SYNTHESIS OF KEY INFORMANT INTERVIEWS

INTRODUCTION

During the period February to August 2012, the RESPOND Project conducted a series of key informant interviews with 18 individuals from a range of international donor, multilateral, and nonprofit organizations to discuss the current programmatic and political environment and how it affects contraceptive choice in family planning (FP) programs. The findings from the interviews will provide background for a consultation on contraceptive choice to be conducted at the Rockefeller Foundation's Bellagio Conference Center September 4–7, 2012. The purpose of the consultation is to explore what contraceptive choice means in programmatic and operational terms through the lens of a particular method, female sterilization. The focus on female sterilization was chosen because matters of choice are heightened with this method: It is the most widely used contraceptive method worldwide, yet its availability across regions is quite varied, and it is the method most often a focus of reproductive rights abuses.

Informants were queried about the current political and program environment for reproductive health (RH) and FP programs today, the global image of female sterilization, reproductive intentions to space and limit births, concerns about access and rights abuses, program factors that affect the availability of contraceptive options, and recommendations for action. The findings and recommendations are summarized below:

FINDINGS

- **Current political and programmatic environment for FP/RH programs**

  There was a consensus among the key informants regarding the improvement in the political environment for FP programs in recent times, following a period of neglect during much of the last decade. Noted signs of support that were mentioned included the two International Conferences on Family Planning, held in Uganda (2009) and in Senegal (2011); the formation of an Alliance in 2010 among the U.S., U.K., and Australian governments and the Bill and Melinda Gates Foundation with the purpose of reducing unmet need for FP by 100 million women; and the recent FP Summit in London in July 2012, which was hosted by the Gates Foundation and the UK government to generate additional commitment and support from other governments and donors. Most felt that this positive shift in the environment for FP programs signals that it is a good time to consider anew the issues of contraceptive choice.

  Many expressed concerns about the lack of focus on FP programs since the International Conference on Population and Development (ICPD) in Cairo in 1994 and the shift in global health priorities towards HIV and AIDS and toward disease prevention. As a result, several interviewees felt that ground had been lost and that there was much work to do to revitalize FP efforts to reach the more than 215 million women with an unmet need for FP. Some felt that the last 10–15 years were "the lost decade for FP." One respondent believed there was a "chilling effect" from the politics of the last decade and that while it is thawing, the effects linger. However, FP champions and advocates continued to find ways to generate political will for FP, by emphasizing maternal and child health, which prove less political than pursuing a rights rationale organized around giving women the right to control their fertility. Informants felt that other "positives" occurred during this period of neglect. While HIV diverted energy and money, some felt that it also brought focus on issues regarding gender, sexuality,

stigma, and marginalized populations that are important for RH/FP programs as well. Others felt that the increased attention during the past few years on integration and on health systems strengthening was also important, as vertical FP programs are less likely to be sustained.

- **Global image of sterilization**

  Most believed that the overall global image of female sterilization among political and program leaders is at best neutral. Several informants said that not enough people know that female sterilization is the most widely used method in the world. There is an overall absence of dialogue about the issue, and when it is mentioned, it is usually in the context of concerns regarding incentives and human rights abuses. Many said that its image depends on what countries or regions are being discussed or "who you are talking to." In many Asian and Latin American countries, female sterilization is widely used (some said overused), but the experience has been much less positive overall in Africa, with a few notable exceptions (Kenya and Malawi).

  All key informants believed that female sterilization is an appropriate option within FP programs for women who have completed their family size; several key informants representing international donor organizations believed that it is an important method and that efforts are needed to ensure it is included in FP programs. Some felt that stigma is no longer a major issue, while others believed that the method is plagued by poor press and a history of abuse. Several informants said that with a shift of global development priorities to Africa, sterilization has lost some relevance at the global level, since African FP programs are focused more on birth spacing than on fertility limitation, and it is assumed cultural barriers for female sterilization are greater than for other modern methods there. In addition, some informants argued that female sterilization is part of the method mix in countries with more "mature" programs but that the health care infrastructure in Africa is too poor to accommodate the addition of female sterilization in a significant way. One informant theorized that female sterilization has been "crowded out" by program trends that favored the community-based and private-sector provision of contraception and that have deemphasized systems for clinical care.

  One respondent characterized female sterilization as the method of "last resort/next resort," meaning that program leaders often find reasons to put off tackling the political and system challenges that must be overcome in making it available. It also is considered the method of last resort by a woman who, it is assumed, would do anything else before resorting to permanently ending her fertility. Another respondent indicated that she, too, had believed that female sterilization was not appropriate in Africa—until she saw the numbers of women lining up for mobile services (in Kenya) when the method was offered and the resulting satisfied clients.

- **Concerns regarding access barriers "versus" rights abuses**

  Interviewees were asked how they balanced concern about the "two sides of contraceptive choice," defined as women experiencing "no barriers" and "no coercion" to use a contraceptive method. While all informants felt that both issues were important and there is no dichotomy between ensuring choice and protecting against coercion, the majority expressed greater urgency about the need to remove the barriers that women face in accessing contraception than concern about coercion. While coercion is an egregious abuse of individual rights, most felt that its occurrence was limited and that the international community has learned how to monitor and address abuses when they happen.

  However, a few respondents expressed concern about the existence of more nuanced situations where choice may be compromised, such as in programs that include performance-based financing of particular contraceptive methods or that experience provider bias toward certain methods. One

respondent indicated her hope that a result of the FP Summit would be a deeper discussion about pay-for-performance plans and when payments or incentives to providers are appropriate. Rights are hampered by poor quality of services and whether a health system is oriented to clients' preferences and reproductive intentions.

- **Reproductive intent for limiting**
  Many respondents noted that there is a significant unmet need among women who intend to limit future pregnancies and that it is especially important to reduce unwanted pregnancies for this group. Most respondents felt that programs pay overwhelming attention to the needs of those who are interested in spacing births, particularly given the use of the maternal health rationale for promoting FP. However, some felt that programs are more likely to address spacing because it is less politically charged than talking about limiting. One respondent noted that from a demographic standpoint, the young age structures of many countries imply that spacing issues are more pressing; however, systems need to prepare for when these people age and their reproductive intentions shift toward limiting.

- **Program factors that affect sterilization as a contraceptive option**
  The respondents provided many ideas about the factors that affect the position of female sterilization within the global discourse on contraception and its availability in countries. Most respondents noted that support for female sterilization has waned, given donors' interest in supporting the availability of long-acting contraception. Since the IUD is effective for 15 years and lower-cost implants have become real options in many countries, the rationale for providing a surgical option seems to have lessened. One respondent noted that there are passionate advocates for expanding access to implants and IUDs, but none for sterilization. Others noted that initiatives to address contraceptive security are focused on "products" and "commodities" and that surgical methods are absent from the conversation. Also, a few respondents noted the tendency for the international community to focus on utilizing new technologies rather than expanding the use of the "old."

  Many respondents expressed the view that investing in sterilization was perceived by planners and managers to be just "too hard a slog," despite its cost-effectiveness and potential contribution as an option for women who would prefer a one-time option and who do not want hormonal methods or an IUD. Without a different approach and renewed attention, some felt that female sterilization use would continue to plateau or lose ground in FP programs.

  A few respondents noted that programmatic effectiveness is measured by overall contraceptive prevalence and by couple-years of protection; however, the same kind of attention is not given to contraceptive method mix as an indicator. What constitutes an appropriate method mix is a question that is difficult to answer, as there is no "ideal mix"; however, more attention is needed to understand and address the skews that exist and that represent the lack of overall choice in programs.

  Regarding factors at the country level, these are organized below into three distinct categories following EngenderHealth's Supply, Enabling Environment, and Demand (SEED) programming model. By far, most of the comments concerned barriers to supply, although two respondents thought that demand factors were equally important.

  Supply Factors
  Human capacity and infrastructure requirements were the factors most often mentioned by respondents as limiting the availability of the method. Many felt that the lack of skilled and competent providers was the main barrier that needed to be overcome. When it is offered, there is an urban bias, and it is less available for rural, hard-to-reach populations. Lack of FP in preservice training for

clinicians is a key problem, given the overall neglect of FP in recent years. “As FP goes, so goes sterilization, but even more so.” In low-prevalence countries, one called the dearth of providers in quality sterilization services a “Catch-22,” in which the lack of practice leads to low quality of care, which undermines the method and its use. Poor quality of care leads to failure, infection, poor counseling, and in some programs, subtle and not-so-subtle coercion.

Other important supply-related factors noted by the respondents include the lack of dedicated space and time available at overcrowded facilities (usually at the district level) for elective surgery for contraception. One respondent noted, “Why should voluntary sterilization be done in a weak system? Since IUDs are as good as a permanent option, programs should start with other methods before adding female sterilization.” Others felt that surgical contraception programs have the added benefit of strengthening the capacity of both providers and systems to offer quality facility-based services.

Mobile outreach strategies were often mentioned as means for addressing the supply barriers. Respondents were mixed about the strategy, with some praising it as a solution for overcoming health system inadequacies and expanding choice while keeping cost down. However, a few respondents questioned the consequences related to managing follow-up and continuity of care.

Enabling Environment Factors

Many respondents mentioned that a key barrier affecting the availability of female sterilization is the upfront cost of providing and of obtaining the service. Many lamented that there are no recent data on the costs and benefits to programs and individuals of offering female sterilization as an option. Others felt that although most countries espouse rights-based rationales for FP, they pay little real attention or devote little advocacy to women’s health and choice. As one respondent said, “Programs don’t listen to women. What is easier? Getting a sterilization procedure or using a temporary method for 30-plus years?”

Some respondents noted that variations in the availability of sterilization within the method mix depend on program context and history. It is available in countries where it was promoted or emphasized and became normative in terms of provision as well as use. One respondent expressed a minority view by stating, “If people are happy with one-method programs, then it might be OK. It is hard to get rid of provider bias, but even that could be OK if women are well served.”

Demand Factors

The majority of respondents said that one of the biggest barriers to female sterilization is the lack of accurate information regarding the method. Like all contraceptive methods, female sterilization is subject to myths and misconceptions and, in many countries, it has a negative image that is difficult to overcome. Many mentioned the existence of cultural norms on fertility and gender as contributing to the barriers for women to access a permanent method. Little is currently known about the characteristics and motivations of women who choose this method, as most studies about choice and female sterilization in developing countries date back to the 1980s and 1990s. Further, one respondent asked, “What would women choose in the absence of barriers?” perhaps with the underlying implication that that no one would choose sterilization unless there were no other options available.

Others mentioned that barriers may result from a lack of counseling-related skills among providers and that programs compensate by building in requirements (age, parity, spousal consent) that impede access and show little faith in women’s decision-making ability. Some felt that providers worried about regret and about changed circumstances (marital status or number of male children), and that these might result in retaliation from angry spouses toward the wife (and the provider).

RECOMMENDATIONS

Respondents provided their thoughts on recommendations for how to improve contraceptive choice overall and what might be done to increase attention to and availability of female sterilization as an option within FP programs. With respect to choice, there were several recommendations to reorient policymakers and providers to the "nuances" of choice. It is important not only to have in place policies that protect individuals from abusive and coercive practices, but also to understand the broader limitations on choice that affect women's ability to access the contraceptive methods that they need and want. A few respondents recommended that providers be trained to deal with rights. Several discussed the importance of ensuring that the method is included in clinicians' preservice training and that more attention be devoted to task-shifting responsibility for sterilization to clinical officers in places where there are physician shortages. Others thought that more energy should be devoted to finding new ways or technologies appropriate for low-resource settings and pain management. Mobile outreach services were recommended by several respondents, although a few countered with cautionary concerns.

Many informants suggested a research agenda to support advocacy for improved contraceptive choice and proposed studies to better understand the costs and benefits of voluntary sterilization for individuals and health systems; case studies of countries that have successful program efforts that include voluntary sterilization; client studies that address use-dynamics and decision making about contraceptive choices; and research on the effects of incentives. One respondent recommended an effort to advance female sterilization similar to one implemented over the last several years by a large foundation to support the availability of long-acting methods. He suggested a demonstration project that would provide an infusion of funding and technical assistance to "bring it all together" in 2–3 countries with enough of a developed health system (e.g., Ethiopia) and with a high unmet need for limiting, to demonstrate the resources required to provide quality, scaled-up services and show that female sterilization is an appropriate and desired option among women.

Finally, there was a call to "listen to women" and to focus attention on addressing their needs and preferences throughout the reproductive life cycle. One respondent said that we need to reorient health systems so that there is "more counseling, more listening, and more faith in women."