Family Planning in Fragile States: Overcoming Cultural and Financial Barriers

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Edited Transcript—Grace Kodindo

Good afternoon. My name is Grace Kodindo. I am from Chad. For 30 years, from 1977 to 2007, I worked in Chad, first as a general practitioner, then as an OB/GYN, and then as an advocate. I advocate principally for maternal mortality and morbidity. I have made a film with the BBC, Dead Mums Don't Cry, about this issue in Chad. But for the last three years now, I have been working with other humanitarian relief organization to improve rural family services for displaced people, especially refugees in Africa, Latin America, and some part of Asia.

I'm going to talk about Chad. As you can see, Chad is a landlocked country, sharing its border with six more African countries. It's a very large country and this already constitutes a real barrier to access to family planning services and other maternal health services. The second slide shows how Chad is a real example of a fragile state. Chad became independent in 1960, and from 1960 until today, we have known conflict, civil war, instability. Even last week, last weekend, they had a very hot fight between government and rebel armies in the border of Darfur and Chad. Like in many countries where conflicts are almost perpetual, maternal services are not the priority. The priority in this country is first, of course, war; maternal services are not really considered as a priority in Chad.

Since 2003, we have not only had our own conflict, but also the one in Dafur. In Chad there are 280,000 refugees from Dafur. We have 170,000 displaced people in Chad, and we have 55,000 refugees from Central Africa Republic, so that places a large burden on the state's already weak capacity to address the needs for family planning.

In Chad, unlike Nigeria, we don't have a very big population. We have only 10,325,000 people Forty-seven percent of them, however, are 15 years old or less. You can imagine the additional needs for family planning and other maternal services that will be added to the huge existing unmet need when this children come of reproductive age.

Almost 75 percent of the population in Chad live in rural area, and this is another problem, because these areas lack access to quality services. These are where most women are dying. This is where women have difficulty accessing maternal health services, including family planning, because of the lack of trained staff.

Life expectancy in Chad for a man is 46. For a woman, it's 47. The under five mortality rate is 209 for every 1,000. You will have, of course, high desired fertility, because children are dying—so many that they want to have as many as possible to replace those who are dying. So the fertility rate in Chad is 6.3 percent. The maternal mortality rate is 1,099 per 100,000 thousand live births. Contraceptive prevalence, of any method, is 2.8 percent.

There are links between infant mortality, fertility, maternal mortality, and prevalence of family planning services. When children are not well spaced, the infant mortality rates tends to increase. Each one of these different components impacts each other.

This is why I think more in term of comprehensive reproductive services than one group working on family planning, another on maternal mortality, and another on children's health. They should be together, because they all impact each other, especially in rural areas.

I also want to talk about the cultural barriers in Chad. Chad, like many other countries, has a pro-naturalist culture. This is why in the beginning the government was so afraid of using the "family planning" term—for them, it's too linked to family limitation, so they prefer to use "family well-being" instead of "family planning." Contraception was promoted in the beginning only for spacing, for birth spacing. That was because they were afraid to go against the cultural belief, and also because birth spacing actually is also cultural in Africa. In our traditions, the right space was about three to four years, even five years. This is why in older times, when a woman delivered, she was sent back to her family to stay there for three or four years before coming back to her husband. That was a way of family planning. I used to tell some of my African colleagues that with contraception, at least, you can keep your wife with you instead of sending her to her family for three to four years. So you should be happy and grateful. I'm teasing about that.

The status of women is another important cultural factor. Women used to be valued by the number of children they produced where the more they had, especially if they had boys, the greater they were valued in the family. Today that's no longer the case. It was in the past,

but today, they have seen that educated woman fair better and can play a role in society, so value in producing more offspring is no longer as important.

I also want to talk about, as my colleagues have said before, cultural factors. There is a high level of illiteracy in Chad—almost 80 percent of woman are illiterate—but there should not be too much emphasis put on this figure, when there is access to services, and when good explanations and information are available, this is not really a problem. The problem is mostly lack of information—good, accurate information—and also, of course, the difficulty of accessing services.

Another cultural factor concerns health providers, which themselves can be real barriers to family planning. One month ago, I was in a refugee camp in Bahai, on the border between Chad and Dafur. We had a problem with a woman, a married woman, whose husband sent her to seek family planning services, but who was denied by her provided. Her provider was asking her, "Are you married? Where is your husband? Did your husband give you authorization?" So sometimes, even the health provider can also be a real barrier. This is why they need to be trained and they need to know about new laws.

Chad is a French-speaking country. French-speaking African countries are very different from English ones. We, after colonization, inherited the old French law, dating from 1920, that prohibits the sale or promotion of family planning. The French themselves got rid of this law, but we Africans, we kept it. We stuck with it until the beginning of the 21st century. Can you believe that?

We are starting to pass new laws modifying this old one, but efforts haven't been made until recently, which is why family planning programs in French-speaking African countries have started later. In Chad, we only started talking about family planning methods in the late 1980s. That has really produced a delay between us and the Anglophone countries. So this law has been a barrier for many years. The law has changed since 2002, but we need to do more as many people, such as the health provided I mentioned earlier, are still unaware.

Our problem in Chad is still, however, mostly the availability of services. If not for the UNFPA, there would be no contraceptives in Chad's public sector. The UNFPA is the only donor and UNFPA contraceptives, in some places, are given for free, so anyone can have access to them. But in rural or remote areas, contraceptive access is still lacking because, as my colleagues have said before, not only is there a lack of information and services, but there

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is also a lack of trained staff because few individuals are posted there and transportation is so difficult.

Thank God we have the IPPF Chad Association. I am one of the founding members and this association is, along with the UNFPA, is the only provider of good quality contraceptives. Products from private pharmacies are just too expensive—there is no way for common people to purchase these supplies from private pharmacies.

What has worked in Chad? I think advocacy. Advocacy is very important. First toward the county government, pushing to change policies and to enact laws that would facilitate the provision of contraceptives. This is very important, but so is advocacy toward donor governments. If countries like the United States can show that women's lives and health is important, they can influence the government of the country where women's status is not so high. When they know about it, when they consider that a woman's life is very important, then they make sure that this is a priority when dealing with government's like that of the United States. Countries will be forced to put women's status on their agenda, which in many places is not always standard.

There is also the issue of services. When accurate information and quality services are available, people use them. One month ago, I was in that refugee camp training the midwife from Darfur, and we were talking about contraceptive use. These women are from the Muslim Zaghawa tribe.

I had always been told that the Zaghawa don't like contraception, especially long-term contraception. But when I sat down with them, and when I started to talk with them, I found out that no convincing was necessary. They were convincing me about the benefits of family planning. Some of them were telling me that they feel like they are hens with a line of chicks walking behind them. That was their expression. They are overburdened in the way they are dealing with everyday life. They are refugees. They have a lot of children to look after, and they want, they need contraception. They told me that it's only ignorance, it's only lack of information, that holds people back. If someone can sit down with them and explain to them exactly how these drugs work, what are the side effects, there is really no problem. So the first priority is to make the services available, and from there you will see that a lot of the misperceptions that these people don't want the services is not necessarily the case.

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In Chad, we have seen that in two districts where, in 2007, they began using a mobile clinic to bring services to where people live, the conception of family planning has markedly increased. People were not using contraception and family planning services because they didn't have access. It was as simple as that. In places where access is a problem, mobile clinics could be very, very helpful.

Our problem in Chad is that we depend only on one donor—the UNFPA. From 2003-2005, years during which the UNFPA was undergoing difficulties, we did not have contraceptives in my hospitals—this was for two years. So we see that we need to have more donors, more funding, and that individuals who have been neglected—those in rural areas, adolescents, refugees, and the displaced—need to be included.

People used to think that refugees and displaced persons only needed food, shelter, and sanitation—this is not true. If you go to them, if you see them, they have the same needs of all other human beings and they have the same right to services as anyone else. They have the same problems, the same needs. So we should be approaching problems in ways that respond to their needs. Rather than making assumptions, we should go into the field, do the research, and provide services that really respond to the needs of people.

I had a chance to work with stabile populations while I was working in Chad. Now, I'm working more with those who have been displaced. Their needs exist, they want us to help them, and that is their right. We really need to respond to their needs just as we do for everyone else. And for this we need, of course, more funding. We need donors. We need government and focus group programs that really can reach these people with good quality services. These services, however, must not be imposed on them—you have to implement them in a very respectful way. You have to respect their rights. Services must be made accessible, but from there they can decide which type of contraception meets their needs.

People are also overemphasizing the factor of culture, the idea that one culture or another prevents people from using family services. In Chad, just before I left, even Muslim husbands were coming to me asking for contraception. That was not happening 10 years ago, but culture changes. Cultural factors change. This is very important for us to know that. They change.

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The fact that men are against contraception—this can also be a misconception. Men may feel threatened. I'm sure that even men here in the United States maybe feel threatened by the contraception. I am sure. But changes in life circumstances also produce changes in attitudes, and we should not forget that.

The benefits of family planning are now known by everybody. With good information affordable services we'll really be able to much better help to meet their needs. Thank you very much for your attention.

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