

THE REPORT OF UPDATE WORKSHOP ON
INTRAUTERINE CONTRACEPTIVE DEVICES

HELD ON 20 FEBRUARY 1990
KENYATTA CONFERENCE CENTER
NAIROBI, KENYA

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I. EXECUTIVE SUMMARY ON THE UPDATE WORKSHOP ON
INTRAUTERINE CONTRACEPTIVE DEVICES (IUD)

This one-day workshop was held on 20th February, 1990 in Nairobi, Kenya. During a previous workshop on the update on contraceptive technology, the providers had indicated that the use of the IUD was gradually declining. Some of the factors were identified as being, 1) lack of adequate and proper information on the side effects and mechanisms of action; 2) oxidation of the currently available IUD device in the programme; 3) lack of clear guidelines for the IUD use; 4) irregularities in the supply of the devices and 5) absence of training of the providers on newer devices.

Thus this workshop was held to create a forum where the providers could discuss these problems and find possible solutions. It was organized by the Department of Obstetrics and Gynaecology, University of Nairobi.

It was attended by eighty people who were health providers, policy makers and scientists.

It was sponsored by the Population Council. However, the Family Health International sent a representative.

The main objective of the workshop was to improve the acceptance and continuation use rates for IUD in the National Family Planning Programmes through the updating of the providers knowledge about the method.

The specific objectives were 1) to update the health providers knowledge on the current status of the IUD in general with a special emphasis on the Copper T380A device which is the commonly available device in the government services; 2) to identify, define, and discuss problems related to IUD with an emphasis on CuT.380A from the providers point of view in order to increase the acceptability of the device by the clients through the providers; 3) to improve on the providers attitudes toward IUD as a means of contraception; 4) to set up guidelines on the use of IUD in Kenya and 5) to share experiences in the IUD provision in the different clinics in Nairobi area. The resource persons were: Gynaecologist and Obstetricians, research scientists, FP providers and scientists, International organizations: Population Council, Nairobi and Family Health International, U.S.A.

The problems of the tarnishing or "oxidation" of the IUDs was discussed and it was concluded that the scientific evidence indicate that there were still effective and safe. However, it was noted that the manufactures are assessing this problem and are trying to find solutions.

The worldwide experience of the IUD use show that many women are currently using different types of IUDs and that they were very few side effects which can be minimized either at the time of insertion or removal.

The studies on postpartum IUDs indicate that the type of the IUD is not the issue but the time of the insertion and the expertise of the person doing the insertion. However, some attempts are being made to improve the retention rate by special adaptations of standard IUDs such as use of biodegradable suture or knots. The insertion done at the time of the caesarean section seems to have the most success results., with the expulsion and continuation rates approaching that of the interval insertion of IUDs.

Thus a programme of the postpartum IUD insertion should be considered by family planning programmes which have a difficulty in bringing back the women to FP clinic for interval visits.

The family planning programme at Kenyatta National Hospital, a referral and teaching hospital, was reviewed. It was noted that the clinic had used many types of the IUDs since the introduction of the devices in the national programme. This clinic offers almost all the available FP methods including Norplant. The providers recently experienced some problems related to the use of TCu.380A which were distributed due to the fact that the devices were "oxidized".

The experience of the Family Planning Association of Kenya which is a non-government organization was outlined and statistics were given on the use of IUD. Their programme currently offers TCu. 380A, Multiload, and Lippes loop. The IUD ranks third after the injectables, and the pills but if sterilization is included then it becomes fourth. It was noted that the programme has a good mechanism for counselling of their clients for all methods. The method failure was very low in both the static and outreach clinics.

The barriers to IUD use were identified as mainly being: lack of adequate information to both the providers and the clients; lack of the national guidelines; unclarified issues pertaining to IUD contraception; misunderstanding of the mechanism of action, rumours and misconception regarding IUDs and their availability and the cost especially in the private sectors.

On the topics of motivation and counselling, it was noted that the general features of counseling were to facilitate active participation by the client, to assist the client examine a problem, and clarify the conflicting issue, to enable the client to discover alternative ways of dealing with the problem, to guide the client to come up with the best and suitable method for the union and this method of communication should be client centered

and not provider-centered. Ways to motivate the client to continue using the device should be sought instead of encouraging removal because of minor problems. Instructions should be given to the clients to ensure that they have fully understood the discussions. They should be instructed to come back if they experience any of the side effects.

An open discussion was held to assess ways of increasing IUD use. It was found that counselling was not adequate in the existing programme set up. The providers should have some update courses on counselling and ways of utilizing non-medical personnel to do the counselling in the FP clinics should be encouraged. This was because the providers normally have limited client-provider contact time.

The main recommendation was that the IUD should continue to be used in the programme, however, efforts should be made to increase its use. This could be done by 1) holding regular training programmes for the providers, 2) including or improving family planning curriculum of all future health providers, 3) posting counsellors to family planning units, 4) setting up minimum standards and guidelines for IUD use, 5) having regular supply of the devices (at least 2 different brands), 6) improving on the referral system for management of side-effects and method failures. The current evidence show that the tarnished TCU 380A were still effective and safe to use however, operational research should be carried to evaluate the non-use or the decline in the use of the IUD contraception in the Programme.

II. INTRODUCTION AND OBJECTIVES OF THE WORKSHOP -
Dr. C. Sekadde-Kigonda

Intra-Uterine Contraceptive Devices (IUD) have continued to play a role in the contraceptive practices of women the world over. In some of the communities it is the most commonly used method. In Kenya it has been the second mostly used method, however, recently other methods have better acceptance rates. In one area in Kenya IUDs are now ranking fourth to Depot - medroxy progesterone acetate (DMPA), Oral contraceptives (OCs) and Implants. This drop in IUD use has been due to several factors including:

1. LACK OF ADEQUATE AND PROPER INFORMATION

This has led to poor attitudes among both the providers and users. These poor attitudes often lead to poor policies and low utilization of the method. There are two major areas where this has continued to be a problem.

a) Side Effects:

i) The relationship between IUD use and pelvic infection and subsequent fertility has remained unclear to most providers and users despite the available information.

ii) The effect of oxidation of devices within their shelf life has also raised fears of hitherto unknown side effects.

b) Mechanism of Action:

The mechanism of action of IUDs has remained unclear in the minds of the providers and users despite the recent developments. Most of them still believe that the major mode of action is through prevention of implantation rather than prevention of fertilization as is currently known for the copper containing devices. This has made them look at IUDs as devices causing abortion and therefore objecting to their use.

2. LACK OF PROPER AND CLEAR GUIDELINES:

This has been left to a few individuals to develop and quite often these are people who have not been kept informed of new developments in this area. This has often led to confusing instructions. Even in cases where these have been well developed, their dissemination has been poor leaving the actual providers uninformed.

3. **SUPPLIES:**

There are many different types of devices on the market today and this may cause confusion to the provider and the user. Since some of these devices work differently it calls for training on all the different devices. The supplies are also inconsistent such that when users request the method it is not available and this makes them lose confidence in the services.

4. **TRAINING:**

Most of the service providers do not receive adequate training in the insertion techniques. This is mainly because the training often utilizes one type of device and they are confronted with new devices they have no idea of how to proceed. This may account for an apparent increase in failure rates and some of the side effects.

JUSTIFICATION:

From the brief introduction above it can be seen that there was a need for the update workshop if IUDs are going to continue to play a role in contraception. Although this workshop was for the providers, it was hoped that through these, the message could reach the users in an effective manner.

III.

TARGET POPULATION:

The participants were health providers, researchers and policy makers involved in the provision of family planning services in the Nairobi area. They were drawn from the following organizations:

- i) Ministry of Health Services (Division of Family Health, FP Clinics)
- ii) National Council for Population and Development (NCPD)
- iii) Members of Kenya Obstetrical and Gynaecological Society (K.O.G.S)
- iv) City Commission Health Services
- v) Private Sector Health Services
- vi) University of Nairobi (Department of Obstetrics and Gynaecology at Kenyatta National Hospital)
- vii) Other non-governmental Organizations (e.g. Family Planning Association of Kenya (FPAK)
- viii) International Organizations (Population Council, and Family Health International).

A total of 80 people participated in the workshop.
A list of the participants is annexed (Appendix 1)

IV.

RESOURCE PERSONS:

They came from the following disciplines and organizations:

1. Obstetrician/Gynecologist: Dr. Wanjala, Dr. Thagana, Dr. Gavi, and Dr. Saighvi, of University of Nairobi,
2. Researchers Dr. Schutte-Kigundu, University of Nairobi,
3. Health Providers, World Health Organization (WHO) Association of Kenya (HAK): Dr. Achwal, and Ms. Ogenbo,
4. International Organization: Dr. Chikamata, Population Council, and Dr. Petrick, Family Health International, U.S.A.

THE PROGRAMME

The programme consisted of the following items (annex 2)

- o Objectives of the workshop
- o Overview of IUDs, mechanism of action, safety and efficacy
- o International studies on IUDs
- o Kenyan Experience with IUDs in Kenya (Family Planning Association of Kenya, Kenyatta National Hospital)
- o Postpartum IUD use
- o Barriers to IUD use
- o Strategies for increasing IUD use
- o Discussions and recommendations
- o Film on currently used IUDs (Intra-uterine Devices from International Planned Parenthood Federation; IPPF).

A lot of literature was distributed to each participant for further reference and reading.

THE OBJECTIVES OF THE WORKSHOP WERE OUTLINED AS FOLLOWS:
MAIN OR OVERALL OBJECTIVE:

To improve the acceptance and continuation of use of IUDs among women wishing to practice family planning in Kenya.

SPECIFIC OBJECTIVES:

1. To update health providers' knowledge on the current status of IUDs in general with a special emphasis on the Copper TCU.380A device which is the commonly available device in the government services.
2. To identify, define, and discuss problems related to IUDs with an emphasis on the Copper TCU.380 A from the providers point of view in order to increase the acceptability of this device by the clients through the providers.
3. To improve on the provider's attitudes towards IUDs as a means of contraception.
4. To set up guidelines on the use IUDs in Kenya.
5. To share experiences in IUD provision in different clinics in Nairobi Area.

V.a OPENING REMARKS (Dr. S.H. Wanjala)

The acting Chairman of the department thanked the organizers of the workshop and welcomed the collaboration between the Population Council and the Dept. of Ob/Gyn in addressing the issues that has been raised by family planning providers. The department will continue to work with international organizations to improve the provision of family planning programmes in Kenya and the health of women in general.

VI.b REMARKS BY THE DIRECTOR OF THE DIVISION OF FAMILY HEALTH

The workshop was officially opened by Dr. A.O. Oyoo, Director, Division of Family Health of the Ministry of Health. In his opening remarks, he welcomed the participants and he gave the mandate to the participants to look into the following items:

- o Policy of the IUD use in Kenya,
- o Evaluation of the different types of the IUDs,
- o Availability of these commodities to the clients,
- o Attitudes of the providers and clients as far as IUDs are concerned,
- o Information and materials to be given to the clients,
- o Guidelines to help the clients to come up with her method of choice,
- o Update courses on different family planning methods.

Everyone was encouraged to contribute to various discussions as specified in the program. He indicated that this information should be compiled and disseminated to relevant personnel including the Division of Family Health.

VI.

PRESENTATIONS:

VI.A

AN OVERVIEW OF THE IUD MECHANISM OF ACTION
THE POPULATION COUNCILS EXPERIENCE

This was presented by Dr. D.M. Chikamata.

Intrauterine contraceptive devices have been used throughout the world for almost three decades. They are effective, safe and convenient. However, the IUDs have not gained wide acceptance in Sub Saharan Africa. Only 0.5% of women of reproductive age use IUDs compared to 25% in Scandinavian countries and 35% in China. The health providers, including physicians in both developed and developing countries are reluctant to use the intrauterine contraceptive device because they are not convinced of the high degree of efficacy of this contraceptive method and they are still afraid of expressed concerns about certain issues about IUD. These have included the use and safety of IUDs, the increased risk of pelvic inflammatory disease (PID) and subsequent infertility. In the developing countries the issue of the occasional presence of tarnish on CuT 380A has worried the providers that the IUD may no longer be sterile or may have lost its effectiveness.

These are some of the reasons that have lead to many women not to be offered this method of contraception. The IUD is a long-acting contraceptive usually without systematic effects.

The following topics were reviewed:

- i) the copper bearing IUDs
- ii) mechanism of action
- iii) efficacy,
- iv) side effects: infection, pain/bleeding and expulsion and
- v) tarnishing.

IUDs are usually classified as unmedicated e.g. ring devices, usually made of stainless steel and plastic devices and medicated e.g. copper or hormone-releasing. In Sub Saharan Africa, the Lippes Loop, made of polyethylene is the most widely available unmedicated IUD. The review focussed on the second generation of copper bearing IUDs.

In the late 60s researchers discovered that adding copper to a plastic IUD frame increased the effectiveness. This lead to the development of second generation of IUDs in the 1960s and 1970s. The hormone-releasing IUDs were also developed in the 1970s, however, these are not available in Sub Saharan national family planning programmes.

The first generation of Copper bearing IUDs were smaller than the plastic devices and they caused fewer side effects but just as effective in preventing pregnancy. These had to be replaced every few years. Therefore a second generation of copper bearing IUDs was developed, including the TCU 380A, the TCU 220, the Nova T, the Multi-load 375 and others. The features that have made copper bearing IUDs more popular include:

- i) high effectiveness
- ii) fewer side effects
- iii) long lasting

These improved IUDs are now becoming widely available.

MECHANISM OF ACTION

The mechanism by which IUDs act as contraceptives are still not fully understood. Many studies have attempted to explain the mode of action of IUDs by the morphological changes that take place in the endometrium. The embryo is thought to be lost during the time of implantation because the IUD alters the cellular and biochemical environment in the endometrial cavity.

The introduction of an IUD into the uterine cavity induces a foreign body reaction in the surrounding endometrium which is characterized by the infiltration of polymorphonuclear leucocytes and macrophages into the endometrial stroma and subsequently through the surface epithelium. Leucocyte migration is greater with copper IUDs than with inert IUDs. Besides the morphological changes, the biochemical composition of the endometrium and the uterine fluid undergoes changes during the use of inert and medicated IUDs. The copper bearing IUD increases the concentration of copper in the uterine fluid and enhances some specific enzyme activities whereas steroid-releasing IUDs exerts a strong suppressive effect on the proliferative activity of the endometrium and influences the enzymatic activity accordingly.

The addition of copper to an inert IUD has been shown to significantly alter the metabolism of the endometrial cells e.g. the enzymatic activity and the Deoxyribonucleic acid (DNA) synthesis. In addition, similar to that of the inert devices, the hormone-releasing IUDs show massive decidual changes, atrophic glands and sometimes atrophy of the whole functional layer. The morphological changes of the human endometrium and the biochemical changes of the endometrial fluid during the normal cycle play a role in the capacitation of the sperm and as well as the implantation of the blastocyst.

The biochemical changes may influence in a negative way events involving proteolytic activities, e.g. migration and maturation of sperm at mid-cycle and the implantation of blastocyst. The antifertility action of IUDs has been suggested to be related to the presence of the foreign body reaction.

Recently, the weight of scientific evidence indicates that copper bearing IUDs prevent pregnancy beyond the uterine level by:

- i) preventing fertilization of the ovum. The foreign body reaction produces biological response that may interfere with steps of the reproductive process that normally takes place before the ovum reaches the uterine cavity
- ii) diminishing the number of sperm that reach the fallopian tube and
- iii) incapacitating sperm and inhibition of sperm transport.

IUDs, and particularly copper devices decrease the likelihood that the ova can be found in the fallopian tube shortly after ovulation.

For a long time scientists and even the developers of IUDs have believed that IUDs are abortifacient. This was based on the false concept that IUDs operate at the uterine level, by destroying fertilized ova in a hostile environment where it is phagocytized, destroyed by toxic products or that it withers because it is unable to implant in an altered endometrium.

A variety of studies demonstrate that IUD use diminishes both the number of sperm reaching the oviduct and their capacity to fertilize ova.

The type of the IUD is also important in hindering the sperm from penetrating the cervical mucus, the sperms are phagocytized by leukocytes, are incapacitated with head-tail separation in the presence of copper and suffer other cytotoxic effects in the IUD-altered uterine fluid.

In the fallopian tubes of copper IUD users, the ova are found significantly less frequently than in controls. The ova as with sperm are affected, apparently by the altered uterine fluid.

The primary mode of IUD action appears to be interference with conception rather than implantation. Therefore the IUDs prevent pregnancy as a contraceptive and not abortifacient.

EFFICACY

Research on IUDs in the past decade has resulted in development of new devices that have both higher continuation rates and lower rates of expulsion and removal for bleeding abnormalities. A number of large-scale randomized multi-centre studies have been undertaken by the WHO Special Programme of Research, Development and Research Training in Human Reproduction and Non-governmental Organizations (NGOs) such as The Population Council and Family Health International; these studies have covered both new and IUDs already in use in national family planning programmes.

Large, multi-centre, randomized clinical trials demonstrate that IUD failure rates are strongly affected by the age of participants, notably by the proportion of women under the age 25 admitted to the trials.

Non medicated IUDs such as Lippes loop have pregnancy rates above 2 per 100 woman years. The first generation of copper bearing IUDs, the Cu.7 and the Tcu 200, do not markedly differ in pregnancy rates from standard plastic devices with rates significantly above 2 per 100 woman years. The second generation copper IUDs have failure rates below 2 per 100 woman-years.

The CuT 380A is one of the most effective methods of contraception ever developed. In large multi-centre trials pregnancy rates are less than one per 100 women in the first year of use. The cumulative pregnancy rate after 6 years of use is just 1.4 per 100 women according to a WHO international study (3). The IPPF and some other agencies provide the Nova T and multi-load as well as Tcu 380A. Most national family planning programmes are currently using the second generation of IUDs.

The current generation of IUDs is safe for many women and 99% effective over one year of use. But not all women should use IUDs. The provider must screen potential users, insert the device correctly and follow up the clients.

The attention now is shifting toward identifying appropriate IUD users and providing high-quality medical care and counselling to maximize safety and acceptability.

Based on the promising information available about the second generation of Copper bearing IUDs, international donor agencies are now providing these IUD for use in developing country programmes.

The IUD is highly effective in preventing pregnancy but like with all reproductive choices, including pregnancy, has both health benefits and risks. The side-effects associated with use of IUDs may be serious, such as ectopic pregnancy or pelvic inflammatory disease or troublesome to the woman such as pain and increased blood loss and anaemia.

SIDE EFFECTS

RISK OF PID

New studies and new analyses of earlier studies show that the risk of infection is largely limited to the first four months after insertion and to women exposed to sexually transmitted diseases (STDs). The increased risk of PID with IUD use centres around the time of insertion. To women who are not exposed to STDs there appears to be no risk of infertility. Similarly, evidence shows that Copper and all-plastic IUDs do not increase the risk of ectopic pregnancy in fact, they provide some protection against them.

The use of a copper IUD coupled with a stable relationship does not cause an increase in tubal infertility.

Careful selection of candidates for intrauterine devices may further reduce the risk of IUD-associated pelvic inflammatory disease.

PAIN/BLEEDING

In clinical trials 4 to 15 % of women stop using IUDs for this reason within a year of insertion. Percentages are higher for non-medicated devices than for copper IUDs. Older women and women with children generally have lower rates of removal due to bleeding and pain.

With unmedicated IUDs, blood flow increases on average by 50 to 100% above pre-insertion levels. With TCu.380A IUD the increase above the pre-insertion levels 20 to 50%.

EXPULSION

Expulsion vary from less than one to more than 10 per 100 women in the first year of use. In general, non-medicated IUDs are expelled more often than Cu. IUDs. Among the Cu. IUDs the Nova T and Multiload are least expelled. Most expulsions occur in the first year and especially within the first 3 months of insertion. Factors that are associated with expulsion include the age and the parity of the woman. Correct insertion with an IUD placed up to the fundus is thought to reduce the chances of expulsion.

TARNISHING OF TCu.380A

Family planning providers in Kenya and other developing countries have recently expressed concern about the occasional presence of tarnish on TCu.380A within the package. The providers worry that the IUD may no longer be sterile or may not be effective. All available evidence indicates that tarnished IUDs are both safe and effective as long as the package remains intact. The copper wire or sleeves on IUDs tarnish because gases can pass into the IUD package, causing a copper oxide to form on the copper surface. The IUDs have a shelf life of four years.

These factors; effectiveness; long lasting; safety and acceptability, have permitted the IUD to play an important role in family planning programmes, especially in the developing world.

If the usual criteria for the use of IUD is followed, i.e., women over 25, ideally multiparous and with a stable relationship, the fear of infection is not higher than with any other type of contraception. "The use of IUDs in both developed and developing countries should continue to be supported as a reliable and safe method of reversible fertility regulation".

SUGGESTED FURTHER READING:

1. Population Reports IUDs a new look series B. No. 5 April 1989.
2. Cramer DW et al Tubal infertility and the intrauterine device. *New Engl J Clin Med* 1985; 312(15):941-947.
4. Johannisson E. Mechanism of Action of Intrauterine Devices: Biochemical Changes. *Contraception* 1987 (36)1 11-22
5. WHO Technical Series 753. Mechanism of action, safety and efficacy of intrauterine devices, WHO, Geneva. 1987.

VI.2.

WORLDWIDE EXPERIENCE OF THE IUD USE

Dr. Petrick, from Family Health International, USA, reviewed the worldwide experience of the IUD use. It was indicated that the IUDs are still approved for use in the United States and they have never been withdrawn by the Food and Drug Agency (FDA). However, the manufacturers decided on withdraw from the market for the following reasons:

- 1. enormous risk of law suits
- 2. high monetary losses suffered there after.

However, at present time Gynopharma Inc. has obtained approval to market the T Cu. 380A which is supplied worldwide by United States Agency for International Development (USAID) and the Population Council.

The cost of use of IUD in USA is at the moment very prohibitive.

The review of the worldwide data showed that TCu 380A has been found to be one of the best devices. The relationship between pelvic inflammatory disease (PID) has been widely studied including a study carried out both in Kenya and Nigeria. The two studies in Kenya and Nigeria involving the administration of prophylactic doxycycline at the time of IUD insertion to see whether the incidence of post-insertion PID in the first 3 months could be reduced.

Approximately 3600 patients were involved in a randomized, double-blind (placebo vs doxycycline study). In Kenya, the results were that placebo patients developed PID with a rate of 1.9% while those who were given doxycycline did so at a rate of 1.3%. In Nigeria it was 1.4% and 1.5% respectively. Due to overall low incidence of PID (diagnosed by reasonably restrictive methods), this number of patients did not provide power to detect a difference. Clinical reviews, however, indicates that little was accomplished by prophylactic doxycycline. In an full project at five different sites, there was no difference in the development of PID in 1265 clients randomly given stringed and stringles IUDs. Thus ascending infection was minimal.

The suggested approaches to the reduction of post-insertion PID are:

1. Better screening of subjects. (Appendix 3)
2. Better disinfection at insertion.
3. Stringles IUDs or a disinfectant build into the string.
4. Prophylactic antibiotics for user at high risk for PID at insertion.

He also reviewed the problems found at the time of IUD insertion such as failure to insert, perforation and cervical lacerations. There was a need for an analysis for cervical dilation at the time of insertion. There was a difference between the developed and developing countries regarding the rate of hospitalization after the insertion of IUDs. In a study done by FHI using data base of 100,000 subjects using IUDs to determine the difficulties found at the time of removal, three reasons predominate for difficult removals:

1. Embedding
2. Perforation
3. "Fishing" out a missing string

It was, however, found that a significant number of these events were associated with only 2 IUDs (the post-partum T and the TCU.200B), a partial problem at the time of long-term use and removal was found for the Lippes Loop D. Breastfeeding at the time of insertion was the only identified risk factor. On the other hand, age, parity and previous caesarean section were not. The overall difficulty at removal was 21/100 attempts to remove or 0.4/100 insertions.

There was no difference for normal return to fertility from any other form of reversible contraception.

He concluded that the events which were reported on were quite rare and definitely did not give reasons to limit the use modern IUDs particularly the TCU 380A.

VI.3 EXPERIENCE WITH TCu. 380A IN CLINIC 66, KENYATTA NATIONAL HOSPITAL

This was reviewed by Ms. H.V. Ogembo.

She outlined the following:

- . History of IUDs
- . IUD performance
- . Types of IUD
- . Mechanism of action
- . Non contraceptive benefits.

She indicated that clinic 66 was the largest (family planning) service delivery point in South of the Sahara. The daily average number of client was 300.

The most popular methods at the clinic 66 included the following:

1. Intrauterine contraceptive devices
2. Oral contraceptives
3. Injectable (depot medoxy Progestone Acetate)
4. Barrier methods (condom and conceptrol)
5. Sterilization
6. Norplant Implant (introduced in October 1989).

She noted that the clinic has been using various types of IUDs including the lippes loop, Saf.T, Copper T.200B, T Cu.220, Nova T, Copper T, Multiload 250, Multiload 375 and since 1987, TCu. 380A. It was noted that since the TCu.380A was introduced, the providers have received various complaints from their clients such as heavy and irregular periods, painful periods, lower abdominal pain, feeling weak and dizzy, fever and loss of appetite and vaginal discharges. These complaints were received more from the client who had been given "oxidized devices".

The providers experience with "oxidized" TCu.380A in clinic 66 of Kenyatta National Hospital revealed a high intrauterine pregnancy rate, high expulsion rate, increased menstrual bleeding often with pain, repeated local infection (vaginal discharge) and exegerated lower abdominal pain which resulted in request/demand for removal of the device. She recommended that a clinical trial with T.Cu.380A should have been done in Kenya before the device was introduced for the use in the National family planning programmes. The introduction of new devices should be discussed with the providers. The feelings of the clients should be respected. Proper record keeping is recommended so that data can be collected

to evaluate the services.

VI.4

BARRIERS TO IUD USE

This topic was discussed by Dr. N.G. Thagana. The main reasons were identified as:-

1. Lack of adequate information to both the providers and clients. This could be improved by regular update courses and creating simple and easy channels for obtaining the information on IUDs. This is also important to the clients as well.
2. The need to produce national policies on the use of IUDs regarding parity, marital status, time of insertion, and the types of IUDs to be used in the programmes. Clarification of the policies on IUDs in the countries where these devices are manufactured or obtained from.
3. There was need to clarify certain issues pertaining to IUD use since the withdrawal of certain IUD brands can create fears and rumours among the providers and clients.
4. There was a need to counsel the clients properly on these fears before the device is inserted with continued support during use.
5. The mechanism of action can be misunderstood by some religious affiliation. The associated fear of the presence of foreign body and the concept of the long duration of action need clarification to many clients and their spouses.
6. Rumours and misconceptions regarding IUDs are many. Some of these are related to the development of infertility, STDs, cancers etc. These should be minimized and clarified in the communities by the support of local data.
7. The availability and cost of the IUDs can be prohibitive in some sectors of the society.

VI.5 THE EXPERIENCE OF FAMILY PLANNING ASSOCIATION OF KENYA
(FPAK) ON INTRAUTERINE DEVICE

This was presented by Dr. I. Achwal, Programme Officer (Medical). According to the Kenya contraceptive prevalence survey of 1984, Family Planning Association of Kenya used to offer 27% of the family planning services, however, the 1989 Demographic and Health Survey indicates that now the Association provides 30% of the services.

Clients who patronize FPAK clinics for family planning services are usually counselled (giving all necessary information including information on alternative family planning methods) and informed of the type of IUD to be inserted and the proper time for replacement if it is a medicated device. Currently the clinics only offer TCu 380A, multiload and Lippes loop. The clients are encouraged to maintain regular follow-up visits and they are informed to come back any time before follow-up visit date if she misses a period or is unable to locate the transcervical thread of the IUD, or if she develops fever, pelvic pain and tiredness, unusual bleeding or unusually severe cramps.

In 1988 through the Associations thirteen base clinics, 30,908 new acceptors and 53,254 continuing acceptors were served while the 54 outreach clinics served 7,206 new acceptors and 13,020 continuing acceptors in the following ratio.

-	Injectables	Depo-provera 42%
		Noristerat 2%
-	Pills	37%
-	IUD	10%
-	Foaming tablets	6%
-	Condoms	2%
-	Diaphragm	0.07%
-	Jellies	2%
.	Total	<u>100%</u>

The same year (1988) 2227 tubal ligation and 11 vasectomies were performed.

In 1989 the 13 static clinics served 34,521 new acceptors and 56,420 continuing acceptors. The method distribution was depo-provera: 34.8%, Noristerat: 7.5%, Pills: 23.1%, IUD: 14.8%, Condoms: 8.58%, Foaming tablets: 4.6%, Jellies: 1.14%, Diaphragm: 0.6% and others: 5.3%.

DISCUSSION

IUDs rank as the third most popular method in FPAK (but fourth when voluntary surgical contraception is included). The selection of newer copper-bearing devices such as TCU 380A and multiload 375 which are appropriate, safe, smaller, effective and have a prolonged duration of use has enhanced the acceptability. The devices which come in sterile packs over the years have also shown a drop in method specific, infection rate. The newer devices are also small and have less expulsion rate.

Perforation rarely occurs in FPAK clinics due to well trained personnel, who are familiar with the few IUD devices available. Although the IUD may be inserted at any time convenient to the user, the programme's standards insist on use of sound tenaculum and insertion during the menstrual period when there is less likelihood of inserting the device into a pregnant uterus, when the cervix is more patulous and the bleeding associated with inserting is less likely to cause anxiety.

However, since all the Associations static clinics are used for training many family planning providers, it has been noted that the complication rates rise during training and within one month after the training. Likewise, the request for change of method rises considerably within one month of the training. While we will continue support the trainings, the Association requires, the trainees to know the difference between information and motivation of clients as opposed to counselling. It is the client who, when equipped with adequate knowledge on different types of contraceptives and their advantages and disadvantages, should be allowed to choose a method of their own choice rather than motivating clients to a particular method for case experience purposes or service provider bias.

From April this year (1990) the Association will phase out all devices which use pushing technique for insertion, which has been found to have higher chances of perforation and will only retain devices which use withdrawal of applicators technique leaving the device in place and ensuring better fundal placement.

While the medicated devices have more advantages, the Association has noted the need to clearly inform clients about the proper time for replacement and giving them a written document (e.g. client appointment card), with the date of removal. Of the method failure cases followed by the Association in 1987, 90% had medicated IUDs in place two-three years past the documented removal period.

Though the FPAK has not received a batch of partially oxidized copper devices, and though copper devices work by oxidation, as a leading agency in family planning, we strongly, feel that an operation research should be carried out to compare the lifespan of devices oxidized in packs as compared to devices inserted without visible signs of oxidation to allay the providers anxiety and possible bias and to minimize the clients fears.

CONCLUSION:

After more than two decades widespread use, IUDs are now used by some 20,000 women in Kenya. In order to sustain confidence in the method and to increase its use, the service providers should endeavour to use the most modern medicated devices which have high efficacy, low failure rates, less complications and long duration of use. Vigilance should be maintained and training of the service providers to equip them with very high standards of service. Careful counselling of clients but not mere information and motivation of clients should be made mandatory. Service providers should change their attitudes from the informer and the judge and adopt the attitude of teacher to client, thus leaving the clients to be their own judges.

SUGGESTED FURTHER READING:

1. Mechanism of action, safety and efficacy of intrauterine devices. Report of a WHO scientific group. Geneva, December 1986.
2. Issued statement on Intrauterine Devices by International Medical Advisory Panel (IMAP) IPPF February 1989.
3. Dr. Siddle (Br. Med, J. 288:1554-55, 1984)
4. Contraceptive News Vol. 5 No. 1 1985.

IV.6

THE USE OF POSTPARTUM IUDS
FAMILY HEALTH INTERNATIONAL'S EXPERIENCE AND DATA REVIEW

This topic was presented by Dr. T. Petrick of FHI, U.S.A. The idea of IUD insertion in the postpartum period is a seductive one, especially when the presence of the woman in a postpartum ward is the probable last chance to start family planning before she disappears forever. This is true enough in developed countries; developing countries have even greater problems getting women to return for any reason after delivery and before the next pregnancy.

With this reasoning in mind, attempts have been made for years to find the optimum time of inserting during this period and to determine the best type or style of IUD and insertion technique. A review of the data obtained around the world indicate that the timing is most critical. The studies using "immediate postpartum" insertion (no later than 10 minutes postplacenta) have yielded the most promising results. The expulsion rates are still higher than for interval insertion for the first 3 months, but tend to level off thereafter. On the other hand, a somewhat higher rate of expulsion should be acceptable for a group of women for whom no other form of family planning will be given once the opportunity is lost.

The type of IUD is generally not a sensitive issue. The reviewed data show that most IUDs can be inserted (if at the proper time after delivery) with similar success rates. This applies most specifically to the IUDs currently available for insertion, especially the copper-bearing ones. Some attempts have been made to improve uterine retention by special adaptations of standard IUDs, such as biodegradable suture and knots (to be implanted in the myometrium) but to date these changes have not shown any great improvement in expulsion rates, especially when comparative studies have been done.

A much more important factor is the training level or expertise of the inserter. Data obtained from a number of studies, including one currently underway by FHI for a major international pharmaceutical firm, demonstrate that there is a real "learning curve".

One final note is that insertions done at the time of Cesarean section seem to have the most successful results, with expulsion and continuation rates approaching closely those of interval insertion.

A program of postpartum insertion should be considered by family planning programs which have difficulty in bringing women into clinics for interval visits. Whether a specially prepared IUD and inserter are used or not appears not to be nearly as important as the timing of the insertion (within 10 minutes of placental delivery) and the training/expertise of the investigator.

VI.7

MOTIVATION AND COUNSELLING:

This paper was prepared by Ms. H. Ogembo but she could not present it in person. However, each participant was given a copy. The main points are summarized below:

Counselling is defined as a mutual exchange of ideas, opinions, discussion and deliberation. It is a two-way communication process which involves face to face interaction.

The main purpose of counselling is the provision of a situation which enables the client to search for answers and solutions to their own problems.

The General Features of Counselling are:

- a) Counselling facilitates active participation by the client.
- b) It assists the client to examine a problem, and clarify conflicting issues.
- c) It enables the client to discover alternative ways of dealing with a problem.
- d) This method is communication with client, rather than health worker centred.

The purpose of counselling in Family Planning is to "help clients understand Family Planning issues and methods and then apply this understanding to their own circumstances so that they can make informed decisions about fertility"

Counselling helps to fill in gaps in the client's information through dual way communication.

Counselling is private and neutral i.e. it is not intended to persuade or influence people to choose a particular method of Family Planning. It aims at assisting clients to reach their own firm and comfortable decisions.

The intended outcome of counselling is free and informed choice. This goal is based on the basis that "all couples and individuals have the basic right to decide freely and responsibly, the number and spacing of their children, to have the information, education and means to do so".

The Provider's Role is to ensure that:

- i) The women interested in using IUDs are carefully screened. Women who have or might get sexually transmitted diseases should not use IUDs.
- ii) A careful insertion, carried out under sterile conditions with disinfected instruments, ensures that the IUDs are placed high in the uterus (in the Fundus). This will minimize pain during the insertion, the risk of perforation and infection, and the chances of pregnancy and expulsion.
- iii) There is informative and empathetic counselling. IUD users need to know and remember what signs call for medical attention, when copper or hormone-releasing IUD should be replaced and that the IUD does not protect against Acquired Immune Deficiency Syndrome (AIDS) and other sexually transmitted diseases.
- iv) The clients have regular follow-up and quick access to medical care.

The objective of IUD insertion is to place the IUD correctly while minimizing the client's discomfort and the risk of complications. Successful IUD insertion requires:

- a) Explaining the procedure to the client and responding to her questions and concern. This helps the client relax, making insertion easier and less painful.
- b) Careful technique during all phases of insertion. This reduces the client's discomfort and reduces the chances of uterine perforation, cervical laceration and other complications.
- c) Aseptic (sterile) technique throughout the procedure including careful disinfection of all instruments. This minimizes the chance of pelvic inflammatory diseases.
- d) Careful general, bimanual pelvic examination and sounding of the uterus to determine the depth and direction. This reduces the risk of perforating the uterus, which usually occurs because the sound or IUD inserted too deeply or at the wrong angle.
- e) IUD placement high in the uterus (that is at the fundus). This minimizes expulsions, accidental pregnancies and possibly bleeding.

After the insertion, clear, simple and concise instructions to the client are very important.

These include the following:-

- i) The return visit should be scheduled in three months' time for check up, however, the client is encouraged to come for revisits whenever there is a need.
- ii) Return to the clinic if you or your partner are dissatisfied with the method.
- iii) Return to clinic any time you decide you want the IUCD removed. Only trained health workers should remove the IUCD.
- iv) Come back at once if you experience any of the following danger signs:
 - Delayed period (pregnancy), abnormal spotting or bleeding
 - Abdominal pain, pain during intercourse.
 - Infection exposure (such as Gonorrhoea), abnormal discharge.
 - Not feeling well, fever and chills.
 - String missing, short or longer.

Side Effects of Contraceptives

All contraceptives have side-effects. The main problem with the side-effects of contraception is the fact that Family Planning service providers on most occasions have not warned the users or have given inadequate information to users on possible side effects of the contraceptives of their choice.

Once side effects appear in an uninformed user, they generate fear of the unexpected and of the unknown. Rumours about the side-effects arise and often are grossly exaggerated thus reinforcing the elements of fear and encourage the drop out from the use of contraceptives. Currently there are improved information, education and communication mechanisms. It is hoped that these will reduce the volume of rumours on the complications of Family Planning methods and help reduce the number of drop outs.

Counselling in Family Planning can achieve the following if used correctly:

- i) Assist the clients to make informed decisions, averts regrets, clears doubts, fear and misconceptions, examines motives and attitudes.
- ii) Helps identify clients at high risk of negative reaction after Family Planning contraceptive have been accepted.
- iii) Assists clients to identify why they are suitable for the type of Family Planning method they are selecting and are helped to look for alternatives if the choice of method is found to be unsuitable for them.
- iv) Eliminates coercion.
- v) Seeks client satisfaction i.e. going beyond providing factual medical information to include examination of psychological and social aspects of the decision.
- vi) Provides the privacy needed in dealing with the socially sensitive matters.

VI.8

STRATEGIES FOR INCREASING IUD USE:

This was an open discussion session whose prime objective was to draw some light on how best IUD use can be improved through appropriate motivation and counselling. During the session the following issues came up:

1. Counselling in family planning helps clients understand FP issues and methods so that they can make informed decisions about their fertility.
2. Usage of IUD, as any other FP method, depends on the quality of counselling prior to and after method selection. Hence, counselling should be a continuous exercise in FP.
3. The client - provider (counsellor) relationship is important in ensuring confidentiality and trust between the two. Such a relationship (if good) results in flow of correct information that would adequately counter at any form of mis information and rumours. Thus, client, counsellor relationship should at all times be positive.
4. Intensive counselling would be very helpful in the first 4 months of IUD use. This is the period when highest IUD drop-out rate is experienced.
5. As majority of medical personnel have limited training on counselling skills. They also have limited time to perform the same. As a result, social workers are the most ideal skilled people to conduct the counselling of FP clients. This approach has been empirically tried at FPAK FP clinics and the results are very encouraging.
6. Adequate counselling should always be an integral part of quality care that must be provided by clinics and other staff. In isolation, counselling may not yield the desired results.

7.

RECOMMENDATION

From the presentation and discussions the following recommendations were made:

1. The IUD contraception is safe to use in the family planning programmed in Kenya. The TCu.380A should continue to be used in the national family planning programme.
2. There should be a trained counsellor in all the FP clinics who need not be a nurse.
3. The minimum standards for IUD services should be set up for all the family planning units.
4. There is a need for training courses for health providers to update them on technique and clinical management of insertion of CuT. 380A and other newer models of IUDs within the family planning programme.
5. Family planning technology should be included in curricula of medical, nursing and paramedical teaching schools. At the same time, there is a need to review family planning curricula in these institutions.
6. The participants recommended that the Ministry of Health should post persons interested in Family Planning to run the family planning services.
7. There is a need to clarify the check list and guidelines for the IUD use in Kenya. This should be acted on immediately by the relevant organizations.
8. The referral system (e.g. when there is a pregnancy) should be strengthened. There was a need for a proper and early referral system for counselling of such clients and this should be well-spelled out.
9. The problem of tarnished IUDs was discussed and the existing scientific evidence indicate that the tarnished CuT.380A were safe and effective.
10. The participants felt that the current scientific evidence indicates that the IUDs are safe and effective, provided the would-be acceptors are well-screened before the insertion.

11. Operation research studies should be carried out in local clinics to evaluate the IUDs in use in the family planning programme.
12. IUDs should be used by women of proven fertility with at least full term pregnancy.
13. It was recommended that the Family Planning Programme should provide at least a choice of two to three types of the devices in clinics at any one time.

These recommendations will be sent to the Director, DFH as requested in his opening remarks.

Appendix I.

NAMES AND ADDRESS OF THE PARTICIPANTS
IN THE WORKSHOP

NAME	DESIGNATION	INSTITUTION	BOX NO
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Ms. J. W.Kibugi	KRN/KRM FP	FPAK	326 E
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APPENDIX 2.

PROGRAMME

The Update Workshop on Intrauterine Contraceptive Device
20th February, 1990
Nairobi, Kenya

8.00 - 8.30 a.m.	Registration Chairman:	Dr. C.Sekadde- Kigundu
8.30 - 8.35 a.m.	Objectives of the workshop	Dr. C. Sekadde- Kigundu
8.35 - 8.40 a.m.	Remarks by the Chairman Dept. of Ob/Gyn	Dr. S.H.Wanjala
8.40 - 9.00 a.m.	Remarks by the Director Division of Family Health Official opening of Workshop	Dr. A.O.Ayoo
9.00 - 9.30 a.m.	Overview of IUDs Mechanism of Action, Safety, Efficacy	Dr. D.M.Chikamata (The Population Council)
9.30 - 10.30 a.m.	International Studies on IUDs	Dr. T.Petric (Family Health International, USA)
10.30 - 10.45 a.m.	T E A	
10.45 - 11.15 a.m.	Discussion	

12.30 - 12.45 p.m.	Barriers to IUD Use Discussion:	Dr. N.G.Thagana
1.00 - 2.00 p.m.	Lunch Tin Tin Restaurant Chairman:	Dr. H.C.G.Sanghvi
2.00 - 2.30 p.m.	Strategies for increasing IUD Use	Open discussion
	Motivation and Counselling	Sister H.Ogembo
2.30 - 2.45 p.m.	Discussion:	
2.45 - 3.30 p.m.	Films Currently used IUDs in Kenya	
3.30 - 3.45 p.m.	Discussions & Recommendation	
3.45 - 4.30 p.m.	Panel Discussion/Recommendations:	
	1. Dr. I. Achwal - FPAK	
	2. Dr. D.M.Chikamata - Pop.Council	
	3. Dr. C. Sekadde-Kigõndu-Dept.of Ob/Gyn, KNH	
	4. Dr. P.M. Ndavi - Dept. of Ob/Gyn, KNH	
	5. Dr. T. Petrick - FHI, USA	
	6. Dr. H.C.G. Sanghvi - Dept.of Ob/Gyn, KNH	
4.30 - 5.00 p.m.	T E A B R E A K	
5.00 - 5.15 p.m.	Closing Remarks	Dr. C.Sekadde- Kigõndu
5.15 - 6.00	Films	

APPENDIX 3:

Screening form for IUD Users:

	Yes	No	N o t s u r e
Heart disease			
Heart murmur			
Hepatitis or severe liver disease			
Wilson's disease			
Diabetes			
Leukemia			
Fainting attacks			
Steroid therapy			
Anemia or blood clotting problems			
Current suspected or possible pregnancy			
Ectopic pregnancy (pregnancy outside of the uterus)			
Recent pregnancy			
Recent abortion or miscarriage			
Abnormalities of the uterus			
Bleeding between periods			
Cancer of the uterus (womb) or cervix			
Suspicious or abnormal Pap smear			
Prior IUD use			
IUD in place now			
Heavy menstrual flow			
Severe menstrual cramps			

Multiple sexual partners

	Yes	No	Not sure
A sexual partner who has multiple sexual partners			
Pelvic infection (Including pus in fallopian tubes)			
Infection of the uterus (womb) or cervix			
Genital sores or lesions			
Sexually transmitted disease (venereal disease) such as herpes, gonorrhea, chlamydia or acquired immune deficiency syndrome (AIDS)			
Unexplained genital bleeding			
Uterine or pelvic surgery			
Vaginal discharge or infection			

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