

## Post-it Notes and family planning



Chabikuli and Lukanu<sup>1</sup> are to be congratulated on their paper, given the constraints of working in a country with unremitting conflict and deprivation. The few hundred women studied were fortunate in receiving good care and desired control of their own fertility, albeit only by a permanent method and at a higher mean family size than they probably would have chosen if they had had access to better provision of reversible contraception.

The authors' main finding was that, at the point of being sterilised, there was no significant difference in the average birth interval between those who reported they were contraceptive users and non-users. They interpret this as suggesting a high prevalence of inconsistent or incorrect use of contraception. Yet surely this reflects more on the innumerable obstacles that all the women would have had, in obtaining continuity of supply and correct information about modern methods of contraception.

This is the key message of a most valuable paper by Martha Campbell.<sup>2</sup> She highlights the analogy with normal consumer behaviour: what happens when a consumer first becomes aware of something completely new, maybe before he or she has fully recognised a need or conceived of the possibility that anything could be done about a need. Post-it™ Notes are an excellent example of products we never knew we wanted until they appeared. The same applies to family planning: 'For forty years we have been asking, in surveys and one-on-one anthropological investigations in sub-Saharan Africa ... whether parents used contraception or worried about the inability to control family size. The answers have been the same. The parents had not practised birth control because they had no access to services. They had never contemplated restricting family size because *without the methods for doing so, it was unimaginable*' (my italics).

Campbell's analogy between Post-It Notes and family planning in Africa rang so many bells for myself, born in Burundi and raised in Rwanda. None of us knew how much we needed those sticky notelets until they came along! Similarly, women in Rwanda or DRC Congo start from a position that the number of children they have is 'up to God' (and their husbands). They cannot know reversible contraception exists as an option or how much they would wish to use it until it is realistically available and accessible. This means as a minimum:

- reducing **gender discrimination and abuse** in its many forms
  - removing the also largely man-caused, if not religion-caused, **barriers** to women having control over their fertility, including the infamous sexual double standard 'if my wife has contraception I won't be able to trust her not to go with other men' (the fact that the husband often goes with other women is not seen as relevant!)
  - an **effective supply chain** for the methods, especially the long-acting methods like injections and implants (avoiding medical barriers by primarily using social marketing through small shops and pharmacies, for pills and injections not just condoms)
  - all combined with **education** along with empowering media publicity that includes correct information about the methods of contraception and, very often,
  - the correction of much **mis**-information. In Kigali in October 2006 I was told of the persistent myth in the community that the Pill permanently harms future fertility. Moreover it is widely believed everywhere in Africa that contraceptives are 'dangerous' and it's better to be 'natural'. Yet the 'natural' risk in a woman's lifetime of dying from pregnancy, including unsafe abortion, is between 1:10 and 1:20 in sub-Saharan Africa whereas it is 1:30 000 in Sweden – where contraceptives are universally used.
- Costa Rica, Cuba, Iran, Korea, Mexico, Morocco, Sri Lanka, Taiwan, Thailand and *South* India (even) have reduced their total fertility rate (TFR or 'average family size') to close to 2 – as quickly as China, but without the coercion that exists in China. How? What do these vastly different developing countries have in common? Their governments recognised the population-poverty connection and took steps to remove the barriers to fertility planning.
- The women studied by Chabikuli and Lukanu ended by choosing to be sterilised when, on average, they had had 6.9 children. In any situation of perceived high child mortality, if sterilisation is about the only effective method available it will be used late and not accepted until the family size includes a wide 'safety margin'. Experience from the 'success story' countries above suggests that *if only* (a forlorn hope in war-torn Congo) they had been able to select earlier from the widest possible range of reversible methods – especially the long-acting ones, the IUCDs, injectables and implants – those women would have accepted effective contraception at a much smaller family size.

Though the coercive aspects of its birth control policy are rightly rejected, it is instructive how little China has used sterilisation in preventing 400 million births since 1980.

'In many of today's countries with persistently high fertility, contraceptive commodities are in short supply, the extent and range of barriers to their use are not yet well understood by governments, and misinformation is often stifling demand in the lowest resource settings ... it should not be surprising that demand for contraception changes when correct information arrives with the needed technologies – in keeping with normal consumer behaviour'.<sup>2</sup>

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2. Campbell M. Consumer behaviour and contraceptive decisions: resolving a decades-long puzzle. *J Fam Plann Reprod Health Care* 2006; 32(4): 241-244.
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