

MODULE – 5

Post Partum Intrauterine Contraceptive Device (PPIUCD)

Participant's Handout



**Federal Democratic Republic of Ethiopia
Ministry of Health
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FOREWORD

As a signatory to the United Nations Millennium Declaration, Ethiopia strives to attain a substantial reduction in maternal deaths in line with the indicator set in Millennium Development Goal 5 of the Declaration. Ethiopia has formulated and issued strong policies, strategies and guidelines for implementation of programs related to maternal health, including the Health Sector Development Program (HSDP), now in its fourth and final stage of implementation, governed by the Five Year National Growth and Transformation Plan (2010/2011 – 2014/2015).

Family planning is a basic right, not only of the woman, but also of the family in general. In the Cairo International Conference on Population and Development (ICPD) Plan of Action adopted in September 1994, of which Ethiopia is a signatory, Principle 8 clearly states: *“All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.* The Constitution of the Federal Democratic Republic of Ethiopia affirms the same circumstance. Article 35 on the Rights of Women states: *“To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right of access to family planning education, information and capacity.”*

The Federal Ministry of Health (FMoH) has embarked on a new path for the enhancement of its commitment to make family planning readily available and accessible to the needy populations of the country, so as to increase the contraceptive prevalence rate (CPR) from 32% to 66% and reduce unmet need for family planning from 34% to 10%. The FMoH has developed and issued the National Family Planning Guideline, revised the National Reproductive Health Strategy, and developed and issued this comprehensive Postpartum Intrauterine Contraceptive Device (PPIUCD) Training Manual for the training of health professionals.

To assure uniform high-quality counseling and service provision in family planning in the country, the FMoH recognized the need for standardized family planning training, based on a standard training curriculum and training materials, and grounded in the objective reality of the country. This comprehensive PPIUCD Training Manual can be used uniformly by all reproductive health stakeholders involved in training health workers. The manual is meant to serve as a standard guide for pre-service and in-service training of health professionals on family planning.

The FMoH would like to extend its compliments to those individuals and organizations that have expended their precious time and resources for the realization of this PPIUCD Training Manual.

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Members of the technical working group who made major contributions to the adaptation of this PPIUCD Participant’s handout and reference manual include:

Name	Organization
Aschalew Seyoum, MD	Marie Stopes International-Ethiopia
Aster Berhe	Federal Ministry of Health, Ethiopia
Berhanu Sendek, MD, Obs/Gyn, MPH	Marie Stopes International-Ethiopia
Demeke Desta Biru, MD, MPH	Ipas Ethiopia
Dereje Negusie, MD, Obs/Gyn	EngenderHealth
Eyasu Mesfin, MD, Obs/Gyn	AAU-MF
Jemal Kassaw	EngenderHealth
Kidest Lulu, MD, MPH	IFHP
Mengistu Hailemariam, MD, Obs/Gyn	Federal Ministry of Health, Ethiopia
Nega Tesfaw, MD, Obs/Gyn	Maternal and Child Health Integrated Program(MCHIP)
Serawit Lisanework, MPH	Maternal and Child Health Integrated Program(MCHIP)
Sintayehu Abebe	Federal Ministry of Health, Ethiopia
Yewondwessen Tilahun, MD, Ob/Gyn	IFHP
Yirgu G.hiwot, MD, Ob/Gyn, MSc	AAU-MF
Zerihun Bogale, MD, MBA	EngenderHealth

Acronyms

AMTSL	Active management of the third stage of labor
ANC	Antenatal care
ARHP	Association of Reproductive Health Professionals
ARV	Antiretroviral [medications/therapy]
BPM	Beats per minute
CBC	Complete blood count
COC	Combined Oral Contraceptives
DMPA	Deoxy Medroxy Progesterone Acetate
HLD	High-level disinfected
HSDP	Health Sector Development Program
ICPD	International Conference on Population and Development
IP	Infection prevention
IUCD	Intrauterine contraceptive device
LAM	Lactational amenorrhea method
MEC	Medical Eligibility Criteria
MNCH	Maternal, newborn and child health
NSAID	Nonsteroidal anti-inflammatory drug
PID	Pelvic inflammatory disease
POP	Progestin Only Pill
PPC	Postpartum care
PPFP	Postpartum family planning
PPIUCD	Postpartum intrauterine contraceptive device
PROM	Prolonged rupture of membranes
STI	Sexually transmitted infection
USAID	United States Agency for International Development
USG	Ultrasonography
WHO	World Health Organization

FAMILY PLANNING TRAINING COURSE OVERVIEW

COURSE DESCRIPTION:

This clinical training course is designed to provide you with the latest technical information and skills about the basics in family planning and the different family planning methods. It enables you to explain family planning services and provide different family planning methods. The course has 5 modules to be given as a block training or on modular basis. The training course is designed to actively involve you in the learning process.

COURSE GOAL:

To enable you provide quality family planning services by ensuring up-to-date knowledge, positive attitude and standard clinical skills.

TRAINING DESIGN:

The training course builds on your past knowledge and uses a **competency-based learning process and evaluation** of performance.

Specific characteristics of this training are as follows:

- During the morning of the first day, you will demonstrate your knowledge of basics in family planning by completing a written **Pre-course Questionnaire**.
- Classroom and clinical sessions focus on key aspects of family planning in respective modules.
- Clinical skills training builds on your previous experience relevant to the specific family planning methods. To standardize your skills on the provision and follow up of the family planning methods, you will practice first with anatomic models, using specific learning guides that list the key tasks and steps for performing the procedures for client counseling and assessment, provision of a family planning method, and follow-up.
- The facilitator uses competency-based skills checklists to evaluate each participant's performance with models in a simulated setting and on clients at selected health facilities.
- Clinical decision-making is learned and evaluated through case studies and simulated exercises and during clinical practice on clients. It is the clinical facilitator's responsibility to observe each participant's overall performance in providing the family planning methods during the self-directed practicum using the specific skills checklists.
- Appropriate interpersonal skills are learned through behavior modeling and evaluation during clinical practice with clients.

Successful completion of the course is based on competency in providing the specific family planning methods in respective modules following the standards. A participant who completes the respective modules competently will be given a “**Certificate of Attendance**” at the end of the training. After satisfactory completion of the training, you are expected to organize your respective health facilities to enable you provide the family planning methods that you are trained on and initiate service provision following the standards. Facilitators/facilitative supervisors will later come to your facility to mentor and evaluate the status of the facility’s FP service provision and your on-site performance. If you are evaluated as providing the service according to the standard, you will be eligible for a “**Certificate of Competency**”.

Components of the family planning learning resource package (LRP):

This clinical training course uses the following learning resources:

- A **participant’s handout** containing the need-to-know information, learning guides and skills checklists, case studies, role plays, and clinical simulations
- A **facilitator’s guide**, containing answer keys for questionnaires, case studies & role plays, and detailed activity script/information for conducting the course
- **Well designed training/learning aids** such as videotapes, presentation graphics and anatomic models
- Competency-based performance evaluation

The main reference manuals recommended for the course are ***World Health Organization. Family Planning, A Global Hand Book For Providers: 2011*** and ***World Health Organization. Medical Eligibility Criteria for contraceptive use: 4th Edition, 2009***. Additional module-specific major references are included in each module.

Organization of the Training Modules:

The training course consists of 5 modules with similar arrangements in both the participant’s handout and facilitator’s guide.

- **Module 1:** Basics in Family Planning and Short-Acting Family Planning Methods.
- **Module 2:** Counseling for Family Planning Use.
- **Module 3:** Long-Acting Family Planning Methods.
- **Module 4:** Permanent Family Planning Methods.
- **Module 5:** Post partum IUCD (PPIUCD)

Each module has a module-specific course syllabus (module syllabus) with the following components and arrangement:

- **Module Description**
- **Module Goal**
- **Learning Objectives**
- **Training/Learning Methods**
- **Training/learning Materials**
- **Participant Selection Criteria**
- **Methods of Evaluation**
 - **Participant**
 - **Module**
- **Module Duration**
- **Course Schedule**

Each module in this training course is subdivided into parts and sessions. Each module uses a variety of training/learning methods intended to actively involve you in the process.

PART –I: PARTICIPANT’S GUIDE

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Introduction

During the postpartum period, many women are not aware of their risk for pregnancy, which may occur as early as 4 to 6 weeks after birth. Although postpartum women may want to either space or limit subsequent births and would like to use contraception, most in developing countries are not. Mothers are often “too busy” taking care of their new babies and their families, and may mistakenly believe that they cannot get pregnant as long as they are breastfeeding. Some may be unsure of their contraceptive options or where they can access services, if available. And **the next time they go to the health facility, it is often too late**: they are pregnant again. It may also be too soon.

When pregnancies are spaced too closely together (<24 months, from birth to next pregnancy¹), mothers and babies are at increased risk for adverse health outcomes. Family planning, including postpartum family planning (PPFP), saves lives by enabling women to delay or limit their pregnancies. As such, family planning/PPFP has the potential to dramatically decrease maternal and child mortality and morbidity rates.

The most successful PPFP programs will focus on providing PPFP counseling to women at every opportunity. Ideally, counseling would be initiated during pregnancy, such as at an antenatal care (ANC) visit. Services should continue into the postpartum period, for routine follow-up and management of potential problems.

The goal of PPFP services is threefold: to—

1. **Assist** women and couples in understanding their risk of unintended pregnancy and the benefits of healthy spacing of pregnancies (or limiting, if desired); clarifying their fertility intentions; and choosing a contraceptive method that is well-suited to them;
2. **Provide** the chosen method, in adherence with international global standards and local protocols;
3. **Support** the woman and couple throughout the process—with kindness and respect, up-to-date information, quality care and, when needed, reassurance—to help ensure continued use of the method or smooth transition to another method of their choosing if appropriate.

The intrauterine contraceptive device (IUCD) inserted postpartum (up to 48 hours after birth, optimally within 10 minutes of delivery of the placenta) is an excellent choice for many postpartum women, including those who are breastfeeding.² Because the postpartum IUCD (PPIUCD) is inserted so soon after birth, **a woman can leave the birth facility with a safe and extremely effective, long-acting, reversible contraceptive method already in place.**

This course aims to save lives by preparing a range of qualified service providers who can deliver high-quality PPIUCD services as part of a comprehensive PPFP program.

¹Per the World Health Organization's recommendations for healthy spacing (2009).

²Current recommendations are for the Copper T 380A to be used in postpartum insertions.

PPIUCD Course Overview

Course Description

Before Starting the Course

Welcome to the PPIUCD clinical skills training course! You may benefit from understanding a few things about the course before getting started. **First**, it will be conducted in a way that is very different from traditional training courses—based on the assumption that you are here because you:

- Are **interested** in providing PPIUCD services;
- Wish to **improve** your knowledge and skills in PPIUCD service delivery, and thus your job performance; and
- Desire to be **actively involved** in course activities.

Therefore, the course will be very participatory and interactive, helping to create an environment that is more conducive to learning. **Second**, the development and assessment of your skills throughout the course will focus more on your performance than on what you know or have memorized. This is because clients deserve providers who *are able to provide* safe and effective services, *not just knowledgeable* about them. **Third**, a variety of educational technologies will be used to maximize the effectiveness and efficiency of course activities, enhancing your learning experience while conserving valuable resources. The training approach to be used is discussed in more detail on pages 1-13 to 1-16.

Course Design

This clinical skills course is designed to prepare qualified service providers (primarily maternal, newborn and child health [MNCH] providers [e.g., midwives, nurse-midwives, doctors] and other clinicians) who are capable of delivering high-quality PPIUCD services to women—beginning with counseling when they are pregnant (ideally) and continuing through their first PPIUCD follow-up at 4 to 6 weeks. Throughout the course, the Facilitator will use a variety of approaches to develop the participants' skills and to assess their performance. Key skills development and performance assessment methods and processes are described briefly below.

Knowledge Update

- During the morning of the first day, participants are introduced to the key features of the course and are briefly assessed (using the **Precourse Knowledge Assessment**, a standardized written test) to determine their individual and group knowledge of the provision of PPIUCD services. Based on the results of this assessment (which will be summarized and analyzed using the **Individual and Group Assessment Matrix**):
 - The Facilitator and participants identify their collective strengths and weaknesses, and decide what adjustments should be made to the course schedule/outline—in terms of time allotted to topics and activities.
 - Each participant develops a **Personal Learning Plan** to articulate how she/he will use the course to achieve the **PPIUCD Performance Standards**.
- The knowledge component of the course includes interactive presentations, discussions and other activities designed to help participants develop a *working understanding* of the latest, evidence-based information about the IUCD and PPIUCD.

- Progress in knowledge-based learning is assessed informally during the course through discussions and other activities. It is formally measured using a standardized written test (**post-training Knowledge Assessment**). This assessment will be given at the time in the course when content from all subject areas has been presented. A score of 85% or more indicates mastery of this material. For participants scoring less than 85% on their first attempt, the clinical Facilitator will review the results with the participant individually and provide guidance on using the Reference manual in the Participant's handout to learn the required information. Participants scoring less than 85% can take the test again at any time during the remainder of the course.

Skills Development and Assessment

Classroom and clinic sessions focus on **key aspects of PPIUCD service delivery** (e.g., counseling and screening of clients, performing the IUCD insertion procedure in the context of routine obstetric services, managing side effects and other potential problems during follow-up).

- Participants will first practice skills “in simulation” (on anatomic models) using a detailed step-by-step **Counseling Guide** and **Clinical Skills Checklists**, which list the key steps in counseling and screening clients and postpartum insertion of the IUCD. In this way, they learn the skills needed to provide PPIUCD services more quickly and in a standardized manner, without placing clients at risk.
- Once the Facilitator determines that a participant has achieved an adequate level of skill with anatomic models, or in simulation, s/he will be able to practice the new skills in the clinical setting with actual clients. Progress in learning new skills is assessed (formally and informally) and documented throughout the course using the **Counseling Guide, Clinical Skills Checklists** and **Skills Tracking Sheet**.

Qualification

Although qualification is a statement by the Facilitator that the participant has met the requirements of the course, the responsibility for becoming qualified is shared by the participant and the Facilitator. Qualification is based on demonstrated mastery of, or competency in, the following areas:

- **Knowledge:** A score of at least 85% on the Midcourse Knowledge Assessment
- **Skills:** Satisfactory performance of PPIUCD counseling and clinical skills (as outlined in the checklists)
- **Provision of Services (Practice):** Demonstrated ability to provide safe and effective PPIUCD services in the clinical setting

A true determination of a participant's competency can be made only through observing how the participant applies all that s/he has learned with actual clients.

After the Course

It is recommended that within 1 to 2 months of qualification, the participants be observed and assessed at their workplace by a course Facilitator, using the same counseling and clinical skills checklists used in the course. (At the very least, participants should be observed by a skilled provider soon after completing training.) This post course assessment is important for several reasons. **First**, it not only gives the newly trained providers direct feedback on their performance (so that they can work on further strengthening their skills, from competency to proficiency), but also provides the opportunity for them to discuss any start-up problems or constraints to

implementing the new skills in service delivery (e.g., due to lack of instruments, supplies or support staff). **Second**, and equally important, it provides the training center, via the clinical Facilitator, key information on the adequacy of the training and its appropriateness to local conditions. With this type of feedback, programs can be improved in a targeted manner to better meet the needs providers and communities. Without this type of feedback, training easily can become routine, stagnant and irrelevant to service delivery needs.

Course Syllabus

Course Description

This 3-day clinical training course is designed to prepare the participant to become competent in:

- **Counseling** women/couples about PFP and the PPIUCD as a contraceptive method;
- **Screening** women to ensure that they do not have any characteristics or conditions that would make the IUCD an unsuitable option for them;
- **Inserting the IUCD** in different postpartum scenarios, while incorporating appropriate infection prevention practices: postplacental insertion (within 10 minutes of delivery of placenta), both with an instrument (forceps) and manually; intracesarean insertion (during a cesarean section); and early postpartum insertion (not immediate but up to 48 hours after childbirth); and
- **Managing** side effects and other potential problems associated with the use of IUCDs.

Course Goals

- To influence in a positive way the attitudes of the participant toward the benefits and appropriate use of IUCDs during the postpartum period
- To provide the participant with the knowledge, skills and attitudes necessary to provide PPIUCD services

Learning Objectives

By the end of the course, the participant will be able to:

- Discuss the importance of healthy spacing (or limiting) of pregnancies and the benefits of postpartum family planning.
- Explain basic information about the IUCD (interval and postpartum): its effectiveness, safety, mechanism of action, advantages and limitations, and other general attributes; and the medical eligibility criteria and other client assessment criteria used to determine whether the IUCD is a good option for the woman.
- Explain what is unique about the IUCD in the postpartum context.
- Demonstrate appropriate counseling and assessment of antenatal women for PFP in general and the PPIUCD in particular.
- Demonstrate appropriate counseling and screening of women in early/inactive labor or the early postpartum period for insertion of the IUCD.
- Demonstrate appropriate infection prevention practices related to IUCD service provision.
- Perform postplacental insertion of the IUCD (with forceps and manually).

- Perform intracervical insertion of the IUCD.
- Perform early postpartum insertion of the IUCD.
- Demonstrate proper post-insertion counseling and care.
- Describe the potential side effects and complications of the PPIUCD and how to manage them.
- Describe the organization and management of a high-quality PPIUCD program.

Training/Learning Methods

- Illustrated lectures and group discussion
- Individual and group exercises
- Role plays
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities (focusing on counseling, screening and PPIUCD insertion)

Learning Materials

This training package is designed to be used with the following materials:

- Module 1: Basics in Family Planning and short acting Family planning Methods(Facilitator's and Participant's handouts)
- Module 2: Counselling for Family Planning Use(Facilitator's and Participant's handouts)
- Module 5: *Postpartum Intrauterine Contraceptive Device (PPIUCD)* (Facilitator's Guide and Participant's handout)
- PPIUCD insertion kit and Copper T 380A IUCDs in sterile packages
- Anatomic models for practicing PPIUCD insertion

Participant Selection Criteria

Participants for this course should be providers who are:

- Working in a health care facility (health center or hospital) that provides women's health services including antenatal care, labor and childbirth, and postpartum care, including family planning
- Familiar with providing interval IUCD insertion and removal services
- Willing to update their knowledge and acquire the skills and attitudes essential to provide PPIUCD services

PPIUCD service delivery is often a team effort, requiring the knowledge, skills and attitudes of trained clinicians and other types of health professionals, such as health or family planning educators and counselors. Although this course is designed for the individual health professional, it is easily adapted for training two-person teams (e.g., a clinician, such as a midwife, and a non-clinician, such as a counselor or health assistant) in all aspects of PPIUCD service provision.

The person who actually performs the counseling or inserts the IUCD may vary from facility to facility, depending on national and programmatic policies and availability of trained health care providers. Thus, opportunities are provided for learning and practicing the range PPIUCD services: counseling and clinical skills, infection prevention, recordkeeping and follow-up of clients. Even if a participant will not carry out a specific task at the workplace, s/he needs to be familiar with what it involves in order to help ensure transfer of new skills to the workplace and high-quality service delivery. Therefore, **all course participants** have the opportunity to observe or perform all of the tasks associated with the safe and effective delivery of PPIUCD services.

Methods of Assessment

Participant

- Pre- and Post-training Knowledge Assessment
- Counseling Guide (antenatal and immediately after the childbirth)
- Clinical Skills Checklists for PPIUCD services:
 - Postplacental IUCD Insertion—Instrument Technique
 - Postplacental IUCD Insertion—Manual Technique
 - Intrauterine IUCD Insertion
 - Early PPIUCD Insertion

Course

- Course Evaluation (to be completed by each participant)

Course Duration

- Five days, ten sessions including model practice
- Additionally, F i v e d a y s o f clinical practice in labor room

Suggested Course Composition

- 16 participants, depending upon the PPIUCD caseload
- Four clinical Facilitators

Course Schedule for Training on PPIUCD

Date	Time	Topics	Duration (Mins.)	Facilitator
Day One	8:30–8:50	Registration	20	
	8:50–9:00	Welcoming and opening remarks	10	
	9:00– 9:45	Introductory Session: Introduction of Participants, Ground Norms, Participants’ Expectations, and Introduction of training objectives	45	
	9:45–10:15	Pre-training knowledge assessment (pre-test)	30	
	10:15-10:30	Tea Break	15	
	10:30–11:50	Module 1: Introduction to family planning	80	
	11:50-12:30	Module 1: Overview of anatomy and physiology of reproductive organs (female and male)	40	
	12:30–1:30	Lunch	60	
	1:30-2:20	Module 1,: Natural family planning methods	50	
	2:20-3:40	Module 1,: Short-acting modern family planning methods	80	
	3:40-3:55	Tea Break	15	
	3:55-4:20	Module 1: Emergency contraception	25	
	4:20-5:00	Module 1: Overview of long-acting and permanent family planning methods	40	
	5:00-5:10	Daily wrap-up and reflections	10	

Day Two	8:30–8:40	Recap and agenda for Day-2	10	
	8:40-9:10	Module 1: Family Planning for clients with special needs	30	
	9:10-9:50	Module 1: Medical eligibility and client assessment	40	
	9:50-10:30	Module 1: Infection prevention in family planning	40	
	10:30-10:45	Tea Break	15	
	10:45:-12:05	Module 1: Logistics and health management information systems in family planning	80	
	12:05-12:30	Module 2: Counseling clients for Family Planning	25	
	12:30-1:30	Lunch	60	
	1:30-2:00	Module 2: Providers' beliefs and attitudes	30	
	2:00-3:00	Module 2: Ensuring optimal communication	60	
	3:00-3:20	Module 2: Who are our clients?	20	
	3:20-3:35	Tea Break	15	
	3:35-4:15	Module 2: Introduction to the REDI framework	50	
	4:15-5:10	Module 2: Filling clients' knowledge gaps and addressing misconceptions	55	
5:10-5:20	Daily wrap-up and reflections	10		

Day Three	8:30–8:40	Recap and agenda for day-3	10	
	8:40-10:10	Module 2: Helping clients’ in making or confirming a decision and in implementing decision	90	
	10:10-10:40	Module 2: Counseling return clients	30	
	10:40-10:55	Tea Break	15	
	10:55-11:15	Module 2: Helping clients continue or switch methods	20	
	11:15-11:40	Module 2: Strengthening skill in partner communication and negotiation	25	
	11:40-12:30	Counseling role plays	50	
	12:30-1:30	Lunch	60	
	1:30-2:00	Module 5: Healthy spacing of pregnancy and its health benefits	30	
	2:00-2:20	Module 5: Review Group & individual knowledge Matrix	20	
	2:20-3:30	Module 1 and Module 5: Postpartum and Post abortion Family planning	70	
	3:30-3:45	Tea break	15	
	3:45-4:00	Module 5: Exercise one: Brainstorming: What is different about the PPIUCD?	15	
	4:00-5:15	Module 5: Postpartum IUCD Overview and Postpartum IUCD Counseling	75	
5:15-5:25	Daily wrap-up and reflections	10		
Date	Time	Topics	Duration (Mins)	Facilitator
Day Four	8:30–8:40	Recap & Agenda for Day-4	10	
	8:40–9:20	Module 5: Exercise 2: Medical Eligibility/Client Assessment for PPIUCD	40	
	9:20-10:00	Module 5: Infection prevention for PPIUCD	40	
	10:00–10:15	Tea break	15	
	10:15-11:40	PPIUCD Counseling role plays	85	
	11:40-12:00	Module 5: Review of performance standards: Development of personal learning plan (Action plan)	20	
	12:00-12:30	Module 5: Exercises three & Four: Identify the IP Steps and PPIUCD Frequently Asked Questions (FAQs)	30	
	12:30-1:30	Lunch	60	

Date	Time	Topics	Duration (Mins)	Facilitator
	1:30–2:20	Module 5: Management of PPIUCD Side Effects and Complications	50	
	2:20–3:10	Demonstrations: post placental insertion of IUCD, Intraesarean insertion of IUCD and immediate postpartum insertion of IUCD	50	
	3:10-3:25	Tea Break	15	
	3:25-4:05	Demonstration of PPIUCD insertion video	40	
	4:05–5:05	PPIUCD Insertion practice on anatomic models	60	
	5:05–5:15	Daily wrap-up and reflections	10	
Day Five	8:30–8:40	Recap & Agenda for day 5	10	
	8:40–10:30	PPIUCD Insertion practice on anatomic models cont.	110	
	10:30-10:45	Tea Break	15	
	10:45-11:00	Module 5: Exercise 5: Infection Prevention (IP) principles, Question and Answer	15	
	11:00–12:00	PPIUCD Insertion practice on anatomic models cont.	60	
	12:30–1:30	Lunch	60	
	1:30–4:30	Practice in Wards Counseling: Of clients for PPFP and PPIUCD (ANC facility; postpartum ward) Clinical: Insertion of post placental, intraesarean, early postpartum IUCD (labor and delivery ward; postpartum ward)	210	
	4:30-5:00	Review Skills Tracking Sheet	30	
	5:00-5:10	Daily wrap-up and reflections		
From Day 6 to Day 10 morning, the clinical practice in wards continues including the nights.				
Day 10 (Afternoon)	1:30–2:15	Post training knowledge Assessment (Post-test)	45	
	2:15–2:35	Review of Post-training knowledge assessment (Post Test)	20	
	2:35–3:30	Review of personal learning plan (Action Plan)	55	
	3:30–3:45	Tea break	15	
	3:45–3:55	End Course Evaluation	10	
	3:55–4:10	Closing and certificate distribution	15	

Training Approach Used

In the context of clinical skills training, the mastery learning approach assumes that all participants can master—or “achieve competency” in—the knowledge and skills required to provide a specific health service, provided that sufficient time is allotted and appropriate training methods are used. The goal of mastery learning is for 100% of those being trained to be **competent** in providing beginning-level services by the end of the course. (Providers will only become proficient in newly-acquired skills once they have regularly used them in the workplace.)

Key points about the mastery learning approach, as used in this course, follow:

- From the outset, **participants know (as individuals and a group) what they are expected to learn** and where to find the information they need. They have ample opportunity for discussion with the clinical Facilitator about course content and their performance. This makes the training less stressful.
- Because people vary in their abilities to absorb new material, and learn best in different ways (e.g., through written, spoken or visual means), a **variety learning methods** are used. This helps to ensure that all participants have the opportunity to succeed.
- **Self-directed learning** enables participants to become active participants in their progress toward course goals. To facilitate this participant role, the clinical Facilitator serves as a facilitator or “coach,” rather than as more traditional instructor. Participants are also supported in identifying their own weaknesses and creating individualized plans for success.
- **Continual assessment** increases participants’ opportunities for learning. Through a variety of techniques, the Facilitator keeps participants informed of their progress in learning new information and skills, so that participants will know where they need to focus their efforts to achieve competency.

What if assessment could be just as much about **LEARNING** as it is about being **EVALUATED**?

Well, in this course, it is...

- **“Formative”** assessment is used continually, often informally, to **help you learn**. For example, during a discussion, the Facilitator will ask questions to assess participants’ understanding of the information being presented; he/she will recognize and reinforce correct answers, but will also help a participant who answers incorrectly to arrive at the correct answer—by exploring the rationale behind his/her answer, asking additional questions, etc. All learning activities are an opportunity for formative assessment. The Facilitator may use evidence of what participants have not yet mastered to make changes in the course to better meet participant needs.
- The Facilitator uses **“summative”** assessment, which is more formal, to determine whether you are ready to move on to the next level of responsibility (e.g., to move from practicing skills in simulation to practicing them with real clients). These assessments occur at specific points during the course to evaluate participants’ progress toward achieving course objectives and, ultimately, qualification.

With the mastery learning approach as a foundation, this course has been developed and will be conducted according to **adult learning principles**—learning should be participatory, relevant and practical—and:

- Uses **behavior modeling**;
- Is **competency-based**; and
- Incorporates **humanistic training techniques**.

Behavior Modeling

A person learns most rapidly and effectively by watching someone *model* (perform or demonstrate) a skill/activity or an attitude that they are trying to master. For modeling to be successful, the Facilitator must clearly demonstrate the service delivery-related skill/activity so that participants have a clear picture of the performance that is expected of them. Learning to perform a skill takes place in three stages, as shown in the box below.

Skill Acquisition	Knows the steps and their sequence (if applicable) to perform the required skill or activity but needs assistance
Skill Competency	Knows the steps and their sequence (if applicable) and can perform the required skill or activity at a “beginning level” (the goal of the course)
Skill Proficiency	Knows the steps and their sequence (if applicable) and efficiently performs the required skill or activity (achieved only through continued practice at workplace)

In addition, the Facilitator is continually modeling attitudes through his/her interactions with other Facilitators, participants and clients. Attitudes are demonstrated and explored in certain learning activities, such as discussions and role plays.

Competency-Based Training

Competency-based training (CBT) is distinctly different from traditional educational process; it is **learning by doing**. How the participant performs is emphasized rather than just what information the participant has acquired. This course focuses on the specific knowledge, skills and attitudes needed to carry out PPIUCD service delivery-related tasks.

An essential component of CBT is coaching. Coaching incorporates **questioning, providing positive feedback and active listening** to help participants develop specific competencies, while encouraging a positive learning climate. In the role of coach, the Facilitator first explains the skill or activity and then demonstrates it using an anatomic model or other training aid, such as a video or a checklist. Once the procedure has been demonstrated and discussed, the Facilitator/coach observes and interacts with the participant to provide guidance as she/he practices the skill or activity. The Facilitator continues monitoring participant progress—providing suggestions and feedback, as needed, to help the participant overcome problems, build confidence and work toward greater independence.

Humanistic Training Techniques

The use of humane (humanistic) techniques also contributes to better clinical training. A major component of humanistic training is the use of anatomic models, which closely simulate the human body, and other learning aids such as videos. The effective use of models or other simulations facilitates learning, shortens training time and minimizes risks to clients. For example, by using anatomic models initially, participants more readily reach a level of performance that enables them to safely work with clients in the clinical setting, which is where they can achieve competency.

Before a participant attempts a clinical procedure with a client, two learning activities should occur:

- The clinical Facilitator should demonstrate the required skills and client interactions several times using an anatomic model or a simulation and appropriate audiovisual aids (e.g., video, computer graphics).
- While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting that is as similar as possible to the real clinical scenario.

Only when the participants have correctly and consistently demonstrated skills or interactions with models or in simulation should they have their first contacts with clients.

Summary points on the training approach used in this course.

- **First**, it is based on adult learning principles, which means that it is interactive, relevant and practical. Moreover, it requires that the Facilitator facilitate the learning experience rather than serve in the more traditional role of an instructor or lecturer; this allows participants to become active participants.
- **Second**, it involves use of behavior modeling and formal demonstration to facilitate learning a standardized way of performing a skill or activity.
- **Third**, it is competency-based. This means that it focuses on the participant's performance of a procedure or activity, not just on what or how much has been learned.
- **Fourth**, where possible, it relies heavily on the use of anatomic models and other training aids (i.e., it is humanistic) to enable participants to practice repeatedly the standardized way of performing the skill or activity **before** working with clients.

Through applying the above principles, by the time the Facilitator evaluates the participant's performance using the checklist, every participant should be able to perform **every** skill or activity competently. **And this is the ultimate goal of mastery training!**

Components of the PPIUCD Training Package

In designing the training materials for this course, particular attention has been paid to making them user-friendly, as well as to permit the course participants and clinical Facilitator to easily adapt the training to the participants' (group and individual) learning needs. This course is built around use of the following components (further described below):

- The **Participant's handout** containing answer sheets, exercise prompts, counseling and skills checklists: This is the "road map" that guides the participant through each phase of the course. It contains the course syllabus and course schedule, as well as all supplemental printed materials (precourse knowledge assessment, clinical skill checklists and course evaluation) needed during the course.

Need-to-know information can be obtained in the reference manual included in the **Participant's handout**: The handout provides all of the content needed for the course about the provision of high-quality PPIUCD services. It serves as the "text" for participants and the "reference source" for the Facilitator. In addition, because the manual contains only information that is consistent with the course goals and objectives, it becomes an integral part of all classroom exercises. It is also a valuable resource for participant– providers when they return their workplace.

- **A facilitator’s manual** including answer keys (for written assessments and exercises), as well as detailed information for conducting the course and individual course activities: This document contains the same material as the Participant’s handout, as well as special material for the Facilitator. It includes the course outline, precourse knowledge assessment answer key, midcourse knowledge assessment answer key, exercise answer keys and guidance for conducting the course/course activities.
- **Teaching aids and audiovisual materials**, such as video, slides presentations, anatomic model and other training aids: These are used in conjunction with course activities to enhance and increase the efficacy and efficiency of the learning experience.
- **Competency-based skills development and performance assessment tools:** These materials help to ensure that learning and assessment of learning are standardized, which is a cornerstone of quality training and, ultimately, service provision.

Pre-Training Knowledge Assessment

Using the Individual and Group Assessment Matrix

The main objective of the **Pre-training Knowledge Assessment** (which is taken/ scored anonymously) is to assist both the **Facilitator** and the **participant** as they begin their work together by assessing what the participants, individually and as a group, already know about the course topics. This allows the Facilitator to identify topics that may need to be emphasized or de-emphasized during the course.

Questions are presented in an easy-to-score, true-false format. And a special form, the **Individual and Group Assessment Matrix** (following), is provided to record the scores of all course participants. Using this form, the Facilitator can quickly chart the number of correct answers for each of the questions and share them with the participants. By examining the data in the matrix, group members can easily determine their collective strengths and weaknesses and jointly plan with the Facilitator how best to use the course time to achieve the desired learning objectives.

For the Facilitator, the assessment results will identify particular topics that may need additional emphasis during the learning sessions. Conversely, for those categories where 85% or more of participants answer the questions correctly, the Facilitator may elect to use some of the allotted time for other purposes.

For the participants, the questions alert them to content that will be presented in the course, whereas their results enable them to focus on their individual learning needs. The corresponding topic areas, from the Reference manual in the Participant's handout, are noted beside the answer column. To make the best use of limited course time, participants are encouraged to address their individual learning needs by studying accordingly.

Pre-training Knowledge Assessment—Answer Sheet

Instructions: Select the single best answer to each question. Circle or tick your answer.

Postpartum IUCD Overview

1. In many developing countries, postpartum women have:
 - a. BETTER access to family planning services than women who are not postpartum
 - b. Worse access to family planning services than women who are not postpartum
 - c. No interest in family planning services

2. For health reasons, how long should women wait after delivering a baby before trying to become pregnant again?
 - a. For at least 1 year
 - b. For at least 2 years
 - c. Until regular monthly periods have started again

3. For health reasons, how long should women wait after a miscarriage before trying to become pregnant again?
 - a. No wait is necessary
 - b. 3 months
 - c. 6 months

4. Which of the following is TRUE about expulsion of the postpartum IUCD?
 - a. To prevent expulsion, women who choose the PPIUCD should not breastfeed.
 - b. The expulsion rate is lowest when the IUCD is inserted within 10 minutes of delivery of the placenta.
 - c. Tying knots of catgut on the cross arms of the IUCD will reduce expulsion.

5. Which of the following is an acceptable time to insert an IUCD postpartum?
 - a. When the baby is 1 day old
 - b. When the baby is 1 week old
 - c. When the baby is 3 weeks old

Postpartum Anatomy and Physiology

6. Which of the following is TRUE about how postpartum anatomy and physiology affect IUCD insertion?
 - a. When an IUCD is inserted 2 weeks postpartum, the risk of expulsion is very low because it is easier to reach the fundus.
 - b. The standard IUCD inserter tube can be used to place both interval IUCDs and postpartum IUCDs.
 - c. In order to reach the fundus, the uterus must be “elevated” (pushed up in the abdomen) to smooth out the vagino-uterine angle.

7. Because of normal postpartum changes:
 - a. The woman is less likely to notice initial slight bleeding and cramping caused by the IUCD.
 - b. The strings should be trimmed immediately after insertion of the IUCD.
 - c. The woman should check for the IUCD strings at least once a day (to ensure that it has not been expelled).

Counseling

8. Which of the following statements is TRUE *and* should be shared with a woman during postpartum IUCD counseling?
 - a. An IUCD placed during the postpartum period can be used to delay or prevent pregnancy for as long as the woman desires, even up to 12 years.
 - b. Placement of an IUCD during the immediate postpartum period has a slightly higher risk of uterine perforation than placement during the interval between pregnancies.
 - c. Women who choose the PPIUCD should limit breastfeeding in order to reduce the risk of expulsion.
9. Counseling about the use and benefits of a PPIUCD can be provided:
 - a. Only during routine antenatal care visits, if the husband has agreed to it.
 - b. During active labor, so that the IUCD can be placed immediately after delivery of the placenta.
 - c. During the latent phase labor, if the woman is comfortable.

Infection Prevention

10. Which of the following IP practices is acceptable?
 - a. Surgical (metal) instruments that have been decontaminated and thoroughly cleaned can be safely used for insertion of the IUCD postpartum.
 - b. It is not necessary to use an antiseptic when inserting an IUCD immediately after delivery because the provider is still wearing sterile gloves.
 - c. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments used in IUCD insertion should be soaked first for 10 minutes in 0.5% chorine solution.
11. If an IUCD is still inside an undamaged, sealed package but appears tarnished or discolored, the provider should:
 - a. Insert the IUCD if the package is not beyond the expiration date.
 - b. Send the IUCD back to the manufacturer.
 - c. Discard the IUCD because it is unsterile.

PPIUCD Client assessment

12. In which of the following women would it be safe to insert an IUCD immediately following delivery of the placenta?
 - a. A woman who has a fever of 38°C
 - b. A woman who has had ruptured membranes for 12 hours
 - c. A woman who is HIV+ with a low CD4 count
13. If a woman was successfully treated for chlamydia during this pregnancy and wants an IUCD, the provider can:
 - a. Insert the IUCD if the infection has been gone for more than 6 weeks.
 - b. Insert the IUCD but provide antibiotics for 1 week.
 - c. Tell the woman to return for insertion at 4 weeks postpartum.
14. Which of the following is a condition for which PPIUCD insertion is considered Category 4 (meaning the method should not be used), according to the World Health Organization's Medical Eligibility Criteria (WHO MEC)?
 - a. AIDS
 - b. Puerperal sepsis
 - c. Cesarean section

Postpartum IUCD Insertion

15. Which of the following is the best technique for inserting an IUCD on the first day after delivery?
 - a. Using instruments, such as a Kelly placental forceps
 - b. Using hands (manually)
 - c. Using an inserter tube and plunger
16. Which of the following statements is TRUE about placement of the PPIUCD during cesarean section?
 - a. A sponge-holding (ring) forceps must be used to ensure that the IUCD is placed at the fundus
 - b. The strings of the IUCD should not be passed through the cervix into the vagina
 - c. The PPIUCD should be stitched in place at the fundus with a 0 chromic suture
17. If a woman has had a normal vaginal delivery and an immediate/postplacental IUCD insertion is planned:
 - a. The IUCD should be inserted 30 minutes after active management of the third stage of labor is performed
 - b. Active management of the third stage of labor should be performed as usual, immediately before the IUCD is inserted
 - c. Active management of the third stage labor should be avoided, if possible, if the woman is having a PPIUCD

Follow-Up Care/Management of Potential Problems

18. A woman had a postplacental PPIUCD inserted 3 weeks ago. Over the past 24 hours, she has become hot and feverish. She should:
- Be told to take paracetamol and oral antibiotics for 7 days.
 - Come into the clinic right away to have the PPIUCD removed.
 - Come into the clinic right away for evaluation.
19. Which one of the following is TRUE about IUCD strings?
- The strings should be passed through the cervix into the vagina during intracesarean placement.
 - The strings should not be visible at the cervix after immediate/postplacental insertion of the IUCD.
 - The woman should check for the strings each month to make sure the IUCD has not fallen out.
20. A woman who has had an IUCD placed in the immediate postpartum period should have a follow-up exam:
- Every year to check the strings
 - Only if she thinks the IUCD has fallen out
 - At 4 to 6 weeks postpartum to reinforce counseling, answer any questions and screen for potential problems

Individual and Group Assessment Matrix

Course _____ Dates: _____ Clinical Facilitator(s) _____

QUESTION NUMBER	CORRECT ANSWERS (PARTICIPANTS)															SECTION 1.01 TOPIC AREA
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
1.																HEALTHY PREGNANCY SPACING AND PPFPP/PPIUCD OVERVIEW (Manual, Handouts 1–3; selections as specified)
2.																
3.																
4.																
5.																
6.															POSTPARTUM ANATOMY AND PHYSIOLOGY (Manual, Handouts 3, 4; selections as specified)	
7.																
8.															COUNSELING (Manual, Handouts 5, 6; selections as specified)	
9.																
10.															INFECTION PREVENTION (Manual, Handout 7; selections as specified)	
11.																
12.															CLIENT SCREENING (Manual, Handouts 5, 6; selections as specified)	
13.																
14.																
15.															PPIUCD INSERTION (Manual, Handout 7; selections as specified)	
16.																
17.																
18.															FOLLOW-UP CARE/ MANAGEMENT OF POTENTIAL PROBLEMS (Manual, Handout 8; selections as specified)	
19.																
20.																

Personal Learning Plan

Using the Personal Learning Plan

Learning should be tied directly to performance and should be related to on-the-job application of the learned knowledge and skills. For participants to be ready and eager to learn, they need to understand the relevance of the training to them and their clinical situation. To increase participants' sense of relevance, the Facilitators should ask them: (a) to consider the PPIUCD Performance Standards (Manual, Annex J) in the context of their own skills, as well as the "situation" at their workplace; and (b) to create a Personal Learning Plan based on their findings.

Before Training

You may have observed PPIUCD services at your facility and compared them to established service delivery standards or guidelines (e.g., the PPIUCD Performance Standards). In doing so, you likely identified "gaps"—areas where training is necessary to achieve the standards. If you were not familiar with PPIUCD services in your own practice or at your facility, review of the standards would still benefit you, helping to create a clear picture of what will be expected of you in this course.

During Training

At the start of the training, you will review the standards again; identify which standards are not being met by you or at your workplace, and what knowledge and skills gaps exist. You will record these gaps in your plan, as goals to be achieved; this practice will help to ensure that you acquire the knowledge, skills and attitudes needed to achieve the standards once you return to your workplace. This becomes your **Personal Learning Plan**, which functions as a kind of contract between you and your Facilitator(s).

After Training

Upon returning to your workplace, you should apply your newly acquired skills to achieve the defined standards. Your **Personal Learning Plan** serves as a guide to what you will work on immediately upon return to the workplace and allows you to communicate with your supervisor, coworkers and Facilitators—in a specific, concrete way—the knowledge, skills and attitudes you have learned during this course. It can also aid in discussing how you will initiate changes and lead a team effort to improve the quality of care in PPIUCD services at your facility.

Blank Personal Learning Plan

Instructions: Complete the first four columns of this Personal Learning Plan by reviewing the PPIUCD Performance Standards and thinking about how you will use this training to prepare you to achieve those standards. At the end of the course, complete the final column about how this course has helped you to achieve the standards.

Participant Name:		Designation:		Date:	
Facility Name:		Location:			
Performance Standard # or Area	What is required in order to achieve this standard at your facility?	Who will help you to achieve this standard?	When will you achieve this standard?	How did this training prepare you to achieve this standard?*	
Signatures: _____ (Participant); _____, _____ (Facilitator[s], PPIUCD Course)					

*Final column to be completed at end of course.

Sample Personal Learning Plan

Instructions: Complete the first four columns of this Personal Learning Plan by reviewing the PPIUCD Performance Standards and thinking about how you will use this training to prepare you to achieve those standards. At the end of the course, complete the final column about how this course has helped you to achieve the standards.

Participant Name: <i>Elizabeth Johnson</i>		Designation: <i>Nurse-Midwife</i>		Date: <i>1 November 2010</i>	
Facility Name: <i>Eastern District Hospital</i>		Location: <i>Big City, Eastern District</i>			
Performance Standard # or Area	What is required in order to achieve this standard at your facility?	Who will help you to achieve this standard?	When will you achieve this standard?	How did this training prepare you to achieve this standard?	
<i>#3 Screening/assessment</i>	<i>In my hospital, the IUCD is not very popular. I need updated knowledge about client screening for PPIUCD so I know who can use the IUCD postpartum.</i>	<i>My director, the medical officers and labor ward assistants</i>	<i>I will begin screening women as soon as I return to my hospital</i>	<i>I now understand the new criteria for providing this method.</i>	
<i>#15 Postplacental insertion</i>	<i>We do not practice this method and are not familiar with this technique. I need to learn the steps for postplacental IUCD insertion.</i>	<i>The medical officers in charge of the labor ward, as well as the assistants and educators/counselors</i>	<i>I will provide this method once I have educated clients about it and found some who are interested in and eligible for it</i>	<i>I am now competent to insert postplacental IUCD. I will need more practice with clients to become proficient.</i>	
Signatures: _____ (Participant); _____, _____ (Facilitator[s], PPIUCD Course)					

*Final column to be completed at end of course.

Exercise One: What Is Different about the PPIUCD?

Objectives

The purpose of this activity is to:

- Identify things that are common or different about provision of postpartum IUCD services as opposed to interval IUCD services.
- Identify different equipment and supplies needed for PPIUCD insertion.
- Consider different client characteristics for PPIUCD procedures.

Time Allotted

- 15 minutes

Resources/Materials Needed

- Skills Station for PPIUCD
- Flipchart paper and markers

NOTE: Instructions to be provided by Facilitator.

Exercise Two: Medical Eligibility for the PPIUCD

Objectives

The purpose of this activity is to:

- Dispel common myths and misconceptions about client eligibility for the PPIUCD.
- Clarify and reinforce identification of those few conditions/characteristics that pose health risks with use of the PPIUCD.

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Flipchart paper and markers for small group activity
- Copies of the blank WHO Medical Eligibility Criteria (MEC) PPIUCD chart (either as handout or from Participant's handout)
- Completed MEC PPIUCD chart as answer key (for the Facilitator)

NOTE: Instructions to be provided by Facilitator.

Exercise Two: Answer Sheet

Instructions: Below is a chart listing various conditions/characteristics that may have an impact on whether the PPIUCD is a good choice for a particular woman. For each condition/characteristic, place a check mark in the appropriate column, indicate the WHO Category (1–4) and give a reason in the space provided.

MATERNAL CONDITION	INSERT PPIUCD	DO NOT INSERT PPIUCD	REASON/COMMENT
Plans to have another baby in 2 years			
3 weeks postpartum			
Delivered 20 hours after rupture of membranes (ROM)			
Has AIDS and has not been taking ARV			
Younger than 20 years of age			
History of gonorrhea as a teenager			
History of ectopic pregnancy			
Has a genital laceration that extends into the rectum			
Has a fever of 38°C postpartum			
Has a history of anemia			
Persistent vaginal hemorrhage after delivery			
Partner has penile discharge and dysuria			
HIV-positive and receiving care at the HIV clinic			
History of PID, treated with antibiotics 5 years ago			
Has fever and abdominal pain in association with an incomplete abortion			

Exercise Three: Infection Prevention Steps

Objectives

The purpose of this activity is to:

- Reinforce infection prevention IP principles.
- Identify the steps of insertion of the PPIUCD that are for the purpose of infection prevention.
- Clarify how infection prevention is carried out.

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Clinical Skill Checklists for Postplacental Insertion (Instrumental and Manual) and Early Postpartum Insertion PPIUCD

NOTE: Instructions to be provided by Facilitator.

Exercise Four: PPIUCD Frequently Asked Questions (FAQs)

Objectives

The purpose of this activity is to:

- Reinforce principles for the provision of PPIUCD services.
- Clarify concepts of PPIUCD service provision.

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Reference manual in the Participant's handout

NOTE: Instructions to be provided by Facilitator.

Exercise Five: Infection Prevention Principles

Objectives

The purpose of this activity is to:

- Reinforce infection prevention principles.
- Clarify concepts of infection prevention.

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Reference manual in the Participant's handout

NOTE: Instructions to be provided by Facilitator.

Counseling Guide and Clinical Skills Checklists

The Clinical Skills Checklists for PPIUCD insertion contain the steps or tasks performed by the clinician when providing PPIUCD services. These tasks correspond to the information presented in *Postpartum Intrauterine Contraceptive Device (PPIUCD) Services: A Reference manual in the Participant's handout for Providers* (Jhpiego 2010). These checklists are designed to help the participant learn the steps or tasks involved in:

- Postplacental insertion of an IUCD (instrumental, manual)
- Intracervical insertion of an IUCD
- Early postpartum insertion of an IUCD

In addition, the counseling guide serves as a checklist for the skills needed for counseling a client for postpartum family planning, particularly those interested in insertion of an IUCD in the postpartum period.

Job aids and other tools from the Reference manual in the Participant's handout (which provide detailed "content") can be used in conjunction with the counseling guide and skills checklists, supporting both learning and the transfer of new skills to the workplace.

Using Skills Checklists for Learning

The **checklists** are designed to be used for both learning and assessment. During skill acquisition, participants use the checklists to:

- Understand the steps of the procedure.** The Facilitator introduces the skill by describing the steps and how they are accomplished. The Reference manual in the Participant's handout describes the steps in greater detail, providing illustrations, more detailed explanations and tips.
- Follow along as the Facilitator conducts a demonstration of the procedure on an anatomic model.** The participants will use the clinical skills checklist as a guide to the sequence and correct performance of the individual steps of the procedure.
- Guide his/her own clinical practice on the anatomic model.** The participant will practice the clinical skills on the anatomic models with the assistance and support of colleagues and Facilitators. In this context, the checklist provides a mechanism for colleagues and Facilitators to discuss and provide explicit, constructive feedback on performance.
- Check whether s/he is ready for formal assessment by the Facilitators.** Ultimately, participants will need to be assessed by the Facilitators to determine their level of achievement in the skill being practiced. Since the skill will be assessed by the Facilitator using the exact same clinical skill checklist, participants can rate their own readiness for assessment by self-evaluating their performance based on the checklist.
- Guide practice with actual clients in the clinical setting.** Once a skill is "mastered" in the skills lab, participants will be ready to practice the skill under supervision with actual clients in the clinical setting. The checklist is used again in this context as a guide to strengthen performance.

What happened to learning guides? Previously, many training courses used learning guides as a learning tool and checklists as an assessment tool. While similar to each other, learning guides had a greater level of detail about the steps in the procedure. Modern approaches to learning and performance have caused Facilitators to rethink that approach. Instead of having separate tools for learning and performance, the emphasis is now on the link between the two. Because checklists are more concise and easily transferred to the workplace, they are now used to guide learning, assessment and performance.

Using Skills Checklists for Assessment

The same **checklist** used for learning/practice is used by the Facilitator for assessment of each clinical skill, in terms of both readiness for—and competency in—working with actual clients. The final phase of learning in the context of this course, known as skill competency, is determined by the Facilitator using the checklist as an objective measure of the achievement of all the steps of the procedure with actual clients. The checklist, therefore, is used for assessment by the Facilitators and participants in the following ways:

- **As a template for feedback.** Space is provided on the checklist for Facilitators and colleagues (other participants) to score the performance of a given step in a procedure. Under the column marked CASES, observers should rate whether a participant correctly performed the step in the following way:

Place a “✓” in case box if task/activity is performed **satisfactorily**, an “x” if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by Facilitator

Along with those who are observing and coaching, the participant should describe correct practice and specifically note the ways in which steps can be done correctly. The specificity of the checklist is an example of the level of detail that should be provided through description/feedback.

- **For determination of “readiness.”** When the Facilitator and the participant both believe that the participant is ready to practice with clients, the checklist is used. Since the checklist is a focused listing of all the necessary steps of the procedure, it is expected that the participant will perform all the steps correctly.
- **For “qualification,” certification of competency.** At the bottom of the checklist is a box for the Facilitator to sign, certifying that the participant performed the skill competently. This is signed and dated as the statement of competency in both the skills lab and the clinical setting.

FACILITATOR CERTIFICATION

	<u>With Models</u>	<u>With Clients</u>
Skill performed competently:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signed:

Date:

Counseling Guide for PFP/PPIUCD Counseling

This guide provides a “framework” for counseling—both general and specific to women interested in the PPIUCD.

Place a “”✓ in case box if task/activity is performed **satisfactorily**, an “x” if it is **not** performed **satisfactorily**, or **N/O** if not observed.
Provide comments to the participant to allow him or her to improve her performance.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by Facilitator

Participant _____ Date Observed _____

COUNSELING ON PPIUCD SERVICES					
ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
<i>Establish good rapport and initiate counseling on PFP.</i>					
1. Establishes a supportive, trusting relationship.	<input type="checkbox"/> Greets the woman, using her name and introducing self.				
	<input type="checkbox"/> Shows respect for the woman and helps her feel at ease.				
2. Allows the woman to talk and listens to her.	<input type="checkbox"/> Encourages the woman to explain her needs and concerns and ask questions.				
	<input type="checkbox"/> Listens carefully and supports the woman’s informed decisions.				
3. Engages woman’s family members.	<input type="checkbox"/> Includes woman’s partner or important family member in the discussion, as the woman desires and with her consent.				
<i>Determine reproductive intentions, knowledge of pregnancy risk and use of various contraceptives.</i>					
4. Determines any previous experiences with family planning.	<input type="checkbox"/> Explores woman’s knowledge about the return of fertility and the benefits of pregnancy spacing or limiting (as desired).				
	<input type="checkbox"/> Asks whether she has had prior experience with family planning methods, any problems, reasons for discontinuing, etc.				
5. Assesses partner/family attitudes about family planning.	<input type="checkbox"/> Explores partner’s/family’s knowledge about the return of fertility and the benefits of pregnancy spacing/limiting.				

COUNSELING ON PPIUCD ERVICES

ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
6. Assesses reproductive intentions.	<input type="checkbox"/> Asks about desired number of children, desire to space or limit births, desire for long-term family planning, etc.				
7. Assesses need for protection against sexually transmitted infections (STIs).	<input type="checkbox"/> Explores woman's need for protection from STIs, including HIV.				
	<input type="checkbox"/> Explains and supports condom use, as a method of dual protection.				
8. Determines interest in a particular family planning method.	<input type="checkbox"/> Asks whether she has a preference for a specific method, based on prior knowledge or the information provided.				
<i>Provide the woman with information about PPFM methods.</i>					
9. Provides general information about benefits of healthy pregnancy spacing (or limiting, if desired).	<input type="checkbox"/> Advises that to ensure her health and the health of her baby (and family), she should wait at least 2 years after this birth before trying to get pregnant again.				
	<input type="checkbox"/> Advises about the return of fertility postpartum and the risk of pregnancy. Advises how LAM and breastfeeding are different.				
	<input type="checkbox"/> Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired).				
10. Provides information about PPFM methods.	<input type="checkbox"/> Based on availability and on woman's prior knowledge and interest, briefly explains the advantages, limitations and use of the following methods:				
	- LAM				
	- Condoms				
	- POPs, COCs				
	- DMPA (injections)				
	- PPIUCD				
	- No-scalpel vasectomy (male sterilization)				
	- Postpartum tubal ligation (female sterilization)				
	<input type="checkbox"/> Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUCD, using a contraceptive tray.				
<input type="checkbox"/> Corrects any misconceptions about family planning methods.					

COUNSELING ON PPIUCD SERVICES

ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
<i>Assist the woman in making a choice; give her additional information that she might need to make a decision.</i>					
11. Helps the woman to choose a method.	<input type="checkbox"/> Gives woman additional information that she may need and answer any questions.				
	<input type="checkbox"/> Assesses her knowledge about the selected method; provides additional information as needed.				
12. Supports the woman's choice.	<input type="checkbox"/> Acknowledges the woman's choice and advises her on the steps involved in providing her with her chosen method.				
<i>Determine whether she can safely use the method; provide key information about how to use the method (focus on PPIUCD, per her choice).</i>					
13. Evaluates the woman's health and determine if she can safely use the method.	<input type="checkbox"/> Asks the woman about her medical and reproductive history.				
14. Provides key information about the PPIUCD with the woman:	<input type="checkbox"/> Effectiveness: Prevents almost 100% of pregnancies				
	<input type="checkbox"/> Mechanism for preventing pregnancy: Causes a chemical change that damages the sperm BEFORE the sperm and egg meet				
	<input type="checkbox"/> Duration of IUCD efficacy: Can be used as long (or short) as woman desires, up to 12 years (for the Copper T 380A)				
	<input type="checkbox"/> Removal: Can be removed at any time by a trained provider with immediate return to fertility				
15. Discusses advantages of the PPIUCD:	<input type="checkbox"/> Simple and convenient IUCD placement, especially immediately after delivery of the placenta				
	<input type="checkbox"/> No action required by the woman after IUCD placement (although one routine follow-up visit is recommended)				
	<input type="checkbox"/> Immediate return of fertility upon removal				
	<input type="checkbox"/> Does not affect breastfeeding or breast milk				
	<input type="checkbox"/> Long-acting and reversible (as described above)				

COUNSELING ON PPIUCD SERVICES					
ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
16. Discusses limitations of the PPIUCD:	<input type="checkbox"/> Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum women)				
	<input type="checkbox"/> Does not protect against STIs, including HIV				
	<input type="checkbox"/> Higher risk of expulsion when inserted postpartum (though less with immediate postpartum insertion)				
17. Discusses warning signs; explains that she should return to the clinic as soon as possible if any arise.	<input type="checkbox"/> Bleeding or foul-smelling vaginal discharge (different from the usual lochia)				
	<input type="checkbox"/> Lower abdominal pain, especially if the first 20 days after insertion—accompanied by not feeling well, fever or chills				
	<input type="checkbox"/> Concerns she might be pregnant				
	<input type="checkbox"/> Concerns the IUCD has fallen out				
18. Confirms that the woman understands instructions.	<input type="checkbox"/> Encourages the woman to ask questions.				
	<input type="checkbox"/> Asks the woman to repeat key pieces of information.				
<i>Plan for next steps and for when she will arrive to hospital for delivery.</i>					
19. Plans for next steps. [Note: In this counseling guide, “return” refers to a subsequent visit after an initial PPF/PPIUCD counseling session, but before birth and IUCD insertion. “Return,” as a part of post-insertion counseling, is addressed in the insertion checklists, following.]	<input type="checkbox"/> Makes notation in the woman’s medical record about her PPF choice or which methods interest her.				
	<input type="checkbox"/> If the woman cannot arrive at a decision at this visit, asks her to plan for a follow-up discussion at her next visit; advises her to bring partner/family member with her.				
	<input type="checkbox"/> Provides information about when the woman should come back, as appropriate.				

To be used by the FACILITATOR when the checklist is used as a skill assessment tool:

When the participant is ready for assessment of his/her skills in counseling, use this Counseling Guide as an assessment tool. Ensure that the participant satisfactorily addresses all of the elements noted in the Counseling Guide and mark his/her achievement under the column marked **ASSESSMENT**.

**FACILITATOR
CERTIFICATION**

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

Role Play Exercises: Counseling Potential PPIUCD Users

Here are some sample scenarios for use in counseling role plays. Participants should use their course materials as well as any informational/educational brochures or counseling job aids during practice. Facilitators may design additional role plays based on their past experience providing family planning counseling. Instructions will be provided by the facilitator.

1. Abebech is 23 years old and works as a teacher in a primary school. She is 6 months pregnant and attends the antenatal clinic at the District Women's Hospital regularly. She does not want a second child for 2 to 3 years. She does not know what method she will use, but is thinking her husband should use condoms. Sr. Zenebech, a health counselor in the District Women's Hospital, has recently returned from a PPIUCD services training course and has been providing PFP education to antenatal care clients.
 - a. **How can Sr. Zenebech provide guidance to Abebech regarding her options?**
 - b. **What are Abebech's options?**

2. Derartu has one son who is 1 year old. She and her husband have been using condoms and abstinence to prevent pregnancy. Her mother-in-law advised Derartu that she will not become pregnant as long as she breastfeeds her baby, but now she finds that she is 4 months pregnant. The couple is quite concerned because although they definitely want 2 children, they were not planning to have them so close together. They think they may not want any more children after this one is born, but want the children to grow before Derartu has female sterilization. Derartu has heard rumors about the IUCD; she's heard that it can move up into the body and cause headaches. Instead of the IUCD, she thinks she will try contraceptive injections after having this baby. Dr. Ayele is counseling Derartu about all the methods of PFP, and Derartu has many questions about the IUCD.
 - a. **How should Dr. Ayele address Derartu's concerns?**
 - b. **What information should Dr. Ayele provide Derartu about the IUCD?**

3. Tirhas is 23 years old. Her husband is a farmer. She delivered their third child last night in the hospital. She learned from the health counselor there about benefits of spacing her births for her own health, as well as that of her children. She also received information about a variety of contraceptives. She and her husband do not want more children, but her mother-in-law thinks they should not hurry to decide. When she is asked by her postpartum care provider about PFP, Tirhas tells her she is interested in the IUCD. She says her husband is outside with her mother-in-law. She asks the provider, "Can you please go talk to them, too?"
 - a. **How should the provider speak with the family about Tirhas's wishes?**
 - b. **What are some of the important things to discuss?**

4. Dr. Dawit, a young assistant professor in a teaching hospital's Obstetrics and Gynecology (Ob/Gyn) department, recently attended a workshop on PPIUCD services. The country's government has recently launched a PPIUCD initiative. Dr. Dawit is excited about making the IUCD available to postpartum women in the hospital, as well as teaching the young residents about it. Dr. Alemtsehai is a full professor in the Ob/Gyn department. When she became aware of Dr. Dawit's intentions, she called him into her office and expressed concerns about the high expulsion and perforation rates associated with the PPIUCD, as well as difficulties with insertion techniques. Dr. Alemtsehai advised the young doctor to be very careful about these PPIUCDs and to focus instead on laparoscopic tubal ligation (TL).

a. How can Dr. Dawit present the new evidence and correct the misconceptions that Dr. Alemtsehai has?

b. What are the most important things for the young doctor to discuss with Dr. Alemtsehai?

Clinical Skills Checklists

Postplacental (Instrumental) Insertion of the IUCD (Copper T 380A)

(To Be Used by Participants and Facilitators)

Participants: Study this tool together with the appropriate Handout in the Reference manual in the Participant's handout to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients.

Your colleagues should offer specific feedback using this tool to guide their observations.

Facilitators: Use this tool when the participant is ready for assessment of competency in this clinical skill. Place a "✓" in case box if task/activity is performed **satisfactorily**, an "x" if it is **not** performed **satisfactorily** or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by Facilitator

Participant _____ Date Observed _____

CHECKLIST FOR <u>POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUCD</u>					
STEP/TASK	CASES				
Tasks to Perform upon Presentation (done prior to managing active labor and vaginal delivery)					
1. Reviews the woman's record to ensure that she has chosen the IUCD.					
2. Checks that she has been appropriately counseled and screened for PPIUCD insertion. (Note: If she has not and she is comfortable and in early/inactive labor, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that woman still wants IUCD.					
5. Explains that the IUCD will be inserted following delivery of baby and placenta. Answers any questions she might have.					
Tasks to Perform after Presentation but prior to Insertion					
6. Confirms that correct sterile instruments, supplies and light source are available for immediate postplacental (instrumental) insertion; obtains PPIUCD kit/tray.					
7. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to					
8. Manages labor and delivery (including using a partograph and performing active management of third stage of labor [AMTSL]) and performs second screening to confirm that there are no delivery-related conditions that preclude insertion of IUCD now: <ul style="list-style-type: none"> - Rupture of membranes for greater than 18 hours - Chorioamnionitis - Unresolved postpartum hemorrhage 					
9. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD, and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					

CHECKLIST FOR <u>POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUCD</u>				
STEP/TASK	CASES			
10. If insertion is performed by same provider who assisted birth, keeps on same pair of HLD or sterile gloves for insertion, provided they are not contaminated. OR: If insertion is performed by a provider different from the one who assisted birth, ensures that AMTSL has been completed, then performs hand hygiene and puts on HLD or sterile gloves.				
11. Inspects perineum, labia and vaginal walls for lacerations. If there are lacerations that are bleeding, applies clamp to the bleeding area to stop the bleeding and proceeds with IUCD insertion. (Repairs lacerations, if needed, <u>after</u> inserting IUCD.)				
Insertion of the IUCD				
12. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if				
13. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.				
14. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.				
15. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.				
16. Gently grasps anterior lip of the cervix with the ring forceps. (Speculum may be removed at this time, if necessary.) Leaves forceps aside, still attached to cervix.				
17. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.				
18. With nondominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.				
19. With dominant hand, uses placental forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.				
20. Gently lifts anterior lip of cervix using ring forceps.				
21. Gently inserts and slowly advances IUCD (this step overlaps with Step 22): <ul style="list-style-type: none"> - While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUCD—through cervix into lower uterine cavity. - Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. - Keeping placental forceps firmly closed, lowers ring forceps and gently removes them from cervix; leaves them on sterile towel. 				
22. “Elevates” the uterus (this step overlaps with Steps 21 and 23): <ul style="list-style-type: none"> - Places base of nondominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and - Gently pushes uterus upward in abdomen to extend lower uterine segment. 				

CHECKLIST FOR <u>POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUCD</u>				
STEP/TASK	CASES			
23. Passes IUCD through vagino-uterine angle (this step overlaps with Step 22): <ul style="list-style-type: none"> - Keeping forceps closed, gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus. - Lowers the dominant hand (hand holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus. 				
24. Continues gently advancing forceps until uterine fundus is reached, when provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUCD has reached the fundus.				
25. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.				
26. Keeping forceps slightly open, slowly removes them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus. Takes particular care not to dislodge IUCD or catch IUCD strings as forceps are removed.				
27. Keeps stabilizing uterus until forceps are completely withdrawn. Places forceps aside on sterile towel.				
28. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; positions same IUCD in forceps inside sterile package				
29. Repairs any lacerations (episiotomy) as necessary.				
30. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.				
Post-Insertion Tasks				
31. Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.				
32. Disposes of waste materials appropriately.				
33. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
34. Performs hand hygiene.				

CHECKLIST FOR <u>POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUCD</u>				
STEP/TASK	CASES			
35. Tells woman that IUCD has been successfully placed; reassures her and answers any questions she may have. Advises her that instructions will be reviewed prior to discharge, and provides the following instructions for now: <ul style="list-style-type: none"> - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for PPIUCD/postpartum and newborn check-up(s) - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS⁵) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 				
36. Records information in the woman's chart or record. Attaches IUCD cards (which woman will be given at discharge) to woman's record.				
37. Records information in the appropriate register(s).				

FACILITATOR CERTIFICATION

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

⁵The acronym PAINS may be helpful in remembering IUCD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping or abdominal pain with sexual intercourse; **I**nfection with or exposure to a STI or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from IUCD are missing or are longer or shorter than normal.

Postplacental (Manual) Insertion of the IUCD (Copper T 380A)

(To Be Used by Participants and Facilitators)

Participants: Study this tool to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Facilitators: Use this tool when the participant is ready for assessment of competency in this clinical skill. Place a “✓” in case box if task/activity is performed **satisfactorily**, an “x” if it is **not** performed **satisfactorily**, **N/D** if not done, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Done: Step, task or skill not performed by participant during evaluation by Facilitator

Not Observed: Step, task or skill not observed by Facilitator during evaluation of participant

Participant _____ Date Observed _____

CHECKLIST FOR <u>POSTPLACENTAL (MANUAL) INSERTION OF THE IUCD</u>					
STEP/TASK	CASES				
Tasks to Perform upon Presentation (done prior to managing active labor and vaginal delivery)					
1. Reviews woman’s record to ensure that she has chosen the IUCD.					
2. Checks that she has been appropriately counseled and screened for PPIUCD insertion. (If she has not <u>and</u> she is comfortable and in early/inactive labor, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that the woman still wants IUCD.					
5. Explains that the IUCD will be inserted following delivery of the baby and the placenta. Briefly describes procedure. Answers any question the woman might have.					
Tasks to Perform after Presentation but prior to Insertion					
6. Confirms that correct sterile instruments, supplies and light source are available for immediate postplacental (manual) insertion; obtains PPIUCD kit/tray.					
7. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to					
8. Manages labor and delivery (including using a partograph and performing active management of third stage of labor [AMTSL]) and performs second screening to confirm that there are no delivery-related conditions that preclude insertion of IUCD now: <ul style="list-style-type: none"> - Rupture of membranes for greater than 18 hours - Chorioamnionitis - Unresolved postpartum hemorrhage 					
9. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD, and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					

CHECKLIST FOR POSTPLACENTAL (MANUAL) INSERTION OF THE IUCD				
STEP/TASK	CASES			
<p>10. (Note: Elbow-length gloves are needed for manual insertion.) If insertion is performed by same provider who assisted birth, keeps on same pair of HLD or sterile gloves for insertion, provided they are not contaminated. OR: If insertion is performed by provider different from the one who assisted birth, ensures that AMTSL has been completed, then performs hand hygiene and puts on new HLD or sterile gloves.</p>				
11. Inspects perineum, labia and vaginal walls for lacerations. If there are lacerations that are bleeding, applies clamp to the bleeding area to stop the bleeding and proceeds with IUCD insertion. (Repairs lacerations, if needed, <u>after</u> inserting IUCD.)				
Insertion of the IUCD				
12. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if				
13. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.				
14. Gently visualizes the cervix by depressing the posterior wall of the vagina. (Note: If cervix is not easily seen, applies fundal pressure so that the cervix descends and can be seen.)				
15. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.				
16. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.				
17. With nondominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.				
18. With dominant hand, grasps and then holds the IUCD at end of fingers, by gripping the vertical rod between the index and middle				
19. "Stabilizes the uterus" (this step overlaps with Step 20): Moves the nondominant hand up onto the abdomen. Stabilizes the uterus with firm downward pressure through the abdominal wall. (Note: This prevents the uterus from moving upward in the abdomen as the hand holding the IUCD is inserted.)				
20. "Gently inserts and slowly advance the IUCD" (this step overlaps with Step 19): <ul style="list-style-type: none"> - Gently inserts the dominant hand into the vagina and through the cervix. Avoids touching the walls of the vagina with the IUCD. - Slowly moves the dominant hand in an upward motion toward the fundus (in an angle toward the umbilicus), taking care to follow the contour of the uterine cavity and taking extra care not to perforate the uterus. 				
21. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the dominant hand has reached the fundus.				
22. Releases the IUCD at the fundus and slowly removes the hand from the uterus. Takes particular care not to dislodge the IUCD as the hand is removed.				
23. Keeps abdominal hand on the fundus to stabilize the uterus until the other hand is completely out of the uterus.				

CHECKLIST FOR POSTPLACENTAL (MANUAL) INSERTION OF THE IUCD				
STEP/TASK	CASES			
24. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, remove and reinsert IUCD.				
25. Repairs any lacerations (episiotomy) as needed.				
26. Places all instruments used in 0.5% chlorine solution so they are totally submerged.				
Post-Insertion Tasks				
27. Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.				
28. Disposes of waste materials appropriately.				
29. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
30. Performs hand hygiene.				
31. Tells woman that IUCD has been successfully placed; reassures her and answers any questions she may have. Advises her that instructions will be reviewed prior to discharge, and provides the following instructions for now: <ul style="list-style-type: none"> - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for PPIUCD/postpartum and newborn check-up(s) - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS[®]) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 				
32. Records information in the woman's chart or record. Attaches IUCD card (which woman will be given at discharge) to woman's record.				
33. Records information in the appropriate register(s).				

**FACILITATOR
CERTIFICATION**

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

Intracesearean Insertion of the IUCD (Copper T 380A)

(To Be Used by Participants and Facilitators)

Participants: Study this tool together with the appropriate Handout in the Reference manual in the Participant's handout to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients.

Your colleagues should offer specific feedback using this tool to guide their observations.

Facilitators: Use this tool when the participant is ready for assessment of competency in this clinical skill. Place a "✓" in case box if task/activity is performed **satisfactorily**, an "x" if it is not performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by Facilitator

Participant _____ Date Observed _____

CHECKLIST FOR <u>INTRACESAREAN</u> INSERTION OF THE IUCD					
STEP/TASK	CASES				
Tasks to Perform upon Presentation (done prior to performing cesarean section)					
1. Reviews the woman's record to ensure that she has chosen the IUCD.					
2. Checks that she has been appropriately counseled and screened for PPIUCD insertion. (If she has not and she is comfortable and in early/inactive labor, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that the woman still wants IUCD.					
5. Explains that the IUCD will be inserted following delivery of the baby and the placenta. Briefly describes procedure. Answers any question the woman might have.					
Tasks to Perform after Presentation but prior to Insertion					
Note: For intracesearean insertion, the IUCD is inserted manually through the uterine incision. This takes place after birth of baby, delivery of placenta and second screening, but prior to repair of uterine incision.					
6. Confirms that correct sterile instruments, supplies and light source are available for intracesearean insertion; obtains PPIUCD kit/tray.					
7. Confirms that IUCDs are available; obtains a sterile IUCD, keeping the package sealed until immediately prior to insertion.					
8. Delivers baby and placenta via cesarean section and performs second screening to confirm that there are no delivery-related conditions that preclude insertion of IUCD now: <ul style="list-style-type: none"> - Rupture of membranes for greater than 18 hours - Chorioamnionitis - Unresolved postpartum hemorrhage 					
9. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					
10. Inspects uterine cavity for malformations, which could preclude use of IUCD.					

CHECKLIST FOR <u>INTRACESAREAN</u> INSERTION OF THE IUCD					
STEP/TASK	CASES				
Insertion of the IUCD					
11. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in a sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area.					
12. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.					
13. With nondominant hand, holds IUCD package (stabilizing IUCD through the package); with dominant hand, removes plunger rod, inserter tube and card from package.					
14. With dominant hand, grasps and then holds the IUCD at end of fingers, by gripping the vertical rod between the index and middle fingers. (Alternatively, uses forceps to hold the IUCD. Holds IUCD by the edge, careful not to entangle strings in the forceps.)					
15. Stabilizes uterus by grasping it at fundus, through abdomen, with nondominant hand.					
16. With dominant hand, inserts IUCD through uterine incision and moves to fundus of uterus.					
17. Releases IUCD at fundus of uterus.					
18. Slowly removes hand from uterus. Takes particular care not to dislodge IUCD as hand is removed.					
19. Points IUCD strings toward lower uterine segment, but does not push them through the cervical canal or pull the IUCD from its fundal					
20. Closes the uterine incision, taking care not to incorporate IUCD strings into the suture.					
Post-Insertion Tasks					
21. Disposes of waste materials appropriately.					
22. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
23. Performs hand hygiene.					
24. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record.					
25. Records information in the appropriate register(s).					
26. Ensures that woman will receive post-insertion instructions on post-operative Day 2 or 3. The discharge provider should: <ul style="list-style-type: none"> - Review IUCD side effects and normal postpartum symptoms - Tell woman when to return for IUCD/postpartum and newborn check-up(s) - Emphasize that she should come back any time she has a concern or experiences warning signs - Review warning signs for IUCD (PAINS⁷) - Review how to check for expulsion and what to do in case of expulsion - Ensure that woman understands post-insertion instructions - Give written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 					

**FACILITATOR
CERTIFICATION**

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

Early Postpartum Insertion of the IUCD (Copper T 380A)

(To Be Used by Participants and Facilitators)

Participants: Study this tool together with the appropriate Handout in the Reference manual in the Participant’s handout to learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients.

Your colleagues should offer specific feedback using this tool to guide their observations.

Facilitators: Use this tool when the participant is ready for assessment of competency in this clinical skill. Place a “✓” in case box if task/activity is performed **satisfactorily**, an “x” if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step, task or skill not performed by participant during evaluation by Facilitator

Participant _____ Date Observed _____

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD					
STEP/TASK	CASES				
Tasks to Perform in Postpartum Ward (prior to Procedure)					
1. Reviews the woman’s record to ensure that she has chosen the IUCD.					
2. Ensures that she has been appropriately counseled and screened for PPIUCD insertion.					
3. Greets the woman with kindness and respect.					
4. If she has not been counseled and assessed for postpartum IUCD, provides that service now.					
5. Confirms that the woman still wants IUCD.					
6. Briefly describes procedure. Answers any question the woman might have.					
7. Confirms that correct sterile instruments, supplies and light source are available for early postpartum insertion; obtains PPIUCD kit/tray.					
8. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to					
Pre-Insertions Tasks (in Procedure Room)					
Note: For early postpartum insertion, the procedure is very similar to postplacental (instrumental) insertion. There are some differences, however, especially due to the postpartum changes that are already occurring in the woman’s body. For example, depending on how much uterine involution has taken place, the provider may consider using a regular ring forceps for insertion, as it may be long enough to reach the fundus.					
9. Confirms that there are no delivery-related conditions that preclude insertion of IUCD now: <ul style="list-style-type: none"> - Rupture of membranes for greater than 18 hours - Chorioamnionitis - Puerperal sepsis - Continued excessive postpartum bleeding - Genital trauma so severe that repairs would be disrupted by postpartum placement of an IUCD (confirmed by inspection of genitalia, Step 15) 					
10. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	CASES			
11. Ensures that woman has recently emptied her bladder.				
12. Helps the woman onto table. Drapes her lower abdominal/pelvic area.				
13. Determines level/length of uterus and confirms that there is good uterine tone.				
14. Performs hand hygiene and puts HLD or sterile surgical gloves on both hands.				
15. Inspects genitalia for trauma/repairs.				
Insertion of the IUCD				
16. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if				
17. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.				
18. Gently inserts Simms speculum and visualizes cervix by depressing the posterior wall of vagina.				
19. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.				
20. Gently grasps anterior lip of the cervix with the ring forceps. (Note: Slightly more pressure may be needed to close forceps than with postplacental insertion because cervix has become firmer and begun to resume its pre-pregnancy state.) (Speculum may be removed at this time, if necessary.)				
21. Leaves forceps aside, still attached to cervix.				
22. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.				
23. With nondominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.				
24. With dominant hand, uses placental forceps to grasp IUCD inside sterile package. Holds IUCD by the edge, careful not to entangle strings in the forceps.				
25. Gently lifts anterior lip of cervix using ring forceps.				
26. Gently inserts and slowly advances IUCD (this step overlaps with Step 27): <ul style="list-style-type: none"> - While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUCD—through cervix into lower uterine cavity. (Note: If difficult to pass placental forceps through the cervix, it may be necessary to use a second ring forceps to help widen cervical opening.) - Gently moves IUCD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. - Keeping placental forceps firmly closed, lowers ring forceps and 				
27. "Elevates" the uterus (this step overlaps with Steps 26 and 28): <ul style="list-style-type: none"> - Places base of nondominant hand on lower part of uterus (midline, just above pubic bone with fingers toward fundus); and - Gently pushes uterus upward in abdomen to extend lower uterine segment. 				

CHECKLIST FOR <u>EARLY POSTPARTUM</u> INSERTION OF THE IUCD				
STEP/TASK	CASES			
28. Passes IUCD through vagino-uterine angle (this step overlaps with Step 27): <ul style="list-style-type: none"> - Keeping forceps closed, gently moves IUCD upward toward uterine fundus, in an angle toward umbilicus. - Lowers the dominant hand (hand holding placental forceps) down, to enable forceps to easily pass vagino-uterine angle and follow contour of uterine cavity. Takes care not to perforate uterus. (Note: Although this step may be more difficult in the early postpartum period, it is essential that the IUCD reach the fundus.)				
29. Continues gently advancing forceps until uterine fundus is reached, when provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUCD has reached the fundus.				
30. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUCD at fundus.				
31. Keeping forceps slightly open, slowly removes them from uterine cavity by sweeping forceps to the sidewall of uterus and sliding instrument alongside wall of uterus. Takes particular care not to dislodge IUCD or catch IUCD strings as forceps are removed.				
32. Keeps stabilizing uterus until forceps are completely withdrawn. Places forceps aside on sterile towel.				
33. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, removes IUCD using same forceps used for first insertion; positions same IUCD in forceps inside sterile package				
34. Checks any repairs made, as necessary, to ensure that they have not been disrupted.				
35. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.				
Post-Insertion Tasks				
36. Allows the woman to rest a few minutes. Continues routine postpartum and newborn care.				
37. Disposes of waste materials appropriately.				
38. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
39. Performs hand hygiene.				
40. Tells woman that IUCD has been successfully placed; reassures her and answer any questions she may have. Tells her that detailed instructions will be provided prior to discharge, and provides the following instructions: <ul style="list-style-type: none"> - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for IUCD/postnatal/newborn checkup - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS[®]) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 				
41. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record.				
42. Records information in the appropriate register(s).				

**FACILITATOR
CERTIFICATION**

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

⁸The acronym PAINS may be helpful in remembering IUCD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping or abdominal pain with sexual intercourse; **I**nfection with or exposure to a STI or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from IUCD are missing or are longer or shorter than normal.

Clinical Skills Tracking Sheet

Using the PPIUCD Clinical Skills Tracking Sheet

As participants, you must achieve multiple competencies during the PPIUCD training course. These include both knowledge and skill competencies. This sheet will assist you in tracking the development of those competencies.

Items 1 to 4: Fill out the top portion of the sheet with your personal information.

Item 5: Note your score on the Precourse Knowledge Assessment here.

Item 6: When you have successfully completed the Midcourse Knowledge Assessment, note your score here.

Item 7: You and your Facilitator can use this form to track the development of multiple competencies over the 3 days of this PPIUCD course.

First set of columns: When you have had the opportunity to practice each of the clinical skills on anatomic models, you will be assessed by a clinical Facilitator using a Clinical Skills Checklist. When your Facilitator determines that you are ready to work with actual clients, ask him/her to tick the appropriate box, sign the form and date it.

Second set of columns: The development of clinical skills with clients is more challenging in the provision of PPIUCDs because the cases are not able to be scheduled regularly. Therefore, you may work with a variety of different Facilitators. When you have the chance to manage a particular case under the supervision of a Facilitator, share this form with him/her to show that you have successfully completed skills practice with models. Once your Facilitator determines that you have achieved competency with clients, ask him/her to tick the appropriate box, sign the form and date it.

The PPIUCD Clinical Skills Tracking Sheet

1. Name _____
2. Designation _____
3. Facility _____
4. Dates of Training _____
5. Score on Precourse Knowledge Assessment _____
6. Score on Midcourse Knowledge Assessment _____

7. Clinical Skills Assessment

	Experience on Anatomic Models			Experience with Clients		
	Ready*	Signed	Date	Competent	Signed	Date
Counseling	<input type="checkbox"/>			<input type="checkbox"/>		
Postplacental Insertion of the IUCD (Instrumental)	<input type="checkbox"/>			<input type="checkbox"/>		
Postplacental Insertion of the IUCD (Manual)	<input type="checkbox"/>			<input type="checkbox"/>		
Intracesarean Insertion of the IUCD	<input type="checkbox"/>			<input type="checkbox"/>		
Early Postpartum Insertion of the IUCD	<input type="checkbox"/>			<input type="checkbox"/>		

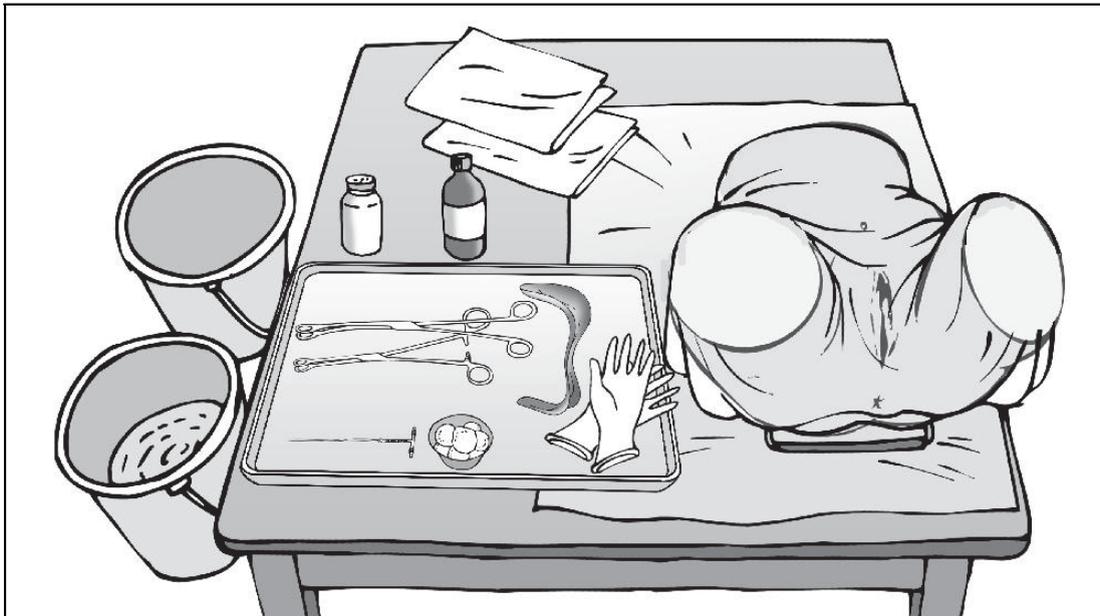
*In the skills being practiced, the participant has reached a level of achievement that indicates his/her "readiness" to practice with actual clients.

Set-Up of Clinical Skill Practice Station

The clinical skills station is set up at the start of the PPIUCD clinical skills course and is used for multiple activities including:

- Exercise One: What Is Different about Postpartum IUCD?—where participants compare what they see at the skills station with what they know about interval IUCD services
- Demonstration of PPIUCD Insertion Technique—where participants are introduced to the proper technique while following along on the checklist
- Models Practice for PPIUCD Services—when participants work in groups and get to practice the clinical skills of PPIUCD insertion while being coached by their Facilitators

The clinical skills station gives the participants an introduction to the supplies and equipment needed, as well as the clinical and communication behaviors for proper PPIUCD insertion. The skills station must be set up properly as shown in the following figure, so that all steps of the procedure can be correctly simulated.



PPIUCD Training Evaluation

(To be completed by Participants at the end of the training)

Please indicate your opinion of the course components using the following rate scale:

5-Strongly Agree 4-Agree 3-No Opinion 2-Disagree 1-Strongly Disagree

COURSE COMPONENT	RATING
1. The Pre course Knowledge Assessment helped me to study more effectively.	
2. I have a good understanding of healthy spacing (or limiting) of pregnancy and the importance of FP/PPFP, and I believe that I can share this information with clients.	
3. I understand the client screening criteria and can correctly identify clients who would be appropriate for the PPIUCD.	
4. The role play sessions on counseling skills were helpful.	
5. There was sufficient time scheduled for practicing counseling through role play and with clients (and volunteers, if applicable).	
6. The demonstration helped me gain a better understanding of how to insert PPIUCDs prior to practicing with the anatomic models.	
7. The practice sessions with the anatomic models made it easier for me to perform PPIUCD insertion when working with actual clients.	
8. There was sufficient time scheduled for practicing PPIUCD insertion with clients.	
9. The interactive training approach used in this course made it easier for me to learn how to provide PPIUCD services.	
10. The time allotted for this course, and its different components, was sufficient for learning how to provide PPIUCD services.	
11. I feel confident in performing PPIUCD postplacental insertion (instrumental).	
12. I feel confident in performing PPIUCD postplacental insertion (manual).	
13. I feel confident in PPIUCD intracesarean insertion.	
14. I feel confident in early PPIUCD postpartum insertion.	
15. I feel confident in using the infection prevention practices recommended for PPIUCD services.	
16. I feel confident in conducting routine PPIUCD follow-up at 4 to 6 weeks, and identifying and managing (or referring) potential problems.	

(See next page.)

Additional Comments

What topics (if any) should be **added** (and why) to improve the course?

What topics (if any) should be **deleted** (and why) to improve the course?

What should be done to **improve** how this course is conducted?

Also, feel free to provide additional **explanation for** any of **your ratings** (Items 1 to 16).

PART – 2: Reference manual

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Handout -1. Introduction

The period of time preceding and immediately following the birth of a woman's child represents a valuable opportunity for the woman or couple to learn about and take advantage of family planning services. These are times when women are most likely to access formal health care—through antenatal care (ANC) visits and skilled birth attendance—and they are *motivated* to space or limit subsequent pregnancies.

The extended postpartum period, however, poses a challenge for women, especially in developing countries, because postpartum women are unlikely to be using contraception and are vulnerable to unintended pregnancy. A study of postpartum women in 27 Demographic and Health Surveys (DHS) for 6 years¹ shows that 40% of women who intend to use a contraceptive during the first year postpartum are not; moreover, although only a small percentage of women (3%–8%) want another child within 2 years of their last birth, 35% have children within this timeframe.



Some reasons for these statistics are the unpredictability of return to fertility, resumption of sexual activity and ongoing confusion among providers and clients regarding the contraceptive effects of breastfeeding—breastfeeding is **not** the same thing as the lactational amenorrhea method (LAM). In addition, women are not likely to access services for themselves during the postpartum period²; whereas a majority of women receive at least some ANC, and an increasing number in some countries are getting delivery care, a much smaller proportion seek postpartum services.

The **intrauterine contraceptive device (IUCD)** is a highly effective, long-acting, reversible family planning method that is safe for use by most postpartum women—including those who are breastfeeding. It is also relatively inexpensive and convenient and has a very low rate of complications. The **postpartum IUCD (PPIUCD)**, inserted **within 10 minutes or up to 48 hours after birth:**

Handout 1: Introduction

- Is readily accessible for women who deliver at health care facilities;
- Has no effect on the amount or quality of breast milk;
- Is safe for use by HIV-positive women;
- Is reversible and can be removed at any time (with immediate return to fertility)—should the woman’s contraceptive or reproductive desires change;
- Does not require any daily action on the part of the user to be effective; and
- Does not require a separate visit to the facility or, if inserted within 10 minutes of the birth, a separate procedure.

A postpartum woman who chooses the PPIUCD can leave the facility, after having her baby, with reliable contraception **already in place**—enabling her to gain control over her fertility throughout the postpartum period and for however long she chooses (up to 12 years for the Copper T 380A). And again, this is especially critical in developing countries, where *if women seek services for themselves at all, it may only be when they are pregnant or about to give birth.*

Did you know that many postpartum women:

- Want to limit their pregnancies or delay the next pregnancy for at least 2 years
- Want to use contraception and plan to start it after their menses return
- Will become fertile again (ovulate) **before** their menses return, as early as 4 to 6 weeks postpartum
- Will resume sexual activity within the first few months postpartum
- Mistakenly believe that as long as they breastfeed their baby, they are protected from pregnancy
- Have many demands on their time and, especially in developing countries, are not likely to return to the facility for postpartum care or family planning
- Do not want to be perceived as needing contraception during the postpartum period—in cultures where postpartum abstinence is customary—for fear of being judged
- End up not using contraception at all, especially in developing countries, and become pregnant too soon after the last birth, increasing their and their children’s risk for poor health outcomes
- Can prevent death and disability, for themselves and their children, through PPF

What you can do: *It takes only a few additional minutes, immediately after the delivery of the placenta, to give postpartum women who choose the PPIUCD **safe and effective contraceptive protection for up to 12 years.***

By enabling women/couples to space their pregnancies or prevent unintended pregnancy, family planning, including postpartum family planning (PPFP), helps to ensure maternal and newborn survival and health. Maternal, newborn and child health (MNCH) service providers (midwives, nurse-midwives, doctors, etc.) have many opportunities—in the course of caring for women and their children—to introduce and counsel the woman about the PPIUCD, among other PPF options.

This manual and the accompanying materials are intended to help prepare MNCH providers, along with health educators and counselors, to deliver high-quality PPIUCD services to their clients, as part of a comprehensive PPF program.

Handout -2. Need for Postpartum Family Planning

Multiple studies performed around the world have shown that adverse maternal, perinatal and infant outcomes are related to pregnancies spaced too closely together. The risks are particularly high for women who become pregnant very soon after a previous pregnancy, miscarriage or abortion. Table 1 presents a summary of findings.³

The good news is that family planning/PPFP enables women/couples to achieve healthy intervals between births—potentially averting 25% to 40% of maternal deaths⁴ and reducing child mortality by an estimated 10%.⁵

Table 1. Risks of Adverse Health Outcomes after Very Short Interval Pregnancy^{6–11}

Increased Risks when Pregnancy Occurs 6 Months after a Live Birth		
Adverse Outcome	Increased Risk	
Induced abortion	650%	
Miscarriage	230%	
Newborn death (<9 months)	170%	
Maternal death	150%	
Preterm birth	70%	
Stillborn	60%	
Low birth weight	60%	
Increased Risks when Pregnancy Occurs Less than 6 Months after an Abortion or Miscarriage		
Increased Risk	With 1–2 Month Interval	With 3–5 Month Interval
Low birth weight	170%	140%
Maternal anemia	160%	120%
Preterm birth	80%	40%

Healthy Spacing of Pregnancies

In June 2005, the World Health Organization (WHO) brought together over 30 technical experts to review the available global scientific evidence regarding healthy intervals between pregnancies. The following recommendations are based on the results of this technical consultation:¹²

1. **After a live birth**, a woman should **wait at least 24 months** (but not more than 5 years) before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes. Women should plan a healthy birth-to-birth interval of about 36 months, or 3 years, between children.
2. **After a miscarriage or induced abortion**, a woman should **wait at least 6 months** before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes.
3. **Adolescents should delay first pregnancy until at least 18** years of age to reduce the risk of adverse maternal, perinatal and infant outcomes.

Every woman and every maternal/newborn health or family planning worker should know and understand the key recommendations for healthy spacing of pregnancies. (Specific messages related to the healthy spacing of pregnancies are presented in Annex A.)

Key Terminology: To be able to counsel women and families effectively about healthy spacing of pregnancies, providers must clearly understand several terms.

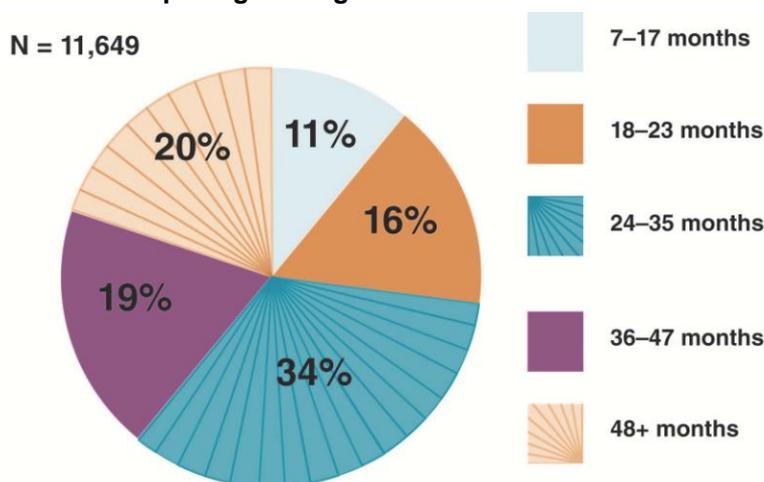
- **Birth-to-pregnancy interval:** Time period between a *live birth* and *start* of the next pregnancy.
- **Birth-to-birth interval:** Time period between a *live birth* and the *next live birth*.

When reviewing scientific studies or technical messages, health professionals can convert a birth-to-pregnancy interval to a birth-to-birth interval by adding 9 months to a year.

Unmet Need for PPF

Despite the adverse health outcomes associated with short birth intervals, a significant proportion of births are spaced too closely together. In India, for example (Figure 1), approximately 61% of births occur at intervals shorter than the recommended birth-to-birth interval of approximately 36 months. And in many developing countries, the situation is comparable to that in India^a—which adds to the myriad health challenges and risks that these mothers and babies must face.

Figure 1. Birth Spacing Among All Women in India—All Births in Last 5 Years¹³

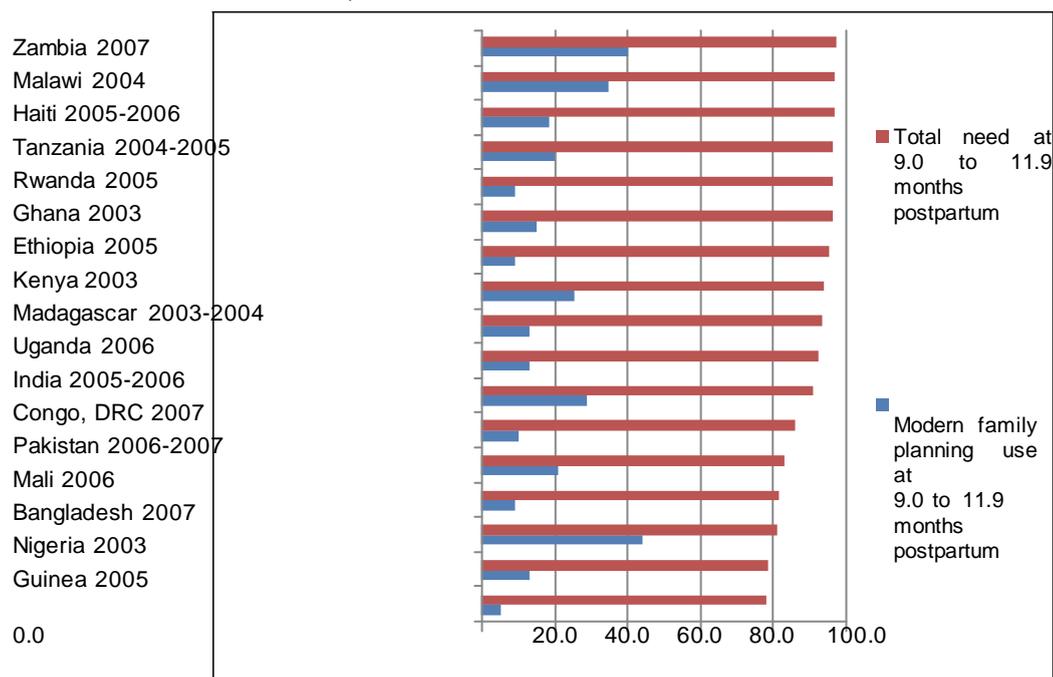


Family planning during the first year postpartum has the potential to reduce a significant proportion of these unintended pregnancies because, as research has demonstrated, women experience a large “unmet need” for family planning during this time.¹ **Loosely defined, unmet need refers to the percentage of women who do not wish to become pregnant but are not currently using a contraceptive.** In a recent study, women in 14 of 17 countries were less likely to be using family planning by the end of the extended postpartum period (11.9 months) than married women in the general population. Those *using* contraception made up only a small proportion of those *needing* it (Figure 2).¹⁴

^aAccording to the last available DHS (2003–2006) in seven African countries (Kenya, Malawi, Mali, Nigeria, Senegal, Tanzania and Uganda), 68% of women age 20–29 years reported that they became pregnant 26 months or less after their last birth.

Handout 2: Need for PFP

Figure 2. Percentage of Women 9.0–11.9 Months Postpartum Who Are Using Family Planning versus Those Who Need It, DHS 2003–2007



Factors That Contribute to Short Birth Intervals

Given the unmet need for family planning and prevalence of shorter-than-recommended birth intervals, women and their health care providers should understand the factors that contribute to the high risk of unintended pregnancy among postpartum women.

Return to Fertility

□ **Postpartum women are frequently fertile again before they realize it.** A woman will ovulate before she begins regularly menstruating again. And the chance of a woman's fertility returning before menstruation resumes increases as the postpartum period extends.¹⁵

□ **An individual woman's return to fertility cannot be predicted.** Most non-breastfeeding women experience menses return within 4 to 6 weeks. Breastfeeding delays the resumption of ovulation and the return of menses, but it cannot be relied upon for contraceptive protection unless the woman is practicing LAM (further discussed on the following page).

□ **Women often initiate family planning after their menstruation resumes.** Individual studies appear to draw a correlation between return of menses and initiation of contraceptive use and suggest that family planning—if used at all during the postpartum period—is most likely to be initiated in the month following the return of menses, which is often too late.^{1,16}

And in one study, 8%–10% of women who were still experiencing postpartum amenorrhea conceived.¹⁷

Resumption of Sexual Activity

□ **Reported return to sexual activity after a birth varies greatly.** A recent study of 17 developing countries looked at percentages of couples returning to sexual activity by 3 to 5.9 months. At one end of the range is Guinea, where about 10% of women have resumed sexual activity within that timeframe; at the other end are Bangladesh and Rwanda, where almost 90% of women are having sex again by 6 months.¹⁴

Handout 2: Need for PPF

- **Postpartum abstinence, in countries that practice it, is not always strictly observed.**

Qualitative research has indicated that even among those countries practicing postpartum abstinence, sexual activity may occur irregularly early on, gradually progressing to more regular activity.¹⁸

- **Women may be unwilling to ask for contraception “too soon” after birth.** If a woman resumes sexual activity sooner after the birth than is deemed appropriate in her culture, she may assume that the provider will judge her if she asks for contraception. As a result, the woman may forego contraception even though this will put her at risk for unintended pregnancy.

Breastfeeding versus LAM

- **Breastfeeding ≠ LAM.** To prevent unintended pregnancy, breastfeeding women must use a method of contraception (breastfeeding is not a contraceptive). One option is LAM, which is 98.5% effective for up to 6 months postpartum—provided that the woman exclusively breastfeeds her baby on demand (whenever the baby wants, day or night; no other food or other fluids in between), and her menses have not returned. As effective and convenient as LAM is, it still is not widely practiced.

- **LAM is effective only for 6 months.** For women using LAM, it is likely their fertility will return (often before menstruation resumes) after 6 months, even if they continue to breastfeed. This is why women practicing LAM must transition to another method as soon as any of the three LAM criteria is no longer being met.

- **Exclusive breastfeeding drops off after 3 months.** Although many women exclusively breastfeed their babies in the first few months following delivery, the rate drops off significantly after 3 months—which leads to return of fertility.

Implications for Family Planning Programming

In addition to ensuring that high-quality PPF services are available, the objective of PPF programs is to help women and couples understand their risk of unintended pregnancy, as well as the maternal and newborn benefits of spacing pregnancies at healthy intervals (or limiting pregnancy, if desired). Linkage of MNCH and family planning services is critical to achieving pregnancy-spacing recommendations and to addressing unmet need for family planning.

Information on healthy spacing of pregnancies should be incorporated into health education, counseling and service delivery for women and their families wherever they receive medical care. Suggested service delivery approaches include:

- Giving clients complete information about the benefits of and recommendations for healthy spacing of pregnancies as a part of routine family planning services, during both general and method-specific education and counseling.
- Emphasizing the importance of timely initiation of a family planning method after childbirth, miscarriage or abortion (and a “transition” method after LAM) as a part of routine antenatal, postpartum and postabortion care.
- Providing family planning services to women while they are still in the health care facility, following a facility-based delivery.

Handout 3: The PPIUCD—An Overview

- Integrating family planning services with other health services, such as immunization and newborn or child care services.
- Helping clients to exercise their right to make a free and informed choice regarding family size, fertility goals and contraceptive options.

Remember: The right contraceptive for a woman **is the one she chooses for herself**, provided there are no medical reasons why the method should be withheld. As providers, we can give the woman the information she needs to make a suitable choice, but the choice is hers to make.

Handout -3. The PPIUCD—An Overview

For more than 30 years, women throughout the world have been using the IUCD as their primary method of contraception. It is, in fact, the most commonly used reversible method among married women of reproductive age worldwide. According to recent estimates, almost one in five (or 153 million) married contraceptive users is currently using the IUCD.¹⁹

In a U.S.-based study, women who use the IUCD are more satisfied with their choice of contraception than those using other reversible methods (e.g., 99% versus 91% or pill users).²⁰ Moreover, the advantages of IUCD use outweigh the risks for the vast majority of women, even in the presence of many conditions previously thought to preclude IUCD use, such as HIV/AIDS, history of pelvic inflammatory disease (PID) and history of ectopic pregnancy.

Postpartum insertion of an IUCD, within 10 minutes or up to 48 hours after birth, has been shown to be safe, effective and convenient for women²¹—like the regular or “interval” IUCD. (*Interval* refers to IUCDs inserted at any time between pregnancies, at or after 4 weeks postpartum, or completely unrelated to pregnancy.) For many women who rarely access health care services, the insertion of an IUCD immediately postpartum presents a unique opportunity for them to initiate a long-acting and reversible method of family planning. The popularity of the PPIUCD in countries as diverse as China, Mexico and Egypt supports the feasibility and acceptability of this approach.²²

What Is the IUCD?

The IUCD is a small, flexible frame generally made of plastic in the shape of a “T,” which is inserted into the uterine cavity by a trained service provider. Almost all types of IUCDs have one or two monofilament (single-strand) strings that extend, through the cervix, from the uterus into the vagina.

Types of IUCDs

Common types of IUCDs available worldwide are:

- **Copper-bearing:** Copper T 380A (TCu 380A, TCu 380A with Safe Load) and TCu 200C, the Multiload (MLCu 250 and Cu375) and the Nova T
- **Hormone-releasing:** Mirena[®] and the levonorgestrel-releasing intrauterine system (LNG-IUS[®])

For programs and providers who wish to offer the IUCD in the postpartum period, the use of the Copper T 380A is recommended at this time. With additional evidence and experience, this recommendation may be revised.

Mechanism of Action

Copper-bearing IUCDs like the Copper T 380A act by preventing fertilization.²³ Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg. These actions are largely local with no measurable increase in the woman’s serum copper level. And because there are no effects on the quantity or quality of breast milk, copper-bearing IUCDs can be used immediately after delivery regardless of whether the woman is breastfeeding.

Handout 3: The PPIUCD—An Overview

Duration of Action

The latest scientific evidence shows that the Copper T 380A is effective for at least 12 years.²⁴ Clients who have had a Copper T inserted should be advised that it be replaced or removed 12 years from the date of insertion. The contraceptive effects of the Copper T stop as soon as it is removed, with immediate return to fertility.

A Word about Shelf Life and Tarnishing: Unless the package is damaged or torn, an IUCD is safe to insert up to the day before the package expiration date (even if the IUCD is tarnished/darkened). The expiration date refers to the **sterility** of the contents of an intact IUCD package, which is maintained until that date; it does not refer to the effectiveness of the IUCD. **The IUCD is effective for 12 years from the date of insertion, not from the expiration date.**

Effectiveness

The IUCD is one of the most highly effective methods of long-acting, reversible contraception. Its effectiveness is essentially equivalent to the effectiveness of hormonal implants or male or female sterilization. For example, if 1,000 women use the Copper T 380A IUCD, only six to eight would become pregnant over the first year of use, meaning it is more than 99% effective.

While the effectiveness of the Copper T with **correct use** is the same, whether it is used as a PFP method or as an interval method, the **typical-use** effectiveness is influenced by a slightly higher expulsion rate of IUCDs inserted in the postpartum period.^b Several factors appear to influence the risk of expulsion postpartum. Proper insertion to achieve high fundal placement of the IUCD (more easily done immediately postpartum) is essential to ensuring IUCD retention.

Side Effects

Side effects that copper-bearing IUCD users may experience are described in the box on the following page. There is no evidence to suggest that the PPIUCD (compared to the interval IUCD) increases the frequency or severity of these side effects. In fact, some studies suggest that the PPIUCD, when successfully inserted, may be better tolerated than the interval IUCD. This is because many IUCD-related side effects are similar to the bleeding and cramping typically encountered during this time, as a normal part of recovery. Therefore, they may simply be less noticeable to postpartum women, which is a considerable advantage of the PPIUCD.

The most common side effects associated with the copper-bearing, interval IUCD are as follows:

- A change in the amount and duration of menstrual flow and an increase in the amount of menstrual cramping—this is the most common reason for removal²⁵;
- Changes in bleeding patterns, such as spotting/light bleeding (between periods), in the first few weeks; and
- Discomfort or cramping during IUCD insertion²⁶ and for the next several days.

^bCorrect use refers to what can be expected under ideal circumstances (e.g., the IUCD is inserted properly, is not expelled), whereas typical use refers to what may happen in real life (e.g., the IUCD is not inserted properly, is expelled).

Handout 3: The PPIUCD—An Overview

All women should be advised of common side effects before IUCD insertion, assessed for conditions that may make the IUCD a poor choice given such side effects (e.g., history of severe dysmenorrhea, severe anemia or current pelvic pain) and counseled about side effects as needed during follow-up. Nonsteroidal anti-inflammatory drugs (NSAIDs) can lessen symptoms of pain²⁷, and good counseling can encourage continued use of the method.^{28,29}

Timing of PPIUCD Insertion

PPIUCD insertion refers only to those IUCDs placed during the immediate or early postpartum period (within 10 minutes or up to 48 hours after birth). **IUCDs inserted during the immediate postpartum period (i.e., postplacental and intracesarean) have the highest rates of retention**, but the IUCD can be safely inserted at any time during the early postpartum period, that is, within the first 48 hours after the birth. The three types of PPIUCD insertion are:

- **Postplacental:** *Immediately* following the delivery of the placenta (active management of the third stage of labor [AMTSL]) in a vaginal birth, the IUCD is inserted with an instrument or manually before the woman leaves the delivery room.
- **Intracesarean:** *Immediately* following the removal of the placenta during a cesarean section, the IUCD is inserted manually before closure of the uterine incision, before the woman leaves the operating theater.
- **Early postpartum:** Not immediately following the delivery/removal of the placenta but within 2 days/48 hours of the birth (preferably within 24 hours, such as on the morning of postpartum Day 1), the IUCD is inserted with an instrument during a separate procedure.

The IUCD **should not be inserted between 48 hours and 4 weeks postpartum** because of an overall increase in the risk of complications, especially infection and expulsion. IUCDs inserted at 4 weeks postpartum and beyond are considered interval IUCDs, rather than PPIUCDs, because the same technique and services are required.

Key Differences and Characteristics of the PPIUCD

PPIUCD Advantages

Safety: The safety profile of PPIUCDs is similar to that of interval IUCDs. Insertion postpartum

appears to have a **lower rate of uterine perforation**, possibly because the insertion instrument used is blunter and the wall of the uterus is thicker just after pregnancy. The provider can also be **certain that the woman is not pregnant** at the time of immediate (postplacental, intracesarean) and early postpartum insertion.

Access to services: The integration of PPIUCD with labor and delivery services overcomes multiple barriers to service provision. Access to services for long-acting and permanent methods of family planning is generally limited for a number of reasons, including a lack of trained providers and adequately equipped and accessible facilities. Also, returning for services often poses a challenge to postpartum women, who have many competing demands on their time.

Cost-effectiveness: A study conducted in Peru³⁰ compared the cost of providing IUCDs while the woman was in the hospital during the postpartum period versus when she returned to an outpatient facility later. The cost of providing PPIUCD services immediately after delivery (\$9) was found to be significantly less than when provided on an outpatient basis (\$24). This reduced cost may make the PPIUCD more feasible for many women.

Handout 3: The PPIUCD—An Overview

Time and service efficiency: Inserting the IUCD in the immediate postpartum period (postplacental, intracesarean) saves time for both the woman and provider—because the procedure is conducted in the same setting and involves only a few minutes of additional time. Although inserting the IUCD in the early postpartum period (first 48 hours) does require a separate clinical procedure, it does not require an additional visit—which increases the likelihood that the woman will have it done. Providing PPF services at the birth facility also helps to relieve overcrowded outpatient facilities, allowing more women to be served.

Postpartum Insertion versus Interval Insertion: Challenges and Considerations

In a study done in Egypt in 2004³¹, women were provided with family planning counseling during the antenatal and immediate postpartum periods. Of those counseled, 28.9% chose the PPIUCD as their method of family planning. If the woman requested immediate or early insertion of the IUCD while still in the hospital postpartum, she was much more likely to have an IUCD inserted (71.2%) than those who elected to wait until 6 or more weeks postpartum for IUCD insertion (7.1%).

This 10-fold difference in provision of the method when women chose immediate/early postpartum versus delayed (interval) insertion could reflect the level of commitment of the women to their choice of method (i.e., they were more certain of their choice than those who chose to delay insertion). Or, it may reflect the reality that—given all they have to manage in their lives—women may find it difficult to return for the IUCD in a timely manner.

In any case, the findings underscore the responsibility of the clinician to help women anticipate and overcome barriers to achieving their reproductive goals and protecting their health and that of their families. If it is far less likely that a woman who declares her desire for a method will be able to return for that method after she has left the hospital, then service providers should make an extra effort to provide it for her during her hospitalization, if that is her desire.

PPIUCD Limitations

Limitations of the PPIUCD are minimal and basically the same as for the interval IUCD. Regardless of when an IUCD is inserted, it will not protect against HIV or other sexually transmitted infections (STIs). Menstrual changes are a common side effect of the IUCD, but again, these may be less bothersome for postpartum women. All women who have had an IUCD inserted may be able to better tolerate such side effects when properly counseled and reassured that these symptoms are not harmful to their health. Having an IUCD inserted, or removed, always requires a procedure performed by a specially trained provider in a clinical setting; however, having the device inserted postpartum will not require a separate visit or—when done immediately after the placenta—a separate procedure.

A limitation unique to the PPIUCD is that the strings will not be initially visible after postpartum insertion, because of the length of the string compared to the length of the postpartum uterus. Usually the strings will descend through the cervix and into the vagina by the time of the first PPIUCD follow-up visit (at 4 to 6 weeks). This occurrence, however, may be delayed. Although lack of the strings' descending will not adversely affect the efficacy of the device, it may require some additional follow-up or investigation to reassure the woman or the provider that the IUCD has not fallen out.

PPIUCD Health Risks

There are few potential health risks associated with the PPIUCD. However, the lack of well-designed, peer-reviewed studies of the PPIUCD leaves important questions unanswered about exact complication rates and such variables as timing and technique of insertion; these are the subject of

Handout 3: The PPIUCD—An Overview

ongoing research. Still, conclusions about the following complications can be drawn based on consistent findings across countries, clinical sites and provider type—from nurses to midwives to physicians.

- **Uterine perforation—In a recent systematic review of the literature regarding PPIUCD insertion, there were no reported cases of uterine perforation during PPIUCD insertion in any of the studies reviewed.**³² Perforation of the uterine wall during interval IUCD insertion is rare. When it does occur, it is most often caused by the instrument used to “sound” the uterus, which is not involved in postpartum IUCD insertion.
- **Infection—Postpartum insertion appears to have no significant effect on the risk of genital tract infection, which is very low in interval IUCD insertion as well.** Among continuing users of the IUCD, the risk of upper genital tract infection, such as endometritis or salpingitis, is less than 1%, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUCD insertion, and is thought to be related to either insertion technique (due to lack of proper infection prevention practices) or pre-existing infection, rather than to the IUCD itself. After the first 20 days, the risk of infection among IUCD users appears to be comparable to that among non-IUCD users.³³
- **Expulsion—IUCD failure is rare, but the most common cause is spontaneous expulsion of the IUCD from the uterus.**³⁴ Rates of spontaneous expulsion appear to be higher with the PPIUCD than with interval IUCD insertions. **Immediate postpartum insertion (within 10 minutes) is associated with a lower risk of expulsion than early postpartum insertion (up to 48 hours).**³² Interval insertion at 4 weeks after delivery and beyond is associated with the lowest risk of expulsion postpartum. All women who have an IUCD inserted should be aware of this risk and the fact that most expulsions occur within the first 3 months after insertion.³⁵

Timing, Technique, Training—Key Factors in PPIUCD Expulsion³⁶

Although individual risk estimates of expulsion vary between studies, a consistent relationship among **the timing of PPIUCD insertion, the technique used** and respective expulsion rates has emerged, regardless of country, clinical site or type of provider.

Clinical trials have shown that there is a lower expulsion rate with immediate postpartum (postplacental, intracesarean) insertion than with early postpartum insertion (within 48 hours). This is likely because reliably reaching the uterine fundus (which is critical to retention) is easier during immediate insertion, whereas the uterus begins to contract and regain its firmness immediately thereafter—which makes insertion more difficult during the early postpartum period.

In several clinical studies, expulsion rates varied greatly among clinical sites. This variation has been attributed to **lack of provider skill and consistency in insertion techniques**, which underscores the importance of standardized training to minimize expulsion rates.

Public Health Approach to the Issue of Spontaneous Expulsion

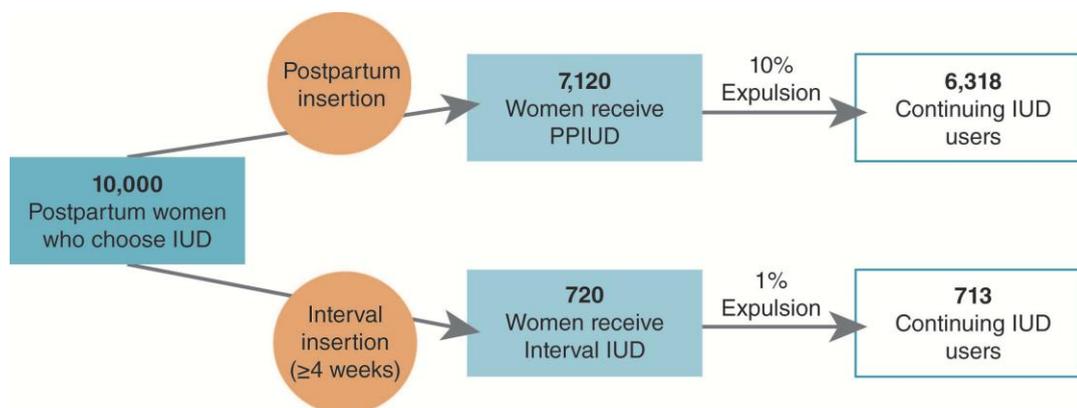
Although the PPIUCD expulsion rate may be as high as 10%–15%^c, the retention rate is more than 85%–90%—which, which from a public health perspective, may be an acceptable rate. And in situations where access to health care is limited or use of postpartum follow-up services is infrequent, this potential for continued use of contraception is an important consideration.

^cPostpartum expulsion rates may be reduced to 4%–5% through proper insertion technique.

Handout 4: PPIUCD Services in Context

Using data from a 2003 study done in Egypt³¹, it is possible to estimate the magnitude of the difference that can be made by offering immediate postpartum IUCD insertion. In the study by Mohamed et al., 71.2% of the women who requested immediate postpartum IUCD insertion were able to have one inserted. In cases where they requested immediate postpartum insertion, but were told to return at 6 weeks to the outpatient department for the procedure, only 7.2% ultimately had an IUCD inserted. This suggests that women who request the IUCD and are provided it immediately have perhaps a 10-fold greater chance of receiving it than those who are told to return for later insertion. Therefore, given that provision of the IUCD in the immediate postpartum period is Category 1 according to WHO's Medical Eligibility Criteria [MEC], all women who request immediate postpartum insertion, and have been properly counseled and evaluated for its safe provision, should be provided the method at the time of their choosing.

Figure 3. Public Health Approach to PPIUCD



Handout -4. PPIUCD Services in Context

As part of a comprehensive family planning/PPFP program, PPIUCD services should be fully integrated with MNCH services—from ANC, through intrapartum and postpartum/newborn care. Done correctly, insertion of an IUCD postpartum will not interfere with the conduct of routine care. And the PPIUCD must never take precedence over prompt, proper treatment of life-threatening conditions that may arise during labor, delivery and the postpartum/newborn period—because insertion can easily be deferred until an appropriate time when the mother and newborn are medically stable. Sound clinical judgment should always prevail.

The services themselves must take into account the ongoing needs of the woman and her child during this critical time, as well as accommodate the transformation the woman's body is undergoing. The recommended technique for, as well as timing of, PPIUCD insertion directly address the dramatic changes that take place in the woman's cervix and uterus during the immediate/early postpartum period. These simple adjustments to the technique used for interval IUCD insertion are essential to achieve proper placement of the device in the uterine fundus, and thus minimize the risk of expulsion.

Finally, although it is up to the woman whether and when to have a PPIUCD inserted, the provider can and should make recommendations based on which practices have been shown to lead to the best outcomes for potential PPIUCD users.

Remember: PPIUCD services are not only about the PPIUCD: they are about choice. If the woman expresses interest in a long-acting method, then the PPIUCD may be a good choice for her. But it must be presented as one in a range of contraceptive options that are available to her.

PPIUCD and Other Intrapartum/Postpartum Services

PPIUCD services are readily integrated with other elements of essential maternal and newborn care, including:

- Managing normal birth based on the latest recommendations—such as use of a partograph, performing AMTSL (see box, below), etc.;
- Providing essential newborn care;
- Conducting a postpartum examination and ongoing monitoring;
- Facilitating early and exclusive breastfeeding, as appropriate;
- Delivering effective postpartum/newborn counseling, which will include specific messages regarding proper use of the PPIUCD; and
- Screening for and identifying complications or conditions that require prompt management or referral.

AMTSL, an obstetric “best practice,” has been shown to prevent postpartum hemorrhage and maternal death. It should be offered to every woman during every birth because of the unpredictability of this life-threatening complication.

- There have been no clinical trials to assess the interaction between AMTSL and immediate postplacental insertion of the IUCD. However, an expert panel was convened by WHO in 2004 to discuss the issue and concluded that **there is no interaction between AMTSL and postpartum insertion of the IUCD and the two practices do not interfere with each other.**
- **Postpartum insertion of the IUCD should not be deferred or delayed** in a woman who has undergone AMTSL.
- Likewise, **do not delay administration of oxytocin, as part of AMTSL, because of concerns about IUCD expulsion.** There is no evidence to suggest that the contractions resulting from the uterotonic drug will push the IUCD out once it is placed at the fundus; in fact, it is likely to be held there, rather than being pushed out, by the ongoing contractions. This is because postpartum contractions are strong and uniform, whereas labor contractions emanate from the uterine fundus and proceed downward like a wave—from the top to the bottom of the uterus—causing cervical dilation and fetal descent.

All three steps of AMTSL—injection of a uterotonic, controlled cord traction to aid in removal of the placenta and (initial) fundal massage—**should be successfully completed before PPIUCD insertion.**

Importance of Proper Technique in PPIUCD Insertion

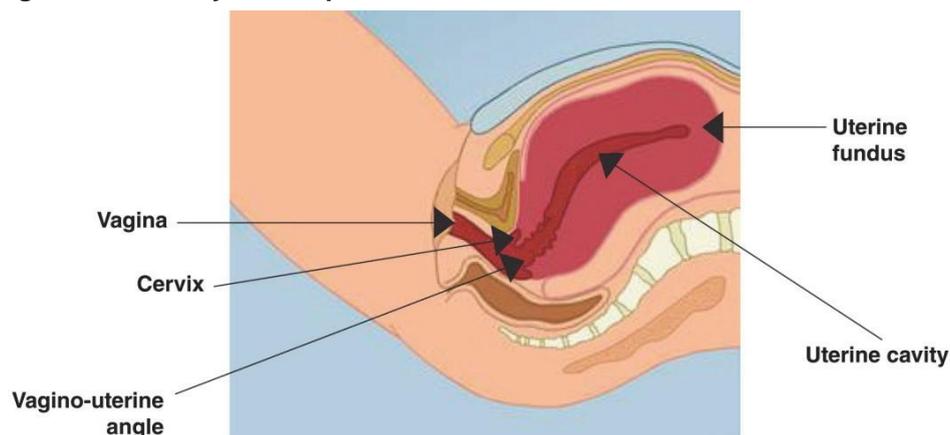
The single most important way to reduce the expulsion rate of IUCDs that are inserted in the postpartum period is to ensure proper insertion of the device. An understanding of what is happening in the woman’s body during the postpartum period is critical to mastering the proper insertion technique for the PPIUCD.

Immediate and Early Postpartum Changes and Recommendations

During the first 48 hours after the delivery of the placenta, the state of the uterus and cervix are favorable for quick, easy placement of the IUCD.

- The **uterus** is approximately the size of a 5-month pregnancy, about 1 kg in weight and 30 cm in length. Generally, the fundus (top of uterus) can be felt through the abdominal wall, just below the umbilicus. The anterior and posterior walls of the uterine body are close together, each about 4 to 5 cm in thickness. The lower uterine segment of the uterus is stretched thin and is extremely floppy—adding to the marked mobility of the body of the uterus, which is usually tilted forward. This disparity in consistency and weight between the body of the uterus and the lower uterine segment creates a sharp angle between the vagina and the uterus (Figure 4), which must be effectively negotiated by the provider during insertion. Within 48 hours, the uterus may decrease slightly in length, but it is still floppy enough to be manipulated and thus is conducive to the procedure.
- Like the lower uterine segment, the **cervix** is stretched thin and is floppy. The cervical opening is large; its outer margins are ragged and extremely soft. For the first 10 minutes after birth, the cervix can generally stretch enough to admit either a small hand or long placental forceps with a fenestrated end, which makes either manual or instrumental insertion an easy option. Beyond 10 minutes and up until 48 hours after birth, however, the cervix is no longer stretched open enough for manual insertion, but insertion with fenestrated forceps is still generally possible.

Figure 4. Anatomy of Postpartum Uterus



With minor adjustments to the interval IUCD technique as well as the instruments used (see box on the following page), proper placement of the device at the fundus can be readily achieved and the risk of IUCD expulsion can be minimized.

Key Adjustments in PPIUCD Insertion Technique

- **“Elevating” the uterus** using a specific hand maneuver to straighten the lower segment of the uterus.
- **Negotiation of the vagino-uterine angle** with the hand or forceps to ensure that the IUCD will be deposited at the fundus, rather than midcavity.
- **Use of an alternative method of insertion**, either long forceps with a fenestrated end or a hand, rather than the inserter tube used in interval insertions (which is not long enough or rigid enough).
- **Kelly placental forceps, or other similar long instrument, are long enough to reach the fundus and rigid enough to negotiate the vagino-uterine angle.** There has not been a clinical trial to determine whether using Kelly placental forceps versus ring/sponge-holding forceps results in a lower expulsion rate. But experience suggests that because Kelly forceps are longer, they may allow the fundus to be more easily reached. Also, the slight curve at the end of the forceps may prevent the strings from getting caught in the instrument, which may decrease the risk of displacing the IUCD during forceps withdrawal.
- Numerous clinical trials have found that manual postplacental insertion and instrumental (using ring forceps) postplacental insertion techniques are equivalent in terms of expulsion rates.²²
- **Careful confirmation of fundal placement** using specific criteria: for instrumental insertion, resistance to the IUCD-holding forceps is felt at the fundus (may also be felt through the abdomen at the fundus) and most of the forceps is inside the woman’s body (i.e., the hand holding the forceps is very close to the perineum); and no part of the IUCD, including the strings, is visible at the cervix or in the vagina.

Later Postpartum Changes and Recommendations

Between 48 hours and 4 weeks after birth, the uterus becomes smaller (involuting) and begins to resume its anteverted or retroverted position, making it harder to reach the fundus. In this situation, it is common for the provider to think that she/he has reached the fundus, and to release the IUCD in the midportion of the cavity. This leads to high rates of expulsion, as well as discouragement for both providers and clients.³⁵ During this time, the cervix closes and becomes firmer, making the passage of any instrument through its opening more difficult. For these reasons, **insertion of the IUCD between 48 hours and 4 weeks after birth is not recommended.**³⁷ At after 4 weeks from birth, the uterus and cervix have mostly returned to their pre-pregnant state; at this time, the typical interval IUCD insertion approach (using the standard inserter tube and instruments) is recommended. This procedure is covered elsewhere.³⁸

PPIUCD Services—Key Elements

Key elements of PPIUCD services are as follows (some may happen in a different order or overlap with others):

- **PPFP education/counseling:** The woman receives basic information about healthy spacing of pregnancies (and limiting, if desired) and the PPFP methods available to her (e.g., effectiveness, duration of protection); the woman's fertility goals and individual circumstances are discussed to help her choose a method that is well-suited to her needs.
- **Method-specific counseling:** Women interested in a certain method, such as the PPIUCD, are provided more specific information about the method (e.g., side effects, warning signs).
- **Annotation of the woman's PPFP choice on her record:** If a woman has chosen a method, her choice is documented prominently at the top of her medical record—to inform other providers of her decision. This may be done some time after counseling, after the woman has had a chance to discuss the issue with her partner or others.
- **Initial screening:** A woman who chooses the PPIUCD is screened for existing characteristics/ conditions (according to WHO's MEC for IUCDs) that would make the IUCD a poor choice for her, or medical reasons why the method should be withheld.
- **First confirmation of the woman's choice of the PPIUCD:** When the woman presents for delivery, the provider confirms that she still wants an IUCD and when she wants it inserted. The provider reassures or counsels the woman, as needed. (Again, though, PPFP/PPIUCD counseling should occur during the antenatal period, whenever possible.)
- **Ensuring that supplies and instruments are available and ready for use:** The provider then ensures that a sterile Copper T IUCD and the supplies/instruments and light source needed are available and ready for use.
- **Managing labor and delivery:** Including using a partograph, performing AMTSL and addressing any problems that may arise, obstetric care is integrated with PPIUCD services and takes precedence when appropriate.
- **Second screening:** After the birth, the woman is screened for conditions resulting from labor and delivery that would make the IUCD a poor choice for her, or medical reasons why the method should be withheld.
- **Second confirmation of the woman's choice of the PPIUCD:** Immediately before the PPIUCD is inserted, the provider tells the woman she/he is about to insert the IUCD if the woman is ready. This helps prepare the woman and reconfirms her choice.
- **Insertion of the PPIUCD:** After the final determination has been made that the woman will have an IUCD inserted, the supplies/instruments are arranged and the IUCD is removed from the package using the "no-touch" technique (described on page 2-35). The IUCD is then gently inserted according to recommended practices, either immediately postpartum (postplacental, intracesarean) or early postpartum (up to 48 hours).
- **Post-insertion counseling:** The woman receives information about side effects, warning signs and when to return to the clinic for follow-up. This should be integrated with routine postpartum/newborn care.

Handout 4: PPIUCD Services in Context

□ **Follow-up:** At 4 to 6 weeks after the birth, the woman returns for routine PPIUCD follow-up. She is screened for potential problems related to the IUCD; any problems are managed or referred.

Throughout all high-quality services:

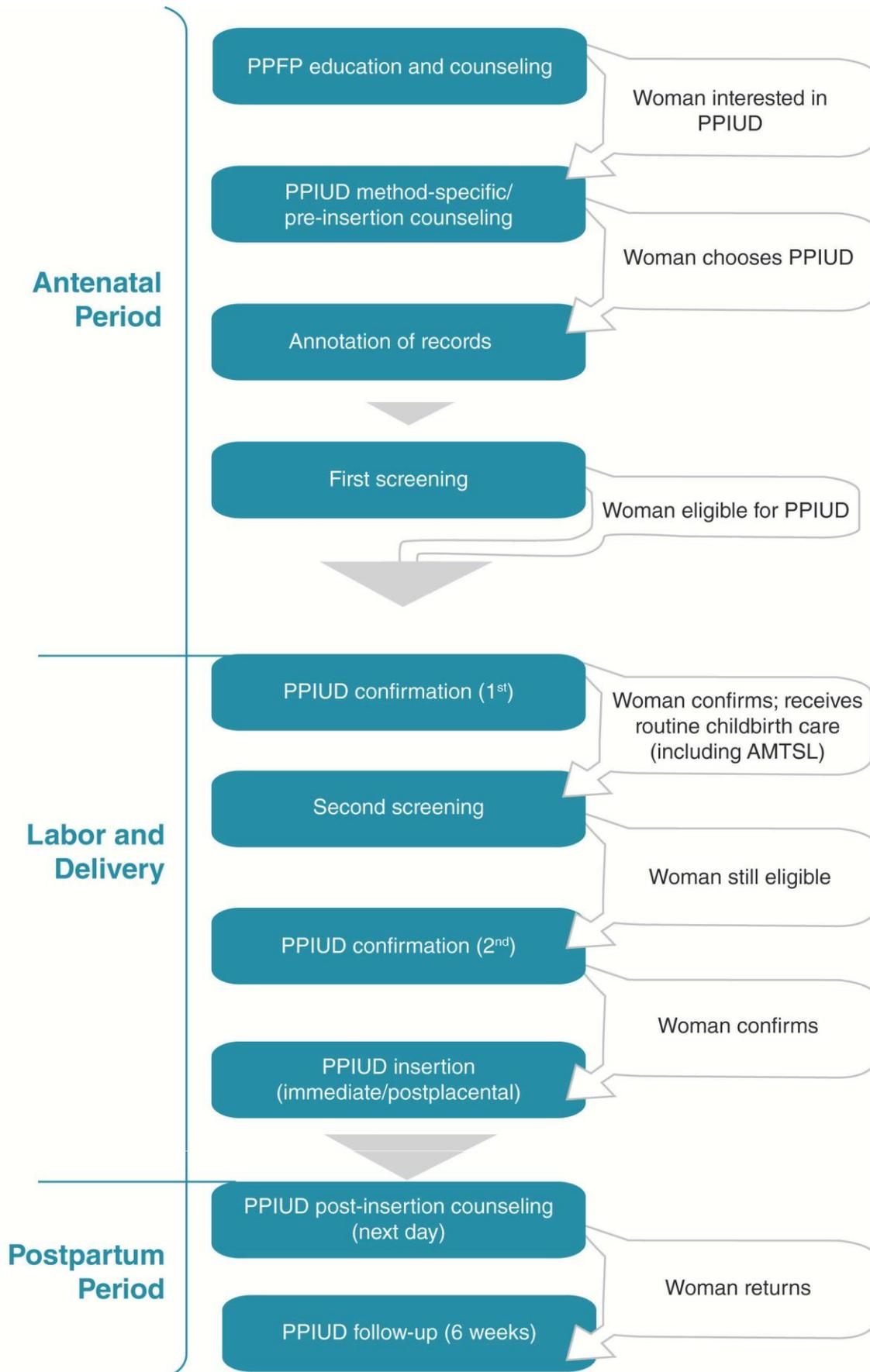
- **Clients are treated with kindness, courteousness and respect;** the woman who chooses the PPIUCD should do so freely and should be provided that method, if appropriate, in accordance with the latest evidence-based recommendations and global standards of care.
- **Providers and other health staff employ infection prevention practices as appropriate,** in accordance with global standards.

PPIUCD Service Scenarios

Whether a woman is counseled on and chooses the PPIUCD during the antenatal period, in the early stage of labor or after the baby is born has a direct effect on how services will be provided, creating different “PPIUCD service scenarios.” These different scenarios are described/illustrated on the following page.

□ **Antenatal introduction to the PPIUCD:** This allows more time for counseling, for the woman to consider her PPF options and freely choose the PPIUCD, and for the provider to conduct the initial screening. It may also make immediate postpartum insertion, which is associated with higher IUCD retention rates, more likely. Figure 5 presents this “optimal PPIUCD service scenario.”

Figure 5. “Optimal PPIUCD Service Scenario”—Antenatal Introduction to the PPIUCD with Immediate Postpartum Insertion



Handout 5: Counseling and Initial Screening of Potential PPIUCD Users

- **Intrapartum introduction to the PPIUCD:** Services can be compressed, if needed, to enable a woman who chooses the IUCD in the early/inactive stage of labor to have one inserted postpartum. However:
 - This leaves less time for counseling, which may cause the woman to delay the insertion to the early postpartum period—which is associated with higher expulsion rates and requires a separate procedure—or even later. A woman in this situation should be counseled on the benefits of immediate insertion and reminded that she can change her mind or have the IUCD removed at any time for any reason.
 - It also leaves less time for initial screening; although if the woman has a normal vaginal delivery, it is unlikely that she has certain conditions (e.g., distorted uterus) that would make the IUCD a poor choice for her, or that there are medical reasons why the method should be withheld.
- **Postpartum introduction of the PPIUCD:** Services can be initiated after the baby is born, even in the postpartum ward, so that the woman who chooses the PPIUCD can have one inserted before she leaves the facility (within 48 hours of the birth).
 - The higher risk of expulsion for IUCDs inserted during the early postpartum period, versus the immediate postpartum period, can be minimized by performing the procedure within the first 24 hours (e.g., on the morning of Day 1 postpartum).
 - Although this scenario requires a separate procedure, it is still more convenient and cost-effective—and more likely to result in an actual IUCD insertion—than if the woman is expected to return for the procedure after she has left the birth facility.

Introduction to the PPIUCD is not recommended during active labor because the woman is likely to be exhausted and unable to concentrate, and should not be asked to make important decisions at this time.

Handout -5. Counseling & Initial Screening of Potential PPIUCD Users

In counseling for PPF services, a trained and skilled counselor or service provider explicitly and purposefully gives his/her time, attention and skills to assist clients in:

- Understanding the benefits of healthy spacing of pregnancy;
- Exploring their future reproductive intentions;
- Identifying and acting upon contraceptive solutions that are realistic and well-suited to their needs, goals and life situation (access to services, resources available, etc.); and
- Being prepared for return to fertility.

In settings where women lack awareness about IUCDs or where misinformation about the method is very prevalent, quality education and counseling are critical to overcoming barriers to IUCD use.

For potential PPIUCD users (women who are interested in or have chosen the method), **method-specific counseling** consists of:

- Ensuring that the IUCD is a good choice for the woman/couple and offers what they seek in a contraceptive; and
- Discussing the “optimal PPIUCD service scenario” (the benefits of immediate postpartum insertion).

For women who have chosen the PPIUCD, the **initial screening** determines whether they can have a PPIUCD inserted based on the WHO MEC for contraceptives. This can be done as part of individual counseling because it does not involve any physical examination, only a series of questions regarding the woman’s medical history.

All providers should keep in mind that although all methods of family planning have some associated risks, the risks to a woman and her family’s health may be greater if she uses no method at all and has an unintended or badly timed pregnancy. When a provider counsels and screens a woman properly, that woman is more likely to:

- Make a reasonable contraceptive choice for achieving her reproductive health goals;
- Be satisfied with her chosen method; and
- Use her chosen method correctly and for a longer time.

Rushing or bypassing either of these processes, counseling or screening, may cause a woman to choose a method that is not right for her or avoid choosing any method at all, leaving her more likely to have unprotected sex and more vulnerable to unintended pregnancy and other health consequences.

PPIUCD Counseling

Ideally, PPIUCD counseling should begin during the antenatal period and occur in stages:

- First, as **part of general health education** (often group-based) about the benefits of healthy spacing of pregnancies (and limiting, if desired) and about the PPFM methods available to women in the community. At this stage, the counselor/provider may offer very basic information about the PPIUCD, among other methods.
- This should be followed by **individual counseling about PPFM methods**, in which a woman is provided with more detailed information about a particular method (or methods) and is supported in making an informed choice about a method that is well-suited to her individual needs and circumstances in the postpartum period. Often a woman will take time to discuss her options with her partner or others before making a final decision.
- Then, as the **focus of method-specific counseling about the PPIUCD:**
 - For those women who have chosen the IUCD for postpartum insertion, pre-insertion counseling provides more detailed information about the insertion procedure and other attributes of the method. Again, this is also an ideal opportunity for initial screening.
 - And finally, for women who have had the IUCD inserted postpartum, post-insertion counseling provides information about returning for follow-up, recognizing warning signs and what to do if they occur, and managing side effects. (See Handout 6.)

Key messages about healthy spacing of pregnancies are summarized in Annex A. Job aids for PPFM counseling are presented in Annex B. General counseling techniques and approaches for effective health education and counseling on family planning and PPFM are presented in great detail elsewhere.³⁸⁻⁴⁰

Remember: All individuals and couples have a right to make their own decisions about family planning. They also have a right to the accurate, up-to-date information they need to make those decisions responsibly, as well as access to a full range of safe and reliable contraceptive options. Family planning education and counseling play a central role in empowering clients to exercise these and other basic rights and should be conducted at a time and in a manner that aids client choice, and does not persuade, pressure or induce a person to use a particular method.

Content of Method-Specific PPIUCD Counseling

Once a woman has chosen the PPIUCD and a level of confidence and trust has been established between her and the counselor/provider, the **method-specific portion of counseling** can begin. This counseling should include more detailed messages about the method, such as those shown in the table below, and should be tailored to the woman's/couple's individual needs, concerns and circumstances.

Table 2. Client Messages about Basic Attributes of the IUCD and PPIUCD

	Basic Attributes	Messages
General Information	What it is	<input type="checkbox"/> The IUCD is a small plastic device that is inserted into the uterus.
	Effectiveness	<input type="checkbox"/> The IUCD is more than 99% effective at preventing pregnancy, which makes it one of the most effective contraceptive methods currently available.
	Mechanism of action	<input type="checkbox"/> The IUCD prevents pregnancy by preventing the sperm from fertilizing the egg.
	When it is inserted	<input type="checkbox"/> For interval IUCD insertion, the device can be inserted any time it is reasonably certain the woman is not pregnant—including during menstruation. <input type="checkbox"/> The PPIUCD can be inserted either immediately after the placenta comes out (after a vaginal birth or during a cesarean section) or in the early postpartum period (not immediate but up to 48 hours after delivery). <input type="checkbox"/> Postplacental/immediate IUCD insertion is preferred because it has a lower rate of expulsion than early postpartum (not immediate but up to 48 hours) insertion, and it is easier/more convenient for both the woman and provider.
Screening-Related Information	Duration of protection	<input type="checkbox"/> The IUCD begins to work immediately and the Copper T is effective for up to 12 years. <input type="checkbox"/> It can be removed at any time, for any reason, with immediate return to fertility—which means it is a long-acting but reversible method of family planning. <input type="checkbox"/> Women who have the IUCD inserted postpartum will have contraceptive protection in place even before they leave the birth facility.
	Who can use it	<input type="checkbox"/> Most women can use the IUCD, including those who are young/nulliparous, are postpartum and breastfeeding , or do hard work—as well as those who have certain medical conditions such as HIV or diabetes. It is especially well-suited to women who think they are finished having children, but want to delay sterilization until they are certain.
	Who cannot use it	<input type="checkbox"/> Some women who should not use the IUCD include those who have a misshapen uterus (e.g., from fibroids), a high personal risk of STIs or current pelvic infection, PID, gonorrhea or chlamydia. <input type="checkbox"/> Sometimes women develop an infection during the time of birth. These women should wait until after the infection has been treated to have the IUCD inserted. (Pages 2-29 to 2-30 present guidance on initial assessment; Annex C provides a complete listing of exclusion criteria.)

	Basic Attributes	Messages
	<p>Breastfeeding</p> <p>Protection against HIV and other STIs</p>	<p><input type="checkbox"/> Women who are breastfeeding can safely use the IUCD.</p> <p>Using the IUCD postpartum will not affect the amount or quality of breast milk.</p> <p><input type="checkbox"/> The IUCD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs. If a woman thinks she has a “very high personal risk” for certain STIs, she should not use the IUCD.</p>
Other Considerations	Limitations and risks	<p><input type="checkbox"/> The IUCD must be inserted and removed by a skilled provider. The PPIUCD is more convenient than interval IUCD because it will not require a separate visit or (if postplacental) a separate procedure.</p> <p><input type="checkbox"/> The IUCD has some associated risks/complications but they are rare and few, all of which can be virtually eliminated through proper screening and insertion technique:</p> <p><input type="checkbox"/> Uterine perforation is a rare occurrence and infection occurs in less than 1% of cases (both risks may be even lower in PPIUCD).</p> <p><input type="checkbox"/> Although it is not a problem for most women, expulsion of the IUCD is the main risk. Risk of expulsion is higher for PPIUCD insertion than for interval IUCD insertion. When the IUCD is inserted postpartum, about 5 to 10 women out of 100 will find that the IUCD has fallen out during the first 3 months. (Fewer IUCDs inserted during the immediate postpartum period [postplacental, intraccesarean] are expelled than those inserted within 24 to 48 hours after birth.) If the IUCD is expelled, the woman should return to the clinic and have another IUCD inserted to continue protection against pregnancy.</p> <p><input type="checkbox"/> Strings may not be visible initially after postpartum insertion, which might require some additional follow-up or investigation to ensure that the IUCD has not fallen out.</p>
	Advantages and benefits	<p><input type="checkbox"/> Safe and effective: The IUCD is safe and effective, with a very low rate of complications.</p> <p><input type="checkbox"/> Cost-effective and convenient: Once it is inserted until it must be removed, it requires no additional actions, supplies or costs on the part of the woman. In most cases, only one follow-up visit to the clinic is required (at 4 to 6 weeks). Getting a PPIUCD is especially cost- effective and convenient. The device will be placed before the woman leaves the health care facility (will not require a separate visit nor [if immediate postpartum] a separate procedure).</p> <p><input type="checkbox"/> Versatile and quick-acting: It is both long-acting and reversible—can be used to prevent pregnancy for a short time or as long as 12 years, and fertility returns as soon as it is removed. It also begins preventing pregnancy immediately upon insertion.</p> <p><input type="checkbox"/> Reduces overall risk of ectopic pregnancy (IUCD users are much less likely to have an ectopic pregnancy than non-contraceptive users); however, if a woman becomes pregnant with an IUCD in place, she has an increased risk of ectopic pregnancy.</p>

	Basic Attributes	Messages
User Information/Instructions	Side effects	<ul style="list-style-type: none"> <input type="checkbox"/> Copper-bearing IUCDs (e.g., the Copper T) have no “hormonal side effects” (such as those associated with DMPA injections, implants, the pill), but sometimes cause an increase in the amount, duration and painfulness of menstrual periods. These symptoms usually lessen or go away during the first few months after insertion. <input type="checkbox"/> Often these symptoms are not noticed by postpartum women because they are still recovering from pregnancy and childbirth. And women who are breastfeeding may not yet have resumed their menstrual periods. <input type="checkbox"/> If side effects become very bothersome to the woman, she should return to the facility for care.
	Warning signs	<p>Warning signs for IUCD users, as follows, indicate that the woman should return to the facility as soon as possible for urgent attention and care:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Foul-smelling vaginal discharge (different from the usual postpartum lochia) <input type="checkbox"/> Lower abdominal pain, especially if accompanied by not feeling well, fever or chills <input type="checkbox"/> Concerns that the IUCD has fallen out <input type="checkbox"/> Signs of pregnancy
	Removal	<ul style="list-style-type: none"> <input type="checkbox"/> The woman can have the IUCD removed at any time for any reason by a skilled provider. She should return to the facility to have it removed no later than 12 years after insertion. A new IUCD can be inserted at this time, if the woman desires.

Service Delivery Tips for Method-Specific PPIUCD Counseling

Who should do it/when:

To be most effective, method-specific should be carried out (as a follow-on to PPF education/counseling) with the pregnant woman during the antenatal period if possible, as part of routine care, by a trained counselor or her ANC provider. This is especially advantageous for women who have chosen contraceptives that are initiated during the immediate or early postpartum period, such as PPIUCD, LAM or tubal ligation. This allows:

- Multiple opportunities (potentially) to address the woman's concerns and answer her questions before she makes a decision;
- A chance for the woman to discuss her choice with her partner, as well as for counseling to be extended to her partner and/or other family members (if the provider or woman considers this to be important); and
- Ample time for initial screening.

Other opportunities:

- **For a woman who presents at the facility for non-routine care:** If a woman is undergoing evaluation or treatment for an antenatal complication or other concern, she may be counseled for PPF/PPIUCD. This is actually a good time to discuss the health benefits of pregnancy spacing (or limiting, if desired) for both the mother and her children. The woman/couple may be especially interested in ways to increase the likelihood of a positive health outcome for a future pregnancy.
- **For a woman who presents at the facility for delivery care:** If a woman is in the early/inactive stage of labor and has not been counseled, the PPIUCD is still an option if a counselor or the clinician can provide adequate PPF counseling. Because choosing a contraceptive is an important decision to make on such short notice, it is important that a woman interested in the PPIUCD understands that it is non-permanent and can be removed whenever she wants—and that she can change her mind at any time.
- In general, **a woman should NOT be counseled for the first time about PPIUCD during active labor.** The stress of labor makes this a difficult time for a woman to focus sufficiently on the information provided and make an informed choice about contraception.

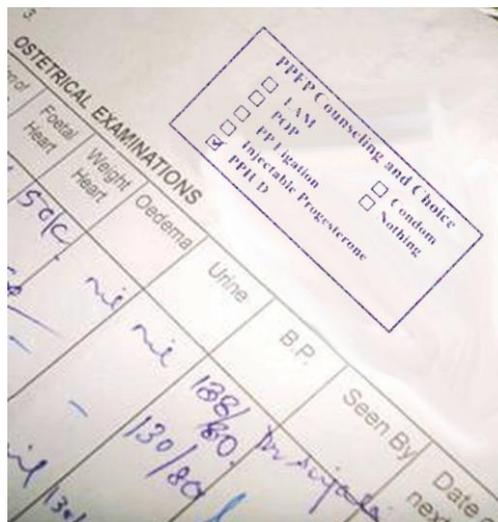
After counseling:

A woman's **choice about PPF should be clearly documented** on her antenatal card or medical record (as shown in Figure 6). This is especially critical for women who choose the PPIUCD (or other labor/delivery-related methods) during the antenatal period—alerting labor and delivery room staff so that preparations can be made to provide the method immediately following delivery of the placenta (or in the early postpartum period). The annotation should be obvious and noticeable enough to serve as a reminder to all MNCH providers.

Assessment of the Potential IUCD User Assessment for provision of PPIUCD services should occur in **two phases** (Figure 7).

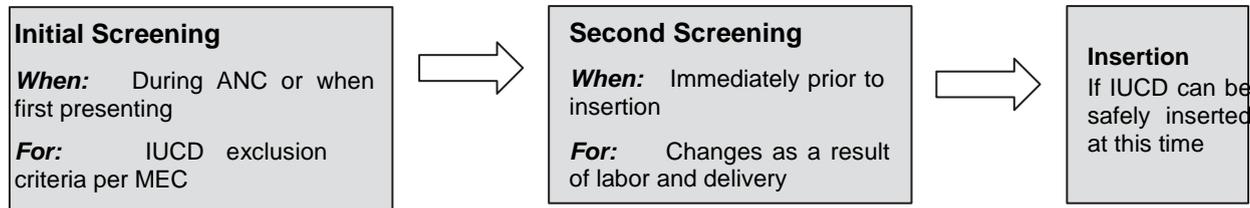
- The **initial screening** is a general review of the woman’s medical history to identify specific *existing* characteristics and conditions and determine her eligibility for the method.
- A **second screening** is done immediately prior to insertion (following delivery of the placenta or within 48 hours after birth) to assess for conditions resulting from labor and delivery that may have an impact on whether an IUCD can be safely inserted at this time.

Figure 6. Documentation of Woman’s PPFPP Choice in Medical Record



If any such characteristics/conditions are identified, the provider and client should weigh the risks posed by the IUCD against those posed by unintended pregnancy to determine whether an IUCD should be inserted at this time.

Figure 7. Assessment Scheme for Women Who Choose the PPIUCD



Content of Initial Screening for Potential IUCD Users

The WHO MEC form the scientific foundation for client assessment regarding family planning methods.⁴⁰ These criteria give detailed guidance regarding whether a woman with a certain condition can safely use a given method of family planning (Annex C). The MEC has four categories, as shown in Table 3.

Table 3. WHO Medical Eligibility Categories

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	

Handout 5: Counseling and Initial Screening of Potential PPIUCD Users

During the initial assessment, the provider is looking for the following conditions, listed in the MEC and relevant to PPIUCD services, which make the IUCD an unsuitable choice for this woman:

- Known distorted uterine cavity (uterine septum, fibroid uterus, etc.) (Category 4)
- Acute purulent (pus-like) discharge (Category 4)
- High individual likelihood of exposure to gonorrhea or chlamydia (Category 3)
- Malignant or benign trophoblastic disease (Category 4/3)
- AIDS and not clinically well or not on antiretroviral therapy (Category 3)

Service Delivery Tips for Initial Screening of Potential IUCD Users

Who should do it/when:

- Again, ideally, the initial screening should be carried out with the pregnant woman during the antenatal period by her ANC provider. However, for women who present at the facility for delivery care, and who have not had a prior screening, the clinician must use her/his clinical judgment about the likelihood of characteristics/conditions that would make the IUCD a poor choice for her, or whether there are medical reasons to withhold the method.
- If a woman has just experienced a normal, vertex, full-term vaginal delivery, it is reasonable to assume that she does not have a distorted uterine cavity, have malignant or benign trophoblastic disease, or suffer from acute illness due to unmanaged HIV/AIDS.
- If she does not report purulent cervicitis in the final trimester of pregnancy, it is reasonable to assume that she does not have an undiagnosed chlamydia or gonorrhea. As with screening for the interval IUCD, it is reasonable to provide IUCDs to women without prior STI testing.

After the initial screening:

- **If NO exclusion criteria are identified;** the provider should advise the woman that it is safe to insert the IUCD postpartum, provided that results of the second screening are also favorable. The provider should then:
 - Provide any additional counseling, as appropriate.
 - Discuss and decide/confirm the timing of the insertion, reminding the woman that immediate postpartum (postplacental, intracesarean) insertions are associated with fewer problems than those that take place later, within 48 hours.
 - Get the woman's verbal consent.
 - Answer any questions she may have.
- **If ANY exclusion criteria are identified,** the provider should explain the reason why an IUCD cannot be inserted and assist the woman in choosing another method (or for Category 3 conditions, assist her in weighing the pros and cons of using this method versus another method). Annex B offers additional information about other PPIUCD options.

Handout - 6. Postpartum Insertion of the IUCD—A Process

The main element of PPIUCD services is insertion of an IUCD, within 10 minutes of the delivery of the placenta or up to 48 hours after birth. Because PPIUCD insertion occurs in the context of other important health events, it is helpful to think of insertion not just as a clinical procedure, but as a process—fully integrated with intrapartum, postpartum and newborn care—that occurs in many stages:

- Beginning with **confirmation** (of *choice*) that the woman still wants the PPIUCD;
- Continuing with the **second assessment** of the woman, to ensure that there are no conditions resulting from labor and delivery that make IUCD insertion unsafe at this time, followed by another **confirmation** (of *readiness*); and **IUCD insertion** in the immediate (postplacental, intracesarean) or early postpartum period, as appropriate; and
- Ending with **post-insertion counseling**.

How and when these different stages of the process are carried out will depend on a variety of factors—including the woman’s preferences and what services she has received up to this point, the skills of her provider and the policies and capacities of the health care facility. **Respectful treatment** of the woman and her family and adherence to global **infection prevention standards** are integral to the PPIUCD insertion process, regardless of how this process unfolds.

Confirming Choice/Readiness of the Potential PPIUCD User

Before the woman has an IUCD inserted postpartum, the provider should confirm with her that she still wants one: once before active labor begins, if possible; and again immediately before the procedure.

- The **first confirmation** is especially important if the woman chose the PPIUCD before presenting for labor and delivery care (i.e., during the antenatal period)—to ensure that she has not changed her mind. In addition, it gives the delivery room staff ample time to prepare for the procedure, for example by ensuring that IUCDs are available on the ward and gathering necessary supplies and equipment (Annex D). Confirming the woman’s contraceptive choice is a matter of respect, as well, presenting an opportunity for the woman to ask questions she may still have and for the provider to counsel her as needed.
- The **second confirmation** happens after the second assessment, which follows the birth but immediately precedes insertion of the IUCD postpartum. The provider explains that she/he is about to insert an IUCD, briefly explains what the procedure will involve and ensures that the woman is ready (thereby confirming that she still wants an IUCD).

Second Screening of the Potential PPIUCD User

The purpose of the second screening is to ensure that the process of labor and birth has not produced a clinical situation for which insertion of the PPIUCD would not be advised. Specifically, after the delivery of the placenta, the woman should be assessed for:

- Chorioamnionitis (discussed further below)
- Postpartum endometritis/metritis (Category 4)

Handout 6: Postpartum Insertion of the IUCD—A Process

- Puerperal sepsis (Category 4)
- More than 18 hours from rupture of membranes to delivery of the baby (discussed further below)
- Unresolved postpartum hemorrhage (discussed further below)
- Extensive genital trauma, the repair of which would be disrupted by postpartum placement of the IUCD (discussed further below)

Annex E provides a job aid for the second screening. **It should be noted that the conditions listed below are not represented in the WHO MEC for IUCD use; however, they are regarded as exclusions or precautions based on clinical trials and expert opinion.**

1. **Chorioamnionitis** is an infection that may occur when membranes are ruptured and amniotic fluid is leaking. The management principle for this infection is to deliver the fetus, which will clear the infection from the mother. Therefore, antibiotics are administered and the fetus is delivered as quickly as possible. No additional antibiotics are needed after a normal vaginal delivery in a woman with chorioamnionitis because the infection has been addressed; however, IUCD insertion is not advised (Category 3) as the woman is at increased risk for puerperal infection.

Diagnosis of Chorioamnionitis

Chorioamnionitis is an intra-amniotic infection of the fetal membranes and amniotic fluids prior to or during labor that is characterized by:

- Temperature of 38°C
- Abdominal pain

PLUS one of the following:

- Tender uterus
- Leaking of foul-smelling amniotic fluid
- Fetal tachycardia (>160 BPM)

2. **Prolonged rupture of membranes (PROM) for more than 18 hours prior to delivery** is listed as an exclusion criterion in most research studies about PPIUCDs. Because PROM increases the woman's risk of postpartum uterine infection or puerperal sepsis, IUCD insertion is not advised (Category 3). However, there is no strong or definitive evidence for this exclusion criterion, and thus it is open to review.

3. **Unresolved postpartum hemorrhage** may make it physically challenging to insert an IUCD; there is also the chance that the flow of the hemorrhage will dislodge the IUCD. In addition, the provider should be focused on addressing the cause of the bleeding and stabilizing the woman, rather than inserting an IUCD. For these reasons, an IUCD should not be inserted (Category 4). The IUCD can be inserted once the hemorrhage is controlled and the woman is in stable condition.

4. **Extensive genital trauma** from the delivery does not mean that a woman cannot have an IUCD at this time, but it *will* affect how the provider approaches insertion.

- If the woman is found to have substantial genital trauma **immediately after delivery of the placenta**, an instrumental or manual insertion is recommended **prior to starting the repair of the lacerations/episiotomy**. In this case, the provider should cover the posterior wall of the vagina with a towel or several gauze sponges to limit the possibility of contamination, and avoid contamination of the IUCD while inserting it.

Handout 6: Postpartum Insertion of the IUCD—A Process

□ If a woman is found to have substantial genital trauma while being evaluated **during the early postpartum period** (within 48 hours of delivery), the provider should take special care in performing the insertion to ensure that any previously made repairs are not disrupted during the insertion.

Who Should Do It/When

The second screening should be done immediately prior to IUCD insertion by the person who will perform the procedure (i.e., the provider who managed the birth).

□ If a **postplacental insertion** is planned, the second assessment is best carried out during the second stage of labor so that insertion can be performed immediately following AMTSL and the delivery of the placenta without any delay.

□ If an **intracesarean insertion** is planned, the second assessment should take place during the pre-operative activities prior to surgery.

□ If a **postpartum insertion** is planned for the first day postpartum (or second day, if the first is not possible), the second assessment should take place during the initial postpartum evaluation.

After the Second Screening

□ **If NO exclusion criteria are identified**, then the provider should advise the woman that it is safe to insert the IUCD and can proceed with preparations for insertion.

□ **If ANY exclusion criteria are identified**, the provider should explain the reason why an IUCD cannot be inserted and assist the woman in choosing another, *at least temporary method* (or for Category 3 conditions, assist her in weighing the pros and cons of using this method versus another method). Annex B offers additional information about other PFP options. **Also:**

□ It should be made clear that the situation identified by the second assessment is a temporary clinical situation, and that if she still would like the IUCD as her postpartum method of family planning, it can be provided to her at 4 weeks.

□ She should be scheduled for a postpartum visit at 4 to 6 weeks.

Infection Prevention during PPIUCD Insertion^d

The key objectives of infection prevention during PPIUCD insertion are reduction of the risk of infection associated with PPIUCD insertion technique and facility-related disease transmission to PPIUCD clients, and protection of health care workers at all levels from exposure to disease.

To achieve these objectives, service providers and health care staff must:

□ Implement standard precautions;

□ Use the aseptic/“no-touch” technique (page 2-35) during every PPIUCD insertion; and

^dBecause providers are likely to be well-grounded already in the basic principles of infection prevention, only practices that are essential to the safe delivery of PPIUCD services are reviewed here. Annex F provides additional information about infection prevention.

Handout 6: Postpartum Insertion of the IUCD—A Process

- Use high-level disinfected (HLD)/sterilized equipment, with appropriate disposal of waste after every procedure.

These measures are applied—in the appropriate setting, with staff and clients appropriately attired (Table 4)—as described below and summarized in Annex F.

Table 4. Appropriate Setting and Attire for Infection Prevention during PPIUCD Insertion

Timing	Setting	Staff Attire
Postplacental	Delivery room, the same bed used for labor and birth	<ul style="list-style-type: none"> □ Personal protective equipment appropriate for vaginal delivery (e.g., impermeable gowns or long-sleeved gowns with rubber aprons; eye and mouth protection); elbow-length gloves are needed for manual insertion □ Sterile gloves do not need to be changed before insertion if not contaminated
Intracesarean	Operating theater, procedure table	<ul style="list-style-type: none"> □ Personal protective equipment □ Sterile gloves do not need to be changed before insertion if not contaminated
Early postpartum	Clinical procedure room, procedure table	<ul style="list-style-type: none"> □ The arms of the health care provider covered by a long-sleeved gown □ Use of eye and mouth protection is optional □ When using “no-touch” technique, use of clean exam gloves is sufficient

Immediately before PPIUCD Insertion

- Ensure that instruments and supplies are available and ready for use (Annex D).
- Ensure that the IUCD package is unopened and undamaged and check the expiration date. (Regardless of timing or setting, the IUCD package should not be opened until the final decision to insert the IUCD has been made.)
- Open and arrange all sterile instruments and supplies onto a dry, sterile surface (sterile field) such as a drape/towel or steel basin. **Particular care is required immediately after delivery to ensure an adequate sterile field. Use of a separate table or stand is recommended to prevent cross-contamination with instruments used during delivery.**
- Keep the IUCD to the side of the sterile field.
- For early postpartum insertion, wash or have the woman wash her perineal area with soap and water before prepping the vagina and cervix and beginning insertion. **If immediately after delivery, cleaning the perineal area gently with a sterile gauze or towel is sufficient in the absence of obvious fecal contamination.**

Note: Antiseptic preparation of the vulva, perineum and perirectal area is not required. Moreover, there is no evidence that shaving the genital area for delivery or PPIUCD insertion decreases the infection rate.

Handout 6: Postpartum Insertion of the IUCD—A Process

- Place a dry, sterile cloth on the woman's abdomen, just above the symphysis pubis. This will protect the provider's nondominant hand from contamination as it applies upward pressure to "elevate" the uterus.
- When available, place another dry, sterile cloth between the woman's genital area and the surface of the examination table for patient comfort and to minimize the risk of contamination of sterile instruments and the IUCD during insertion.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- Put HLD or sterile surgical gloves on both hands. **Remember to use elbow-length gloves for manual vaginal (versus intracesean) insertion.**
- Using sterile gauze and a sterile sponge/ring clamp or its equivalent, apply an appropriate water-based antiseptic agent to the vagina and cervix two or more times before IUCD insertion. Cleanse from the inside of the cervical opening outward.
- The most commonly used lower genital tract antiseptics are: iodophors, such as povidone iodine, and chlorhexidine. If an iodophor is used, allow 1 to 2 minutes before proceeding with the procedure after application. Iodophors such as povidone iodine require "contact time" to act.
- Do not use alcohol as an antiseptic in the lower genital tract. Not only is it painful for the patient, but it may also actually increase the risk of infection by drying and damaging the vaginal and cervical mucosa.
- If sterile gloves are contaminated during the antiseptic application process, change to a new pair before proceeding with insertion.

During IUCD Insertion (as applicable)

- Remember that gloves that have been used to touch the perineum or vagina are contaminated and no longer sterile.
- Beginning with removing the IUCD from its sterile package and throughout the procedure, use the "**no-touch**" technique to reduce the risk of contaminating the uterine cavity. Using the no-touch technique during PPIUCD insertion means that the IUCD is:
 - Touched only by uncontaminated sterile gloves and sterile equipment.
 - Not allowed to touch the buttock drape, the perineum, the vaginal walls or the blades of the speculum (or any other nonsterile surface that may contaminate it)
- If successful fundal placement is not achieved, or if the IUCD is dislodged or removed, and a "repeat attempt" is planned, the same IUCD can be reinserted unless it has been contaminated. If possible contamination of the IUCD has occurred, a new IUCD from a sterile package should be used; additional application of antiseptic to the vagina may also be required.

After IUCD Insertion

- Before removing your gloves:
 - Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.

Handout 6: Postpartum Insertion of the IUCD—A Process

- Dispose of waste materials (e.g., cotton balls and gauze) by placing them in a leak-proof container (with a tight-fitting lid) or plastic bag.
- Immerse both gloved hands in 0.5% chlorine solution.
- Remove gloves by turning them inside out.
- Dispose of gloves by placing them in a leak-proof container or plastic bag.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- After the client has left, wipe the procedure table with 0.5% chlorine solution to decontaminate.
- Ensure that all instruments, gloves and other reusable items are further processed according to recommended infection prevention practices (Annex F).

Clinical Technique for Insertion of the PPIUCD

This section provides step-by-step guidance on four types of PPIUCD insertion: during the immediate postpartum period: postplacental (1) instrumental or (2) manual insertion; (3) cesarean (manual) insertion; and (4) early postpartum (instrumental) insertion.⁶

The goal of all types of insertions is to insert the IUCD safely, in a manner that reduces the risk of spontaneous expulsion.

Postplacental Instrumental Insertion

Postplacental instrumental insertion of the IUCD is done immediately following delivery of the placenta, typically within 10 minutes using a Kelly or ring forceps. The woman has been counseled and

prepared prior to the start of active labor, preferably during the antenatal period. The woman is in the labor/delivery room and has not yet gotten up from the delivery bed. She is still in the lithotomy position following delivery, or assumes the lithotomy position if an alternative position has been used for delivery. The insertion takes place immediately following AMTSL and the delivery of the placenta. These steps are described in full detail in Table 5 and summarized in Annex G.

Tips for Reducing Spontaneous Expulsion

Right Time:

- Recommend postplacental and intracesarean insertions, which have the lowest expulsion rates.

Right Technique/Instrument:

- “Elevate” the uterus to straighten its lower segment.
- Use an instrument that is rigid enough to negotiate the vagino-uterine angle, and long enough to reach the fundus (such as a Kelly or ring forceps).
- If using an instrument:
 - Keep instrument closed until the fundus is reached.
 - Sweep instrument to the side after placing the IUCD.
 - Keep instrument open while withdrawing.
- Confirm proper IUCD placement.

⁶In the Learning Resource Package that accompanies this manual, checklists are included for each of the insertion procedures, which can be used in learning and assessment exercises.

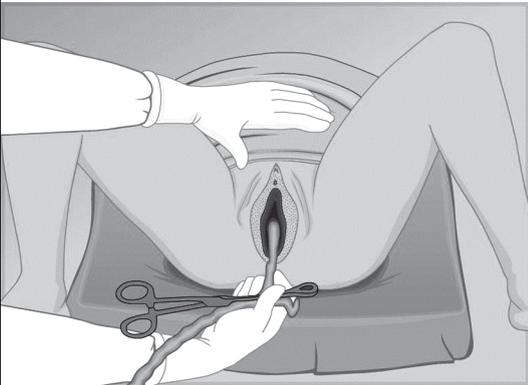
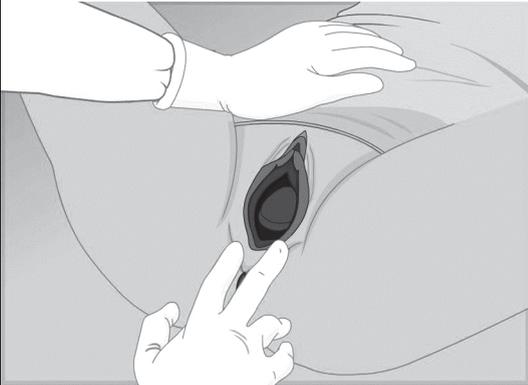
Handout 6: Postpartum Insertion of the IUCD—A Process

Table 5. Postplacental Insertion of the IUCD Using Forceps

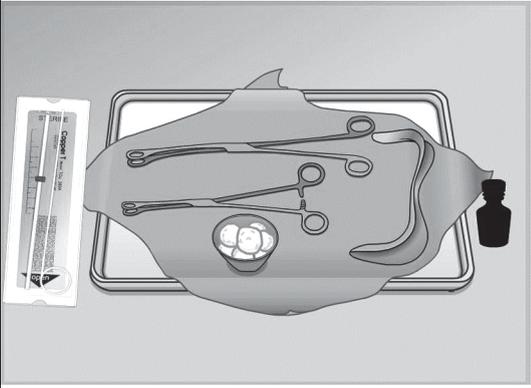
Tasks to Perform before Active Labor and Delivery		
No.	Step	Explanation/Additional Guidance
Steps 1–5		
Ensure that the woman has chosen to have an IUCD inserted immediately postpartum, and that it is an appropriate method for her.		
1.	Review the woman’s medical record to ensure that she has chosen the PPIUCD.	<i>Before approaching the woman’s bedside, the provider reviews the woman’s record. If she has chosen the PPIUCD, ensure that she has been:</i>
2.	Ensure that she has been appropriately counseled and screened for PPIUCD insertion.	<ul style="list-style-type: none"> <input type="checkbox"/> Educated/counseled regarding PPFPP and provided in-depth information about the PPIUCD. <input type="checkbox"/> Screened for characteristics and conditions that would make the IUCD a poor contraceptive choice for her (i.e., according to the WHO MEC).
3.	Greet the woman with kindness and respect.	
4.	Explain that you will insert the IUCD immediately following delivery of the baby and placenta (if needed, remind her that this is the best time). Confirm with the woman that she still wants the PPIUCD.	
5.	<p>Answer any questions the woman might have; provide reassurance, as needed. (Provide counseling, as needed.)</p> <p>Note: Key messages that may be appropriate at this time are:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Immediate insertion is best. <input type="checkbox"/> She can change her mind at any time. <input type="checkbox"/> The IUCD can be removed at any time with immediate return to fertility. 	
Steps 6, 7		
Ensure that supplies/equipment and sealed IUCD are available and ready to use.		
6.	Once the woman has confirmed that she wants the PPIUCD, obtain a PPIUCD kit/tray (or gather the correct sterile instruments, supplies, light source) for the procedure.	<i>The provider should ensure that all of the items needed are available and ready to use so that there is no unnecessary delay after the placenta is delivered. Keep the tray wrapped/covered until after the birth of the baby.</i>
7.	Obtain a sterile IUCD ; keep the package sealed until immediately prior to insertion.	<i>The package should be kept sealed to maintain its sterility until it is absolutely certain the IUCD will be inserted (i.e., after the woman’s second screening and final confirmation).</i>

‘If the woman has not received an initial screening, she can still have a PPIUCD. If the woman has an uneventful pregnancy and birth, it is unlikely that she has any of the conditions that would exclude the IUCD as an option. The second screening addresses the most critical concerns.

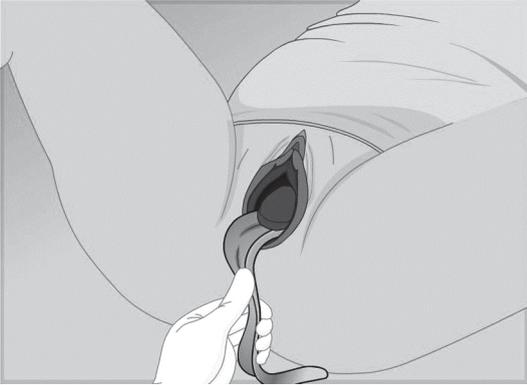
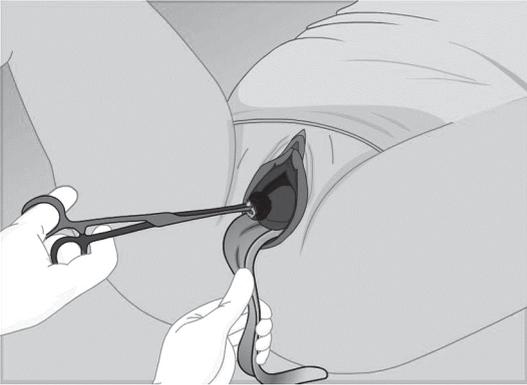
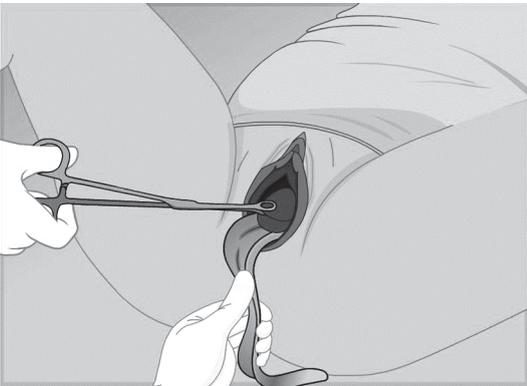
Handout 6: Postpartum Insertion of the IUCD—A Process

Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	Step	Explanation/Additional Guidance
Steps 8–11		
Perform AMTSL and the second screening.		
8.	<p>After labor and delivery (including performing AMTSL), screen for delivery-related conditions that preclude insertion of IUCD now:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prolonged rupture of membranes for more than 18 hours <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Unresolved postpartum hemorrhage <p>[Further discussed on pages 2-31, 2-33; see also Annex G.]</p>	 <p>Remember: AMTSL should be performed as usual to prevent postpartum hemorrhage. The processes of AMTSL and postplacental IUCD insertion do not interfere with each other.</p>
9.	<p>Before continuing with the second screening, perform infection prevention measures as appropriate:</p> <ul style="list-style-type: none"> <input type="checkbox"/> <u>The provider who manages the birth and inserts the IUCD</u> does not need to change gloves. <input type="checkbox"/> <u>The provider who did not manage the birth but inserts the IUCD</u> should ensure that AMTSL has been completed, then perform hand hygiene and put on sterile or HLD gloves. 	<p>If the same provider does the delivery and the IUCD insertion, new gloves are not needed because the IUCD is grasped with the Kelly forceps inside the wrapper; therefore, the provider never touches the IUCD (i.e., the “no-touch” technique is used).</p> <p>However, if a different/new provider does the IUCD insertion, that provider should perform hand hygiene and put on a new pair of sterile or HLD gloves.</p>
10.	<p>Inspect perineum, labia and vaginal walls for lacerations.</p> <ul style="list-style-type: none"> <input type="checkbox"/> If there are lacerations and they are bleeding, <i>apply a clamp to the bleeding areas to stop the bleeding and proceed with the IUCD insertion procedure.</i> <input type="checkbox"/> Repair lacerations, if needed, after the procedure. <p>[Further discussed on pages 2-31 to 2-33.]</p>	 <p>The provider does not need to delay insertion to repair minor lacerations.</p>
11.	<p>If any of the conditions exists, speak with the woman and explain that now is not a safe time for insertion of the IUCD. Counsel her and offer her another PPF method as appropriate.</p>	<p>Women who cannot receive the IUCD now may be able to receive it on postpartum Day 1 or 2. Otherwise, advise the woman to return at 4 weeks postpartum for re-evaluation and possible IUCD insertion; and/or assist her in choosing another PPF method.</p>

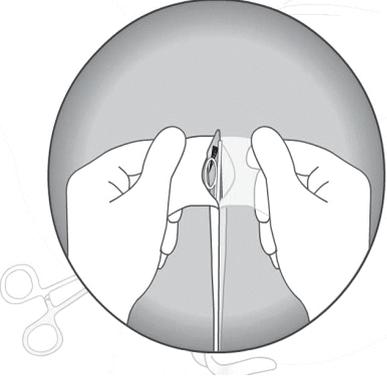
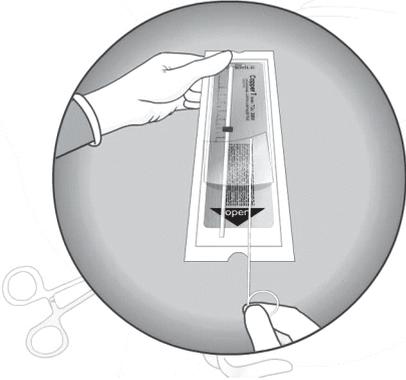
Handout 6: Postpartum Insertion of the IUCD—A Process

Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	Step	Explanation/Additional Guidance
Steps 12, 13 <i>Let the woman know that you are about to insert the IUCD, if that is acceptable to her, and arrange instruments/supplies.</i>		
12.	If the second screening has revealed no conditions that contraindicate insertion of the IUCD at this time, ensure that the woman is ready to have an IUCD inserted. Answer any questions the woman might have; provide reassurance, as needed.	 <p><i>Just as the woman should be talked to and supported during labor and delivery, it is important continue these behaviors throughout the IUCD insertion procedure.</i></p>
13.	Open the PPIUCD kit/tray and arrange insertion instruments and supplies in a sterile field. Keep the IUCD in its sterile package to side of the sterile field. Place a dry, sterile cloth on the woman's abdomen.	 <p><i>To prevent infection, it is critical that all instruments and supplies have been properly processed and are protected in a sterile field. The IUCD should be to the side because it is in a package whose exterior is not sterile. The sterile towel on the woman's abdomen will protect the provider's hand from contamination while "elevating" the uterus.</i></p>

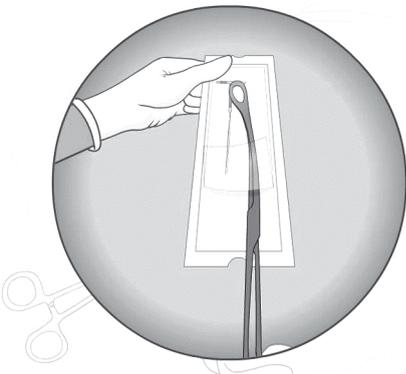
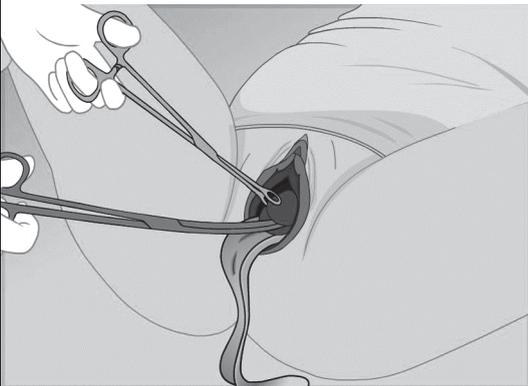
Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 14–16		
Prepare the woman's vagina and cervix for insertion.		
14.	Gently insert the Simms speculum and visualize the cervix by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, gently apply fundal pressure so that the cervix descends and can be seen.)	 <p>The provider holds the Simms or other appropriate speculum in her/his left (or nondominant) hand and uses it to visualize the cervix.</p> <p>It is usually not necessary to have an assistant hold the speculum in place, but if the provider is having difficulty, an assistant may use the retractor to gently visualize the cervix.</p>
15.	Clean the cervix and vagina with antiseptic solution two times, using two gauzes (a separate gauze each time).	 <p>Using betadine or chlorhexadine to gently clean the cervix and edges of the vagina helps to prevent infection.</p>
16.	Gently grasp the anterior lip of the cervix with the ring forceps. (The speculum may be removed at this time, if necessary.) Let the forceps out of your hand, keeping them attached to the cervix.	 <p>The same ring forceps that was used to clean the cervix and edges of vagina can be used to grasp the anterior lip of the cervix and apply gentle traction.</p>

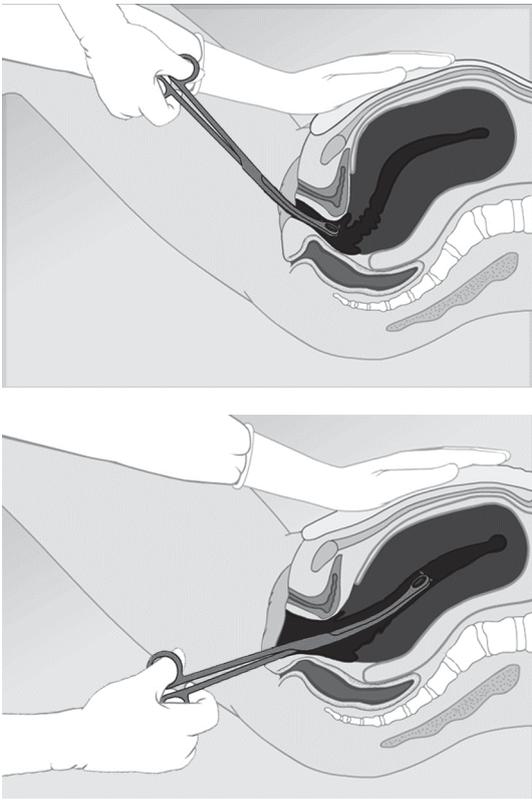
Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 17–19		
Open the IUCD package and remove IUCD.		
17.	<p>Open the sterile package of the IUCD from the bottom, by pulling back the plastic cover approximately one third of the way.</p>	 <p>The “no-touch” technique for removing the IUCD from the package (Steps 17 to 19) helps to ensure that the IUCD remains perfectly sterile throughout the insertion procedure.</p>
18.	<p>Remove everything except the IUCD from the package:</p> <ul style="list-style-type: none"> □ Holding the IUCD package at the closed end with the nondominant hand, stabilize the IUCD in the package by pressing it between the fingers and thumb of the nondominant hand—through the package. □ With the other hand, remove the plunger rod, inserter tube and card from the package. 	 <p>The plunger rod and inserter tube are not needed for the postpartum insertion of the IUCD. The card will not be needed until later.</p>

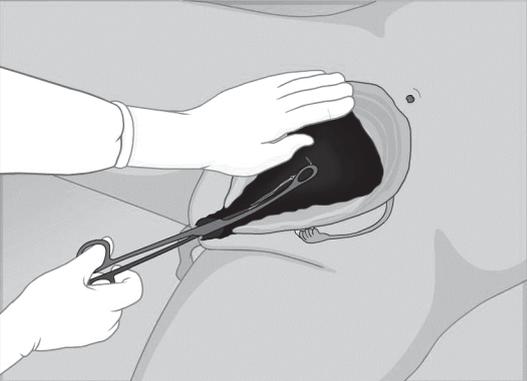
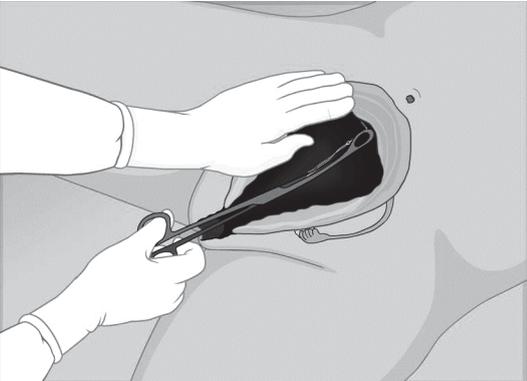
Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 17–19		
Open the IUCD package and remove IUCD. (cont.)		
19.	With your dominant hand, use the placental forceps to grasp the IUCD inside the sterile package .	 <p>As shown below, the IUCD should be held just at the edge of the placental forceps so that the IUCD will be easily released from the forceps when they are opened at the uterine fundus.</p> 
Steps 20, 21		
Insert the IUCD gently, using the “no-touch” technique.		
20.	Gently lift the anterior lip of the cervix using the ring forceps, adjusted to one notch.	Lifting the anterior lip opens the cervical os to allow the IUCD to pass through.
21.	<ul style="list-style-type: none"> □ While avoiding touching the walls of the vagina, insert the placental forceps—which are holding the IUCD—through the cervix and into the lower uterine cavity. □ Gently move the IUCD further into the uterus, toward the point where slight resistance is felt against the back wall of the lower segment of the uterus. Be sure to keep the placental forceps firmly closed. □ Lower the ring forceps and gently remove them from the cervix; leave them in the sterile field. 	 <p>Limiting the extent to which the IUCD comes in contact with the vaginal walls helps to prevent infection. Keeping the placental forceps firmly closed helps avoid dropping the IUCD midcavity during insertion. Forceps are placed in the sterile field in case they are needed again.</p>

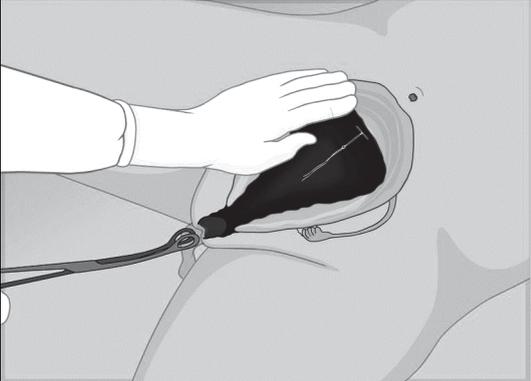
Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 22–24	“Elevate” the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached.	
22.	<p>“Elevate” the uterus:</p> <ul style="list-style-type: none"> □ Place the base of your nondominant hand on the lower segment of the uterus (midline, just above the pubic bone with the fingers toward the fundus). □ Through the abdominal wall, push the entire uterus superiorly (in the direction of the woman’s head). □ Maintain this position to stabilize the uterus during insertion. 	<p><i>This maneuver, elevating the uterus, is done to smooth out the angle between the uterus and the vagina so that the instrument can easily move upward toward the uterine fundus.</i></p> 

Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 22–24	“Elevate” the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached. (cont.)	
23.	<p>Keeping the forceps closed, advance the IUCD by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gently moving the IUCD upward toward fundus, in an angle toward the umbilicus. <input type="checkbox"/> Lowering the dominant hand (the IUCD/forceps-holding hand), so that the forceps can pass easily through the vagino-uterine angle. <input type="checkbox"/> Following the contour of the uterine cavity. <input type="checkbox"/> If significant resistance is felt before the fundus is reached, the provider should try repositioning the uterus (again, by gently pushing it upward) and re-attempt to advance the instrument. 	 <p>The provider moves the instrument upward in the uterus, following an arc toward the umbilicus, to negotiate the angle between the vagina and uterus more easily. Even though the angle has been lessened by “elevation” of the uterus (Step 22), insertion still requires careful technique.</p> <p>Note: Throughout this part of the procedure, the provider should (1) take care not to apply excessive force (if not careful, the provider could perforate the back wall of the uterus); and (2) always keep the instrument closed so that the IUCD is not inadvertently dropped in the midportion of the uterine cavity.</p>
24.	<p>Continue gently advancing the forceps until the uterine fundus is reached, when you will feel a resistance. Confirm that the end of the forceps has reached the fundus.</p>	 <p>When the instrument reaches the uterine fundus, the provider will feel resistance. She/he may also be able to feel the instrument at the fundus with her/his nondominant hand through the abdominal wall.</p> <p>Note: An added advantage of the Kelly placental forceps is that the broad ring at the distal end makes it extremely unlikely that the forceps will perforate the uterine fundus.</p>

Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 25–27		
Release the IUCD at the fundus and withdraw the forceps, being careful not to dislodge the IUCD.		
25.	While continuing to stabilize the uterus, open the forceps , tilting them slightly toward midline, to release the IUCD at the fundus.	
26.	Keeping the forceps slightly open, slowly remove them from the uterine cavity , being careful not to dislodge the IUCD. Do this by: <ul style="list-style-type: none"> <input type="checkbox"/> <u>Sweeping the forceps</u> to the side wall of the uterus, and <input type="checkbox"/> <u>Sliding the instrument</u> against the side of the uterine wall. 	 <p><i>Keep the nondominant hand in position to maintain stabilization of the uterus. This aids in proper placement of the IUCD.</i></p> <p><i>If the forceps close and/or catch the strings of the IUCD, the forceps can inadvertently pull the IUCD down from its fundal position, and increase the risk of expulsion.</i></p>
27.	Keep stabilizing the uterus until the forceps are completely withdrawn. Place the forceps aside, in the sterile field.	 <p><i>Forceps are returned to the sterile field in case they are needed again.</i></p>

Handout 6: Postpartum Insertion of the IUCD—A Process

Insertion of the IUCD		
No.	Step	Explanation/Additional Guidance
Steps 28, 29	Examine the cervix and begin processing instruments.	
28.	<p>Examine the cervix to see whether any portion of the IUCD or the IUCD strings are protruding from the cervix.</p> <p>If the IUCD or the IUCD strings are seen protruding from cervix:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Remove the IUCD using the same forceps used for the first insertion; <input type="checkbox"/> Position the same IUCD in the forceps inside the sterile package (as in Steps 18 and 19); and <input type="checkbox"/> Reinsert the device (repeating Steps 20–27). 	<p><i>It is important to check that the IUCD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUCD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher.</i></p> <p><i>The same IUCD can be reinserted if it has not been contaminated.</i></p>
29.	Remove all instruments and place them in a 0.5% chlorine solution.	<i>This is the first step in infection prevention processing. Forceps should be “open”; all instruments should be totally submerged.</i>
Tasks to Perform after Insertion		
No.	Step	Explanation/Additional Information
Steps 30–33	While the woman rests, continue infection prevention measures.	
30.	Allow the woman to rest for a few minutes. Support the initiation of routine postpartum care, including immediate breastfeeding as appropriate.	<i>The woman should rest on the table for several moments following the insertion procedure. Routine care for the mother and baby become the provider’s focus now.</i>
31.	Dispose of waste materials in the appropriate container(s).	<i>Because this insertion has taken place immediately after a vaginal delivery, the provider should follow all routine delivery-related infection prevention practices, as well as those described earlier in this Handout.</i>
32.	<p>Process gloves prior to removal and disposal.</p> <ul style="list-style-type: none"> <input type="checkbox"/> Immerse both gloved hands in 0.5% chlorine solution. <input type="checkbox"/> Remove gloves by turning them inside out and properly dispose of them. 	
33.	Perform hand hygiene.	

Handout 6: Postpartum Insertion of the IUCD—A Process

Tasks to Perform after Insertion		
No.	Step	Explanation/Additional Information
Steps 34–36	Provide post-insertion counseling and update records.	
34.	<p>Tell the woman that the IUCD has been successfully placed and provide her with post-insertion counseling, including IUCD instructions. Tell her these instructions will be provided again prior to discharge.</p> <p>Reassure her and answer any questions that she may have.</p>	 <p><i>IUCD instructions should be provided again by the staff of the postpartum unit to the woman, and perhaps to her family, to be certain that the instructions are understood. If possible, instructions should also be provided to the woman in writing, for her to take home.</i></p>
35.	<p>Record information in the woman's chart or record. Attach an IUCD card to the chart/record, for the woman to take home with her upon discharge.</p>	<p><i>Including essential information regarding the IUCD insertion in the woman's record (and on a card she can take with her) helps facilitate appropriate clinical follow-up, including proper timing for removing the IUCD and inserting a new one or switching to a different family planning method, as the woman desires.</i></p>
36.	<p>Record information in the procedure room register.</p>	<p><i>Basic information should also be recorded, along with contact information, in a PPIUCD register to ensure that the PPFPP/PPIUCD program is being successfully implemented.</i></p>

Postplacental Manual Insertion

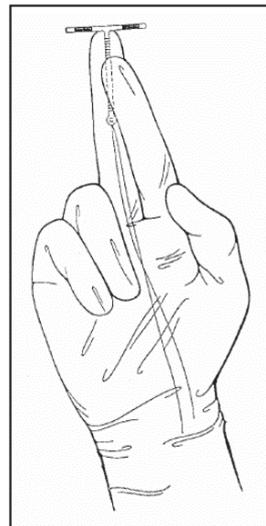
Following a service delivery scenario similar to that for postplacental instrumental insertion, manual insertion of the IUCD—using the provider's own hand—is also done immediately following delivery of the placenta, typically within 10 minutes. Key differences are highlighted in the box below.

Handout 6: Postpartum Insertion of the IUCD—A Process

For postplacental manual insertion, use elbow-length sterile or HLD gloves and supplement Steps 19 to 27 in the illustrated guide “*Postplacental Insertion of the IUCD Using Forceps*” (pages 2-37 to 2-47), with the following:

- Grasp and hold the IUCD by gripping its vertical rod between the index and middle fingers of the dominant hand (Figure 8).
- Move the nondominant hand up onto the abdomen. Stabilize and “elevate” the uterus with firm upward pressure through the abdominal wall.
- Slowly insert the IUCD-holding hand into the vagina and through the cervix. Limit the extent to which the IUCD comes in contact with the vaginal walls.
- Gently move the IUCD-holding hand in an upward motion toward the fundus (in an angle toward the umbilicus), taking care to follow the contour of the uterine cavity.
- By feeling the uterus through the abdominal wall, confirm with the abdominal hand that the IUCD-holding hand has reached the fundus.
- Release the IUCD at the fundus and slowly remove the hand from the uterus. Take particular care not to dislodge the IUCD as the hand is removed.
- Keep the nondominant hand in place to stabilize the uterus until the other hand is completely out of the uterus.

Figure 8. Manual IUCD Insertion



Intracesarean Insertion

For intracesarean insertion, the woman has been counseled and prepared prior to the start of the operation, preferably during the antenatal period. She will still be in the operating theater, in the lithotomy position on the operating table. Typically, manual insertion is sufficient (as opposed to instrumental insertion) because the provider can easily reach the uterine fundus. After the placenta is removed, the provider:

- Holds the IUCD between the index and middle fingers of the hand, passes it through the uterine incision and places it at the uterine fundus;
- Slowly withdraws the hand, ensuring that the IUCD remains properly placed; and
- Closes the uterine incision, taking special care not to incorporate the IUCD strings into the suture.

Note: The strings can be pointed toward the cervix but should NOT be pushed through the cervical canal. This helps prevent both uterine infection (caused by contamination of the uterine cavity with vaginal flora) and displacement of the IUCD from the fundus (caused by drawing the strings downward toward the cervical canal).

Early Postpartum Insertion

Early postpartum insertion is done after the immediate postplacental period has passed but within 48 hours of the birth. If the woman has not yet received counseling, a designated family planning counselor or postpartum caregiver can provide group PPF education/counseling on the postpartum ward, followed by individual PPIUCD counseling to women who are interested in the method. The same postpartum caregiver or another trained provider can insert the IUCD in a procedure or examination room on the postpartum ward. It is preferable that postpartum insertion be done within 24 hours of birth—for example, on the morning of postpartum Day 1, rather than Day 2—to reduce expulsion rates and also to avoid logistical issues at the time of postpartum discharge.

Handout 6: Postpartum Insertion of the IUCD—A Process

Postpartum insertion is essentially the same as postplacental instrumental insertion, but the process of uterine involution is under way and several anatomic changes that may have an influence on the instruments or technique used should be noted:

- **The cervix will have become firmer and will begin to resume its round, tubular shape.**

For this reason, manual insertion is not possible and should not be attempted. These changes may also have an impact on which type of forceps works best.

- Although the ring forceps can still be used to grasp the cervix, slightly more pressure may be required to close them (on the cervix).

- If the provider notes some difficulty in passing the Kelly placental forceps through the cervix, due to the width of the distal ring of the instrument in relation to the dilation of the cervix, she/he should consider using a second ring forceps to introduce the IUCD. The provider should ensure that the ring forceps are long enough to reach the fundus. It is possible that a normal ring forceps will be sufficient, depending on how much involution of the uterus has taken place.

- **The uterus has begun to resume its original anteverted or retroverted position;** therefore, it may become slightly more difficult to advance the instrument through the uterus to the fundus. However, it is still critically important to reach the uterine fundus. Failure to reach the uterine fundus is likely a principal factor in the higher spontaneous expulsion rates that occur following early postpartum insertion compared to immediate postplacental insertion. Additional care should be taken.

- The provider must ensure that the IUCD is placed at the uterine fundus and should visually examine the cervix following insertion.

- If the IUCD is visible, or if the strings seem inappropriately long, the provider should consider whether the IUCD is at the fundus. If there is doubt, it is better to remove the IUCD and reinsert it.

Immediate Post-Insertion Care and Counseling

After the insertion procedure, global standards/local protocols for postpartum and newborn care should be observed. The woman who has just had an IUCD inserted should have additional counseling, focused on correct use of the IUCD, timely management of problems that may occur and return for follow-up. (Management of IUCD/PPIUCD-related problems is covered in the next handout.) This counseling should be done by the provider who inserted the IUCD when the woman is rested and able to concentrate.

- For women who receive a postplacental or an intracervical insertion, counseling is best done the following day, when the woman has rested and is better able to concentrate.

- If the insertion was done in the early postpartum period (not immediate but within 48 hours), the post-insertion counseling can be done shortly after the insertion.

Immediate Care

The client should be advised to report any of the following, which should be promptly addressed:

- **Increase in vaginal bleeding.** Vaginal hemorrhage related to uterine atony should be managed—per global standards/local protocols—with uterine massage and uterotonics, as necessary. Note that the PPIUCD does not increase the risk of uterine atony.

Handout 6: Postpartum Insertion of the IUCD—A Process

- **Severe uterine cramping.** If this persists after PPIUCD insertion, a speculum or bimanual exam should be performed to check for partial or complete expulsion. (See page 2-52.)
- **Feeling feverish.** Fever should prompt a full clinical evaluation to determine the source. In the presence of presumed endometritis, an accepted antibiotic regimen should be used for treatment. (See page 2-56.) Note that it is not necessary to remove the IUCD while treating presumed endometritis.

Take-Home Messages

Provide reassurance and advise the woman to:

- Expect lochia but note heavy bleeding or blood clots.
- Be aware that postpartum symptoms, such as intermittent vaginal bleeding and cramping, are normal for the first 4 to 6 weeks postpartum—and may be hard to distinguish from IUCD side effects.
- Take ibuprofen, paracetamol or other pain reliever as needed. (Aspirin is not advised in the early postpartum period because it has an anti-blood-clotting effect.)
- Regarding possible IUCD expulsion:
 - Spontaneous expulsion is most likely to occur during the first 3 months postpartum.
 - Check the bed sheets in the morning and your undergarments when you change clothes.
 - At 6 weeks postpartum, you may be able to feel the IUCD strings. It is not necessary to check for them, but if you do, do not pull on them.
 - Your provider will check for the strings when you return for your postpartum visit. That is why it is important for you to return to see the same provider, or at least someone in the same clinic, who is aware of PPIUCD services.
- Continue to exclusively breastfeed your baby, as appropriate; the IUCD and breastfeeding do not interfere with each other.
- Remember that the IUCD does not protect against STIs and HIV.
- Resume intercourse at any time you feel ready; the IUCD offers full protection against pregnancy immediately upon insertion.
- Return for removal of the IUCD any time you wish (up to 12 years); after the IUCD is removed, fertility will return immediately.

When to Return

Before discharge, the following **danger signs** should be highlighted. The client should be advised to call or return to the facility immediately for assessment if any of these signs occur:

- Heavy vaginal bleeding
- Severe lower abdominal discomfort
- Fever
- Not feeling well

The client should also call or come in if any of the following occur:

- Unusual vaginal discharge is present.
- IUCD expulsion is suspected—woman can either feel IUCD in the vagina or has seen it expelled from the vagina.
- She has any other problems/questions related to her IUCD.
- She wants the IUCD removed or 12 years have elapsed since IUCD insertion.

Reminder Card for the PPIUCD Client

If possible, give the client a card with the following information in writing:

- Type of IUCD inserted
- Date of IUCD insertion
- Month and year when IUCD will need to be removed or replaced
- Date of postpartum/PPIUCD follow-up visit
- Where to go or call if she has problems or questions about her IUCD

Handout - 7. Routine Follow-Up of the PPIUCD User and Management of Potential Problems

The long-term success of any family planning program can be achieved only when service providers and other staff recognize the importance of providing strong support services to their clients. High-quality follow-up care for family planning clients contributes to greater user satisfaction, as well as to safe, effective and continued use of the method.

Once the IUCD is in place, patient care and advice are almost identical for women who have had an interval or a postpartum insertion. Routine follow-up for many PPIUCD users (at 4 to 6 weeks) may involve little more than answering questions and reinforcing key messages. Some users, such as those who are bothered by side effects, may require additional care and support. Serious problems related to IUCD use are uncommon, but when they do occur, prompt and appropriate management is essential.

Routine Follow-Up Care for PPIUCD Clients

Key objectives of follow-up care are to:

- Assess the woman's overall satisfaction with the IUCD
- Identify and manage potential problems
- Address any questions or concerns the woman may have
- Reinforce key messages regarding removal and duration of action

Follow-up for women who receive an IUCD in the immediate or early postpartum period should be integrated with postpartum care per global standards/local protocols. In addition to the usual elements of the postpartum check-up, the following should be addressed in all women who report (or whose records indicate) PPIUCD insertion:

- Ask the client if she has experienced any problems and if she thinks the IUCD has fallen out.
- Do a clinical assessment for anemia if she complains of excessive or prolonged bleeding.
- If possible, perform a speculum examination to see whether the IUCD strings have descended into the vagina. If they appear long, trim them so that approximately 3–4 cm of string protrudes from the cervix.
- Conduct a pelvic examination only if the following conditions are suspected: an STI or PID, suspected partial or complete expulsion, pregnancy. Routine pelvic examination at any subsequent follow-up visit is not required.
- Provide counseling and treatment for side effects, as needed.
- Advise the client to return if she is concerned about possible IUCD-related problems or if she wants it removed or to change to another family planning method.
- Review danger signs that indicate a need to return to the clinic immediately.

Handout 7: Follow-Up of the PPIUCD User

- Remind the client to keep monitoring for possible IUCD expulsion during/after her first few menstrual periods.
- Encourage use of condoms for STI protection, as appropriate.

If the IUCD has been expelled, offer the client another contraceptive method or plan to insert another IUCD, if she wishes. The IUCD may be reinserted the same day as expulsion if: there is no sign of infection; pregnancy is not suspected; and it is NOT between 48 hours and 4 weeks after the client's delivery.

If the IUCD is in place and the client has no problems, no other follow-up visits are required. Annual checks of the IUCD are not necessary. Clients should be advised to return for removal as desired but no later than the recommended length of pregnancy protection (12 years for the Copper T).

Who Should Do It/Where

If possible, the provider who did the insertion should do the clinical follow-up, at the same facility where the insertion was done. This helps to ensure the client continuity of care; it also enables the provider to see the clinical results of his/her care and establish a “personal expulsion rate”—with the aim of strengthening his/her technique as needed. Follow-up also greatly enhances the ability to track a PPFPP/PPIUCD program's success and make improvements as necessary. Information from the insertion registers should be available during follow-up, so that there can be correlation of findings. (A sample data collection form is included as Annex K.)

If it is not possible or practical for follow-up to be done by the same provider at the same facility, it can be done by a provider clinically oriented to PPIUCD services in a facility that has the minimum set-up needed for conducting counseling and performing pelvic exams—as well as referral capacity for ultrasound, as needed. Ideally, the provider/facility would be able to report back on the findings to the originating PPFPP/PPIUCD program.

When It Should Be Done

The WHO currently recommends at least one postpartum visit by 6 weeks after delivery.⁴¹ This is a good opportunity for women who have had an IUCD inserted in the immediate/early postpartum period to receive PPIUCD follow-up services because by 6 weeks postpartum, the uterus has undergone complete involution. In any case, PPIUCD follow-up should happen within the first 3 months postpartum, because the majority of expulsions occur during this time.

Identification and Management of Common Side Effects and Potential Problems⁴²

Most side effects associated with the use of IUCDs are not serious and will resolve spontaneously. And most IUCD-related problems can be avoided through:

- Careful screening of clients
- Meticulous attention to appropriate insertion technique
- Strict adherence to correct infection prevention techniques

Handout 7: Follow-Up of the PPIUCD User

- Performing PPIUCD insertion procedures slowly and gently to assure technical accuracy and client comfort and safety

Some problems that may arise, however, require specific management. The purpose of the guidelines provided in Table 6 is to assist the health care provider in providing appropriate support for a woman who experiences such side effects or problems. In most cases, the woman can continue to use the IUCD while awaiting or undergoing evaluation. Some of the problems associated with IUCD use that require specific management include:

- Changes in menstrual bleeding patterns
- Cramping or pain
- Infection
- IUCD string problems (or possible IUCD expulsion)
- Partial or complete IUCD expulsion (confirmed)
- Pregnancy with an IUCD in place

General management principles are as follows:

- The woman should be reassured and provided with any information she needs to support her in continuing (or discontinuing) the method, as appropriate and as she desires.
- If problems are encountered that are not covered in the management guidelines, the provider should conduct further evaluation and provide treatment according to global standards/local protocols (refer if needed).
- If the provider does not have the training or resources to perform any of the assessments, procedures or treatments indicated in the management guidelines, she/he should refer the woman to an appropriate facility.
- If the woman wants the IUCD removed for any reason, and/or to use a different contraceptive method, the provider should remove the IUCD or schedule an appointment (or refer) for IUCD removal, as appropriate. Guidance for IUCD removal is provided in Annex H.

Table 6. Identification and Management of Common Side Effects and Problems Encountered at Follow-Up

Problem (Signs/Symptoms)	Explanation	Management
<p>Changes in Menstrual Bleeding Patterns</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increase in amount of menstrual bleeding above what is usually expected in the postpartum period <input type="checkbox"/> Increase in duration of menstrual bleeding above what is usually expected in the postpartum period <input type="checkbox"/> Spotting/light bleeding between periods once they resume postpartum 	<p>Changes in menstrual bleeding patterns are a common side effect among IUCD users, regardless of timing of insertion.</p> <p>In the first 6 weeks postpartum, such changes may be masked by the usual irregular bleeding and spotting associated with uterine involution during the postpartum period. Also, for a woman who is exclusively breastfeeding her baby, amenorrhea is likely up to 6 months—whether or not she is using an IUCD.</p> <p>Menstrual changes caused by the IUCD are usually not harmful to the woman and diminish or disappear within the first few months after IUCD insertion. If, however, these symptoms are severe, persistent or accompanied by certain other signs/symptoms, they require special follow-up.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Determine severity of symptoms: how much more bleeding than usual; how long have symptoms lasted; when did the symptoms start; are they accompanied by other symptoms (e.g., pain, fever); how well is the woman tolerating them? <input type="checkbox"/> If symptoms are mild and consistent with uterine involution, provide reassurance. <input type="checkbox"/> Where appropriate, rule out other gynecologic pathology and refer her to a qualified practitioner, if indicated. <input type="checkbox"/> Where appropriate, rule out pregnancy by history or available testing. <input type="checkbox"/> Where appropriate, check for IUCD expulsion: palpate strings on bimanual exam or by using a speculum. <input type="checkbox"/> If client desires treatment, offer a short course of NSAIDs, continued for 3 to 5 days. If heavy bleeding is the problem, aspirin should not be used because it has an anti-blood-clotting effect. <input type="checkbox"/> If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anemia (e.g., pallor, weakness), offer iron replacement therapy and consider IUCD removal with the patient's consent. <input type="checkbox"/> If client finds bleeding unacceptable, remove IUCD and counsel her regarding alternative methods of family planning.
<p>Cramping or Pain</p> <ul style="list-style-type: none"> <input type="checkbox"/> Increased cramping or pain that may or may not be associated with menstruation 	<p>Mild intermittent cramping may occur in the first few weeks after IUCD insertion, but is generally masked by the usual cramping associated with uterine involution postpartum (“afterpains”).</p> <p>Increased cramping and pain may also be noted with return of menstruation and is a common side effect among IUCD users. Special follow-up is needed if symptoms are bothersome, severe or associated with other signs/symptoms.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Determine severity of symptoms: how severe is pain; how long has pain lasted, when did pain start; is pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain? <input type="checkbox"/> Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test; complete blood count [CBC], cultures) to rule out other possible causes of pain or infection; partial IUCD expulsion, such as: uterine perforation; pregnancy/ectopic pregnancy; urinary tract infection. If appropriate, see section for management of infection (page 2- 56) and pregnancy with the IUCD in place (page 2- 58). <input type="checkbox"/> If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure the woman. <input type="checkbox"/> Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping that are bothersome to the client. <input type="checkbox"/> If cramping or pain is severe, remove the IUCD. If the IUCD was improperly placed, partly expelled or appeared to be abnormal/distorted, discuss insertion of a new IUCD with the client. If the IUCD appeared to be normal and in proper position, counsel the woman regarding alternative forms of family planning.

Problem (Signs/Symptoms)	Explanation	Management
<p>Infection</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lower abdominal pain <input type="checkbox"/> Fever <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Bleeding after sex or between periods once resumption of normal monthly menses has occurred postpartum <input type="checkbox"/> New onset of pain associated with periods <input type="checkbox"/> Abnormal vaginal discharge <input type="checkbox"/> Nausea and vomiting 	<p>Although the risk of infection after interval IUCD insertion is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhea or chlamydia infection. Similar risk estimates are not available for PPIUCD insertion, but studies suggest the risk is very low. Because pelvic infection can lead to infertility and other serious problems, providers should treat all suspected cases. Of note, the IUCD should never be inserted when puerperal infection such as chorioamnionitis or endometritis is suspected.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems, such as: endometritis, appendicitis, partial IUCD expulsion, uterine perforation, pregnancy/ectopic pregnancy or urinary tract infection. If appropriate, see section for management of pregnancy with the IUCD in place (page 2-58). <input type="checkbox"/> Suspect PID if any of the following signs/symptoms are found and no other causes can be identified: <ul style="list-style-type: none"> <input type="checkbox"/> Lower abdominal, uterine or adnexal tenderness (tenderness in the ovaries or fallopian tubes) <input type="checkbox"/> Evidence of cervical infection: yellow cervical discharge containing mucus and pus, cervical bleeding when it is touched with a swab, positive swab test <input type="checkbox"/> Tenderness or pain when moving the cervix and uterus during bimanual exam (cervical motion tenderness) <input type="checkbox"/> Other possible sign/symptoms: purulent cervical discharge, enlargement or hardening (induration) of one or both fallopian tubes, a tender pelvic mass, pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness) <input type="checkbox"/> If endometritis or PID is suspected, begin treatment immediately with an appropriate antibiotic regimen per global standards/local protocols for gonorrhea, chlamydia and anaerobic infections. Remove the IUCD only in the presence of sepsis or if symptoms do not improve within 72 hours. Studies have not indicated that removing the IUCD affects outcomes of PID treatment.³⁴ <input type="checkbox"/> If the woman does not want to keep the IUCD in during treatment, remove the IUCD 2 to 3 days after antibiotic treatment has begun. <input type="checkbox"/> Where appropriate and when an STI is suspected, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner.

Problem (Signs/Symptoms)	Explanation	Management
<p>IUCD String Problems (Missing, Long, Short)</p>	<p>Missing or longer or shorter-than-expected strings may indicate a variety of problems, including pregnancy, IUCD expulsion and IUCD malpositioning. Sometimes there is no real problem at all—it is simply that the strings have not descended yet. In some circumstances, the IUCD strings may never descend through the cervix into the vagina following postpartum insertion.</p> <p>Because strings are not trimmed at postpartum insertion, they typically extend well into the middle of the vagina and perhaps all the way to the vulva by 4 to 6 weeks postpartum.</p> <p>Remember: IUCD strings are not related to efficacy; their purpose is to facilitate removal and confirmation of intrauterine positioning only.</p>	<p>Missing Strings (Annex I presents a job aid for managing missing strings.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ask the woman if she thinks the IUCD has fallen out. <input type="checkbox"/> Rule out pregnancy by history or laboratory examination. <input type="checkbox"/> Probe the cervical canal using an HLD or sterile cervical brush or narrow forceps (e.g., Bose, alligator) to locate the strings and gently draw them out so that they are protruding into the vaginal canal. <input type="checkbox"/> If the strings are not located in the cervical canal, refer the woman for an X-ray or ultrasound to confirm normal intrauterine positioning. Provide a back-up method while waiting for results. Manage as appropriate based on findings: <input type="checkbox"/> If the IUCD is located inside the uterus and the woman wants to keep the IUCD, do not remove it. Explain to her that the IUCD is still protecting her from pregnancy but that she will no longer be able to feel the strings. Review signs and symptoms of spontaneous expulsion. <input type="checkbox"/> If the IUCD is located inside the uterus and the woman wants it removed, refer her for IUCD removal by a specially trained provider. <input type="checkbox"/> If the IUCD cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUCD expulsion (below). <p>Long Strings</p> <p>Trim strings, as needed, up to 3–4 cm from cervical os.</p> <p>Short Strings (if Bothersome to Woman or Partner)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reassure the woman and her partner that the strings are very flexible and not harmful. <input type="checkbox"/> If it is very bothersome, advise the woman that the IUCD strings can be cut shorter, so that the string curves around the cervical lip. Trim as needed.

Problem (Signs/Symptoms)	Explanation	Management
<p>Partial or Complete IUCD Expulsion</p> <ul style="list-style-type: none"> <input type="checkbox"/> New onset of irregular bleeding and/or cramping <input type="checkbox"/> Expelled IUCD seen (complete expulsion) <input type="checkbox"/> IUCD felt/seen in the vaginal canal (partial expulsion) <input type="checkbox"/> Delayed or missed menstrual period (See Pregnancy with an IUCD in Place, below.) <input type="checkbox"/> Missing or longer strings (See IUCD string problems, page 2- 57) 	<p>Partial or complete IUCD expulsion can occur “silently” (with no signs/symptoms) or it may be associated with other signs/symptoms, such as: missing or longer than expected IUCD strings, or a delayed or missed menstrual period. The following guidelines address management of confirmed partial or complete IUCD expulsions.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Conduct an appropriate assessment, including: pelvic examination to rule out other possible causes of symptoms such as infection and pregnancy. <input type="checkbox"/> When other possible causes of symptoms are ruled out, manage based on findings. <input type="checkbox"/> If complete expulsion of the IUCD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): replace IUCD immediately, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method. <input type="checkbox"/> If partial IUCD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUCD and replace it, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method. <input type="checkbox"/> If the IUCD appears to be embedded in the cervical canal and cannot be easily removed in the standard fashion: refer the woman for IUCD removal by a specially trained provider. <input type="checkbox"/> If complete expulsion of the IUCD is confirmed and pregnancy diagnosed, manage ANC per national and regional standards.
<p>Pregnancy with an IUCD in Place⁴³</p> <ul style="list-style-type: none"> <input type="checkbox"/> Delayed or missed menstrual period <input type="checkbox"/> Other signs/symptoms of pregnancy <input type="checkbox"/> Missing strings <input type="checkbox"/> Strings that are shorter or longer than expected 	<p>Although the IUCD is one of the most effective forms of reversible contraception, failures can occur. Approximately one-third of IUCD-related pregnancies are due to undetected partial or complete expulsion of the IUCD. When pregnancy does occur with an IUCD in place, ectopic pregnancy must be ruled out and the IUCD should be removed. If the IUCD is left in place during pregnancy, there is an increased risk of preterm labor, spontaneous abortion and septic abortion.</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to global standards/local protocols and refer to an appropriate provider, if needed. <input type="checkbox"/> Rule out ectopic pregnancy: sharp/stabbing abdominal pain (which is often unilateral), abnormal vaginal bleeding, light-headedness/dizziness, fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a facility with surgical capability. <input type="checkbox"/> When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester: <ul style="list-style-type: none"> <input type="checkbox"/> Counsel the woman on the benefits and risks of immediate removal of the IUCD. Removing the IUCD slightly increases the risk of miscarriage; leaving the IUCD in place can cause second trimester miscarriage, infection and preterm delivery. <input type="checkbox"/> If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUCD is still in the uterus or has been expelled. If the IUCD is still in place, it cannot be safely removed. Follow, as below, with plans to remove the IUCD at delivery. <input type="checkbox"/> If the woman declines removal, provide support and care per standard global guidelines/local protocols and arrange close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Plan to remove the IUCD at delivery.

Handout - 8. PPIUCD Clinical Services

Provision of PPIUCD clinical services can only be safely accomplished in a clinical facility that has adequate infrastructure, supplies/equipment and personnel. Although counseling and assessment may take place during normal working hours through the ANC delivery system, insertion of the PPIUCD—especially using the postplacental or intracesarean approaches—can take place at any time, day or night. For this reason, PPIUCD services must be integrated with the delivery care system for intrapartum care; all personnel of the obstetrics/maternity care team should be oriented to PPIUCD service provision. This helps to ensure that counseling messages are uniform and consistent, and that accurate information is disseminated during the period when PPIUCD services are being established, both of which are key to generating demand.

Provision of PPIUCD services requires careful coordination and collaboration of antenatal, intrapartum and postpartum care services—both in the community and the facilities.

Each program and clinical facility will determine which insertion technique is appropriate for implementation based on its staffing and service delivery capacity as well as on national and local norms and policies.

Considerations for Starting a PPIUCD Program

Any facility that provides basic obstetric care, including intrapartum care services, can be prepared to offer PPIUCD clinical services to women. It is recommended that clinical services be provided by a health care provider—such as a midwife, nurse or doctor—who has been trained to competency in PPIUCD service provision.

During the initial analysis of a facility to determine the best way to establish PPIUCD services, it is important to review the patterns of care, clinical volume and staff responsibilities. Consider the following factors that will be important to address during program start-up:

- Where are family planning services provided now? Is there an existing mechanism for providing family planning to women in the postpartum ward? How can IUCDs be made available on the labor and delivery unit?
- Who currently provides family planning counseling and services? Will different or the same providers provide PPIUCD services? What experiences do these providers have in counseling and IUCD insertion techniques?
- Where do women who deliver at this facility receive their ANC? Is it in the clinic of this same facility or from an outside network of health centers? How can communication about the woman's postpartum contraceptive choice be communicated to the staff of this facility?
- Do many women who deliver at this facility arrive having received no ANC? Will they be managed or counseled differently from women who have received care at this facility?
- What is the current volume of maternity patients? What is the anticipated number of PPIUCD insertions on a monthly basis? If volume is low, how will trained providers maintain their clinical skills in insertion technique?
- How will records be maintained? What is the existing recordkeeping system for deliveries and family planning visits? Are any elements of those recordkeeping systems similar?
- With what information will the woman leave the facility after the postpartum insertion of the IUCD?

Handout 8: PPIUCD Clinical Services

Careful planning and consideration of these factors will help facility managers to introduce and successfully establish PPIUCD services.

PPIUCD insertion during cesarean section or immediately following delivery of the placenta is preferred because expulsion rates are lower, and this timeframe is more convenient for the woman. However, certain facilities may be well-equipped to provide these services to clients on the postpartum ward, during the early postpartum period. In this service delivery context, dedicated counselors and service providers can review the situation and family planning needs of women on the postpartum ward and provide care in a planned and directed manner.

Minimum Criteria for PPIUCD Service Provision

The **minimum service delivery criteria** for the safe and effective provision of PPIUCD services include:

- **Informed demand:** This is critical to the success of PPIUCD program. Women, families and communities need accurate, understandable and timely information about the PPIUCD in order to make an informed choice about PPF options. Although this information may come through group education and individual counseling targeting PPF clients, it may also be provided through other health services, mass media campaigns, community health workers/volunteers or peer recommendations. Demand also helps maintain the flow of PPIUCD clients, which enables providers to maintain skill competency and develop proficiency.
- **Infrastructure:** An outpatient care area for both antenatal screening and counseling as well as postpartum follow-up and evaluation; an intrapartum care area, where deliveries are conducted and postplacental insertions can take place; and an examination/treatment room on or near the postpartum ward, where early postpartum insertions can take place.
- **Supplies:** A delivery/examination table with footrests (or an area for the woman to place her feet); insertion instruments such as a Simms speculum, ring forceps and long forceps (e.g., Kelly placental forceps); sterile towels, sterile or HLD gloves (including long gloves if the manual insertion technique is to be practiced); antiseptic solution, such as povidone iodine (i.e., Betadine®) or chlorhexidine gluconate (i.e., Savlon® or Hibiclens®); and IUCDs in their sterile packaging.

PPIUCD programs will benefit from having “PPIUCD insertion kits” already prepared and wrapped in sterile trays. This facilitates both the safety and efficiency of the procedure.

- **Personnel:** A clinical service provider, such as a midwife, doctor or nurse, who regularly attends to women in labor and who has been trained to competency in the provision of PPIUCD services, including counseling, infection prevention, insertion/removal techniques and management of side effects or complications.
- **Coordination of care:** A system of communication and sharing of information between the ANC service, the labor/delivery unit, the postpartum ward and the outpatient postpartum care unit.
- **Management systems:** Adequate integration of all of the above so that services are provided in a manner that ensures continuity of care, good counseling, appropriate infection prevention practices and adequate follow-up.

Using Performance Standards for PPIUCD Services

Performance standards break down the tasks that a specific skill or skill set comprises into observable steps. Achievement of each standard can be verified by certain verification criteria, using a tool in a modified checklist format. This tool can serve as a self-empowering guide—by service providers, supervisors and program managers—for establishing and maintaining high-quality PPIUCD services.

- Service providers can use the PPIUCD Performance Standards assessment tool (Annex J) as a way to develop and assess their or their colleagues' clinical performance. This tool can also be used as a job aid.
- Supervisors can use the assessment tool as a specific and detailed way of providing oversight of PPIUCD services. This can allow them to provide specific feedback to providers and managers about what is being done well and the areas that may need additional attention.
- Sequential measurement of performance compared to the standards allows program managers and district/state officials to monitor the quality of service over time and be able to compare performance of facilities in a quantifiable manner.

Recordkeeping

After insertion of the IUCD, the provider should make several notations in the woman's record, as well as in a delivery or PPIUCD insertion logbook/register. In addition, when the woman returns for follow-up, the provider should make notations; if any problem is identified at this time, the insertion logbook/register should be consulted to identify factors that could have predicted or caused the problem. A sample data collection form is included as Annex K.

Maintaining careful records is critical to building a successful PPIUCD program. This is because client selection criteria and insertion technique are directly related to expulsion rate and, thus, potentially, to overall program success. If it appears that a larger than expected number of clients are returning with partially or completely expelled IUCDs, it is helpful to be able to review notations recorded at the time of insertion (e.g., findings from screenings, difficulties faced by the provider). Likewise, follow-up notations can also provide critical insights—into both successful and problematic insertions. Either way, recordkeeping allows program managers and supervisors to observe provider insertion and client assessment practices and to determine whether changes are needed.

ANNEXES, REFERENCES & KEY POINTS

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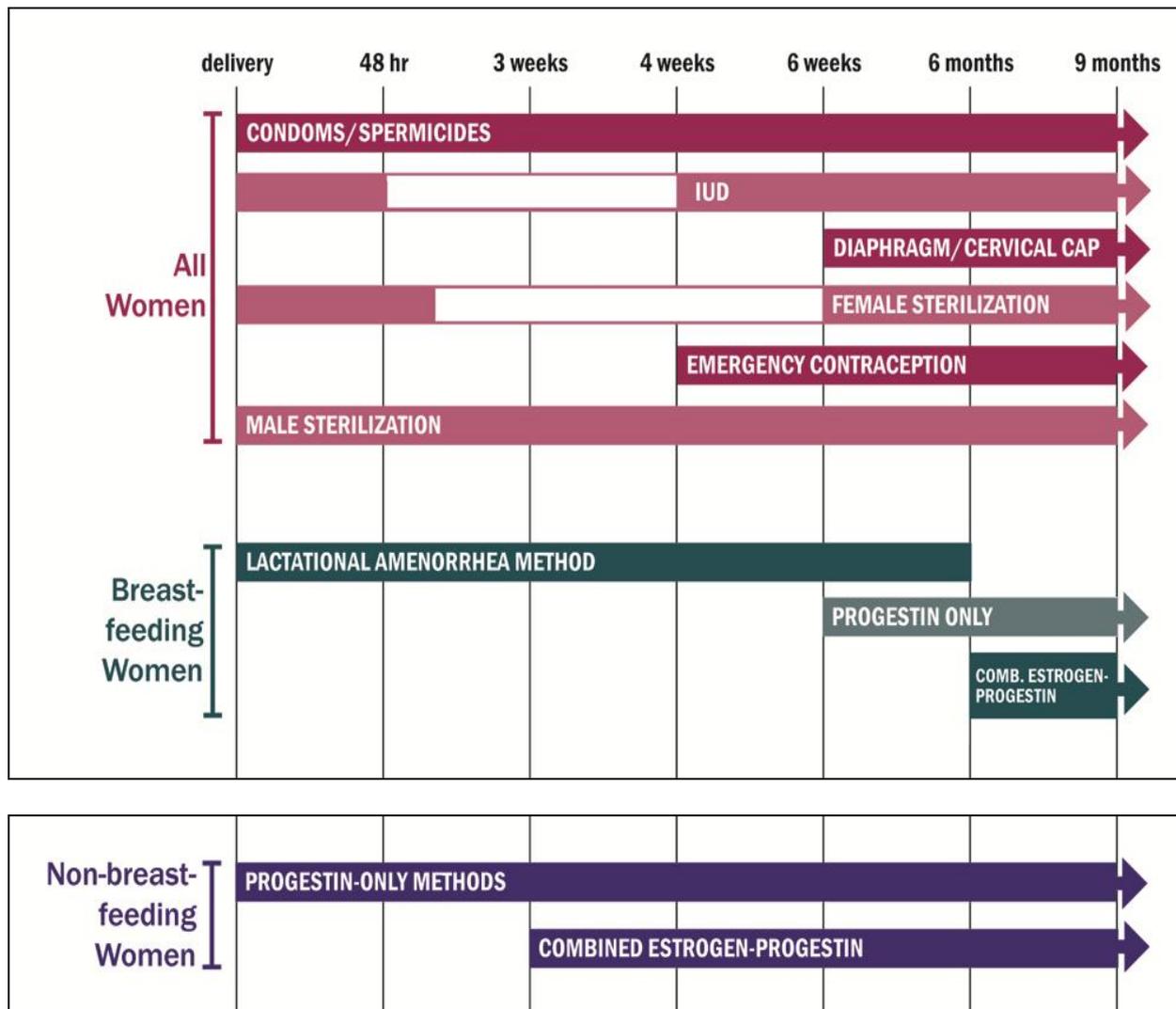
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Annex A: Key Messages for Healthy Spacing of Pregnancies

	For clients who desire a next pregnancy after a live birth	For clients who desire a next pregnancy after a miscarriage or induced abortion	For clients who desire a pregnancy and are adolescents (<18 years)
Return to Fertility	<p>If you are not exclusively breastfeeding, return to fertility may occur within 4 to 6 weeks of childbirth.</p> <p>If you do not want to become pregnant, start a family planning method of your choice shortly after birth.</p>	<p>Fertility may return as early as 2 weeks after a miscarriage or abortion.</p> <p>If you do not want to become pregnant, start a family planning method of your choice immediately after miscarriage or abortion.</p>	
Exclusive Breastfeeding	<p>Exclusive breastfeeding up to 6 months postpartum can prevent fertility from returning. If you are practicing LAM (of which exclusive breastfeeding is just one of three essential criteria), fertility may return when:</p> <ul style="list-style-type: none"> <input type="checkbox"/> The baby is 6 months of age OR <input type="checkbox"/> You are no longer exclusively breastfeeding OR <input type="checkbox"/> Your menses have returned <p>If you do not want to become pregnant, start a family planning method of your choice immediately when any of these criteria are no longer met.</p>		
Pregnancy Spacing	<p>For the health of the woman and the baby, wait at least 24 months, but not more than 5 years, before trying to become pregnant again.</p> <p>If you do not want to become pregnant, use a family planning method of your choice during that time.</p>	<p>For the health of the woman and the baby, wait at least 6 months before trying to become pregnant again.</p> <p>If you do not want to become pregnant, use a family planning method of your choice during that time.</p>	<p>For your health and your baby's health, wait until you are at least 18 years of age before trying to become pregnant.</p> <p>If you do not want to become pregnant, use a family planning method of your choice until you are 18 years old.</p>

Annex B: PFP Counseling Job Aids

JOB AID: COUNSELING GUIDE—ATTRIBUTES OF PFP METHODS			
Methods	Advantages	Limitations	Client Assessment/Considerations
PPIUCD	<ul style="list-style-type: none"> <input type="checkbox"/> Available right after delivery—no delay <input type="checkbox"/> Like interval IUCD: <ul style="list-style-type: none"> <input type="checkbox"/> >99% effective <input type="checkbox"/> Immediate return of fertility upon removal <input type="checkbox"/> Short-acting or long-acting protection <input type="checkbox"/> No additional supplies/materials or user action needed (up to 12 years) <input type="checkbox"/> Reduces overall risk of ectopic pregnancy (by preventing pregnancy) 	<ul style="list-style-type: none"> <input type="checkbox"/> May have heavier, more painful menses, especially first few cycles; often less noticeable for postpartum women <input type="checkbox"/> Slightly elevated risk of expulsion <input type="checkbox"/> Like interval IUCD, does not protect against STIs, including HIV <input type="checkbox"/> Like interval IUCD, requires clinical procedure 	<ul style="list-style-type: none"> <input type="checkbox"/> Not appropriate for women who have: <ul style="list-style-type: none"> <input type="checkbox"/> Cervical cancer or trophoblastic disease <input type="checkbox"/> Uterine distortion (fibroids, septum) <input type="checkbox"/> Increased risk of having gonorrhea/chlamydia <input type="checkbox"/> AIDS <u>and</u> not clinically well or not on antiretroviral therapy <input type="checkbox"/> Not appropriate for postpartum women with certain conditions resulting from labor and delivery <input type="checkbox"/> Must be inserted within 48 hours of delivery.
Progestin-Only Pills	<ul style="list-style-type: none"> <input type="checkbox"/> More effective if used by women who are also breastfeeding <input type="checkbox"/> About 99% effective <input type="checkbox"/> No delay in return of fertility after stopping pills 	<ul style="list-style-type: none"> <input type="checkbox"/> Pill must be taken every day, at the same time <input type="checkbox"/> Woman may experience bleeding changes <input type="checkbox"/> Does not protect against STIs, including HIV 	<ul style="list-style-type: none"> <input type="checkbox"/> Not appropriate for women who: <ul style="list-style-type: none"> <input type="checkbox"/> Have cirrhosis or active liver disease <input type="checkbox"/> Take medications for tuberculosis or seizures <input type="checkbox"/> Have a blood clot in legs or lungs now <input type="checkbox"/> Have a history of breast cancer <input type="checkbox"/> Provide supply before discharge. <input type="checkbox"/> Woman should start 6 weeks postpartum.
Condom	<ul style="list-style-type: none"> <input type="checkbox"/> Can prevent against pregnancy and some STIs (including HIV) <input type="checkbox"/> Can use once couple resumes intercourse 	<ul style="list-style-type: none"> <input type="checkbox"/> Must have reliable access to resupply <input type="checkbox"/> About 85% effective 	<ul style="list-style-type: none"> <input type="checkbox"/> Must be used with EVERY act of sex. <input type="checkbox"/> Must be used correctly every time. <input type="checkbox"/> A supply can be provided before discharge.
Postpartum Tubal Ligation	<ul style="list-style-type: none"> <input type="checkbox"/> Permanent method of family planning <input type="checkbox"/> >99% (not 100%) effective <input type="checkbox"/> Simple procedure; serious complications are rare 	<ul style="list-style-type: none"> <input type="checkbox"/> Does not protect against STIs, including HIV <input type="checkbox"/> Requires surgical procedure 	<ul style="list-style-type: none"> <input type="checkbox"/> For women who are certain they want no more children <input type="checkbox"/> Hospital must be set up to offer the surgery. <input type="checkbox"/> Can be done in first 7 days postpartum.
LAM <i>Encourage breastfeeding for all women</i>	<ul style="list-style-type: none"> <input type="checkbox"/> Good for mother and newborn <input type="checkbox"/> 98.5% effective if all three criteria met <input type="checkbox"/> No side effects <input type="checkbox"/> Start immediately after birth <input type="checkbox"/> No additional supplies/materials 	<ul style="list-style-type: none"> <input type="checkbox"/> Does not protect against STIs, including HIV <input type="checkbox"/> Short-acting method—reliable for 6 months 	<ul style="list-style-type: none"> <input type="checkbox"/> Effective if ALL three criteria are met: <ol style="list-style-type: none"> 1. Exclusive breastfeeding on demand, day and night, with no food or other fluids given 2. Monthly bleeding has not returned 3. Baby is less than 6 months old <input type="checkbox"/> Transition to another contraceptive method if any one of three criteria is not met
Vasectomy	<ul style="list-style-type: none"> <input type="checkbox"/> Permanent method of family planning <input type="checkbox"/> >99% (not 100%) effective <input type="checkbox"/> Safe, simple procedure; serious complications are rare <input type="checkbox"/> Procedure does not require hospitalization 	<ul style="list-style-type: none"> <input type="checkbox"/> Does not protect against STIs, including HIV <input type="checkbox"/> Requires outpatient surgical procedure 	<ul style="list-style-type: none"> <input type="checkbox"/> For couples who are certain they want no more children <input type="checkbox"/> 3-month delay in taking effect <input type="checkbox"/> Can be done at any time <input type="checkbox"/> Does not affect male sexual performance



Annex C: Medical Eligibility Criteria for IUCD/PPIUCD Use⁹

CATEGORY 1 CONDITIONS <i>Use the method in any circumstance</i>	CATEGORY 2 CONDITIONS <i>Generally use the method</i>
<ul style="list-style-type: none"> <input type="checkbox"/> Immediate postplacental or during cesarean section <input type="checkbox"/> More than 4 weeks postpartum <input type="checkbox"/> Postpartum <48 hours <input type="checkbox"/> Age: >20 years <input type="checkbox"/> Parity 1 or more <input type="checkbox"/> Irregular menstrual bleeding (metrorrhagia) without heavy menstrual bleeding <input type="checkbox"/> History of ectopic pregnancy <input type="checkbox"/> Cigarette smoking <input type="checkbox"/> Obesity <input type="checkbox"/> Cardiovascular disease risk factors <input type="checkbox"/> Hypertension or history of hypertension <input type="checkbox"/> Thrombembolic disease (past or current) <input type="checkbox"/> Hyperlipidemias <input type="checkbox"/> Uncomplicated valvular heart disease <input type="checkbox"/> Headaches (any type) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Depression <input type="checkbox"/> Benign ovarian tumors <input type="checkbox"/> Cervical intraepithelial neoplasia <input type="checkbox"/> Benign breast disease or breast cancer <input type="checkbox"/> Women taking antibiotics or anticonvulsants <input type="checkbox"/> Thyroid, liver or gallbladder disease or diabetes <input type="checkbox"/> Malaria <input type="checkbox"/> Non-pelvic tuberculosis <input type="checkbox"/> History of PID (with subsequent pregnancy) <input type="checkbox"/> Previous pelvic surgery, including previous cesarean section 	<ul style="list-style-type: none"> <input type="checkbox"/> Age: menarche to <20 years <input type="checkbox"/> Nulliparity <input type="checkbox"/> Heavy or prolonged vaginal bleeding <input type="checkbox"/> Complicated valvular heart disease <p>[Note: Use antibiotic prophylaxis prior to insertion in a woman who has complicated valvular heart disease.]</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lupus on immunosuppressive therapy <input type="checkbox"/> Endometriosis <input type="checkbox"/> History of PID (with subsequent pregnancy) <input type="checkbox"/> High risk of HIV <input type="checkbox"/> Women who are HIV-positive and on antiretroviral therapy <input type="checkbox"/> Anemia (thalassemia or iron-deficiency)
CATEGORY 3 CONDITIONS <i>Generally, do not use the method unless other more appropriate methods are not available or not acceptable</i>	CATEGORY 4 CONDITIONS <i>Do not use the method</i>
<ul style="list-style-type: none"> <input type="checkbox"/> Between 48 hours and 4 weeks postpartum <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Prolonged rupture of membranes (PROM) >18 hrs* <input type="checkbox"/> Extensive genital trauma where insertion may disrupt the repair* <u>[Note: This only applies to insertion on postpartum Day 1 or 2]</u> <input type="checkbox"/> AIDS, but no antiretroviral therapy or no access to care <input type="checkbox"/> High individual risk of chlamydia and gonococcal infection (partner has current purulent discharge or STI) <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Benign trophoblastic disease <input type="checkbox"/> Lupus with severe thrombocytopenia 	<ul style="list-style-type: none"> <input type="checkbox"/> Puerperal sepsis <input type="checkbox"/> Postpartum endometritis <input type="checkbox"/> Unresolved postpartum hemorrhage* <input type="checkbox"/> Pregnancy (known or suspected) <input type="checkbox"/> Unexplained vaginal bleeding <input type="checkbox"/> Current PID, gonorrhea, or chlamydia <input type="checkbox"/> Acute purulent (pus-like) discharge <input type="checkbox"/> Distorted uterine cavity <input type="checkbox"/> Malignant trophoblastic disease <input type="checkbox"/> Known pelvic tuberculosis <input type="checkbox"/> Genital tract cancer (cervical or endometrial)

⁹Although the MEC has been updated in recent years to provide clearer guidance on use of the IUCD in general, specific information about the PPIUCD is limited. Therefore, it is necessary to review the MEC with respect to the use of the IUCD in the postpartum period and to expand the list of conditions for which the IUCD might or might not be appropriate. Although the focus of the initial screening includes the more established, general criteria for IUCD use, the second screening focuses on these expanded criteria (which appear in *bold*).

*These conditions are not specifically mentioned in the WHO MEC; however, their inclusion is considered a prudent interpretation of that publication.

Annex D: Supplies and Equipment Needed for PPIUCD Services

<p>ANTENATAL CARE/COUNSELING</p> <ul style="list-style-type: none"> <input type="checkbox"/> Samples of contraceptive methods as visual aids during counseling <input type="checkbox"/> PPIUCD illustration <input type="checkbox"/> PFP Counseling Job Aid (Annex B) <input type="checkbox"/> PPIUCD card, given to the woman who can present it at time of delivery <input type="checkbox"/> Stamp for recording PFP choice on ANC card <p>POSTPLACENTAL OR INTRACESAREAN INSERTION^h</p> <ul style="list-style-type: none"> <input type="checkbox"/> Counseling materials (as described above), if necessary <input type="checkbox"/> Pre-insertion Screening Job Aid (Annex E) <input type="checkbox"/> Table or tray for instruments and supplies: <ul style="list-style-type: none"> <input type="checkbox"/> Long placental forceps (33 cm) for insertion <input type="checkbox"/> Ring forceps for grasping the cervix <input type="checkbox"/> Retractor or Simms speculum <input type="checkbox"/> Gauze pads/cotton balls <input type="checkbox"/> Antiseptic solution, such as povidone iodine (i.e., Betadine[®]) or chlorhexidine gluconate (i.e., Savlon[®] or Hibiclens[®]) <input type="checkbox"/> Sterile or HLD gloves <input type="checkbox"/> IUCD in its sterile package <input type="checkbox"/> Sterile towels (2) <input type="checkbox"/> Data collection form (Annex K) <input type="checkbox"/> PPIUCD Insertion Register <input type="checkbox"/> PPIUCD discharge instructions card to give to the woman 	<p>EARLY POSTPARTUM INSERTION</p> <ul style="list-style-type: none"> <input type="checkbox"/> Counseling materials (as described above), if necessary <input type="checkbox"/> Pre-Insertion Screening Job Aid (Annex E) <input type="checkbox"/> Table or tray for instruments and supplies (as described above) <input type="checkbox"/> Sterile or HLD gloves <input type="checkbox"/> IUCD in its sterile package <input type="checkbox"/> Sterile towels (2) <input type="checkbox"/> Data collection form (Annex K) <input type="checkbox"/> PPIUCD Insertion Register <input type="checkbox"/> PPIUCD discharge instructions card to give to the woman <p>FOLLOW-UP</p> <ul style="list-style-type: none"> <input type="checkbox"/> Data collection form (Annex K) <input type="checkbox"/> Follow-Up Register <input type="checkbox"/> Supplies for performing speculum exam as needed: <ul style="list-style-type: none"> <input type="checkbox"/> Simms or Cusco or Graves speculum <input type="checkbox"/> Long forceps <input type="checkbox"/> Scissors <input type="checkbox"/> Medications for management of common complaints <ul style="list-style-type: none"> <input type="checkbox"/> Ibuprofen (400 mg) tablets <input type="checkbox"/> Iron tablets
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^hOther standard supplies for labor and delivery are not mentioned here.

Annex E: Job Aid for Second PPIUCD Screening

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

Ask the woman whether she still desires the IUCD for PPFPP	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Review her medical record and be certain that:		
<input type="checkbox"/> Her initial screening shows that an IUCD is an appropriate method for her	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> She has had family planning counseling while not in active labor and there is evidence of consent in her chart	<input type="checkbox"/> No	<input type="checkbox"/> Yes
OR		
<input type="checkbox"/> She is being counseled in the postpartum period	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Review the course of her labor and delivery and ensure that <u>none</u> of the following conditions are present:		
If planning an <i>immediate postplacental or intracesarean insertion</i> , check that <u>none</u> of the following conditions are present:		
<input type="checkbox"/> Chorioamnionitis (during labor)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> More than 18 hours from rupture of membranes to delivery of baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Unresolved postpartum hemorrhage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If planning an <i>early postpartum insertion</i> , check that <u>none</u> of the following conditions are present:		
<input type="checkbox"/> Puerperal sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Postpartum endometritis/metritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Continued excessive postpartum bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Extensive genital trauma where the repair would be disrupted by early postpartum placement of an IUCD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Confirm that sterile instruments are available*	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Confirm 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 checked, 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.

Annex F: Summary of Steps for Processing Instruments and Other Items Used in PPIUCD Services

Item	Decontamination	Cleaning	HLD	Sterilization
	First Step in Handling Dirty Instruments; Reduces Risk of Hepatitis B and HIV Transmission	Removes All Visible Blood, Body Fluids and Dirt	Recommended Method of Final Processing; Destroys All Viruses, Bacteria, Parasites, Fungi and Some Endospores	Alternative Method of Final Processing; Destroys All Microorganisms Including Endospores
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material remains after decontamination.	Not necessary	Not necessary
Instruments used for IUCD insertion or removal (e.g., speculum, placental/ring forceps, retractor/speculum)	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.*	Using a brush, wash with soap and water. Rinse with clean water. If they will be sterilized, air or towel dry and package.	<ul style="list-style-type: none"> ☐ Steam or boil for 20 minutes. ☐ Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage. 	<ul style="list-style-type: none"> ☐ Dry heat for 1 hour after reaching 170°C (340°F), or ☐ Autoclave at 121°C (250°F) and 106 kPa (15 lb/in²) for 20 minutes (30 minutes, if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.**	Wash with soap and water. Rinse with clean water, air or towel dry.	Boil container and lid for 20 minutes. If container is too large: <ul style="list-style-type: none"> ☐ Fill container with 0.5% chlorine solution and soak for 20 minutes. ☐ Rinse with water that has been boiled for 20 minutes and air dry before use. 	<ul style="list-style-type: none"> ☐ Dry heat for 1 hour after reaching 170°C (340°F), or ☐ Autoclave at 121°C (250°F) and 106 kPa (15 lb/in²) for 20 minutes (30 minutes, if wrapped).

*If unwrapped, use immediately; if wrapped, may be stored up to 1 week before use.

**Avoid prolonged/excessive exposure to chlorine solution (more than 20 minutes, more than 0.5%) to minimize corrosion of instruments and deterioration of rubber or cloth products.

Annex G: Job Aid for Instrumental PPIUCD Insertion Steps

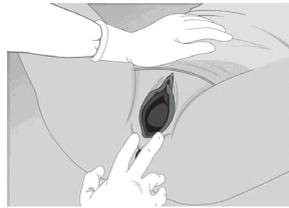
Talk to the woman during the procedure. Use gentle “no-touch” technique. Follow all recommended infection prevention practices.



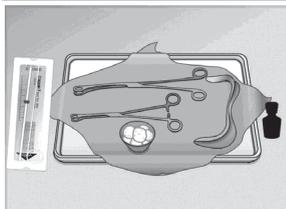
1. Ensure that woman has chosen IUCD and been counseled.



2. Manage labor and delivery, including AMTSL.



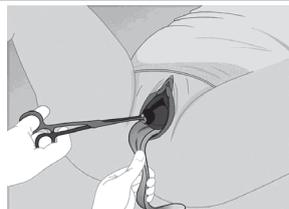
3. Do second screening, including inspection of woman if she is ready for IUCD insertion.



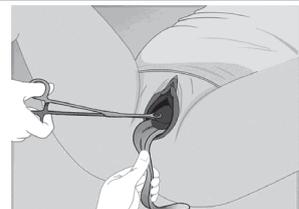
5. Arrange supplies and equipment, with IUCD to side.



6. Visualize cervix using retractor.



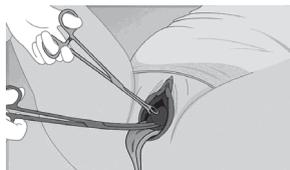
7. Clean cervix and vagina TWICE with two separate gauzes.



8. Grasp anterior lip of cervix with ring forceps.



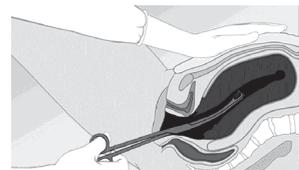
9. Open IUCD package and by grasp IUCD with other forceps.



10. Insert forceps with IUCD through cervix to lower uterine cavity; avoid touching vagina and keep forceps closed.



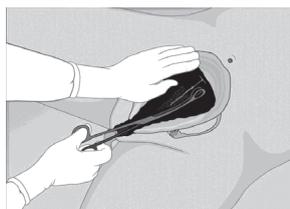
11. Let go of ring forceps and place hand on abdomen.



12. “Elevate” uterus pushing upward toward woman’s head.*



13. Move IUCD and forceps upward—toward umbilicus—until fundus is felt; follow contour of uterine cavity.



14. Open forceps and release IUCD at fundus.



15. Sweep forceps to side wall of uterus.



16. Slowly remove forceps—keeping them slightly open.

Allow the woman to rest. Be sure she gets complete postpartum care. Provide post-insertion instructions.

*This maneuver will help straighten the lower uterine segment and vagino-uterine angle for ease of insertion.

Annex H: Guidelines for IUCD Removal^{38,43}

IUCD removal is usually an uncomplicated and relatively painless routine procedure. Unless an IUCD is removed for a medical reason or because the woman wishes to discontinue the method, a new IUCD can be inserted **immediately** after removing the old one, if she so desires. Appropriate assessment and care, before and after the procedure, depend on the reason for IUCD removal, and whether the woman is having another IUCD inserted or is starting a different method. Use proper infection prevention practices.

Note: For routine IUCD removals (especially if replacing the IUCD), removal may be easier during the woman's menstrual period, when the cervix softens. However, **IUCDs can be removed at any time during the woman's menstrual cycle.**

Before Removing the IUCD

- Ask the woman her reasons for having the IUCD removed:
- If the woman wants her IUCD removed for **personal reasons** (or offers **no reason at all**), remove her IUCD. The woman has a right to discontinue the method at any time, regardless of the reason.
- If the woman is having her **IUCD replaced** (i.e., at the end of its effective life), ensure that she has undergone appropriate assessment to determine whether she is eligible for IUCD reinsertion at this time.
- If she is having the IUCD removed for **medical reasons** (e.g., pregnancy, dangerously heavy menstrual bleeding), ensure that she has undergone the appropriate assessment to determine whether routine IUCD removal is safe for her at this time. Refer for special removals, if needed.
- If she will be **starting a different method**, ask when her last menstrual period began. This will help determine whether she will need to use a back-up method.
- Ensure that she understands the following key points about having her IUCD removed, as appropriate:
 - “You can get pregnant again immediately after IUCD removal.”
 - “If you do not want to become pregnant, you should have another IUCD inserted immediately or start another contraceptive method.”
 - “No rest period is needed between IUCDs.”
- Review her reproductive goals and need for protection against STIs.
- Help her choose a different contraceptive method, if appropriate.

Removing the IUCD

Using gentle, “no-touch” (aseptic) technique throughout, performs the following steps:

STEP 1: Prepare the client:

- Give the woman a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed.
- Remind her to let you know if she feels any pain.

STEP 2: Put new/clean examination or HLD surgical gloves on both hands.

Annex H

STEP 3: Insert an HLD (or sterile) speculum and visualize the cervix and the IUCD strings.

- If the strings cannot be seen, **manage as Missing Strings** (Annex I).

STEP 4: Cleanse the cervix and vagina with an appropriate antiseptic: Thoroughly apply an appropriate antiseptic (e.g., povidone iodine or chlorhexidine) two or more times to the cervix (wiping from inside the os outward) and vagina. If povidone iodine is used, ensure that the woman is not allergic to iodine and wait 2 minutes for the solution to act.

STEP 5: Alert the woman immediately before you remove the IUCD:

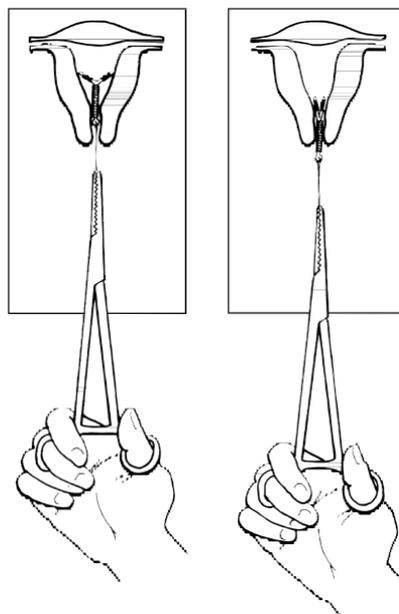
- Ask her to take slow, deep breaths and relax.
- Inform her that she may feel some discomfort and cramping, which is normal.

Do **not** use force at any stage of this procedure.

STEP 6: Grasp the IUCD strings and apply gentle traction:

- Grasp the strings of the IUCD with a high-level disinfected (or sterile) narrow forceps (Figure I-1, Left panel).
- Apply steady but gentle traction, gently pulling the strings toward you with the forceps (Figure I-1, Right panel). (The device can usually be removed without difficulty.)
 - If the strings break off but the IUCD is visible, grasp the device with the forceps and remove it.
 - If removal is difficult, do **not use excessive force!** See box below for guidance on managing this problem.

Figure I-1 Removing the IUCD



Guidelines for Difficult IUCD Removals

If you have partially removed the IUCD but have difficulty drawing it through the cervical canal:

- Attempt a gentle, slow twisting of the IUCD while gently pulling.
- Continue as long as the woman remains comfortable.
- If the IUCD can still not be removed, refer the woman to a specially trained provider who can dilate the cervix.

If there seems to be a sharp angle between the uterus and cervix:

- Place a high-level disinfected (or sterile) tenaculum on the cervix, and apply gentle traction downward and outward.
- Attempt a gentle, slow twisting of the IUCD while gently pulling.
- Continue as long as the woman remains comfortable.
- If the IUCD can still not be removed, refer the woman to a specially trained provider who can dilate the cervix.

Annex H

STEP 7: Show the woman the IUCD, and place it in 0.5% chlorine solution for 10 minutes for decontamination.

STEP 8: Insert a new IUCD, if the woman so desires and there are no precautions to continued use. If she is not having a new IUCD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.

After Removing the IUCD

Ask the woman how she is feeling, and whether she is experiencing any of the following symptoms:

- Nausea
- Mild-to-moderate lower abdominal pain/cramping
- Dizziness or fainting (rare)

- If the woman is experiencing any of these symptoms, provide reassurance and allow her to remain on the examination table to rest until she feels better.

Important: Although most women will **not** experience problems after IUCD removal, all women should remain at the clinic for 15 to 30 minutes before being discharged as a precaution.

If the woman is starting a new contraceptive method, it should be provided now—along with a back-up method if needed.

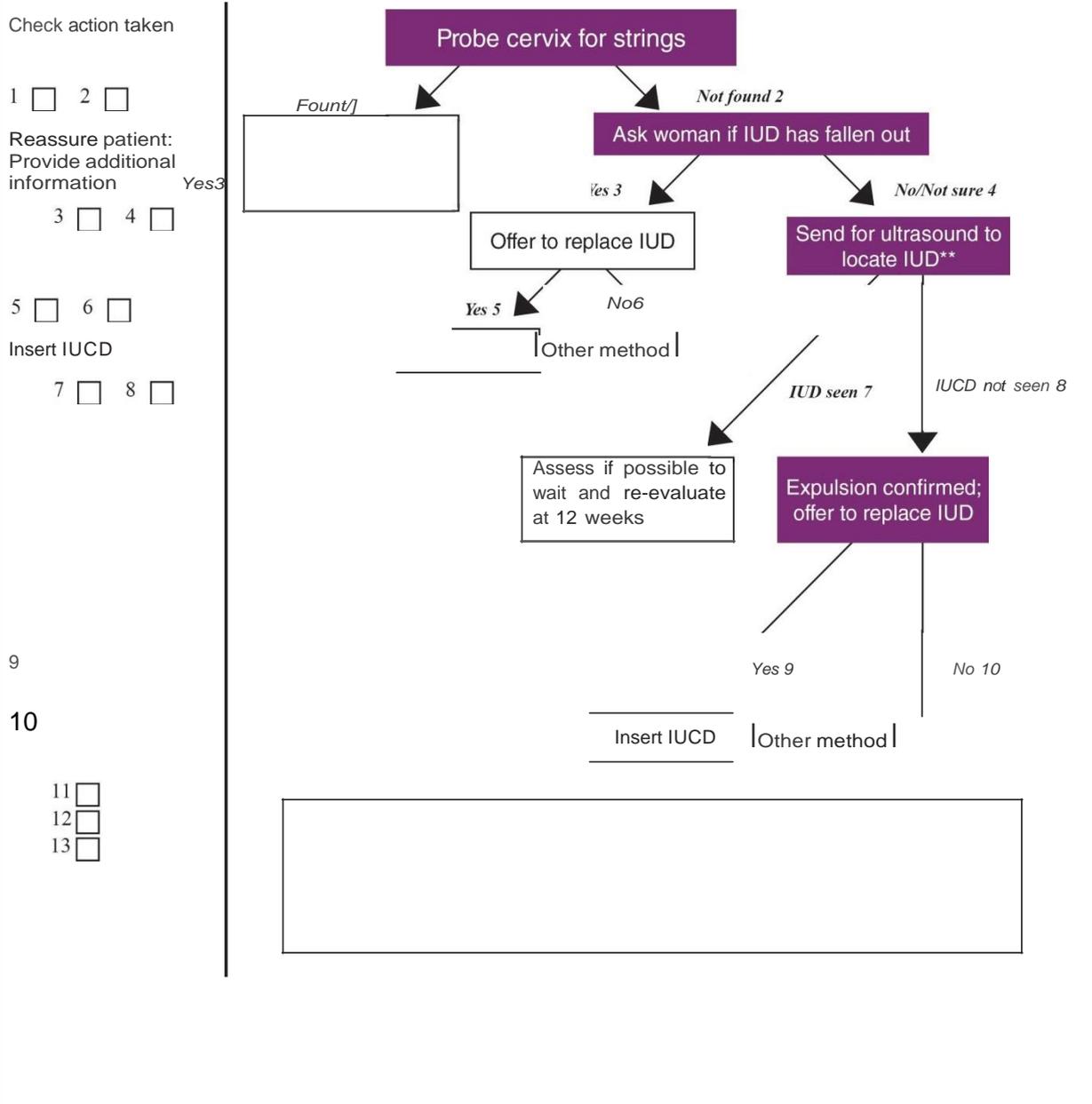
Annex I: Protocol for Management of Missing PPIUCD Strings*

Case# _____

Date _____

Protocol for Management of Missing PPIUCD Strings*

Situation: Use this protocol when you do not find the strings of the IUCD protruding from the cervix on exam of a woman who has returned following postpartum placement of the IUCD



* If strings not seen at 3 months, repeat the protocol from start. If strings still not found, either:

1. Reassure and follow-up 11
2. Remove IUCD with hook and replace 12

** Consider X-ray of abdomen instead of, or to augment, findings of ultrasound 13

Annex J: Performance Standards for PPIUCD Counseling and Servicesⁱ

Performance Standards for PPIUCD Counseling and Services			
Number	Area	Performance Standards	
		Number	Total
1	PPFP/PPIUCD education and counseling and initial client screening during ANC; follow-up care/return visits	1–8	8
2	PPFP/PPIUCD education and counseling and client assessment during early/inactive labor or the postpartum period	9–3	5
3	IUCD insertion	14–21	8
4	Management of PPIUCD services and recordkeeping	22–26	5

ⁱSources for these performance standards include the Jhpiego Family Planning Performance Standards for Afghanistan, the WHO/CCP's *Family Planning: A Global Handbook for Providers* and the Postpartum IUCD training materials by Acquire/Engender Health.

FACILITY: _____

ASSESSMENT TEAM: _____ DATE: _____

Performance Standards	Verification Criteria	Y/N, N/A ¹	Y/N, N/A	Comments
Area 1: PFP/PPIUCD Education and Counseling and Initial Client Screening during ANC; Follow-Up Care/Return Visits				
<i>Instructions for the Assessor: Observe standards 1–6 in sequence with two women receiving PFP counseling during an ANC visit. Observe provision of care to at least two women for standards 7 and 8.</i>				
1. Provider/counselor uses recommended counseling techniques for PFP during ANC.	Observe in the appropriate clinical services area with client that the provider/counselor:			
	<input type="checkbox"/> Shows respect for the woman and helps her feel at ease.			
	<input type="checkbox"/> Encourages the woman to explain needs, express concerns and ask questions.			
	<input type="checkbox"/> Includes the woman’s husband or an important family member, with the woman’s consent.			
	<input type="checkbox"/> Listens carefully.			
	<input type="checkbox"/> Respects and supports the woman’s informed decisions.			
	<input type="checkbox"/> Checks to be sure the woman understands PFP counseling messages.			
2. Provider/counselor provides information on benefits of healthy pregnancy spacing (or limiting, if desired) and explores the woman’s knowledge about (postpartum) family planning methods.	Observe that the provider/counselor:			
	<input type="checkbox"/> Explores woman’s knowledge about the benefits of pregnancy spacing.			
	<input type="checkbox"/> Asks about previous family planning methods used and knowledge about all family planning methods (LAM, progestin-only pills, postpartum ligation, condoms and the PPIUCD).			
	<input type="checkbox"/> Addresses any related needs such as protection from STIs, including HIV and support for condom use.			

¹Y = Yes; N = No; N/A = Not Applicable

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
Use the PPFP Counseling Job Aids (Annex B) to facilitate this task.	<input type="checkbox"/> Corrects misinformation.			
	<input type="checkbox"/> Discusses the woman's situation, her plans and what is important to her about a method.			
	<input type="checkbox"/> Helps the woman consider suitable methods. If needed, helps her reach a decision.			
	<input type="checkbox"/> Supports the woman's choice.			
3. Provider/counselor does a brief screening to determine whether the IUCD is an appropriate method for the woman interested in a PPIUCD.	If the woman is interested in the PPIUCD, observe that the provider/counselor:			
	<input type="checkbox"/> Determines that the woman does not have any of the following conditions:			
	<input type="checkbox"/> Malignant trophoblastic disease			
	<input type="checkbox"/> Cervical, endometrial or ovarian cancer			
	<input type="checkbox"/> Abnormalities of the reproductive tract/uterine fibroids that distort the uterine cavity			
	<input type="checkbox"/> Pelvic tuberculosis			
	<input type="checkbox"/> Increased personal risk of having gonorrhea or chlamydia infection			
	<input type="checkbox"/> AIDS <u>and</u> not clinically well or not on antiretroviral therapy			
	<input type="checkbox"/> If none of the above conditions are present, tells the woman that she is likely eligible to use the IUCD.			
	<input type="checkbox"/> Proceeds with method-specific counseling for this method.			
	<i>[NOTE: The woman will be reassessed immediately postpartum for other conditions resulting from labor/delivery that may make the IUCD a poor choice for her at this time.]</i>			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
4. Provider/counselor gives method-specific information about the IUCD.	Observe that the provider/counselor:			
	<input type="checkbox"/> Uses visual aids (poster, demonstration IUCD) during counseling.			
	<input type="checkbox"/> Discusses key information with the woman:			
	<input type="checkbox"/> How effective the IUCD is: prevents almost 100% of pregnancies			
	<input type="checkbox"/> How the IUCD prevents pregnancy: causes a chemical change that damages the sperm BEFORE the sperm and egg meet			
	<input type="checkbox"/> How the IUCD is used: inserted after delivery and then requires no additional care (Ensure that the woman knows it can be inserted at other times as well.)			
	<input type="checkbox"/> How long the IUCD prevents pregnancy: up to 12 years (Copper T 380A)			
	<input type="checkbox"/> How the IUCD can be removed at any time by a trained provider and fertility will return immediately			
	<input type="checkbox"/> Provides information about when the woman should come back.			

Performance Standards	Verification Criteria	Y/N, N/A ⁱ	Y/N, N/A	Comments
5. Provider/counselor gives the woman more specific information about the PPIUCD (e.g., advantages, limitations, when to return).	Observe that the provider/counselor:			
	<input type="checkbox"/> Discusses the following advantages:			
	<input type="checkbox"/> Immediate placement after delivery			
	<input type="checkbox"/> No action required by the woman			
	<input type="checkbox"/> Immediate return of fertility upon removal			
	<input type="checkbox"/> Does not affect breastfeeding			
	<input type="checkbox"/> Long-acting and reversible: can be used to prevent pregnancy for a short time or as long as 12 years.			
	<input type="checkbox"/> Discusses the following limitations:			
	<input type="checkbox"/> Heavier and more painful menses, especially the first few cycles (may not be as noticeable to the postpartum woman because of the recovery process)			
	<input type="checkbox"/> Does not protect against STIs, including HIV			
	<input type="checkbox"/> Small risk of perforation			
	<input type="checkbox"/> Higher risk of expulsion when inserted postpartum (but this risk can be minimized through immediate [postplacental, intracesarean] insertion, using appropriate technique and instruments)			
	<input type="checkbox"/> Discusses the following warning signs and explains that the woman should return to the clinic as soon as possible if she has any of the following:			
	<input type="checkbox"/> Foul-smelling vaginal discharge, different from the usual lochia			
	<input type="checkbox"/> Lower abdominal pain, especially if accompanied by not feeling well, fever or chills			
<input type="checkbox"/> Concerns that she might be pregnant				
<input type="checkbox"/> Concerns that the IUCD has fallen out				

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
6. Provider/counselor annotates the woman's medical record to alert other care providers that she has chosen the PPIUCD.	Observe that the provider/counselor:			
	<input type="checkbox"/> Makes a notation of which PPF method has been chosen.			
	<input type="checkbox"/> Documents on ANC record/card that the woman has been counseled and has requested the PPIUCD.			
	<input type="checkbox"/> Instructs the woman that, when she comes in labor to deliver, she should tell the provider in the facility that she wants an IUCD after delivery.			
	<input type="checkbox"/> Gives the woman the card that shows she has consented to postpartum insertion of the IUCD.			
Note: In reality, between Steps 6 and 7, the woman has had her baby, undergone AMTSL (following vaginal delivery), had an IUCD inserted and been discharged from the facility with instructions to return at 6 weeks for routine follow-up, or whenever she has problems or concerns.				
7. The provider conducts follow-up care/return visits appropriately.	Observe that the provider:			
	<input type="checkbox"/> Greets the woman politely.			
	<input type="checkbox"/> Identifies the purpose of the visit.			
	<input type="checkbox"/> Ensures privacy and confidentiality.			
	<input type="checkbox"/> Allows the woman to ask questions.			
	<input type="checkbox"/> Asks if the woman has concerns or problems related to the IUCD.			
	<input type="checkbox"/> Enquires about breastfeeding (if applicable).			
	<input type="checkbox"/> Asks the woman whether she has resumed sexual relations and whether she has concerns that she might be at increased risk of exposure to STI/HIV. Describes and offers condoms for dual protection, as appropriate.			
	<input type="checkbox"/> Where possible, performs pelvic examination and documents presence and length of string.			
	<input type="checkbox"/> Trims string, if appropriate or desired by the woman.			
	<input type="checkbox"/> Reminds the woman to return, if needed, and that she can have the IUCD removed at any time at her request.			
	<input type="checkbox"/> Documents this and other information from visit in the chart.			

Performance Standards	Verification Criteria	Y/N, N/A ⁱ	Y/N, N/A	Comments
<p>8. The provider identifies women with problems and manages complications, as necessary.</p> <p>A more detailed discussion of management of side effects and complications is found in <i>Family Planning: A Global Handbook for Providers</i> (WHO and CCP 2007).</p>	Observe that the provider:			
	<input type="checkbox"/> Asks the woman if she is experiencing any side effects or problems with the PPIUCD.			
	<input type="checkbox"/> If side effects and/or problems are identified, conducts brief assessment and provides initial management: (noted here) and either manages accordingly or refers for additional treatment.			
	<input type="checkbox"/> <i>Heavy vaginal bleeding:</i> provides explanation and reassurance, assesses for anemia, performs pelvic exam, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), provides iron tablets. Aspirin should not be used because it has an anti-blood-clotting effect.			
	<input type="checkbox"/> <i>Irregular bleeding:</i> provides explanation and reassurance, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), provides iron tablets.			
	<input type="checkbox"/> <i>Low abdominal pain or cramping:</i> assesses for endometritis by palpating abdomen and observing vaginal discharge, provides explanation and reassurance, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days).			
	<input type="checkbox"/> <i>Severe lower abdominal pain:</i> assesses for ectopic pregnancy or pelvic infection.			
	<input type="checkbox"/> <i>Fever and purulent vaginal discharge:</i> performs pelvic exam, assesses for pelvic infection. (Note: it is not necessary to remove the IUCD during treatment)			
	<input type="checkbox"/> <i>Suspected pregnancy:</i> performs pelvic exam, assesses for pregnancy.			
	<input type="checkbox"/> <i>Suspected expulsion:</i> performs pelvic exam: if the IUCD is partially expelled, removes and replaces it; if the IUCD is not found, asks the woman if the IUCD was expelled (offers replacement or another method); if the IUCD is not found and the woman is unaware of expulsion, considers X-ray or ultrasound.			
	<input type="checkbox"/> <i>String problems:</i> too long—trims strings; not found—assesses for expulsion. Considers ultrasound to check location of the IUCD.			
	<input type="checkbox"/> If initial management approaches are not effective, refers the woman for additional evaluation and management, as necessary.			
<input type="checkbox"/> Offers to remove the IUCD for any woman who requests to have it removed.				

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
Area 2: IUCD Counseling and Client Assessment during Labor or Postpartum Period				
<i>Instructions for the Assessor: Observe provision of service to at least one woman for each of standards 9, 10 and 11. Observe provision of care to at least two women for standards 12 and 13.</i>				
9. The provider re-confirms with the <u>laboring</u> woman that she has chosen the IUCD for postpartum family planning.	Observe that the provider:			
	<input type="checkbox"/> Greets the patient (and her companion, if present) with respect.			
	<input type="checkbox"/> Introduces self to the patient (and her companion, if present).			
	<input type="checkbox"/> Confirms the patient identifier information (name, date of birth).			
	<input type="checkbox"/> If the woman is in labor, is sensitive to the woman's discomfort and pauses the discussion during contractions/labor pains.			
	<input type="checkbox"/> Determines, using the <i>Pre-Insertion Screening Job Aid</i> , that the woman meets criteria for postplacental insertion.			
	<input type="checkbox"/> Has had family planning counseling when not in active labor.			
	<input type="checkbox"/> Has indicated consent.			
	<input type="checkbox"/> Insertion can occur immediately following delivery.			
10. The provider re-confirms with the <u>postpartum</u> woman that she has chosen the IUCD for PFP.	Observe that the provider:			
	<input type="checkbox"/> Greets the patient (and her companion, if present) with respect.			
	<input type="checkbox"/> Introduces self to the patient (and her companion, if present).			
	<input type="checkbox"/> Confirms the patient identifier information (name, date of birth).			
	<input type="checkbox"/> Determines that the woman meets criteria for postplacental insertion.			
	<input type="checkbox"/> Has had family planning counseling when not in active labor.			
	<input type="checkbox"/> Has indicated consent.			
	<input type="checkbox"/> Determines, using the <i>Pre-Insertion Screening Job Aid</i> , that the IUCD is appropriate for the woman (see Standard 12) and that she still desires the IUCD.			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
11. The provider counsels and screens a woman who was not identified during ANC for the PPIUCD.	Observe that the provider:			
	<input type="checkbox"/> Identifies laboring and postpartum women who are interested in the PPIUCD.			
	<input type="checkbox"/> If the woman is in early labor or postpartum, ensures woman is comfortable and capable of making an informed choice.			
	<input type="checkbox"/> Performs a brief screening assessment and determines whether the PPIUCD is an appropriate method for the woman (see Standard 3).			
	<input type="checkbox"/> Provides method-specific information about the PPIUCD (see Standards 4 and 5).			
	<input type="checkbox"/> Makes a notation in the medical record and notifies other care providers that the woman has chosen postpartum insertion of the IUCD.			
12. The provider ensures the IUCD is an appropriate postpartum contraceptive method for a laboring/recently postpartum woman.	Observe that the provider:			
	<input type="checkbox"/> Uses the <i>Pre-Insertion Screening Job Aid</i> to ensure that none of the following medical conditions are present:			
	<input type="checkbox"/> Postpartum endometritis/metritis			
	<input type="checkbox"/> Puerperal sepsis			
	<input type="checkbox"/> More than 18 hours from rupture of membranes to delivery of the baby			
	<input type="checkbox"/> Unresolved postpartum hemorrhage			
<input type="checkbox"/> Extensive genital trauma where the repair would be disrupted by postpartum placement of the IUCD				

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
13. The provider demonstrates good client-provider interaction.	Observe that the provider:			
	<input type="checkbox"/> Uses the patient's name, as appropriate for the setting.			
	<input type="checkbox"/> Provides the patient with an opportunity to ask questions; answers the patient's (and if present, her companion's) questions.			
	<input type="checkbox"/> Maintains privacy and confidentiality for the woman.			
	<input type="checkbox"/> Demonstrates active listening.			
	<input type="checkbox"/> Speaks respectfully and professionally with the patient in clear and simple language.			
	<input type="checkbox"/> Ensures that the patient understands the information provided.			
Area 3: IUCD Service Provision				
Instructions for the Assessor: Observe the provision of IUCD services to at least two women each for standards 14–21. If there are no women, have providers demonstrate service provision on anatomic models, AND review the clinical record of the two most recent cases of each type of service provision (postplacental, intracesarean and early postpartum). Cases should not be more than 6 months old.				
Immediate PPIUCD Insertion				
14. The provider completes all pre-insertion tasks for postplacental or intracesarean IUCD insertion. Use the Pre-Insertion Screening Job Aid to help facilitate this task.	Observe that the provider:			
	<input type="checkbox"/> Ensures that the woman has consented to PPIUCD insertion.			
	<input type="checkbox"/> Ensures that the needed supplies and equipment are available in the room.			
	<i>For postplacental insertion:</i>			
	<input type="checkbox"/> Long placental forceps for insertion			
	<input type="checkbox"/> Ring forceps for grasping the cervix			
	<input type="checkbox"/> Retractor or Simms speculum			
	<input type="checkbox"/> Gauze pads/cotton balls			
	<input type="checkbox"/> Betadine			
	<i>For intracesarean insertion:</i>			
	<input type="checkbox"/> Ring forceps for inserting the IUCD			
	<input type="checkbox"/> Opens the IUCD onto a sterile delivery tray (postplacental) or an instrument tray (intracesarean).			

Performance Standards	Verification Criteria	Y/N, N/A ⁱ	Y/N, N/A	Comments
<p>15. The provider correctly inserts the IUCD within 10 minutes after placental expulsion after a vaginal delivery (instrument insertion).</p> <p><i>NOTE: The IUCD should be inserted following performance of AMTSL and confirmation that postpartum bleeding is minimal.</i></p> 	<p>Observe that the provider:</p>			
	<input type="checkbox"/> After completing AMTSL, asks the woman if she is ready for IUCD insertion and if she has any questions.			
	<input type="checkbox"/> Performs hand hygiene; puts on HLD or sterile gloves.			
	<input type="checkbox"/> Arranges instruments and supplies on a sterile tray or draped area.			
	<input type="checkbox"/> Grasps the IUCD with Kelly placental forceps or ring forceps. Leaves aside.			
	<input type="checkbox"/> Inspects the perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, repairs them, if needed, after inserting the IUCD.			
	<input type="checkbox"/> Gently visualizes the cervix by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, applies fundal pressure so that the cervix descends and can be seen.)			
	<input type="checkbox"/> Cleans cervix and vagina with antiseptic solution two times using two gauzes.			
	<input type="checkbox"/> Gently grasps the anterior lip of the cervix with ring forceps.			
	<input type="checkbox"/> Exerts gentle traction on the anterior lip of the cervix using ring forceps.			
	<input type="checkbox"/> Inserts IUCD into the lower uterine cavity. Avoids touching the walls of the vagina with the IUCD.			
	<input type="checkbox"/> Stabilizes the uterus by “elevating” it with the palm of the hand against the uterine body.			
	<input type="checkbox"/> Gently moves the IUCD upward toward the fundus, following the contour of the uterine cavity. Takes care not to perforate the uterus.			
	<input type="checkbox"/> Keeps the forceps closed so the IUCD does not become displaced.			
	<input type="checkbox"/> Confirms that the end of the placental/ring forceps has reached the fundus.			
	<input type="checkbox"/> Opens the forceps and releases the IUCD at the fundus.			
	<input type="checkbox"/> Sweeps the placental/ring forceps to the side wall of the uterus.			
	<input type="checkbox"/> Slowly removes the forceps from the uterine cavity, keeping them slightly open. Takes particular care not to dislodge the IUCD as the forceps are removed.			
	<input type="checkbox"/> Stabilizes the uterus until the forceps are completely out of the uterus.			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
	<input type="checkbox"/> Examines the cervix to ensure there is no bleeding. If the IUCD or strings are seen protruding from the cervix, removes the IUCD and reinserts it.			
	<input type="checkbox"/> Removes all instruments used and places them in 0.5% chlorine solution.			
	<input type="checkbox"/> Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.			
16. The provider correctly inserts the IUCD during cesarean section.	Observe that the provider:			
	<input type="checkbox"/> Inspects the uterine cavity for malformation, which limits the woman's successful use of the IUCD (e.g., septate uterus, bicornuate uterus, submucosal or distorting intramural fibroids).			
	<input type="checkbox"/> Stabilizes the uterus by grasping it at the fundus.			
	<input type="checkbox"/> Inserts the IUCD through the uterine incision and to the fundus of the uterus.			
	<input type="checkbox"/> Releases the IUCD at the fundus of the uterus.			
	<input type="checkbox"/> Slowly removes the hand/forceps from the uterus. Takes particular care not to dislodge the IUCD as the hand is removed.			
	<input type="checkbox"/> Places the IUCD strings in the lower uterine segment near the internal cervical os.			
	<input type="checkbox"/> Takes care not to include the IUCD strings in the repair of uterine incision.			
	<input type="checkbox"/> Does NOT pass the strings through the cervix. (Note: this increases risk of infection and is unnecessary. Strings will spontaneously pass through the cervix and into the vagina after involution)			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
Early PPIUCD Insertion				
17. The provider completes all pre-insertion tasks for early PPIUCD insertion.	Observe that the provider:			
	<input type="checkbox"/> Opens HLD instrument pan or sterile pack/container without touching instruments.			
	<input type="checkbox"/> Prepares the instrument tray with the following instruments/supplies:			
	<input type="checkbox"/> Bivalve or Simms speculum			
	<input type="checkbox"/> Long placental forceps for insertion of the IUCD			
	<input type="checkbox"/> Ring forceps for cleaning and grasping the cervix			
	<input type="checkbox"/> Galley pot/bowl for antiseptic			
	<input type="checkbox"/> Gauze pads			
	<input type="checkbox"/> Sterile gloves			
	<input type="checkbox"/> Pours antiseptic solution in a cup.			
	<input type="checkbox"/> Opens the IUCD onto the sterile instrument tray.			
18. The provider performs a pelvic examination before early postpartum insertion of the IUCD.	Observe that the provider:			
	<input type="checkbox"/> Explains the nature and purpose of the examination to the patient.			
	<input type="checkbox"/> Ensures that the woman has recently emptied her bladder.			
	<input type="checkbox"/> Helps the woman onto the examination table.			
	<input type="checkbox"/> Determines the level of the uterus and that there is good uterine tone.			
	<input type="checkbox"/> Places a clean drape over the woman's abdomen and underneath her buttocks.			
	<input type="checkbox"/> Performs hand hygiene and puts HLD or sterile gloves on both hands.			
	<input type="checkbox"/> Arranges the instruments and supplies on an HLD or sterile tray or draped area.			
	<input type="checkbox"/> Grasps the IUCD with Kelly or ring forceps. Leaves aside.			
	<input type="checkbox"/> Inspects the external genitalia.			
	<input type="checkbox"/> Gently inserts the speculum.			
<input type="checkbox"/> Maneuvers the speculum to visualize the cervix.				

Performance Standards	Verification Criteria	Y/N, N/A ⁱ	Y/N, N/A	Comments
19. The provider correctly inserts IUCD during the early postpartum period.	If the exam is normal, observe that the provider:			
	<input type="checkbox"/> Asks the woman if she is ready for IUCD insertion and if she has any questions.			
	<input type="checkbox"/> Cleans the cervix and vagina with antiseptic solution two times using two gauzes.			
	<input type="checkbox"/> Gently grasps the anterior lip of the cervix with ring forceps.			
	<input type="checkbox"/> Exerts gentle traction on anterior lip of the cervix using ring forceps.			
	<input type="checkbox"/> Inserts the IUCD into the lower uterine cavity. Avoids touching the walls of the vagina.			
	<input type="checkbox"/> Releases the hand that is holding the cervix-holding forceps, moves this hand to the abdomen and places this hand on top of the uterine fundus.			
	<input type="checkbox"/> Stabilizes the uterus by “elevating” it with the palm of the hand against the uterine body.			
	<input type="checkbox"/> Gently moves the IUCD upward toward the fundus (angle toward umbilicus), following the contour of the uterine cavity. Takes care not to perforate the uterus. (<i>Note: Remember that the lower uterine segment may be contracted postpartum and therefore some slight pressure may be necessary to advance the IUCD and achieve fundal placement.</i>)			
	<input type="checkbox"/> Keeps the forceps closed so the IUCD does not become displaced.			
	<input type="checkbox"/> Confirms that the end of the forceps has reached the fundus.			
	<input type="checkbox"/> Opens the forceps and releases the IUCD at the fundus.			
	<input type="checkbox"/> Sweeps the placental/ring forceps to the side wall of the uterus.			
	<input type="checkbox"/> Keeping the forceps slightly open, slowly removes them from the uterine cavity. Takes particular care not to dislodge the IUCD as the forceps are removed.			
	<input type="checkbox"/> Stabilizes the uterus until the forceps are completely out of the uterus.			
	<input type="checkbox"/> Examines the cervix to ensure there is no bleeding. If the IUCD is seen protruding from the cervix, removes the IUCD and reinserts it.			
<input type="checkbox"/> Removes all instruments used and places them in 0.5% chlorine solution.				
<input type="checkbox"/> Allows the woman to rest a few minutes, helps her off the table if necessary.				

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
20. The provider or another staff member correctly carries out post-procedure infection prevention tasks and instrument processing.	Observe that the provider and/or ancillary staff member:			
	<input type="checkbox"/> Disposes of waste materials appropriately.			
	<input type="checkbox"/> Submerges the speculum and metal instruments in 0.5% chlorine solution for 10 minutes for decontamination.			
	<input type="checkbox"/> Immerses both gloved hands in 0.5% chlorine solution.			
	<input type="checkbox"/> Removes gloves by turning them inside out and disposes of them in a designated container.			
	<input type="checkbox"/> Performs hand hygiene after removing gloves.			
21. The provider provides post-insertion instructions to the woman. <i>Note: This needs to be done for cesarean section patients on the 2nd or 3rd day postpartum.</i>	Observe that the provider:			
	<input type="checkbox"/> Notes the type of IUCD and the date of insertion on the discharge card.			
	<input type="checkbox"/> Reviews IUCD side effects and normal postpartum symptoms.			
	<input type="checkbox"/> Tells the woman when to return for postpartum check-up/IUCD follow-up.			
	<input type="checkbox"/> Emphasizes that the woman should come back at any time she has a concern or experiences warning signs.			
	<input type="checkbox"/> Reviews the warning signs for the IUCD.			
	<input type="checkbox"/> Reviews how to check for expulsion and what to do in case of expulsion.			
	<input type="checkbox"/> Assures the woman that the IUCD will not affect breastfeeding and breast milk.			
	<input type="checkbox"/> Ensures that the woman understands post-insertion instructions.			
	<input type="checkbox"/> Gives written post-insertion instructions, if possible.			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
Area 4: Management and Recordkeeping				
Instructions for the Assessor: Review the clinical record of the two most recent cases of PPIUCD insertion for standard 22. Review the delivery room and procedure room record for standard 23. For standards 24–26 interview the clinic administrator and one service provider, plus review the organization and readiness of the relevant service delivery areas.				
22. The provider records, in the patient’s chart, relevant information about the services provided.	Determine through two record reviews whether the following information is recorded:			
	<input type="checkbox"/> Date of service			
	<input type="checkbox"/> Type of insertion (postplacental, intracesean or early postpartum), if the IUCD is chosen			
	<input type="checkbox"/> Complications, if they occurred			
	<input type="checkbox"/> Follow-up plan			
23. The provider records relevant information about services provided in the register.	Determine through review of the delivery room register and the procedure room register whether the following information is recorded:			
	<input type="checkbox"/> Patient name, age and parity			
	<input type="checkbox"/> Patient address			
	<input type="checkbox"/> Delivery and complications			
	<input type="checkbox"/> Method of IUCD insertion and timing			
	<input type="checkbox"/> Complications of the procedure			
	<input type="checkbox"/> Follow-up plan			

Performance Standards	Verification Criteria	Y/N, N/A ^j	Y/N, N/A	Comments
24. The facility has adequate supplies and materials for PFP.	Determine by interview with a provider or clinic administrator that the facility has:			
	<input type="checkbox"/> A full range of available PFP options in stock.			
	<input type="checkbox"/> Condoms			
	<input type="checkbox"/> IUCDs			
	<input type="checkbox"/> Progestin-only pills			
	<input type="checkbox"/> Has a number of postpartum insertion kits equal to 50% of the number of women who deliver on a daily basis.			
	<input type="checkbox"/> Has long placental forceps packaged separately for postplacental insertion.			
	<input type="checkbox"/> Has postpartum information to distribute to patients.			
	<input type="checkbox"/> IUCDs available on the labor ward. <input type="checkbox"/> IUCDs available in the postpartum procedure room.			
25. The provider(s) have the required qualifications.	Determine by interview with provider or clinic administrator that:			
	<input type="checkbox"/> Providers performing PPIUCD insertion have been trained in a competency-based training course and meet facility/institutional/regional proficiency and certification standards for delivery of the service. <input type="checkbox"/> Providers are midwives, medical doctors or other health cadres who are able to perform IUCD insertion that is consistent with national practice standards.			

Performance Standards	Verification Criteria	Y/N, N/A ⁱ	Y/N, N/A	Comments
26. There is an organized, facility-wide system in place to ensure that every postpartum woman is counseled and offered PFP.	Determine by interview with a provider or clinic administrator that:			
	<input type="checkbox"/> Designated postpartum care providers are trained to provide family planning counseling.			
	<input type="checkbox"/> The postpartum ward provides an area where counseling can be done in private.			
	<input type="checkbox"/> The postpartum ward has a family planning client record system that ensures all patients receive counseling before discharge.			
	<input type="checkbox"/> The postpartum ward has informational posters or panels on the family planning services offered, including interval IUCD insertion.			
	<input type="checkbox"/> There is information on clients' rights regarding family planning.			
	<input type="checkbox"/> There is information on the family planning methods offered in the postpartum ward.			
	<input type="checkbox"/> The postpartum ward has an updated flip chart on family planning methods.			
	<input type="checkbox"/> The postpartum ward has samples of family planning methods for use during counseling.			
	<input type="checkbox"/> The postpartum ward periodically obtains and incorporates client feedback on the services provided.			
<input type="checkbox"/> The postpartum ward promotes activities to improve the quality of family planning services.				

Summary of Assessment				
Area	Total Number of Standards	Number Observed	Number Achieved	Percentage
Area 1: Antenatal Assessment and Return Visits	8			
Area 2: Counseling and Assessment during Labor/Postpartum	5			
Area 3: IUCD Service Provision	8			
Area 4: Management and Recordkeeping	5			
Overall	26			

Annex -K: Sample PPIUCD Service Delivery Data Collection Form

Insertion Details			
Serial No. (of IUCD):	Registration No.:	Woman's Name:	Date of Completing Form:
Age: <input type="checkbox"/> <20 <input type="checkbox"/> 20–35 <input type="checkbox"/> >35		Parity: <input type="checkbox"/> 1 <input type="checkbox"/> 2–4 <input type="checkbox"/> >4	No. of Living Children:
Address:		Phone No.:	
		Phone No.:	
		Mobile No.:	
Booked: <input type="checkbox"/> Yes <input type="checkbox"/> No	Period of Gestation at Delivery: <input type="checkbox"/> 21–32 Wks <input type="checkbox"/> 33–36 Wks <input type="checkbox"/> 37–41 Wks		Time of Counseling: <input type="checkbox"/> ANC <input type="checkbox"/> Early Labor <input type="checkbox"/> Postpartum
Type of Insertion: <input type="checkbox"/> Postplacental <input type="checkbox"/> Intracesearean <input type="checkbox"/> Early Postpartum		Instrument Used for Insertion: <input type="checkbox"/> Sponge Holder <input type="checkbox"/> Kelly Forceps <input type="checkbox"/> Manual	
Duration of Membrane Rupture: <input type="checkbox"/> <6 Hours <input type="checkbox"/> 6–12 Hours <input type="checkbox"/> 12–18 Hours <input type="checkbox"/> >18 Hours		Perforation during Insertion: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Provider Assessment: <i>On a scale of 1 to 10 (with 10 being easiest)</i> Ease of Insertion: 1 2 3 4 5 6 7 8 9 10 <input type="checkbox"/> could not insert with Kelly forceps <input type="checkbox"/> could not insert with sponge holder		Client's Experience: <i>On a scale of 1 to 10 (with 10 being most pain or anxiety)</i> Pain: 1 2 3 4 5 6 7 8 9 10 Anxiety: 1 2 3 4 5 6 7 8 9 10	
Follow-Up Details (to be completed at follow-up visit)			
Expulsion: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes—</i> <input type="checkbox"/> <6 weeks <input type="checkbox"/> 6 weeks–3 months			
Removal: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reason For Removal: <input type="checkbox"/> wants pregnancy <input type="checkbox"/> infection <input type="checkbox"/> excessive bleeding <input type="checkbox"/> pain <input type="checkbox"/> partial expulsion <input type="checkbox"/> voluntary	
Failure: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes—</i> <input type="checkbox"/> 0–3 months <input type="checkbox"/> >3 months		Infection: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes—</i> <input type="checkbox"/> 1–3 days <input type="checkbox"/> 4–7 days <input type="checkbox"/> 1–2 wks <input type="checkbox"/> >2 weeks	
Strings at Follow-Up: Initial visit: <input type="checkbox"/> seen <input type="checkbox"/> not seen <input type="checkbox"/> need to cut Subsequent visit: <input type="checkbox"/> seen <input type="checkbox"/> not seen <input type="checkbox"/> need to cut		Action Taken for Strings: Initial visit: <input type="checkbox"/> USG done <input type="checkbox"/> Strings pulled down Subsequent visit: <input type="checkbox"/> USG done <input type="checkbox"/> Strings pulled down	
Client Satisfaction: <i>“On a scale of 1 to 10 (with 10 being most), how satisfied are you with your IUCD overall?”</i>			
Initial visit:		1 2 3 4 5 6 7 8 9 10	
Subsequent visit:		1 2 3 4 5 6 7 8 9 10	

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TEN KEY POINTS REGARDING PFP/PPIUCD SERVICES

- 1. Many women want to delay or limit their pregnancies, and they desire information about family planning (PFP) methods, as well as a range of methods from which to choose.**
- 2. Postpartum women in developing countries are especially vulnerable to unintended pregnancy** because their fertility may return before they realize and most are not using contraception.
- 3. There are many opportunities throughout the course of caring for women and children to provide PFP education and counseling.** A successful PFP program will employ several strategies for reaching women with key PFP messages.
- 4. When possible, and particularly where the postpartum IUCD (PPIUCD) or tubal ligation are available, PFP counseling should be initiated during antenatal care** so that there is ample time for the woman and her partner to consider different options, ask questions and choose the method that is best for them.
- 5. Whether it is inserted postpartum or during the “interval,” the IUCD is a safe, highly effective, long-acting (12 years for the Copper T) but reversible contraceptive, with a high rate of user satisfaction.**
- 6. If the woman chooses the PPIUCD, her choice should be clearly noted** on her medical record and she should be:
 - **Provided more in-depth information about the method** (e.g., duration of efficacy, side-effects, warning signs), which helps to support correct, continued use; and
 - **Advised on the advantages of having it inserted immediately after delivery of the placenta** (postplacental, intracesarean) versus on Day 1 or 2 postpartum: immediate postpartum insertion is associated with lower rates of expulsion and is more cost-effective and convenient than early postpartum insertion.
- 7. The vast majority of women can use the IUCD.**
 - An **initial screening**, according to the latest WHO Medical Eligibility Criteria, helps the provider determine whether a woman is a suitable candidate.
 - A **second screening**, immediately after birth, focuses on conditions resulting from labor and delivery that may mean the method should be withheld or delayed.

Note: In some cases, the provider and woman may need to weigh the risk of not having an IUCD inserted against those of having it inserted.
- 8. The slightly higher rates of expulsion with the PPIUCD (versus interval IUCD) can be greatly reduced with proper postpartum insertion technique.** This technique focuses on ensuring high fundal placement of the IUCD, which is the most important factor in retention.
- 9. The PPIUCD does not interfere** with routine intrapartum care, including active management of third stage of labor, which should be performed before the IUCD is inserted. It also does not interfere with routine postpartum or newborn care, **nor does it affect breast milk or breastfeeding.**
- 10. In general, IUCD side effects are temporary (and better tolerated by postpartum women) and complications are rare or uncommon.** Potential problems can be identified and managed at the routine follow-up visit (only one is usually needed). As with all PFP services, quality follow-up—including treatment, referral and reassurance, as needed—has a strong positive impact on client satisfaction and correct, continued use of the method.

