Investing in the Future—The Case for Long-acting and Permanent Contraception in Sub-Saharan Africa

John M. Pile, The ACQUIRE Project/EngenderHealth (jpile@engenderhealth.org)
Fredrick Ndede [Presenter], EngenderHealth (fndede@Eengenderhealth.org)
Isaiah Ndong, EngenderHealth.org (indong@engenderhealth.org)
Roy Jacobstein, The ACQUIRE Project/EngenderHealth (rjacobstein@engenderhealth.org)
Nalin Johri, The ACQUIRE Project/EngenderHealth (njohri@engenderhealth.org)

Paper submitted to the
Union for African Population Conference
Arusha, Tanzania: 10-14 December 2007

Topic 2: Reproductive Health and Family Planning
Session 204: The future of family planning programmes in Africa

(Abstract) In Sub-Saharan Africa, 48.8 million women—nearly half the married women of reproductive age—want to space births or limit their number of births. However, fewer than half (22 million) currently use any contraceptive method, and less than one in seven uses a modern method. There are compelling reasons to invest in long-acting and permanent contraceptive methods (LAPMs)—IUDs, implants, and male and female sterilization—in Sub-Saharan Africa. LAPMs can address a full range of women's and couples' needs. Only 2.7 million women currently use these methods, yet evidence suggests that if and when potential clients have correct information on the methods and services are made widely available, LAPMs will be adopted.

LAPMs are needed, wanted, and crucial. This paper 1) addresses the case for investing in LAPMs in Africa, 2) reviews current trends, and 3) outlines strategies for increasing access and utilization of LAPM services.

USAID FROM THE AMERICAN PEOPLE
the ACQUIRE project

Investing in the Future—The case for Long-acting and Permanent Contraception in Sub-Saharan Africa

John M. Pile[i], Fredrick Ndede[ii], Isaiah Ndong[iii], Roy Jacobstein[i], Nalin Johri[i]

Paper presented at the
Union for African Population Conference
Arusha, Tanzania: 10-14 December 2007

The last five decades have seen a revolution in the availability, use, and funding of family planning worldwide. However, contraceptive use remains low and need for it high in much of Sub-Saharan Africa. Family planning is at a crossroads—after rising to prominence in Sub-Saharan Africa the 1990s, many programs appear to have lost momentum. Family planning has yielded the regional and national policy spotlights, as well as substantial amounts of funding, to issues such as HIV/AIDS and poverty alleviation. In many countries, family planning funding has stagnated or fallen dramatically, even as family planning demand has risen.

The Sub-Saharan Africa region's unmet need for family planning is the highest in the world—48.8 million women, nearly half the married women of reproductive age— want to space or limit the number of children they have. However, less than half (21 million women) are currently using a contraceptive method and less than one in seven married women of reproductive age are using a modern method of contraception.[1] The reasons to invest substantially in family planning are compelling. Family planning is a human right; it is critical to individual health and welfare and to a country's economic development. Family planning saves the lives of women and children. When more women use modern family planning to space and limit pregnancies, the number of unintended pregnancies will fall. This, in turn, will reduce the number of abortions and the number of unintended births. Effective family planning use prevents mother-to-child transmission of HIV, not only providing a health benefit, but also averting the high cost of health care for an HIV-positive infant.[2]

Long-acting and permanent methods (LAPMs)[iv] can address a full range of women's and couples' needs. Yet in Sub-Saharan Africa, only 2.7 million women are currently using these methods—fewer than one in eight contraceptive users. Although LAPMs are generally in low use in sub-Saharan African family planning programs, evidence suggests that if and when potential clients have correct information on the methods and services are made widely available, long-acting and permanent contraceptive methods will be adopted. LAPMs are needed, wanted, and crucial.

WHY INVEST IN LAPMs?

The health and cost benefits of investing in family planning are well known, well documented, and substantial. LAPMs have clear advantages over short-acting methods of family planning that benefit both clients and health systems. LAPMs increase the contraceptive method options that couples have, especially as their needs evolve over time. Experience has repeatedly demonstrated

[i] The ACQUIRE Project/EngenderHealth, New York
[ii] The ACQUIRE Project/EngenderHealth, Kenya
[iii] EngenderHealth, New York

[iv] IUDs, implants {Norplant®, Jadelle® and Implanon® and male and female sterilization.

that the more contraceptive methods that are available, the greater the total number of couples who use contraception.

LAPMs address a full range of women's and couples' family planning needs

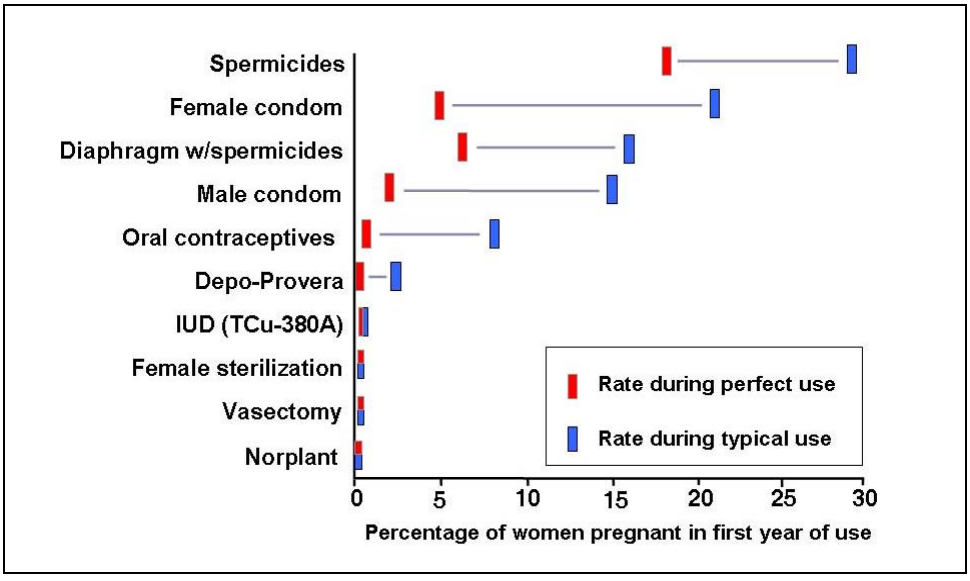
LAPMs are an important and attractive method option for women and couples who wish to delay a first birth, to space births, or to limit family size once they decide that they do not want to have more children. Contrary to many myths, *almost all women* can use IUDs, implants, and/or sterilization, and *almost all men* can use vasectomy. The number of individuals who cannot use LAPMs (including the IUD) is *actually quite small*. LAPMs are equally suitable for younger and older women, for women who have been pregnant and those who have not, for HIV-positive and HIV-negative individuals, and for postpartum as well as post-abortion women.[3]

Once initiated, they are convenient and extremely easy to use. They do not require continuous resupply (as do condoms, oral and injectable contraceptives), thus lessoning the burden on health care systems. Serious complications are rare and minor complications occur in 10% or less of procedures. There are very few medical conditions for which the use of LAPMs represent an unacceptable health risk

LAPMs are the most effective modern contraceptive methods, have lower discontinuation rates than short-acting methods and are the most cost effective.

As a group, LAPMs are the most effective modern contraceptive methods, with failure (pregnancy) rates in the range of one to five per 1,000 women during the first year of use. [Figure 1][4] Permanent methods (female and male sterilization) have the lowest failure rate, and so are important options for those who are certain that they do not want to have more children. Unwanted births and abortions are effectively avoided with LAPMs. The dangers and deleterious effects of pregnancy effectively avoided.

Figure 1: Pregnancy rates by method



Discontinuation rates for LAPMs are much lower than short-acting temporary methods. Overall first-year discontinuation rates for IUDs and implants are 13-14% versus 48% for pills and injectables and 52% for condoms[5]. These levels of discontinuation for short-acting methods are highly inefficient and costly to programs, and represent very poor quality service for individuals and often lead to unplanned pregnancies and a bad image for family planning programs.

Intrauterine Devices (IUDs), female sterilization and vasectomy are the most cost-effective of all contraceptives. For example, for the same contraceptive protection for 3.5 years, the cost of an IUD, of injectables and oral contraceptives would be $0.58, 13.50 and $10.90 respectively. While the initial price of implants is high, they can be cost-effective when used for a number of years. For example, at the cost of US$21 for Jadelle, if a woman uses the implant for a full five years, the cost per cycle is US$0.32 (assuming 13 cycles per year). This is within the range of the cost of a cycle of oral contraceptives (US$0.16-US$0.63 per cycle).[6] Over the long term, making implants available reduces health system workloads and thus costs, because implants are more effective and have higher continuation rates than most other methods.

CURRENT AND FUTURE NEED FOR LAPMs

Of sub-Saharan Africa's 113 million married women of reproductive age (MWRA), 21 million—one in five—use family planning. Less than one of seven MWRA, 14.7 million women, currently uses modern contraception, of which only 2.7 million MWRA use long-acting or permanent contraception.

Unmet need remains an important issue in family planning.[7] Although the percentage of total demand satisfied exceeds 80 percent in most of the countries outside of sub-Saharan Africa, it has reached only 43 percent, on average, in sub-Saharan Africa.[8] In West Africa, unmet need for family planning ranges from 16 to 34 percent. A similar range is evident in East and Southern Africa (13 to 38 percent). Contraceptive prevalence is somewhat lower in West Africa, as is the overall demand for family planning and the percentage of demand satisfied. Total demand in West Africa averages 42 percent compared with 57 percent in East and Southern Africa.

The marked uptake of modern contraception that occurred in the 1990s in many family planning service programs in Sub-Saharan Africa has diminished considerably during the 2000s. Whereas in the 1990s, modern method use almost doubled in Ghana, more than doubled in Zambia and Tanzania, and almost quadrupled in Malawi, this decade's increases in contraceptive prevalence have been much more modest.[9] [Table 1]

Use of LAPMs is remarkably low, despite very high levels of desire to space or limit family size

Use of LAPMs is very low, even among couples using family planning to limit family size. [Table 2] In thirteen countries for which data are available, LAPMs accounted for an average of 17.1 % (range 2.2-37.8%) of the method mix for contraceptors who did not want any more children (limiters). In only Burkina Faso, Kenya, Malawi and Tanzania do LAPMs account for more that 20% of the family planning method mix? Among contraceptors who wanted to delay their next birth (spacers), on average only 3.3% (range 0.5-8.4%) were using LAPMs.

Table 1: Average annual gain in modern method use among all women, 1990s-2000s, selected countries in Sub-Saharan Africa[10]

Region/country	Annual gain, any modern method use	
East/Southern Africa		
Kenya	1.0	-0.2
Malawi	1.9	0.2
Tanzania	1.4	0.4
Uganda	1.1	-0.2
West Africa		
Burkina Faso	0.3	1.0
Cameroon	0.5	0.9
Ghana	0.7	0.9
Nigeria	0.6	0.0
Senegal	0.6	0.1

Table 2: Percent of Spacers and Limiters Using LAPMs

Country	Total FP use	LAPM use	Using to space	% spacers using LAPMs	Using to limit	% limiters using LAPMs
East and Southern Africa						
Ethiopia	14.7	0.6	6.7	2.2	8.4	9.2
Kenya	39.3	8.4	14.3	7.7	25	31
Madagascar	27.1	2.0	12.3	1.5	14.9	12
Malawi	32.5	6.4	15.5	1.8	17.0	37.8
Rwanda	17.4	1.0	7.4	2.0	9.9	7
Tanzania	26.4	3.3	15.5	2.6	10.9	25
Zambia	34.2	2.4	19.2	0.7	1`5.0	15
West Africa						
Benin	18.6	1.4	12	2.9	6.6	8.8
Burkina Faso	13.8	1.7	9.9	8.4	3.9	24.2
Ghana	25.2	3.8	13.7	4.3	11.4	26
Guinea	9.1	0.3	5.9	0.5	3.2	8.8
Mali	8.1	0.6	5.1	1.0	3.0	15.1
Senegal	11.8	1.6	7.3	7.5	4.5	2.2

This low use of LAPMs can be attributed to limited access. Awareness ("cognitive access") of LAPMs is much less than that of short-acting methods (pills, condoms, injectables). In 19 DHS studies conducted in the past five years, while awareness of any modern method averaged 89%, only 41% know of IUD, 34% know of implants, 51% know of female sterilization, 21% know of vasectomy. Since LAPMs are provider dependent methods, they are only available within the health care system ("health care system access"). The system's policies, structures and organization of services and the providers' practices greatly influence client access to LAPMs. Eligibility criteria specifying what categories of clients may obtain them limit access to the full range of LAPMs. There is a perception among providers as well as clients that long-acting

methods (i.e. implants and the IUD) are not appropriate for women/couples who want to space, rather than limit.

Unlike other regions of the world, the unmet need for spacing births, as well as the use of contraception for this purpose, is the main pattern in Sub-Saharan Africa. Exceptions include South Africa, Namibia, Ghana, Malawi, Lesotho, and Kenya, where smaller family norms are more developed. All of the countries in West Africa show a greater use as well as unmet need for spacing rather than for the limiting of births regions. Language conditions thought. IUDs and implants are often described at "long-term" methods suggesting that they needed to be used for the full 5 to 10 years of effective use. "long-acting" is a characteristic of the method, whereas "long-term" is a characteristic of the clients use—a women can use a "short-acting" or ""long-acting" method for a short or long period of time.

STRATEGIES FOR INCREASING ACCESS AND UTILIZATION OF LAPM SERVICES

Evidence that LAPMS are acceptable for Africa

Though LAPM use is low, experience in many countries confirms that when made available, people want them and use them. Experience in many countries, such as Ghana, Malawi, and Kenya confirms that raising awareness of methods and removing policy and program barriers leads to increased use of LAPMs:

- Ghana removed policy barriers to allow trained nurses to insert implants. They trained 600 nurses, and as a result more than 88,000 Ghanaian chose Norplant as their method of contraception and an estimated 44,000 are currently using the method... From 1998 to 2006, the CPR for implants rose more than 10-fold, from 0.1% to 1.2%.
- A project in Ghana demonstrated that vasectomy is a viable contraceptive choice when effective and strategic media campaigns oriented to potential clients are coupled with supply side interventions that focused on issues of quality and access. During the project year vasectomies increased by 350% and awareness of and vasectomy more than doubled. Similar supply-demand interventions in Kenya and Tanzania have demonstrated that despite commonly held assumptions about male attitudes or societal prohibitions, African men are interested in or acceptant of vasectomy.
- A project to revitalize the IUD in western Kenya included a "myth-busting" campaign that directly countered the most entrenched rumors about the IUD and positioned it as a flexible method with many unique benefits. Client and provider acceptance of the method rose and the number of insertions during the one year project increased by more than 120 percent.
- In Ghana, Kenya and Malawi, all with a history of successfully removing barriers to who can provide and who can receive (age and parity barriers) have more than one-fifth of their modern CPR represented by long-acting and permanent methods.
- Malawi, with a per capita income of less than $0.50/day and severe shortages in skilled personnel, saw its CPR for female sterilization more than triple from 1992 to 2005, to almost 5% overall (when clinical officers allowed to perform female sterilization)

Programming for success

The ACQUIRE Project[v] has identified guiding principles for LAPM service programs that when applied in an integrated model of supply, demand and advocacy will result in increased access to, quality of, and use of LAPM services.

1. *The heart of LAPM service delivery is the encounter between client and provider.* A quality client-provider interaction takes place between a knowledgeable, empowered client and a skilled, motivated service provider, at an appropriately staffed, managed and functioning service site. The outcome of such encounters is that well-informed clients have their needs met in a quality manner. Given the community and health system context, as well as the larger socio-cultural, economic, and political environment, achieving such ideal outcomes should be the goal of LAPM programs.

2. *The fundamentals of care are the bedrock of quality LAPM service programs.* The fundamentals of care—informed choice, medical safety, and quality improvement—are essential for FP/RH services, especially clinical services. LAPM clients must be able to exercise their right to make an informed, voluntary choice based on accurate information and a range of contraceptive options, free of provider bias. Methods and services are safe when skilled and properly equipped providers deliver them according to up-to-date, evidence-based standards, protocols, and guidelines and manage any side effects or complications that may arise. Ongoing quality improvement mechanisms and activities (which rely on local resources and need not be complicated or expensive) ensure the maintenance of quality of and access to LAPM services over time.

3. *LAPM service programs need to be holistic, integrating "supply", "demand" and "advocacy" program elements*. A service-delivery system, like a chain, is only as strong as its weakest link. A holistic approach that integrates supply, demand and advocacy can create synergy via a coordinated package of mutually reinforcing interventions. On the supply side, this entails ensuring the security of essential equipment, supplies, and logistics, ensuring the readiness of service sites to provide LAPMs, and addressing the training and other performance improvement needs of providers. On the demand side, the provision of up-to-date, understandable information via multiple channels of communication—interpersonal, community, mass media—increases the accurate knowledge of clients, potential clients, and communities. When communities are freed of attendant misconceptions and myths, the image of long-acting and permanent methods and services is enhanced, and communities are engaged and mobilized to ask more of their health service system. In the context of LAPM service delivery, advocacy entails working to: promote supportive and rational service policies based on the best available medical and program evidence; secure greater human and financial resources for LAPM services based on informed estimates of need; involve men as full partners in LAPM decision making, services, and programs; and advance gender equity. The resultant improved policy and program environment is reflected in a better-resourced and more productive, widely supported, equitable, and sustainable LAPM program.

[v] The ACQUIRE Project (Access, Quality, and Use in Reproductive Health) is a global initiative supported by the U.S. Agency for International Development (USAID) and managed by Engenderhealth in partnership with the Adventist Development and Relief Agency International (ADRA), CARE, IntraHealth International, Inc., Meridian Group International, Inc., and the Society for Women and AIDS in Africa (SWAA).

4. *Stakeholder participation is critical to fostering ownership and sustainability.* Widespread stakeholder participation is critical to program success and sustainability. Important stakeholders whose participation in and championship of LAPM services are needed include political leaders, religious and other opinion leaders, program leaders and managers, the medical community, clinic managers and LAPM service providers, advocacy groups, community organizations, and individual female and male clients.. Engaging stakeholders helps LAPM service programs to be context-specific, locally owned, and responsive to the needs and realities of different constituents—increasing the chances for program sustainability.

5. *Use of locally generated, context specific data and other evidence to inform policy and program decisions.* The use of both locally generated and applicable international data for decision making in resource allocation, program strategy, design, implementation, and evaluation leads to sounder programs and to greater transparency and ownership. Such data or evidence may result because there is no "uniform blueprint" or "one right way" to provide LAPM services, it is important to use locally generated data specific to the cultural and resource context to inform stakeholders as they develop LAPM strategies, policies, program designs, and interventions. Evidence may result from local needs assessments, quantitative baseline survey data, qualitative consumer research, operations research, forecasting projections and/or other available secondary data, or evidence-based international standards and guidance and best practices and/or models proven effective in other settings.

6. *Apply principles and best practices of behavior change theory to achieve sustained LAPM program improvement***.** Achieving widespread availability of, access to, and use of quality LAPM services requires behavior change at every level: clients and communities; providers and facility units; program managers and supervisors; and policymakers and donors. The challenge is to turn the latest scientific knowledge and best practices into shared perceptions and understanding—"truths"—held by these system agents, who will in turn *act* upon these new truths with appropriate new behavior. (The extent of this challenge is evident in the various rumors, myths, and biases about different LAPMs that are widespread in most countries.)

7. *The security of LAPM commodities, equipment, and supplies is critical for reliable service availability.* Long-term contraceptive security must be continually planned for and met. Health-sector reform and decentralization pose particular challenges to achieving this goal. For services to be continuous, LAPM commodities (IUD or implant), specialized instruments and equipment (e.g., specula or no-scalpel vasectomy instruments), and expendable supplies (including those required for infection prevention and anesthesia) must be on hand. Private areas for confidential counseling and dedicated clinical space for procedures are also needed. If a national, subnational, and/or district reproductive health and family planning program relies on an Essential Drug List, the list must include essential commodities, equipment, and supplies needed for providing LAPM services.

8. *LAPMs must be accessible if they are to be used*. Access to LAPM services means the degree to which these services can be obtained at an effort and cost acceptable to and within the means of a majority of the population. There are many types of barriers to LAPM access: cognitive, socio-cultural, geographic, financial, and health care system–related. Barriers in any of these areas can prevent even motivated clients from receiving LAPM services. Thus, service programs must go beyond the difficult challenge of increasing the availability of LAPM commodities, equipment, and supplies and of skilled providers, to address various access barriers as well.

Call to Action

The challenges facing sub-Saharan Africa as it strives to meet its development objectives remain the most daunting facing any region in the world. It is imperative that sub-Saharan Africa's governments, civil society and the donor community give priority attention to family planning to ensure that poverty-reduction strategies and programmes gain and maintain momentum.

Many governments and donors do not see family planning as a priority and, as a result, have diverted family planning resources to other areas. Even when central-level family planning support is strong, decentralization has devolved decision-making responsibility to the local level, where commitment may be weak. Additionally, numerous cultural barriers continue to inhibit the provision, expansion, and use of existing services. Yet the evidence is clear: family planning saves lives, and it is critical to social and economic development. When family planning commitment wanes, the lives of women and children are at risk, and a nation suffers. LAPMs are needed and wanted by people wishing to plan their childbearing, which is vital to achieving a healthy society and other national goals. National policy makers and public health planners in developing countries, along with leaders in the international donor and multilateral communities, must work in concert to protect the health and welfare of individuals and societies by investing and sustaining support for family planning in general and LAPMs in particular.

---

[1] United Nations 2006. *World Contraceptive Use 2005*. United Nations, Department of Economic and Social Affairs, Population Division. New York, NY. CD-Rom.

[2] The ACQUIRE Project 2007a. *Call to Action—Invest in Long-Acting and Permanent Methods of Contraception*. The ACQUIRE Project, Engenderhealth. New York, NY.

[3] WHO. 2004. *Medical eligibility for contraceptive use. Third Edition*. Geneva.

[4] Hatcher 2004.

[5] The ACQUIRE Project 2007b. *Reality √ Family Planning Forecasting Too—User's Guide*. The ACQUIRE Project, EngenderHealth. New York, NY. Working draft September 2007.

[6] The ACQUIRE Project 2007a. op. cit.

[7] Casterline, J.B. and S.W. Sinding. 2000. Unmet need for family planning and implications for population policy. *Population and Development Review* 26(4): 691-723.

[8] Westoff, Charles F. 2006. *New Estimates of Unmet Need and the Demand for Family Planning.* DHS Comparative Reports No. 14. Calverton, Maryland, USA. Macro International Inc.

[9] Jacobstein et. al. 2007. *Fragile, Threatened, and in Great Need: Family Planning Programs in Sub-Saharan Africa*. Paper presented at Union of African Population Conference, Arusha, Tanzania, 10-14 December 2007.

[10] The ACQUIRE Project 2007b. op. cit.