IUD POSTPLACENTA

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Objectives:

1. To update postpartum contraception
2. To review IUD POSTPLACENTA
3. To discuss medical barriers
Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality & empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria & other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

MDGs challenges are not new; what is new is that they involve concrete, time-bound & quantitative targets for action by 2015.

GOAL 5 Improve Maternal Health

TARGET 6

Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
Maternal mortality ratio, by country, 2005

Maternal deaths per 100,000 live births

- < 10
- 10 - 199
- 200 - 499
- 500 - 999
- ≥ 1,000
- not available

• Maternal mortality is an indicator of gross inequality, human rights abuse and development failure.

• “All maternal health problems are preventable as long as the government pays attention and prioritizes maternal health.”

Dr. S.T.Mathai, UNFPA, *The Jakarta Post*, 13 Jan., 2010

• Of the 11 countries that contribute to 65 percent to global maternal death, five are in Asian countries including Indonesia, Bangladesh, Pakistan, India and Afghanistan.

• A high maternal mortality rate is an indicator of the status of poor functioning of a country’s health system including lack of supportive and protective legal and policy environment.

Dr. S.T. Mathai, UNFPA, The Jakarta Post, 13 Jan. 2010

GOAL 5 Improve Maternal Health

• Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicators:
• Maternal mortality ratio
• Percentage of births attended by skilled health personnel
• Contraceptive prevalence rate
Three-pronged strategy to reducing maternal mortality

- Family planning to ensure that every birth is wanted
- Skilled care by a health professional with midwifery skills for every pregnant woman during pregnancy and childbirth
- Emergency Obstetric Care (EmOC) to ensure timely access to care for women experiencing complications.

UNFPA, 2009

Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
PERENCANAAN KELUARGA

1. Seorang wanita telah dapat melahirkan, segera setelah ia mendapat haid yang pertama (menarche)
2. Kesuburan seorang wanita akan terus berlangsung, sampai mati haid (menopause)
3. Kehamilan dan kelahiran yang terbaik, artinya risiko paling rendah untuk ibu dan anak, adalah antara 20-35 tahun
4. Persalinan pertama dan kedua paling rendah risikonya
5. Jarak antara dua kelahiran sebaiknya 2-4 tahun

Affandi, 1984

Affandi B. Postpartum Contraception & Medical Barrier. Building Momentum MDGs 4&5, RSIA Budi Kemuliaan, Jakarta, 28 Sept. 2010
POLA PERENCANNAAN KELUARGA

Fase

Menunda Kehamilan

Fase

Menjarangkan Kehamilan

Fase

Tidak Hamil lagi

2 - 4

20

35

Affandi, 1984

Affandi B. Postpartum Contraception & Medical Barrier. Building Momentum MDGs 4&5, RSIA Budi Kemuliaan, Jakarta, 28 Sept. 2010
PEMILIHAN KONTRASEPSI RASIONAL

Fase menunda Kehamilan

- Pil
- IUD
- Sederhana
- Suntikan
- Implant

Fase Menjarangkan Kehamilan

2 - 4

- IUD
- Suntikan
- Mini Pil
- Pil
- Implant
- Sederhana

Fase Tidak hamil lagi

35

- Steril
- IUD
- Implant
- Suntikan
- Sederhana
- Pil

Affandi, 1984

Affandi B. Postpartum Contraception & Medical Barrier. Building Momentum MDGs 4&5, RSIA Budi Kemuliaan, Jakarta, 28 Sept. 2010
CONTRACEPTIVE PREVALENCE
INDONESIA, 1970-2007

## Current Contraceptive Users
**Indonesia, March 2006**

<table>
<thead>
<tr>
<th>METHODS</th>
<th>USERS</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>INJECTABLES</td>
<td>9,743,550</td>
<td>35.2</td>
</tr>
<tr>
<td>PILLS</td>
<td>7,796,474</td>
<td>28.1</td>
</tr>
<tr>
<td>IUDs</td>
<td>5,218,196</td>
<td>18.8</td>
</tr>
<tr>
<td>IMPLANTABLES</td>
<td>3,156,705</td>
<td>11.4</td>
</tr>
<tr>
<td>STERILIZATION</td>
<td>1,515,406</td>
<td>5.5</td>
</tr>
<tr>
<td>OTHERS</td>
<td>278,473</td>
<td>1.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>27,708,804</td>
<td>100.0</td>
</tr>
</tbody>
</table>

BKKBN, 2007

**Affandi B.**  
Unsafe Abortion : Indonesian Experience  
1st International Congress on Women Health & Unsafe Abortion, Bangkok, Thailand, 20-23 January 2010
BIRTH RATE

STILL HIGH !!!

4.5 – 5 Million/year

FAKTA

1. Pascasalin OVULASI dapat terjadi dalam waktu 21 hari

2. Pascakeguguran OVULASI dapat TERJADI dalam waktu 11 hari


Affandi B. Kontrasepsi Terkini dan IUD Pascaplasenta. Pertemuan Koordinasi Peningkatan KB Pascapersalinan di Rumah Sakit, Makassar 31 Agustus 2010
Definitions

- **Postpartum contraception** is the initiation and use of family planning methods during the first year after delivery
  - **Post-placental** – within 10 minutes after placenta delivery
  - **Immediate postpartum** – within 48 hours after delivery (e.g., voluntary sterilization)
  - **Early postpartum** – 48 hours up to 6 weeks
  - **Extended postpartum** – 48 hours up to one year after birth
Unmet Need: Fertility Preferences of Postpartum Women

- According to many DHS surveys:
  - 92-97% of women do not want another child within 2 years after giving birth
  - But 35% of women had their children spaced at 2 years apart or less
  - 40% of women who intend to use a FP method in the first year postpartum are not using one

*Ross JA and Winfrey WL, 2001*
Birth Spacing Saves Infant Lives

Interval between births:
- 48+ months
- 24-47 months
- 1 - 23 months

Contraception after Childbirth: Basic Care and Services

Basic care should include:

- Discussion of contraceptive needs
  - Considering client’s reproductive goals
- Information and counseling about methods, their effectiveness rates, and side effects
- Short- and long-term method choices
Contraception after Childbirth: Basic Care and Services (cont’d)

- Assurance of contraceptive re-supply with access to follow-up care

- Integration with other maternal-infant child care
  - ANC and postpartum visits
  - Newborn care
  - Immunizations

- HIV/STI prevention
  - To help clients assess their risk and make necessary changes in behavior and choose appropriate FP method
Counseling

- Encourage breastfeeding for all postpartum women
- Do not discontinue breastfeeding to begin use of a contraceptive method
- There are many contraceptive choices for breastfeeding women
  - These methods do not have negative effects on breast milk or breastfeeding
## Simplified Classification of Eligibility Criteria (WHO)

<table>
<thead>
<tr>
<th>Classification</th>
<th>With Clinical Judgement</th>
<th>With Limited Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstance</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Generally use the method</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Use of the method not usually recommended unless other more appropriate methods are not available or not acceptable</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td>No</td>
</tr>
</tbody>
</table>
12. The use of progestogen-only methods in the first 6 weeks postpartum does not appear to have an adverse effect on breast milk volume (Grade B).

13. The use of progestogen-only methods when breastfeeding provides over 99% efficacy (Grade B).

14. The problematic bleeding associated with progestogen-only methods appears to be more acceptable than that experienced by women who are not breastfeeding (Grade B).

After counselling, breastfeeding women may choose to use a progestogen-only method of contraception before 6 weeks postpartum if other contraceptive methods are unacceptable.


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
17. DMPA use before 6 weeks postpartum is not usually recommended (Grade C).

18. Troublesome bleeding can occur with DMPA use in the early postpartum period (Grade C).

- DMPA will not require the injection until Day 21 postpartum, but if the risk of immediate subsequent pregnancy is high it may be given before this time.


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
• Breastfeeding women may choose to use a progestogen-only implant before Day 28 without the need for additional contraceptive protection.

• **IMPLANT will not be required until Day 28 postpartum, but if the risk of immediate subsequent pregnancy is high it may be given before this time.**


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010

1. Use of progestin-only methods, with the exception of the levonorgestrel bearing IUD, is not usually recommended for women who are less than 6 weeks postpartum and breastfeeding, unless other more appropriate methods are unavailable or unacceptable.

2. Beyond 6 weeks postpartum, there is no restriction for the use of progestin only contraceptive methods among breastfeeding women.

3. The levonorgestrel-bearing IUD is not usually recommended for the first 4 postpartum weeks, unless other more appropriate methods are unavailable or unacceptable. Beyond 4 weeks postpartum, there is no restriction on its use.
Affandi B. Perkembangan Kontrasepsi, Teknik Penapisan dan KB Postpartum, BPMPPKB, Balikpapan, 24 Juni 2010
• The postpartum insertion of IUDs has a number of advantages, including ease of insertion, availability of skilled personnel and appropriate facilities, and convenience for the woman.

• Practitioners have been concerned about the possibility of higher expulsion, infection and perforation rates.


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
• Postplacental (preferably within 10 minutes after expulsion of the placenta) and immediate postpartum insertion during the first week after delivery (but preferably within 48 hours) are convenient effective and safe times to insert copper IUDs.

{Managing Contraception 2005-2007, page 92}
Teknik Pemasangan AKDR

Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
Fundal placement

• The way the IUD is inserted is more important than the design of the device.

• Differences in IUD expulsion rates between centers participating in the trials were generally greater than expulsion rates for different IUDs;

• FHI data show that emphasis needs to be given to the fundal placement of the device.

• The provider should be able to feel the device through the abdominal and uterine walls at the time of insertion.

• Retraining is necessary for those individuals who report high expulsion rates


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
Teknik Pemasangan AKDR

Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
4. Open IUCD on sterile tray; hold in forceps.
12. Move IUCD + forceps upward until it can be felt at fundus. Follow contour of uterine cavity.
13. Open forceps and release IUD at fundus.
14. Sweep forceps to side wall of uterus.
15. Slowly remove forceps—keep slightly open.
16. Stabilize uterus until forceps are out.
• Allow the woman to rest.
• **Be sure she gets complete postpartum care.**
• Provide post insertion instructions.
Expulsion

• After birth, as the uterus returns to normal size (involution), uterine contractions expel retained placental and blood clots and may have a similar effect on any foreign body introduced into the uterus.

• IUDs inserted within 10 minutes of placenta expulsion have a much lower expulsion risk than those inserted later in the postpartum period.  


Affandi B. Postpartum Contraception & Medical Barrier. Department of Obstetrics & Gynecology, University of Indonesia, Jakarta, 22 Sept. 2010
**Barrier That Prevent Contraceptive Success**

<table>
<thead>
<tr>
<th>Barrier to effective family planning services</th>
<th>Outcome when barrier are overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Medical knowledge</td>
</tr>
<tr>
<td>Legal</td>
<td>Process</td>
</tr>
<tr>
<td>Appropriate</td>
<td>Communication skills</td>
</tr>
<tr>
<td>eligibility criteria</td>
<td>Gender</td>
</tr>
<tr>
<td>Counseling skills</td>
<td>Location</td>
</tr>
<tr>
<td>and services</td>
<td>Time</td>
</tr>
<tr>
<td>Partner</td>
<td>Sociocultural norms</td>
</tr>
<tr>
<td>preferences</td>
<td>Regulatory</td>
</tr>
<tr>
<td>Provider bias</td>
<td></td>
</tr>
</tbody>
</table>

- ↑ Access to service
- ↑ Contraceptive preference
- ↑ Quality services

**MAQ Exchange curriculum (Online) Maximizing Access and Quality initiative, Washington DC, 2001**

**Affandi B. Postpartum Contraception & Medical Barrier. Building Momentum MDGs 4&5, RSIA Budi Kemuliaan, Jakarta, 28 Sept. 2010**
Medical barriers were defined as "practices, derived at least partly from a medical rationale, that result in a scientifically unjustifiable impediment to, or denial of, contraception" Shelton JD, et al. *Lancet*, 1992;340:1334-1335
Medical Barriers that restrict access to family planning services

1. **Provider bias** — When the provider is for or against a specific method

2. **Overly restrictive eligibility criteria** — Who can get what contraceptive

3. **Unnecessary process hurdles** — Requirements that, from the user's point of view, make it difficult to obtain a contraceptive


Affandi B. Perkembangan Kontrasepsi, Teknik Penapisan dan KB Postpartum, BPMPPKB, Balikpapan, 24 Juni 2010
4. Inappropriate contraindications — Medical conditions that restrict the use of some contraceptives
5. Overly restrictive regulations — National laws and clinic or hospital regulations
6. Provider limitation — Who can provide what method
7. Inappropriate management of side effects — Actions taken by the provider to help the user tolerate a contraceptive method

Checklists
Reduce Medical Barriers

• Medical barriers often prevent clients from using their desired method of family planning.
• The pregnancy, COC, DMPA, and IUD checklists can effectively increase access to family planning while helping ensure client safety.
• Introduction of checklists into service delivery settings should include careful training on how to use the checklists as well as the medical eligibility criteria on which they are based.
PILIHAN KONTRASEPSI
Pascapersalinan dan Pascakeguguran sebelum pulang dari Rumah Sakit

<table>
<thead>
<tr>
<th>NO.</th>
<th>KONTRASEPSI</th>
<th>KETERANGAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>MOW/MOP</td>
<td>UNTUK YANG TIDAK INGIN PUNYA ANAK LAGI</td>
</tr>
<tr>
<td></td>
<td>IUD Pascapersalinan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post Plasenta</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post SC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 3 Hari Pascapersalinan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IUD Pascakeguguran</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>IUD Pascapersalinan</td>
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<tr>
<td></td>
<td>• Post Plasenta</td>
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<tr>
<td></td>
<td>• Post SC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 3 Hari Pascapersalinan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IUD Pascakeguguran</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Untuk yang ingin menunda kehamilan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Masa pakai sampai dengan 10 tahun</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pascapersalinan: Kesuburan dapat kembali pada hari ke-21 setelah melahirkan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pascakeguguran: Kesuburan dapat kembali pada hari ke-14 setelah keguguran</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>IMPLANT</td>
<td>Isi : Progestin Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tidak mengganggu produksi ASI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Masa pakai sampai dengan 3 tahun</td>
</tr>
<tr>
<td>4.</td>
<td>SUNTIK</td>
<td>Isi : Progestin Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tidak mengganggu produksi ASI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Masa pakai 3 bulan</td>
</tr>
<tr>
<td>5.</td>
<td>MINIPIL</td>
<td>Isi : Progestin Only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tidak mengganggu produksi ASI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pemakaian 1 strip untuk 1 Bulan</td>
</tr>
<tr>
<td>6.</td>
<td>KONDOM</td>
<td>Pilihan kontrasepsi untuk pria</td>
</tr>
</tbody>
</table>

Sumber:
Hasil Workshop Peningkatan Pelayanan KB di RS, April 2009
Narasumber: Prof. Dr. dr. Biran Affandi, Sp.OG(K)

Informasi lebih lanjut hubungi:
Direktorat Kelangsungan Hidup Ibu, Bayi dan Anak (Ditnak)
Telp/Fax: (021) 8007388, 8009029 ext. 671
Knowing is not enough, we must apply Willing is not enough, we must do

...Goethe

Affandi B. Postpartum Contraception & Medical Barrier. Building Momentum MDGs 4&5, RSIA Budi Kemuliaan, Jakarta, 28 Sept. 2010