent with the reproductive rights recommendations of the ICPD Programme of Action.

A central component of the Bruce framework is that clients should have a real choice of methods. Ross and others (2002), in a cross-national study, have shown that availability of methods is strongly related to the prevalence of each method and that overall prevalence is related to the overall availability of several methods. Because couples have different contraceptive needs and preferences, and as these needs and preferences vary over their life, a programme should ideally include a range of methods in order to cater for the various inclinations. Where a variety of methods are available to meet the varying needs of clients, one can expect prevalence and client satisfaction to be highest.

Khan, Boon-Ann and Mehta (1998) in their assessment of the quality of care of family planning programmes in the Asian and Pacific region five years after ICPD noted that in many programmes there were a limited number of methods available and that in some programmes where a variety of methods were available, provider biases or method-based incentives reduced choice. While programme managers at the national level have shown clear commitment to broaden effective choice, the understanding of informed choice and indeed the whole concept of quality of care have been shown to be lacking among many providers (Abdullah 1999).

The consequences of a lack of informed choice are low levels of client satisfaction, high levels of contraceptive discontinuation and increased numbers of unplanned pregnancies. Johansson and others (1996), in a study of abortion in two villages in Viet Nam, argue that many abortions were related to the limited choice

of contraceptives available in the service delivery system. Essentially the only method available was the IUD and many women who had discontinued IUD use because of side effects became pregnant and resorted to abortion.

Informed choice of methods does not simply mean making all methods available. Programmes need to be able to incorporate the new methods into their service delivery system and clients must fully understand the implications of using each method. The inappropriate inclusion of a method into a service delivery system can have adverse impacts on women's health and increase the risk of an unplanned pregnancy. Hull (1998) describes how in an eastern province of Indonesia a lack of knowledge and skill among providers in the removal of contraceptive implants, combined with a related lack of understanding of clients about when removal should occur or even if it should occur, resulted in many women not having the implants removed at the appropriate time.

The difficulties in instituting real informed choice of contraceptive methods is clearly shown in the case of China. China's family planning programme has operated with strict and clearly defined birth limitation rules and within the context of one main method on, the IUD (see Attané 2002; Winckler 2002). In the years following ICPD, the Government of China has taken steps to relax some aspects of their programme through promoting aspects of quality-of-care, while retaining population regulations. These steps, which were tentative at first, have now quickened and there are quality of care initiatives in many of the numerous counties in China. One pilot project, designed to introduce informed contraceptive choice, commenced in Deqing county of Zhejiang province in 1995. An assessment of the pilot project in 1998 shows that within the confines of a strict and mandatory policy on the number of births allowed, women are being provided with greater choice of methods and that this results in greater satisfaction for them and has also oriented providers to the importance of women's preferences (Gu and others 2002).

A central component of instituting a client-centred approach to reproductive health services, particularly family planning services, is the removal of targets within family planning programmes. The record of abolition of targets in the family planning programmes of countries in the region is very mixed. Of 25 Asian and Pacific countries and areas responding to an ESCAP questionnaire about their reproductive health programmes in the five years after Cairo, 18 said that their

programmes had included quantitative targets and only 4 responded that they had removed those targets after Cairo. India was one of the countries that reported removing programme targets (ESCAP 1998). Murthy and others (2002), based on the results of three case studies in various parts of India, found that experiences varied markedly between their three research sites. In all sites some progress towards eliminating targets was achieved, but the extent of change was limited. Significantly, they note that easing targets did not reduce contraceptive levels and may have resulted in increased use of temporary methods. The findings of this study illustrate the difficulties of changing entrenched practices at lower levels of family planning programmes.

However, attempts are being made within the region to change practices not consistent with the quality-of-care approach. For example, Jain and others (2002) report on a pilot project in the Philippines that used information about the needs of clients, expressed by the clients, to design provider work plans and direct service efforts. This new approach replaced an existing system based primarily on demographic and medical criteria. Unfortunately, this example of a client-centred management approach to providing services is the exception rather than the norm.

Other aspects of quality of care also need to be improved in reproductive health programmes in Asia and the Pacific. Schuler and Hossain (1998), for example, argue that there remain major problems or poor interpersonal communication between providers and clients in the Bangladesh national family planning programme. They recommend that institutional norms, policies and incentives have to follow a client-centred approach if these problems are to be overcome. Koenig and others (2000), in a review of studies that have examined the quality of care under the India Family Welfare Programme, suggest that even though some changes in the Indian Family Welfare Programme were made in 1996 and 1997 to accommodate ICPD recommendations, there has been little improvement at the local level. They state that most studies indicate a lack of concern for client needs and preferences, and that poor women are particularly disadvantaged within the programme in obtaining an appropriate quality of care. Although direct evidence is lacking, they state: “poor quality of care likely has contributed to high levels of foregone, delayed, or discontinued practice of contraception and consequently to unwanted pregnancy among current or potential clients” (p. 13).

Overall there has been progress in improving the quality of care provided in reproductive health programmes in the Asian and Pacific region. However, this progress has been hampered by a lack of understanding and appreciation of the importance of client preferences and by service delivery systems that are resistant to change (Abdullah 1999). Change in reproductive health programmes has been most apparent in improvement in the quality of services rather than in terms of quality of care. A similar conclusion is also made by Hardee and others (1999, p. s8), who state that the "reproductive rights aspects of Cairo have received far less attention than the health aspects".

Priority roles for family planning programmes

Much of the region, especially areas of South Asia, remains in a situation where birth rates are high, levels of contraceptive use are low, unmet need for family planning is high and childbirth is accompanied by a high risk of death for both the mother and her new-born infant. In these countries, efforts need to be made to ensure that individuals are provided with the means to achieve their desired family sizes within programmes that provide the highest possible quality of care. In these countries, to the extent practicable, other elements of reproductive health should be integrated with family planning.

There are many other developing countries in the region, however, which have made great strides in increasing contraceptive use, lowering birth rates and improving the health of mothers and children. It is the situation in this latter group of countries, particularly with regard to the roles of family planning programmes, that is focused upon below.

Serving vulnerable groups

What are the roles that the family planning programmes of these countries should play? Should the structure and funding patterns of the programmes change? Should the programmes exist at all? These questions are being faced by a number of family planning programmes in South-East and East Asia. Jones and Leete (2002) argue that there are two priorities for family planning programmes of countries in the region where fertility has fallen below replacement level. The first is to turn over more of the provision of contraceptive and other reproductive health services to the private sector. Potts and others (1999) argue that shortfalls in

expected international and domestic resources for reproductive health services require that much more emphasis be placed on commercial family planning services in developing countries. The role of the Government in this situation would be to ensure that the quality of services is maintained at a high standard and that services to those segments of the population that cannot afford to pay for them are maintained.

Ensuring that vulnerable groups have access to affordable reproductive health services in a context where many programmes are attempting to broaden user fees is a priority issue for Governments. In countries where high priority is placed on family planning, such as China, this can mean that family planning services remain free to all through the government family planning services. In other areas of reproductive health, such as maternal care, where user fees are required, there is increasing concern that many poorer women do not have access to services (IHS 2002). Although many couples in China could undoubtedly afford to pay for family planning services, and indeed many urban women do so, there remains a need to subsidize access to the full range of reproductive health services for poorer women.

There are other population groups that for one reason or another do not have access to reproductive health services. Lack of access may result from social barriers, lack of information, limited physical access, economic difficulties or even discrimination. These groups, which vary from country to country, can include migrants, particularly international migrants, minority groups and slum dwellers. Programmes need to identify the groups that cannot access services and ensure that appropriate services are provided.

In the Bangladesh family planning programme, the change from a field-based to a fixed-site contraceptive delivery system is based, in part, on a desire to reduce the high cost of the family planning programme. Utilizing a fixed-site system would also allow the programme to promote more effective methods such as the IUD and sterilization. Arends-Kuenning (2002) argues, however, that fieldworkers have been most effective at meeting the family planning needs of poor and uneducated women and that removing fieldworkers completely from the family planning programme could affect the contraceptive choices that these women can make.

The issue of the extent to which national family planning programmes need to play a role in providing affordable contraceptives and other reproductive health services came forcefully to the fore during the recent "economic crisis" that affected South-East Asia and parts of East Asia. The crisis raised fears that large segments of the population might not be able to obtain contraception in those countries, such as Thailand, where increasing proportions of women had begun to access contraception through the private sector. Prachuabmoh and Mithranon (2002) report on the results of a pilot study in Thailand that indicate that although overall the crisis appeared to have little impact on the use of contraception, those women most affected by the crisis were the most likely to report that they would abort if they became pregnant. These results suggest that in a context such as that of Thailand, where low-fertility preferences have become so entrenched, contraceptives are seen as a priority good and will be purchased even in poor personal economic circumstances. The desire to avoid pregnancy in these situations, however, may also lead to higher levels of abortion when contraceptive failure occurs. In order to not place an undue burden on poor couples and provide them with affordable and effective contraception, family planning services are still required for vulnerable groups in societies where fertility has reached low levels.

Some might also argue that family planning programmes may also play a role where the policy objective of a "low-fertility" country is to increase fertility. McDonald (2002) in reviewing public policy options to increasing fertility does not mention a role for family planning programmes, although he does see an active role for policy in this area. Those countries where fertility has declined to such low levels that a policy response to increase fertility has been elicited, have primarily been developed countries where national family planning programmes have not existed. As an increasing number of developing Asian countries reach a point where increasing fertility is seen as an objective, national family planning programmes could play a role through providing fertility services for those who cannot afford to access the private sector and through promoting positive attitudes towards childbearing (see also Harbison and Robinson 2002).

Providing services to the unmarried

The second priority area identified by Jones and Leete (2002) is to ensure that the unmarried have adequate access to reproductive health information and services. Demographic and social transformations in the

Asian and Pacific region have led to calls for a greater focus on the reproductive health of adolescents. Adolescents are one of the fastest growing segments of the population. Rising ages of marriage also result in longer periods during which adolescents remain unmarried. This trend, combined with social changes that are weakening social norms against premarital sex, is resulting in higher levels of sexual activity among the unmarried (Mehta and others 1998; Gubhaju 2002).

Increased levels of sexual relations among the young, subsequent increases in levels of premarital pregnancy and the spread of sexually transmitted diseases among the young are of concern to many policy makers. Increases in levels of unsafe abortion among the unmarried (Ahman and Shah 2002) and high proportions of adolescents among those persons infected with HIV are further indications of the dire need for reproductive and sexual health services for the unmarried. It should be noted, however, that where adolescent reproductive health services are provided, in the majority of instances, activities have been confined to providing adolescents with "family values education".

The provision of adolescent reproductive health services is constrained by cultural proscriptions about providing sexual information to adolescents, particularly the unmarried, and widespread beliefs that providing information on sexual issues will lead to an increase in premarital sexual behaviour. The result is limited political commitment to establish and/or strengthen adolescent reproductive health programmes.

At a UNFPA-sponsored workshop in 2000 that reviewed the existing situation of adolescent reproductive health in East and South-East Asia and the Pacific island countries, the lack of reproductive and sexual health knowledge of adolescents was highlighted (UNFPA 2000). Many issues raised during the workshop revolved around the greater vulnerability, and the more severe consequences resulting from sexual behaviour, of adolescent girls compared with boys. For both sexes it was noted that parents generally did not discuss sexual issues with their adolescent children, that school-based programmes on sexual education were either non-existent or extremely limited in their approaches and that adolescents lacked resources to access private sector reproductive health services.

The use of public sector services is often restricted for adolescents. Many countries in the region restrict access to publicly funded family planning services to married women of reproductive age. Even in programmes where unmarried persons can theoretically use services, provider's perceptions may hinder their access. Tu and others (2002), in a study of family planning workers' attitudes to providing sexual and reproductive health services to unmarried youth in China, found that many providers expressed reservations about providing services to the unmarried. Tangmunkongvorakul and others (2002) report that providers in both the public and private sectors in northern Thailand were ambivalent about providing reproductive health services to unmarried youth, and tended to view unmarried clients in a negative light. Given the reception that they are likely to receive when seeking reproductive health services, it is not surprising that many unmarried adolescents are hesitant to seek services from the formal health sector.

The proposed "Pattaya Programme of Action on Adolescent Reproductive Health" made recommendations to improve adolescent reproductive health that were aimed at the individual, provider and societal levels (UNFPA, 2000). Concentrated efforts to change some of the underlying societal factors that increase the vulnerability of adolescents in the areas of reproductive health, particularly those factors related to gender inequality, were recommended. These efforts are required to bring about long-term change. However, the removal of barriers to providing friendly and respectful reproductive and sexual services to adolescents should be the immediate programme priority. Preventive programmes that stress abstinence from sexual relations are needed and innovative ways to present information about the benefits of abstinence to youth should be explored. Where abstinence is not possible or is not the choice made by the unmarried, reproductive health services that include the provision of affordable contraception should be made available.

Improving sexual health

In addition to and in some ways crosscutting the two areas discussed above, a further priority area for family planning programmes should be to integrate sexual health services into their services. Although sexual health is included in the definition of reproductive health of the ICPD Programme of Action, there were few recommendations on how the provision of sexual health services should be improved. In assessing how countries in the Asian and Pacific region had adjusted

their reproductive health programmes after ICPD, Abdullah (1999) observed that apart from sex education for adolescents, few countries appear to have incorporated aspects of sexuality or sexual health into their programmes.

A major difficulty in attempting to incorporate sexual health into family planning and other aspects of reproductive health is the sensitivity associated with discussing topics related to sex. Even researchers have tended to shy away from directly researching aspects of sexuality. Hawkes, Pachauri and Mane (2002) note information on sexuality in Asia has been limited until recently and it has only been the impact of HIV/AIDS that has spurred efforts to understand more deeply the relationship between sexual and reproductive health.

Dixon-Mueller (1993) argues that family planning providers need to learn about the sexual preferences of their clients in order to provide services that meet their clients' particular needs. For example, the type of contraceptive preferred may relate to how it affects sexual relationships. In providing STI services, it is also important to understand the sexual practices of clients. However, except for NGOs, there have been only sporadic attempts to provide family planning workers with counselling skills in the area of sexuality.

The issue of gender-based power imbalances in sexual relationships is of particular salience for reproductive health. Lack of power takes away the ability to make choices. Where this lack of choice occurs in the context of sexual relations, it can lead to adverse reproductive health outcomes. Such outcomes can include the inability to protect oneself against STIs or unwanted pregnancy, being denied access to reproductive health services or being denied sexual pleasure (see Blanc 2001).

Blanc (2001, p. 208) calls for programme interventions that attempt to ameliorate power imbalances in relationships as a strategy for improving aspects of reproductive health. She notes that improving spousal communication seems to be important "in preventive behavior for HIV/AIDS and STIs as well as in the prevention of unwanted pregnancies and the improvement of sexual pleasure". A study of married couples in India also found that there was very limited communication among spouses about RTIs and that this lack of communication affected treatment-seeking behaviour (Santhya and Dasvarma 2002).

There is increasing evidence of high levels of non-consensual sex, particularly among adolescents. Gubhaju (2002), in reviewing some of the limited research available on this topic for Asia, notes many young women in relationships are at particular risk of being coerced into sex. Such coercion can also occur in work situations where males have authority over women. Evidence from a study in rural India indicated that a high proportion of abortions among unmarried women resulted from decisions to end unwanted pregnancies that were outcomes of non-consensual sex (Ganatra and Hirve 2002). We have little information in Asia about the males being coerced into sex.

The whole issue of gender-based violence has received scant programme attention and little research attention in Asia. Hardee and others (1999, p. s8) in their review of the post-Cairo progress of eight countries, including Bangladesh, India and Nepal, concluded that "gender-based violence remains outside the scope of most programs".

Family planning in reproductive health programmes

Family planning programmes have several well-documented advantages in providing broader reproductive health services. This includes the presence of a network that in many countries reaches down to the village level. Through this network it is possible to disseminate information and provide basic services to the bulk of the population. Family planning workers are also well versed in dealing with sensitive topics. In many societies, family planning has been considered to be a private matter and it has taken considerable time and effort to enable family planning workers to discuss contraceptive issues. In areas such as the provision of HIV/AIDS services, family planning workers would seem to have an initial advantage in taking on this role. The basis for this new role is that AIDS is primarily a sexually transmitted disease. In the provision of contraceptive services, family planning personnel have shown that it is possible to discuss matters that are sexually related, although much more training is required in this area. Finally, the condom is well known in many countries as a contraceptive method and its use as a dual-protection method could be promoted within this context.

In order to take full advantage of family planning programmes in providing other reproductive health services, there is, however, a need to expand the perceptions of the target populations of clients. Family planning

programmes in most countries have been established to target married women of reproductive age. As noted above, this often means that interests of other segments of the population, such as unmarried women, are often ignored. The focus on married women of reproductive age can also result in negative outcomes for this target population. For example, one of the most effective strategies for treating RTIs, including STIs, for women in low resource settings is using the syndromic approach to manage male urethral discharge and genital ulcers. Treatment of males is very effective in reducing transmission of infection to their female partners. Applying the syndromic approach to women is less effective because of the large proportion of women who are asymptomatic, or who may be reinfected by their male partners after their own treatment (Haberland and others 2002). Given the more limited power that women have in influencing the conditions of sexual relations, prevention activities directed at women will be less effective unless their male partners are also included. As family planning programmes evolve into more comprehensive reproductive health programmes, they must actively seek to involve both women and men in their programmes.

In the regional review of progress towards integration of reproductive health services, Walker (1998) concluded that significant progress had been made in integrating services. He notes that further progress requires a better understanding of how gender issues influence the provision and use of reproductive health services. The need to clearly define what services are to be integrated and the resource needs for such integration are also cited as necessary practical elements in taking integration forward. These issues remain central to efforts to integrate family planning with other reproductive health services.

Conclusion

During and following ICPD, concern was expressed that the emphasis on reproductive rights of women would weaken family planning efforts. This concern was rooted in the view that family planning programmes were a key factor in constraining fertility and that reducing the primacy accorded to family planning programmes within the area of reproductive health would be detrimental to long-held societal goals of reducing birth rates. This view is still held by many.

However, the experience accumulated in the eight years since ICPD should help to allay these fears. The integration of family planning into expanded reproductive health programmes that provide women and men with choice in planning their reproductive lives, while still incomplete, has not led to reversals in fertility decline. Couples in very diverse contexts throughout the region have demonstrated that they wish to choose the number of children they have and under what conditions they have those children. At the individual level, this may mean a need for reproductive health services to provide assistance to couples that cannot reach their desired family size. But for the majority of couples it means providing them with choice to limit their fertility while enjoying a healthy life.

What is required is efforts to systematically document and disseminate the efforts that have been made to change the reproductive health services to become more responsive to clients. Through exposure to the successful impacts of changes in policies and programmes, decision makers may be more likely to support the fundamental changes required to implement a reproductive rights- based approach to reproductive health. At the same time, there needs to be continuing research, particularly in the form of evaluation of pilot projects, to address some of the issues that are of concern to policy makers.

The issues from the Programme of Action where considerable work remains to be undertaken are many. Some of the priority areas are related to difficulties in transforming cultural values that support an environment and that limit the informed choice of individuals belonging to some groups in the population. For example, the development of adolescent reproductive health programmes has been hampered by the widespread belief that unmarried adolescents should not be exposed to information and/or services related to reproductive health. Entrenched systems that support gender inequality also restrict choices available to women while some societies provide legitimation for limited involvement of men in reproductive health.

There is also the need to move forward from considering only ICPD in considering how to improve reproductive health. As noted in this paper, the interrelationships between sexual relationships and reproductive health were not a main focus at ICPD. However, the centrality of sexual relationships to reproductive health cannot be disputed and there is an urgent need for programme interventions aimed at fostering reproductive health through improving the quality

of sexual relationships for both men and women. Family planning programmes, while not the only institutions that can be utilized to improve sexual health, are ideally placed to provide such services.

Family planning programmes remain central to reproductive health. In many countries of the region, some of the more traditional roles of family planning programmes, such as the provision of free contraception and efforts made to change family size norms, are of declining programme relevance. In other countries, these activities remain important. In all programmes as one moves forward efforts to foster improvements in reproductive health in the region, further development of family planning services within the context of improving the sexual and reproductive choices of women and men is required. Family planning programmes must ensure that the poor and other vulnerable groups are able to access quality family planning and other reproductive health services.

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