USAID
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the ACQUIRE project

THE POSTPARTUM INTRAUTERINE DEVICE

Participant Handbook

A Training Course for Service Providers

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Contents

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Module 1
Introduction to the Postpartum IUD Training Course

A. Introduction

This is a clinical skills training course. The emphasis in this course is on skills practice, combining practice on models, supervised clinical observation, and practice on actual clients.

In addition to providing instructions and practice opportunities for inserting the IUD during the postpartum period, this course also contains information on postpartum contraception, counseling, postpartum anatomy and physiology, client assessment, infection prevention, follow-up care, possible side effects and complications, informing clients and communities about the postpartum IUD, and developing and managing postpartum IUD services.

This course is intended for a broad range of health care providers (e.g., physicians, midwives, nurses, clinical officers, etc). The term "providers" is used here to refer to any or all of these. Local policies and regulations identify who among their service providers will be in charge of implementing this service.

B. An Overview to the Training

Course Purpose

The purpose of this course is to provide you with the training you will need to offer safe, effective postpartum IUD services.

Objectives

By the end of this course, you will be able to:

- Offer postpartum IUD services at your facilities
- Use safe postpartum IUD insertion techniques
- Know the key elements of counseling for postpartum IUD clients
- Describe the different elements of safe postpartum IUD services, such as client assessment, infection prevention practices, postinsertion follow-up, and the prevention and management of side effects and complications

Note: Based on field experience, EngenderHealth has learned that even experienced providers have difficulty teaching themselves the postpartum IUD insertion techniques. Participants should not attempt to perform postpartum IUD insertion until they have received supervised clinical training.

During this training course, you will use the following training materials:

- The Participant Handbook
- Job aids and other references
- Sample IUDs, instruments, and pelvic models

The Participant Handbook

This Participant Handbook contains information on all of the topics that will be covered in a typical postpartum IUD training workshop. This book is used throughout the training to assist you in learning the course content. After the course, you may use the Participant Handbook as a review guide. The handbook also contains diagrams, charts, and other graphic materials, some of which you may want to adapt for use with your clients, as appropriate.

If you have received the Participant Handbook in advance of the postpartum IUD training course, review it in preparation for the training.

Job Aids and Other References

There are a number of materials that the trainer will be using and should make available to you during the training; we recommend the following:

- The Capacity Project. 2006. *IUD guidelines for family planning service programs: A problem solving reference manual*. Baltimore: JHPIEGO.
- EngenderHealth. 2000. *Infection prevention: A reference booklet for health care providers*. New York.
- EngenderHealth. 2003. *Infection prevention practices in emergency obstetric care*. New York.
- Salem, R. M. 2006. New attention to the IUD: Expanding women's contraceptive options to meet their needs. *Population Reports*, series B, no. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health,The INFO Project.
- World Health Organization (WHO). 2004. *Medical eligibility criteria for contraceptive use, 3rd edition*. Geneva.
- WHO. 2004. *Selected practice recommendations for contraceptive use, 2nd edition*. Geneva.

C. Evaluation and Posttraining Follow-Up

There will be written pretests and posttests to assess your level of knowledge at the beginning and end of the training course. The results of the pretest will help the trainers to adjust the content and length of the course sessions to best address your needs; the posttest will indicate how well the course met those needs and the degree to which the required content was learned.

Evaluation of Clinical Performance

This is a competency-based learning course, which means that your ability to provide safe, effective postpartum IUD services, as judged by an experienced trainer using a skills checklist, will be the measure of satisfactory evaluation in this course.

One of the most important learning and evaluation tools in this package is the Postpartum IUD Skills Learning Guides (Clinical and Counseling and Skills checklists for Trainers) (Appendix A). The learning guides will help you to learn the detailed steps for postpartum IUD insertion so that you can practice on the models. A trainer will use a skills checklist to evaluate your clinical skills. When the trainer evaluates your performance as satisfactory, you will be competent to perform postpartum IUD services unsupervised. Likewise, if you are responsible for counseling, the Counseling Skills Learning Guides will help you learn the details of counseling for postpartum IUD clients. A counseling skills checklist will be used to evaluate your skills.

Both the learning guides and the checklist include the critical steps of the procedure (highlighted in bold). The critical steps are those steps that cannot be missed; they must be performed correctly and in the proper sequence for you to be certified as competent.

You can use the learning guides:
- As a learning tool, as you work through the modules and then practice on the model
- As a way to evaluate your performance on the model
- As a reference during clinical observation and supervised clinical practice, as well as for clinical practice once you return to your workplace

If there are not enough clients to allow you to have adequate clinical practice, or if the trainer does not rate your performance of the procedure as satisfactory, the trainer may need to make arrangements to reevaluate your performance after the course has ended. In the event that the facility's caseload during daytime and evening hours is not adequate, it is possible that to increase the likelihood of performing a postpartum IUD insertion for a client, the trainers and trainees will be on call to the maternity facility for the arrival of a client in labor who is interested in a postpartum IUD.

Posttraining Follow-Up—Support and Supervision

Learning about postpartum use of the IUD does not end with this course. Though most participants in this training will gain competence in this new technique, you will gain proficiency as you practice postpartum IUD insertion over the next few months. *Competence* describes the state of **having acquired** the skills, knowledge, and attitudes needed to perform the critical procedural steps in the correct sequence (as measured against preestablished criteria—in this case, the clinical skills learning guides). *Proficiency* is the state of knowing the steps and their sequence and being able to **efficiently perform** the required skill or activity.

Some participants may encounter difficulties in initiating postpartum IUD services at their facilities; others may need continued supervision before independently providing postpartum IUD services. For these and other reasons, follow-up support and supervision is an important part of the learning experience and should be discussed before the end of the course.

Module 2
Postpartum IUD Overview

A. Introduction

This module covers the key points about postpartum IUD use: how the IUD works; the benefits of postpartum contraception services, including those involving the IUD; and the key components of the fundamentals of care, including the importance of good client-provider interaction. If you have any previous knowledge of or experience providing interval IUD insertion, you will find it useful in learning to provide postpartum IUD services. However, the insertion techniques for the postpartum IUD are very different from those for interval IUD use.

Objectives

By the end of this module, you will be able to:

- State the following information about the postpartum IUD:
  - How it works
  - Its effectiveness
  - Its characteristics
  - Recommended timings for insertion
  - New evidence for who can use the IUD
- Discuss the benefits to the woman of postpartum contraceptive methods, including the postpartum IUD
- Describe the key components of the fundamentals of care related to postpartum IUD service delivery

Recommended reading material: Salem, R. M. 2006. New attention to the IUD: Expanding women's contraceptive options to meet their needs. *Population Reports*, series B, no. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health, The INFO Project.

B. Postpartum Contraception, IUD Update, and the Postpartum IUD

Provision of family planning counseling and methods during the postpartum period is critical to ensuring subsequent maternal and child health. Recent studies estimate that the prevention of unplanned and unwanted pregnancies could help avert 20–35% of maternal deaths and as many as 20% of child deaths. Evidence also indicates that postnatal provision of family planning counseling and methods increases subsequent contraceptive awareness and use.

It is estimated that almost 115 million women worldwide have an unmet need for family planning—that is, they express a desire to limit or space future births, but they are not currently using a family planning method. The appropriate spacing of births has been shown to have positive impacts on women's health and on their social and economic well-being. The postpartum period presents a critical window of opportunity to provide family planning counseling and methods to women who

may not otherwise receive family planning services. Many family planning methods can be used immediately following childbirth and will help prevent subsequent mistimed or unwanted pregnancies, especially since women's fertility can return within weeks of delivery. The World Health Organization's recently revised guidelines on postpartum and newborn care include a provision for family planning counseling as a core component of postpartum care.

IUD Basics

How IUDs work

Copper T IUDs prevent pregnancy by causing chemical changes in the uterus that make the sperm unable to fertilize the egg.

Types of IUD

The three main IUDs used currently are the Copper T 380A, the Multiload Copper 375, and the levonorgestrel-releasing IUD.

The Copper T 380A is widely available, and it will be used in this training course. Its characteristics and cost make it the best choice for postpartum IUD service programs. The Copper T 380A is effective for **at least 12** years.

The levonorgestrel-releasing IUD (such as Mirena) is not widely available, it is expensive, and it is not usually recommended for postpartum IUD insertion unless other, more appropriate methods are not available or are acceptable (Category 3 in WHO's medical eligibility criteria).

Effectiveness

The IUD is a highly effective method of contraception. If 1,000 women used the Copper T 380A, 3–8 would become pregnant after one year. This means that between 992 and 997 of the 1,000 users would *not* become pregnant during the first year of IUD use. Thus, the failure rate for the Copper T 380A would be between three to eight pregnancies per 1,000 women during the first year of use.

Expulsion rates vary from two to eight per 100 women in the first year of use with *interval* IUD insertion. Expulsion rates (both partial and complete) after postpartum IUD insertion are higher; postplacental insertions have a lower expulsion rate than do insertions occurring later. Expulsion rates are minimized when the insertion occurs postplacentally, is performed by experienced providers, and has the IUD placed high in the uterus fundus.

Expulsion rates vary by the timing of insertion:

- Postplacental insertion: Expulsion rates are generally 13–16%, but they can be as low as 9–12.5% among experienced providers.
- Transcesarean insertion: Expulsion rates range from 4% to 13%.
- Immediate postpartum insertion: Expulsion rates vary from 28% to 37%.
- Delayed postpartum (between 48 hours and four weeks following delivery): IUD insertion during this period is not recommended.

However, the benefits of providing highly effective contraception immediately after delivery often outweigh the disadvantage of the higher postpartum expulsion rates. Pregnancy rates do not differ by timing of IUD insertion.

Characteristics

The IUD has a number of characteristics, including the following:

- The IUD is highly effective.
- It is a long-acting method.
- Its contraceptive effect is quickly reversible following removal.
- The IUD is convenient to use, as users need do nothing at intercourse once the IUD is in place.
- The IUD can be used by women who are younger than 20 and by women who have no children.
- When used postpartum, the IUD does not interfere with lactation.
- Increased menstrual bleeding is common with the copper IUD.
- Uncommon side effects or complications include expulsion of the IUD and perforation of the uterus.
- The IUD offers no protection against sexually transmitted infections, including HIV.
- When it is used postpartum, the IUD:
  - ➢ Does not interfere with lactation
  - ➢ Appears to have rates of uterine perforation and of postinsertion infection similar to those associated with interval insertion
  - ➢ Shows fewer complaints about bleeding than for interval insertion

Cost effectiveness

Since an IUD can be used for many years and the user does not need to be resupplied, the IUD can be cost-effective for both programs and clients over time, even though its initial costs may be higher than those for other reversible contraceptive methods. One way to keep costs down is for programs to offer immediate postpartum IUD insertion at the facilities where births take place. Postpartum IUD provision can keep costs down because sterile conditions are already in place in the delivery room. In addition, postpartum IUD insertion reduces clients' transportation costs, since only one follow-up visit postinsertion is needed.

The IUD and sexually transmitted infections

According to the World Health Organization's 2004 medical eligibility criteria, the following women with sexually transmitted infections (STIs) and with HIV-related conditions generally can start using IUD:

- ☑ Women who have had pelvic inflammatory disease (PID) in the past, as long as they have no known current risk factors for STIs. (If they have had a subsequent pregnancy, they can use the IUD—they are appropriate for postpartum IUD insertion.) The risk of infertility is very low.
- ☑ Women who have HIV but who do not have AIDS.
- ☑ Women who have AIDS and who are doing clinically well on antiretroviral therapy (ART).

Postpartum IUD timing

An IUD may be safely inserted during the first 48 hours postpartum, following an abortion, or during the interval period. This training course will focus primarily on postplacental and immediate postpartum insertion.

Postpartum is a general term for when an IUD insertion takes place after delivery (or after a pregnancy ends). The various types of postpartum insertion are:

- **Postplacental:** Insertion occurs within 10 minutes after the placenta is expelled following a vaginal delivery.
- **Immediate postpartum:** Insertion is performed after the postplacental period, but within 48 hours of delivery and before the client leaves the hospital.
- **Transcesarean:** Insertion takes place following a cesarean delivery, before the uterus incision is sutured.
- **Postabortion:** The IUD is inserted following an abortion.

Note: An interval IUD insertion is one that takes place at any time more than four weeks after delivery.

C. Postpartum Contraception: Benefits and Methods

Several contraceptive methods, including the IUD, are appropriate for use soon after a woman delivers a baby. Postpartum contraception offers several benefits to women:

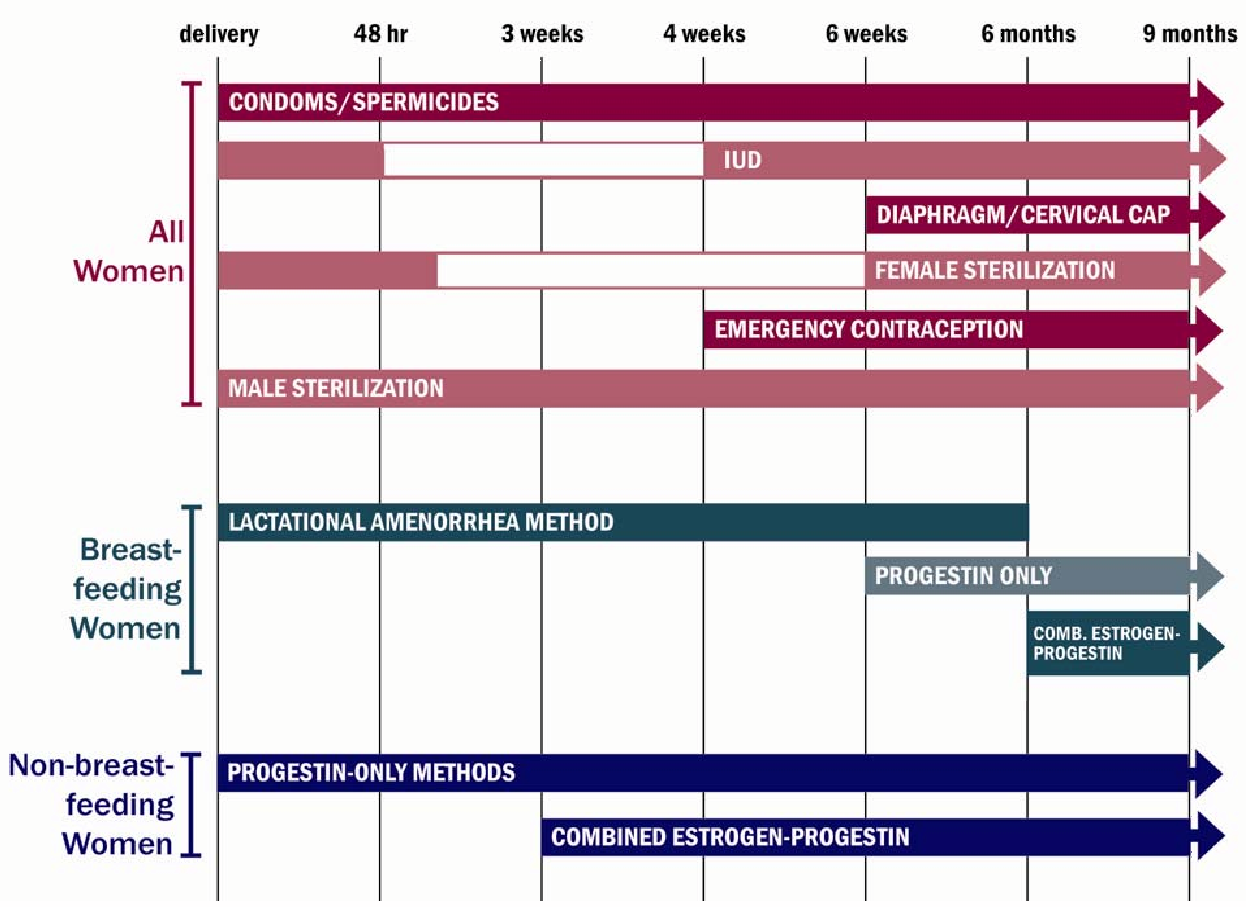
1. ***Convenience:*** The woman or her partner leaves the hospital with a method of contraception. It is also convenient and efficient for the provider to insert the IUD after the client has just delivered or before she is discharged from the facility.
2. ***Safety:*** The provider is assured that the woman is not pregnant when the IUD is provided postplacentally or immediately postpartum.
3. ***Meeting women's needs:*** Research studies have shown that many pregnant and postpartum women are interested in learning about and using postpartum contraception, but that services are often unavailable.
4. ***Healthy mothers and babies:*** Postpartum contraception helps couples practice healthy spacing of pregnancies, which promotes optimal outcomes for both infants and mothers.
5. ***Spacing pregnancies:*** According to the report of WHO Technical Consultation on Birth Spacing in 2005 (WHO, 2006), after a live birth, the recommended interval before attempting the next pregnancy is at least 24 months, so as to reduce the risk of adverse maternal, perinatal, and infant outcomes.
6. ***Access to services:*** Many women visit health care facilities for services associated with childbirth—during the antenatal period, for delivery, and after the birth of the baby. Each such client-provider interaction is an opportunity for clients and their partners to ask questions, as well as for providers to offer information and counseling for informed decision making and to supply the contraceptive method the client chooses.
7. ***Cost-effectiveness:*** Postpartum contraception can be cost-effective. A study conducted at a large hospital found that the costs of offering postpartum contraceptive services were significantly less than the costs of providing these services on an outpatient basis. In addition, providing postpartum contraceptive services helped to relieve overcrowded outpatient facilities, thus allowing more women to be served. It also eliminates transportation costs and service fees paid by women for making an additional visit for IUD insertion beyond the postpartum period, if that visit does not coincide with infant care services.
8. ***Preventing lost opportunities:*** In a study conducted at the University of New Mexico, a chart review of women delivering at that hospital who indicated at discharge that they wanted an IUD

inserted at some point after discharge, only 60% received an IUD. Barriers to insertion often include providers' advising against IUD use based on outdated knowledge, providers' lacking skills in postpartum IUD provision, and clients' having a difficult time in returning for a postpartum visit, resulting in early repeat unintended pregnancy.

Family Planning Methods Appropriate for Postpartum Use

The graphic below shows the postpartum use of various family planning methods, including the IUD inserted postplacentally and immediately postpartum.

Family Planning Methods Appropriate for Postpartum Use



Source: ACCESS-FP. *Postpartum Contraception: Family Planning Methods and Birth Spacing After Childbirth*. USAID/ACCESS-FP Program, MAQ Mini-U Meeting, November 14, 2006.

D. Key Components of the Fundamentals of Care Related to Postpartum IUD Service Delivery

The fundamentals of care are the essential elements for ensuring the quality of facility-based service delivery. They are based on the framework of clients' rights and staff needs for quality services.

Clients' Rights and Staff Needs

This section describes some of the issues related to postpartum IUD provision that are associated with each of the seven clients' rights and three providers' needs below:

Rights of Clients

- Information
- Access to services
- Informed choice
- Safe services
- Privacy and confidentiality
- Dignity, comfort, and expression of opinion
- Continuity of care

Needs of Providers

- Facilitative supervision and management
- Information, training, and development
- Supplies, equipment, and infrastructure

Clients have the right to:

- **Information:** that the IUD can be inserted immediately after placental expulsion or within 48 hours of delivery; the range of postpartum contraceptive options that are available
- **Access to services:** where the PPIUD can be provided, as well as the locations where other postpartum contraceptives can be provided
- **Informed choice:** the range of postpartum contraceptive options, including the postpartum IUD or the use of no method; accurate and complete information with which a client can make a decision
- **Safe services:** receipt of the postpartum IUD following a procedure that follows correct insertion practices, that adherence to infection prevention practices, and that includes the provision of instructions to ensure that the client is able to use the method effectively
- **Privacy and confidentiality:** services that protect postpartum IUD clients from auditory and visual exposure; services that prevent client information from being accessed by others not directly involved in a client's care
- **Dignity, comfort, and expression of opinion:** postpartum IUD provision with precautions taken to ensure minimal discomfort; services where a client's opinions are sought and her wishes or perspective are respected
- **Continuity of care:** accurate and complete documentation of the client's medical record and follow-up history, to ensure appropriate client management and clinical safety

Health care staff have a need for:

- **Facilitative supervision and management:** a supportive work environment; a supervisory system that helps staff perform postpartum IUD services to the best of their abilities
- **Information, training, and development:** staff knowledgeable and skilled in providing postpartum IUD services, with ongoing opportunities for refresher and/or coaching to maintain desired performance
- **Supplies, equipment, and infrastructure:** sufficient and appropriate supplies; existence of an instruments and logistics infrastructure to ensure uninterrupted postpartum IUD services

The Fundamentals of Care

The fundamentals of care, which are derived from the framework of clients' rights and staff needs, are the bedrock of quality services and are essential to ensuring high-quality postpartum IUD service delivery (The ACQUIRE Project, 2006). They are grouped in the following three categories:

I. Informed and voluntary choice

Programs must provide good counseling and real access to contraceptive options, free of any provider bias for or against particular methods, so that clients can exercise their right to make informed and voluntary decisions based on accurate, up-to-date information. This is both ethically correct and sound program practice. Counseling that helps clients choose and correctly use a contraceptive method that meets their needs has a positive impact on method adoption, continuation, and satisfaction and enables clients to achieve their reproductive goals and good health outcomes. Clients' satisfaction with the family planning service spreads by word of mouth in their communities, leading to further knowledge and use of family planning.

1. ***Effective client-provider interaction*** helps to ensure that clients' needs are correctly assessed and met.
2. An ***informational program*** for clients and other audiences, such as community members and health providers, is a key service-delivery component. The purpose of such a program is to let people know that postpartum contraceptive methods, such as the IUD, are available, as well as to overcome any myths or misunderstandings about the methods.
3. ***Counseling*** is important to ensuring timely and informed choice about the method. *Detailed coverage of this content can be found in Module 4: Counseling and Informed Choice.*

II. Safety for clinical techniques and procedures

Clinical techniques and services are considered safe when skilled and properly equipped providers deliver services according to up-to-date, evidence-based standards, protocols, and guidelines, within a facility or physical structure appropriate for managing clinical and surgical services. This includes appropriate management of any complications or subsequent side effects.

1. Providers must be **well-trained** in how to assess clients, perform the postpartum IUD insertion techniques—particularly techniques to minimize expulsion and to provide follow-up care, including management of side effects and complications. Providers must also be skilled in providing updated and accurate information about the IUD during information-giving and counseling activities, and must adhere to recommended infection prevention practices. Support staff—including nurses, counseling staff, and record-keeping staff—must also be well-trained to provide postpartum IUD–related tasks that contribute to safe and quality services.
2. Service-delivery sites must **be ready with** the equipment and supplies required to provide postpartum IUD services *safely* and *effectively* (e.g., informational materials to distribute to clients, instruments for insertion and removal, functional sterilization or high-level disinfection equipment, and expendable supplies, such as gloves).

III. Ongoing quality improvement and management

At the provider level, service quality improvement and management efforts focus on strengthening providers' knowledge, skills, motivation, and performance. At the facility level, supportive supervisors, participatory processes for ongoing problem solving and quality improvement, and a generally supportive work structure, including an appropriate reward system, are essential. At the program level, there need to be well-functioning service training, supervision, and supply and logistics

systems, based on updated standards, norms, guidelines, protocols, and procedures that are geared to meeting clients' needs.

1. Ensuring high-quality postpartum IUD services is a **continuous process** requiring strong management, quality assurance, and supervision systems that create an enabling and supportive environment capable of training enough providers who are "hands-on providers" of postpartum IUD services, so that this service can be offered 24 hours a day, seven days a week.
2. Effective functioning of facility-based postpartum IUD services and high-quality provider performance **depend on a variety of systems and performance-related factors** within and outside of the organization. These systems and factors are also essential to ensuring informed choice and clinical safety and include clear job expectations for all staff involved in postpartum IUD service delivery, and regular and supportive feedback on job performance, staff motivation, infrastructure, supplies, equipment, knowledge, and skills to support postpartum IUD services.

Management of Postpartum IUD Services

Postpartum IUD services must be carefully structured and well-organized to be effective. (For example, antenatal counseling is necessary for clients to receive postplacental and transcesarean IUD insertion.) The number of service providers involved, the unpredictable nature of the obstetric client volume in a particular setting, and the importance of the timing of the IUD insertion all contribute to the complexity of structuring a postpartum IUD program. Antenatal clinic, labor/delivery room, postnatal services and the family planning clinic of the facility must all work together if a postpartum IUD program is to succeed. To maximize counseling and referral opportunities before the client arrives at the hospital for delivery or before she is discharged, and to increase the likelihood that the client will return for follow-up care, it is important to involve staff from various departments, such as antenatal care (inclusive of staff at primary health facilities that may not have maternities but that provide antenatal and postnatal care services), obstetrics, maternity, postnatal care, family planning, and well-baby services.

Module 3
Postpartum Anatomy and Physiology

A. Introduction

This module reviews postpartum anatomy and physiology and the implications for IUD insertion. It also covers the anatomic and physiological differences between postpartum women and nonpregnant women.

Objectives

By the end of this module, you will be able to:

- Describe the changes that occur in the uterus and cervix during the postpartum period
- Describe the key aspects of postpartum anatomy and physiology that pertain to proper postpartum IUD insertion
- Describe the key anatomic and physiological differences between postpartum women and nonpregnant women
- Explain why the immediate postpartum period is the most appropriate time for postpartum IUD insertion (as opposed to the period between 48 hours and four weeks postpartum)

B. Knowledge Review and Discussion of Postpartum Changes in the Uterus and Cervix

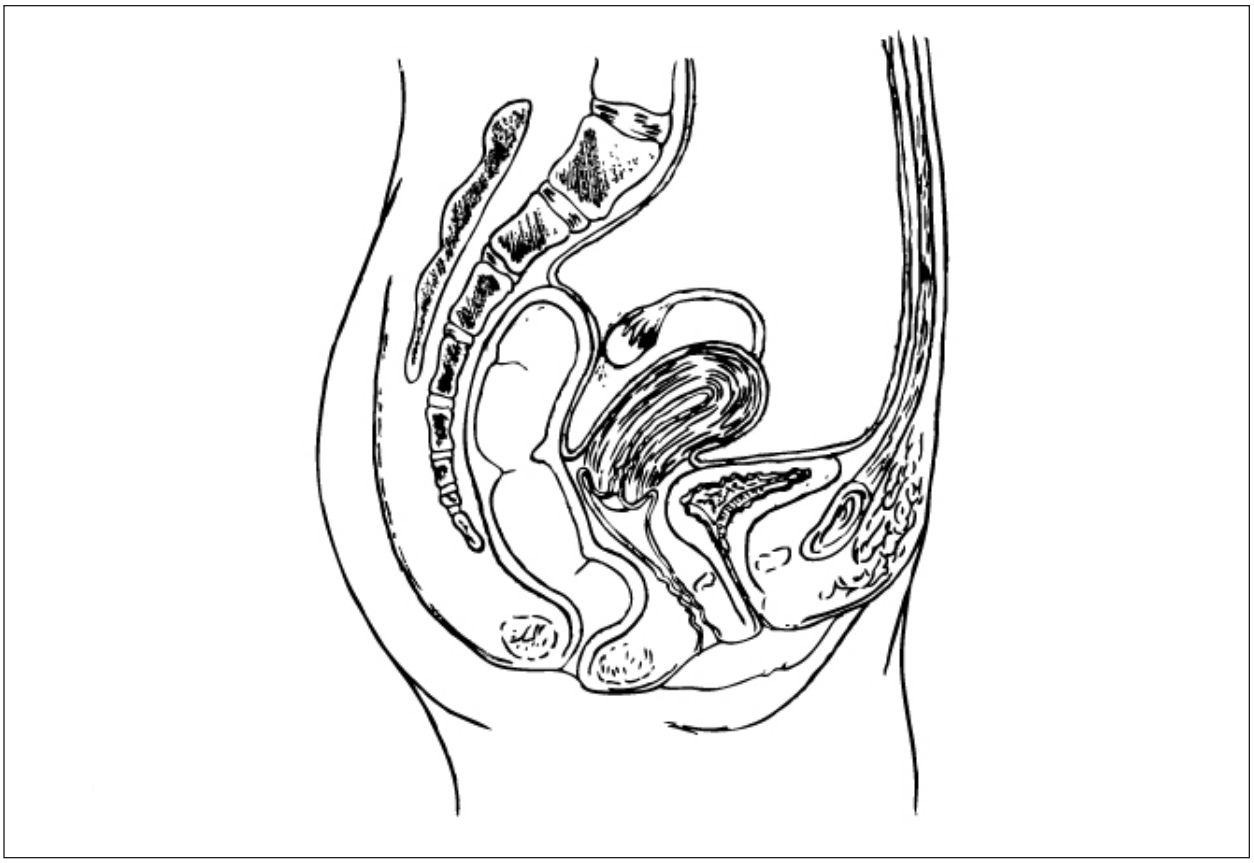
Instructions: Match each term on the left side of the page with the correct descriptive phrase on the right side of the page.

Term	Description
1. Postpartum contraction of the lower part of the uterus	a. A hollow organ with its inner walls spread apart
2. Involution	b. Intrapelvic
3. The nonpregnant uterus	c. The anatomic change that can cause a provider inserting an IUD to mistakenly believe that the fundus has been reached and that the IUD is being properly placed at the fundus when it is not
4. The anatomical location of the nonpregnant uterus	d. The rapid process by which the immediate postpartum uterus (weighing approximately 1 kg) decreases in size so that one week later it weighs about 500 g, by the end of the second week it decreases to 300 g, and soon it decreases to 100 g or less
5. Postpartum lochia and uterine contractions	e. Dilated and flabby; the outer margin is usually lacerated, especially laterally
6. The condition of the cervix following delivery of the placenta	g. A small and firm organ with inner walls that touch each other
7. The postpartum uterus	h. May cause IUD side effects to be less noticeable to clients

Changes in the Uterus and Cervix during the Postpartum Period

The postpartum period is the period of adjustment after pregnancy and delivery when the anatomic and physiological changes of pregnancy are reversed and the body returns to its normal nonpregnant state (see Figure 3.1).

Figure 3.1: Normal Nonpregnant Uterus (Side View)



The postpartum period consists of four stages:

- The *postplacental* period—within the first 10 minutes after expulsion of the placenta
- The *immediate postpartum* period—includes the first 48 hours postpartum
- The *early postpartum* period—extends until the first week postpartum
- The *remote postpartum* period—which includes the period of time required for the complete involution of the genital organs and has traditionally extended through the fourth week postpartum

The postplacental and immediate postpartum periods are appropriate times for inserting a postpartum IUD.

Changes in the Uterus

Immediately after delivery of the placenta, the fundus of the uterus is just below the umbilicus (the postplacental period). The uterus itself weighs about 1 kg and is roughly the size of a 20-week pregnancy, measuring between 25 cm and 30 cm from cervix to fundus.

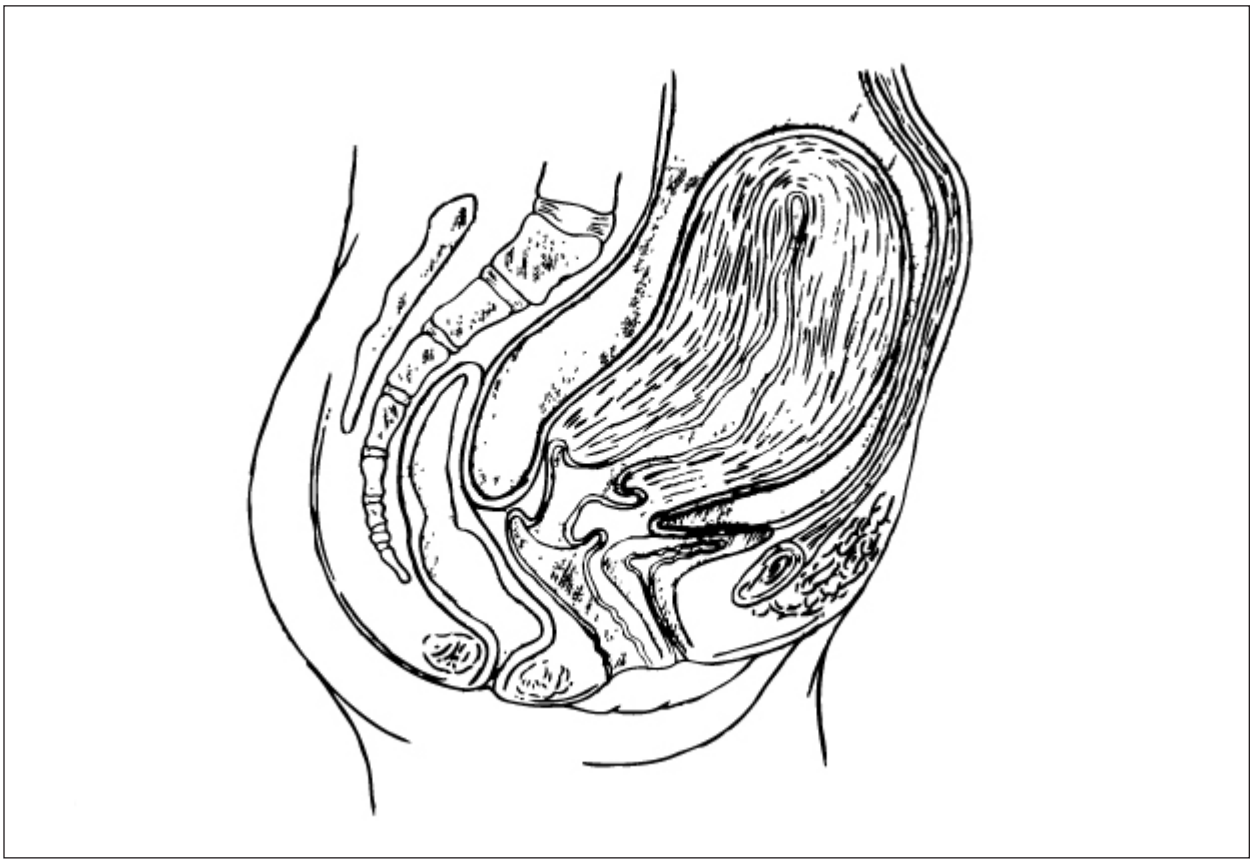
During the first 12 hours postpartum, uterine contractions are regular, strong, and coordinated. The intensity, frequency, and regularity of contractions decrease after the first postpartum days, as involution proceeds.

Immediately postpartum, the uterus is a smooth cavity with narrow apposition of the anterior and posterior walls, each of which is 4–5 cm thick. As the uterus involutes, its walls come together gradually (Figure 3.2).

During the first days, the very thinned-out inferior segment is folded (accordioned), which permits great mobility to the corpus (still thick and heavy) and causes it to tilt forward. This mobility of the corpus is aided by the transitory lengthening of the suspensory uterine ligaments, which occurs during pregnancy.

During this process, the uterine walls are soft and are therefore more subject to perforation—for example, by a conventional IUD inserter). However, a hand or ring forceps are both large enough to use to insert an IUD (if the IUD is not forced aggressively pushed into the uterine wall) so that uterine perforation is very rare.

Figure 3.2: The Uterus, Immediately Postpartum



In the immediate postpartum woman, the lower uterine segment is contracted. This anatomical change may cause a provider to mistakenly believe that he or she has already reached the fundus when inserting an IUD and that the IUD is properly placed at the fundus when it is not. Inserting the IUD in this incorrect position may result in an expulsion

During the following days and weeks, involution of the uterus will continue; by the fourth week, the uterus will be back to its nonpregnant position, size, and characteristics.

Changes in the Cervix

Immediately after the expulsion of the placenta, the cervix and lower uterine segment are collapsed and limp. The cervix then slowly contracts. As the cervix narrows, it thickens, and a canal is reformed. Up to 48 hours postpartum, it is fairly easy to use ring forceps to pass the IUD. After 48 hours, this may be more difficult. As the cervix narrows, it is difficult to pass any instrument through it.

Using an inserter for postpartum insertion between 48 hours and four weeks will allow passing through the cervix, but this is not recommended because the uterus is soft at this stage, which increases the risk of uterine perforation.

C. Key Differences between the Postpartum and the Nonpregnant Uterus and Cervix

The following chart shows some of the key anatomic and physiological differences in the uterus and cervix between nonpregnant women and postpartum women.

Anatomic Structure	Nonpregnant	Postpartum
Uterus	Weighs approximately 100 g or less	Can weigh as much as 1 kg immediately postpartum
	Is situated in the pelvis	Immediately after birth, is just below the umbilicus; then gradually moves lower, until it is back in the nonpregnant position
	Usually contracts only during menses	Experiences regular, strong, contractions that decrease slowly after the first postpartum days
	Has walls that are together, creating a "virtual" uterine cavity	Has distended and separated walls at first, but which then come together during involution
Cervix	Is a narrow canal communicating between the uterine cavity and vagina	Is collapsed and limp (along with the lower uterine segment) immediately after the third stage of labor, but then slowly contracts

D. Postplacental and Immediate Postpartum Periods: Appropriate Times for IUD Insertion

- **Postplacental** IUD insertion is done within 10 minutes after expulsion of the placenta, following a vaginal delivery.
- **Immediate postpartum** IUD insertion is when the insertion is done after the postplacental period, but within 48 hours of delivery.
- **Transcesarean** IUD insertion is when the insertion takes place following a cesarean delivery, before the uterus incision is sutured.

These periods are recommended for the following reasons:

- It is possible to use instrumented or manual insertion postplacentally (within 10 minutes after expulsion of placenta) because the cervix is open and limp and an IUD can easily be placed high in the fundus, either manually or using forceps. Use of an instrument is preferred, for reasons both of client comfort and of infection prevention.
- It continues to be possible to insert an IUD with an instrument for up to 48 hours postpartum. After this period, the cervix is not open enough to allow for an easy and relatively **painless** instrument insertion.

Module 4
Counseling and Informed Choice for Postpartum IUD Use

A. Introduction

This module discusses informed choice and family planning counseling in the context of postpartum contraceptive use, with an emphasis on postpartum IUD use. Although the provider inserting the IUD postpartum may not be responsible for all or most of the counseling, he or she is responsible for ensuring that the client has received adequate counseling and makes an informed choice *before this method is provided*.

Objectives

By the end of this module, you will be able to:

- Define informed choice
- List particular challenges to ensuring informed choice in postpartum IUD service delivery
- Define client-provider interactions and the role of counseling
- Describe important characteristics of family planning counseling, including special features of counseling for postpartum family planning and how to overcome the constraints associated with it
- Explain the provider's role and responsibilities in counseling postpartum IUD clients
- Demonstrate basic counseling steps for providers to follow when confirming informed choice for the postpartum IUD

Note: This module provides a brief review of important issues in family planning counseling, with an emphasis on issues related to postpartum IUD use. EngenderHealth recommends extensive training for staff who have primary responsibility for counseling, using the following resource: The ACQUIRE Project. 2008. *Counseling for effective use of family planning*. New York: The ACQUIRE Project/EngenderHealth.

B. Definition of Informed Choice and Challenges to Informed Choice

Informed choice refers to a voluntary decision by the client about whether or not to use a contraceptive method or undergo a particular procedure. The decision is based on the client's full understanding of the method or procedure, including its characteristics, actions, and possible risks and side effects. In addition to easily understandable information, informed choice requires availability of different contraceptive options that are accessible to clients.

Informed choice is vitally important to clients' adoption and continued use of contraception, and for this reason it is also important to the overall success of a program. Clients who are not allowed to make a choice, who are not given their method of choice, or who are not adequately informed are more likely to be dissatisfied with their method, more likely to discontinue using that method, and less likely to go back to the service site for follow-up visits or for other services. Overall

contraceptive use rates may also suffer, as members of the community learn by word of mouth about some clients' negative experiences.

Many situations and practices challenge or compromise informed choice. In order to introduce a postpartum IUD program at their facilities, you may need to address such challenges to informed choice, using the knowledge you have of your program. The bulleted list below is not a complete list of challenges to informed choice, and you may have other suggestions for your particular program.

- Insufficient contraceptive choice and inadequate method mix
- Medical barriers and provider bias
- Absence of information and counseling
- Absence of good linkages among services
- Lack of trained providers and other

Finally, a number of different issues may contribute to inadequate access or to clients' being pressured to accept methods they do not want, such as incentives for providers, recruiters, or clients, quantitative targets for family planning programs, and reimbursements to providers for some procedures and not for others.

C. Client-Provider Interaction and Family Planning Counseling

Client-provider interaction refers to interpersonal communications, either verbal or nonverbal, between providers, other health care staff, and the clients who seek health care services. Clients' positive perceptions of medical and nonmedical staff—not only of providers—can contribute to their satisfaction with services.

Family planning counseling—or counseling in general—is an important part of the overall client-provider interaction. Counseling is much more than the provision of information, and the information provided must be correct, complete, easily understood, and nonbiased, with a focus on the client's needs. Counseling uses a two-way communication process. It assists clients in reaching reproductive or other health goals and is a critical component to ensuring informed choice. Family planning counseling has the following *goals*:

- To help the client make a voluntary, informed, and well-considered choice that meets her needs, whatever that choice may be
- To enable her to use the method effectively
- To prepare the client for the procedure and to help her be comfortable during the procedure
- To review what the client can expect with the use of the method or after the procedure, such as possible side effects and how to manage them, when to return, and what follow-up care is needed
- To increase client satisfaction

Different types of staff can provide family planning counseling, including doctors, nurses, midwives, educators, other health workers, and volunteers, but they need to be well-trained for this important task. It is not sufficient just to have knowledge of family planning.

Good family planning counseling has several *characteristics*:

- The provider uses effective communication techniques to ensure two-way communication and active involvement of the client during counseling.

- The provider has good interpersonal skills, shows respect for the client and her opinions, and is not judgmental.
- The counseling focuses on the client's individual circumstances and helps the client make decisions that can be implemented in the client's particular circumstances.
- Such counseling helps the client apply the information to her individual needs, motivations, and feelings.
- Such counseling is provided in an area that ensures privacy, and the information is kept confidential. However, the counselor involves partner(s) and family members, as needed and as desired by the client.

D. Counseling for Postpartum Contraception: Special Issues for Clients and Providers

As we have seen, counseling is an extremely important part of family planning services. This includes postpartum family planning programs, which provide an opportunity for clients to receive up-to-date information on contraception and discuss reproductive health concerns. At this critical time, providers help clients make an informed choice about whether and when to use contraception for optimum health and well-being for themselves and their infant.

Special Issues: The Client's Perspective

Pregnant and postpartum women have particular needs and issues that must be considered in postpartum family planning programs. They include (but are not limited to) the following:

- Pregnant or postpartum women may or may not be interested in discussing contraception, and their wishes should be respected. Many studies (Landry et al., 1992; Rivera, Kennedy, & Balogh, 1994) have shown that the majority of women are interested in family planning during the postpartum period but may be too shy to discuss sexuality and contraception. It is the health care provider's professional responsibility to ask about a client's fertility intentions and discuss her return to fertility and to sexuality and the methods that can be used to prevent an unintended or poorly timed pregnancy.
- A pregnant or postpartum woman is likely to be most concerned about her own health and that of her baby.
- Clients, if they plan to breastfeed, often worry about the effects of contraception on breast milk.
- Pregnant/postpartum women often experience psychological changes, physical discomfort, and other stress, which may make decision-making about family planning difficult.
- Pregnant or postpartum women may be concerned about their sexuality (such as whether and when it is safe to have sex after delivery), but they may be reluctant to discuss these concerns with providers.
- Many women follow cultural norms about postpartum sexual abstinence, and thus may not need immediate postpartum contraception. Yet others may not follow such norms and may need to adopt contraceptive use sooner.

Special Issues: The Provider's Perspective

Providers need to apply their general counseling skills for postpartum family planning and, at the same time, consider the special needs and issues of postpartum clients. In particular, they need to be familiar with the World Health Organization's medical eligibility criteria as they pertain to

family planning for this category of clients. As we have seen, special issues and constraints include the importance of timing and the need for strong linkages with other service providers, many of whom do not have a family planning background. Some special issues are described in the table below.

Special Issues and Constraints in Counseling for Postpartum Contraception

Timing of Counseling	Constraints
The best time to counsel for postpartum family planning is during the antenatal period, before the stress of labor and delivery. This is a good time to involve the husband/partner and other relevant family members, as culturally appropriate	The pregnant woman and her partner and/or family are often more concerned about other issues during the antenatal period (such as the woman's own health and the health of her baby before, during, and after delivery), and thus they may not be able to focus on family planning issues.
If counseling was not provided during the antenatal period, maternity staff can provide it before the woman is discharged.	Family planning counseling is *never* recommended during **active labor** or **delivery,** when the client is under extreme stress (such as if the health of the newborn baby is in question, the client experiences pain/discomfort, or the client is sedated), or if the client does not want contraception. The client may be too distracted by the needs of her new baby or by her own physical condition to think about family planning. Maternity staff may be too busy to provide adequate counseling before the woman is discharged. If the client learns about the IUD, implants, or sterilization for the first time, the period after delivery and before discharge may not be enough time for her and her partner to adequately consider the choices available.
Effective counseling about and provision of postpartum family planning services require good communication between antenatal, labor and delivery, maternity, and family planning services.	Within the same institution, these different services are often in separate places, with separate staff and separate record-keeping systems. Communication between them is often poor. Women often receive antenatal care and family planning services through community health centers, which may have weak links to maternity or delivery services.
Counseling as well as service provision for postpartum family planning are often provided by antenatal, labor and delivery, and maternity staff.	These staff members are often not trained in family planning. They may not be aware of which methods are available for postpartum use. They may not be trained in counseling.

E. Counseling for Postpartum IUD Clients

For postpartum IUD clients, several issues need to be addressed and specific information needs to be provided to ensure that the client makes an informed choice. Ideally, such counseling is initiated during antenatal visits. If the IUD insertion is to be postplacental or transcesarean, the decision-making portion of counseling *must* be initiated antenatally, since there will not be time to do so between delivery and insertion. Often, antenatal counseling is not done, or there is no record of it. In these cases, counseling may be provided after delivery by staff members in the postpartum ward or by family planning staff who visit the postpartum ward to provide counseling before discharge. In these cases, the IUD can be inserted before the client is discharged, provided that she has had enough time to consider her decision.

In addition to the information provided to IUD clients in general, the postpartum IUD client needs to receive the following information:

- If the client wants an IUD, she can have it inserted within 48 hours of delivery before leaving the facility, *or* she can have it inserted four weeks after delivery.
- Postpartum IUD (Copper-T 380A) insertion does not affect breast milk and breast feeding.
- Both postpartum IUD insertion and IUD insertion four weeks after delivery are safe procedures.
- The expulsion rate is higher for an IUD inserted postpartum. The client needs to be on the lookout for an expulsion, by checking on whether the strings suddenly lengthen or the IUD actually appears. If she does this, she can usually identify an expulsion.
- If the client experiences an expulsion, she can usually have another IUD inserted after four weeks
- If the IUD is expelled, the client will need another method of contraception if she resumes sexual relations. The back-up method could be full breastfeeding (lactational amenorrhea method, or LAM), condoms (which also protect against sexually transmitted infections), or emergency contraception.
- During the first follow-up visit, the possibility of "missing strings" is higher than for a postpartum IUD insertion than for an interval insertion, because the strings may be still in the uterine cavity or just beginning to come down into the cervical canal. Advise the client to use an alternative method such as LAM or condoms and told to return in four weeks. At the follow-up visit, if the strings are not visible, consider the need for x-ray or sonographic evaluation.
- It is particularly important for the client to return for a follow-up visit after receiving the postpartum IUD. Be sure to discuss any possible difficulties related to her returning for a follow-up visit.

For more complete information about these and other issues that you need to discuss with clients, review carefully The Postpartum IUD Counseling Skills Learning Guide in Appendix A.

F. The Provider's Responsibilities in Counseling

The postpartum IUD provider who does not often provide the entire postpartum IUD service is ultimately responsible for the quality of the entire service. Even though the provider may not personally conduct all of the counseling, he or she is responsible for ensuring 1) that the client has received high-quality family planning counseling before the IUD insertion; 2) that the client is comfortable during the insertion procedure; and 3) that the client knows about warning signs and needed follow-up. The provider needs to ensure that the following steps occur:

1. ***Prior to inserting the postpartum IUD:*** Confirm that the client has made an informed, voluntary decision. Key tasks and questions to ask the client include the following:
   - Show the client a sample of the Copper-T 380A and explain that this is the type of IUD she will receive.
   - What do you know about the postpartum IUD?
   - What made you choose this method?
   - What do you know about the side effects?
   - What questions do you have?

In addition, it is important to assess the client's **access to a health care facility for follow-up care** prior to inserting the IUD while at the same time considering the risk of not inserting the IUD. Questions to discuss with the client include the following:

- Where will you go for postpartum care and follow-up?
- Where will you go to have the strings shortened when they pass through the cervix?
- Where will you go if you want to have the IUD removed?
- Where will you go for medical treatment if you have (or think you may have) any problem associated with the IUD?

Expulsion following postpartum IUD insertion is more common that with interval insertion; this is usually recognizable by the woman when she is taught what to look for. The IUD can be reinserted before 48 hours or after four weeks, should expulsion occur. As a preventive measure, a breastfeeding woman can be counseled regarding the criteria necessary to use breastfeeding as a contraceptive method and supported to rely on LAM. In addition, emergency contraception and/or condoms can be provided to the woman as a back-up method, in the event that the IUD is expelled and she has difficulty returning for reinsertion in a timely manner. If expulsion is recognized and an alternate method of family planning is adopted, expulsion will not put the women at risk of unintended pregnancy.

It is the provider's responsibility to make sure the client understands that, with an IUD, there will be times when she will need access to health care services.

Whether a client who does not have easy access to IUD follow-up care services is an appropriate postpartum IUD candidate requires consideration on a case-by-case basis. The decision should be made together by the provider and the client.

2. ***Before and during postpartum insertion of the IUD:*** Put the client at ease by talking with her. Specifically:
   - Find out the client's name and use it when talking to her.
   - Talk to the client. Tell her what you are doing—distract her with conversation.
   - Explain to the client that she will experience some discomfort, maybe even pain due to cramping and tenderness, but that the procedure will not last long.
   - Explain that relaxing and taking deep breaths will help, and help her do so. If possible or appropriate and desired, offer that someone can hold the client's hand.
   - Periodically, during the procedure, ask the client if she is comfortable.
   - During the procedure, listen to and watch the client for signs of discomfort, and remind her of the relaxation techniques.

3. ***After the insertion:*** The period following IUD insertion is an important time to review important issues related to postpartum IUD use:
   - Give her a client card with the name of the IUD and the date of insertion.
   - Give her written postinsertion instructions, if she has not yet received them (See Appendix B: Sample Written Postinsertion Instructions for Clients).
   - Assure her that the Copper-T 380A does not affect breast milk or breastfeeding.

Ask the client about warning signs and other issues related to postpartum IUD use and follow-up, as appropriate, assessing her need for reviewing these subjects and making sure not to repeat information when it is not needed:

- What are the warning signs you need to look out for? (Remind the client that women experience afterbirth pains during the first few days after delivery. The presence of an IUD does not increase these pains. Fever, foul-smelling vaginal discharge, and pelvic tenderness are not normal.)
- What do you do if you experience warning signs? (Or, Where will you go if you experience warning signs?)
- When are you returning for your follow-up visit? Where are you going for your follow-up visit? (Make an appointment, if possible.)
- How soon can you have sexual relations again after delivery? When are you planning to have sexual relations again? (Be sensitive to local customs.)
- What are you planning to do if you also need protection against sexually transmitted infections (STIs)?
- Remind her that if she has concerns or questions or if the IUD is expelled, she should return to a facility, where a provider can evaluate her concerns.
- Explain how to check for expulsion.
- Explain that she does not need to check the strings. Explain how to check the strings if she wants to, once she has healed after the postpartum period.
- If she is not planning to fully breastfeed, explain that a back-up method is needed in case of expulsion once she resumes sexual relations. Discuss condoms and emergency contraception.

4. ***At the first follow-up visit after postpartum IUD insertion:*** Review the client's record and put her at ease:
   - Ask her about problems, concerns, or questions about the IUD and about her health after delivery. (Ask about *warning signs*.)
   - Address any problems that are identified.
   - Review possible side effects and how to manage them.
   - Discuss or help with breastfeeding, if applicable.
   - Discuss condom use for prevention of HIV and other STIs, exploring possible risks of infection.

G. Role Plays of Counseling Situations

The following cases can help you think through the range of counseling situation that you may face and will be used as the basis for a group exercise.

Client No. 1: Mrs. A is 26 years old and has two children (including the one who was just born). She learned about postpartum IUD use during family planning group education sessions while waiting to be discharged after delivery. Her husband agrees that this would be a good method for them,

since they have already tried using contraceptive pills and condoms and may want another child in the future. Mrs. A is now ready to have an IUD inserted, and then she will be discharged.

Client No. 2: Mrs. B, 30 years old, has just delivered her fourth child and is ready to have an IUD inserted before going home. But she knows very little about family planning and has never used any form of it. The postpartum nurse told her that she should be sterilized before leaving the hospital. Mrs. B said no, so the nurse told her she would not be allowed to leave unless she had an IUD inserted postpartum. Mrs. B agreed, even though she knows nothing about the method.

Client No. 3: Mrs. C is 18 years old and has just delivered her first child. She wants to use an IUD but is nervous about extra bleeding and spotting. She does not know how she would explain that to her husband, who is much older than she is and refuses to touch her when she is bleeding.

Client No. 4: Mrs. D is in labor and is close to completing a normal delivery. She is 29 years old and has five children already. The doctor examines her chart and sees a note that she should have a postplacental IUD insertion. However, the chart does not indicate that she has received any family planning counseling. (During antenatal visits, Mrs. D said she would think about using something for family planning after delivery. But no one explained the methods to her, and she has no idea that an IUD has been recommended for her. Furthermore, she does not even know what an IUD is.)

Client No. 5: Miss E is 20 years old and unmarried; she has just delivered her third child. She is interested in using an IUD, but is reluctant to talk about family planning with her partner. She seems fairly knowledgeable about family planning methods.

Client No. 6: Mrs. F is 22 years old, has just delivered her third child, and wants to use an IUD postpartum. Women in her social group are not supposed to touch themselves, so she has one question for the provider: Does she really have to touch herself to check for the strings?

Module 5
Client Assessment for Postpartum IUD Use

A. Introduction

This module covers client assessment, which includes taking the client's medical and obstetric history, assessing her risk for sexually transmitted infections (STIs), performing a physical examination, and comparing the findings to the postpartum IUD medical eligibility criteria.

Objectives

By the end of this module, you will be able to:

- State the information that needs to be obtained from in a medical history and physical exam, as appropriate, for a client wanting a postpartum IUD.
- Perform an STI risk assessment and manage STIs appropriately, if necessary.
- State the medical eligibility criteria for postpartum IUD insertion.

B. Overview of Client Assessment

One component of quality care is a thorough client assessment. Client assessment, combined with effective client counseling, helps to ensure an appropriate match between the client's clinical condition and her contraceptive selection.

An effective client assessment addresses client safety and considers the client's general health. A provider skilled in client assessment involves the client in the assessment process in a way that furthers her understanding of why the assessment is needed, her own health status, and some of the potential problems that can result from inappropriate postpartum IUD service provision.

Few women are clinically inappropriate for postpartum IUD insertion. A thorough client assessment enables the provider to identify those women for whom the postpartum IUD is not a viable contraceptive method, and it helps them to select a satisfactory and clinically suitable method.

If at any point during the client assessment process it is decided that the postpartum IUD is not an appropriate method for the client, she must receive additional family planning counseling and leave with another method, if she chooses.

Components of a Client Assessment

1. Taking and assessing the client's medical history, including
   a. General medical, obstetric, and gynecologic history
   b. STI risk assessment
2. Performing a physical examination

After these steps have been completed and the client has been determined to be an appropriate postpartum IUD candidate, the provider may insert the IUD and provide postinsertion instructions to the client.

C. Client History: General Medical, Obstetric, and Gynecologic History

The first step in taking a client's history is to confirm that she wants an IUD inserted postpartum. While this may seem obvious, this critical information is sometimes overlooked. Confirming the client's choice not only saves time for the provider and the client, but it also ensures that the client has made an informed choice and has another opportunity to change her mind, if she wishes.

To ensure that a client is an appropriate candidate for a postpartum IUD, the provider must gain an understanding of her health history. A review of her medical, obstetric, gynecologic, and family planning method history (either from the client's records or from an interview with the client) must be conducted.

- The obstetric history includes the client's current pregnancy and delivery.
- Providers need to confirm that the client has access to follow-up care.
- Providers should follow their health care facility's guidelines for the content of the clinical history.

The provider who inserts the postpartum IUD may not need to conduct an entire history-taking session if this has already been done (for example, during antenatal visits). If this is the case, the provider is responsible for reviewing the history and confirming the information with the client. (Confirming the history with the client helps her to understand the importance of a clinical evaluation.)

Key points to assess during the client assessment just prior to the insertion:

- Confirm the client's desire for a postpartum IUD, her understanding of possible side effects, and her access to follow-up care.
- Review the client's records, with attention to her antenatal and intrapartum course.
- Review the course of the client's labor and delivery.
- Assess any preexisting conditions that could outweigh the advantages of using the IUD.

D. Client History: Infection Risk Assessment

One concern associated with the use of IUD is whether it increases the risk of pelvic inflammatory disease (PID); it is important to assess the client's risk of having an STI, to decrease the likelihood of inserting an IUD in a client who has an STI or is at high individual risk for STIs.

Reproductive tract infection (RTI)

An RTI is an infection in the reproductive organs and tissues. There are several types of RTIs: STIs; infections not caused by sexual contact (such as yeast infections or bacterial vaginosis); infections that either predate the onset of labor—e.g., Group B Strep (GBS)—or that set in during the course of labor or in the postpartum period (such as GBS or other organisms or multiple organisms); and infections caused by poor infection prevention practices.

Sexually transmitted infection (STI)

An STI is an infection that can result from sexual contact. Ideally, an STI risk assessment should be conducted during antenatal care. If a client who is to receive the IUD immediately postpartum has not had as STI assessment, conduct the screening, using the job aid for STI assessment. (See Appendix D for illustrative sensitive questions.)

In 2004, the World Health Organization (WHO) revised its recommendations regarding initiation of the IUD. It gives increased recognition to the difference between *high individual risk* (e.g., a woman or her partner has multiple partners or has a partner with STI symptoms and fails to use condoms consistently and correctly) versus *high general risk* (e.g., a woman is young, not in a stable relationship, or lives in an area with a high prevalence of STIs) (see Appendix D).

The WHO recommendations clearly indicate that:
- A woman at **high *individual* risk** is ineligible to use the IUD.
- A woman with only **high *general* risk** is eligible the use the IUD.

Note: The risk of PID is much lower than some providers believe. IUDs alone do not cause PID. In the presence of an existing infection with gonorrhea or chlamydia, IUDs can increase PID risk, primarily around the time of insertion (Shelton, 2001).

HIV
A woman with HIV is *eligible* to use the IUD. WHO currently recognizes that the advantages of initiating the use of an IUD generally outweigh the risks for women with HIV and for women at high risk for HIV.

Note: Use of the IUD does not appear to increase the risk that a woman will acquire HIV or to speed HIV-infected women's progression toward AIDS. IUD use by HIV-infected women does not increase genital shedding of the virus. Complications of IUD use are comparable to complication rates among IUD users who are not HIV-infected.

AIDS
According to WHO, a woman with AIDS is not recommended to *initiate* use of an IUD unless she is doing clinically well on antiretroviral therapy. However, it is recommended that a woman who develops AIDS while using an IUD *continue* IUD use.

For additional information, **review the table** on page 10 of New attention to the IUD: Expanding women's contraceptive options to meet their needs. *Population Reports*, series B, no. 7.

E. Client History: Other Medical Categories
WHO lists several other health categories for which the risk of initiating IUD use generally outweighs the advantages; in these cases, the method **should not** be used. Conditions that apply to a postpartum IUD insertion include:
- Unexplained vaginal bleeding before clinical evaluation
- Gestational trophoblastic disease (benign or malignant)
- Hemorrhage
- Extended genital trauma, including cervical tears and lacerations
- Anatomical uterine abnormality that prevents proper fundal placement of the IUD
- Known or strongly suspected cancer of the uterus or known pelvic tuberculosis
- AIDS in a women not clinically stable on antiretroviral therapy

In contrast, being anemic, being HIV-positive, or having AIDS but being clinically well while receiving antiretroviral therapy are all conditions listed as Category 2 in the WHO Medical Eligibility Criteria: conditions where the advantages of using the method generally outweigh the theoretical or proven risk. In these cases, the IUD can be used.

Conditions That Predispose to Postpartum Infection

Other delivery-related conditions that increase the risk of infection, and therefore that require a thorough assessment before a postpartum IUD can be provided, are:

- Prolonged rupture of membranes (>24 hours)
- Prolonged labor (>24 hours)
- Fever (>38°C or 100.4°F)
- Puerperal genital infection
- Puerperal sepsis
- Extensive genital trauma

While prolonged ruptured membranes, prolonged labor, and extensive genital trauma are not precautions to the use of the IUD postpartum per se, these conditions can predispose to postpartum infection. In the presence of these situations, the client wanting to use an IUD should have the insertion deferred until the earliest postpartum visit (e.g., four weeks), when she can be assessed and have the insertion once infection has been ruled out. The woman should be counseled to practice LAM or to use another family planning method of her choosing until she is able to return for insertion. Insertion of an IUD in the presence of postpartum sepsis may substantially worsen the condition.

F. Physical Examination

Relevant information obtained from the physical examination includes:

- The client's general well-being or overall postpartum condition
- Normal temperature
- Assessment of uterus contraction
- Assessment of the condition of the birth canal, and absence of extensive genital trauma or lacerations
- Bleeding within normal limits
- No evidence of infection

Postplacental Insertion

If the insertion is to be performed postplacentally, the provider has already performed active management of the third stage of labor and has confirmed that the uterus is contracted and there is not bleeding (if necessary, massaging the uterus until it becomes firm and bleeding subsides). The genital area needs to be examined, and if an episiotomy was performed or if there are vaginal lacerations or the cervix has tears and lacerations, these should be repaired **after** the IUD insertion. Postplacental insertion can be done with instruments (**preferred** in the absence of long gloves or water-impermeable gowns) or manually.

Immediate Postpartum Insertion

Instrument insertion with ringed forceps is the recommended insertion technique for immediate postpartum insertion. In addition to the points above, the provider should ensure that the uterus is

continuing to normally involute, that there is no abnormal bleeding, and that any repair of an episiotomy or vaginal/cervical lacerations is healing normally.

There is no laboratory test required for postpartum IUD insertions. Providers should check in the antenatal and obstetric record for any laboratory test done at that moment as a good practice.

G. Medical Eligibility Criteria for Postpartum or Postabortion IUD Insertion

The following table provides details on the WHO's medical eligibility criteria for postpartum IUD use and specifically for postabortion IUD insertion (excerpted from WHO, 2004). The complete WHO Medical Eligibility Criteria for the IUD can be found in Appendix C.

Intrauterine Devices (IUDs)		
Condition	**Category** I = Initiation, C = Continuation	**Clarifications/Evidence**
Postpartum (breastfeeding or nonbreastfeeding, including postcesarean section)		
a. <48 hours	1*	**Evidence:** There was some increase in expulsion rates with delayed postpartum insertion compared to immediate insertion and with immediate postpartum insertion compared to interval insertion.
b. 48 hours to <4 weeks	3	Not recommended, expulsion rates are high and there is increased risk of complications.
c. >4 weeks	1	Safe
d. Puerperal sepsis	4	Not recommended
Postabortion		
a. First trimester	1	**Clarification:** IUDs can be inserted immediately after first-trimester, spontaneous, or induced abortion **Evidence:** There was no difference in risk of complications for immediate versus delayed insertion of an IUD after abortion. Expulsion was greater when an IUD was inserted following a second-trimester abortion versus following a first-trimester abortion. There were no differences in safety or expulsions for postabortion insertion of a levonorgestrel-releasing IUD compared with a copper IUD.
b. Second trimester	2	Still safe
c. Immediate postseptic abortion	4	Not recommended

*The initial version of the WHO medical eligibility criteria had categorized this as Level 2 (provide with caution), but a review and revision conducted in 2008 has led to a change here to Level 1 (safe). See introduction to Appendix C for an explanation of the ratings.

H. Client Assessment: Case Studies

Review each of the cases described below. Based on what you have learned in this module about client assessment and contraindications to postpartum IUD insertion, answer these two questions for each case:

- Is this client a candidate for postpartum IUD insertion?
- Why or why not?

Case Study No. 1

The client has a normal medical history and physical exam. The client denies having sexual partner(s) other than her husband, but she does not know if he has other partners. The couple have used the condom sporadically over the years.

Case Study No. 2

A client had hemoglobin of 8 g/dl just before delivery, and there is no history of hemoglobin levels during pregnancy.

Case Study No. 3

A client requests a postpartum IUD after receiving antenatal family planning counseling. Forty hours before delivery, her membranes rupture. At delivery, the baby is fine, and the mother has a low-grade fever.

Case Study No. 4

A client who requested a postpartum IUD during antenatal care presents at the maternity in active labor. At admission, her blood pressure is 180/104, she has edema of the face and hands, her deep-tendon reflexes are brisk, and she has proteinuria. During the course of her labor, she is safely managed for severe pre-eclampsia; following delivery, mother and baby are doing well. Her condition is slowly stabilized. The client is now 36 hours postpartum and is anxious to receive the IUD before she leaves the hospital.

Case Study No. 5

A client who has been receiving antiretroviral therapy (ART) for two years and has been participating in the program for prevention of mother-to-child transmission of HIV (PMTCT) is in active labor with her fifth child (her fourth child is 10 years old). Although the client does not want to have any more children and has received family planning counseling during her ART and PMTCT care visits over time, she is fearful of tubal ligation and would prefer to have an IUD inserted after delivery since “it will last a long time.” The client is likely to deliver within the next hour.

Module 6
Infection Prevention

A. Introduction

This module highlights the infection prevention practices used in providing safe postpartum IUD services.

Objectives

By the end of this module, you will be able to:

- Review key terms related to infection prevention
- Define the provider's role in infection prevention for postpartum IUD insertion (including oversight of other staff)
- Describe the importance of infection prevention, including the potential consequences of poor infection prevention practices
- Describe infection prevention procedures particularly important to postpartum IUD insertion

B. Definitions

Instructions: Match each infection prevention term in the list below with the correct definition in the chart on the next page, and write the term in the corresponding box in that chart.

Antiseptic	Decontamination	High-level disinfection (HLD)
Aseptic technique	Disinfectant	Standard precautions
Chlorine solution	Disinfection	Sterilization
Cleaning	Gluteraldehyde	

C. The Importance of Infection Prevention

Appropriate infection prevention practices must be followed to minimize the risk of infection and serious diseases for the client, the provider, all facility staff members, and the community. Infection prevention is for everyone.

As someone providing postpartum IUD services, you are responsible for client and staff safety. This includes ensuring that appropriate infection prevention practices are followed at your facility.

Using ineffective or inappropriate infection prevention practices during postpartum IUD insertion or subsequent clinic visits may lead to several serious consequences:

- Postinsertion infections such as endometritis
- Infections such as HIV, hepatitis, and others commonly found in clinic settings (such as staphylococus and streptococcus) that may be transmitted to clients, providers, and other clinic staff

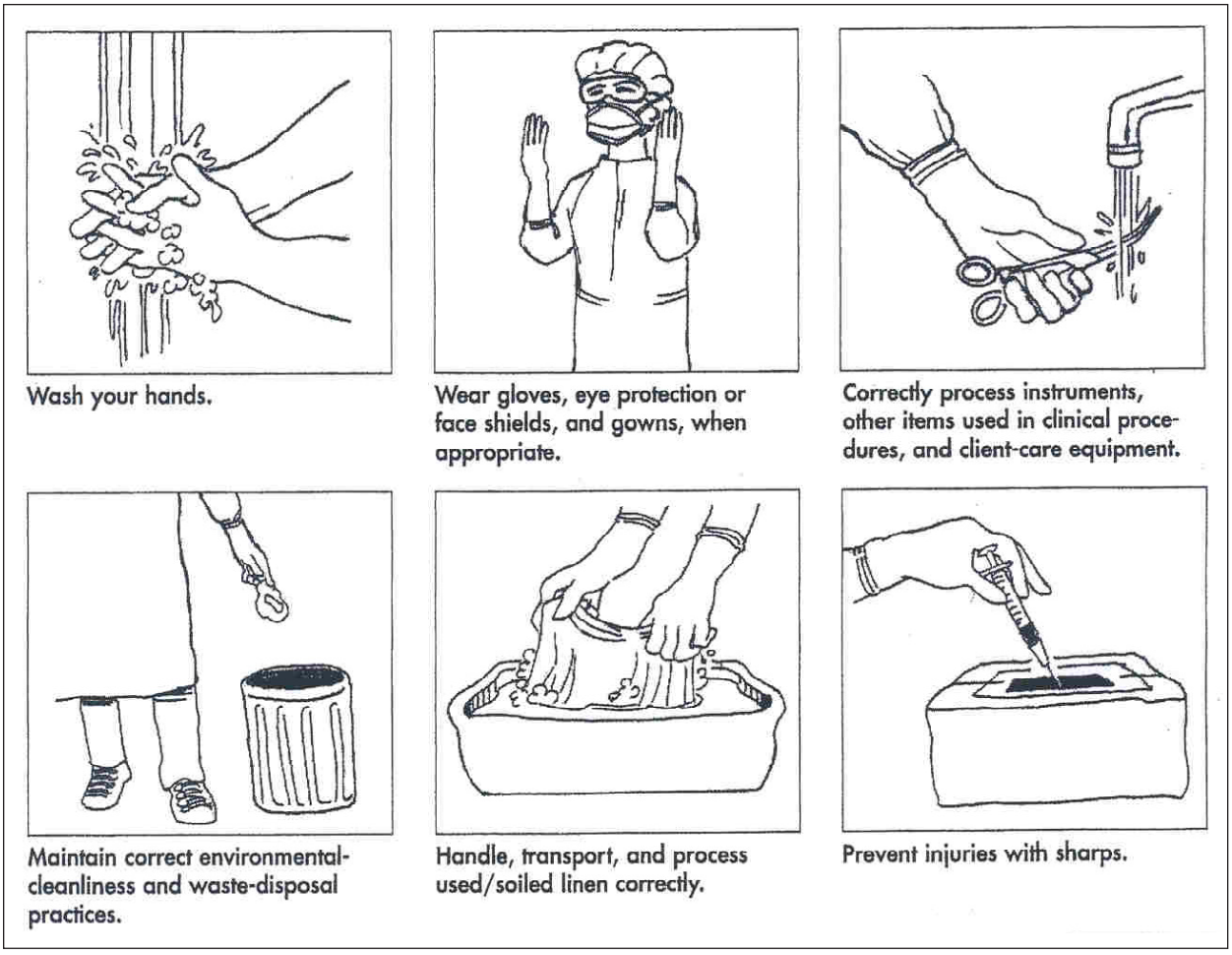
Term	Definition
1.	A practice that helps to reduce the risk of postprocedure infections in clients by decreasing the likelihood that microorganisms will enter into areas of the body where they can cause an infection. Includes use of gloves, maintenance of a sterile field, and proper preparation of the surgical site.
2.	The process that makes instruments and other items that have been used during procedures safer for staff to handle during cleaning.
3.	The process that, by scrubbing with detergent and water, physically removes all visible blood, body fluids, and other foreign material from instruments and other items.
4.	A chemical agent used on skin and mucous membranes to reduce the number of microorganisms without causing damage or irritation. Not meant to be used on inanimate objects (such as instruments and surfaces).
5.	A disinfectant solution commonly available in a number of commercial products for use in sterilization or high-level disinfection of instruments and other items.
6.	The process that eliminates most microorganisms from inanimate objects (such as instruments and surfaces).
7.	The process that eliminates all microorganisms, except high numbers of bacterial endospores, from instruments and other items. Suitable for use when these items will come into contact with broken skin and intact mucous membranes. (If sterilization is not available or feasible, this is the **only** acceptable alternative for items that will come in contact with the bloodstream or tissues under the skin.)
8.	Guidelines designed to minimize the risk of transmission of bloodborne and other infections to clients and staff in health care settings through the use of gloves and other barriers, hand washing, and other infection prevention measures. To be applied to all clients, regardless of their presumed infection status.
9.	A disinfectant solution that is easily made from liquid bleach, bleach powder, or chemical tablets. Can be used for decontamination, high-level disinfection, and housekeeping activities.
10.	A chemical agent used on inanimate objects (such as instruments and surfaces) to reduce the number of microorganisms. Not meant to be used on skin or mucous membranes.
11.	A process that eliminates all microorganisms, including bacterial endospores, from instruments and other items. Recommended when these items will come into contact with the bloodstream or tissues under the skin.

D. Stopping the Transmission of Infection

People with infections, both clients and staff members, may not have any signs or symptoms of the infections they carry. This is particularly notable for HIV and the hepatitis viruses, but it is the case for other infections as well. Therefore, **it is important for *all* staff to practice proper infection prevention at *all* times with *all* clients.**

The best way to prevent infections at a health facility is to follow standard precautions. These are a set of recommendations designed to help minimize both clients' and staff's risk of exposure to infectious materials (Figure 6.1).

Figure 6.1: Standard Precautions for Infection Prevention



Standard precautions should be followed with every client, regardless of whether you believe that the client might have an infection. This is important because it is not always possible to tell who is infected with viruses such as HIV and the hepatitis virus, and often the infected person themselves do not know that they are infected. It is safer to act as if every client is infected rather than apply standard precautions to some clients and not to others.

E. The Provider's Role in Infection Prevention

Along with good personal infection prevention practices, the provider has a responsibility to supervise the infection prevention practices of other staff and to facilitate improved infection prevention practices at his or her facility.

Following the guidelines below will help to continue improving infection prevention practices at your facility:

- Provide adequate equipment, supplies, and facilities for implementing new or improved infection prevention practices.
- Conduct periodic reviews to make sure that the implementation of infection prevention practices is going well and to address any staff concerns.
- Provide staff with orientations and training before any new infection prevention procedures are begun. Review the key role that each staff member plays in infection prevention.
- Establish procedures to address situations in which clients and staff are exposed to the risk of infection.

F. Infection Prevention Practices Important to Postpartum IUD Insertion

Postplacental IUD insertion can be performed in the delivery room immediately following the delivery or in the surgical ward during a cesarean section; insertions in the immediate postpartum period can take place in a postpartum IUD procedure room.

While good infection prevention is important at all times, the following practices are critical to the postpartum IUD insertion procedure.

Handwashing

Thorough handwashing, coupled with the use of gloves, is a necessary key step in minimizing the risk of infection for clients, providers, and staff. *Handwashing is the single most important procedure to reduce the spread of infection in health care settings*. The vigorous rubbing together of all surfaces of lathered hands mechanically removes and often inactivates most organisms

When to wash hands:

- When arriving at work
- Before and after examining a client
- After touching any object that might be contaminated
- Before putting on gloves for clinical procedures
- After removing gloves
- After going to the toilet
- Before and after eating or drinking
- Before leaving work

Use running water and soap or antiseptics.

Gloving

Sterile gloves should be worn for postpartum IUD insertion. For a postplacental insertion, a new pair of sterile gloves should be worn. For an insertion using the ring forceps, these could be regular sterile surgical gloves. In the case of a manual insertion, the provider should put on a new pair of sterile long-sleeved (up to the elbow) gloves. Long-sleeved gloves are required—the hand and wrist extend far into the vagina and are exposed to a lot of blood. If long-sleeved gloves are not available, use standard gloves, combined with a gown that is water impermeable. A standard cloth gown does not offer the same protection. **If long-sleeved gloves or water-impermeable gowns are not available, then the health provider should perform a ring forceps insertion.**

Aseptic Technique

In the context of the postpartum IUD, aseptic technique refers to the practices performed just before or during the insertion to reduce the client's risk of infection, by reducing the likelihood that microorganisms will enter the uterine cavity or areas where they can cause infection. It includes appropriate client preparation, such as by applying antiseptic solutions, using barriers, and minimizing manipulation.

Aseptic technique also includes using the "no-touch" technique. The no-touch technique means loading the ring forceps without touching IUD or handling it only with sterile gloves, and minimizing the tissue that the IUD touches as it is passed through the vagina and the cervix. It also means that the IUD is not passed through the cervix more that once.

Antiseptics

An antiseptic is a chemical agent used on skin and mucous membranes to reduce the number of microorganisms without causing damage or irritation. In addition to removing or killing microorganisms, antiseptics may also prevent the growth and development of microorganisms, depending on the type of antiseptic and microorganism.

Antiseptic agents appropriate for postpartum IUD insertion are:

- Iodophors (such as povidone iodine)
- Chlorhexidine gluconate (such as Hibiclens and Savlon)

Antiseptics for vaginal and cervical use must be water-based; alcohols should not be used, because they dry and irritate mucous membranes (which promotes the growth of microorganisms). If iodophors are used, the provider should allow 1–2 minutes before proceeding. Iodophors require up to two minutes of contact time to release their free iodine.

Disinfectants

A disinfectant is a chemical agent used to kill microorganisms on inanimate objects, such as instruments and surfaces. Disinfectants are not meant to be used on skin or mucous membranes.

1. **High-level disinfectants** kill bacteria, viruses, and fungi, as well as some (but not necessarily all) bacterial endospores. Some high-level disinfectants are also chemical sterilants and, given sufficient time, will destroy endospores. Examples include Glutaraldehyde (Cidex®) and chlorine solution, among others.

2. **Low-level disinfectants** kill most bacteria and some viruses and fungi but do not kill tuberculosis-causing organisms and bacterial endospores (which cause such diseases as tetanus and gangrene). Examples include carbolic acid (phenol) and benzalkonium chloride (Lysol), among others.

Remember: Disinfectants are harsh chemicals that can damage tissues; they kill a broader range of microorganisms more effectively than antiseptics. Because of the potential for tissue damage, they should **never** be used on skin or mucous membranes.

G. Processing of Equipment and Instruments

The chart on page 39 describes the processing steps that must be followed to keep equipment and instruments specific to postpartum IUD insertion clean and safe to use.

H. Housekeeping, Safe Environment, and Waste Disposal

Housekeeping

Procedure room cleaning requirements

- Each day, clean the floor with a damp mop (using water only) and wipe the counters and tabletops with a damp rag (water only) before any procedures begin.
- After caring for each client, wipe down the procedure table, the floor around the table, the instrument stands, and other potentially contaminated areas (such as light switches and countertops) with a 0.5% chlorine solution. If organic material remains after decontamination, wash with detergent and water. It is especially important to decontaminate and clean between clients because there may be more blood with postpartum IUD insertion than with interval insertion.
- At the end of the day, repeat the above procedure with a disinfectant cleaning solution that contains both a disinfectant (such as chlorine) and a detergent.

Maintaining a Safe Environment

The following are a number of ways in which the procedure room used for postpartum IUD insertion can be kept safe and clean:

- Limit the entry of unauthorized individuals to the procedure room.
- Close doors and curtains during the procedure.
- Do not used the procedure room as a storage room.
- Promptly remove any used or unused instruments or supplies.
- Safely handle any sharps, and dispose of them in a puncture-safe container.
- Thoroughly clean the procedure room at least once a week. Use a disinfectant cleaning solution to scrub the walls, floors, and equipment. Wash it from the top to the bottom, so that debris that fall on the floor will be cleaned up last.

Waste Disposal

Contaminated waste may carry high loads of microorganisms. If it is not disposed of properly, it may be infectious to any persons who contact or handle it and to the community at large. Waste from postpartum IUD procedure rooms, delivery rooms, and operating rooms should be considered contaminated.

Equipment and Instruments	Process
Procedure tabletop (or other large surface area)	1. *Decontamination:* Wipe with a 0.5% chlorine solution. 2. *Cleaning:* Wash with detergent and water. *Note:* Decontamination and cleaning of the tabletop between clients is especially important for postpartum IUD insertions, because there is more blood with such insertions than with interval insertions.
Linens (caps, gowns, masks, and sterile drapes)	1. *Decontamination:* Decontamination of linens is impractical and is not recommended. Wear gloves to handle, transport, and process used linen soiled with blood or other body fluids in a way that prevents exposure of skin and mucous membranes and contamination of clothing. 2. *Cleaning:* Presoak linens to facilitate washing. Wash with detergent and abundant water. Rinse with clean water. Air- or machine-dry. 3. *Sterilization and high-level disinfection:* Not necessary for caps, gowns, and masks.
Gloves	1. *Decontamination:* Dip gloved hands in decontamination solution. Remove gloves by inverting them. Discard them according to standard precautions and international guidelines. *Note:* If gloves require reprocessing, refer to EngenderHealth's *Infection Prevention: A Reference Booklet for Health Care Providers*.
Instruments	1. *Decontamination:* Soak in a 0.5% chlorine solution for 10 minutes before cleaning. Rinse or clean immediately. 2. *Cleaning:* Using a brush, wash well with detergent and water. Rinse with clean water. Air- or towel-dry. 3. *Sterilization (preferable to high-level disinfection):* Use steam or dry heat. *High-level disinfection:* Boil or use chemicals only if sterilization is not feasible.
Metal containers for instrument storage	1. *Decontamination:* Soak in a 0.5% chlorine solution for 10 minutes before cleaning. Rinse or clean immediately. 2. *Cleaning:* Wash with detergent and water, removing all particles. Rinse with clean water. Air- or towel-dry. 3. *Sterilization:* Use steam or dry heat. *High-level disinfection:* Boil container and lid. If container is too large, fill the container with the chlorine solution and soak for 20 minutes. Air-dry before use. Disinfect weekly, when empty, or when contaminated.

Module 7
Postpartum IUD Insertion Techniques

A. Introduction

This module covers the various timings and insertion techniques for the postpartum IUD. It also explains how the techniques differ as a result of the various timings.

Objectives

By the end of this module, you will be able to:

- Understand which insertion technique is appropriate to the various times at which an IUD can be inserted postpartum
- Describe the approach of each postpartum insertion technique
- List the factors to consider while selecting an insertion technique
- Discuss key considerations related to insertion techniques and active management of the third stage of labor
- Present the different insertion techniques, following the steps in the learning guides

B. Insertion Times and Techniques

As is discussed in Module 2, **postpartum** is a general term for any IUD insertion that takes place within 48 hours after delivery. The insertion itself can be performed **postplacentally** or in the **immediate postpartum** period. There are three main types of postpartum IUD insertion:

- **Postplacental insertion** is when the IUD insertion is done within **10 minutes after expulsion of the placenta** following a vaginal delivery. Postplacental insertion can be done using ringed forceps or manually. In this period, the cervix is still almost fully dilated; this allows the passage of either forceps or the hand. An interval-type IUD inserter tube should not be used postplacentally, because the inserter tube is too short to reach to the uterine fundus. In addition, because the uterus is soft, a narrow inserter can more easily perforate the uterus than can forceps or a hand.
- **Immediate postpartum** insertion is when the insertion is done **after the postplacental period, but within 48 hours of a vaginal delivery.** The technique used for immediate postpartum insertion involves use of the ringed forceps. The cervix is gradually contracting during the postpartum period, but within 48 hours of delivery, the cervix is still sufficiently dilated to allow passage of ringed forceps (but not passage of a hand). An interval-type IUD inserter tube should **not** be used at this time, for the same reasons that it is not to be used postplacentally.
- **Transcesarean** insertion is when IUD is inserted following a cesarean delivery, before the uterus incision is sutured. Since the uterus is open, the IUD can simply be placed in the uterus fundus either manually or with any grasping instrument.

Insertion of the IUD between 48 hours and four weeks postpartum is not recommended, based on the following evidence as reported in the WHO Medical Eligibility Criteria: "There was some increase in expulsion rates with delayed postpartum insertion compared to immediate insertion and with immediate postpartum insertion compared to interval insertion" (WHO, 2004).

Postabortion IUD insertion is a general term for IUD insertion that follows a spontaneous or induced abortion:

- After a first-trimester abortion, the **interval technique** (involving use of an inserter tube) is appropriate: The cervix is only minimally dilated; only an inserter tube is small enough to pass through it; the uterus is relatively small and firm; the risk of perforation with an inserter tube is small.
- After a second-trimester abortion, the **forceps technique** or **interval technique** can be used. The forceps technique is used if the cervix is open enough to allow passage of forceps. If the cervix does not allow passage of the forceps, the interval technique is used.

Interval IUD insertion is an insertion that takes place at any time more than **four** weeks after delivery, using the inserter tube that comes with the IUD.

This curriculum will teach *only* the **forceps** and **manual insertion** techniques for postplacental, transcesarean, and immediate postpartum IUD insertion.

Note: The risk of complications following postabortion insertion (perforation, bleeding, and infection) is no greater than that following interval IUD insertion, as long as the cervix or uterine cavity is not infected and the uterus has been completely evacuated. Postabortion and interval insertion techniques using the inserter tube are not taught in this course.

C. Choice of the Timing and Technique of IUD Insertion

In selecting the timing and the insertion technique to be used, the provider should take into consideration the following issues, which range from clinical to service management factors:

Postplacental vs. Immediate Postpartum Timing

For postplacental insertion, the provider should consider the following points:

- The client needs to be counseled during the antenatal period, and the provider attending the delivery should also be trained in postpartum IUD provision.
- IUDs and the instruments and supplies needed for insertion should be available in the delivery room.
- Postplacental IUD insertions have a lower risk of spontaneous expulsion than do immediate postpartum IUD insertions.

For immediate postpartum insertion, the provider should consider the following points:

- Counseling can be provided at any time between delivery and the insertion, just so it takes place before 48 hours postpartum.
- A postpartum IUD procedure room may be useful. This would allow the provider to perform several insertions, therefore increasing efficiency.

- IUD insertions can be done at a time convenient for the staff, thus addressing the potential lack of 24-hour availability of trained staff to perform postplacental insertion.
- Infection prevention practices may be more readily ensured.
- In several clinical studies, expulsion rates varied greatly among clinical sites. Such a variance has been attributed to lack of uniform training in insertion techniques across the sites. This underscores the importance of training to minimize expulsion rates.
- Among well-trained, experienced providers, expulsion rates range from 9% to 12.5% at six months.

Postplacental Insertion: Forceps vs. Manual Insertion

The few studies comparing manual insertion versus forceps insertion in terms of complication rates or expulsion rates have shown no major differences among the techniques. Nevertheless, other factors may affect which method is implemented.

Forceps insertion may be more appropriate than manual insertion for the following reasons:

- A forceps insertion is much less painful for the client (unless she is under regional anesthesia).
- A forceps insertion could be easier to perform in the event that the client has a well-contracted uterus and benefited from active management of the third stage of labor.
- With a forceps insertion, it is easier for the clinician to maintain appropriate infection prevention, because long sterile gloves (or regular-length gloves with a water-impermeable gown) are not required.
- During manual insertion, the IUD may be accidentally displaced into the lower uterine cavity or pulled out entirely as the hand is withdrawn. This problem is less likely with forceps insertion because forceps are smaller than a hand.

D. Steps before Insertion

There are a number of steps to take care of before the postpartum IUD insertion procedure, regardless of the timing of the insertion.

Steps Associated with the Delivery

Clients should be provided with appropriate delivery care, including provision of the active management of the third stage of labor (AMTSL), as is recommended by the World Health Organization (WHO). Implementing AMTSL is the first step for a safe postpartum IUD insertion.

AMTSL consists of three steps:

1. Provision of oxytocin 10 units intramuscularly within one minute of childbirth
2. Delivery of the placenta by controlled traction on the umbilical cord and counterpressure to the uterus
3. Massage of the uterus through the abdomen after delivery of the placenta

Every year, there are 14 million cases of postpartum hemorrhage (excessive bleeding that occurs after childbirth). Postpartum hemorrhage also causes significant long-term morbidity. Research has validated AMTSL as a best practice that reduces:

- The incidence of postpartum hemorrhage from uterine atony (i.e., the failure of the uterus to contract after delivery) by up to 60%
- The need for blood transfusion (with its related medical risks, hospital stay, and costs)
- Ultimately, the incidence of death and ill health from postpartum hemorrhage

AMTSL is:
- A safe, cost-effective, and sustainable intervention
- More humane and ethical than having to deal with the complications of postpartum hemorrhage, especially for women who already may be anemic or malnourished
- A practice that can save facilities money
- A way to increase the effectiveness and economic impact of maternal and child health programs
- A practice that has been adopted by many types of providers, after relatively short training sessions that include practical experience

Refer to Appendix E for more information on AMTSL.

If an episiotomy was performed or if the client presents with vaginal or cervical tears, these should be repaired after the IUD insertion (in the case of postplacental insertion). If there is heavy bleeding from a tear, a postplacental insertion should be postponed and the tear or laceration should be repaired. An immediate postpartum IUD insertion can later be performed.

Steps Associated with the IUD Insertion

The provider needs to ensure that appropriate client assessment was performed, that counseling took place, and that the client is suited for postpartum IUD insertion. If the insertion is to be performed postplacentally some of these need to be addressed before delivery; in the event of an immediate postpartum insertion, these steps should be done before the client is taken to the procedures room.

Attention:
1. Do not routinely perform a manual examination of the uterus before postpartum IUD insertion.
2. Do not provide special or additional anesthesia, beyond that which is given during delivery.
3. Do not use prophylactic antibiotics for postpartum IUD insertion, as they are not needed.

E. Equipment for Postpartum IUD Insertion

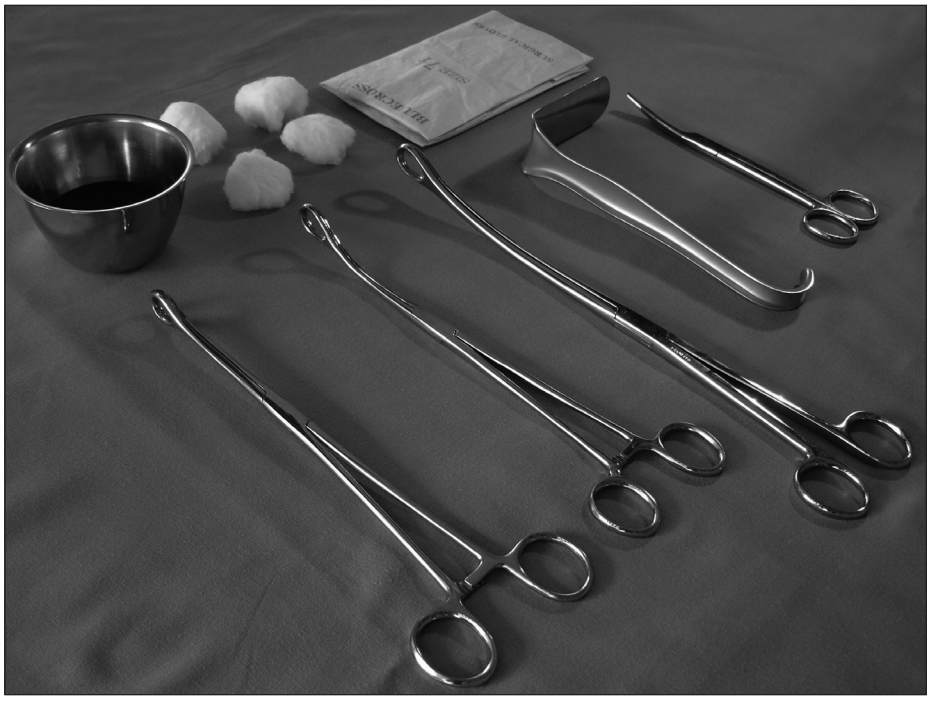
Following are lists of the equipment needed for various postpartum IUD insertion procedures. Sterile packs can be made using equipment from your facility's supplies, combined with special items such as the Kelly placental forceps.

It is also convenient to learn how to arrange your instruments on the tray; this will facilitate the insertion procedure and help you to maintain a sterile area. Instruments should be organized from

Forceps Insertion	Manual Insertion	Transcesarean Insertion
• Vaginal retractor (valve) or Sims speculum (for visualization of the cervix) • Sterile gloves • Ringed forceps to grasp the cervix (not the tenaculum used for interval insertion) • **Kelly placental forceps curved 12"** (if not available, you will need a second long-ringed forceps) • Gauze • Antiseptic solutions • Sterile drapes to cover the client	• Vaginal retractor or Sims speculum (for visualization of the cervix) • Sterile long-sleeved gloves ***or* standard sterile gloves combined with water-impermeable sterile gown** • Ringed forceps **to grasp the cervix** (not the tenaculum used for interval insertion) • Gauze • Antiseptic solutions • Sterile drapes to cover the client	• Sterile gloves • Ringed forceps • Gauze

left to right, such that on the far left is the instrument you will use first, to the right of it is the instrument you will use second, and so on (see Figure 7.1).

Figure 7.1: Appropriate Tray Arrangement of IUD Insertion Instruments



F. Insertion Techniques

Note: Postpartum IUD insertion techniques include a series of tasks and steps that should be performed correctly and in the proper sequence, including a series of preinsertion and postinsertion tasks and steps that are needed to guarantee client safety. The description below includes only the tasks and steps of the insertion technique. The learning guides included in Appendix A include all of the tasks and steps (i.e., preinsertion and postinsertion tasks and steps, as well as those to be performed during insertion).

Ringed Forceps Insertion Technique

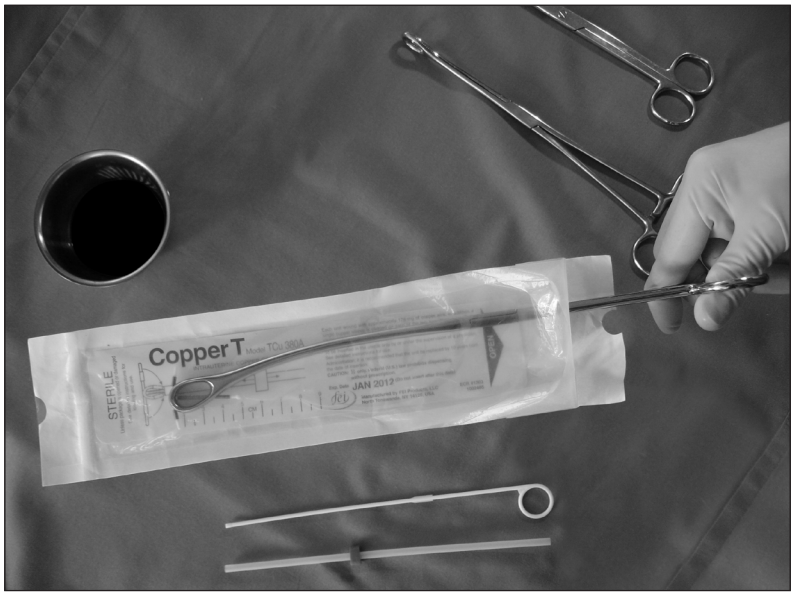
This procedure will **require an assistant,** to ensure asepsis and the smooth and safe insertion of the IUD. In the following description, the steps performed by the assistant are indicated using *italics*.

Regardless of the insertion timing (postplacental or immediate postpartum), the ringed forceps insertion technique is as follows (only relevant steps are presented below; see the corresponding learning guide for a complete list of task and steps):

- Palpate the uterus to evaluate the height of the fundus and its contraction, and massage the uterus, if necessary, to promote steady contraction. It is important to assess the size of the uterus: This will provide you with important information to anticipate if the strings are likely to protrude through the cervix after insertion.
- Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry).
- Wear a new pair of sterile gloves.
- Place a clean sterile drape over the client's lower abdomen and underneath her buttocks.
- Arrange all necessary instruments and supplies on top of an auxiliary table covered with a sterile drape.
- Ensure that the client's buttocks are at the very end of the table (with or without leg supports). This will allow you to lower the forceps sufficiently to then direct them adequately anteriorly.
- In the case of a postplacental insertion, insert a valve into the vagina and visualize the cervix, checking for lacerations. If lacerations and/or an episiotomy (if one was performed), are not actively bleeding, they can be repaired after IUD insertion.
- In the case of a postpartum insertion, very gently insert a valve into the vagina (holding it in place with your nondominant hand) and visualize the cervix.
  (*Note:* In any of these situations, moisten the valve with antiseptic solution. This helps the valve to advance more easily into the vagina and keeps the client more comfortable.)
- Using your dominant hand, clean the cervix and the vaginal walls with a liberal application of an antiseptic solution, and allow time for the antiseptic to work.
- Gently grasp the anterior lip of the cervix with ring forceps. (Do not use a toothed tenaculum, because it may tear the cervix.) Close the forceps one notch only.
- Once the cervix is visualized and grasped with the ring forceps, visualization should be maintained. It can be uncomfortable for the client for you to try to reachieve visualization.
- *At this moment, the assistant opens the IUD package so you can load the forceps. The package should be just half open, allowing you to use the Kelly forceps to enter the package and take hold of the IUD without taking it out of the package.*
- *The assistant places the half-open package on the sterile tray so you can reach it.*

- Grasp the IUD inside the package with the Kelly placental forceps or with a second pair of a long standard-ring forceps (see Figure 7.2).

Figure 7.2: Grasping the IUD inside the Package



- The IUD should be held by its vertical arm; the horizontal arm of the IUD should be slightly out of the ring, in the same direction of the rings, and slightly to the side. This will facilitate the release of the IUD at the fundus and will decrease the risk of your pulling it out while removing the forceps (see Figure 7.3).

Figure 7.3: Appropriate Holding of the IUD inside the Package

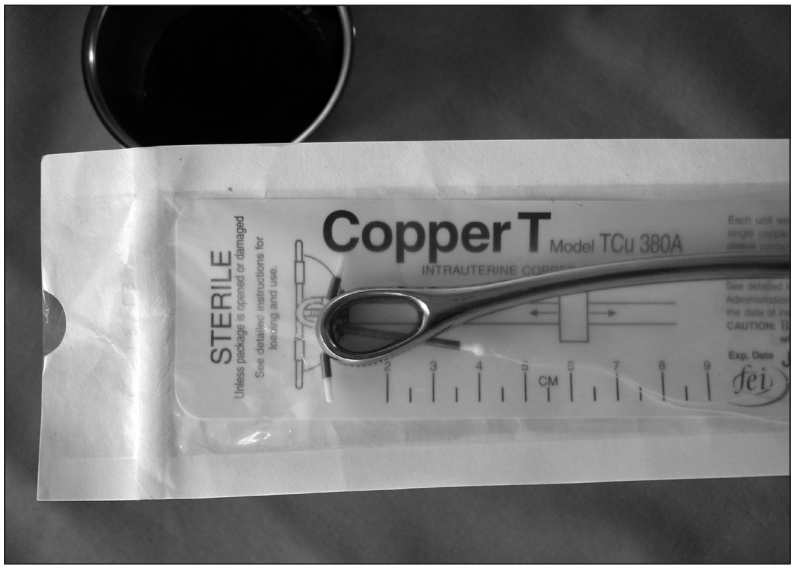
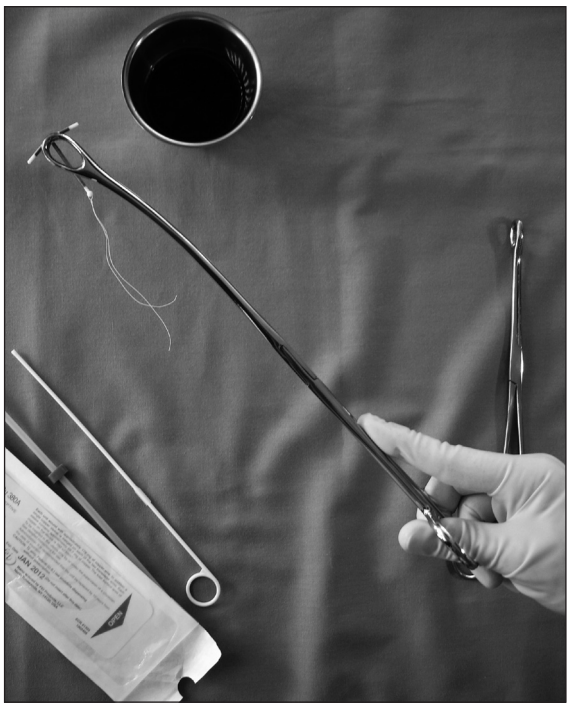


Figure 7.4: Appropriate Direction of IUD and Placement of the Strings



- Place the IUD toward the inner curve of the Kelly forceps (not the outer curve), with the strings away from the forceps. Then, as the forceps are withdrawn, it is easy to follow the curve of the uterus as the forceps are pulled laterally away from the IUD, and the strings will not be pulled (see Figure 7.4).
- *The assistant holds the valve while you hold the IUD-loaded forceps with your dominant hand and the cervix-holding forceps with the other hand.*
- Gently pull the cervix-holding forceps toward you, and visualize the cervix.
- Insert the IUD-loaded forceps through the vagina and cervix, perpendicular to the plane of the woman's back (Figure 7.5 and Figure 7.6, page 49). This will diminish client discomfort and minimize contact between the IUD and the vagina walls.
- *Once the IUD-loaded forceps has passed the cervix into the lower uterine cavity, the assistant removes the valve.*

Note: Perform insertion while seated. Standing seems to change the mechanics and tends to make you direct the IUD-holding forceps too much toward the back.

- Release the cervix-holding forceps and move your hand to the abdomen, placing it on top of the uterine fundus.
- With the abdominal hand, stabilize the uterus with firm downward pressure through the abdominal wall. This prevents the uterus from moving upward in the abdomen as the IUD-holding forceps is gently pushed up.

Figure 7.5: Position of the IUD as It Is Held to Enter the Vagina

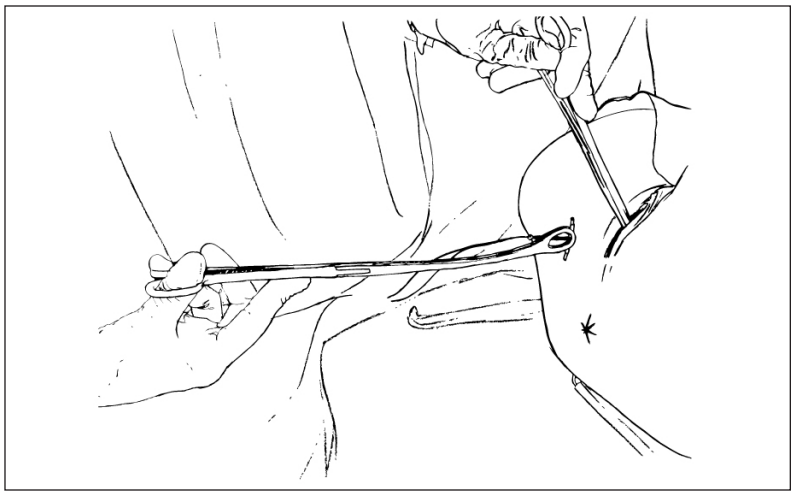
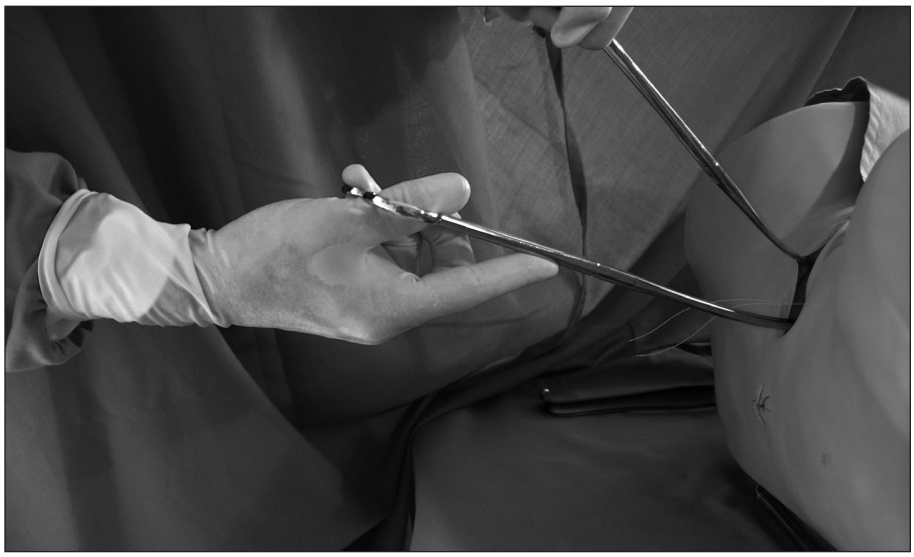
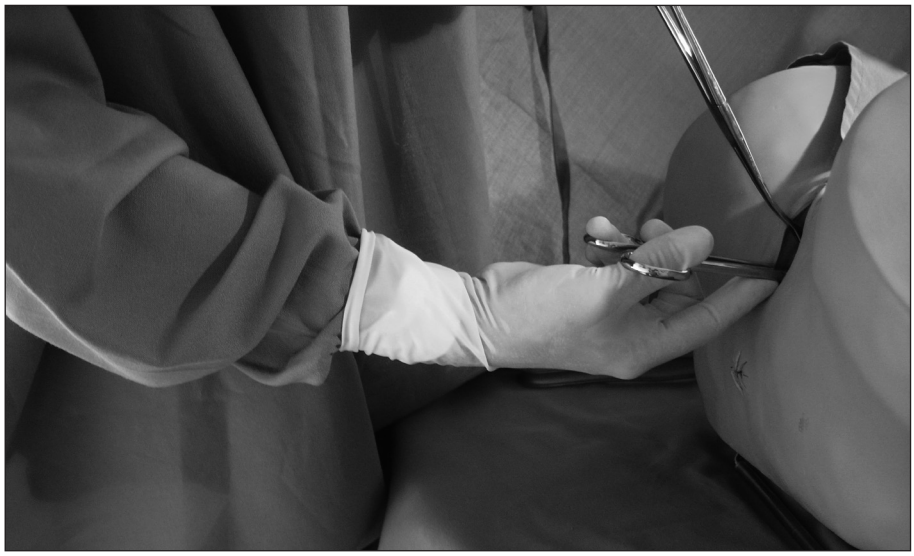


Figure 7.6: The Vaginal Valve Is Removed and the Forceps Holding the IUD Are Pushed into the Vagina



- Move the IUD-holding forceps in a gentle upward motion all the way toward the fundus (directed toward the umbilicus) while remaining seated. Remember that the lower uterine segment may be contracted, and therefore you may need to exert some slight pressure to advance the IUD and achieve fundal placement (see Figure 7.7).
- If you meet resistance, slightly withdraw the forceps and redirect the forceps more anteriorly toward the abdominal wall, moving your wrist slightly downward.
  Note: If the client has delivered vaginally after a previous cesarean delivery, take care to keep the ring forceps pressed against the posterior uterine wall, to avoid placing the IUD through any previous incision site.

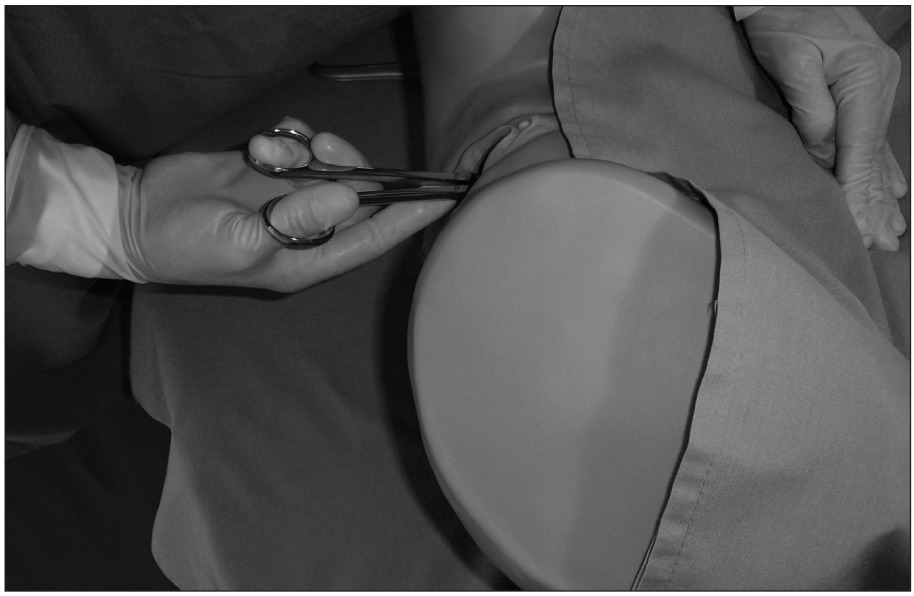
Figure 7.7: The Forceps and the IUD Reach the Uterine Fundus



- Stand and confirm with the abdominal hand that the tips of the forceps have reached the fundus (see Figure 7.8).
- At this point, turn the forceps 45 degrees to the right, to position the IUD horizontally in the highest area of the fundus (see Figure 7.9).
- Open the forceps to release the IUD.
- Slowly remove the forceps from the uterine cavity, keeping it slightly open and keeping it to the side, following the lateral uterus wall as you pull the forceps out in the opposite direction.

Figure 7.8: Placement of Hand on Abdomen to Confirm That Forceps Holding the IUD Have Reached the Uterine Fundus

Figure 7.9: The Forceps Holding the IUD Are Turned 45° to the Right



- Gently pull down the introitus with two fingers and visualize the interior of the vagina
  Note: Sometimes, when the uterus is well-contracted and small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event that the uterus is large, as per your assessment at the beginning of the procedure, if you see the strings, this may indicate that the IUD has not reach the fundus. In this situation, you should remove the IUD and attempt a new insertion, using a new sterile forceps and new sterile IUD (no-touch technique) for correct placement.
- Remove the cervix-holding forceps from the anterior lip of the cervix.
- Proceed with repair of any lacerations or an episiotomy, if needed.

Postplacental Insertion (Manual) Technique

This technique should *only* be used within 10 minutes following delivery of the placenta.

The primary *differences* in technique from that of instrumental insertion include the following:

- Use a long-sleeved sterile pair of gloves or standard gloves *with* a water-impermeable gown; for instrument insertion, standard gloves and gown are sufficient.
- Use your hand rather than ringed forceps to insert the IUD.
- Hold the IUD by gripping the vertical rod between the index and middle fingers of your dominant hand (see Figure 7.10).
- With the help of a vaginal valve, visualize the cervix, and hold it with ring forceps.

Figure 7.10: The IUD Held Appropriately, between the Index Finger and the Middle Finger

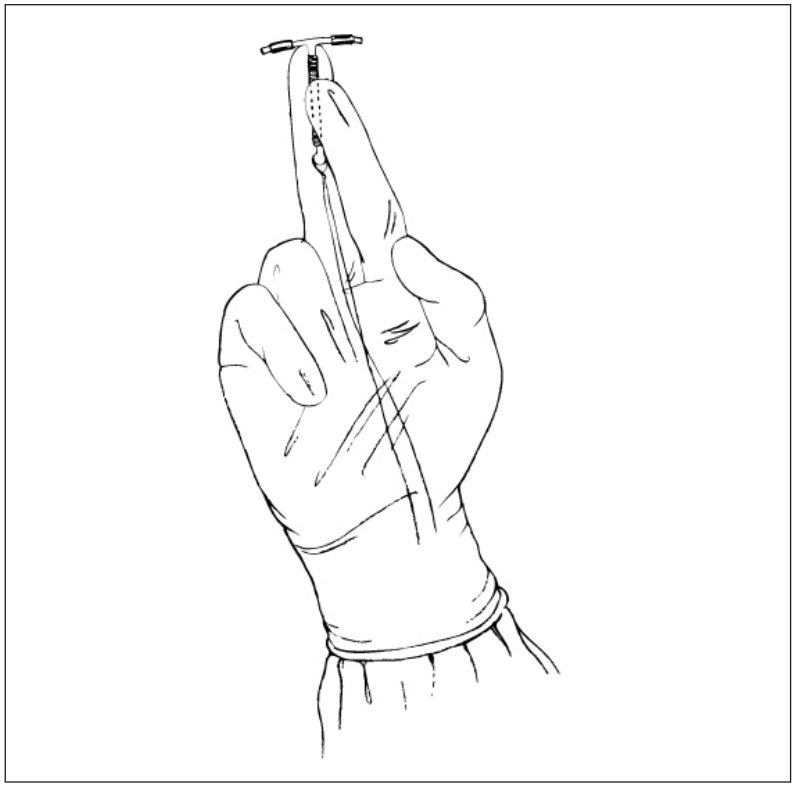


Figure 7.11: Position of the Hand to Enter the Vagina

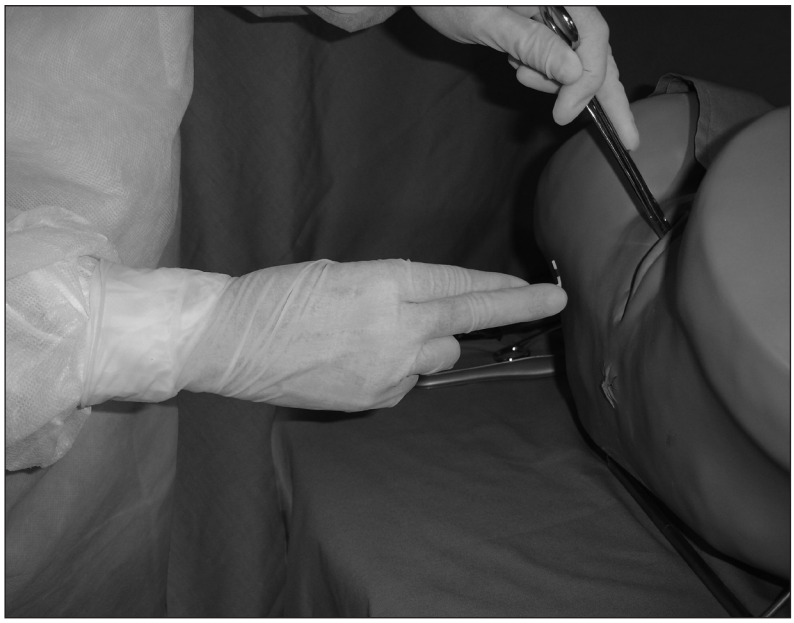
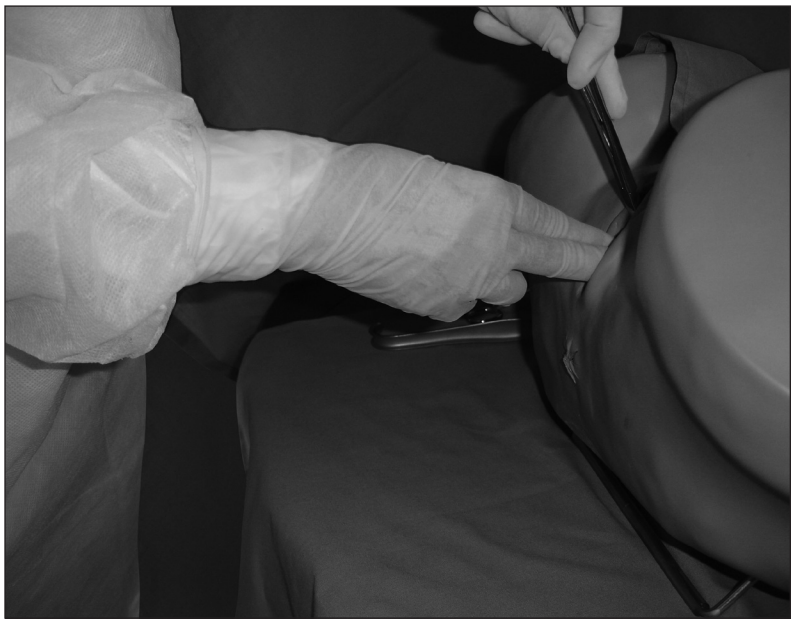
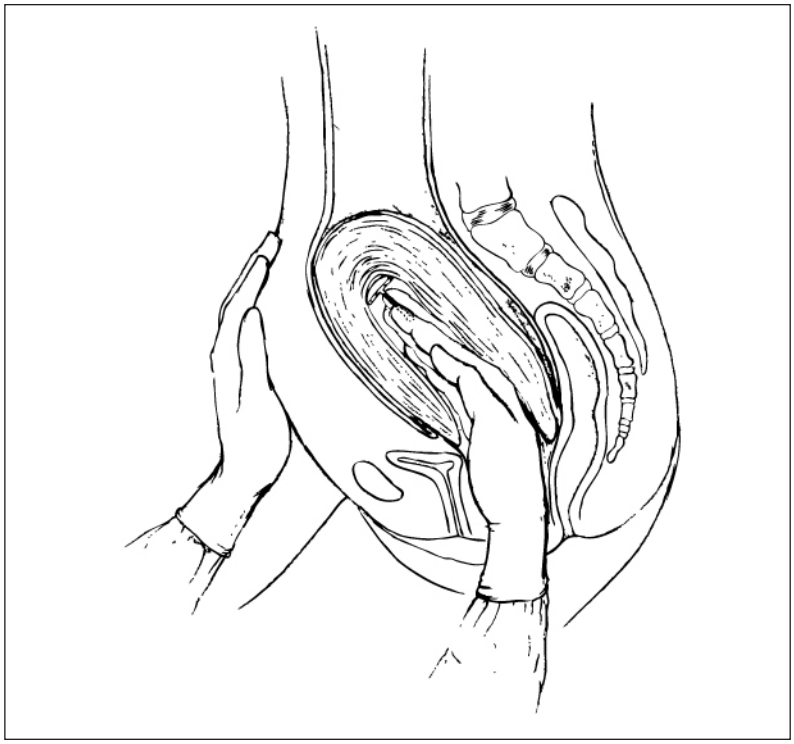


Figure 7.12: The Hand Holding the IUD Enters the Vagina



- Remove the valve and prepare to enter the vagina (Figure 7.11).
- Slowly, and perpendicular to the plane of the woman's back, insert your IUD-holding hand into the vagina and through the cervix into the uterus (see Figure 7.12), in the direction of the abdomen.
- Release the forceps that were holding the cervix and place your nondominant hand on the abdomen to firmly hold the uterus through the relaxed uterine wall. Stabilizing the uterus with downward pressure prevents it from moving up higher in the abdomen as you insert the IUD-holding

Figure 7.13: Placement of the IUD at the Uterine Fundus



hand; this also helps you know the direction in which you need to direct the IUD-holding hand and to confirm (by palpation with the external hand) that you have reached the fundus. Once you have reached the fundus, turn the IUD-holding hand 45 degrees to the right to position the IUD horizontally and place it in the fundus (see Figure 7.13).

- Remove your hand slowly, moving close to the lateral wall of the uterus.
- Take particular care not to dislodge the IUD as you remove your hand.

Transcesarean Insertion Technique

Following a cesarean delivery:

- Massage the uterus until the bleeding subsides; make sure that no tissue is left in the uterine cavity.
- Place the IUD at the uterine fundus manually or with a grasping instrument.
- Before suturing the uterine incision, place the strings in the lower uterine segment near the internal cervical os. Do not pass the strings through the cervix, because this increases the risk of infection.

G. Steps after All Insertions

- Following any IUD insertion, regardless of technique, these steps should be followed:
- Place all used instruments in a 0.5% chlorine solution for decontamination.
- Appropriately dispose of all waste materials.
- Remove your gloves after decontamination in a 0.5% chlorine solution and dispose of them.
- Wash your hands with soap and water and dry them with a clean, dry cloth.
- Complete an IUD card for the client and write all necessary information in the client record.

H. Hints

To visualize the cervix and the vagina (to check for tears and lacerations and for appropriate preparation), you must use a vaginal valve or retractor; additionally, as explained, you must use a ring forceps to hold the anterior lip of the cervix. The use of a vaginal retractor will accomplish both of these steps with minimal discomfort for the client (whose genitals will be painful).

Kelly placental forceps are recommended over standard ring forceps for instrumental insertion of the IUD because Kelly placental forceps are longer (12 inches), thus making it easier to reach the fundus.

The most important point is that, regardless of the insertion technique, the IUD must be placed **high** in the fundus.

Matching Exercise

Column A	Column B
1. _____ Interval	a. IUD is placed in the uterus through the uterine incision following delivery of the placenta.
2. _____ Postabortion – first trimester	b. An IUD is inserted into the uterine cavity using a Kelly or ring forceps within 10 minutes of placental delivery.
3. _____ Postabortion – second trimester	c. An IUD is inserted into the uterine cavity using a Kelly or ring forceps within the first 48 hours of delivery.
4. _____ Postplacental	d. An IUD is inserted into the uterine cavity anytime the woman is not pregnant, from four weeks postpartum onward, using a tenaculum, a sound, and an IUD inserter, with the "withdrawal" technique.
5. _____ Transcesarean	e. An IUD is inserted into the uterine cavity immediately following evacuation of the uterus in the absence of sepsis, using the interval insertion technique.
6. _____ Immediate postpartum	f. An IUD is inserted into the uterine cavity following uterine evacuation, using a Kelly or ring forceps.
7. _____ Insertion technique that increases risk of uterine perforation	g. An IUD is inserted into the uterine cavity after placental delivery, using an IUD inserter with the withdrawal technique.

Module 8
Supervised Clinical Practice

A. Introduction

This module provides the information on the clinical and counseling skills practice necessary for you to perform postpartum IUD insertion correctly, safely, and effectively, as well as an opportunity for you to practice these skills on a pelvic model and on clients. Your performance will be assessed using the skills checklists for trainers and through an individual practicum meeting with the trainer.

Objectives

By the end of this module, you will be able to:

- Demonstrate correct client assessment procedures for postpartum IUD insertion
- Demonstrate appropriate client-provider interaction during the clinical procedure
- Demonstrate the use of correct infection prevention techniques before, during, and after postpartum IUD insertion
- Competently perform all of the tasks and steps in at least three postpartum IUD insertions, as described in the Postpartum IUD Clinical Skills Learning Guides (Appendix A)
- In each postpartum IUD procedure performed, demonstrate the provision of postinsertion instructions to the client, as described in the Postpartum IUD Clinical Skills Checklists (Appendix A) and the Sample Written Postinsertion Instructions for Clients (Appendix B)

Note: Based on field experience, EngenderHealth has learned that even experienced clinicians have difficulty teaching themselves postpartum IUD insertion techniques. Do not attempt to perform postpartum IUD insertion until you have received supervised clinical training.

B. Guidelines for Clinical Observation and Practice

The most important concerns during clinical observation and practice are to ensure the client's *comfort* and to provide a *safe*, *effective* procedure. Therefore:

- If you are observing a postpartum IUD insertion, do not interfere with the work of the provider performing the insertion.
- If you are observing a postpartum IUD insertion, hold your questions and comments until after the procedure is completed.
- If you notice a problem or a break in sterile technique that was unobserved by the trainer, you are responsible for reporting the situation to the trainer immediately in a way that does not alarm the client.
- If a complication arises during any procedure, the trainer is responsible for managing the situation and will complete the procedure.

The following may help you with clinical practice:

- Be patient with yourself. You are learning a new technique, and it will take repetitive performance on the model and on clients before you become comfortable with the technique. If you have difficulty inserting an IUD postpartum, the trainer may ask you to stop and he or she may

take over the procedure. You may then assist or observe. If this happens, understand that this is a normal part of learning a new technique.
- The trainer is present to provide you with support and guidance. Ask questions and ask for assistance, if needed.
- After the procedure, review the case with the trainer and with the other training participants.

To maximize your practice experience, the trainers will separate the participants into small groups. Each group will observe and practice the different elements of care: client assessment; client-provider interaction; and the procedure itself. Some of these activities may not take place in the same ward; however, one trainer will be with you all of the time, to guide the practice.

C. Client Assessment, Client-Provider Interaction, and Infection Prevention Highlights

Client Assessment

- Review the client's medical history (or interview the client) to verify that the client is suited for a postpartum IUD insertion.
- For an immediate postpartum insertion, review the delivery record to verify that the client is suited for a postpartum IUD insertion.

Client-Provider Interaction

Before the procedure:
- Determine that the client has been counseled.
- Confirm that the client has chosen the IUD.
- Ask the client if she has any questions, and answer questions accordingly.
- Describe the insertion procedure and tell the client what to expect.
- Warn the client that she may experience some discomfort.

During the procedure, you can do several things to minimize the client's tension and maximize her comfort:
- Talk to the client. Be attentive to her needs.
- Inform the client about each step of the procedure before it happens.
- Support the client if she is feeling discomfort.
- Before, during, and after the procedure, be aware of the client's need for privacy.

Infection Prevention

Before the procedure:
- Wash your hands thoroughly between clients, before putting on your gloves.

During the procedure:
- Clean the procedure area and apply antiseptic solutions.
- Use only instruments, gloves, and drapes that have been sterilized.
- Maintain asepsis.

After the procedure:
- While still wearing your gloves, dispose of contaminated wastes.

- Ensure that all instruments, reusable items, and contaminated surfaces are submerged in a chlorine decontamination solution.
- Wash your hands after removing your gloves.

D. Overview of the Postpartum IUD Technique

You will have the opportunity to observe procedures performed by the trainer and other participants in the training course. In addition to insertion techniques, you will probably also observe and practice preprocedure tasks (such as client assessment, and counseling) and postprocedure tasks (such as giving instructions to the client). The goal is for you to have a comprehensive understanding of all of the steps involved in delivering postpartum IUD services.

The first step in understanding the procedure is to pay close attention to each step of the postpartum IUD technique described by the trainer during the demonstration. You need to follow along with the Postpartum IUD Clinical Skills Checklist (Appendix A) as you observe. In addition to watching for the steps of insertion, observe how the provider interacts with the client and what the provider does in terms of infection prevention practices.

E. Demonstration and Pelvic Model Practice

Practice on a pelvic model facilitates the process of acquiring postpartum IUD insertion skills. By the time you perform your first postpartum IUD insertion on a client, you will already be:

- Knowledgeable about all of the steps of the insertion techniques and their sequence
- Confident in your basic skills

During the demonstration, the trainer will go over all the steps needed to prepare a client for a postpartum IUD insertion, the steps needed to perform the procedure, and the steps to be followed after the procedure.

After the demonstration, you will practice the postpartum IUD technique on the pelvic model. Your trainer will form groups for model practice. One person will be the provider, another will play the role of a client, and others can observe. Among the observers, one person can read off the steps in the learning guide while the "provider" performs the steps on the model. You will then change roles until all are comfortable with the steps of postpartum IUD insertion on the model. When you are ready, the trainer will evaluate your postpartum IUD insertion skills on the model before you move on to supervised clinical practice. Everyone will continue to practice until all have mastered the IUD insertion procedure.

F. Supervised Clinical Practice

After your skills have been evaluated as satisfactory on the pelvic model and after you have observed at least one postpartum IUD insertion, you will perform a postpartum IUD insertion procedure under the trainer's supervision.

You should not perform postpartum IUD insertion until the trainer has evaluated your skills on the pelvic model as satisfactory, using the Postpartum IUD Clinical Skills Checklist for Trainers (see Appendix A).

In the event that the caseload during training hours is not adequate, it is possible that, to increase the likelihood of performing postpartum IUD insertions on clients, you will need to be on-call to the maternity ward to attend clients who want an IUD inserted postpartum.

G. Evaluation of Clinical Skills

Evaluation is ongoing throughout the clinical practice. Following each insertion that you do, you will complete the appropriate Postpartum IUD Learning Guide (Appendix A). This will help you to identify your progress and the steps where you need assistance.

The trainer will also complete the appropriate Postpartum IUD Clinical Skills Checklist for Trainers, as he or she observes each of your IUD insertions. The trainer also will hold an individual meeting with you, to provide you with feedback.

Module 9
Postinsertion Care

A. Introduction

This module covers immediate postinsertion care, routine follow-up care, and management of unscheduled visits. If you have experience in providing routine IUD follow-up care, you will find it useful in studying postpartum IUD follow-up.

Objectives

By the end of this module, you will be able to:

- List the key components of immediate postinsertion care
- Explain key messages that should be covered with clients following postpartum IUD insertion, to ensure successful and safe use of the method
- State the timing for the first follow-up visit for a woman receiving an IUD postpartum
- Explain the early warning signs that IUD clients should look for as indicators that they should return for medical management
- List the key components of the first routine postpartum IUD follow-up visit and subsequent visits

B. Immediate Postinsertion Care

After the insertion procedure, the client can return to her bed to rest for few hours. All postpartum women will experience a postpartum vaginal discharge containing a mixture of blood, mucus, and placental tissue (known as lochia) and uterine contractions or afterbirth pains. The health care provider needs to advise all postpartum clients to pay attention if there is any increase in her bleeding or in her postpartum discomfort. In the presence of any of these, the provider should check the uterus and massage it as recommended after AMTSL. If discomfort continues, it is advisable to do a pelvic exam to assess if the IUD has been partially expelled or if the discomfort is caused by other issues.

Before discharge, the health provider should check that expulsion has not occurred and that the client is comfortable.

Standard postpartum instructions concerning rest, nutrition, and hygiene should be given at this time. Additionally, review the postpartum warning signs:

- Bright red bleeding for which the client needs to change her pad more than six times a day
- Unusual abdominal or pelvic pain (not after-birth pain)
- Unusual vaginal discharge or pain, or fever

If the woman is breastfeeding, her menses will be delayed, and most women will experience lochia from 2-6 weeks after delivery. The client should be advised to wait until her vaginal discharge is no longer bloody and she feels ready before she engages in sexual relations.

Additionally, the following are warning signs related to postpartum IUD insertion:
- The amount of bleeding has increased.
- She feels cramps and feels the hard plastic of the IUD.
- The IUD has come out.

The client should be advised about the possibilities of expulsion during the first few days and weeks after insertion. If she notices an expulsion, she should come back to the health facility for management.

C. First Routine and Subsequent Postpartum Follow-Up Visits

1. The first routine postpartum IUD follow-up visit should occur at the same time as the routine 3–6-week postpartum checkup. In addition to the usual elements of the postpartum checkup, you should do the following:
   - Ask the client if she has any questions or has experienced any of the warning signs, and respond appropriately.
   - Perform a speculum examination to inspect the cervix.
   - Check if the strings are already visible.
   - If necessary, shorten the string length to approximately (but no less than) 4 cm from the cervical canal. (Shortening the strings more than this can result in the strings drawing up into the uterus, making eventual removal more difficult. Also, if the strings are quite short, they may be more noticeable to the partner during sexual intercourse.)
   - If no strings are present and if the client has not noticed an expulsion, follow the protocol for missing strings (see "Missing Strings," Module 10, pages 69–70).
   - Perform a bimanual examination and assess the client for any signs of infection.
   - Advise the client to return at any time, especially if she is concerned about possible IUD-related problems or if she wants to change the method.
   - If the IUD has been expelled, offer the client another contraceptive method or insert another IUD (after four weeks postpartum), if she wishes.

2. The following information should have been provided to the client orally and in writing at the time of IUD insertion. You should review this information with the client during her first follow-up visit:
   - The type of IUD inserted
   - How long the IUD will be effective
   - The potential need of protection against STIs (including HIV) and the benefits of condom use
   - Possible side effects
   - What to do in the event of expulsion or problems
   - The warning signs of possible complications (see Module 10, pages 63–64)
   - Where to seek help if a problem occurs
   - The possibility of IUD removal if the client changes her mind about the method
   - When and where to return for check-ups

3. Clients should be advised to return at any time to discuss side effects or other problems. A subsequent postpartum follow-up visit is the same as any other interval or postabortion IUD insertion follow-up; at this time, findings and management are no different than for any other IUD-related

visit. An annual visit is not required for women with an IUD, although such visits could be good general practice.

At the follow-up visit, be sure to:

- Ask the client if she has any questions or has experienced any warning signs or problems, and respond appropriately.
- Conduct a speculum and bimanual examination.
- Confirm the presence of the strings.
- Review with the client the warning signs of possible IUD-related problems that require immediate medical attention (see below).
- Look for signs of any reproductive tract infection, and treat or refer the client if one is present.
- Find out if she has noticed an expulsion.
- Ask to assess if her family planning needs have changed.
- Make an appointment for a subsequent visit, as necessary.
- Remind the client when the IUD needs to be removed.

Module 10
Prevention and Management of Side Effects and Complications

A. Introduction

It is important to note that what is different about the postpartum IUD is the timing and the technique of the insertion. Once the IUD is in place, the possible side effects and complications that may develop are related to the IUD, not to the postpartum timing of the insertion. Therefore, any side effects and complications that may arise should be managed as they are for an interval IUD.

Objectives

By the end of this module, you will be able to:

- Distinguish between *side effects* and *complications*
- List common side effects and possible complications of postpartum IUD use
- State how to prevent insertion-related complications
- Describe the clinical management of the most common side effects
- Describe the management of a client presenting with warning signs of potential IUD-related complications

B. Side Effects and Complications

Definitions

The following are technical definitions that are not intended to be used with clients.

Side effect: A consequence or outcome of a procedure, contraceptive method, or medication other than what was intended. A side effect does not require exceptional intervention, but it may require attention and management. (Spotting is an example of a side effect of IUD use.)

Complication: An unexpected condition or outcome that requires intervention or management beyond what was planned or what is normally provided. (Endometritis is an example of a postpartum IUD complication.)

One of the advantages of postpartum IUD adoption (as is mentioned in Module 2) is that some of the postinsertion side effects associated with IUD insertion are masked by normal postpartum events (e.g., postpartum bleeding and postpartum cramps).

There are few side effects or complications that are specifically related to postpartum IUD insertion. The side effects and complications that could arise after the insertion are similar to those associated with interval IUD insertion. For further details, see: McIntosh, N., Kinzie, B., and Blouse, A. 2006. *IUD guidelines for family planning service programs: A problem solving reference manual. 3rd edition*. Baltimore: JHPIEGO.

Problems related to the postpartum IUD include the following:
- During insertion:
  - ❏ Side effects can include severe pain.
  - ❏ Complications can include uterine perforation and cervical laceration.
- Postinsertion:
  - ❏ Most postpartum clients experience cramping and bleeding, regardless of the presence or absence of an IUD. Therefore, it is important to assess if there is an increase in these symptoms.
  - ❏ Complications can include heavy bleeding that does not diminish over time, constant and increasing cramping that requires medications, fever, abdominal pain, observed IUD expulsion, and vaginal discharge with foul smell.

Clients are less likely to discontinue IUD use if they expect and understand the possible side effects and know how to manage them.

In some instances, problems may arise during insertion. These are neither side effects nor complications, by definition, but the provider should be aware of them and manage them appropriately:
- The IUD is drawn back while the provider is removing his or her hand (during a manual postplacental insertion) or while the provider is removing the forceps (after a ringed forceps insertion). A *new IUD* should be inserted.
- The IUD strings seem a lot longer that they should be, based on the initial assessment of uterine size. In this case, remove the IUD and insert a *new IUD*.

Preventing Complications Related to Postpartum IUD Insertion

Many complications related to postpartum IUD insertion can be prevented, by taking the following steps:
- Carefully screen clients
- Strictly adhere to correct infection prevention techniques
- Follow appropriate insertion techniques
- Perform postpartum IUD insertion procedures slowly and gently, to ensure technical accuracy and the client's comfort and safety

C. Management of Side Effects and Complications

The following are specific steps to follow to minimize or avoid some of the side effects and complications discussed above:
- *Pain during insertion*. Perform the process slowly and gently. *Remember* that the client just had a delivery. Follow the insertion technique carefully. Explain to the client what you will do before you do it. Provide analgesics after the insertion. The client may find IUD insertion using ringed forceps less uncomfortable than manual insertion.
- *Cervical laceration*. If there is a need to use a forceps to hold the cervix, do not use a tenaculum or toothed forceps; use ringed forceps. Apply only very mild traction to the cervix. If there is a laceration, repair it, as needed.
- *Perforation*. Although perforation of the uterus is very rare, when it occurs, it almost always occurs at the time of insertion. The basic steps for managing a uterine perforation are the same, whether the insertion is interval or postpartum.

If a perforation is recognized or suspected at the time of inserting the IUD:

1. Stop the insertion immediately. If the IUD already has been placed, remove it, if possible, by pulling on the string.
2. Keep the client at rest and observe her for signs of intraabdominal bleeding, such as falling blood pressure, rising pulse, and severe abdominal pain, tenderness, guarding, or rigidity. In addition, start an IV and monitoring her for bleeding with a complete blood count (CBC) and hematocrit.
3. Check the client's vital signs by monitoring her pulse, respiration, and blood pressure every 15 minutes during the first 90 minutes following the perforation. If the vital signs, inclusive of temperature, are stable, continue monitoring every hour for the next four hours, and then every four hours for 24 hours.
4. If there is a change in vital signs or if the client exhibits spontaneous pain or peritoneal signs, continue monitoring and evaluate the client for surgery.
5. Even if the vital signs are stable, the client should stay hospitalized and should be monitored at least for 24 hours.
6. Prophylactic antibiotics should be prescribed.

Case Study Situations

The following case studies can help you think through the sorts of situations that you may face, and they will be used for a group exercise to discuss with others how particular sets of circumstances may best be managed.

Case 1: Mercy comes for her first postpartum IUD follow-up visit six weeks after delivery. She reports not having any problems with the IUD; she denies having any cramping, pain, spotting, or bleeding. Mercy's menses have not returned, and she is exclusively breastfeeding. On examination, you do not see the IUD strings. How will you manage this case?

Case 2: Three months postpartum, Evelyn returns for her first postpartum IUD follow-up visit. (Evelyn was not able to return for the first scheduled follow-up visit at six weeks postpartum.) Evelyn presents complaining of lower abdominal pain during intercourse. A physical examination, including a speculum exam, does not reveal any other signs. Strings are visible through the cervix with an appropriate length. How will you manage this case?

Case 3: Agnes had an IUD inserted before discharge from the facility where she delivered a stillborn. Agnes comes to the facility today, three months postpartum, complaining of heavy bleeding for seven days with her first postpartum period and of heavy but slightly shorter bleeding in her most recent period. She has not had spotting between the two periods and has had no cramping or pain. How will you manage this case?

D. Management of a Client Presenting with IUD Warning Signs

Warning signs include: cramping; irregular bleeding (heavy, spotting); pain; unusual vaginal discharge; fever; and missing strings. Bleeding and cramping side effects may not be evident during postpartum IUD use, since these are characteristic of involution. However, side effects of any kind over time should be assessed and managed according to international recommendations and practices.

- Cramping that is constant or increasing cramping that requires medications is considered a warning sign and requires a medical exam to discard a partial expulsion. Within the first week or so, it may be difficult for a client to differentiate between normal afterbirth cramping and cramping due to IUD expulsion. Heavy bleeding that does not diminish over time could also be a sign of a partial expulsion.
- Fever, lower abdominal pain, and vaginal discharge with foul smell are all signs of infection. If infection occurs within the first four weeks following insertion, it is probably due to the introduction of endogenous vaginal bacteria into the uterus. To avoid infection, it is critical that postpartum IUD insertion be performed using careful infection prevention techniques.
- Pelvic inflammatory disease (PID) may also develop following postpartum IUD insertion when a preexisting sexually transmitted infection in the cervix is introduced into the uterus.

Management of IUD-Related Side Effects and Complications

Complaint/ Condition	Management	Comments
Spotting/bleeding during first three months	Rule out uterine pregnancy or ectopic pregnancy; infection; and IUD expulsion. If the client desires treatment, a short course of nonsteroidal antiinflammatory drugs (NSAIDs) (e.g., ibuprofen) may be given *during the days of bleeding*. ☞ Offer an NSAID such as Ibuprofen 200–400 mg three times daily for three days ☞ Remind the client that menstrual changes will resolve after the first few months. If the woman presents with persistent spotting and bleeding, exclude gynecologic problems, as indicated by history and physical assessment. If a gynecologic problem is identified, treat the condition or refer for care. If no gynecologic problems are found, and she finds the bleeding unacceptable, remove the IUD and help her choose another method.	Spotting or light bleeding is common during the first 3–6 months of use of a copper-bearing IUD. It is not harmful and usually decreases over time. *Note 1:* Changes in menstrual bleeding patterns—increased in amount, duration, and cramping—are the most common side effect for copper IUDs. These symptoms usually resolve spontaneously. Up to 50% of women using IUDs will discontinue use within five years; the most common reasons for discontinuation are unacceptable bleeding and pain. *Note 2:* If increased flow or duration of bleeding occurs, the quantity of blood lost **rarely** is enough to cause anemia.
Heavy bleeding	Exclude gynecologic problems, as indicated by history and physical assessment. If a gynecologic problem is identified, treat the condition or refer the client for care.	Heavier and longer menstrual bleeding is common during the first 3–6 months of use of a copper-bearing IUD. Usually, this is not harmful, and bleeding usually becomes lighter over time.

continued

Management of IUD-Related Side Effects and Complications (*continued*)

Complaint/ Condition	Management	Comments
Heavy bleeding (*continued*)	The following treatment may be offered during the days of menstrual bleeding: ☞ NSAIDs ☞ Tranexamic acid (a hemostatic agent) *Aspirin should NOT be used.* If the bleeding continues to be very heavy or prolonged, especially if there are clinical signs of anemia, or if the woman finds the bleeding to be unacceptable, remove the IUD and help her choose another method. To prevent anemia, provide an iron supplement and/or encourage her to consume foods containing iron.	**However,** if bleeding lasts twice as long or is twice as heavy as usual, it is a warning sign indicating a need to return to the facility for immediate care. It is not known what the mechanisms underlying IUD-associated bleeding abnormalities are.
Cramping	Rule out: pregnancy; ectopic pregnancy; infection; and IUD expulsion. If none of the above, ☞ Offer NSAID such as Ibuprofen 200–400 mg every 4–6 hours immediately before and during menses to help relieve the discomfort. ☞ Remind the client that menstrual changes will resolve themselves after the first few months.	*Note:* If cramping is stronger than usual, it might be due to impending expulsion. Expulsion of an IUD occurs in approximately one in 20 women, is most common in the first three months after insertion, and often occurs during menstruation. Other symptoms associated with expulsion include irregular bleeding, pain with intercourse, unusual vaginal discharge, postcoital bleeding, and delayed menses.

continued

Management of IUD-Related Side Effects and Complications (*continued*)

Complaint/ Condition	Management	Comments
Missing strings/threads	**At first postinsertion visit:** The strings may not have descended yet. If the client is otherwise well, has experienced no cramping or bleeding, and has not felt the IUD or observed it to have been expelled, then: ☞ *If the client is breastfeeding:* Provide her with an appointment in four weeks; if at that time the strings have not come out, see point 2, below. ☞ *If the client is not breastfeeding:* Provide her with an alternative contraceptive method (like oral contraceptives or condoms). ☞ Ask the client to return in four weeks; if at that time the strings have not come out, see point 2, below. **At any other visit:** 1. Rule out pregnancy. 2. Try to locate string; probe the cervical canal using narrow forceps (e.g., alligator or Bozeman) and gently draw the string out, if it is located. 3. If the strings are located but cannot be retrieved and the clients wants the IUD removed, remove the IUD with alligator forceps or any other retrieval instrument. 4. If the strings are located but cannot be retrieved and the client wants to keep the IUD, reinforce information about what to do in the event of an expulsion. 5. If the strings cannot be located, use a uterine sound to check whether the IUD is in place.	*Note:* Missing strings may be due to expulsion, to uterine perforation, or to ascent for no known reason.

continued

Management of IUD-Related Side Effects and Complications (*continued*)

Complaint/ Condition	Management	Comments
Missing strings/threads (*continued*)	6. If the strings cannot be located after checking with a sound, perform an ultrasound or X-ray to determine whether the IUD has been expelled. *Provide back-up contraception if the procedure cannot be done immediately.* **If the IUD has been expelled:** 1. Offer emergency contraception, if appropriate 2. Discuss method options, including another IUD	
Pregnancy	☞ Rule out ectopic pregnancy. ☞ Explain to the client that she is at an increased risk of first- and second-trimester miscarriage (including potentially life-threatening septic miscarriage) and of preterm delivery if the IUD is left in place. The removal of the copper-bearing IUD reduces these risks, although the procedure itself entails a small risk of miscarriage. ☞ If the client does not want to continue the pregnancy, counsel her accordingly. ☞ If the client wishes to continue the pregnancy, reinforce to her the increased risks of first- and second-trimester miscarriage and of preterm delivery if the copper-bearing IUD is left in place. Advise the client to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. ☞ Proceed with the IUD removal **If the IUD strings are visible or can be retrieved safely from the cervical canal, then:** ☞ Advise the client that it is best to remove the IUD.	*Note:* The overall risk of ectopic pregnancy while using the IUD is very low (1 in 1,000 over 5 years).

continued

Management of IUD-Related Side Effects and Complications (*continued*)

Complaint/ Condition	Management	Comments
Pregnancy (*continued*)	☞ If the IUD is to be removed, remove it by pulling on the strings gently. ☞ Explain to the client that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. ☞ If she chooses to keep the IUD, advise the client to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. **If the IUD strings are not visible and cannot be safely retrieved from the cervical canal, then:** ☞ Where available, perform ultrasound to locate the device. If no IUD is found, the device has been expelled. ☞ If ultrasound is not possible or if the IUD has been found to be inside the uterus on ultrasound, review the risks with the client and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever. Monitor closely.	
PID • Symptoms mild or vague • Purulent vaginal discharge, abdominal or pelvic pain, pain with sexual intercourse, and fever.	Treat using appropriate antibiotics. ☞ If the client does not want to keep the IUD, remove it after antibiotic treatment has been started. ☞ If the IUD is removed, offer the client emergency contraceptive pills, if appropriate, and/or counsel her for other contraceptive options.	There is no need to remove the IUD if the client wishes to continue to use it. *Note:* Removing the IUD provides no additional benefit once PID is being treated with appropriate antibiotics.

continued

Management of IUD-Related Side Effects and Complications (*continued*)

Complaint/ Condition	Management	Comments
PID (*continued*) Treat in the presence of uterine, adnexal, or cervical motion tenderness. Other diagnostic criteria include: • Oral temperature >38.3C • Abnormal cervical or vaginal discharge • Presence of white blood count or wet mount • Elevated erythrocyte sedimentation rate • Lab documentation of gonorrheal or chlamydial infection (if available)	☞ If the infection does not improve (within 72 hours), remove the IUD and continue antibiotics. If the IUD is not removed, antibiotics should also be continued. In both circumstances, monitor the client's health closely. ☞ Provide comprehensive management for sexually transmitted infections, including counseling about condom use (dual method use).	

References

ACCESS-FP. 2006. Postpartum contraception: Family planning methods and birth spacing after childbirth. PowerPoint presentation. MAQ Mini-U Meeting, Washington, DC. Nov. 14, 2006. Accessed at: www.accesstohealth.org/toolres/pdfs/ACCESSFP_ppcontraceptionPPT.pdf.

The ACQUIRE Project. 2006. *Fundamentals of care resource package*. New York: EngenderHealth.

The ACQUIRE Project. 2008. *Counseling for effective use of family planning*. New York: The ACQUIRE Project/EngenderHealth.

The Capacity Project. 2006. *IUD guidelines for family planning service programs: A problem solving reference manual*. Baltimore: JHPIEGO.

EngenderHealth. 2000. *Infection prevention multimedia package: Training CD-ROM and reference booklet*. New York.

EngenderHealth. 2003. *Infection prevention practices in emergency obstetric care*. New York.

Landry, E., et al. 1992. *Postpartum contraception: Perspectives from clients and service providers in six countries*. *Final report (GLO-06-EV)*. New York: Association for Voluntary Surgical Contraception.

Rivera, R., Kennedy, K., and Balogh, S. 1994. *Postpartum contraception*. Research Triangle Park, NC: Family Health International (FHI).

Salem, R. M. 2006. New attention to the IUD: Expanding women's contraceptive options to meet their needs. *Population Reports*, series B, no. 7. Baltimore: Johns Hopkins Bloomberg School of Public Health,The INFO Project.

Shelton, J. 2001. Risk of clinical pelvic inflammatory disease attributable to an intrauterine device. *Lancet* 357(9254):443.

World Health Organization (WHO). 2004. *Medical eligibility criteria for contraceptive use, 3rd Edition*. Geneva.

WHO. 2004. *Selected practice recommendations for contraceptive use, 2nd edition*. Geneva.

WHO. 2006. *Report of a WHO technical consultation on birth spacing, Geneva, Switzerland, 13–15 June 2005*. Geneva.

Appendix A

Postpartum IUD Assessment Tools

This appendix contains the following assessment tools:

- Postpartum IUD Knowledge Assessment Test
- Postpartum IUD Clinical Skills Learning Guides for Copper-T 380A
  - For postplacental forceps insertion
  - For immediate postpartum forceps insertion
  - For manual insertion
  - For transcesarean insertion
- Postpartum IUD Clinical Skills Checklists for Trainers
  - For postplacental forceps insertion
  - For immediate postpartum forceps insertion
  - For manual insertion
  - For transcesarean insertion
- Postpartum IUD Counseling Skills Learning Guide
- Postpartum IUD Counseling Skills Checklist for Trainers

Postpartum IUD Knowledge Assessment Test

Decide whether each of the following statements is T (true) or F (false). Write your answer in the space provided for each statement.

Postpartum IUD Overview

1. _____ Postpartum contraception helps couples practice healthy spacing of pregnancies.
2. _____ The most appropriate timing for postpartum IUD insertion is between 48 hours and four weeks postpartum.
3. _____ Complaints about bleeding after postpartum IUD insertion are reported to be less than those for interval insertion.

Postpartum Anatomy and Physiology

4. _____ Immediately after the placenta is expelled, the cervix and lower uterine segment are collapsed and limp.
5. _____ The immediate postpartum uterus is a smooth cavity with narrow apposition of the anterior and posterior walls, each of which is 4–5 cm thick.
6. _____ In the immediate postpartum woman, the lower uterine segment is contracted, and slight pressure with the forceps is needed to move the IUD to the fundus.

Counseling and Informed Choice

7. _____ An IUD should not be inserted postpartum if the client has not been counseled.
8. _____ The best time to counsel a client for postpartum family planning is immediately following delivery.
9. _____ It is important to inform clients that during the first follow-up visit, the possibility of "missing strings" is higher for postpartum IUD insertion than for interval IUD insertion.

Client Assessment

10. _____ A general medical and obstetric history, a sexually transmitted infection (STI) risk assessment; and a confirmation of marital status are essential components of a client history for a postpartum IUD candidate.
11. _____ Prolonged rupture of membranes or prolonged labor could increase the risk of infection; the provision of an IUD postpartum might need to be postponed.

12. _____ If a complete client history has been taken, the provider does not need to perform a postdelivery physical exam before the IUD is inserted postpartum.

Infection Prevention

13. _____ The best way to prevent infections at a health facility is by following standard precautions.

14. _____ Decontamination and cleaning of the table top are necessary at the end of each day, not in between clients.

15. _____ When using the "no-touch" technique, if the IUD is inserted into the uterus and then removed back through the cervix, it cannot be reinserted through the cervix once again.

Postpartum IUD Insertion Techniques

16. _____ Postplacental insertion should take place within 10 minutes after expulsion of the placenta following a vaginal delivery.

17. _____ There is the same probability of IUD expulsion after a ringed forceps postplacental insertion as after a ringed forceps immediate postpartum insertion.

18. _____ A forceps insertion could be easier to perform in client whose uterus has contracted due to the active management of the third stage of labor.

19. _____ Anesthesia in addition to that which is given during delivery is required for postpartum IUD insertion.

Postpartum IUD Follow-Up

20. _____ Pain with intercourse is a common side effect of postpartum IUD insertion.

21. _____ Regardless of the reason, if the client requests it, the IUD should be removed.

22. _____ If the IUD strings are not visible at the first routine follow-up visit after a postpartum insertion, expulsion has definitely occurred.

Prevention and Management of Side Effects and Complications

23. _____ Bleeding and cramping side effects may not be attributed by the client to the postpartum IUD, since these are characteristic of the uterus's postpartum involution.

24. _____ The risk if expulsion after postpartum IUD insertion is minimal.

25. _____ Sometimes during the first postpartum IUD postinsertion visit, the strings may have not yet descended.

Postpartum IUD Knowledge Assessment Test

Answers

Postpartum IUD Overview
1. T
2. F
3. T

Postpartum Anatomy and Physiology
4. T
5. T
6. T

Counseling and Informed Choice
7. T
8. F
9. T

Client Assessment
10. F
11. T
12. F

Infection Prevention
13. T
14. F
15. T

Postpartum IUD Insertion Techniques
16. T
17. F
18. T
19. F

Postpartum IUD Follow-Up
20. F
21. T
22. F

Prevention and Management of Side Effects and Complications
23. T
24. F
25. T

Postpartum IUD Clinical Skills Learning Guide

For Postplacental Forceps Insertion

This is a learning tool for postpartum IUD trainees. The trainee uses the learning guide as a tool to rate his or her performance of each step, and even as a job aid upon returning to the workplace. The learning guide should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice.) In addition to use by trainees, trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of training. *This learning guide presupposes that clients have been counseled*.

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. Critical steps are in **bold,** and trainees need to make sure that they cover all of the components within these steps and in proper sequence. **All critical steps (in bold) must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide postpartum IUD services.** (However, trainees should continue to improve until they achieve a score of 2 in each step.)

For postplacental IUD insertions, the provider attending the delivery must be a provider trained in postpartum IUD insertion. The help of an assistant is needed for this technique; the steps performed by the assistant are in *Italics*.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet the client, introduce yourself, and confirm that the client has request a postpartum IUD during her antenatal care.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to her antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review the general medical and obstetric history with the client, ensure that she is not at high individual risk for sexually transmitted infections (STIs). Record that the IUD is an appropriate choice for this client.						
5. Check for obstetric events related to the present delivery that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
6. Explain to the client what you will do next and also that you will explain each step throughout, so as to avoid surprising her. Ask her to relax by taking deep breaths. Ask the client if she has any questions.						
Preinsertion Tasks—In the delivery room						
7. Ensure that supplies and equipment needed for postpartum IUD insertion are available in the delivery room, along with delivery-related supplies and equipment.						
8. Prepare to attend the delivery (at the appropriate time): • Wash your hands (surgical scrub) • Put on a sterile gown and gloves						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
9. **Attend the delivery and actively manage the third stage of labor:** • Give oxytocin 10 units intramuscularly within one minute of childbirth. • Deliver the placenta by controlled traction on the umbilical cord and counterpressure to the uterus. • Massage the uterus through the abdomen after delivery of the placenta.						
10. Proceed if everything is normal.						
11. Explain to the client what you are doing at each step; remind her to relax by taking deep breaths.						
12. **Palpate the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus; massage the uterus if necessary.**						
13. Remove the gloves and gown.						
14. **Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry).**						
15. **Put new sterile gloves on both hands.**						
16. *Assistant gently cleans the external genital area with a clean cloth and antiseptic solution.*						
17. Place a new clean drape over the client's abdomen and underneath her buttocks.						
18. **Arrange the instruments and supplies on a sterile tray or a draped area without touching the parts of the instruments that will go into the uterus.**						
19. *Assistant pours antiseptic solution into a cup and opens the gauze package.*						
Pelvic Examination						
20. Ask the assistant to position the light source.						
21. Ensure that the client's buttocks are at the very edge of the table.						
22. Inspect the external genitalia.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
23. Moisten the valve with the antiseptic solution.						
24. **Insert the valve gently:** Spread the labia with two fingers and then insert the valve, starting obliquely and then rotating it clockwise to the horizontal position. • Gently maneuver to be able to inspect the cervix and the vagina to check for tears. • Continue if there is no bleeding from cervical or vaginal tears or from an episiotomy. (If an episiotomy was performed and or tears occurred, these should be repaired after the IUD is inserted.) *Note:* if bleeding is significant, IUD insertion should be postponed; an immediate forceps insertion can be performed later.						
Insertion Tasks						
25. If the exam results are normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						
26. **Clean the cervix and the vagina with antiseptic solution two times using two gauzes, and allow some time for the solution to act.**						
27. While holding the valve with one hand and ring forceps with the other hand, with palms turned upward, gently grasp the anterior lips of the cervix, with the forceps at the one side of the cervix. *Note:* Do not lock the forceps beyond the first notch. Do not use a toothed tenaculum.						
28. *At this moment, assistant opens the IUD package for you to load the forceps. The package is opened only half way, allowing you to use the Kelly forceps to enter and grasp the IUD without taking the IUD out of the package.*						
29. *Assistant places the half-open package on the sterile tray for you to reach it.*						
30. **Grasp the IUD with the Kelly placental forceps (or with a second pair of standard ringed forceps). The IUD should be held by its vertical arm; the horizontal arm of the IUD should be slightly out of the ring in the same direction as the rings and slightly to the side.** Offset the IUD toward the inner curve of the Kelly forceps—not the outer curve. This						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
will facilitate the liberation of the IUD in the fundus, decreasing the risk of pulling it out while removing the forceps. *Note:* If you are using Kelly forceps, you must maintain constant pressure on the forceps, as these forceps do not have a catch and could allow the IUD to drop or move. The IUD is kept in place by your holding the forceps.						
31. *Assistant holds the valve, while you hold the IUD-loaded forceps with the dominant hand and the cervix-holding forceps with the other hand.*						
32. Exert gentle traction toward you on the cervix-holding forceps.						
33. **Insert the forceps, passing the IUD through the cervix, following a plane that is perpendicular to the plane of the woman's back and into the lower uterine cavity. Avoid touching the walls of the vagina with the IUD.** *Note:* Perform IUD insertion while seated. Standing tends to make you direct the IUD-holding forceps too posteriorly.						
34. *The assistant removes the valve.*						
35. **Release the hand that is holding the cervix-holding forceps; move the hand to the abdomen, placing it on top of the uterine fundus.**						
36. With the abdominal hand, **stabilize the uterus with firm downward pressure through the abdominal wall.** This prevents the uterus from moving upward in the abdomen as the IUD is pushed up.						
37. **Move the IUD-holding forceps in an upward motion all the way toward the fundus (directed toward the umbilicus).**						
38. If you meet resistance, slightly withdraw the forceps and redirect the forceps more anteriorly toward the abdominal wall, while moving your wrist slightly down. *Note:* If the client has delivered vaginally after a previous cesarean delivery, take care to avoid placing the IUD through any defect in the previous incision by maintaining your ring forceps pressed against the posterior uterine wall.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
39. **Stand and confirm with the abdominal hand that the tips of the forceps reach the fundus.**						
40. **At this point, turn the forceps 45° to the right to position the IUD horizontally in the highest part of the fundus.**						
41. **By opening the forceps, release the IUD.**						
42. **Slowly remove the forceps from the uterine cavity, keeping it slightly open, and keeping it to the side following the lateral uterus wall as the forceps are pulled out in the opposite direction.**						
43. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well-contracted and small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reached the fundus. In this situation, you should remove the IUD and attempt a new insertion with new sterile forceps and a new sterile IUD (no-touch technique) for correct placement.						
44. Remove the cervix-holding forceps from the anterior lip of the cervix.						
45. Examine the cervix and vagina. Repair any tears and the episiotomy, if necessary.						
46. Gently remove all instruments used and place them in 0.5% chlorine decontamination solution.						
47. Allow the client to rest for a few minutes; help her off the table when she feels ready. (*Hint:* The postinsertion tasks can be performed while she is resting.)						
Postinsertion Tasks						
48. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.						
49. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, and place them in a leakproof container or plastic bag.						

continued

Clinical Skills								
Task/Steps	**Cases** (M for model or C for client)							
50. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth or air dry them.								
51. Provide postinsertion instructions. Remind the client to check for expulsion and review warning signs.								
52. Complete the IUD card, client record, and IUD register/log (as applicable).								
53. *After the client has left, the assistant, wearing utility gloves, cleans the examination table with the 0.5% chlorine decontamination solution.*								

Postpartum IUD Clinical Skills Learning Guide

For Immediate Postpartum Forceps Insertion

This is a learning tool for postpartum IUD trainees. The trainee uses the learning guide as a tool to rate his or her performance of each step, and even as a job aid upon returning to the workplace. The learning guide should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice). In addition to use by trainees, trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of training. *This learning guide presupposes that clients have been counseled*.

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. Critical steps are in **bold,** and trainees need to make sure that they cover all of the components within these steps and in proper sequence. **All critical steps (in bold) must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide postpartum IUD services.** (However, trainees should continue to improve until they achieve a score of 2 in each step.)

The help of an assistant is needed for this technique; the steps performed by the assistant are in *Italics*.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment						
1. Greet the client politely, introduce yourself, and ensure privacy for IUD insertion.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to her antenatal and intrapartum course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review her general medical and obstetric history with the client. Ask for and record the following information to confirm that the IUD is an appropriate choice for the client and to ensure that she is not at high individual risk for sexually transmitted infections (STIs), and confirm that there are no delivery-related conditions that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Postpartum fever (>38°C or 100.4°F) or other signs of abdominal or pelvic infection • Unexplained vaginal bleeding before evaluation • Gestational trophoblastic disease (benign or malignant) • Postpartum hemorrhage • Extensive genital trauma						
5. Explain to the client that you will do a vaginal exam and insert the IUD if all is normal, and also that you will explain each step throughout, so as to avoid surprising her. Explain that clients often experience cramping and some discomfort. Ask her to relax by taking deep breaths. Ask the client if she has any questions.						
Preinsertion Tasks						
6. Ensure that needed supplies and equipment are available in the procedure room.						
7. Confirm that the client has recently emptied her bladder.						
8. Help the client onto the examination table.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
9. **Palpate the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus; massage the uterus if necessary.** Client should have active management of the third stage of labor.						
10. **Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry).**						
11. **Put new sterile gloves on both hands.**						
12. *Assistant gently cleans the external genital area with a clean cloth and antiseptic solution.*						
13. Place a clean drape over the client's abdomen and underneath her buttocks.						
14. **Arrange the instruments and supplies on a sterile tray or a draped area without touching the parts of the instruments that will go into the uterus.**						
15. *Assistant pours antiseptic solution into a cup and opens the gauze package.*						
Pelvic Examination						
16. Ask the assistant to position the light source.						
17. Ensure that the client's buttocks are at the very edge of the table.						
18. Inspect the external genitalia.						
19. Moisten the valve with the antiseptic solution.						
20. **Insert the valve gently:** Spread the labia with two fingers and then insert the valve, starting obliquely and then rotating it clockwise to the horizontal position. • Gently maneuver to be able to inspect the cervix and the vagina; continue if findings are normal.						
Insertion Tasks						
21. If the exam results are normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
22. **Clean the cervix and the vagina with antiseptic solution two times using two gauzes, and allow some time for the solution to act.**						
23. While holding the valve with one hand and ring forceps with the other hand, with palms turned upward, gently grasp the anterior lips of the cervix, with the forceps at the one side of the cervix. *Note:* Do not lock the forceps beyond the first notch. Do not use a toothed tenaculum.						
24. *At this moment, the assistant opens the IUD package for you to load the forceps. The package is opened only half way, allowing you to use the Kelly forceps to enter and grasp the IUD without taking the IUD out of the package.*						
25. *Assistant places the half-open package on the sterile tray for you to reach it.*						
26. **Grasp the IUD with the Kelly placental forceps (or with a second pair of standard ring forceps). The IUD should be held by its vertical arm; the horizontal arm of the IUD should be slightly out of the ring in the same direction as the rings and slightly to the side.** Offset the IUD toward the inner curve of the Kelly forceps—not the outer curve. This will facilitate the liberation of the IUD in the fundus, decreasing the risk of pulling it out while removing the forceps. *Note:* If you are using Kelly forceps, you must maintain constant pressure on the forceps, as these forceps do not have a catch and could allow the IUD to drop or move. The IUD is kept in place by your holding the forceps.						
27. A*ssistant holds the valve, while you hold the IUD-loaded forceps with the dominant hand and the cervix-holding forceps with the other hand.*						
28. **Exert gentle traction toward you on the cervix-holding forceps.**						
29. I**nsert the forceps, passing the IUD through the cervix, following a plane that is perpendicular to the plane of the woman's back and into the lower uterine cavity. Avoid touching the walls of the vagina with the IUD.** *Note:* Perform IUD insertion while seated. Standing tends to make you direct the IUD-holding forceps too posteriorly.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
30. *The assistant removes the valve.*						
31. **Release the hand that is holding the cervix-holding forceps; move the hand to the abdomen, placing it on top of the uterine fundus.**						
32. With the abdominal hand, **stabilize the uterus with firm downward pressure through the abdominal wall.** This prevents the uterus from moving upward in the abdomen as the IUD is pushed up.						
33. **Move the IUD-holding forceps in an upward motion all the way toward the fundus (directed toward the umbilicus). Remember that the lower uterine segment may be contracted, and therefore some slight pressure may be necessary to advance the IUD and achieve fundal placement.** *Note:* If the client has delivered vaginally after a previous cesarean delivery, take care to avoid placing the IUD through any defect in the previous incision by maintaining your ring forceps pressed against the posterior uterine wall.						
34. **Stand and confirm with the abdominal hand that the tips of the forceps reach the fundus.**						
35. **At this point, turn the forceps 45° to the right to position the IUD horizontally in the highest part of the fundus.**						
36. **By opening the forceps, release the IUD.**						
37. **Slowly remove the forceps from the uterine cavity, keeping them slightly open and keeping them to the side following the lateral uterus wall as the forceps are pulled out in the opposite direction.**						
38. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well-contracted or small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reached the fundus.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
39. Remove the cervix-holding forceps from the anterior lip of the cervix.						
40. Examine the cervix and vagina.						
41. Place all used instruments in 0.5% chlorine decontamination solution.						
42. Allow the client to rest for a few minutes; help her off the table when she feels ready. (*Hint:* The postinsertion tasks can be performed while she is resting.)						
Postinsertion Tasks						
43. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.						
44. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, and place them in a leakproof container or plastic bag.						
45. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry them).						
46. Provide postinsertion instructions. Remind the client to check for expulsion and review warning signs.						
47. Complete the IUD card, client record, and IUD register/log (as applicable).						
48. *After the client has left, the assistant, wearing utility gloves, cleans the examination table with the 0.5% chlorine decontamination solution.*						

Postpartum IUD Clinical Skills Learning Guide

For Postplacental Manual Insertion

This is a learning tool for postpartum IUD trainees. The trainee uses the learning guide as a tool to rate his or her performance of each step, and even as a job aid upon returning to the workplace. The learning guide should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice). In addition to use by trainees, trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of training. *This learning guide presupposes that clients have been counseled*.

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. Critical steps are in **bold,** and trainees need to make sure that they cover all of the components within these steps and in proper sequence. **All critical steps (in bold) must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide postpartum IUD services.** (However, trainees should continue to improve until they achieve a score of 2 in each step.)

For postplacental insertions, the provider attending the delivery must be trained in postpartum IUD insertion. The help of an assistant is needed for this technique; the steps performed by the assistant are in *Italics*.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet client, introduce yourself, and confirm that the client has requested a postpartum IUD during her antenatal care.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review her general medical and obstetric history with the client, ensure that she is not at high individual risk for sexually transmitted infection (STIs). Record that the IUD is an appropriate choice for this client.						
5. Check for obstetric events related to the present delivery that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
6. Explain to the client what you will do next and also that you will explain each step throughout, so as to avoid surprising her. Ask her to relax by taking deep breaths. Ask the client if she has any questions.						
Preinsertion Tasks—At the delivery room						
7. Ensure that supplies and equipment needed for postpartum IUD insertion are available in the delivery room, along with delivery-related supplies and equipment.						
8. Prepare to attend the delivery (at the appropriate time): • Wash your hands (surgical scrub) • Put on a sterile gown and gloves						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
9. **Attend the delivery and actively manage the third stage of labor (AMSTL):** • Give oxytocin 10 units intramuscularly within one minute of childbirth • Deliver the placenta by controlled traction on the umbilical cord and counter pressure to the uterus • Massage the uterus through the abdomen after delivery of the placenta						
10. Proceed if everything is normal.						
11. Explain to the client what you are doing at each step; remind her to relax by taking deep breaths.						
12. **Palpate the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus; massage the uterus if necessary.**						
13. Remove the gloves and gown.						
14. **Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry them).**						
15. **Place new sterile gloves on both hands and put on a clean gown.** (You need to have a long-sleeve, sterile pair of gloves or standard gloves with water-impermeable gown.)						
16. *Assistant gently cleans the external genital area with a clean cloth and antiseptic solution.*						
17. Place a new clean sterile drape over the client's abdomen and underneath her buttocks.						
18. **Arrange the instruments and supplies on a sterile tray or a draped area without touching the parts of the instruments that will go into the uterus.**						
19. *Assistant pours antiseptic solution into a cup and opens a gauze package.*						
Pelvic Examination						
20. Ask the assistant to position the light.						
21. Ensure that the client's buttocks are at the very edge of the table.						
22. Inspect the external genitalia.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
23. Moisten the valve with the antiseptic solution.						
24. **Insert the valve gently:** Spread the labia with two fingers and then insert the valve, starting obliquely and then rotating it clockwise to the horizontal position. • Gently maneuver to be able to inspect the cervix and the vagina to check for tears. • Continue if there is no bleeding from cervical or vaginal tears or from an episiotomy. (If an episiotomy was performed and/or tears occurred, these should be repaired after the IUD is inserted.) *Note:* If bleeding is significant, IUD insertion should be postponed; an immediate forceps insertion can be performed later.						
Insertion Tasks						
25. If the exam results are normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						
26. **Clean the cervix and the vagina with antiseptic solution two times using two gauzes, and wait two minutes for the solution to act.**						
27. Remove the valve.						
28. **Hold the IUD by gripping the vertical rod between the index and middle fingers of your dominant hand.**						
29. **Slowly open the introitus with two fingers of the other hand, gently pushing the posterior wall downward.**						
30. **Slowly insert your IUD-holding hand into the vagina and through the cervix into the uterus, in the direction of the abdominal wall.**						
31. Remove the forceps that are holding the cervix.						
32. **Put your other hand on the abdomen to hold the uterus.**						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
33. **Stabilizing the uterus by downward pressure, prevent it from going higher in the abdomen, as you insert the IUD-holding hand.**						
34. **Confirm, by palpation with the abdominal hand, that the fundus has been reached.**						
35. **Once the fundus has been reached, turn the IUD-holding hand 45° to the right to position the IUD horizontally and place it in the fundus.**						
36. **Slowly remove your hand from the uterus. Take particular care not to dislodge the IUD as the hand is removed.**						
37. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well-contracted and small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reached the fundus. In this situation, you should remove the IUD and attempt a new insertion with new sterile forceps and a new sterile IUD (no-touch technique) for correct placement.						
38. Examine the cervix and vagina. Repair any tears and the episiotomy, if necessary.						
39. Allow the client to rest for a few minutes; help her off the table when she feels ready (*Hint:* The postinsertion tasks can be performed while she is resting.)						
Postinsertion Tasks						
40. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.						
41. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, and place them in a leakproof container or plastic bag.						
42. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry them).						

continued

Clinical Skills								
	Task/Steps	**Cases** (M for model or C for client)						
43.	Provide postinsertion instructions. Remind the client to check for expulsion and review warning signs.							
44.	Complete the IUD card, client record, and IUD register/log (as applicable).							
45.	*After the client has left, the assistant, wearing utility gloves, cleans the examination table with the 0.5% chlorine decontamination solution.*							

Postpartum IUD Clinical Skills Learning Guide

For Transcesarean Insertion

This is a learning tool for postpartum IUD trainees. The trainee uses the learning guide as a tool to rate his or her performance of each step, and even as a job aid upon returning to the workplace. The learning guide should be used to assess practice on clients. In addition to use by trainees, trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of training. *This learning guide presupposes that clients have been counseled.*

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. Critical steps are in **bold,** and trainees need to make sure that they cover all of the components within these steps and in proper sequence. **All critical steps (in bold) must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide IUD services.** (However, trainees should continue to improve until they achieve a score of 2 in each step.)

This learning guide only includes the tasks and steps related to the IUD insertion during a cesarean section delivery. It does not cover any of the tasks and steps related to cesarean section. It refers only to the steps performed by the IUD provider.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet the client, introduce yourself, and confirm that the client has requested a postpartum IUD during her antenatal care.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to her antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review her general medical and obstetric history with the client, and ensure that she is not at high individual risk for sexually transmitted infections (STIs). Record that the IUD is an appropriate choice for this client.						
5. Check for obstetric events related to the present delivery that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
Preinsertion Tasks—During the cesarean delivery						
6. Perform cesarean section and deliver baby, as per international and local guidelines.						
7. **Actively manage the third stage of labor:** • Give oxytocin 10 units intramuscularly within one minute of childbirth • Deliver the placenta by controlled traction on the umbilical cord and counterpressure to the uterus • **Massage the fundal uterus**						
8. Control bleeding of incision, as per international and local guidelines.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Insertion Tasks						
9. **Slowly insert your IUD-holding hand through the incision into the fundus of the uterus.**						
10. **Make sure to place the IUD high in the fundus.**						
11. **Carefully release the IUD.**						
12. Before suturing the uterine incision, place the strings in the lower uterine segment near the internal cervical os.						
13. Do not pass the strings through the cervix, because this increases the risk of infection.						
14. Suture the uterine insertion, avoiding incorporating the IUD strings into the closure.						
Postinsertion Tasks						
15. Make sure to register the IUD insertion in the client's record.						
16. Complete the IUD card and IUD register/log (as applicable).						
17. Before the client is discharged, make sure to include IUD-related postinsertion instructions.						
18. Remind the client to check for expulsion and review warning signs.						

Postpartum IUD Clinical Skills Checklist for Trainers

For Postplacental Forceps Insertion

This checklist is to be used by trainers to assess trainees' competency. The checklist should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë pelvic model and C for client practice). **Use one checklist per participant.**

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. This checklist includes all of the steps of the procedure, and all of the **critical steps** are shown in **bold; the critical steps must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide IUD services.** During the final assessment of a participant's performance, the trainer should focus on the correct performance of the critical steps. If a participant does not performed all of the critical steps in a satisfactory manner, he or she cannot be consider certified. Conversely, the participant does not need to perform **all** of the noncritical steps to be considered competent. However, trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice at their home facility.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet the client, introduce yourself, and confirm that the client has request a postpartum IUD during her antenatal care.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to her antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review her general medical and obstetric history with the client, and ensure that she is not at high individual risk for sexually transmitted infections (STIs). Record that the IUD is an appropriate choice for this client.						
5. Check for obstetric events related to the present delivery that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
6. Explain to the client what you will do next and that you will explain each step throughout, so as to avoid surprising her. Ask her to relax by taking deep breaths. Ask the client if she has questions.						
Preinsertion Tasks—In the delivery room						
7. Ensure that supplies and equipment needed for postpartum IUD insertion are available in the delivery room, along with delivery-related supplies and equipment,						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
8. Prepare to attend the delivery (at the appropriate time): • Wash your hands (surgical scrub) • Put on a sterile gown and glows						
9. **Attend the delivery and actively manage the third stage of labor:** • Give oxytocin 10 units intramuscularly within one minute of childbirth • Deliver the placenta by controlled traction on the umbilical cord and counterpressure to the uterus • Massage the uterus through the abdomen after delivery of the placenta						
10. Proceed if everything is normal.						
11. Explain to the client what you are doing at each step; remind her to relax by taking deep breaths.						
12. **Palpate the uterus to evaluate the height of the fundus and the size and degree of contraction of the uterus; massage if necessary.**						
13. Remove the gloves and gown.						
14. **Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry them).**						
15. **Put new sterile gloves on both hands.**						
16. *Assistant gently cleans the external genital area with a clean cloth and antiseptic solution.*						
17. Place a new clean drape over the client's abdomen and underneath her buttocks.						
18. **Arrange the instruments and supplies on a sterile tray or a draped area without touching the parts of the instruments that will go into the uterus.**						
19. *Assistant pours antiseptic solution into a cup and opens the gauze package.*						
Pelvic Examination						
20. Ask the assistant to position the light source.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
21. Ensure that the client's buttocks are at the very edge of the table.						
22. Inspect the external genitalia.						
23. Moisten the valve with the antiseptic solution.						
24. **Insert the valve gently:** Spread the labia with two fingers and then insert the valve, starting obliquely and then rotating it clockwise to the horizontal position. • Gently maneuver to be able to inspect the cervix and the vagina to check for tears. • Continue if there is no bleeding from cervical or vaginal tears or from an episiotomy. (If an episiotomy was performed and/or tears occurred, these should be repaired after the IUD is inserted.) *Note:* If bleeding is significant, IUD insertion should be postponed; an immediate forceps insertion can be performed later.						
Insertion Tasks						
25. If the exam results are normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						
26. **Clean the cervix and the vagina with antiseptic solution two times using two gauzes, and allow some time for the solution to act.**						
27. While holding the valve with one hand and ring forceps with the other hand, with palms turned upward, gently grasp the anterior lips of the cervix, with the forceps at the one side of the cervix. *Note:* Do not lock the forceps beyond the first notch. Do not use a toothed tenaculum.						
28. *At this moment, assistant opens the IUD package for you to load the forceps. The package is opened only half way, allowing you to use the Kelly forceps to enter and grasp the IUD without taking the IUD out of the package.*						
29. *Assistant places the half-open package on the sterile tray for you to reach it.*						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
30. **Grasp the IUD with the Kelly placental forceps (or with a second pair of standard ring forceps). The IUD should be held by its vertical arm; the horizontal arm of the IUD should be slightly out of the ring in the same direction as the rings and slightly to the side.** Offset the IUD toward the inner curve of the Kelly forceps—not the outer curve. This will facilitate the liberation of the IUD in the fundus, decreasing the risk of pulling it out while removing the forceps. *Note:* If you are using Kelly forceps, you must maintain constant pressure on the forceps, as these forceps do not have a catch and the IUD could drop or move. The IUD is kept in place by your holding the forceps.						
31. *Assistant holds the valve, while you hold the IUD-loaded forceps with the dominant hand and the cervix-holding forceps with the other hand.*						
32. **Exert gentle traction toward you on the cervix-holding forceps.**						
33. **Insert the forceps, passing the IUD through the cervix, following a plane that is perpendicular to the plane of the woman's back and into the lower uterine cavity. Avoid touching the walls of the vagina with the IUD.** *Note:* Perform IUD insertion while seated. Standing tends to make you direct the IUD-holding forceps too posteriorly.						
34. *Assistant removes the valve.*						
35. **Release the hand that is holding the cervix-holding forceps; move the hand to the abdomen, placing it on top of the uterine fundus.**						
36. With the abdominal hand, **stabilize the uterus with firm downward pressure through the abdominal wall.** This prevents the uterus from moving upward in the abdomen as the IUD is pushed up.						
37. **Move the IUD-holding forceps in an upward motion all the way toward the fundus (directed toward the umbilicus).**						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
38. If you meet resistance, slightly withdraw the forceps and redirect the forceps more anteriorly toward the abdominal wall, while moving your wrist slightly down. *Note:* If the client has delivered vaginally after a previous cesarean delivery, take care to avoid placing the IUD through any defect in the previous incision by maintaining your ring forceps pressure against the posterior uterine wall.						
39. **Stand and confirm with the abdominal hand that the tips of the forceps reach the fundus.**						
40. **At this point, turn the forceps 45° to the right to position the IUD horizontally in the highest part of the fundus.**						
41. **By opening the forceps, release the IUD.**						
42. **Slowly remove the forceps from the uterine cavity, keeping it slightly open, and keeping it to the side following the lateral uterus wall as the forceps are pulled out in opposite direction.**						
43. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well-contracted and small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reached the fundus. In this situation, you should remove the IUD and attempt a new insertion with new sterile forceps and new sterile IUD (no-touch technique) for correct placement.						
44. Remove the cervix-holding forceps from the anterior lip of the cervix.						
45. Examine the cervix and vagina. Repair any tears and the episiotomy, if necessary.						
46. Gently remove all instruments used and place them in 0.5% chlorine decontamination solution.						
47. Allow the client to rest for a few minutes; help her off the table when she feels ready. (Hint: The postinsertion tasks can be performed while she is resting.)						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Postinsertion Tasks						
48. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.						
49. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, and place them in a leakproof container or plastic bag.						
50. Wash your hands thoroughly with soap and water and dry them with a clean, dry cloth (or air dry them).						
51. Provide postinsertion instructions. Remind the client to check for expulsion and review warning signs.						
52. Complete the IUD card, client record, and IUD register/log (as applicable).						
53. *After the client has left, the assistant, wearing utility gloves, cleans the examination table with the 0.5% chlorine decontamination solution.*						
Total						

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Postpartum IUD Clinical Skills Checklist for Trainers

For Immediate Postpartum Forceps Insertion

This checklist is to be used by trainers to assess trainees' competency. The checklist should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice.) **Use one checklist per participant.**

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. This checklist includes all of the steps of the procedure, and all of the **critical steps** are shown in **bold; the critical steps must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide IUD services.** During the final assessment of a participant's performance, the trainer should focus on the correct performance of the critical steps. If a participant does not performed all of the critical steps in a satisfactory manner, he or she cannot be consider certified. Conversely the participant does not need to perform **all** of the noncritical steps to be considered competent. However, trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice at their home facility.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment						
1. Greet client politely, introduce oneself and ensure privacy for IUD insertion.						
2. Ask client if she still wants the IUD inserted.						
3. Review with client information in her record with attention to antenatal and intrapartum course. Ensure that she has been appropriately counseled for IUD insertion; ask client what questions she has about the IUD or the insertion.						
4. Review general medical and obstetric history with client. Ask for and record the following information to confirm that the IUD is an appropriate choice for the client and ensure is not at high individual risk for STIs, confirm there are not delivery related conditions where the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Postpartum fever (>38°C or 100.4°F) or other signs of abdominal or pelvis infection • Unexplained vaginal bleeding before evaluation. • Gestational trophoblastic disease (benign or malignant) • Postpartum hemorrhage • Extensive genital trauma						
5. Explain to client that you will do a vaginal exam and insert the IUD if all is normal and also that you will explain each step throughout in order to avoid surprising her. Explain that clients often experience cramping and some discomfort. Ask her to relax by taking deep breaths. Ask client if she has questions.						
Preinsertion Tasks						
6. Ensure that needed supplies and equipment are available in the procedure room.						
7. Confirm that the client has recently emptied her bladder.						
8. Help the client onto the examination table.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
9. **Palpate the uterus to evaluate the height of the fundus, size and contraction of the uterus, massage if necessary.** Client should have AMTSL.						
10. **Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.**						
11. **Put new sterile gloves on both hands.**						
12. *Gently clean the external genital area with a clean cloth and antiseptic solution.*						
13. Place clean drape over the client's abdomen and underneath her buttocks.						
14. **Arrange instruments and supplies on a sterile tray or draped area without touching the parts of the instruments that will go into the uterus.**						
15. *Assistant pours antiseptic solution in a cup, open gauze package.*						
Pelvic Examination						
16. Ask assistant to position light source.						
17. Ensure that client's buttocks are at the very edge of the table.						
18. Inspect external genitalia.						
19. Moisten the valve with the antiseptic solution.						
20. **Insert the valve gently** by spreading the labia with two fingers and then inserting starting obliquely and then rotating it clockwise to the horizontal position: • Gently maneuver to inspect the cervix and the vagina, continue if findings are normal.						
Insertion Tasks						
21. If exam is normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						
22. **Clean the cervix and the vagina with antiseptic solution 2 times using 2 gauzes, and wait allow some time for the solution to act.**						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
23. While holding the valve with one hand and ring forceps with the other hand, with palms turned upwards, gently grasp the anterior lips of the cervix with the forceps at the one side of the cervix. *Note:* Do not lock the forceps beyond the first notch. Do not use a toothed tenaculum.						
24. *Assistant at this moment opens the IUD package for you to load the forceps. The package is opened only half way, allowing the Kelly forceps to enter and grasp the IUD without taking the IUD out of the package.*						
25. *Assistant places the half open package on the sterile tray for you to reach it.*						
26. **Grasp the IUD with the Kelly placental forceps or with a second pair of standard ring forceps. The IUD should be held by its vertical arm; the horizontal arm of the IUD should be slightly out of the ring in the same direction of the rings and slightly sided.** Offset the IUD toward the inner curve of the Kelly forceps—not the outer curve. This will facilitate the liberation of the IUD in the fundus, decreasing the risk of pulling it out will removing the forceps. *Note:* If you are using Kelly forceps, you must maintain constant pressure on the forceps, as these forceps do not have a catch and the IUD could drop or move. The IUD is kept in place by your holding the forceps						
27. *Assistant holds the valve while you hold the IUD-loaded forceps with dominant hand and the cervix-holding forceps with the other hand.*						
28. **Exert gentle traction towards you on the cervix-holding forceps.**						
29. **Insert the forceps passing the IUD through the cervix, following a plane that is perpendicular to the plane of the woman's back and into the lower uterine cavity. Avoid touching the walls of the vagina with the IUD.** *Note:* Perform insertion while seated. Standing tends to make you direct the IUD-holding forceps too posteriorly						
30. *The assistant removes the valve.*						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
31. **Release the hand that is holding the cervix-holding forceps; move the hand to the abdomen placing it on top of the uterine fundus.**						
32. With the abdominal hand, **stabilize the uterus with firm downward pressure through the abdominal wall.** This prevents the uterus from moving upward in the abdomen as the IUD is pushed up.						
33. **Move the IUD-holding forceps IUD in an upward motion all the way toward the fundus (directed towards the umbilicus). Remember that the lower uterine segment may be contracted and therefore some slight pressure may be necessary to advance the IUD and achieve fundal placement.** *Note:* If the client has delivered vaginally after a previous cesarean delivery, take care to avoid placing the IUD through any defect in the previous incision by maintaining your ring forceps pressured against the posterior uterine wall.						
34. **Stand and confirm with the abdominal hand that the tips of the forceps reach the fundus.**						
35. **At this point turn the forceps 45° to the right to position the IUD horizontally in the highest of the fundus.**						
36. **By opening the forceps, release the IUD.**						
37. **Slowly remove the forceps from the uterine cavity, keeping them slightly open and keeping them to the side following the lateral uterus wall as the forceps is pulled out in opposite direction.**						
38. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well contracted or small, the strings can be seen through the cervix. If this is the case, don't do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reach the fundus.						
39. Remove the cervix-holding forceps from the anterior lip of the cervix.						

continued

Clinical Skills							
Task/Steps	**Cases** (M for model or C for client)						
40. Examine the cervix and vagina.							
41. Place all used instruments in 0.5% chlorine decontamination solution.							
42. Allow the client to rest few minutes; help her off the table when she feels ready (*Hint:* The postinsertion tasks can be performed while she is resting).							
Postinsertion Tasks							
43. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.							
44. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, place them in a leakproof container or plastic bag.							
45. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.							
46. Provide postinsertion instructions. Remind client to check for expulsion and review warning signs.							
47. Complete the IUD card, client record and IUD register/log (as applicable).							
48. *After the client has left, wear utility gloves and clean the examination table with the 0.5% chlorine decontamination solution.*							
Total							

continued

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Postpartum IUD Clinical Skills Checklist for Trainers

For Postplacental Manual Insertion

This checklist is to be used by trainers to assess trainees' competency. The checklist should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice.) **Use one checklist per participant.**

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. This checklist includes all of the steps of the procedure, and all of the **critical steps** are shown in **bold; the critical steps must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide IUD services.** During the final assessment of a participant's performance the trainer should focus on the correct performance of the critical steps. If a participant does not performed all of the critical steps in a satisfactory manner, he or she cannot be consider certified. Conversely, the participant does not need to perform **all** of the noncritical steps to be considered competent. However, trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice at their home facility.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet client, introduce oneself and confirm client has requested a postpartum IUD during her antenatal care.						
2. Ask client if she still wants the IUD inserted.						
3. Review with client information in her record with attention to antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask client what questions she has about the IUD or the insertion.						
4. Review general medical and obstetric history with client, ensure that the client is not at high individual risk for STIs. Record that the IUD is an appropriate choice for the client.						
5. Check for obstetrical events related to present delivery where the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
6. Explain to client what you will do next and also that you will explain each step throughout in order to avoid surprising her. Ask her to relax by taking deep breaths. Ask client if she has questions.						
Preinsertion Tasks—At the delivery room						
7. Ensure that needed supplies and equipment for postpartum IUD insertion are available in the delivery room, along with delivery supplies and equipment.						
8. Prepare to attend the delivery (at the appropriate time): • Wash hands (surgical scrub) • Put sterile gown and glows						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
9. **Attend delivery and actively manage the third stage of labor (AMSTL):** • Give oxytocin 10 units intramuscularly within 1 minute of childbirth • Deliver the placenta by controlled traction on the umbilical cord and counter pressure to the uterus • Massage the uterus through the abdomen after delivery of the placenta						
10. Proceed if everything is normal.						
11. Explain to client what you are doing at each step; remind her to relax by taking deep breaths.						
12. **Palpate the uterus to evaluate the height of the fundus, size and contraction of the uterus, massage if necessary.**						
13. Remove gloves and gown.						
14. **Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.**						
15. **Put new sterile gloves on both hands and a clean gown.** (You need to have a long-sleeve sterile pair of gloves or standard gloves WITH water-impermeable gown.)						
16. *Assistant gently cleans the external genital area with a clean cloth and antiseptic solution.*						
17. Place new clean sterile drape over the client's abdomen and underneath her buttocks.						
18. **Arrange instruments and supplies on a sterile tray or draped area without touching the parts of the instruments that will go into the uterus.**						
19. *Assistant pours antiseptic solution in a cup, opens gauze package.*						
Pelvic Examination						
20. Ask assistant to position light.						
21. Ensure that client's buttocks are at the very edge of the table.						
22. Inspect external genitalia.						
23. Moisten the valve with the antiseptic solution.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
24. **Insert the valve** gently by spreading the labia with two fingers and then inserting, starting obliquely and then rotating it clockwise to the horizontal position: • Gently maneuver to be able to inspect the cervix and the vagina to check for tears. • Continue if there is no bleeding from cervical or vaginal tears or from an episiotomy—if it was performed, these should be repaired after the IUD is inserted. *Note:* If bleeding is significant, the insertion should be postponed and an immediate forceps insertion can be performed later.						
Insertion Tasks						
25. If exam is normal, tell the client that she is ready for the IUD insertion; ask her if she has any questions.						
26. **Clean the cervix and the vagina with antiseptic solution 2 times using 2 gauzes, and wait 2 minutes for the solution to act.**						
27. Remove the valve.						
28. **Hold the IUD by gripping the vertical rod between the index and middle fingers of your dominant hand.**						
29. **Slowly open the introitus with two fingers of other hand, gently pushing the posterior wall downward.**						
30. **Slowly insert your IUD-holding hand into the vagina and through the cervix into the uterus, in the direction of the abdominal wall.**						
31. Remove the forceps used to hold the cervix open.						
32. **Put your other hand on the abdomen to hold the uterus.**						
33. **Stabilize the uterus by downward pressure to prevent it from going up higher in the abdomen, as you insert the IUD-holding hand.**						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
34. **Confirm, by palpation with the abdominal hand, that the fundus has been reached.**						
35. **Once the fundus has been reached, turn the IUD-holding hand 45° to the right to position the IUD horizontally and place it in the fundus.**						
36. **Slowly remove hand from the uterus. Take particular care not to dislodge the IUD as the hand is removed.**						
37. Gently push down the introitus with two fingers and visualize the interior of the vagina. *Note:* Sometimes, when the uterus is well contracted and small, the strings can be seen through the cervix. If this is the case, do not do anything. In the event of a large uterus, as per your assessment at the beginning of the procedure, if you see the strings, this will be an indication that the IUD has not reach the fundus; in this situation, the provider should remove the IUD and attempt a new insertion with new sterile forceps and new sterile IUD (no-touch technique) for correct placement.						
38. Examine the cervix and vagina. Repair tears and episiotomy if necessary.						
39. Allow the client to rest for a few minutes; help her off the table when she feels ready. (*Hint:* The postinsertion tasks can be performed while she is resting.)						
Postinsertion Tasks						
40. Dispose of waste materials such as cotton balls or gauze by placing them in a leakproof container or plastic bag.						
41. **Immerse both gloved hands in 0.5% chlorine decontamination solution.** Remove gloves by turning them inside out, and place them in a leakproof container or plastic bag.						
42. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.						
43. Provide postinsertion instructions. Remind client to check for expulsion and review warning signs.						
44. Complete the IUD card, client record and IUD register/log (as applicable).						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
45. *After the client has left, wear utility gloves and clean the examination table with the 0.5% chlorine decontamination solution.*						
Total						

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Postpartum IUD Clinical Skills Checklist for Trainers

For Transcesarean Insertion

This checklist is to be used by trainers to assess trainees' competency. The checklist should be used to assess practice on clients as well as on the Zoë pelvic model. (Mark the top of the column accordingly—M for the Zoë Pelvic Model and C for client practice.) **Use one checklist per participant.**

To provide quality postpartum IUD insertion, trainees need to perform each step correctly. This checklist includes all of the steps of the insertion procedure, and all of the **critical steps** are shown in **bold; the critical steps must be performed satisfactorily and in the correct sequence for a trainee to be considered competent to provide IUD services.** During the final assessment of a participant's performance, the trainer should focus on the correct performance of the critical steps. If a participant does not performed all of the critical steps in a satisfactory manner, he or she cannot be consider certified. Conversely, the participant does not need to perform **all** of the noncritical steps to be considered competent. However, trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice at their home facility.

This checklist does not include the tasks and steps of performing a cesarean section.

Use the following rating scale:

2 Competently performed: Step performed correctly in proper sequence
1 Needs improvement: Step performed correctly but out of sequence
0 Not done or done incorrectly: Step omitted or not performed correctly

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Preinsertion Medical Assessment—Performed before delivery						
1. Greet the client, introduce yourself and confirm that the client has requested a postpartum IUD during her antenatal care.						
2. Ask the client if she still wants the IUD inserted.						
3. Review with the client the information in her record, with attention to her antenatal course. Ensure that she has been appropriately counseled for IUD insertion; ask the client what questions she has about the IUD or about the insertion.						
4. Review her general medical and obstetric history with the client, and ensure that she is not at high individual risk for sexually transmitted infections (STIs). Record that the IUD is an appropriate choice for this client.						
5. Check for obstetric events related to the present delivery that would indicate the IUD should not be used: • Prolonged rupture of membranes (>24 hours) • Prolonged labor (>24 hours) • Fever (>38°C or 100.4°F) • Intrapartum hemorrhage • Extensive genital trauma						
Preinsertion Tasks—During the Cesarean section						
6. Perform the cesarean section and deliver the baby, as per international and local guidelines.						
7. **Actively manage the third stage of labor:** • Give oxytocin 10 units intramuscularly within one minute of childbirth • Deliver the placenta by controlled traction on the umbilical cord and counter pressure to the uterus • **Massage the fundal uterus**						
8. Control bleeding of incision, as per international and local guidelines.						

continued

Clinical Skills						
Task/Steps	**Cases** (M for model or C for client)					
Insertion Tasks						
9. **Slowly insert your IUD-holding hand into the incision into the fundus of the uterus.**						
10. **Make sure to place the IUD high in the fundus.**						
11. **Carefully release the IUD.**						
12. Before suturing the uterine incision, place the strings in the lower uterine segment near the internal cervical os.						
13. Do not pass the strings through the cervix, as this increases the risk of infection.						
14. Suture the uterine insertion, avoiding incorporating the IUD strings into the closure.						
Postinsertion Tasks						
15. Register the IUD insertion in the client's record.						
16. Complete the IUD card and IUD register/log (as applicable).						
17. Before discharge, make sure to include IUD-related postinsertion instructions.						
18. Remind the client to check for expulsion and review the warning signs.						
Total						

continued

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Postpartum IUD Counseling Skills Learning Guides

Insertion

This is a learning tool for PPIUD insertion counseling. To provide quality counseling, counselors need to address and perform each step well. Trainees can use the learning guide to rate each step, or even as a job aid upon their return to the workplace after participating in postpartum IUD training. All steps must be performed satisfactorily to ensure good postpartum IUD counseling. If not, further practice and improvement are needed. The areas in *italics* relate particularly to postpartum IUD counseling; those not in italics are part of recommended IUD counseling in general. Critical steps are in **bold,** and trainees need to make sure that they cover all of the components within these steps and in proper sequence.

Trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of the postpartum IUD training. The providers can also share this learning tool with counselors in their workplace to help set expectations for postpartum IUD counseling. **The counseling session below presupposes that the client already expressed interest in the IUD and/or postpartum IUD insertion (i.e., she has already received information on all available methods).** This counseling should preferably take place during antenatal care, but it could take place in the facility where the delivery takes place for immediate postpartum insertion within 48 hours after delivery.

Use the following rating scale:

2 Competently performed: Step performed correctly
1 Needs improvement: Step performed partially or incorrectly
0 Step omitted: Step not done

Counseling Skills						
Components and Steps	**Cases**					
Preinsertion Counseling Using the REDI Framework						
Rapport Building						
1. Greet the client politely, introduce yourself, and offer the client a seat.						
2. Ensure privacy without interruptions throughout the counseling session.						
3. Ask the client's name, age, and contact information. (Document this and subsequent information collected in the client's record, as required.)						
4. Explain the need to ask personal and sometimes sensitive questions of all clients to help them select a safe and appropriate family planning (FP) method based on their individual needs, while assuring the client of confidentiality.						
Exploration						
5. Ask the client to tell about past FP use, and explore what the client knows about FP methods, her satisfaction with method(s), and what makes her interested in the IUD and/or postpartum IUD insertion.						
6. **Explore the client's reproductive goals and history:** • Pregnancy history and outcome, ages of children • Whether she wants more children and, if yes, when, to explore the nature of contraceptive protection desired (duration, effectiveness, etc.)						
7. ***Explore the client's plans for breastfeeding her baby, including use of the lactational amenorrhea method.***						
8. **Focus on the IUD:** Explore what the client already knows, fill in knowledge gaps, and correct misperceptions, ensuring that the client understands the advantages and disadvantages of the IUD: • Effectiveness • Use of method—insertion procedure • How the IUD works						

continued

Counseling Skills						
Components and Steps	**Cases**					
• ***Postpartum IUD options as appropriate for the client's situation: postplacental insertion within 10 minutes, immediate postpartum insertion within 48 hours of delivery, interval insertion after four weeks, or transcesarean*** • ***Follow-up required for postpartum IUD use and the client's access to such services*** • IUD and/or ***postpartum IUD side effects vs. postnatal recovery*** • Benefits, risks, and possible complications						
9. Show a sample of the IUD and encourage the client to touch it; provide brochures or other printed information as you provide information, and ask what questions the client has.						
10. ***Explore the client's circumstances and relationships:*** • Partner/husband/family involvement and support for postpartum IUD/contraceptive use • Other factors that may influence postpartum IUD use, including *access to a health facility for follow-up care* • Past and current experience with violence and/or rape						
11. Explore issues related to sexuality, as appropriate: • Questions/concerns/problems that the client has about sexual relations/practices, including problems related to possible side effects, such as longer and more frequent bleeding • Possible customs related to abstinence after delivery and when the client plans to resume sexual relations						
12. **Explain that the IUD does not protect against sexually transmitted infections (STIs) and HIV,** and explore the client's knowledge about STIs/HIV, including prevention; fill in knowledge gaps; ask the client about condom use or other safe sex practices, and what questions the client might have.						
13. **Explore the client's history of STIs/HIV** and explain prevention of mother-to-child transmission of HIV (PMTCT): • Any current unusual vaginal discharge, pain with sex, or lower abdominal pain • History of STIs within the last three months • More than one sexual partner within the last three months (either partner)						

continued

Counseling Skills						
Components and Steps	**Cases**					
• Partner's STI history or presence of current penile discharge in partner • HIV status of client and partner, if known (for referral to PMTCT services, including special counseling for serodiscordant couples)						
14. **Screen the client for possible medical conditions** by asking her whether she has any health concerns, including known or suspected health problems, including but not limited to: • Cancer of the genital tract, trophoblastic disease • Bleeding/spotting between periods or after sex • Severe anemia • Possible allergies						
15. Ask the client to describe her periods before her pregnancy (how long they were, how much bleeding there was, how much pain/cramping she had).						
Decision Making (based on information exchange above)						
16. ***Help the client reconfirm her selection of the IUD and/or postpartum IUD use,*** and assess whether her decision can actually be carried out (given her relationship with her husband/partner, her family situation, her economic situation); encourage her to ask questions for clarification, and *determine her preferred timing for IUD insertion (postplacental insertion vs. insertion within 48 hours vs. after four weeks postdelivery).*						
17. Help the client think through how she and her partner would react or feel if she were to experience common ***side effects,*** considering their possible impact on sexual relations, religious practice, or family life. (Focus on increased/longer/irregular bleeding and spotting, cramping.)						
18. Help the client to: • Assess her individual risk for STIs/HIV • Decide if she needs to take action to reduce her risk, considering the lack of protection provided by the IUD, and to think through the need for dual method use, including condom use						

continued

Counseling Skills						
Components and Steps	**Cases**					
Implementation (ensure client's understanding by having her repeat or explain)						
19. ***For antenatal clients selecting postplacental (or transcesarean) or immediate postpartum insertion within 48 hours, focus on:*** • What the client needs to do to obtain the method when she arrives at the facility for delivery • **Explaining the relevant insertion procedure**						
20. Address the following issues during FP counseling (during antenatal care or before insertion): • Freedom to switch methods if/when her needs and preferences change • What she can do if faced with side effects (use of analgesic—i.e. NSAID—for cramping/pain) • Need to return in case of warning signs • If she is at high individual risk for STIs/HIV, possible concerns about condom use, such as partner reaction (demonstrate and have client demonstrate condom use) • Possible problems with partner or family; development of strategies; practice and role play communication and negotiations, as needed • Issues related to violence, if this seems to be a concern for the client (refer if applicable/possible) • What happens during IUD insertion and how to relax during insertion • ***Follow-up postpartum IUD care***						
Postinsertion Instructions						
21. ***Ensure that the client understands her postinsertion instructions:*** • Tell the client what type of IUD she had inserted and provide her with a card showing the type of IUD and the date of insertion. • Review IUD-related side effects vs. those related to postnatal recovery, and what to do about side effects. • Tell the client when to return for an IUD checkup (do postnatal care at the same time, if possible) or give her a follow-up appointment, emphasizing that she should come back any time she has a concern or experiences warning signs. • Review the warning signs for the IUD.						

continued

Counseling Skills						
	Components and Steps	**Cases**				
	• Review how to check her underpants/pad for expulsion and what to do in case of expulsion, considering whether the client is fully breastfeeding or not. • Explain when and how to check strings (if she wants to). • Assure the client that the IUD does not affect breastmilk/breastfeeding. • Review when the client can safely resume sexual relations after delivery. • Give the client written postinsertion instructions.					

Postpartum IUD Counseling Skills Learning Guide

Follow-up after Postpartum IUD Insertion

This is a learning tool for counseling training in postpartum IUD follow-up. To provide quality postpartum IUD counseling, trainees need to address and perform each step well. Trainees can use the learning guide to rate each step, or even as a job aid upon their return to the workplace. All steps must be performed satisfactorily for a trainee to be considered a competent IUD counselor. If not, further practice and improvement are needed. The areas in *italics* need particular attention for postpartum IUD clients—areas that are not in italics are recommended practices for IUD follow-up in general. Critical steps are in **bold,** and trainees need to make sure they cover all of those components within these steps and in proper sequence.

Trainers/supervisors/peers can use the learning guide to observe and help trainees develop skills as part of training. For subsequent follow-up visits, the learning guide for the interval IUD should be used.

Use the following rating scale:

2 Competently performed: Step performed correctly
1 Needs improvement: Step performed partially or incorrectly
0 Step omitted: Step not done

Counseling and Clinical Skills				
Components and Steps	**Cases**			
Postpartum IUD: First Follow-up Visit				
Rapport Building				
All Clients				
1. Greet the client politely, to maintain a good client-provider interaction (offer her a seat, and ensure her privacy throughout visit).				
2. Identify the purpose of her visit and remind the client that you need to ask all clients personal and sometimes sensitive questions, but that what she says will remain confidential.				
Exploration				
All Clients				
3. **Ask the client:** • ***What questions, concerns, or problems might she have about the IUD, about her recovery, and about her health after delivery?*** • ***What questions, concerns, or problems might she have about changes in her medical history or circumstances since delivery?*** • ***What questions or concerns might she have about possible problems with breastfeeding (if applicable)?*** Document her responses and any other information from the session, as required.				
4. Ask the client if she has resumed sexual relations. il she has, ask whether she has changed partner (or had any new partners) and whether she has any concerns that she might be exposed to sexually transmitted infections (STIs) and HIV through her partner(s); ask about dual method use. (For *return clients with no problems,* proceed to decision-making; for *return clients with problems, continue below.*)				

continued

Counseling and Clinical Skills				
Components and Steps	**Cases**			
Return Clients with Problems 5. Explore in depth with the client her reasons for dissatisfaction or the problems that she faces and encourage the client to ask questions. Issues may include the following: • ***If symptoms are part of postnatal recovery, manage and explain these as applicable.*** • ***If the string is missing or the string length has changed, explain the need for examination and counsel her based on the results.*** • ***If there is possible IUD expulsion, explain her options.*** • If she is experiencing side effects, discuss what she has done/what can be done to manage them; if the side effects are severe and there is nothing else to try, discuss removal. • If she is experiencing a lack of partner or family support for using the IUD and other pressures to remove the IUD, discuss possible communications strategies that she could try to continue using the IUD. • If a client who may want or need to have the IUD removed, screen and counsel the client so that she is able to make an informed choice about a new contraceptive method.				
Decision-Making				
All Clients				
6. Help the client assess her individual risk for STIs/HIV and consider her possible need for protection. *Then go to the appropriate client categories below:*				
Client Wants to Continue with the IUD				
Return Client with No Problems/Satisfied Client: 7. Help the client identify what services she needs during this return visit (for example, a regular well-woman visit) and discuss with her what she should do if she were to experience problems. (*Then go to "All Clients" under Implementation.*)				
Return Client with Problems/Dissatisfied Client: 8. ***If she still desires good protection against pregnancy,* help the client *continue with the IUD,*** making this decision based on correct information and a careful and realistic assessment of her own and her partner's preferences and other circumstances, to ensure that she is able to implement her decision.				

continued

Counseling and Clinical Skills				
Components and Steps	**Cases**			
Return Client Who Has Expelled the IUD 9. Assist the client to reconfirm her decision to continue IUD use; explain reinsertion.				
Client Wants the IUD Removed				
Return Client with Side Effects or Client Who Is Dissatisfied 10. ***If she still desires good protection against pregnancy,* help the client make the decision *to remove the IUD and use a different method,*** based on correct information and a careful and realistic assessment of her own and her partner's preferences and other circumstances, to ensure that she is able to implement her decision. (*Then go to "All clients" under Implementation.*)				
11. ***If the client suspects pregnancy,* help her accept that removal of the IUD is needed.** (*Then go to "All clients" under Implementation.*)				
Implementation				
All Clients				
12. Address issues such as partner or family collaboration that are important for successful implementation of client's plan; develop and practice communication and strategies as needed, including conducting a condom demonstration.				
13. Describe needed follow-up, referral, or subsequent schedule for regular visits. (For clients who are having the IUD removed, go to "Client wants the IUD removed.")				
14. Ask a client who is continuing with the IUD or who is getting a new contraceptive method to tell you how to use the method and when to return in case of side effects or complications.				
15. *Provide messages (as per protocol) related to recommended birth spacing, breastfeeding, nutrition for breastfeeding mothers, and other positive health behaviors.*				
Client Wants the IUD Removed				
16. Explain IUD removal, counsel the client on other suitable methods, and respond to her questions.				

Postpartum IUD Counseling Skills Checklist for Trainers

Insertion

This checklist is to be used by trainers to assess trainees' counseling skills competency. **Use one checklist per participant.**

The areas in *italics* need particular attention for postpartum IUD clients—areas that are not in italics are recommended practice for IUD follow-up in general.

During the final assessment of a participant's performance, the trainer should focus on the correct performance of the **all of the critical steps.** The critical steps are in **bold.** If a participant does not perform all of the critical steps satisfactorily, he or she cannot be consider certified. Trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice at their home facility.

Use the following rating scale:

2 Competently performed: Step performed correctly
1 Needs improvement: Step performed partially or incorrectly
0 Step omitted: Step not done

Counseling Skills						
Components and Steps	**Cases**					
Preinsertion Counseling Using the REDI Framework						
Rapport Building						
1. Greet the client politely, introduce yourself, and offer the client a seat.						
2. Ensure privacy without interruptions throughout the counseling session.						
3. Ask the client's name, age, and contact information. (Document this and subsequent information in the client's record, as required.)						
4. Explain the need to ask personal and sometimes sensitive questions of all clients to help them select a safe and appropriate family planning (FP) method based on their individual needs, while assuring the client of confidentiality.						
Exploration						
5. Ask the client to tell about past FP use, and explore what the client knows about FP methods, her satisfaction with method(s), and what makes her interested in the IUD and/or postpartum IUD insertion.						
6. Explore the client's reproductive goals and history: • Pregnancy history and outcome, ages of children • Whether she wants more children and, if yes, when, to explore the nature of contraceptive protection desired (duration, effectiveness, etc.)						
7. *Explore the client's plans for breastfeeding her baby, including use of the lactational amenorrhea method.*						
8. Focus on the IUD: Explore what the client already knows, fill in knowledge gaps, and correct misperceptions, ensuring that the client understands the advantages and disadvantages of the IUD: • Effectiveness • Use of method—insertion procedure • How the IUD works						

continued

Counseling Skills						
Components and Steps	**Cases**					
• *Postpartum IUD options as appropriate for the client's situation: postplacental insertion within 10 minutes, immediate postpartum insertion within 48 hours of delivery, interval insertion after four weeks, or transcesarean* • *Follow-up required for postpartum IUD use and the client's access to such services* • *IUD and/or postpartum IUD side effects vs. postnatal recovery* • Benefits, risks, and possible complications						
9. Show a sample of the IUD and encourage the client to touch it; provide brochures or other printed information as you provide information, and ask what questions the client has.						
10. *Explore the client's circumstances and relationships:* • Partner/husband/family involvement and support for postpartum IUD/contraceptive use • Other factors that may influence postpartum IUD use, including *access to a health facility for follow-up care* • Past and current experience with violence and/or rape						
11. Explore issues related to sexuality, as appropriate: • Questions/concerns/problems that the client has about sexual relations/practices, including problems related to possible side effects, such as longer and more frequent bleeding • Possible customs related to abstinence after delivery and when the client plans to resume sexual relations						
12. Explain that the IUD does not protect against sexually transmitted infections (STIs) and HIV, and explore the client's knowledge about STIs/HIV, including prevention; fill in knowledge gaps; ask the client about condom use or other safe sex practices, and what questions the client might have.						
13. Explore the client's history of STIs/HIV and explain prevention of mother-to-child transmission of HIV (PMTCT): • Any current unusual vaginal discharge, pain with sex, or lower abdominal pain • History of STIs within the last three months • More than one sexual partner within the last three months (either partner)						

continued

Counseling Skills						
Components and Steps	**Cases**					
• Partner's STI history, or presence of current penile discharge in partner						
• HIV status of client and partner, if known (for referral to PMTCT services, including special counseling for serodiscordant couples)						
14. Screen the client for possible medical conditions by asking her whether she has any health concerns, including known or suspected health problems, including but not limited to: • Cancer of the genital tract, trophoblastic disease • Bleeding/spotting between periods or after sex • Severe anemia • Possible allergies						
15. Ask the client to describe her periods before her pregnancy (how long they were, how much bleeding there was, how much pain/cramping she had).						
Decision-Making (based on information exchange above)						
16. *Help the client reconfirm her selection of the IUD and/or postpartum IUD use* and assess whether her decision can actually be carried out (given her relationship with her husband/partner, her family situation, her economic situation); encourage her to ask questions for clarification, and *determine her preferred timing for IUD insertion (postplacental insertion vs. insertion within 48 hours vs. after four weeks postdelivery).*						
17. Help the client think through how she and her partner would react or feel if she were to experience common *side effects,* considering their possible impact on sexual relations, religious practice, or family life. (Focus on increased/longer/irregular bleeding and spotting, cramping.)						
18. Help the client to: • Assess her individual risk for STIs/HIV • Decide if she needs to take action to reduce her risk, considering the lack of protection provided by the IUD, and to think through the need for dual method use, including condom use						

continued

Counseling Skills						
Components and Steps	**Cases**					
Implementation (ensure client's understanding by having her repeat or explain)						
19. *For antenatal clients selecting postplacental (or transcesarean) or immediate postpartum insertion within 48 hours, focus on:* • What the client needs to do to obtain the method when she arrives at the facility for delivery • Explaining the relevant insertion procedure						
20. Address the following issues during FP counseling (during antenatal care or before insertion): • Freedom to switch methods if/when her needs and preferences change • What she can do if faced with side effects (use of analgesic—i.e. NSAID—for cramping/pain) • Need to return in case of warning signs • If she is at high individual risk for STIs/HIV, possible concerns about condom use, such as partner reaction. (Demonstrate and have client demonstrate condom use.) • Possible problems with partner or family; development of strategies; practice and role play communication and negotiations, as needed • Issues related to violence, if this seems to be a concern for the client (refer if applicable/possible) • What happens during IUD insertion and how to relax during insertion • *Follow-up postpartum IUD care*						
Postinsertion Instructions						
21. *Ensure that the client understands her postinsertion instructions:* • Tell the client what type of IUD she had inserted and provide her with a card showing the type of IUD and the date of insertion. • Review IUD-related side effects vs. those related to postnatal recovery, and what to do about side effects. • Tell the client when to return for an IUD check-up (do postnatal care at the same time, if possible) or give her a follow-up appointment, emphasizing that she should come back any time she has a concern or experiences warning signs.						

continued

Counseling Skills						
Components and Steps	**Cases**					
• Review the warning signs for the IUD. • Review how to check her underpants/pad for expulsion and what to do in case of expulsion, considering whether the client is fully breastfeeding or not. • Explain when and how to check strings (if she wants to). • Assure the client that the IUD does not affect breastmilk/breastfeeding. • Review when the client can safely resume sexual relations after delivery. • Give the client written postinsertion instructions.						
Total						

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Postpartum IUD Counseling Skills Checklist for Trainers

Follow-up after Postpartum IUD Insertion

This checklist is to be used by trainers to assess trainees' counseling skills competency. **Use one checklist per participant.**

The areas in *italics* need particular attention for PPIUD clients; areas that are not in italics are recommended practice for IUD follow-up in general.

During the final assessment of a participant's performance, the trainer should focus on the correct performance of the **all of the critical steps.** The critical steps are in **bold.** If a participant does not perform all of the critical steps satisfactorily, he or she cannot be considered certified. Trainees should continue to improve until they achieve a score of 2 in all steps; at that point, they will be proficient, a level of competency usually attained through continuous practice.

Use the following rating scale:

2 Competently performed: Step performed correctly
1 Needs improvement: Step performed partially or incorrectly
0 Step omitted: Step not done

Counseling and Clinical Skills				
Components and Steps	**Cases**			
First Follow-up Visit				
Rapport Building				
All Clients				
1. Greet the client politely, to maintain a good client-provider interaction (offer her a seat, and ensure her privacy throughout the visit).				
2. Identify the purpose of her visit and remind the client that you need to ask all clients personal and sometimes sensitive questions, but that what she says will remain confidential.				
Exploration				
All Clients				
3. Ask the client: • ***What questions, concerns, or problems might she have about the IUD, about her recovery, and about her health after delivery?*** • ***What questions, concerns, or problems might she have about changes in her medical history or circumstances since delivery?*** • ***What questions or concerns might she have about possible problems with breastfeeding (if applicable)?*** Document this and other information from the session as required				
4. Ask the client if she has resumed sexual relations. If she has, ask whether she has changed partners (or had any new partners) and whether she has any concerns that she might be exposed to sexually transmitted infections (STIs) or HIV through her partner(s); ask about dual method use. (*For return clients with no problems, proceed to decision making; for return clients with problems, continue below.*)				
Return Clients with Problems 5. **Explore in depth with the client her reasons for dissatisfaction** or the problems that she faces, and encourage the client to ask questions. Issues may include the following:				

continued

Counseling and Clinical Skills				
Components and Steps	**Cases**			
• ***If symptoms are part of postnatal recovery, manage and explain these as applicable.*** • ***If the string is missing or the string length has changed, explain the need for examination and counsel her based on the results.*** • ***If there is possible IUD expulsion, explain her options.*** • If she is experiencing side effects, discuss what she has done/what can be done to manage them; if the side effects are severe and there is nothing else to try, discuss removal. • If she is experiencing a lack of partner or family support for using the IUD and other pressures to remove the IUD, discuss possible communications strategies that she could try to continue using the IUD. • If a client who may want or need to have the IUD removed, screen and counsel the client so that she is able to make an informed choice about a new contraceptive method.				
Decision-Making				
All Clients				
6. Help the client assess her individual risk for STIs/HIV and consider her possible need for protection. *Then go to the appropriate client categories below:*				
Client Wants to Continue with the IUD				
Return Client with No Problems/Satisfied Client 7. Help the client identify what services she needs during this return visit (for example, a regular well-woman visit) and discuss with her what she should do if she were to experience problems. (*Then go to "All Clients" under Implementation.*)				
Return Client with Problems/Dissatisfied Client 8. ***If she still desires good protection against pregnancy,* help the client *continue with the IUD,*** making this decision based on correct information and a careful and realistic assessment of her own and her partner's preferences and other circumstances, to ensure that she is able to implement her decision.				
Return Client Who Has Expelled the IUD 9. Assist the client to reconfirm her decision to continue IUD use; explain reinsertion.				

continued

Counseling and Clinical Skills				
Components and Steps	**Cases**			
Client Wants the IUD Removed				
Return Client with Side Effects or Client Who Is Dissatisfied 10. ***If she still desires good protection against pregnancy,* help the client make the decision *to remove the IUD and use a different method,*** based on correct information and a careful and realistic assessment of her own and her partner's preferences and other circumstances, to ensure that she is able to implement her decision. (*Then go to "All clients" under Implementation.*)				
11. ***If the client suspects pregnancy,* help her accept that removal of the IUD is needed.** (*Then go to "All clients" under Implementation.*)				
Implementation				
All Clients				
12. Address issues such as partner or family collaboration that are important for successful implementation of client's plan; develop and practice communication and strategies as needed, including conducting a condom demonstration.				
13. Describe needed follow-up, referral, or subsequent schedule for regular visits. (For clients who are having the IUD removed, go to "Client wants the IUD removed.")				
14. Ask a client who is continuing with the IUD or who is getting a new contraceptive method to tell you how to use the method and when to return in case of side effects or complications.				
15. *Provide messages (as per protocol) related to recommended birth spacing, breastfeeding, nutrition for breastfeeding mothers, and other positive health behaviors.*				
Client Wants the IUD Removed				
16. Explain IUD removal, counsel the client on other suitable methods, and respond to her questions.				

continued

Model practice satisfactory Yes ____ No ____	Clinical practice grade ____
Competent in postpartum IUD insertion ____	Not yet competent in postpartum IUD insertion ____
Comments/Action Plan	
____ Could become competent with additional experience (3–6 cases) supervised by clinical trainer or experienced service provider	
____ Routine follow-up visit in 3–6 months	
____ Other (specify)	
Trainer's Name	Date
Trainer's Signature	

Appendix B

Sample Written Postinsertion Instructions for Clients

Client's name: _____ Record number: _____

Date of IUD insertion: _____

Here is some information about your IUD:
- The name of your IUD is the *Copper T 380A*.
- The Copper T 380A protects from pregnancy for 12 years. You should have the IUD removed or changed after 12 years. If you choose to, you can have the IUD taken out at any time. A health care worker should take it out. Do not take it out yourself.
- Now that you have an IUD, you can still breastfeed your baby. The IUD will not affect the breast milk or the baby in any way.
- When their periods return, some women may have more cramping, heavier bleeding during their periods, longer periods, or spotting or bleeding between periods. These side effects usually go away after a few months of IUD use.

Please follow these instructions for the safe use of your IUD:
- You will have a check-up three to six weeks after you had your baby. At that time, the IUD will also be checked. A health provider will check for the strings protruding through the cervix.
- IUDs sometimes come out. This is most likely to happen in the first weeks after insertion. Watch for this by checking your pads/clothes for the IUD during menses. If you think that the IUD has come out, return to the clinic. Use another contraceptive method in the meantime (e.g., breastfeed fully, use condoms).
- The IUD will not protect you or your partner against HIV infection and other sexually transmitted infections (STIs). Aside from abstinence, the condom is the most effective method of protection against HIV and other STIs. Return to the clinic or an STI clinic if you think there is any chance you may have been exposed to HIV or another STI so you can be examined, treated, and/or referred for treatment and for counseling and testing.

If you desire to, you can check the strings. This is how to do it:
1. Wash your hands with soap and water.
2. Sit in a squatting position, or stand with one foot up on a step or ledge.
3. Gently insert your finger into your vagina. Feel for the cervix. It feels firm, like the tip of your nose.
4. Feel for the strings, but do not pull the strings.

You can return to the clinic at **any time if you have any questions or worries about the IUD.**

Return to the clinic if you have any of these warning signs:
- You have a late period or other signs of pregnancy.
- You have severe cramping that does not decrease over time or with medications.
- You have severe pain in your belly.
- You have pain during intercourse.
- You have unusual discharge from your vagina beyond six weeks after delivery.
- You have bleeding or spotting between periods or after intercourse.
- You can feel the IUD or the strings become longer.

Clinic address: _____

Appendix C

World Health Organization Medical Eligibility Criteria—IUD Excerpts

Table of contents Intrauterine devices

Interpreting the Medical Eligibility Criteria for the IUD

The medical eligibility criteria presented in this Appendix were developed by the World Health Organization (WHO) as part of a systematic process of discussion and review. (Readers should consult the complete document, at www.who.int/reproductive-health/publications/mec/mec.pdf.)

Each condition listed on the following pages was defined as representing either an individual's characteristics (e.g., age, history of pregnancy) or a known preexisting medical/pathological condition (e.g., diabetes, hypertension). It is expected that national and institutional health and service delivery environments will decide the most suitable means for screening for conditions according to their public health importance. Client history will often be the most appropriate approach.

The conditions affecting eligibility for the use of each contraceptive method were classified under one of the following four categories:

1. **A condition for which there is no restriction for the use of the contraceptive method.**
2. **A condition where the advantages of using the method generally outweigh the theoretical or proven risks.**
3. **A condition where the theoretical or proven risks usually outweigh the advantages of using the method.**
4. **A condition which represents an unacceptable health risk if the contraceptive method is used.**

Using the categories in practice Categories 1 and 4 are self-explanatory. Classification of a method/condition as category 2 indicates the method can generally be used, but careful follow-up may be required. However, provision of a method to a woman with a condition classified as category 3 requires careful clinical judgment and access to clinical services; for such a woman, the severity of the condition and the availability, practicality, and acceptability of alternative methods should be taken into account. For a method/condition classified as category 3, use of that method is not usually recommended unless other more appropriate methods are not available or acceptable. Careful follow-up will be required.

Where resources for clinical judgment are limited, such as in community-based services, the four-category classification framework can be simplified into two categories. With this simplification, a classification of Category 3 indicates that a woman is not medically eligible to use the method.

Category	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Yes (Use the method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	No (Do not use the method)
4	Method not to be used	

INTRAUTERINE DEVICES

Cu-IUD = Copper-bearing IUD
LNG-IUD = Levonorgestrel-releasing IUD (20 µg /24hours)

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY			
PREGNANCY	4	4	**Clarification:** The IUD is not indicated during pregnancy and should not be used because of the risk of serious pelvic infection and septic spontaneous abortion.
AGE*			
a) Menarche to < 20 years	2	2	
b) ≥ 20 years	1	1	
PARITY*			
a) Nulliparous	2	2	**Evidence:** There are conflicting data regarding whether IUD use is associated with infertility among nulliparous women, although recent, well-conducted studies suggest no increased risk.[1-9]
b) Parous	1	1	
POSTPARTUM* (breastfeeding or non-breastfeeding, including post-caesarean section)			
a) < 48 hours	2	3	**Evidence:** There was some increase in expulsion rates with delayed postpartum insertion compared to immediate insertion and with immediate postpartum insertion compared to interval insertion.[10-16]
b) 48 hours to < 4 weeks	3	3	
c) ≥ 4 weeks	1	1	
d) Puerperal sepsis	4	4	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
POST-ABORTION*			
a) First trimester	1	1	**Clarification:** IUDs can be inserted immediately after first-trimester, spontaneous or induced abortion. **Evidence:** There was no difference in risk of complications for immediate versus delayed insertion of an IUD after abortion. Expulsion was greater when an IUD was inserted following a second-trimester abortion versus following a first-trimester abortion. There were no differences in safety or expulsions for post-abortion insertion of an LNG-IUD compared with Cu-IUD.[17-30]
b) Second trimester	2	2	
c) Immediate post-septic abortion	4	4	
PAST ECTOPIC PREGNANCY*	1	1	
HISTORY OF PELVIC SURGERY (see postpartum, including caesarean section)	1	1	
SMOKING			
a) Age < 35 years	1	1	
b) Age ≥ 35 years			
(i) < 15 cigarettes/day	1	1	
(ii) ≥ 15 cigarettes/day	1	1	
OBESITY ≥ 30 kg/m^2 body mass index (BMI)	1	1	
BLOOD PRESSURE MEASUREMENT UNAVAILABLE	NA	NA	**Clarification:** While a blood pressure measurement may be appropriate for good preventative health care, it is not materially related to safe and effective IUD use. Women should not be denied use of IUDs simply because their blood pressure cannot be measured.

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
CARDIOVASCULAR DISEASE			
MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE (such as older age, smoking, diabetes and hypertension)	1	2	
HYPERTENSION*			
For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, risk of cardiovascular disease may increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.			
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension in pregnancy)	1	2	
b) Adequately controlled hypertension where blood pressure CAN be evaluated	1	1	
c) Elevated blood pressure levels (properly taken measurements)			
(i) systolic 140-159 or diastolic 90-99	1	1	
(ii) systolic $\geq$ 160 or diastolic $\geq$ 100	1	2	
d) Vascular disease	1	2	.
HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY (where current blood pressure is measurable and normal)	1	1	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)*			
a) History of DVT/PE	1	2	
b) Current DVT/PE	1	3	
c) Family history of DVT/PE (first-degree relatives)	1	1	
d) Major surgery			
(i) with prolonged immobilization	1	2	
(ii) without prolonged immobilization	1	1	
e) Minor surgery without immobilization	1	1	
KNOWN THROMBOGENIC MUTATIONS (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	1	2	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
SUPERFICIAL VENOUS THROMBOSIS			
a) Varicose veins	1	1	
b) Superficial thrombophlebitis	1	1	
CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE*	1	I: 2 / C: 3	
STROKE* (history of cerebrovascular accident)	1	2	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
KNOWN HYPERLIPIDAEMIAS	1	2	**Clarification:** Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
VALVULAR HEART DISEASE			
a) Uncomplicated	1	1	
b) Complicated (pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)	2	2	**Clarification:** Prophylactic antibiotics to prevent endocarditis are advised for insertion.
NEUROLOGIC CONDITIONS			
HEADACHES*		I / C	
a) Non-migrainous (mild or severe)	1	1 / 1	**Clarification:** Any new headaches or marked changes in headaches should be evaluated.
b) Migraine			
(i) without aura			
Age < 35	1	2 / 2	
Age ≥ 35	1	2 / 2	
(ii) with aura, at any age	1	2 / 3	
EPILEPSY	1	1	
DEPRESSIVE DISORDERS			
DEPRESSIVE DISORDERS	1	1	**Clarification**: The classification is based on data for women with selected depressive disorders. No data on bipolar disorder or postpartum depression were available. There is a potential for drug interactions between certain antidepressant medications and hormonal contraceptives.

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**CLARIFICATIONS/EVIDENCE**
	Cu-IUD		**LNG-IUD**		
REPRODUCTIVE TRACT INFECTIONS AND DISORDERS					
VAGINAL BLEEDING PATTERNS*			I	C	
a) Irregular pattern *without* heavy bleeding	1		1	1	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	2		1	2	**Clarification:** Unusually heavy bleeding should raise the suspicion of a serious underlying condition. **Evidence:** Among women with heavy or prolonged bleeding, LNG-IUDs were beneficial in treating menorrhagia.[31-35]
UNEXPLAINED VAGINAL BLEEDING (suspicion for serious condition)	I	C	I	C	**Clarification:** If pregnancy or an underlying pathological condition (such as pelvic malignancy) is suspected, it must be evaluated and the category adjusted after evaluation. There is no need to remove the IUD before evaluation.
Before evaluation	4	2	4	2	
ENDOMETRIOSIS*	2		1		**Evidence:** LNG-IUD use among women with endometriosis decreased dysmenorrhoea and pelvic pain.[36, 37]
BENIGN OVARIAN TUMOURS (including cysts)	1		1		
SEVERE DYSMENORRHOEA*	2		1		
TROPHOBLAST DISEASE*					
a) Benign gestational trophoblastic disease	3		3		
b) Malignant gestational trophoblastic disease	4		4		.
CERVICAL ECTROPION	1		1		
CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)*	1		2		
CERVICAL CANCER* (awaiting treatment)	I	C	I	C	
	4	2	4	2	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**CLARIFICATIONS/EVIDENCE**
	Cu-IUD		**LNG-IUD**		
BREAST DISEASE*					
a) Undiagnosed mass	1		2		
b) Benign breast disease	1		1		
c) Family history of cancer	1		1		
d) Breast cancer:					
(i) current	1		4		
(ii) past and no evidence of current disease for 5 years	1		3		
ENDOMETRIAL CANCER*	I	C	I	C	
	4	2	4	2	
OVARIAN CANCER*	3	2	3	2	
UTERINE FIBROIDS*					
a) Without distortion of the uterine cavity	1		1		**Evidence:** Among women with fibroids, there were no adverse health events with LNG-IUD use and there was a decrease in symptoms and size of fibroids for some women.[38-44]
b) With distortion of the uterine cavity	4		4		
ANATOMICAL ABNORMALITIES*					
a) Distorted uterine cavity (any congenital or acquired uterine abnormality distorting the uterine cavity in a manner that is incompatible with IUD insertion)	4		4		
b) Other abnormalities (including cervical stenosis or cervical lacerations) not distorting the uterine cavity or interfering with IUD insertion	2		2		

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**CLARIFICATIONS/EVIDENCE**
	Cu-IUD		**LNG-IUD**		
PELVIC INFLAMMATORY DISEASE (PID)*	I	C	I	C	
a) Past PID (assuming no known current risk factors for STIs)					
(i) with subsequent pregnancy	1	1	1	1	
(ii) without subsequent pregnancy	2	2	2	2	
b) PID - current	4	2	4	2	**Clarification for continuation:** Treat the PID using appropriate antibiotics. There is usually no need for removal of the IUD if the client wishes to continue its use. (See *Selected Practice Recommendations for Contraceptive Use*. WHO: Geneva, 2002). Continued use of an IUD depends on the woman's informed choice and her current risk factors for STIs and PID. **Evidence:** Among IUD users treated for PID, there was no difference in clinical course if the IUD was removed or left in place.[45-47]
STIs*	I	C	I	C	
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	4	2	4	2	**Clarification for continuation:** Treat the STI using appropriate antibiotics. There is usually no need for removal of the IUD if the client wishes to continue its use. Continued use of an IUD depends on the woman's informed choice and her current risk factors for STIs and PID. **Evidence:** There is no evidence regarding whether IUD insertion among women with STIs increases the risk of PID compared with no IUD insertion. Among women who have an IUD inserted, the absolute risk of subsequent PID was low among women with STI at the time of insertion but greater than among women with no STI at the time of IUD insertion.[48-54]
b) Other STIs (excluding HIV and hepatitis)	2	2	2	2	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	2	2	2	2	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**				
CONDITION	**CATEGORY** I=Initiation, C=Continuation				**CLARIFICATIONS/EVIDENCE**
	Cu-IUD		**LNG-IUD**		
STIs (Cont'd)					
d) Increased risk of STIs	2/3	2	2/3	2	**Clarification for initiation**: If a woman has a very high individual likelihood of exposure to gonorrhoea or chlamydial infection, the condition is a Category 3. **Evidence:** Using an algorithm to classify STI risk status among IUD users, one study reported that 11% of high STI-risk women experienced IUD-related complications compared with 5% of those not classified as high risk.[50]
HIV/AIDS					
HIGH RISK OF HIV*	I	C	I	C	
	2	2	2	2	**Evidence:** Among women at risk of HIV, copper IUD use did not increase risk of HIV acquisition.[55-65]
HIV-INFECTED	2	2	2	2	**Evidence:** Among IUD users, there is limited evidence showing no increased risk of overall complications or infection-related complications when comparing HIV-infected women with non-infected women. Furthermore, IUD use among HIV-infected women was not associated with increased risk of transmission to sexual partners.[55, 66-69]
AIDS	3	2	3	2	**Clarification for continuation:** IUD users with AIDS should be closely monitored for pelvic infection.
Clinically well on ARV therapy	2	2	2	2	
OTHER INFECTIONS					
SCHISTOSOMIASIS					
a) Uncomplicated	1		1		
b) Fibrosis of the liver (if severe, see cirrhosis)	1		1		
TUBERCULOSIS*	I	C	I	C	
a) Non-pelvic	1	1	1	1	
b) Known pelvic	4	3	4	3	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
MALARIA	1	1	
ENDOCRINE CONDITIONS			
DIABETES*			
a) History of gestational disease	1	1	
b) Non-vascular disease			
(i) non-insulin dependent	1	2	
(ii) insulin dependent	1	2	
c) Nephropathy/ retinopathy/ neuropathy	1	2	
d) Other vascular disease or diabetes of >20 years' duration	1	2	
THYROID DISORDERS			
a) Simple goitre	1	1	
b) Hyperthyroid	1	1	
c) Hypothyroid	1	1	
GASTROINTESTINAL CONDITIONS			
GALL-BLADDER DISEASE			
a) Symptomatic			
(i) treated by cholecystectomy	1	2	
(ii) medically treated	1	2	
(iii) current	1	2	
b) Asymptomatic	1	2	
HISTORY OF CHOLESTASIS*			
a) Pregnancy-related	1	1	
b) Past COC-related	1	2	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	**IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.**		
CONDITION	**CATEGORY** I=Initiation, C=Continuation		**CLARIFICATIONS/EVIDENCE**
	Cu-IUD	**LNG-IUD**	
VIRAL HEPATITIS*			
a) Active	1	3	
b) Carrier	1	1	
CIRRHOSIS*			
a) Mild (compensated)	1	2	
b) Severe (decompensated)	1	3	
LIVER TUMOURS*			
a) Benign (adenoma)	1	3	
b) Malignant (hepatoma)	1	3	
ANAEMIAS			
THALASSAEMIA*	2	1	
SICKLE CELL DISEASE*	2	1	
IRON-DEFICIENCY ANAEMIA*	2	1	
DRUG INTERACTIONS			
DRUGS WHICH AFFECT LIVER ENZYMES			
a) Rifampicin	1	1	**Evidence:** One study found that rifabutin, which is in the same class of drugs as rifampicin, has no impact on the effectiveness of LNG-IUD.[70]
b) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1	1	
ANTIBIOTICS (excluding rifampicin)	1	1	
a) Griseofulvin	1	1	
b) Other antibiotics	1	1	

* See also additional comments at end of table

INTRAUTERINE DEVICES (IUDs)	IUDs do not protect against STI/HIV. If there is risk of STI/HIV (including the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.				
CONDITION	CATEGORY I=Initiation, C=Continuation				CLARIFICATIONS/EVIDENCE
	Cu-IUD		LNG-IUD		
ANTIRETROVIRAL THERAPY	I	C	I	C	
	2/3	2	2/3	2	**Clarification**: There is no known drug interaction between ARV therapy and IUD use. However, AIDS as a condition is classified as Category 3 for insertion and Category 2 for continuation unless the woman is clinically well on ARV therapy in which case, both insertion and continuation are classified as Category 2. (See AIDS condition above.)

Additional comments

AGE
Menarche to < 20 years: There is concern both about the risk of expulsion due to nulliparity and risk of STIs due to sexual behaviour in younger age groups.

PARITY
Nulliparous: Nulliparity is related to an increased risk of expulsion.

POSTPARTUM
< 48 hours, 48 hours to < 4 weeks, ≥ 4 weeks: Concern that the neonate may be at risk due to exposure to steroid hormones with LNG-IUD use during the first 6 weeks postpartum is the same as for other POCs.

Puerperal sepsis: Insertion of an IUD may substantially worsen the condition.

POST-ABORTION
Immediate post-septic abortion: Insertion of an IUD may substantially worsen the condition.

PAST ECTOPIC PREGNANCY
The absolute risk of ectopic pregnancy is extremely low due to the high effectiveness of IUDs. However, when a woman becomes pregnant during IUD use, the relative likelihood of ectopic pregnancy is greatly increased.

HYPERTENSION
There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)
Some progestogens may increase the risk of venous thrombosis, although this increase is substantially less than for COCs.

CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE
There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

STROKE
There is theoretical concern about the effect of LNG on lipids. There is no restriction for copper IUDs.

Additional comments (*cont.*)

HEADACHES
Aura is a specific focal neurologic symptom. For more information on this and other diagnostic criteria, see: Headache Classification Subcommittee of the International Headache Society. The International Classification of Headache Disorders, 2nd Edition. Cephalalgia. 2004; 24 (Suppl 1): 1- 150.
http://216.25.100.131/ihscommon/guidelines/pdfs/ihc_II_main_no_print.pdf

VAGINAL BLEEDING PATTERNS
LNG-IUD use frequently causes changes in menstrual bleeding patterns. Over time, LNG-IUD users are more likely than non-users to become amenorrhoeic, thus LNG-IUDs are sometimes used as a treatment to correct heavy bleeding.

ENDOMETRIOSIS
Copper IUD use may worsen dysmenorrhoea associated with the condition.

SEVERE DYSMENORRHOEA
Dysmenorrhoea may intensify with copper IUD use. LNG-IUD use has been associated with reduction of dysmenorrhoea.

TROPHOBLAST DISEASE
There is an increased risk of perforation since the treatment for the condition may require multiple uterine curettages.

CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)

There is some theoretical concern that LNG-IUDs may enhance progression of CIN.

CERVICAL CANCER (awaiting treatment)
There is concern about the increased risk of infection and bleeding at insertion. The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

BREAST DISEASE
Breast cancer: Breast cancer is a hormonally sensitive tumour. Concerns about progression of the disease may be less with LNG-IUDs than with COCs or higher-dose POCs.

ENDOMETRIAL CANCER
There is concern about the increased risk of infection, perforation and bleeding at insertion. The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

OVARIAN CANCER
The IUD will likely need to be removed at the time of treatment but, until then, the woman is at risk of pregnancy.

UTERINE FIBROIDS
Without distortion of the uterine cavity: Women with heavy or prolonged bleeding should be assigned the category for that condition.

With distortion of the uterine cavity: Pre-existing uterine fibroids that distort the uterine cavity may be incompatible with insertion and proper placement of the IUD.

ANATOMICAL ABNORMALITIES
Distorted uterine cavity: In the presence of an anatomic abnormality that distorts the uterine cavity, proper IUD placement may not be possible.

PELVIC INFLAMMATORY DISEASE (PID)
IUDs do not protect against STI/HIV/PID. In women at low risk of STIs, IUD insertion poses little risk of PID. Current risk of STIs and desire for future pregnancy are relevant considerations.

STIs
IUDs do not protect against STI/HIV/PID. Among women with chlamydial infection or gonorrhoea, the potential increased risk of PID with IUD insertions should be avoided. The concern is less for other STIs.

HIGH RISK OF HIV

IUDs do not protect against STI/HIV/PID.

TUBERCULOSIS
Known pelvic: Insertion of an IUD may substantially worsen known the condition.

Additional comments (*cont.*)

DIABETES
Whether the amount of LNG released by the IUD may slightly influence carbohydrate and lipid metabolism is unclear. Some progestogens may increase the risk of thrombosis, although this increase is substantially less than for COCs.

HISTORY OF CHOLESTASIS
There is concern that a history of COC-related cholestasis may predict subsequent cholestasis with LNG use. Whether there is any risk with use of an LNG-IUD is unclear.

VIRAL HEPATITIS
Active: POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

CIRRHOSIS
POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. This concern is similar to, but less than, that with COCs.

LIVER TUMOURS
POCs are metabolized by the liver and their use may adversely affect women whose liver function is compromised. In addition, POC use may enhance the growth of tumours. This concern is similar to, but less than, that with COCs.

THALASSAEMIA
There is concern about an increased risk of blood loss with copper IUDs.

SICKLE CELL DISEASE
There is concern about an increased risk of blood loss with copper IUDs.

IRON-DEFICIENCY ANAEMIA
There is concern about an increased risk of blood loss with copper IUDs.

References for intrauterine devices

1. Cramer DW et al. Tubal infertility and the intrauterine device. *New England Journal of Medicine,* 1985, 312:941-7.
2. Daling JR et al. Primary tubal infertility in relation to the use of an intrauterine device. *New England Journal of Medicine,* 1985, 312:937-41.
3. Daling JR et al. The intrauterine device and primary tubal infertility. *New England Journal of Medicine,* 1992, 326:203-4.
4. Delbarge W et al. Return to fertility in nulliparous and parous women after removal of the GyneFix intrauterine contraceptive system. *European Journal of Contraception & Reproductive Health Care,* 2002, 7:24-30.
5. Doll H, Vessey M, Painter R. Return of fertility in nulliparous women after discontinuation of the intrauterine device: comparison with women discontinuing other methods of contraception. *BJOG: an International Journal of Obstetrics & Gynaecology,* 2001, 108:304-14.
6. Hubacher D et al. Use of copper intrauterine devices and the risk of tubal infertility among nulligravid women. *New England Journal of Medicine,* 2001, 345:561-7.
7. Skjeldestad FE, Bratt H. Return of fertility after use of IUDs (Nova-T, MLCu250 and MLCu375). *Advances in Contraception,* 1987, 3:139-45.
8. Urbach DR et al. Association of perforation of the appendix with female tubal infertility. *American Journal of Epidemiology,* 2001, 153:566-71.
9. Wilson JC. A prospective New Zealand study of fertility after removal of copper intrauterine contraceptive devices for conception and because of complications: a four-year study. *American Journal of Obstetrics & Gynecology,* 1989, 160:391-6.
10. Brenner PF. A clinical trial of the Delta-T intrauterine device: immediate postpartum insertion. *Contraception,* 1983, 28:135-47.
11. Chi IC, Wilkens L, Rogers S. Expulsions in immediate postpartum insertions of Lippes Loop D and Copper T IUDs and their counterpart Delta devices--an epidemiological analysis. *Contraception,* 1985, 32:119-34.
12. El-Shafei M. Postpartum and postabortion intrauterine device insertion unmet needs of safe reproductive health: three year experience of Mansoura University Hospital. *European Journal of Contraception & Reproductive Health Care,* 2000, 26:253-62.
13. Grimes D et al. Immediate post-partum insertion of intrauterine devices.[update of *Cochrane Database Systematic Reviews*, 2001, CD003036; PMID: 11406064]. [Review] [30 refs]. *Cochrane Database of Systematic Reviews,* 2003, CD003036.
14. Morrison C et al. Clinical outcomes of two early postpartum IUD insertion programs in Africa. *Contraception,* 1996, 53:17-21.
15. Thiery M et al. The ML Cu250; clinical experience in Belgium and The Netherlands. *British Journal of Obstetrics & Gynaecology,* 1982, 89:51-3.
16. Thiery M, Delbeke L, Van Kets H. Comparative performance of two copper-wired IUDs (ML Cu 250 and T Cu 200): immediate postpartum and interval insertion. *Advances in Contraceptive Delivery Systems,* 1980, 1:27-35.
17. The World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction. Task Force on Intrauterine Devices for Fertility Regulation. The Alza T IPCS 52, a longer acting progesterone IUD: safety and efficacy compared to the TCu22OC and multiload 250 in two randomized multicentre trials. *Clinical Reproduction & Fertility,* 1983, 2:113-28.
18. The World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction. Task Force on Intrauterine Devices for Fertility Regulation. IUD insertion following termination of pregnancy: a clinical trial of the TCu 220C, Lippes loop D, and copper 7. *Studies in Family Planning,* 1983, 14:99-108.
19. The World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction. Task Force on Intrauterine Devices for Fertility Regulation. IUD insertion following spontaneous abortion: a clinical trial of the TCu 220C, Lippes loop D, and copper 7. *Studies in Family Planning,* 1983, 14:109-14.
20. El Tagy A et al. Safety and acceptability of post-abortal IUD insertion and the importance of counseling. *Contraception,* 2003, 67:229-34.
21. Gillett PG et al. A comparison of the efficacy and acceptability of the Copper-7 intrauterine device following immediate or delayed insertion after first-trimester therapeutic abortion. *Fertility & Sterility,* 1980, 34:121-4.

22. Grimes D, Schulz K, Stanwood N. Immediate postabortal insertion of intrauterine devices.[update of Cochrane Database Syst Rev. 2000;(2):CD001777; PMID: 10796820]. [Review] [28 refs]. *Cochrane Database of Systematic Reviews,* 2002, CD001777.
23. Gupta I, Devi PK. Studies on immediate post-abortion copper "T" device. *Indian Journal of Medical Research,* 1975, 63:736-9.
24. Moussa A. Evaluation of postabortion IUD insertion in Egyptian women. *Contraception,* 2001, 63:315-7.
25. Pakarinen P, Toivonen J, Luukkainen T. Randomized comparison of levonorgestrel- and copper-releasing intrauterine systems immediately after abortion, with 5 years' follow-up. *Contraception,* 2003, 68:31-4.
26. Stanwood NL, Grimes DA, Schulz KF. Insertion of an intrauterine contraceptive device after induced or spontaneous abortion: a review of the evidence. *BJOG: an International Journal of Obstetrics & Gynaecology,* 2001, 108:1168-73.
27. Suvisaari J, Lahteenmaki P. Detailed analysis of menstrual bleeding patterns after postmenstrual and postabortal insertion of a copper IUD or a levonorgestrel-releasing intrauterine system. *Contraception,* 1996, 54:201-8.
28. Timonen H, Luukkainen T. Immediate postabortion insertion of the copper-T (TCu-200) with eighteen months follow-up. *Contraception,* 1974, 9:153-60.
29. Tuveng JM, Skjeldestad FE, Iversen T. Postabortal insertion of IUD. *Advances in Contraception,* 1986, 2:387-92.
30. Zhang PZ. Five years experience with the copper T 200 in Shanghai - 856 cases. *Contraception,* 1980, 22:561-71.
31. Barrington JW, Arunkalaivanan AS, Abdel-Fattah. Comparison between the levonorgestrel intrauterine system (LNG-IUS) and thermal balloon ablation in the treatment of menorrhagia. *European Journal of Obstetrics, Gynecology & Reproductive Biology,* 2003, 108:72-4.
32. Hurskainen R et al. Quality of life and cost-effectiveness of levonorgestrel-releasing intrauterine system versus hysterectomy for treatment of menorrhagia: a randomised trial. *Lancet,* 2001, 357:273-7.
33. Istre O, Trolle B. Treatment of menorrhagia with the levonorgestrel intrauterine system versus endometrial resection. *Fertility & Sterility,* 2001, 76:304-9.
34. Lethaby AE, Cooke I, Rees M. Progesterone/progestogen releasing intrauterine systems versus either placebo or any other medication for heavy menstrual bleeding. *Cochrane Database of Systematic Reviews,* 2000, CD002126.
35. Stewart A et al. The effectiveness of the levonorgestrel-releasing intrauterine system in menorrhagia: a systematic review. *BJOG: an International Journal of Obstetrics & Gynaecology,* 2001, 108:74-86.
36. Fedele L et al. Use of a levonorgestrel-releasing intrauterine device in the treatment of rectovaginal endometriosis. *Fertility & Sterility,* 2001, 75:485-8.
37. Vercellini P et al. A levonorgestrel-releasing intrauterine system for the treatment of dysmenorrhea associated with endometriosis: a pilot study. *Fertility & Sterility,* 1999, 72:505-8.
38. Fedele L et al. Treatment of adenomyosis-associated menorrhagia with a levonorgestrel-releasing intrauterine device. *Fertility & Sterility,* 1997, 68:426-9.
39. Grigorieva V et al. Use of a levonorgestrel-releasing intrauterine system to treat bleeding related to uterine leiomyomas. *Fertility & Sterility,* 2003, 79:1194-8.
40. Mercorio F et al. The effect of a levonorgestrel-releasing intrauterine device in the treatment of myoma-related menorrhagia. *Contraception,* 2003, 67:277-80.
41. Wildemeersch D, Schacht E, Wildemeersch P. Treatment of primary and secondary dysmenorrhea with a novel 'frameless' intrauterine levonorgestrel-releasing drug delivery system: a pilot study. *European Journal of Contraception & Reproductive Health Care,* 2001, 6:192-8.
42. Wildemeersch D, Schacht E. The effect on menstrual blood loss in women with uterine fibroids of a novel "frameless" intrauterine levonorgestrel-releasing drug delivery system: a pilot study. *European Journal of Obstetrics, Gynecology & Reproductive Biology,* 2002, 102:74-9.
43. Wildemeersch D, Schacht E, Wildemeersch P. Contraception and treatment in the perimenopause with a novel "frameless" intrauterine levonorgestrel-releasing drug delivery system: an extended pilot study. *Contraception*, 2002, 66:93-99.
44. Wildemeersch D, Schacht E, Wildemeersch P. Performance and acceptability of intrauterine release of levonorgestrel with a miniature delivery system for hormonal substitution therapy, contraception and treatment in peri and postmenopausal women. *Maturitas,* 2003, 44:237-45.

45. Larsson B, Wennergren M. Investigation of a copper-intrauterine device (Cu-IUD) for possible effect on frequency and healing of pelvic inflammatory disease. *Contraception,* 1977, 15:143-9.
46. Soderberg G, Lindgren S. Influence of an intrauterine device on the course of an acute salpingitis. *Contraception,* 1981, 24:137-43.
47. Teisala K. Removal of an intrauterine device and the treatment of acute pelvic inflammatory disease. *Annals of Medicine,* 1989, 21:63-5.
48. Faundes A et al. The risk of inadvertent intrauterine device insertion in women carriers of endocervical Chlamydia trachomatis. *Contraception,* 1998, 58:105-9.
49. Ferraz do Lago R et al. Follow-up of users of intrauterine device with and without bacterial vaginosis and other cervicovaginal infections. *Contraception,* 2003, 68:105-9.
50. Morrison CS et al. Use of sexually transmitted disease risk assessment algorithms for selection of intrauterine device candidates. *Contraception,* 1999, 59:97-106.
51. Pap-Akeson M et al. Genital tract infections associated with the intrauterine contraceptive device can be reduced by inserting the threads into the uterine cavity. *British Journal of Obstetrics & Gynaecology,* 1992, 99:676-9.
52. Sinei SK et al. Preventing IUCD-related pelvic infection: the efficacy of prophylactic doxycycline at insertion. *British Journal of Obstetrics & Gynaecology,* 1990, 97:412-9.
53. Skjeldestad FE et al. IUD users in Norway are at low risk for genital C. trachomatis infection. *Contraception,* 1996, 54:209-12.
54. Walsh TL et al. IUD Study Group. Effect of prophylactic antibiotics on morbidity associated with IUD insertion: results of a pilot randomized controlled trial. *Contraception,* 1994, 50:319-27.
55. European Study Group on Heterosexual Transmission of HIV. Comparison of female to male and male to female transmission of HIV in 563 stable couples. *BMJ,* 1992, 304:809-13.
56. Carael M et al. Human immunodeficiency virus transmission among heterosexual couples in Central Africa. *AIDS,* 1988, 2:201-5.
57. Kapiga SH et al. Risk factors for HIV infection among women in Dar-es-Salaam, Tanzania. *Journal of Acquired Immune Deficiency Syndromes,* 1994, 7:301-9.
58. Kapiga SH et al. The incidence of HIV infection among women using family planning methods in Dar es Salaam, Tanzania. *AIDS,* 1998, 12:75-84.
59. Mann JM et al. HIV infection and associated risk factors in female prostitutes in Kinshasa, Zaire. *AIDS,* 1988, 2:249-54.
60. Martin HL, Jr. et al. Hormonal contraception, sexually transmitted diseases, and risk of heterosexual transmission of human immunodeficiency virus type 1. *Journal of Infectious Diseases,* 1998, 178:1053-9.
61. Mati JK et al. Contraceptive use and the risk of HIV infection in Nairobi, Kenya. *International Journal of Gynaecology & Obstetrics,* 1995, 48:61-7.
62. Nicolosi A et al. Italian Study Group on HIV Heterosexual Transmission. The efficiency of male-to-female and female-to-male sexual transmission of the human immunodeficiency virus: a study of 730 stable couples. *Epidemiology,* 1994, 5:570-5.
63. Plourde PJ et al. Human immunodeficiency virus type 1 infection in women attending a sexually transmitted diseases clinic in Kenya. *Journal of Infectious Diseases,* 1992, 166:86-92.
64. Sinei SK et al. Contraceptive use and HIV infection in Kenyan family planning clinic attenders. *International Journal of STD & AIDS,* 1996, 7:65-70.
65. Spence MR et al. Seroprevalence of human immunodeficiency virus type I (HIV-1) antibodies in a family-planning population. *Sexually Transmitted Diseases,* 1991, 18:143-5.
66. Morrison CS et al. Is the intrauterine device appropriate contraception for HIV-1-infected women? *BJOG: an International Journal of Obstetrics & Gynaecology,* 2001, 108:784-90.
67. Sinei SK et al. Complications of use of intrauterine devices among HIV-1-infected women. *Lancet,* 1998, 351:1238-41.
68. Mostad SB et al. Hormonal contraception, vitamin A deficiency, and other risk factors for shedding of HIV-1 infected cells from the cervix and vagina. *Lancet,* 1997, 350:922-7.
69. Richardson BA et al. Effect of intrauterine device use on cervical shedding of HIV-1 DNA. *AIDS,* 1999, 13:2091-7.
70. Bounds W, Guillebaud J. Observational series on women using the contraceptive Mirena concurrently with anti-epileptic and other enzyme-inducing drugs. *Journal of Family Planning and Reproductive Health Care, 2002,* 28:78-80.

Appendix D

When Is a Woman at Very High Individual Risk of Gonorrhea or Chlamydia?

When Is a Woman at Very High Individual Risk of Gonorrhea or Chlamydia?

For IUD insertion, the World Health Organization (WHO) Medical Eligibility Criteria state that for a woman with a "very high individual likelihood of exposure to gonorrhea or chlamydial infection, the condition is a Category 3."[1] This statement was specifically written to ensure that the individual woman's case is evaluated before a decision is made. The bar was deliberately placed at "very high" because even in populations where the prevalence of gonorrhea or chlamydia is as high as 10%, the risk of clinical pelvic inflammatory disease attributable to the IUD is still relatively low.

Still, this presents the challenge of defining the concept of "very high individual risk" and putting the definition into operation at the program level. A number of studies have been conducted to identify good determiners of risk, and some of these have been reasonably successful. However, indicators that are good predictors of infection at one site may not necessarily be as good at other sites. So there is no single algorithm to apply in all situations, and there is no clear approach to this question.

Nevertheless, in keeping with the standard of "very high individual risk," some questions generally elicit answers that have a reasonable positive predictive value.[2] For example, if the answer to a question is yes, at least in some settings, there is some reasonable likelihood the client will indeed have gonorrhea or chlamydia. This is the most reasonable available approach for using client history, even though collectively the questions may not be very "sensitive" (i.e., they may not identify the majority of women who have gonorrhea or chlamydia).

Such illustrative questions include:
- Within the last three months, have you been told you have a sexually transmitted infection (STI)?
- Within the last three months, have you had more than one sexual partner?
- Do you think your partner has had another sexual partner within the last three months?
- Within the last three months, has your partner been told he has an STI or has he had any penile discharge?
- Do you believe you are at high risk of an STI?

Source: This appendix is adapted from Maximizing Access and Quality (MAQ) Initiative. No date. *IUD toolkit*. Baltimore: INFO Project. Accessed at: www.maqweb.org/iudtoolkit/gen_info/index.shtml/.

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[1] Category 3 indicates that the method is usually not recommended unless other, more appropriate methods are not available or not acceptable. The risks of using the method usually outweigh the advantages, but if the client does use the method, careful follow-up will be required. For more information, see WHO, 2007.

[2] Positive predictive value reflects the proportion of clients who have a positive test result and who truly have the disease in question. A test with a high positive predictive value indicates that the patient who has a positive test result probably has the disease.

Appendix E

Active Management of the Third Stage of Labor—Resources

Active Management of the Third Stage of Labor Fact Sheet

FACT SHEET

Active Management of the Third Stage of Labor for Prevention of Postpartum Hemorrhage:
A Fact Sheet for Policy Makers and Program Managers

WHAT?

Active management of the third stage of labor (AMTSL) includes three steps:

1. Administration of a uterotonic drug (oxytocin, 10 IU injection, is the drug of choice)
2. Controlled cord traction
3. Uterine massage after delivery of placenta

WHY?

Every year, there are 14 million cases of postpartum hemorrhage (PPH), or excessive bleeding that occurs after childbirth. PPH accounts for approximately 25% of maternal deaths worldwide[1] and for up to 60% of deaths in some countries.[2] PPH also causes significant long-term morbidity.[3] Research has validated AMSTL as a best practice that reduces:

- The incidence of PPH from uterine atony (i.e., the failure of the uterus to contract after delivery) by up to 60%[4]
- The need for blood transfusion (with medical risks, hospital stay, and attendant costs)[5]
- Ultimately, death and ill health from PPH[3]

Active management of the third stage of labor is:

- A safe, cost-effective, and sustainable intervention
- More humane and ethical than having to deal with the complications of PPH, especially for women who already may be anemic or malnourished[2]
- A practice that can save facilities money, according to studies conducted in Guatemala, Vietnam, and Zambia[6,7]
- A way to increase the effectiveness and economic impact of maternal and child health programs
- A practice that has been adopted by many types of providers, after relatively short training sessions that include practical experience

WHEN?

AMTSL should be offered to every woman, at every birth, by every provider, because:

- The vast majority of cases of PPH cannot be predicted in advance,[2] but they can be prevented with AMTSL.
- The health status of many women is compromised by anemia at the time of delivery, making even a small amount of blood loss dangerous, so reducing blood loss at birth could be life-saving.

WHAT can be done to increase the use of active management of the third stage of labor?

Advocacy:

- Create policy support for the routine use of AMTSL as one of the most effective interventions to prevent PPH—the major killer of women in childbirth—and save women's lives.
- Introduce international research findings and guidelines into national policy dialogue and development—e.g., the International Confederation of Midwives (ICM)/ International Federation of Gynecology and Obstetrics (FIGO) joint statement on AMTSL[8] and the World Health Organization (WHO) guideline.[9]
- Promote community- and facility-based commitment for routine availability and use of AMTSL for all women during childbirth.
- Partner with regional task forces, civil society, and professional associations to promote local commitment.
- Collaborate with the U.S. Agency for International Development (USAID), WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), and other donors and cooperating agencies to gain support for including AMTSL at all levels and integrating it into service-delivery guidelines.

Training:

- Include AMTSL in appropriate preservice and in-service curricula and trainings.
- Provide support for training (e.g., through audiovisuals, anatomic models, reference materials, job aids, and training supplies).
- Carry out training follow-up, monitoring, and supervision.
- Confirm authorization and legal authority of provider cadres who can deliver AMTSL and related services, including injections. (Consider facility and community level.)
- Integrate AMTSL into comprehensive safe motherhood training programs. (Skills training in AMTSL alone is possible when a comprehensive training is not possible or was recently completed.)

Service delivery:

- Ensure adequate infrastructure, labor/delivery space, and utilities (e.g., running water, toilets, and electrical power), if possible.
- Support training using job aids, supervision, and monitoring.
- Make available logistics system support (e.g., cold or cool chain with light protection for drug commodities and appropriate packaging and dosage for prophylaxis and treatment, including oxytocin and/or ergometrine or syntometrine, on the Essential Drugs List).
- Support cross-cutting issues (e.g., quality improvement, infection prevention, and access to skilled assistance at delivery).
- Provide supplies (e.g., oxytocin, needles, and syringes).

REFERENCES

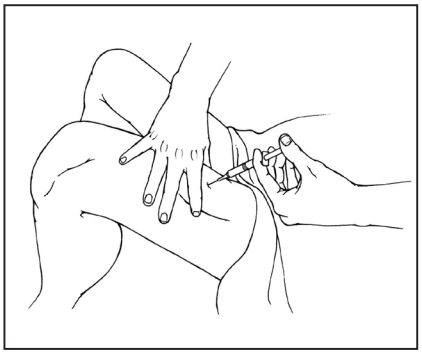
1. World Health Organization (WHO) Department of Reproductive Health and Research. 2004. *Maternal mortality in 2000: Estimates developed by WHO, UNICEF, and UNFPA*. Geneva. Available at: www.childinfo.org/maternal_mortality_in_2000.pdf.
2. AbouZahr, C. 1998. Antepartum and postpartum haemorrhage. In *Health dimensions of sex and reproduction*, ed. by C.J.L. Murray and A.D. Lopez AD. Boston: Harvard University Press, pp. 165–190.
3. WHO. 1994. *Mother-baby package: Implementing safe motherhood in countries*. WHO/FHE/MSM/94.11. Geneva.
4. Prendiville, W.J., et al. 1988. The Bristol third stage trial: active versus physiological management of third stage of labour. *British Medical Journal* 297(6659):1295–1300.
5. McCormick, M.L., et al. 2002. Averting maternal death and disability: Preventing postpartum hemorrhage in low-resource settings. *International Journal of Gynecology and Obstetrics* 77(3):267–275.
6. Fogarty, L., et al. 2005. *Is active management of third stage of labor cost effective for health facilities? A case-comparison study in Guatemala and Zambia*. Baltimore, MD: JHPIEGO.
7. Tsu, V., et al. 2005. *Reducing postpartum hemorrhage in Vietnam: Assessing the effectiveness of active management of third-stage labor*. Hanoi/Seattle: Vietnam Ministry of Health/PATH.
8. International Confederation of Midwives and International Federation of Gynecology and Obstetrics. 2003. *Joint statement: Management of the third stage of labour to prevent postpartum haemorrhage.*
9. WHO, UNFPA, UNICEF, and World Bank. 2000. *Managing complications in pregnancy and childbirth.* WHO/RHR/00.7. Geneva.

Active Management of the Third Stage of Labor Poster

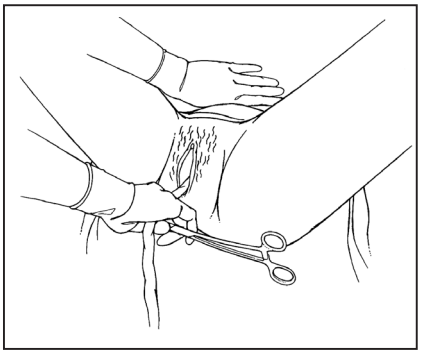
Active Management of the Third Stage of Labor (AMTSL)

Offer to every woman…

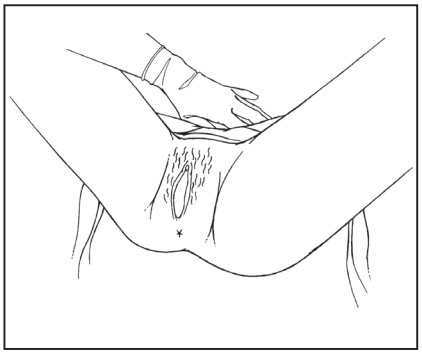
1 **Give oxytocin within 1 minute of childbirth.**



2 **Deliver the placenta by controlled traction on the umbilical cord and counter-pressure to the uterus.**



3 **Massage the uterus through the abdomen after delivery of the placenta.**



! **During recovery, palpate the uterus through the abdomen every 15 minutes for two hours to make sure it is firm and monitor the amount of vaginal bleeding.**

…at every birth, by every skilled provider.

USAID FROM THE AMERICAN PEOPLE

RTI International PATH EngenderHealth
International Confederation of Midwives JHPIEGO
International Federation of Gynecology and Obstetrics (FIGO)

POPPHI Prevention of Postpartum Hemorrhage Initiative

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