

**Knowledge Sharing Meeting II**  
**18 October 2002**  
**Discussion Summary**

*Refocusing on Clinical Family Planning Services and Revitalizing IUD Use and Repositioning Vasectomy:*

Dr. Mark Barone outlined the key issues for clinical family planning services:

- Major differences in service provision for short-term versus clinic-based methods
- The public sector provides most clinic-based services
- Sustained effort is critical for success
- Demonstrating impact requires adequate resources
- Country context is critical

He concluded with thoughts on reinvigorating clinical family planning:

- The public sector is critical
- Strengthen what is already working and do more
- Don't abandon the "tried and true"
- Seize missed opportunities – especially women who want to limit but are still using short-term methods
- Sustained improvements required ongoing and long-term attention and efforts

Dr. Matthew Tiedemann reviewed the issues to revitalize IUD use and reposition vasectomy. He suggested that each method is "excellent – yet neglected" He discussed a program in Kenya to revitalize IUD use. Regarding vasectomy he suggested improved performance of vasectomy requires providing male friendly services, community outreach and media campaigns. Because of the socio-cultural factors that affect the choice of vasectomy, a sustained approach to informing about the method is required.

Dr. Tiedemann concluded with some issues for both donors and family planning programs:

- More clinical services are needed
- Male involvement is essential
- Dual protect and condom use
- Continued attention to and support for research utilization
- Continued support for research to answer policy and service issues from the field

The discussion that followed included strategies to reinvigorate clinical family planning, as well as issues of provider and/or program bias toward clinical methods.

### *Strategies to reinvigorate clinical family planning:*

Simply training providers on IUD insertion is not an effective answer. Continuation rates of IUDs are relatively long, but some providers are reticent about inserting IUDs because they do not provide this method very often. One idea is to position IUDs with sterilization in specialized centers to give these methods more focus. It is important to look at where the clients come from. If a provider only performs one insertion a year then the quality will not be as good.

Doctors and midwives generally feel most comfortable with IUD procedures but in some regions midwives not allowed to insert them. Perhaps changing standards is one way to address this.

In any effort to reinvigorate FP, it is important to understand current provider biases as well as determine if the commodity is available.

The public sector is critical for reaching the poor, but we also need to look at the private sector. There is a resource gap that the public sector cannot fill. Studies show that many clients can afford and indeed are willing to pay for health services. We need a shift in thinking about the private sector. If the public sector says they will provide free services, then there is no incentive for those who can afford to pay to do so. We need to look at ways of amortizing costs. Furthermore, the public sector is changing...we need to think of where it will be in 10 years.

It is important that we think creatively. What about voucher programs? One successful example of creative thinking is that of the geographical strengthening of clinical services in Kenya. Perhaps we could look at market segmentation or social marketing for IUDs – so much more can be done.

In addition to demand generation, promoting the contraceptive image is important. Programs need to educate people so they can understand the potential health benefits.

We must look at root cause of lack of use – are these systematic causes or other?

As we look to reinvigorate FP, we should also keep in mind some of the technological changes that are taking place in this regard. We also need to think about contraceptive image and what can be done to ensure a positive image.

Finally, we need to consider the community perspective, particularly their definition of quality and quality methods/services.

### *Provider Bias*

Provider bias is an issue that needs to be taken into account. What strategies can be employed to overcome this?

Some countries have larger program biases – not just limited to individual providers. In some cases, monitoring indicators can encourage a particular focus. Perhaps we could employ different monitoring methods or rewards for providers providing expanded choices and counseling. Many providers cannot

get reimbursed for counseling without providing a service so there is little incentive for them to provide counseling.

Often it is not just a provider, but an entire facility or site that promotes a certain bias. Sometimes even when providers are trained, clients are still unable to receive services because the providers are not there.

IUDs require more demand generation. There exists a demand for sterilization – perhaps these two can be linked.

One strategy is to look at the positive deviants. Look at those cases where we “know what to do.” Issues regarding resources still remain, but successful systems have been created. Despite great differences from country to country, we can learn a lot from successes in places where we have already “graduated.”

Many clients choose services that their friends/neighbors have had done, thus neighbors serve as promoters. One method becomes the norm. On the reverse side, if an individual is dissatisfied with a particular service, the individual will share that with his/her neighbors. It is important to encourage “friendly” clinical sites so that clients have a positive experience.

### *Vasectomies*

We need to explore linking vasectomies with other male reproductive health issues. Our focus may be too narrow. Key to promoting reproductive health among men is understanding what are their priority health issues. What do they need/care about? Some programs have taken this approach and found that largely men’s health concerns are associated with sexual function, STIs, or dental care. However, this may be region specific

We must think outside of the box in regards to promoting men’s reproductive health including vasectomies. Perhaps working with the military, large companies, or using male outreach workers. It is important to focus promotional campaigns.

Experience has shown that men who desire vasectomies have generally participated in RH for their partner before. Additionally, most of these men have previously talked to other men who have had the procedure. Ethiopia is an example where “male champions” of vasectomies have been very effective in encouraging other men to have the procedure performed. Of great concern is what will it be like after the vasectomy is performed. Sexual dysfunction is a major concern. Yet, there exists no good provider reference for this. Something needs to be developed.

The approach towards men and reproductive health must be different than that of women. Even in clinics, men must be counseled differently. One hindering factor is that some providers are not comfortable working with men.

It is important to look at why men are coming to the clinics and how that relates to reproductive health. Are they coming for TB, STDs, VCT, or HIV? How does it relate to FP methods?

Postpartum is one of the most neglected areas, and could be added as an option. Vasectomy in post-abortion care has been effective in Turkey. Postpartum FP is usually either in the form of IUDs or sterilization. But it is generally pediatricians rather than reproductive health providers that have interactions with families postpartum.

Antenatal care is also a time when FP counseling can be effective. This way, by delivery it is not a new topic and a decision to use a FP method may have already been made.

Not only must we look at IUDs and sterilization, but also at Depo and Norplant. Furthermore, we must consider the needs of unmarried women and adolescent girls. This group is under-served and has a great deal of misinformation. Some national programs are reluctant to address this group, as are providers in clinics. Overall, we should look at pockets of unmet need.

To what extent is IUD being used in immediate post-abortion care? This depends. Some medical barriers exist, as providers are worried about the risk of infection. India's national guidelines state that IUDs should not be used in post-abortion care.

Rates of unmarried girls becoming pregnant post-abortion are twice as high as that of other women. Some estimates say 80 percent of these girls are pregnant again within two years. This underscores the importance of reaching adolescents with clinical methods.

These can be politically sensitive topics (for example, FP in Muslim countries), but we must determine our main goal - to provide quality healthcare choices. The local environment must determine the specifics of what is available. It must be "their" program (decided upon by the community) not USAID's. Iran is an example of a very successful vasectomy program. Voluntarism must be emphasized.

Vasectomy repositioning in FP – clinics must provide good male healthcare services, but there must also be good outreach programs associated with this.

There have been successful pilot programs, but then we must determine how to effectively scale up. Iran and Mexico have done so successfully. We need to look at countries that have had successful programs in the past and determine why they have changed.