Expanding contraceptive choices for women

Promising results for the IUD in sub-Saharan Africa

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Marie Stopes International delivers quality family planning and reproductive healthcare to millions of the world’s poorest and most vulnerable women.

Vision: A world in which every birth is wanted
Mission: Children by choice, not chance

Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<tr>
<td>LAPM</td>
<td>Long-acting and permanent method</td>
</tr>
<tr>
<td>MSI</td>
<td>Marie Stopes International</td>
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For citation purposes


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1. Executive summary

The intrauterine device (IUD) plays an important role for family planning programmes in sub-Saharan Africa, where contraceptive uptake is principally motivated by a woman’s desire to space or limit the number of births. However, updates from World Contraceptive Use 2009 revealed that the IUD is under-utilised as a contraceptive method in sub-Saharan Africa. Across the region, only 2% of users of any contraceptive method use the IUD, in spite of its low cost and effectiveness.

Over the past 30 years, contraceptive provision in many sub-Saharan African countries has relied predominantly on short-term methods. Increasing access to quality services for long-acting and permanent methods (LAPMs) such as IUDs, and expanding the role of the private sector in the provision of LAPMs, are pivotal to increasing women’s contraceptive choices and their choice of provider.

To address this huge unmet need in sub-Saharan Africa, Marie Stopes International (MSI) has been dramatically increasing access to comprehensive family planning services for underserved and hard-to-reach women in the region. The introduction and expansion of IUD services has been an integral component of MSI’s mission: “Children by choice not chance”.

For over 30 years, MSI has been providing men and women around the world with high quality contraceptive services through three main service channels:
1. MSI clinics
2. Mobile clinical outreach programmes, and

By the end of 2010, over ten million individuals in more than 40 countries worldwide were currently using modern contraceptive methods as a result of MSI services. With a focus on introducing LAPMs to the method mix, MSI provided over two million LAPMs across more than 40 countries in 2010 alone. Notably, the IUD consistently contributed to nearly 50% of all LAPMs provided by MSI between 2008 and 2010. In 2010, MSI provided more than 600,000 LAPMs in sub-Saharan Africa.
Between 2008 and 2010, MSI’s IUD provision in sub-Saharan Africa more than doubled. MSI provided 71,059 IUD insertions in 2008, 99,327 in 2009 and more than 167,000 in 2010. A majority of these IUD insertions occurred via mobile clinical outreach teams, which provide IUD services to women living in remote locations of sub-Saharan Africa who would otherwise have little or no access to LAPMs.

A comparison of recent MSI IUD insertion numbers in selected sub-Saharan African countries against initial baseline estimates for total IUD user numbers highlights the increased role that MSI has played in IUD provision in this region. For instance, with only around 9,000 women using an IUD in Tanzania in 2005, MSI’s provision of more than 15,000 IUDs in 2009 and 27,000 IUDs in 2010 has had a significant impact upon the total number of IUD users in this country. This pattern is consistent across other sub-Saharan African countries where MSI works, such as Sierra Leone, Madagascar and Uganda.

These figures demonstrate MSI’s growing success in increasing contraceptive choices and providing IUDs to underserved women in sub-Saharan Africa. MSI’s success in IUD provision is attributable to a number of innovative approaches: public-private partnerships; use of social franchising and voucher schemes; task shifting (delivery of services by mid-level providers); and provision of IUD services at outreach settings in rural communities. Recent evidence shows high client satisfaction levels and low IUD discontinuation rates at outreach settings, which highlights MSI’s effectiveness in maintaining high quality services to poor and underserved women.

In 2010, the average direct cost per MSI IUD insertion was around £9 in countries such as Sierra Leone, Tanzania and Uganda, demonstrating that IUD provision in sub-Saharan Africa can be cost effective from the perspective of the family planning provider.

The increasing uptake of MSI’s IUD services in recent years suggests that providing this method is possible and cost effective, and that there is a vast untapped potential for wider IUD use in sub-Saharan Africa.

To increase women’s contraceptive choices in sub-Saharan Africa, and to expand access to quality LAPM services such as the IUD, MSI recommends the following:
• training healthcare providers to reduce bias against provision of LAPMs
• collaborating with governments to remove policy and regulatory barriers to expanding method choice
• working with governments to ensure a steady and reliable supply of LAPMs and equipment
• engaging with private providers to build their capacity to provide high quality, client-focused LAPM services
• expanding availability of IUD services in rural areas, through the use of mid-level providers
• increasing public awareness about the benefits of IUDs by employing method-specific marketing and interpersonal communications campaigns with a mixed media approach, including community theatre, radio and peer-to-peer interaction, in order to reach potential IUD and LAPM clients in rural and underserved areas.

IUD provision in sub-Saharan Africa can be cost effective from the perspective of the family planning provider.
2. Background

2.1 The intrauterine device
The intrauterine device (IUD) is a long-term reversible contraceptive method that is suitable for women of all reproductive ages,1 and represents the most cost effective reversible method for preventing unwanted pregnancies.2 In 2007, the IUD was used by an estimated 23% of the 721 million users of any contraceptive method,3 making it the most commonly used reversible method worldwide.

2.2 Under-utilisation of the IUD in sub-Saharan Africa
The global figure of IUD prevalence masks the variation of IUD use across the globe. Updates from World Contraceptive Use 20097 indicate that 25% of users of any contraceptive method used the IUD in Asia, followed by 20% in Europe. These proportions are reflected by the predominance of IUD use in China (50% of all users). When excluding China from the global estimates, IUDs account for 12% of all contraceptive use worldwide. However, the IUD represents only 2% of modern method contraceptive use in sub-Saharan Africa, revealing the under-utilisation of this method in the region despite the IUD being such an important choice for women elsewhere.

Increasing access to quality IUD services is particularly important in sub-Saharan Africa, where family planning uptake is often motivated by women’s desire to limit the number of births. Evidence from sub-Saharan Africa suggests there is a large discrepancy between the proportion of women who want no further children and the proportion using an LAPM. This implies large unmet need for LAPMs such as the IUD.6 Furthermore, contraceptive provision in many sub-Saharan African countries has relied predominantly on short-term methods, such as oral pills, condoms and injectables.9 This is particularly evident when comparing public and private sector investment in family planning in sub-Saharan Africa. Public sector investment in LAPM provision has had mixed results in the last 30 years. The private sector has largely focused upon delivery of short-term contraceptive methods via social marketing. Expanding the role of the private sector in the provision of LAPMs is pivotal to improving the method mix and expanding contraceptive choices in this region.

BOX 1. Features of the IUD

- the IUD is appropriate for women of all reproductive ages (15-49 years) and parities.4 Given the immediate return to fertility after IUD removal, the IUD is highly appropriate for adolescents and young women
- the IUD can be used for women seeking medium- or long-term contraception
- after initial insertion, the IUD requires almost no attention on the part of the user and its effectiveness is not dependent on daily or monthly action, resulting in low failure rate.5
- the IUD is one of the most cost effective methods for women and family planning programmes.6
The under-utilisation of the IUD in sub-Saharan Africa might be explained by different factors affecting family planning service provision at the policy, programme and individual levels. At the policy and programme level, family planning programmes might favour the promotion and provision of one contraceptive method over another. In developing countries, family planning programme managers may be reluctant to offer long-acting methods such as the IUD, due to the perceived cost barriers or the lack of provider skills. This in turn impedes IUD provision.¹⁰¹¹ The availability of the IUD may also be restricted to adequately equipped health facilities in urban settings, thus limiting its access for individuals living in rural communities.¹²

At the individual level, potential IUD users may be influenced by their level of knowledge of the method, its risks and benefits, and the acceptability of family planning within their community.¹³ A recent study in six sub-Saharan African countries showed that use of contraception (any method) was significantly associated with community approval of family planning.¹⁴ For instance, data from Ghana and Tanzania showed that the level of community approval had a greater effect on women's contraceptive choice compared to perceived approval of the women's partners. These findings highlight the importance of targeted, community-specific family planning campaigns to demystify prevailing attitudes and cultural norms against the acceptance of IUDs.

Providing women with greater contraceptive choices is an integral element to raising overall levels of contraceptive use and reducing rates of unwanted pregnancies. Making this a reality is particularly pertinent in sub-Saharan Africa, where the unmet need for family planning and unintended pregnancy remains high. To address this huge unmet need, MSI delivers comprehensive family planning services across sub-Saharan Africa, with the strategic goal of widening women's contraceptive choices.
3. MSI’s comprehensive family planning programme

3.1 MSI’s service delivery model
Over the last two decades, MSI has pioneered innovative approaches to providing men and women with high quality contraceptive services across the globe. Promising service delivery models that reach individuals across socio-demographic divides while satisfying levels of unmet need include three main service channels:
1. MSI clinics
2. Mobile clinical outreach programmes, and

By the end of 2010, over 10 million women in more than 40 countries worldwide were currently using modern contraceptive methods as a result of MSI services.15

3.2 MSI’s LAPM provision
With a focus on expanding contraceptive choices and introducing LAPMs to the method mix in various settings, MSI has seen great success in sterilisations, implants and IUD provision across its family planning programmes over the past decade (Figure 1).

In 2010 alone, MSI provided more than two million LAPMs across more than 40 countries, representing an approximate 76% increase over the past three years. Notably, the IUD consistently contributed to between 40% and 50% of all MSI LAPMs provided in the past three years. In 2010, MSI provided more than 600,000 LAPMs in sub-Saharan Africa.

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**FIGURE 1.** MSI’s provision of long-acting and permanent methods, 2001-2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Male &amp; female sterilisations</th>
<th>Implants</th>
<th>IUDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>159,601</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>171,106</td>
<td></td>
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<tr>
<td>2003</td>
<td>232,242</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>416,876</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>565,997</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>681,876</td>
<td></td>
<td></td>
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<tr>
<td>2007</td>
<td>996,778</td>
<td></td>
<td></td>
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<td>2008</td>
<td>1,167,359</td>
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</tr>
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<td>2009</td>
<td>1,733,897</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>2,057,644</td>
<td></td>
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</tr>
</tbody>
</table>

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Male & female sterilisations Implants IUDs

Source: MSI Partnership service statistics, 2001–2010

2010 figures were not finalised at time of going to print and may change slightly.
3.3 MSI’s IUD provision in sub-Saharan Africa

In the past three years, MSI has provided increasing numbers of IUDs to women in sub-Saharan Africa (Figure 2). Between 2008 and 2010, MSI’s IUD provision in the region more than doubled. MSI provided 71,059 IUD insertions in 2008, 99,327 in 2009 and 167,337 in 2010.\textsuperscript{11}

Figure 2 displays MSI’s actual number of IUD insertions in 20 African countries and the estimated number of women using an IUD from 2008–2010 in sub-Saharan Africa. When comparing MSI IUD insertions to the estimated total number of women using an IUD in the region, MSI contributed about 13% in 2008, 18% in 2009 and 30% in 2010, which indicates the consistent expansion in MSI’s IUD provision over this period.\textsuperscript{16}

Table 1 provides a comparison of recent MSI IUD insertion numbers in selected sub-Saharan African countries between 2008 and 2010 against initial baseline estimates (based on DHS data) for the total number of IUD users prior to 2008.\textsuperscript{*} The numbers highlight the increased role that MSI has played in IUD provision in this region in recent years. For example, with only around 9,000 women using an IUD in Tanzania in 2005, MSI’s provision of more than 15,000 IUDs in 2009 and 27,000 IUDs in 2010 has had significant impact upon the total number of IUD users in this country. This pattern is consistent across other countries where MSI works, such as Sierra Leone, Madagascar and Uganda (Table 1).


### FIGURE 2. MSI IUD insertions versus total IUD users in 20 sub-Saharan African countries, 2008-2010\textsuperscript{iv}

![Graph showing MSI IUD insertions versus total IUD users in 20 sub-Saharan African countries, 2008-2010](image)

*This estimate is based upon UN population data and IUD prevalence rates from latest available Demographic and Health Survey (DHS) data, some of which are out of date. Consequently these figures should be treated as estimates only. Note that this data relates to user numbers, whereas MSI data relates to insertion numbers.

Source: MSI Partnership service statistics (MSI IUD insertions); MSI REACH Calculator (UN/DHS) (total IUD users).
TABLE 1. Number of MSI IUD insertions against estimated total number of IUD users, selected countries

<table>
<thead>
<tr>
<th>MSI country programme</th>
<th>Estimated number of women using IUDs: baseline estimates for specified year*</th>
<th>Number of MSI IUD insertions 2008-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2008</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>13,296 (2006)</td>
<td>0</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>16,985 (2005)</td>
<td>6,674</td>
</tr>
<tr>
<td>Madagascar</td>
<td>31,654 (2008)</td>
<td>1,305</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>4,166 (2008)</td>
<td>2,482</td>
</tr>
<tr>
<td>Tanzania</td>
<td>8,956 (2005)</td>
<td>4,500</td>
</tr>
<tr>
<td>Uganda</td>
<td>6,349 (2006)</td>
<td>6,709</td>
</tr>
</tbody>
</table>

*Denominator = Married women of reproductive age (MWRA), UN World Population Prospects; DHS: Demographic and Health Survey (2005-2008).

These IUD numbers are not based upon sales figures; instead they are based upon numbers of actual insertions provided by trained MSI providers.

These figures are likely to be an overestimate. The denominator (estimated total number of IUD users in the region) is calculated based upon United Nations (UN) population data and IUD prevalence rates from the latest available DHS data, some of which are out of date.

2010 IUD insertion numbers were not finalised at time of going to print and may change slightly.

This figure is calculated from data from the latest available DHS survey (or similar).
FIGURE 3. Number of MSI IUD insertions across seven selected African countries, 2008-2010

- This figure is calculated as the median value based on the ‘Progress Out of Poverty index’ poverty assessment tool, developed by Grameen Foundation and www.microfinance.com. Data is from MSI services in Ethiopia, Ghana, Malawi and Mali. The World Bank defines extreme poverty as living on less than US $1.25 per day.

- Note that these costs reflect only the direct costs of providing these services. This cost per IUD insertion includes providers’ time, supplies and travel costs etc. It excludes indirect costs such as capital investments, technical assistance, training costs and administrative overheads.

Source: MSI Partnership service statistics
Figure 3 further highlights MSI’s success in IUD service provision in seven selected sub-Saharan African countries from 2008 to 2010. All countries showed a significant increase in IUD insertions over this period, ranging from around 2,500 insertions in Burkina Faso to nearly 28,000 insertions in Tanzania in 2010.

3.4 Maintaining high quality services

The figures shown above demonstrate MSI’s increasing success in expanding contraceptive choices and providing IUDs to underserved women in sub-Saharan Africa. MSI’s success in IUD provision is attributable to the following innovative service delivery mechanisms:

- public-private partnerships
- use of social franchising and voucher schemes
- task shifting (delivery of services by mid-level providers)
- provision of IUD services at outreach settings in rural and underserved communities.

Through these approaches, MSI programmes are able to maintain consistent client-focused and high quality services to poor and underserved women. Data from MSI exit interviews conducted in 2010 in four sub-Saharan African countries showed that our programmes are reaching around 23% of individuals who live on less than $1.25 a day. High quality standards are maintained in all settings through the adherence to a wide range of measures, including use of informed consent, counselling on method choice, clinical standards guidelines and clinical audits.

MSI has been able to reach hundreds of thousands of underserved women living in rural areas who have the greatest levels of unmet need through its mobile clinical outreach services. Recent evidence from a multi-country evaluation of MSI outreach services suggests that MSI provides high quality services at outreach settings. For instance, client knowledge about follow-up mechanisms was high (79%-99%) and contraceptive discontinuation prevalence was lower than, or in line with, discontinuation figures from the DHSs. Client satisfaction levels were also high (72.5%-93%), suggesting high quality counselling. Similar or higher levels of service quality were observed across MSI clinics and social franchising programmes.

Additionally, MSI’s IUD provision in sub-Saharan Africa has proven to be cost effective. In 2010, the average direct cost per MSI IUD insertion was estimated at around £9 in Sierra Leone, Tanzania and Uganda. The figures highlight the fact that provision of IUDs in sub-Saharan Africa can be cost effective from the perspective of the family planning provider.

Data from 2010 MSI exit interviews in four sub-Saharan African countries showed that our programmes are reaching around 23% of individuals who live on less than $1.25 a day.
4. Implications for family planning programmes

The continued uptake in MSI’s IUD services in recent years suggests that IUD provision is possible and that a vast untapped potential for wider IUD use in sub-Saharan Africa exists. The steady increase in MSI’s IUD provision over the past three years demonstrates that this effort can be sustainable with appropriate investments in family planning programmes.

Previous studies have shown that approximately 80% of IUD users in sub-Saharan Africa continue IUD use for at least one year. This is consistent with evidence that continuation rates for LAPMs are higher than those for short-term methods. Unintended pregnancies are often due to the failure or discontinuation of contraception. Therefore, increasing the provision of an easier and more effective method, such as the IUD, would contribute towards the prevention of unwanted pregnancies and could have vast benefits for women’s reproductive health in this region. Increasing IUD provision across sub-Saharan Africa would expand women’s contraceptive choices, with great implications for increasing overall contraceptive prevalence and reducing unintended pregnancies in the region.

To increase women’s contraceptive choices in sub-Saharan Africa, and to expand access to quality LAPM services such as the IUD, MSI recommends the following:

- training healthcare providers to reduce bias against provision of LAPMs
- collaborating with governments to remove policy and regulatory barriers to expanding method choice
- working with governments to ensure a steady and reliable supply of LAPMs and equipment
- engaging with private providers to build their capacity to provide high quality, client-focused LAPM services
- expanding availability of IUD services in rural areas, through the use of mid-level providers
- increasing public awareness about the benefits of IUDs by employing method-specific marketing and interpersonal communications campaigns with a mixed media approach, including community theatre, radio and peer-to-peer interaction, in order to reach potential IUD and LAPM clients in rural and underserved areas.

Increasing IUD provision across sub-Saharan Africa would expand women’s contraceptive choices, with great implications for increasing overall contraceptive prevalence and reducing unintended pregnancies in the region.
References


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