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Contraception, synergies and options

Rashid Jooma,* Adnan A. Khan
Ministry of Health, Pakistan.
*Corresponding author

Many countries that prospered in the later half of the 20th century did so only once their populations stabilized.[1] This is logical since limited resources can only be stretched so far and because strategizing for development and growth is difficult, particularly if the growth targets keep moving further away. Pakistan is the 6th most populous country in the world and is growing at 1.9% annually.[2] Although this rate is lower than it historically has been, it still means that the country is nearly 6 times as populous as it was in 1947. With Pakistan showing slow or negative growth on numerous human development indicators, and with crucial and worsening crises of water, power and food, it is imperative that population stabilization becomes an urgent priority of the government.

According to the Pakistan Demographic Health Survey 2007, only about 22% of married women aged 14-49 use a modern contraception method and another 25% feel that they will do so, provided these are available (the unmet need).[3] In Pakistan, both the government as well as the private sector promote contraception, and within the government sector, both the Ministry of Health and the Ministry of Population Welfare provide contraceptives. The former does so at no cost to the public whereas the latter uses social mobilization methods, thereby shifting some costs to the public. There is considerable debate which approach is better, or whether both ministries should agree on a single approach.

Within this context, there are two larger questions. One is that of synergy between the efforts of the two ministries that are seeking to achieve nearly the same goal while the other is that regardless of the method for supply of contraceptives, only 1 in 5 married couples are using contraceptives, indicating a huge unmet need of about 25%.

The question of synergy between the two ministries plays out at both policy and implementation levels. At the implementation level, the Ministry of Health operates via Basic Health Units (BHUs) and Rural Health Centres where in-house personnel (physicians, nurses, LHVs) and the Lady Health Workers (LHWs) that visit families in the communities, promote contraceptives. The Ministry of Population Welfare operates Reproductive Health Centres but mostly has mobile vans that visit communities twice or thrice a week. There are individual examples where the Ministry of Health and the staff of the Ministry of Population Welfare coordinate and work out of BHUs. In most other instances, the two teams operate in parallel. At the policy and planning level, the two ministries seized the opportunity arising from the circumstance of an ex-Secretary and an ex-Director General of Health becoming ministers of health and population welfare respectively, to set up a task force led by their respective Directors Generals to facilitate coordination between them. The technical teams, which have met thrice so far, commissioned a study to explore the potential and modalities for collaboration. The study described current linkages in a number of theme areas; it suggested strengthening of existing arrangements, improved training and supply chain management and increased institutional collaboration. In addition, formal curricula have been developed for training of nurses, paramedics and LHWs. The task force has recently constituted separate work groups to oversee and guide analysis in reproductive health outreach services, static services and commodities supply security to allow a coherent approach for synergies to be formulated and pursued.

The use of contraception by couples may be explained in the perspective of the Diffusion of Innovations theory that has been widely used to explain how ideas and new products are taken up by societies.[4] According to this theory, ideas (or new products) are started by 'innovators' and then are taken up quickly by 'early adopters,' who are both highly receptive and good proponents of the new idea. The ideas or products are then slowly picked up by the 'early majority,' who need to be convinced of this change. More slowly, the idea is accepted by the 'late majority,' and there are always "laggards" that are difficult to convince. The theory was initially used in public sphere to explain adoption of new technologies by farmers but has since been extensively applied to explain marketing of new products. In all likelihood, the 22% of the married couples that use contraception and the 25% that would do so if it were

available, are the early adopters and it is telling that the combined efforts of the government and the civil society are insufficient to meet their demand.

This leads to the other crucial question of how public and private sector efforts fit into the overall needs scenario. Since all providers combine to meet only 22% of the need for contraception, with the unmet need being 25%, it is likely that only about half of those who are ready to use contraception (i.e., the early adopters) are being reached. For these people, the question is not so much of being convinced to use contraception but of contraception availability. Once contraception is available, they will use it. A supply chain that is inadequate to reach these suggests serious management issues. More difficult to penetrate will be the early majority—people who can be convinced to use contraception but require some efforts. The early majority may be convinced by emulating the early adopters among their contacts, but this will largely require behaviour change counselling via active outreach, contraception promotion and perhaps to some extent via creation of an enabling environment by virtue of advocacy and use of mass media. To date, efforts at reaching the late adopters have largely been inconsistent, disjointed and ineffective.

All of these suggest a crucial role for the inter-ministerial task force in overseeing the national effort to improve contraception uptake. The ministries recognize that they are not (or can be) the sole providers of contraception to all. Their role is more of coordination and to fill in gaps that are left out by the civil society. In this context, the role of the task force may be to coordinate approaches for both early adopters and the early majority. For the early adopters, the critical issue is ensuring ready supply. The task force aims to do so by anticipating supply and demand, by addressing supply chain management issues in the public sector and by encouraging some supply from the civil society. The question of payments versus supplying for free is somewhat unimportant, given that the early adopters are the most likely to pay for contraception from amongst all groups. Once inroads have been made into the early majority, the question of paying for contraception will become crucial since there is some evidence that increasing cost detracts some people from availing these methods.

Once the supply of contraceptives is ensured, the next most important question for the ministries and the civil society is how to convince the early and late majorities. Surely some research should help to identify who these people are and what messages will work for them. However, there is considerable global and regional experience that can be brought to bear in our context. These include aspects of mass communication, facility-based approaches, focusing on men as key decision-makers for contraception, piloting family size reduction as a poverty alleviation measure, and perhaps most importantly, promoting outreach with individual families for interpersonal counselling. The main challenge for the task force, therefore, is to formulate a cohesive and executable plan that is grounded both in our national context as well as national and international evidence.

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