Family planning research

For fifteen years, WHO has been involved in research into new methods of family planning and ways of overcoming infertility of the couple. Dr José Barzelatto, Director of the Special Programme of Research, Development and Research Training in Human Reproduction (HRP), was interviewed for *World Health* by Mr Valery Abramov of WHO's information section.

**World Health:** What are the main thrusts today of your programme’s activities?

**J. Barzelatto:** Firstly, coordination. As you know, WHO has a constitutional mandate to coordinate activities worldwide in relation to health, and this includes research, so our programme is very much involved. Secondly, research and development; we have the mandate to support research to develop new and better methods for fertility regulation. Thirdly, there is institution strengthening. That is to say, to promote research in developing countries, so that they can become self-reliant in terms of research in human reproduction in order to solve their own problems. There is a fourth thrust — also an important one — which is to advise governments in respect of policy and practical matters in the field of human reproduction. In particular, we receive frequent enquiries about product regulation — what new products can, or should, be put into use in different countries.

**WH:** You have always preferred the term “family planning” to “birth control”. How do you understand the concept of family planning?

**JB:** I would say that the preference for the term family planning is a natural one, because the word “control” may imply a sense of coercion. And family planning, almost by definition, is a voluntary decision of a couple. To me, this is the ethos of what family planning is all about — the right of individuals, and of couples, to decide on how many children they want, and when. Now, in order to make such a decision one must be fully informed about all the possibilities; this means...
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education of the people. They must have access to methods – be they contraception or infertility treatment – that are readily affordable by everybody. And, finally, for the couple to be really free to decide, there must an awareness of society’s legitimate needs and obligations.

WH: So you think the final decision of a couple on whether to have children or not should also take into account the general demographic situation in any given country?

JB: Of course, but I would prefer to use the word “population” rather than “demographic.” Family planning is not just something you do in order to decrease the number of people in a country. That is why I want to get away from the “demography” which may suggest too many people.” Family planning is much more than that.

Yes, there are areas in the world which are over-populated, and societies there are concerned about further growth of the population – as is the case in China. In other regions you have under-population, and yet there too there will still be the need for family planning for its health benefits. So people must be aware not only of their own preferences, but also of their own responsibilities. They must be fully educated about how reproduction can be regulated, but must at the same time understand the responsibility they have as individuals and as members of their society.

WH: How does family planning tie in with primary health care at the professional level?

JB: I would say that family planning is a basic tool to improve the health status of people, particularly in developing countries. If you could limit pregnancies to between the ages of 20 and 35 – so that teenagers didn’t become pregnant and women aged over 35 didn’t have children; if pregnancies were so spaced that there were two or three years between each birth; and if the number of children could be limited to, let’s say, a maximum of five – if you put all these things together you would immediately produce, in the developing countries, a spectacular decrease in mortality, both of mother and child. Of course, in developed countries with very good health indices, you start from low figures of morbidity and mortality of mother and child, so the effect is less spectacular. But it is there. So, all this means that family planning must be a part of primary health care, and this was recognised from the very beginning. The Alma-Ata Declaration of 1978 includes family planning as one of the elements of primary health care.

WH: And yet research in fertility regulation is not getting full backing today. What, in your view, are the main constraints to your programme?

JB: Our research is under a number of constraints worldwide. First of all, there has never been a very large investment in this research. By the end of the 1970s, when – according to published data – support for reproductive research was at its peak, it did not represent more than about US$ 150 million per year. This means less than one per cent of the total investment in health research. But during the current decade, things have become worse. There is a decrease in the amount of funds going into research – a quite noticeable and steady decline. I would say that secondly there has been a re-awakening of various groups opposed to family planning. This began as a questioning of the ethical and moral implications of abortion, particularly in the United States. It extended, however, to the questioning of family planning in general and now this has led to hardening attitudes worldwide – including many developing countries – for a variety of reasons. Since some powerful countries that contribute most of these investments are sympathetic to these views, there is bound to be an influence on funding.

I would say that a third constraint on funding in this area is again a problem that originated in the USA, which is now being exported, at least, to Western Europe. This is the liability issue. The American society is by tradition a litigious society, and the number of companies, doctors and hospitals that are being sued in respect to contraceptives is considerable. The result is that pharmaceutical companies – large international pharmaceutical companies, that in the past had a major share in terms of research for new products – have shied away from research. In fact,
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there are now only three of these companies which have a comprehensive research programme in contraceptive development. Several large companies have closed down their research units on fertility regulation. Research being done in the private sector of pharmaceutical companies is now mainly oriented towards maintaining and improving their position with existing products, rather than looking into really new, innovative products.

WH: Nevertheless there have been advances. What, in your opinion, are the major achievements of the WHO programme during its 15 years of existence?

JB: Because the programme is very comprehensive, there are many ways of looking at achievements. Let us remember that these issues were not much discussed in public 15 years ago when the Programme was set up. The sum of the credit for this change goes to WHO. The fact that the programme has developed a network of collaborating centres around the world – mainly in the developing countries – which are capable of performing high-quality research, carrying out sophisticated laboratory work or collecting very good epidemiological data, is in itself an important achievement. Not only do we train people and provide them with new equipment, we have also involved them in the research to develop and introduce a new generation of contraceptives. But what really matters is that this is being done worldwide. Another important component in our programme is quality control, and standardization of laboratory procedures. Not only is this sophisticated research going on but the results from all the centres are comparable, because we have a standard quality control. So what is reported in Singapore is the same as what is reported in Lusaka.

WH: What about the inter-connection between economic conditions and family planning, especially in developing countries?

JB: I have no doubt about the inter-connection, although some people have challenged this. There are already five billion of us in the world today and this figure will be doubled in another century; 97 per cent of this growth will result in a considerable additional strain on the availability of food, clean water, energy, education services and job opportunities, while the population growth will accelerate deforestation and soil erosion. Those countries are increasingly facing major challenges as they try to balance the complex relationships between growing populations, the available resources, the environment and development.

WH: Given the varying ethnic, social and cultural backgrounds in different countries and continents, there are bound to be many different approaches to family planning at every level. Can you suggest some examples?

JB: You are absolutely right. As all personal decisions are influenced by our social and economic circumstances and other cultural values – the approaches will be different, particularly in such an intimate field as reproduction, the use of contraceptives, and treatment for fertility. In some religions the only acceptable contraceptive method is the so-called natural family planning. In some countries and regions injectable contraceptives are preferable to other methods.
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From the way I've been brought up, to me it seems much easier to take a tablet than to have an injection. Nevertheless, in South-East Asia, particularly in Indonesia and Thailand, injectables have been singularly popular.

In the past, the condom was a male contraceptive, in the sense that it was the man who bought it, but this is now changing. In Japan, most of the sales and purchases of contraceptives are made by women; and there is house-to-house distribution. I recently heard that in the USA women are buying condoms more freely than in the past. And so things change.

**WH:** As we have already briefly related family planning to maternal and child morbidity and mortality, can you give some specific examples?

**JB:** If you want an example of how important these issues are from the public health point of view, I might refer to a personal experience in my own country - Chile, where abortion was and still is illegal. When contraceptives were limited in terms of real, affordable, easy-to-obtain availability, there was a tremendous increase in morbidity and mortality due to complications of illegal abortions. This was really a dramatic scene; it was difficult to find a bed for a normal delivery because all the obstetrics and gynaecology beds were filled to capacity by complications of illegal abortions. It is a very horrible way of dying. In 1964, the government (there was a Catholic President at the time) - under pressure from the medical profession who insisted it was intolerable that abortion had become a health problem - decided to introduce contraceptive advice and methods into the national health services.

Four years later the mortality due to complications of illegal abortion dropped to half of what it had been, and it has continued to drop. The only change made at that time was the introduction of legislation that made contraceptive methods freely available. It is interesting to note that there has been no influence on the country's population growth. Hitherto, women who decided that they could not, or did not want, to have more children were forced to use illegal abortion methods. Now the introduction of contraceptives has led to a tremendous saving in lives, in suffering and in costs to the health service.