INCREASING ACCESS TO HIGH-QUALITY VOLUNTARY PERMANENT METHODS OF CONTRACEPTION IN LOW-RESOURCE SETTINGS

Consensus Statement: Marie Stopes International, EngenderHealth, IntraHealth International, International Planned Parenthood Federation, Population Council, Jhpiego, Population Services International, Pathfinder International, Wispivas, Dhaka Medical College, APROFAM, PASMO Guatemala

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Permanent methods of contraception are an essential component of comprehensive voluntary family planning services. As such, we commit ourselves to supporting increased access to quality permanent contraceptive methods and call upon all programs serving women and men in need of family planning to:

- Ensure that permanent methods are included in voluntary family planning counseling
- Provide high-quality, voluntary permanent method services, or referrals for male and female sterilization, for women and men who want to limit their family size

Through this statement, Marie Stopes International, EngenderHealth, IntraHealth International, International Planned Parenthood Federation, Population Council, Jhpiego, Pathfinder International, Population Services International, Wispivas, Dhaka Medical College, APROFAM, and PASMO Guatemala commit to ongoing collaboration to achieve the goal of universal access to voluntary family planning, which includes the provision of a broad method mix, including permanent methods, particularly in underserved areas.

Why permanent methods?

Permanent methods of contraception include female sterilization and vasectomy. Female sterilization is the world's most popular contraceptive method, used by 19% of women aged 15–49 who are married or in a union.[1] Female sterilization is safe, reliable, and effective, with a failure rate of less than 2% over the first 10 years of use.[2] Permanent method uptake, however, varies geographically. Female sterilization accounts for approximately 26% of the modern contraceptive method mix in Latin America and the Caribbean, 23% in Asia, 13% in developed countries, but less than 2% in Africa, where unmet need and desire to limit births is highest.

Uptake of male sterilization is even lower; Africa is reported to have the lowest male sterilization prevalence rate (0%).[1] Vasectomy continues to be the least preferred method of contraception when compared with other effective methods in Sub-Saharan Africa. As a one-time procedure, sterilization is convenient for the user, as it requires no further visits to a health care provider. As a surgical method, it avoids many of the side effects that contribute to the discontinuation of user-dependent methods. However, in the recent past, attention to permanent methods of contraception, especially female sterilization, has been limited.

At the International Conference on Population and Development (ICPD), held in Cairo in 1994, one of the global commitments and calls to action made on family planning was that *"All countries should take steps to meet the family-planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. The aim should be to assist couples and individuals to achieve their reproductive goals and give them the full opportunity to exercise the right to have children by choice."*[3] In most low-resource countries, and particularly in Africa, this goal has not been realized. Access to information and to a wide range of high-quality family planning methods that ensure informed choice is not universal. To reenergize the global family planning community, the UK Government and the Bill & Melinda Gates Foundation convened a summit in London on July 11, 2012,[4] where family planning partners launched a groundbreaking effort to make affordable, lifesaving contraceptives, information, services, and supplies available to an additional 120 million women and girls in the world's poorest countries by 2020.

The summit's vision was to ensure that women in developing countries can have the same freedom to access family planning services—without coercion, discrimination, or violence—as women in the developed world. The enthusiasm it unleashed far exceeded expectations. Leaders from 150 donor and developing countries, international agencies, civil society organizations, foundations, and the private sector joined together to endorse the London Summit's goal and the creation of a global partnership called Family Planning 2020 that supports the rights of women and girls to decide, freely and for themselves, whether, when, and how many children they want to have.

Why ensure access to permanent methods?

All women and men who have achieved their reproductive intentions should have access to appropriate information and a range of contraceptive methods that must also include permanent methods. This includes individual women and men, couples, specific groups (such as postpartum or postabortion clients), and those who may face additional barriers to access (including the poor, the disadvantaged, and those living in underserved and hard-to-reach areas). Desired family size globally has decreased significantly in the past decade. In many countries, especially in Africa, this has resulted in an increase in the number of women wanting to limit births rather than space them.[5] Further, an increasing proportion of *younger* women have a demand for limiting births.[6] Access to long-acting reversible contraceptives (LARCs) and permanent methods (PMs) has not increased at a pace comparable to that of the unmet need to limit childbearing, leaving a significant gap between preferred and actual family size.

Innovative approaches to reaching underserved communities

Permanent methods continue to be offered predominantly in urban settings. Yet populations with the highest unmet need live in rural areas and have poor access to health facilities, many of which have no electricity or running water and very few doctors. In most low-resource countries in Africa, Asia, and Latin America and the Caribbean, static public health facilities are the main source of permanent methods. While this presents a challenge in terms of sterilization provision,

family planning organizations have made significant progress through such interventions as setting up mobile outreach teams. The strengthening of public–private-sector partnerships in the provision of family planning services, particularly LARC s/PMs, has contributed to successes in increasing and improving access to a full range of family planning services.[7] Mobile outreach services in the recent past have been identified as a promising high-impact intervention.[8] Through such services, numerous countries, such as Tanzania, Malawi, Ghana, India, and Nepal, have reported reaching more clients, underserved communities, and new users.[9]

Developing and sustaining provider capacity

Clinical training on female and/or male sterilization requires health care providers to be conversant with family planning skills, such as client counseling based on voluntary and informed choice, client assessment, and basic surgical skills. Trainings should be competency-based and conducted in teams, utilizing models prior to being coached on clients in the surgical area. All trainings should include appropriate pain management, including nonpharmacological techniques, as well as adequate follow-up and ongoing support for trained providers until they are fully competent. An important component in the development of provider capacity is the use of a standard, safe, and efficient technical approach. During the "Provision of Permanent Methods of Contraception in Low-Resource Settings" symposium (Nairobi, March 11–12, 2014), clinical issues related to female sterilization were reviewed and agreed upon (see addendum). While male sterilization is included in the method mix in the national programs of most countries in Sub-Saharan Africa, it was acknowledged that the level of preparedness to offer information about this method and provide it is very low (and in some instances nonexistent). Service provision issues related to vasectomy also deserve a close review, and it was agreed that a similar gathering should be held to address vasectomy.

Optimize human resources and reduce costs

Task shifting/sharing the provision of permanent methods to mid-level providers has been shown to greatly expand access to and availability of services. According to World Health Organization (WHO) recommendations,[10] tubal occlusion and vasectomy are widely recognized as acceptable practices for clinical officers, assistant medical officers, health officers, and nonspecialist doctors. To increase capacity more broadly, the integration of permanent methods guidelines into preservice and in-service curricula for health providers is recommended.

Recommendations for increasing access to high-quality permanent methods in low-resource settings

a) Build a body of evidence through clinical research to inform decisions and recommendations for the pain management regimen for minilaparotomy, in light of recent advances in the field of pain management pre-, intra-, and postsurgery.
b) Employ various service delivery modalities to provide permanent methods, including mobile outreach services and integration into routine service delivery within the public and private sectors.
c) Expand access to permanent methods through task shifting/sharing to mid-level providers per WHO guidelines.
d) Invest in adapting and integrating permanent methods guidelines into in-service and preservice curricula.
e) Conduct research on factors affecting the acceptability of and knowledge about voluntary permanent methods, in particular vasectomy, and document effective interventions to increase uptake.
f) Promote regional and country-level discussion to increase voluntary permanent method uptake.

Advocating for universal access to permanent methods

We are committed to ongoing knowledge sharing about effective strategies, best practices, and innovations with the global community of providers, implementing organizations, donors, and governments, to promote greater access to permanent methods through more effective programmatic strategies and optimization of resources. We will work to ensure availability of and access to a wide range of contraceptives, including permanent methods, by continuing to emphasize the importance of clients' rights and informed choice, adopting effective and sustainable approaches to in-service training and service delivery, strengthening training on permanent methods of contraception in preservice education, researching barriers to the uptake/use of voluntary permanent methods, and adopting effective interventions to increase demand.

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CONSENSUS STATEMENT ON FEMALE STERILIZATION TECHNIQUE

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An important strategy to ensure universal access to female sterilization is the promotion of a standard, safe, and efficient technical approach to female sterilization. We believe that minilaparotomy has advantages over the laparoscopic approach for many different contexts, particularly for low-resource countries, as it is less costly, it can be provided by nonspecialist clinicians, and the required equipment, instruments and supplies are readily available in most settings. We are dedicated to the promotion of a standard, safe, and efficient approach to female sterilization.

To that end, the following are the key consensus points on minilaparotomy for female sterilization agreed upon by the representatives of the organizations attending the "Provision of Permanent Methods of Contraception in Low-Resource Settings" symposium (Nairobi, March 11–12, 2014).

Surgical Technique for Minilaparotomy for Female Sterilization

- Procedural steps for minilaparotomy should include client counseling, client assessment and preparation for surgery, pain management, the surgical procedure, and postoperative care and a follow-up plan.
- Modalities for delivering family planning information and services, such as through outreach and mobile services or by routine provision at static facilities, should offer clients a wide range of effective and affordable contraceptives, thus promoting full choice.
- Client counseling must be of a high standard that includes, among other steps and approaches, the provision of full and correct information about all available contraceptive methods that will enable clients to make an informed and voluntary decision. Clients should sign an informed consent form prior to the procedure.
- In all service delivery modalities, client assessment must include history taking and screening, including vital signs, to determine eligibility for minilaparotomy.
- Among several options for management of pain, the preferred option should be effective in eliminating pain, discomfort, and anxiety, with minimal side effects. The recommended regimen is a combination of both pharmacological and nonpharmacological techniques.
- General anesthesia for pain management is recommended only in special circumstances and must be used at a facility with the capacity to provide and offer adequate monitoring care for it.
- The modified Pomeroy technique is the recommended approach for occluding the fallopian tubes.
- The tubal hook is sufficient for retrieving the tubes; providers can utilize a uterine elevator to access the tube if they have been adequately trained and coached in the method.
- Postoperative care and follow-up of clients must include managing pain, monitoring the client's vital signs, providing postprocedure instructions upon discharge, and developing a follow-up plan.
- Up-to-date infection prevention practices must be followed at all times, irrespective of the setting; routine use of antibiotics is not recommended.
- Clear guidelines on the number of procedures that a provider can perform per day must be in place, with mechanisms to ensure that they are adhered to, particularly during outreach or on special service delivery days.
- Irrespective of the service delivery modality, the surgical team should ensure good documentation of informed consent, the client's condition, the procedure and recovery, and any complications encountered.