

1) Need some clarifications on concerns for higher tendency for migration with the LNG IUS

I have not heard about this, but would like to know more. With any IUD or anytime when placing an IUD, the goal is to place the IUD at the fundus without damaging the uterus. This holds true for the LNG IUS or the copper IUD, and whether placing the IUD at postpartum time or internal timeframe. The inserters are different, so clinicians need to be aware of the differences. Note: we at Jhpiego just completed a short video showing how to insert the LNG IUS with the “2-handed” inserter. It will be available soon in English, French, and Spanish.

2) How did you deal with the request of STD's screening before IUD application? In DR is a common argument from doctors.

We touched on this briefly at the end of the first presentation. It depends quite a bit on the setting, but one should follow the Selected Practice Recommendations (either CDC's if in USA or WHO's if global). STI testing should not be mandatory, but may be warranted in some places. Of course, if the cervix appears to be infected an IUD should not be inserted.

3) Is Kyleena new? What are the particularities with Kyleena?

Kyleena is new and released by Bayer 9/2016 in the USA. It is approved by the FDA for 5yrs and has less levonorgestrel (19mcg) than the more common and globally available LNG IUS (52mcg). The frame and the inserter is slightly smaller as well. The advantageous are somewhat dubious and most clinicians feel that this is a case where less or smaller is not necessarily better. In several trials neither clinicians nor patients noticed a clinical difference in the frame size. The bleeding profile with Kyleena may provide more regular bleeding vs potential amenorrhea with the the 52mcg IUD which may be appealing to some patients. As far as I know Kyleena is not available outside the USA.

5) My question is on the challenge of male involvement: How was acceptance for the male partners in post partum IUD?

This varies tremendously from country to country and setting to setting. In many places women have the autonomy to make FP choices. In other places they may have to have their partners approval. This may be a legal requirement or a cultural and unwritten norm. It also

may be that providers impose this asking that women give consent and their partners as well. Of course, the ideal is that couples come to a FP decision together with a provider able to counsel, answer questions, and give all information needed. Too often males are left out of the conversation. In some cases that may be best- think GBV, disenfranchised women, coercion, humanitarian crisis settings, etc- but in many instances, when given the opportunity, men can be a very supportive and helpful addition to FP discussions.

6) What have been some of the challenges faced in educating women about IUDs, particularly in developing countries?

Common myths include that IUDs migrate in the body and cause cancer. Better understanding of the reproductive system helps women and men understand where the IUD goes, why it doesn't move, and why the partner cannot feel it during sex.

7) Which countries is the PPIUD inserter available?

The PPIUD inserter has been introduced in Myanmar, Pakistan, Mali, Nicaragua, Nepal, Guatemala, Haiti and Vietnam by PSI and its affiliates, plus Afghanistan (UNFPA) and Indonesia (DKT)

8) We are seeing in Rwanda, with the introduction of PPFp a huge uptake on FP clients. And Implants and IUD are the most used? do you think this approach could resolve the unmet need among women in our region?

PPFP can help meet needs of women at this important life stage, although general FP services will still be needed to meet the needs of women who haven't yet had children or didn't choose to use a method in the post-partum period.

9) Were the health care providers affected by shortages of Human resource? Or maybe I can rephrase my question, is how much time did the provider take to counsel the client on side effect, and how to manage the side effects?

A good counseling on the IUD or the IUS does not need to be any longer than good counseling on any other method, and they have fewer side effects than most other methods. In facilities with high volumes, providers can give group counseling talks covering the basic benefits of each method, answering common questions and dispelling myths, which can save time in the subsequent individual counseling sessions. The key messages for those who select the IUD or IUS- what to expect and when to come back- can be covered in as little as 5 minutes. Keeping messaging focused and simple helps the client retain the messages, as does post-insertion follow up and simple reminder cards to take home with them.

10) What is the current wisdom on volume of insertions a provider should do (per month) to maintain his/her skills.

In general at least 3/month.

11) Can Laura clarify the graph about IUDs being the most popular reversible method? What other reversible methods are you comparing to?

This is compared to all methods, from an FP2020 analysis of method mix across all countries.

12) For providers trained in LNG-IUS insertion, what kind of (re)training do we expect they will need to be competent in Avibela.

Avibela using the same insertion steps as the ICA foundation product, which is similar but not identical to the Cu380. If providers have been trained using a general LNG-IUS curriculum such as that developed by Jhpiego, they just need to be briefed on the duration of effectiveness for Avibela in their country.

13) Does the dedicated PPIUD inserter reduce the uterine perforation rate?

In the clinical pilot in India, no perforations were observed:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4807754/>

14) Note on ectopic pregnancies with IUDs:

Providers should know that if a pregnancy does occur with an intrauterine device one needs to figure out very quickly where that pregnancy is located.

An important point that often gets missed or not discussed is that any woman using an effective contraceptive method whether it be condoms, pills injectables, or IUDs has a far less chance of having an ectopic pregnancy *at all*. Indeed, contraceptive methods greatly *reduce* the likelihood of an ectopic pregnancy.

For all contraceptive methods if a woman does become pregnant the first step is ascertain where that pregnancy is located.