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# Revitalizing Access to Permanent Methods

## Lessons Learned from MCSP Country Programs

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### Introduction

As of July 2017, more than 317 million women and girls in the 69 Family Planning 2020 (FP2020) focus countries were using a modern method of contraception.<sup>1</sup> While this represents an impressive increase of 38.8 million more women than were using contraception when FP2020 was launched in 2012, 21.7% of married or in-union women of reproductive age across the FP2020 focus countries still had an unmet need for modern methods of contraception during the same time period. A considerable number of these women with unmet need have achieved their desired family size.

Expanding access to a wide range of contraceptives, including permanent methods (PMs), gives women greater choice in selecting a contraceptive that meets their needs for delaying, spacing, or limiting pregnancy. PMs include female sterilization and vasectomy and both are an essential component of comprehensive, voluntary family planning (FP) services. While female sterilization is the world's most popular contraceptive method, used by 19% of women ages 15–49 who are married or in a union, male sterilization is the least used modern contraceptive method, with less than 3% of married women relying on their partner's vasectomy for contraception. However, uptake of PMs varies geographically. While female sterilization accounts for approximately 26% of the modern contraceptive method mix in Latin America and the Caribbean and 23% in Asia, it is just 13% in developed countries and less than 2% in Africa, where unmet need and desire to limit pregnancies is highest.<sup>2</sup> In 2015 in sub-Saharan Africa, female sterilization comprised only 1.6% of the method mix, while male sterilization was largely absent.<sup>3</sup>

The US Agency for International Development (USAID)'s flagship Maternal and Child Survival Program (MCSP) strives to prevent unintended pregnancies with a continued focus on quality service delivery that expands access to a wide range of voluntary contraceptive options, including PMs. Of the 21 countries in which MCSP has supported FP interventions, seven (Rwanda, Nigeria, Tanzania, India, Haiti, Bangladesh<sup>4</sup>, and Togo) included PM activities at the request of the respective ministry of health (MOH) and USAID Mission. MCSP gathered lessons learned about supporting voluntary PM services from those countries through a short survey. Below are the critical actions that emerged and can help pave the way for more countries to revitalize voluntary PM services.

<sup>1</sup> Scoggins S, Bremner J, Sonneveldt E, et al. 2018. *FP2020: Catalyzing Collaboration 2017–2018*. Washington, DC: United Nations Foundation.

<sup>2</sup> Marie Stopes International, EngenderHealth, IntraHealth International, et al. 2014. *Increasing Access to High-Quality Voluntary Permanent Methods of Contraception in Low-Resource Settings*. Washington, DC: Marie Stopes International US.

<sup>3</sup> United Nations, Department of Economic and Social Affairs, Population Division. 2015. *Trends in Contraceptive Use Worldwide*. New York City: United Nations.

<sup>4</sup> MCHIP Associate Award

# Critical Actions for Countries to Revitalize Permanent Methods

## I. Use a broad health systems approach.



CHALLENGES ENCOUNTERED	TESTED SOLUTIONS
<ul style="list-style-type: none"> <li>• Few providers are trained in PMs.</li> <li>• Current national policies do not actively support expanding access to PMs.</li> <li>• There is a lack of facility readiness and infrastructure for PM service provision.</li> <li>• Cost to clients can be prohibitive (see #3 for additional detail).</li> </ul>	<ul style="list-style-type: none"> <li>• Assess facilities for readiness (via facility-based needs assessments) before start of activities to identify gaps.</li> <li>• Advocate for policy change and government support for improving access to and cost reduction for voluntary sterilization services through working with local advocacy bodies or technical working groups.</li> <li>• In collaboration with the MOH and facilities, develop coordinated plans for addressing identified gaps, including any needed on-the-job training/certification for rollout of services or planning dedicated PM service days.</li> <li>• Develop pool of master trainers (requires standardizing knowledge and skills of existing providers per national guidelines) and support them to step down the training to other staff.</li> <li>• Provide missing surgical instruments and consumables to sites that are not adequately stocked.</li> </ul>

### VOICES FROM THE FIELD

*“Identify competent providers and support them to step down the training to other staff and mentor them to develop competency to increase the number of competent providers.” [Nigeria]*

### Program Example: Nigeria

MCSP’s FP approach in Nigeria focused on increasing FP uptake among postpartum women by improving access to postpartum FP (PPFP) information and services across all levels of the health system. To improve the range of available FP options in those locations, MCSP implemented an intervention to improve the provision of tubal ligation services (minilaparotomy with local anesthesia, or MLLA) in the postpartum and interval periods in nine high-volume facilities of Kogi and Ebonyi states. Ten teams of doctors and nurse attendants underwent MLLA training, and their facilities were equipped with the necessary instruments. After assessing the teams’ competency and performance, a subset was certified as trainers, who then cascaded the training, resulting in a pool of 38 trained MLLA providers in Kogi and Ebonyi. While there was demand for limiting future pregnancies by undergoing tubal ligations (TLs) in both states, only 15 women benefited from the services within 6 months of training, as couples were often unable to afford the cost of NGN 5,000 (about USD 14) for the procedure. This resulted in women who initially asked for this method subsequently opting for short-acting or long-acting reversible methods that were free or provided at a minimal cost. MCSP’s

subsequent advocacy with clinicians and hospital administrators to calculate actual costs of services led to a reduction in price across the nine facilities (from NGN 5,000 to NGN 2,500 in Kogi and NGN 3,500 in Ebonyi). While this has enabled more women to regularly seek services, clients numbers remain low, highlighting the need to continue addressing this barrier systemwide to ensure women in Nigeria consistently have access to affordable PMs when they voluntarily choose them, regardless of their socioeconomic status.

## 2. Ensure linkages with the community.



### CHALLENGES ENCOUNTERED

- Community health workers (CHWs) are very project-focused in some countries and are not integrated into planning or implementation of national FP programs.
- Without clear information and instructions, CHWs do not routinely counsel and refer for PMs.
- Couples in the community had low awareness/understanding of PMs and their availability.
- Key stakeholders are not routinely engaged in nuanced discussions about specific types of FP.

### TESTED SOLUTIONS

- Community mobilization, initial counseling, and referrals via CHWs will increase knowledge, demand, and access to PMs.
- Orientation of key community-level stakeholders will increase awareness and support for PMs.
- Develop systems for CHWs and facilities to regularly communicate regarding PM clients.
- When fixed sites are not easily accessible, support mobile PM services in remote areas.

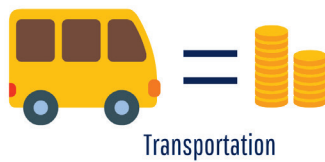
### VOICES FROM THE FIELD

*“To facilitate the communication [between health facilities and CHWs], a WhatsApp group was created and used by all key players in the districts to link health center and hospital providers as well as the MCSP team. The MOH was also added to the group in order to follow what is happening on ground.” [Rwanda]*

### Program Example: Haiti

One of the aims of the MCSP-led *Services de Santé de Qualité pour Haiti (SSQH)* project in Haiti was to increase access to long-term FP methods, particularly in remote areas, by providing services closer to the communities in need through mobile service delivery clinics. After some initial work to have procedures for mobile teams reviewed and approved at the policy level, SSQH established four departmental mobile units that offered long-acting reversible contraceptives (LARCs) and voluntary PMs, both MLLA for female sterilization and no-scalpel vasectomy (NSV). Two weeks before mobile clinics, CHWs, local radios, and *crieurs de rue* (street callers) engaged in FP awareness campaigns to ensure sufficient awareness and demand. During one of the first quarters of implementation, SSQH organized nine mobile clinics serving 363 clients with LARC/PM services.

### 3. Consider both health system costs and costs that clients incur.



CHALLENGES ENCOUNTERED	TESTED SOLUTIONS <sup>5</sup>
<ul style="list-style-type: none"> <li>Both static and mobile clinics are expensive and require a surgical team and use of an operating room, expenses that are not usually part of FP program cost considerations or budgets.</li> <li>The higher cost of PMs means they are out of reach for many clients (and they often use other FP methods for meeting their needs to limit childbearing).</li> </ul>	<ul style="list-style-type: none"> <li>Advocate for inclusion of voluntary PM services in national insurance plans and national-/facility-/program-level budgets.</li> <li>Bring services closer to the communities, prioritizing areas with high unmet need among couples wishing to limit future childbearing.</li> <li>Advocate with national or state MOHs and heads of facilities for reduction in cost to clients and inclusion in health insurance schemes.</li> <li>Conduct prescreening of clients at lower facility and use an appointment system to avoid clients paying for transportation, who are sometimes turned away because of medical conditions or a heavy volume of clients.</li> </ul>

#### VOICES FROM THE FIELD

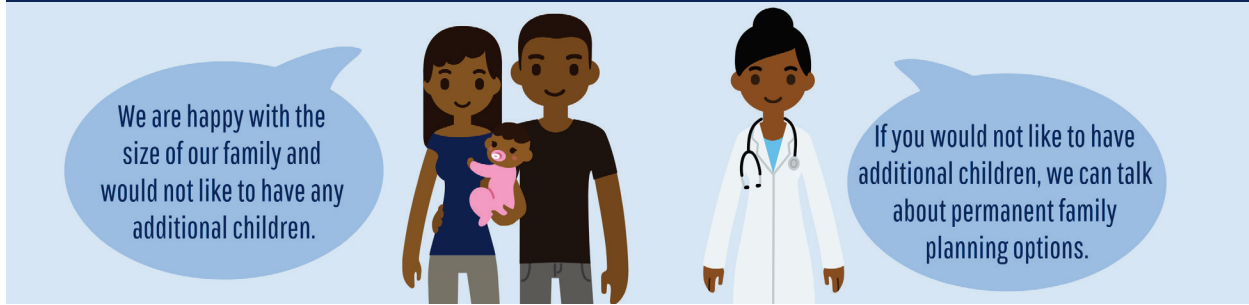
*“Clients cannot afford transportation and costs of food when traveling for the surgery (TL or NSV) when [it is only] available far away from their homes/villages.” [Haiti]*

#### Program Example: Rwanda

The goal of MCSP Rwanda was to assist in scaling up evidence-based, high-impact maternal, newborn, and child health interventions, including FP, contributing to significant reductions in maternal, newborn, and child mortality. MCSP in partnership with the MOH supported PM services (NSV and TL) at the district level by training teams made up of doctors, anesthesiologists, and nurses. To reduce the cost to clients, MCSP and other implementing partners successfully advocated for coverage under community insurance, which pays 90%; clients pay 10% of the total cost (but because MCSP was providing the consumables and drugs needed in the intervention, the hospitals were not charging the 10% of total cost and clients were receiving the services for free). The combination of this and a coordinated effort to engage CHWs and organize mobile services led to a significant increase in TLs—the number of TLs performed increased from 62 pre-intervention (2013–15) to 458 post-intervention (2015–2017). Unfortunately, it did not lead to a significant change in NSV, which was 119 pre-intervention (2013–2015) and only 121 post-intervention (2015–2017). While formal research was not conducted, the country team reported that informal discussion with clients, partners, and community members led them to believe that the main barriers to increased NSV uptake are (1) fear of side effects, particularly around the ability to provide sexual pleasure, and (2) general stigma in the Rwandan community around use of PMs by men instead of their wives.

<sup>5</sup> While MCSP did not support any task shifting for PMs in the countries it worked in, there is an evidence base for task shifting PMs to clinical officers or medical assistants.

## 4. Create and understand demand for PM services.



### CHALLENGES ENCOUNTERED

- Health workers at both clinic and community levels do not routinely counsel on PMs.
- While there is a **perceived lack of demand** for voluntary PM services by budget holders and planners, women are often on long waiting lists to access PM services.

### TESTED SOLUTIONS

- Implement an appointment system or other direct-to-consumer technology to ensure clients who want PM services are captured and know when and where services will be provided to them.
- Make PM services more accessible through the use of fixed day services.
- Support integration of comprehensive FP counseling across the continuum of care, including PFP counseling at antenatal care and maternity wards, to address myths and misconceptions and to allay fears of a surgical procedure.
- Advocate with local governments to mobilize resources to train more providers, including CHWs or facility counselors.
- Expand services to more facilities and strengthen referral systems to meet latent demand.

### VOICES FROM THE FIELD

*“They kept coming back to their CHW seeking advice on how to protect themselves until they can have the procedure done on the next mobile clinic.” [Haiti]*

### Program Example: India

MCSP’s FP team is working with national and state governments in five focus states in India—Assam, Chhattisgarh, Odisha, Maharashtra, and Telangana—to demonstrate delivery of quality FP services through innovative processes. MCSP developed and rolled out *Parivar Swasthya Vaani* (PSV), a mobile technology-based interactive voice response system, in two states. PSV is integrated into the toll-free helpline that provides FP information, including on PMs, and it captures and collates clients’ feedback and schedules appointments. Between July 2018 and January 2019, PSV received 2,590 calls and 1,411 feedback calls (regarding the quality of FP services), and 6,093 appointments were booked for TL services. In addition, MCSP worked with target facilities to establish a schedule of fixed day services where appointments could be booked and services were guaranteed on set days. A shift from provider-centric to client-centric TL services through PSV resulted in improved procedure outcomes and client satisfaction. Client feedback captured through PSV showed 90% of the clients who provided feedback indicated they felt comfortable asking questions of providers and said the providers answered their questions/concerns adequately/satisfactorily. Only 20% reported they incurred out-of-pocket expenditure for the services.



## 5. Address men's fears about vasectomy to increase demand.



### CHALLENGES ENCOUNTERED

- Demand for vasectomy is very low.
- There are culturally entrenched views that FP is the (sole) responsibility of a woman.
- Men's and women's fear of side effects and incorrect knowledge of vasectomy hinder demand.
- Clients cannot afford to lose time at work to go for vasectomy.

### TESTED SOLUTIONS

- Training of providers (at community and facility levels) should address common myths and misconceptions about PMs and seek to understand providers' perspectives around method mix, volunteerism, and informed choice.
- Community mobilization strategies and programming approaches should target men and boys directly (see examples from India below).

### VOICES FROM THE FIELD

*"Demand for vasectomy is very poor due to the widely held misconception that it causes weakness and inability to perform daily tasks by a man." [India]*

### Program Example: India

To ensure male participation in FP and increase demand for NSV, the MCSP Healthy Cities program engaged men by replicating four key interventions developed under the Urban Health Initiative (UHI) and Expanded Access and Quality (EAQ) projects in Uttar Pradesh: *chouraha* approach (male gathering points), rickshaw puller intervention, workplace interventions, and night meetings in slums.

While the intervention periods were different for these two projects (it was first tested under UHI and then scaled up to the private sector under EAQ), the results from both have been promising. The 11 cities implementing these four interventions under UHI contributed 70% of the total NSVs in the state from January–December 2014. Under EAQ, the sites in the six cities that participated via the private sector went from never having performed NSVs to contributing to 37% of the total NSVs in the state from January–December 2016.

During implementation, all four interventions strategies were scaled up as a package, recognizing it takes multiple touch points to achieve behavior change, but subsequent data from EAQ from January–December 2016 were able to isolate the impact of each:

- Percentage of clients from *chouraha* approach: 69%
- Percentage of clients from rickshaw puller intervention: 13%
- Percentage of clients from workplace interventions: 5.4%
- Percentage of clients from night meetings in slums: 13%

This evidence-based, high-impact approach to male engagement was formally adopted by the MOH, and a how-to tool was developed to scale up the approach with government resources. MCSP's Healthy Cities is currently scaling up the same model in 20 cities, which will be taken over by the National Health Mission after 6–9 months of demonstration. The government has already committed financial resources to transition implementation into the public system.

## Conclusion

Ensuring access to high-quality PM services requires a breadth of programming to ensure linkages across the health system, from revising existing policies and guidelines to training providers, ensuring facility infrastructure, working with local governments to ensure costs are affordable to end users, and working with local communities to raise awareness and interest and to increase access for clients.

To reach the 21.7% of married or in-union women of reproductive age across the FP2020 focus countries who still have an unmet need for modern methods of contraception<sup>6</sup> and achieved their desired family size, expanding access to a wide range of contraceptives, including PMs, is critical. More must be done by countries, donors, and implementing partners to address these gaps and prioritize the FP needs of women and men who would benefit most. It is time to revitalize the 2014 [Call to Action to Increase Access to High-Quality Voluntary PMs of Contraception in Low-Resource Settings](#).<sup>7</sup>



Photo: Kate Holt/MCSP

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<sup>6</sup> Scoggins S, Bremner J, Sonneveldt E, et al. 2018. *FP2020: Catalyzing Collaboration 2017–2018*. Washington, DC: United Nations Foundation.

<sup>7</sup> Marie Stopes International, EngenderHealth, IntraHealth International, et al. 2014. *Increasing Access to High-Quality Voluntary Permanent Methods of Contraception in Low-Resource Settings*. Washington, DC: Marie Stopes International US.