Complex challenges hinder the availability, access, and acceptability of long-acting and permanent methods (LAPMs) of contraception in Africa, but these challenges can be overcome. Programs in low-resource settings have demonstrated that when LAPMs are effectively introduced or revitalized, women and men will use them. National efforts have incorporated both traditional and innovative approaches to address key barriers, including responding to concerns about policies, training midlevel providers to provide clinical contraceptives, and launching media campaigns to increase awareness of LAPMs. However, the success of these endeavors has been limited. The continued development, evaluation, documentation, and refinement of effective evidence-based approaches will be essential for improving LAPM provision in the region.

Create a supportive policy environment

Adopting new policies or updating existing ones can increase access to LAPMs. To succeed, policies must also be translated into evidence-based guidelines and protocols to reduce the barriers women and couples might face in obtaining quality services.

Mali was among the first African countries to obtain regulatory approval for and to introduce Norplant without replicating a long and costly clinical trial. It was also among the first to allow counseled adolescents to use the method. The number of women using implants in Mali increased from fewer than 3,000 in 1987 to more than 10,000 in 2001.[1]

The Kenya Ministry of Health and its partners revised the *Kenya Family Planning Guidelines for Service Providers* to reflect recommendations issued by the World Health Organization in 2004. The new guidelines were used to orient providers in Western and Coast Provinces on the expanded eligibility criteria for use of the intrauterine device (IUD). In part owing to this change, the number of new IUD acceptors in AMKENI-supported facilities in these provinces increased from 151 in the first quarter of 2003 to 373 in the fourth quarter of 2005.[2]

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Ensure contraceptive security

A steady and reliable supply of commodities and equipment is vital so that programs can meet existing and emerging demand for all family planning services, including LAPMs. Ensuring that LAPMs appear on lists of essential drugs can also facilitate in-country registration of new contraceptives, which can improve availability.

The governments of Kenya and Tanzania are among those that have shifted from in-kind donor contributions to government-managed financing and procurement of contraceptives. In 2005, the government of Tanzania established a line item in their annual budget for contraceptive procurement. That same year, implants were included on the list of commodities procured.[3]

All drugs considered necessary for a basic health care system are included on the *World Health Organization Model List of Essential Medicines.* In 2007, two-rod levonorgestrel-releasing implants such as Jadelle were added to the list, which already included IUDs. The government of Kenya approved Jadelle in 2003, well before it was included on the international list of essential medicines.

The *Strategic Pathway to Reproductive Health Commodity Security* has helped low-resource countries assess their contraceptive security and develop responsive approaches for creating and maintaining it. Madagascar is among a group of African countries that has already used this tool to develop a new strategy for financing contraceptives, including LAPMs.[4]

Expand services in rural areas

Expanded availability of LAPMs is essential for improving access to a range of family planning methods and services. Several efforts have been made to increase rural women's access to LAPMs by addressing restricted mobility, inadequate information about family planning, and lack of trained personnel as doctors migrate from rural to urban areas for better wages and opportunities.

In 2004, Save the Children USA trained community-based agents in Guinea to deliver information about the IUD and to refer interested clients to available IUD services in Mandiana District. Providers in two rural health centers and one urban facility were also trained on IUD insertion and removal. After the intervention, providers reported that 85 percent of referrals for IUD services were coming from community agents. The number of IUDs inserted in the study area increased more than five-fold (from 13 in the six months before the intervention to 73 in the six months after).[5]

Through the CHOICE Initiative, Marie Stopes International operates mobile teams of LAPM providers in countries such as Zimbabwe, Kenya, Tanzania, and Madagascar. The teams travel in fully equipped vehicles and offer free LAPM services at Ministry of Health posts in rural areas. Because simple technologies are used to give anesthesia, midlevel providers can perform all of the services. In 2006, Marie Stopes Tanzania was operating 19 static centers with more than 600 outreach sites. More than 30,000 implants were provided and more than 47,000 female sterilizations performed.[6]

Maintain a pool of trained providers

To address the lack of skilled LAPM providers in Africa, core groups of health care providers must be adequately trained on providing services and sustaining their skills. Paraprofessionals are an important group for counseling and referring clients, especially outside major urban centers. Initial and ongoing training, as well as continued support and supervision, are essential for the provision of high-quality services.

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The Guatemala Ministry of Health trained and certified professional nurses and nurse auxiliaries to provide IUD services at health centers and health posts in nine rural health areas. Between 2003 and 2004, 90 health providers completed the training and inserted 722 IUDs. The project increased the overall number of IUD services provided by the participating health facilities.[7]

Between 1994 and 2004, EngenderHealth trained more than 300 teams of doctors and nurses in Ghana to perform female sterilization. The project also focused on establishing a sustainable system of training and supervision in all participating facilities. During the project, the number of facilities providing female sterilization nearly tripled. More than 27,000 women chose the procedure.[8]

Provide people with accurate information

Increasing awareness of LAPMs and addressing common myths and misconceptions about the methods can improve acceptability and create demand for services. Projects have disseminated accurate information about LAPMs in various ways, including through television, radio, printed materials, community meetings, and peer-to-peer interactions.

In 2006, the ACQUIRE Project and the Kenya Ministry of Health launched a mulitimedia campaign and accompanying outreach activities to address common myths and misconceptions about the IUD in Kisii District. The campaign featured radio advertisements and interviews, posters and brochures, and satisfied clients who challenged negative perceptions and provided accurate information about the IUD. Between 2005 and 2006, awareness of the IUD improved, and uptake of the method more than doubled in the district. Total LAPM use also increased by 27 percent.[9]

Engage the private sector

Expanding the role of the private sector—which includes both nongovernmental organizations and the commercial sector—can enhance consumer choice by increasing the number of available sources of LAPMs. The private sector may be an especially important alternate source of contraceptives for clients who can afford to pay for services.

Marie Stopes Tanzania partners with the government of Tanzania to reduce spending on training, staff, and equipment for the provision of LAPMs. Marie Stopes International also provides LAPM services throughout Tanzania. These services are provided through central funding that involves multiple donors. However, a cost-recovery system is also in place to help the clinics become more self-sufficient. Between 2001 and 2006, the number of female sterilizations that the organization performed increased significantly from 5,271 to 48,000—more than 50 percent of all female sterilizations performed in Tanzania.[10]

PSI/Nepal's Sun Quality Health Network, created in 2003, is a social franchise composed of partnerships with more than 200 private health clinics. It uses the clinics in conjunction with health fairs to offer high-quality counseling and services for IUDs, vasectomy, and female sterilization. By 2006, nearly 2,000 IUDs had been provided and 6,000 voluntary sterilizations performed at stationary and mobile clinics.[11]

Through the three-year AMUA project in Kenya, Marie Stopes International and Marie Stopes Kenya established a network of 141 social franchises composed of doctors, clinical officers, nurses, and community-based distribution workers who provide LAPM services in five provinces. Between 2004 and 2007, more than 15,000 IUDs were inserted and more than 20,000 female sterilizations performed.[12]

Implement comprehensive approaches

The most successful efforts to introduce or revitalize LAPMs simultaneously increase demand for services and improve the way the services are delivered. The nurturing of "champions" who advocate for LAPMs and the support of governments, medical communities, local leaders, and the general public are important components of a comprehensive approach.

In 2003, the Kenya Ministry of Health launched an initiative to revitalize the IUD. Gaining stakeholder support, building capacity to provide high-quality services, disseminating accurate information about the IUD, and monitoring and evaluating progress were all part of the national reintroduction strategy. During the project, approximately 2,800 women at 97 AMKENI-supported facilities initiated IUD use. The number of new IUD acceptors in those facilities more than doubled between 2003 and 2005.[13]

The Ghana Health Service collaborated with EngenderHealth/The ACQUIRE Project and the U.S. Agency for International Development's Mission in Ghana to determine whether vasectomy was a viable contraceptive option. An intervention in 2004 included community outreach, an intense

media campaign, and training of providers and clinic staff to offer better vasectomy services. The number of vasectomies performed in the program areas increased from 18 in 2003 to 81 in 2004.[14]

Document efforts for sustainability and scale-up

Although traditional and innovative approaches for revitalizing LAPMs have been implemented, documentation on prolonged efforts is limited. Additional research and long-term monitoring and evaluation are still needed to identify the most effective and sustainable interventions. Documenting pilot programs or "promising practices" as they are replicated or enlarged will help identify those interventions that are most likely to improve access to LAPMs and to overall reproductive choice.

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The IUD subcommittee of the U.S. Agency for International Development's Maximizing Access and Quality Initiative developed the IUD Toolkit to help improve the quality of and access to IUD services. Released in 2006, the toolkit is an online resource providing comprehensive evidence-based information on IUDs. Policy-makers, program managers, providers, and others can learn about innovations for expanding access to IUDs, use the toolkit to improve existing IUD services or add new services to their programs, and adapt the toolkit to local contexts. In the first half of 2007, the toolkit received more than 45,000 visits worldwide.

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