



# IUDs: A Resurging Method

*Programs and providers are now making IUDs more available. Reasons for this resurgence include:*

- *Recognition of the IUD's many advantages,*
- *New research findings on safety—resulting in liberalized guidance from WHO,*
- *A new program strategy, focusing on developing a core of skilled providers motivated to offer IUDs.*

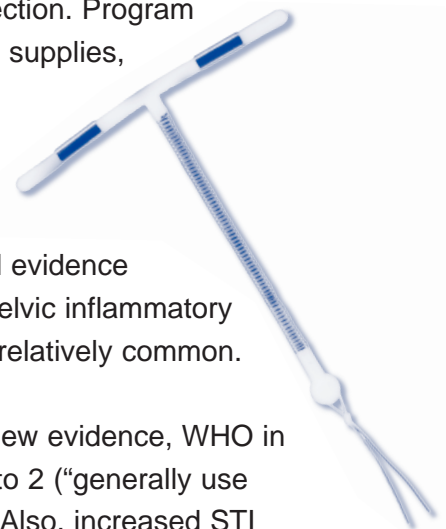
**Main positives:** For Copper-T380A IUDs, positives include very high effectiveness, potentially 10+ years of use, low cost of commodity, convenience, suitability for a wide variety of women and very high client satisfaction generally.

**Main negatives:** Most women report no or negligible side effects. However, an important minority have significant pain, bleeding, spotting or expulsion. In addition, for women at risk of gonorrhea and chlamydia, IUD use increases the possibility of pelvic infection. Program requirements are extensive, including skilled providers, good counseling, supplies, equipment, and time and place to perform insertions.

**New evidence on safety:** A study in Kenya found that HIV+ and HIV- women adopting IUDs had similar rates of complications.<sup>1</sup> A study in Mexico found that IUDs were not associated with infertility.<sup>2</sup> Accumulated evidence from a number of studies indicates that the absolute increase in risk of pelvic inflammatory disease (PID) associated with the IUD is quite low even where STIs are relatively common.

**Broadened eligibility based on WHO guidance:** In response to such new evidence, WHO in late 2003 changed the medical eligibility classification of the IUD from 3 to 2 (“generally use the method”) for HIV+ women and those with successfully treated AIDS. Also, increased STI risk is now a Category 2 unless a woman has a “very high individual likelihood of exposure” to gonorrhea or chlamydia.

**Mechanism of action:** Contrary to the common belief that the IUD works by preventing implantation, in fact the IUD works predominantly to prevent fertilization, by inhibiting sperm from reaching the egg and by altering the egg.





**Unjustified medical barriers:** Common barriers include restrictions on eligibility related to age or parity (in fact, they can be used by women of any age or parity), restricting insertion to the menstrual period, withholding insertion because of a vaginal discharge and mandating excessive follow-up visits (actually one check-up 3 to 6 weeks after insertion or after the next menstrual period is recommended).

**Current problems with IUD programming:** In a number of countries the IUD is the leading method. However, in many others it is a minor method. Contributing factors include: stigma and aftermath of the IUD issues of the 1970s and '80s; exaggeration of the legitimate concern about STIs and the relationship to PID; provider perspective (notably, that providing IUDs is a lot of work, requires skill and confidence and moderately extensive equipment and supplies); and poor management of the side effects that can commonly occur.

**New program approach:** As with any program effort, focus should include training, guidelines, supplies and logistics, communication, supervision, organization of work, etc. In the past, programs have often tried unsuccessfully to advance IUD use by very broad-based approaches such as training many providers across skill levels. While in principle someone with minimal training can insert an IUD, in actual practice such providers may lack the confidence, experience and proficiency or may lose them rapidly without a large volume of IUD clients. An alternative is to focus on a smaller number of skilled providers and support expansion through those providers who perform well. Evidence from Bolivia nationally (where IUDs are the number one method) and smaller efforts in Bangladesh, India and Pakistan supports this approach. In any case, a key step is to learn providers' views and gain insight into what might motivate them to provide IUDs.

Many programs have not taken the IUD seriously because of an incorrect view that STIs are too common in their client population to offer this method. Such concerns can be addressed by building on the new WHO guidance and the new research findings and by removing common medical barriers.

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<sup>1</sup> C.S. Morrison et al., "Is the intrauterine device appropriate contraception for HIV-1-infected women?" *BJOG*. 2001 Aug;108(8): 784-90.

<sup>2</sup> D. Hubacher et al. "Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women." *N Engl J Med*. 2001 Aug 23;345(8)561-7.

**Where to get more information: [www.maqweb.org](http://www.maqweb.org)**

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