

- PN-Act-648 -

A comprehensive training course

7

Intrauterine Devices



Comprehensive
Reproductive Health and Family Planning
Training Curriculum

MODULE 7: INTRAUTERINE DEVICES (IUDs)

Cathy Solter
Medical Services
Pathfinder International
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Medical Services Division
Pathfinder International
9 Galen Street, Suite 217
Watertown, MA 02172

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NOTES TO THE TRAINER

PURPOSE

This training manual is designed for use as part of the comprehensive family planning and reproductive health training of service providers. It is designed to be used to train physicians, nurses, and midwives.

This manual is designed to actively involve the participants in the learning process. Sessions include simulation skills practice, discussions, case studies, role plays and clinical practice, using objective knowledge, attitude, and skills checklists.

At the end of this module, the participant will be able to describe the IUD as an effective child spacing method; counsel and screen clients seeking IUDs; provide insertion and removal services for IUD clients; manage side effects and provide follow up care for IUD acceptors.

DESIGN

The training curriculum consists of 15 modules:

1. Introduction/Overview
2. Infection Prevention
3. Counseling
4. Combined Oral Contraceptives and Progestin-only Pills
5. Emergency Contraceptive Pills
6. DMPA Injectable Contraceptives
7. Intrauterine Devices
8. Breastfeeding and Lactational Amenorrhea Method
9. Condoms and Spermicides
10. Voluntary Surgical Contraception
11. MVA for Treatment of Incomplete Abortion
12. Reproductive Tract Infections
13. Postpartum/Postabortion Contraception
14. Training of Trainers
15. Quality of Care

Included in each module is a set of knowledge assessment questions, skills checklists, trainer resources, participant materials, training evaluation tools, and a bibliography.

SUGGESTIONS FOR USE

- The modules are designed to provide flexibility in planning, conducting, and evaluating the training course.
- The curriculum is designed to allow trainers to formulate their own training schedule, based on results from training needs assessments.
- The modules can be used independently of each other.

- The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
- In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, the overall objective, general, and specific objectives are presented in terms of achievable changes in these three areas.
- Training references and resource materials for trainers and participants are identified.
- Each module is divided into a *Trainer's Module* and *Appendix* section.
- The *Trainer's Module* presents the information in two columns:
 1. *Content*: which contains the necessary technical information.
 2. *Training/Learning Methods*: which contains the training methodology (lecture, role play, discussion, etc.) by which the information should be conveyed and the time required to complete each activity.
- This module is divided into two units. Unit 1 provides an overview of the IUD, while Unit 2 covers the clinical procedure. A training design section is included at the beginning of each unit. It includes the following: An Introduction to the unit, the unit training objectives, specific learning objectives, a simulated skills practicum section, clinical practicum objectives, the training/learning methodology, major references and training materials, resource requirements, evaluation methods, time required and what materials need to be prepared in advance.
- The *Appendix* section contains:
 - Participant handouts
 - Transparencies
 - Pre- & Post-tests (Participant Copy and Master Copy with Key)
 - Participant Evaluation Form
- The *Participant Handouts* are referred to in the *Training/Learning Methods* sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the *Content* of the module to role play descriptions, skills checklists, and case studies.
- The *Participant Handouts* should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended.
- Transparency masters have been prepared where called for in the text. These should be copied onto clear overhead sheets for display during the training sessions.
- The *Participant Evaluation* form should also be copied to receive the trainees' feedback in order to improve future training courses.
- The *Methodologies* section is a resource for trainers for the effective use of demonstration/return demonstration in training.

To ensure appropriate application of learning from the classroom setting to clinical practice, Clinical Practicum sessions are an important part of this training. For consistency in the philosophy of client's rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

CLIENT'S RIGHTS DURING CLINICAL TRAINING

The rights of the client to privacy and confidentiality should be considered at all times during a clinical training course. When a client is undergoing a physical examination it should be carried out in an environment in which her/his right to bodily privacy is respected. When receiving counseling, undergoing a physical examination, or receiving surgical contraceptive services, the client should be informed about the role of each individual inside the room (e.g., service provider, individuals undergoing training, supervisors, instructors, researchers, etc.).

The client's permission must be obtained before having a clinician-in-training/participant observe, assist with or perform any services. The client should understand that s/he has the right to refuse care from a clinician-in-training/participant. Furthermore, a client's care should not be rescheduled or denied if s/he does not permit a clinician-in-training/participant to be present or provide services. In such cases, the clinical trainer or other staff member should perform the procedure. Finally, the clinical trainer should be present during any client contact in a training situation.

Clinical trainers must be discreet in how coaching and feedback are given during training with clients. Corrective feedback in a client situation should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and clinician-in-training.

It can be difficult to maintain strict client confidentiality in a training situation when specific cases are used in learning exercises such as case studies and clinical conferences. Such discussions always should take place in a private area, out of hearing of other staff and clients, and be conducted without reference to the client by name (AVSC, "Tips for Trainers-8," September 1994; **NSV Trainer's Manual**).

DEMONSTRATION TECHNIQUE

The Five-Step Method of Demonstration and Return Demonstration is a training technique useful in the transfer of skills. The technique is used to make sure that participants become competent in certain skills. It can be used to develop skills in cleaning soiled instruments, high-level disinfection, IUD insertion, pill dispensing, performing a general physical examination, performing a breast or pelvic examination, etc. In short, it can be used for any skill which requires a demonstration. The following are the "five steps:"

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill and before they perform them in a clinical situation.
2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.
3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure.

*Note: The trainer does **not** demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.*
4. **Participant Talk-Through:** The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.
5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with her/his partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.

DO'S AND DON'TS OF TRAINING

The following "do's and don'ts" should ALWAYS be kept in mind by the trainer during any learning session.

DO'S

- Do maintain good eye contact
- Do prepare in advance
- Do involve participants
- Do use visual aids
- Do speak clearly
- Do speak loud enough
- Do encourage questions
- Do recap at the end of each session
- Do bridge one topic to the next
- Do encourage participation
- Do write clearly and boldly
- Do summarize
- Do use logical sequencing of topics
- Do use good time management
- Do K.I.S. (Keep It Simple)
- Do give feedback
- Do position visuals so everyone can see them
- Do avoid distracting mannerisms and distractions in the room
- Do be aware of the participants' body language
- Do keep the group on focused on the task
- Do provide clear instructions
- Do check to see if your instructions are understood
- Do evaluate as you go
- Do be patient

DON'TS

- Don't talk to the flip chart
- Don't block the visual aids
- Don't stand in one spot--move around the room
- Don't ignore the participants' comments and feedback (verbal and non-verbal)
- Don't read from curriculum
- Don't shout at participants

UNIT 1: AN OVERVIEW OF THE IUD

INTRODUCTION:

At the end of this module, the participant will be able to describe the IUD as an effective child spacing method; counsel and screen clients seeking IUDs; provide insertion and removal services for IUD clients; manage side effects and provide follow up care for IUD acceptors.

UNIT TRAINING OBJECTIVE:

To prepare participants to describe the IUD as an effective child spacing method and counsel, screen and select, refer for insertion/removal, and manage and follow-up IUD clients.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Explain key messages related to the IUD as a safe and effective child spacing method.
2. Describe the types of IUDs available, the mechanism of action, and effectiveness of the IUD.
3. Explain major advantages and disadvantages of the IUD.
4. Describe indications for using the IUD and rationale for each.
5. Identify eligibility criteria for initiating use of the IUD, and explain rationale for each.
6. Using an assessment checklist, screen a potential IUD client, and refer for insertion or removal.
7. Discuss when to insert and remove an IUD.
8. Using general terms, describe IUD insertion and removal procedures to clients.
9. Describe the early warning signs of IUD complications.
10. Recognize and manage common IUD side effects.
11. Demonstrate effective IUD counseling in role-play exercise.

SIMULATED SKILL PRACTICE:

- Discuss and solve IUD case studies related to client selection, screening, and management of common side effects and complications.
- Through role-play exercise using counseling and history checklists, demonstrate method-specific counseling of a FP client: to include pre- and post-insertion counseling and instructions, client screening and selection, and counseling when managing a client with common side effects and complications.

CLINICAL PRACTICUM OBJECTIVES:

During the clinical practicum, participants will be able to:

- Counsel potential IUD clients using the IUD counseling skills checklist, including pre-/post-insertion and follow-up counseling.
- Screen potential IUD clients using the *Case History Checklist for IUD Users*.
- Manage IUD clients experiencing common side effects or other problems, and refer if necessary.
- Document counseling services and other pertinent information on IUD clients seen in the clinic.

Note: *No minimum number of clients is specified for certification. The number will vary, and the practicum will be considered complete when the trainer is satisfied and prepared to certify that the participant is proficient.*

TRAINING/LEARNING METHODOLOGY:

- Trainer Presentations
- Class Discussions
- Required Reading
- Case Studies
- Case History Checklist for IUD Users
- Learning Guide for IUD Counseling
- Counseling Role Plays
- Clinical Practicum

MAJOR REFERENCES AND TRAINING MATERIALS:

- Alvarez F, et al. New Insights on the Mode of Action of Intrauterine Contraceptive Devices for Women. *Fertility and Sterility* 49 (5) : 768-773 (1988).
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- JHPIEGO. *IUD Course Handbook: Guide for Participants and Guide for Trainers*, 1992.
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- Population Council. IUDs—A New Look. *Population Reports Series B* (5) (March 1988).
- Technical Guidance/Competence Working Group. *Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting*. November 1994.

- Technical Guidance Working Group. *Recommendations for Updating Selected Practices in Contraceptive Use, Volume II*. June 1997.
- World Health Organization, Division of Family Health. *Improving Access to Quality in FP: Medical Eligibility Criteria for Initiating Use of Selected Methods of Contraception*, 1994.
- World Health Organization. A multinational case-control study of ectopic pregnancy. *Clinical Reproduction and Fertility* 3(2) :131-143 (June 1985).

RESOURCE REQUIREMENTS:

- Hand-held IUD models
- IUD samples
- Flipchart
- Marking pens
- Masking tape
- Overhead projector
- Large picture of female pelvic organs (or *Transparency 1.2*)
- Large picture of female pelvic organs with IUD in place (or *Transparency 1.3*)
- Life-size pelvic models
- Hand held uterine models

EVALUATION METHODS:

- Pre- and post-test
- Observation and assessment of participant during role-play, utilizing *Learning Guide for IUD Counseling Skills*
- Observation and assessment of participant during clinical practicum, utilizing *Checklist for IUD Counseling and Clinical Skills*
- Trainer administered examination
- Verbal feedback
- Participant reaction questionnaire

TIME REQUIRED:

Unit 1:	7.5 hours
Clinical practicum:	Up to 6.0 hours (estimated)

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Unit 1 Transparencies
2. Participant Handouts
3. Samples of IUDs, pelvic models, and uterine models
4. Prepare flipcharts on:
 - Key messages
 - Times for IUD insertion

Unit 1: Introduction

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Introduction</p>	<p>Trainer Presentation and Questions/Answers (10 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Briefly review objectives as shown in <i>Transparency 1.1</i> and elicit and respond to questions. • An alternate method of listing objectives is to prepare eleven pages or sheets, each with one objective on it. • Review each objective by looking at each page separately. • Hang up a blank large sheet of paper and ask participants to come up, one-at-a-time and write each one on the new list. • Leave this list of all objectives hanging up in the room during the course. • Review unit objectives, learning methods (audiovisual aids, using checklists, role play, practicum), and evaluation criteria for participant (Px). • Explain differences between Units 1 and 2: <ul style="list-style-type: none"> • Unit 1 emphasizes technical update, counseling, client screening/selection, referral, and follow-up management (i.e., no IUD insertion skills are covered in Unit 1). • Unit 2 builds on Unit 1 and goes on to provide skills training for provision of full IUD services. • Explain the purpose of and then administer the Pre-test for Unit 1 of <i>Module 7: IUDs</i>. <p>(Allow 30 minutes for the pre-test.)</p>

Specific Objective #1: Explain key messages related to the IUD as a safe and effective child spacing method.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Key Messages</p> <ol style="list-style-type: none"> 1. The IUD is a safe, easy-to-use, reversible, effective method of child spacing for couples who are at low risk for STDs/HIV. <i>(The IUD may increase the risk of infection for women exposed to STDs/HIV).</i> <p>Note: <i>It is not necessary to have a child first.</i></p> <ol style="list-style-type: none"> 2. Careful screening and counseling are essential for successful use of an IUD. <i>(The provider must know if the client should not use the IUD. The client must know how the IUD works, what the side-effects might be, how to check for strings, and what the warning signs are.)</i> 3. IUDs can be safely used by breastfeeding women. <i>(The IUD does not affect breastfeeding.)</i> 4. IUDs can be a good choice for women with COC precautions. <i>(The IUD does not affect the blood pressure, cause headaches, or affect the rest of the body.)</i> 5. Different IUDs can remain in from five to ten years. The TCu 380A IUD can be used for ten years. 6. Not using infection prevention practices during insertion and removal can put both client and practitioner at risk for serious infection, including pelvic inflammatory disease (PID), HIV, and hepatitis B. 	<p>Trainer Presentation (15 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Prepare flipchart in advance with key messages. • Explain that these messages relate the major concepts to be covered in the module. • Ask Px to offer rationale for each as presented. • Clarify or elaborate as needed. <p><i>(See Px Handout 1.1.)</i></p>

Specific Objective #2: Describe the types of IUD available, and mechanism of action and effectiveness of the IUD.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Types of IUDs available</p> <p>There are two types of IUDs: medicated (copper or hormone-releasing) or unmedicated (inert). The Copper -T 380A is widely available.</p> <p>Copper T 380A (TCu 380A)</p> <p>More than 25 million TCu 380A IUDs have been distributed in 70 countries throughout the world. This model is made of polyethylene with barium sulphate (for X-rays). The TCu 380A is T-shaped, with 314 mm of copper wire wound around the vertical stem. Each of the two arms of the T has a sleeve of copper measuring 33 mm. The bottom has a clear knotted string, creating a double-string effect. The TCu 380A is inserted into the cavity of the uterus by pulling the outer barrel over the plunger (withdrawal technique). It has a life span of ten years, and the pregnancy rate is less than one per 100 women-years.</p> <p>Mechanism of Action</p> <p>The copper-bearing IUDs' principal mechanism of action (MOA) is to interfere with fertilization. <i>Normally, the lining of the uterus and fallopian tubes are a good environment for sperm to swim and fertilize the egg. But the IUD makes the uterus a "spermicidal environment." The IUD causes the lining of the uterus and fallopian tubes to be inhospitable to sperm. The sperm are killed and cannot reach the egg. Those IUDs, which contain progesterone also, cause the thickening of cervical mucus, which stops the sperm from entering the uterus.</i></p>	<p>Trainer Presentation and Discussion (20 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display <i>Transparencies 1.2 and 1.3</i>, which show the female pelvic organs and the pelvic organs with a TCU 380A in place, respectively. • Distribute sample IUDs to Px to examine. • Briefly review characteristics of each. • Encourage discussion and questions. • Ask PX to explain mechanism of action. • Clarify and elaborate as needed. <p>(See <i>Px Handout 1.2.</i>)</p>

Specific Objective #2: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Effectiveness</p> <p>The IUD is one of the most effective contraceptive methods. It is very effective as typically used, with 0.8 pregnancies per 100 women in the first year of use. It is slightly more effective when used perfectly, with 0.6 pregnancies in the first year of use.</p> <p>Continuation Rates and Client Satisfaction</p> <p>Continuation rates are also high in IUD users--higher than those of most other reversible methods. Large trials conducted in many developing countries show that approximately 70-90% of women are still using their IUDs one year after insertion.</p> <p>Note: <i>Continuation rates are not effectiveness rates, but do represent user satisfaction with the method.</i></p>	<p>Question/Answer (10 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask different Px what they know about IUDs • Correct any misunderstandings immediately. For example, many people have heard that the IUD causes an abortion. This is not so, the IUD stops fertilization (conception) from taking place.

Specific Objective #3: Explain major advantages and disadvantages of the IUD.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Advantages</p> <ul style="list-style-type: none"> • Highly effective (96-99% rate) • Safe for most women not at risk for STDs/HIV • Reversible and economical • May be safely used by lactating and immediate postpartum women • Good choice for older women with COC precautions • Long duration of use (up to ten years for TCu 380A) • One visit for insertion, and minimal follow-up required after first three to six week check-up (unless client has problems) • The client does not have to use anything at the time of sexual intercourse; this allows her privacy and control over her fertility • Does not interact with medications client may use <p>Disadvantages</p> <ul style="list-style-type: none"> • Does not protect against STDs/HIV • If at risk for STD, for any reason, may place client at risk for PID and subsequent infertility if at risk for STD • May expose client to infection during insertion if infection prevention practices are not followed • Trained provider-dependent • Some pain, cramping, minor bleeding on insertion • Heavier/longer menstrual periods, increased cramping, and bleeding/spotting fairly common in first three months • Does not protect against ovarian or endometrial cancer (as does the COC) or cervical cancer (as do barrier methods) 	<p>Brainstorming (30 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Have Px cite advantages and disadvantages. • List on flipchart as identified. Add to list as needed. • Ask Px to explain rationale for selected advantages and disadvantages (i.e., Why is the IUD suitable for a lactating woman? What method does protect from STDs? Why is ectopic pregnancy a disadvantage?). • Elaborate on advantages and disadvantages as needed and correct any misconceptions immediately. • Know the cost of IUDs in-country, in case this question is asked. <p>(See Px Handout 1.3.)</p>

Specific Objective #3: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Disadvantages (cont.)</p> <ul style="list-style-type: none"> • Serious complications require immediate attention and good back-up services <p>Note: <i>IUDs do not increase the risk of ectopic pregnancy. A WHO multi-center study found that IUD users are 50% less likely to experience an ectopic pregnancy than are women using no contraception. However, since IUDs protect better against a pregnancy in the uterus than against ectopic pregnancy, if a client becomes pregnant with an IUD the pregnancy is more likely to be ectopic than in the uterus.</i></p>	

Specific Objective #4: Name at least 3 appropriate users of the IUD.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Appropriate Users of IUDs</p> <p>IUDs are an appropriate choice for a client who:</p> <ul style="list-style-type: none"> • has a healthy reproductive tract (the client does not have any signs of infection or cancer, or reproductive tract abnormalities that would make insertion difficult). • an IUD may be provided to young, nulliparous women only after thorough consideration. An IUD is only recommended for young, nulliparous women if they are living in a stable, mutually faithful relationship. • is in a mutually faithful sexual relationship (she is only having sexual intercourse with one person who is only having sexual intercourse with her). IUDs are appropriate for women who are at no risk/low risk for STDs/HIV. (IUD users with an STD are at risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility.) • has completed childbearing and does not want VSC (IUDs are highly suitable for older women until menopause). • wants a long-term, easily reversible method (IUDs have an excellent rate of return to fertility) • wants an effective method, but precaution(s) exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract). • is breastfeeding (IUDs do not affect lactation). • is immediately postpartum (from delivery of placenta to 48 hours) and wants an effective method that won't interfere with breastfeeding (IUDs do not affect lactation and may be inserted immediately after the placenta or within first 48 hours postpartum. This procedure requires a specially trained provider.) • has successfully used an IUD in past (users with positive past experience tend to tolerate IUDs well). 	<p>Group Discussion (20 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • review and discuss each indication and its rationale with Px. • Trainer should ask Px: <ul style="list-style-type: none"> • <i>What do you need to know about a woman before you give her an IUD?</i> • <i>Why do you need to know this?</i> • <i>Can nulliparous women receive IUDs?</i> • <i>Should young nulliparous women receive IUDs?</i> • Let the Px come up with both the information and why it is important. <p>(See Px Handout 1.4.)</p>

Specific Objective #4: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Appropriate Users of IUDs</p> <p>IUDs are an appropriate choice for a client who:</p> <ul style="list-style-type: none"> • has a healthy reproductive tract (the client does not have any signs of infection, cancer, or reproductive tract abnormalities that would make insertion difficult). • is in a mutually faithful sexual relationship (she is only having sexual intercourse with one person who is only having sexual intercourse with her). IUDs are appropriate for women who are at no risk/low risk for STDs/HIV. (IUD users with an STD are at risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility). • has completed childbearing and does not want VSC (IUDs are highly suitable for older women until menopause). • wants a long-term, easily reversible method (IUDs have an excellent rate of return to fertility). • wants an effective method, but precaution(s) exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract). • is breastfeeding (IUDs do not affect lactation). • is immediately postpartum (from delivery of placenta to 48 hours) and wants an effective method that won't interfere with breastfeeding (IUDs do not affect lactation and may be inserted immediately after the placenta or within first 48 hours postpartum. This procedure requires a specially trained provider). • has successfully used an IUD in past (users with positive past experience tend to tolerate IUDs well). 	

Specific Objective #4: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Summary</p> <p>Crucial factors for safe IUD use are:</p> <ul style="list-style-type: none"> • careful screening and assessment of STD/HIV risk • provider is proficient in IUD insertion and infection prevention practices • reliable back-up services available • careful and complete client counseling 	

Specific Objective #5: Identify eligibility criteria for initiating use of the IUD, and explain rationale for each.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Method (Time Required)																																																															
<p>Certain conditions make the use of an IUD as a method of family planning inappropriate. Listed below are conditions which could effect the decision to use an IUD, followed by the recommendation of whether or not it should be used in that instance.</p> <table border="0"> <thead> <tr> <th data-bbox="287 638 438 670">Condition</th> <th data-bbox="673 638 732 670">Use</th> <th data-bbox="863 638 1009 670">Don't Use</th> </tr> </thead> <tbody> <tr> <td data-bbox="287 707 443 739">Pregnancy</td> <td></td> <td data-bbox="897 707 913 739">√</td> </tr> <tr> <td data-bbox="287 776 455 808">Postpartum</td> <td></td> <td></td> </tr> <tr> <td data-bbox="287 814 584 847">• less than 48 hours</td> <td data-bbox="690 814 707 847">√</td> <td></td> </tr> <tr> <td data-bbox="287 853 648 886">• 48 hours to four weeks</td> <td></td> <td data-bbox="897 853 913 886">√</td> </tr> <tr> <td data-bbox="287 892 614 924">• four weeks or longer</td> <td data-bbox="690 892 707 924">√</td> <td></td> </tr> <tr> <td data-bbox="287 931 556 963">• puerperal sepsis</td> <td></td> <td data-bbox="897 931 913 963">√</td> </tr> <tr> <td data-bbox="287 1000 467 1032">Postabortion</td> <td></td> <td></td> </tr> <tr> <td data-bbox="287 1039 527 1071">• First Trimester</td> <td data-bbox="690 1039 707 1071">√</td> <td></td> </tr> <tr> <td data-bbox="287 1078 572 1110">• Second Trimester</td> <td data-bbox="690 1078 707 1110">√</td> <td></td> </tr> <tr> <td data-bbox="287 1116 601 1149">• Post-septic abortion</td> <td></td> <td data-bbox="897 1116 913 1149">√</td> </tr> <tr> <td data-bbox="287 1185 346 1218">Age</td> <td></td> <td></td> </tr> <tr> <td data-bbox="287 1224 631 1256">• menarche to 20 years</td> <td data-bbox="690 1224 707 1256">√</td> <td></td> </tr> <tr> <td data-bbox="287 1263 559 1295">• 20 years or older</td> <td data-bbox="690 1263 707 1295">√</td> <td></td> </tr> <tr> <td data-bbox="287 1332 409 1364">Smoking</td> <td data-bbox="690 1332 707 1364">√</td> <td></td> </tr> <tr> <td data-bbox="287 1401 606 1433">Essential hypertension</td> <td data-bbox="690 1401 707 1433">√</td> <td></td> </tr> <tr> <td data-bbox="287 1470 628 1502">History of pre-eclampsia</td> <td data-bbox="690 1470 707 1502">√</td> <td></td> </tr> <tr> <td data-bbox="287 1539 409 1571">Diabetes</td> <td data-bbox="690 1539 707 1571">√</td> <td></td> </tr> <tr> <td data-bbox="287 1608 534 1673">Deep venous thromboembolism</td> <td data-bbox="690 1640 707 1673">√</td> <td></td> </tr> <tr> <td data-bbox="287 1709 577 1742">Pulmonary embolism</td> <td data-bbox="690 1709 707 1742">√</td> <td></td> </tr> <tr> <td data-bbox="287 1778 544 1843">Superficial venous thrombosis</td> <td data-bbox="690 1811 707 1843">√</td> <td></td> </tr> </tbody> </table>	Condition	Use	Don't Use	Pregnancy		√	Postpartum			• less than 48 hours	√		• 48 hours to four weeks		√	• four weeks or longer	√		• puerperal sepsis		√	Postabortion			• First Trimester	√		• Second Trimester	√		• Post-septic abortion		√	Age			• menarche to 20 years	√		• 20 years or older	√		Smoking	√		Essential hypertension	√		History of pre-eclampsia	√		Diabetes	√		Deep venous thromboembolism	√		Pulmonary embolism	√		Superficial venous thrombosis	√		<p>Lecturette (30 min.):</p> <p>Give a mini-lecture on conditions, which affect eligibility for the use of IUDs and the rationale for each.</p>
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Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills			Training/Learning Methods (Time Required)
Condition	Use	Don't Use	
Current and history of ischemic heart disease	√		
Stroke	√		
Known hyperlipidaemias	√		
Valvular heart disease	√		
Headaches	√		
Irregular vaginal bleeding	√		
Unexplained vaginal bleeding	√		
Breast disease	√		
Cervical intraepithelial neoplasia	√		
Cervical cancer (awaiting treatment)		√	
Cervical ectropion	√		
Pelvic inflammatory disease			
• Past	√		
• Current or within last three months		√	
STDs			
• Current or within last three months		√	
• Vaginitis without purulent cervicitis		√	
• Increased risk of STDs		√	

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills			Training/Learning Methods (Time Required)
Condition	Use	Don't Use	
HIV/AIDS			
• HIV positive		√	
• AIDS		√	
• High risk of HIV		√	
Biliary tract disease	√		
History of cholestasis	√		
Viral hepatitis	√		
Cirrhosis	√		
Liver tumors	√		
Uterine fibroids	√		
Past ectopic pregnancy	√		
Obesity	√		
Thyroid problems	√		
Thalassemia	√		
Trophoblast disease		√	
Sickle cell disease	√		
Iron deficiency anemia	√		
Epilepsy	√		
Schistosomiasis	√		
Malaria	√		
Drug interactions	√		

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills			Training/Learning Methods (Time Required)
Condition	Use	Don't Use	
Nulliparous	√		
Distorted uterine cavity		√	
Severe dysmenorrhea	√		
Tuberculosis			
• Non-pelvic	√		
• Pelvic		√	
Endometriosis		√	
Benign ovarian tumors	√		
History of pelvic surgery	√		
<p>For additional information on any of these eligibility criteria, please refer to: World Health Organization. <i>Improving Access to Quality Care in Family Planning</i>, Geneva 1996.</p>			

Specific Objective #6: Using an assessment, screen a potential IUD client and refer for insertion/removal.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Key Client Assessment Questions</p> <p>The IUD is more appropriate for some women than for others. Careful screening is crucial for successful IUD use. Some serious side effects can be prevented by thorough screening.</p> <p><i>Why screen?</i></p> <ul style="list-style-type: none"> • to determine indications for use • to identify precautions • to identify other health or special problems <p>Using a screening checklist helps one to obtain information systematically and completely.</p> <p>Using IUD screening checklist</p> <p>Refer to <i>Px Handout 1.7: Client Assessment Checklist for Small Group Exercise</i>.</p>	<p>Trainer Presentation and Small Group Exercise (60 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide Px into groups of 3. • Hand out to each group a copy of <i>Px Handout 1.7: Client Assessment Checklist for Small Group Exercise</i>. Before the class, check off "yes" responses to different screening questions on each copy. • Explain that the purpose of this exercise is to familiarize Px with essential screening questions and the rationale for each. • It also serves to strengthen Px analytic and problem-solving skills when screening IUD clients. • Finally, it encourages them to get into the habit of referring to the checklist when dealing with IUD clients. • Instruct each group to look up the rationale for asking the question with the "yes" response checked in <i>Recommendations for Updating Selected Practices in Contraceptive Use</i>. (See <i>Px Handout 1.6A</i>). • Ask them to fill in the column marked "rationale for question." Then, depending on the "yes" response checked off, each group will fill in the "Action/Plan" column with their recommendation on how to manage client. <p>(See <i>Px Handout 1.6 and 1.7</i>)</p>

Specific Objective #6: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	<p>Small group exercise instructions (cont.):</p> <ul style="list-style-type: none"> • Give the Px 15 minutes in their small group, encourage them to ask questions if they have problems. • When the Px have filled in the rationales and action plans, ask each small group to present their cases to the larger group. • They should state the problem or "yes" response, the rationale for asking the question, and the plan for managing the client. • The trainer may guide group discussion and encourage Px to offer each other solutions and constructive feedback.

Specific Objective #7: Discuss when to insert and remove an IUD.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Timings for IUD Insertion</p> <p>1. Any time during menstrual cycle, if you are reasonably certain the client is not pregnant. A clinician may be "reasonably certain" if the client has not had intercourse since last normal menses, or if she has been using another reliable method since her menses, and her pelvic exam does not show any signs of possible pregnancy.</p> <p>Many clinicians prefer to insert during or very soon after the menstrual period since then there is little likelihood of pregnancy. Another reason to insert the IUD at this time is that the woman is already bleeding, and the cramping may be less noticeable. Other clinicians prefer mid-cycle when the cervical os is a little larger.</p> <p>2. Postpartum</p> <ul style="list-style-type: none"> • Immediately postpartum (within 10 minutes) following delivery of the placenta, during or immediately after a cesarean section. This requires special training. • Within the first 48 hours postpartum. <p>Note: <i>IUD insertion at immediate or 48 hours postpartum requires special training and should not be attempted without having received the required training.</i></p> <p>Expulsion rates may be higher for IUDs inserted during this time. Insertions after one week and before four weeks should be avoided because of the higher risk of uterine perforation.</p> <ul style="list-style-type: none"> • As early as four weeks postpartum for those who come for routine postpartum care and who request an IUD. Copper IUDs may be safely inserted at this time. 	<p>Trainer Presentation (30 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • List on a flipchart these times for IUD insertions: <ul style="list-style-type: none"> • anytime during the menstrual cycle if you reasonably certain client is not pregnant • immediately postpartum • around four to six weeks postpartum • immediately postabortion up to seven days • Ask the Px why each of these are the best times. • Describe when the IUD should not be inserted immediately post-abortion. • Again, have the Px tell you under which conditions they would not insert the IUD post-abortion. • For example, you may say, "Why wouldn't you insert an IUD post-abortion if the pregnancy had been 16 weeks or greater?" • Then review the follow-up schedule for IUD clients. • Again, you may ask the Px why they should schedule these follow up visits. • Finally, list the best times for IUD removals and have the Px explain why to remove at these times. <p>(See Px Handout 1.8.)</p>

Specific Objective #7: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Timings for IUD Insertion (cont.)</p> <p>3. Immediately Postabortion: The IUD may be inserted immediately postabortion (spontaneous or induced) if the uterus is not infected, or during the first seven days postabortion (or anytime you can be reasonably sure that the client is not pregnant).</p> <p>IUDs should not be inserted immediately postabortion in the following situations:</p> <ul style="list-style-type: none"> • When there is the possibility of infection (signs of unsafe or unclean induced abortion, signs of infection, or inability to rule out infection), do not insert an IUD. Do not insert IUD until risk of infection has been ruled out or infection has fully resolved (approximately three months). • When there is serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns), do not insert IUD until healed. • When there is hemorrhage and severe anemia, IUDs (inert or copper-bearing) are not advised until hemorrhage or severe anemia is resolved. However, progestin-releasing IUDs can be used in cases of severe anemia (they decrease menstrual blood loss). • Immediate postabortion IUD insertion after 16 weeks' gestation requires special training of the provider. If the pregnancy went beyond 16 weeks, delay insertion for six weeks postabortion. <p>Follow-up schedule (after IUD insertion)</p> <p>a) There should be one follow-up visit approximately three-to-six weeks after insertion; thereafter, there is no need for a fixed follow-up schedule.</p>	

Specific Objective #7: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Follow-up schedule (cont.)</p> <p>b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has:</p> <ul style="list-style-type: none"> • late period (possible pregnancy). • prolonged or excessive abnormal spotting or bleeding. • abdominal pain or pain during intercourse. • infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain, especially with fever. • string missing or string seems shorter or longer. <p>c) Encourage clients to come in for other preventive reproductive health care if available, including provision of condoms, when appropriate.</p> <p>Timings for IUD Removal</p> <ul style="list-style-type: none"> • IUD may be removed at any time during the menstrual cycle. Some clinicians prefer to remove IUD during menses because the os may be slightly open and the patient will not be concerned if she has any bleeding. • Anytime the client requests--for any stated reason, or for no reason at all. • Evidence of IUD perforation. • Known or suspected pregnancy. • Partial expulsion--the old IUD may be removed and replaced with a new one. • Persistent side effects or other health problems. • Client is now at risk for STDs. • When IUD has been in utero for its effective life--a new IUD may be inserted immediately if no precautions are present. 	

Specific Objective #7: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
Timings for IUD Removal (cont.) <ul style="list-style-type: none">• Known or suspected PID--the client must also receive antibiotic treatment.• Severe pain or severe bleeding with evidence of marked anemia.	

Specific Objective #8: Using general terms, describe the IUD insertion and removal procedure to clients.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Suggested simple explanation</p> <p>One could say: The IUD is a small device made of plastic and copper. It is placed in the uterus through the vagina and the opening of the uterus using a small applicator. It has two thin strings attached, which hang down into the vagina. These strings allow you to check each month after your menstrual period that the IUD is still in place and that you are still protected from getting pregnant. The strings are also used to remove the IUD. Removing the IUD takes only a few minutes and is usually not painful. When you want the IUD removed a doctor or trained health worker must do it.</p> <p>Inserting the IUD is simple. You may feel uncomfortable for a few minutes. Most women, however, say that it is not too painful and compare the feeling to having heavy menstrual cramps. Before I insert the IUD, I will need to ask you some questions (take a history), and perform a pelvic examination to make sure the IUD is right for you.</p>	<p>Demonstration and Group Discussion (15 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Use a modified role play approach, to demonstrate how to explain the insertion/removal procedure to client with a volunteer Px. Important points: <ul style="list-style-type: none"> • Use hand-held model (or local flipchart) to demonstrate insertion/removal. • Let the client feel and hold the IUD (good idea for Px to keep an outdated IUD on desk for this purpose). • Encourage Px to use simple/local words for "uterus," "vagina," etc. • Keep description simple and ask client if she has questions after explanation has been given. <p>(See Px Handout 1.9.)</p>

Specific Objective #9: Describe the early warning signs of IUD complications.

<p align="center">CONTENT Knowledge/Attitudes/Skills</p>	<p align="center">Training/Learning Methods (Time Required)</p>
<p>Warning Signs for IUD Users</p> <p>These five signs are the warning signs of infection or IUD failure (expulsion or pregnancy).</p> <ul style="list-style-type: none"> • Abnormal bleeding: no period, heavy bleeding, abnormal spotting • Abnormal discharge • Pain: dyspareunia (pain during intercourse) • Fever: chills, or not feeling well • String missing, or shorter or longer <p>If a client notices any of these signs, she should see her healthcare provider.</p>	<p>Trainer Presentation (20 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Describe warning signs and ask Px to suggest what possible complication may be indicated by each sign. • List on flipchart. • Elaborate and clarify, as needed. • Discuss with Px how to prepare a local referral system for their clients with complications: <ul style="list-style-type: none"> • to whom to make referrals • how to ensure that client will be seen promptly • how to get feedback from specialist on diagnosis/treatment and necessary follow-up of client <p>(See Px Handout 1.10.)</p>

Specific Objective #10: Recognize and manage common IUD side effects.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Common side effects and their management</p> <p>As with most contraceptive methods, IUDs are associated with certain common side effects. Most are not serious and can be handled by the provider or practitioner. Some may need referral to a specialist.</p> <p>Side effects and complications may include:</p> <ul style="list-style-type: none"> • Cramping • Irregular or heavy bleeding • Syncope/bradycardia, vasovagal episode during insertion (fainting, becoming dizzy, or lowered heart rate during insertion) • Missing strings • Amenorrhea • Expulsion of IUD • Pelvic infection • Suspected uterine perforation • Ectopic pregnancy 	<p>Trainer Presentation (15 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Ask Px to identify side effects and list them on flipchart. • Discuss briefly and ask Px to describe how they might manage the most common, least serious side effects (cramping, irregular/heavy bleeding, and fainting). • Relate serious side effects and complications back to danger signs. • Review <i>Px Handout 1.11 and 1.11A - E</i>. • When discussing more complex side effects or complications, stress need for Px to refer immediately to an Ob/Gyn specialist and to ensure that client is seen immediately. <p>Case Study Exercise (45 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide the Px into four groups. • Distribute the case studies on IUD complications found in <i>Px Handout 1.12</i>, one to each group. • Each group should discuss the material, and develop a course of action based on the study. Allow 20 minutes for this. • Reconvene the large group and discuss the case studies.

Specific Objective #11: Demonstrate effective IUD counseling in role-play exercise.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Key IUD Information/Messages</p> <p>A main ingredient for successful use of the IUD (or any method) is an informed client. A client who understands the benefits, risks, advantages, disadvantages, what she must do to use the method correctly, and knows what side effects she may experience (and does not panic if they should occur), will be a far more satisfied and successful user than one who does not.</p> <p>Informing the client may take more time, but it will pay off in a client who is more satisfied and who understands her method.</p>	<p>Role Play Exercise (60 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Divide the Px into groups of three. In each team, assign one person to play the client, one the counselor, and the third to observe. • Assign each team one of the role plays in <i>Px Handout 1.14</i>, but only allow the person playing the client in each group to see the case study. • Distribute copies of <i>Px Handout 1.15: Learning Guide for IUD Counseling Skills</i> to each Px. • Ask the "client" and "counselor" to role play the counseling session and the observer to comment on the role play using <i>Px Handout 1.16</i>. Refer to <i>Px Handouts 1.16A and 1.16B</i> for supplemental information on counseling. • The "counselor" (who has not been told the situation) must identify the client's feelings and determine the client's situation in order to assist in the decision-making process. The "counselor" must demonstrate respect, caring, honesty and confidentiality. • Process the role play by asking the "client" and "counselor" to give their impressions and/or reactions to the exercise and the observers to make comments based on their observation of the case studies. • Reassign the role plays, having "observers," "counselors," and "clients" switch roles. <p>(See <i>Px Handout 1.13 – 1.16B</i>)</p>

Specific Objective #11: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Key IUD Information/Messages</p>	<p>Role Play Exercise: (cont.)</p> <ul style="list-style-type: none"> • Interrupt role plays at key moments to point out problems to the Px, and to identify possible solutions. • To summarize the session, remind the Px that, "the counselor must recognize and respond to each client as a unique person with attitudes, values, and experiences reflected in his or her personal situation. The counselor must recognize the individual needs of each client." • Analyze the role play by asking the following questions: <ul style="list-style-type: none"> • What were the dynamics between "counselor" and "client"? • Did the counselor listen actively? • Respond to questions appropriately? • Ignore non-verbal cues? • Convey negative/positive cues? • Was the information given too technical, or did the counselor use language the client could understand? • Was the information accurate and complete? • Congratulate the Px on their active participation.

Summary

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
	<p>Summary and Closure (20 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Briefly summarize major concepts covered in the unit, and review overall learning objectives. <p>Administer Post-Test (30 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Administer the post-test for Unit 1 of <i>Module 7: IUDs</i>.

UNIT 2: PROVIDING SERVICES

INTRODUCTION:

Unit 2 is competency-based clinical-skills training that builds on the essential IUD knowledge base and method-specific counseling skills which participants acquired in Unit 1 of this module.

Before advancing to the clinical practicum, the trainee must demonstrate:

- Basic IUD technical knowledge as assessed by a written test.
- Clinical and counseling skill competency in simulated situations (i.e., counseling role play, IUD insertion and removal in anatomical models, and infection prevention practices demonstration).

Note: *These will be assessed through direct observation by a trainer, using standardized skills assessment checklists from the appendix.*

After the clinical practicum, the participant will be certified as a provider when the trainer is satisfied with her/his proficiency in all aspects of IUD service delivery. Upon completion of this module and certification of proficiency as described above, the participant will be qualified to offer high-level IUD services in her/his clinic setting, which must fulfill minimum standard criteria explained in this unit. The participant also must agree to be interviewed and possibly observed by a program-designated monitor while delivering IUD services, six-to-twelve months after completing certificate course requirements. The purpose of these visits is to monitor and provide ongoing improvements in the training of subsequent generations of trainees, as well as to help the trained provider solve any problems encountered and upgrade her/his practice skills.

UNIT TRAINING OBJECTIVE:

To prepare the participants to insert and remove IUDs competently; to provide high-quality IUD services, including counseling, screening, and selecting clients; and to manage and provide follow-up for clients who choose an IUD.

SPECIFIC LEARNING OBJECTIVES:

By the end of the unit, participants will be able to:

1. Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs.
2. Load the TCu 380A while it is still inside the sterile package, without touching it directly.
3. Perform efficiently and in correct sequence all the steps in safe and gentle IUD

- insertion and removal, according to written standardized protocols for TCu 380A.
4. Describe recommended infection-prevention practices in the provision of IUD services, in order to minimize risk to client and provider.
 5. Provide pre- and post-insertion counseling to IUD clients
 6. Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications.
 7. Describe the facilities and recordkeeping tasks necessary to organize and manage high-quality IUD services.

SIMULATED SKILL PRACTICE:

- Using a pelvic model, practice and demonstrate speculum and bimanual pelvic exam.
- Using a pelvic model, practice and demonstrate IUD insertion and removal.
- Observe and demonstrate exam-room set-up and infection prevention practices including decontamination, cleaning, HLD or sterilization, and waste disposal.

CLINICAL PRACTICUM OBJECTIVES:

During the clinical practicum, participants will be able to:

- Counsel IUD clients in initial, method-specific, pre- and post-insertion, and follow-up visit sessions.
- Assess and screen potential IUD clients.
- Perform IUD insertions and removals.
- Provide follow-up care to IUD clients.
- Manage IUD clients experiencing side effects and other problems, if available.
- Practice infection-prevention activities in the clinical setting.
- Using a standard form, document history, physical findings, and other pertinent information.

Note: *As a general rule in the training of new service providers, each participant is expected to provide IUD services to at least five to ten clients. In determining competence, the judgment of a skilled clinical trainer is the most important factor. Thus, in the final analysis, the level of demonstrated competence carries more weight than the number of performed insertions.*

TRAINING/LEARNING METHODOLOGY:

- Lecture
- Video
- Discussion
- Required reading
- Role Plays
- Case Studies
- Simulated practice on models
- Demonstration
- Clinical practicum
- Use of checklists and learning guides

MAJOR REFERENCES AND TRAINING MATERIALS:

- Alvarez F, et al. New Insights on the Mode of Action of Intrauterine Contraceptive Devices for Women. *Fertility and Sterility*, 49 (5): 768-773 (1988).
- Blackburn R, et al. *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff*. Johns Hopkins Population Information Program, July 1997.
- Burnhill MS, et al. Safely Using IUDs. *American Journal of Gynecologic Health*, New York, Supplement, May/June 1989.
- Cronin L, McIntosh N, Tietjen L. *Infection Prevention for Family Planning Service Programs*. JHPIEGO, 1992.
- Farley T, et al. Intrauterine devices and pelvic inflammatory disease: an international perspective. *The Lancet* 330: 785-788 (1992).
- Hatcher, et al. *Contraceptive Technology*. 16th revised ed. 1994.
- Indian Medical Association/Development Associates. *Family Planning Course Module 8: Intrauterine Contraceptive Devices: An Overview*. 1994.
- INTRAH. *Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers*. 1992 (Chap. 7).
- IUDs—A New Look. *Population Reports*, Series B (5), March 1988.
- JHPIEGO. *IUD Course Handbook: Guide for Participants and Guide for Trainers*. 1992.
- JHPIEGO. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual*. 1993.
- JHPIEGO. Video: *Insertion and Removal of the Copper-T 380A IUD*. 1997.
- The Population Council and the Program for Appropriate Technology in Health (PATH) *The Copper-T 380A IUD: A Manual for Clinicians*. 2nd ed. Seattle, Washington: PATH, 1989.
- Program for International Training in Health (INTRAH). *Guidelines for Clinical Procedures in Family Planning and Sexually Transmitted Diseases: A Reference for Trainers*. Chapel Hill, North Carolina: INTRAH, 1989.
- Technical Guidance Working Group. *Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting*. November 1994.
- WHO, Division of Family Health. *Improving Access to Quality in FP: Medical Eligibility Criteria for Initiating Use of Selected Methods of Contraception*. 1994.
- WHO. A multinational case-control study of ectopic pregnancy. *Clinical Reproduction and Fertility* 3 (2): 131-143, (June 1985).

RESOURCE REQUIREMENTS:

- hand-held IUD models
- IUD samples
- flipchart
- marking pens
- masking tape
- overhead projector
- large picture (or transparency) of female pelvic organs
- large picture (or transparency) of female pelvic organs with IUD in place
- life-size pelvic models

Module 7/Unit 2

- infection prevention supplies
- speculum and other IUD insertion equipment, light source
- notebooks for use by participants to record results of clinical practicum
- materials necessary for infection prevention: leak-proof container with tight-fitting lid or plastic bag, plastic bucket, chlorine, gloves (either single-use or reusable), detergent, soft brush, HLD container, cooker pot, forceps

EVALUATION METHODS:

- Pre-/post-test
- Observation and assessment of participant during simulated practice, utilizing *IUD Counseling and Clinical Skills Learning Guide*
- Observation and assessment of participant during clinical practicum, utilizing *IUD Counseling and Clinical Skills Learning Guide*
- Trainer administered examination
- Verbal feedback
- Participant Evaluation Form

TIME REQUIRED:

Workshop/simulated practice:	11.5 hours
Clinical practicum:	time depends on availability of clients and experience of Px

MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:

1. Unit 2 Transparencies
2. Participant Handouts
3. Samples of IUDs, life-sized pelvic models, uterine models, IUD insertion equipment including light source and other supplies
4. Video player and required videos

Specific Objective #1: Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Once a client has made the decision to use an IUD based on complete general method counseling, she needs to have IUD method-specific counseling (as covered in Unit 1 of this module). Before you can assure her that the IUD is an appropriate choice for her, she needs to have a limited history and physical exam in order to achieve the following objectives:</p> <ul style="list-style-type: none"> • Rule out conditions which might affect eligibility, including the possibility of pregnancy, genital tract abnormalities, infection, or risk of STDs. • Rule out conditions which might be made worse by an IUD, such as severe dysmenorrhea (cramping), metrorrhagia (bleeding between periods), or anemia. • Rule out conditions which when combined with IUD use may place client at risk, such as valvular heart disease, severe diabetes, immunosuppression, etc. <p>To aid the practitioner in obtaining client history and giving rationale for asking each question (as well as aiding decision-making in case of a precaution), practitioners may use checklists such as <i>Participant Handout 2.2: Client Assessment Checklist</i>.</p> <p>Note: <i>Microscopic examination of vaginal secretions is not necessary for IUD insertion.</i></p> <p>After the history, practitioner should rule out severe anemia by examining the mucous membranes and skin.</p>	<p>Introduction and Trainer Presentation/Class Discussion (3 hours):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Display <i>Transparency 2.1</i> and discuss Unit 2 Objectives. • Administer Unit 2 pre-test. (Allow 30 minutes) • Discuss main concepts. • Describe pelvic exam in detail. • Introduce and review <i>Px Handouts 2.1, 2.2, and 2.3</i>. • Ask Px to discuss the meanings of various positive checklist findings and management options for each. • Use brainstorming approach as a way to assess the knowledge learned in Unit 1 of this module. <p>If available, show the JHPIEGO video on insertion and removal of the copper T 380A IUD.</p> <p>Simulated Demonstration of Pelvic Exam and Simulated Practice:</p> <p>After presenting the content, the trainer should:</p> <ul style="list-style-type: none"> • Get a sense of the knowledge and skills levels that the Px have prior to learning the skills in Unit 2 from the pre-test and other means. • While some Px will have no experience in performing a pelvic exam, other may have a lot.

Specific Objective #1: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Finally, practitioner should perform a complete pelvic exam in order to:</p> <ul style="list-style-type: none"> • determine position and size of uterus • rule out likelihood of pregnancy • rule out presence of visible and/or palpable abnormalities, including infections, masses, tumors, etc. <p>If any of these are present, an IUD should not be inserted until the problem is investigated and resolved. Again, the trainer and practitioner can use <i>Px Handout 2.3: Pelvic Bimanual and Speculum Checklist</i>.</p>	<p>Simulated Practice (cont.):</p> <ul style="list-style-type: none"> • Some of those may also have learned habits which must be "unlearned" if they are to perform according to the learning guides. • Before giving Px the opportunity to practice on the life-size pelvic model, the trainer should demonstrate on the model, pointing out its parts and how to use them. • After demonstrating a pelvic exam on the model, the trainer will allow each participant to do the same, while being coached by the trainer at first and then by a fellow participant who will use <i>Px Handout 2.3</i>. • The trainer will then assess the skills of the participant in distinguishing anteverted from retroverted uterus, non-pregnant from pregnant uterus, and abnormal from normal cervix (done by trainer changing optional organs in the pelvic model without Px observing). • Throughout the simulated practice, Px needs to be encouraged to practice her/his role as clinician by talking to the "client" while performing the exam, explaining what is taking place and why, what sensations the client may be feeling, and what the findings are.

Specific Objective #2: Load the TCu while it is still inside sterile package, without touching it directly.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>There are at least two reasons to load the TCu inside the sterile package instead of using sterile gloves to load the IUD outside the package:</p> <ul style="list-style-type: none"> • Not touching the IUD directly will ensure its sterility, thus avoiding PID risk to client • Loading the TCu while it is in the package is cost-saving because it eliminates the need to use sterile gloves. (HDL gloves are adequate because nothing that will be introduced into the uterus will be touched directly.) <p>In addition, sterile gloves frequently are inadvertently contaminated by the inexperienced practitioner, again increasing the risk of PID to the client.</p> <p>At first, loading the TCu inside the sterile package may appear awkward and time-consuming; however, with help from the trainer and some practice, the participant will be able to perform this maneuver in less than 20 seconds.</p>	<p>Demonstration and Practice (30 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss the reasons for loading the Tcu in the sterile package. • Have sample IUDs on hand, some out of the package and some still inside of the sterile package. • Distribute one or two TCu's in sealed package to each Px (expired IUDs may be used). • Display <i>Transparency 2.2</i> (an IUD with all of the parts identified). Always use the same name for those parts. • Ask the Px to point to the following parts in the packages they are holding and name them: arms, stem, inserter tube, blue depth gauge, ID card, white rod, thumb grip. • Name the two parts of the IUD package, the clear plastic and the white backing flap. • Demonstrate the steps needed to achieve the objective, loading the TCu 380A in the sterile package. • Observe Px as s/he follows the steps in order. (See <i>Px Handout 2.5: Instructions for Loading the TCu 380A in the Sterile Package.</i>) • Allow the Px to practice until competent; alternatively, s/he may choose to practice at home or work and then demonstrate the skill, once acquired, to the trainer. <p>(See <i>Px Handout 2.4.</i>)</p>

Specific Objective #3: Perform efficiently and in correct sequence all steps in safe and gentle IUD insertion and removal, according to written standardized technique for TCU 380A IUDs.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Participants will achieve this objective through a variety of training methodologies. The step-by-step IUD insertion and removal sequence is found in <i>Participant Handout 2.10</i>. The JHPIEGO video on IUD insertion and removal also details the procedure.</p> <p>Throughout insertion and removal training, certain basic principles are to be emphasized:</p> <ul style="list-style-type: none"> • Gentle techniques to minimize discomfort and emotional trauma to the client. In order to perform a comfortable IUD insertion, force is neither necessary nor desirable. • No-touch technique, in which the tip of the uterine sound that will touch the upper genital tract will not have previously touched anything that may contaminate it: hands, speculum, vagina, table top, etc. • As already indicated in Specific Objective #2, the TCU is loaded using the no-touch technique, inside package. • The cervix and vagina should be thoroughly prepped with antiseptic. Use a water-based antiseptic such as an iodophor (Betadine or Povidone Iodine) or Chlorhexidine (Hibitane) <p>Note: <i>If an iodophor is used, wait one or two minutes before proceeding because iodophors take up to two minutes contact time to release free iodine.</i></p> <ul style="list-style-type: none"> • The uterine cavity should always be sounded to confirm the position of the uterus and the depth of the cavity. • Set the depth gauge on the IUD to the level on the uterine sound. • Insert the IUD high in the fundus of the uterus by withdrawal technique, as there is less risk of expulsion. 	<p>Discussion/Video (Up to 4 hours depending on the availability of models and the number of Px)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Provide a brief review of key performance features of TCU 380A, referring back to Unit 1. • Use the JHPIEGO video and/or slide set to describe standard insertion and removal techniques. • Demonstrate insertion and removal both on the hand-held and life-size pelvic models. • During this demonstration, role play a provider, speaking to the "client." • Demonstrate insertion and removal exactly, and in the same order, as in <i>Px Handout 2.10</i>. (See <i>Demonstration technique</i>, pg.v) • Divide the Px into pairs and distribute <i>Px Handouts 2.9 and 2.10</i>. • Have one Px use the Guide to coach the other Px, step-by-step, in the insertion and removal technique. • Each participant will have a chance both to coach a colleague and to insert and remove the IUD on the model under observation by trainer. • The rest of the Px may spend this time working with hand-held models, practicing loading the TCU inside the package, or viewing slides or video, etc.

Specific Objective #3: Continued

<p align="center">CONTENT Knowledge/Attitudes/Skills</p>	<p align="center">Training/Learning Methods (Time Required)</p>
	<p>(Cont.)</p> <ul style="list-style-type: none"> • Use the steps outlined in <i>Px Handout 2.7: Passing a Uterine Sound</i> and <i>Px Handout 2.8: Inserting the Loaded Copper T 380A IUD</i> to review. <p>(See <i>Px Handout 2.6 – 2.10</i>)</p> <p>Insertion Practice:</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Be available after this group activity, as Px will need access to the life-size pelvic model to practice until s/he feels ready for competency-based evaluation by trainer. • The trainer needs to be available at pre-set times to meet with Px and correct any misinformation or steps not performed correctly, etc. • The time required per Px will vary and is defined only by the time necessary for trainer and Px to be satisfied of skill competency. (i.e., the Px will perform all key steps of IUD insertion and removal in correct manner and in correct order, as determined by the trainer, using <i>Px Handout 2.10</i>). • At this skills acquisition stage, Px may also spend time observing IUD insertions and removals in clients by trainer or training-center staff and obtaining more experience in pelvic examination.

Specific Objective #3: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
	<p>Clinical Practicum (until deemed proficient by trainer): (Time: depends on availability of clients and experience of Px) The trainer should:</p> <ul style="list-style-type: none"> • Permit Px to do clinical practicum once certified competent to insert and remove IUDs in the simulated-practice setting. • Accompany all Px and observe Px's interpersonal communication with clients, infection-prevention precautions, etc. • Remind participant of any forgotten key steps, monitor the practice of gentle and no-touch techniques, suggest improvements and, if necessary, replace Px if trainer feels that clients may suffer injury or risk without her/his intervention. • As in Learning Objective #1, discuss each case with the participant and sign off each case in the Px's Client Record Notebook. • When confident of Px's proficiency (evaluated using checklists), certify participant as capable of delivering IUD services in her/his clinic. • Note: <i>Final certification cannot take place until all module Learning Objectives have been achieved.</i>

Specific Objective #4: Describe recommended infection prevention practices in the provision of IUD services to minimize risk to client and provider.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>Infection Prevention Guidelines for IUD Insertion or Removal</p> <p><i>Decontamination</i></p> <ol style="list-style-type: none"> 1. After completing either an IUD insertion or removal, and while still wearing gloves, dispose of contaminated objects (gauze, cotton, and other waste items) in a properly marked leak-proof container (with a tight-fitting lid) or plastic bag. 2. Fully immerse all metal instruments in a plastic bucket containing 0.5% chlorine solution (bleach) for 10 minutes before allowing staff and cleaning personnel to handle or clean them. (This pre-wash soak kills most microorganisms, including HBV and HIV.) 3. All surfaces (such as the procedure table or the instrument stand) that could have been contaminated by blood and mucus also should be decontaminated by wiping down with chlorine solution. 4. If single-use (disposable) gloves were used, carefully remove them by inverting and place in the leak-proof waste container. If gloves are reusable, first briefly immerse both gloved hands in bucket containing chlorine solution and then carefully remove by inverting. Deposit gloves in chlorine solution. 	<p>Lecturette, Discussion and Demonstration (45 min.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Begin the discussion by asking Px to identify sources of infection in IUD insertion or removal procedures. • Review with them Infection Prevention Guidelines for IUD Insertion or Removal and Infection Prevention Tips for both IUD insertion and removal as seen in the "Content." • Set up a demonstration area with the following supplies: <ul style="list-style-type: none"> • leak-proof container with tight-fitting lid or plastic bag • plastic bucket • chlorine • gloves—either single-use or reusable • detergent • soft brush • 2% glutaraldehyde or 8% formaldehyde solution • HLD container • cooker pot • forceps • Demonstrate all of the steps of infection prevention before, during, and after IUD insertion and removal following the Learning Guide. <p>(See Px Handout 2.11.)</p>

Specific Objective #4: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p><i>Cleaning and Rinsing</i></p> <p>After decontamination, thoroughly clean instruments with water, detergent, and soft brush, taking care to brush all teeth, joints, and surfaces. Next, rinse well after cleaning to remove all detergent (some detergents can render chemical disinfectants inert). Dry instruments before further processing.</p> <p><i>High-Level Disinfection</i></p> <p>High-level disinfection through boiling or the use of chemicals is the recommended practice. Surgical (metal) instruments and reusable gloves should be boiled for 20 minutes. Begin timing when boiling action starts. Alternatively, instruments can be soaked for 20 minutes in a 2% glutaraldehyde or 8% formaldehyde solution. After cooling (if boiled) or rinsing in boiled water (if chemical disinfectants used) and drying, instruments are ready to use. Use immediately or store for up to 1 week in a clean, dry, HLD container with a tight-fitting lid or cover.</p> <p><i>Sterilization</i></p> <p>Alternatively, instruments and reusable gloves used for IUD insertion and removal can be sterilized by autoclaving (121°C [250°F] and 106 kPa [15 lb/in²] for 20 minutes if unwrapped and 30 minutes if wrapped).</p> <p>Note: <i>Dry heat sterilization (170°C [340°F] for 60 minutes) can be used only for metal or glass instruments.</i></p>	<p>Discussion (cont.):</p> <ul style="list-style-type: none"> • Discuss with Px how to best manage specifics of infection prevention in their individual clinics. Who will do cleaning, rinsing, HLD or sterilization? If not the provider, how will the provider train other staff?

Specific Objective #4: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p><i>Storage</i></p> <p>Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.</p> <p><i>Infection Prevention Tips: IUD Insertion</i></p> <p>To minimize the client's risk of post-insertion infection, clinic staff should strive to maintain an infection-free environment. To do this:</p> <ul style="list-style-type: none"> • Exclude clients who are by history and physical examination at risk for STDs. • Wash hands thoroughly with soap and water before and after each procedure. • When possible, have the client wash her genital area before doing the screening pelvic examination. • Use clean, high-level disinfected (or sterilized) instruments and gloves (both hands) or use disposable (single-use) examination gloves. • After inserting the speculum and while looking at the cervix, thoroughly apply antiseptic solution several times to the cervix and vagina before beginning the procedure. • Load the IUD in the sterile package. • Use a "no-touch" insertion technique to reduce contamination of the uterine cavity (i.e., do not pass the uterine sound or loaded IUD through the cervical os more than once). • Properly dispose of waste material (gauze, cotton, and disposable gloves) after inserting the IUD. • Decontaminate instruments and reusable items immediately after using them. 	

Specific Objective #4: Continued

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>When these tips are followed, post-insertion infection rates are low; therefore, use of prophylactic antibiotics is not recommended.</p> <p><i>Infection Prevention Tips: IUD Removal</i></p> <p>IUD removal should be performed with similar care. To minimize the risk of infection during IUD removal:</p> <ul style="list-style-type: none"> • Wash hands thoroughly with soap and water before and after each procedure. • When possible, have the client wash her genital area before doing the screening pelvic examination. • Use clean, high-level disinfected (or sterilized) instruments and gloves (both hands) or use disposable (single-use) examination gloves. • After inserting the speculum and while looking at the cervix, before beginning the procedure, apply antiseptic solution several times to the cervix and vagina. • Properly dispose of waste material (gauze, cotton, and the removed IUD and disposable gloves) after removal. • Decontaminate instruments and reusable items immediately after using them. 	

Specific Objective #5: Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Follow-up management of the IUD client involves routine follow-up visits as well as problem visits and management of common side effects. Routine follow-up visits should include at least a first check-up three to six weeks after IUD insertion.</p> <p>The client can return for a visit to have the IUD removed when it has been in place for the recommended number of years (10 years for the Tcu 3 380A), or when client wishes to have it removed for any reason. In addition, the client should be able to return for a visit if she has questions, concerns, or any signs/symptoms she thinks may be caused by the IUD. If facilities are available, it is also recommended that clients have routine gynecological checkups, but these are not a necessary part of IUD management.</p> <p>Remember to teach her the warning signs. If she has any of these signs she must return for a visit immediately:</p> <ul style="list-style-type: none"> • no period • heavy bleeding • abnormal spotting • abnormal discharge • pain • dyspareunia (pain during intercourse) • fever, chills, or not feeling well • string missing, or shorter or longer <p>When a client comes for follow-up care, follow recommendations in <i>Participant Handout 2.13</i>. For problem visits and management of side effects and complications, follow protocols and recommendations in the <i>Participant Handout 2.14 and 2.15</i>.</p>	<p>Question/Answer: (2.5 hrs.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Use Q/A to develop lists for the following questions: <ul style="list-style-type: none"> • When should an IUD client return for routine follow ups? • When should IUD client return for IUD removal? • What are warning signs and symptoms? • For discussion of complications, review the case studies found in <i>Px Handout 1.12</i>. Each small group then presents their analysis for reaction from the large group. • Finally, have Px help to compile a definitive list of local specialists or clinics to which clients may be referred, procedures for referral, and ways to obtain information back from the specialist. • During clinical practicum, Px will participate in management of clients with side effects or complications <p>(See <i>Px Handout 2.12, 2.13, 2.14, 2.15.</i>)</p>

Specific Objective #5: Continued

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
If a complication such as PID, pregnancy with IUD, perforation, difficulty in IUD removal, or missing strings is suspected, the participant should be instructed to refer the client to an Ob/Gyn or specialist (trainer) for management.	

Specific Objective #6: Describe the facilities and recordkeeping tasks necessary to organize and manage high-quality IUD services.

CONTENT Knowledge/Attitudes/Skills	Training/Learning Methods (Time Required)
<p>In order to offer quality IUD services, the provider needs to meet minimum criteria of space, privacy, equipment, supplies, recordkeeping, and availability of referrals. The minimum clinic requirements are:</p> <ul style="list-style-type: none"> • space, separate from waiting area for counseling, which ensures privacy for client • examination table and procedure area which ensures client privacy • supply cabinet to store instruments and IUDs • water, adequate light, and toilet facility in or very near office • basic standardized equipment and supplies sufficient for 2 IUD insertions: <ul style="list-style-type: none"> • 2 specula • 2 tenacula • 2 uterine sponge forceps • 2 pair scissors • 2 uterine sounds • 2 utility forceps • cotton or gauze • antiseptic • covered instrument trays • six pair reusable gloves or one box disposable gloves • client record forms • cooker or stove • fuel supply • glutaraldehyde or 8% formaldehyde solution • chlorine solution (bleach) • decontamination bucket <p>The trained provider will also establish a routine for receiving and serving IUD clients: referring them when necessary, and training her/his support staff in infection prevention, waste disposal, etc. In addition, client information materials should be made available to clients and families.</p>	<p>Lecture/Discussion (1 hr.)</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Discuss with Px the minimum criteria needed in order to give quality IUD services.

Specific Objective #7: Provide pre- and post-insertion counseling to IUD clients.

<p style="text-align: center;">CONTENT Knowledge/Attitudes/Skills</p>	<p style="text-align: center;">Training/Learning Methods (Time Required)</p>
<p>Trainer Summary</p> <p>Each participant will need to demonstrate skill proficiency in counseling, IUD insertion/removal, case management, and infection prevention in order to be certified by trainer.</p>	<p>Role Play/Simulated Practicum/ Clinical Practicum (2 hrs.):</p> <p>The trainer should:</p> <ul style="list-style-type: none"> • Explain the summary statement from the <i>Content</i>. • Repeat the Role Play Exercise from <i>Px Handout 1.14</i>, changing the role plays, slightly. • Each role play will be performed twice. In the first of each set, one Px will play the provider and the other Px will use <i>Px Handouts 1.15 and 1.16</i> to give feedback to role play "provider." • Enlist one or two Px to role-play clients. In the second role play of each set, the trainers will play the "provider" but will do an inadequate job, and the Px will use the <i>Handouts</i> to list all errors, omissions, etc. • These role plays will serve as a review of the minimum to be covered in IUD method-specific counseling: pre-insertion, post-insertion, and follow-up visit. • Administer post-test and participant reaction forms for this module.

Participant Handout 1.1: Key Messages

1. The IUD is a safe, easy-to-use, reversible, effective method of child spacing for couples who are at low risk for STDs/HIV. *(The IUD may increase the risk of infection for women exposed to STDs/HIV).*

Note: *It is not necessary to have a child first.*

2. Careful screening and counseling are essential for successful use of an IUD. *(The provider must know if the client should not use the IUD. The client must know how the IUD works, what the side-effects might be, how to check for strings, and what the warning signs are.)*
3. IUDs can be safely used by breastfeeding women. *(The IUD does not affect breastfeeding.)*
4. IUDs can be a good choice for women with COC precautions. *(The IUD does not affect the blood pressure, cause headaches, or affect the rest of the body.)*
5. Different IUDs can remain in from five to ten years. The TCu 380A can be used for ten years.
6. **Not using good infection prevention practices during insertion and removal can put both client and practitioner at risk for serious infection, including pelvic inflammatory disease (PID), HIV, and hepatitis B.**

Participant Handout 1.2: The IUD as a Method

Types of IUDs available

There are two types of IUDs: medicated (copper or hormone-releasing) or unmedicated (inert). The Copper-T380A is widely available.

Copper-T 380A (TCu 380A)

More than 25 million TCu 380A IUDs have been distributed in 70 countries throughout the world. This model is made of polyethylene with barium sulphate (for X-rays). The TCu 380A is T-shaped, with 314mm of copper wire wound around the vertical stem. Each of the two arms of the T has a sleeve of copper measuring 33mm. The bottom has a clear knotted string, creating a double-string effect. The TCu 380A is inserted into the cavity of the uterus by pulling the outer barrel over the plunger (withdrawal technique). It has a lifespan of ten years, and pregnancy rate is less than one per 100 women-years.

Mechanism of Action

The copper-bearing IUDs' principal mechanism of action (MOA) is to interfere with fertilization. (Normally, the lining of the uterus and fallopian tubes are a good environment for sperm to swim and fertilize the egg). **But the IUD makes the uterus a "spermicidal environment." The IUD causes the lining of the uterus and fallopian tubes to be inhospitable to sperm. The sperm are killed and cannot reach the egg.** Those IUDs, which contain progesterone also, cause the thickening of cervical mucus, which stops the sperm from entering the uterus.

Effectiveness

The IUD is one of the most effective contraceptive methods. Pregnancy rates range from less than one to three per 100 women-years for various types. Older and inert devices have a failure rate of more than two per 100 women-years. TCu 380A rates are less than one per 100 women-years.

Continuation Rates and Client Satisfaction

Continuation rates are also high in IUD users--higher than those of most other reversible methods. Large clinical trials conducted in many developing countries show that approximately 70-90% of women are still using their IUDs one year after insertion.

Note: *Continuation rates are not effectiveness rates, but do represent user satisfaction with the method.*

Participant Handout 1.3: Advantages and Disadvantages

Advantages

- Highly effective (96-99% rate)
- Safe for most women not at risk for STDs/HIV
- Reversible and economical
- May be safely used by lactating and immediate postpartum women
- Good choice for older women with COC precautions
- Long duration of use (up to ten years for TCU 380A)
- One visit for insertion, and minimal follow-up required after first three to six week checkup (unless client has problems)
- The client does not have to use anything at the time of sexual intercourse; this allows her privacy and control over her fertility
- Does not interact with medications client may use

Disadvantages

- Does not protect against STDs/HIV
- May place client at risk for PID and subsequent infertility if at risk for STD.
- May expose client to infection during insertion if infection prevention practices are not followed
- Trained provider-dependent
- Some pain, cramping, minor bleeding on insertion
- Heavier/longer menstrual periods, increased cramping, and bleeding/spotting fairly common in first three months
- Does not protect against ovarian or endometrial cancer (as does the COC) or cervical cancer (as do barrier methods)
- Serious complications require immediate attention and good back-up services

Note: IUDs do not increase the risk of ectopic pregnancy. A WHO multi-center study found that IUD users are 50% less likely to experience an ectopic pregnancy than are women using no contraception. However, since IUDs protect better against a pregnancy in the uterus than against ectopic pregnancy, if a client becomes pregnant with an IUD the pregnancy is more likely to be ectopic than in the uterus.

Participant Handout 1.4: Appropriate Users of IUDs

Appropriate Users of IUDs

IUDs are an appropriate choice for a client who:

- has a healthy reproductive tract (the client does not have any signs of infection or cancer, or reproductive tract abnormalities that would make insertion difficult).
- is in a mutually faithful sexual relationship (she is only having sexual intercourse with one person who is only having sexual intercourse with her). IUDs are appropriate for women who are at no risk/low risk for STDs/HIV. (IUD users with an STD are at risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility).
- has completed childbearing and does not want VSC (IUDs are highly suitable for older women until menopause).
- wants a long-term, easily reversible method (IUDs have an excellent rate of return to fertility).
- wants an effective method, but precaution(s) exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract).
- is breastfeeding (IUDs do not affect lactation).
- is immediately postpartum (**from delivery of placenta to 48 hours**) and wants an effective method that won't interfere with breastfeeding (IUDs do not affect lactation and may be inserted immediately after the placenta or within first 48 hours postpartum. **This procedure requires a specially trained provider**).
- has successfully used an IUD in past (users with positive past experience tend to tolerate IUDs well).

Summary

Crucial factors for safe IUD use are:

- careful screening and assessment of STD/HIV risk.
- provider is proficient in IUD insertion and infection prevention practices.
- reliable back-up services available.
- careful and complete client counseling.

Participant Handout 1.5: Eligibility Criteria

Certain conditions make the use of an IUD as a method of family planning inappropriate. Listed below are conditions which could effect the decision to use an IUD, followed by the recommendation of whether or not it should be used in that instance.

Condition	Use	Don't Use
Pregnancy		√
Postpartum		
• less than 48 hours	√	
• 48 hours to four weeks		√
• four weeks or longer	√	
• puerperal sepsis		√
Postabortion		
• First trimester	√	
• Second trimester	√	
• Post-septic abortion		√
Age		
• menarche to 20 years	√	
• 20 years or older	√	
Smoking	√	
Essential hypertension	√	
History of pre-eclampsia	√	
Diabetes	√	
Deep venous thromboembolism	√	
Pulmonary embolism	√	
Superficial venous thrombosis	√	
Current and history of ischemic heart disease	√	
Stroke	√	

Participant Handout 1.5: Eligibility Criteria for IUDs (cont.)

Condition	Use	Don't Use
Known hyperlipidaemias	√	
Valvular heart disease	√	
Headaches, etc.		√
Irregular Vaginal Bleeding	√	
Unexplained Vaginal Bleeding	√	
Breast Disease	√	
Cervical Intraepithelial Neoplasia	√	
Cervical Cancer (Awaiting Treatment)		√
Cervical Ectropion	√	
Pelvic Inflammatory Disease		
• Past	√	
• Current or within last three months		√
STDs		
• Current or within last three months		√
• Vaginitis without purulent cervicitis	√	
• Increased risk of STDs		√
HIV/AIDS		
• HIV Positive		√
• AIDS		√
• High risk of HIV		√
Biliary Tract Disease	√	
History of Cholestasis	√	

Participant Handout 1.5: Eligibility Criteria for IUDs (cont.)

Condition	Use	Don't Use
Viral Hepatitis	√	
Cirrhosis	√	
Liver Tumors	√	
Uterine Fibroids	√	
Past Ectopic Pregnancy	√	
Obesity	√	
Thyroid Problems	√	
Thalassemia	√	
Trophoblast Disease		√
Sickle Cell Disease	√	
Iron Deficiency Anemia	√	
Epilepsy	√	
Schistosomiasis	√	
Malaria	√	
Drug Interactions	√	
Nulliparous	√	
Distorted uterine cavity		√
Severe Dysmenorrhea	√	
Tuberculosis		
• Non-pelvic	√	
• Pelvic		√

Participant Handout 1.5: Eligibility Criteria for IUDs (cont.)

Condition	Use	Don't Use
Endometriosis		√
Benign Ovarian Tumors	√	
History of Pelvic Surgery	√	

For additional information on any of these eligibility criteria, please refer to:
The World Health Organization. *Improving Access to Quality Care in Family Planning*.
Geneva 1996.

Participant Handout 1.6: Screening

Key History Screening Questions

The IUD is more appropriate for some women than for others. Careful screening is crucial for successful IUD use. Some serious side effects can be prevented by thorough screening.

Why screen?

- to determine indications for use
- to identify precautions
- to identify other health or special problems

Using a screening checklist helps to obtain information systematically and completely.

Using IUD screening checklist

Refer to *Participant Handout 1.7: Case History Checklist for IUD Users*.

Participant Handout 1.6A: Recommendations for Updating Selected Practices in Contraceptive Use

Q.1. When can an IUD be inserted (interval)?

Recommendations

- a) The IUD may be inserted at anytime during the menstrual cycle, at the user's convenience, when you can be reasonably sure the woman is not pregnant (see Appendix A.)**

(See Q.2. for postpartum insertion Q.3. for post-abortion insertion).
The IUD is effective immediately.

Rationales

- a) The IUD prevents pregnancy if inserted before implantation.**

1) Tatum HJ, Connell EB. A decade of intrauterine contraception: 1976 to 1986. *Fertility and Sterility* 1986;46(2):173-192.

Q.2. When can an IUD be inserted postpartum?

Recommendations

An IUD may be inserted:

- a) Immediately post-placental, or during or immediately after a Cesarean-section (special training required).**
- b) Prior to hospital discharge (up to 48 hours after delivery) (special training required).**
- c) As early as 4 to 6 weeks postpartum, to accommodate women who come to the clinic for routine postpartum care and who request an IUD. Copper T IUDs may be safely inserted at this time. For other types of IUDs, it may be prudent to wait until 6 weeks postpartum.**
- d) In breastfeeding women.**

Rationales

a-b) With the appropriate technique, IUDs inserted immediately after placental delivery or Cesarean section can be safe and effective. Expulsion rates for postpartum insertion vary greatly depending on both the IUD type and provider's technique. Current information indicates that the expulsion rates may be higher from 10 minutes to 48 hours after delivery than in the first 10 minute period. To minimize risk of expulsion, only

Participant Handout 1.6A: Continued

properly trained providers (according to relevant national or institutional standards) should insert IUDs postpartum. Use of an inserter for IUD placement tends to reduce expulsion risk. Clients should be counseled that expulsion rates are higher postpartum than for interval insertion and should be carefully trained to detect expulsions.

c) A Cooper T may be safely inserted at 4 or more weeks postpartum. The withdrawal technique for Cooper T insertion presumably helps minimize perforations when inserting IUDs at the routine 4 to 6 weeks postpartum visit. Other IUDs that have a different profile or a push insertion technique might have different perforation rates. Given the relative lack of information on other IUDs at 4 to 6 weeks postpartum, it is prudent to wait until 6 weeks for the insertion of IUDs other than Cooper Ts.

- 1) Chi I, Farr G. Postpartum IUD contraception—a review of an international experience. *Advances in Contraception* 5:127-146 (1989).
- 2) O'Hanley K, Huber D. Postpartum IUDs: Keys for success. *Contraception* 45:351-361 (1992).
- 3) Mishell DR, Roy S. Copper intrauterine contraceptive device event rates following insertion 4 to 8 weeks postpartum. *American Journal of Obstetrics and Gynecology* 143(1): 29-33 (1982).

d) It has been shown that IUDs can be safely used in breastfeeding women.

- 1) Farr G, Rivera R. Interactions between intrauterine contraceptive devices use and breastfeeding status at time of intrauterine contraceptive device insertion: Analysis of Tcu 380A acceptors in developing countries. *Advances in Contraception* 167(1): 144-151(1992).

Q.3. Can an IUD be inserted immediately post-abortion?

Recommendations

a) Yes, the IUD may be inserted immediately post-abortion (spontaneous or induced) **if the uterus is not infected**, or during the first seven days post-abortion, (or anytime you can be reasonably sure the women is not pregnant-see Appendix A.)

b) IUDs should **not** be inserted in the following situations:

- With confirmed or presumptive diagnosis of infection (sign of unsafe or unclean induced abortion, signs and symptoms of sepsis or infection, or inability to rule out infection), do not insert IUD until risk of infection has been ruled out or infection has fully resolved (approximately 3 months).
- With serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns), do not insert IUD until trauma has healed.
- With hemorrhage and sever anemia, IUDs (insert or copper-bearing) are not advised until hemorrhage or sever anemia is resolved. However, progestin-releasing IUDs can be used with severe anemia (they decrease menstrual blood loss).

Participant Handout 1.6A: Continued

- Post-abortion IUD insertion after 16 weeks gestation requires special training of the provider for correct fundal placement. If this is not possible, delay insertion for six weeks.

Rationales

a) With appropriate technique, IUDs can be safely inserted post-abortion (spontaneous or induced). Expulsion rates vary greatly depending on both the IUD type and provider. To minimize risk of expulsion, only providers with proper training (according to relevant national or institutional standards) and experience should insert IUDs. Clients should be carefully trained to detect expulsions.

Fertility returns almost immediately post-abortion (spontaneous, or induced): within 2 weeks for first trimester abortion and within 4 weeks for second trimester abortion. Within 6 weeks of abortion, 75% of women have ovulated.

1) Lahtenmaki P, Ylostalo P, Sipinen S, et al. Return of ovulation after abortion and after discontinuation of oral contraceptives. *Fertility and Sterility* 34(3): 246-249 (1980).

b) After 16 weeks gestation, the uterine cavity will be too enlarged for post-abortion IUD placement to be accomplished by routine IUD insertion techniques. Only providers trained to do postpartum IUD insertion should perform immediate post-abortion IUD insertion for post-abortion clients after 16 weeks gestation.

1) Prichard JA, Macdonald PC (eds). Maternal adaptation to pregnancy. *Williams Obstetrics*. 16th edition. New York: Appleton-Century-Crofts, 1980, p223.

2) Leonard AH, Ladipo OA. Postabortion family planning: Factors in individuals choice of contraceptive methods. *Advances in Abortion Care* 4(2):1-4 (1994).

Q.4. What is an appropriate follow-up schedule after IUD insertion?

Recommendations

- a) There should be one follow-up visit **approximately** one month after insertion; thereafter, there is no need for a fixed follow-up schedule.
- b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has:
- late period (possible pregnancy),
 - prolonged or excessive abnormal spotting or bleeding,
 - abdominal pain or pain with intercourse,
 - infection exposure (such as gonorrhea), abnormal vaginal discharge
 - or pelvic pain especially with fever, or
 - string missing or string seems shorter or longer.
- c) Visits are encouraged for other preventive reproductive health care as available, including provision of condoms, when appropriate.

Participant Handout 1.6A: Continued

Rationales

a-c) A follow-up visit at 3 to 6 weeks is prudent as the peak incidence of PID post-IUD insertion is at one month. Thereafter, there is no need for a fixed follow-up schedule. The best quality of care is to focus clinic resources and attention on those women who come back to the clinic with complaints or problems.

1) Farley TM, Rosenberg MJ, Rowe PJ, et al. Intrauterine devices and pelvic inflammatory disease: An international perspective. *The Lancet* 339: 785- 788 (1992).

2) Janowitz B, Dighe NM, Hubacher D, et al. Assessing the impact of IUD revisits. *Family Health International*. Presented at a meeting of the American Public Health Association in San Francisco, California (October 1992).

Q. 5. Is there a need for a routine pre-exam (a separate visit) before IUD insertion?

Recommendations

a) No. If at all possible, handle all counseling and screening the same day as the insertion.

Rationales

a) There is no medical need for a pre-exam (separate visit); it may be difficult for a woman to make two visits, and she may be at risk of pregnancy during this interval.

Q.6. Is there a minimum or maximum age to receive IUDs?

Recommendations

a) There is no minimum or maximum age, as long as the woman is at risk of pregnancy.

b) To receive an IUD, all women, especially young women, should be at low risk of STDs and receive careful counseling in order to understand potential risk of PID/infertility (possibly due to infection during IUD insertion and/or lack of protection against pelvic infection when exposed to STDs).

Rationales

a-b) The risk of PID is higher, statistically, among younger women. IUDs, in comparison to all other modern contraceptive methods, increase the risk of PID when a woman is infected with an STD. In addition, poor aseptic procedure during IUD insertion may introduce bacteria into the upper genital tract, which may lead to PID. Clients must be informed of these facts before choosing IUDs.

1) Farley TM, Rosenberg MJ, Rowe PJ, et al. Intrauterine devices and pelvic inflammatory disease: An international perspective. *The Lancet* 339:785-788 (1992).

Participant Handout 1.6A: Continued

- 2) Lee NC, Rubin GL, Ory HW, et al. Type of intrauterine device and the risk of pelvic inflammatory disease. *Obstetrics and Gynecology* 62:1-6 (1983).
- 3) Lee NC, Rubin GL, Borucki R. The intrauterine device and pelvic inflammatory disease revisited: New results from the women's health study. *Obstetrics and Gynecology* 72(1):1-6 (1988).
- 4) Cramer DW, Schiff I, Schoenbaum SC, et al. Tubal infertility and intrauterine device. *The New England Journal of Medicine* 15:941-6 (1985).
- 5) Darling JR, Weiss NS, Voigt LF, et al. The intrauterine device and primary tubal infertility. *Letter to The New England Journal of Medicine* 326(3): 203-4 (1992).
- 6) Darling JR, Weiss NS, Metch BJ, et al. Primary tubal infertility in relation to use of an intrauterine device. *The New England Journal of Medicine* 312(15):937-41(1985).
- 7) Task Force on Intrauterine Devices, Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization. PID associated with fertility regulating agents. *Contraception* 30 (1)1-21(1984).

Q.7. Can nulliparous women receive IUDs?

Recommendations

- a) Yes. However, IUDs should not be the first choice of contraception in nulliparous women. To receive IUDs, all women, especially young women, should not be at risk of STDs and need careful counseling to understand potential risk of PID/infertility (possibly due to poor infection prevention practices during IUD insertion and/or lack of protection against pelvic infection when exposed to STDs). Therefore, it is appropriate to warn women that the IUD has an increased risk of STD-associated PID and infertility.

Rationales

- a) Because nulliparous women are typically young and may have patterns of sexual activity that lead to STD risk, the relative risk of PID for nulliparous IUD users may be high.

- 1) Task Force on Intrauterine Devices, Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization. PID associated with fertility regulating agents. *Contraception* 30(1): 1-21(1984).
- 2) Peterson KR, Brooks L, Jacobsen B, et al. Intrauterine devices in nulliparous women. *Advances in Contraception* 7(4): 333-8 (1991).

Additionally, nulliparous women receiving IUDs may be at higher risk for expulsion, bleeding, and pain.

- 1) Petersen KR, Brooks L, Jacobsen B, et al. Intrauterine devices in nulliparous women. *Advances in Contraception* 7(4): 333-8 (1991).

Participant Handout 1.6A: Continued

The degree to which the client values future fertility is an important factor in the choice of a contraceptive method. Studies have shown that the risk of PID and subsequent tubal-factor infertility is directly proportional to the risk of exposure to sexually transmitted disease. IUDs fail to protect women against PID.

1) Angle MA, Brown LA, Buekens P. IUD protocols for international training. *Studies in Family Planning* 24(2): 125-31(1993).

Nevertheless, women should be allowed to make their own choice (e.g., an older nulliparous woman who is sure she does not want children may be a reasonable IUD candidate.)

**Q.8. a) Is there a need for a "rest period" with IUDs after a certain period of use?
b) Are there medical reasons for removal of an IUD?**

Recommendations

- a) If a woman wants a new IUD when an old one has expired, no rest period is needed.
- b) IUD removal is indicated if:
- the woman requests removal
 - the woman develops precautions/contraindications
 - the effective life of the IUD is reached (e.g., the full effective life of the CuT 380A is currently 10 years)

Rationales

a-b) The removal and reinsertion of an IUD exposes a woman to a small risk of introduction of vaginal or endocervical canal microorganisms into the upper genital tract. For this reason, long-acting IUDs are preferred. The Copper T 380A has been shown to be effective for at least 10 years.

1) Farley TM, Rosenberg MJ, Rowe PJ, et al. Intrauterine devices and pelvic inflammatory disease: An international perspective. *The Lancet* 339:785-788 (1991).

2) Kjaer A, Laursen K, Thormann L, et al. Copper release from copper intrauterine devices removed after up to 8 years of use. *Contraception* 47(4): 349-350 (1993).

3) Copper T 380A intrauterine device is effective for 10 years. News Release, The Population Council, New York, NY, September 27, 1994.

Participant Handout 1.6A: Continued

Q.9. Following removal of an IUD (for reasons of partial expulsion without infection, or expiration of the IUD), should one wait to insert another?

Recommendations

a) If the client wants to continue the method, do not wait to reinsert a new IUD after old IUD removal, provided pregnancy has been ruled out, and no new precautions/contraindications have developed (see Q.1).

b) Make sure removal of the first IUD is indicated (i.e., for reasons of partial expulsion without infection or expiration of the IUD).

Rationales

a-b) Even with proper technique, the removal and reinsertion of an IUD exposes a woman to the risk of introduction of vaginal and endocervical canal microorganisms into the upper genital tract. Therefore, removal and insertion at the same time avoids two separate exposures.

1) Farley TM, Rosenberg MJ, Rowe PJ, et al. Intrauterine devices and pelvic inflammatory disease: An international perspective. *The Lancet* 339:785-788 (1992).

In an interval between removal of one IUD and insertion of another, the woman will not be protected against pregnancy by the method of her choice.

Q.10. If a woman is at low risk of STDs based on history, may IUDs be inserted without any lab tests if there is no mucopurulent endocervical discharge or clinically apparent PID or cervicitis?

Recommendations

a) Yes, if the woman has no current risk factors for STDs (by history and on exam) and she has no apparent clinical signs or symptoms of infection (including normal bimanual exam).

b) If PID, mucopurulent endocervical discharge, cervicitis, or clinically apparent vaginitis is present, do **not** insert IUD, but treat for infection. Consider other contraceptive methods, if a STD is suspected.

Note: *Not all clinically apparent vaginal infections are due to STDs.*

Participant Handout 1.6A: Continued

Rationales

a-b) Currently available lab tests may be impractical and often unaffordable (even in the developed world) to rule out endocervical colonization by infectious agents capable of ascending and causing PID. Most chlamydia tests are only 80 to 90% sensitive, tests for mycoplasma and ureaplasma are not routinely available, and cervical gram stain is less sensitive for gonorrhea. However, where gonorrhea culture and chlamydia tests are affordable, negative test results provide reassurance to corroborate the woman's history.

1) Kramer D, Brown S. Sexually transmitted diseases and infertility. *International Journal of Gynecology and Obstetrics* 22:19-27 (1982).

2) Bell TA, Grayston JT. Centers for Disease Control guidelines for prevention and control of Chlamydia trachomatis infections. *Annals of Internal Medicine* 104:524-526 (1986).

3) Nasello M, Callihan D, Menpus M, et al. A solid-phase enzyme immunoassay (gonozyme) test for direct detection of Neisseria gonorrhoeae antigen in urogenital specimens from patients at a sexually transmitted disease clinic. *Sexually Transmitted Diseases* (October-December): 198-202 (1985).

Q.11. Should an IUD be removed if the partner complains about the string?

Recommendations

Not necessarily.

a) Explain to the woman and/or her partner what the partner is feeling and recommend they try again.

b) Describe to the client her other options (and their disadvantages):

- The string can be cut short so that it does not protrude from the cervical os; inform the woman that she would not be able to feel the string and that, at the time IUD removal, narrow forceps will be needed to remove the IUD (this entails a small additional infection risk). If a string is cut flush with the cervix, record in the chart, and tell the woman that the string is located at the opening of the os for future removal.

OR

- Offer to remove the IUD, if other options are not acceptable.

c) If partner complaints occur frequently, the service provider's technique should be reviewed. Strings should be cut approximately 3 cm from the external os.

Participant Handout 1.6A: Continued

Rationales

a-c) For IUD services, the woman's preferences are the service provider's appropriate focus.

Q.12. If the cervix is red due to eversion of the squamocolumnar junction (ectopy/ectropion), may the IUD be inserted without further investigation?

Recommendations

a) Yes, the IUD may be inserted for clients with cervical ectopy/ectropion, if not at risk of STDs and the pelvic exam is normal (no cervicitis).

Rationales

a) Cervical ectropion (the presence on the ectocervix of columnar epithelial cells from the endocervix) is a normal condition in adolescents and in pregnancy, and is distinct from the cervical infection.

1) Paavonen J, Koutsky LA, Kiviat N. Cervical neoplasia and other STD related genital and anal neoplasias, in: Holmes KK, Mardh P, Sparling PF, et al (eds). *Sexually Transmitted Diseases*. New York: McGraw-Hill Book Co., 1984: 561-592.

IUD insertion and continued use of the IUD have no relation to risk of cervical carcinoma.

1) Lasse DL, Savitz DA, Hamman RF, et al. Invasive cervical cancer and intrauterine device use. *International Journal of Epidemiology* 20(4): 865-870 (1991).

Since chlamydia is an intracellular parasite of columnar epithelial cells, women with ectropion may be more likely to have positive chlamydia tests.

1) Harrison HR, Costin M, Meder JB, et al. Cervical chlamydia trachomatis infection in university women: Relationship to history, contraception, ectopy and cervicitis. *American Journal of Obstetrics and Gynecology* 153(3): 244-51 (1985).

Q.13. If a woman complains of heavier menses or bleeding between menses, is there a medical basis for the IUD to be removed?

Recommendations

Not necessarily.

a) As in pre-method choice counseling, women should be informed that menses are normally heavier with the IUD and intermenstrual bleeding may occur, especially in the first few months. Inert IUDs should not be the first choice, for this reason.

Give nutritional advice on the need to increase the intake of iron-containing foods.

Participant Handout 1.6A: Continued

- b) For mild to moderate bleeding and pain in the first month post-insertion, with no evidence of clinically apparent pelvic infection, and if reassurance is not sufficient but the woman wants to keep the IUD, a short course of a non-steroidal anti-inflammatory agent other than aspirin (e.g., ibuprofen) may be given.
- c) Bleeding generally decreases over time. If bleeding is heavy or the woman is anemic, treatment using oral iron can improve hemoglobin levels.
- d) If bleeding or pain is severe, or the client wishes to discontinue use, remove the IUD.
- e) If suspected, abnormal conditions which cause prolonged or heavy bleeding should be evaluated and treated as appropriate.
- f) If pelvic infection is diagnosed, remove the IUD, and treat with antibiotics. (In the case of mild uterine tenderness without any other evidence of pelvic infection, broad spectrum antibiotics or chemotherapeutics may solve the problem; use clinical judgement regarding whether or not to remove the IUD).

Rationales

a) In general, IUDs (especially inert IUDs) commonly increase the amount of menstrual blood loss, according to IUD type, particularly in the first few months post-insertion.

1) Cohen B, Gibor Y. Anemia and menstrual blood loss. *Obstetrical and Gynecological Survey* 35(10): 597-618 (1980).

Copper IUDs may increase normal menstrual blood loss by 50%, which may be clinically significant for women who are already anemic. (Progestin-releasing IUDs decrease menstrual blood loss; the more progestin an IUD releases, the more effectively it decreases menstrual blood loss.)

1) Andrade A, Pizarro E. Quantitative studies on menstrual blood loss in IUD users. *Contraception* 36(1): 129-144 (1987).

b) Non-steroidal anti-inflammatory drugs (e.g., ibuprofen) decrease uterine bleeding and cramping.

1) Drug facts and comparisons. St. Louis, MO, *Facts and Comparisons* 1993: 251.

Note: *Nonsteroidal anti-inflammatory drugs (e.g., ibuprofen) should be used instead of aspirin because of aspirin's stronger and longer-lasting inhibitory effects on platelet aggregation (aspirin promotes bleeding).*

1) *American Hospital Formulary Service Drug Information*. Bethesda, MD: American Society of Hospital Pharmacists, 1994: 1208.

2) Field CS. Dysfunctional uterine bleeding. *Primary Care* 15(3): 561-574 (1988).

Participant Handout 1.6A: Continued

Q.14. Can IUDs be safely inserted by trained nurses and midwives?

Recommendations

a) Yes, IUDs (including immediate postpartum and post-abortion insertion) can be safely inserted by nurses and midwives, who are appropriately trained according to relevant national or institutional standards.

Rationales

a) Nurses or midwives have been shown to have equal or superior competence in IUD insertion when compared to doctors.

1) Eren V, Ramos R, Gray RH. Physicians vs. auxiliary nurse-midwives as providers of IUD services: A study in Turkey and the Philippines. *Studies in Family Planning* 14: 43-47(1983).

Q.15. How much time should elapse between STD treatment and insertion? What about previous STD incidence?

Recommendations

a) If the client will **not** be at high risk of an STD in the future, treat the STD today, and insert the IUD when the infection is resolved (for acute PID, wait 3 months).

If she remains at increased risk of PID, advise against IUD use.

Rationales

a) PID may take several weeks to resolve clinically, and, in the case of severe PID, waiting several months, in theory, allows healthy tissues (free of microabscesses) to form.

1) Sweet RL, Draper DL, Hadley WK. Etiology of acute salpingitis: Influence of episode number and duration of symptoms. *Obstetrics and Gynecology* 58: 62-68 (1981).

Women with prior PID are at increased risk of repeat PID. A woman who has had an episode of upper reproductive tract infection may be at increased risk of repeat episodes of non-sexually transmitted PID regardless of IUD use. Theoretically, a previous episode of upper reproductive tract infection may result in tubal damage increasing susceptibility of the fallopian tubes to opportunistic lower genital tract flora.

1) Westrom L, Mardh P. Acute pelvic inflammatory disease (PID). In: Hølems KK, Mardh P, Sparling PF, et al (eds). *Sexuality Transmitted Diseases*. 2nd edition. New York: McGraw-Hill Information Services Company, Health Professions Division, 1990: 596-613.

2) Keith L, Berger GS. The etiology pelvic inflammatory disease. *Research Frontiers in Fertility Regulation* 3(1):1-16 (1984).

Participant Handout 1.6A: Continued

Q.16. Should IUDs be provided if infection prevention measures cannot be followed?

Recommendations

a) No.

All sites inserting and/or removing IUDs should follow basic infection prevention measures, including:

- aseptic technique (including appropriate handwashing by the provider and careful preparation of the cervix)
- sterile (or high-level disinfected) IUDs and equipment
- correct decontamination of instruments
- safe disposal of contaminated disposables

Rationales

a) The potential for infection in IUD users is increased in areas where genital tract infections (GTI) such as gonorrhea and chlamydia are prevalent. By following recommended infection prevention processes, however, health workers can minimize the risk of post-IUD insertion infection to clients, and the danger of transmitting infections, even hepatitis B or AIDS, to their clients, their co-workers or themselves.

1) Tietjen L, Cronin W, McIntosh N. *Infection Prevention for Family Planning Service Programs: A Problem Solving Reference Manual*. Durant, OK: Essential Medical Information Systems, Inc., 1992: 168.

Sterilization is the safest and most effective method for processing instruments, which come in contact with the bloodstream, tissue beneath the skin or tissues which are normally sterile. When sterilization equipment is either not available or not suitable, high level disinfection (HLD) is the only acceptable alternative. HLD destroys all microorganisms, including viruses causing hepatitis B and AIDS, but does not reliably kill all bacterial endospores. For example, in family planning facilities, either sterilization or HLD are acceptable for processing instruments and gloves used for pelvic exams and IUD insertion and removal, since problems with endospores (*Clostridia* species) have not been reported with IUD use. Regardless of the method selected, however, HLD can only be effective when used (soiled) instruments and gloves are first decontaminated, thoroughly cleaned, and rinsed before disinfection.

1) Tietjen L, Cronin W, McIntosh N. *Infection Prevention for Family Planning Services Programs: A Problem-Solving Reference Manual*. Durant, OK: Essential Medical Information Systems, Inc., 1992: 34.

Participant Handout 1.6A: Continued

Contaminated wastes may carry high loads of micro-organisms, which are potentially infectious to any persons who contact or handle the waste. Incineration provides high temperatures and destroys microorganisms; therefore, it is the best method for disposal of contaminated wastes. Incineration also reduces the bulk size of wastes to be buried. If incineration is not possible, all contaminated wastes must be buried to prevent scattering the waste materials.

1) Tietjen L, Cronin W, McIntosh N. *Infection Prevention for Family Planning Service Programs: A Problem-Solving Reference Manual*. Durant, OK: Essential Medical Information Systems, Inc., 1992: 97.

Source: *Recommendations for Updating Selected Practices in Contraceptive Use: Results of a Technical Meeting*. Volume I, 1994.

Participant Handout 1.7: Client Assessment Checklist for Small Group Exercise

Clinician's Questions	Rationale for Question	Client Response		Recommended Action/Plan
		NO	YES	
1. Did your last full-term pregnancy end less than four weeks ago?				
2. Have you had a miscarriage or an abortion within the past four weeks?				
3. Is there a chance that you could be pregnant; is your period late or have you missed a recent period?				
4. Do you consider the bleeding during your menstrual periods to be unusually heavy ? Heavier than other women? How many days? How often must you change pads/cloths? Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?				
5. Over the past three months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?				
6. Over the past three months, have you had fever or chills, accompanied by pain in the lower abdomen?				

Participant Handout 1.7: Continued

Clinician's Questions	Rationale for Question	Client Response		Recommended Action
		NO	YES	
(Assure client of confidentiality before asking questions 7, 8, 9)				
7. Is there any possibility that you or your partner have sex partner(s) outside the relationship?				
8. Do you want more children in the future? Are you at risk for STDs?				
9. Are you concerned that you might have AIDS?				
10. Do you have an immune-system disease that causes you to develop infections easily? Do you now have severe diabetes? Do you take insulin (shots) for your diabetes? Are you taking any other medicines or undergoing any medical treatments?				
11. Do you have problems with the valves of your heart? Have you ever had an infection of the heart?				
12. Have you ever had a pregnancy outside the womb--for example, in one of your tubes?				

Source: Adapted from *Guidelines for Clinical Procedures in Family Planning: A reference for Trainers*. INTRAH, Chapel Hill North Carolina 1993 (Chap.7).

Participant Handout 1.8: Timings for IUD Insertion

1. **Any time during menstrual cycle, if you are reasonably certain the client is not pregnant.** A clinician may be "reasonably certain" if the client has not had intercourse since last normal menses, or if she has been using another reliable method since her menses, and her pelvic exam does not show any signs of possible pregnancy.

Many clinicians prefer to insert during or very soon after the menstrual period since then there is little likelihood of pregnancy. Another reason to insert the IUD at this time is that the woman is already bleeding, and the cramping may be less noticeable. Other clinicians prefer mid-cycle when the cervical os is a little larger.

2. **Postpartum**

- Immediately postpartum (within 10 minutes) following delivery of the placenta, or during or immediately after a cesarean section. **This requires special training.**
- Within the first **48 hours postpartum.**

Note: *IUD insertion immediately or 48 hours postpartum requires special training and should not be attempted without having received the required training.*

Expulsion rates may be higher for IUDs inserted during this time. Insertions after one week and before four-to-six weeks should be avoided because of the higher risk of uterine perforation.

- As early as four-to-six weeks postpartum for those who come for routine postpartum care and who request an IUD. Copper IUDs may be safely inserted at this time.

3. **Immediately Postabortion:** The IUD may be inserted immediately postabortion (spontaneous or induced) **if the uterus is not infected**, or during the first seven days postabortion (or anytime you can be reasonably sure that the client is not pregnant).

IUDs should **not** be inserted immediately postabortion in the following situations:

- When there is the possibility of infection (signs of unsafe or unclean induced abortion, signs of infection, or inability to rule out infection), do not insert an IUD. **Do not insert IUD until risk of infection has been ruled out or infection has fully resolved (approximately three months).**
- When there is serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns), do not insert IUD until healed.
- When there is hemorrhage and severe anemia, IUDs (inert or copper-bearing) are not advised until hemorrhage or severe anemia is resolved. However, progestin-releasing IUDs can be used in cases of severe anemia (they decrease menstrual blood loss).
- Immediate postabortion IUD insertion after 16 weeks' gestation requires special training of the provider. If the pregnancy went beyond 16 weeks, delay insertion for six weeks postabortion.

Participant Handout 1.8: Timings for IUD Insertion (cont.)

Follow-up schedule (after IUD insertion)

- a) There should be one follow-up visit **approximately** three-to-six weeks after insertion; thereafter, there is no need for a fixed follow-up schedule.
- b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has:
 - late period (possible pregnancy)
 - prolonged or excessive abnormal spotting or bleeding
 - abdominal pain or pain during intercourse
 - infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain, especially with fever
 - string missing or string seems shorter or longer
- c) Encourage clients to come in for other preventive reproductive health care if available, including provision of condoms, when appropriate.

Timings for IUD Removal

- IUD may be removed at any time during the menstrual cycle. Some clinicians prefer to remove IUD during menses because the os may be slightly open and the patient will not be concerned if she has any bleeding.
- Anytime the client requests--for any stated reason, or for no reason at all
- Evidence of IUD perforation
- Known or suspected pregnancy
- Partial expulsion--the old IUD may be removed and replaced with a new one
- Persistent side effects or other health problems
- Client is now at risk for STDs
- When IUD has been in utero for its effective life--a new IUD may be inserted immediately if no precautions are present.
- Known or suspected PID--the client must also receive antibiotic treatment.
- Severe pain, or severe bleeding with evidence of marked anemia

Participant Handout 1.9: Suggested simple explanation of IUDs

One could say:

The IUD is a small device made of plastic and copper. It is placed in the uterus through the vagina and the opening of the uterus, using a small applicator. It has two thin strings attached, which hang down into the vagina. These strings allow you to check each month after your menstrual period that the IUD is still in place and that you are still protected from getting pregnant. The strings are also used to remove the IUD. Removing the IUD takes only a few minutes and is usually not painful. When you want the IUD removed, it must be done by a doctor or trained health worker.

Inserting the IUD is simple. You may feel uncomfortable for a few minutes. Most women, however, say that it is not too painful and compare the feeling to having heavy menstrual cramps. Before I insert the IUD, I will need to ask you some questions (take a history), and perform a pelvic examination to make sure the IUD is right for you.

Participant Handout 1.10: Warning Signs for IUD Users

Warning Signs for IUD Users

These five signs are the warning signs of infection or IUD failure (expulsion or pregnancy).

- Abnormal bleeding: no period, heavy bleeding, abnormal spotting
- Abnormal discharge
- Pain: dyspareunia (pain during intercourse)
- Fever: chills, or not feeling well
- String missing, or shorter or longer

If a client notices any of these signs, she should see her healthcare provider.

Participant Handout 1.11: Common Side Effects and their Management

As with most contraceptive methods, IUDs are associated with certain common side effects. Most are not serious and can be handled by the provider or practitioner. Some may need referral to a specialist.

Side effects and complications may include:

- Cramping
- Irregular or heavy bleeding
- Syncope/bradycardia, vasovagal episode during insertion (fainting, becoming dizzy, or lowered heart rate during insertion)
- Missing strings
- Amenorrhea
- Expulsion of IUD
- Pelvic infection
- Suspected uterine perforation
- Ectopic pregnancy

Participant Handout 1.11A: Cramping

Investigation Steps

A) Has client had the IUD less than three months? **Remember:** some cramping pain is common during the first 24-48 hours after insertion.

Management

- A-1) Speculum and bimanual exams are needed in order to rule out PID and other causes of cramping, such as partial expulsion of the IUD, perforation of the uterus or cervix, or ectopic pregnancy. *If there are signs of any of these conditions, go to the section on managing these complications.*
- A-2) If no cause is found and the cramping is not severe, provide an analgesic (such as paracetamol).
- A-3) If no cause is found but the cramping is severe, remove the IUD. Look at the removed IUD. If it looks normal, counsel the woman to use another method, tell her the IUD is not for her. If the IUD looks different (distorted) or if difficulties in removal suggest that it was or had become improperly placed, replace the IUD immediately with a new IUD.

Note: *If progestin-containing IUDs are available, they would be a better choice, since they cause less cramping than IUDs without progestin.*

Investigation Steps

B) Has she had the IUD more than three months?

Management

- B-1) If the IUD has been in place more than three months and cramping is new, examine the client for other causes of cramping, such as PID, perforation, or pregnancy. In such cases go to the section on managing these complications.
- B-2) If no cause is found and the cramping is very mild and occurs only around menses, provide paracetamol.
- B-3) If no cause is found but the cramping is severe and not due to menses, remove the IUD. Look at the removed IUD. If it looks normal, counsel the woman to use another method, tell her the IUD is not for her. If the IUD looks different (distorted or partially embedded) and there is **NO** evidence of infection, replace the IUD immediately with a new IUD.

Participant Handout 1.11B: Amenorrhea

Investigation Steps

- A) Ask the client:
- when she had her last menstrual period (LMP)
 - when she last felt the strings
 - if she has symptoms of pregnancy
- B) Perform speculum and bimanual exams to check for strings and rule out pregnancy. (Do pregnancy test if available.)

Management

If exam (or pregnancy test where available) shows that client is pregnant:

- B-1) Rule out ectopic pregnancy. If the pregnancy is ectopic, refer immediately to a hospital with surgical facilities.
- B-2) Explain to the client that because she is pregnant with an IUD in place, miscarriage and infection are quite likely.
- B-3) If the strings are visible and the pregnancy is less than 13 weeks, it may mean that the IUD has moved higher up in the uterus, or the IUD has fallen out. Have her return to the clinic if she has excessive bleeding, cramping, pain, foul discharge, or fever.
- B-4) If the strings cannot be located at the cervical os and/or the pregnancy is beyond the first 13 weeks, removal is more difficult. Remind the client that if she is pregnant with an IUD in place, there is a high risk of spontaneous abortion and infection. Counsel the client as to all available options.
- B-5) If the woman wants to or must continue her pregnancy, but does not want her IUD removed, advise her that there is an increased risk of spontaneous abortion and infection and that the pregnancy should be followed closely. Stress the importance of reporting all abnormal symptoms immediately. Tell her to report any sign of infection immediately. She should be watched closely during her pregnancy. Refer her to a specialist for her pregnancy care.

Participant Handout 1.11C: Expelled IUD

Investigation Steps

- A) Ask the client when she saw the IUD fall out.

Management:

- A) If the client saw the IUD fall out, rule out pregnancy. If she is not pregnant and wants another IUD, counsel her to use another method (condoms for example) until her next menses. Insert a new IUD during her next menses.

Participant Handout 1.11D: Missing Strings

Investigation Steps

A) Ask the client:

- when she last felt the strings
- if she has any symptoms of pregnancy
- if she used a back-up method (such as condoms) from the time she noticed the missing strings
- when she had her LMP

Management

- A-1) Perform a speculum and bimanual exam. Strings may be high up in the vagina or hidden in a fold of the cervix. Take a sterile cotton swabstick and gently probe the folds of the cervical canal.
- A-2) Check for signs of pregnancy. Rule out ectopic pregnancy. (IUDs do not prevent ectopic pregnancy as well as they prevent intrauterine pregnancy.) If exam shows an ectopic pregnancy, refer immediately to a hospital with surgical facilities.
- A-3) If exam shows intrauterine pregnancy **and** the strings are visible, explain to the client that the risk of miscarriage with infection is very high if the IUD is left in place, and the IUD should be removed to protect her health. Pregnancy is twice as likely to succeed if the IUD is removed, although miscarriage may still occur. Refer for IUD removal, or remove the IUD yourself, according to local clinic guidelines.
- A-4) If the exam reveals pregnancy and the strings are **not** visible, refer with a letter stating that the client is pregnant and that the IUD may still be in place.

Investigation Steps

- B) If no strings are visible on vaginal exam and client is **not** pregnant, it may mean that:
- the IUD has moved higher up in the uterus, or
 - the IUD has fallen out

Management

- B-1) It is possible that strings will be felt in the cervical canal. If the strings are not felt, the client should **use a non-hormonal method** (such as condoms and/or spermicide) **and return during menses, or in four weeks** if her period does not start. The strings may come down with menses.

Participant Handout 1.11D: Missing Strings (cont.)

Investigation Steps

- B) If client comes back while having her period, a speculum exam will show whether strings are now visible.

Management

- C) If the strings came down with menses, reassure the client that the strings are present, and help the client feel them.

Investigation Steps

- D) If she comes back while having her period and strings are **still not visible**:

Management

- D-1) Rule out infection. IUD perforations are uncommon but can cause acute abdominal infections. If infection is present, treat as for PID and promptly refer client to hospital.
- D-2) Rule out pregnancy, by means of history and pelvic exam. If the client is pregnant, see "A" above. If she is **not** pregnant:
- D-3) Refer her for X-ray (or ultrasound, depending on which is available; X-ray may provide more information). If the IUD is seen on the X-ray, it may be in the uterus or may have perforated the uterus; refer her to a hospital for treatment. If the IUD has been in the abdominal cavity for six-to-eight weeks or more, and the client has no symptoms, it may be best to leave the IUD in place. However, the multi-load and all ring-shaped devices should be removed, if a skilled laparoscopist is available, since these IUDs can cause blockage of the bowel.
- D-4) The IUD may have been expelled without having been seen. If X-ray or ultrasound is negative, and history and physical exam give no evidence of PID, infection, or pregnancy, insert a new IUD, or help the client make an informed choice of another method.

Investigation Steps

- E) If she comes back **without** menses, rule out pregnancy.

Management

- D) Rule out pregnancy by means of history, speculum, and bimanual exams (or laboratory test if available and affordable). See if the strings have come down. If the client is pregnant, see "A-3" and "A-4" above. If she is not pregnant, see "D-3" and "D-4" above.

Participant Handout 1.11E: Irregular or Heavy Bleeding

Investigation steps

- A) Has client had the IUD less than three months?

Management

- A-1) Perform speculum and bimanual exams to look for obvious cervical disease or evidence of intrauterine or ectopic pregnancy.
- A-2) If the exam is normal, reassure the client and give her iron tablets (ferrous sulfate up to 200mg, three times daily for three months). Ask her to return in three months for another check-up.

Investigation Steps

- B) How much has she bled?

Management

- C) Check for signs of marked anemia (pale conjunctivae or nail beds, hemoglobin less than nine). Recommend IUD removal if severe anemia present, and help the client make an informed choice of another method.

Note: *If progestin-containing IUDs are available, they should be used for clients with severe anemia in order to decrease blood loss.*

Investigation Steps

- C) Has she had the IUD more than three months?

Management

- C-1) Perform speculum and bimanual exams to rule out cervical pathology or intrauterine or ectopic pregnancy.
- C-2) If the bimanual exam shows an enlarged uterus due to new fibroids, tell the client the problem and refer her as appropriate for evaluation. Do a bimanual (and speculum) exam every six months to rule out rapid growth. Remove the IUD if bleeding worsens or if the client requests it.
- C-3) If the client has prolonged intervals between very heavy periods, suspect endometrial hyperplasia (overgrowth of the uterine lining), beginning of menopause, or other gynecological problem. Refer her as appropriate. A change of method is not necessary unless the client is uncomfortable, has reached menopause (one year without menses), or a gynecologic cancer is found.

Participant Handout 1.12: Case Studies

Case Study 1: Woman requests IUD and is not having her menses

Problem: Woman is not having her menses or is not within a few days of her menses. Could this woman be pregnant?

Subjective: 21 year-old woman had normal delivery of her second child eight weeks ago. She is fully breastfeeding. She has not had a menstrual period since delivery. She used an IUD between her two pregnancies and was happy with it. She has had intercourse in the last month. She has no primary or secondary precautions.

Objective: Normal pelvic examination. Uterus anterior, small, firm, and non-tender.

Questions for Discussion:

1. Is it appropriate to insert an IUD in this client today? Discuss the pros and cons.
2. If you do not provide her with an IUD today, what information will you give her?
3. Under what circumstances is it appropriate to go ahead with an IUD insertion in a client who is not during or just after her menstrual period?

Discussion: It is important that the practitioner be "reasonably certain" that the client is not pregnant. In this example the woman had her baby eight weeks ago and is fully breastfeeding, which is a reliable form of contraception (LAM). Her pelvic exam is normal. If it is possible, a pregnancy test could rule out pregnancy. However, even if no pregnancy test is done, this client should be provided with an IUD if she has no other precautions.

It is appropriate to insert an IUD in a client who is not during or just after her menstrual period if:

- she is less than 48 hours postpartum
- she is more than four weeks postpartum and has not had intercourse
- she is more than four weeks postpartum and has had intercourse, but has used a reliable method of contraception
- she is less than seven days postabortion and the uterus is not infected
- at any time in the menstrual cycle as long as the practitioner is "reasonably certain" that she is not pregnant.

Participant Handout 1.12: Case Studies (cont.)

Case Study 2: Pregnancy with IUD

Problem: Sometimes the IUD does not prevent pregnancy (less than 1% of the time with the TCU 380A). How will you manage a woman who has an intrauterine pregnancy with an IUD?

Subjective: Two years ago a 28 year-old para II had a TCU 380A inserted at six weeks postpartum. Her menses were regular until two months ago, when she had a very heavy period. She has not had a menstrual period since then and she tells you she now feels pregnant.

Objective: Client is anxious and upset. Her BP is 126/84. Breasts are enlarged. Pelvic exam reveals a normal vagina, a slightly bluish cervix with IUD string protruding, a soft, somewhat enlarged non-tender uterus, and normal adnexa.

Questions for Discussion:

1. What are some of the complications of pregnancy that may occur with an IUD in place? Should the practitioner strongly recommend removal of all IUDs when strings are visible?
2. What might have caused this client to become pregnant after two years of using the IUD successfully?
3. How should the service provider manage such a case?

Discussion: Pregnancy with an IUD in utero will terminate in spontaneous abortion in 50% of cases. Occasionally, these will be septic abortions, which place the woman at risk of severe morbidity and mortality. Most experts agree that an IUD should be removed if the strings are visible. IUD removal is associated with spontaneous abortion in 25% of cases.

One-third of IUD-related pregnancies are due to undetected partial or complete expulsion. Partial expulsion may occur if the IUD is not inserted to the fundus of the uterus, or sometimes with an unusually heavy period. When a woman using an IUD becomes pregnant, it is important to rule out ectopic pregnancy. IUDs provide less protection against ectopic than against intrauterine pregnancy; approximately 5% of women who become pregnant with an IUD will experience an ectopic pregnancy.

Participant Handout 1.12: Case Studies (cont.)

Case Study 2: Pregnancy with IUD (continued).

Diagnosis: Pregnancy with IUD in place; eight weeks gestation with possible ectopic pregnancy.

Plan: Counsel client about all her options and potential consequences for each course of action. If she wishes to continue the pregnancy, she should be referred promptly to an M.D. Ob/Gyn specialist for IUD removal, ruling out of ectopic pregnancy, and further observation and management.

Participant Handout 1.12: Case Studies (cont.)

Case Study 3: PID with IUD

Problem: A client who was at risk for developing a STD was not screened adequately. She has now developed PID.

Subjective: A 20-year-old para I has been using the COC for one year, but recently she has developed severe migraine-like headaches, and you have recommended that she discontinue the pills because the headaches may be caused or aggravated by estrogen. She has chosen to try an IUD and had a TCU 380A inserted five months ago. She has returned and she tells you that she noted a yellowish, bloody discharge and pain with intercourse starting three weeks ago.

Objective: Temp: 37 degrees; BP: 120/75; young woman does not appear to be in any discomfort. Abdominal exam shows no upper abdominal pain or guarding; lower abdomen slightly tender to pressure, no guarding. Pelvic exam normal. External genitalia and vagina: IUD string protruding from os; a mucopurulent discharge is seen emanating from the cervix. Bimanual exam elicits tenderness on cervical motion in any direction. Adnexa are also tender to pressure, but no mass is noted. Uterus is mid-position, firm, tender to pressure, fairly mobile.

Questions for Discussion:

1. Do IUDs cause PID?
2. What might the service provider have overlooked in this client's history that may explain her problem?
3. What practices in the standard IUD-insertion protocol are specifically designed to prevent infections? (Use *Clinical and Counseling Skill Learning Guides* as aids in answering this question.)
4. How will you manage her case?

Discussion: The IUD does not cause PID. However, it does increase the risk of infection if the woman is already at risk or becomes at risk of getting an STD. An infection in the first three weeks after insertion is usually due to poor infection prevention procedures at the time of insertion. If the infection develops after three months or more post-insertion, it is probably due to new exposure to infection. Before selecting an IUD the client should be asked about the number of sexual partners, if her sexual partner(s) has other sexual partners, and her history of STDs.

Participant Handout 1.12: Case Studies (cont.)

Case Study 3: PID with IUD (continued)

Plan: If the client does get an infection, the IUD should be removed. If the patient only has uterine tenderness, she should get doxycycline 100mg bid for 14 days. If she also has cervical motion tenderness (as this client does), she needs ceftioxin (2g IM) plus probenecid (1g orally) OR ceftriaxone (250mg IM) plus doxycycline (100mg bid) orally for 14 days. She should be counseled about how to avoid STDs, advised to use condoms, and to get her partner seen for treatment.

Participant Handout 1.12: Case Studies (cont.)

Case Study 4: Missing Strings

Problem: "I can't feel the strings of my IUD." The client's inability to locate her IUD strings during a routine self-check may indicate one of several possible problems.

Subjective: A 28-year-old para I, who wishes to delay her next pregnancy for two to three years, had a TCu 380A inserted six months ago. The insertion was very painful, and the pain persisted for several hours. She has had no problems since then and has been able to feel the strings herself.

The client's last menses started two weeks ago and it was normal; but since her menses, she has not been able to feel the IUD strings. She did not see the IUD come out during her period.

Objective: Abdominal exam and pelvic exam are normal; the uterus is retroverted, small, firm, non-tender. Adnexa are non-tender, and no masses or swelling are noted. The cervix is normal in appearance. No IUD strings are visible.

Questions for Discussion:

1. What are the possible reasons for the missing strings?
2. What will you recommend as a management plan for this woman?

Discussion: If a client can not feel the strings of her IUD, it could mean that the IUD has perforated the uterus or that it has come out with the menses. In this case either could have happened. The fact that she had a lot of pain on insertion, may mean that the IUD was placed so high in the fundus that it later became embedded (stuck) in the uterus. On the other hand, the fact that she had no problem feeling her strings for the first six months and then stopped being able to feel them after her period may mean that the IUD came out with her period (even if she did not see it come out).

Plan: If strings are not noted on exam and client is not pregnant, see if strings can be located with gentle exploration of lower cervical canal with (sterile or high-level disinfected) narrow sponge forceps. If you are not able to locate strings, refer client to Ob/Gyn for further management. Before client leaves your office, provide her with a supply of condoms to protect her from pregnancy in case IUD is not in the uterus.

Participant Handout 1.13: Key Information and Messages

A main ingredient for successful use of the IUD (or any method) is an informed client. A client who understands the benefits, risks, advantages, disadvantages, what she must do to use the method correctly, and knows what side effects she may experience (and does not panic if they should occur), will be a far more satisfied and successful user than one who does not.

Informing the client may take more time, but it will pay off in a client who is more satisfied and who understands her method.

Participant Handout 1.14: Role Play Situations

A. General Counseling Role Play

Participant should be able to demonstrate key messages about the IUD. Practice telling this to:

- a very young woman.
- a woman much older than you are.
- someone who is related to you.
- someone who believes her husband has another partner.

The person playing the client should act out reactions to these situations, and the person playing the provider should demonstrate the ability to talk to different people with different levels of education, status, age, etc.

B. Deciding to choose an IUD--Client Assessment and Counseling Role Plays

"Client" models for role play

- 17 year old with no children and wants to become pregnant in two years.
- 35 year old woman with four children, has regular periods, does not want anymore children.
- 27 year old with two children, has had PID once since the birth of her last child; she wants more children in the future.
- 20 year old who is fully nursing a four week old baby.
- 40 year old who has had all the babies she wants, but is still having regular bleeding; she has severe diabetes and must inject herself with insulin.
- 19 year old sex worker who has four children, history of PID, hepatitis, and is HIV positive.
- 32 year old woman with two children who has heavy periods, she needs to change her pads every two hours, she bleeds for eight days, and on the first two days her cramps are so strong that she cannot go to her job.
- 27 year old woman with six children; she is very pale with light conjunctiva. She says that after her last baby was born, six months ago, she bled so much she had to go to the hospital. She complains that she has no strength. She does not want anymore children.
- 30 year old woman with four children; she is not sure if she wants any more children. She is in a mutually monogamous relationship.
- 30 year old woman with four children. She is not sure if she wants any more children. Her husband travels for work and she thinks he may be having a relationship with a woman in another town.

Participant Handout 1.14: Role Play Situations (cont.)

C. Findings on Pelvic Exam

- 25 year old with three children states no problems during medical history. On speculum exam you see that her cervix is red, with a bubbly green/gray discharge. What do you tell her? What do you do?
- Same history. You find a painless lesion on her vulva.
- Same history. Pelvic exam normal. When sounding her uterus you find it is deeper than 10 cm. What do you do? Why?

Note: The first two role plays above are STD risks and client should use condoms.

D. Post-insertion Role Plays

Role play telling the client the kind of IUD she has, when it has to be replaced, when she needs to come back, the danger signs, when the IUD becomes effective, how to check the strings, why the strings need to be checked, when and what changes she might expect with her period, how to protect herself from GTI/STDs, and reasons why she can have her IUD replaced. Practice telling this to:

- a very young woman
- a woman much older than you are
- someone who is related to you
- someone who believes her husband has another partner

The person playing the client should act out reactions to these situations, and the person playing the provider should demonstrate the ability to talk to different people with different levels of education, status, age, etc.

E. Removal Role Plays

Role play counseling for each situation as well as what to tell any woman having her IUD removed, what to expect, when she can become pregnant again, how she can protect against pregnancy and STDs, etc.

"Client" models for role play:

- 30 year old woman with three children, does not want any more children. Her periods are normal and she has had no problem with the IUD, which she has been using for six years. Her mother-in-law told her that this is too long to have the IUD. She is worried and she wants the IUD taken out so she can give her body a rest.
- Same situation, but she really doesn't want to take a rest. She is telling you this story because she knows her husband has another sexual partner. She is worried that she is at risk for GTI/STD, but is ashamed to tell you.
- 26 year old with five children she has decided that she wants the IUD removed because she is ready to have another child.
- 35 year old woman with four children, she doesn't want any more children. She has had the IUD in place for 10 years and comes in to have it replaced.

Instructions: Rate the performance of each task/activity observed using the following rating scale:

- 1. Needs Improvement:** Step not performed correctly and/or out of sequence (if required) or is omitted.
- 2. Competently Performed:** Step performed correctly in proper sequence (if required) but lacks precision, and/or the trainer/critiquer needed to assist/remind the participant in a minor way.
- 3. Proficiently Performed:** Step performed correctly in proper sequence (if required) and precisely without hesitation or need for any assistance.
- N/O Not Observed:** Step not performed by participant during observation by trainer/critiquer.

Participant: _____ **Course Dates:** _____

TASK/ACTIVITY	CASES				
Counseling (Insertion)					
Initial Interview (Client Reception Area)					
1. Greets client in friendly and respectful manner.					
2. Establishes purpose of visit and answers questions.					
3. Provides general information about family planning.					
4. Explains what to expect during clinic visit.					
5. Asks client about her reproductive goals (i.e., does she want to space or limit births?).					
6. Explores any attitudes or religious beliefs that either favor or rule out one or more methods.					
Method-Specific Counseling (Counseling Area)					
7. Ensures necessary privacy.					
8. Obtains biographical information (name, address, etc.).					

Participant Handout 1.15 (cont.)

9. Gives the client information about the contraceptive choices available and the risks and benefits of each: <ul style="list-style-type: none"> • shows where and how the IUD is used • explains how it works and its effectiveness • explains possible side effects and other health problems • explains benign nature of the most common side effects 					
10. Discusses the client's needs, concerns, and fears in a thorough and sympathetic manner.					
11. Helps the client begin to choose an appropriate method.					
If she chooses an IUD:					
12. Screens the client carefully to make sure there is no medical condition that would be a problem (completes Client Assessment Checklist).					
13. Explains potential side effects and makes sure that they are fully understood.					
Pre-Insertion Counseling (Examination/Procedure Area)					
14. Reviews Client Assessment Checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place.					
15. Informs client about required physical and pelvic examinations.					
16. Checks that client is within seven days of last menstrual period.					
17. Rules out pregnancy if beyond day seven (refers for medical care, if non-medical counselor).					
18. Describes the insertion process and what client should expect during and afterwards.					
Post-Insertion Counseling					
19. Completes client record.					
20. Teaches client how and when to check for strings.					
21. Discusses what to do if client experiences any side effects or problems.					
22. Provides follow-up visit instructions.					
23. Reminds client that the TCU 380A can be left in for 10 years.					
24. Assures client that she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to have the IUD removed.					
25. Asks the client to repeat instructions.					
26. Answers client's questions.					
27. Observes client for at least 15 minutes before sending her home.					

Participant Handout 1.15 (cont.)

Counseling (Removal)					
Pre-Removal Counseling (Client Reception Area)					
1. Greets client in friendly and respectful manner.					
2. Establishes purpose of visit.					
3. Asks client her reason for removal and answers any questions.					
4. Asks client about her present reproductive goals (i.e., does she want to continue spacing or limiting births?).					
5. Describes the removal process and what she should expect during the removal and afterwards.					
Post-Removal Counseling					
6. Discusses what to do if client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).					
7. Asks client to repeat instructions.					
8. Answers any questions.					
9. Reviews general and method-specific information about family planning methods, if client wants to continue spacing or limiting births.					
10. Assists client in obtaining new contraceptive method or provides temporary method (barrier) until method of choice can be started.					
11. Observes client for five minutes before sending her home.					

Adapted from: Development Associates & The Indian Medical Association. *Module 8, Family Planning Course, Intra – Uterine Contraceptive Devices: An Overview*, 1994.

Participant Handout 1.16: Observer's Role Play Checklist for Counseling Skills

Instructions: Use the checklist to record your observations of the role-play. Observe the counseling process as well as content. Note whether the doctor applies the steps in GATHER (as appropriate to the role play). Does the doctor address the problem adequately? Does s/he address the "client's" concerns? Is the information given correct and complete? What is the client's behavior? How does the "doctor" behave? What non-verbal messages are communicated by client or doctor?

Task	Performed	
	Yes	No
Doctor's Nonverbal Communication		
Friendly/welcoming/smiling?		
Non-judgmental/receptive?		
Listens attentively/nods head to encourage and acknowledge client's responses?		
Appears rushed/impatient?		
Doctor's Verbal Communication		
Phrases questions clearly and appropriately? Uses non-technical terms?		
Listens to client's responses closely?		
Answers client's questions?		
Uses language the client can understand?		
GATHER Process and Content		
Greets the client in a friendly and respectful manner?		
Asks client about self? <ul style="list-style-type: none"> • client's needs and concerns? • reproductive goals? 	_____ _____ _____	_____ _____ _____
Tells client about FP methods? <ul style="list-style-type: none"> • tells about all methods available? • asks which method interests client? • asks what client knows about method? • corrects myths/rumors/incorrect information? • describes how method works and its effectiveness? • uses A/V aids during counseling? • describes benefits and risks? • describes potential side effects? • answers client's questions clearly? 	_____ _____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____ _____

Participant Handout 1.16: Observer's Role Play Checklist for Counseling Skills (cont.)

GATHER (cont.)	YES	NO
Helps client to reach an informed decision? • asks if anything not understood? • asks "what method do you want?"	_____ _____ _____	_____ _____ _____
Explains how to use method? • explains clearly what client has to do to use method successfully? • instructions to client are complete and clear? • asks client to repeat back instructions? • reminds client of potential minor side effects? • reminds client of danger signs? • explains to client what to do if problems?	_____ _____ _____ _____ _____ _____ _____ _____	_____ _____ _____ _____ _____ _____ _____ _____
Return visit planned?	_____	_____
PROBLEM SOLVING		
Does "doctor" respond appropriately to the client's needs and problems?	_____	_____
Is "doctor" convincing in advice given?	_____	_____
Is advice given/method provided appropriate?	_____	_____
Does "doctor" treat client/family with respect?	_____	_____
Is the counseling • doctor-controlled? • client-controlled? • balanced?	_____ _____ _____	_____ _____ _____
Is "doctor" convincing in her/his role? Is "client" convincing in her/his role?	_____ _____	_____ _____

What did you learn from observing this role play?

Please record your comments/observations for feedback to participants (both positive and negative):

Participant Handout 1.16A: Additional Counseling Information

Counseling Process

Thorough and accurate counseling is the most critical element to client satisfaction. Giving the clients complete, accurate, and clear information about IUDs (or any method) will make the method and potential side effects more widely accepted.

Service providers must have the competence and skills in counseling women who either want to use IUDs or want information about the various FP methods.

Bearing in mind the six steps in the counseling process ("GATHER") the following points should be taken into consideration:

Greet the client in a friendly, warm, respectful, and helpful way. Create confidence, develop rapport, and make them feel at ease.

Ask clients about their needs and reproductive goals. Know your clients. Obtain a history using standard forms. If you need to ask the client about sensitive matters, wait until she feels at ease with you.

Tell the client about her choices for family planning. Tell your client about the IUD. When giving information about IUDs (or any other method) the following should be made clear: mechanism of action, effectiveness, side effects, return to fertility, and follow-up appointments.

Help the client to choose a method. Help your client choose a method by making her consider the suitability of each method to her health and lifestyle. Let your client do the talking. Allow her plenty of time to ask questions and express concerns. If your client chooses the IUD, help her feel confident that she has opted for an effective, safe, and convenient FP method.

Explain the correct use of the method. Explain how the IUD is inserted and removed.

Repetition of the method instructions by the client to help assess clarity of communication. Ensure that the client will return to the clinic for her follow-up visit. It is wise to give clients an appointment card on which is written the date of this visit. Tell the clients they may visit the clinic anytime as needed for concerns or problems.

Source: Population Reports. *Why Counseling Counts*. Series J: 36, 1990.

Participant Handout 1.16B: Additional Counseling Information

Skills for Effective Counseling

Both verbal and nonverbal communication skills are crucial in the counseling process. The acronyms "CLEAR" and "ROLES" help providers remember appropriate behaviors (both verbal and nonverbal) during counseling.

Appropriate Verbal Behaviors:

Clarify
Listen
Encourage
Acknowledge
Reflect and Repeat

Appropriate Nonverbal Behaviors:

Relax
Open and Approachable
Lean toward Client
Eye Contact
Sit straight and Smile

Source: Population Reports. *Why Counseling Counts*. Series J: 36, 1990.

Participant Handout 2.1: IUD Screening

Once a client has made the decision to use an IUD based on complete general method counseling, she needs to have IUD method-specific counseling (as covered in Unit 1 of this module). Before you can assure her that the IUD is an appropriate choice for her, **she needs to have a limited history and physical exam in order to achieve the following objectives:**

- Rule out conditions which might affect eligibility, including the possibility of pregnancy, genital tract abnormalities, infection, or risk of STDs.
- Rule out conditions which might be made worse by an IUD, such as severe dysmenorrhea (cramping), metrorrhagia (bleeding between periods), or anemia.
- Rule out conditions which when combined with IUD use may place client at risk, such as valvular heart disease, severe diabetes, immunosuppression, etc.

To aid the practitioner in obtaining client history and giving rationale for asking each question (as well as aiding decision-making in case of a precaution), practitioners may use checklists such as *Participant Handout 2.2: Client Assessment Checklist*.

Note: *Microscopic examination of vaginal secretions is not necessary for IUD insertion.*

After the history, practitioner should rule out severe anemia by examining the mucous membranes and skin.

Finally, practitioner should **perform a complete pelvic exam in order to:**

- determine position and size of uterus
- rule out likelihood of pregnancy
- rule out presence of visible and/or palpable abnormalities, including infections, masses, tumors, etc.

If any of these are present, an IUD should not be inserted until the problem is investigated and resolved. Again, the trainer and practitioner can use *Participant Handout 2.3: Pelvic Bimanual and Speculum Checklist*.

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Participant Handout 2.2: Client Assessment Checklist

Service Provider's Questions	NO	YES	Service Provider's Instructions (and Rationale)
Ask the client the following questions:			If the client's response falls in the "YES" column, follow the instructions below:
1. Did your last full-term pregnancy end less than four weeks ago?			1. Do not insert. It is advisable not to insert an IUD after the first 48 hours postpartum or until four weeks postpartum. During this time, the risk of uterine perforation is greater due to the rapidly involuting (shrinking) uterus.
2. Have you had a miscarriage or an abortion within the past four weeks?			2. Women who have recently had a miscarriage or abortion can have an IUD inserted if there is no sign of infection on pelvic examination. If you are unsure, make appropriate referral.
3. Is there a chance that you could be pregnant; is your period late or have you missed a recent period?			3. Do not insert the IUD if there is any chance that client is pregnant. Perform a pelvic exam and a urine pregnancy test (if available). If you are unsure if she is pregnant, have the client use a barrier method and return in four weeks or upon beginning her menses.
4. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths? Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?			4. If answer is "yes" to either question, encourage client to consider another effective method. Explain to her that the IUD may make her bleeding even heavier and she may become anemic. The IUD could also make her cramps worse. If she still prefers the IUD, insert and ask her to come back if her bleeding or cramps become heavier.
5. Over the past three months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?			5. These symptoms may indicate a health problem, such as cervicitis, cervical polyps, or, rarely, cancer. Look for signs of these problems when you do the speculum and bimanual examination.
6. Over the past three months, have you had fever or chills, accompanied by pain in the lower abdomen?			6. These symptoms may indicate PID. Look for signs of tenderness, discharge, or guarding during pelvic examination. If you think infection is present, do not insert the IUD.

Participant Handout 2.2: Continued

<p>7. Have you recently had severe pelvic infection (with fever, chills, pain in the womb and/or discharge)? Or have you had problems with recurrent PID?</p>			<p>7. Do not insert IUD, since IUD users with a history of PID may become infertile. Help client make an informed choice of another effective contraceptive method. Discuss using condoms as primary contraceptive method or as a backup method to prevent PID.</p>
<p>8. Assure the client of confidentiality before asking the following questions:</p> <ul style="list-style-type: none"> • As far as you know, does your sex partner have other sex partners besides yourself? • Do you have more than one sex partner? 			<p>8. If "yes" to one or both questions, client needs to be screened for possible GTIs or other STDs. Counsel client on risks associated with HIV, GTIs or other STDs, help her choose another contraceptive method, and advise her to use condoms and/or spermicide to protect herself against these diseases.</p>
<p>9. Do you think you may be infected with HIV? Do you have AIDS?</p>			<p>9. If the client has AIDS, is infected with HIV or is being treated with any medicines that make her body less able to fight infections, do not insert the IUD. Help her choose another effective method. Whatever method she chooses, urge her to use condoms.</p>
<p>10. Do you have any cancer in the female organs or pelvic tuberculosis?</p>			<p>10. Known cervical, endometrial or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method.</p>
<p>11. Are you currently taking any medications, such as high-dose corticosteroids, insulin injections, immunosuppressive therapy, anticoagulant therapy, or receiving radiation therapy?</p>			<p>11. People using high-dose corticosteroids or immunosuppressive drugs or receiving radiation therapy are at higher risk of infection. So are women who have such severe diabetes that they use insulin. Also, anticoagulant therapy may increase blood loss. Do not insert the IUD. Help her to choose another effective method.</p>

Source: Blouse A, Kinzie B, McIntosh N. *IUD Guidelines for Family Planning Service Programs*. JHPIEGO, 1992.
 Blackburn R, et al. *The Essentials of Contraceptive Technology*. Baltimore, MD: Population Information Program/Center for Communication Programs, The Johns Hopkins School of Public Health, July 1997.

Participant Handout 2.3: Pelvic Bimanual and Speculum Exam Checklist

Service Provider's Observations	NO	YES	Service Provider's Instructions (and Rationales)
Look for the abnormalities listed below:			If a response falls in the "YES" column, follow the instructions below.
1. Is there marked tenderness of cervix, uterus, or adnexal area?			1. Do not insert an IUD. This suggests PID or cervicitis. Help client make an informed choice of another effective method. Encourage client to use condoms and/or spermicide to protect against GTIs and other STDs, including AIDS.
2. Is the cervix immobile, or is there a palpable mass or ulcer?			2. Do not insert an IUD. These abnormalities may indicate a tumor or, rarely, cervical cancer. Help client make an informed choice of another method, and refer for further evaluation.
3. Are you unable to determine the position of the uterus?			3. Do not insert an IUD. If you are unsure of the position of the uterus after bimanual palpation, seek consultation or refer for further evaluation.
4. Is the uterus enlarged, soft, and smooth?			4. Do not insert an IUD. If the woman has also missed a period, she is likely to be pregnant. If you are certain she is not pregnant, an IUD may be inserted.
5. Is the uterus enlarged, firm, and/or irregular?			5. Do not insert an IUD. This may indicate uterine fibroids which can change the shape of the uterine cavity. Attempt to insert the IUD only if you are experienced; otherwise, refer or help her to choose another method. If you refer, help her choose another method to use until she gets her IUD.
6. Is there a palpable mass in the adnexal area?			6. Do not insert an IUD. This may indicate PID or a tumor of the ovary or tube. Help client make an informed choice of another nonhormonal method until problem is solved. Make appropriate referral.

Service Provider's Observations	NO	YES	Service Provider's Instructions (and Rationales)
Look for the abnormalities listed below:			If a response falls in the "YES" column, follow the instructions below.
7. On sounding, is the uterine cavity irregular or deeper than 10 cm?			7. Do not insert an IUD. This may mean that she has fibroids, is pregnant, or the uterus was perforated by the sound. If perforation is suspected, observe the client for evidence of intra-abdominal bleeding: decreased BP, rising pulse and/or syncope.
8. Are there ulcers or sores on the external genitalia, or enlarged glands (buboes) in the groin area?			8. Do not insert an IUD. Any of these findings suggest a possible GTI such as syphilis, chancroid, lymphogranuloma, or herpes. Help client make informed choice of another method. Refer if necessary for further evaluation.
9. Is the vaginal wall inflamed, and is there a discharge from the vagina?			9. Do not insert an IUD. This suggests vaginitis. Diagnose cause and treat vaginitis before considering insertion of an IUD. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STDs, including AIDS.
10. Is the cervix red and inflamed, and is there discharge from the cervical canal?			10. Do not insert an IUD. This suggests cervicitis. Diagnose and treat cervicitis. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STDs, including AIDS.
11. Is there a mass, ulcer, or bleeding on contact with the cervix?			11. Do not insert an IUD. This suggests possible cervical polyp, severe cervicitis or, rarely, cervical cancer. Help client make informed choice of another method. Refer if necessary for further evaluation.

Adapted from: INTRAH. *Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers.* Chapel Hill, North Carolina: INTRAH, 1993 (Chap.7).

Participant Handout 2.4: Rationale for Loading the TCU 380A in the Sterile Package

There are at least two reasons to load the TCU inside the sterile package instead of using sterile gloves to load the IUD outside the package:

- Not touching the IUD directly will ensure its sterility, thus avoiding PID risk to client
- Loading the TCU while it is in the package is cost-saving because it eliminates the need to use sterile gloves. (HDL gloves are adequate because nothing that will be introduced into the uterus will be touched directly.)

In addition, sterile gloves frequently are inadvertently contaminated by the inexperienced practitioner, again increasing the risk of PID to the client.

At first, loading the TCU inside the sterile package may appear awkward and time-consuming; however, with help from the trainer and some practice, the participant will be able to perform this maneuver in less than 20 seconds.

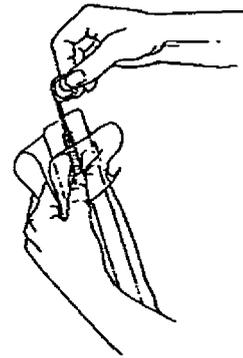
Participant Handout 2.5: Instructions for Loading the Copper T 380A in the Sterile Package

How to Load the Copper T 380A

Do **not** open the sterile package containing the IUD or load it until the final decision to insert an IUD has been made (i.e., after the pelvic examination, including both speculum and bimanual exams, has been performed). In addition, do not bend the **arms** of the "T" into the **insertor tube** (as instructed below) more than five minutes before it is introduced into the uterus.

Step 1: Make sure that the **vertical stem** of the T is fully inside the **insertor tube** (the T can be shifted through the unopened package) and that the end of the insertor tube opposite the T is close to the **seal** at the end of the package.

Step 2: Place the package on a clean, hard, flat surface with the **clear plastic side up**. Partially open the end of the package **farthest** from the IUD. Open the package approximately halfway to the blue **depth-gauge**.

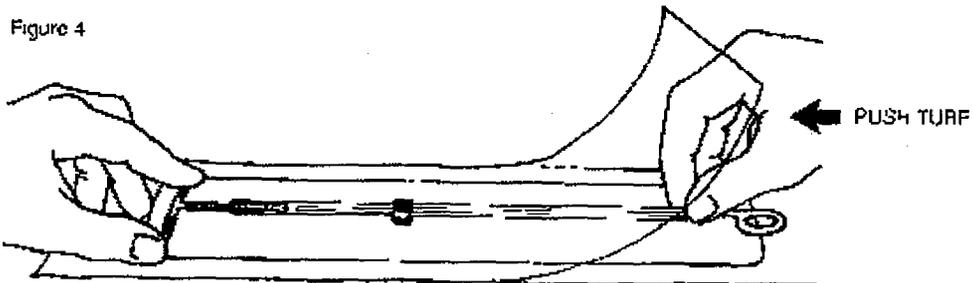


Step 3: Pick up the package, holding the open end up towards the ceiling so that the contents do not fall out. Bend the **clear plastic cover** and **white backing "flap"** at the open end of the package away from each other. (This will help maintain sterility of the **white rod** during loading.) Using your free hand, grasp the **white rod**, which is behind the **I.D. card**, by the thumb grip and remove it from the package. Be careful not to touch the tip of the white rod or brush it against another surface. Put the **white rod** inside the **insertor tube** and gently push rod up into the insertor tube until it almost touches the bottom of the T.

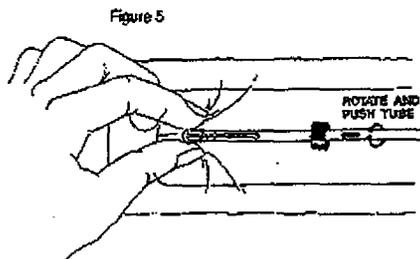
Step 4: Release the **white backing "flap"** so that it is flat, and place the package on a flat surface with the **clear plastic side up**.

Participant Handout 2.5: Instructions for Loading the Copper T 380A in the Sterile Package (cont.)

Step 5: Through the clear plastic cover, place your thumb and index finger over the ends of the **horizontal arms** of the T and hold the T in place. At the open end of the package, use your free hand to push the *I.D. card* so that it slides underneath the T and stops at the **top seal** of the package. While still holding the tips of the **horizontal arms** of the T, use your free hand to grasp the **insertor tube** against the arms of the T, as indicated by the arrow in the figure below. This will start the arms of the T bending downward, towards the stem of the T, as indicated in the drawing on the *I.D. card*.



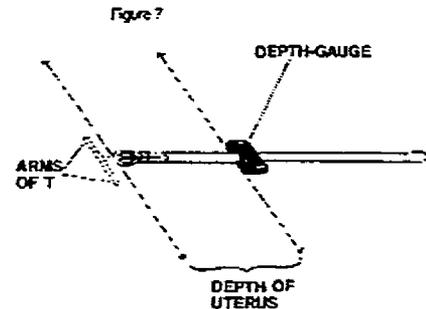
Step 6: Continue bending the arms of the T by bringing the thumb and index finger together. When the arms have folded enough to touch the sides of the **insertor tube**, pull the insertor tube out from under the tips of the arms. Then push and rotate the **insertor tube** onto the tips of the arms so that the arms become trapped inside the insertor tube next to the stem. Insert the folded arms into the tube only as far as necessary to ensure retention of the arms. **Do not try to push the copper bands on the arms into the insertor tube; they will not fit.**



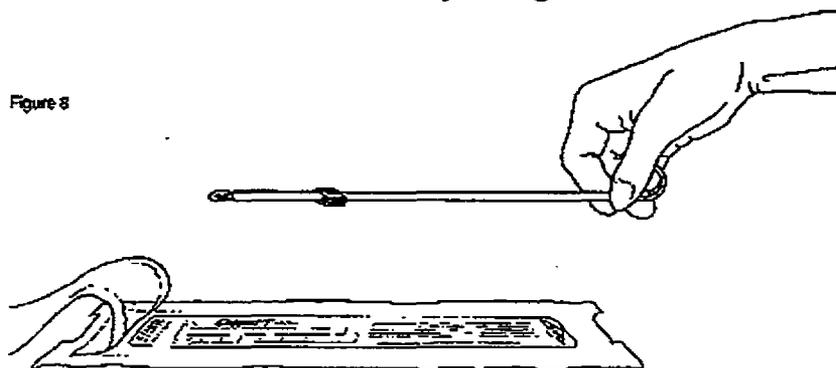
Participant Handout 2.5: Instructions for Loading the Copper T 380A in the Sterile Package (cont.)

Step 7: The **blue depth-gauge** on the inserter tube is used to mark the depth of the uterus and to show the direction in which the arms of the T will unfold once they are released from the inserter tube.

Holding the blue depth-gauge in place through the clear plastic wrapper, grasp the inserter tube at the open end of the package with your free hand. Pull the inserter tube gently until the distance between the top of the folded T and the edge of the **blue depth-gauge** closest to the T is equal to the depth of the uterus as measured on the uterine sound. Rotate the inserter tube so that the long axis of the blue depth-gauge is on the same horizontal plane as the arms of the T.



Step 8: The IUD is now ready to be placed in the woman's uterus. Carefully peel the clear plastic cover of the package away from the white backing. Lift the loaded inserter, keeping it horizontal, so that the T or white rod doesn't fall out. Be careful not to push the white rod towards the T until you are ready to release the T in the fundus. **Do not let the inserter tube or the tip of the IUD touch any unsterile surfaces. If it touches any unsterile surfaces it must not be inserted in the uterus. Throw it away and get another one.**



Source: The Population Council and the Program for Appropriate Technology in Health (PATH): *The Copper T 380A IUD: A Manual for Clinicians*. 2nd ed. Seattle, Washington: PATH, 1989.

Participant Handout 2.6: Basic Principles for IUD Insertion and Removal

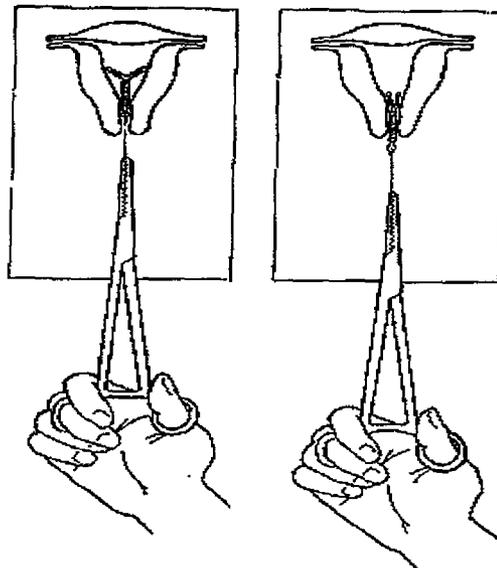
Participants will achieve this objective through a variety of training methodologies. The step-by-step IUD insertion and removal sequence is found in *Participant Handout 2.10*. The JHPIEGO video on IUD insertion and removal also details the procedure.

Throughout the IUD insertion and removal training, **certain basic principles** are to be emphasized:

- **Gentle techniques** to minimize discomfort and emotional trauma to the client. In order to perform a comfortable IUD insertion, force is neither necessary nor desirable.
- **No-touch technique**, in which the tip of the uterine sound that will touch the upper genital tract will not have previously touched anything that may contaminate it: hands, speculum, vagina, table top, etc.
- As already indicated in Specific Objective #2, the TCu is loaded using the no-touch technique, inside package.
- The cervix and vagina should be thoroughly prepped with antiseptic. Use a water-based antiseptic such as an iodophor (Betadine® or Povidone Iodine) or Chlorhexidine (Hibitane®).

Note: *If an Iodophor is used, wait one or two minutes before proceeding because iodophors take up to two minutes contact time to release free iodine.*

- The uterine cavity should always be sounded to confirm the position of the uterus and the depth of the cavity.
- Set the depth gauge on the IUD to the level on the uterine sound.
- Insert the IUD high in the fundus of the uterus by withdrawal technique, as there is less risk of expulsion.



Participant Handout 2.7: Passing a Uterine Sound

Sounding the uterus is recommended for all copper IUDs inserted by the "withdrawal" technique, in order to ensure high fundal placement.

Purpose of Sounding the Uterus

- To check the position of the uterus and check for obstructions in the cervical canal.
- To measure the direction of the cervical canal and uterine cavity, so that the inserter can be shaped appropriately to follow the canal.
- To measure the length from external cervical os to the uterine fundus so that the blue depth gauge on the insertion tube (TCu 380A IUD) can be set at the same distance, so that the IUD will be placed high in the uterine fundus.

Procedure for Sounding the Uterus

Use gentle, no-touch (aseptic) technique throughout:

Note: *Before attempting to sound the uterus, a screening speculum and bimanual exam should have been performed to rule out the possibility of vaginal and cervical infection and to determine the size of the uterus.*

Step 1: Put on **high-level disinfected or sterile** gloves.

Step 2: Insert the speculum. Thoroughly clean the cervix with an antiseptic solution e.g., Chlorhexidine Gluconate (Hibiclens®, Hibiscrub®, Hibitane® or Savlon® note: concentration of Savlon® may vary) or iodophors (Povidone Iodine, Betadine®, Wesodyne®).

Step 3: Apply the HLD or sterile tenaculum at the 10 and 2 o'clock positions on the cervix. Close tenaculum **one notch at a time**, slowly, and no further than necessary.

Step 4: Pick up the handle of the sound, do not touch the tip. Turn the sound so that it is in the same direction as the uterus. Gently pass HLD or sterile tip of the uterine sound into the cervical canal. At the same time keep a firm grip with the tenaculum. (Be careful not to touch walls of the vagina with tip of sound.)

Carefully and gently insert the uterine sound in the direction of the uterus while gently pulling steadily downwards and outward on the tenaculum. If there is resistance at the internal os, use a smaller sound, if available. **Do not attempt to dilate the cervix unless well qualified. Gentle traction on the tenaculum may enable the sound to pass more easily. If client begins to show symptoms of fainting or pallor with slow heart rate, STOP.**

Participant Handout 2.7: Continued

Step 5: Slowly withdraw the sound, it will be wet and darker where it was in the uterus. Place the sound next to the IUD and set the blue depth gauge at the depth of the uterus.

Step 6: Apply the (one or two-toothed) tenaculum at the 10 and/or 2 o'clock positions on the cervix.

Note: *The tenaculum should be used by all persons learning to do IUD insertions. Very experienced clinicians may find a tenaculum is only needed when the fundus is flexed sharply, or when the internal os is partially stenosed.*

Gently pull either the anteverted or retroverted uterus toward you with constant smooth traction on the tenaculum, in a downward and outward direction.

Step 7: Gently pass the sterile tip of the uterine sound into the cervical canal while maintaining traction with the tenaculum. If there is an obstruction at the level of the os, use a smaller sound if available.

Insert the sound carefully and gently into the uterine cavity while pulling steadily downwards and outwards on the tenaculum. From the bimanual exam, you know the general direction of the uterus, so direct the sound gently toward where you expect the fundus to be.

Gently exerting traction on the tenaculum may enable the sound to pass more easily. If the client begins to show symptoms of fainting, or pallor with slow heart rate, **STOP**.

Step 8: When a slight resistance indicates that the tip of the uterine sound has reached the fundus, note the present direction of the uterine cavity, and remove the sound. Let go of the tenaculum, but leave it attached to the cervix.

Step 9: Determine the length of the uterus by noting the mucus and or blood on the sound. The average uterus will sound to a depth of 6 to 8 centimeters (cm). **Do not attempt to insert an IUD into a uterus that measures 6.0 cm or less in depth.**

Participant Handout 2.7: Continued

If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. DO NOT inset an IUD. If perforation is suspected, observe the client in the clinic carefully:

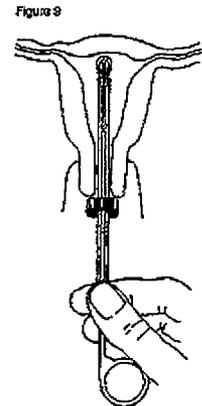
- a) For the first hour, keep the woman at bed rest and check the pulse and BP every 5 to 10 minutes.
- b) If the woman remains stable after one hour, check the hematocrit/hemoglobin if possible, allow her to walk, check vital signs as needed, and observe for several more hours. IF she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice of a different contraceptive.
- c) IF there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.

Source: INTRAH. *Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers*. Chapel Hill, North Carolina: INTRAH, 1993 (Chap.7).

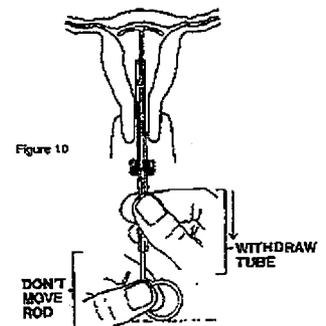
Participant Handout 2.8: Inserting the Loaded TCu 380A IUD

Step 1: Grasp the tenaculum (which is still in place on the cervix after sounding the uterus) and pull firmly to pull the uterine cavity and cervical canal in line with the vaginal canal. Gently place the loaded inserter tube through the cervical canal. Keep the blue depth-gauge in a horizontal position.

Advance the loaded IUD until the blue depth-gauge touches the cervix or resistance of the uterine fundus is felt. Keep the blue depth-gauge in a horizontal position.



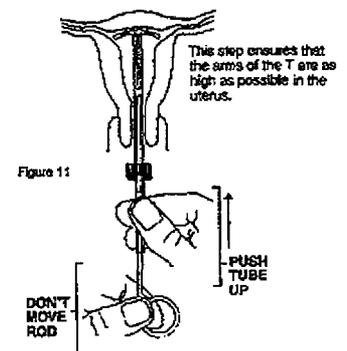
Step 2: Hold the tenaculum and the white rod in place in one hand. With your other hand, withdraw (pull toward you) the inserter tube until it touches the thumb grip of the white rod. This will release the arms of the Copper-T 380A high in the uterine fundus.



Step 3: Once the arms have been released, again very gently and carefully push the inserter tube upward, toward the top of the uterus, until you feel a slight resistance.

This step ensures that the arms of the T are as high as possible in the uterus.

Hold the inserter tube still while removing the white rod.

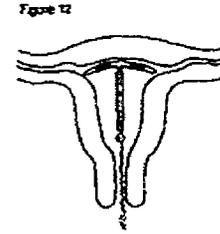


Step 4: Gently and slowly withdraw the inserter tube from the cervical canal. The strings should be visible protruding from the uterus. Cut the strings so that they protrude only 3-4 cm into the vagina.

Remove the tenaculum. If the cervix is bleeding from the tenaculum site, press a swab to the site, using clean forceps, until the bleeding stops.

Participant Handout 2.8: Inserting the Loaded TCu 380A IUD (cont.)

Step 5: Help the client to get up from the table very slowly. Watch her in case she gets dizzy or feels faint. Teach her how and when to check the strings. Ask her to check the strings now. Ask her if she has any questions and answer them in simple words she can understand. Tell her to return in 3-6 weeks. If she can read, give her written instructions or tell her the warning signs of problems and how to get help if she needs it.



Source: The Population Council and The Program for Appropriate Technology in Health (PATH). *Copper T 380A IUD: A Manual for Clinicians*. 2nd ed. Seattle, Washington: PATH, 1989.

Participant Handout 2.9: Using the Clinical and Counseling Skills Checklist

The **Checklist for IUD Counseling and Clinical Skills** is used by the trainer to certify each participant's competency in providing IUD services (i.e., counseling, infection prevention practices, insertion or removal, and follow-up care). The checklist focuses only on key steps in the entire process.

The trainer uses this checklist to evaluate for certification the performance of each participant as s/he provides IUD services to 1 or more clients. Criteria for satisfactory performance by the participant are based on the knowledge, attitudes, and skills set forth in the module.

Satisfactory: Performs the task or skill according to written procedure or guidelines without requiring assistance from trainer.

Unsatisfactory: Does not perform the task or skill according to written procedure or guidelines or requires assistance from trainer.

Not Observed: Task or skill not performed by participant during evaluation by trainer.

In preparing for formal evaluation (certification) by the trainer(s), participants may familiarize themselves with the content of the checklist by using it to critique each other's counseling skills (role play or with a client) and clinical skills (using a pelvic model or with a client).

In general, a participant is expected to demonstrate satisfactory counseling skills and to perform satisfactorily at least five to ten insertions in clients before being certified as competent. When determining competence, the judgment of a skilled trainer is the most important factor. In order to enable **every** participant to achieve competency, additional training in counseling techniques and/or insertion may be necessary.

It is recommended that, if possible, participants who have been certified later be observed and evaluated in their own clinic by a **course trainer**, using the same checklist, within three-to-six months of certification. (At the very least, the graduate should be observed by a **skilled provider** soon after completing training.) This post-course evaluation is important for several reasons. **First**, it provides the graduate with experience in handling direct constraints to service delivery (e.g., lack of instruments, supplies, or support staff). **Second**, and equally important, it provides the training center, via the trainer, with key information on the adequacy of the training and its appropriateness to local conditions. Without this type of feedback, training can easily become routine, stagnant, and irrelevant to service delivery needs.

Participant Handout 2.10: Checklist for IUD Counseling and Clinical Skills

Place a check mark (✓) in the 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 task or skill according to written procedure or guidelines without requiring assistance from trainer.

Unsatisfactory: Does not perform the task or skill according to written procedure or guidelines or requires assistance from trainer.

Not Observed: Task or skill not performed by participant during evaluation by trainer.

Participant _____ **Course Dates** _____

TASK/ACTIVITY	CASES				
Pre-Insertion Counseling					
1. Greets client in friendly and respectful manner.					
2. Asks client about her reproductive goals.					
3. Determines that the client's contraceptive choice is the IUD.					
4. If IUD counseling was not done, provides or arranges for counseling prior to performing procedure.					
5. Reviews Client Screening Checklist to determine if the client is an appropriate candidate for the IUD.					
6. Assesses client's knowledge about the IUD's major side effects.					
7. Is responsive to client's needs and concerns about the IUD.					
8. Describes insertion process and what to expect.					
Pre-Insertion Tasks					
1. Obtains or reviews brief reproductive health history.					
2. Washes hands with soap and water.					
3. Asks client if she has emptied her bladder.					
4. Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities.					
5. Tells client what is going to be done and encourages her to ask questions.					
6. Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.					
7. Performs speculum examination.					

Participant Handout 2.10: Continued

TASK/ACTIVITY	CASES				
8. Collects specimens of vaginal and cervical secretions, if indicated.					
9. Performs bimanual examination.					
10. Performs rectovaginal examination, if indicated.					
11. Removes gloves and properly disposes (single-use) or immerses (reusable) in chlorine solution.					
12. Performs microscopic examination, if indicated (and if equipment is available).					
13. Washes hands thoroughly with soap and water and dries with clean cloth or allows to air-dry.					
14. Loads Tcu 380A inside sterile package.					
IUD Insertion					
15. Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.					
16. Inserts vaginal speculum (and vaginal wall elevator if using single-valve speculum).					
17. Swabs cervix and vagina with antiseptic.					
18. Gently grasps cervix with tenaculum or Vulsellum Forceps.					
19. Sounds uterus using "no-touch" technique.					
20. Sets blue depth gauge on the loaded IUD inserter to the depth on the sound.					
21. Inserts the IUD using the withdrawal technique.					
22. Cuts strings and gently removes tenaculum.					
Post-Insertion Tasks					
23. Places used instruments in chlorine solution for decontamination.					
24. Disposes of waste materials according to guidelines.					
25. Removes reusable gloves and places them in chlorine solution.					
26. Washes hands with soap and water.					
27. Completes client record.					

Participant Handout 2.10: Continued

Post-Insertion Counseling				
28. Teaches client how and when to check for strings.				
29. Discusses what to do if client experiences any side effects or problems.				
30. Assures client that she can have the IUD removed at any time.				
31. Observes client for at least 15 minutes before sending her home.				
Pre-Removal Counseling				
1. Greets woman in friendly and respectful manner.				
2. Asks client her reason for removal and answers any questions she may have.				
3. Reviews client's present reproductive goals.				
4. Describes the removal procedure and what to expect.				
Removal of IUD				
1. Washes hands thoroughly with soap and water and dries with clean cloth.				
2. Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.				
3. Performs bimanual exam.				
4. Inserts vaginal speculum and looks at length and position of strings.				
5. Swabs cervix and vagina with antiseptic.				
6. Grasps strings close to cervix and pulls gently but firmly to remove IUD.				
Post-Removal Tasks				
7. Places used instruments in chlorine solution for decontamination.				
8. Disposes of waste materials according to guidelines.				
9. Removes reusable gloves and places them in chlorine solution.				
10. Washes hands with soap and water.				
11. Records IUD removal in client record.				
Post-Removal Counseling				
12. Discusses what to do if client experiences any problems.				
13. Counsels client regarding new contraceptive method, if desired.				
14. Assists client in obtaining new contraceptive method or provides temporary (barrier) method until method of choice can be started.				

Source: JHPIEGO. *IUD Course Handbook: Guide for Trainers*. Baltimore, MD: JHPIEGO, 1992.

Participant Handout 2.10: (continued)

Comments (summary):

Recommendations:

Certified (If not, why):

Trainer's Signature _____ **Date** _____

Participant Handout 2.11: Infection Prevention for IUDs

Decontamination

1. After completing either an IUD insertion or removal, and while still wearing gloves, dispose of contaminated objects (gauze, cotton, and other waste items) in a properly marked leak-proof container (with a tight-fitting lid) or plastic bag.
2. Fully immerse all metal instruments in a plastic bucket containing 0.5% chlorine solution (bleach) for 10 minutes before allowing staff and cleaning personnel to handle or clean them. (This pre-wash soak kills most microorganisms, including HBV and HIV.)
3. All surfaces (such as the procedure table or the instrument stand) that could have been contaminated by blood and mucus also should be decontaminated by wiping down with chlorine solution.
4. If single-use (disposable) gloves were used, carefully remove them by inverting and place in the leak-proof waste container. If gloves are reusable, first briefly immerse both gloved hands in bucket containing chlorine solution and then carefully remove by inverting. Deposit gloves in chlorine solution.

Cleaning and Rinsing

After decontamination, thoroughly clean instruments with water, detergent, and soft brush, taking care to brush all teeth, joints and surfaces. Next, rinse well after cleaning to remove all detergent (some detergents can render chemical disinfectants inert). Dry instruments before further processing.

High-Level Disinfection

High-level disinfection through boiling or the use of chemicals is the recommended practice. Surgical (metal) instruments and reusable gloves should be boiled for 20 minutes. Alternatively, instruments can be soaked for 20 minutes, **begin timing when boiling action starts**, in a 2% glutaraldehyde or 8% formaldehyde solution. After cooling (if boiled) or rinsing in boiled water (if chemical disinfectants used) and drying, instruments are ready to use. Use immediately or store for up to 1 week in a clean, dry, HLD container with a tight-fitting lid or cover.

Sterilization

Alternatively, instruments and reusable gloves used for IUD insertion and removal can be sterilized by autoclaving (121°C [250°F] and 106 kPa [15 lb/in²] for 20 minutes if unwrapped and 30 minutes if wrapped).

Note: *Dry heat sterilization (170°C [340°F] for 60 minutes) can be used **only** for metal or glass instruments.*

Participant Handout 2.11: Infection Prevention for IUDs (cont.)

Storage

Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.

Infection Prevention Tips: IUD Insertion

To minimize the client's risk of post-insertion infection, clinic staff should strive to maintain an infection-free environment. To do this:

- Exclude clients who are by history and physical examination at risk for STDs.
- Wash hands thoroughly with soap and water **before** and **after** each procedure.
- When possible, have the client wash her genital area **before** doing the screening pelvic examination.
- Use **clean, high-level disinfected** (or sterilized) instruments and gloves (**both hands**) or use disposable (single-use) examination gloves.
- After inserting the speculum and while looking at the cervix, thoroughly apply antiseptic solution several times to the cervix and vagina before beginning the procedure.
- Load the IUD in the sterile package.
- Use a "no-touch" insertion technique to reduce contamination of the uterine cavity (i.e., do **not** pass the uterine sound or loaded IUD through the cervical os more than once).
- Properly dispose of waste material (gauze, cotton, and disposable gloves) after inserting the IUD.
- Decontaminate instruments and reusable items **immediately** after using them.

When these tips are followed, post-insertion infection rates are low; therefore, use of prophylactic antibiotics is **not** recommended.

Infection Prevention Tips: IUD Removal

IUD removal should be performed with similar care. To minimize the risk of infection during IUD removal:

- Wash hands thoroughly with soap and water **before** and **after** each procedure.
- When possible, have the client wash her genital area **before** doing the screening pelvic examination.
- Use **clean, high-level disinfected** (or sterilized) instruments and gloves (**both hands**) or use disposable (single-use) examination gloves.
- After inserting the speculum and while looking at the cervix, before beginning the procedure, apply antiseptic solution several times to the cervix and vagina.

Participant Handout 2.11: Continued

- Properly dispose of waste material (gauze, cotton, and the removed IUD and disposable gloves) after removal.
- Decontaminate instruments and reusable items **immediately** after using them.

Source: Blouse A, Kinzie B, McIntosh N. *IUD Guidelines For Family Planning Service Programs: A Problem Solving Reference Manual*. Baltimore, MD: JHPIEGO, 1992.

Participant Handout 2.12: IUD Follow Up Care

Follow-up management of the IUD client involves routine follow-up visits as well as problem visits and management of common side effects. Routine follow-up visits should include at least a first check-up three to six weeks after IUD insertion.

The client can return for a visit to have the IUD removed when it has been in place for the recommended number of years (10 years for the Tcu 380A), or when client wishes to have it removed for any reason. In addition, the client should be able to return for a visit if she has questions, concerns, or any signs/symptoms she thinks may be caused by the IUD. If facilities are available, it is also recommended that clients have routine gynecological checkups, but these are not a necessary part of IUD management.

Remember to teach her the warning signs. If she has any of these signs she must return for a visit immediately:

- no period
- heavy bleeding
- abnormal spotting
- abnormal discharge
- pain
- dyspareunia (pain during intercourse)
- fever, chills, or not feeling well
- string missing, or shorter or longer

When a client comes for follow-up care, follow recommendations in *Participant Handout 2.13*. For problem visits and management of side effects and complications, follow protocols and recommendations in the *Participant Handout 2.14*.

If a complication such as PID, pregnancy with IUD, perforation, difficulty in IUD removal, or missing strings is suspected, the participant should be instructed to refer the client to an Ob/Gyn or specialist (trainer) for management.

Participant Handout 2.13: Post-insertion and Follow Up Care

Background

Long-term success, as defined by satisfied clients and high continuation rates, will take place only if service providers recognize the importance of providing follow-up care (including counseling) and prompt management of side effects, as well as other problems should they occur.

Most clients will not experience problems following IUD insertion. When they do occur, however, immediate problems may include:

- nausea
- mild to moderate lower abdominal pain (cramping)
- syncope (fainting), rarely

Because of these potential problems, it is recommended that all clients remain at the clinic for 15 or 30 minutes before being discharge.

Note: *Because counseling does not end once the IUD is inserted, this time can always be put to productive use.*

Client Instructions

Telling a client about common IUD side effects, as well as what to do if certain problems occur, promotes continued use. In particular, she should know:

What kind of IUD she has and when it needs to be replaced

- Following insertion, the effective life of the Copper T 380A IUD is 10 years. The provider should give her a card with the date of insertion and the IUD's effective life.

When to come back for a check-up

- Normally, clients should return for a routine check after the first post-insertion menses (three-to-six weeks) but not later than three months after insertion. (Give her a follow-up appointment before she leaves.)

What are the health risks with IUDs?

- IUDs do not completely protect the user from having an ectopic (outside the uterus) pregnancy.

Participant Handout 2.13: Post-insertion and Follow Up Care (cont.)

What are the health risks with IUDs? (cont.)

- A woman who has an IUD is at a somewhat greater risk of developing infections in the uterus and/or fallopian tubes during the first month following insertion. These infections are known as pelvic inflammatory disease (PID). Thereafter, unless she is at risk for STDs (e.g., either she and/or her partner has more than one sexual partner), it is unlikely that she will get a pelvic infection. Also, a woman who has an IUD should avoid douching if possible, as douching may increase the chance of infection.
- IUDs, although extremely effective, may fail, even if they are correctly in place. **If a woman who has an IUD thinks she is pregnant, she should go to the clinic as soon as possible for a check-up.** If she is pregnant, the IUD should be removed, because there is a greater chance of miscarriage and the possibility of developing a pelvic infection.

How she can tell if she has one of these health problems

A woman with an IUD should come to the clinic as soon as possible if any of the following occur:

- Period late with pregnancy symptoms (nausea, breast tenderness, etc.).
- Persistent or crampy lower abdominal pain, especially if accompanied by nausea, fever, or chills (these symptoms suggest possible pelvic infection).
- Strings missing or the plastic tip of the IUD can be felt when checking for the strings.
- Either the client or her partner *begins* having sexual relations with more than one partner; IUDs do not protect against sexually transmitted genital tract infections, including hepatitis B and AIDS.

How soon after insertion the IUD is effective

- It is effective immediately, and unless she has just had a baby, she can have sex as soon as she wants. **The client should be told that there might be some bleeding or spotting during the first few days after insertion.** She should not worry if this happens.

When to check the IUD strings

- During the first month after insertion, the client should check the strings several times, including after her next menstrual period. After the first month, she should check the strings after each menstrual period.

Participant Handout 2.13: Post-insertion and Follow Up Care (cont.)

When to check the IUD strings

Also check the strings if any of the following occur:

- Cramping in the lower part of the abdomen
- Spotting between periods or after intercourse
- Pain after intercourse, or if her husband or partner experiences discomfort during sex

Any of these symptoms may suggest that the IUD is being expelled. If they persist, or if she finds during a check that the strings are longer or shorter or missing, or the hard part (plastic) of the IUD can be felt in the vagina, she should return to the clinic for a check-up. If the symptoms stop, but she cannot find the strings, this may mean the IUD has already been expelled, and she must return immediately for a check-up and use another contraceptive method until her IUD is replaced.

- The most common time that IUDs come out is during menstruation. The IUD user should check menstrual cloths, pads, or tampons, as well as the toilet or latrine during menstrual periods. **If she has lost the IUD, she should return to the clinic for possible insertion of another IUD. She should use another contraceptive method until her IUD is replaced.**

Why and how to check the IUD strings

The client should know that it is important to check the IUD strings so that she can be sure the IUD is still in place.

To check the IUD strings, she should:

- Wash her hands.
- Insert either her second or middle finger into the vagina to find the opening to the uterus (the cervix). She will know it because it feels firm, like the tip of her nose.
- Feel for the strings. If she feels the strings, and they feel like they felt the last time she checked, it means that the IUD is correctly in place. **She must never pull on the strings.** This could cause the IUD to come out and could damage the cervix.
- If she cannot feel the strings, or if they feel longer or shorter than the last time she checked, or she feels the stem of the IUD protruding from the cervix, she should return to the clinic for a check-up. She should **not** have sex until the IUD is replaced, unless she uses another contraceptive method.



Participant Handout 2.13: Post-insertion and Follow Up Care (cont.)

What to do if there are changes in her menstrual periods

- For most women, the first few periods will be heavier, last longer, and involve more cramping. This is not harmful. However, if the bleeding lasts twice as long as usual or if she uses twice as many pads, cloths, or tampons, she should see a health-care provider.

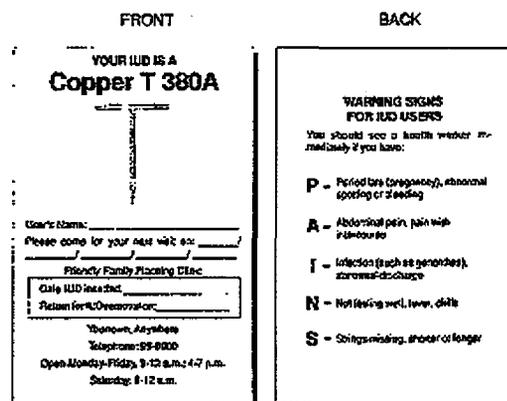
How to protect herself from GTIs and other STDs, including hepatitis B and AIDS

- She should use condoms and/or spermicide in addition to the IUD if she thinks there is any chance that she or her partner is at risk for exposure to sexually transmitted GTIs and other STDs.

When to have the IUD removed

- If the client desires
- If the client wants to get pregnant
- If she experiences persistent side effects or other health problems
- At the end of the effective life of the IUD. For example, the TCu 380A should be removed after 10 years.

To have the IUD removed, the woman should return to the clinic. She should **never** try to remove the IUD herself or ask an untrained person to remove the IUD. Normal fertility returns soon after IUD removal. If the client does not want to become pregnant, another IUD can be inserted immediately. There is no need for a "rest period" before inserting another IUD. Finally, remember to tell the client that **she can have the IUD removed at any time for any reason** and choose another contraceptive method. To help the client understand and remember the most important points, be sure to explain them to her clearly and simply, and repeat them several times. It also is useful to give the client printed material, if available, with the name and a picture of the IUD as well as the date of insertion and time for removal (see **figure** below).



Prototype Information Card for the IUD User

Participant Handout 2.13: Post-insertion and Follow Up Care (cont.)

Follow Up Care

Normally, clients should return after the first post-insertion menses (three to six weeks), but not later than three months, for their first check-up. At the first regular check-up:

- inquire about problems, questions, complications or side effects
- answer the client's questions or concerns
- perform a speculum and bimanual exam to:
 - see the strings
 - check for vaginal discharge or cervicitis suggestive of a GTI
 - gently palpate the cervical os for any plastic which might indicate that the IUD is dislodged from the fundus (partially expelled)
 - check for uterine and adnexal tenderness or other signs of infection

Provide oral iron supplementation if she appears to be anemic (e.g., Hgb. less than 9 gm/dl or Hct. less than 30; conjunctiva (inside of eyelids); or nail beds look pale).

If the client is satisfied with the IUD and there are no precautions for continued use:

- remind her about the warning signs; tell her if she has any of the warning signs to come back immediately
- schedule her for a return visit in about 12 months
- remind her at each annual visit of the date (month/year) her IUD needs to be removed/replaced

IUD users normally need follow-up visits only once a year.

It is important to remember that successful IUD programs require well-trained providers who exhibit:

- good clinical judgment in selecting acceptors
- care, sensitivity, and thoroughness in informing the user about IUDs and common side effects
- skill in inserting (and removing) the IUD
- knowledge of and ability to recognize real or potential problems
- ability to take clinical action for these problems, including knowing when (and where) to refer clients with serious complications

Long-term success, as defined by satisfied clients and high continuation rates, will only take place if the provider can recognize the importance of providing follow-up care.

Sources: The Population Council and the Program for Appropriate Technology in Health (PATH). *The Copper T 380A IUD: A Manual for Clinicians*. 2nd ed. Seattle, Washington: PATH, 1989.

The Population Council and the Program for Appropriate Technology in Health (PATH). *The Copper T 380A IUD: A Guide for Health Workers*. 2nd ed. Seattle, Washington: PATH, 1989.

Participant Handout 2.14: Management of Side Effects

Background

Most side effects and other health problems associated with the use of IUDs are not serious. Changes in menstrual bleeding patterns are the most common adverse side effects. In addition, during the first few menstrual cycles, clients may experience increased discomfort with their menses (dysmenorrhea).

In this handout there is more information on the most important health problems and serious side effects associated with IUD use. These include:

- Management of early pregnancy with an IUD in place
- Extrauterine (ectopic) pregnancy
- Pelvic infection (PID)
- Management of uterine perforation

Finally, also included in this handout is a **Problem, Assessment and Management Chart**, which outlines the steps in evaluating and managing most common side effects and other problems.

Pregnancy

Approximately one-third of IUD-related pregnancies are due to undetected partial or complete expulsion of the IUD. Pregnancies may occur, however, even if the IUD is correctly in place. There is an increased risk of septic abortion, which can result in septicemia, septic shock and death, in clients becoming pregnant with an IUD in place. For this reason, if pregnancy is diagnosed, the IUD always should be removed.

- If the strings are visible and the pregnancy is less than 13 weeks (first trimester), the IUD should be removed. If the IUD is removed within this period, there should be no adverse effect other than a slightly increased risk of spontaneous abortion. If the client consents, remove the IUD with gentle traction. Ask her to return if she experiences bleeding, cramping, or signs of infection.
- If you cannot see the strings or find them behind the cervix and/or the pregnancy is beyond the 1st trimester, removal is more difficult. If this is the case, carefully discuss all options with the client.
- If the client wants to continue her pregnancy but does **not** want her IUD removed, advise her that there is an increased risk of spontaneous abortion and infection. She should be watched closely during her pregnancy, and she should come in immediately if she has any of these danger signs: fever, lower abdominal pain and/or vaginal bleeding.

Extrauterine (Ectopic) Pregnancy

Because IUDs provide less protection against extrauterine pregnancies than intrauterine pregnancies, a pregnancy that occurs while a woman is using an IUD is somewhat more likely to be extrauterine. Therefore, those clients who become pregnant should be carefully evaluated for an ectopic pregnancy.

Participant Handout 2.14: Management of Side Effects

Pelvic Inflammatory Disease (PID)

Pelvic inflammatory disease with an IUD in place can cause serious complications, which may lead to loss of fertility. The symptoms of PID include abnormal vaginal discharge, abdominal or pelvic pain, pain with sexual intercourse (dyspareunia), fever, and chills. If these symptoms occur during the first cycle, they may be due to infection at the time of insertion. If symptoms occur after several cycles they are more likely due to a STD. The practitioner should perform speculum and bimanual exams and GTI testing of cervical discharge (when possible).

If she does not have cervical tenderness leave the IUD in place and begin doxycycline (100 mg bid for 14 days).

If the woman has a tender uterus and pain when the cervix is touched, she may have PID. Treat by removing the IUD and starting on one of the following antibiotics:

- Cefoxitin (2g IM) plus probenecid (1 g orally),
- Ceftriaxone (250 mg IM) plus doxycycline (100 mg bid orally) for 14 days

If there is no improvement in 24-48 hours, the client should be referred to a facility where she can receive intravenous antibiotics.

Uterine Perforation, Embedding and Cervical Perforation

The IUD can perforate (go through) the uterus. This mostly happens during the insertion. The IUD sometimes will perforate the uterus later on, and may be "silent," with no symptoms of bleeding or pain. The IUD may also perforate the cervix, this may happen if the IUD comes out by itself. The IUD may be embedded (stuck) in the wall of the uterus, and part of it may perforate the cervix. Only an experienced clinician should attempt to remove an IUD that is perforating the cervical wall. (To remove it, grasp the exposed tip with an alligator or Bozeman forceps, push it back up into the uterine cavity, and then gently remove it in the usual manner.)

Signs of uterine perforation are missing IUD strings, inability to withdraw the IUD if the strings are still present, and seeing the IUD in a x-ray or ultrasound. Ultrasound can find Copper IUDs in the pelvis, but can't find IUDs that have moved into the abdomen. X-rays are better for finding lost IUDs.

Removal of an IUD in the abdomen should be done **only** if the perforation is found within the first few days (or weeks) after insertion. Removal should be performed **only** by a surgeon experienced in removing IUDs by laparoscopy; otherwise, leave it in place.

Source: Blouse A, Kinzie B, McIntosh N. *IUD Guidelines For Family Planning Service Programs: A Problem Solving Reference Manual*. Baltimore, MD: JHPIEGO, 1992.

Participant Handout 2.15: Management of Side Effects

Side Effect or Problem	Assessment	Management
<p>Amenorrhea</p> <p>Absent menses with IUD in place</p>	<p>Ask client when she had her last menstrual period (LMP).</p> <ul style="list-style-type: none"> ▪ When she last felt the strings, and ▪ If she has any symptoms of pregnancy <p>If necessary do a speculum & bimanual examination to rule out pregnancy.</p>	<p>If pregnancy less than 13 weeks (by LMP) and strings visible, explain that IUD should be removed to minimize risk of pelvic infection.</p> <p>Do not attempt to remove if:</p> <ul style="list-style-type: none"> • strings are not visible, or • pregnancy is greater than 13 weeks (by LMP). <p>(This woman is at risk of spontaneous abortion & sepsis and must be followed closely.)</p>
<p>Cramping</p> <p>Remember: Some cramping pain is common in the first 24-48 hours after IUD insertion.</p>	<p>Do abdominal and pelvic (speculum and bimanual) exams to check for PID and other causes of cramping, such as partial expulsion of the IUD, cervical or uterine perforation, or ectopic pregnancy.</p>	<p>Client has had IUD less than three months:</p> <ul style="list-style-type: none"> • If no cause found and cramping not severe, reassure the client, and provide aspirin or similar analgesic. • If no cause found but cramping severe, remove the IUD. Replace with a new IUD or help the client choose another method. <p>Client has had IUD more than three months:</p> <ul style="list-style-type: none"> • If no cause found, remove IUD. If there is no evidence of infection, replace with a new IUD or help the client choose another method.
<p>Ectopic Pregnancy</p>	<p>Irregular bleeding with or without symptoms of pregnancy or infection, pelvic pain or tenderness, or palpable adnexal mass.</p>	<p>Refer to appropriate facility for complete evaluation.</p>

Participant Handout 2.15: Management of Side Effects (cont.)

<p>Irregular or Heavy Bleeding</p>	<p>Perform speculum and bimanual exams to ensure that there is neither cervical pathology nor evidence of intrauterine or ectopic pregnancy or spontaneous abortion.</p> <p>How much has she bled?</p> <ul style="list-style-type: none"> • Check for signs of marked anemia (pale conjunctivae or nail beds, low hemoglobin/hematocrit). 	<p>Client has had IUD less than three months:</p> <ul style="list-style-type: none"> • If exam is normal, reassure and give iron tablets (one tablet daily for one to three months). Ask client to return in three months for another check. Use locally approved drugs, such as ibuprofen, during bleeding episode, if available. • If bimanual exam shows enlarged or irregular uterus due to fibroids, inform client of the problem. Remove if client is anemic or requests removal, and help client select another method. <p>Client has had IUD more than three months:</p> <ul style="list-style-type: none"> • If negative exam and short (less than three weeks) bleeding intervals, suspect anovulation; if longer intervals (more than six weeks) suspect delayed ovulation; if with hot flashes, suspect menopause (if age over 35) or gynecologic endocrine problem. Refer to specialist. <p>Recommend removal if severe anemia present (e.g., less than 9 gm/dl Hgb or 30 %Hct) and help client choose another method. If IUD is inert (Lippes Loop) and IUD is still client's choice, remove current IUD and insert a new IUD; give three more months of iron tablets and re-examine in three months. If client already has copper IUD, remove IUD and help client select another method.</p>
<p>IUD Sterile Package Damaged</p>		<p>Discard IUD and use another IUD from a sterile package.</p>

Participant Handout 2.15: Management of Side Effects (cont.)

<p>Missing Strings</p>	<p>Ask the client whether she knows if the IUD has come out/been expelled. If client does not know if IUD was expelled, ask her:</p> <ul style="list-style-type: none"> • when she had her LMP • when she last felt the strings • if she has any symptoms of pregnancy • if she used a back-up method (e.g., condom) from the time she noticed the missing strings. <p>Do speculum and bimanual examination; check for signs of pregnancy.</p> <p>If she comes back while having her period, do a speculum examination.</p> <p>If strings are still not seen, rule out perforation.</p> <p>If she comes back with delayed (greater than four weeks) menses, check for pregnancy.</p>	<p>If client knows the IUD fell out, check for pregnancy, provide back-up method, and reinsert IUD during her next period, if client desires.</p> <p>Perform a vaginal examination:</p> <ul style="list-style-type: none"> • If exam reveals suspected pregnancy, refer to appropriate facility for complete evaluation. • If no strings are seen on vaginal exam, it may mean that the IUD has fallen out or strings may be in the cervical canal (not visible), or high in the vagina. • If strings are not found by carefully probing the cervical canal, client should use a non-hormonal method and return with menses or in four weeks if her period does not start. <p>Strings may come down with menses. If strings are seen, reassure client that strings are present, and help her feel them.</p> <p>Refer to check for IUD either by carefully sounding the uterus, X-ray, or ultrasonography.</p> <ul style="list-style-type: none"> • If IUD not found on referral, it may have been expelled without being seen. Insert another IUD or help client choose another method. <p>If pregnant, see "Amenorrhea" above.</p>
<p>Partner complains about strings</p>	<p>Check to be sure that IUD is in place (i.e., not partially expelled).</p>	<p>Counsel client that one option is to cut string to a length even with cervical os (inform client that she will no longer be able to feel string,) and record in chart that string has been cut evenly with cervix for future removal information.</p>

Participant Handout 2.15: Management of Side Effects (cont.)

<p>Pelvic Infection</p> <p>Cramping accompanied by abdominal tenderness, fever, flu-like symptoms, headache, chills, nausea or vomiting, vaginal discharge, painful intercourse, and/or palpable pelvic mass.</p>	<p>Perform abdominal and pelvic (speculum and bimanual) exams and GTI testing if available.</p> <p>If urethritis or cervicitis (purulent discharge or beefy red cervix), check Gram stain of cervical discharge.</p>	<p>If abdominal and pelvic exams confirm uterine and/or adnexal tenderness and/or microscopic testing supports the diagnosis of PID:</p> <ul style="list-style-type: none"> • Remove IUD. • Treat with antibiotic, or immediately refer for treatment. <p>If diagnosis equivocal, treat with antibiotics without removing IUD. Observe carefully for results of antibiotic treatment. If woman does not improve in 2-3 days after starting treatment refer her to a hospital. Her sex partner should be checked for an STD.</p>
<p>Suspected Uterine Perforation At time of insertion</p>		<p>When sounding the uterus:</p> <ul style="list-style-type: none"> • Stop the procedure. Observe for signs of intra-abdominal bleeding (i.e., falling BP, rising pulse, severe abdominal pain, tenderness, guarding and rigidity). • Take BP and pulse every 15 minutes for 90 minutes. From resting position, have client sit up rapidly. Observe for syncope or pulse greater than 120/min. • If negative after two hours, discharge with instructions for warning signs which require immediate return to clinic. Have client return after one week for check-up. <p>When inserting the IUD (complete or partial):</p> <ul style="list-style-type: none"> • Stop the procedure. Remove the IUD and initiate steps as above.

Participant Handout 2.15: Management of Side Effects (cont.)

<p>Syncope, bradycardia, vasovagal episode during IUD insertion or removal</p>	<p>Is woman anxious? Does she have a small uterus or relative cervical stenosis? (These characteristics increase risk for syncope and/or vasovagal reaction.)</p>	<p>Everything done at time of IUD insertion and removal should be done slowly and gently.</p> <ul style="list-style-type: none"> • Maintain a calm, relaxed, unhurried atmosphere with a gently reassuring approach to the client. • At the earliest sign of fainting, stop the insertion. • Put a cool, wet cloth to the client's forehead. • If severe pain occurred as the IUD was being inserted through the cervical canal, leave the IUD in place and allow the patient to rest. Keep the client supine, the head lowered, and legs elevated, to ensure adequate blood flow. • Avoid overtreatment; observation and support are usually all that is required. Use analgesics (paracetamol or ibuprofen) for abdominal pain or cramping. • Remove IUD if pain persists and is not relieved by analgesics or if client requests removal. Help her choose another method.
<p>Vaginal Discharge</p>	<p>Check history for GTIs or other STD exposure and examine for vaginitis or purulent cervicitis or beefy red cervix.</p> <p>Examine saline and KOH wet mounts of vaginal discharge for trichomonas, monilia (candida), gardnerella.</p> <p>Prepare Gram stain of vaginal or cervical discharge. Observe for Gram negative intracellular diplococci (GNID) and WBC (PMNs).</p>	<p>If saline or KOH wet mounts are positive, treat for specific organism.</p> <p>If positive for GNID, treat for GC. If negative for GNID and purulent cervicitis or beefy red cervix, treat for chlamydia. Do GC culture if available.</p>

Source: Program for International Training in Health (INTRAH). *Guidelines for Clinical Procedures in Family Planning and Sexually Transmitted Diseases: A Reference for Trainers*. Chapel Hill, North Carolina: INTRAH, 1989.

Blouse A, Kinzie B, McIntosh N. *IUD Guidelines for Family Planning Service Programs*. Baltimore, MD: JHPIEGO, 1992.

Participant Handout 2.16: Minimum Standards for IUD Services

In order to offer quality IUD services, the provider needs to meet minimum criteria of space, privacy, equipment, supplies, recordkeeping, and availability of referrals.

The minimum clinic requirements are:

- space, separate from waiting area for counseling, which ensures privacy for client
- examination table and procedure area which ensures client privacy
- supply cabinet to store instruments and IUDs
- water, adequate light, and toilet facility in or very near office
- basic standardized equipment and supplies sufficient for 2 IUD insertions:
 - 2 specula
 - 2 tenacula
 - 2 uterine sponge forceps
 - 2 pair scissors
 - 2 uterine sounds
 - 2 utility forceps
 - cotton or gauze
 - antiseptic
 - covered instrument trays
 - six pair reusable gloves or one box disposable gloves
 - client record forms
 - cooker or stove
 - fuel supply
 - glutaraldehyde or 8% formaldehyde solution
 - chlorine solution
 - decontamination bucket

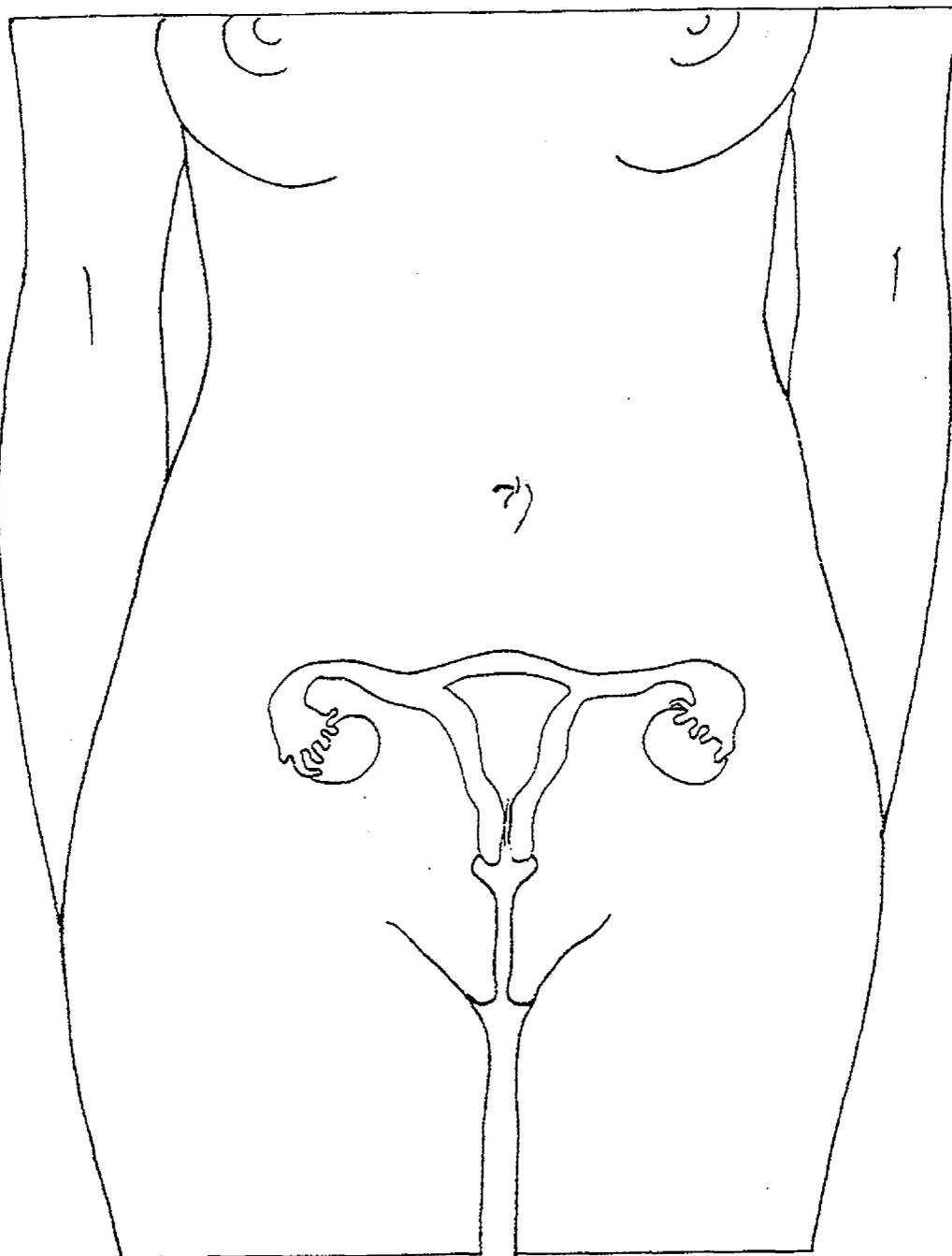
The trained provider will also establish a routine for receiving and serving IUD clients: referring them when necessary and training her/his support staff in infection prevention, waste disposal, etc. In addition, client information materials should be made available to clients and families.

Transparency 1.1: Unit 1 Objectives

1. Explain key messages related to the IUD as a safe and effective child spacing method.
2. Describe the types of IUDs available, the mechanism of action, and effectiveness of the IUD.
3. Explain major advantages and disadvantages of the IUD.
4. Describe indications for using the IUD and rationale for each.
5. Identify eligibility criteria for initiating use of the IUD, and explain rationale for each.
6. Using a history checklist, screen a potential IUD client and refer for insertion or removal.
7. Discuss when to insert and remove an IUD.
8. Using general terms, describe IUD insertion and removal procedures to clients.
9. Describe the early warning signs of IUD complications.
10. Recognize and manage common IUD side effects.
11. Demonstrate effective IUD counseling in role-play exercise.

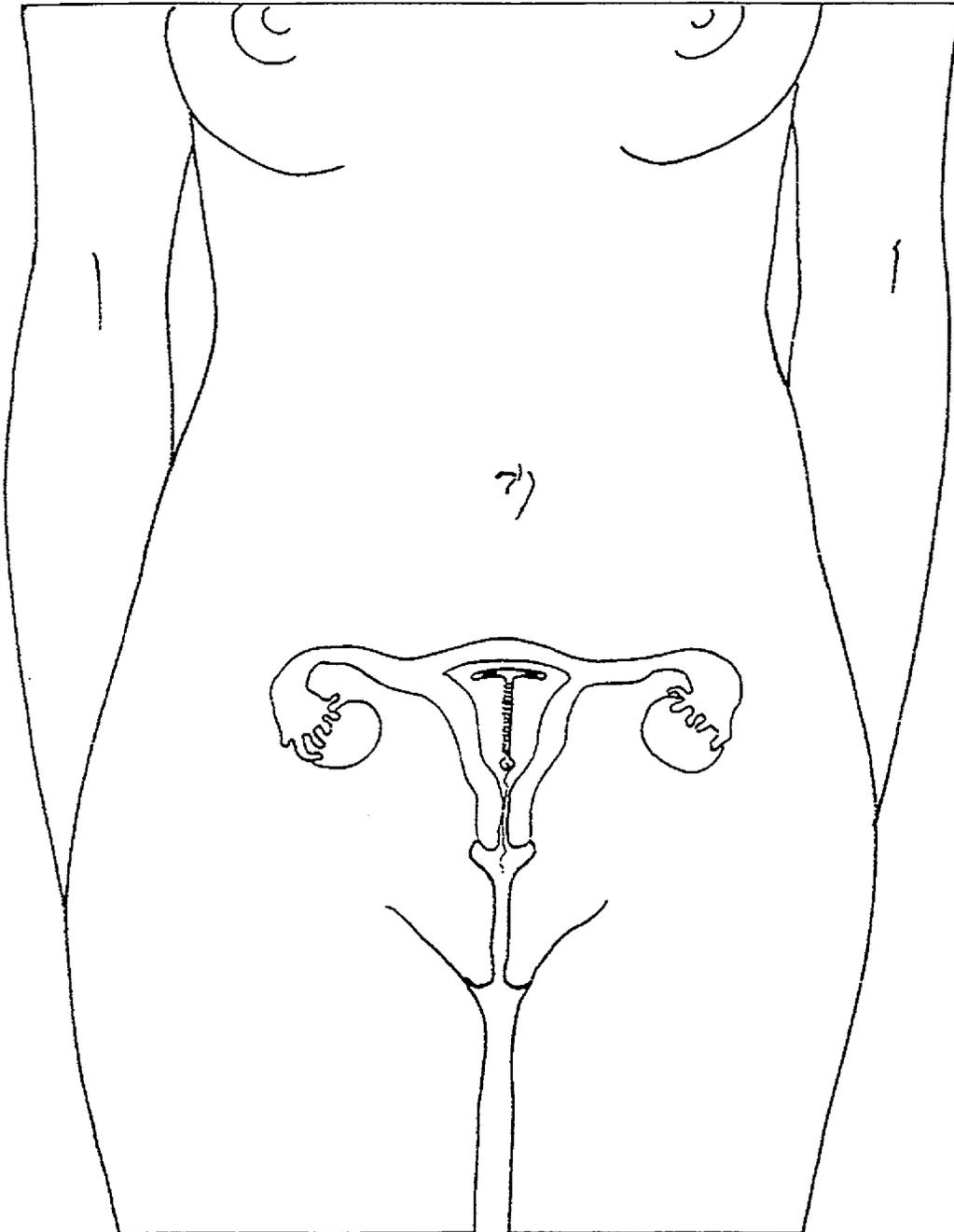
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Transparency 1.2: Female Pelvic Organs



Source: Path. *The Copper T 380A IUD: A Guide for Health Workers.* 2 ed. New York, NY: The Population Council, 1989.

Transparency 1.3: Female Pelvic Organs with IUD

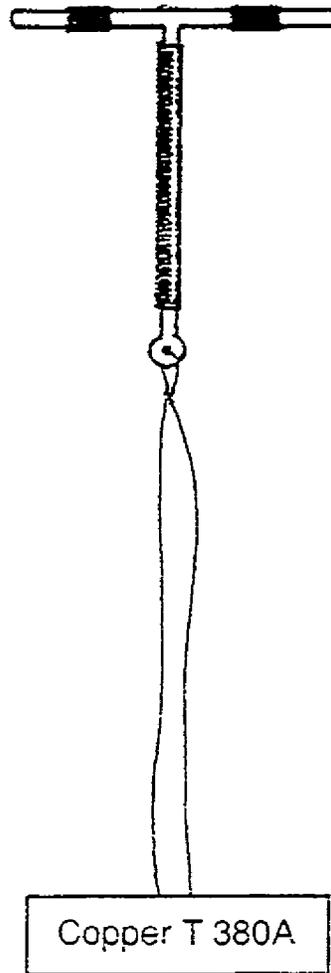


Source: Path. *The Copper T 380A IUD: A Guide for Health Workers*. 2 ed. New York, NY: The Population Council, 1989.

Transparency 2.1: Unit 2 Objectives

1. Use standard checklists to take a limited history and perform a limited physical exam in order to advise, screen, and select clients who request IUDs.
2. Load the TCu while it is still inside the sterile package, without touching it directly.
3. Perform efficiently and in correct sequence all the steps in safe and gentle IUD insertion and removal, according to written standardized protocols for TCu IUDs.
4. Describe recommended infection-prevention practices in the provision of IUD services in order to minimize risk to client and provider.
5. Provide pre- and post-insertion counseling to IUD clients.
6. Provide follow-up management of the IUD client, including appropriate management of common side effects and referrals for complications.
7. Describe the facilities and recordkeeping tasks necessary to organize and manage high-quality IUD services.

Transparency 2.2: The TCU 380A IUD



Source: Path. *The Copper T 380A IUD: A Guide for Health Workers*. 2 ed. New York, NY: The Population Council, 1989.

**THE IUD: AN OVERVIEW
PRE/POST-TEST
Unit 1**

Participant Name _____

Instructions: **Circle the letter(s) that correspond to the correct answer(s)
(some questions may have more than one correct answer).**

1. Who is the best -qualified person to choose a contraceptive method for a woman in good health?
 - a. A trained physician
 - b. A woman's mother-in-law
 - c. The woman herself
 - d. The person who counseled her

2. Women who are not in a mutually faithful relationship (i.e., she or her partner have other sexual partners) may be at increased risk of
 - a. uterine perforation with IUD insertion
 - b. STDs
 - c. ovarian cancer
 - d. all of the above

3. The IUD not only protects a woman from undesired pregnancy, but also from
 - a. developing fibroids
 - b. HIV infection
 - c. anemia
 - d. all of the above
 - e. none of the above

4. When an IUD client presents with a late period, you should rule out
 - a. allergy to copper
 - b. pregnancy
 - c. cervical cancer
 - d. PID

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5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
 - a. three days
 - b. one week
 - c. three to six weeks
 - d. three to six months

6. The most likely mechanism of action of the IUD is that
 - a. it interferes with implantation
 - b. it interferes with fertilization
 - c. it interferes with ovulation
 - d. it acts as a barrier to prevent sperm from entering uterus

7. The IUD is NOT an appropriate contraceptive method for a woman who
 - a. is taking rifampin
 - b. is not sure she wishes to have a tubectomy
 - c. has had two daughters and hopes for a son
 - d. knows that her husband is not faithful

8. During counseling on the IUD, a client should be informed that common side effects of the IUD may include
 - a. nausea
 - b. headaches
 - c. mild cramping and light spotting
 - d. heavy vaginal discharge

9. The IUD may **not** be the best method for women who have:
 - a. gall-bladder disease
 - b. acute/sub-acute pelvic infections
 - c. tuberculosis
 - d. known or suspected pregnancy
 - e. undiagnosed vaginal bleeding
 - f. hypertension
 - g. PID within the last three months

10. The IUD is
 - a. 90-95% effective
 - b. greater than 99% effective
 - c. 100% effective
 - d. none of the above

11. Correctly loading the Copper T 380A IUD in the sterile package:
- a. should be done only if sterile gloves are available
 - b. assures that the IUD will remain sterile until it is removed from the package
 - c. is not necessary for physicians
 - d. all of above

12. List the five warning signs that alert the client that something is wrong:

13. TRUE or FALSE. Mark "T" or "F" in the blank to indicate true or false.

- a. ___ Counseling should be integrated into each and every interaction with a FP client.
- b. ___ Following IUD insertion, heavy, yellow vaginal discharge is common.
- c. ___ An IUD should only be removed during menstruation.
- d. ___ An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.
- e. ___ After an IUD is removed, a healthy woman may expect several months' delay in return to fertility.
- f. ___ It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.
- g. ___ IUDs increase the risk of ectopic pregnancy.

**THE IUD: AN OVERVIEW
PRE/POST-TEST
UNIT 1**

Participant Name _____

Instructions: Circle the letter(s) that correspond to the correct answer(s) (some questions may have more than one correct answer).

1. Who is the best-qualified person to choose a contraceptive method for a woman in good health?
 - a. A trained physician
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2. Women who are not in a mutually faithful relationship (i.e. she or her partner have other sexual partners) may be at increased risk of
 - a. uterine perforation with IUD insertion
 - b. **STDs**
 - c. ovarian cancer
 - d. all of the above

3. The IUD not only protects a woman from undesired pregnancy, but also from
 - a. developing fibroids
 - b. HIV infection
 - c. anemia
 - d. all of the above
 - e. **none of the above**

4. When an IUD client presents with a late period, you should rule out
 - a. allergy to copper
 - b. **pregnancy**
 - c. cervical cancer
 - d. PID

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 - b. one week
 - c. **three to six weeks**
 - d. three to six months

6. The most likely mechanism of action of the IUD is that
 - a. it interferes with implantation
 - b. **it interferes with fertilization**
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 - e. **undiagnosed vaginal bleeding**
 - f. hypertension
 - g. **PID within the last three months**

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 - a. should be done only if sterile gloves are available
 - b. assures that the IUD will remain sterile until it is removed from the package
 - c. is not necessary for physicians
 - d. all of above

12. List the five warning signs that alert the client that something is wrong:

Abnormal bleeding: (no period, heavy bleeding, abnormal spotting)

Abnormal discharge

Pain/dyspareunia

Fever

String missing or shorter or longer

13. TRUE or FALSE. Mark "T" or "F" in the blank to indicate true or false.

- a. T Counseling should be integrated into each and every interaction with a FP client.
- b. F Following IUD insertion, heavy, yellow vaginal discharge is common.
- c. F An IUD should only be removed during menstruation.
- d. T An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.
- e. F After an IUD is removed, a healthy woman may expect several months' delay in return to fertility.
- f. F It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.
- g. F IUDs increase the risk of ectopic pregnancy.

THE IUD: PROVIDING SERVICES PRE/POST-TEST (UNIT 2)

Participant Name _____

Instructions: Circle the letter(s) that correspond to the correct answer (some questions may have more than one correct answer).

1. In counseling a woman about the advantages of the TCu IUD, you would inform her that the IUD
 - a. is permanent
 - b. is highly effective
 - c. has few side effects for most women
 - d. does not interfere with sexual intercourse
 - e. Is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD for a particular woman?
 - a. Pregnancy
 - b. Three or more children
 - c. At risk for STDs
 - d. History of candidiasis
 - e. Retroverted uterus
 - f. Current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
 - a. determine uterine position and size
 - b. rule out anteversion
 - c. rule out pregnancy
 - d. rule out presence of infection, masses, and tumors

4. Prior to an IUD insertion all metal instruments used should be
 - a. decontaminated with soap and water
 - b. decontaminated in 0.5% chlorine solution for 10 minutes
 - c. cleaned with formaldehyde and water
 - d. cleaned with detergent and water
 - e. high-level disinfected by boiling in a covered pot for 20 minutes
 - f. high-level disinfected by autoclaving (unwrapped) for 20 minutes at 106 kPa pressure at 121° degrees

5. Key infection-prevention activities for IUD insertion include
 - a. washing hands carefully
 - b. cleaning the cervix and vagina with an antiseptic solution
 - c. decontaminating, cleaning, and high-level disinfecting, or sterilizing all instruments used
 - d. proper contaminated-waste disposal
 - e. training and supervision of cleaning staff in infection prevention

6. Reasons for follow-up visits after an IUD insertion can include
 - a. first check-up one week after insertion
 - b. first check-up three-to-six weeks after insertion
 - c. client wants device removed because she doesn't like it
 - d. removal when the IUD has been in place for one year

7. The following are warning signs that you should teach to an IUD client, which indicate that she may be having a problem with her IUD and should seek medical attention:
 - a. Cramping with menses
 - b. Increased length of menstrual cycle
 - c. Sexual partner has abnormal penile discharge
 - d. String is longer than usual
 - e. Pain with intercourse

8. IUD clients should be counseled
 - a. before the insertion
 - b. after insertion
 - c. during each follow-up visit
 - d. all of the above

True or False: Mark "T" or "F" in the blank to indicate true or false.

9. ___ A woman herself is best at selecting her own contraceptive method.
10. ___ Douching daily after an IUD infection is recommended to prevent PID.
11. ___ A physical exam for an IUD client must include abdominal, speculum, and bimanual exams.
12. ___ You must use high-level disinfected or sterile gloves to place a copper- IUD in its inserter.
13. ___ A tarnished IUD in a sealed, undamaged package can be used.
14. ___ An IUD can be inserted in a woman who is ovulating.
15. ___ The "push" technique should be used when inserting copper T IUDs.
16. ___ The "no-touch" technique should be used when inserting IUDs.
17. ___ An IUD client who has moderate bleeding for seven-to-ten days after insertion should have the IUD removed immediately.
18. ___ If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. ___ If an IUD is partially expelled, it should be removed and a new IUD can be inserted immediately.
20. ___ If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.

THE IUD: PROVIDING SERVICES PRE/POST-TEST (UNIT 2)

Participant Name _____

Instructions: Circle the letter(s) that correspond to the correct answer (some questions may have more than one correct answer).

1. In counseling a woman about the advantages of the TCu IUD, you would inform her that the IUD
 - a. is permanent
 - b. **is highly effective**
 - c. **has few side effects for most womewn**
 - d. **does not interfere with sexual intercourse**
 - e. is effective in preventing anemia.

2. Which of the following conditions are precautions, which influence the suitability of IUD for a particular woman?
 - a. **Pregnancy**
 - b. Three or more children
 - c. **At risk for STDs**
 - d. History of candidiasis
 - e. Retroverted uterus
 - f. **Current pelvic infection**

3. Prior to IUD insertion, a pelvic exam is performed to
 - a. **determine uterine position and size**
 - b. rule out anteflexion
 - c. **rule out pregnancy**
 - d. **rule out presence of infection, masses, and tumors**

4. Prior to an IUD insertion all metal instruments used should be
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 - d. **cleaned with detergent and water**
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 - d. **proper contaminated-waste disposal**
 - e. **training and supervision of cleaning staff in infection prevention**

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18. T If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. T If an IUD is partially expelled, it should be removed, and a new IUD can be inserted immediately.
20. F If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.

Comprehensive FP/RH Curriculum Participant Evaluation

Module 7: Intrauterine Devices

Rate each of the following statements as to whether or not you agree with them, using the following key:

- | | |
|---|----------------------------|
| 5 | Strongly agree |
| 4 | Somewhat agree |
| 3 | Neither agree nor disagree |
| 2 | Somewhat disagree |
| 1 | Strongly disagree |

Course Materials

I feel that:

- | | |
|---|-----------|
| • The objectives of the module were clearly defined. | 5 4 3 2 1 |
| • The material was presented clearly and in an organized fashion. | 5 4 3 2 1 |
| • The pre-/post-test accurately assessed my in-course learning. | 5 4 3 2 1 |
| • The competency-based performance checklists were useful. | 5 4 3 2 1 |

Technical Information

I learned new information in this course. 5 4 3 2 1

I will now be able to:

- | | |
|--|-----------|
| • provide appropriate counseling to women considering the IUD as a contraceptive method. | 5 4 3 2 1 |
| • screen clients to determine if the IUD is a good method for them. | 5 4 3 2 1 |
| • provide safe IUD insertion and removal services. | 5 4 3 2 1 |
| • manage side effects and complications of IUDs. | 5 4 3 2 1 |

Training Methodology

- | | |
|--|-----------|
| The trainers' presentations were clear and organized. | 5 4 3 2 1 |
| Class discussion contributed to my learning. | 5 4 3 2 1 |
| I learned practical skills in the role plays and case studies. | 5 4 3 2 1 |
| The required reading was informative. | 5 4 3 2 1 |
| The trainers encouraged my questions and input. | 5 4 3 2 1 |

Training Location & Schedule

The training site and schedule were convenient.

5 4 3 2 1

The necessary materials were available.

5 4 3 2 1

Suggestions

What was the most useful part of this training? _____

What was the least useful part of this training? _____

What suggestions do you have to improve the module? Please feel free to reference any of the topics above. _____

