

## Strategic Leadership

**C**ontraceptive use in the developing world has increased from 10% of couples in 1965 to 60% in 2003, sometimes dubbed the family planning revolution. Contraceptive use has risen historically in much of the developing world. It is already at ceiling levels in some countries, and it continues to rise in many others. However, the pattern is uneven: a few of the largest countries such as India and Pakistan, have far to go, and much of sub-Saharan Africa still registers low level of use. Contraceptive use is intrinsically tied to how policy makers and programme managers address the issue of unmet need.

### Strategic Leadership to Reduce Unmet Need for Family Planning

The unmet need for family planning (FP) is defined as the proportion of fecund married women who wish to avoid further child bearing altogether or postpone their next child for at least 2 years but who are using no method of contraception. Globally the current unmet need is about 17% for married women and 13% for all women. Translated, it implies that there are 105 million married women and 8 million unmarried women with unmet need, more than half of them live in Asia. In addition, unmarried sexually active women have unmet need for contraception. Fulfilment of unmet need is estimated to reduce fertility by about 15% in Asia. However, as some critics have pointed out, unmet need may change over time for an individual as they change their desire for child bearing. Also, there is a gap between unmet need and intention to use contraception, as we shall discuss later.

Unmet need has served as one of the considerations for programme planning, as it was emphasized at the 1994 International Conference on Population and Development (ICPD). It reflects the puzzling gap between the desire to avoid pregnancy and the failure to use contraception leading to not-desired or mis-timed pregnancies. Some of these pregnancies result in abortion, often with attendant risk of unsafe abortion. If every woman in the developing world with an unmet need for a modern method began using one, an additional 52 million unintended pregnancies each year could be avoided<sup>1</sup>.

The total wanted fertility rate (TWFR) is the same as the total fertility rate except that any birth that exceeds the respondent's ideal family size is considered unwanted. On average, the difference between TFR and TWFR is one child; in some countries, it is a two-child difference.

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<sup>1</sup> Adam Sonfield, "Working to Eliminate the World's Unmet Need for Contraception", Guttmacher Policy Review, Winter 2006 Vol. 9 No. 1.

“ Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of all childhood deaths. ”

source: Cleland, John, et al. 2006.

#### Checklist



Have you consulted key stakeholders on an appropriate shared vision and how to create it?



FP/RH services for men

## Create a Shared Vision

Activists and early NGO programmes for FP (until about 1950) were guided by concerns for women’s health and right to determine their own fertility. However, many countries launched large national population programmes to arrest high population growth resulting from significant declines in death rate. These programmes tried to create a shared vision that slowing down population growth was necessary to accelerate economic development. In the countries where population control was a sensitive topic, birth spacing for improved maternal health was the argument.

By early 1990s, three forces gathered momentum. **One**, contraceptive prevalence had increased to nearly 50% and consequently, global population growth rate had begun to decline. **Two**, several economists argued that population growth and economic growth rate were not strongly correlated, thus weakening the case for population control. **Three**, a few programmes exercised some coercion but many programmes paid inadequate attention to women’s health, particularly reproductive health.

Therefore, the Programme of Action (POA) at the 1994 ICPD was a paradigm shift. It asked for the inclusion of reproductive rights in programmes. “These (reproductive) rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have information and the means to do so, and the right to attain the highest standards of sexual and reproductive health” (Para 7.3). Accordingly, it enjoined FP programmes to enable couples and individuals to exercise their reproductive rights.

The POA stated that “Government goals for FP should be defined in terms of unmet needs for information and services”. In 1999, at the five-year review of the conference, governments set a new benchmark: reducing unmet need by at least 50% by 2005, 75% by 2010 and entirely by 2015, without the use of recruitment targets or quotas.

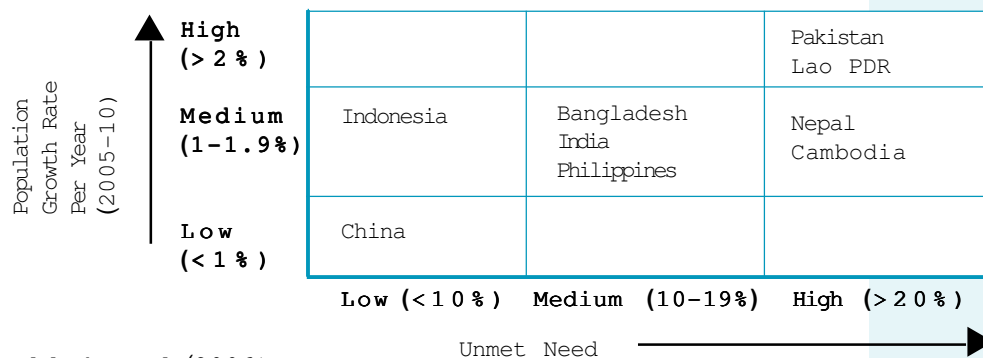
Creating a shared vision for reducing unmet need for FP poses several challenges. **First**, the issue for reproductive rights or reducing unmet need is not easy to translate into physical equivalent unlike ‘zero tolerance for maternal death’ or HIV infections. **Second**, while the population control vision has weakened, a new vision has not taken a strong hold.

The argument for birth spacing and smaller families to improve maternal health remains persuasive but is not considered as important to reduce maternal deaths as the availability of a skilled birth attendant or emergency obstetric care, when needed.

Thus, creating a shared vision for reducing unmet need for FP remains a challenge. The shared vision would depend upon the context and severity of the problem (see Table 1 for shared vision around different themes).

Figure 1 classifies the 10 SLD countries in terms of population growth rate and unmet need (Myanmar data was not available).

Figure 1. Population Growth Rate and Unmet Need



Source: Cleland, et. al (2006)

In countries or areas with high unmet need (such as in sub-Saharan Africa and a few countries in Asia), creating a shared vision around maternal health may be the best, particularly for health service providers. Women’s groups often try to create a shared vision around ‘rights’ framework. The households need to share a vision of responsibly planning their families and avoiding unplanned pregnancies. The means used to create shared vision (a mix of IEC, advocacy, consultation and co-creation) would have to be fashioned accordingly.



Women in the Muslim community

Shared Vision Around	Advantages	Disadvantages
A. Reproductive rights	<ul style="list-style-type: none"> <li>Emphasizes human/women’s rights. In consonance with ‘rights-based’ development approach</li> </ul>	<ul style="list-style-type: none"> <li>Is difficult to measure.</li> <li>Many governments are reluctant to embrace ‘rights-based approach’.</li> </ul>
B. Reduce unwanted pregnancies/ unmet needs for FP	<ul style="list-style-type: none"> <li>Is based on ‘welfare’ approach.</li> <li>Focuses on assisting couples/individuals to meet their goals.</li> <li>Should lead to reduced abortions and hence their possible complications.</li> </ul>	<ul style="list-style-type: none"> <li>Can only be measured by surveys.</li> <li>Couples/individuals may change their goals if their contexts change.</li> </ul>
C. Maternal health (Birth spacing)	<ul style="list-style-type: none"> <li>Relates directly to MDGs on maternal health.</li> <li>Is universally accepted.</li> <li>Focuses on often neglected aspect of maternal health.</li> </ul>	<ul style="list-style-type: none"> <li>Sense of urgency is less.</li> <li>Often it does not attract attention of decision-makers.</li> <li>Many women may wish to shorten their child-rearing span.</li> </ul>
D. Family values (Small family is happy prosperous family)	<ul style="list-style-type: none"> <li>Many faiths emphasize family values.</li> <li>Appeals to families with upwardly mobile aspirations</li> </ul>	<ul style="list-style-type: none"> <li>Difficult to marshal persuasive evidence that ‘small family is a happy family’.</li> <li>May not appeal to poor households where children add to labour pool of the family.</li> </ul>
E. Population control	<ul style="list-style-type: none"> <li>Appeals to decision makers, particularly with large population.</li> <li>Simple to visualize where the pressure on space and basic services is felt.</li> </ul>	<ul style="list-style-type: none"> <li>Has declined in saliency as population growth rate has been reducing.</li> <li>Evidence on population relationship between growth and socio-economic development is mixed.</li> </ul>



Young family

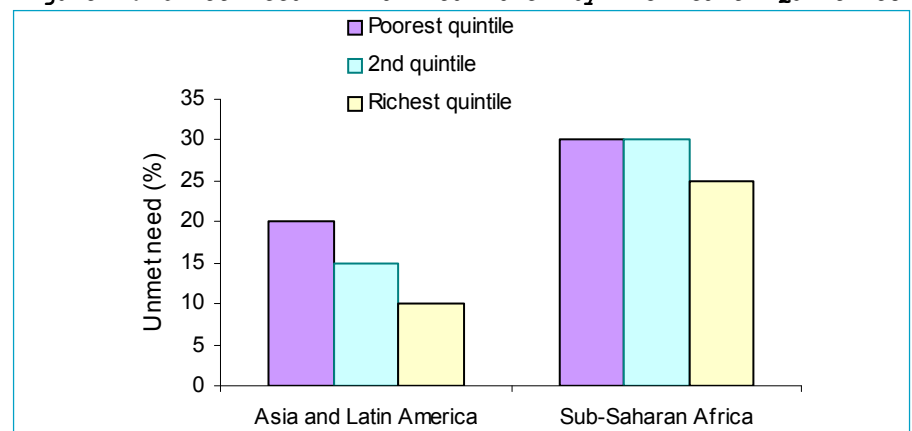
## Assess Vision-Reality Gap

The Demographic and Health Survey (DHS) help assess the vision-reality gap on unmet need for family planning.

**Over time** Successive DHS, if they are available, will identify the changes in unmet need over time. Globally, the population of married women with unmet need declined from 19% to 17% in the 1990s. In Bangladesh, for instance, unmet need was 16% in 1996-97, 15% in 1999-2000 and 11% in 2005.

**Over space and age group** Generally unmet need in rural areas is higher than urban areas. There are also differences in various divisions of the country as well as in terms of income and education levels (Figure 2). This information is useful to guide the programme efforts.

Figure 2. Unmet Need in Married Women by DHS Wealth Quintiles



Source: Cleland, et. al (2006)

Despite the declines, unmet need for FP remains at significant levels for most of the countries where DHS has been carried out and thus continues to be important for population and reproductive health policy. For example, youth in need: The 15-19 age group accounts for 33% of all unmet need among married women while the 20-24 age group contains twice the number in need.

It should be noted that unmet need does not mean intention to use contraceptive. Some of those with unmet need do not intend to use a method, but others without apparent need do plan to use. Ross et.al., comment, "It must be remembered that many women who say they intend to use will in fact not to do so, at least not in the near future. A wide range of deterrents exist such as personal ambivalence, family opposition, and weak programmes that provide neither information nor physical access to a choice of methods. Nevertheless the intention to use suggests the presence of a market for contraception that supplements unmet need information. In summary, close attention should be paid by managers and planners to levels and trends for both intention to use and unmet need. They are the best gauges of public interest in contraceptive use, whether supplied by the public or private sector.

**From higher level objectives** The poor suffer the most. The proportion of demand (use/(use + need)) satisfied for the poorest quintile was 50% (1996-2000) compared to 70.7% for the richest quintile. It is important to meet FP needs of poor couples as large families often

### Checklist

- Is the unmet need declining over time at desired pace?
- If yes, then will it continue to decline at the desired pace for medium term? (If yes, then there is no need for action.)
- If the answer to questions above is no, then, have you assessed vision-reality gap by space, age-group, income levels and other socio-economic determinants of unmet need?

perpetuate inter-generational poverty. Large families are often unable to adequately invest in human resources (education, health) for their children who, in turn, are unable to fully participate in economic activities.

## Finding Path/Strategy

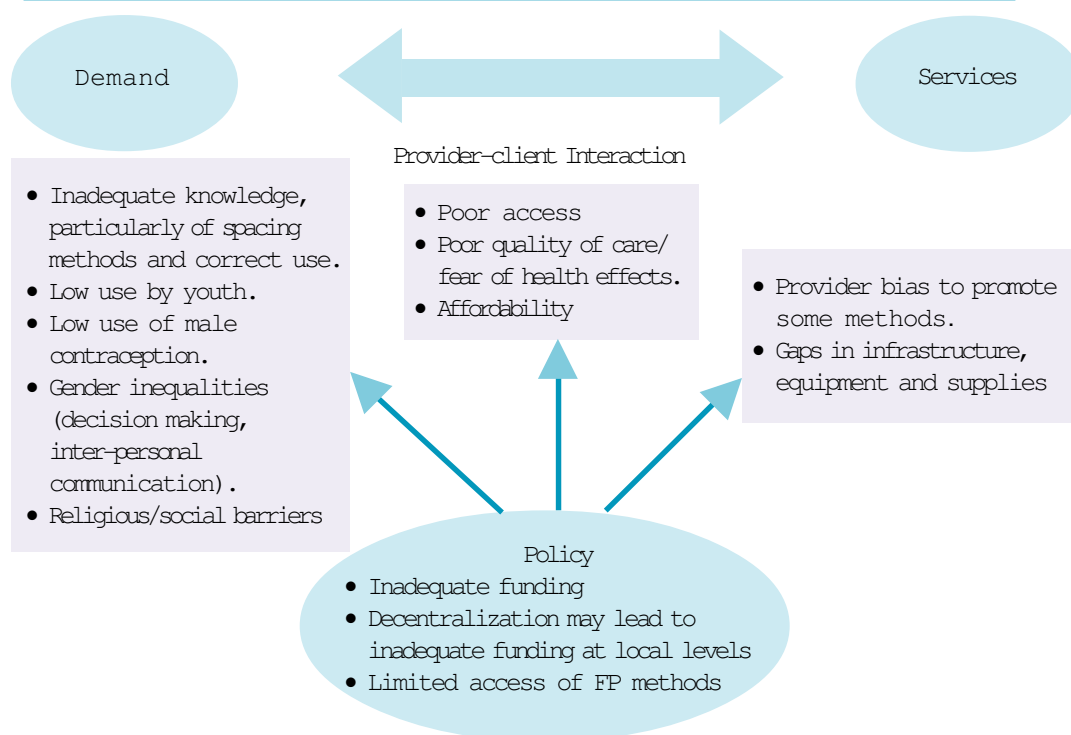
Translating information on vision-reality gap to finding a path and to determine strategy is the most critical challenge of strategic leadership.

Finding the path to reduce vision-reality gap depends upon the reasons for the gap. An analysis of the reasons for non-use among women classified with an unmet need for FP indicates that perceived lack of exposure to the risk of pregnancy is the principal explanation, followed by method-related problems and opposition to the practice of contraception.



Reaching out to poor women

**Figure 3. Framework for Addressing Unmet Need in Family Planning**



However, there is considerable variation in the reasons for non-use. Therefore, programmes to reduce the unmet need will differ. We can use the “why-why” technique or “reality-tree analysis” to find the root cause of unmet need. Figure 3 provides a framework for addressing unmet need in FP.

Broadly, the path could be one or more of the following :

- Creating a shared vision of family planning
- Improving quality of care.
- Reaching poor and underserved.
- Increasing social/religious acceptability.
- Reaching men.
- Reducing early marriage and teenage pregnancies.
- Strengthening the overall programme.



Getting the men involved

Success of FP programmes depends on political commitment. Therefore, the first step is to attempt to create a broad coalition of support among key sectors of society, including religious, secular, and traditional leaders and professional groups to create a shared vision on FP.

### *Improving Quality of Care*

IPPF uses a framework for quality of care centred on client's rights and provider's needs:



- **Client's rights** for information, access to all services, informed choice, safe services, privacy and confidentiality, dignity, comfort and expression of opinion, continuity of care
- **Provider's needs** for facilitative supervision and management; information, training and development; supplies, equipment and infrastructure

Broadly, four approaches are used to improve quality of care to address method-related problems and fear of side effects:



Getting FP information to young women

1. **Quality assurance:** establish quality standards; monitor performance against standards; take corrective action; repeat the cycle.
2. **Continuing improvement of quality:** Provider team assesses quality of care; identifies actions to improve quality; implements these actions; repeats the cycle.
3. **Situation analysis:** Analyze quality of care through client interviews and observations of service delivery functioning; identify management systems (such as training, logistics) to improve; improve the systems; repeat the cycle.
4. **Total quality management** will include all of the above to create an organizational culture for quality of care.

### *Reaching poor and underserved*

The poor face several barriers - informational, physical, social and financial - in practising family planning. Therefore, besides improving quality of care, access to information, services and contraceptives for poor and underserved are needed to reduce unmet need. The possible actions for this purpose require community-based or appropriate outreach services. Three strategies for mobilisation have been used for community participation: (1) women's groups, (2) men's groups, and (3) community leaders to promote FP and community-based distribution. For community-based distribution, trained community-health workers or volunteers do home visits to provide information and services. They provide non-clinical contraceptive, either free or at subsidized prices, and make referral for clinical methods. If social barriers are strong, they may accompany the clients to the clinic. More recently, other reproductive health services have been added to their tasks in some programmes.

### *Increasing social/religious acceptability.*

Successful programmes have worked with religious leaders to increase acceptability of contraception. BKKBN in Indonesia engaged the religious

leaders in dialogues and then modified its service delivery based upon their feedback. For instance, because clients objected to IUD insertion by male providers, the programme ensured that IUD insertion would be allowed if it was performed by female providers or if another woman or client's husband was in the room.

### ***Involving Men***

Unequal gender relations and opposition from husband are significant causes of unmet need. Most of the burden of contraception is borne by women. The strategies are to utilize men as community workers and counselors; form men's groups; and provide informed choice for men's contraceptive methods such as non-scalpel vasectomy. IEC and services could also be organized where men predominate such as work places, market places and social marketing. Some organizations have also successfully utilized male-only clinics.

### ***Reducing early marriage and teen pregnancies***

Teenage pregnancies carry higher maternal health risks and may account for a significant proportion of abortion complication. However, their nature differs. Most of the teenage pregnancies in South Asia are due to early marriage whereas in parts of Asia they are out of marriage. Therefore, the strategies to address early marriage and teen pregnancies would differ depending on the context.

### ***Comprehensive programmes***

When the unmet need is high and is pervasive across geographic areas and age-groups, comprehensive programmes that address key demand, supply and provider-client interaction may be needed. These would include expansion of service delivery to provide a wider choice of methods through a broad range of service delivery channels; involving community; addressing social including gender and religious barriers; strengthening health system; and reaching youth. For this purpose, political commitment, enabling policy, adequate financial resources, needed human resources and functioning systems of logistics and management information would be needed. Partnership with private sector and NGOs would also be necessary.

## **Inspiring/Empowering Stakeholders**

The key stakeholders and the strategies to inspire/empower them to reduce unmet need for FP depend upon the shared vision selected and path/strategy chosen. However, generally these would include clients and their families, public and private service providers, programme managers at various levels, and community (including religious leaders).

The strategies to inspire/empower them depend upon: (a) how much their interest is affected; (b) how influential they are; and (c) how supportive they are. The basic actions to inspire/empower the stakeholders include: involving them in the process; influencing them by connecting with them at an emotional level (advocacy); and providing support for them to perform their role effectively. In this, the strategic leader needs to be mindful of political landscape.

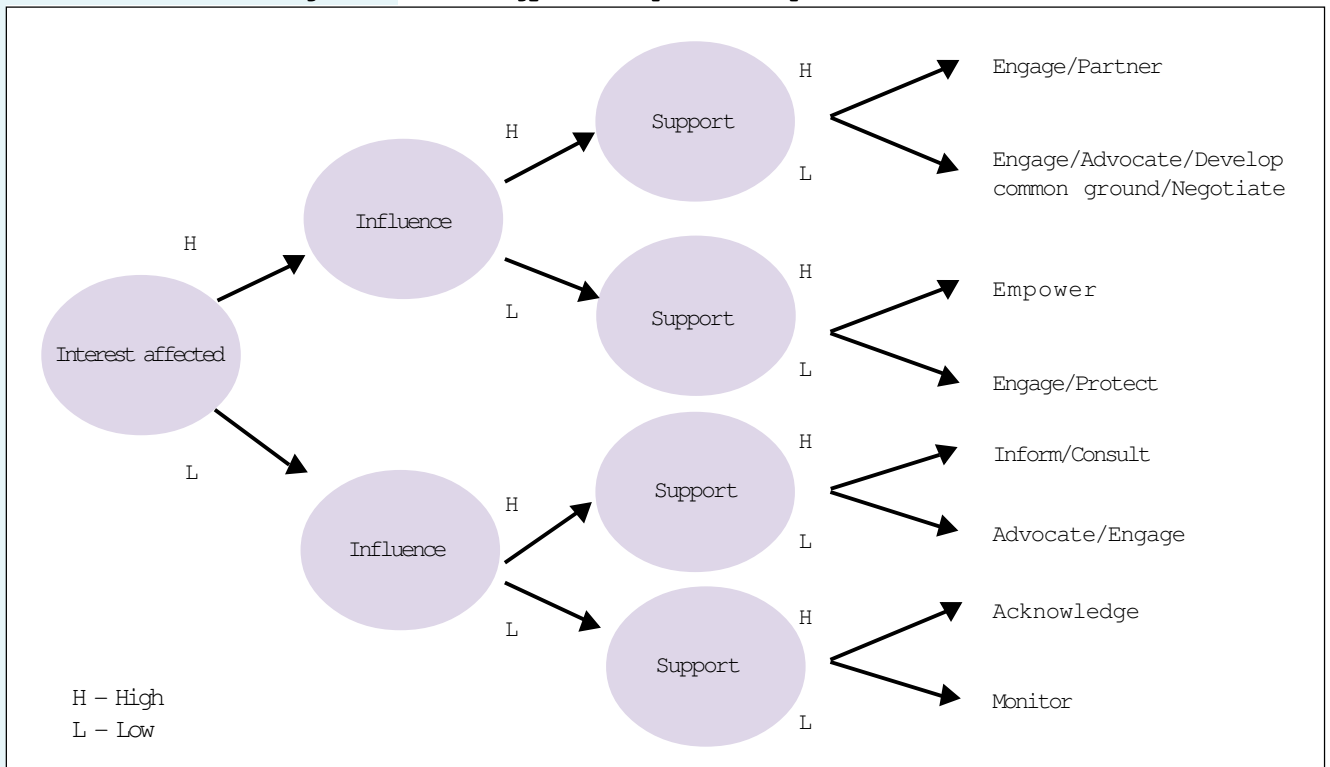
#### **Checklist**

- Have you selected the subgroup you wish to address?
- Have you developed a path based on reasons for unmet need for the selected subgroups?
- Does the process of path finding inspire/empower key stakeholders?

#### **Inspiring/Empowering Key Stakeholders by:**

- **Involvement**
- **Influence**
- **Support**

Figure 4. Strategy to Inspire & Empower Stakeholders



Source : S P, Sofia and Emily Pelton (2001). "Advocacy Tools and Guidelines: Promoting Policy Change", Atlanta: CARE

#### Checklist

- Are the key stakeholders inspired/empowered?
- If not, then do you know why? Refashion the process of inspiring/empowering key stakeholders?

Figure 4 shows a strategy for inspiring/empowering stakeholders. For instance, a woman wishing to practise contraception may have low influence because of gender inequalities. She is, therefore, in the category of high interest affected, and has low influence but high support. The strategy would be to empower her through enhancing her capacity to claim her right (through women's groups, for instance), increase male participation, and improve access and quality of services.

Some of the possible actions (though not comprehensive) to inspire/empower stakeholders are:

- **Clients** - increase their capacity to claim their rights, increase male participation; improve access to information and wide range of methods; increase youth awareness; and create an enabling environment for services.
- **Families** - increase information; enhance spousal communication; advocate with elders in the family.
- **Government service providers** - information training and development; provide supplies, equipment and infrastructure, and facilitative supervision and management; and evaluation.
- **Private service providers** - import laws for contraceptives, budgetary support, logistics support, social marketing, community-based distribution.
- **Programme managers** - advocacy for more resources, supportive policies, involvement of civil bureaucracy, coordination with multiple ministries.
- **Community** - promote participation of women's groups; involve community leaders; advocate at community meetings, community advisory committees; and advocacy with religious leaders.

## Action Plan of the Philippines SLD Team

### Applying Strategic Leadership Framework to Reduce Unmet Need for Family Planning

Framework	Actions
1. Create shared vision to reduce unmet need.	Hold orientation meetings with the mayor, rural health unit staff, barangay health workers and religious leaders.
2. Assess vision-reality gap on unmet need and its causes.	Focus group discussion followed by some interviews with the rural health unit staff, barangay health workers, husbands, wives, and young persons.
3. Find the path.	<ul style="list-style-type: none"> <li>• Team reviews its options and their cost-effectiveness and charts a path for short-, medium- and long-term actions; and</li> <li>• Sets goals as well as strategies.</li> </ul>
4. Inspire/empower stakeholders (Depends on the path chosen).	Work with religious leaders.
5. Implement the strategy.	Prepare action plan, organize/implement and monitor.
6. Complete the circle.	Once, the path is proven: <b>(a)</b> share it with others; and <b>(b)</b> repeat the cycle until the problem is solved.
7. Use strategic leadership competencies.	Address other reproductive health issues.

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