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PERSONAL OPINION

Slaughtering sacred cows: Six institutional obstacles to advances in family planning

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ABSTRACT In order to capitalise on new opportunities to advance contraceptive and reproductive health choices globally, organisations working in these fields will need to overcome six institutional obstacles. These are: (i) committee management; (ii) over-medicalisation; (iii) fear of risk and controversy; (iv) conferences, meetings, and symposia; (v) obsession with coordination; and (vi) fear of sex. The reproductive health community will require energy, innovative approaches, and a sharp focus on service delivery to address these hurdles that will otherwise slow down and misdirect programmatic momentum.

KEYWORDS Abortion; Birth control; Condoms; Contraception; Family planning; Implants; IUDs; Reproductive health

INTRODUCTION

In spite of the acceptance and use of contraception globally, world population has more than doubled from 3 billion in 1960 to 7 billion presently[1]. Most of these people live in Asia (4 billion) and Africa (1 billion) and projections suggest that world population will hit 9 billion by 2042 unless current fertility rates drop.

In the last several years, there has been a renewed enthusiasm for family planning (FP) and reproductive health programmes, highlighted most recently in the July 2012 London *Family Planning Summit*. Achieving the ambitious objectives set at the summit will require energy, innovative approaches, and a steady focus on service delivery. However, professionals tackling these issues will be confronted with six organisational obstacles which, if left unchecked, will slow down and misdirect the momentum required to implement and strengthen effective programmes. These are:

- Committee management
- Over-medicalisation
- Fear of risk and controversy
- Conferences, meetings, symposia
- Obsession with coordination
- Fear of sex.

COMMITTEE MANAGEMENT

A legacy of voluntary organisations (and many donor agencies) is the tradition of management by committee.

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Leadership is often linked to such groups, which slows decision-making and dulls management focus.

The need for committees is typically rationalised on the grounds that the involvement of multiple decision-makers prevents potential opposition and helps to legitimise whatever is decided. While such a strategy can placate opposition, this often results in inertia rather than in democratic consensus. And, the dividend of legitimisation is more than offset by losses due to inefficiency, waste, and the sapping of morale.

If sexual and reproductive health (SRH) care programmes are to be effective, they need responsive and dynamic management. Managers must have the authority to make decisions quickly, responding to the ever-changing conditions of the marketplace. Constant referral to committees (or, in some cases, headquarters) wastes time, absorbs energy and stunts creative leadership. The United Nations provides some telling examples. A recent plan for 'comprehensive condom programming' by the United Nations Population Fund (UNFPA) called for a local committed structure with participation by local ministries of health, finance, gender, tourism, and education, plus the donor community, 'civil society', and more[2]. Such a group, should it ever come into existence, would likely be frozen into immobility.

CONTINUED OVER – MEDICALISATION

To its credit, the FP community has made significant progress in de-medicalising SRH services and access to contraceptives. In many countries, midwives and nurses are now routinely trained in the insertion of intrauterine devices (IUDs) and implants[3]. Similarly, in the developing world, oral contraceptives and emergency contraceptive pills can often be obtained from a pharmacist without an official prescription[4]. In Ethiopia, a large cadre of community health workers has been trained to provide contraceptive injections and implants[5]. In many countries, women never see a doctor in order to obtain their contraceptives.

These gains should be zealously defended as we push for even greater de-medicalisation. Task-shifting services away from doctors to other healthcare providers results in greater access, choice, and affordability for women, at very little risk.

The dominance of the medical ethos in the past meant that clients seeking contraception were – and all too often they still are – treated as if they were needy and motivated to the same extent as people who are ill. They were/are expected to visit distant clinics at inconvenient hours on vague promises of future intangible benefits, to wait in intimidating and crowded surroundings, to tolerate treatment by patronising staff, and to undergo embarrassing interrogations with the tolerance of sick patients. But since the majority of women seeking contraception are in good health, the medical concepts of SRH care delivery are largely irrelevant.

Effective fertility control requires creating and meeting a mass demand for contraceptives. This is not medicine; it is marketing. The latter, unlike medical care, is based on the premise that all activities must be tailored to the wants of the consumer. In medicine, on the other hand, the patient is normally expected to conform to the needs of the doctor.

Marketing birth control works[6,7]. This means that we must offer professionally promoted, packaged, and readily available services and products in the manner most acceptable to the consumer. FP clinics should be attractive and colourful places. Vasectomies, implants, and IUDs should be available at a range of venues not staffed by doctors but by specialised contraceptive technicians and counsellors (both Marie Stopes International [MSI] and DKT International are doing this in numerous countries). Contraceptives should be available on the shelves of supermarket and village stores.

FEAR OF RISK AND CONTROVERSY

Common to most FP organisations is the fear of risk and, as a result, controversy. This is a legacy of past battles and a reaction to the delicate nature of contraception as a topic.

In some cases, this fear has a crippling effect before a good idea can be germinated – the 'we-can't-possibly-do-that-because…' syndrome. Innovative and out-of-the-box ideas are watered down in order to adhere to concepts of inclusion (management by committee) and political palatability.

Fear of controversy is simply not justified. The 1877 trial of Annie Besant and Charles Bradlaugh in Britain and the 1916 arrest and subsequent trial of Margaret Sanger in the USA[8] did more to publicise and advance birth control during the early years than almost anything else. MSI has always welcomed the controversies

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surrounding their UK abortion clinics by offering protestors cups of tea and cookies, generating positive publicity. At DKT, a recent controversy surrounding an 'indecent' condom advertisement in Pakistan has helped catalyse a public debate about FP.

Some reasonable risk is inherent in the management of birth control programmes and should be embraced and even encouraged. Good ideas that fail must be seen as a cost of success[9]. However, because failure is feared, programmes rarely test genuinely new ideas (they might fail!) and, instead, continue to do the same thing expecting a different result. If leaders in the domain of contraception want real changes, they should get comfortable with risk and controversy.

CONFERENCES, MEETINGS, SYMPOSIA

As the FP movement has become institutionalised, so too has the swamp of conferences, meetings, and symposia. Too often, such meetings provide few benefits beyond networking. Given (especially) the advent of the Internet, much of the sharing of information, research findings, new technologies, or effective strategies can be done remotely.

For many FP organisations, however, such meetings are viewed as a way to meet or influence funders. These organisations spend substantial senior leadership time planning strategies for engaging and communicating. Meetings may include multiple representatives from one organisation attending the same meeting at a cost which includes airfares, hotels, per diems and, critically, senior management time. While a degree of corporate communications may be a necessary cost of doing business, connecting with colleagues and donors should be possible while reducing the glut of organisational commitments to such gatherings.

OBSESSION WITH COORDINATION

FP organisations need to coordinate with one another and with government programmes. However, contraceptives and SRH services are increasingly supplied through a multitude of independently managed activities, and efforts to coordinate these often just slow down and weaken the results. For all major private players – pharmaceutical companies, non-governmental organisations (NGOs), social marketing projects, commercial sales agents, distribution and advertising firms – to be 'coordinated' simply stifles their efforts.

Related to this is the idea that local governments should feel 'ownership' of programmes. But there is no inherent benefit in local government ownership beyond the government's own programme. Indeed, government ownership of private initiatives usually means control or interference. Why should donor representatives of democratic, free-market countries want African or Asian governments to take ownership of private provision of contraception? The US government does not 'own' Planned Parenthood nor does the British government control Marie Stopes International.

Donors often suggest that some coordination is necessary to prevent duplication and wastage. But free exchange of information, now facilitated by the Internet, can normally solve this problem. On the other hand, the integration of activities of otherwise independent grantees almost invariably leads to homogenised 'safe' programming, slow decision-making, and endless meetings which vitiate energy and creativity. If two organisations offer similar products and services, the worst that can happen is that consumers have more choice.

We should celebrate diversity in approaches to contraceptive and SRH service delivery. The more parties provide contraceptives, the better. Competition between providers, brands, and different methods of delivery is healthy and serves consumers well.

FEAR OF SEX

It is one of the great enduring ironies that the FP movement has distanced itself from sexuality. The purpose of birth control is to permit couples to enjoy the pleasures of sex without procreation, and family planners should capitalise on that.

Pandering to the squeamishness of Western audiences and donors' political demands, and in search of greater 'respectability', leaders in the reproductive health community have carefully avoided language that associates contraception with sexuality and pleasure. But in this accommodation, rich opportunities have been squandered. 'Modern advertising', noted J. Mayone Stycos in 1977, 'has spent the last half century infusing the subject of sex into areas where it has no business, [while] family planners have been busily eradicating sex from the one place where it uniquely

belongs'[10]. Surely the time has come for a revolution in this area. Sex belongs in birth control. We should accept that fact and celebrate it.

CONCLUSION

The call for action aimed at contraception and reproductive health care organisations is clear and challenging, but it is threatened by these institutional obstacles. By re-thinking some of our cherished assumptions, it should be possible to re-align programming so that zeal and pragmatism become more dominant than political correctness; risk-taking and efficiency are seen as more important than playing it safe; and the energy of the commercial approach can be fully harnessed to meet this important social objective.

Declaration of interest: The authors are associated with either Marie Stopes International or DKT International (or both). The authors alone are responsible for the content and the writing of the paper.

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REFERENCES

1. Sivin I. Seven billion people today, many more tomorrow – How we got there and what we expect and wish. *Eur J Contracept Reprod Health Care* 2012;17:1–6.
2. Harvey P. In family planning service programmes 'coordination' is greatly overrated. *J Fam Plann Reprod Health Care* 2011;37:43–4.
3. Prager S, Gupta P, Chilambwe J, *et al*. Feasibility of training Zambian nurse-midwives to perform postplacental and post partum insertions of intrauterine devices. *Int J Gynaecol Obstet* 2012;117:243–7.
4. Grindlay K, Burns B, Grossman D. Prescription requirements and over-the-counter access to oral contraceptives: A global review. *Contraception* 2013;88:91–6.
5. Olson DJ, Piller A. Ethiopia: An emerging family planning success story. *Stud Fam Plann* 2013;44:445–59.
6. Jato MN, Simbakalia C, Tarasevich JM, *et al*. The impact of multimedia family planning promotion on the contraceptive behavior of women in Tanzania. *Int Fam Plann Perspect* 1999;25:60–7.
7. Purdy C. Fruity, fun and safe: Creating a youth condom brand in Indonesia. *Reprod Health Matters* 2006;14:127–34.
8. Chesler E. *Woman of valor – Margaret Sanger and the birth control movement in America*. New York, NY: Simon & Schuster 1992.
9. McArdle M. *The up side of down: Why failing well is the key to success*. New York, NY: Viking Adult 2014.
10. Stycos JM. Desexing birth control. *Fam Plann Perspect* 1977;9:286–92.