Contraceptive Security for Long-Acting and Permanent Contraception (LA/PMs), & the Compelling Case for the Postpartum IUD

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Managing Partner: EngenderHealth; Associated Partners: Family Health International; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council

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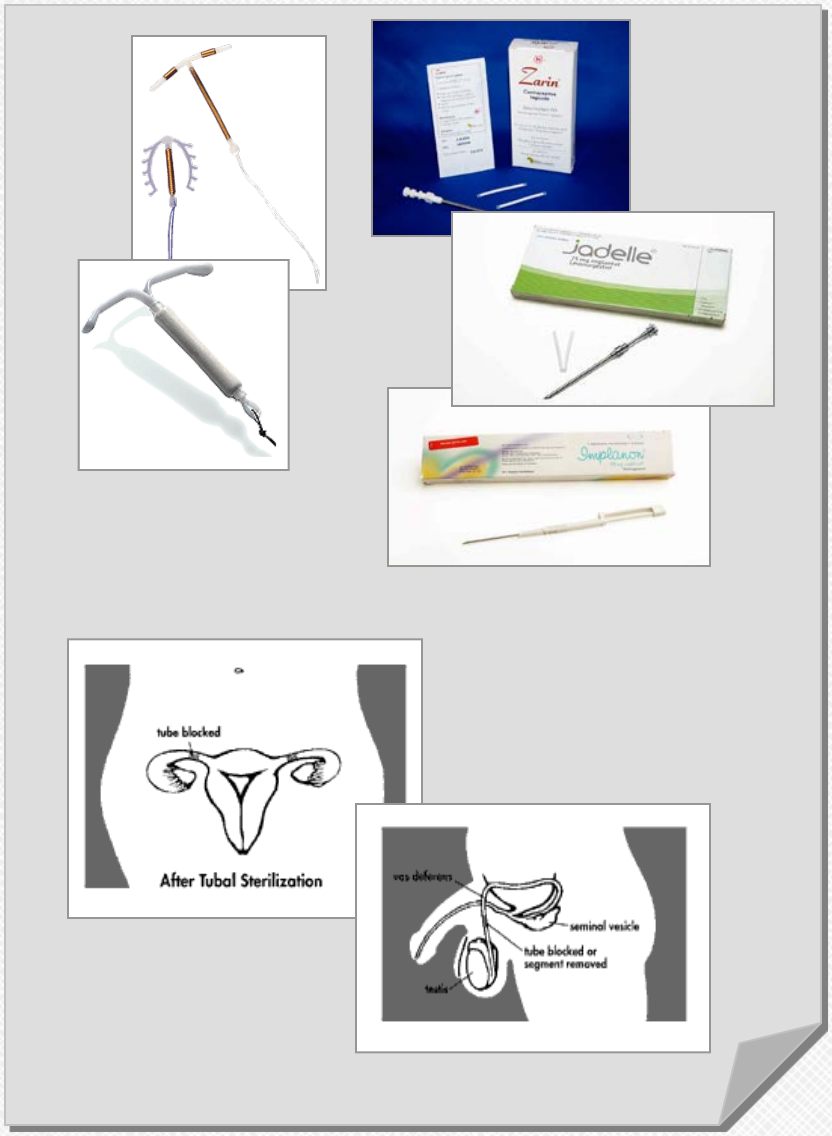
The Four Long-acting and Permanent Methods (LA/PMs)

- **Long-acting reversible methods**
  - **IUDs:**
    - > *CuT380A, ML-375*
    - > *LNG-IUS*
  - **Implants:**
    - > *Jadelle*
    - > *Sino-implant II (Zarin)*
    - > *Implanon*
- **Permanent methods**
  - **Female sterilization**
  - **Male sterilization** (Vasectomy)



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The LA/PMs: Key characteristics

- Clinical methods
- "Provider-dependent"
  - Need skilled, motivated, enabled providers
  - "No provider, no program"
- Need medical equipment, instruments, & expendable supplies
- Require suitable service setting
- Need to insure free and informed choice

6 Reasons LA/PMs Underemphasized in CS

1. Planning tools are inadequate
2. LA/PMs are more demanding to deliver
3. Up-front costs of LA/PMs are high (& difficult to “amortize”)
4. Language used in CS strategies and plans is a barrier
5. CS efforts have almost exclusively focused on contraceptive commodities and supplies, not on services
6. Better indicators (more specific to LA/PMs) are needed:
   - “What doesn’t get measured, doesn’t get done”

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Reason 1: Inadequate planning tools
Reason 2: LA/PMs are more difficult to provide

MEDICAL INSTRUMENTS NEEDED TO PROVIDE LONG-ACTING AND PERMANENT METHODS OF CONTRACEPTION

Hormonal Implant

Insertion *(Jadelle®, Sino-Implant II®)*
(1) Cup/bowl/gallipot
(1) Forceps, sponge-holding, straight, 5.5 inches (14 cm)
(1) Forceps, mosquito, delicate, curved, 5 inches (12.7 cm)
(1) Scalpel, handle, #3, graduated in cm
(1) Trocar (#10)

Insertion *(Implanon®)*
(1) Cup/bowl/gallipot
(1) Forceps sponge-holding, straight, 5.5 inches (14 cm)

Removal
(Implanon®, Jadelle®, Sino-Implant II®)
(1) Cup/bowl/gallipot
(1) Forceps sponge-holding, straight, 5.5 inches (14 cm)
(1) Scalpel, handle, #3, graduated in cm
(1) Forceps, mosquito, straight, 5 inches (12.7 cm)
(1) Forceps, mosquito, curved, 5 inches (12.7 cm)

Intrauterine Device (IUD)

Insertion
(1) Cup/bowl/gallipot
(1) Forceps, Schroeder-Braun uterine tenaculum, 9.75 inches (24.8 cm)
(1) Forceps, sponge, Foerster, straight, 9.5 inches (24.1 cm)
(1) Sound, uterine, Sims, 13 inches (33 cm)
(1) Scissors, operating, Mayo, curved, 6.75 inches (17.1 cm)
(1) Speculum, vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm])

Removal
(1) Forceps, sponge, Foerster, straight, 9.5 inches (24.1 cm)
(1) Speculum, vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm])
(1) Forceps, Bozeman uterine dressing, straight, 10.5 inches (26.7 cm)
(1) IUD removal forceps, alligator jaw, 8 inches*
(1) IUD string retriever*

* The alligator IUD removal forceps and IUD string retriever are needed only on rare occasions, when the IUD strings are not visible and the IUD cannot be removed by the Bozeman forceps alone.

Female Sterilization (via Minilaparotomy)

Abdominal Instruments
(1) Cup/bowl/gallipot
(1) Forceps, sponge, Foerster, straight, 9.5 inches (24.1 cm)
(1) Forceps, dressing, standard pattern, 5 inches (12.7 cm)
(1) Forceps, tissue, delicate pattern, 5.5 inches (14 cm)
(2) Forceps, artery, Kelly, straight, 5.5 inches (14 cm)
(2) Forceps, intestinal, Allis, delicate, (5x6 teeth) 6 inches (15.2 cm)
(2) Forceps, intestinal, baby Babcock, 5.5 inches (14 cm)
(1) Needle holder, Mayo Hegar, 7 inches (17.8 cm)
(2) Richardson-Eastman retractor, small **or** (1) Army-Navy retractor (2-pc.set), double-ended
(1) Scissors, tonsil, Metzenbaum, curved, 7 inches (17.8 cm)
(1) Scissors, Operating, Mayo, Curved, 6.75 inches (17.1 cm)
(1) Scalpel, handle, #3, graduated in cm
(1) Hook, tubal, Ramathibodi

Vaginal instruments
(1) Forceps, sponge, Foerster, curved, 9.5 inches (24.1 cm)
(1) Jackson vaginal retractor (deep blade) 1.5 inches (3.8 cm) x 3 inches (7.6 cm) or (1) Speculum, vaginal, Graves, medium (1.38 inches [3.5 cm] x 4 inches [10.2 cm])
(1) Forceps, Schroeder-Braun uterine tenaculum, 9.75 inches (24.8 cm)
(1) Elevator, uterine, Ramathibodi

No-Scalpel Vasectomy (NSV)

(1) Cup/bowl/gallipot
(1) Forceps, sponge-holding, straight, 5.5 inches (14 cm)
(1) Needle holder, Mayo Hegar, 7 inches (17.8 cm)
(1) Scissors, operating, Mayo, straight, 5.5 inches (14 cm)
(1) NSV ringed clamp (forceps), 4 mm
(1) NSV dissecting forceps

Written by: Levent Cagatay, MD; Carmela Cordero, MD; and Roy Jacobstein, MD, MPH.
Information drawn from EngenderHealth medical/clinical staff and *Surgical Instruments Catalogue* (Miltex Instruments Company).

http://www.engenderhealth.org/files/pubs/family-planning/LAPM-Equipment-List.pdf

Reason 3: Unit costs of LA/PMs are high
(but not IUD)

Unit costs of contraceptive methods

Method	Unit Cost
Condoms	$0.025
Pill	$0.21
IUD	$0.37
Female condom	$0.77
Injectable	$0.87
Male sterilization	$4.95
Sino-implant II	$~$8.00
Female sterilization	$9.09
Implant (Jadelle; Implanon)	$24.089

Ross, Weissman, and Stover, 2009

Reason 4: The muddy waters of CS language

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Problems with the language in CS

- **Ambiguity, lack of specificity, imprecision**
- **Different words used to mean the same thing**
- **Same words or phrases used to mean different things**
- **Bias against LA/PMs**
  - **"Language conditions thought":**
    - > ***Is vasectomy a "product"? Is female sterilization?***
    - > ***Is sterilization or vasectomy a "commodity"?*** *(a thing, something tangible that you can hold in your hand)*
    - > *A **difference between** a **"contraceptive"** (what you hold in your hand, thus not FS or V) and a **"contraceptive method"** (includes FS and V):*

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Imprecise and incomplete definitions

International definitions of contraceptive security: equate it to "supplies"

"Ensuring that all people … can access and use affordable, high-quality **supplies** to ensure their better reproductive health."

(RH Supplies Coalition website)

"Reproductive health contraceptive security exists when people are able to choose, obtain and use the RH **supplies** they want….."

(JSI/DELIVER SPARHCS)

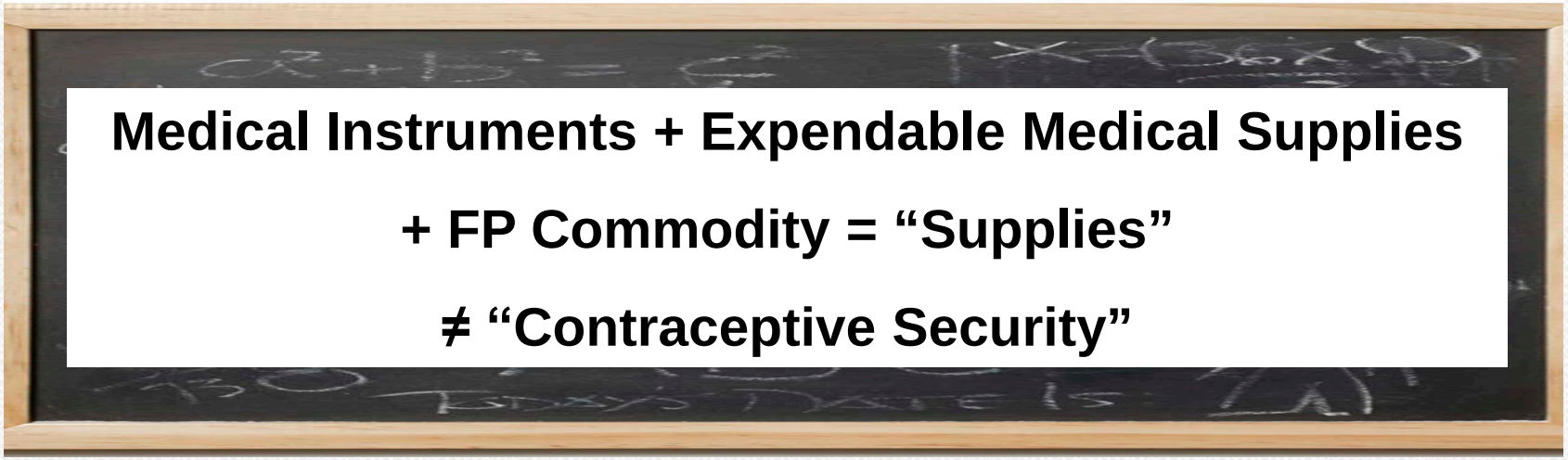
Ambiguity and vagueness in national strategies

"Definition of Contraceptive Security"

"For family planning programs, the vital importance of contraceptives is often summed up by the slogan: *No Product, No Program.* Without contraceptive security, families will be unable to space their births, limit their family size, and time pregnancies."

(Albania, National Contraceptive Security Strategy, June 2003)

Reason 5: *Services*: Medical instruments and expendable medical supplies: necessary, but not sufficient (alone)



Services are needed

to provide clinical methods of family planning

and to ensure contraceptive security

("to choose, obtain, and use")

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So, why does it matter (if LA/PMs are neglected)?

Photo by P. Perchal/EngenderHealth

Photo by Staff/EngenderHealth

1. Highly effective
2. High unmet need for delaying, spacing & limiting
3. Good fit with reproductive intentions
4. Popular: people want & use LA/PMs when accessible
5. Cost effective
6. LA/PMs save lives, ↑health
7. Reduce inequity

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Rationale 1. LA/PMs are highly effective

Relative effectiveness of various FP methods in preventing pregnancy

Method	# of unintended pregnancies among 1,000 women in 1st year of typical use
No method	850
Withdrawal	270
Female condom	210
Male condom	150
Pill	80
Injectable	30
IUD (CU-T 380A / LNG-IUS)	8 / 2
Female sterilization	5
Vasectomy	1.5
Implant	0.5

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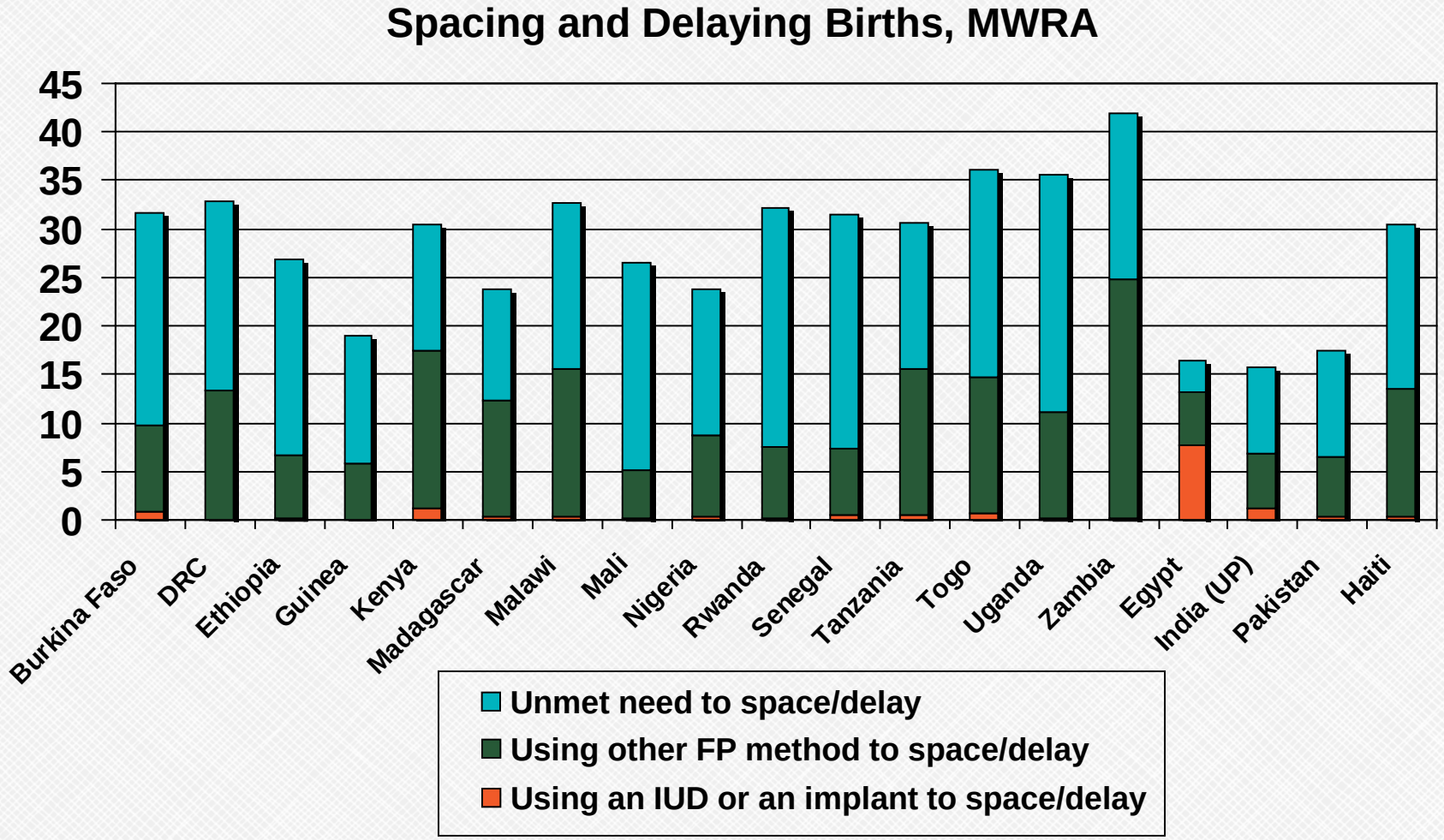
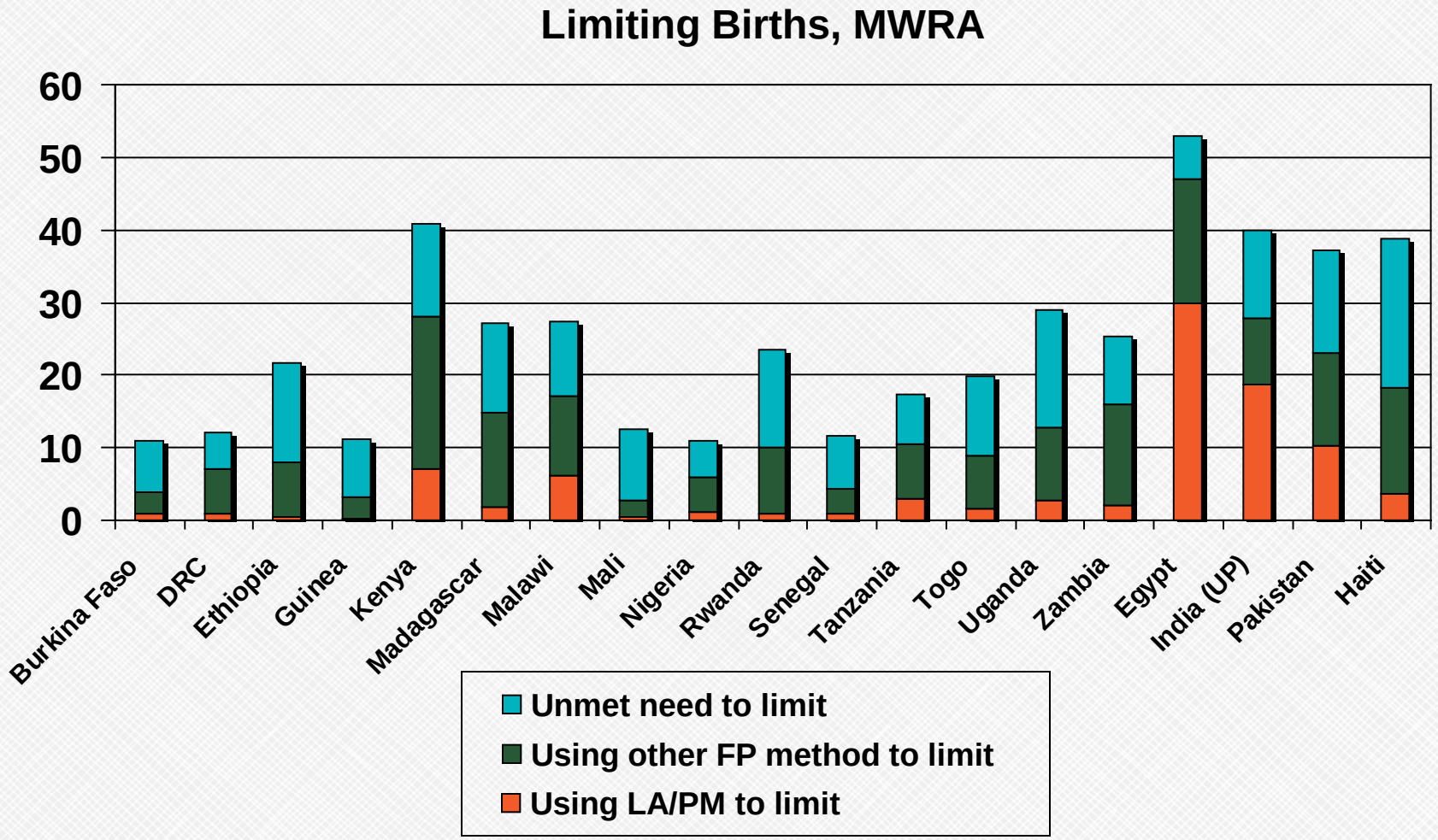
Source: Trussell J. Contraceptive efficacy. In Hatcher RA, et al. *Contraceptive Technology: Nineteenth Revised Edition*. New York NY: Ardent Media, 2007.

Rationale 2. High unmet need: Spacers & delayers worldwide: Low use of long-acting contraception (IUDs & implants)



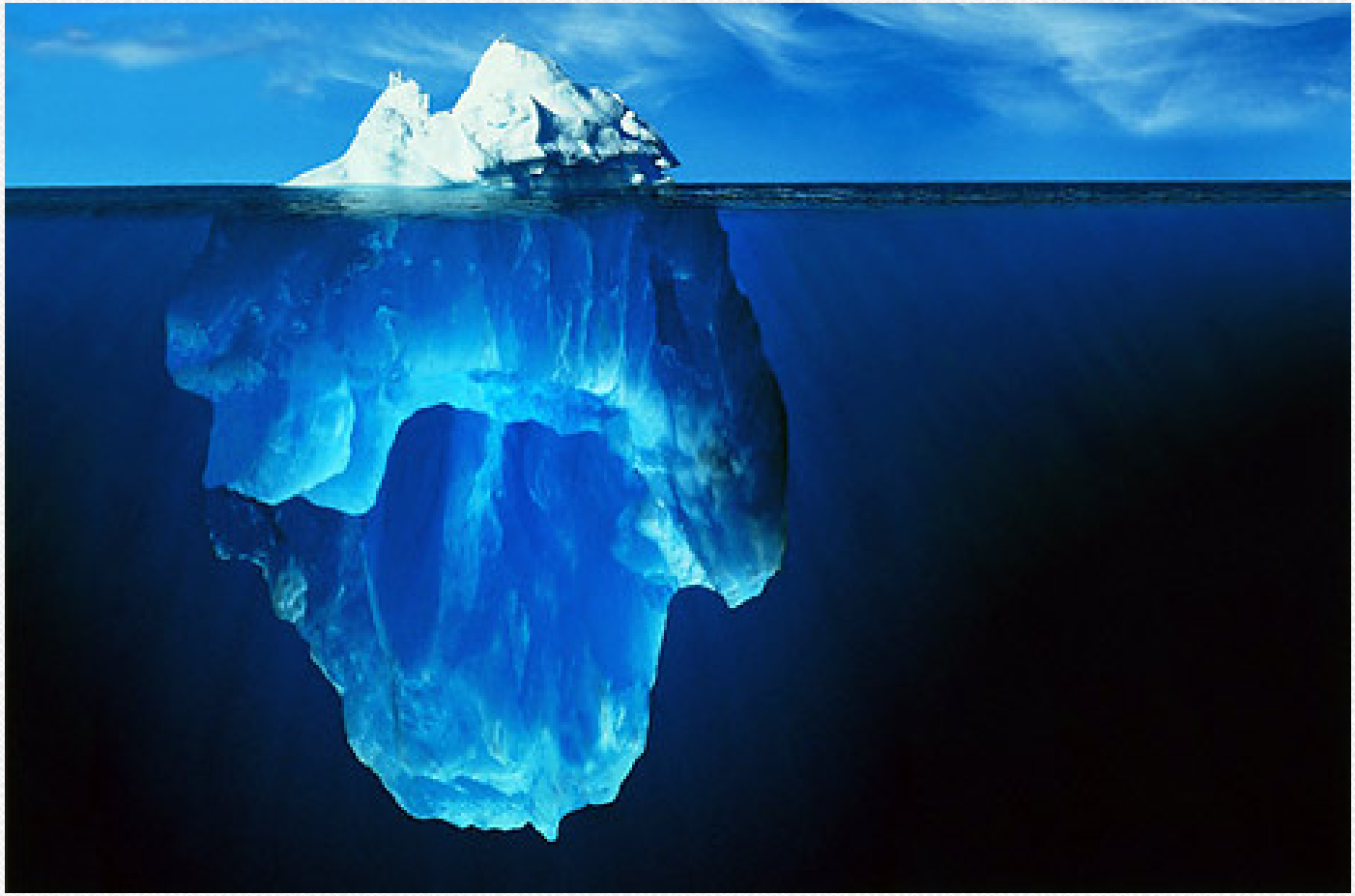
Source: DHS

Limiters worldwide: Relatively high demand and unmet need to limit, low LAPM use (esp in SSA)



Source: DHS

High unmet need is only the tip of the iceberg



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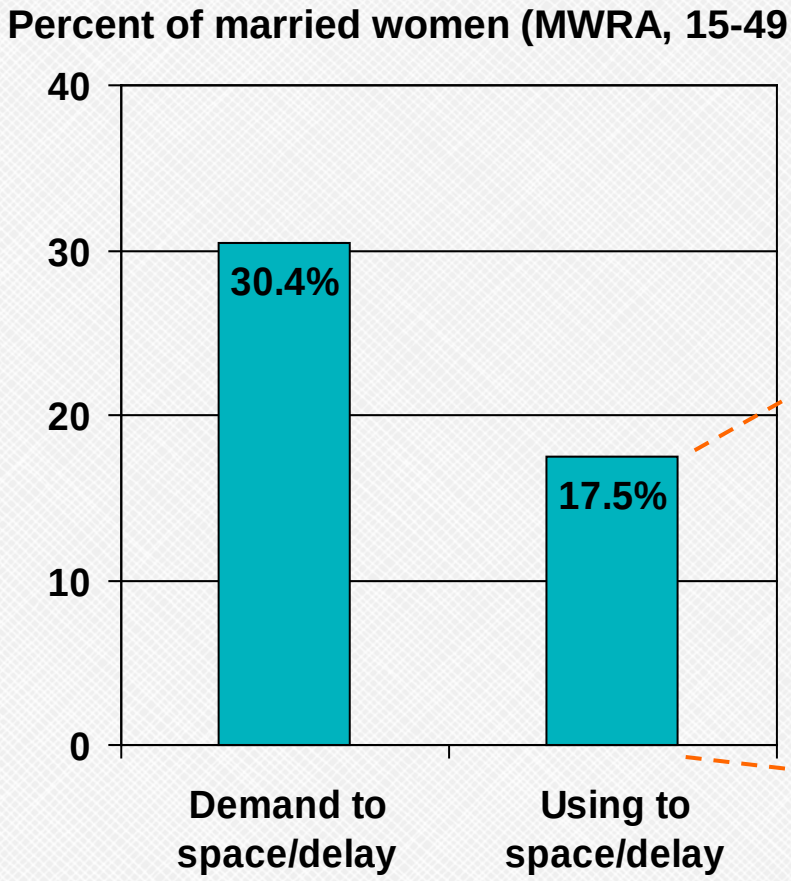
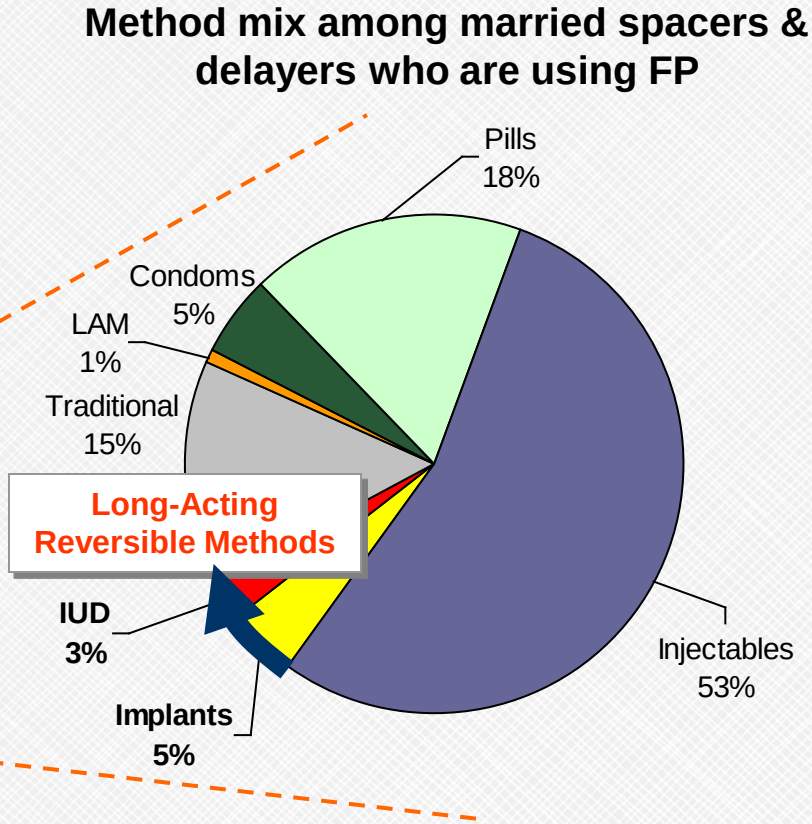
Rationale 3. Reproductive intentions & contraceptive choice among delayers and spacers in Kenya

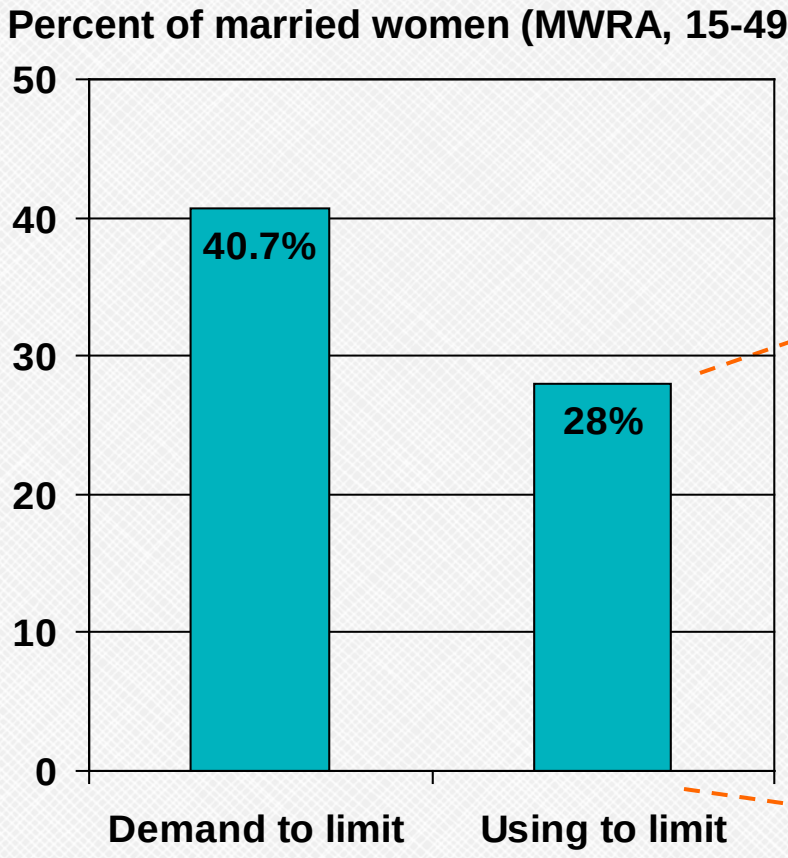


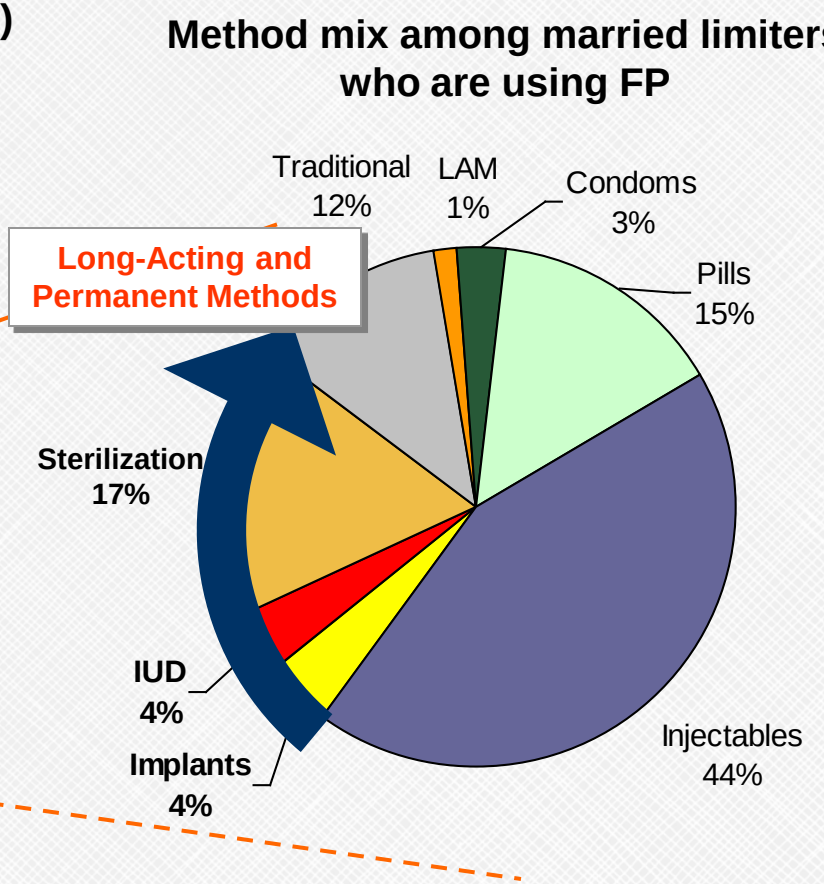


Source: MEASURE/DHS, Kenya DHS Survey, 2003; World Population Prospects: The 2008 Revision.

Only 8% of spacers/delayers who use FP are IUD or implant users

Reproductive intent and contraceptive choice: Among limiters using FP in Kenya, LA/PMs are underutilized





Source: MEASURE/DHS, Kenya 2003 DHS Survey.
World Population Prospects: The 2008 Revision.

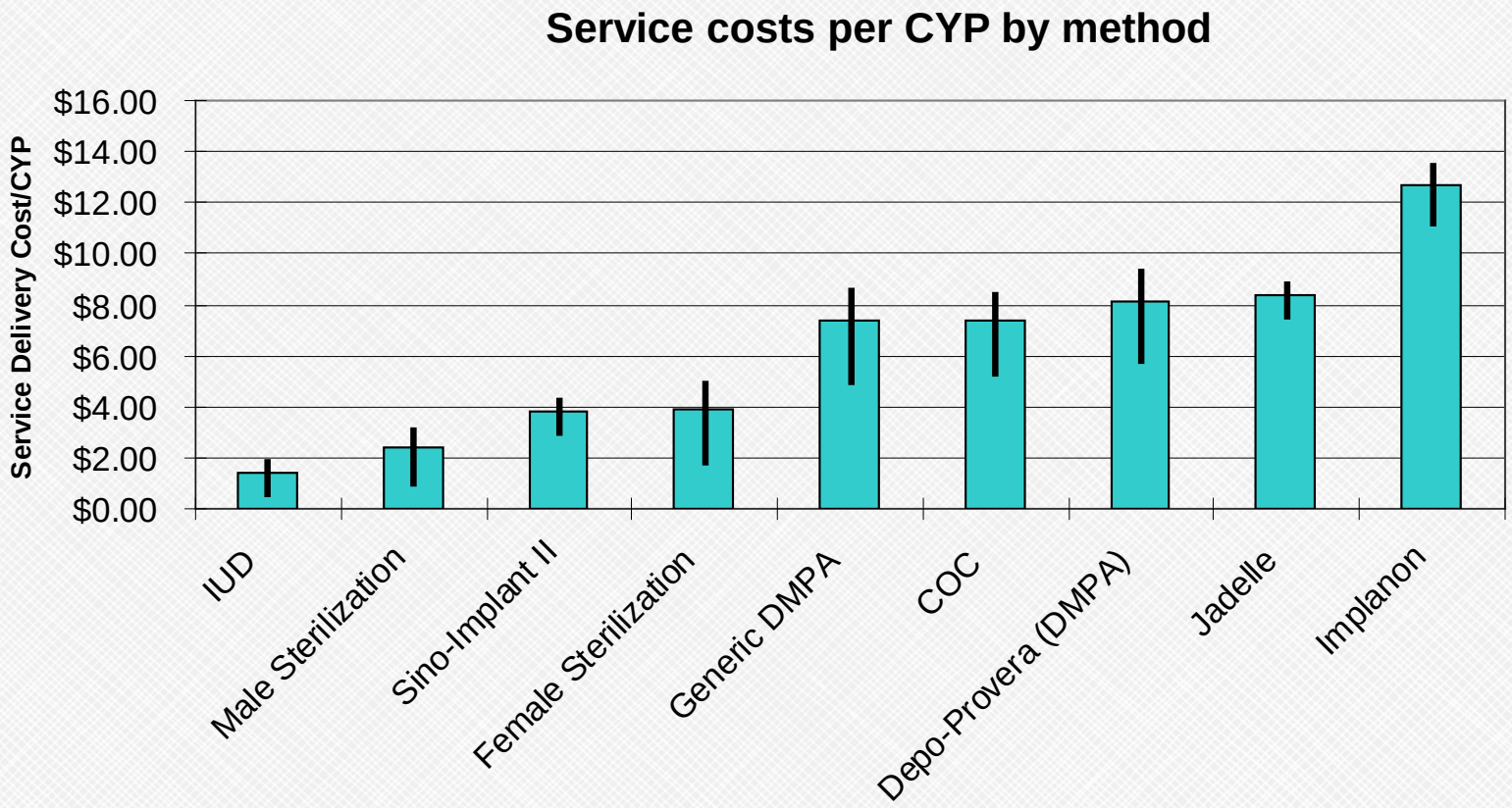
Only 25% of limiters using FP use any of the LA/PMs

Rationale 4: When LA/PMs are made available, people choose them and like them

Kenya focuses on IUDs, in context of full choice, and "FP revitalization"	More than 200,000 married women use an IUD. Satisfaction is high.
Ghana's midwives are trained and allowed to insert implants	CPR for implants rose 10-fold from 0.1% to 1.0% [1998-2003]
Ethiopia makes greater commitment to FP services	Procurement of implants rises from 31,000 to 830,000 units (2005-2009)
Malawi's clinical officers allowed to perform female sterilization	CPR for female sterilization more than triples to 6% (MWRA). Rises seen in all 5 wealth quintiles.
FP access high for all methods in South Africa; modern CPR: 58%	1 of every 4 women in union (14%) relies on sterilization.
In United Kingdom, few access barriers, wide range of methods, CPR 75%	LAPM use by all women very high: 14% rely on vasectomy; 8% female sterilization, 2% implants; 7% IUD

Sources: DHS; Reproductive Health Supplies Coalition

Rationale 5. High cost effectiveness of LA/PMs



Tumlinson, et al. In press.

* Costs include the commodity, materials and supplies, labor time inputs and annual staff salaries. The height of each bar shows the average value of costs per CYP across the 13 USAID priority countries, while the height of the line represents the range of costs across the same countries.

Rationale 6: LA/PMs save lives & improve health

- If 20% of women who use pills and injectables in Africa wanted more secure contraception, & switched to implants, would avert, over 5 yrs:
  - **1.8 million unintended pregnancies**
  - **576,000 abortions (many of them unsafe)**
  - **10,000 maternal deaths**
  - **300,000 cases of serious maternal morbidity (e.g., obstetric fistula)**
- Same (or greater) benefits accrue from switch to the IUD or a permanent method
- Greater benefit if switch from no method, traditional method, or condom
- And this was only if 1 in 5 women switched … if 2 in 5 switch, double the above benefits

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Hubacher D, Mavranezouli I, McGinn E. *Contraception* 2008.

So, what do you think we all should do about it?

- **Recommendation 1:** ***Advocate for LA/PMs within CS efforts***
- **Recommendation 2:** ***Secure financing for LA/PMs***
- **Recommendation 3:** ***Include LA/PMs fully on essential drug and equipment lists***
- **Recommendation 4:** ***Expand and update CS tools and indicators***
- **Recommendation 5:** ***Refine logistics management and training to include LA/PMs***
- **Recommendation 6:** ***Use precise, consistent, and unambiguous language that encompasses LA/PMs***
- **Recommendation 7:** ***Encourage task-shifting and task-sharing***
- **Recommendation 8:** ***Build program capacity to provide LA/PMs***

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Recommendation 9:
Adopt a clearer definition of contraceptive security

Contraceptive security exists when all women and men are able to choose, obtain, and use the contraceptive methods and services they want, in order to achieve their reproductive intentions at all stages of their reproductive life.

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