

# Expanding long-acting and permanent contraceptive use in sub-Saharan Africa to meet FP2020 goals

By Thoai D. Ngo<sup>1</sup>, Olivia Nuccio<sup>1</sup>, Kate Reiss<sup>1</sup>, Shreya K. Pereira<sup>1</sup>

## Summary

There is a vast unmet contraceptive need in sub-Saharan Africa, a region that has a high fertility rate coupled with a desire among women to space and limit their number of births.<sup>1</sup> Short-term family planning methods have traditionally been used here,<sup>2</sup> and long-acting reversible contraceptives and permanent contraceptive methods (LARC/PM) have been under-utilised despite their effectiveness and low cost.<sup>3</sup> To increase women's contraceptive choice and address the unmet need in sub-Saharan Africa, Marie Stopes International (MSI) has implemented a cross-country LARC/PM expansion programme. This study evaluated the effectiveness of the programme in expanding access to a range of LARC/PM and addressing the unmet need in 11 sub-Saharan African countries between 2008 and 2012.

Findings showed a substantial overall increase in LARC uptake over the time period studied (from 140,408 services in 2008 to 895,041 services in 2012). The results also indicated that the programme had been successful in reaching under-served women in the region (women who had not used a modern contraceptive method in the past three months and women who switched from a short-term contraceptive method to a LARC/PM), and clients situated not only in urban and peri-urban locations, but also rural areas.

The effectiveness of the MSI LARC/PM expansion programme in these 11 sub-Saharan African countries demonstrates a vast untapped potential for wider LARC/PM use in the region, and suggests that this service delivery model can help family planning programmers in reaching the goals of Family Planning 2020.<sup>4</sup>



## Findings at a glance

- Between 2008 and 2012, there was a 250% increase in the use of MSI's LARC/PM services across 11 countries in sub-Saharan Africa; from just under 300,000 services in 2008 to just over 1 million services in 2012.
- The MSI expansion programme was able to address the region's unmet contraceptive need. Overall, 42% of LARC users and 46% of PM users were adopters, and 51% of LARC users and 47% of PM users had switched from a short-term family planning method.
- The average percentage of young (aged <25 years) LARC users across the 11 countries was substantially higher than the cross-country DHS average (38% versus 13%).
- There were high levels of client satisfaction among LARC/PM clients in the 11 country expansion programmes. 99% of clients indicated that they would recommend MSI to a friend.

## Background

The Family Planning 2020 (FP2020) initiative was launched in 2012 with the aim of providing access to contraception by 2020 for an additional 120 million girls and women in the world's poorest countries.<sup>4</sup> Sub-Saharan Africa has the greatest unmet need for contraception, only one in four women in Africa uses a modern contraceptive method despite the region having a high fertility rate coupled with a desire among women to space and limit births.<sup>1</sup> Access to family planning services in sub-Saharan Africa is especially low among rural, less educated, poorer women.<sup>5</sup>

Long-acting reversible contraceptives (LARC) such as the intrauterine device (IUD) and permanent contraceptive methods (PM) are highly effective and associated with high levels of user satisfaction, and they are also cost effective.<sup>6,7</sup> As these methods are not user dependent, they have very low levels of failure leading to unintended pregnancy.<sup>6</sup> However, use of LARC/PM in sub-Saharan Africa is low, and the region has predominantly relied on short-term family planning methods over the past 30 years. Expanding access to a variety of LARC/PM in sub-Saharan Africa is key to increasing women's contraceptive choice and addressing the high unmet need, and will contribute towards achievement of the FP2020 goals.

Marie Stopes International (MSI) provides high-quality family planning services around the world via three main service channels: MSI static clinics, mobile outreach units, and social franchising of private provider programmes.<sup>8</sup> MSI is committed to expanding access to a choice of high-quality LARC/PM services for under-served and hard-to-reach women in sub-Saharan Africa, and has developed a cross-country expansion programme in the region to achieve this. The programme involves service supply through MSI's three main service channels, as well as demand generation activities and innovative approaches including voucher schemes (Table 1). To ensure that the MSI LARC/PM expansion programme is effective in expanding access to a choice of LARC/PM services and increasing LARC/PM use among women with an unmet need, we undertook an evaluation in 11 sub-Saharan African countries where the programme has been in place since 2008. The evaluation involved client exit interviews and analysis of routine service data.

## Evaluation methods

The MSI LARC/PM expansion programme was evaluated in the following 11 countries between 2008 and 2012: Ethiopia, Ghana, Kenya, Madagascar, Mali, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda, and Zambia. LARC users were women who chose IUDs or implants and PM users were those who chose tubal ligation (TL).

### Health management information system data:

Between 2008 and 2012, routine clinic service data were collected on a monthly basis from the 11 MSI country programmes. Data were transmitted to central country support offices for quality checks, and inconsistencies were resolved between the support offices and respective clinics. Data were then sent to the London support office for further quality checks, with discrepancies resolved between the London and country support offices.

### Client exit interviews:

Between August and December 2012, over 3,000 client exit interviews were conducted at MSI clinic facilities and sites. In countries where it was possible to visit all facilities/sites, a census of sites approach was used. In countries where this was not possible, cluster sampling was used and a minimum of 30 facilities/sites was visited. Key questions concerned socio-demographic characteristics, contraceptive behaviour, and perspectives on MSI LARC/PM services. MSI's Independent Ethics Committee provided ethical approval of the exit interview protocol.<sup>9</sup>

### Data analysis and weighting:

The statistical chi-squared test was used to assess differences in the socio-demographic and reproductive characteristics of IUD clients versus implant clients. Results were weighted according to annual client flow through each service delivery channel type and country, and an aggregate weighting was also used.

### Proxy indicators:

Two proxy indicators for 'unmet need' were used: (i) clients who were 'adopters' (women who had not used a modern family planning method in the last three months); and (ii) clients who were 'switchers' (women who switched from a short-term family planning method to a LARC/PM). Although 'first-time users' is the metric commonly used by family planning programmers to assess their success in reaching additional users, this measure can underestimate the extent to which a programme reaches women with an unmet need. MSI therefore developed the 'adopter'

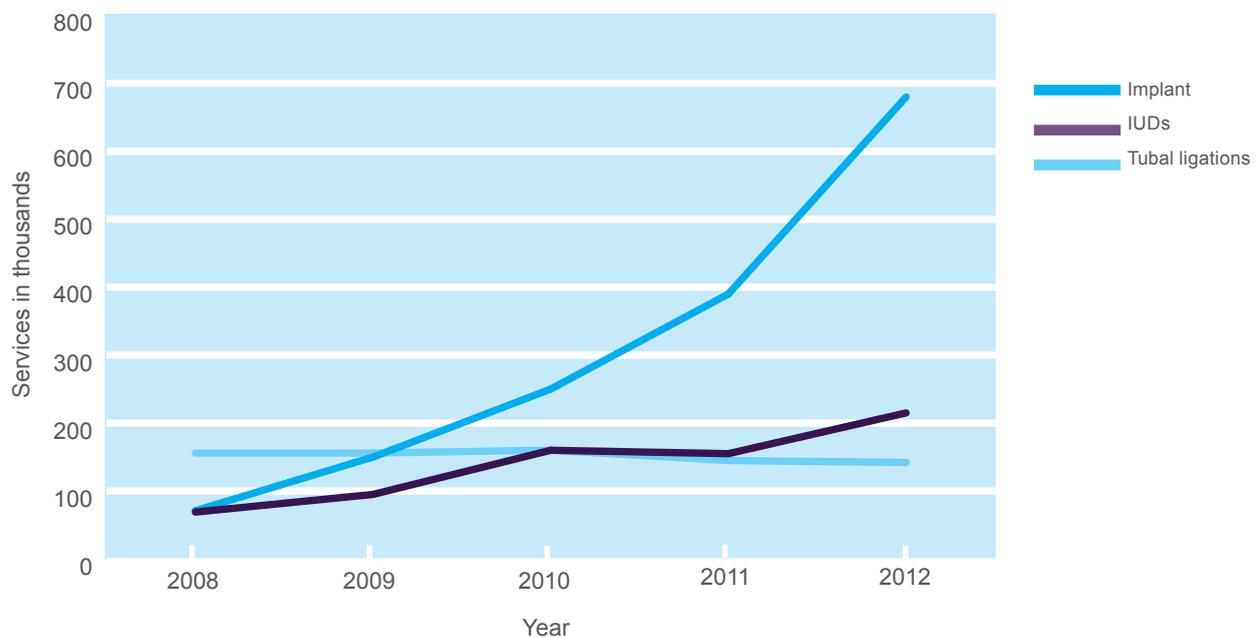
**TABLE 1:** Service delivery approaches used in the MSI LARC/PM expansion programme.

Channel/Intervention	Description
<b>Static clinic</b>	<ul style="list-style-type: none"> <li>located in urban areas</li> <li>competitively priced</li> <li>income generated from clinics located in wealthier areas subsidises clinics in urban slums and/or mobile outreach units</li> <li>serves as a base for training and logistics to support mobile outreach units, social franchisees, and community-based distributors.</li> </ul>
<b>Mobile outreach</b>	<ul style="list-style-type: none"> <li>visit communities with limited access to modern family planning methods, such as rural villages and urban slums</li> <li>provide free or subsidised family planning services</li> <li>pre-visit demand generation activities are conducted in partnership with local healthcare workers</li> <li>typical team includes mid-level healthcare providers</li> <li>operate from tents, vehicles or at government buildings</li> <li>team may visit government clinics and complement the short-term methods provided.</li> </ul>
<b>Social franchising of private sector providers</b>	<ul style="list-style-type: none"> <li>partner with existing private healthcare providers, predominantly in small towns and urban/peri-urban slums</li> <li>enables rapid scale up of access to quality family planning and reproductive health services.</li> </ul>
<b>Task sharing</b>	<ul style="list-style-type: none"> <li>mid-level healthcare providers trained to provide clinical procedures otherwise restricted to higher level cadres</li> <li>enabled MSI to increase the number of service providers and family planning procedures in rural and peri-urban areas.</li> </ul>
<b>Alternative financing mechanisms</b>	<ul style="list-style-type: none"> <li>aims to increase access to family planning among clients who may otherwise be unable to afford services</li> <li>paper or electronic vouchers (sent via SMS) for a particular service</li> <li>public-private partnership: contracting local government authority outreach provision</li> <li>working with health insurance schemes and development of community-based health insurance schemes.</li> </ul>
<b>Demand generation</b>	<ul style="list-style-type: none"> <li>use of local media; eg, radio spots</li> <li>education and awareness raising through community health workers and satisfied clients</li> <li>road shows</li> <li>paper-based flyers and posters</li> <li>such activities promote the entire range of contraceptives that MSI offers, but where knowledge of a particular method(s) is low, or where certain myths are a barrier to uptake, the programmes aim to address these information gaps.</li> </ul>

profile to better capture this group.<sup>10</sup> A proxy indicator for client location was also used (facility type visited): MSI static clinics represented urban locations, mobile outreach units represented rural locations, and social franchise clinics represented peri-urban locations.

The percentages of clients who were young (aged <25 years) were compared with regional figures for each country using data from Demographic Health Surveys (DHS).

**FIGURE 1:** The number of implant, intrauterine device (IUD), and tubal ligation service provisions from 2008 to 2012 in 11 country programmes.



## Findings

### LARC/PM uptake:

The use of LARC/PM services across the 11 MSI country programmes increased from just under 300,000 in 2008 to just over 1 million in 2012, representing a 250% increase (Figure 1).

The number of LARC services in 2012 was over five times the number in 2008. The biggest increase in LARC uptake was seen for implants (from 71,321 in 2008 to 679,946 in 2012, representing an 853.4% increase). IUD uptake increased by 211.3% between 2008 and 2012 (from 69,087 in 2008 to 215,095 in 2012). TL uptake showed an increase between 2008 and 2010 and in 2012, but a decrease in 2011. Overall, between 2008 and 2012, TL uptake decreased by 8.9%.

### Socio-demographic characteristics:

Of the 3,019 LARC clients included in the exit interviews,

38% were aged 15-24 years, 49% had no/some primary education, 83% were married/living with a partner, and 69% lived in a rural location. Compared with implant users, IUD users were slightly older and more educated, more frequently married/living with a partner, and more frequently living in an urban location (Table 2).

Just over half (56%) of TL clients were aged over 35 years, 73% had no/some primary education, 93% were married/living with a partner, and 87% lived in a rural location. Compared with LARC service users, TL users were older, had more children, had lower education levels, more frequently lived in rural areas, and were more frequently married/living with a partner.

### Contraceptive behaviour:

Overall, 42% of LARC users were adopters and 51% had switched from a short-term family planning method. Among PM clients, 46% were adopters and 47% had switched from a short-term family planning method.

**TABLE 2:** Demographics of long-acting reversible contraceptive and tubal ligation clients from 11 country programmes.

	Overall LARC (IUD and implant) clients N=3,019	IUD clients N=926	Implant clients N=2,094	TL clients N=282
<b>Age (years)</b>				
				(%)
15-24	38	28	41	3
25-34	43	45	41	37
35+	17	25	15	56
Unknown	3	2	3	4
<b>Parity</b>				
None	8	7	8	0
1 - 2	39	33	40	4
3 - 4	31	34	29	18
5+	21	25	21	78
Unknown	1	1	1	0
<b>Education</b>				
None/some primary	49	42	51	73
Primary/some secondary	36	37	36	21
Completed secondary/above	15	22	13	6
<b>Marital status</b>				
Single	13	13	14	4
Currently married/living with partner	83	85	82	93
Divorced/widowed/separated	3	2	4	3

Abbreviations: IUD intrauterine device; LARC long-active reversible contraceptive; TL tubal ligation.

#### Client satisfaction:

There were high levels of client satisfaction among LARC and PM clients across all service delivery channels in the 11 country programmes. 96% of LARC users indicated that they would use MSI services in the future and 99% of LARC and PM clients indicated that they would recommend MSI to a friend. As part of the client exit interviews, clients used a Likert scale to rate aspects of the service delivery (eg, waiting times, length of time with a healthcare provider, quality of advice and information, friendliness/respect from staff). A score of 1 (indicating very bad) to 5 (indicating

very good) was given for each aspect of the service. Across all clients, the average score given was 4.5.

#### Comparison with DHS datasets:

On average, 38% of LARC users in our evaluation were aged 15-24 years. By comparison, the cross-country DHS average for this group of women is 13%. Among TL users, 37% were aged 25-34 years in our evaluation, whereas the cross-country DHS average for this group is 17%.

## Conclusion

The continued increase in LARC uptake between 2008 and 2012 across the 11 sub-Saharan countries included in this evaluation suggests that LARC/PM provision in this region is possible and that there exists a vast untapped potential for wider LARC/PM use in sub-Saharan Africa.

MSI's LARC/PM expansion programme also demonstrates the effectiveness of approaches such as voucher distribution schemes and demand generation activities in advance of outreach visits. The complementary service delivery channels of static clinics, mobile outreach units, and social franchising of private sector providers allowed the expansion programme to bridge socio-economic divides and reach women in all

areas of the countries, including underserved women living in rural locations. The programme was also successful in increasing LARC uptake among younger women aged below 25 years, who frequently have the greatest unmet contraceptive need.

With appropriate investments in family planning programmes, the achievements made since 2008 through this expansion programme can be continued in the future. This will increase contraceptive choice for more women in sub-Saharan Africa and contribute to the prevention of unwanted pregnancies in the region, with great benefits for women's reproductive health. Additional LARC/PM expansion programmes of this nature will also ensure that the goals of FP2020 are reached.

## Key lessons learnt

Based on the results of this evaluation, in order to increase women's contraceptive choice in sub-Saharan Africa and expand access to quality LARC/PM services, we recommend that programmers undertake the following:

- train healthcare providers to reduce bias against provision of LARC/PM
- collaborate with governments to remove policy and regulatory barriers to expanding method choice
- work with governments to ensure a steady and reliable supply of LARC/PM
- engage with private providers to build their capacity to provide high-quality, client-focused LARC/PM services
- expand the availability of LARC/PM services in rural areas through the use of mid-level providers
- increase public awareness about the benefits of LARC/PM by employing method-specific marketing and interpersonal communications campaigns with a mixed media approach.

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## For citation purposes

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