

MODULE – 5

Post Partum Intrauterine Contraceptive Device (PPIUCD)

Facilitator's Guide



**Federal Democratic Republic of Ethiopia
Ministry of Health
2013**

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FOREWORD

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

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

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

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

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

ACKNOWLEDGEMENTS

The Federal Ministry of Health (FMoH) would like to thank Jhpiego for availing its training material for national adaptation. EngenderHealth, Ipas Ethiopia, Integrated Family Health Program (IFHP), Addis Ababa University, Medical Faculty (AAU-MF), MarieStopes International Ethiopia, and Jhpiego deserve special thanks for their major technical contributions to the adaptation of this Postpartum Intrauterine Contraceptive Device (IUCD) Training Manual for national use.

The production of the original Postpartum Intrauterine Contraceptive Device (PPIUCD) Training Manual was funded by the ACCESS Program. Revisions to the manual were funded by the Maternal and Child Health Integrated Program (MCHIP).

This training manual was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

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Acronyms

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

FAMILY PLANNING TRAINING COURSE OVERVIEW

COURSE DESCRIPTION:

This clinical training course is designed to provide participants with the latest technical information and skills about the basics in family planning and the different family planning methods. It prepares them to be able to explain family planning services and provide different family planning methods as safe and effective methods of contraception. The course has 5 modules to be given as a block training or on modular basis, at a designated training site. The training course is designed to actively involve the participants in the learning process.

COURSE GOAL:

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

TRAINING DESIGN:

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

Specific characteristics of this training are as follows:

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

Successful completion of the course is based on competency in providing the specific

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

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

This clinical training course uses the following learning resources:

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

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

Organization of the Training Modules:

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

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

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

- **Module Description**
- **Module Goal**
- **Learning Objectives**
- **Training/Learning Methods**

- **Training/earning Materials**
- **Participant Selection Criteria**
- **Methods of Evaluation**
 - **Participant**
 - **Module**
- **Module Duration**
- **Course Schedule**

Each module in this training course is subdivided into parts and sessions. The facilitator's guide provides instructions for facilitating the training for the specific module. Each module contains scripts of all activities in every session and all the materials needed, including notes, interactive presentations, case studies, role plays, group activities, tests, test keys and skills checklists. The variety of training methods is intended to actively involve learners and address different learning styles.

Although modules 1 and 2 can be used individually as standalone trainings, they are mainly intended to be used as a prelude to training on long-acting (module 3), permanent family planning methods (module 4) and/or postpartum IUCD (module 5).

SECTION ONE: GUIDE FOR PARTICIPANTS

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SECTION ONE: GUIDE FOR PARTICIPANTS

Introduction

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

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

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

The goal of PPFP services is threefold: to—

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

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

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

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

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

PPIUCD Training Overview

Training Description

Before Starting the Training

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

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

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

Training Design

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

Knowledge Update

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

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

Skills Development and Assessment

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

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

Qualification

Although qualification³ is a statement by the Facilitator that the participant has met the requirements of the training, the responsibility for becoming qualified is shared by the participant and the Facilitator. Qualification is based on demonstrated mastery of, or competency in, the following areas:

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

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

³ Qualification does not imply certification. Providers can be certified only by specifically designated organizations

After the Training

It is recommended that within 1 to 2 months of qualification, the participants be observed and assessed at their workplace by a training Facilitator, using the same counseling and clinical skills checklists used in the training. (At the very least, participants should be observed by a skilled provider soon after completing training.) This post training assessment is important for several reasons. **First**, it not only gives the newly trained providers direct feedback on their performance (so that they can work on further strengthening their skills, from competency to proficiency), but also provides the opportunity for them to discuss any start-up problems or constraints to implementing the new skills in service delivery (e.g., due to lack of instruments, supplies or support staff). **Second**, and equally important, it provides the training center, via the clinical Facilitator, key information on the adequacy of the training and its appropriateness to local conditions. With this type of feedback, programs can be improved in a targeted manner to better meet the needs providers and communities. Without this type of feedback, training easily can become routine, stagnant and irrelevant to service delivery needs.

Training Syllabus

Training Description

This 10-day clinical training is designed to prepare the participant to become competent in:

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

Training Goals

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

Learning Objectives

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

- Discuss the importance of healthy spacing (or limiting) of pregnancies and the benefits of postpartum family planning.
- Explain basic information about the IUCD (interval⁴ and postpartum): its effectiveness, safety, mechanism of action, advantages and limitations, and other general attributes; and the medical eligibility criteria and other client assessment criteria used to determine whether the IUCD is a good option for the woman.

⁴Interval refers to IUCDs inserted at any time between pregnancies, at or after 4 weeks postpartum, or completely unrelated to pregnancy.

- Explain what is unique about the IUCD in the postpartum context.
- Demonstrate appropriate counseling and assessment of antenatal women for PPF in general and the PPIUCD in particular.
- Demonstrate appropriate counseling and screening of women in early/inactive labor or the early postpartum period for insertion of the IUCD.
- Demonstrate appropriate infection prevention practices related to IUCD service provision.
- Perform postplacental insertion of the IUCD (with forceps and manually).
- Perform intracervical insertion of the IUCD.
- Perform early postpartum insertion of the IUCD.
- Demonstrate proper post-insertion counseling and care.
- Describe the potential side effects and complications of the PPIUCD and how to manage them.
- Describe the organization and management of a high-quality PPIUCD program.

Training/Learning Methods

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

Learning Materials

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

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

Participant Selection Criteria

Participants for this training should be providers who are:

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

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

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

Methods of Assessment'

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

Course

- Course Evaluation (to be completed by each participant)

Course Duration

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

Suggested Course Composition

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

Course Schedule for Training on PPIUCD

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

	8:30–8:40	Recap and agenda for Day-2	10	
	8:40-9:10	Module 1: Family Planning for clients with special needs	30	
	9:10-9:50	Module 1: Medical eligibility and client assessment	40	
	9:50-10:30	Module 1: Infection prevention in family planning	40	

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

Day Three	8:30–8:40	Recap and agenda for day-3	10	
	8:40-10:10	Module 2: Helping clients' in making or confirming a decision and in implementing decision	90	
	10:10-10:40	Module 2: Counseling return clients	30	
	10:40-10:55	Tea Break	15	
	10:55-11:15	Module 2: Helping clients continue or switch methods	20	
	11:15-11:40	Module 2: Strengthening skill in partner communication and negotiation	25	
	11:40-12:30	Counseling role plays	50	
	12:30-1:30	Lunch	60	
	1:30-2:00	Module 5: Healthy spacing of pregnancy and its health benefits	30	
	2:00-2:20	Module 5: Review Group & individual knowledge Matrix	20	

	2:20-3:30	Module 1 and Module 5: Postpartum and Post abortion Family planning	70	
	3:30-3:45	Tea break	15	
	3:45-4:00	Module 5: Exercise one: Brainstorming: What is different about the PPIUCD?	15	
	4:00-5:15	Module 5: Postpartum IUCD Overview and Postpartum IUCD Counseling	75	
	5:15-5:25	Daily wrap-up and reflections	10	

Date	Time	Topics	Duration (Mins)	Facilitator
Day Four	8:30–8:40	Recap & Agenda for Day-4	10	
	8:40–9:20	Module 5: Exercise 2: Medical Eligibility/Client Assessment for PPIUCD	40	
	9:20-10:00	Module 5: Infection prevention for PPIUCD	40	
	10:00–10:15	Tea break	15	
	10:15-11:40	PPIUCD Counseling role plays	85	
	11:40-12:00	Module 5: Review of performance standards: Development of personal learning plan (Action plan)	20	
	12:00-12:30	Module 5: Exercises three & Four: Identify the IP Steps and PPIUCD Frequently Asked Questions (FAQs)	30	
	12:30-1:30	Lunch	60	
	1:30–2:20	Module 5: Management of PPIUCD Side Effects and Complications	50	
	2:20–3:10	Demonstrations: post placental insertion of IUCD, Intraesarean insertion of IUCD and immediate postpartum insertion of IUCD	50	
	3:10-3:25	Tea Break	15	
	3:25-4:05	Demonstration of PPIUCD insertion video	40	
	4:05–5:05	PPIUCD Insertion practice on anatomic models	60	
	5:05–5:15	Daily wrap-up and reflections	10	
Day Five	8:30–8:40	Recap & Agenda for day 5	10	
	8:40–10:30	PPIUCD Insertion practice on anatomic models cont.	110	
	10:30-10:45	Tea Break	15	
	10:45-11:00	Module 5: Exercise 5: Infection Prevention (IP) principles, Question and Answer	15	
	11:00–12:00	PPIUCD Insertion practice on anatomic	60	

Date	Time	Topics	Duration (Mins)	Facilitator
		models cont.		
	12:30–1:30	Lunch	60	
	1:30–4:30	Practice in Wards Counseling: Of clients for PFP and PPIUCD (ANC facility; postpartum ward) Clinical: Insertion of post placental, intracesarean, early postpartum IUCD (labor and delivery ward; postpartum ward)	210	
	4:30-5:00	Review Skills Tracking Sheet	30	
	5:00-5:10	Daily wrap-up and reflections		
From Day 6 to Day 10 morning, the clinical practice in wards continues including the nights.				
Day 10 (Afternoon)	1:30–2:15	Post training knowledge Assessment (Post-test)	45	
	2:15–2:35	Review of Post-training knowledge assessment (Post Test)	20	
	2:35–3:30	Review of personal learning plan (Action Plan)	55	
	3:30–3:45	Tea break	15	
	3:45–3:55	End Course Evaluation	10	
	3:55–4:10	Closing and certificate distribution	15	

Training Approach Used

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

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

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

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

Well, in this training, it is...

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

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

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

Behavior Modeling

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

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

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

Competency-Based Training

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

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

Humanistic Training Techniques

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

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

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

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

Summary points on the training approach used in this training.

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

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

Components of the PPIUCD Training Package

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

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

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

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

Pre-training Knowledge Assessment

Using the Individual and Group Assessment Matrix

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

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

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

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

Pre-training Knowledge Assessment—Answer Sheet

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

Postpartum IUCD Overview

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

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

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

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

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

Postpartum Anatomy and Physiology

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

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

Counseling

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

Infection Prevention

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

PPIUCD Client Assessment

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

Postpartum IUCD Insertion

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

Follow-Up Care/Management of Potential Problems

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

Individual and Group Assessment Matrix

Training _____ Dates: _____ Clinical Facilitator(s) _____

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

Personal Learning Plan

Using the Personal Learning Plan

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

Before Training

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

During Training

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

After Training

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

Blank Personal Learning Plan

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

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

*Final column to be completed at end of training.

Sample Personal Learning Plan

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

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

*Final column to be completed at end of training.

Exercise One: What Is Different about the PPIUCD?

Objectives

The purpose of this activity is to:

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

Time Allotted

- 15 minutes

Resources/Materials Needed

- Skills Station for PPIUCD
- Flipchart paper and markers

NOTE: Instructions to be provided by Facilitator.

Exercise Two: Medical Eligibility for the PPIUCD

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

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

NOTE: Instructions to be provided by Facilitator.

Exercise Two: Answer Sheet

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

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

Exercise Three: Infection Prevention Steps

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

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

NOTE: Instructions to be provided by Facilitator.

Exercise Four: PPIUCD Frequently Asked Questions (FAQs)

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Reference Manual

NOTE: Instructions to be provided by Facilitator.

Exercise Five: Infection Prevention Principles

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Reference Manual

NOTE: Instructions to be provided by Facilitator.

Counseling Guide and Clinical Skills Checklists

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

- Post placental insertion of an IUCD (instrumental, manual)
- Intracesarean insertion of an IUCD
- Early postpartum insertion of an IUCD

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

Job aids and other tools from the Reference Manual (which provide detailed “content”) can be used in conjunction with the counseling guide and skills checklists, supporting both learning and the transfer of new skills to the workplace.

Using Skills Checklists for Learning

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

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

Section One: Guide for Participants

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

Using Skills Checklists for Assessment

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

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

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

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

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

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

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

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

**FACILITATOR
CERTIFICATION**

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

Signed: _____

Date: _____

Counseling Guide for PFP/PPIUCD Counseling

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

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

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

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

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

Participant _____ Date Observed _____

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

ITEM	COUNSELING ON PPIUCD SERVICES		COMMENTS	ASSESSMENT		
	STEP/TASK					
6. Assesses reproductive intentions.	<ul style="list-style-type: none"> Asks about desired number of children, desire to space or limit births, desire for long-term family planning, etc. 					
7. Assesses need for protection against sexually transmitted infections (STIs).	<ul style="list-style-type: none"> Explores woman's need for protection from STIs, including HIV. 					
	<ul style="list-style-type: none"> Explains and supports condom use, as a method of dual protection. 					
8. Determines interest in a particular family planning method.	<ul style="list-style-type: none"> Asks whether she has a preference for a specific method, based on prior knowledge or the information provided. 					
<i>Provide the woman with information about PPFPP methods.</i>						
9. Provides general information about benefits of healthy pregnancy spacing (or limiting, if desired).	<ul style="list-style-type: none"> Advises that to ensure her health and the health of her baby (and family), she should wait at least 2 years after this birth before trying to get pregnant again. 					
	<ul style="list-style-type: none"> Advises about the return of fertility postpartum and the risk of pregnancy. Advises how LAM and breastfeeding are different. 					
	<ul style="list-style-type: none"> Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired). 					
10. Provides information about PPFPP methods.	<ul style="list-style-type: none"> Based on availability and on woman's prior knowledge and interest, briefly explains the advantages, limitations and use of the following methods: 					
	- LAM					
	- Condoms					
	- POPs, COCs					
	- DMPA (injections)					
	- PPIUCD					
	- No-scalpel vasectomy (male sterilization)					
	- Postpartum tubal ligation (female sterilization)					
	<ul style="list-style-type: none"> Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUCD, using a contraceptive tray. 					
<ul style="list-style-type: none"> Corrects any misconceptions about family planning methods. 						

COUNSELING ON PPIUCD				
ITEM	STEP/TASK	COMMENTS	ASSESSMENT	
<i>Assist the woman in making a choice; give her additional information that she might need to make a decision.</i>				
11. Helps the woman to choose a method.	<ul style="list-style-type: none"> Gives woman additional information that she may need and answer any questions. 			
	<ul style="list-style-type: none"> Assesses her knowledge about the selected method; provides additional information as needed. 			
12. Supports the woman's choice.	<ul style="list-style-type: none"> Acknowledges the woman's choice and advises her on the steps involved in providing her with her chosen method. 			
<i>Determine whether she can safely use the method; provide key information about how to use the method (focus on PPIUCD, per her choice).</i>				
13. Evaluates the woman's health and determine if she can safely use the method.	<ul style="list-style-type: none"> Asks the woman about her medical and reproductive history. 			
14. Provides key information about the PPIUCD with the woman:	<ul style="list-style-type: none"> Effectiveness: Prevents almost 100% of pregnancies 			
	<ul style="list-style-type: none"> Mechanism for preventing pregnancy: Causes a chemical change that damages the sperm BEFORE the sperm and egg meet 			
	<ul style="list-style-type: none"> Duration of IUCD efficacy: Can be used as long (or short) as woman desires, up to 12 years (for the Copper T 380A) 			
	<ul style="list-style-type: none"> Removal: Can be removed at any time by a trained provider with immediate return to fertility 			
15. Discusses advantages of the PPIUCD:	<ul style="list-style-type: none"> Simple and convenient IUCD placement, especially immediately after delivery of the placenta 			
	<ul style="list-style-type: none"> No action required by the woman after IUCD placement (although one routine follow-up visit is recommended) 			
	<ul style="list-style-type: none"> Immediate return of fertility upon removal 			
	<ul style="list-style-type: none"> Does not affect breastfeeding or breast milk 			
	<ul style="list-style-type: none"> Long-acting and reversible (as described above) 			

COUNSELING ON PPIUCDSERVICES				
ITEM	STEP/TASK	COMMENTS	ASSESSMENT	
16. Discusses limitations of the PPIUCD:	<ul style="list-style-type: none"> Heavier and more painful menses for some women, especially first few cycles after interval IUCD (less relevant or noticeable to postpartum women) 			
	<ul style="list-style-type: none"> Does not protect against STIs, including HIV 			
	<ul style="list-style-type: none"> Higher risk of expulsion when inserted postpartum (though less with immediate postpartum insertion) 			
17. Discusses warning signs; explains that she should return to the clinic as soon as possible if any arise.	<ul style="list-style-type: none"> Bleeding or foul-smelling vaginal discharge (different from the usual lochia) 			
	<ul style="list-style-type: none"> Lower abdominal pain, especially if the first 20 days after insertion—accompanied by not feeling well, fever or chills 			
	<ul style="list-style-type: none"> Concerns she might be pregnant 			
	<ul style="list-style-type: none"> Concerns the IUCD has fallen out 			
18. Confirms that the woman understands instructions.	<ul style="list-style-type: none"> Encourages the woman to ask questions. 			
	<ul style="list-style-type: none"> Asks the woman to repeat key pieces of information. 			
<i>Plan for next steps and for when she will arrive to hospital for delivery.</i>				
19. Plans for next steps. [Note: In this counseling guide, “return” refers to a subsequent visit after an initial PFP/PPIUCD counseling session, but before birth and IUCD insertion. “Return,” as a part of post-insertion counseling, is addressed in the insertion checklists, following.]	<ul style="list-style-type: none"> Makes notation in the woman’s medical record about her PFP choice or which methods interest her. 			
	<ul style="list-style-type: none"> If the woman cannot arrive at a decision at this visit, asks her to plan for a follow-up discussion at her next visit; advises her to bring partner/family member with her. 			
	<ul style="list-style-type: none"> Provides information about when the woman should come back, as appropriate. 			

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

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

**FACILITATOR
CERTIFICATION**

Skill performed competently:

With Models

Yes No

With Clients

Yes No

Signed:

Date:

Section One: Guide for Participants

Role Play Exercises: Counseling Potential PPIUCD Users

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

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

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

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

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

Clinical Skills Checklists

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

(To Be Used by Participants and Facilitators)

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

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

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

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

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

Participant _____ Date Observed _____

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

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

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

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

FACILITATOR CERTIFICATION

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

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

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

(To Be Used by Participants and Facilitators)

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

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

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

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

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

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

Participant _____ Date Observed _____

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

CHECKLIST FOR <u>POSTPLACENTAL (MANUAL) INSERTION OF THE IUCD</u>				
STEP/TASK	CASES			
10. (Note: Elbow-length gloves are needed for manual insertion.) If insertion is performed by same provider who assisted birth, keeps on same pair of HLD or sterile gloves for insertion, provided they are not contaminated. OR: If insertion is performed by provider different from the one who assisted birth, ensures that AMTSL has been completed, then performs hand hygiene and puts on new HLD or sterile gloves.				
11. Inspects perineum, labia and vaginal walls for lacerations. If there are lacerations that are bleeding, applies clamp to the bleeding area to stop the bleeding and proceeds with IUCD insertion. (Repairs lacerations, if needed, <u>after</u> inserting IUCD.)				
Insertion of the IUCD				
12. Confirms that the woman is ready to have the IUCD inserted. Answers any questions she might have and provides reassurance if				
13. Has the PPIUCD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUCD in sterile package is kept to the side of sterile draped area. Places a dry, sterile cloth on the woman's abdomen.				
14. Gently visualizes the cervix by depressing the posterior wall of the vagina. (Note: If cervix is not easily seen, applies fundal pressure so that the cervix descends and can be seen.)				
15. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.				
16. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately one-third of the way.				
17. With nondominant hand still holding the IUCD package (stabilizing IUCD through the package), uses dominant hand to remove plunger rod, inserter tube and card from package.				
18. With dominant hand, grasps and then holds the IUCD at end of fingers, by gripping the vertical rod between the index and middle				
19. “Stabilizes the uterus” (this step overlaps with Step 20): Moves the nondominant hand up onto the abdomen. Stabilizes the uterus with firm downward pressure through the abdominal wall. (Note: This prevents the uterus from moving upward in the abdomen as the hand holding the IUCD is inserted.)				
20. “Gently inserts and slowly advance the IUCD” (this step overlaps with Step 19): – Gently inserts the dominant hand into the vagina and through the cervix. Avoids touching the walls of the vagina with the IUCD. – Slowly moves the dominant hand in an upward motion toward the fundus (in an angle toward the umbilicus), taking care to follow the contour of the uterine cavity and taking extra care not to perforate the uterus.				
21. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the dominant hand has reached the fundus.				
22. Releases the IUCD at the fundus and slowly removes the hand from the uterus. Takes particular care not to dislodge the IUCD as the hand is removed.				
23. Keeps abdominal hand on the fundus to stabilize the uterus until the other hand is completely out of the uterus.				

CHECKLIST FOR <u>POSTPLACENTAL</u> (<u>MANUAL</u>) INSERTION OF THE IUCD					
STEP/TASK	CASES				
24. Examines cervix to see if any portion of IUCD or strings are visible or protruding from cervix. If IUCD or strings are seen protruding from cervix, remove and reinsert IUCD.					
25. Repairs any lacerations (episiotomy) as needed.					
26. Places all instruments used in 0.5% chlorine solution so they are totally submerged.					
Post-Insertion Tasks					
27. Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.					
28. Disposes of waste materials appropriately.					
29. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.					
30. Performs hand hygiene.					
31. Tells woman that IUCD has been successfully placed; reassures her and answers any questions she may have. Advises her that instructions will be reviewed prior to discharge, and provides the following instructions for now: <ul style="list-style-type: none"> - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for PPIUCD/postpartum and newborn check-up(s) - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS⁶) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion 					
32. Records information in the woman's chart or record. Attaches IUCD card (which woman will be given at discharge) to woman's record.					
33. Records information in the appropriate register(s).					

**FACILITATOR
CERTIFICATION**
With Models
With Clients

Skill performed competently:

 Yes No

 Yes No

Signed:

Date:

⁶The acronym PAINS may be helpful in remembering IUCD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping or abdominal pain with sexual intertraining; **I**nfection with or exposure to a STI or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from IUCD are missing or are longer or shorter than normal.

Intracesearean Insertion of the IUCD (Copper T 380A)
(To Be Used by Participants and Facilitators)

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

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

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

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

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

Participant _____ Date Observed _____

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

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

⁷The acronym PAINS may be helpful in remembering IUCD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping or abdominal pain with sexual intertraining; **I**nfection with or exposure to a STI or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from IUCD are missing or are longer or shorter than normal.

**FACILITATOR
CERTIFICATION**

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

Early Postpartum Insertion of the IUCD (Copper T 380A)
(To Be Used by Participants and Facilitators)

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

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

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

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

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

Participant _____ Date Observed _____

CHECKLIST FOR <u>EARLY POSTPARTUM</u> INSERTION OF THE IUCD				
STEP/TASK	CASES			
Tasks to Perform in Postpartum Ward (prior to Procedure)				
1. Reviews the woman’s record to ensure that she has chosen the IUCD.				
2. Ensures that she has been appropriately counseled and screened for PPIUCD insertion.				
3. Greets the woman with kindness and respect.				
4. If she has not been counseled and assessed for postpartum IUCD, provides that service now.				
5. Confirms that the woman still wants IUCD.				
6. Briefly describes procedure. Answers any question the woman might have.				
7. Confirms that correct sterile instruments, supplies and light source are available for early postpartum insertion; obtains PPIUCD kit/tray.				
8. Confirms that IUCDs are available on labor ward; obtains a sterile IUCD, keeping the package sealed until immediately prior to				
Pre-Insertions Tasks (in Procedure Room)				
Note: For early postpartum insertion, the procedure is very similar to postplacental (instrumental) insertion. There are some differences, however, especially due to the postpartum changes that are already occurring in the woman’s body. For example, depending on how much uterine involution has taken place, the provider may consider using a regular ring forceps for insertion, as it may be long enough to reach the fundus.				
9. Confirms that there are no delivery-related conditions that preclude insertion of IUCD now: - Rupture of membranes for greater than 18 hours - Chorioamnionitis - Puerperal sepsis - Continued excessive postpartum bleeding - Genital trauma so severe that repairs would be disrupted by postpartum placement of an IUCD (confirmed by inspection of				
10. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUCD and offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).				

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

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

CHECKLIST FOR <u>EARLY POSTPARTUM</u> INSERTION OF THE IUCD				
STEP/TASK	CASES			
40. Tells woman that IUCD has been successfully placed; reassures her and answer any questions she may have. Tells her that detailed instructions will be provided prior to discharge, and provides the following instructions: - Reviews IUCD side effects and normal postpartum symptoms - Tells woman when to return for IUCD/postnatal/newborn checkup - Emphasizes that she should come back any time she has a concern or experiences warning signs - Reviews warning signs for IUCD (PAINS ⁸) - Reviews how to check for expulsion and what to do in case of expulsion - Ensures that the woman understands post-insertion instructions - Gives written post-insertion instructions, if possible - Provides card showing type of IUCD and date of insertion				
41. Records information in the woman's chart or record. Attaches IUCD card (which women will be given at discharge) to woman's record.				
42. Records information in the appropriate register(s).				

FACILITATOR CERTIFICATION

With Models

With Clients

Skill performed competently:

Yes No

Yes No

Signed:

Date:

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

Clinical Skills Tracking Sheet

Using the PPIUCD Clinical Skills Tracking Sheet

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

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

Item 5: Note your score on the Pre-training Knowledge Assessment here.

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

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

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

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

The PPIUCD Clinical Skills Tracking Sheet

1. Name _____
2. Designation _____
3. Facility _____
4. Dates of Training _____
5. Score on Pre-training Knowledge Assessment _____
6. Score on Mid-training Knowledge Assessment _____

7. Clinical Skills Assessment

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

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

PPIUCD Training Evaluation

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

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

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

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

(See next page.)

Additional Comments

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

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

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

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

SECTION TWO: FACILITATOR'S GUIDE

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Preparing for the Training

A successful training does not come about by accident, but rather through careful planning. This planning takes thought, time, preparation and often some study on the part of the clinical skills Facilitator. The Facilitator is responsible for ensuring that the training is carried out essentially as it was designed. The Facilitator must also make sure that the classroom and clinical practice sessions are conducted appropriately. To prepare for the training, the following steps are recommended:

- Review training materials:
 - **Review the participant’s guide (Section One)** carefully, to be familiar with the information and tools to which the participants have access. This is an exact duplicate of the Training Handbook for Participants.
 - **Pay special attention to the training schedule and training syllabus**, including the training description, goals, learning methods, training materials, methods of evaluation, training duration and suggested training composition.
 - **Note the section on the “Training Approach Used in This Training.”** Content on this subject has not always been provided to participants. Its inclusion here helps participants know what to expect and also supports the idea that developing competency is a “shared responsibility” between participants and the Facilitator.
 - **Review the Facilitator’s guide (Sections Two and Three)** well before the training begins.
 - **Study the training outline.** This provides detailed suggestions regarding the teaching of each objective and the facilitation of each activity. Based on suggestions in the training outline and the Facilitator’s own ideas, the Facilitator will gather the necessary equipment, supplies and materials. The Facilitator should also compare time estimates in the training outline to the schedule to ensure that sufficient time has been allotted for all sessions and activities. The Facilitator may also annotate the outline to help ensure smooth execution of the day’s activities.
 - **Review all of the exercises/activities** to get a clear sense of how they will work.
 - **Allow time to review and “absorb” Section Three: Tips for Facilitators.** While much of the content and principles are applicable to any skills training, there are tips and examples throughout that are specific to the PPIUCD training.

Make copies of pre- and midtraining knowledge assessment answer sheets and other materials as needed. Note that many “pieces” from Training Handbook for Participants and Facilitator’s Guide are available as PDFs (and sometimes Word files) in the Additional Resources folder on the CD.

- **Study the reference manual** to help ensure complete familiarity with the content to be presented during the training.
- **Review PowerPoint slides presentations**, including notes (beneath each slide). Create narration notes (see sample in Presentations folder on CD), if desired.
- **Watch video.**

- **Confirm that all audiovisual equipment** is available and in working order (e.g., overhead projector, video player, flipchart stand).
- **Check all anatomic models** (e.g., that they are clean, in good condition and all parts are in place).
- **Practice all clinical procedures** using the anatomic model(s) and skills checklists found in the participant's guide.
- **Obtain information about the participants who will be attending the training.** It is important for the Facilitator to know basic information about participants such as:
 - The **experience and educational background** of the participants. The Facilitator should attempt to gather as much information about participants as possible before training. If this is not possible, the Facilitator should inquire about their backgrounds and expectations during the first day of the training.
 - The types of **clinical activities** the participants will perform in their daily work after training. Knowing the exact nature of the work that participants will perform after training is critical for the Facilitator. The Facilitator must use appropriate, job-specific examples throughout the training so that participants can draw connections between what is being taught and what they will need to do. This is an excellent way to reinforce the importance of what is being learned.
- **Give participants “pretraining” assignments, if any.** For example, according to program specifications, a copy of the Individual Learning Plan and Performance Standards may be sent/e-mailed to training participants beforehand so that they can do an informal self- assessment of their own practices, as well as those of others at their facility.
- **Meet with coFacilitator(s), special content experts and clinical setting counterparts** to review individual roles and responsibilities. In order for the training to go well, the lead Facilitator(s) work with others involved to ensure that there is understanding and consensus about how the training will be conducted.

Planning and preparation are further discussed in Section Three: Tips for Facilitators.

Model Training Outline

The training outline presented here is a model plan of the training to be delivered. It presents enabling objectives needed to accomplish the learning objectives described in the training syllabus. For each enabling objective, there are suggestions regarding appropriate learning activities and needed resources and materials. The Facilitator may develop other practice activities and prepare case studies, role plays or other learning situations that are specific to the country or group of participants.

The training outline is divided into four columns:

- **Time.** This section of the outline indicates the approximate amount of time to be devoted to each learning activity.
- **Objectives/Activities.** This column lists the enabling objectives and learning activities. Because the objectives outline the sequence of training, the objectives are presented here in order. The combination of the objectives and activities (introductory activities, small-group exercises, clinical practice, breaks, etc.) outlines the **flow** of training.
- **Training/Learning Methods.** This column describes the various methods, activities and strategies to be used to deliver the content and skills related to each enabling objective.
- **Resources/Materials.** The fourth column in the training outline lists the resources and materials needed to support the learning activities.

PPIUCD Training Course outline, 10 days		
TOPICS/ACTIVITIES	TRAINING/LEARNING METHODS	RESOURCES OR MATERIALS
<p>Activity:</p> <ul style="list-style-type: none"> • Registration • Welcome & opening • Introduction of participants, group norms, participants' expectations and review of training objectives and schedule 	<ul style="list-style-type: none"> • Facilitate registration of participants • Open training with a word of welcome by organizers, lead Facilitators, etc. • Facilitate the introductions of all participants and facilitators • Ask for participants to make a list of norms that govern all participants & facilitators during the training • Ask for participants' expectations for the training. Allow participants to freely explore them. When reviewing training objectives (next), address which expectations can be met and which cannot. • Review the training goals/objectives, participant selection criteria and expected outcomes. • Review the training schedule, including starting and ending times and times for breaks and lunch 	<ul style="list-style-type: none"> • Prepared welcome sign • Flipchart, tape and markers • Name tents or badges • Flipchart with training objectives

<p>Activity:</p> <ul style="list-style-type: none"> Assess participants' pre-training knowledge 	<ul style="list-style-type: none"> Ask participants to turn to the Pre-training Knowledge Assessment sheet. Assign a number to each participant and ask him/her to write the number on the pre-training Knowledge Assessment sheet. Advise them to answer each question and turn the answer sheet over when finished Allow 30 minutes for the Pre-training Knowledge Assessment Immediately review the correct responses—do not spend a lot of time on any questions, but assure the participants that the material will be covered during the training Have participants grade their own papers and collect the papers after reviewing all of the answers Use the papers to prepare the “large-format” Group and Individual Knowledge Matrix and then return the papers 	<ul style="list-style-type: none"> Pre-training Knowledge Assessment Small pieces of paper with numbers Group and Individual Knowledge Matrix
<p>Activity:</p> <ul style="list-style-type: none"> Discuss Reproductive Health/Family Planning 	<ul style="list-style-type: none"> Use the PowerPoint presentation to review reproductive health (RH)/family planning (FP) general concepts, sexual & reproductive rights, and FP situation in Ethiopia. Use brain-storming to assess participants' prior knowledge on RH/FP. Show participants the different FP methods and ensure that they understand the methods 	<ul style="list-style-type: none"> Flipchart and markers Samples of contraceptives Sexual & Reproductive rights table LCD projector & laptop computer
<p>Activity:</p> <ul style="list-style-type: none"> Review anatomy and physiology of reproductive organs (female and male) 	<ul style="list-style-type: none"> Use PowerPoint presentation to review the structure & functions of both male & female reproductive organs Allow participants to label the reproductive organs on a sheet of paper with pictures of the reproductive organs 	<ul style="list-style-type: none"> Power-point slides on anatomy & physiology of reproductive organs LCD projector & laptop computer Flip chart and markers Picture of reproductive organs.

<p>Activity:</p> <ul style="list-style-type: none"> Review Natural family planning methods 	<ul style="list-style-type: none"> Use the power-point slides to present natural FP methods 	<ul style="list-style-type: none"> Power-point slides on natural family planning methods LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Discuss Short Acting Modern FP Methods 	<ul style="list-style-type: none"> Use the power-point slides to present on short acting FP methods Show samples of short acting FP methods 	<ul style="list-style-type: none"> Power-point slides on short acting family planning methods LCD projector & laptop computer Flip chart & markers Samples of short acting FP methods
<p>Activity:</p> <ul style="list-style-type: none"> Review emergency contraception 	<ul style="list-style-type: none"> Use the power-point slides to present on emergency contraception 	<ul style="list-style-type: none"> Power-point slides on emergency contraception LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Overview of Long-acting and Permanent Family Planning Methods 	<ul style="list-style-type: none"> Use the power-point slides to present on long acting and permanent FP methods Show samples of long acting FP methods 	<ul style="list-style-type: none"> Power-point slides on long acting & permanent FP methods LCD projector & laptop computer Flip chart & markers Samples of long acting FP methods
<p>Activity:</p> <ul style="list-style-type: none"> Review FP for Clients with Special Needs 	<ul style="list-style-type: none"> Use the power-point slides presentation to review the general concepts of FP for clients with special needs 	<ul style="list-style-type: none"> Power-point slides on FP for clients with special needs LCD projector & laptop computer Flip chart & markers

<p>Activity:</p> <ul style="list-style-type: none"> Review Medical eligibility criteria and client assessment for family planning 	<ul style="list-style-type: none"> Use PowerPoint presentation on Medical Eligibility Criteria and client assessment for use of family planning Ask participants to turn to the Medical Eligibility Criteria (MEC) wheel or chart. Break participants into two groups and ask them to review the chart on Medical Eligibility Criteria for a range of contraceptive methods 	<ul style="list-style-type: none"> Powerpoint slides on MEC & client assessment Flipcharts and markers MEC wheels or charts
<p>Activity:</p> <ul style="list-style-type: none"> Discuss infection prevention in Family Planning 	<ul style="list-style-type: none"> Use the power-point presentation to review the general concepts of infection prevention (IP) in FP Demonstrate hand washing & instrument processing 	<ul style="list-style-type: none"> Power-point slides on Infection Prevention <p>Flip chart & markers</p>
<p>Activity:</p> <ul style="list-style-type: none"> Overview of logistics and Health Management Information Systems (HMIS) in Family Planning 	<ul style="list-style-type: none"> Use the power-point slides presentation to review logistics and HMIS in FP 	<ul style="list-style-type: none"> Power-point slides on logistics & HMIS in FP LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <p>Discuss counseling clients for family planning</p>	<ul style="list-style-type: none"> Use the PowerPoint slides presentation on Counseling clients for family planning 	<ul style="list-style-type: none"> PowerPoint slides on counseling Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Overview of Providers' beliefs and attitudes 	<ul style="list-style-type: none"> Use the power-point slides presentation on providers' beliefs & attitudes about FP methods. Ask questions of the participants and engage them in the presentation of the information. 	<ul style="list-style-type: none"> Power-point slides presentation on providers' beliefs and attitudes LCD projector & laptop computer Flip chart & markers

<p>Activity:</p> <ul style="list-style-type: none"> Review on ways of ensuring optimal communication 	<ul style="list-style-type: none"> Use the power-point slides presentation on ensuring optimal communication in counseling FP clients 	<ul style="list-style-type: none"> Power-point slides presentation on ensuring optimal communication LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Provide overview on who are our clients 	<ul style="list-style-type: none"> Use the power-point slides presentation on who are our clients 	<ul style="list-style-type: none"> Power-point slides presentation on ensuring optimal communication LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Discuss the REDI framework 	<ul style="list-style-type: none"> Use the power-point slides presentation on the REDI framework 	<ul style="list-style-type: none"> Power-point slides presentation on REDI LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Discuss clients' knowledge gaps & misconceptions 	<ul style="list-style-type: none"> Use the power-point slides presentation on knowledge gaps & misconceptions 	<ul style="list-style-type: none"> Power-point slides presentation on knowledge gaps & misconceptions LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Provide overview on helping clients in making or confirming a decision and in implementing decision 	<ul style="list-style-type: none"> Use the power-point slides presentation on helping clients in making or confirming decisions & implementing decisions 	<ul style="list-style-type: none"> Power-point slides presentation on helping clients in making or confirming decisions & implementing decisions LCD projector & laptop computer Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> Discuss counseling return clients 	<ul style="list-style-type: none"> Use the power-point slides presentation on counseling return clients 	<ul style="list-style-type: none"> Power-point slides presentation on counseling return clients LCD projector & laptop computer Flip chart & markers

<p>Activity:</p> <ul style="list-style-type: none"> • Overview on helping clients continue or switch methods 	<ul style="list-style-type: none"> • Use the power-point slides presentation on helping clients continue or switch methods 	<ul style="list-style-type: none"> • Power-point slides presentation on helping clients continue or switch methods • LCD projector & laptop computer • Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> • Discuss skills in partner communication and negotiation 	<ul style="list-style-type: none"> • Use the power-point slides presentation on strengthening skills in partner communication & negotiation 	<ul style="list-style-type: none"> • Power-point slides presentation on strengthening skills in partner communication & negotiation • LCD projector & laptop computer • Flip chart & markers
<p>Activity:</p> <ul style="list-style-type: none"> • Facilitate role Plays on Family Planning Counseling 	<ul style="list-style-type: none"> • Have participants break into groups of three persons each. Ask them to read the role plays on counseling. Ask them to practice counseling using these role plays. One participant is the counselor, one participant is the client and one participant is the observer. • Have them take turns with different role plays, each time having the participants play a different role. • While participants are doing the role plays, observe them. Use the Counseling Guide to ensure that their counseling approach and technical information are appropriate and accurate 	<ul style="list-style-type: none"> • Counseling Role Plays in the participants’ hand out • Counseling Guide in the participants’ hand out • Counseling Role Plays—Answer Key in the facilitator’s guide
<p>Activity: Presentation/Discussion on: ? Pregnancy Spacing and Health Benefits of FP</p>	<p>? Use the PowerPoint slides presentation to provide information on the impact of pregnancy spacing on maternal, newborn and child health. ? Ask questions of the participants and engage them in the presentation of the information.</p>	<p>PowerPoint slides presentation on: ? Healthy Spacing of Pregnancy</p>

<p>Activity:</p> <ul style="list-style-type: none"> ● Review Group and Individual Knowledge Matrix. 	<ul style="list-style-type: none"> ● While one facilitator is presenting the above presentation, another facilitator should compile the results of the Pre-training Knowledge Assessment and fill out the Group and Individual Knowledge Matrix. This is then presented to the participants to demonstrate where attention is needed (i.e., where many or most participants provided incorrect answers). (Note: A large-format version of the matrix in the CHL should be prepared <u>beforehand</u>. Alternatively, this activity can be done by having participants fill out their matrices in the CHL, as the facilitator shares the compiled results aloud.) 	<ul style="list-style-type: none"> ● “Large-format” Group and Individual Knowledge Matrix (or matrices in CHL)
<p>Activity:</p> <p>Presentation/Discussion on:</p> <ul style="list-style-type: none"> ● Postpartum and post abortion Family Planning 	<ul style="list-style-type: none"> ● Use the PowerPoint slides presentation to review the general concepts of postpartum and post abortion family planning. ● Ensure that participants understand the many different types of PFP, and the use of LAM as a gateway method. 	<p>PowerPoint slides presentation on:</p> <ul style="list-style-type: none"> ● Postpartum & Postabortion Family Planning
<p>Exercise One:</p> <ul style="list-style-type: none"> ● Brainstorming: What Is Different about the Postpartum IUCD? 	<ul style="list-style-type: none"> ● Before this exercise, set up a skills station for postpartum IUCD insertion. Refer participants to the illustration of the skills station (CHL). ● Ask participants to gather around the skills station and brainstorm (rapid responses without much discussion) about all the things they see that are different about this set up for PPIUCD insertion compared to “interval” IUCD insertion. ● Write their responses on a flipchart without discussion or qualification. Refer back to this list during the next presentation on PPIUCD services. 	<ul style="list-style-type: none"> ● The Skills Station Set-Up Illustration (CHL) ● Anatomic models, supplies, instruments, linen for the skills station (See Set-Up of Clinical Skill Practice Station in the CNT.) ● Flipchart and markers
<p>Activity:</p> <p>Presentation/Discussion on:</p> <ul style="list-style-type: none"> ● Postpartum IUD Overview ● Postpartum IUD Counseling 	<ul style="list-style-type: none"> ● Use the PowerPoint slides presentation to review the technical information about postpartum IUDs and the important aspects of counseling. ● Ask questions of the participants and engage them in the presentation of the information. 	<p>PowerPoint slides presentations on:</p> <ul style="list-style-type: none"> ● Postpartum IUD Overview ● Postpartum IUD Counseling

<p>Activity: Exercise Two:</p> <ul style="list-style-type: none"> ● Client Assessment for PPIUD 	<ul style="list-style-type: none"> ● Ask participants to turn to Exercise Two in their CHL. Break participants into two groups and ask them to review the chart on Medical Eligibility Criteria for PPIUD. ● Give the groups 10–15 minutes to fill in the chart. Ask them to provide a reason why they would insert or not insert the IUD in this postpartum situation. ● Ask the first team to present their responses for items 1–8. Engage the second team in the discussion. Do they agree or disagree? Then have the second team present their responses for items 9–16. Record the answers on a blank summary table posted on a flipchart. ● Lead a discussion about PPIUD client assessment criteria. ● Review the Pre-Insertion Screening Job Aid as a tool for helping ensure that clients are screened prior to insertion. 	<ul style="list-style-type: none"> ● Reference Manual ● Exercise Two (CNT) ● Pre-Insertion Screening Job Aid (Reference Manual) ● Flipcharts and markers
<p>Activity: Presentation/Discussion on:</p> <ul style="list-style-type: none"> ● Infection Prevention for PPIUD Services 	<ul style="list-style-type: none"> ● Use the PowerPoint slides presentation to review the general concepts of infection prevention as they relate to provision of postpartum IUD services. ● If there is time, use Exercise Three (Identify the Infection Prevention Steps) as a way to strengthen participants' understanding of IP concepts. (There is a "placeholder" for this activity in the presentation itself.) 	<p>PowerPoint slides presentation on:</p> <ul style="list-style-type: none"> ● Infection Prevention
<p>Activity: Participant Practice:</p> <ul style="list-style-type: none"> ● Role Plays on Counseling 	<ul style="list-style-type: none"> ● Have participants break into groups of three persons each. Ask them to read the role plays on counseling contained in the CHL. Ask them to practice counseling using these role plays. One participant is the counselor, one participant is the client and one participant is the observer. ● Have them use the Counseling Guide to aid in covering the important steps in counseling. Have them take turns with different role plays, each time having the participants play a different role. ● While participants are doing the role plays, observe them. Use the Counseling Guide to ensure that their counseling approach and technical information are appropriate and accurate. 	<ul style="list-style-type: none"> ● Counseling Role Plays (CHL) ● Counseling Guide (CHL) ● Counseling Role Plays—Answer Key (CNT)

<p>Activity:</p> <ul style="list-style-type: none"> ● Review the PPIUD Performance Standards to develop a Personal Learning Plan. 	<ul style="list-style-type: none"> ● Review the Postpartum IUD Clinical Standards (in Reference Manual). Ask each participant to identify four to five standards that they will focus on during this course, and commit to implementing upon their return to their clinical facility. (Note: Ideally, participants would have done an assessment using the standards back in their place of work and come to the training course with a clear idea of their Personal Learning Plan.) This exercise will focus participants' practice during the course, as well as their performance after the course. ● Have them write their plans on the Personal Learning Plan form in their CHL. Also ask them to write their standards (those that they will focus on) on a piece of paper, and attach those papers to the flipchart. 	<ul style="list-style-type: none"> ● Flipchart paper ● Small pieces of paper, tape and markers ● PPIUD Clinical Standards (in Reference Manual) ● Personal Learning Plan (CHL)
<p>Exercises Three and Four:</p> <ul style="list-style-type: none"> ● Exercise Three: Identify the IP Steps ● Exercise Four: PPIUCD FAQs 	<ul style="list-style-type: none"> ● If there is any free time while on the wards waiting for cases, review and discuss Exercises Three and Four. ● Exercise Three: Identify the IP Steps. Review each step in the clinical skills checklist and consider if it is an infection prevention step. Discuss and clarify the basic points about infection prevention. ● Exercise Four: PPIUCD FAQs. Assign one of the questions to each participant and ask them to discuss their answer. Reinforce (and add to, as needed) correct answers, correct misinformation and clarify any remaining questions about PPIUCDs. 	<ul style="list-style-type: none"> ● Exercise Three— Answer Key (CNT) ● Exercise Four—Answer Key (CNT)
<p>Presentation/Discussion:</p> <ul style="list-style-type: none"> ● Side Effect and Complication Management 	<ul style="list-style-type: none"> ● Use the PowerPoint slides presentation to share and discuss the management of PPIUCD side effects and complications. Use cases from the clinical experience yesterday to reinforce concepts and principles. 	<p>PowerPoint slides presentation on:</p> <ul style="list-style-type: none"> ● PPIUCD Side Effects and Complications Management

<p>Demonstration:</p> <ul style="list-style-type: none"> ● Immediate Postplacental Insertion of IUCD (manual, instrumental) ● Intracesearean Insertion of IUCD ● Early Postpartum Insertion of IUCD <ul style="list-style-type: none"> ● PPIUCD insertion video 	<ul style="list-style-type: none"> ● Set up two skills stations—one on postplacental IUCD insertion (instrumental and manual technique) and one on early postpartum IUCD insertion. ● Gather participants around the two skills stations. Ask them to use their skills checklists to follow along. Conduct a demonstration of the proper technique for insertion. First demonstrate postplacental instrumental insertion (instrumental and manual technique), then early postpartum insertion. ● Also, discuss and review step-by-step the techniques for intracesearean insertion. <ul style="list-style-type: none"> ● PPIUCD Insertion video ● Ask questions of the participants and assess their understanding of the technique. ● Remind participants that they will have an opportunity to practice these skills (and be assessed for readiness to practice with actual clients) in the afternoon at the skill practice and assessment stations. 	<ul style="list-style-type: none"> ● Fully equipped skills stations for postplacental and early postpartum insertion ● Clinical Skills Checklists (CHL) <p>(Video)</p>
<p>Skill Practice and Assessment</p> <ul style="list-style-type: none"> ● All participants rotate between different skills stations for demonstration, discussion, practice and assessment. 	<ul style="list-style-type: none"> ● Prepare two skills stations with everything needed for all four clinical insertion techniques. Use the diagram in the CNT to guide the setup of these stations. ● Divide participants into two groups. Have them work in teams at the skills station to practice the four skills. Use the clinical skills checklists to guide practice. ● Allow participants to practice the postplacental insertion (instrumental and manual) and early postpartum insertion on the models. Use illustrations to guide simulated practice for intracesearean insertion. ● When participants are ready, assess for competency using checklists. ● Record the skills achieved on the Skills Tracking Sheet for each participant. <p>(Insertion video may be shown at this time if time allows.)</p>	<ul style="list-style-type: none"> ● Fully equipped skills stations for postplacental and early postpartum insertion ● Clinical Skills Checklists (CHL) ● Skills Tracking Sheet (CHL) <p>(Video)</p>
<p>Exercise Five:</p> <ul style="list-style-type: none"> ● IP Principles—Q&A 	<ul style="list-style-type: none"> ● If there is any free time while on the wards waiting for cases, review and discuss Exercise Five: IP Principles—Q&A. ● Exercise Five: IP Principles. Assign one of the questions to each participant and ask them to discuss their answer. Reinforce (and add to, as needed) correct answers, correct misinformation and clarify any remaining questions about infection prevention practices for the PPIUCD. 	<ul style="list-style-type: none"> ● Exercise Five (CNT)

<p>Practice on the Wards:</p> <ul style="list-style-type: none"> ● Counseling and Clinical Practice for Provision of PPIUCD Services 	<ul style="list-style-type: none"> ● Break participants into teams of two teams, with two or three participants per team. ● Team 1 will go to the ANC clinic and provide counseling about PFP options, including the PPIUCD, to antenatal clients. Team 1 should also provide counseling and services to women with IUCDs in place who come to the family planning clinic for follow-up or evaluation for side effects. ● Team 2 will go to the labor/delivery ward for experience with postplacental, early postpartum and intracesarean insertion of the PPIUCD. If there are no clients ready for insertion at this time, take the participants to the postpartum ward and have them to provide counseling to postpartum clients about the PPIUCD. <p>(Note: The facilitators should be aware of the volume and distribution of services. If there are several clients who are appropriate for PPIUCD insertion, the facilitator should call the participants from the ANC clinic to come to the labor/delivery ward for clinical experience.)</p>	<ul style="list-style-type: none"> ● Reference Manual in the participant's hand out ● Clinical Skills Checklists (CHL) ● Clinical Skills Tracking Sheet (CHL)
<p>Review of Skills Tracking Sheet</p>	<ul style="list-style-type: none"> ● Each participant should review his/her personal Skills Tracking Sheet and make sure it is completed accurately. ● Facilitators should review these with the participants and get a sense of the overall experience of the participants from the day's clinical activity. Based on this, a plan for clinical experience for tomorrow should be developed. 	<ul style="list-style-type: none"> ● Clinical Skills Tracking Sheet (CHL)
<p>Practice on the Wards:</p> <ul style="list-style-type: none"> ● Counseling and Clinical Practice for Provision of PPIUCD Services 	<ul style="list-style-type: none"> ● Continue clinical practice. Shift participants from the ANC clinic to the labor/delivery and postpartum wards, and vice versa. 	<ul style="list-style-type: none"> ● Clinical Skills Checklists (CNT) ● Clinical Skills Tracking Sheets (CHL)

Post training Knowledge Assessment	<ul style="list-style-type: none"> ● Make copies of the Post training Knowledge Assessment and give each participant a copy. ● Ask participants to put their names on the first page. ● Review the instructions printed on the questionnaire. There is one single best answer for each question. ● Participants may silently leave the room and go for lunch when they have completed the questionnaire. ● The facilitator(s) should score the questionnaire, mark the score on the top and be prepared to return the questionnaire to the participants when they return from lunch. ● Record the score on the participants' Skills Tracking Sheet. 	<ul style="list-style-type: none"> ● Copies of the Post training Knowledge Assessment
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Review Post training Knowledge Assessment	<ul style="list-style-type: none"> ● Answers should be reviewed with the entire group. The facilitator will meet with those participants scoring less than 85%. After discussing the items missed, the participants should spend additional study time and then retake the questionnaire until they achieve a score of at least 85%. 	<ul style="list-style-type: none"> ● Post training Knowledge Assessment – Answer Key (CNT)
Activity: <ul style="list-style-type: none"> ● Course Evaluation and Review of Personal Learning Plan 	<ul style="list-style-type: none"> ● Bring the participants back together in a group. Ask each one to review their Personal Learning Plan developed on the first day of the course. Ask participants to state whether they were able to accomplish their learning goals and how they will use this training when they return to their facility. ● At the conclusion of the group work, have participants fill out and turn in the course evaluation form. 	<ul style="list-style-type: none"> ● Personal Learning Plans ● Course evaluation forms
Certificate Distribution and Closing	<ul style="list-style-type: none"> ● Closing remarks by training organizers. ● Distribute certificates to participants. 	<ul style="list-style-type: none"> ● Completed certificates

Pre-training Knowledge Assessment

Using the Pre-training Knowledge Assessment

The Pre-training Knowledge Assessment is not intended to be a test but rather an assessment of what the participants, individually and as a group, know about the training topic. Participants, however, are often unaware of this and may become anxious and uncomfortable at the thought of being “tested” in front of their colleagues on the first day of a training. The clinical Facilitator should be sensitive to this attitude and administer the questionnaire in a neutral and non-threatening way as the following guide illustrates:

- Participants draw numbers to assure anonymity (e.g., from 1 to 12 if there are 12 participants in the training).
- Participants complete the pre-training questionnaire quietly and individually without discussion.
- After everyone is finished, the clinical Facilitator gives the answers to each question.
- The clinical Facilitator passes around the individual and group assessment matrix for each participant to complete according to her/his number.
- The clinical Facilitator posts the completed matrix.
- The clinical Facilitator and participants discuss the results of the questionnaire as charted on the **Individual and Group Assessment Matrix** (pages 1-22) and jointly decide how to allocate training time.

Pretraining Knowledge Assessment—Answer Key

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

Postpartum IUCD Overview

1. In many developing countries, postpartum women have:
 - a. BETTER access to family planning services than women who are not postpartum
 - b. WORSE ACCESS TO FAMILY PLANNING SERVICES THAN WOMEN WHO ARE NOT POSTPARTUM**
 - c. No interest in family planning services
2. For health reasons, how long should women wait after delivering a baby before trying to become pregnant again?
 - a. For at least 1 year
 - b. FOR AT LEAST 2 YEARS**
 - c. Until regular monthly periods have started again
3. For health reasons, how long should women wait after a miscarriage before trying to become pregnant again?
 - a. No wait is necessary
 - b. 3 months
 - c. 6 MONTHS**
4. Which of the following is TRUE about expulsion of the postpartum IUCD?
 - a. To prevent expulsion, women who choose the PPIUCD should not breastfeed.
 - b. THE EXPULSION RATE IS LOWEST WHEN THE IUCD IS INSERTED WITHIN 10 MINUTES OF DELIVERY OF THE PLACENTA.**
 - c. Tying knots of catgut on the cross arms of the IUCD will reduce expulsion.
5. Which of the following is an acceptable time to insert an IUCD postpartum?
 - a. WHEN THE BABY IS 1 DAY OLD**
 - b. When the baby is 1 week old
 - c. When the baby is 3 weeks old

Postpartum Anatomy and Physiology

6. Which of the following is TRUE about how postpartum anatomy and physiology affect IUCD insertion?
 - a. When an IUCD is inserted 2 weeks postpartum, the risk of expulsion is very low because it is easier to reach the fundus.
 - b. The standard IUCD inserter tube can be used to place both interval IUCDs and postpartum IUCDs.
 - c. IN ORDER TO REACH THE FUNDUS, THE UTERUS MUST BE “ELEVATED” (PUSHED UP IN THE ABDOMEN) TO SMOOTH OUT THE VAGINO-UTERINE ANGLE.**

7. Because of normal postpartum changes:
 - a. **THE WOMAN IS LESS LIKELY TO NOTICE INITIAL SLIGHT BLEEDING AND CRAMPING CAUSED BY THE IUCD.**
 - b. The strings should be trimmed immediately after insertion of the IUCD.
 - c. The woman should check for the IUCD strings at least once a day (to ensure that it has not been expelled).

Counseling

8. Which of the following statements is TRUE *and* should be shared with a woman during postpartum IUCD counseling?
 - a. **AN IUCD PLACED DURING THE POSTPARTUM PERIOD CAN BE USED TO DELAY OR PREVENT PREGNANCY FOR AS LONG AS THE WOMAN DESIRES, EVEN UP TO 12 YEARS.**
 - b. Placement of an IUCD during the immediate postpartum period has a slightly higher risk of uterine perforation than placement during the interval between pregnancies.
 - c. Women who choose the PPIUCD should limit breastfeeding in order to reduce the risk of expulsion.
9. Counseling about the use and benefits of a PPIUCD *can* be provided:
 - a. Only during routine antenatal care visits, if the husband has agreed to it.
 - b. During active labor, so that the IUCD can be placed immediately after delivery of the placenta.
 - c. **DURING THE LATENT PHASE LABOR, IF THE WOMAN IS COMFORTABLE.**

Infection Prevention

10. Which of the following IP practices is acceptable?
 - a. Surgical (metal) instruments that have been decontaminated and thoroughly cleaned can be safely used for insertion of the IUCD postpartum.
 - b. It is not necessary to use an antiseptic when inserting an IUCD immediately after delivery because the provider is still wearing sterile gloves.
 - c. **TO MINIMIZE THE RISK OF STAFF CONTRACTING HEPATITIS B OR HIV/AIDS DURING THE CLEANING PROCESS, INSTRUMENTS USED IN IUCD INSERTION SHOULD BE SOAKED FIRST FOR 10 MINUTES IN 0.5% CHORINE SOLUTION.**
11. If an IUCD is still inside an undamaged, sealed package but appears tarnished or discolored, the provider should:
 - a. **INSERT THE IUCD IF THE PACKAGE IS NOT BEYOND THE EXPIRATION DATE.**
 - b. Send the IUCD back to the manufacturer.
 - c. Discard the IUCD because it is unsterile.

PPIUCD Client Assessment

12. In which of the following women would it be safe to insert an IUCD immediately following delivery of the placenta?
 - a. A woman who has a fever of 38°C
 - b. A WOMAN WHO HAS HAD RUPTURED MEMBRANES FOR 12 HOURS**
 - c. A woman who is HIV+ with a low CD4 count

13. If a woman was successfully treated for chlamydia during this pregnancy and wants an IUCD, the provider can:
 - a. INSERT THE IUCD IF THE INFECTION HAS BEEN GONE FOR MORE THAN 6 WEEKS**
 - b. Insert the IUCD but provide antibiotics for 1 week.
 - c. Tell the woman to return for insertion at 4 weeks postpartum.

14. Which of the following is a condition for which PPIUCD insertion is considered Category 4 (meaning the method should not be used), according to the World Health Organization's Medical Eligibility Criteria (WHO MEC)?
 - a. AIDS
 - b. PUERPERAL SEPSIS**
 - c. Cesarean section

Postpartum IUCD Insertion

15. Which of the following is the best technique for inserting an IUCD on the first day after delivery?
 - a. USING INSTRUMENTS, SUCH AS A KELLY PLACENTAL FORCEPS**
 - b. Using hands (manually)
 - c. Using an inserter tube and plunger

16. Which of the following statements is TRUE about placement of the PPIUCD during cesarean section?
 - a. A sponge-holding (ring) forceps must be used to ensure that the IUCD is placed at the fundus
 - b. THE STRINGS OF THE IUCD SHOULD NOT BE PASSED THROUGH THE CERVIX INTO THE VAGINA**
 - c. The PPIUCD should be stitched in place at the fundus with a 0 chromic suture

17. If a woman has had a normal vaginal delivery and an immediate/postplacental IUCD insertion is planned:
 - a. The IUCD should be inserted 30 minutes after active management of the third stage of labor is performed
 - b. ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOR SHOULD BE PERFORMED AS USUAL, IMMEDIATELY BEFORE THE IUCD IS INSERTED**
 - c. Active management of the third stage labor should be avoided, if possible, if the woman is having a PPIUCD

Follow-Up Care/Management of Potential Problems

18. A woman had a postplacental PPIUCD inserted 3 weeks ago. Over the past 24 hours, she has become hot and feverish. She should:
- Be told to take paracetamol and oral antibiotics for 7 days.
 - Come into the clinic right away to have the PPIUCD removed.
 - COME INTO THE CLINIC RIGHT AWAY FOR EVALUATION.**
19. Which one of the following is TRUE about IUCD strings?
- The strings should be passed through the cervix into the vagina during intracesarean placement.
 - THE STRINGS SHOULD NOT BE VISIBLE AT THE CERVIX AFTER IMMEDIATE/POSTPLACENTAL INSERTION OF THE IUCD.**
 - The woman should check for the strings each month to make sure the IUCD has not fallen out.
20. A woman who has had an IUCD placed in the immediate postpartum period should have a follow-up exam:
- Every year to check the strings
 - Only if she thinks the IUCD has fallen out
 - AT 4 TO 6 WEEKS POSTPARTUM TO REINFORCE COUNSELING, ANSWER ANY QUESTIONS AND SCREEN FOR POTENTIAL PROBLEMS**

Personal Learning Plan: Facilitator's Instructions

Guide the development of the Personal Learning Plan in the following manner:

- Ask participants to review the Personal Learning Plan. Refer them to the section in the Reference Manual with the PPIUCD Performance Standards, or the National Service Delivery Guidelines for PPIUCD services, as appropriate.
- Have them review these standards briefly and determine which ones are *not* being achieved in their workplace. Guide them to standards that are related to knowledge and skills, if necessary.
- Ask them to consider whether these standards are not being met due to a lack of knowledge and skills. (They might consider any challenges they faced on the Pretraining Knowledge Assessment, which they will have just completed.)
- Ask them to note down four to five performance standards or areas that they want to work on during this training.
- Ask them to note what knowledge and skills will be required to achieve this standard in their workplace. (If they feel that other things such as supplies, materials, administrative support, etc., would also be necessary, ask them to note that as well.)
- Ask them to consider who will assist them in order to achieve this standard. Perhaps this includes coworkers, supervisors or other colleagues/staff who do counseling or infection prevention.
- Ask them to determine a timeframe for achieving this standard, based on what they anticipate they will learn during this training. Note this on the form.
- Do not fill in the final column at this time.
- Both the participant and the Facilitator should sign the form at this time, as a contract to achieve the participant's individual learning goals.

On a flipchart, note the performance standards or areas that the participants want to focus on.

At the beginning of each day, review this flipchart to keep the participants and the Facilitators focused on the achievement of concrete goals for the training.

At the conclusion of the training, ask the participants to again review their Personal Learning Plan and to complete the final column on how this training prepared them to achieve their goals and stated standards. They should take the plan back to their workplace and show it to their coworkers and supervisor as part of their effort to implement what they have learned.

After the training, Facilitators or other personnel in the system of clinical supervision should use the Personal Learning Plan to guide visits to the workplace.

Exercise One: What Is Different about Postpartum IUCD?

Objectives

The purpose of this activity is to:

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

Time Allotted

- 15 minutes

Resources/Materials Needed

- Skills Station for PPIUCD
- Flipchart paper and markers

Facilitator's Instructions

- Before this exercise, set up a skills station for postpartum IUCD insertion. (See Skills Station Set-Up Guide on page 2-58.)
- Have participants look at the illustration of the skills station in their notebook first.
- Then, ask participants to gather around the skills station and brainstorm (rapid responses without much discussion) about all the things they see that are different about the set up for PPIUCD insertion compared to interval IUCD insertion.
- Write their responses on a flipchart without discussing them. When the list seems sufficient, tell participants: "This is good for now. We will discuss your responses later."
- Refer back to this list during the next presentation on PPIUCD services.

NOTE: This activity can be used as an introduction to the next presentation, *Postpartum Intrauterine Contraceptive Device (PPIUCD)*. It also serves to break up the sequence of three presentations in a row, which is necessary to cover all of the material before the afternoon practice session.

NOTE: In case participants have limited experience with provision of interval IUCD services, this activity can be modified by gathering the supplies and equipment needed for PPIUCD services and having participants set up the skills station themselves. Through this process, they will learn the name and function of each item. They will then be better able to participate in the discussion about PPIUCD services that follows.

Exercise Two: Medical Eligibility for the PPIUCD

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

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

Facilitator Guidance

- Divide participants into small groups and ask each group to work as a team OR ask participants to work individually.
- Give each individual or group a copy of a blank Medical Eligibility Criteria (MEC) chart and ask them to review carefully and complete by placing a check mark in the “Insert” or “Do Not Insert” column. Ask participants to give a reason for each answer and to note the appropriate WHO MEC category in the space provided.
- Bring participants back together after 15 minutes and ask volunteers to share their answers one at a time.
- Use one blank chart on a flipchart and fill in the correct answers during the discussion so that all participants can see the correct answers.
- Reinforce correct answers, address incorrect answers and clarify issues raised during this discussion.

Exercise Two—Answer Key

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

MATERNAL CONDITION	INSERT PPIUCD	DO NOT INSERT PPIUCD	REASON/COMMENT
Plans to have another baby in 2 years	✓		Category 1
3 weeks postpartum		✓	Category 3: increased risk of expulsion
Delivered 20 hours after rupture of membranes (ROM)		✓	May be at increased risk of infection/sepsis
Has AIDS and has not been taking ARV		✓	Category 3 if clinically unwell
Younger than 20 years of age	✓		Category 1
History of gonorrhea as a teenager	✓		Category 1 unless at high current individual risk of STI
History of ectopic pregnancy	✓		Category 1
Has a genital laceration that extends into the rectum	✓		Cover perineum with a cloth and ensure no-touch technique during insertion
Has a fever of 38°C postpartum		✓	Category 4 if puerperal sepsis likely
Has a history of anemia	✓		Category 1
Persistent vaginal hemorrhage after delivery		✓	Category 4: avoid insertion if woman is clinically unstable
Partner has penile discharge and dysuria		✓	Category 3: high current individual risk of STI
HIV-positive and receiving care at the HIV clinic	✓		Category 2 if clinically well
History of PID, treated with antibiotics 5 years ago	✓		Category 2
Has fever and abdominal pain in association with an incomplete abortion		✓	Category 4

Exercise Three: Infection Prevention (IP) Steps

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

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

Facilitator Guidance

- Divide participants into two groups:
 - Have Group 1 review Postplacental Insertion (Instrumental and Manual).
 - Have Group 2 review Early Postpartum Insertion.
- Ask them to discuss together and identify the IP steps in each checklist. Ask them to present their ideas to the whole group: first one group, then another.
- Review and clarify the IP steps, according to the Answer Key (next page).
 - Ask participants if they will have any difficulty achieving these steps in their facility.
- Reinforce correct answer, address incorrect answers and clarify issues raised during this discussion.

NOTE: This activity can be done as an exercise while waiting for clinical cases on the labor ward.

Exercise Three—Answer Key

INFECTION PREVENTION (IP) STEPS—ANSWER KEY			
Checklist for <u>Postplacental</u> Insertion of the IUCD Using		Checklist for <u>Early Postpartum</u> Insertion of the IUCD	
Step	Rationale	Step	Rationale
2	Client screening of women who may not be suitable candidates for the IUCD because of high personal risk of STI	2	Client screening of women who may not be suitable candidates for the IUCD because of high personal risk of STI
8	Client screening to be certain that there is no increased risk of infection due to labor characteristics	9	Client screening to be certain that there is no increased risk of infection due to labor characteristics
6	Use of sterile instruments	7	Use of sterile instruments
10	Hand hygiene (as needed) and, for manual insertion, use of elbow-length gloves	14	Hand hygiene and use of gloves
13	Open and arrange tray at appropriate time	17	Open and arrange tray at appropriate time
15	Use of antiseptics	19	Use of antiseptics
17 (manual, 22)*	Open IUCD package correctly (at appropriate time), holding package from bottom so that IUCD does not fall out	22	Open IUCD package correctly (at appropriate time), holding package from bottom so that IUCD does not fall out
19 (manual, 24)	Grasp IUCD inside sterile package, using no-touch technique	25	Grasp IUCD inside sterile package, using no-touch technique
21 (manual, 20)	Insert IUCD, using no-touch technique	26	Insert IUCD, using no-touch technique
30 (manual, 26)	Initiate instrument processing	35	Initiate instrument processing
32 (manual, 28)	Waste disposal	37	Waste disposal
33 (manual, 29)	Processing or disposing of gloves	38	Processing or disposing of gloves
34 (manual, 30)	Hand hygiene	39	Hand hygiene

*These are steps for which the numbering is different in instrumental and manual checklists.

Exercise Four: PPIUCD Frequently Asked Questions (FAQS)

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Reference Manual for reference

Facilitator Guidance

- Make small pieces of paper, each with a number on it (1–10). Have participants pick a number and ask them to read out and answer the question.
- Review their answers with the answers provided below.

NOTE: This activity can be done as an exercise while waiting for clinical cases on the labor ward.

Exercise Four—Answer Key

1. Aren't the expulsion rates for postpartum IUCDs unacceptably high? Is it really worth it to invest in this kind of program?

Studies over the last 30 years have shown varied rates of spontaneous expulsion of the IUCD when it is inserted postpartum. In general, the literature in the last 20 years has shown the expulsion rate is 10%–15%. While this is higher than the expulsion rate for the interval IUCD, it is still acceptable because it means 85%–90% of users will have an effective, long-acting (up to 12 years with the Copper T 380A), reversible contraceptive in place before they leave the facility *and they will retain it*. **In other words, even if the expulsion rate is as high as 10%, the PPIUCD presents a great opportunity for family planning programs to address the high unmet need that exists for postpartum family planning, especially among postpartum women. This is because the IUCD is so effective and high-quality PPIUCD services are safe and convenient for women.**

In addition, modifications to the technique have reduced expulsion rates to about 2% in some studies. These changes include using a longer instrument, focusing on immediate/postplacental (rather than early postpartum) insertion, elevation of the uterus to lessen the vagino-uterine angle and careful withdrawal of the instrument.

During counseling, women should be informed about the chance of spontaneous expulsion and told to return to the clinic if they think that the IUCD has fallen out.

2. What is the best way to ensure a low expulsion rate?

High fundal placement of the IUCD by an experienced provider who has completed competency-based PPIUCD training is the best assurance of a low expulsion rate. Training in interval IUCD insertion is not sufficient because of the differences in technique. There are three main components that are fundamental to ensuring high fundal placement and reducing the expulsion rate:

- Unpublished data suggest that PPIUCD placement with a Kelly placental forceps may be associated with a lower expulsion rate, but further study is required to document these findings. The critical principle here is that the *instrument used for insertion is long enough to reach the fundus*. Kelly forceps are 33 cm in length.
- *Elevation of the uterus* into the abdomen, in order *to smooth out the sharp vagino-uterine angle* that exists after delivery, is essential to ensure that the instrument holding the IUCD can reach the fundus.
- Once the IUCD is released at the fundus, *the instrument must be kept open during withdrawal* to prevent the strings from being caught and the IUCD inadvertently pulled too far down into the uterine cavity.

The lowest rates of expulsion are with immediate postpartum (postplacental or intracesarean) insertion. Expulsion rates are higher if insertion is performed during the early postpartum (up to 48 hours), although Day 1 is preferable over Day 2. Insertion after postpartum Day 3 (but before 4 weeks postpartum) is not recommended because the expulsion rates are unacceptably high.

3. Can women who have anemia during pregnancy get the IUCD postpartum?

Yes. Monthly menstrual bleeding does increase slightly with the IUCD, especially in the first 3 months after insertion. However, blood loss is not usually the cause of anemia, so it is **safe to provide an IUCD to an already-anemic woman**. Standard treatment for anemia (iron and folate) should be continued.

4. Which other kinds of clients can get the postpartum IUCD?

Almost all women regardless of age, marital status or parity are candidates for IUCD placement up to 48 hours postpartum. Studies have shown that even women with the following characteristics and conditions are excellent candidates for the PPIUCD:

- Under 20 years of age and/or primiparous
- HIV-infected and clinically well
- AIDS and on antiretroviral therapy (ARV) and clinically well
- History of ectopic pregnancy
- History of PID (assuming not at current high individual risk for STIs)
- Living in an area with high STI prevalence (assuming not at current high individual risk for STIs)

5. Which kinds of clients should not get the IUCD in the postpartum period?

IUCDs should not be offered to women with the following conditions, most of which occur only rarely in the general population:

- Current evidence of gonorrhea or chlamydia
- Purulent (pus-like) vaginal/cervical discharge (e.g., at the onset of labor)
- Immediately after a septic abortion
- Suspected puerperal sepsis
- A distorted uterine cavity
- Malignant trophoblastic disease
- Pelvic tuberculosis
- Genital tract cancers (cervical or endometrial)

Although WHO MEC does not address the following issues specifically, PPIUCD placement is not recommended for women with unresolved postpartum hemorrhage, ruptured membranes for more than 18 hours or suspected chorioamnionitis because of concerns regarding increased expulsion and infection rates. Because of an increase in expulsion rates, and a possible increase in infection rates, PPIUCDs are generally not offered to women between 48 hours and 4 weeks postpartum unless other methods are not available or acceptable (WHO Category 3). Other Category 3 conditions for the PPIUCD include untreated AIDS, high individual risk of STIs, ovarian cancer and benign trophoblastic disease.

6. Is there a difference between manual and instrumental insertion?

Studies comparing manual and instrumental insertion technique have failed to show a difference in expulsion rates. Other outcomes such as rates of infection and perforation—as well as client satisfaction and ease of technique for the provider—have yet to be systematically investigated. Manual insertion should be considered only in the postplacental period (i.e., within 10 minutes after expulsion of the placenta), when the cervix is maximally dilated and the provider’s hand can pass through without excessive force. If the cervical canal has narrowed too much to accommodate a hand (which will happen after birth), instrumental insertion is recommended. All other PPIUCD insertions beyond 10 minutes and up to 48 hours postpartum should be performed with a long-handled placental (e.g., Kelly) or ring forceps.

7. Should a woman who is having an IUCD inserted postpartum receive active management of third stage of labor (AMTSL)?

AMTSL, an obstetric “best practice,” has been shown to prevent postpartum hemorrhage and maternal death. It should be offered to every woman during every birth because of the unpredictability of this life-threatening complication. **All three steps of AMTSL—*injection of a uterotonic, controlled cord traction to aid in removal of the placenta and initial fundal massage*—should be successfully completed before PPIUCD insertion is attempted.**

There have been no clinical trials to assess the interaction between AMTSL and immediate postplacental insertion of the IUCD. However, an expert panel was convened by WHO in 2004 to discuss the issue and concluded that there is no interaction between AMTSL and postpartum insertion of the IUCD and the two practices do not interfere with each other.

The uterotonic drug does not increase the risk of IUCD expulsion. In fact, the IUCD is more likely to be held in place, rather than pushed out by the ongoing contractions. This is because postpartum contractions are strong and uniform, as opposed to labor contractions, which emanate from the uterine fundus and proceed down like a wave from the top to the bottom of the uterus, causing cervical dilation and fetal descent.

8. When the IUCD is placed postpartum, how should the strings be managed?

Regardless of whether placement occurs immediately postpartum (postplacental, intracesarean) or up to 48 hours after vaginal delivery, strings should not be cut at the time of insertion. During cesarean section, IUCD strings should NEVER be passed through the cervix into the upper vagina, but should be left in the lower uterine segment. Strings generally descend during involution and will be found curled-up in the posterior vaginal fornix on speculum exam at the first follow-up visit (by 6 weeks to 3 months) in more than 75% of cases. If the strings are too long, they can be cut at the first routine follow-up visit, especially if the woman complains or if they protrude from the introitus. In general, pelvic examination and a “string check” are not required in subsequent visits (only when a problem is suspected). And they should be done only in adequately equipped facilities.

9. What kind of follow-up is necessary for women who get an IUCD postpartum?

A follow-up visit at 4 to 6 weeks postpartum is generally recommended. If possible, a pelvic examination to check and trim the strings can be conducted at that visit. Referral to an appropriate facility is required only if expulsion is suspected. If IUCD strings are not visible or palpable on pelvic examination, proper IUCD positioning can be confirmed by ultrasound or X-ray examination. A standard protocol for missing strings is provided in the Reference Manual (Annex I).

10. Is any special record-keeping or recording necessary for PPIUCD services?

Every woman should be given a card after insertion for her personal records; it should document the type of IUCD inserted, the date of insertion and the expected duration of efficacy (12 years for the Copper T). Appropriate facility guidelines for medical record-keeping should also be observed. As soon as the woman has been counseled on her PPFPP options, chosen a method and received specific counseling on that method, a note should be made to her medical record—it should be prominent enough that subsequent providers will notice it. When the IUCD is inserted, notes should be added to the client's medical record, documenting date of insertion, type of IUCD inserted, provider name and any difficulties faced, complications or unusual findings. These details should also be recorded in an insertion or delivery room register. Follow-up findings should also be noted in the appropriate register. A sample PPIUCD services data collection form is provided in the Reference Manual (Annex K).

Exercise Five: Infection Prevention Principles—Q&A

Objectives

The purpose of this activity is to:

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

Time Allotted

- As time permits in the clinical setting

Resources/Materials Needed

- Infection Prevention Manual for reference

Facilitator Guidance

- Make small pieces of paper, each with a number on it (1–8). Have participants pick a number and ask them to read out and answer the question.
- Review their answers with the answers provided below.

NOTE: This activity can be done as an exercise while waiting for clinical cases on the labor ward.

Exercise Five—Answer Key

1. Which is the most important of the standard precaution practices?
Handwashing
2. Which is the first step in instrument processing and what is its purpose?
Decontamination—to make instruments safer to handle for the person who processes them
3. What is the key difference between sterilization and high-level disinfection?
Sterilization destroys all endospores; high-level disinfection destroys only some.
4. When inserting an IUCD, the client should put on a clean gown—true or false?
FALSE. There is no need for a clean gown if the woman has been in the facility for the delivery.
5. List the two antiseptics that may be used to cleanse the cervix and vagina prior to IUCD insertion or removal.
Povidone iodine or chlorhexidine gluconate
6. If the same service provider who provided labor and delivery care conducts and inserts the IUCD (postplacental or intraccesarean), it is not necessary for him/her to change gloves—true or false?
TRUE. This provider does not always need to put on a new pair of sterile or HLD gloves for insertion of the IUCD (e.g., if the gloves have not been contaminated). Regardless of whether a new pair of gloves is worn, the IUCD should be loaded into the placental forceps inside the sterile package, to avoid directly touching the IUCD. If the IUCD is provided to the woman during the postpartum period, the provider should always wear a new pair of sterile or HLD gloves.
7. A tarnished IUCD inside its intact, sterile package is contaminated and should not be used—true or false?
FALSE. If a tarnished IUCD is inside an intact, sterile package and the expiration date has not passed, it is safe to use. The IUCD has become tarnished by a reaction of the copper of the IUCD and the sterile oxygen molecules inside the sealed package. The date on the package indicates how long the package contents remain sterile.

Role Play Exercises: Counseling Potential PPIUCD Users— Answer Key

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

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

a. How can Sr. Zenebech provide guidance to Abebech regarding her options?

b. What are Abebech’s options?

ANSWER:

This scenario is about the need for general PFP education about all methods. There are many options available to the woman, and the provider should briefly discuss them all so that the woman can make an informed decision about which would be best for her. **Sr. Zenebech** should also reinforce the client’s decision to think about PFP during pregnancy and encourage her to bring her partner or another family member to the next appointment (if either the provider or client thinks this is important). The next counseling session will be a more individualized (based on the client’s/couple’s reproductive history and intentions).

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

a. How should Dr. Ayele address Derartu’s concerns?

b. What information should Dr. Ayele provide Derartu about the IUCD?

ANSWER:

This scenario is more specifically about use of the PPIUCD. The client is considering a permanent method but is not sure she is ready. The provider should reinforce Derartu’s intention to begin thinking about PFP now, while she is pregnant. She should describe all of the long-term and permanent methods and explain how the PPIUCD will provide her with long-term but reversible contraception. Derartu can have it removed, and have immediate return to fertility, if she decides to have another baby. Dr. Ayele should gently correct Derartu’s misconceptions about the IUCD, reassure her that the

PPIUCD is safe, and explain that it can be provided very simply and easily following delivery. She might point out that the injection means that Derartu will need to return to the clinic every 3 months for her injection. With the IUCD, once it is placed, there is no need for ongoing follow-up after an initial return visit—as long as she is doing well and having no difficulty. The provider should counsel Derartu about the method-specific characteristics of the PPIUCD. Once Derartu makes a decision, whether at this or a subsequent visit, Dr. Ayele should indicate her choice—very prominently—in Derartu’s medical record.

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

a. How should the provider speak with the family about Tirhas’s wishes?

b. What are some of the important things to discuss?

ANSWER:

In this scenario, the woman expresses the need for her family to be included in the counseling about PPF options, especially about use of the IUCD. The provider needs to gently explore the ideas of the woman’s family members and understand their desires and concerns. The provider should speak to them with respect and help them to learn about the benefits of the PPIUCD, especially since it is the woman’s choice.

The provider should describe the method as being highly effective with few side effects, and especially that it does not interfere with breastfeeding. She should explain that it is long-term and can be used for 12 years. However, if the family decides at some point that they would like another child, it can be removed with immediate return of fertility. If Tirhas wants to continue the IUCD for contraception, another IUCD can be placed after 12 years, thus providing the woman with an alternative to permanent sterilization.

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

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

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

ANSWER:

The young doctor should explain that the PPIUCD has been shown to be safe, highly effective and easy to use. Perforation is extremely rare (with none reported in a large 2009 review study), and expulsion rates are lower than previously thought—especially when the IUCD is inserted using the correct postpartum techniques, which Dr. Alemtsehai learned in this training. These techniques allow the provider to insert the IUCD immediately (after vaginal birth or cesarean) or up to 48 hours postpartum.

Integrating family planning with labor and delivery care is a more efficient use of facility space and other resources, and has a great potential for meeting unmet need for family planning among postpartum women.

- Because immediate insertions are performed immediately after birth (in the same setting), they are more convenient and cost-effective for the facility, provider and clients. Immediate insertions are also associated with a lower rate of expulsion than early insertions.
- Early insertions also have advantages over asking women who have chosen the IUCD to come back at 4 to 6 weeks for “interval” insertion. Early insertions do require a separate procedure and are associated with a slightly higher expulsion rate than immediate or interval insertions. However, because early postpartum insertion is performed before the woman leaves the facility, it is much more likely to occur than an insertion planned for 4 to 6 weeks or beyond, because the woman often does not return.

Mid-training Knowledge Assessment

Using the Mid-training Knowledge Assessment

This knowledge assessment is designed to help the participants monitor their progress during the training. By the end of the training, **all** participants are expected to achieve a score of 85% or better.

The questionnaire should be given at the time in the training when all subject areas have been presented. A score of 85% or more correct indicates knowledge-based mastery of the material presented in the reference manual. For those scoring less than 85% on their first attempt, the clinical Facilitator should review the results with the participant individually and guide her/him on using the reference manual to learn the required information. Participants scoring less than 85% can retake the questionnaire at any time during the remainder of the training.

Repeat testing should be done **only** after the participant has had sufficient time to study the reference manual.

Mid-training Knowledge Assessment—Answer Sheet

Name: _____ Date: _____

Instructions: Select the single best answer to each question and either circle/tick your answer or write the letter in the blank next to the corresponding number on the answer sheet.

There are *3 types of questions* on this knowledge assessment. Please read the instructions at the beginning of each section to be certain that you know the best way to answer the question.

MULTIPLE CHOICE QUESTIONS

*Choose the one answer that is BEST from among the three answers. Each question is worth **3 points**.*

1. It is recommended that a woman wait at least 2 years after a live birth before planning the next pregnancy. The benefits of a 2-year birth-to-pregnancy interval include all of the following, EXCEPT:
 - a. It is LESS likely that the mother will be anemic during her next pregnancy.
 - b. It is MORE likely that the newborn will survive to age 2 and beyond.
 - c. It is less likely that the mother will get pre-eclampsia in her next pregnancy.

2. Which of the following combinations is necessary for a woman to use LAM as a family planning method?
 - a. She should be within 6 months postpartum, she should feed the baby every 6 hours and her menstruation should not have returned.
 - b. She should exclusively breastfeed her baby, she should be within 6 months postpartum and her menstruation should not have returned.
 - c. She should have no bleeding since delivery, she should feed the baby every 4 hours, and she should provide the baby with only breast milk and water that has been boiled and cooled.

3. Which of the following is TRUE about postpartum IUCD programs?
 - a. The Multiload IUCD is as good as the Copper T IUCD for use in the postpartum period.
 - b. Postpartum IUCDs have a retention rate of about 90% or higher.
 - c. Postpartum IUCDs are safe and convenient for women, but expulsion and perforation rates are slightly higher than for interval IUCDs.

4. Which of the following is NOT an acceptable time to insert an IUCD postpartum?
 - a. 20 minutes after expulsion of placenta
 - b. 36 hours postpartum
 - c. 2 weeks postpartum

5. Which of the following family planning methods is acceptable for a woman who has HIV and TB **and** is on antiretroviral therapy and rifampicin and is not sick?
 - a. Progestin only pills (POPs)
 - b. Intrauterine contraceptive device (IUCD)
 - c. Combined oral contraceptive pills (COCs)

6. Because of normal postpartum changes:
 - a. The IUCD strings should be trimmed to the proper length before insertion of the IUCD so that they do not interfere with recovery.
 - b. The woman should check her undergarments for expulsion of the IUCD each time after breastfeeding.
 - c. The woman is less likely to notice initial slight bleeding and cramping caused by the IUCD.

7. Which of the following is TRUE about what should be included in counseling a woman for postpartum IUCD?
 - a. Because perforation rates are higher with postpartum IUCD insertion, a doctor should perform the procedure when possible.
 - b. It is not well-suited to a multiparous woman because it may more easily fall out of the uterus.
 - c. The postpartum IUCD is a good method for women who seek to limit their number of children, as well as those who want to space pregnancies.

8. Which of the following statements about counseling women for a PPIUCD is TRUE?
 - a. It is best to wait to counsel a woman until her final antenatal care visit because then she is close to delivery and will be able to make a good decision.
 - b. You should never counsel a woman during the early/inactive stage of labor because her labor pains make it impossible for her to focus on the counseling.
 - c. A woman can be counseled about the PPIUCD and have one inserted during the first 2 days postpartum, even if she did not receive any antenatal care or previous counseling.

9. When should a clinician start counseling a woman for immediate postplacental IUCD insertion?
 - a. During the antenatal period if possible, so that she has time to think about it and consult her family, if she desires.
 - b. Before pregnancy, during the “interval,” so that she has the ability to consider her reproductive plans.
 - c. Only if the woman specifically requests counseling, to ensure she has a free choice.

10. From the list given below, choose the best antiseptic to be used to clean the vagina and cervix before placement of an IUCD postpartum:
- 65% alcohol
 - Dettol
 - Povidone iodine
11. Which of the following statements is TRUE about a tarnished (discolored) Copper T 380A IUCD still inside the undamaged, sealed package?
- It should not be used and should be discarded.
 - It can be used if it has not expired (based on the expiration date).
 - It can be used, but will only be effective until the expiration date.
12. Which of the following will REDUCE the chance that a woman who receives an immediate postpartum IUCD will develop a uterine infection?
- The “no-touch” technique is used for insertion of the IUCD.
 - The IUCD should be handled only with sterile or HLD gloves.
 - If possible, the woman should be given a 7-day supply of oral antibiotics before discharge.
13. For which of the following clients is the postpartum IUCD NOT a good contraceptive choice?
- A woman who is HIV-positive and on antiretroviral therapy.
 - A woman who was treated for chlamydia in her third trimester.
 - A woman who has had an ectopic pregnancy in the past.
14. If a woman is having a normal, full-term vertex vaginal delivery, some of the following WHO MEC Category 3/4 exclusion criteria can reasonably be considered irrelevant. Examples include:
- Current infection with gonorrhea or chlamydia
 - Ovarian cancer
 - Distorted uterus or abnormally shaped reproductive tract
15. You are requested to see a woman who is 36 hours postpartum from a vaginal delivery. She received three ANC visits at an unknown clinic and is interested in PPIUCD. Which of the following suggests that you should NOT perform a postpartum insertion of an IUCD?
- On postpartum Day 1, she had a maximum temperature of 37.4°C.
 - She had a 4th degree laceration and needed extensive perineal repair.
 - She was cared for in early labor by a family member and came to the hospital when she was 5 cm dilated, with intact membranes.

16. Which of the following is the best technique to insert an IUCD throughout the first 48 hours following a vaginal birth?
- Using a Kelly placental forceps
 - Using the hand (manually)
 - Using an inserter tube and plunger, if available
17. Which of the following approaches is MOST LIKELY to ensure that an IUCD is properly placed at the fundus and will stay there?
- Perform manual insertion, so that you can feel that the IUCD is at the fundus.
 - Release the IUCD from the forceps at the fundus and move the forceps to the side, keeping them open, before withdrawing the forceps.
 - Apply counter-traction by holding firmly on the anterior lip of the cervix while moving the IUCD directly upward toward the fundus.
18. Which of the following statements is TRUE regarding active management of third stage of labor (AMTSL) and postpartum IUCD insertion?
- The dose of oxytocin should be reduced to 5 units to reduce the risk of expulsion.
 - Active management should be performed after insertion of the IUCD or it will be too difficult to insert the IUCD.
 - AMTSL should be done as normal, including uterine massage to ensure uterine tone before inserting the IUCD.
19. Which one of the following is FALSE about the IUCD strings?
- The strings usually spontaneously descend and pass through the cervix during uterine involution.
 - The woman does not need to check for the strings each month because most women will know if the IUCD has fallen out.
 - The provider should trim the strings before insertion of the IUCD postpartum.
20. Which of the following is essential at every follow-up visit of a woman with an IUCD?
- Tell the woman for how long she should keep her IUCD.
 - Review her understanding of the IUCD and ask if she has any questions.
 - Perform a pelvic exam to look for the strings or a partially protruded IUCD.

MULTIPLE TRUE—FALSE

Each subject or topic is followed by several statements. For each of the statements, indicate (by circling or underlining) whether the statement is true or false. Each statement is worth **2 points**.

21. In general, regarding postpartum return to fertility:
- a. At 6 months, most postpartum women are exclusively breastfeeding and therefore do not need additional contraception. **TRUE or FALSE**
 - b. Before a year postpartum, most women's menstrual cycle has returned, and therefore they are at risk of pregnancy. **TRUE or FALSE**
 - c. Only after a woman's menstrual cycle has returned is she able to get pregnant. **TRUE or FALSE**
 - d. Slightly less than half of women resume sexual activity again within 8 months postpartum. **TRUE or FALSE**
22. Postpartum involution of the uterus causes which of the following changes:
- a. The cervix becomes softer. **TRUE or FALSE**
 - b. The uterus becomes smaller. **TRUE or FALSE**
 - c. Slight postpartum bleeding and discharge, known as lochia, continues for several days to weeks following the delivery. **TRUE or FALSE**
 - d. It becomes easier to reach the uterine fundus to insert the IUCD. **TRUE or FALSE**
23. Which of the following steps for the insertion of an IUCD during a caesarean section are correct/true?
- a. The IUCD must be placed high in the fundus of the uterus, using either a hand or an instrument. **TRUE or FALSE**
 - b. The strings of the IUCD must then be passed through the cervical canal. **TRUE or FALSE**
 - c. While closing the uterine incision, special care must be taken to ensure that the strings do not get entangled in the uterine repair. **TRUE or FALSE**

SHORT ANSWER

Write the word or phrase that *BEST* completes the sentence or makes the most sense in the blank space in the sentence. Each answer is worth **3 points**.

24. A woman has just delivered a healthy baby and, according to her records and your previous discussion with her, she has requested insertion of an IUCD in the postplacental period. Before insertion, you need to assess for three labor characteristics/factors that suggest you should not insert the IUCD now. One is unresolved postpartum hemorrhage. What are the other two conditions?

25. After __ hours postpartum, the PPIUCD should not be inserted due to increased risk of expulsion. This is a WHO MEC Category 3 condition.

26. The BEST instrument for insertion of the PPIUCD during the immediate postpartum period is the __ because it is long enough to reach the fundus, and rigid enough to get around the sharp angle between the vagina and uterus.

27. Following immediate postpartum insertion of the IUCD, a woman should be requested to return to the facility for follow-up _____.

28. The three MOST important steps in the insertion technique to reduce the risk of spontaneous expulsion of the PPIUCD are:

Bonus Question!

A woman should not be counseled for postplacental insertion of the IUCD for the first time during active labor. The reason for this precaution is because:

Mid-training Knowledge Assessment—Answer Key

Name: _____ Date: _____

Instructions: Select the single best answer to each question and either circle/tick your answer or write the letter in the blank next to the corresponding number on the answer sheet.

There are *3 types of questions* on this knowledge assessment. Please read the instructions at the beginning of each section to be certain that you know the best way to answer the question.

MULTIPLE CHOICE QUESTIONS

*Choose the one answer that is BEST from among the three answers. Each question is worth **3 points**.*

1. It is recommended that a woman wait at least 2 years after a live birth before planning the next pregnancy. The benefits of a 2-year birth-to-pregnancy interval include all of the following, EXCEPT:
 - a. It is LESS likely that the mother will be anemic during her next pregnancy.
 - b. It is MORE likely that the newborn will survive to age 2 and beyond.
 - c. **IT IS LESS LIKELY THAT THE MOTHER WILL GET PRE-ECLAMPSIA IN HER NEXT PREGNANCY.**

2. Which of the following combinations is necessary for a woman to use LAM as a family planning method?
 - a. She should be within 6 months postpartum, she should feed the baby every 6 hours and her menstruation should not have returned.
 - b. **SHE SHOULD EXCLUSIVELY BREASTFEED HER BABY, SHE SHOULD BE WITHIN 6 MONTHS POSTPARTUM AND HER MENSTRUATION SHOULD NOT HAVE RETURNED.**
 - c. She should have no bleeding since delivery, she should feed the baby every 4 hours, and she should provide the baby with only breast milk and water that has been boiled and cooled.

3. Which of the following is TRUE about postpartum IUCD programs?
 - a. The Multiload IUCD is as good as the Copper T IUCD for use in the postpartum period.
 - b. **POSTPARTUM IUCDS HAVE A RETENTION RATE OF ABOUT 90% OR HIGHER.**
 - c. Postpartum IUCDs are safe and convenient for women, but expulsion and perforation rates are slightly higher than for interval IUCDs.

4. Which of the following is NOT an acceptable time to insert an IUCD postpartum?
 - a. 20 minutes after expulsion of placenta
 - b. 36 hours postpartum
 - c. **2 WEEKS POSTPARTUM**

5. Which of the following family planning methods is acceptable for a woman who has HIV and TB and is on antiretroviral therapy and rifampicin, and is not sick?
 - a. Progestin only pills (POPs)
 - b. **INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)**
 - c. Combined oral contraceptive pills (COCs)

6. Because of normal postpartum changes:
 - a. The IUCD strings should be trimmed to the proper length before insertion of the IUCD so that they do not interfere with recovery.
 - b. The woman should check her undergarments for expulsion of the IUCD each time after breastfeeding.
 - c. **THE WOMAN IS LESS LIKELY TO NOTICE INITIAL SLIGHT BLEEDING AND CRAMPING CAUSED BY THE IUCD.**

7. Which of the following is TRUE about what should be included in counseling a woman for postpartum IUCD?
 - a. Because perforation rates are higher with postpartum IUCD insertion, a doctor should perform the procedure when possible.
 - b. It is not well-suited to a multiparous woman because it may more easily fall out of the uterus.
 - c. **THE POSTPARTUM IUCD IS A GOOD METHOD FOR WOMEN WHO SEEK TO LIMIT THEIR NUMBER OF CHILDREN, AS WELL AS THOSE WHO WANT TO SPACE PREGNANCIES.**

8. Which of the following statements about counseling women for a PPIUCD is TRUE?
 - a. It is best to wait to counsel a woman until her final antenatal care visit because then she is close to delivery and will be able to make a good decision.
 - b. You should never counsel a woman during the early/inactive stage of labor because her labor pains make it impossible for her to focus on the counseling.
 - c. **A WOMAN CAN BE COUNSELED ABOUT THE PPIUCD AND HAVE ONE INSERTED DURING THE FIRST 2 DAYS POSTPARTUM, EVEN IF SHE DID NOT RECEIVE ANY ANTENATAL CARE OR PREVIOUS COUNSELING.**

9. When should a clinician start counseling a woman for immediate postplacental IUCD insertion?
- DURING THE ANTENATAL PERIOD IF POSSIBLE, SO THAT SHE HAS TIME TO THINK ABOUT IT AND CONSULT HER FAMILY, IF SHE DESIRES.**
 - Before pregnancy, during the “interval,” so that she has the ability to consider her reproductive plans.
 - Only if the woman specifically requests counseling, to ensure she has a free choice.
10. From the list given below, choose the best antiseptic to be used to clean the vagina and cervix before placement of an IUCD postpartum:
- 65% alcohol
 - Dettol
 - POVIDONE IODINE**
11. Which of the following statements is TRUE about a tarnished (discolored) Copper T 380A IUCD still inside the undamaged, sealed package:
- It should not be used and should be discarded.
 - IT CAN BE USED IF IT HAS NOT EXPIRED (BASED ON THE EXPIRATION DATE).**
 - It can be used, but will only be effective until the expiration date.
12. Which of the following will REDUCE the chance that a woman who receives an immediate postpartum IUCD will develop a uterine infection?
- THE “NO-TOUCH” TECHNIQUE IS USED FOR INSERTION OF THE IUCD.**
 - The IUCD should be handled only with sterile or HLD gloves.
 - If possible, the woman should be given a 7-day supply of oral antibiotics before discharge.
13. For which of the following clients is the postpartum IUCD NOT a good contraceptive choice?
- A woman who is HIV-positive and on antiretroviral therapy.
 - A WOMAN WHO WAS TREATED FOR CHLAMYDIA IN HER THIRD TRIMESTER.**
 - A woman who has had an ectopic pregnancy in the past.

14. If a woman is having a normal, full-term vertex vaginal delivery, some of the following WHO MEC Category 3/4 exclusion criteria can reasonably be considered irrelevant. Examples include:
- Current infection with gonorrhea or chlamydia
 - Ovarian cancer
 - DISTORTED UTERUS OR ABNORMALLY SHAPED REPRODUCTIVE TRACT**
15. You are requested to see a woman who is 36 hours postpartum from a vaginal delivery. She received three ANC visits at an unknown clinic and is interested in PPIUCD. Which of the following suggests that you should NOT perform a postpartum insertion of an IUCD?
- On postpartum Day 1, she had a maximum temperature of 37.4°C.
 - SHE HAD A 4TH DEGREE LACERATION AND NEEDED EXTENSIVE PERINEAL REPAIR.**
 - She was cared for in early labor by a family member and came to the hospital when she was 5 cm dilated, with intact membranes.
16. Which of the following is the best technique to insert an IUCD throughout the first 48 hours following a vaginal birth?
- USING A KELLY PLACENTAL FORCEPS**
 - Using the hand (manually)
 - Using an inserter tube and plunger, if available
17. Which of the following approaches is MOST LIKELY to ensure that an IUCD is properly placed at the fundus and will stay there?
- Perform manual insertion, so that you can feel that the IUCD is at the fundus.
 - RELEASE THE IUCD FROM THE FORCEPS AT THE FUNDUS AND MOVE THE FORCEPS TO THE SIDE, KEEPING THEM OPEN, BEFORE WITHDRAWING THE FORCEPS.**
 - Apply counter-traction by holding firmly on the anterior lip of the cervix while moving the IUCD directly upward toward the fundus.
18. Which of the following statements is TRUE regarding active management of third stage of labor (AMTSL) and postpartum IUCD insertion?
- The dose of oxytocin should be reduced to 5 units to reduce the risk of expulsion.
 - Active management should be performed after insertion of the IUCD or it will be too difficult to insert the IUCD.
 - AMTSL SHOULD BE DONE AS NORMAL, INCLUDING UTERINE MASSAGE TO ENSURE UTERINE TONE, BEFORE INSERTING THE IUCD.**

19. Which one of the following is FALSE about the IUCD strings?
- The strings usually spontaneously descend and pass through the cervix during uterine involution.
 - The woman does not need to check for the strings each month because most women will know if the IUCD has fallen out.
 - THE PROVIDER SHOULD TRIM THE STRINGS BEFORE INSERTION OF THE IUCD POSTPARTUM.**
20. Which of the following is essential at every follow-up visit of a woman with an IUCD?
- Tell the woman for how long she should keep her IUCD.
 - REVIEW HER UNDERSTANDING OF THE IUCD AND ASK IF SHE HAS ANY QUESTIONS.**
 - Perform a pelvic exam to look for the strings or a partially protruded IUCD.

MULTIPLE TRUE—FALSE

Each subject or topic is followed by several statements. For each of the statements, indicate (by circling or underlining) whether the statement is true or false. Each statement is worth 2 points.

21. In general, regarding postpartum return to fertility:
- At 6 months, most postpartum women are exclusively breastfeeding and therefore do not need additional contraception. **TRUE** or **FALSE**
 - Before a year postpartum, most women's menstrual cycle has returned, and therefore they are at risk of pregnancy. **TRUE** or **FALSE**
 - Only after a woman's menstrual cycle has returned is she able to get pregnant. **TRUE** or **FALSE**
 - Slightly less than half of women resume sexual activity again within 8 months postpartum. **TRUE** or **FALSE**
22. Postpartum involution of the uterus causes which of the following changes:
- The cervix becomes softer. **TRUE** or **FALSE**
 - The uterus becomes smaller. **TRUE** or **FALSE**
 - Slight postpartum bleeding and discharge, known as lochia, continues for several days to weeks following the delivery. **TRUE** or **FALSE**
 - It becomes easier to reach the uterine fundus to insert the IUCD. **TRUE** or **FALSE**

23. Which of the following steps for the insertion of an IUCD during a caesarean section are correct/true?
- The IUCD must be placed high in the fundus of the uterus, using either a hand or an instrument. **TRUE** or **FALSE**
 - The strings of the IUCD must then be passed through the cervical canal. **TRUE** or **FALSE**
 - While closing the uterine incision, special care must be taken to ensure that the strings do not get entangled in the uterine repair. **TRUE** or **FALSE**

SHORT ANSWER

Write the word or phrase that *BEST* completes the sentence or makes the most sense in the blank space in the sentence. Each answer is worth **3 points**.

24. A woman has just delivered a healthy baby and, according to her records and your previous discussion with her, she has requested insertion of an IUCD in the postplacental period. Before insertion, you need to assess for three labor characteristics/factors that suggest you should not insert the IUCD now. One is unresolved postpartum hemorrhage. What are the other two conditions?
- Presence of chorioamnionitis**
 - Rupture of membranes for 18 hours or greater**
25. After 48 hours postpartum, the PPIUCD should not be inserted due to increased risk of expulsion. This is a WHO MEC Category 3 condition.
26. The BEST instrument for insertion of the PPIUCD during the immediate postpartum period is the **Kelly placental forceps** because it is long enough to reach the fundus, and rigid enough to get around the sharp angle between the vagina and uterus.
27. Following immediate postpartum insertion of the IUCD, a woman should be requested to return to the facility for follow-up **after 4 weeks, at 6 weeks, OR by 12 weeks** [Note: All of these answers acceptable, but 6 weeks may be most convenient because of the routine postpartum 6-week visit.]
28. The three MOST important steps in the insertion technique to reduce the risk of spontaneous expulsion of the PPIUCD are:
- Use a long instrument, like Kelly placental forceps, in order to reach the uterine fundus.**
 - “Elevate” the uterus by pushing it up into the abdomen, to reduce the vagino-uterine angle.**
 - Withdraw the forceps carefully to avoid displacing the IUCD.**

Bonus Question!

A woman should not be counseled for postplacental insertion of the IUCD for the first time during active labor. The reason for this precaution is because:

The woman needs to fully understand the benefits and limitations of the IUCD, and be free to choose the method. It is difficult for her to do this when she is focused on the process of labor and birth. Insertion the IUCD in women without their informed choice and consent not only violates the rights of that individual woman, but it also can undermine an otherwise successful PPF/PPIUCD program. Women who feel they were pressured into getting a PPPIUCD (or any other method) may share their experience with other women and discourage them from getting the method or using the PPF services.

Clinical Practice, Assessment and Qualification

Using the Counseling Guide

The **counseling guide** (page 1-32 to 1-38) is provided to structure the development and assessment of PPF and PPIUCD counseling skills. It recognizes that counseling is not a linear process that requires a rigid sequence of steps. Instead, counseling is a two-way, interactive process that is shaped by a variety of factors—such as the woman’s reproductive intentions, health and life situation, as well as methods that are available and desirable to the woman. Some of the “steps” in counseling may overlap or be done simultaneously, while others are done only at the appropriate moment or as needed.

Participants should use the counseling guide to structure their approach to counseling clients about PPF and PPIUCD, and to master the content and practice the skills involved. The main counseling principles are in the left hand column and techniques for each principle are in the next column. Facilitators (and participants) should follow along with the counseling guide when they observe a participant providing counseling services, either in simulations or the clinical setting. They should provide feedback based on (or make specific comments in) the counseling guide to help the participant to improve his or her performance.

When the participant is ready to be assessed, either for readiness to work with clients or for qualification, the **Facilitator** uses the counseling guide as a formal assessment tool to evaluate the competency of the participant in providing counseling services. As in the clinical skills checklists, there is a space at the end of the counseling guide where the Facilitator can make a notation when the participant has achieved competency in counseling in simulation and with actual clients.

Using the Clinical Skills Checklists

The **skills checklists** (pages 1-41 to 1-54) for this training represent the critical steps that must be performed by the participant/service provider to correctly and safely carry out the procedures that are part of high-quality PPIUCD services. These checklists incorporate counseling (although not in detail), client screening and infection prevention practices—in addition to the IUCD insertion technique itself—in a single tool designed for both learning and assessment.

The level of detail in the checklists is limited to what is necessary to understand the essential steps for IUCD insertion. Additional information about the procedure (including the rationales, helpful tips, precautions and illustrations) is contained in the Handout of the reference manual that deals with the insertion technique.

The participant uses these checklists to learn the steps of insertion and to guide practice of these clinical skills. The Facilitator *and* participants use the checklists when observing a participant during skills acquisition and practice—in the skills lab or the clinical setting—to provide detailed, specific feedback to the participant. The steps of the checklist provide an explicit, agreed-upon list of essential steps, and thus make the learning process easier and assessment more objective and “transparent” (in that participants know exactly what the Facilitator will be assessing).

The Facilitator uses these checklists more formally as well, to determine whether the participant has achieved skill competency in each of the different PPIUCD insertion techniques. Each

checklist will be used in the skills lab (with anatomic models) to determine the participant's readiness to practice in the clinical setting with actual clients. The Facilitator will also use it to determine whether the participant can be qualified to provide PPIUCD services.

The evaluation criteria for use of the checklists are noted at the top of each checklist. A step is performed according to the standard or it is not. The checklists are written in a way to minimize ambiguity and therefore be more objective. Facilitators will determine whether the step was performed correctly and will mark it following the instructions in the table that appears at the top of every checklist:

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

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

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

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

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

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

The columns marked **CASES** at the right of the checklists are for noting the observation of the observer or Facilitator during practice and assessment opportunities. The observer or Facilitator should also make some specific comments or notations on the checklist, which will give the participants explicit, objective guidance for improving their skills.

This training package contains four clinical skills checklists. Unfortunately, there is not an adequate anatomic model for each of these insertion techniques. Therefore, the following recommendations are made about initial assessment of participants in the clinical skills learning lab using these checklists.

- *Postplacental Instrumental Insertion* (page 1-41)—Use the checklist with the recommended postpartum IUCD insertion model. Focus directly on the insertion technique because clients who accept the method in the immediate postplacental period have typically been counseled during ANC.
- *Postplacental Manual Insertion* (page 1-45)—Same as above.
- *Postpartum Insertion* (page 1-51)—Use the checklist with the recommended postpartum IUCD insertion model. In addition to assessing clinical skills, evaluate the participant's counseling approach since these clients often have presented to the facility without the opportunity for adequate counseling in the antenatal period.
- *Intracerebral Insertion* (page 1-48)—Use the checklist along with an illustration of the immediate postpartum uterus during cesarean section. Alternatively, use a hot-water bottle with a slit in the lower segment to approximate the postpartum uterus during cesarean section. Ask participants to follow all of the steps in the process of insertion using one of these items.

When assessing participants' competency in the skills lab, ensure that the assessment scenario is as close to reality as possible. Follow the guidance in the *Set-Up of Clinical Skills Practice Station* (page 2-58). Once participants are competent with anatomic models, allow them to gain experience with actual clients in the clinical settings. Again, use the checklists for assessment of competency in the clinical area.

At the end of the checklist is a summary notation of competence that is filled in and signed by the Facilitator. It is the Facilitator's affirmation that the participant has adequately performed the skill, first in the skills lab with models, and then in the clinical setting with clients. The certification of each clinical skill is part of the overall requirements for achievement of the objectives of the training and, ultimately, qualification of the participant.

Facilitator Certification

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

Qualification

This clinical training is designed to produce qualified service providers capable of providing PPIUCD services to postpartum women. Qualification is a statement by the Facilitators that the participant has met the requirements of the training in knowledge, skills and practice. Qualification does **not** imply certification.

Qualification is based on the participant's achievement in three areas:

- **Knowledge:** A score of at least 85% on the Mid-training Knowledge Assessment
- **Skills:** Satisfactory performance of postpartum IUCD counseling and clinical skills
- **Practice:** Demonstrated ability to provide postpartum IUCD services in the clinical setting

Evaluating the Achievement of Knowledge

At the beginning of the training, participants take a Pre-training Knowledge Assessment that provides both the individual participant and the clinical Facilitator a sense of what areas should be priorities during the training. The group's performance on this assessment helps the Facilitator to plan for activities and learning interventions during the training.

Before the end of the training, the participants take a Mid-training Knowledge Assessment, which evaluates whether the participant has gained the knowledge needed for safe and correct service provision. The passing score is set at 85%. If participants do not score 85% or above on their first attempt, they will be asked to repeat the knowledge assessment prior to completion of the training. This is a fundamental principle of mastery learning—for every participant to be supported in mastering the critical content of the training before the training is completed.

Section Two: Guide for Facilitators

There are several things to consider if the participant needs to take the Mid-training Knowledge Assessment again:

- Ensure confidentiality. Do not announce publically who will be asked to repeat the knowledge assessment.
- Review the questionnaire with the participant to determine if there is confusion or lack of understanding about the material.
- Identify a time and a place to retake the assessment.
- Allow the participant time to review the material again before taking the assessment.
- If possible, use a different knowledge assessment questionnaire. If another one is not available, then use the same questionnaire.
- Mark the examination immediately, so that the participant is aware of his or her performance, as well as being able to manage the logistics of certificate distribution in a timely manner.
- If a participant retakes the exam, his or her final score on the exam should still only be the minimum passing score of 85%.

Evaluating the Achievement of Skills

Participants will develop counseling and clinical skills in the clinical skills lab, as well as in the hospital or clinical setting. The clinical skills checklists are used to assess that the participant has achieved skill competency. In this training, as in others, there are multiple skills to be learned by the participants. The Facilitator and participants, therefore, use the Skills Tracking Sheet to record the development of numerous competencies.

The Facilitator acts as a clinical coach to participants as they develop their clinical skills. The checklists should be used to objectively assess the performance of each step in the clinical skill.

When using the checklist, Facilitators should offer specific and detailed feedback to participants so that they may improve their performance and ultimately achieve skill competency. At the bottom of each checklist and counseling tool is a box where the Facilitator signs that the participant has achieved competency in the skill. It should be noted when the participant develops competency in the practice setting of the skills lab and when he/she achieves competency in the clinical area.

If a participant does not achieve competency in all the clinical skills of the training, the Facilitator, as well as the certifying organization, must make a decision about provision of the certificate. It is not acceptable to provide a certificate of qualification for the training if the participant has not achieved all the required objectives of the training. This defeats the purpose of a competency-based and mastery learning approach. Some considerations for this scenario include:

- Work in the evenings during the training to allow the participant more practice time and greater access to clinical cases.
- Arrange for the participant to remain at the training site for additional time in order to get the clinical experience required.

- Withhold the certificate and ask the participant to return to his or her facility and try to identify cases. The Facilitator will come to the facility at a specified time to work with the participant and evaluate his or her performance. Provide the certificate once all the required competencies are achieved.
- Withhold the certificate and ask the participant to return to the training site at another time when there is less competition for cases so that the participant may have greater access to clinical cases. Provide the training certificate once the participant has achieved the remaining competencies.

Evaluating the Achievement of Competency in the Clinical Practice Setting during the training, it is the clinical Facilitator's responsibility to observe each participant's overall performance in providing IUCD services. Only by doing this can the clinical Facilitator assess the way the participant uses what s/he has learned (e.g., her/his attitude toward clients). This provides a key opportunity to observe the impact of the participant's attitude on clients—a critical component of quality service delivery.

When anatomic models are used for initial skill acquisition, nearly all participants will be judged to be competent after only two to four cases. **Clinical skill proficiency**, however, invariably requires additional practice. In training of participants who will become **new** PPIUCD service providers (i.e., participants without prior training or experience), each participant may need to provide PPIUCD services to at least 5 to 10 clients in order to “feel confident” about her/his skills. Thus the judgment of a skilled clinical Facilitator is the most important factor in determining competence (i.e., whether the participant is qualified).

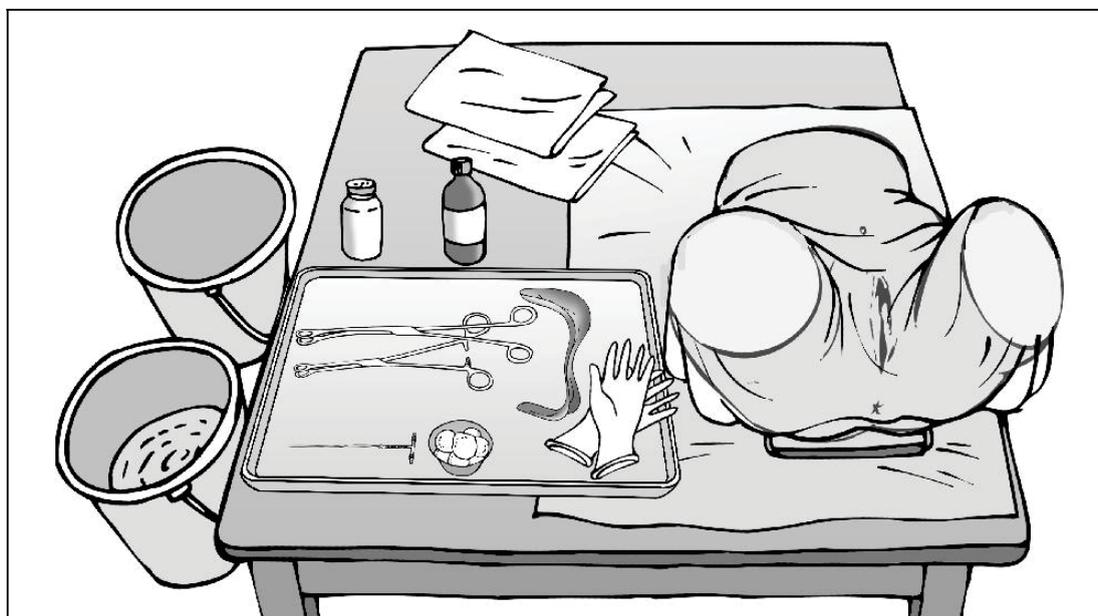
The goal of this training is to enable **every** participant to achieve competency (i.e., be qualified to provide PPIUCD services). Therefore, if additional practice is needed, additional cases may be needed to allow the participant to gain clinical confidence. This confidence is necessary for participants to be able to return to their facilities and initiate the provision of PPIUCD clinical services. Without this independence, the goal of the training is not realized and the ability of impact of the program cannot be realized.

Set-Up of Clinical Skill Practice Station

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

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

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



Items Required for the PPIUCD Insertion Skills station

<p>MODEL:</p> <ul style="list-style-type: none"> ● Postpartum IUCD insertion simulator 	<p>TRAINING AID:</p> <ul style="list-style-type: none"> ● Illustration of sink for handwashing
<p>EQUIPMENT:</p> <ul style="list-style-type: none"> ● Instruments: <ul style="list-style-type: none"> - Ring forceps (1) - Kelly placental forceps (1) - Speculum ● Cloth towels (2) ● Bowl for betadine 	<p>SUPPLIES:</p> <ul style="list-style-type: none"> ● Cotton balls ● Betadine solution ● Gloves ● Talcum powder ● Buckets: <ul style="list-style-type: none"> - 1 labeled "Waste" - 1 labeled "0.5% Chlorine"

SECTION THREE: TIPS FOR FACILITATORS

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Section Three: Tips for Facilitators

Creating a Positive Learning Environment

In addition to taking responsibility for the organization of the training, the Facilitator must be able to give presentations, conduct demonstrations and lead other training activities—effectively and efficiently—which requires:

- Careful preparation, as briefly discussed in Section Two;
- Timely execution of a plan for training preparation, as discussed in this section;
- Ensuring that the physical classroom and clinical environment are well suited to learning, as discussed in this section; and
- Effective training/facilitation skills on the part of the Facilitator, further discussed in the next section.

Well-planned and well-executed classroom and clinical sessions help to create a positive learning environment. And a positive learning environment, as is further discussed throughout this section, is critical to learning.

Training Preparation Timeline

The planning checklist below shows a suggested timeline for preparing a PPIUCD Clinical Skill Training. (See a printable handout for this checklist in the Additional Resources folder of the CD.)

TIME PRIOR TO PPIUCD TRAINING	ACTIVITY	X
3 months	Confirm the training dates.	
	Coordinate participant selection and number with program manager or appropriate other.	
	Confirm with the medical superintendent of the clinical training site.	
2 months	Confirm participants with program manager or appropriate other, including in the official invitation: the participant criteria; information about the training (such as dates, location and logistical information); and a copy of the training syllabus.	
	Initiate administrative arrangements.	
	Confirm hostel/lodging accommodations.	
	Confirm Facilitators and/or content experts.	
1 month	Order learning materials, supplies and equipment.	
	Visit the potential participants in their clinical sites (if possible).	
	Ensure that adequate supplies are available.	
	Ensure that appropriate PPIUCD service provision practices are being followed.	
	Ensure that clinic staff are aware that individuals in training will be working in the clinic and that they are aware of the training objectives.	
	Review and adapt, if necessary, training syllabus, schedule and outline.	
	Send copies of the syllabus and schedule to Facilitators.	
	Review content material and prepare for each session to be delivered by Facilitator.	
Prepare audiovisuals (transparencies, slides, flipcharts, videos, etc.).		
Arrange for all audiovisual equipment (overhead projector, LCD projector, DVD player, screen, etc.).		

TIME PRIOR TO PPIUCD TRAINING	ACTIVITY	X
1 week	Reconfirm Facilitators and/or content experts.	
	Confirm receipt of learning materials, supplies and equipment.	
	Finalize administrative arrangements.	
	Reconfirm hostel/lodging arrangements.	
1 week	Review the training syllabus.	
	Review the training outline.	
	Review the training schedule.	
	Review the checklists.	
	Review the pre- and midtraining knowledge assessments.	
	Review the PPIUCD reference manual.	
	Prepare presentation notes.	
	Assemble learning materials.	
	Prepare supporting audiovisuals.	
	Check all audiovisual equipment.	
	Prepare anatomic models, instruments and other equipment.	
	Practice clinical procedures with models.	
	Review final list of participants for information on experience and clinical responsibilities.	
	Arrange/ensure participant transportation to and from the clinical training site.	
	Visit classroom training site and confirm arrangements.	
	1 to 2 days	Arrange to set up the room the day before the training begins.
Prepare classroom.		
Make sure the furniture is arranged appropriately.		
Prepare and check audiovisual equipment and other learning aids.		
Arrange models and all needed instruments and supplies.		
Check with Co-Facilitators to be sure there are no other arrangements that need to be made.		

Classroom Preparation

In **preparing the classroom**, make sure that:

- Tables are arranged in a U-shape or other formation that will allow as many of the participants as possible to see one another and the Facilitator (this may be difficult in a lecture hall where chairs are attached to the floor).
- There is a table in the front of the room where the Facilitators can place their training materials.
- Space is available for audiovisual equipment (e.g., flipchart, screen, LCD projector, overhead projector, DVD player, monitor); the Facilitator should make sure that participants will be able to see the projection screen and other audiovisuals.
- Space is available for participants to work in small groups (i.e., either arrange chairs in small circles or work around the tables), unless separate breakout rooms (see below) are available.
- Space is available to set up simulated clinics (e.g., for activities with anatomic models or counseling practice).
- Breakout rooms are available for small group work (e.g., case studies, role plays, clinical simulations, problem-solving activities) are available if necessary, and are set up with tables, chairs and any materials that the participants will need.
- The room is properly heated or cooled and ventilated.
- The lighting is adequate, and the room can be darkened enough to show audiovisuals and still permit participants to take notes or follow along in their learning materials.
- There will be adequate electric power throughout the training, and contingency plans have been made in case the power fails.
- Furniture such as tables, chairs and desks is available. The chairs are comfortable and tablecloths are available.
- There is a writing board with chalk or marking pens, as well as an information board available for posting notes and messages for participants.
- Audiovisual equipment is in working order, with spare parts such as bulbs readily available. The video monitor is large enough so that all participants can see it well. There are sufficient electrical connections, extension cords, electrical adaptors and power strips (multi-plugs).
- There are toilet facilities that are adequately maintained.
- Telephones are accessible and in working order, and emergency messages can be taken.

Clinical Practice Site Preparation

Once an appropriate site for **clinical practice** has been selected, consider all the different aspects of clinical practice as you prepare for the activity—the physical environment, logistics, client caseload and the clinic staff. Consider the following questions when preparing for clinical practice:

- Is there **room for gathering the participants for discussion or small group activities**? You will need some space for meeting with participants before and after each clinical experience. If there are times when there are no clients, the meeting room can be used for the participants to participate in case studies, role plays or other small group activities. Arrange for a room or space before the clinical practice session.

- Again, are the **essential drugs, supplies and equipment available**? For example, for PPIUCD services, the equipment and supplies must be available. Clinical facilities must have enough instruments and supplies to provide services to clients on an ongoing basis. It may be necessary to supplement the clinic's basic supplies of consumable items (e.g., gloves, IUCDs) and to bring additional instruments needed for the procedure to be taught (or even to ask participants to bring supplies/equipment).

Another important aspect of preparing the clinical practice environment is managing **logistics**. Consider the following as you prepare:

- **With whom do you need to coordinate clinical practice?** Who in administration, the clinic or floor management needs to assist you in making arrangements for and conducting clinical practice? Arrange times with site administration and the head of the related floor or area for the clinical visit.
- **Is practice scheduled at a time when clients are available and that is convenient for clinical staff?** You should schedule practice at times when participants will have enough exposure to clients but not interfere with regular service provision.
- **What preparations are needed to ensure adequate and appropriate client flow for clinical practice sessions?** The client caseload has already been considered during selection of the clinical site, so preparations involve ensuring appropriate client caseload and flow for each clinical practice session. Consider the following as you prepare:
 - Will you need to schedule clients? Certain skills (counseling and screening) may require scheduling clients to ensure a sufficient caseload. Coordinate with the staff to arrange for a sufficient number of appropriate clients for the clinical practice visit.
 - Are there appropriate types of clients in the appropriate numbers? The type of clients is just as important as the number of clients. If clients who request certain procedures or who have specified health problems are needed, arrange with clinic staff to schedule appointments or help select appropriate clients from the wards.

Well before the training begins, **recruit clients through a health education campaign** and have them sign up to receive targeted services during the clinical practice part of the training. This can be done by posting flyers in the facility and surrounding area well in advance. The flyer should state the purpose of the training and welcome clients to participate. Clinic staff can also help spread the word.

Being an Effective Clinical Facilitator

Equally important as careful planning and preparation to creating a positive learning environment is skilled facilitation. Health professionals conducting clinical skills trainings are continually changing roles. They are most like traditional **instructors** when presenting illustrated lectures (PowerPoint slides presentations) and giving classroom demonstrations. Once they have demonstrated a clinical procedure, they shift to the role of the **coach** as the *participants* begin practicing. Throughout the training, they act as **facilitators**—especially when conducting small group discussions and using role plays, case studies and clinical simulations—helping participants move toward greater independence and confidence in developing the desired competencies.

Creating an Environment Where Learning Is Easy (or Easier)

*The environment within which learning occurs has a tremendous impact on the quality of the learning experience. A positive learning environment maximizes the effectiveness of training, thereby helping participants to achieve the training objectives. Because the **clinical Facilitator sets the tone** for the training, how she/he delivers information is the key to establishing and maintaining a positive learning environment during training—**how** something is said is as important as **what** is said. The effective Facilitator **creates an atmosphere of capability**, one that supports the participants' sense that they cannot only build competence in the new knowledge, skills and attitudes being taught, but that they can ultimately master them and apply them in their work to provide improved services to the communities they serve. Participants need to feel that they can achieve, and the Facilitator helps to build that feeling by creating and maintaining a positive learning environment—largely through **effective facilitation**.*

Characteristics of an Effective Facilitator and Coach

An effective **Facilitator**:

- Is proficient in the skills to be taught.
- Encourages participants in learning new skills.
- Promotes open (two-way) communication.
- Provides immediate feedback:
 - Informs participants whether they are meeting the training objectives.
 - Does not allow a skill or activity to be performed incorrectly (i.e., gently guides the participant toward the correct way to do something as soon as she/he begins to make mistakes).
 - Gives positive feedback as often as possible.
 - Avoids negative feedback and instead offers specific suggestions for improvement.
- Seeks and is able to receive feedback:
 - **Asks for it.** Talk to clinical skills Facilitators who will be direct with you—and participants— about your performance. Ask them to be specific and descriptive about ways you can be more effective.
 - **Directs it.** If you need additional information/input to answer a particular question or pursue a learning goal, ask for it. For example, during a demonstration, you might ask: “Does everyone have a clear view of how I am holding the instrument?”

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- **Accepts it.** Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.
- Recognizes that training can be stressful and knows how to **manage participant as well as Facilitator stress**:
 - Uses appropriate humor.
 - Observes participants and watches for signs of stress.
 - Provides regular breaks.
 - Provides changes in the training routine when needed.
 - Focuses on participant successes as opposed to failures.

Coaching is a training technique in which the Facilitator:

- Describes the skills and client interactions that the participant is expected to learn;
- Demonstrates (models) the skill in a clear and effective manner using learning aids, such as slide sets, videos and anatomic models; and
- Provides detailed, specific feedback to participants as they practice the skills and client interactions, using the anatomic model and actual instruments (if appropriate), in a simulated clinical setting and as they provide services to actual clients during practicum.

The characteristics of an **effective coach** are basically the same as those of an **effective Facilitator**; the characteristics especially important for the coach include:

- Being patient and supportive.
- Providing praise and positive reinforcement.
- Correcting participants' errors while maintaining participants' self-esteem.
- Listening and observing.

Understanding How People Learn

Being an effective clinical skills Facilitator also depends on understanding how adults learn. The Facilitator *must have a clear understanding of what the participants need and expect, and the participants must have a clear understanding of why they are there.* Adults who attend trainings to acquire new knowledge, attitudes and skills share the characteristics described below:

- Require learning to be **relevant**. The Facilitator should offer participants learning experiences that **relate directly to their current or future job responsibilities**. At the beginning of the training, the objectives should be stated clearly and linked to job performance. The Facilitator should take time to explain how each learning experience relates to the successful accomplishment of the training objectives.

- Are highly **motivated** if they believe learning is relevant. People bring **high levels of motivation and interest to** learning. Motivation can be increased and channeled by the Facilitator who provides clear learning goals and objectives. To make the best use of a high level of participant interest, the Facilitator should explore ways to incorporate the needs of each participant into the learning sessions. This means that the Facilitator needs to know quite a bit about the participants, either from studying background information about them or by allowing participants to talk early in the training about their experience and learning needs.
- Need **participation and active involvement** in the learning process. Few individuals prefer just to sit back and listen. The effective Facilitator will design learning experiences that **actively involve the participants in the training process**. Examples of how the Facilitator may involve participants include:
 - Allowing participants to provide input regarding schedules, activities and other events
 - Questioning and feedback
 - Brainstorming and discussions
 - Hands-on work
 - Group and individual projects
 - Classroom activities
- Desire a **variety** of learning experiences. The Facilitator should use a variety of learning methods including:
 - Audiovisual aids
 - Illustrated lectures
 - Demonstrations
 - Brainstorming
 - Small group activities
 - Group discussions
 - Role plays, case studies and clinical simulations
- Desire **positive feedback**. Participants need to know **how they are doing**, particularly in light of the objectives and expectations of the training. Is their progress in learning clinical skills meeting the Facilitator's expectations? Is their level of clinical performance meeting the standards established for the procedure? **Positive feedback provides this information**. Learning experiences should be designed to move from the known to the unknown or from simple activities to more complex ones. This progression provides positive experiences and feedback for the participant. To maintain positive feedback, the Facilitator can:
 - Give verbal praise either in front of other participants or in private.
 - Use positive responses during questioning.
 - Recognize appropriate skills while coaching in a clinical setting.
 - Let the participants know how they are progressing toward achieving learning objectives.

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- Have **personal concerns**. The Facilitator must recognize that many participants fear failure and embarrassment in front of their colleagues. Participants often have concerns about their ability to:
 - Fit in with the other participants.
 - Get along with the Facilitator.
 - Understand the content of the training.
 - Perform the skills being taught.
- Need an **atmosphere of safety**. The Facilitator should open the training with an introductory activity that will help participants feel at ease. It should communicate an atmosphere of safety so that participants do not judge one another or themselves. For example, a good introductory activity is one that acquaints participants with one another and helps them to associate the names of the other participants with their faces. Such an activity can be followed by learning experiences that support and encourage the participants.
- Need to be recognized as **individuals** with unique backgrounds, experiences and learning needs. A person's past experiences is a good foundation upon which the Facilitator can base new learning. To help ensure that participants feel like individuals, the Facilitator should:
 - Use participants' names as often as possible.
 - Involve all participants as often as possible.
 - Treat participants with respect.
 - Allow participants to share information with others during classroom and clinical instruction.
- Must maintain their **self-esteem**. Participants need to **maintain high self-esteem** to deal with the demands of a clinical training. Often the clinical methods used in training are different from clinical practices used in the participants' clinics. It is essential that the Facilitator shows respect for the participants, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires the Facilitator to:
 - Reinforce those practices and beliefs embodied in the training content.
 - Provide corrective feedback when needed, in a way that the participants can accept and use it with confidence and satisfaction.
 - Provide training that adds to, rather than subtracts from, their sense of competence and self-esteem.
 - Recognize participants' own career accomplishments.
- Have **high expectations** for themselves and their Facilitator. People attending trainings tend to set **high expectations both for the Facilitators and for themselves**. Getting to know their Facilitators is a real and important need. Facilitators should be prepared to talk modestly, and within limits, about themselves, their abilities and their backgrounds.
- Have **personal** needs that must be taken into consideration. All participants have personal needs during training. Taking timely breaks and providing the best possible ventilation, proper lighting, and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.

Skill Development and Assessment: The Coaching Process

No matter what type of skill the Facilitator is demonstrating—whether a psychomotor or hand skill, a clinical decision-making skill or a communication skill—the coaching methodology for skill development includes these steps or phases:

- **Demonstration** of the clinical skill by the Facilitator, using models, simulations and an assessment tool (usually a checklist) to outline critical steps. For clinical decision-making, a “demonstration” of the skill entails explaining to participants the rationale for each decision made. In this way, participants are “walked through” the thought process of a provider who is proficient in clinical decision-making.
- **Practice** of the skill by the participant (using the same checklist) with feedback from the Facilitator, first in simulation and then with clients.
- **Assessment** of the participant’s skill competency by the Facilitator in simulation and then with clients (using the same checklist).

These three phases can be broken down further into the following steps:

- First, during interactive classroom presentations, **explaining** the skill or activity to be learned.
- Next, using a video or slide set, showing the skill or activity to be learned.
- Following this, **demonstrating** the skill or activity using an anatomic model (if appropriate), role play (e.g., counseling demonstration) or clinical simulation.
- Then, allowing the participants to **practice** the demonstrated skill or activity with an anatomic model or in a simulated environment (e.g., role play, clinical simulation) as the Facilitator functions as a coach.
- After this, **reviewing** the practice session and giving constructive feedback.
- After adequate practice, **assessing** each participant’s performance of the skill or activity on models or in a **simulated situation**, using the competency-based checklist.
- After a certain level of competence is gained with models or **practice** in a simulated situation, having participants begin to practice the skill or activity with clients under a Facilitator’s guidance.
- Finally, **assessing** the participant’s ability to perform the skill according to the standardized procedure, as outlined in the competency-based checklist.

During initial skill acquisition, the Facilitator demonstrates the skill as the participant observes. As the participant practices the skill, the Facilitator functions as a coach and observes and assesses performance. When demonstrating skill competency, the participant is now the person performing the skill as the Facilitator evaluates performance.

Assessment is a continuous process: The results of assessment should be used both formatively (to help develop participant competence) and summatively (to help evaluate and make decisions about participant competence).

- In **formative assessment**, the focus is on giving feedback to participants, helping them to improve their performance and prepare for later assessments. Formative assessment has been described as “assessment FOR learning.”
- In **summative assessment**, the results are recorded and used to determine whether the participant should move on to a next phase in the training (such as from working with models to working with actual clients) and, ultimately, pass the training. Summative assessment is sometimes described as an “assessment OF learning” and is used to formally assess and document participant progress at specific times.

Note: Assessment tools such as written knowledge assessments, skills checklists and performance standards should not be modified by Facilitators. These tools have been created and validated by a group of experts to ensure that skills are developed and assessed in a standardized manner, and that the tools provide an accurate means of measuring participant competency and ultimately determining qualification.

Using Effective Presentation Skills

It is also important to use effective presentation skills. Establishing and maintaining a positive learning climate during training depend on how the Facilitator delivers information because the **Facilitator sets the tone** for the training. In any training, **how** something is said may be just as important as **what** is said. Some common techniques for effective presentations are listed below:

- **Follow a plan and use Facilitator’s notes**, which include the session objectives, introduction, body, activity, audiovisual reminders, summary and evaluation.
- **Communicate in a way that is easy to understand.** Many participants will be unfamiliar with the terms, jargon and acronyms of a new subject. The Facilitator should use familiar words and expressions, explain new language, and attempt to relate to the participants during the presentation.
- **Maintain eye contact with participants.** Use eye contact to “read” faces. This is an excellent technique for establishing rapport and getting feedback on how well participants understand the content.
- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone and inflection to maintain participants’ attention. Avoid using a monotone voice which is guaranteed to put participants to sleep!
- **Avoid the use of slang or repetitive words, phrases or gestures** that may become distracting with extended use.
- **Display enthusiasm about the topic and its importance.** Smile, move with energy and interact with participants. The Facilitator’s enthusiasm and excitement are contagious and directly affect the morale of the participants.
- **Move around the room.** Moving around the room helps ensure that the Facilitator is close to each participant at some time during the session. Participants are encouraged to interact when the Facilitator moves toward them and maintains eye contact.
- **Use appropriate audiovisual aids** during the presentation to reinforce key content or help simplify complex concepts.
- Be sure to ask both **simple and more challenging questions**.
- **Provide positive feedback** to participants during the presentation.

- **Use participants’ names as often as possible.** This will foster a positive learning climate and help keep the participants focused on the presenter.
- Display a **positive use of humor** related to the topic (e.g., humorous stories, cartoons on transparency or flipchart, cartoons for which participants are asked to create captions).
- **Provide smooth transitions between topics.** Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, participants may become confused and lose sight of how the different topics fit together in the bigger picture. Before moving on to the next topic, the Facilitator can ensure that the transition from one topic to the next is smooth by:
 - Providing a brief summary;
 - Asking a series of questions;
 - Relating content to practice; or
 - Using an application exercise (case study, role play, etc.).
- **Be an effective role model.** The Facilitator should be a positive role model in appearance (appropriate dress) and attitude (enthusiasm for the training), and by beginning and ending the session at the scheduled times.

Teaching Clinical Decision-Making

Clinical decision-making is the systematic process by which skilled providers make judgments regarding a client’s condition, diagnosis and treatment. Although the process can be difficult to teach, it can be broken down into a series of steps to facilitate discussion and learning, as shown below. As the Facilitator facilitates learning activities and assessments, she/he should identify—and encourage participants to try to identify—“where they are” in the clinical decision-making process. And depending on where they are, the Facilitator can employ a range of strategies to bring participants into, and help them navigate through, the clinical decision-making process.

- **Assessment or gathering information**—In providing PPIUCD services, this step in the process may occur during counseling (e.g., learning about the couple’s fertility intentions) or screening (e.g., identifying any medical reasons why the method should be withheld).
- **Diagnosis or interpreting the information**—In providing PPIUCD services, this step in the process may occur after the counseling and screening are completed (e.g., determining that a woman who has chosen the IUCD can safely have one inserted in the postpartum).
- **Planning or developing the care plan**—In providing PPIUCD services, this step in the process may consist of documenting the woman’s choice on her medical record so that labor and delivery room staff are aware of the woman’s choice, or ensuring that all of the necessary equipment and supplies are available and ready for use.
- **Intervention or implementing the care plan**—In providing PPIUCD services, this step would consist of the process of inserting the IUCD: beginning with ensuring that the woman has been properly counseled and screened and confirming her choice, continuing with the actual insertion, and ending with post-insertion counseling.
- **Evaluation or evaluating the care plan**—In providing PPIUCD services, this step in the process may occur during routine follow-up at 4 to 6 weeks postpartum (e.g., *Is the woman happy with her choice? Is she having any problems?*).

An important strategy in teaching clinical decision-making is to be sure that participants are aware of this step-by-step process and what occurs in each step. They also must understand that, although there is a sequence of steps for clinical decision-making, movement through the steps is rarely linear or sequential. Rather it is an ongoing, circular process in which the provider moves back and forth between the steps as the clinical situation changes and different needs or problems emerge.

Another key strategy in teaching clinical decision-making is to provide as much experience and practice in decision-making as possible. This experience, together with clinical knowledge, is a key component of successful decision-making. Teachers should:

- Expose participants to as many and as wide a **variety of clients** as possible.
- Put participants in the **clinical setting** as early as possible and provide careful guidance as they gain their experience.
- Give participants as much **structured independence** as possible; they must be given the opportunity and time to draw their own conclusions and consider their own decisions.
- Provide participants with a forum, for example, case studies, for **comparing their decisions** with the decisions made by others.

Finally, the teacher should give participants feedback on how the clinical decision-making process was applied in a given situation. This will strengthen future performance more effectively than focusing on whether or not the “correct answer” was identified. In fact, a wrong answer for the right reason should receive more positive feedback than a right answer for the wrong reason.

Tools for teaching clinical decision-making, such as job aids, are presented throughout this learning resource package. The role plays have been designed to facilitate the teaching of decision-making by reinforcing the steps involved in the process. Tools alone, however, will not effectively teach clinical decision-making. The teacher must take an active role in discussing, questioning, explaining and challenging the participants about **how** decisions are being made each time one of these tools is used—for example, “What were you thinking when you asked the client that question?” “Why did you advise the client that the PPIUCD was not a good choice for her?” And this kind of interaction must continue as the participants move into the clinical setting to work with clients.

Clinical decision-making is still a difficult skill to teach. But by beginning early in the training and continually providing practice opportunities and guidance—whether by using the tools included in this learning resource package or through experience with clients—Facilitators will help participants more fully understand the decision-making process and develop their decision-making skills. As a result, the quality of care received by clients will be improved.

Conducting Learning Activities

Every session (or learning activity) conducted during a training should begin with an **introduction** to capture participant interest and prepare the participant for learning. After the introduction, the Facilitator may deliver content using an **illustrated lecture, demonstration, small group activity** or **other learning activity**. Throughout the presentation, **questioning** techniques can be used to encourage interaction and maintain participant interest. Finally, the Facilitator should conclude the presentation with a **summary** of the key points or steps.

Delivering Interactive Presentations

Introducing Presentations

The first few minutes of any presentation are critical. Participants may be thinking about other matters, wondering what the session will be like, or have little interest in the topic. The introduction should:

- Capture the interest of the entire group and prepare participants for the information to follow.
- Make participants aware of the Facilitator's expectations.
- Help foster a positive learning climate.

The Facilitator can select from a number of techniques to provide variety and ensure that participants are not bored. Many introductory techniques are available including:

- **Reviewing the session objectives.** Introducing the topic by a simple restatement of the objectives keeps the participant aware of what is expected of her/him.
- **Asking a series of questions about the topic.** The effective Facilitator will recognize when participants have prior knowledge concerning the training content and encourage their contributions. The Facilitator can ask a few key questions, allow participants to respond, discuss answers and comments, and then move into the body of the presentation.
- **Relating the topic to previously covered content.** When a number of sessions are required to cover one subject, relate each session to previously covered content. This ensures that participants understand the continuity of the sessions and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.
- **Sharing a personal experience.** There are times when the Facilitator can share a personal experience to create interest, emphasize a point, or make a topic more job-related. Participants enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.
- **Relating the topic to real-life experiences.** Many training topics can be related to situations most participants have experienced. This technique not only catches the participants' attention, but also facilitates learning because people learn best by "anchoring" new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.
- **Using a case study, clinical simulation or other problem-solving activity.** Problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.

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- **Using a video/DVD** or other audiovisual aid. Use of appropriate audiovisuals can be stimulating and generate interest in a topic.
- **Giving a classroom demonstration.** Most clinical training trainings involve equipment, instruments and techniques that lend themselves to demonstrations, which generally increase participant interest.
- **Using a game, role play or simulation.** Games, role plays and simulations generate tremendous interest through direct participant involvement and therefore are useful for introducing topics.
- **Relating the topic to future work experiences.** Participants' interest in a topic will increase when they see a relationship between training and their work. The Facilitator can capitalize on this by relating objectives, content and activities of the training to real work situations.

Using Questioning Techniques: Questions can be used at any time to:

- Introduce a topic.
- Increase the effectiveness of the illustrated lecture.
- Promote brainstorming.
- Supplement the discussion process.

Use a variety of questioning techniques to maintain interest and avoid a repetitive style.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some participants may dominate while others may not participate.
- **Target the question to a specific participant by using her/his name prior to asking the question.** The participant is aware that a question is coming, can concentrate on the question, and respond accordingly. The disadvantage is that once a specific participant is targeted, other participants may not concentrate on the question.
- **State the question, pause and then direct the question to a specific participant.** All participants must listen to the question in the event that they are asked to respond. The primary disadvantage is that the participant receiving the question may be caught off guard and have to ask the Facilitator to repeat the question.

The key in asking questions is to avoid a pattern. The skilled Facilitator uses all three of the above techniques to provide variety and maintain the participants' attention. Other techniques follow:

- **Use participants' names** during questioning. This is a powerful motivator and also helps ensure that all participants are involved.
- **Repeat a participant's correct response.** This provides positive reinforcement to the participant and ensures that the rest of the group heard the response.
- **Provide positive reinforcement for correct responses** to keep the participant involved in the topic. Positive reinforcement may take the form of praise, displaying a participant's work, using a participant as an assistant, or using positive facial expressions, nods, or other nonverbal actions.

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- **When a participant's response is partially correct**, the Facilitator should reward the correct portion and then improve the incorrect portion or redirect a related question to that participant or to another participant.
- **When a participant's response is incorrect**, the Facilitator should make a noncritical response and restate the question to lead the participant to the correct response.
- **When a participant makes no attempt to respond**, the Facilitator may wish to follow the above procedure or redirect the question to another participant. Come back to the first participant after receiving the desired response and involve her/him in the discussion.
- **When participants ask questions**, the Facilitator must determine an appropriate response by drawing upon personal experience and weighing the individual's needs against those of the group. If the question addresses a topic that is relevant but has not been previously discussed, the Facilitator can either:
 - Answer the question and move on; or
 - Respond with another question, thereby beginning a discussion about the topic.

Summarizing Presentations

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:

- Be brief.
- Draw together the main points.
- Involve the participants.

Many summary techniques are available to the Facilitator:

- **Asking the participants for questions** gives participants an opportunity to clarify their understanding of the instructional content. This may result in a lively discussion focusing on those areas that seem to be the most troublesome.
- **Asking the participants questions** that focus on major points of the presentation helps the participants summarize what they have just heard.
- **Administering a practice exercise or test** gives participants an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a discussion by asking for correct answers and explaining why each answer is correct.
- **Using a game to review main points** provides some variety, when time permits. One popular game is to divide participants into two teams, give each team time to develop review questions, and then allow each team to ask questions of the other. The Facilitator serves as moderator by judging the acceptability of questions, clarifying answers and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

Facilitating Group Discussions

The **group discussion** is a learning method in which most of the ideas, thoughts, questions and answers are developed by the participants. The Facilitator typically serves as the **facilitator** and guides the participants as the discussion develops.

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Group discussion is useful:

- At the conclusion of a presentation
- After viewing a video
- Following a clinical demonstration or skills practice session
- After reviewing a case study or clinical simulation
- After a role play
- Any other time when participants have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when participants have limited knowledge or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When participants are familiar with the topic, the ensuing discussion is likely to **arouse participant interest, stimulate** thinking and **encourage active participation**. This interaction affords the facilitator an opportunity to:

- Provide positive feedback.
- Stress key points.
- Develop critical thinking skills.
- Create a positive learning climate.

The facilitator must consider a number of factors when selecting group discussion as the learning strategy:

- Discussions involving **more than 15 to 20 participants** may be difficult to lead and may not give each participant an opportunity to participate.
- Discussion requires **more time** than an illustrated lecture because of extensive interaction among the participants.
- A poorly **directed discussion may move off target** and never reach the objectives established by the facilitator.
- **If control is not maintained**, a few participants may dominate the discussion while others lose interest.

In addition to a **group discussion** that focuses on the session objectives, there are two other types of discussions that may be used in a training situation:

- **General discussion** that addresses participants' questions about a learning event (e.g., why one type of episiotomy is preferred over another)
- **Panel discussion** in which a moderator conducts a question-and-answer session between panel members and participants

Follow these key points to ensure successful group discussion:

- **Arrange seating to encourage interaction** (e.g., tables and chairs set up in a U-shape or a square or circle so that participants face each other).
- **State the topic** as part of the introduction.

- **Shift the conversation** from the facilitator to the participants.
- **Act as a referee** and intercede only when necessary.
Example: “It is obvious that Seema and Radhika are taking two sides in this discussion. Seema, let me see if I can clarify your position. You seem to feel that....”
- **Summarize the key points** of the discussion periodically.
Example: “Let’s stop here for a minute and summarize the main points of our discussion.”
- **Ensure that the discussion stays on the topic.**
- **Use the contributions of each participant** and provide positive reinforcement.
Example: “That is an excellent point, Rosminah. Thank you for sharing that with the group.”
- **Minimize arguments among participants.**
- **Encourage all participants to get involved.**
- **Ensure that no single participant dominates the discussion.**
- **Conclude the discussion with a summary** of the main ideas. The facilitator must relate the summary to the objective presented during the introduction.

Facilitating a Brainstorming Session

Brainstorming is a learning strategy that **stimulates thought and creativity** and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts, or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that participants have some background related to the topic.

The following guidelines will facilitate the use of brainstorming:

- **Establish ground rules.**
Example: “During this brainstorming session we will be following two basic rules. All ideas will be accepted and Jemal will write them on the flipchart. Also, at no time will we discuss or criticize any idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not....”
- **Announce the topic or problem.**
Example: “During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is ‘indications and contraindications for PPIUCD and the WHO medical eligibility criteria.’ I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Joel....”
- **Maintain a written record of the ideas and suggestions on a flipchart or writing board.**
This will prevent repetition and keep participants focused on the topic. In addition, this written record is useful when it is time to discuss each item.
- **Involve the participants and provide positive feedback** in order to encourage more input.
- **Review written ideas and suggestions** periodically to stimulate additional ideas.

- **Conclude brainstorming by reviewing all of the suggestions** and clarifying those that are acceptable.

Facilitating Small Group Activities

There are many times during training that the participants will be divided into several **small groups**, which usually consist of four to six participants. Examples of small group activities include:

- Reacting to a case study, which may be presented in writing or orally by the Facilitator, or introduced through video or slides
- Preparing a role play within the small group and presenting it to the entire group as a whole
- Dealing with a clinical situation/scenario, such as in a clinical simulation, which has been presented by the Facilitator or another participant
- Practicing a skill that has been demonstrated by the Facilitator using anatomic models

Small group activities offer many advantages including:

- Providing participants an opportunity to **learn from each other**
- **Involving** all participants
- Creating a sense of **teamwork** among members as they get to know each other
- Providing for a **variety of viewpoints**

When small group activities are being conducted, it is important that participants are not in the same group every time. Different ways the Facilitator can create small groups include:

- **Assigning** participants to groups
- Asking participants to **count off** “1, 2, 3,” etc. and having all the “1s” meet together, all the “2s” meet together, etc.
- Asking participants to **form their own groups**
- Asking participants to **draw a group number** (or group name)

The room(s) used for small group activities should be large enough to allow different arrangements of tables, chairs and teaching aids (models, equipment) so that individual groups can work without disturbing one another. The Facilitator should be able to move easily about the room to visit each group. If available, consider using smaller rooms near the primary training room where small groups can go to work on their problem-solving activity, case studies, clinical simulations, or role plays. Note that it will be difficult to conduct more than one clinical simulation at the same time in the same room/area.

Activities assigned to small groups should be **challenging, interesting and relevant**; should require **only a short time to complete**; and should be **appropriate for the background of the participants**. Each small group may be working on the same activity or each group may be taking on a different problem, case study, clinical simulation or role play. Regardless of the type of activity, there is usually a time limit. When this is the case, inform groups when there are 5 minutes left and when their time is up.

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Instructions to the groups may be presented:

- In a handout
- On a flipchart
- On a transparency
- Verbally by the Facilitator

Instructions for small group activities typically include:

- **Directions**
- **Time limit**
- A **situation or problem** to discuss, resolve or role play
- Participant **roles** (if a role play)
- **Questions** for a group discussion

Once the groups have completed their activity, the clinical training facilitator will **bring them together** as a large group for a discussion of the activity. This discussion might involve:

- **Reports** from each group
- **Responses** to questions
- **Role plays** developed in each group and presented by participants in the small groups
- **Recommendations** from each group
- **Discussion of the experience** (if a clinical simulation)

It is important that the Facilitator provide an effective summary discussion following small group activities. This provides closure and ensures that participants understand the point of the activity.

Conducting an Effective Clinical Demonstration

When a new clinical skill is being introduced, a variety of methods can be used to demonstrate the procedure. For example:

- Show **slides** or a **video** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Use **anatomic models** such as the postpartum IUCD clinical simulator to demonstrate the procedure and skills.
- Perform **role plays** in which a participant or surrogate client simulates a client and responds much as a real client would.
- Demonstrate the procedure with **clients** in the clinical setting (clinic or hospital).

Whatever methods are used to demonstrate the procedure, the Facilitator should set up the activities using the “**whole-part-whole**” approach.

- Demonstrate the whole procedure from beginning to end to give the participant a visual image of the entire procedure or activity.

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- Isolate or break down the procedure into activities (e.g., pre-operative counseling, getting the client ready, pre-operative tasks, performing the procedure, etc.) and allow practice of the individual activities of the procedure.
- Demonstrate the whole procedure again and then allow participants to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure, either using anatomic models or with clients, if appropriate, the Facilitator should use the following guidelines:

- Before beginning, **state the objectives** of the demonstration and point out what the participants should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that **everyone can see** the steps involved.
- **Never** demonstrate the skill or activity incorrectly.
- Demonstrate the procedure in as **realistic** a manner as possible, using instruments and materials in a simulated clinical setting.
- Include **all steps** of the procedure in the **proper sequence** according to the approved performance standards. This includes demonstrating “nonclinical” steps such as pre- and postoperative counseling and communication with the client during surgery, use of recommended infection prevention practices, etc.
- During the demonstration, **explain to participants what is being done**, especially any difficult or hard-to-observe steps.
- **Ask questions** of participants to keep them involved.
- Example: “What should I do next?” “What would happen if...?”
- **Encourage** questions and suggestions.
- **Take enough time** so that each step can be observed and understood. Remember that the objective of the demonstration is for participants to learn the skills, **not** for the Facilitator to show her/his dexterity and speed.
- **Use equipment and instruments properly** and make sure participants clearly see how they are handled.

In addition, participants should use a clinical skills **checklist** developed specifically for the clinical procedure to observe the Facilitator’s performance during the initial demonstration. Doing this:

- Familiarizes the participant with the use of competency-based clinical skills check lists.
- Reinforces the standard way of performing the procedure.
- Communicates to participants that the Facilitator, although very experienced, is not absolutely perfect and can accept constructive feedback on her/his performance.

As the role model the participants will follow, the Facilitator must practice what s/he **demonstrates** (i.e., the approved **standard method** as detailed in the learning guide). Therefore, it is essential that the Facilitator use the standard method. During the demonstration, the Facilitator should also provide supportive behavior and cordial, effective communication with **the client** and **staff** to reinforce the desired outcome.

Managing Clinical Practice

Getting the most out of clinical practice requires that the Facilitator be well acquainted with the clinical practice sites. Ideally, the Facilitators should be staff from the hospital or clinic where the clinical practice for the training will take place. If that is not the case, then being very familiar with the health care facility before training begins allows the Facilitator to develop a relationship with the staff, overcome any inadequacies in the situation and prepare for the best possible learning experience for participants. Even the best planning, however, is not always enough to ensure a successful clinical practice experience. In the classroom, the Facilitator is able to control the schedule and activities to a large extent; whereas in the clinic, the Facilitator must always be alert to unplanned learning opportunities that may arise at any time and be ready to modify the schedule accordingly.

Performing Clinical Procedures with Clients

The final stage of clinical skill development involves practicing procedures with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling and reacting human being. The **disadvantages** of using real clients during clinical skills training are obvious. Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. When possible and appropriate, participants should be allowed to work with clients only after they have **correctly and consistently demonstrated the skills with** an anatomic model or in a simulated situation. In this PPIUCD training, the participants are provided the opportunity to learn PPIUCD insertion techniques on Day 1. All participants should practice and be qualified in the procedure before they proceed to the clinical areas.

The **rights of clients** should be considered at all times during a clinical training training. The following practices will help ensure that clients' rights are routinely protected during clinical training:

- The right to **bodily privacy** must be respected whenever a client is undergoing a physical examination or procedure. The client should be draped appropriately for all examinations and procedures.
- The **confidentiality** of any client information obtained during counseling, history taking, physical examinations, or procedures must be strictly observed. Clients should be reassured of this confidentiality. Confidentiality can be difficult to maintain when actual cases are used in learning exercises such as case studies and clinical meetings. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.
- When receiving counseling, undergoing a physical examination, or receiving postpartum family planning services, **the client should be informed about the role of each person involved** (e.g., Facilitators, individuals undergoing training, support staff).
- The **client's permission should be obtained** before having a clinician-in-training observe, assist with, or perform any procedures. Understanding the right to refuse care from a clinician-in-training is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the Facilitator or other staff member should perform the procedure.

- The **Facilitator should be present during any client contact** in a training situation and the client should be made aware of the Facilitator’s role. Furthermore, the Facilitator should be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.
- The **Facilitator must be careful how coaching and feedback are given** during practice with clients. Corrective feedback in the presence of a client 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 the clinician-in-training.
- **Clients should be chosen carefully** to ensure that they are appropriate for clinical training purposes. For example, participants should **not** practice with “difficult” clients until they are proficient in performing the procedure.

Creating Opportunities for Learning

Planning for Learning

The Facilitator should **develop a plan for each day spent in the health care facility**. The plan will provide a daily focus that is consistent with the learning objectives and help to ensure that all required skills will be adequately addressed. When preparing the plan, the Facilitator should consider the following points:

- Clinical practice should progress from **basic to more complex skills**. This not only helps ensure the safety and quality of care provided by participants, but also allows them to gain self-confidence as they demonstrate competency in the basic skills.
- Some **opportunities for PPIUCD insertion cannot be planned or predicted**. The Facilitator must be alert to identify appropriate clinical situations and distribute them equally among the participants. Before each day’s practice, the Facilitator should ask the staff to notify her/him of any clients that may be of particular interest, so that participants can be assigned to work with them. This can be done by ensuring that the entire clinical teams on the labor and delivery or postpartum wards are aware that clinical training is taking place.

To maximize these opportunities, the Facilitator should consider the following strategies:

- **Postplacental insertions**—Review the charts of those women in labor to see if they have been counseled about the postpartum IUCD. Determine if women in latent phase labor are comfortable enough to engage in a discussion about postpartum family planning. Notify staff on the labor ward about the training and ask them to call you if additional cases arrive during the day.
- **Intracesarean insertions**—Check the morning schedule of planned cesareans. Determine if those women have been offered the IUCD as a postpartum method of family planning.
- **Early postpartum insertions**—Work with the postpartum team or postpartum counselor to identify clients who may be interested candidates. (Note: training participants should provide counseling to postpartum women about their interest in a postpartum family planning method.)
- To get sufficient clinical experience, **participants may need to work in the evening hours** when deliveries are occurring which may offer the chance to develop PPIUCD insertion skills. If this is necessary, a Facilitator or other trained clinician must accompany the participant on the labor ward.

- **There may be more participants than can be accommodated** comfortably in one area of the health care facility at the same time. Generally, three or four participants are the most that a specific area of a facility can absorb without affecting service delivery. If there are more, the Facilitator should plan a rotation system that allows each participant to have equal time and opportunity in each clinical area. In this PPIUCD training, participants will spend time in four areas:
 - The labor and delivery (L&D) unit, including the OT, for insertion experience
 - The antenatal care (ANC) clinic for experience counseling women about their postpartum family planning options
 - The postpartum unit, for counseling experience with women who before delivery had not chosen a method of postpartum family planning
 - The family planning clinic, to understand the management of complications and side effects
- In addition to daily practice of specific clinical skills, the **Facilitator’s plan should include other areas of focus** such as infection prevention, facility logistics or client flow. Although these topics may not be directly assessed with a checklist or other they play an important role in the provision of high-quality PPIUCD services. To make sure that participants give adequate attention to these topics, the Facilitator should design and develop activities that address each one, such as:
 - Observing the infection prevention practices used in the facility. Which recommended practices are being used, and which are not? Are they being used consistently and correctly? Why or why not?
 - Reviewing facility-based family planning records for the past several months to identify the types of family planning clients seen. Additional information could be obtained, such as the most common complications and side effects and how to manage them.
- Inevitably there will be **times when there are few or no opportunities for clinical practice on PPIUCD insertion with clients**. The Facilitator should have ready additional activities and learning exercises, such as those described on the schedule, for the participants. **Even without clients, learning must continue**. Taking extended breaks or leaving the clinical site early is not an acceptable option. The exercises prepared for discussion during slow periods in the clinical practice area include:
 - Exercise Three: Identify the IP Steps
 - Exercise Four: The PPIUCD Frequently Asked Questions
 - Exercise Five: Reviewing the IP Principles—Q&A

In the Health Care Facility

As has been mentioned, planning alone is not sufficient to guarantee a successful clinical practice. There are several key strategies that a Facilitator can use in the health care facility to increase the likelihood of success.

- The trainer must **actively monitor** the skills each participant is able to practice, and with what frequency, so that each participant has adequate opportunities to develop competency. A participant who demonstrates competency in postplacental insertion should not be provided additional opportunities for practice until other participants have had an opportunity to develop this competency. The Facilitators should use the Skills Tracking Sheet for tracking these competencies.

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- It is essential that the Facilitator be **flexible and constantly alert to learning opportunities** as they arise. This requires knowing about the health care facility—how it is set up and functions, the client population, etc.—as well as having a good working relationship with the staff. The Facilitator will need to rely on the staff's cooperation in notifying her/him of eligible clients and allowing participants to provide services to these clients. This relationship is most easily established if the Facilitators come from that clinical site, but can also be established beforehand, during site preparation and other visits made by the Facilitator.
- The **participants also should be encouraged to watch** for such learning opportunities. The Facilitator may then decide which, and how many, of the participants will be assigned to a particular client. The Facilitator and participants should remember that clinical experiences need to be shared equally. The participant who identifies a case may not be assigned to it if this participant has had a similar case before. It is not appropriate to subject the client to a procedure multiple times simply so that all participants can practice a skill.
- To take advantage of opportunities as they occur may require that the Facilitator **modify the plan for that day and subsequent days**, but with as little disruption as possible to the provision of services. Participants should be notified of any changes as soon as possible so that they can be well prepared for each clinical day.
- Occasionally, all participants may not have the opportunity to work with all types of clients. The Facilitator will need to **supplement, with work on anatomic models and discussions, the work done with clients**. The Facilitator will need to determine if a participant can be qualified as competent to provide PPIUCD services if he or she has not completed all the skills that are deemed the central objectives of the training.

Conducting Pre- and Post-Clinical Practice Meetings

Although every health care facility will not have a meeting room, the Facilitator must make every effort to find a space that:

- Allows **free discussion**, small group work, and practice on models.
- Is **away from the client care area** if possible, so as to not interfere with efficient client care or other staff duties.

Pre-Clinical Practice Meetings

The Facilitator and participants should meet at the beginning of each clinical practice session. The meeting should be brief. Items to be covered include:

- The learning objectives for that day
- Any scheduling changes that may be needed
- Participants' roles and responsibilities for that day, including the work assignments and rotation schedule if applicable
- Special assignments to be completed that day
- The topic for the post-clinical practice meeting, so that the participants can take special note of anything happening during the day that would contribute to the discussion
- Questions related to that day's activities or from previous days if they can be answered concisely; if not, they should be deferred until the post-clinical practice meeting

Post-Clinical Practice Meetings

The Facilitator should end each clinical day with a meeting to review the day's events and build on them as learning experiences. A minimum of 30 minutes is recommended. These meetings are used to:

- Review the day's learning objectives and assess progress toward their completion.
- Present cases seen that day, particularly those that were interesting, unusual or difficult.
- Respond to clinical questions concerning situations and clients in the health care facility or information in the reference manual.
- Plan for the next clinical session, making changes in the schedule as necessary.
- Conduct additional practice with models if needed.

The Facilitator as Supervisor

In the role of supervisor, the Facilitator must monitor participant activities in the health care facility so that:

- Each participant receives appropriate and adequate opportunities for skill practice;
- Participants do not disrupt the efficient provision of services within the facility or interfere with staff and their duties; and
- The care provided by each participant does not harm clients or place them in an unsafe situation.

The Facilitator must always be with participants when they are working with clients, especially when they are performing clinical procedures. Facilitators may have more than one or two participants to supervise. Because the Facilitator cannot be with all of them at the same time, other methods of supervision must be used.

- Participants must understand what they can do independently and what requires Facilitator supervision, so that they can keep busy when the Facilitator is involved with another participant. Participants should be made responsible for ensuring that they are supervised when necessary. The Facilitator however still holds the ultimate responsibility.
- Additional activities that require no direct supervision will give participants the opportunity to be actively engaged in learning when they are not with clients.
- Clinical staff also can act as supervisors if the Facilitator is confident of their clinical skills and ability to provide appropriate feedback. The possibility of having clinical staff supervise participants is another reason why the Facilitator should get to know the staff before the training begins. During clinical site preparation, the Facilitator can observe the skills of the staff members, and verify that they are competent, if not proficient, service providers. The Facilitator may also have the opportunity to assess their coaching skills. There may even be time to work with staff members to improve their skills so that they can serve as role models and support participant learning.
- The more participants there are in the facility, the more the Facilitator relies upon the staff to act also as Facilitators. The Facilitator has the ultimate responsibility for each participant including final assessment of skill competency. For this reason, if multiple clinical sites are used during a training, a Facilitator must be assigned to each site.

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- Because clinical staff usually is not involved in the classroom portion of a training, they do not have an opportunity to get to know the participants and their abilities before they arrive at the facility. It is a good idea to share such information with the clinical staff whenever they will have to take over a large part of the participant supervision. Clinical staff should also be encouraged to do an initial assessment of participants' skills before allowing them to work with clients so that they can feel confident that the participants are well prepared.
- Clinical staff should also be aware of the feedback the Facilitator would like to receive from them about participants.
 - Will it be oral, written, or both? If written feedback is needed, the Facilitator should design an instrument or form to guide the clinical staff. The Facilitator should furnish a sufficient number of copies of the form and instruct the staff in its use. The Facilitator should develop a form that staff members can complete quickly and easily.
 - How frequently will feedback be provided?
 - Should both positive and corrective feedback be provided?
 - Are there appropriate administrative channels through which the feedback should be transmitted? In some clinics, for example, staff members provide their feedback to the individual in charge of the health care facility who then prepares a report for the Facilitator.
- When designing the feedback system, the Facilitator should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinical staff, who already have a very busy schedule. It is best to keep the system as simple and easy to use as possible.

The Facilitator as Coach

One of the most difficult tasks for the Facilitator, and one with which even experienced Facilitators struggle, is to be a good coach and provide feedback in the clinical setting. No matter how comfortable a Facilitator may be in giving feedback in the classroom or while working with models, the situation changes in the facility. The clients, staff and other participants are nearby and the emergency services need to keep running smoothly and efficiently. The Facilitator often feels pressured to keep things moving because other clients need to be seen. The Facilitator also needs to be available to all the participants. Spending "too much time" with any one client or participant has an impact on everyone.

Feedback Sessions

The feedback sessions before and after practice are often skipped in an effort to save time. These sessions however are very important for the continued development of the participant's psychomotor or decision-making skills. Without adequate feedback and coaching, the participant may miss an important learning opportunity and take longer to achieve competency. Keep in mind that by this time the participant has already demonstrated competency on a model and may not need extensive feedback. To minimize disruption of services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.

The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is for a participant's performance with models or with clients.

- The participant should first identify personal strengths and the areas where improvement is needed.

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- Next, the Facilitator should provide specific, descriptive feedback that includes suggestions of not only what, but also how, to improve.
- Finally, the participant and the Facilitator should agree on what will be the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the Facilitator places a hand on the participant's shoulder, it is a signal to stop and wait for further instructions.

The feedback session before practice should be given before the Facilitator and participant enter the room to work with the client. The feedback session after practice can be delayed until the client's care has been completed or the client is in stable condition so that continuous care is no longer needed. The Facilitator should try not to delay feedback any longer than necessary. Feedback is always more effective when given as soon after care as possible. This will also allow the participant to use the feedback with the next client for whom services are provided, if appropriate.

Feedback during a Procedure

Be sure the client knows that the participant although already a service provider is also a participant. Reassure the client that the participant has had extensive practice and mastered the skill on models. The client should expect to hear the Facilitator talk to the participant and understand that it does not mean that something is wrong. Finally, the client should clearly understand that the Facilitator is a proficient service provider and is there to ensure that the procedure is completed safely and without delay.

Positive Feedback

Positive feedback is often easy to give and can be provided in the presence of the client. Facilitators often think that hearing feedback, even positive feedback, will disturb the client. Many clients, however, find it comforting to hear the service provider being given positive feedback.

- Keep the feedback restrained and low-key; overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, "What is being hidden?" "Why is it so surprising that this person is doing a good job?"
- Positive feedback can be conveyed by facial expression and tone of voice rather than words, and still be highly effective.

At the same time, the **absence** of feedback of any kind can be disturbing to the participant. By this phase of skill development the participant is expected to do a good job even with the first client, and is accustomed to hearing positive comments. To maintain the participant's confidence, it is still important to give positive feedback.

Corrective Feedback

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback low-key and restrained. There are a number of techniques that will make it easier.

- Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.
- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner. Do not go into lengthy explanations of why you are making the suggestion or offering an observation—save that for the post-practice feedback session.

Section Three: Tips for Facilitators

- To help a participant avoid making a mistake, the Facilitator can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the participant to name the next step before doing anything further could help avoid an error. This is not the time to ask hypothetical questions about potential side effects and complications, as this may distract the participant and alarm the client.
- Sometimes, even though they have had extensive practice on models, participants make mistakes that can potentially harm the client. In these instances, the Facilitator must be prepared to step in and take over the procedure at a moment's notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.

Where Practice Meets Reality

*Practicing in simulation (or in a classroom) is necessary preparation for gaining practical experience in the clinical setting—but the “practicing,” as such, continues. Again, true skills competency can only be achieved by practicing with actual clients. This is because part of being competent is being able to provide high-quality services in real-life situations **with living, breathing people**—despite difficult emotions, unexpected findings and other unanticipated occurrences. So although Facilitators and participants will continue to use many of the tools and methods they became familiar with in the classroom, building on what they already know, no one knows what will actually happen in the clinical setting ... not even the Facilitator. Ensuring that participants can practice and finally demonstrate the desired competencies in this “uncharted territory” requires careful planning, clear communication, flexibility and a firm commitment to protecting the safety and rights of clients—on the parts of everyone involved: the Facilitator(s), participants and clinical staff.*

