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# INFECTION PREVENTION FOR POSTPARTUM IUCD SERVICES

*Postpartum IUCD Training Course*

# Objectives

- Discuss the role of the provider in infection prevention related to the provision of PPIUCD services
- Describe infection prevention practices that are part of PPIUCD services



# Definition

- Infection Prevention – practices and procedures that limit the transmission of infectious agents to patients, staff and the community
- Many activities in health care facilities have a component of infection prevention
- IP practices are everyone's responsibility, but leadership in infection prevention must be demonstrated by service providers



# IP Practices Important in PPIUCD Services

- Handwashing
- Use of personal protective equipment
- Use of antiseptics
- Proper aseptic technique during procedures
- Instrument processing and use of disinfectants
- Housekeeping and waste disposal



# Handwashing

- Hands that are visibly dirty or contaminated with proteinaceous material, should be washed with soap and water
- If hands are NOT visibly soiled or contaminated, an alcohol-based hand rub product can be used
- Ensure hands are dry before starting any activity



Hand hygiene before and after contact with every patient is among the most important means of preventing the spread of infection



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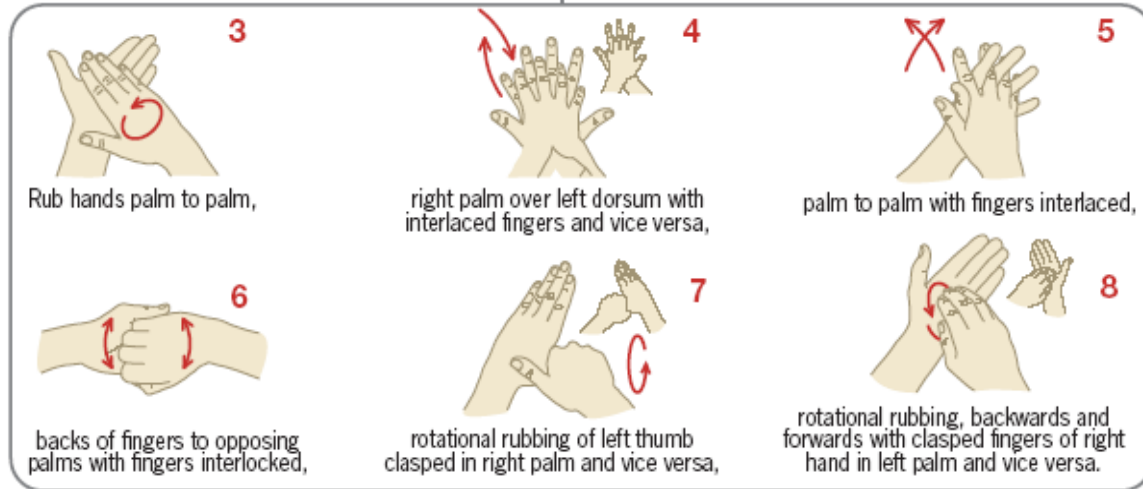
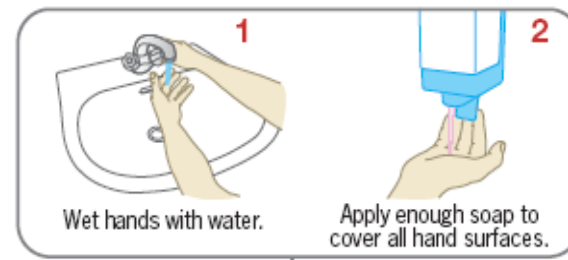


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# Handwashing

- Use of soap and water

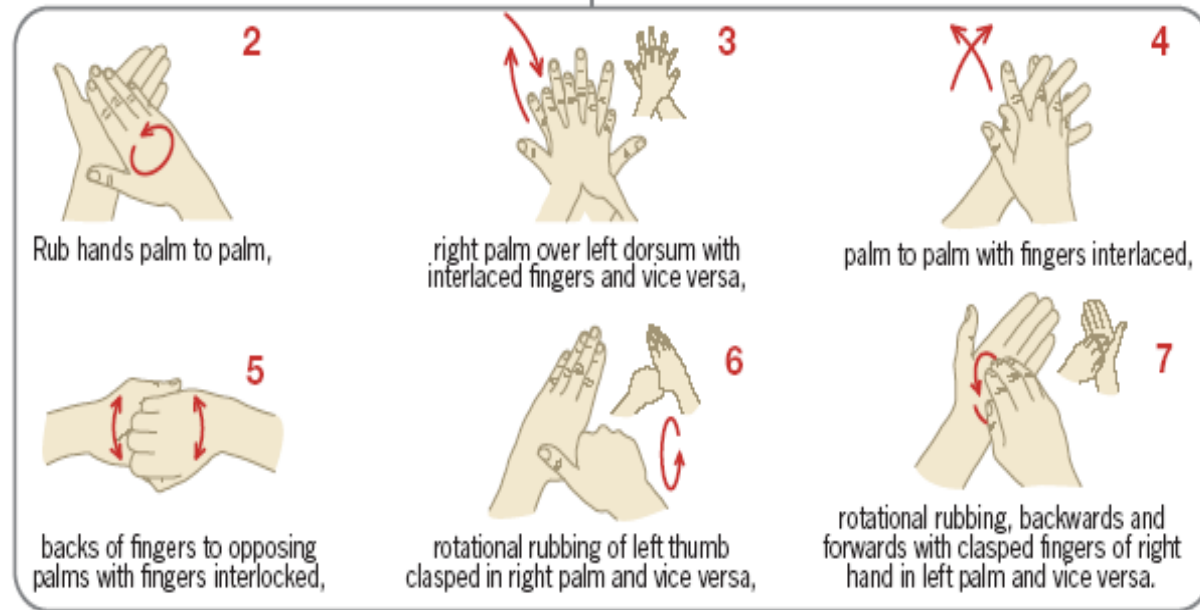
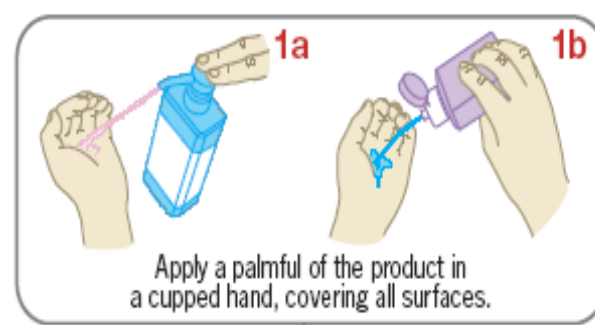
Adapted from *WHO guidelines on hand hygiene in health care (advanced draft): A summary*, World Alliance for Patient Safety, World Health Organization, 2005



# Handwashing

- Use of alcohol – based handrub

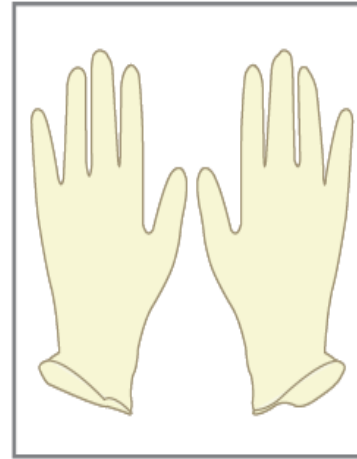
Adapted from *WHO guidelines on hand hygiene in health care (advanced draft): A summary*, World Alliance for Patient Safety, World Health Organization, 2005





# Use of Personal Protective Equipment (PPE)

- **Postplacental insertion:**
  - Routine PPE for delivery
  - Gown, gloves, haircover, eyewear and medical mask
- **Postpartum insertion:**
  - Apron and gloves
- **Intraccesarean:**
  - Routine PPE for surgery
  - Gown, gloves, haircover, eyewear and medical mask



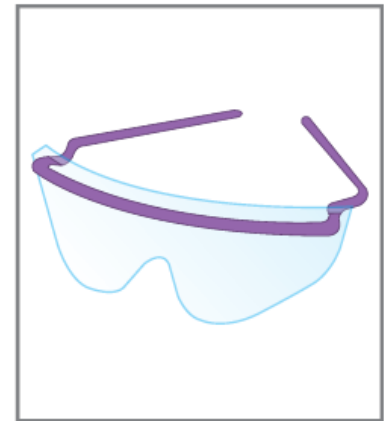
Gloves



Gown – other types and styles are also appropriate.



Medical mask – other types and styles are also appropriate.

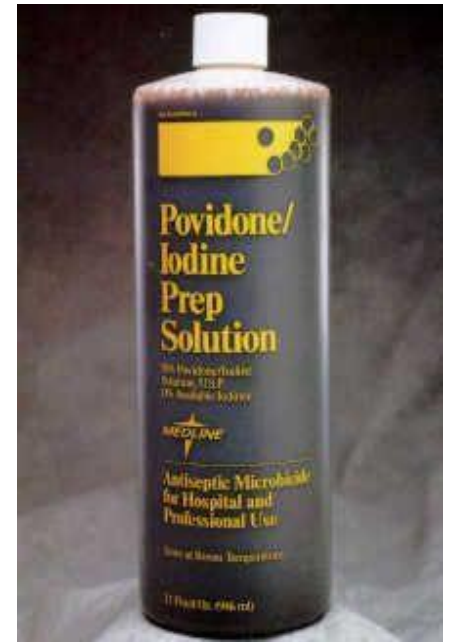


Protective eyewear - eye visors, goggles, and face shields are examples of protective



# Use of Antiseptics

- Acceptable antiseptics on mucous membranes:
  - Povidone iodine (Betadine)
  - Chlorhexidine gluconate (savlon, Hibiclens)
- Not acceptable
  - Alcohol
  - Peroxide
- How does an iodophor work? Timing?



# Aseptic Technique During Procedures

## Exercise:

- What are the steps in the clinical skills checklists for postplacental, postpartum and intracesarean insertion that are infection prevention steps?



# Instrument Processing

- **Decontamination**

- Soak instruments for 10 minutes in 0.5% chlorine solution

- **Cleaning**

- Use a brush and wash all instruments with soap and running water until visibly clean

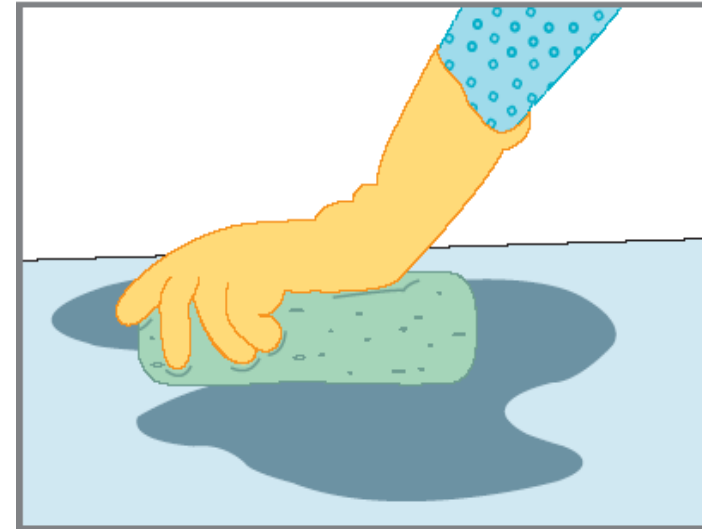
- **High level disinfection or Sterilization**

- Sterilize in an autoclave
- HLD by boiling or by chemical soaking



# Housekeeping and Waste Disposal

- Clean up after any procedure
- Dispose of waste in a leak proof container
- Place instruments in bucket with 0.5% chlorine solution
- Wipe surfaces using cloth and 0.5% chlorine solution
- Dispose of sharps in puncture proof container



*PPE, including rubber gloves and gown, must be worn during cleaning and disinfecting.*



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# Infection Prevention Summary

- Infection prevention is everyone's responsibility
- Patterns are set and habits are formed by watching the senior members of the team
  - Therefore, senior members need to practice IP practices carefully and encourage others to do so also
- Handwashing is the single most important means of preventing the spread of infection
- Aseptic technique is critical to prevent infection during postpartum insertion of IUCDs



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# COUNSELING and INFORMED CONSENT for POSTPARTUM IUCD

Postpartum IUCD Training Course

# Objectives

- Discuss the optimal time for counseling a client about the PPIUCD
- Describe the content of counseling for PPIUCD, including method specific counseling
- Demonstrate good counseling approaches
- Discuss the importance of informed choice in selection of a PFP method





# When to Provide PPIUCD Counseling

- Women in labor are not in the best situation to understand and consider their family planning options.
- Counseling for PFP should ideally occur during antenatal care.
- Since postplacental insertion of the IUCD is the most convenient time and has the lowest rate of complications, service providers should make efforts to make this possible. This means adequate counseling for PPIUCD during ANC.



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# When to Provide PPIUCD Counseling

- Realistically not every woman who may benefit from PPIUCD comes for ANC
- Counseling for PPIUCD can take place:
  - During ANC
  - During the early stages of labor (latent phase)
  - During a hospitalization for an ANC complication
  - While preparing for a scheduled cesarean section
  - During the first 2 days postpartum



# Elements of Good Counseling

A good counselor has the following goals during any counseling session:

- To establish a supportive and trusting relationship with the woman
- To allow the woman to express her ideas and to listen to her
- To engage the woman's family members
- To ensure that the woman understands the information and instructions given.



# Including Husbands in Counseling

- When we are finished counseling, the woman may say
  - “That sounds good. I will need to talk to my husband.”
- Strategies:
  - Invite husband in for counseling
  - Have husband group discussion together or separate from women
  - Provide woman information to take home to facilitate discussion with husband
  - Make a notation in the chart and follow up on the discussion next time



# Components of Counseling for PPIUCD

- Provide general information on all benefits of pregnancy spacing
- Provide method specific information about the IUCD
- Give information about the advantages and limitations of the PPIUCD, including potential side effects
- Plan for next steps



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# Elements of Counseling for PPIUCD

- Consider discussing the elements of an *ideal* contraceptive method
- Ask the woman how important these method characteristics are to her

- Effectiveness
- Action needed by client
- Need to remember
- Chance of method failure
- Permanence
- Return to fertility
- Side effects
- Other health benefits



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# What We Say... and How We Say It

- Think about the technical information you want to provide.
- Consider your own thoughts and biases in presenting that information.
- How do these statements differ?
  - “The IUCD is more than 99% effective in preventing pregnancy. It is really just as good as sterilization, but not permanent.”
  - “The IUCD is not perfect, it is 99% effective, which isn’t 100%. So you really can’t be as sure as with sterilization.”



# Approach to Counseling

- **New client with a method in mind**
  - Ensure that the client knows her options.
    - This can be done through group discussion
  - Check that the client's understanding of her chosen method is accurate.
  - Support the client's choice, if client is medically eligible.
  - Discuss how to use the method and how to cope with any side effects.



# Approach to Counseling

- **New client with no method in mind**
  - Discuss the client's situation, plans and what is important to her about a method.
  - Help the client consider methods that might suit her. If needed, help her reach a decision.
  - Support the client's choice, give instructions on use, and discuss how to cope with any side effects.



# Method-specific Counseling about PPIUCD

- Discuss key characteristics of the IUCD.
- Discuss advantages and limitations.
- Discuss differences between interval IUCD and PPIUCD.
- Explain side effects and warning signs.



# Method-specific Counseling about PPIUCD

## ● Discuss key characteristics of the IUCD

- Effectiveness: prevents almost 100% of pregnancies for up to 12 years (approved for 10 years)
- Mechanism of action: causes a chemical change that damages the sperm BEFORE the sperm and egg meet.
- How the IUCD is used: inserted after delivery and then requires no additional care
- Removal and return to fertility: IUCD can be removed at any time by a trained provider and fertility will return immediately
- Return instructions: the woman should come back 6 weeks post partum



# Method-specific Counseling about PPIUCD

- **Discuss advantages**

- Immediate placement after delivery
- No action required by the woman
- Immediate return of fertility upon removal
- Does not affect breastfeeding
- Long-acting and reversible: Can be used to prevent pregnancy for a short time, as little as a month or as long as 12 years



# Method-specific Counseling about PPIUCD

- **Discuss limitations:**

- Heavier and more painful menses, especially first few cycles
- Does not protect against STIs, including HIV/AIDS
- Small risk of perforation
- Higher risk of expulsion when inserted postpartum





# Method-specific Counseling about PPIUCD

- Discuss differences between interval IUCD and PP IUCD
  - PPIUCD placed following delivery meaning it is easy and convenient for the woman
  - Provides protection immediately, so when she needs contraception she already has it in place
  - Initial side effects of IUCD (increased bleeding and cramping) may be perceived as less during post partum period
  - Insertion of the IUCD in postpartum period may result in higher chance of expulsion



# Method-specific Counseling about PPIUCD

- Discuss the following warning signs and explain them to the woman.
- “You should return to the clinic as soon as possible if you have any of the following...”
  - Foul smelling vaginal discharge different from the usual lochia
  - Lower abdominal pain, especially if accompanied by not feeling well, fever or chills, especially during the first 20 days after insertion
  - Concerns you might be pregnant
  - Concerns the IUCD has fallen out



# Informed Choice

- Voluntary decision by a client about whether or not to use a contraceptive method or undergo a particular procedure.
- An informed choice is a choice made by the woman
- Informed choice can be limited by
  - Medical barriers
  - Provider bias and assumptions
  - Lack of information
  - Lack of counseling
  - Myths and misconceptions



# PPIUCD Counseling Summary

- Gain the trust and confidence of your client
- Help her choose the best method for her and her needs
- Explain what she needs to know
- Follow up on her questions and decision making process.





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# POSTPARTUM INTRAUTERINE CONTRACEPTIVE DEVICE

*Postpartum IUCD Training Course*

# Objectives

By the end of this presentation, participants will be able to

- List the clinical criteria for provision of the IUCD in the postpartum setting
- Describe the key method characteristics of the IUCD when provided postpartum
- Discuss the advantages and limitations
- Discuss the key elements of postpartum IUCD service provision



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# The Context for Postpartum IUCD

- If we accept that pregnancy spacing of at least 24 months is recommended, and
- If we recognize that there is large unmet need for postpartum FP, and
- If we have learned that there have been advances in understanding the IUCD, and
- If we see that the new focus on Skilled Attendance at Birth gives us a unique and new opportunity to provide women with postpartum FP, then....



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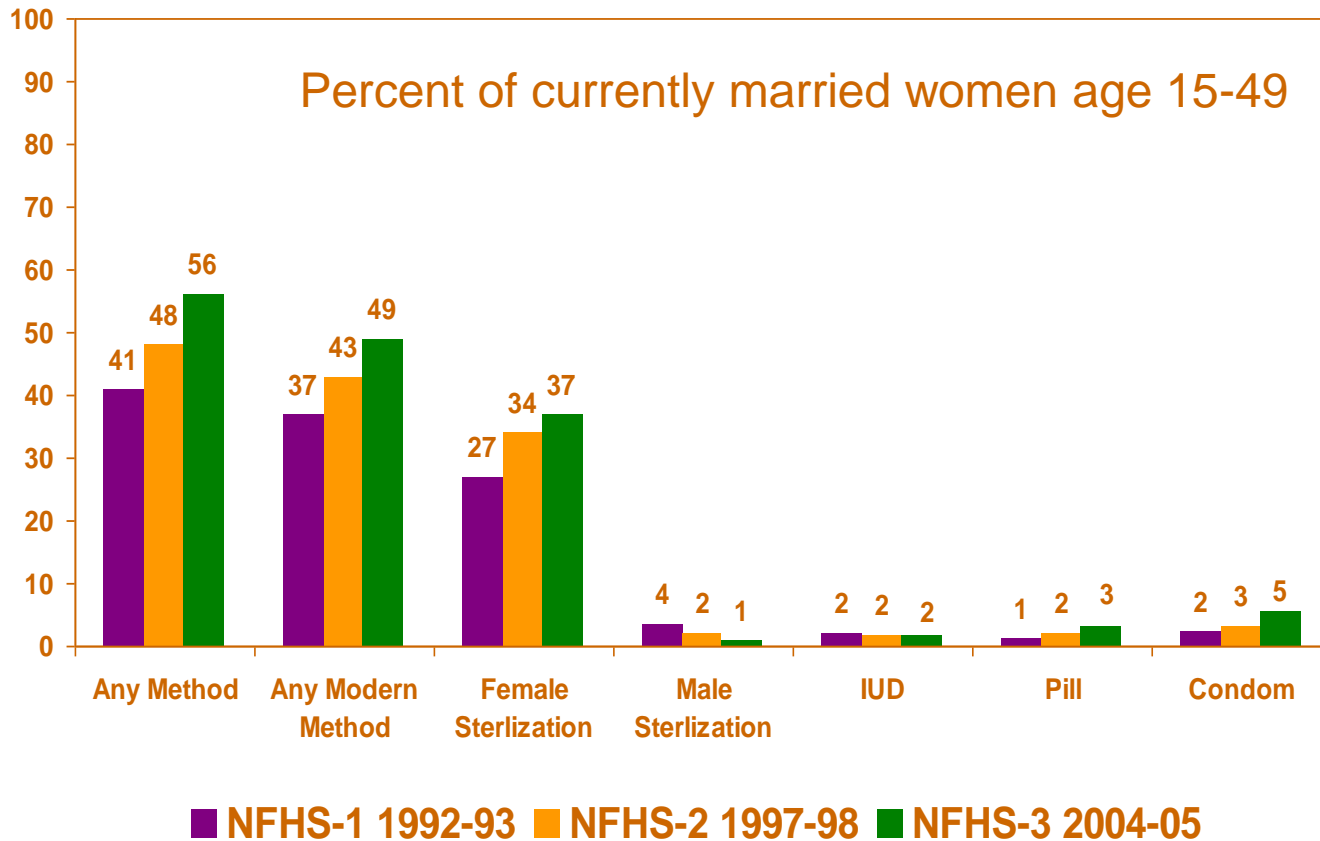
# The Context for Postpartum IUCD

- The postpartum IUCD is a potential answer to issues of:
  - Variety of different methods
    - More choices increases satisfaction
  - Possibility of a long term reversible method
    - IUCD may be an alternative to tubectomy for some couples
  - Access
    - Immediate postpartum insertion is convenient for women





# Trends in Current Contraceptive Use by Method India 1992 – 2005



# But...Resurgence of Interest in the IUCD

- India-wide national strategy to increase IUCD services
- Global changes in thinking about IUCD
- New advances and new understanding about IUCD
  - Recent research has led to important changes in WHO Medical Eligibility Criteria (MEC)
- Rediscovering a “languishing innovation”
  - Despite persistent misconceptions, IUCD users have higher **satisfaction rates** (99% versus 91% for pill users) and **continuation rates** than users of many other methods
  - **Risk of PID in IUCD users is negligible**
  - **Opportunities exist for program expansion**

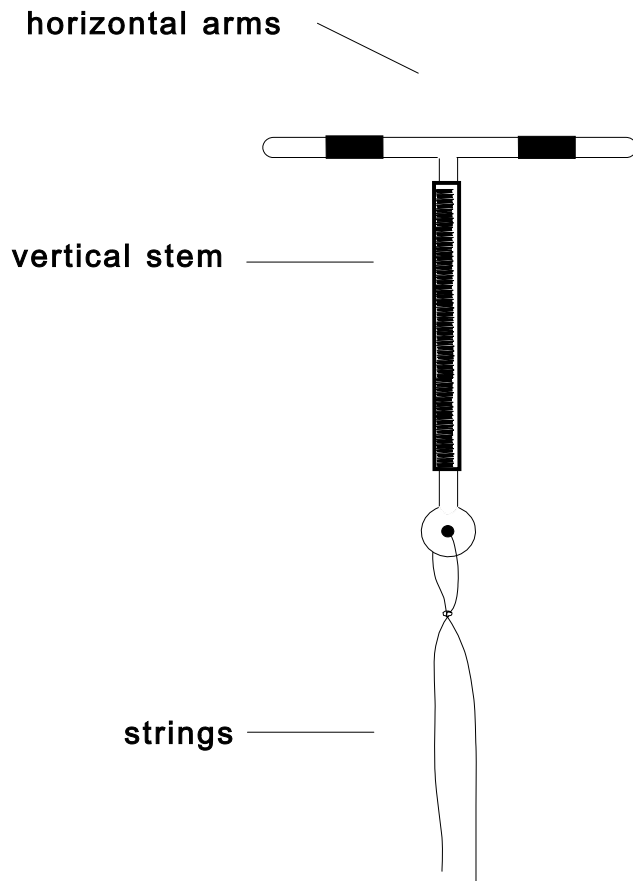


# IUCDs – the Basics

- Mechanism of action
- Effectiveness and length of use
- Advantages and limitations
- Client assessment
- Side effects and precautions



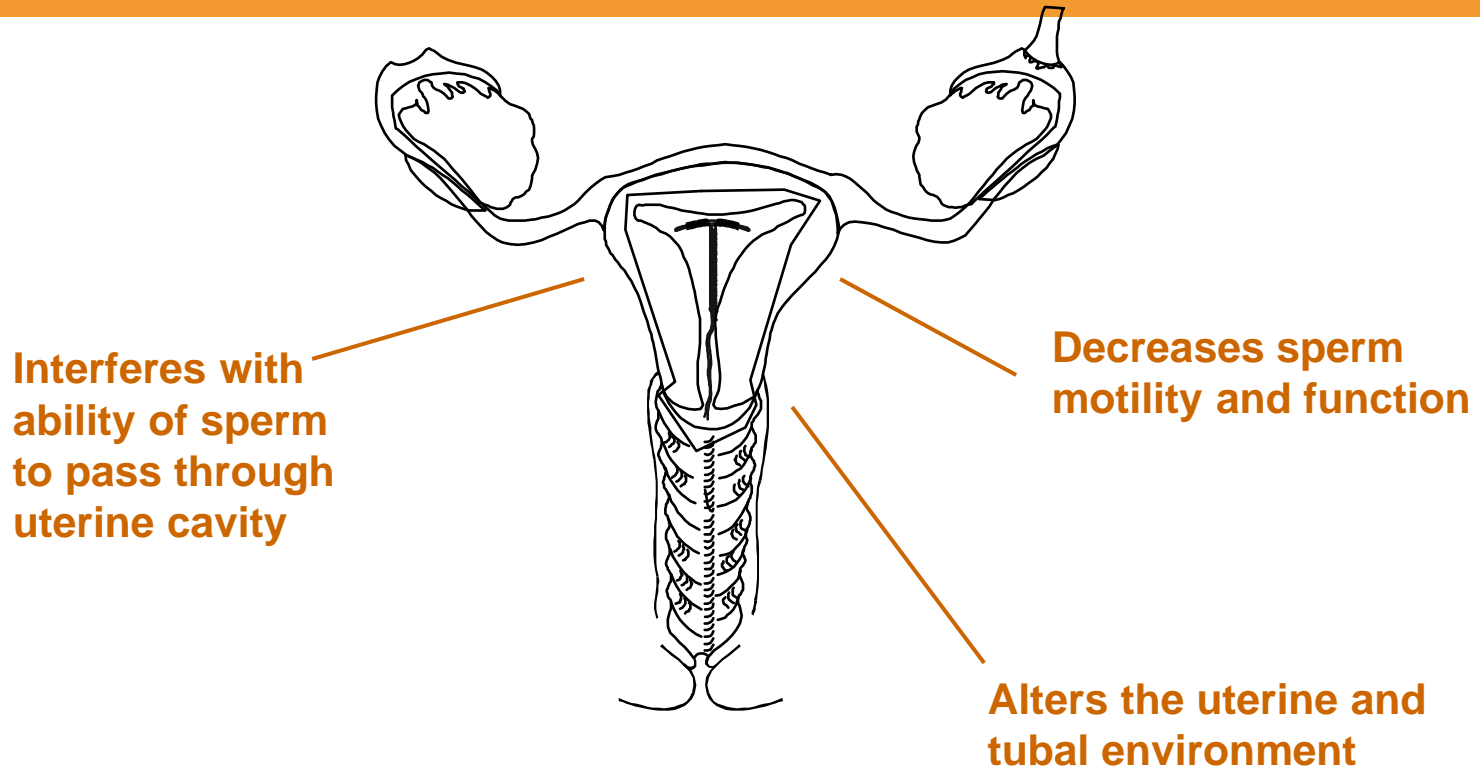
# Copper T 380A



- Comes in regular and Safe Load varieties
- Monofilament string
- Effective for up to 12 years; approved for 10 years of use In India



# Mechanisms of Action



**Summary: Acts to prevent pregnancy before fertilization occurs**



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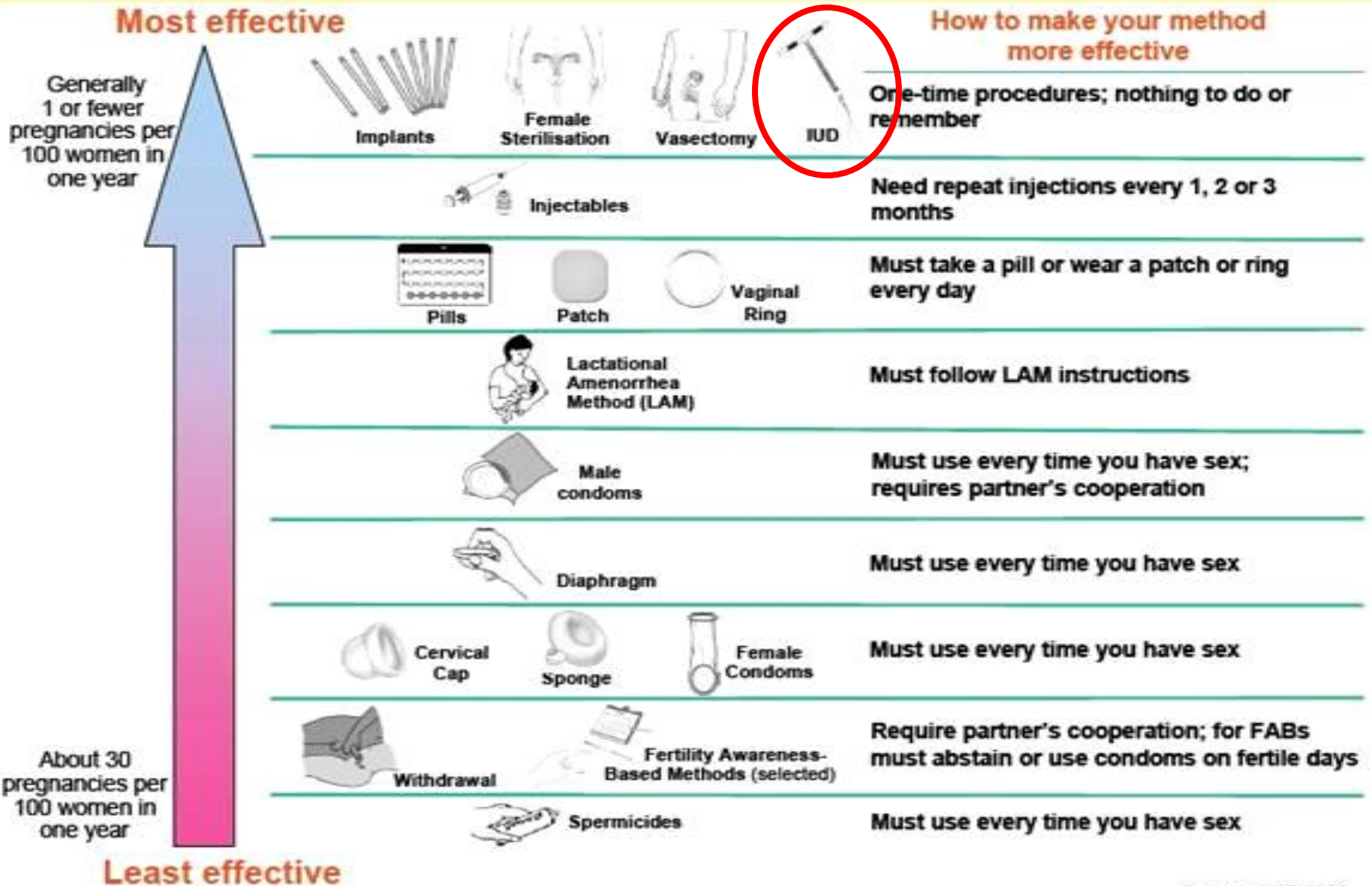
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# Effectiveness

- Effectiveness: > 99% effective
  - 6 – 8 pregnancies per 1 000 women in first year
- Effective immediately upon insertion
- Immediate return to fertility once removed
- Effective for 10+ years
- Can be used as short-term method



# Comparing Typical Effectiveness of Contraceptive Methods



Source: WHO 2006

# WHO Eligibility Criteria

(+)

- **Category 1:** No restrictions to use
- **Category 2:** Advantages generally outweigh risks; generally use
- **Category 3:** Risks generally outweigh advantages; generally do not use

(-)

- **Category 4:** Too risky to use; do not use



Source: WHO 2004.



# IUCDs: Who Should Not Use (WHO Category 4)

## IUCDs should NOT be used if a woman:

- Is pregnant (known or suspected)
- Has unexplained vaginal bleeding
- Has current PID, gonorrhea, or chlamydia
- Has acute purulent (pus-like) discharge
- Has distorted uterine cavity
- Has malignant trophoblast disease
- Has known pelvic tuberculosis
- Has genital tract cancer (cervical or endometrial)

Source: WHO 2004.



# IUCDs: Conditions Requiring Precautions (WHO Category 3)

IUCDs are not recommended for insertion—unless other methods are not available or acceptable—if a woman has:

- AIDS, but no antiretroviral therapy or access to care
- A high individual risk of chlamydia and gonococcal infection (partner has current purulent discharge or STI)
- Ovarian cancer
- Benign trophoblastic disease



Source: WHO 2004

# MEC and Postpartum IUCD

The MEC are less specific in this area

- **Category 4:**

- Immediately after septic abortion
- Immediately after puerperal sepsis
- Unresolved postpartum hemorrhage (not mentioned in MEC)

- **Category 3:**

- Between 48 hours and 4 weeks (6 weeks as per GoI guidelines)
- Prolonged ROM > 18 hours (not mentioned in MEC)

- **Category 2:** no conditions

- **Category 1:**

- Immediate post placental or postpartum <48 hours
- > 4 weeks (6 weeks as per GoI guidelines)



# Using Judgment to Understand Category 4

If a woman has a normal full-term vertex pregnancy we can assume that she probably does not have:

- Distorted uterine cavity
- Malignant trophoblast disease
- Known pelvic tuberculosis
- Cervical or endometrial cancer
- Fulminant HIV
- Unexplained vaginal bleeding
- Current PID, gonorrhea, or chlamydia



# The Most Likely Precautions

## ● Therefore, in the most typical situation, providers should watch out for:

- Unresolved hemorrhage (still having worrisome bleeding)
- Chorioamnionitis/puerperal sepsis
- Rupture of membranes >18 hours (potential for infection)
- Recent purulent cervicitis

## PPIUCD Pre-insertion Screening

In preparation for insertion of the IUCD, confirm the following information about the woman and her clinical situation:

<b>Ask the woman</b> whether she still desires the IUCD for Immediate PFPF	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Review her antenatal record</b> and be certain that:		
• her antenatal screening shows that an IUCD is an appropriate method for her	<input type="checkbox"/> No	<input type="checkbox"/> Yes
• she has had FP counseling while not in active labor and there is evidence of consent in her chart <b>OR</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
• she is being counseled in the post partum period	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Review the course of her labor and delivery</b> and ensure that <u>none</u> of the following conditions are present		
If planning an <i>immediate post placental insertion</i> , check whether <u>any</u> of the following conditions are present:		
• Chorioamnionitis (during labor)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• More than 18 hours from rupture of membranes to delivery of baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Unresolved postpartum hemorrhage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If planning a <i>immediate postpartum insertion</i> , check whether <u>any</u> of the following conditions are present:		
• Puerperal sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Postpartum endometritis/metritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Continued excessive postpartum bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Extensive genital trauma where the repair would be disrupted by immediate postpartum placement of an IUCD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Confirm</b> that sterile instruments are available*	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Confirm</b> that IUCDs are available and accessible on the labor ward*	<input type="checkbox"/> No	<input type="checkbox"/> Yes

If **ANY** box is checked in this column, defer insertion of the IUCD and provide the woman with information about another method.

If **ALL** the boxes in this column are ticked, then proceed with IUCD insertion.

\*If correct instruments or sterile IUCDs are not available, proceed with IUCD insertion if they become available within an appropriate time period.



# Postpartum Insertion Advantages and Limitations

## Advantages:

- Very effective, reversible, long-term method
- Safe, convenient and no increased risk of perforation or infection
- Does not affect the quantity or quality of breastmilk
- Greater coverage of population possible

## Limitations:

- Changes in monthly bleeding pattern
- Slightly higher rate of expulsion
  - 8 – 14%
    - with good technique: 4 – 5%
  - Meaning 86-92% retention
- Requires special training of providers



# IUCD and Anemia

- Monthly menstrual bleeding increases slightly with the IUCD, especially in first 3 months
- Blood loss which results in anemia is rare
- Therefore, it is safe to provide an anemic woman with an IUCD (WHO MEC Category 2)
- If a woman is anemic and has the IUCD in place, continue to treat anemia with iron/folate



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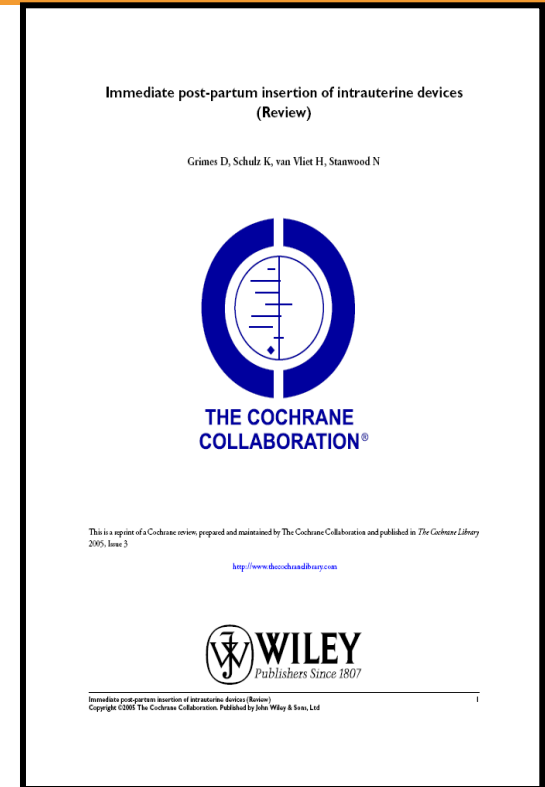


# Review of Safety of Postpartum IUCD

Cochrane database review, 2003

## Main results

- No randomized controlled trials that directly compared immediate post-partum insertion with either delayed post-partum or interval insertion.
- Most studies showed no important differences between insertions done by hand or by instruments.
- Expulsion rates are highly variable.
- Copper T (CuT380A) are better than Lippes Loops and Progestasert for PPIUCD



*Grimes D, Schulz K, van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices. The Cochrane Database of Systematic Reviews 2003, Issue 1*





# Review of Safety of Postpartum IUCD

Cochrane database review, 2003

## Authors' conclusions

- Immediate post-partum insertion of IUDs appeared **safe** and **effective**.
- Advantages: **high motivation**, assurance that the woman is **not pregnant**, and **convenience**.
- Few contraindications to method
- **Expulsion** rates appear to be **higher** than with interval insertion.
- The popularity of immediate post-partum IUD insertion in countries as diverse as China, Mexico, and Egypt support the **feasibility** of this approach.
- **Early follow-up** may be important in identifying spontaneous IUD expulsions

*Grimes D, Schulz K, van Vliet H, Stanwood N. Immediate post-partum insertion of intrauterine devices. The Cochrane Database of Systematic Reviews 2003, Issue 1*



# Postpartum IUCD Insertion and Active Management Third Stage Labor

No clinical trials, but expert review panel

Main results:

- No increase in IUCD expulsions or perforations associated with AMTSL
- The use of oxytocic agents and fundal massage does not increase the risk of IUCD expulsion or perforation, even in the cases when IUCD is inserted two to forty hours after expulsion of the placenta.
- Postplacental insertion has lower risk of expulsion and perforation than postpartum insertion



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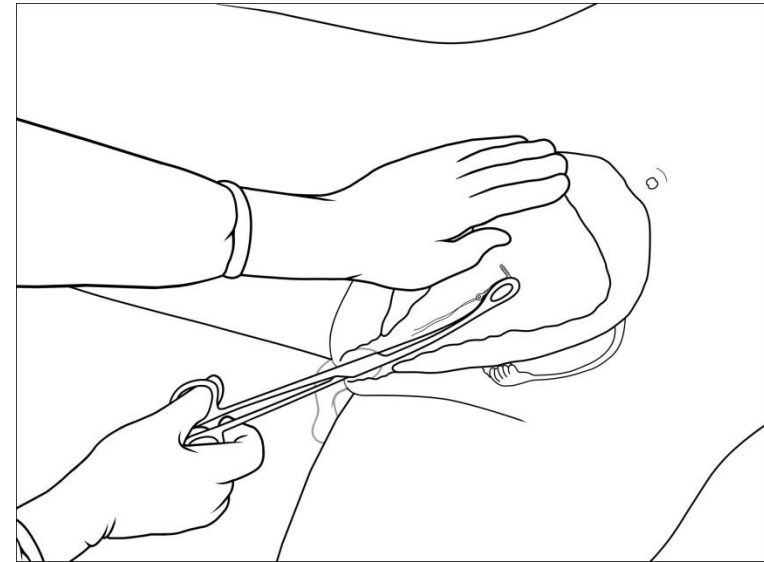
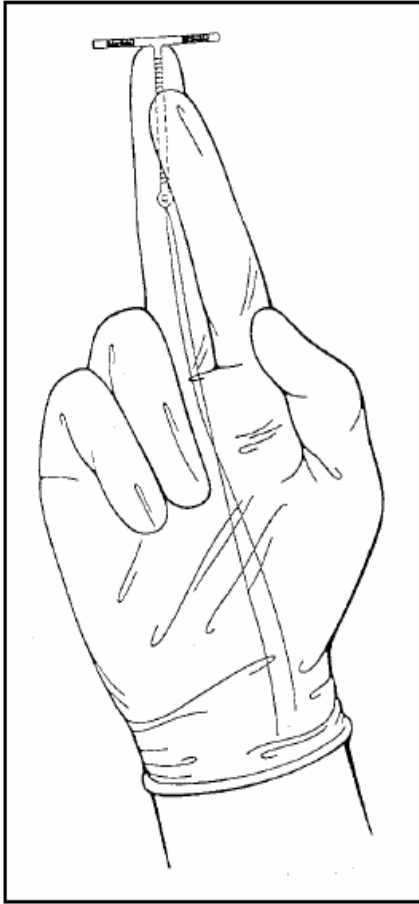


# Timing of Postpartum IUCD Insertion

- IUCDs can be inserted postpartum
  - Right after birth = Postplacental (10 minutes after placenta)
  - Soon after birth = Immediate postpartum ( < 48 hours after delivery)
  - During cesarean section = Intracesarean
  - **Six or more weeks postpartum (GOI)** 4 or more weeks (Global)
- IUCDs should **not** be inserted between 48 hrs and 6 weeks (GoI)



# Postplacental insertion



## Manual vs. Instrumental Insertion

# Overview of the steps of insertion

- Counseling
  - During ANC or postpartum
- Ensure that the instruments are ready and IUCD available in sealed sterile package
- Confirm that the woman wants the method
- Identify the cervix and clean with antiseptic
- Slowly insert the IUCD and ensure fundal placement



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# Risk of Expulsion and Timing of Insertion Postpartum

- Expulsion rates vary from 3 – 37%.
- In general, expulsion rates for PPIUCD range between 10 – 14%
  - Good technique can reduce expulsion to 4 – 5%
- Postplacental expulsion rates are lower than postpartum expulsion rates





# Expulsion Rates Are Related to Provider

- To reduce expulsion:
  - Use correct technique
    - place all the way at fundus
    - sweep instrument to the side
    - take care that IUCD does NOT come out during withdrawal
  - Use correct instrument
    - Kelly placental forceps (curved, longer) may be better than ring forceps
  - Insert at the correct time
    - postplacental is better



# Management of Strings

- Do not cut strings while placing IUCD postpartum, postplacental or intracesarean
- During cesarean section, do NOT pass the strings through cervix; leave in lower uterine segment
- Strings will typically descend during involution and curl in posterior vaginal fornix
- Sometimes they may remain in the uterus, but this is not usually a problem
- Strings CAN be cut at follow-up visit
  - If pelvic exam is not possible, then it is not necessary to cut strings
- Strings SHOULD be cut if the woman complains or they protrude from introitus



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# Myths and Misconceptions

## We must work to correct misunderstandings:

### ● IUCDs:

- IUCDs do not cause PID; insertion if there is *undiagnosed* cervicitis may result in PID
- Do not increase the risk of contracting STIs, including HIV
- Do not make a woman infertile
- Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed
- Do not cause birth defects
- Do not cause cancer
- Do not move to the heart or brain
- Do not cause pain or discomfort for the woman during sex
- Substantially reduce the risk of ectopic pregnancy



# Postpartum IUCDs Summary

- Safe and convenient way to provide an effective long term method
- Part of a re-focus on health benefits of FP
- Limitations of the method are few, especially postpartum precautions
- Insertion times include postplacental, postpartum and intracesarean
- Expulsion rates are related to provider skill



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# POSTPARTUM FAMILY PLANNING

*Postpartum IUCD Training Course*

# Objectives

- Discuss methods of Postpartum Family Planning
- Describe the specific situation of postpartum women
- Discuss breastfeeding and LAM
- Review conditions for use of POPs
- List opportunities and mechanisms for post partum FP integration



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# Menses, sexual activity & breastfeeding in UP



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Borda, M. et al. 2008. ACCESS-FP

# Considerations with Postpartum Family Planning

- Through the first year postpartum
  - Timing of return to fertility
  - Return to sexual activity
  - Breastfeeding and use of various methods
  - Timing of various methods
  - LAM, concurrent use and transition to other methods
- Underlying factors
  - Healthy spacing of the next pregnancy
  - Integration of FP into other service opportunities



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# Return to Fertility

- **Non breastfeeding:**
  - As early as 3 weeks postpartum – 21 days postpartum
- **Breastfeeding**
  - Using LAM accurately:
    - some time after 6 months – variable
  - Breastfeeding without using LAM:
    - possibly even before 6 months, but again, variable.
    - average is 45 days
    - 5 – 10% of breastfeeding women get pregnant in first year PP
- **Remember: fertility returns before menses returns!**



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# Return to sexual activity

- Physiologically women can resume intercourse when the perineum is fully healed
- But she should do so when she is ready
- Typically, sexual activity resumes before a woman is on a effective FP method
- Therefore, the woman is at risk of pregnancy



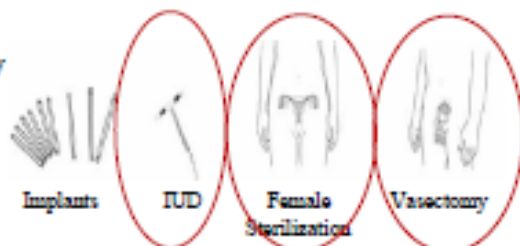
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# Comparing Effectiveness of Family Planning Methods

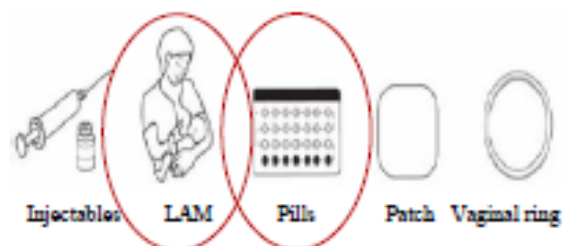
**More effective**  
Less than 1 pregnancy per 100 women in 1 year



**How to make your method more effective**

**Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember

**Vasectomy:** Use another method for first 3 months



**Injectables:** Get repeat injections on time

**Lactational amenorrhea method, LAM (for 6 months):** Breastfed often, day and night

**Pills:** Take a pill each day

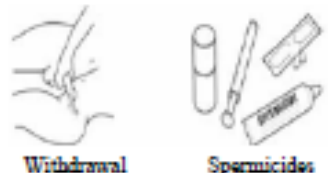
**Patch, ring:** Keep in place, change on time



**Condoms, diaphragm:** Use correctly every time you have sex.

**Fertility awareness methods:** Abstain or use condoms on fertile days. Newest methods (Standard Days Method and Two Day Method) may be easier to use.

**Less effective**  
About 30 pregnancies per 100 women in 1 year



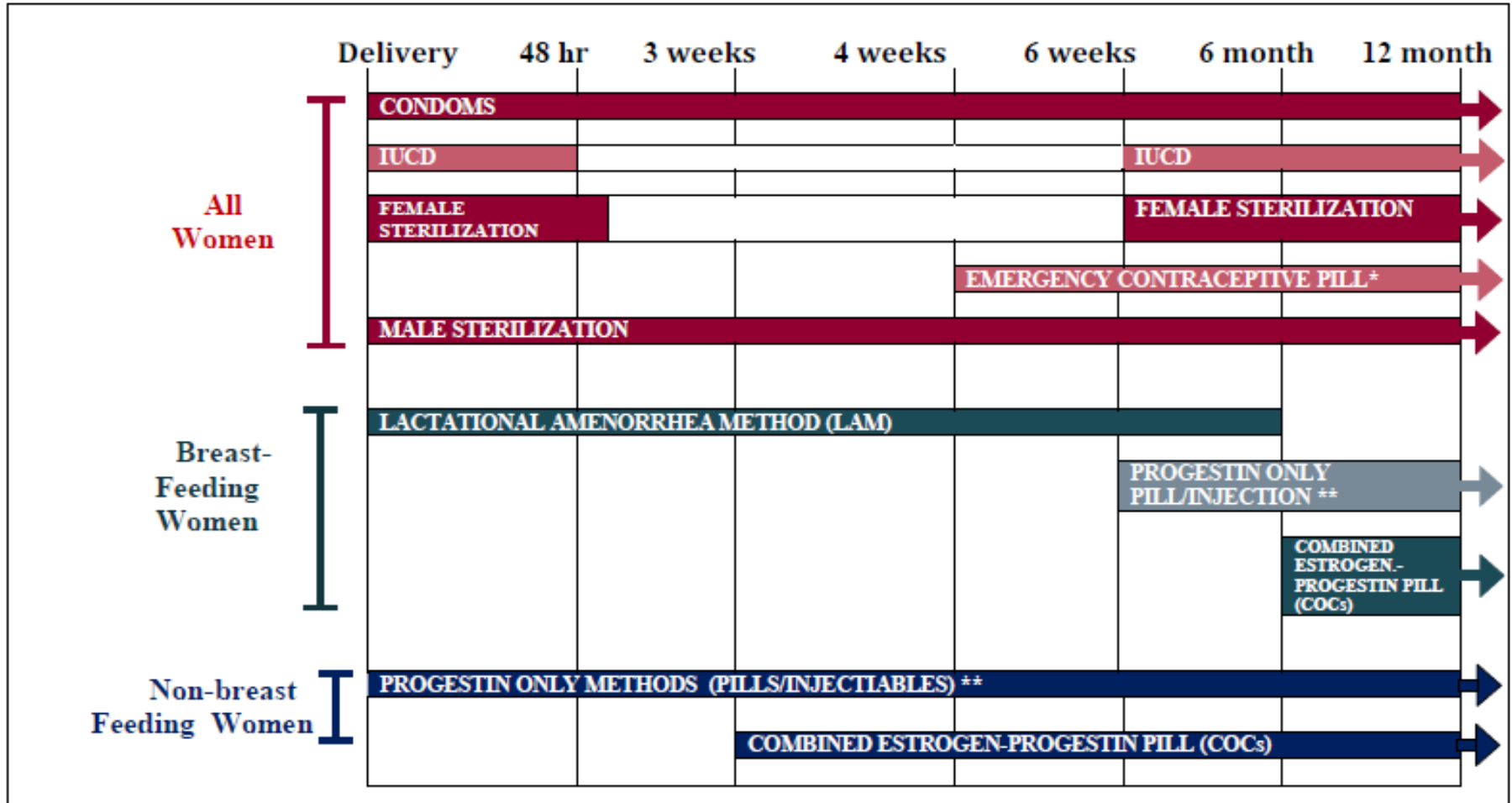
**Withdrawal, spermicides:** Use correctly every time you have sex.



Sources:  
Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized controlled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol* 2006; 195(1):63-91  
World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHS/PH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Provider*. Baltimore, MD and Geneva: CCP and WHO, 2007.  
Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Guest F, Kowal D, eds. *Contraceptive Technology*, Nineteenth Revised Edition. New York: Ardent Media, Inc., in press.



# SAFE TIMES FOR POSTPARTUM INITIATION OF VARIOUS METHODS OF FAMILY PLANNING



\* This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.

\*\* This is available in private sector.



# Timing of Initiating FP Methods Postpartum

- LAM – with breastfeeding
- Condoms – when intercourse resumes
- Progestin-only methods –
  - BF: when good milk supply and BF going well – 6 weeks
  - Non-BF – right away
- Combined Oral Pills (Estrogen + Progestin)
  - BF: when there is no risk if quantity of milk decreases – 6 months
  - Non-BF: when risk of thrombosis is reduced – 3 weeks
- IUCD – when risk of infection and perforation is low
  - First 48 hours or after 4-6 weeks
- Tubectomy – when tubal inflammation and risk of infection low:
  - First 7 days or after 6 weeks



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# LAM: Use and Transition

***If a woman is using LAM, when should she transition to another FP method?***

- If all components are met:
  - Help a woman transition so she is using another method by 6 months
- If any component of LAM is not met:
  - Help her transition as soon as component not met
- Help a woman add another method whenever she is ready
- LAM can be seen as a “gateway” to use of a modern method (OCPs, Progestin-only methods, IUCD)



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# LAM Mechanism of Action

1. Stimulation of nipple causes release of prolactin
2. Prolactin and oxytocin result in increased milk production (which encourages suckling)
3. Prolactin reduces estrogen and suppresses ovulation



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# Effectiveness of LAM

- LAM is 99.5% effective with consistent and correct use and more than 98% effective as typically used
- Effectiveness rates comparable to those of other modern methods



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# LAM Criteria: 1

- **Baby is being only breastfed**
  - The baby is not receiving any other solid food or liquids; only breast milk
- **Breastfeeding on demand**
- **Breastfeeding at least every 4 hours**
  - No more than 4 hours between feeds during day
  - No more than 6 hours between feeds at night



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# Baby is being *only breastfed*

- Why is condition important?
- When baby receives any food, water, or other liquid:
  - The baby becomes full and will not want the breast as often.
  - The mother will not produce as much milk.
  - Infrequent suckling will reduce prolactin and lead to ovulation making the mother's fertility return



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# LAM Criteria: 2

- Amenorrhea – Menstruation has not returned since the birth of the child
  - Bleeding during the first 2 months post-partum does not count as menstruation
  - Bleeding after 2 months post-partum can be an indication of the return of ovulation and the return of fertility



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# LAM Criteria: 3

- The baby is less than 6 months old
  - Biologically appropriate cut-off point.
  - WHO recommends supplementing after 6 months.
  - Supplemental food will decrease suckling.



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# IMPORTANT!

BREASTFEEDING IS NOT  
THE SAME AS LAM!



Photo: © UNICEF/ HQ05-2393/Anita Khemka



# Dispelling Misconceptions / Promoting LAM

- Just as effective among fat or thin women
- Mother's milk alone can fully nourish a baby for the first 6 months of life while using LAM
- Can be used as a transitional method while a couple decides on and meets criteria for another method



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# Progestin-only Contraceptives & Breastfeeding Women

- No proven effect on breastfeeding, breast milk production or infant growth and development
- WHO recommends a delay of 6 weeks after childbirth before starting progestin-only methods as infants may be at some small unknown risk from exposure to the progestin excreted in breastmilk
  - MEC Category 3 – risks outweigh the benefits
- After 6 weeks of age, safe to initiate progestin-only methods
  - MEC Category 1 – safe to use under any situation



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# Use of Progestin-only Pills Postpartum

- **Not appropriate for women who:**
  - Have cirrhosis or active liver disease
  - Take medications for TB or seizures
  - Have a blood clot in legs or lungs now
  - Have a history of breast cancer
- **Provide supply before discharge**
- **Woman should start 6 weeks postpartum**



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# Timings and types of integration: Pre and immediately post pregnancy

## ● During ANC

- Counseling on reproductive intentions, LAM, return to fertility, timing for starting contraception
- Counseling for PPIUCD or sterilization
- Limited association with postpartum FP use

## ● Immediate post-delivery

- Opportunities during mother/baby checks/discharge
- Counseling on reproductive intentions, return to fertility, timing for starting contraception
- PPIUD and sterilization
- LAM or progestin-only for non-breastfeeding women
- Stronger association with starting FP use by offering methods



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# Timings and types of integration: Extended postpartum period

- 1-6 week postpartum consultation(s)
  - Opportunities during mother/baby checks
  - Counseling on reproductive intentions, return to fertility
  - Reinforce LAM, plan transition to other modern methods
  - If ending LAM, transition to IUCD, pills, injectables, implant
  - Strong association with FP use
- Child health consultations
  - Opportunities during health / immunization visits
  - Referral or provision of method
  - Some evidence of association with FP use





# ANC COUNSELING GUIDE: IMMEDIATE POSTPARTUM FAMILY PLANNING

METHODS	BENEFITS	LIMITATIONS	CLIENT ASSESSMENT/CONSIDERATIONS
Postpartum IUCD	<ul style="list-style-type: none"> <li>Used right after delivery; long term protection</li> <li>99% effective.</li> <li>Immediate return of fertility upon removal.</li> </ul>	<ul style="list-style-type: none"> <li>Heavier, painful menses (first few cycles).</li> <li>Does not protect against STIs/ HIV.</li> </ul>	<p>Not appropriate for women who have:</p> <ul style="list-style-type: none"> <li>Chorioamnionitis; ROM &gt;18 hrs; PPH</li> </ul>
Progestin Only Pills	<ul style="list-style-type: none"> <li>Woman can start 6 weeks postpartum, even if breastfeeding.</li> <li>About 99% effective.</li> <li>Immediate return of fertility after stopping pills.</li> </ul>	<ul style="list-style-type: none"> <li>Must be taken daily.</li> <li>Bleeding changes may be experienced.</li> <li>Does not protect against STIs/ HIV.</li> </ul>	<ul style="list-style-type: none"> <li>Not appropriate for women who have: cirrhosis or active liver disease, blood clot in legs or lungs, history of breast cancer or take medications for TB or seizures.</li> </ul>
Condom	<ul style="list-style-type: none"> <li>Can prevent pregnancy, some STIs and HIV.</li> <li>Can be used once couple resumes intercourse.</li> </ul>	<ul style="list-style-type: none"> <li>Must have reliable access to resupply.</li> <li>About 85% effective.</li> </ul>	<ul style="list-style-type: none"> <li>Must be used correctly with EVERY act of sex.</li> <li>Can provide supply before discharge.</li> </ul>
Postpartum Ligation	<ul style="list-style-type: none"> <li>Permanent method of FP. Simple procedure</li> <li>&gt;99% (not 100%) effective.</li> <li>Serious complications are rare.</li> </ul>	<ul style="list-style-type: none"> <li>Does not protect against STIs/HIV.</li> <li>Requires surgical procedure.</li> </ul>	<ul style="list-style-type: none"> <li>For women who certainly want no more children.</li> <li>Hospital must be set up to offer the surgery.</li> <li>Can be done in first 7 days postpartum.</li> </ul>
LAM	<ul style="list-style-type: none"> <li>Good for mother and newborn.</li> <li>Start immediately after birth.</li> <li>98% effective if all 3 criteria met.</li> </ul>	<ul style="list-style-type: none"> <li>Does not protect against STIs/ HIV.</li> <li>Short-term method-reliable for 6 months.</li> <li>Use another method if any criteria not met.</li> </ul>	<ul style="list-style-type: none"> <li>Effective if ALL 3 criteria present: exclusive breastfeeding day &amp; night; menses not returned; baby less than six months old.</li> </ul>
Male Sterilization	<ul style="list-style-type: none"> <li>Permanent method for men. Simple procedure</li> <li>99% effective.</li> <li>Serious complications are rare.</li> <li>No weakness or difficulty during intercourse.</li> </ul>	<ul style="list-style-type: none"> <li>Does not protect against STIs/HIV</li> <li>Requires use of condoms or another contraceptive for three months post-procedure to be effective.</li> </ul>	<ul style="list-style-type: none"> <li>Appropriate for those couples who have decided to limit family; are aware of the permanent nature of the method.</li> <li>Men who do not have infection of the genitalia.</li> </ul>
Emergency Contraception  1. Emergency Contraceptive Pills (ECPs)  2. IUCD	<ul style="list-style-type: none"> <li>Safe, easy to use and available at chemist shop or at health center.</li> <li>Can be used by all women.</li> <li>85% effective if used within 120 hours (5 days) after an unprotected intercourse.</li> <li>IUCD for Emergency Contraception can be continued as a regular method if appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>Not a regular FP method, intended for emergency use only.</li> <li>A regular FP method use required</li> <li>Not effective once implantation of fertilized ovum has begun.</li> <li>Effectiveness dependent on the time of use after the unprotected intercourse.</li> </ul>	<ul style="list-style-type: none"> <li>Not effective in pregnant women.</li> <li>Should not be used as an abortifacient.</li> <li>IUCD not appropriate for women who have: Cervical cancer or trophoblastic disease; Abnormality in the structure of the uterus (fibroids, septum); risk of STIs.</li> </ul>

# Making FP Services Available to the Postpartum Woman

- Focus on pregnancy spacing and health benefits to family
- Ensure a variety of different methods
- Services now are more certain than referrals for later
- Start during antenatal care
- Remember the specifics of the postpartum period
  - Return to fertility
  - Resumption of intercourse
  - Coordination with breastfeeding
- Integrate FP services into PNC, NBC, Immunization, etc



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# Postpartum Family Planning Summary

- There are a variety of postpartum family planning methods:
  - LAM, hormonal methods, IUCD, condom, tubectomy
- Considerations of the postpartum woman:
  - Return to fertility, resumption of intercourse
  - Use of LAM and changes due to breastfeeding
- Starting FP postpartum
  - Counsel early and often – begin during ANC
  - Provide numerous opportunities
  - Make it part of routine care



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# HEALTHY TIMING AND SPACING OF PREGNANCIES

*Postpartum IUCD Training Course*

# Healthy Timing and Spacing of Pregnancies Objectives

By the end of this presentation participants will be able to

- Describe the effects of pregnancy spacing on morbidity, mortality and nutrition
- Define the recommended optimal pregnancy spacing intervals
- Describe the pregnancy spacing situation in **Uattarakhand**



# Definitions

## Birth to pregnancy interval:

time period between a live birth and the start of the next pregnancy

## Birth to birth interval:

time period between a live birth and the next live birth



# Findings: Maternal Outcomes

- Short birth to pregnancy (BTP) intervals < 6 months are associated with increased risk of:
  - maternal mortality
  - induced abortion
  - miscarriage
- Long BTP intervals of > 59 months are associated with increased risk of:
  - pre-eclampsia\*

**Sources:** Conde-Agudelo, A, et al, Effect of birth spacing on maternal health: A systematic review, *American Journal of Obstetrics and Gynecology*, 2006, DaVanzo, J, Hale L, Razzaque A, Rahman M, Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh, *BJOG: An International Journal of Obstetrics and Gynaecology*, 2007; Conde-Agudelo, A, Belizan, JM, Maternal morbidity and mortality associated with interpregnancy interval: cross sectional study. *Br Med J*, 2000, 321(7271): 1255-9



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# Findings: Post-abortion Outcomes

- Induced or spontaneous abortion-next pregnancy intervals of less than six months are associated with increased risk of:
  - premature rupture of membranes, maternal anemia
  - pre-term birth, low birth weight, small for gestational age

Source: Conde-Agudelo, A. et al, “Effect of the interpregnancy interval after an abortion on maternal and perinatal health in Latin America,” *International Journal of Gynecology and Obstetrics*, Vol. 89, Supplement No. 1, April 2005.



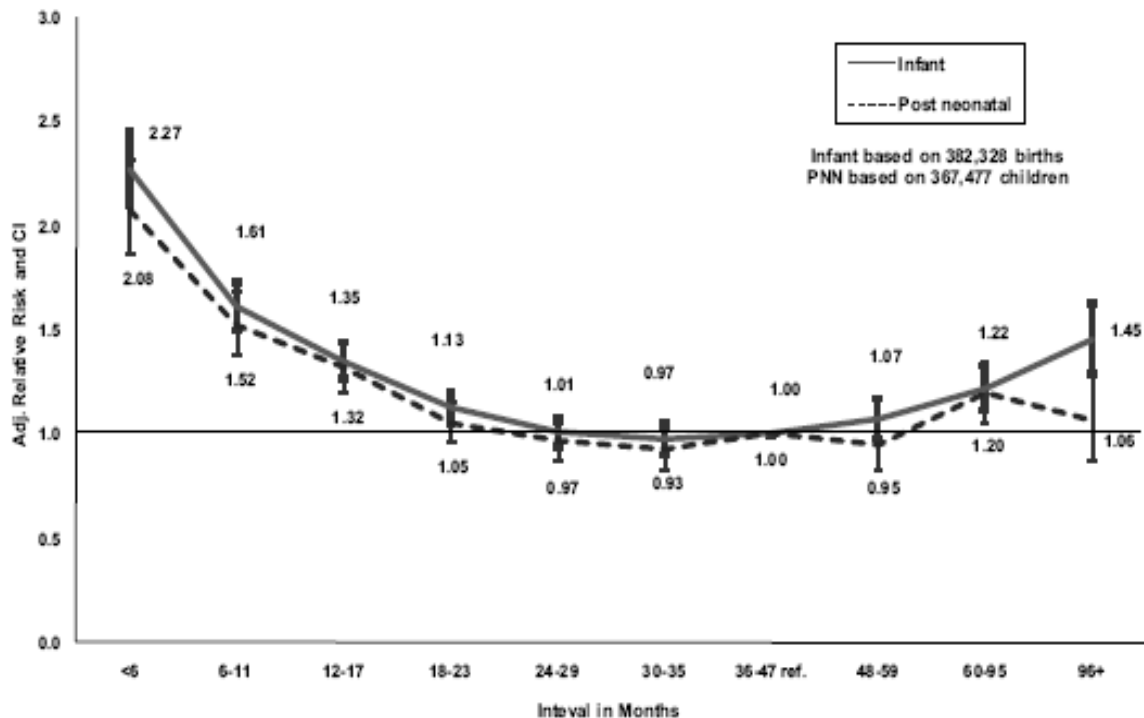
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# Birth to Pregnancy Intervals and Infant and Post Neonatal Mortality

Figure 4 Adjusted Relative Risk of Infant and Post Neonatal Mortality by Birth to Conception Interval 52 DHS Surveys



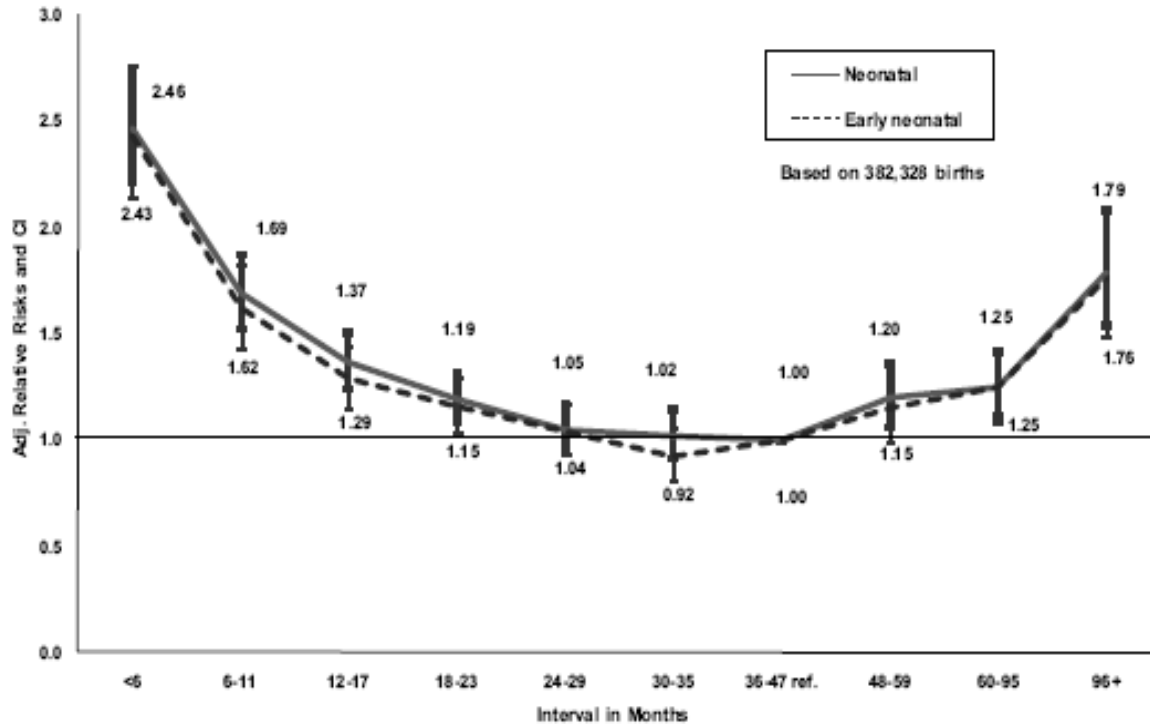
Birth-to-Pregnancy interval of < 24m and > 60m are associated with higher infant and post neonatal mortality

Rutstein SO, 2008, Macro International



# Birth to Pregnancy Intervals and Neonatal and Early Neonatal Mortality

Figure 5 Adjusted Relative Risk of Early Neonatal and Neonatal Mortality by Birth to Conception Interval 52 DHS Surveys



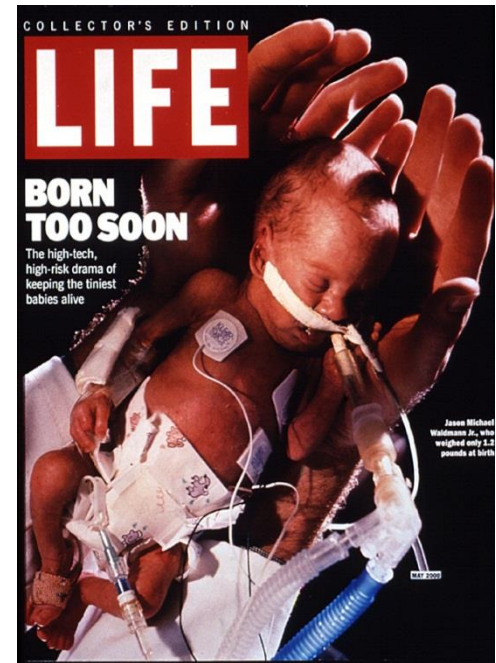
Birth-to-Pregnancy interval of < 24m and > 60m are associated with **higher neonatal and early neonatal mortality**

Rutstein SO, 2008, Macro International



# Findings: Perinatal/Neonatal/Infant Outcomes

- Short birth to pregnancy (BTP) intervals < 18 months as well as long BTP intervals\* of > 59 months are associated with increased risk of:
  - pre-term birth
  - small size for gestational age
  - low birth weight
  - Neonatal/infant mortality (<24 mos BTP)



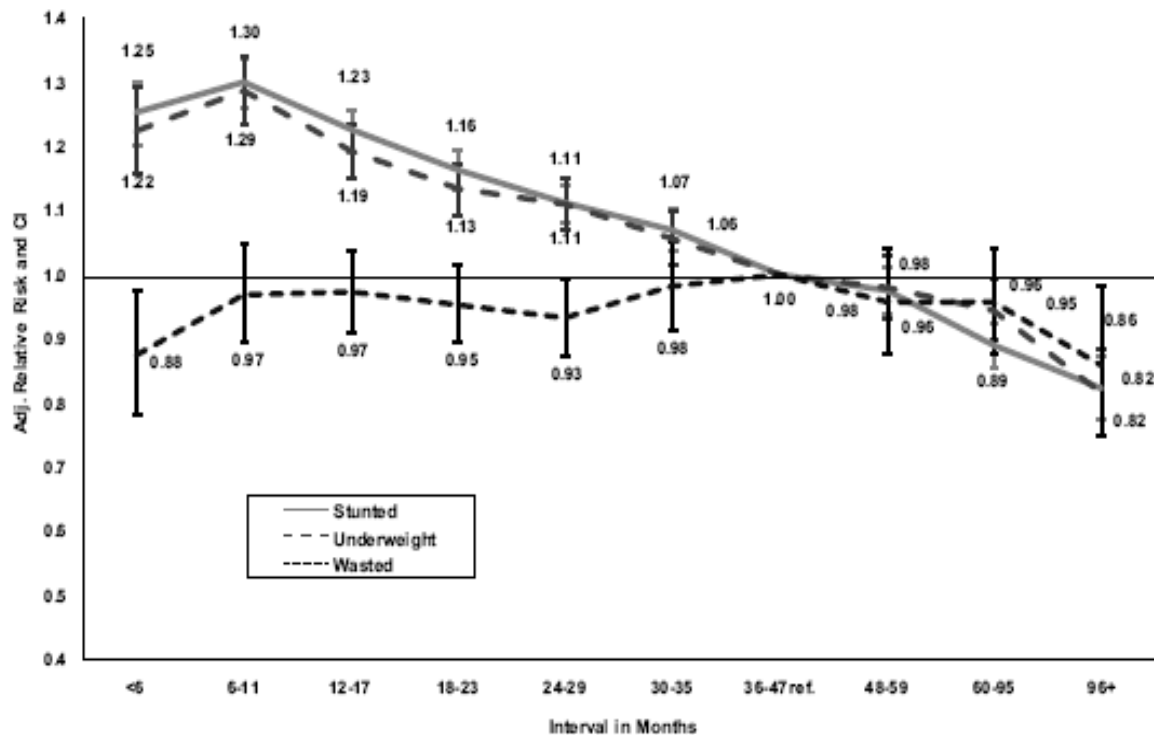
Source: Agustin Conde-Agudelo, et al., “Birth Spacing and the Risk of Adverse Perinatal Outcomes: A Meta-Analysis,” *The Journal of the American Medical Association* 29 (April 19, 2006): 1809-1923.

\* WHO is reviewing the evidence on the association of long intervals and adverse maternal and perinatal outcomes.



# Birth to Pregnancy Intervals and Child Nutrition

Figure 11 Child Malnutrition by Birth to Conception Interval



**Birth-to-Pregnancy interval of <36 m is associated with more childhood malnutrition—more stunting and more underweight children (but less wasting?—probably not statistically significant)**

Rutstein SO, 2008, Macro International

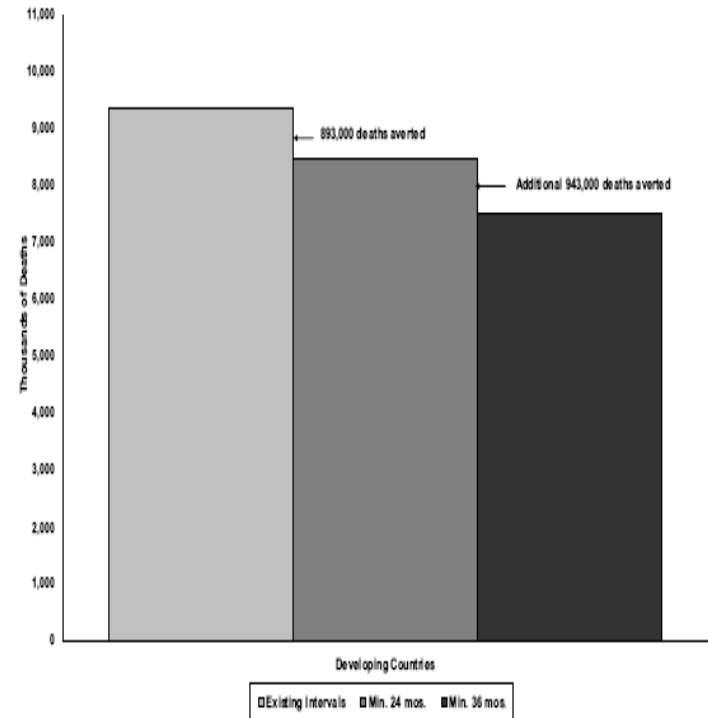


# Birth to Pregnancy Intervals and Deaths Averted

## Increasing birth to pregnancy intervals

- to minimum 24 months will save **893 000 lives/yr**
- to minimum 36 months will save **18 36 000 lives/yr (child deaths averted)**
- “Parents who want their children to survive and thrive would do well to **wait at least 30 months** after a birth to conceive another child.”

Figure 14 Annual Number of Under Five Deaths with Existing Birth to Conception Intervals and with Minimum Intervals of 24 and 36 months



Rutstein SO, 2008, Macro International



# Reducing Maternal and Child Mortality

## ● Maternal Mortality

- Optimal use of Family Planning could avert 32% of maternal deaths
- “In the year 2000, family planning *could* have averted—90% of abortion related and—20% of obstetric related mortality and morbidity”

## ● Child Mortality

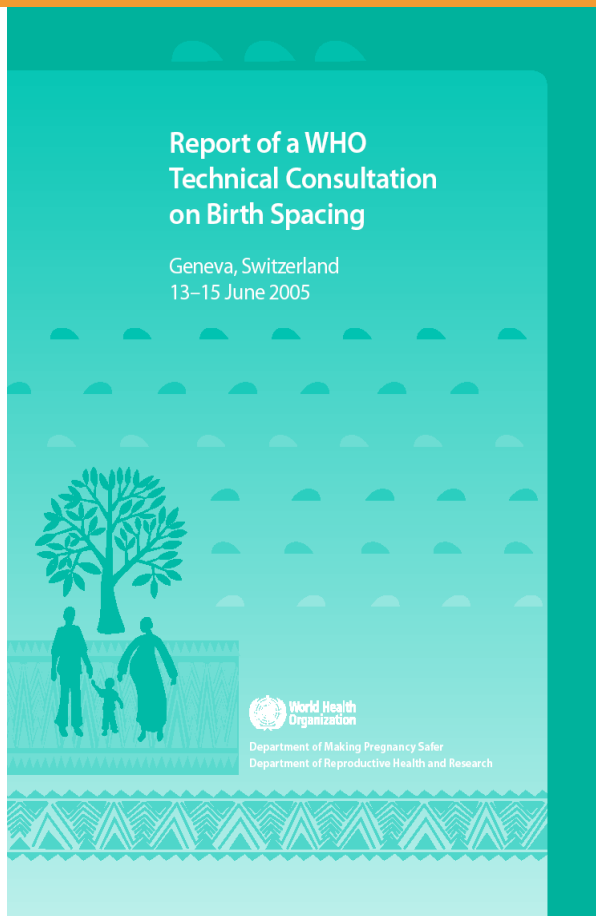
- Conservatively “1 million of the 11 million deaths in children <5 could be averted by elimination of inter-birth intervals of less than 2 years. Effective use of postpartum family planning is the most obvious way in which progress should be achieved.”

Cleland et al. 2006 Lancet Series, Sexual and Reproductive Health  
Volume **368**, Number **9549**, **18 November 2006**





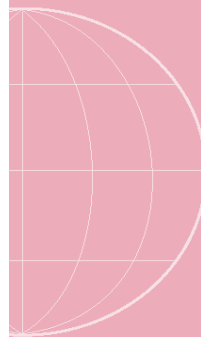
# 2006 WHO Technical Consultation Recommendations



Department of Reproductive  
Health and Research  
Department of Making  
Pregnancy Safer



Policy brief  
Policy brief



World Health  
Organization

## Birth spacing – report from a WHO technical consultation<sup>1</sup>

The World Health Organization (WHO) and other international organizations recommend that individuals and couples should wait for at least 2–3 years between births in order to reduce the risk of adverse maternal and child health outcomes. Recent studies supported by the United States Agency for International Development (USAID) suggest that an interval of 3–5 years might help to reduce these risks even further. Programme managers responsible for maternal and child health at the country and regional levels have requested WHO to clarify the significance of the new USAID-supported findings for health-care practice.

To review the available evidence, WHO, with support from USAID, organized a technical consultation on birth spacing on 13–15 June 2005 in Geneva, Switzerland. The participants included 35 independent experts as well as staff of the United Nations Children's Fund (UNICEF), WHO and USAID. The specific objectives of the meeting were to review evidence on the relationship between different birth-spacing intervals and maternal, infant and child health outcomes, and to provide advice on recommended birth-spacing intervals.

### Method of review and findings of the consultation

Prior to the meeting, USAID submitted to WHO for review six unpublished, draft papers emanating from studies the Agency had supported on birth spacing. These, along with a supplementary paper (also unpublished at the time), served as background papers for the technical consultation.

WHO sent the six draft papers to a selected group of experts, and received a total of 30 reviews. The reviewers' comments were compiled and circulated to all meeting par-

ticipants. At the meeting, the authors of the background papers presented their findings, and selected discussants presented the consolidated set of reviewers' comments, including their own observations. Together, the draft papers and the various commentaries constituted the basis for the consultation's deliberations.

The background papers<sup>2</sup> (see list on the back page of this policy brief) were based on studies that had used a variety of research designs and data analysis techniques. The meeting participants noted that the length of the intervals analysed and the terminology used in the papers varied

<sup>1</sup> This policy brief is based on the report of the WHO technical consultation on birth spacing, held in Geneva, Switzerland, on 13–15 June 2005. This report can be found on the following internet site: [www.who.int/reproductive-health/publications](http://www.who.int/reproductive-health/publications)

<sup>2</sup> It was planned that after the meeting the draft papers would be revised by the authors, taking into account the comments of the participants in the technical consultation.



# 2006 WHO Technical Consultation Recommendations

- Recommendation for spacing after a **live birth**:
  - The recommended interval before attempting the next pregnancy is **at least 24 months ( 2 years)** in order to reduce the risk of adverse maternal, perinatal and infant outcomes
- Recommendation for spacing after spontaneous or induced abortion:
  - The recommended minimum interval to next pregnancy should be **at least six months** in order to reduce risks of adverse maternal and perinatal outcomes

Source: World Health Organization, 2006 Report of a WHO Technical Consultation on Birth Spacing  
These recommendations are currently under review and will potentially be updated soon



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# So what about India and Uttarakhand?



Photo: S Suhowatsky, Jhpiego



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आरम्भ सरकार



NATIONAL RURAL HEALTH MISSION  
एनएचएम

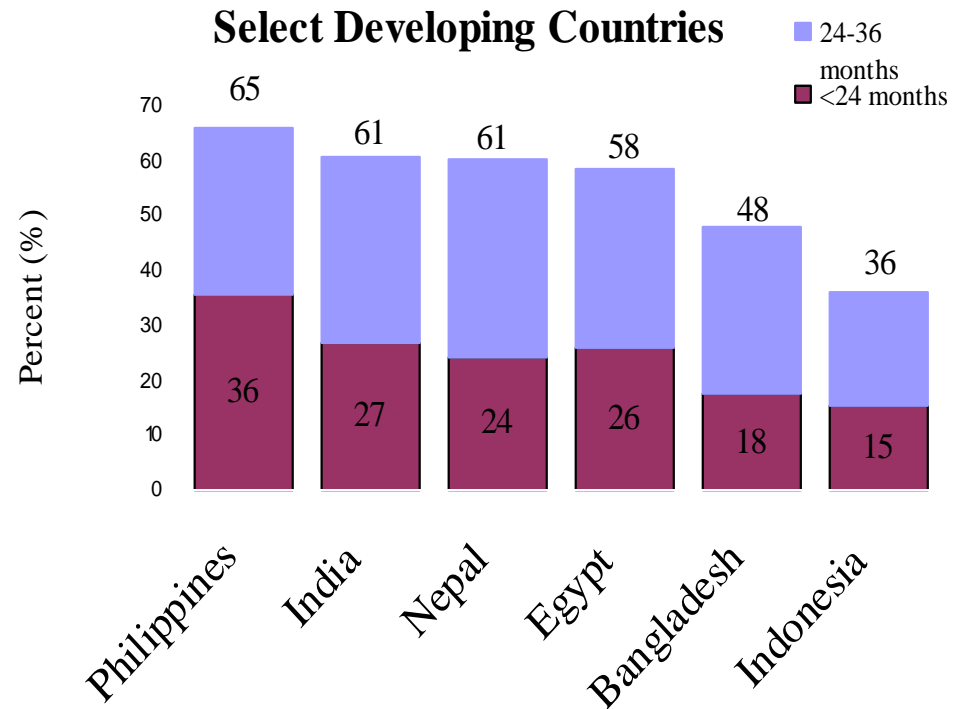


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# Birth Intervals are Short

On average, 57% of births in developing countries occur less than 36 months after the preceding birth

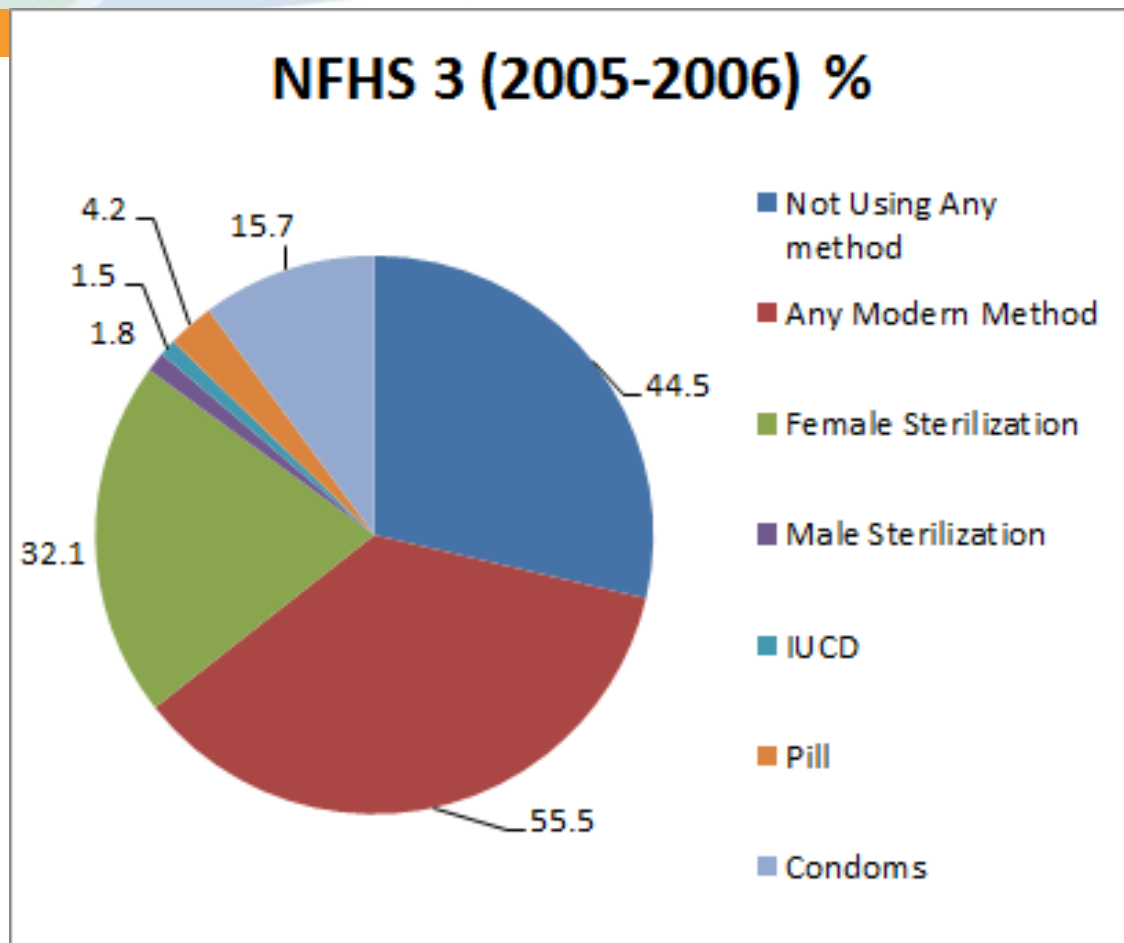
Percent of Birth Intervals that are Short:



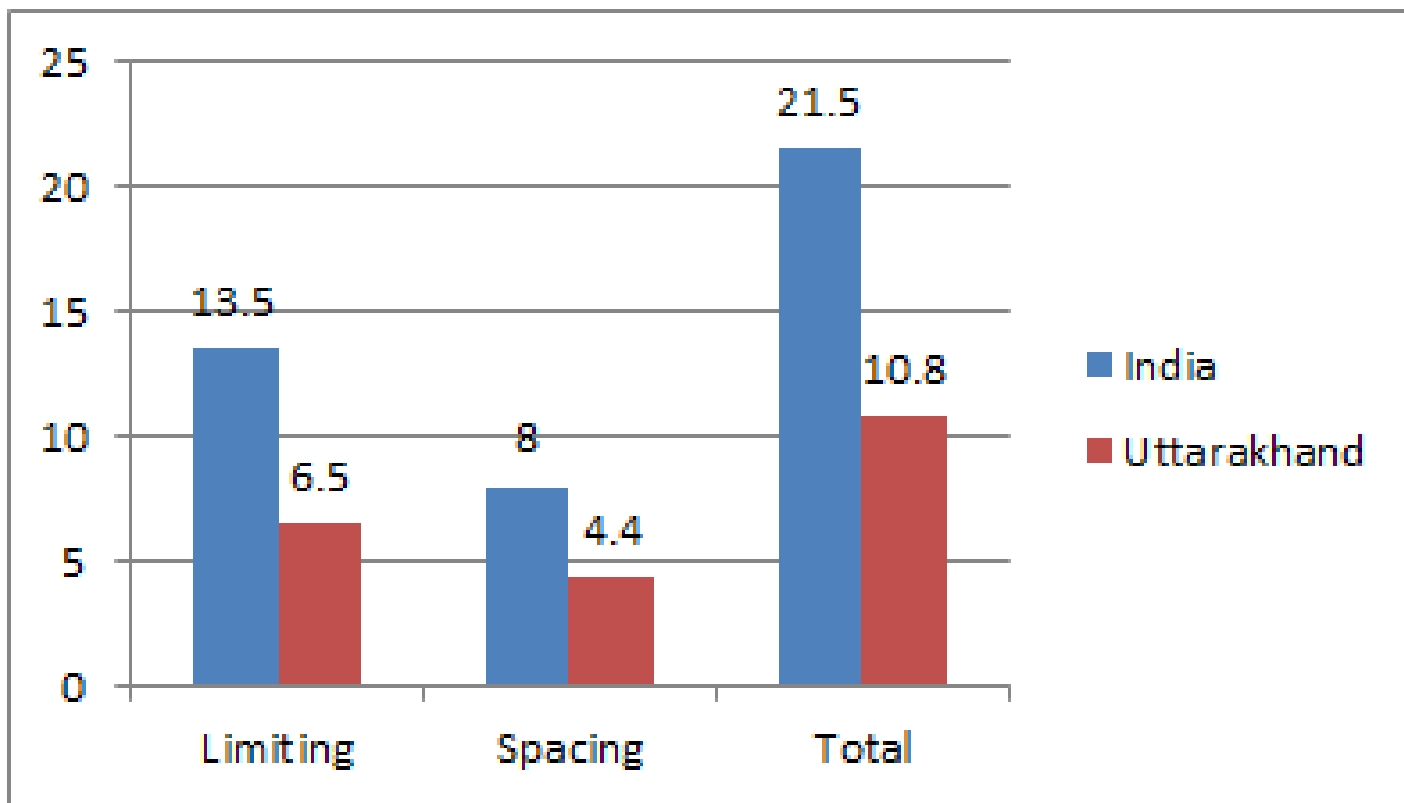
Source: Most recent DHS.



# Postpartum Year 1 Method Mix:

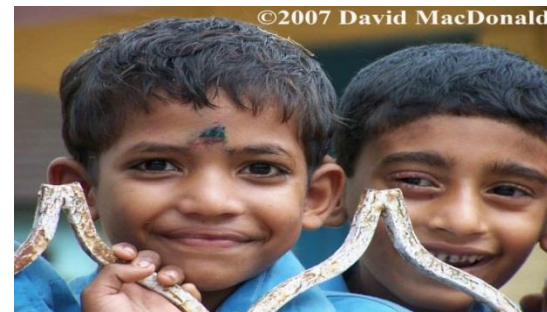


# Unmet Need: First Year Postpartum



# Rationale for Action

- Largest generation of adolescents ever; the main FP demand in <29 age group is for spacing methods (Jansen 2005)
- High percentages of births occur after too short intervals (Rutstein 2005)
- Even higher percentages of young women (ages 15-29) report short birth intervals but want longer intervals
- Only 3-5% of postpartum women want another child within two years (Ross and Winfrey, 2001)
- Significant service delivery gaps (Jansen and Cobb 2004)



# Healthy Timing and Spacing of Pregnancies Summary

- Birth to pregnancy intervals of <2 years are associated with
  - Increased maternal, newborn, child deaths
  - Higher pregnancy-related morbidity
  - Greater malnutrition among children
- WHO Recommends a birth to pregnancy interval of at least 24 months (2 years) for best outcome
- Post partum family planning and pregnancy spacing programs help women to achieve those longer intervals
- Uttarakhand has unmet need for PFP, therefore efforts need to focus in that area



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# MANAGEMENT OF SIDE EFFECTS AND COMPLICATIONS FROM POSTPARTUM IUCD

Postpartum IUCD Training Course

# Objectives

- Discuss common side effects of use of the PPIUCD and their management
- Describe the management of complications from PPIUCD





# Overview: Side Effects and Complications

- Most women who have the IUCD are very pleased with the method
- In general, side effects and complications of IUCD are rare and minor



# Changes in Menstrual Bleeding

- Changes in monthly bleeding patterns happen especially in first 3 – 6 months
- Typically irregular and unpredictable
- Women cope with this better if they are counseled about it prior to insertion
- Is perceived as less for postpartum women
- Prescribe iron/folate and follow up
- Provide reassurance and attention



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# Heavy and Prolonged Bleeding

- Provide reassurance that bleeding is usually not harmful, becomes less after first few months
- Try:
  - Tranexamic acid (1500mg) 3 times daily for 3 days, then 1000mg daily for 2 days
  - NSAIDs (ibuprofen 400mg or indomethacin 25mg) 2 times daily for 5 days
  - Start medications when heavy bleeding starts
- Provide iron / folate tablets
- If bleeding continues, or starts again after long period of normal bleeding, consider other diagnosis or consider removal of IUCD



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# Menstrual Cramping and Pain

- May be less for postpartum women
- Provide reassurance that this is common in first 3 – 6 months
- Offer ibuprofen 400mg or paracetamol 325 – 1000mg for pain relief
- If persistent, check for other conditions
- Consider removal of IUCD
  - If IUCD distorted or difficult to remove, suggest that IUCD was out of proper position and offer new IUCD



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# Prevention of PPIUCD insertion-related complications

- Careful screening of clients
- Strict adherence to infection prevention technique
- Follow appropriate insertion technique
- Perform procedure slowly and gently
- Continued communication with the woman



# Uterine Perforation

- Usually suspected at time of insertion
- If suspected, stop procedure and remove IUCD
  - First hour: bed rest, observation, vital signs every 10 minutes (be vigilant for shock)
  - Stable: observe for several more hours postpartum and be alert for intra abdominal bleeding and shock
    - Consider an additional 10 units oxytocin
  - Unstable: manage for shock
    - give fluids and oxytocin
    - monitor vital signs and vaginal bleeding



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# Expulsion

- **At time of insertion**
  - If IUCD visible at cervix following insertion, remove and replace
- **Partial expulsion found on follow up visit**
  - Remove and counsel woman about repeat insertion or another method
- **Complete expulsion**
  - Most women are aware when their IUCD falls out
    - Reassure woman that she did not cause IUCD to fall out
    - Offer reinsertion or another method
- **If suspected but unsure**
  - Refer for x-ray or ultrasound
- **Remember, rates of expulsion can be reduced by attention to technique during insertion.**



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# Severe Pain in Lower Abdomen

- Possible endometritis/ salpingitis (PID)
  - Treat for GC, chlamydia and anaerobes
  - Not necessary to remove IUCD during treatment
- Possible ectopic pregnancy
  - Perform pregnancy test
  - Manage as an emergency





# Missing Strings

- **Strings come down during the first 6 months**
  - It is not necessary to see the strings if there is no suspicion of expulsion
- **Ask client:**
  - If she suspects IUCD has fallen out
  - If she suspects she might be pregnant
- **Probe gently in cervical canal for strings**
  - 50% of missing strings are found in cervical canal
  - Do not pull the IUCD down while searching for strings
- **Ask about pregnancy**
- **If necessary, refer/perform ultrasound or x-ray for missing IUCD**



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# Who is our patient?

- Remember, the woman is our patient.
- Think about her overall health
  - Weigh the risks of pregnancy vs. IUCD
  - What are her overall health needs
- She may be left with few contraceptive options if various methods (including IUCD) are tried and quickly discontinued because of lack of understanding of side effects
- Postpartum women should have multiple effective methods available to help them space their births, and limit when they are ready



# PPIUCD Side Effects and Complications Summary

- Most side effects are uncommon and not serious
- Careful counseling prior to insertion can reassure the woman about side effects which may occur
- Providers should
  - Manage side effects according to protocols
  - Assure the woman that she can have the IUCD removed at any time
  - Provide her with another method if IUCD is removed

