



Contraceptive Security: Incomplete without Long-Acting and Permanent Methods

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Introduction

Contraceptive security—when people have regular, reliable, and equitable access to a choice of contraceptive methods to meet their reproductive health needs—is of vital importance to family planning programs, and thus contraceptive security has properly been getting increased attention in international family planning circles. Yet few contraceptive security activities clearly articulate the requirements for meeting the needs of the four **long-acting and permanent methods of family planning (LAPMs)**—hormonal implants, IUDs, female sterilization, and vasectomy.

LAPMs are not only highly effective—the most effective of all modern methods—they are also widely adopted when they are made available and affordable as options to clients. Indeed, not only is the principle of providing a broad choice of methods in family planning programs universally accepted (United Nations, 1995), but LAPMs will be used on a large scale when providers have the equipment, supplies, and contraceptive products available within a supportive program environment.

Greater Attention to LAPMs Has Led to Greater LAPM Access and Use

In Egypt, IUD use rose from 4% of married women of reproductive age in 1980 to 36% in 2005 (El-Zanaty & Way, 2006); Jordan, Turkey, and Vietnam have similar or higher rates of IUD use. Even in Sub-Saharan Africa, where LAPM access is more limited, hundreds of thousands of people use LAPMs when such methods are made available, especially when cost and other access barriers are removed. (Experience and evidence in many African countries, such as Ghana, Kenya, Malawi, Tanzania, and Zambia, confirm this observation.) For example, Malawi's openness to using and supporting clinical officers as well as physicians to provide female sterilization has led to a notable rise in female sterilization use, from 1.7% of married women of reproductive age in 1992 to 4.7% in 2000 and to 5.8% in 2004 (NSO & ORC Macro, 2005). And in Kenya, nearly 250,000 married women of reproductive age use female sterilization, and more than 127,000 use an IUD (CBS [Kenya], MOH, & ORC Macro, 2004).

Contraceptive security activities thus need to go further to ensure the availability of the supplies, equipment, commodities,¹ training and other systems (e.g., supervision, management) necessary to regularly, reliably and equitably provide these provider-dependent, clinic-based methods.

¹ Commodities needed to provide LAPMs include: trocars for implants, speculum for the IUD, the tubal hook and uterine elevators for female sterilization, dissecting and ring forceps for no-scalpel vasectomy, sterilizers for infection prevention and expendable supplies.

Underemphasis on LAPMs in Contraceptive Security

There are a number of reasons for why LAPMs are often underemphasized in contraceptive security activities: National contraceptive security strategies do not have specific plans for LAPM support²; assessment tools do not have specific guides for LAPM needs; health logistics management may not focus on LAPM service requirements, especially in decentralized and integrated systems; the capacity to provide LAPMs is limited in many cases; and financial constraints on family planning in general may also limit investment in LAPMs.

Strategies and tools: Logistics programs and national contraceptive security strategies have primarily focused on supporting the forecasting, financing, and distribution of condoms, pills, and injectables for government clinics, social marketing programs, nongovernmental organizations, and community-based distributors. These resupply methods of family planning are more easily delivered and counted than are LAPMs, since they do not require a clinical infrastructure with highly skilled clinical providers. Also, LAPMs pose planning, financing, logistics, and distribution challenges to securing the necessary supplies, equipment, and commodities. Finally, tools that support the development of contraceptive security strategies and that assist with procurement for family planning, such as the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS) and the United Nations Population Fund's (UNFPA's) Country Commodity Manager, only partially address the specific clinic-based needs of LAPM service provision.

Logistics management: The commodities, equipment, and supplies needed to provide LAPMs may not all be on Ministry of Health (MOH) essential drug and equipment lists. Even when LAPM commodities, equipment, and supplies are in the MOH's procurement plan, many managers who handle contraceptive forecasting simply “straight line” orders for clinical methods and supplies, since in their experience increases in the demand for LAPMs have been slight. Consequently, when demand increases (as providers are trained and as communities and individuals come to know and accept LAPM services), programs often experience stock-outs of the commodities, equipment, and/or supplies. For example, Kenya invested significantly in training in implants over the last 15 years, but the resulting client demand so exceeded supplies of implants and related equipment (e.g., trocars) such that only one-third of facilities capable of providing implants in Kenya had them in stock, even though there was demand waiting to be met (NCAPD et al., 2005).

In decentralized health care systems, procurement managers may not know how to forecast and supply for LAPMs services. For example, a logistics management study of decentralization in Guatemala and Ghana noted that shifting responsibility for contraceptive forecasting and funding to lower levels had contributed to a “worse performance... related to procurement, inventory control, storage, logistics management information systems, training, and client contact” (Bossert et al., 2004, page 4).

Shifts from vertical to integrated health logistics systems also may hinder LAPM contraceptive security. While central MOHs still have family planning departments, the responsibility and skills for forecasting, distribution, supply management, and financing have often been moved to integrated health logistics units. Managers of integrated logistics units and systems generally do not have specialized knowledge about every health service that they manage, and they typically lack knowledge of requirements for the provision of clinical family planning services.

² The National Contraceptive Security Strategies that were reviewed included those for Albania, Cameroon, Ghana, Liberia, Madagascar, Nigeria, Togo and the West Africa Region.

Capacity: In many developing countries, the overall capacity to provide LAPMs is challenged. For example, in the 2002 Ghana Service Provision Assessment Survey (GSS et al., 2003), only 60% of *designated* implant sites had the equipment required for the service and only 17% had both the equipment and the infrastructure required for insertion and removal (including infection prevention supplies, clean water, and reliable electricity). Nevertheless, the prevalence of implant use increased more than 10-fold, from 0.1% in 1998 to 1% in 2003 and to 1.2% in 2006 (Asare et al., 2006). If all of the needed commodities and supplies had been available, implant prevalence would likely have been much higher, since preference for implants increased from 4% in 1998 to 11% in 2003 among nonusers of family planning (GSS, NMIMR, & ORC Macro, 2004). Similarly, in Tanzania, among facilities that actually provide IUDs (i.e., excluding facilities that only prescribe or refer), only 54% had IUDs available, and even fewer (39%) had all of the basic equipment needed for IUD insertion and removal. Overall, the capacity to provide IUDs in Tanzania was lacking, with only 8% of eligible facilities having IUDs, associated equipment, and the needed infrastructure for good-quality insertion and removal³ (NBS [Tanzania] and Macro International, 2007).

LAPMs must be provided in a clinical setting or a quality mobile service environment, by specially trained providers, whereas short-acting methods can be provided in nonclinical as well as clinical settings, by lower-level cadres such as health workers, pharmacists, and community agents. However, many hospitals are still called upon to meet the *resupply* needs of current family planning clients, and thus their capacity to deliver LAPMs on a consistent basis is constrained. For example, in Tanzania, 93% of all client visits at district and regional hospitals were for “resupply of short-acting methods” and 90% of all visits for the injectable in Tanzania were for its resupply.⁴ Providing these methods at lower-level settings could free up capacity for LAPM provision, as suggested by the finding that “new clients referred for IUD insertions and other LAPMs from lower level sites are often asked to return another day due to overcrowding and lack of time. It is unclear how many return[ed] at a later date for their preferred method” (Patykewich et al., 2007).

Financing: The international family planning community generally understands that financing for LAPM commodities, equipment, supplies, and services is critical; however, key traditional funders of family planning, such as the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA) have had to cut their family planning budgets in the past decade due to shifting priorities and health emergencies such as HIV, tuberculosis, and malaria.⁵ Yet the annual estimated cost of all needed family planning commodities, including LAPMs, is sizable and growing: A total of US\$900 million was needed in 2005, with an increase of almost 10% projected by 2010 (Ross et al., 2005), and this figure does not take into account the additional costs of the equipment and expendable supplies needed to provide LAPMs.⁶

³ These criteria include all infection control items, visual privacy, an examination bed, an examination light, and the method.

⁴ These dynamics can be seen quite clearly during a walk through a typical family planning clinic in most of the developing world. Women (with their young children) wait in long lines to get their monthly supply of pills or their choice of injectable, losing a half-day or more in travel and waiting times. These resupply clients could easily be served by lower cadres of health workers in more convenient, closer locations.

⁵ According to Population Action International, overall annual U.S. government investments in family planning programs have declined by \$100 million since 1995, a 40% *decline* when adjusted for inflation. Yet during this time, the number of women of reproductive age in the developing world has increased by more than 300 million. The report goes on to say that this situation could change later in 2008 or 2009, as Congress is looking to increase investments significantly (PAI, 2008).

⁶ The growing cost for family planning is largely due to overall increases in the population of women of reproductive age and to modern FP use increasingly becoming a norm in developing countries. In addition, as women and men with HIV and AIDS live longer because of the much wider availability of antiretroviral therapy, their interest in effective modern family planning increases.

What Is Needed for Contraceptive Security for LAPMs?

Strategies and tools: As contraceptive security strategies are being developed in many countries to address the substantial need for supportive policies, systems, human resources, and funding for family planning, these strategies should be broadened to include more LAPM questions and reviews. For example, the successfully implemented SPARHCS process (Hare et al., 2004) could include a module on LAPMs, so that the special requirements for these methods could be incorporated into national planning, purchasing, distribution, and support. Contraceptive procurement and forecasting tools could also benefit from the recently developed Reality $\sqrt{\quad}$ tool, which can be easily used to project the levels and inputs needed for all methods, including LAPMs, as demand and unmet need for family planning rise (ACQUIRE Project, 2007).

LAPMs Integrated into SPARHCS Process in Tanzania: First Time in Any Country Program

In Tanzania in 2007, a joint team from the Ministry of Health and Social Welfare (MOHSW), USAID, the DELIVER II Project, and the ACQUIRE Project introduced LAPMs into the national SPARHCS assessment process. Gaps in logistics management, training, services, and procurement for LAPMs (as well as for short-acting methods) were identified. A broad range of stakeholders at the SPARHCS dissemination workshop agreed that wide availability of LAPMs was needed in Tanzania and agreed to incorporate the full needs of LAPMs into the next procurement cycle(s). To help implement this recommendation, the ACQUIRE and Deliver II projects introduced the Reality $\sqrt{\quad}$ forecasting tool, so that realistic projections of need for LAPMs (and all methods) could be generated for use in the contraceptive procurement tables (CPT) exercise of the MOHSW (Patykewich, 2007). In 2008, Tanzania made plans and allocated the funds to procure more than 150,000 contraceptive implants.

Management and capacity building: A number of management and capacity-building interventions are necessary to improve LAPM contraceptive security. First, LAPM commodities, equipment, and supplies should be included on MOH essential drug and equipment lists if they are not already there or if those lists are incomplete. Standard lists of the equipment and supplies needed to conduct LAPM training and to provide LAPM services are already published and ready for adaptation and use.⁷ Second, staff at national, district, and local levels with any logistics management function or responsibility need to be trained or otherwise oriented to the specific forecasting, procurement, and distribution needs for LAPM commodities, equipment, and supplies. Third, curricula used in training logistics managers, supervisors, and service providers should address LAPM requirements for forecasting, procurement, distribution, and storage, taking into consideration realistic increases in LAPMs once supply is more secure. Finally, programs should work to see that clients using resupply methods receive their continuing supply of pills, injectables, or condoms at the lowest appropriate service level, thus enabling clinical settings to provide more LAPM services and to introduce new clients to the full range of family planning methods.

Financing: High-level advocacy is needed at the national and international levels with donors, finance ministers, politicians, and program leaders to highlight the financial needs for LAPM commodities, supplies, equipment, and services and the health and development benefits that would result from investment in them. Once agreement for greater funding of LAPMs is secured, the specific requirements for LAPM services, commodities, equipment, and supplies need to be factored into

⁷ EngenderHealth equipment lists for all LAPMs are available online at www.engenderhealth.org/lapm-equipment. Each local program will also need to make cost estimates for these supplies and equipment, based on local costs and availability.

plans, budgets, and programming priorities at national, regional and district levels. Periodic and consistent reviews of planned versus actual budget expenditures should be conducted to ensure that LAPMs receive the sustained attention that they warrant.

National family planning programs can explore several potential sources of sizable additional funding for LAPMs. For example, the highly-resourced Global Fund to Fight AIDS, Tuberculosis, and Malaria (“The Global Fund”) recently announced in its Round 8 call for proposals that financing for system strengthening for logistics management and forecasting systems will be accepted (DELIVER Project, 2008). To access some of these funds for LAPM commodities, equipment and supplies, technical assistance to country-level Global Fund stakeholders will likely be needed to help country programs prepare proposals that show the linkages between investments in family planning and improvements in disease outcomes, as required by the Global Fund. Contraceptive security committees and/or USAID, UNFPA, European and other donors, as well as nongovernmental organizations and cooperating agencies, should assist governments in this process.

In addition, the United Nations Millennium Development Goals and the World Bank poverty reduction programs in many developing countries state that family planning plays an important role in reducing maternal mortality and morbidity and promoting healthier families; yet national budgets do not fully fund the requirements for family planning, especially LAPMs. At the national and district levels, advocacy is needed to link family planning, including LAPMs, to poverty alleviation and to set realistic annual budget levels for these services. Longstanding, supportive donors such as USAID, UNFPA, and the UK’s Department for International Development (DFID) should increase their global leadership and financing for family planning, with special attention given to increasing support for LAPMs. Lastly, the private commercial sector, faith-based organizations, and nongovernmental organizations working in reproductive health and poverty alleviation need to support increased access to family planning and LAPMs.

The result of these various efforts aimed at increasing funding for LAPMs could be large inflows of resources for contraceptives and logistics system strengthening—including the commodities, supplies, and equipment needed to provide hormonal implants, IUDs, female sterilization, and vasectomy. This would strengthen contraceptive security and ensure that the most effective methods of family planning are more widely available to the many women and men who want and need them.

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