Global Health Technical Briefs

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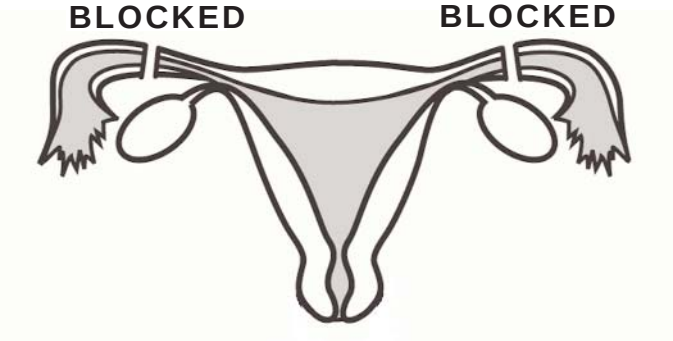
Female Sterilization: The Most Popular Method of Modern Contraception

- ***Female sterilization is the most widely used modern method in the world, including developing regions and many developed countries such as the United States.***
- ***Female sterilization is a safe, highly effective, relatively simple, surgical means of contraception that can usually be provided in an outpatient setting and is intended to be permanent.***
- ***Effective FP/RH programs should have an active, accessible, voluntary female sterilization component that delivers quality services to women who make a free and informed choice for this method from within a range of contraceptive options.***

Method-Specific Characteristics and Considerations

Convenience/Timing: Female sterilization can safely be provided post-partum, post-abortion, or as an interval procedure (unrelated to a pregnancy), under light sedation, in an outpatient facility. It is immediately effective, coitally-independent, and does not require routine follow-up. The post-partum and post-abortion periods are good (if neglected) times to provide sterilization, as it is then technically easier, less expensive and more convenient for many clients; counseling in these situations should be conducted in advance of the procedure or labor.

Effectiveness: Female sterilization is highly effective. Risk of failure (pregnancy), while very low, persists after the procedure, does not diminish with time, and is higher in younger women. Cumulative pregnancy rates of 5.5/1000 procedures at one year, 13/1000 at five years, and 18.5/1000 at ten years have been reported; one-third of such uncommon pregnancies are ectopic.



Safety: Female sterilization is safe, with few medical restrictions. Death is rare: 1–4/100,000 procedures in the U.S. (usually related to general anesthesia), and estimated at 5/100,000 in developing countries. Overall complication rates are generally low, estimated to be between 9–16/1000 procedures. The use of minilaparotomy with local anesthesia and light sedation has allowed wider provision of services.

HIV/AIDS: Female sterilization does not protect against HIV infection. Being HIV-positive is not a reason to be denied sterilization. A woman with AIDS, who is clinically stable, may receive sterilization, in settings with experienced staff and the needed equipment and support.

Regret: Most women who choose sterilization do not regret their decision. There are clear correlates of subsequent regret, however: young age, marital instability, decisions made in the

absence of other long-term options, and decisions made under pressure. Thus pre-sterilization counseling is critical.

Counseling: Free and informed choice calls for "two-way" counseling. It should address: sterilization's intended permanence; the availability and characteristics of alternative methods; the client's reasons for her choice; screening and discussion of risk indicators for regret; details of the procedure; the possibility of failure; and the completion of the informed consent (authorization) process. Younger women may need extra time to consider their future life goals and other options for long-term contraception, such as implants or the IUD. The counseling required for sterilization may require more time than counseling for temporary methods, but it helps to foster greater client satisfaction and community support, as well as to reduce myths and misunderstandings.

Programmatic Considerations

Female sterilization must be provided by well-trained and motivated providers in properly equipped health facilities where full attention is given to good surgical technique, infection prevention, and counseling. There should not be any unjustified policy or practice barriers to provision of these services, including legal restrictions, age and parity restrictions, marriage requirements, spousal or parental consent requirements, and provider bias.

Lessons learned: There are a number of ways to improve access and assure quality of female sterilization services, all of which entail a holistic approach, with a focus on the fundamentals of service delivery:

- Center program effort on the client by providing effective counseling and communication.
- Assure informed choice by providing accurate information and a range of methods.
- Train, equip, supervise, and support providers to offer locally acceptable, feasible, safe and effective female sterilization services.
- Identify, nurture and sustain "champions"
  - Involve influential and committed providers or institutions who provide high quality sterilization services and can advocate for and help to expand services.
  - Involve men as supportive partners, community opinion leaders, potential advocates, and potential alternative sterilization (vasectomy) clients.
  - Strengthen the role of community-based advocates (e.g., satisfied clients, community health workers) for outreach, counseling, and/or demand creation.
- Build "ownership" within communities by ensuring that clinical services are client-responsive and of good quality.
- Collect and use data for program design, to identify champions and to focus program efforts.
- Tailor the program to its local context by developing post-partum and post-abortion, private sector, and mobile outreach services, using appropriate technologies and methodologies.

Where to get more information: www.maqweb.org

References

Contraceptive Sterilization: Global Issues and Trends. EngenderHealth, New York, NY, 2002.
Minilaparotomy for Female Sterilization. EngenderHealth, New York, NY, 2003.

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