

How a 'Reproductive Health' programme can compromise health

In a letter¹ published in the October 2015 issue of this journal, Amir Erfani discusses the new pro-natalist fertility policy in Iran. Erfani believes that the previous family planning programme, which was implemented in Iran for more than two decades, did not offer significant health benefits to the community, and therefore its discontinuation will not impact adversely on community health. Additionally, Erfani supports Iran's Ministry of Health's recently implemented 'Reproductive Health' programme, which is aligned with the pro-natalist policy, and believes that this programme will benefit Iranian reproductive health generally. However, in expressing his views, it appears that Erfani has ignored key evidence to the contrary.

First, the discontinued birth control programme increased contraceptive usage among the Iranian population from 49.0% in 1989 to 73.8% in 2006,² which simply means a lower incidence of sexually transmitted infections and fewer unintended pregnancies. Moreover, the birth control programme included free distribution of all methods of birth control and provided relevant education to the general population. The latter presumably had a positive effect on public awareness and behaviour.

Second, the new reproductive health programme has many deficiencies in respect of preserving Iranian reproductive health. The main objective of this programme is increasing the fertility rate from 1.6 to 2.1. In order to achieve this goal, all the educational materials (e.g. booklets and pamphlets) and information about birth control methods have been removed from health clinics, schools, media outlets, and so on. Even if a woman attends a health clinic seeking reproductive services she will not hear about birth control methods, unless she has a life-threatening medical condition or if she insists that she has no intention of having a further pregnancy. In these circumstances she will be offered educational material and supplied with a birth control method; however, in line with the new guidelines, she will be followed up for further consultation about having more children. Moreover, the programme poses an active interventional approach to persuade all women of

reproductive age with fewer than three children to have more children. This is possible by means of health sector databases. To the best of my knowledge, in some rural areas of Iran health care providers telephone pertinent women to discuss the issue with them, and the programme is evaluated based on the number of women who are contacted in this manner or consulted in person in governmental health clinics. This approach to reproductive health does not seem to preserve reproductive health in a country with a population of 80 million.

Moreover, in the new programme, free distribution of condoms and other birth control methods to the general population no longer occurs. Despite this policy change, Erfani believes that accessibility to birth control methods has not altered, because all the methods are still available in drugstores. Indeed, presence of a method does not necessarily mean that individuals have access to it, especially in a country that has economic problems and in which a large proportion of the population live in poverty. In addition, the accessibility of information has been extremely restricted, which inevitably adversely affects individuals' access to birth control methods. Obviously, these issues will have more negative consequences in remote and rural areas. Surprisingly, in his letter¹ Erfani suggests withdrawal as a free substitute for the birth control programme. However, withdrawal has a 19% failure rate with typical use³ and is not a reliable method, especially when abortion is illegal in Iran. In fact, it is highly likely that the majority of unintended pregnancies will end up in illegal abortion.⁴ All of these consequences present a grave hazard to reproductive health.

Fourth, Erfani stated that only 22% of married fertile women received governmental family planning services in 2014; however a national report by Iran's Ministry of Health states that in 2010–2011 80.9% of women of reproductive age used a family planning method. According to the same report, sterilisation methods were the second most common choice of contraception in Iran, with a prevalence of 14.0%.⁵ However, in the new programme these methods have essentially been rendered unavailable by the placing of restrictive criteria and bureaucratic processes on the approval process for such procedures.

Moreover, the new programme raises crucial ethical concerns as people are

deprived of essential birth control information, and thus are unable to choose a method of birth control autonomously. Additionally, the welfare of low socioeconomic and remote populations has not been considered.⁴ In fact, no guideline should limit the provision of relevant information and services.

Finally, the fifth reference in Erfani's letter¹ does not contain information about the aforementioned reproductive health programme.

In conclusion, it seems that the discontinued family planning programme had a positive impact on Iranian health, whereas the new programme will most likely compromise reproductive health and, equally concerning, also undermines basic ethical considerations.

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