Programming for Long-acting and Permanent Family Planning Methods in Community Settings: Overview

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First WHO Global Symposium on Health Systems Research, Montreux, Switzerland, November 17, 2010

Managing Partner: EngenderHealth; Associated Partners: FHI; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council
The long-acting and permanent methods (LA/PMs)

- Long-Acting Reversible Methods
  - IUDs:
    > CuT380A, ML-375
    > LNG-IUS
  - Implants:
    > Jadelle
    > Sino-implant II
    > Implanon

- Permanent Methods
  - Female Sterilization
  - Male Sterilization (Vasectomy)
Health system requirements to provide quality LA/PM services in community (and clinical) settings

- Suitable service settings
- Supportive service subsystems
  - Logistics; training; supervision; management & structure of work
- Knowledgeable, skilled, motivated, well-supervised providers
  (& not overworked, unbiased toward LA/PMs, adequately-rewarded: “No provider, no program”)
- Empowered, knowledgeable clients & communities
- Contraceptives (implant or IUD)
- Equipment, instruments, expendable medical supplies, essential drugs
- Good counseling; free and informed choice; privacy
- Infection prevention, emergency preparedness
- Follow-up mechanisms & good side effects management
Many health system barriers to LA/PM services at community and clinic levels: “The brick wall to access”

Barriers to effective family planning services:
- Physical
- Location
- Cost
- Political
- Inappropriate eligibility criteria
- Regulatory
- Socio-cultural norms
- Time
- Legal
- Poor CPI
- Stigma
- Medical
- Knowledge
- Process
- Gender
- Provider bias

Outcomes when barriers are overcome:
- Access to services
- Quality of services
- Contraceptive choice
- FP use (including LA/PMs)
Systems thinking: The “What” of LA/PMs

- Intrinsic (“objective”) characteristics of the LA/PM itself
- How these characteristics are perceived by system actors
  - Clients, potential clients, community leaders, other “influentials”
  - Providers, policymakers, decisionmakers, program leaders, donors
- Are the methods beneficial? In what way?
- Does the method represent a big comparative advantage—to them?
- Is it compatible (with “our world,” & “the way we do things”)?
- Is it “simple”?: easy to introduce, adopt, scale-up?
- Can I try it out?
Systems thinking: The “Who” of LA/PMs

- **Who accepts:** clients and potential clients, and communities
  - Reproductive intention?: Limiters / spacers / delayers
  - Do they have (accurate) knowledge of LA/PMs?
  - Other variables with programmatic & health system implications:
    - Age and parity / Marital status / Urban – rural / Income level

- **Who provides:** level (cadre), gender, skills, motivation of providers
  - Need to factor in what makes providers behave in their given service setting and situation

- **Who allows, facilitates, advocates, champions**
  - Sociocultural and community factors
  - Site and program factors and dynamics
  - Focus on early LA/PM adopters
Systems thinking: The “Where” of LA/PMs

- Country: amplitude of health system resources; political will for FP
- Physical location (urban, periurban, rural)
- Level of facility
  - Clinical setting (hospital, referral center, primary care clinic)
  - Community setting
- Nature and dynamics of medical(ized) settings
- Policies, guidelines, standards, norms, rules
- Provider-level factors
  - Workforce (composition, adequacy, readiness)
  - Deployment / workload
  - Remuneration & “reward”
LA/PM service modalities and approaches
- Provided onsite / referral
- Fixed sites, daily / fixed sites, special days
- Within stand-alone FP services, or integrated with other services (MCH, HIV)

Mobile services; “outreach”
- Several models
  > Transport providers to clients
    - Lower-level facility
    - Community (“facility,” “van”)  
    > Transport clients to providers
      - Context-dependent
      - Can have sizeable service impact
      - Requires community mobilization & same Quality of Care
Important to involve “influentials”:
- Community & religious leaders
- Women’s groups
- Men (as partners, clients, change agents)

Important to use multiple channels:
- Mass media
  > Messaging
  > Listener call-ins
- Community events
- Print
- Interpersonal (community workers)
Systems thinking: The “How” of LA/PMs: Creating demand in the community

- Create a positive image / “normalize” method / dispel myths & misconceptions
- Provide information on where and when to get services
- Communicate messages relevant to clients’ and communities’ concerns
Messages need to be relevant to the concerns of communities and clients (address their “truths”)

A VASECTOMY won’t take them away

Vasectomy is a permanent family planning method for men. It won’t affect your sexual appetite or performance. Ask about this method at a health facility displaying this symbol.
Task-shifting / task-sharing

Costs and financing of LA/PM services
- Public sector / private sector
- Social marketing
- Franchising
- Vouchers
- Insurance modalities

Timing of LA/PM service delivery
- “When”:
  - Related to pregnancy:
    - postpartum / postabortion / interval
  - Nulliparous women: don’t forget about them! (for implants and IUDs)
  - Seasonality of demand for services
Community-level champions are essential.
Repetition is the key to LA/PM program success.
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