



Addressing Unmet Need for Family Planning in Developing Countries: The Case for IUDs

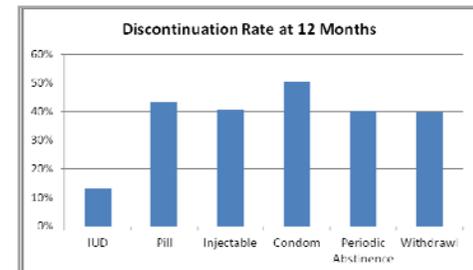
Of the 867 million women in the developing world who are sexually active and want to avoid becoming pregnant, approximately 222 million of them have an unmet need for modern contraception, or 1 in 4 women.ⁱ Those women most affected by this gap in both service provision and utilization of services, reside in the 69 poorest countries, accounting for 73% of all unmet need in the developing world.ⁱⁱ Meeting this demand for modern contraceptive methods would prevent an estimated:

- 54 million unintended pregnancies, including 21 million unplanned births, 26 million abortions (of which 16 million would be unsafe) and seven million miscarriages;
- 79,000 maternal deaths; and
- 1.1 million infant deaths.ⁱⁱⁱ

Benefits of the Copper IUD

With a lifespan of up to 12 years, a greater than 99% effectiveness^{iv}, and a cost of \$0.77 annually per user in developing countries^v, **Copper IUDs** are the most reliable and cost-effective long-acting reversible contraceptive (LARC) method on the market today. When compared to other methods, including other highly-effective LARC methods such as implants, Copper IUDs present several additional advantages:^{vi}

- Serves as both a long *and* short term method, as return to fertility is immediate following removal;
- Effectiveness is not dependent on proper and consistent use, thus resulting in less user error;
- Fewer side effects than hormonal based methods;
- Lower discontinuation rate by 12th month in developing countries (13.1%) than most other forms, including oral contraceptives (43.5%), injectables (40.6%) and condoms (50.4%);^{vii}
- The median length of IUD use is 40+ months compared with 12-18 months for other methods;^{viii}
- Can be inserted immediately postpartum (within 48 hours) and has no effect on breastfeeding, unlike hormonal methods which can require a six week waiting period before starting;
- Can be safely inserted immediately after abortion;
- Can be provided by trained providers at all levels of service delivery, including primary and village level health centers (i.e. doctors and nurses *and* midwives, clinical officers, auxiliary nurses, community health officers and other paraprofessionals can all provide IUD services);
- No additional costs once inserted unlike repeat costs with injections, pills, condoms;
- Can be used as an emergency contraceptive; and
- No adverse reaction with other medications, including antiretroviral therapy.



	Copper IUDs ^{ix}	Implants ^x	Injectable ^{xi}	Oral Pill ^{xii}	Condom ^{xiii}
Cost/user in Developing Countries (USD)	\$0.77	\$7.75	\$8.61	\$7.26	\$4.17
Lifespan	10 to 12 years	3 to 7 years	4, 8 or 13 weeks	28 days/pack	1 time use
Effectiveness (Typical use/Perfect use)	>99%	>99%	97%/ >99%	90-97%/ >99%	85%/98%
Postpartum Use if Breastfeeding	Within 48 hours or 4 weeks after birth	6 weeks	6 weeks	6 weeks	Any time following birth

Despite these advantages and the cost-effective potential of IUDs in reducing unmet need, the IUD is significantly underused in most developing countries. Of women who are using contraceptives, only 8% of women in Sub-Saharan Africa and 9% in South Central Asia use IUDs. In South East Asia the percentage is higher at 22%.^{xiv}

Barriers to IUD Use in Developing Countries

Barriers to IUD use exist at both the policy and service delivery levels. Outdated or inaccurate service delivery guidelines and misinformed attitudes and beliefs among female clients and providers, often impede IUD use. Barriers to access are also attributable to lack of trained providers and properly equipped facilities.

Policy Barriers. Policies and guidelines about service delivery are sometimes based upon inaccurate and outdated information. As such, even when a woman or a provider is properly informed, they may not be able to access/provide these services if the national and local service delivery policies have not caught up. Common policy and service barriers in many countries include:^{xv}

- Only allowing doctors and nurses to provide IUD services, when lower level service delivery providers can in fact insert and remove IUDs with basic training;
- Limiting insertion to the time a woman is menstruating or when a patient is six weeks postpartum, which is a requirement for other forms of contraception but not for IUDs (which can be inserted within 48 hours of delivery);
- Requiring multiple follow-up visits, which is not necessary unless there is pain or a complication; and
- Placing other restrictions on IUD services based on marital status, age, or the number of children that a woman has, none of which are relevant for use.

Lack of knowledge about IUDs as a LARC method. In many cases, providers simply do not possess adequate knowledge about the IUD as a LARC method and consequently, provide incomplete information to potential clients or do not offer the IUD as a reliable method.^{xvi} Some useful facts about IUDs of which providers and users may not be aware include:^{xvii}

- IUDs can be used by women who have never had children;
- All women of reproductive age 15-49 can use IUDs;
- IUDs can be inserted immediately postpartum. Postpartum women who are breastfeeding *can* get pregnant and therefore *do* need a method if they wish to avoid pregnancy;
- A woman does not need to be menstruating at the time of their visit to get an IUD. Women who are amenorrheic *can* get pregnant and therefore *do* need a method if they wish to avoid pregnancy;¹
- IUDs have an effective duration of up to 12 years, but can also be used as a short-term method; and
- Women who are breastfeeding can use an IUD.

Misinformation about health risks and side effects. Without sufficient and accurate knowledge about IUDs, providers, as the counselors on family planning, often end up perpetuating many of the myths and misperceptions surrounding IUDs.^{xviii} While concerns about heavier menstrual bleeding and cramping can be a real side-effect (as with many forms of contraception) most health-risk related concerns are based on inaccurate or partial information. The following corrects some of the more common myths associated with IUDs:

- IUDs cannot migrate to other parts of the body like the heart or brain.^{xix}

¹ According to one study, findings indicate that both women and providers frequently cite that postpartum women cannot get pregnant until their menstruation has returned. Further, the report notes that some providers have required that women be menstruating at the time of their visit as a way to rule out pregnancy before giving them a method. While not specific to postpartum women, this does negatively affect them as many are also amenorrheic following childbirth. (FHI 360, 2012, 4-5.)

- If an IUD tilts or moves slightly in the uterus, it does not result in pregnancy nor can it lead to ectopic pregnancy. In fact, IUDs have a 99 success rate in preventing pregnancy.^{xx}
- IUDs do not cause birth defects.^{xxi}
- IUDs do not cause discomfort or pain for the woman during sex.^{xxii}
- IUDs do not make women infertile, nor is a woman at an increased chance of miscarriage after the IUD is removed.^{xxiii}

Two other cited risks are extremely rare and have mainly been exaggerated:

- IUDs rarely lead to pelvic inflammatory disease (PID), even for those with STIs. The risk is actually quite low for both groups at less than 2% for women without STIs and less than 5% for those with STIs. Further, PID is not caused by IUD insertion alone, but rather is a result of having or becoming infected with STIs like Chlamydia or Gonorrhea.^{xxiv}
- It is extremely rare for the IUD to perforate the uterus, with fewer than 1.5 perforations per 1,000 IUD insertions, and can be avoided with proper training.^{xxv}

Lack of equipment and properly trained staff. In addition to being equipped with accurate information to counsel clients on IUDs, providers – from clinical to community health officers – need to be trained on how to properly insert and remove IUDs. They also require the proper instruments (e.g. forceps), equipment (e.g. beds), supplies (e.g. gloves, cotton balls), and sterilization mechanisms.^{xxvi} In order to guarantee that women have access, it is important that even rural clinics are properly stocked and have well trained staff.^{xxvii}

Overcoming Barriers

Updating guidelines and policies at both the national level and the local service delivery level based on current scientific evidence. The WHO continuously monitors medical literature and research for developing its family planning guidance and can serve as a resource for countries in developing and updating their own policies.^{xxviii} It is also crucial to involve the patients, community, service providers and other key stakeholders in developing these guidelines, so as to ensure they are effective and address all parties' needs.

Consumer directed marketing and communication about the benefits of IUD use coordinated with **supply side interventions** can aid in increasing IUD availability and importantly, demand. Where myths and misperceptions are common, the objective is not only to provide correct knowledge, but to also counteract barriers by specifically addressing prevailing myths, rumors, and health concerns.^{xxix} On the supply side, it is critical to ensure that the IUDs are well stocked, as well as all the other necessary supplies, equipment, and instruments needed for providing the IUDs.^{xxx}

Training providers at the service delivery level is key to increasing uptake. It is essential to focus on training paraprofessionals at the local level who are most likely to be interacting with the women who have an unmet need for family planning. In addition to covering the technical skills for insertion/removal, trainings should address common misperceptions and equip providers with accurate scientific information. Further, trainings should highlight IUDs as a postpartum method and include checklists and methods for ruling out pregnancy.^{xxxi}

References

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- ⁱⁱⁱ Singh, 2012, 1.
- ^{iv} (3) World Health Organization and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs. *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva: CCP and WHO, 2011 update, 131.
- ^v Singh, 2012, 12. *All cost estimates presented in the report include the cost for one year of contraceptive use; annual cost for methods that provide protection for more than one year are obtained by dividing the total cost of that method by the average number of years it is likely to be used. For Copper IUDs this is 4.6 years; for implants this is: Implanon implant, 2.5 years, Sino-Implant, 3.2 years, Jadelle implant, 3.8 years; for injectables an annual average of four three-month injections or 13 one-month injections; 14 pill cycles; and 77 condoms.
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