Long-Acting and Permanent Methods of Contraception: Without Them, a Country's Development Will Be Low and Slow

We've been hearing about family planning for over 25 years—isn't the job done yet?

No, the job is not done yet—far from it:

Although a number of Sub-Saharan African countries have made good progress in family planning (FP), success is *fragile*. Today, *fewer than one of every seven Sub-Saharan African women* (14%) use any modern method of contraception,[1] while in almost every country there is *still a large unmet need for FP*, both for delaying the next birth for two or more years and for limiting further births.

Even the most successful FP programs have of late experienced worrisome stagnation, if not an outright reversal, in their contraceptive prevalence rate (CPR) and their total fertility rate (TFR). In Kenya, for example, modern contraceptive use among married women rose from 4% in 1978 to 31.5% in 1998, and its TFR fell steadily from the late 1970s level of 8.1 lifetime births per woman to 4.7 in 1998. Yet in the next five years, Kenya's modern CPR did not change, and its TFR increased to 4.9 births per woman. Malawi, despite widespread poverty and illiteracy, had an even more dramatic upsurge in modern CPR—almost a quadrupling, from 7.4% in 1992 to 26.1% in 2000—but by 2004 modern CPR had barely risen further, to 28% in 2004.

More than 25 million women in Africa have an unmet demand for FP today—and the largest numbers of people in Africa's history are entering their reproductive years. Urbanization, which helps drive the desire for smaller families, is also continuing to proceed rapidly. Thus, the *demand* and *need* for effective family planning will be *growing considerably for years to come*.

What are the long-acting and permanent methods of contraception?

Four contraceptive methods are categorized as long-acting and/or permanent: *intrauterine devices (IUDs or IUCDs), implants, female sterilization, and vasectomy*. IUDs and implants are *long-acting temporary* methods; when they are removed, return to fertility is prompt. Copper-containing IUDs, the ones generally available in African Ministry of Health (MOH) family planning programs, are effective for up to 12 years. Implants, depending on the type, last for up to 3–7 years. Female sterilization and vasectomy, on the other hand, are *permanent* methods.

What are the most significant attributes of long-acting and/or permanent methods?

Long-acting and permanent methods are *by far the most effective* (99% or greater) methods of modern contraception available, and are *very safe* and *convenient*. They are all *clinical* methods and thus must be provided in health facilities by trained doctors, nurses, and/or midwives. *Only one action* by a client and provider results in *years of protection against unwanted pregnancy*.

Why is long-acting and permanent contraception so important to a country?

Long-acting and permanent contraception is vital to fulfilling the MOH's mission to help protect and improve its citizens' health and to help achieve national development goals. Experience globally as well as in Sub-Saharan Africa confirms that *without widespread availability and use of long-acting and permanent methods of contraception, a country cannot cost-effectively meet its lowered fertility goals*. In turn, inability to reduce high fertility contributes directly and substantially to poor health, poverty, low levels of education, and high under- and unemployment—that is, to *low national productivity, economic growth, and socioeconomic development.*[2]

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[1] Population Reference Bureau. 2006. *2005 World Population Data Sheet*. Washington, DC. By contrast, more than seven of every 10 women in Northern and Western Europe use modern contraception.

[2] Conversely, smaller families can invest more in the health, education, and welfare of each child, and women are more able to reach their potential; this is one of the main explanations for the relatively higher standards of living seen not only in the countries of the West, but also in the "advanced developing countries."

Aren't people in Sub-Saharan Africa afraid to use long-acting and permanent methods of contraception?

No. As in all countries, the most important feature to African women and men is the FP method's *effectiveness* (i.e., *how sure one can be of avoiding pregnancy unless and until it is desired*). Because of their *very high effectiveness* and their *safety and convenience*, long-acting and permanent methods of contraception are chosen by hundreds of thousands of people in Sub-Saharan Africa when such methods are made available, especially when cost and other access barriers are removed.

Experience in many African countries, such as Ghana, Kenya, Malawi, Tanzania, and Zambia, confirms this fact. Ghana, for example, removed policy barriers to allow trained nurses to insert implants. They trained 600 nurses, and as a result more than 88,000 Ghanaian women have chosen Norplant®. From 1998 to 2006, the CPR for implants rose more than 10-fold, from 0.1% to 1.2%. Malawi, with a per capita income of less than $0.50/day and severe shortages in skilled personnel, saw its CPR for female sterilization more than triple from 1992 to 2005, to almost 6% overall. In Kenya, more than one-quarter of its modern CPR is represented by long-acting and permanent methods.

Aren't there many people who cannot use long-acting and permanent methods?

No. The number of individuals who cannot use long-acting and permanent methods of contraception (including the IUD) is *actually quite small*. According to the World Health Organization's latest *Medical Eligibility Criteria for Contraceptive Use* (published in 2004), *almost all women* can use IUDs, implants, and/or sterilization, and *almost all men* can use vasectomy.

Why is unmet need for long-acting and permanent methods of contraception so high?

A number of factors contribute to the lack of wide availability of and access to long-acting and permanent methods of contraception. These include: higher up-front cost to individuals or the MOH; lack of availability of trained providers; lack of commodities and supplies; and/or lack of accurate knowledge about how the methods work and can be accessed. MOHs also must address, with scarce human and financial resources, many competing health priorities.

Isn't long-acting and permanent contraception expensive?

No. Although they have a higher initial cost, long-acting and permanent methods (except for implants) are actually the *most cost-effective of all* contraceptive methods, a feature valued by individuals who choose them, as well as by Ministries of Health trying to serve as many of their citizens as they can.

What should a Minister of Health do?

Become a champion. Tell your staff and officials from other Ministries, as well as other decision makers and opinion leaders in your country, that *sustained investments* in long-acting and permanent contraceptive services and information are needed.[3] Tell them that change will not come immediately.[4] However, over time such investments will lead to savings in family planning and other health expenditures, reduced maternal morbidity and mortality, lowered fertility, decreased infant and child mortality, and improved national socioeconomic development. Tell them that the women and men in your country not only need these services, they *want* them. Finally, remind everyone that *in the absence of widespread availability and use of long-acting and permanent methods of family planning, fertility levels will generally stay high, and national development may be low and slow.*

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[3] Remind them that millions of women in Africa, even in high HIV-prevalence settings, are at greater risk of unwanted pregnancy and maternal morbidity and mortality than they are of HIV, and that effective FP prevents more mother-to-child transmission of HIV than do ARV drugs. Deaths of infants and children decline 24–35% in pregnancies spaced at least three years; pregnancy spacing alone, through effective FP, could save hundreds of thousands of African children *every year*. Africa's very high maternal mortality—for every 109 births, there is a maternal death—could also be greatly reduced. And for every woman who dies in pregnancy or childbirth, approximately 30 other women suffer injuries, infection, and disabilities, many of them debilitating.

[4] For example, it took 11 years of information exchange and educational efforts before just half of American physicians had adopted new, proven ways of treating heart attacks.