

# Level of Satisfaction of the Post Partum Intra Uterine Device Users at Sylvanus Olympio Teaching Hospital of Lome (TOGO)

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**Abstract Introduction:** Family planning in the postpartum are an ideal platform for repositioning contraception; They are aimed at women who wish to space births or prevent pregnancies and the post-partum intrauterine device (PPIUD) is one of the method of choice. **Objective:** To evaluate the level of satisfaction of the post partum intra uterine device users at Sylvanus Olympio teaching hospital of Lome (Togo). **Patients and methods:** The use of the PPIUD in the Gynecology and Obstetrics teaching hospital of the Lome is effective since October 2015. Our work is a descriptive, retrospective and prospective study, from October 1, 2015 to September 30, 2017. Results: From October 2015 to September 2017, 211 out of 18170 eligible deliveries had adopted the IUD in the postpartum period (1.49 %). The average age was 31 years old with extremes of 16 and 49 years old. Of the 211 clients, 9 (4.27%) opted for IUD removal, 191 clients gave their overall impression, with 20 women (9.48%) being lost to follow-up. 184 women (87.20%) are satisfied because of his Efficiency, Long-acting and his Discretion. 7 women (3.32%) were disappointed because of Failure and Side effects poorly supported. Conclusion: The intra-uterine device (IUD) is a modern contraceptive method that has proven to be very beneficial in the postpartum. Therefore, the promotion of this method must be maintained to reduce unmet need for contraception and promote the health of couples and families.

**Keywords:** *post partum family planning, Post partum intra uterine device, satisfaction, Lomé-Togo (Africa)*

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## 1. Introduction

The postpartum is the period during which the maternal organism, modified by the pregnancy, undergoes changes destined to return it to the former state [1]. Family planning (FP) is a key intervention in reducing maternal, neonatal and infant mortality and morbidity by preventing unwanted pregnancies and births that are too close together [2]. Post partum family Planning (PPFP) s address to women who want to have more children (spacing of pregnancies) and those who now have the desired number of children and want to avoid future pregnancies (prevention of pregnancies) [3]. PPFP services are a platform Ideal for repositioning family planning [4]. The Postpartum Intrauterine Device (PPIUD) is the only method for couples who want a reversible, effective, and long-acting family planning method that can be initiated at home.

Immediate postpartum course than during breastfeeding [2]. Thus, in February 2014 in Ouagadougou, Togo pledged to strengthen the activities of the PPFP [5] and, on October 15, 2014, began the activities of the PPDIU marked by the first training of health care providers. As any new method of contraception it must be evaluated in order to be popularized, so we wanted to initiate this.

## 2. Patients and Framework of Study

Our work is a transversal, descriptive and retrospective study, conducted from October 1, 2015 to September 30, 2017 divided into 2 years of study: First year: October 1, 2015 to September 30, 2016 (2015-2016) Second year of study: October 1, 2016 to September 30, 2017 (2016-2017). Included were records of all eligible deliveries who chose to receive the postpartum IUD ( intra uterine device) in the CHU-SO gynecology and obstetrics department during the

study period. Data collection was done through a literature review from the postpartum IUD registry and patient records. The data processing was done by the Excel software and Epi info version7. Before insertion of the IUD, the provider was careful to ensure that the client received quality family planning counseling and that she made an informed and voluntary decision that is notified in the PPIUD registry and in the client's file. This work is purely scientific and concerns the maternal health sector, which is experiencing maternal-fetal morbidity and mortality, which remain a global scourge. No woman will be named in this work, guaranteeing medical confidentiality. The results obtained here and the resulting recommendations will be available to all stakeholders in the fight against maternal-fetal morbidity and mortality.

### 3.2. Socio-demographic Characteristics of Clients

#### 3.2.1. Age of Clients

The average age of clients was 31 years with extremes of 16 and 49 years. The age group of 30 to 34 years was the most represented.

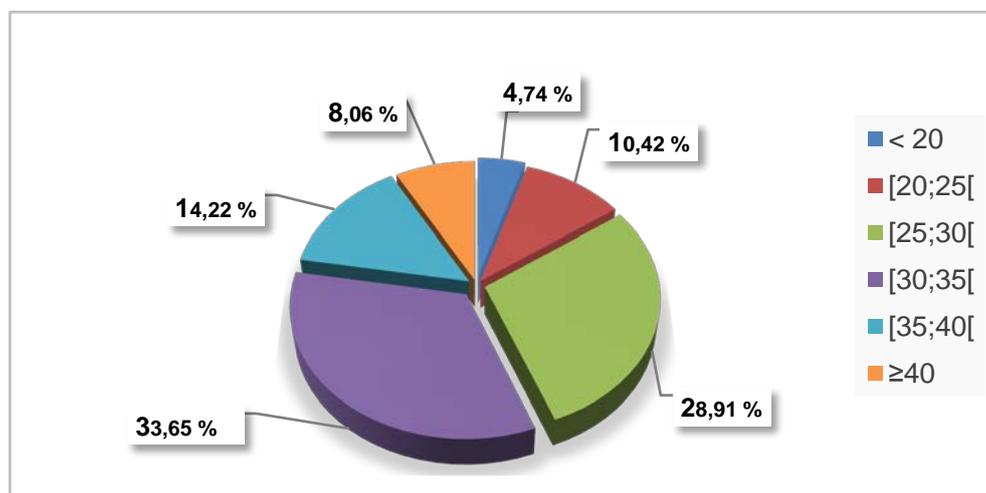


Figure 1. Distribution of births by age group

#### 3.2.2. Level Instruction and Occupations of Clients

Secondary and primary education levels dominated our work.

Table 2. Distribution of clients by level of education and occupation

	Number	%
<b>Instruction level</b>		
Unducated	29	13,74
Primary	74	35,07
Secondary	83	39,34
University	25	11,85
Total	211	100,00
<b>Profession</b>		
Household	27	12,80
Students / Student	18	8,53
liberal *	139	65,87
Officials	27	12,80
Total	211	100,00

\* resellers, traders, seamstresses, hairdressers, ...

## 3. Results

### 3.1. Evolution of the Number of Deliveries Eligible for PPIUD

In our study, 78% of deliveries were eligible for PPIUD.

Table 1. Number of eligible deliveries for the TCu380A IUD-PP

	2015-2016	2016-2017	TOTAL
Number of delivery	9151	9019	18170
Eligible births for the PPIUD	7173	7002	14175
number of patients opting for PPIUD	98	113	211

### 3.2.3. Parity and Obstetrical History of Patients

The paucipar as dominated in our study followed by multiparas. The majority of cohabiting newborns were in our study Number of Living Children: One in 211 women (0.47%) did not have live births. Of the 211 deliveries, 43 (20.38%) had a history of stillbirths, the proportion of which is defined in the following table. Of the 211 deliveries, 50 (23.70%) had a history of abortion.

**Table 3. Distribution of Clients by Gender and Obstetrical History.**

variables	Number	%
<b>Distribution according to the number of live children</b>		
1 – 2	80	38,10
3 - 4	103	49,05
Plus de 4	27	12,85
Total	210	100,00
<b>Distribution according to the number of dead born</b>		
1 – 2	40	93,02
3 - 4	3	6,98
Total	43	100,00
<b>Breakdown by number of NPC*</b>		
1 – 2	46	92
3 - 4	4	8
Total	50	100,00
<b>Distribution according to the location of the NPC</b>		
CHU/CHR**	110	52,38
HD/CMS/USP***	93	44,29
Private clinic	3	1,43
Delivery house	4	1,90
Total	210	100,00

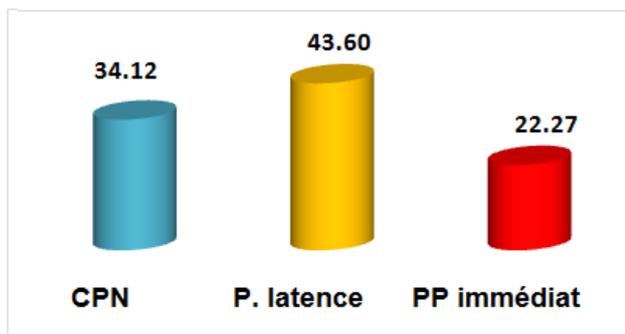
\*NPC prenatal consultation. \*\*University Hospital Center / Regional Hospital Center.

\*\*\* District Hospital / Medical Social Center / Peripheral Care Unit.

### 3.3. Pre-insertion IUD Counseling

#### 3.3.1. Time of Counseling

The latency phase was the predominant counseling time in our study.



\*CPN: Prenatal Consultation;

\*\*P.latence : Latency phase of labour;

\*\*\* PP immediate: Immédiat postpartum

**Figure 2.** Distribution of clients by time of counseling

### 3.3.2. Reasons for Choosing

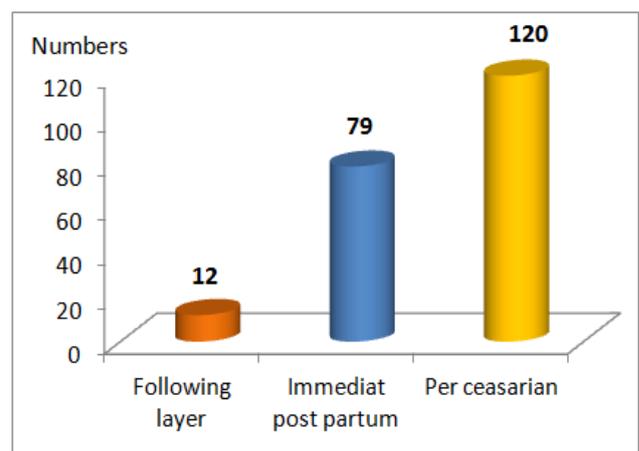
**Table 4. Distribution of clients according to the reasons for choosing PPIUD**

	Number	%
Birth control	146	76,44
Spacing of pregnancies	18	9,42
Maternal pathology	14	7,33
Eviction of unwanted pregnancie	13	6,81
Total	191	100,00

### 3.4. How to Insert the IUD:

#### 3.4.1. Moment of Insertion

The percussive insertions predominated in our work.



**Figure 3.** Distribution of clients by insertion time

#### 3.4.2. Qualification of the Provider of the Insertion of the DIUPP

Gynecologists and specialized study diploma (doctors specializing in gynecology and obstetrics) were the predominant providers.

**Table 5. Distribution of clients according to the qualification of the CPN provider**

	Number	%
Gynecologists and DES *	129	61,14
Midwives	72	34,12
Surgeon	7	3,32
Medical Assistant	3	1,42
Total	211	100,00

\* Specialized study diploma (doctors specializing in gynecology and obstetrics).

### 3.5. Follow-up of Clients

#### 3.5.1. Follow-up of Clients

191 (90.55%) are followed, 20 (9.45%) of our clients are lost to view.

#### 3.5.2. Moment of Follow-up

Very few clients have complied with post-insertion follow-up appointments.

**Table 6. Distribution of clients by period of follow-up.**

variables	Number	%
Before 6 weeks	5	2,37
Between 6 weeks and 6 months	27	12,80
Beyond 6 months	179	84,83
Total	211	100,00

### 3.5.3. Complications and Side Effects

**Table 7. Distribution of clients according to complications and side effects encountered**

		Number	%
<b>Complications</b>	Non-visible wires	7	3,32
	Partial rejection	4	1,90
	Pregnancy occurrence	1	0,47
<b>Side effects</b>	Pelvic cramps	10	4,74
	Hyperménorrhées	2	0,95

## 3.6. Withdrawal

### 3.6.1. Number of Withdrawal

Of the 211 clients, 9 (4.27%) opted for IUD removal. And the Cause of withdrawal:

**Table 8. Distribution of clients by reason of withdrawal**

	Number	%
Partial rejection	4	44,45
Pregnancy occurrence	1	11,11
Major side effects	2	22,22
Desire for pregnancy	1	11,11
Convenience	1	11,11
Total	9	100,00

### 3.6.2. Decision after Withdrawal

Of the 9 clients who decided to remove the IUD, 2 were pregnant. The 7 others had decided: Abandonment in 4 cases (1.90%), IUD interval in 2 cases (0.95%), Barrier method in 1 case (0.47%).

## 3.7. Duration of Use

The duration of use of the IUD among the 191 clients followed is distributed as follows: Less than 1 year in 4 cases (1.90%), 1 to 2 years in 2 cases (0.95%) More than 2 years in 185 (87.68%).

## 3.8. General Impression

Of the 211 women who benefited from PPIUD, 191 clients gave their overall impression, with 20 women (9.48%) being lost to follow-up. Of the 211 clients, 9 (4.27%) opted for IUD removal, 191 clients gave their overall impression, with 20 women (9.48%) being lost to follow-up. 184 women (87.20%) are satisfied because of his Efficiency, Long-acting and his Discretion. 7 women (3.32%) were disappointed because of Failure and Side effects poorly supported.

## 4. Discussion

### 4.1. Difficulties Encountered

During our study, we experienced difficulties that were limits to our work. These difficulties are related to: The scarcity of previous studies on our subject, the absence of certain information in the data carriers, The lost of sight after their exit of the hospital.

### 4.2. Frequency

From October 1, 2014 to September 30, 2016 out of a total of 18170 births registered in the gynecological obstetric clinic of the Sylvanus Olympio CHU in Lomé, 14175 (78%) deliveries met the criteria of medical admissibility of the WHO for the use of IUDs and 211 benefited from postpartum IUD insertion, a prevalence of 1.49% of eligible clients. Sidibé K. [6] in his 2011 study of 5 centers in Bamako, found an eligibility rate of 99% and a prevalence of insertion of PPIUD of 0.83%. Our eligibility rate is significantly lower than that of Sidibé K. This is explained by the fact that the Sylvanus Olympio CHU is a national reference center, the parturients are usually evacuated in case of complications (prolonged rupture of the membranes, eclampsia, third trimester bleeding, ...) contraindicating or limiting the insertion of the IUD-PP. On the other hand our prevalence rate is definitely higher than that of Sidibé K. This increase is due to the fact that many insertions take place during the training and also the appropriation of the insertion of the DIUPP by the trained providers of the CHU SylvanusOlympio who make it a continuous activity. The grant of PPIUD kits in Togo is a significant factor that can explain the increase in our prevalence. However, it is much lower than that of M'BORTCHE BK [7], which found a prevalence of 31% at the ATBEF clinic in Lome in 2017. Nevertheless, during our study, we noted a progression of prevalence of the insertion of the PPIUD which evolved from 0.98% during the first year to 2.01% in the second year, which is double.

### 4.3. Sociodemographic Characteristics of Clients

#### 4.3.1. Age

The average age of our clients was 31 years old with extremes of 16 and 49 years old. The age group of 30-34 years was the most represented with 33.65% of cases.

Sidibé K. [6] found in his study, a predominance of the age group of 35-39 years, 26.5% of cases. Diatta A. in 2008 in Kolda, Senegal, also found a predominance of the age group of 35-39 years (36.66%) against 13.33% for the age group of 30-34 years.

Our differences can be explained by the fact that the PPIUDP is generally used in Togo in order to space births paradoxically to the Sahelian countries (Mali and Senegal) where it is used for birth limitation because of the great multiparity.

#### 4.3.2. Level of Education

In our study, high school deliveries were predominant,

with a rate of 39.34%, followed by those at the primary level (35.07%).

Diatta A. [8] and Sidibé K. [6] found a predominance of out-of-school, 78.3% and 55.3% respectively.

We believe that this discordance is due to the high schooling of Togolese girls, contrary to the realities in predominantly Muslim Sahelian countries with the influence of religious schools, particularly Koranic schools. Surveys conducted in these countries had given illiteracy rates of 66.9% in Mali (2015) [9] and 54.6% in Senegal (2012) [10] against 43.3% in Togo (2016) [11].

#### 4.3.3. Marital Status

Cohabiting clients predominated in our study with a rate of 56.87%. Sidibé K. [6] found a net predominance of brides with a rate of 87.8%. This difference can be explained by the fact that in Togo, married women are those who have made a civil marriage while in Mali, religious and traditional marriages are considered. The predominance of cohabiting women in our study could be explained by their desire to limit births given their marital status.

#### 4.4. Conduct of Prenatal Care (NPC)

Nearly 70% of our clients had benefited from at least 4 NPC during their pregnancy. We found that 96.21% of our clients were followed in public facilities during their pregnancy, including 52.38% in the CHRs and CHUs. Their NPCs were provided mainly by gynecologists (53.81%) and midwives (44.29%).

The review of the literature did not allow us to have information on these indicators. Also in our context, data carriers, including admission and delivery records, and even some files, did not have enough information on these parameters to extend our analyzes to all eligible deliveries for the first time. insertion of the DIUPP. This information from several beneficiaries of the DIUPP in our study were completed during their post-insertion follow-up.

#### 4.5. Pre-insertion Counseling of PPIUD

##### 4.5.1. Time of Counseling

Ninety-two of our clients (43.60%) received counseling during the latency phase and only one third of our clients (34.12%) received counseling during prenatal consultations.

In the Diatta A. series [8], immediate postpartum counseling predominated with a rate of 53.3% followed by NPC (23.3%) and latency (12.5%). In M'Bortché B.K.'s series [7], 47.1% of clients received counseling during ANC. Our differences can be explained by the fact that the majority of our clients come from other care structures and usually referred to the delivery work course.

##### 4.5.2. Reasons for Choosing

One hundred and sixty-six of our clients (78.67%) want to avoid close pregnancies in our series. Diatta A. [8] in her study instead found a predominance of those who no longer want to have children (50.88%) and only 26.66% want to avoid close pregnancies. This difference could be explained by the predominance of large multiparas in the study of Diatta A. whereas in our series the pauciparas

predominated. Also the cesarean deliveries predominant in our series, the DIUPP was chosen to respect the birth interval of 24 months minimum.

#### 4.6. Progress of the Insertion of the PPIUD

##### 4.6.1. Moment of Insertion

In more than half of our clients (56.87%), the IUD was inserted during caesarean section followed by immediate postpartum insertion with a rate of 37.44%. Postplacental insertion accounted for only 5.69% in our series. Sidibé K. [6] in his study, found a predominance of insertion in the immediate postpartum (58.4%) followed respectively by postplacental insertion (36.1%) and peresarial (5.5%).

The predominance of peresarial insertion in our context could be explained by the high rate of cesarean section, and the mode of admission including the increasing number of referred parturients where the high way is strongly indicated.

##### 4.6.2. Qualification of the Agent Having Inserted

Nearly two-thirds of DIUPP were inserted by gynecologists (61.14%) followed by midwives (34.12%). The midwives performed the majority of the DIUPP insertions with 58.8% of the cases in the Sidibé K series [6]. These divergences could be explained by the levels of the health structures where these different studies were carried out: CHU in our study where the gynecologist doctors predominate (63%) against the structures of the peripheral level in the series of Sidibé K.

##### 4.6.3. Incident during Insertion

No incident during insertion was found in our study. It is the same in the series of Diatta A., Sidibé K. and Bah O.H. [12].

#### 4.7. Post insertion Follow-up

##### 4.7.1. Followed Clients

Our study revealed that 90.52% of clients had benefited from post-insertion follow-up. This rate is superimposed on that of Sidibé K. [6] where clients who received the IUDPP performed regular monitoring in more than 9 out of 10 cases. In our study we have a lost rate of view of 9.48%. Sidibé K. [6] found a rate of 4.6%. This non-negligible rate in our series can also be considered as an indicator of good tolerance, if we can assume that lost to follow-up did not show any side effects or complications justifying their absence.

##### 4.7.2. Complications

In our series, there were 4 cases (1.90%) of partial rejections and 1 case (0.47%) of pregnancy following partial rejection. We also found 7 cases (3.32%) of undescended threads. But an ultrasound check done had shown that the IUD was in place. No cases of expulsion have been observed in our work. M'Bortché BK [7] in her study found 5 confirmed cases of expulsion on ultrasound, 2 cases of endometritis managed without removal of the IUD and 9 cases of yarn not visible but normal intrauterine location of the IUD on ultrasound. Diatta A.

[8] found 5% rejection and 4.1% undescended sons in his job. In the Sidibé K. [6] study, IUD expulsion was the most common complication with 2.4% of cases. This low complication rate would be explained by the training of providers on the postpartum IUD, which provided the latter with the professional skills and abilities needed to offer postpartum IUD services.

#### 4.7.3. Side Effects

In our series, we found 10 cases (4.74%) of pelvic cramps and 2 cases (0.95%) of hypermenorrhea. In M'Bortché B.K.'s series [7], no major side effects were found in these women. This low side effect rate reflects the good tolerability of the TCU 380A IUD in our clients.

### 4.8. Withdrawal

#### 4.8.1. Number and Cause of Withdrawal

Of the 211 clients, 9 (4.27%) opted for withdrawal including 2 cases for major side effects, 5 cases of failure (with 1 case of pregnancy) and 2 cases of convenience. Diatta A. [8] in her study had 8 cases (6.6%) of withdrawal for desire of pregnancy but no withdrawal for side effect. This low rate of withdrawal reflects the degree of acceptance of the IUD in the postpartum by our clients.

#### 4.8.2. Decision after Withdrawal

In our study, out of the 9 withdrawal cases, 4 clients (1.90%) decided to discontinue modern contraception, 2 cases opted for an interval IUD and 1 case (0.47%) for the method. barrier. In the Sidibé K. series [6], 2.4% of clients discontinued the IUD. The pressure of the spouse or parents was the only reason for abandonment. Our low dropout rate is a factor of good acceptance of the PPIUD.

### 4.9. General Impression

Of the 211 women who benefited from PPIUD, 191 clients gave their overall impression, with 20 women (9.48%) being lost to follow-up. 184 women were satisfied with the PPIUD, a satisfaction rate of 87.20%. Their satisfaction was about the efficiency, the discretion and the long duration of the method. Only 7 women (3.32%) in our series had been disappointed by the failure

of the method or its poorly tolerated side effects. Bah O.H. [12] in his series had found a good satisfaction.

## 5. Conclusion

The intrauterine device is a modern contraceptive method that meets the unmet need for contraception in the postpartum. Thus, Togo, like other countries such as Egypt and Kenya, opted for its insertion in the immediate postpartum.

In our 24-month study, the benefits of providing contraception to the intrauterine device TCU380A in the immediate postpartum far outweigh the disadvantages. This is confirmed by the satisfaction rate of 87.20% against 3.32% of disappointment with a failure rate of 0.47%. For this reason, the promotion of this method must be maintained in order to reduce the need not satisfied with contraception and promote the health of couples and families.

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