Ten Guiding Principles for LAPM* Service Programs

1. The heart of LAPM service delivery is the encounter between client and provider.

2. The fundamentals of care are the bedrock of quality LAPM service programs.

3. LAPM service programs need to be holistic, integrating 'supply side' and 'demand side' program elements.

4. Evidence-based advocacy for political support at all levels is important to sustain LAPM service programs.

5. Stakeholder participation is critical to fostering ownership and sustainability.

6. Use locally generated, context-specific data and other evidence to inform policy and program decisions.

7. Apply principles and best practices of behavior change theory to achieve sustained LAPM program improvement.

8. LAPM training and supervision need to be maintained and updated.

9. Security of LAPM commodities, equipment and supplies is critical for reliable service availability.

10. LAPMs must be accessible to be used.

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* Long-acting and permanent methods of contraception [IUDs, implants and female and male sterilization]

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1. The heart of LAPM service delivery is the encounter between client and provider.

Central to ideal LAPM service delivery is the encounter between a knowledgeable, empowered client and a skilled, motivated service provider, taking place in an appropriately staffed, managed, and functioning clinical facility. 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 goals of LAPM programs.

2. The fundamentals of care are the bedrock of quality LAPM service programs.

Paying continuous attention to the fundamentals of care must be the bedrock principle of all LAPM service programs. Provision of any LAPM entails a clinical service, often an operation, that is dependent upon a skilled and motivated provider. Programs thus need to take 'a provider perspective' as well as 'a client perspective' as they sustain a focus on three important fundamentals:

a. Informed and voluntary choice

Programs must provide good counseling and real access to contraceptive options, free of any provider bias for or against particular methods, so clients can exercise their right to make informed and voluntary decisions based on accurate, up-to-date information. This is both ethically correct and sound program practice. Counseling that helps clients choose and correctly use an LAPM that meets their needs has a positive impact on method adoption, continuation, and satisfaction, and enables clients to achieve their reproductive goals and good health outcomes. Clients' satisfaction with the LAPM service spreads by word of mouth in their communities, leading to further knowledge and use of LAPMs.

b. Safety for clinical techniques and procedures

Clinical techniques and services are considered safe when skilled and properly equipped providers deliver services according to up-to-date, evidence-based standards, protocols, and guidelines, within a facility or physical structure appropriate for managing clinical and surgical services. This includes appropriate management of any complications or subsequent side effects.

c. Ongoing quality improvement and management

At the provider level, LAPM quality improvement and management efforts focus on strengthening provider knowledge, skills, motivation, and performance. At the facility level, supportive supervisors, participatory processes for ongoing problem-solving and quality improvement, and a generally supportive work structure, including an appropriate reward system, are essential. At the program level, there needs to be well-functioning LAPM training, supervision, and supply and logistics systems, based on updated standards, norms, guidelines, protocols, and procedures that are geared to meeting clients' needs.

3. LAPM service programs need to be holistic, integrating 'supply side' and 'demand side' program elements.

A service delivery system, like a chain, is only as strong as its weakest link. A holistic approach that integrates supply and demand 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 service site readiness to provide LAPMs, and addressing training and other performance improvement needs of providers. On the demand side, this entails using and integrating state-of-the-art marketing communications, community engagement, and mobilization approaches, and employing strategies to promote gender equity and to engage men as partners in family planning decisions and use.

4. Evidence-based advocacy for political support is important to sustain LAPM service programs.

The health sector faces many competing needs and demands. Thus, political and program stakeholders and decision makers, who control the financial and human resources for health, must be engaged and convinced about the value of expanding LAPM services. Advocacy efforts should be informed by data about need, cost, acceptability, and safety of specific methods, and should aim to foster a supportive policy, program, and resource environment. Such efforts should be led by LAPM champions at multiple levels.

5. Stakeholder participation is critical to fostering ownership and sustainability.

Stakeholders important to program success 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 women and men clients. These stakeholders need to be involved at every program stage—planning, design, implementation, evaluation, and dissemination of results and lessons learned—since it is their program, and need to be designed to meet their needs. 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.

6. Use locally generated, context-specific data and other evidence to inform policy and program decisions.

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 local cultural and resource context to inform stakeholders as they develop LAPM strategies, policies, program design, and interventions. Evidence may be results of needs assessments, quantitative baseline survey data, qualitative consumer research, operations research, or evaluations of pilots. Local data may be supplemented where helpful by international standards and guidance (e.g., WHO's Medical Eligibility Criteria and Selected Practice Recommendations), and by evidence-based practices, tools, or models of LAPM service delivery that have been effective in other settings.

7. Apply principles and best practices of behavior change theory to achieve sustained LAPM program improvement.

Achieving widespread availability, access, and use of quality LAPM services requires behavior change at every level: clients and communities, providers and facility units, program managers and supervisors, 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.)

Useful LAPM change strategies include: 1) identifying and nurturing 'champions,' i.e., locally respected providers and individual facilities who provide quality LAPM services; 2) designing messages and interventions that focus on the benefits of LAPMs to clients and providers as *they* perceive them; 3) using early adopters and satisfied clients in interpersonal communication and mass media demand creation efforts; and, 4) designing and implementing initial/pilot efforts with replication and scale-up planned from the start (including involving those expected to implement the replication or scale-up).

It is important to remember that 'change takes time,' especially in the often overburdened and resource-strapped medical/clinical settings where LAPMs must be provided, and where the benefits of providing such labor-intensive, preventive services may not be apparent or valued.

8. LAPM training and supervision need to be maintained and updated.

New LAPM providers must be educated and trained, in both preservice and in-service settings. Current providers must maintain their competence by continually using their clinical skills, and require periodic refresher training to remain current with updated standards and practices. LAPM training and service delivery needs to be informed by the latest scientific information and clinical and surgical methodologies. Policies and practices need to be guided by the latest evidence, standards, and norms. Providers and their supportive supervisors must share common training, understanding, and commitment to perform to established service delivery standards.

9. 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 continuous services, LAPM commodities (IUD or implant), specialized instruments and equipment (e.g., specula, NSV 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 or family planning program relies on an Essential Drug List, the list must include essential commodities, equipment, and supplies needed to provide LAPM services.

10. LAPMs must be accessible 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 those within the health care system. 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 *availability* of LAPM commodities, equipment, and supplies, and of skilled providers, to address various access barriers as well.

- **Cognitive access.** Programs must go beyond creating 'awareness' of an LAPM (in the DHS sense) to ensure true knowledge and understanding among providers, communities, and individuals. This includes accurate information about the method's benefits, its effectiveness, its means and duration of action, its common side effects and what to do about them, and any serious risks and warning signs. Clients and potential clients also need to know where, when, and how to access the method within the medical system. Mass media marketing and interpersonal communication methodologies (i.e., counseling, other client-provider interactions) can be used together at the provider, community, and client levels in this effort. Community-based workers can also provide relevant information (and act as referral agents).

- **Socio-cultural access.** Programs must understand and address various socio-cultural barriers that may be restricting individuals or categories of people from receiving LAPM information and services. This is always contextual, and may entail considerations of gender norms, the roles and rights of women, the sex of the LAPM provider (especially if a pelvic exam is required), prevailing beliefs about and taboos associated with menstruation, and considerations of social distance. There are also socio-cultural (and medical system) barriers for men and for younger clients of either sex, especially if they are unmarried.

- **Geographic access.** The type and location of service sites influences access to use of LAPMs. Programs need to ensure that an adequate number and location of sites offer LAPM services and that this is known to their clientele. Such geographic availability may be achieved with fixed facilities staffed with trained providers and supported by referral systems in the community, or by mobile outreach services provided by teams to hard-to-reach populations. LAPMs may be provided in facilities ranging from hospitals to single-room clinics, run by public, private for-profit, or nongovernmental and faith-based organizations.

- **Financial access (cost and affordability).** LAPM clients face many costs—out-of-pocket service costs, transportation costs, lost wages, monetary and nonmonetary opportunity costs, even social costs. To ease financial barriers, LAPM programs can use sliding scales for fees or insurance coverage options, to lessen up-front costs of LAPM services. Measuring clients' willingness and ability to pay for services and developing strategies tailored to reach different market sectors may also be helpful in maintaining a programmatic and financially viable service that meets clients' needs.

- **Health care system access.** Since LAPMs are provider-dependent methods, they are only available within the health care system. Therefore, the system's policies, structures, and organization of services, as well as its providers' practices, greatly influence client access to LAPMs. Policies governing what cadres of providers can provide what services, and eligibility criteria specifying what categories of clients may obtain them, often limit client access to the full range of LAPMs throughout an entire program. Common examples are the denial of specific LAPMs because of age, parity, marital status, or spousal consent requirements; and limitations on which cadre or site can provide which LAPM (even when ability and safety have been proven). Facility-level factors that may impede LAPM access include inadequate numbers of skilled and motivated personnel, and poor organization of services. They also include 'medical barriers' rooted in either policy or practice.

  Medical barriers are well-intentioned but inappropriate practices based at least in part on a medical rationale, which result in a scientifically unjustifiable impediment to, or denial of, access to LAPMs. Among the most common medical barriers to LAPM access and quality are: overzealous or mistaken application of 'contraindications'; 'process hurdles' (e.g., unnecessary lab test or follow-up requirements); and provider bias against or for a specific method. Another significant provider-level impediment to ongoing use of reversible LAPMs is poor or inappropriate management of side effects.

  Solutions at this level begin with a careful, holistic analysis of service dynamics and areas for improvement. Interventions may range from provision of job aids (handbooks, algorithms, checklists) to interactive updates on the latest LAPM scientific and technical information, guidance, and best practices (beyond mere dissemination and passive uptake). The use of 'champions,' i.e., committed and locally respected medical leaders, is a useful strategy for disseminating new information and reinforcing the provider-level behavior change that ideally would ensue.

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This publication was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID), under the terms of cooperative agreement GPO-A-00-03-00006-00. The contents are the responsibility of The ACQUIRE Project and do not necessarily reflect the views of USAID or the United States government.

Printed in the United States of America. Printed on recycled paper.