# Some thoughts about IUDs and other reproductive issues

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Nationally, but especially in Alaska, we have come to an important milepost in the history of contraceptive use. Use of a popular birth control method, the intrauterine device (IUD) will be limited after this summer. The decreased use of this method of birth control requires people to become knowledgeable about other methods so that unplanned pregnancies do not occur. Health care providers are actively seeking ways to help clients achieve that goal.

The Dalkon Shield is the only IUD that has been banned for medical reasons. It was marketed from 1971 to 1974. In 1974 it was banned because of severe infections, sterility and sometimes death, caused by a defect in its design. A class action lawsuit was intiated against the A. H. Robins Company, the Dalkon Shield manufacturer. They filed for bankruptcy late in 1985, which caused the courts to set the deadline of April 30, 1986, for filing claims against them. Any woman who believes she has suffered injury from complications related to the Dalkon Shield, or suspects problems associated with its use should file a claim before that date.

In September of 1985, the Ortho Company announced its decision to remove its IUD, the Lippes Loop, from the market. In December of 1985, the J. D. Searle Company decided to stop production of its IUDs, the Copper-7 (CU7) and the Tatum-T. These decisions, according to the manufacturers, were economic ones. The companies report high legal costs in fighting suits (most of which they won), and the expense of combatting negative publicity associated with the Dalkon Sheild as reasons why it is no longer cost effective for them to continue production of even these "safe" IUDs.

Some family planning clinics still have small quantities of safe IUDs on hand, and the Indian Health Service reports it has a little less than one year's supply. After that, the only IUD that will be available will be the Progestasert. The Progestasert must be changed yearly. It releases a hormone to prevent pregnancy and some women can't use it. It is also very expensive.

It is important for women who already have these IUDs to realize that it is considered sound medical practice to continue their use. These safe IUDs are still approved for use by the Federal Drug Administration. Only the Dalkon Shield has been absolutely banned from use.

There are important implications with the removal of IUDs from our selection of birth control methods. Dr. Louise Tyrer of Planned Parenthood of America predicts an additional 160,000 pregnancies per year will result from more couples having unprotected intercourse. In Bush Alaska, where distance and communication barriers make the delivery of reproductive health care a more difficult task, the potential for increased unplanned pregnancies is great.

Unplanned pregnancies are a major concern in Alaska, where the IUD has long been the contraceptive method of choice in the Bush areas. In the remote parts of Alaska, where pregnancy rates are already high, it is not uncommon for women to have more than half a dozen children. Many Native women have expressed an interest in tubal ligation but often can't afford the trip to Anchorage or other medical centers where they are done. A few women have selected sterilization, but individuals having federally funded sterilizations need to plan ahead and sign papers 30 days prior to their surgery to be eligible. This includes vasectomies for men.

Because the option of IUDs will be removed in the future, other methods of birth control will need to be explored in depth with a clear understanding of all the methods available to them, nor have they all been active participants in their own reproductive health care. One problem encountered is that when Native women hear the term "birth control" they often assume the health care provider means oral contraceptives. They may respond with, "I don't want any birth control!" when what they might really mean is that they don't want the birth control pill. Also, many women have misconceptions about birth control pills. Providers need to work with the patient to lay these myths and fears to rest.

Many women and men seen in more remote areas of Alaska tend to have a poor understanding of their own reproductive systems. Women, especially, often defer to their male partner on issues having to do with their own bodies. For example, many women seen by providers have never examined their own cervix in a mirror, something that all women should be able to do routinely in order to be on guard against infection and more serious diseases of the reproductive system. Similarly, while most women have the ability to do a Kegel exercise, something that all women of reproductive age should be taught to do daily, few are aware of its beneficial results in childbirth or in the enjoyment of sexual intercourse.

Most Native women seen by health care providers are receptive to this knowledge about their bodies and contraception. Recently, for example, one provider reported having no trouble convincing a women who said she had been using the "rhythm method" as her birth control method to take con-

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traceptive foam home with her **after** she observed many sperm on a slide of her own vaginal secretions. Discussion with this patient was not nearly as effective as actually showing her the evidence under a microscope.

On the use of foam, another provider reports that she asks women if they know how to use it. She continues to be surprised by how many women do not. We tend to assume that because these women have been prescribed foam for years, they therefore know how to use it. Because many women think foam is messy, this provider often squirts some on both their hands and encourages the patient to rub it in as a demonstration of how quickly the foam disperses.

This same provider often puts diaphragms into women just to let them see how comfortable they really are. Observing the woman putting the diaphragm in lets the health care provider see how comfortable the woman is with her own body, and will indicate areas of information about reproductive functioning about which the patient may need further instruction.

Health care providers need to do a great deal of assertiveness training to raise these women's self-esteem. Frequently a patient will say, "but my boyfriend wants..." We should ask, "but what do **you** want?" And if it is important to encourage women to say "no" to the men in their lives when they need to do so, it is also important to be creative in our approaches to men in family planning. Men need to feel welcome in our counseling offices, in our exam rooms if their partners want them there, and in the labor and delivery areas of the hospitals when it is time to give birth.