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ORIGINAL RESEARCH ARTICLE

Family planning and Zika virus: need for renewed and cohesive efforts to ensure availability of intrauterine contraception in Latin America and the Caribbean

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ABSTRACT

Objectives: The advantages of intrauterine contraception (IUC) are well established (highly effective, low discontinuation rate, easy to use, low cost, and suitable for immediate postpartum use), but low levels of use in many countries and declining use in others are causes for concern. Due to the ongoing Zika virus outbreak, public health officials are calling for the continued practice of safe sex and the delay of pregnancy. Our study was conducted to assess the current situation of IUC availability and provision in Latin America and to determine the role of national policies in meeting the contraceptive needs of the populations in these countries.

Methods: A survey was conducted in Latin America and the Caribbean between December 2015 and January 2016 to assess national policies with regard to IUC provision, availability and accessibility. 18 countries participated.

Results: All responding countries had national policies on IUC. Many in the public sector provided the intrauterine device (IUD) free of charge, but the levonorgestrel-releasing intrauterine system (LNG-IUS) was generally available in the private sector. Some countries had very restrictive policies on who was permitted to carry out IUC insertions, but most permitted a range of health professionals to do so. Immediate postpartum IUC insertion was uncommon. Some countries placed restrictions on IUC use in women who were nulliparous, young, at high risk of catching a sexually transmitted infection or who had multiple sexual partners.

Conclusions: IUC is underused in Latin America. The study reveals policy level barriers that may impede access to IUC, one of the most effective, long-acting, non-hormonal, reversible contraceptive methods. Governments should consider reviewing and rethinking their policies on contraception to ensure IUC service provision among populations at high risk of unplanned pregnancy, especially those vulnerable to Zika virus.

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Introduction

Globally, 13.7% of women of reproductive age use intrauterine contraception (IUC), but the distribution of IUC users is strikingly non-uniform. In the least developed countries only around 1% of women use IUC, whereas in other countries >40% of women use IUC. The reasons for this large variation are not well documented; they may be policy- and health system-related, or embedded in misconceptions and provider bias.

In Latin America and the Caribbean region, 6.4% of women use IUC. By contrast, less than 2% of women in Oceania use IUC. The percentages of women who use IUC in Latin America and the Caribbean region also vary (7.7% in the Caribbean, 9.5% in Central America, 4.8% in South America) [1]. International contraception experts have suggested that increasing the low uptake rates of long-acting reversible contraception (LARC) may reduce the rate of unintended pregnancy [2]. Furthermore, Zika virus in the Americas, and its associated congenital and other neurological disorders [3–6], now known as congenital Zika syndrome [7,8], or the threat of Zika virus transmission via breastfeeding [9], is an ongoing public health concern. The World Health Organization (WHO) officially declared it a

public health emergency in February 2016 due to the cluster of microcephaly cases and other neurological disorders reported in Brazil [10]. Following this declaration, Latin American countries led by the Pan American Health Organization (PAHO) issued clinical definitions and research priorities [11,12]. In November 2015, PAHO released a health advisory notice regarding Zika virus, officially recommending that women avoid pregnancy. In January 2016, in response to the growing spread of Zika virus and the proven link between infection during pregnancy and congenital Zika syndrome, health ministers in some Latin American countries officially recommended to the public to postpone or delay pregnancy [13].

Few of the countries affected by Zika virus offer universal access to family planning services [14]. Access to contraception is often limited and the information given to pregnant women regarding Zika virus infection and how to obtain a safe and legal abortion (when available) is insufficient [15]. In addition, due to the conservative nature of these countries, the use of modern methods of contraception or condoms is likely to be resisted [16].

In Brazil and Ecuador, pregnancy avoidance has been recommended indefinitely; in Colombia, the recommendation is to postpone pregnancy for 6–8 months; while in

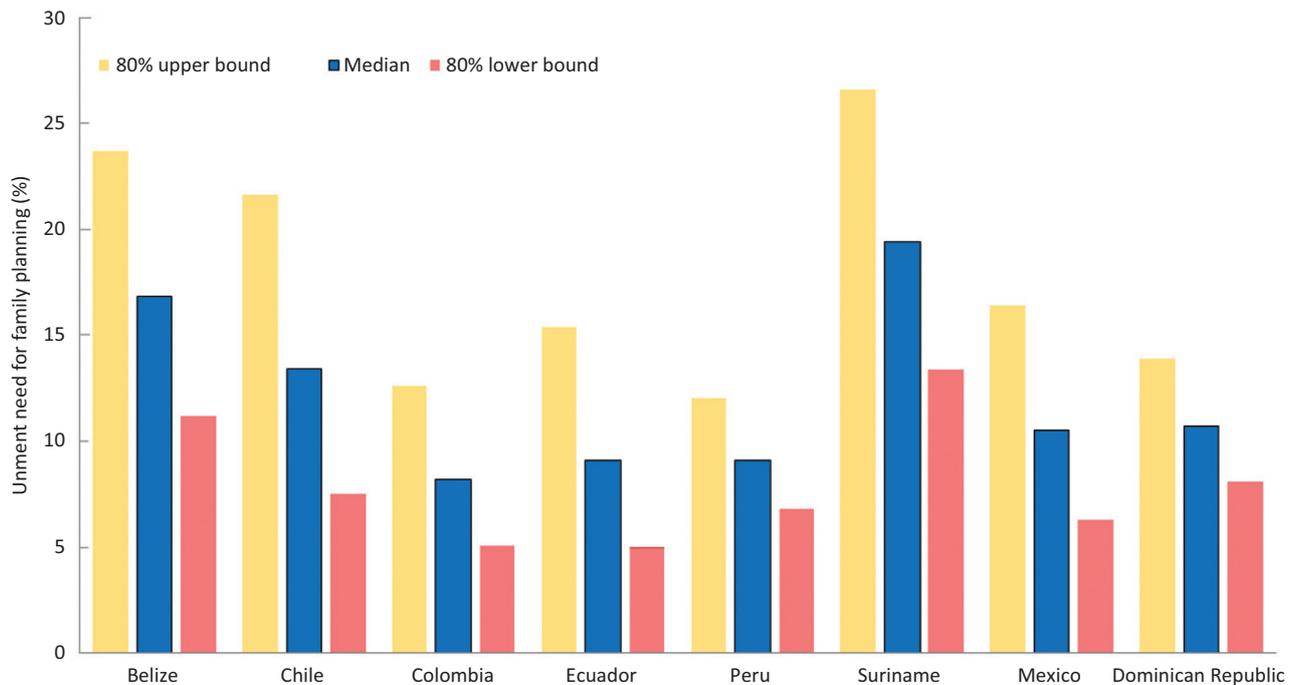


Figure 1. Unmet family planning needs in Latin America. Data taken from reference [1].

Jamaica, it is recommended to wait a full year; in El Salvador, however, women have been advised to avoid pregnancy until 2018 [17]. These countries also have a high unmet need for modern contraception, especially in the poorer quintile of the population [5]. The unmet need for contraception in Latin America has a greater impact among the poorer and most vulnerable members of the population (Figure 1).

In 2011, Blumenthal et al. [18] published an analysis of the effectiveness of LARC methods, noting that the copper intrauterine device (IUD), levonorgestrel-releasing intrauterine system (LNG-IUS) and injectable and implantable contraceptives were safe and effective contraceptive options appropriate for a wide range of women seeking to limit or space childbearing. LARC has been shown to be more cost-effective than other commonly used methods, such as condoms and the pill, achieving 5-year savings of between \$13,373 and \$14,122 [18]. LARC methods, especially the copper IUD or LNG-IUS, are easier to use because they do not require frequent, periodic dosing and visits to health centres. In addition, they can provide up to 10 years of contraceptive protection, depending on the product chosen. Thus, LARC can be a very attractive option for women who want to avoid early repeat pregnancies [19]. However, the United Nations, Department of Economic and Social Affairs, Population Division published a report showing that in Latin American countries and the Caribbean, between 1994 and 2015, the prevalence of IUD use among married or in-union women aged 15–49 decreased from 7.2% to 6.4%, respectively [1], highlighting the need to understand the barriers to IUD access and use. The purpose of this paper is to review policy dimensions that facilitate or impede uptake of IUC in both the public and private sectors in Latin America and the Caribbean.

Methods

The survey was conducted by the WHO's Reproductive Health and Research Department and distributed to

member states through the PAHO regional office for Latin America and the Caribbean. The survey comprised 12 questions regarding the following: existence of policies and guidelines regarding availability of the copper IUD and LNG-IUS, practices surrounding family planning and LARC, donor help in providing IUC, payment methods in the public sector and eligibility restrictions for use of LARC methods.

The survey was conducted between December 2015 and January 2016. A questionnaire was sent to 30 member states of which 18 responded. It was completed by the WHO country offices in consultation with the respective ministries of health. As completion was not mandatory, some health officials did not return the questionnaire, or returned it incomplete. No response to three friendly reminders was considered to be an unwillingness to participate in the survey. The survey data from 18 member states were checked for any errors before analysis.

Results

Target population

18 responses were gathered from the following Latin American and Caribbean countries: Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Nicaragua, Paraguay, Peru, Saint Lucia, Saint Vincent and the Grenadines, Suriname and Uruguay. The responses were checked by the PAHO regional office and analysed (Table 1).

Existence of national IUC policies

With the exception of Barbados and Suriname, respondents stated that they had governmental policies on IUC. Respondents stated that the use of IUCs was included in or was directly part of the national guidelines for sexual and reproductive health or clinical care at governmental level, often in collaboration with the WHO. The respondents from

Table 1. Principal findings from the questionnaires from 18 countries.

Topic	No. of countries	Additional information
Existence of IUC policy	15/18	No policy in Barbados or Suriname, no answer from Saint Lucia
Immediate postpartum IUD availability	Some degree of availability in 9/18	None or very limited availability reported in Barbados, Brazil, Chile, Costa Rica, Guatemala, Saint Lucia, Saint Vincent and the Grenadines, and Suriname
Cost of IUD provision	Free of charge in 16/18	Not free of charge in Barbados or Suriname
Availability of IUDs in public sector	Not available in 17/18	Available in Chile
Availability of IUDs in private sector	Available in 15/18	Not available in Bolivia, Cuba, and Saint Vincent and the Grenadines
No IUC restrictions in young, nulliparous women	No restriction in 11/18	Some restrictions in Barbados, Belize, Costa Rica, Guatemala, Paraguay, and Saint Vincent and the Grenadines; not applicable in Suriname

Colombia and El Salvador stated that there were no exclusive guidelines specifically for IUCs, but their use was included in national guidelines.

IUC availability

All respondents, except Chile, stated that the LNG-IUS was not available in the public sector; 15 respondents replied that the LNG-IUS was available in the private sector. Bolivia, Cuba, and Saint Vincent and the Grenadines reported that it was not available in the private sector.

When asked if immediate postpartum IUC insertion was available, the responses were unevenly divided. Belize, Bolivia, Colombia, Cuba, Dominican Republic, El Salvador, Nicaragua, Paraguay and Uruguay all responded in the positive, with a few qualifiers regarding availability of the products.

Respondents from Barbados, Brazil, Chile, Costa Rica, Guatemala, Saint Lucia, Saint Vincent and the Grenadines, and Suriname responded that it was not universally available or that it was not uniformly practised.

Public and private sector provision

When respondents were asked if the IUC was provided free of charge in the public sector, 16 countries replied positively; only respondents from Barbados and Suriname responded that the IUD was unavailable in the public sector. However, a second question was posed regarding the cost and provision of IUC: when asked if the ministry of health received IUDs free of charge from donors, the majority of respondents (10 countries) replied negatively. For those countries where IUDs were provided free of charge, they were purchased from the ministry of health's national budget. In Cuba, a small percentage was donated by the United Nations Population Fund (UNFPA). However, donation-based acquisition was not widespread.

Eligibility of health care professionals to provide IUC services

The professional level and educational attainment required to insert IUC varied among respondents. When asked who, apart from medical doctors, could carry out an insertion, eight countries responded with answers such as 'nurses', 'trained nursing staff' and 'qualified registered nurses', while nine countries cited midwives and other general practitioners. Only Uruguay responded that it was not permitted

for anyone other than a medical doctor to carry out an insertion.

A few countries (Costa Rica, Paraguay and Peru) responded that health professionals carrying out IUD insertions had to have some obstetric qualifications. In Brazil, Suriname and Uruguay, only medical doctors were allowed to carry out an insertion.

Involvement of non-governmental organisations in IUC provision

Brazil, Chile, Guatemala, Paraguay, Saint Lucia and Suriname reported that there were no current partnerships between non-governmental organisations (NGOs) and the ministry of health to provide or promote IUD use. The remaining respondents reported that there was some involvement with NGOs in this regard. The NGOs mentioned were PASMO, Instituto Nacional de la Mujer (INAMU), UNFPA, PAHO, IOM, Marie Stopes, and the International Planned Parenthood Federation (IPPF), as well as other smaller national organisations. For example, reproductive health law in Barbados allows physicians and midwives to insert IUDs. The Barbados Family Planning Association was founded in 1954, and provides a comprehensive family planning programme working closely with the Barbados Ministry of Health to provide counselling, information and contraception, including voluntary sterilisation and IUDs [20].

Policy implementation

For countries with official guidelines, all were reportedly implemented at national level, except for Guatemala, where policy was implemented at village and rural levels only. There were no explicit policies in Barbados and Suriname. Seven countries reported some form of restriction regarding the use of IUC for various reasons or according to medical guidelines; Barbados, Belize, and Saint Vincent and the Grenadines in particular placed restrictions on the use of IUDs for reasons such as nulliparity, high risk of sexually transmitted infections, or having multiple sexual partners.

Discussion

This study aimed to summarise the national contraceptive policies in Latin America and the Caribbean, in an effort to revitalise and promote the use of IUC. The results show that 15 out of 18 responding countries in Latin America and the Caribbean included IUC as a component of overall

family planning protocols and strategies and many provided IUDs free of charge to users. However, it was also noteworthy that many countries withheld IUC from young, nulliparous women and, even in the absence of formal restrictions, many providers hesitated to offer IUC to this segment of the population. Restrictions against nurses, midwives and other paramedical staff inserting IUDs varied in six out of 18 Latin American countries.

Through this survey, we hope to show national policies relating to IUC use, and offer our findings as a baseline to aid progress and help highlight the changes needed to help vulnerable couples seeking LARC. Currently, in the context of Zika virus, sexual and reproductive health recommendations to all women of childbearing age and men are centred on postponing pregnancy and continuing safe sex practices using condoms. It is also recommended to increase access to effective contraception and give couples the best available information to make an informed decision [5]. Additionally, there is growing scientific evidence that Zika virus can be transmitted sexually; therefore, practising safe sex using a condom will reduce the viral transmission rate [4]. Furthermore, use of effective family planning methods is a key aspect of reducing unwanted pregnancies [18]. Efforts are needed to further dispel misconceptions by increasing awareness in communities [19]. In Latin American countries, many women of childbearing age in areas affected by Zika virus likely want to delay pregnancy or use contraceptive methods for family planning; thus, the need and demand for family planning services and access to LARC are likely to increase.

Our results show that IUC is a large part of the national health plans of most countries, but its availability is concentrated in the private sector and is limited in the public sector where the most vulnerable populations receive care. Additionally, while widely available in some places, postpartum IUD insertion is not universally practised and is subject to availability. The outbreak of Zika virus has led to increased governmental and health system-related pressure to delay pregnancies and increase contraceptive uptake; thus, those countries where IUC is not easy to access or is not a readily available option for most women should re-examine and potentially rethink their policies regarding LARC in order to meet the unmet needs of the population. The health systems must be part of the solution and not part of the problem; each system needs to innovate, redouble its efforts and work towards guaranteeing the right of access to reproductive health care.

Strengths and limitations of the study

The survey did not cover all countries in Latin America and the Caribbean. The results should therefore be interpreted with caution and should not be extrapolated to other countries. However, we still believe that the response rate provided an adequate geographical spread and overview of the region. Second, although the survey was completed by the WHO country offices, it was done in consultation with the respective national ministries of health in order to have a perspective from both sides. Finally, we acknowledge that the survey's specific focus was on IUC and it did not attempt to cover other LARC methods such as

implants, partly because the prevalence of implants is very low (0.3% in 2015 [1]).

Conclusions

Our survey has identified gaps in the availability and use of IUC. It is hoped that the results will focus attention on improving uptake and access to IUC in Latin America and the Caribbean, while also serving as a baseline for reviewing and improving policies supporting the use of LARC, particularly in countries with populations vulnerable to the Zika virus epidemic and with unmet contraceptive needs.

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Disclosure statement

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