

Emergency Contraception in South Asia

In South Asia, Population Council researchers looked at a major public health problem—high rates of unwanted pregnancy—and developed an approach for addressing it: emergency contraception (EC). The research began in Bangladesh and was replicated in India, Nepal, and—through a South-to-South consultation—in Pakistan.

International reproductive health researchers seeking to see their results used and sustained should ask and answer fundamental questions, *before* committing their time and funds to research.

“You ask yourself if your research question is close to the heart of the government, and if it addresses a problem that interests the government,” says M.E. Khan, senior associate in the Council’s India office. “If the answer is yes, then you can think seriously about starting the research.”

Work on EC began in Bangladesh and India well in advance of any intervention (see Timeline). At this time, EC was available in these countries, but was little known and rarely used. But Ministry of Health (MOH) officials were concerned about the high rate of unplanned and unwanted pregnancy, which put millions of women at risk of unsafe abortion.

Council researchers spent several years conducting advocacy to introduce EC, educate and sensitize policymakers, and counteract misunderstandings and “myths” about EC.

“There was some resistance at first,” says Sharif Hossain, a Council senior program manager based in Bangladesh.



A counseling session in India. (Susan Adamchak)

“Some managers believed that EC was abortion; some people thought that EC could be used in an immoral way. We did sensitization meetings, shared evidence from around the world, and put on national workshops for program managers, policymakers, and researchers.” To counter potential misunderstandings, Council researchers framed EC as a reproductive health intervention with large potential benefits for users, rather than as a family planning method. They also conducted media outreach to increase public knowledge about EC and correct misunderstandings. “We sensitized all the stakeholders, and then we held a forum to promote EC. In 2001, the National Technical Committee on Family Planning and Contraception asked for a feasibility study. That was when we formally introduced EC,” Khan says.

A small-scale feasibility study in 2001 showed that both providers and clients supported the introduction of EC as a way to prevent unwanted pregnancy following contraceptive failure and unprotected sex. The study also showed that family planning users resumed

their method after using EC, setting to rest fears that women would drop their regular method and rely only on EC. In fact, over half of nonusers of family planning adopted a method after they used EC, suggesting that EC might function as a “bridge” to family planning use. In 2003, EC was approved for national distribution.

Over the next several years, the Population Council and UNFPA provided technical assistance and support for national scale-up, drug requisition, and training of over 45,000 providers in Bangladesh. This continued commitment is vital to ensure that the necessary steps for sustainable institutionalization—policy change, procurement of drugs, and training—do in fact take place.

Based on the Bangladesh experience, the Council approached the Indian Ministry of Health and Family Welfare

EC timeline: From advocacy to policy change

	1996	2001	2003	2005
Bangladesh	Council international workshop on EC	EC feasibility study	EC approved for distribution	Training on EC throughout Bangladesh
India	Council workshop on EC	2002 EC available by prescription only	2004 EC paraprofessionals study	EC approved for over-the-counter use
Nepal				2007 Pilot introduction in 3 districts
Pakistan				2008 Pilot introduction in 20 districts

about reconsidering its own EC policy, which allowed EC use only with a doctor's prescription. The Council conducted an intervention comparing EC provision by doctors to provision by trained paraprofessionals (auxiliary nurse midwives). A government-sponsored biomedical research organization, the Indian Council of Medical Research (ICMR), worked as a partner in the intervention. Partnerships with local entities—public, private, and nongovernment—are a part of any sustainable intervention. “It’s important, when you’re trying to achieve policy changes, to have a strong partner,” says Khan.

The Council-ICMR study showed that paraprofessionals actually performed better than doctors in providing EC and giving correct counseling on its use. On the basis of that evidence and findings from other countries, the Indian government modified its policy to allow EC distribution by paraprofessionals and began training low-level health workers in EC provision and counseling.

By 2007, the Council was working with two more governments in South Asia: Nepal and Pakistan. “In Nepal and Pakistan, EC was being distributed through social marketing programs, but it was not yet available in the public

sector,” says Hossain. “The Council disseminated information on the Bangladesh study and suggested replicating the Bangladesh experience there. We provided technical assistance with operations research in three districts of Kathmandu Valley and helped the government include EC in its reproductive health policy.”

The dissemination meeting on the Bangladesh experience, which was attended by a Pakistani official, led to a South-to-South collaboration between Pakistan and Bangladesh, mediated by the Population Council.

Pakistan’s Director General of Health initially expressed concern about the EC initiative. “But we put together some write-ups about experience in the field,” says Khan. “We selected a group of program managers from Pakistan and brought them to Bangladesh, where they met with nongovernment organizations, population and health officials, and other researchers.” The Council helped organize a meeting in Pakistan attended by regional program managers from throughout Pakistan. Speakers from Bangladesh, India, and the Council presented the lessons learned from the work in South Asia. “During that meeting, the UNFPA chief in Pakistan spontaneously announced that UNFPA would support the work to

include EC in Pakistan’s reproductive health policy,” Khan recalls.

As of mid-2009, institutionalization of EC is underway in all four countries. EC use is increasing rapidly in India, especially in urban areas, and the Indian government provides EC through its nationwide network of health facilities. The government of Bangladesh is preparing to do the same. In Nepal, expansion of EC provision is proceeding in a phased manner to all of the country’s 75 districts with UNFPA support. Pakistan has introduced EC in some 20 districts, still with donor support. Khan and Hossain emphasize the importance of institutionalization: to become sustainable, the government will have to incorporate EC provision within its own policies and procedures, as in India and Bangladesh.

Ensuring the sustainability of any new approach requires a sustained relationship between partners, often extending beyond the duration of the intervention. “A long-term commitment for technical assistance is definitely necessary,” says Hossain. “I’m still in touch with some officials. It’s not part of my job, but I continue to meet and work with the Bangladesh MOH in an unofficial way.” □