Family Planning Competency-Based Training (FBCBT) 2 Postpartum Intrauterine Contraceptive Device

Handbook for Health Service Providers

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Postpartum Intrauterine Contraceptive Device (PPIUD)

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Foreword

Postpartum family planning is the prevention of unplanned pregnancy through the extended postpartum period which is twelve (12) months following childbirth as defined by the World Health Organization (WHO). During the extended postpartum period, 95 percent of women in low-income and middle-income countries express a desire to avoid pregnancy in the next 24 months, but 70% of them are not using contraception. Based on the 2017 National Demographic and Health Survey, unmet need for family planning is 17 percent of women of reproductive age in the Philippines. More than 10 percent of Filipina women wanted to limit having children, while 7 percent wanted to delay their next pregnancy. Every year, there are close to two million births in the Philippines. The unmet need for modern family planning represents a tremendous number of missed opportunities to provide a life-saving intervention. Postpartum family planning prevents maternal, newborn, and child mortality and morbidity. Pregnancy and childbirth are windows of opportunity for the service provider to talk about pregnancy spacing or limiting because it is during this time that women access health services.

For the past years, there has been a decline in postpartum family planning services in hospitals and health facilities with birthing units. Recognizing that postpartum family planning program can substantially reduce high-risk pregnancies and unmet need for modern family planning and consequently improve the health and survival of the mother and child, the Department of Health (DOH) came up with a "National Strategy towards Reducing Unmet Need for Modern Family Planning as a Means to Achieving MDGs on Maternal Health" (AO 2012-0009). The strategy mandates the enhancement and upgrading of family planning services in public facilities and the designation of DOH regional medical centers as training centers for family planning, including postpartum family planning.

In line with the DOH initiative to reduce the unmet need for modern family planning in postpartum women, there is a need to broaden the family planning options offered to them and further capacitate the service providers by training them on the utilization of various technologies that are now available, such as postpartum intrauterine contraceptive device (IUD) and implant.

The IUD insertion immediately after giving birth and up to 48 hours after birth is one of the options that can be offered to a postpartum woman, whether she is breastfeeding or not. The postpartum IUD provides an effective, safe, and convenient method of contraception before leaving the hospital or birthing facility. The protection afforded by the IUD for 12 years makes it a good alternative for permanent methods in areas where these services are not usually available.

The development of this provider's handbook on the postpartum IUD will intensify the implementation of the Responsible Parenthood and Reproductive Health Law of 2012 by the DOH to reduce the unmet need for modern family planning, especially among postpartum women.

FRANCISCO T. DUQUE III, MD, MSC.
Secretary of Health

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Acknowledgments

The Department of Health wishes to thank the following for their invaluable assistance in the creation of this manual:

- The members of the Technical Working Group, for their tireless effort in supporting and promoting postpartum family planning in the Philippines in their respective fields and facilities, and more so in sharing their insights to ensure that this manual will be useful to health service providers:

  Dr. Rosalie Paje, Department of Health Chair
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  Dr. Hendry Plaza, MindanaoHealth Project
  Dr. Jocelyn Ilagan, Health Policy Development Program (HPDP)
  Dr. Amelia Ang, Davao Regional Medical Center
  Dr. Alicia Layug, Southern Philippines Medical Center
  Ms. Marie Grace Mateo, Jhpiego Consultant

- United States Agency for International Development (USAID) through the MindanaoHealth project implemented by Jhpiego. USAID has been a staunch partner in the creation of this guide.
- Jhpiego, an affiliate of the Johns Hopkins University, for allowing the adaptation of its learning resource package on postpartum family planning/postpartum IUD to cater to the specific training needs of the Philippines.
- Dr. Bernabe R. Marinduque, for his technical leadership and vision to implement PPFP/PPIUD in the Philippines.
- Dr. Dolores C. Castillo and Dr. Martha B. Cayad-an for their encouragement and continuous support in finalizing this manual, Dr. Ricky Lu and Jhpiego-Baltimore for technical guidance and Aldren B. Gonzales, Maharlika Filipina C. Gomez, Vic Ang III and the rest of MindanaoHealth team for final lay-out and printing of this document.
- Dr. Yolanda Oliveros and Consuelo Añonuevo, for their persistent motivation to advance the initiatives of postpartum family planning.
- Usec. Herminigildo Valle, Asec. Maria Rosario Vergeire, Dir. Myrna Cabotaje, Dir. Ruby Constantino and Dr. Diego Danila Jr. and the rest of the team at the Family Health Office, for ensuring that postpartum family planning is strengthened, especially the postpartum IUD program, a recognized life-saving intervention for mothers and their children.

This manual is largely and faithfully adapted from Jhpiego's learning resource package on PPFP/PPIUD.

Acronyms

AIDS	acquired immuno deficiency syndrome
AO	Administrative Order
AMSTL	active management of the third stage of labor
ANC	antenatal care
ARV	antiretroviral
BF	breastfeeding
BTL	bilateral tubal ligation
CBT	competency-based training
COC	combined oral contraceptive
CHC	combined hormonal contraceptive
DHS	Demographic Health Survey
DMPA	depo-medroxyprogestin acetate
DOH	Department of Health
FP	family planning
GnRH	gonadotropin-releasing hormone
HSP	health service provider
HIV	human immunodeficiency virus
HLD	high level disinfection
IUD	intrauterine contraceptive device
LAM	lactational amenorrhea method
LARC	long-acting reversible contraceptives
MDG	Millennium Development Goals
MEC	medical eligibility criteria
MNCH	maternal, neonatal and child Health
PID	pelvic inflammatory disease
PPFP	postpartum family planning
PPIUD	postpartum intrauterine contraceptive device
STI	sexually transmitted infection
WHO	World Health Organization

Introduction

This handbook for health service provider is adapted with permission from Jhpiego's PPIUD Course Notebook for Learners (2010) to suit country needs with regard to competency-based training requirements in the Philippines.

During the postpartum period, many women are not aware of their risk for unplanned 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.

When pregnancies are spaced too closely together (<24 months, from birth to next pregnancyi), 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[ii]. 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:

- 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;
- Provide the chosen method, in adherence with international global standards and local protocols;
- 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 (IUD) 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.iii Because the postpartum IUD (PPIUD) is inserted soon after birth, a woman can leave the birth facility with a safe and extremely effective, long-acting, reversible contraceptive method already in place.

Training Design

General Objective

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

Specific Objectives

At the end if clinical training course, the learner 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 postpartum IUD insertion: 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 IUD is a good option for the woman.
- Explain what is unique about the IUD in the postpartum context.
- Demonstrate appropriate counseling and assessment of antenatal women for PPFP in general and the PPIUD in particular.
- Demonstrate appropriate counseling and screening of women in early/inactive labor or the early postpartum period for insertion of the IUD.
- Ensure compliance to the principles of informed choice and volunteerism and adherence to the implementing rules and regulation of the Responsible Parenthood and Reproductive Health Law with regard to securing consent either from spouse or from parents.
- Demonstrate appropriate infection prevention practices related to IUD service provision.

Course Description

This 4-day clinical training course is designed to prepare the learner to become competent in:

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

Training Methodology

This training will be conducted in a way that is very different from traditional training courses—based on the assumption that learners:

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

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

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 PPIUD insertion)

Learning Materials

This facilitator's guide is designed to be used with the following materials:

- Family Planning Competency Based Training 2: Postpartum Intrauterine Contraceptive Device Handbook for Service Providers
- Performance standards for establishing and managing PPIUD clinical services (included in the manual)
- PPIUD insertion kit and Copper T 380A IUDs in sterile packages
- Anatomic models for practicing PPIUD insertion

Participants

This clinical skills course is designed to prepare qualified service providers (primarily maternal, newborn and child health [MNCH] providers [e.g., midwives, nurse-midwives, doctors] and other clinicians) who are capable of delivering high-quality PPIUD services to women—beginning with counseling when they are pregnant (ideally) and continuing through their first PPIUD follow-up at 4 to 6 weeks.

Selection Criteria

Learners for this course should be providers who are:

- Must have undergone FPCBT 1
- Working in a health care facility (birthing homes, lying-in clinics or hospitals) that provides women's health services such as antenatal care, labor and childbirth, and postpartum care, including family planning
- Willing to update their knowledge and acquire the skills and attitudes essential to provide PPIUD services

Methods of Assessment

A. Training Evaluation

- Pre- and Midcourse Knowledge Assessment (See Annex 1)
- Counseling Guide (antenatal and immediately after the childbirth) See Annex 2
- Clinical Skills Checklists for PPIUD services: See Annex 3
- Postplacental IUD Insertion—Instrument Technique
- Intracesarean IUD Insertion
- Early PPIUD Insertion
- Course Evaluation (to be completed by each learner) See Annex 4

B. Post-Training Evaluation

This post training evaluation is incorporated in supportive supervision and post training monitoring evaluation designed to assess competency and proficiency. Provision of certificates of competency and proficiency to the trained HSP will be decided upon recommendation of the clinical trainers to the Department of Health.

Suggested Course Composition

Four to six learners, depending upon the PPIUD caseload
Two clinical trainers

Model PPIUD Course Schedule

PPFP/PPIUD Clinical Skills Course Schedule			
4-day Course			
Day 1	Day 2	Day 3	Day 4
8:30am to 12:30pm	8:30am to 12:30pm	8:30am to 12:30pm	8:30am to 12:30pm
Welcome Introduction Learners Expectations Agenda Workshop Overview Goals and Objectives Course Materials Schedule Workshop norms Pre-course Knowledge Assessment Review of Performance Standards: Development of Personal Learning Plan Discussion: Training Design Discussion: Healthy Timing and Spacing of Pregnancy	Agenda and Warm up Review of Previous day Discussion of the pre-course knowledge assessment Discussion: Counseling and Informed Choice Discussion: Essentials of Infection Prevention Practices Practice Counseling: ANC and Postpartum clients Clinical: Insertion of post placental, post-partum, Intracesarean IUD	Agenda and Warm Up Review of previous day Midcourse Questionnaire Review of Midcourse Questionnaire Case Conference Practice: Counseling: In ANC and postpartum clients Clinical: Insertion of postplacental, postpartum, Intracesarean IUD. NOTE: Participants will go to the practicum site when clients are available	Agenda and Warm Up Case Conference Practice: Counseling: In ANC and postpartum clients Clinical: Insertion of postplacental, postpartum, Intracesarean IUD Small Group Work: Action Planning for start-up NOTE: Participants will go to the practicum site when clients are available
Lunch	Lunch	Lunch	Lunch
1:30-4:30 pm	1:30-4:30 pm	1:30-4:30 pm	1:30-4:30 pm

PPFP/PPIUD Clinical Skills Course Schedule			
4-day Course			
Day 1	Day 2	Day 3	Day 4
8:30am to 12:30pm	8:30am to 12:30pm	8:30am to 12:30pm	8:30am to 12:30pm
Energizer Discussion: PPFP Overview PPIUD Overview Insertion Techniques Video Demonstration on Model Participants practice on models Review of the Day	Energizer Case Conference Discussion Medical Eligibility/Client assessment for PPIUD Discussion: Side Effects and Complications Discussion: Recording and Reporting Review of the Day	Energizer Frequently asked question Review of client assessment Review of Skills Tracking Sheet Participants to the practicum site Review of the Day	Action Plan Implementation and monitoring presentations Transfer of learning follow up: virtual and on-site mentoring Workshop evaluation Workshop Closing
Reading Assignment and work on the performance standards	Reading Assignment and work on the performance standards	Action Plan	

SECTION 1

Module Narratives

MODULE 1:

Training Approach Used

The material in this module 1 is largely adapted from 2010 Jhpiego's PPIUD Course Notebook for Trainers

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

Key points about the mastery learning approach, as used in this course, follow:
From the outset, learners 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 trainer about course content and their performance. This makes the training less stressful.

Because people vary in their abilities to absorb new material, and learn best in different ways (e.g., through written, spoken or visual means), a variety learning methods are used. This helps to ensure that all learners have the opportunity to succeed.

Self-directed learning enables learners to become active participants in their progress toward course goals. To facilitate this learner role, the clinical trainer serves as a facilitator or "coach," rather than as more traditional instructor. Learners are also supported in identifying their own weaknesses and creating individualized plans for success.

Continual assessment increases learners' opportunities for learning. Through a variety of techniques, the trainer keeps learners informed of their progress in learning new information and skills, so that learners will know where they need to focus their efforts to achieve competency.

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

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

Behavior Modeling

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

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

In addition, the trainer is continually modeling attitudes through his/her interactions with other trainers, learners and clients. Attitudes are demonstrated and explored in certain learning activities, such as discussions and role play.

Competency-Based Training

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

An essential component of CBT is coaching. Coaching incorporates questioning, providing positive feedback and active listening to help learners develop specific competencies, while encouraging a positive learning climate. In the role of coach, the trainer 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 trainer/coach observes and interacts with the learner to provide guidance as she/he practices the skill or activity. The trainer continues monitoring learner progress—providing suggestions and feedback, as needed, to help the learner 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, learners 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 learner attempts a clinical procedure with a client, two learning activities should occur: The clinical trainer 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 learner 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 learners have correctly and consistently demonstrated skills or interactions with models or in simulation should they have their first contacts with clients.

Summary points on the training approach used in this course.

- First, it is based on adult learning principles, which means that it is interactive, relevant and practical. Moreover, it requires that the trainer facilitate the learning experience rather than serve in the more traditional role of an instructor or lecturer; this allows learners 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 learner'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 learners 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 trainer evaluates the learner's performance using the checklist, every learner should be able to perform every skill or activity competently. And this is the ultimate goal of mastery training!

Components of the PPIUD 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 learners and clinical trainer to easily adapt the training to the learners' (group and individual) learning needs. This course is built around use of the following components (further described below):

- FPCBT 2: PPIUD Handbook for Service Providers: provides all of the content needed for the course about the provision of high-quality PPIUD services. It is also a valuable resource for learner– providers when they return their workplace. This handbook also contains answer sheets, exercise prompts, counseling and skills checklists: This is the "road map" that guides the learner through each phase of the course. It contains the course syllabus and course schedule, as well as all supplemental printed materials (pre-course knowledge assessment, clinical skill checklists and course evaluation) needed during the course.
- FBCBT 2: PPIUD Facilitator's Guide are for trainers that provides 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 handbook for service providers, as well as special material for the trainer. It includes the

course outline, pre-course knowledge assessment answer key, midcourse knowledge assessment answer key, exercise answer keys and guidance for conducting the course/course activities.
- Teaching aids and audiovisual materials, such as a 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.

Aside from standardization of clinical skills, learners are expected to reach proficiency level. There is a pathway towards getting the proficiency certificate that the Department of Health issues.

What should the learners expect with regard to becoming certified PPIUD service providers?

Learners need to complete the four-day training and have at least one experience of actual PPIUD insertion. The learner then receives a CERTIFICATE OF TRAINING. However, if the learner does not complete any of the previously mentioned requirements, he or she will only receive CERTIFICATE OF APPEARANCE but the trainer will discuss with the learner on how she can comply and later on get the Certificate of Training. After training, learners should expect supportive supervision visits and post training monitoring evaluation visits from supervisors or clinical trainers to assess their competency and/ or proficiency with regard to PPIUD service provision. The CERTIFICATE OF COMPETENCY is given to the provider based on the assessment of the trainers. The training institution gives this certificate. But the CERTIFICATE of PROFICIENCY is given after PTME upon recommendation of the trainer to the Department of Health. It is the DOH that will issue this certificate. For discussions on the signatories of the certificates, please refer to Annex 5

MODULE 2:

Healthy Spacing of Pregnancies

The discussion in this module has been adapted from 2010 Jhpiego's PPIUD Trainers Guide[iv]

Healthy Spacing of Pregnancies

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

- After a live birth, a woman should wait at least 24 months (but not more than 5 years) before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes. Women should plan a healthy birth-to-birth interval of about 36 months, or 3 years, between children.
- After a miscarriage or induced abortion, a woman should wait at least 6 months before attempting the next pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes.
- Adolescents should delay first pregnancy until at least 18 years of age to reduce the risk of adverse maternal, perinatal and infant outcomes.
- Every woman and every maternal/newborn health or family planning worker should know and understand the key recommendations for healthy spacing of pregnancies.
- Key Terminology: To be able to counsel women and families effectively about healthy spacing of pregnancies, providers must clearly understand several terms.
- Birth-to-pregnancy interval: Time period between a live birth and start of the next pregnancy.
- Birth-to-birth interval: Time period between a live birth and the next live birth.
- When reviewing scientific studies or technical messages, health professionals can convert a birth- to-pregnancy interval to a birth-to-birth interval by adding 9 months to a year.

Unmet Need for PPFP

Despite the adverse health outcomes associated with short birth intervals, a significant proportion of births are spaced too closely together.

Factors That Contribute to Short Birth Intervals

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

Return to Fertility

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

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

Women often initiate family planning after their menstruation resumes. Individual studies appear to draw a correlation between return of menses and initiation of contraceptive use and suggest that family planning—if used at all during the postpartum period—is most likely to be initiated in the month following the return of menses, which is often too late. And in one study, 8%–10% of women who were still experiencing postpartum amenorrhea conceived.

Resumption of Sexual Activity

Reported return to sexual activity after a birth varies greatly. A recent study of 17 developing countries looked at percentages of couples returning to sexual activity by 3 to 5.9 months. At one end of the range is Guinea, where about 10% of women have resumed sexual activity within that timeframe; at the other end are Bangladesh and Rwanda, where almost 90% of women are having sex again by 6 months. Postpartum abstinence, in countries that practice it, is not always strictly observed. Qualitative research has indicated that even among those countries practicing postpartum abstinence, sexual activity may occur irregularly early on, gradually progressing to more regular activity.

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

Breastfeeding versus LAM

Breastfeeding itself is not a contraceptive. Exclusive breastfeeding drops off after 3 months. Although many women exclusively breastfeed their babies in the first few months following delivery, the rate drops off significantly after 3 months—which leads to return of fertility.

Preventing unintended pregnancy by opting to breastfeed is called Lactational Amenorrhea (LAM), which is 98.5 percent effective for up to 6 months postpartum—provided that the woman exclusively breastfeeds her baby on demand (whenever the baby wants, day or night;

no other food or other fluids in between), and her menses have not returned. As effective and convenient as LAM is, it still is not widely practiced.

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

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

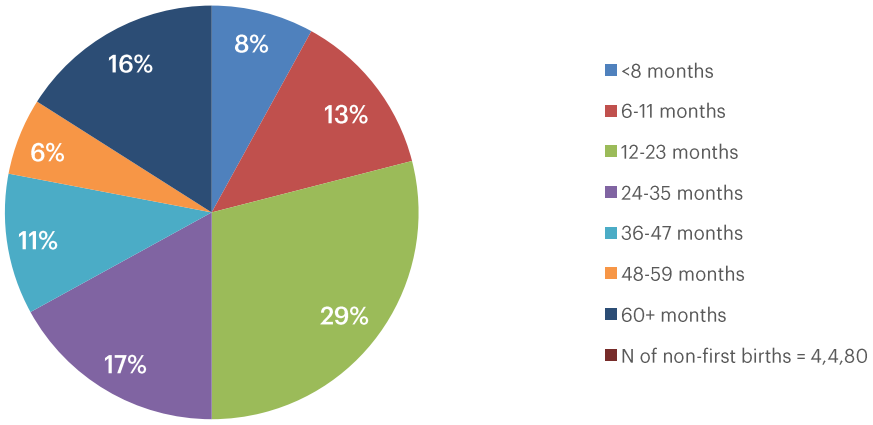
Data on Pregnancy Spacing in the Philippines

Excerpt from USAID MCHIP Advocacy Tool Family Planning Needs during the First Two Years of Postpartum in the Philippines. Refer to Annex 6, for the complete copy of the tool.

Pregnancy Spacing in the Philippines

Figure 1 presents data from women experiencing births in the past five years (2003-2008). In this analysis, only women with pregnancies that resulted in a live birth are included, and the pregnancy duration is calculated at nine months. Of these pregnancies, 8% occur within very short intervals of less than six months, 13% occur within short intervals of less than 12 months, and another 29% occur within intervals of 12–23 months. Thus, half (50%) of all pregnancies in the Philippines occur within short intervals of less than 24 months after the preceding birth.

Figure 1: Birth-to-pregnancy spacing among all women aged 15-49, all non-first births in the last five years



It is noteworthy that the 2008 Philippines DHS data demonstrate a sharp decrease in infant and childhood mortality rates as the length of the birth-to-pregnancy interval increases. Infant mortality decreases by almost half, from 35/1,000 for infants born at birth-to-pregnancy intervals <15 months, to 18/1,000 for infants born at birth-to-pregnancy intervals between 27

and 38 months. Similarly, higher rates of under-five mortality are evidenced for children born at birth-to-pregnancy intervals of less than 15 months (54/1,000) compared with children born at birth-to-pregnancy intervals between 27 and 38 months (26/1,000).

In terms of trending, when compared with 2008 data, the 2017 DHS data show a decreasing trend in under-5 and infant mortalities from 34 to 27 deaths and infant deaths from 25 to 21 deaths per 1,000 live births, respectively. The trend also shows a corresponding decrease in unmet need for family planning from 22 percent in 2008 to 17 percent in 2017 and increasing modern contraceptive method use from 34 percent in 2008 to 40 percent in 2017. (Source: NDHS 2017)

MODULE 3:

Postpartum Family Planning

The information in this module is lifted from the 2014 Family Planning Clinical Standards and Postpartum Family Planning Supplement to the Family Planning Clinical Standards

LACTATIONAL AMENORRHEA METHOD (LAM)

What is the method?

All postpartum women should be encouraged to breastfeed.

Breastfeeding in itself is not a contraceptive method. However, if the following 3 criteria of LAM are met, the method can be used as an effective contraception for a limited period of time:

1. Exclusively breastfeeding or nearly fully breastfeeding
2. Amenorrhea
3. The baby is less than 6 months old

The requirement to exclusively breastfeed means that no other liquid or solid food is given. Also, the baby is fed on demand and often, that is, at least every 4 hours during the daytime and at least every 6 hours at night.

Nearly fully or exclusively breastfeeding means that the baby is given other liquid or food in addition to breastmilk, as long as majority of feedings (more than three-fourths of all feeds) are breastmilk.

When menstruation has returned, it is a signal that the woman's fertility has returned and therefore, breastfeeding/suckling is no longer effective in preventing ovulation.

At six months, the WHO recommends supplemental feeding to be initiated, which will decrease suckling and will consequently reduce effectiveness of LAM.

Women who received LAM counseling and accepted the method are more likely to use a modern method of family planning later on when any of the criteria for LAM is no longer met or even when all 3 criteria are still met. Adding an appropriate method of contraception while the woman is still on LAM will provide continuous protection should she stop breastfeeding, start menstruation, or decide to supplement-feed the baby.

When to start LAM?

Within one hour after birth upon initiation of exclusive breastfeeding.

How effective is LAM?

- Perfect use: 99.5%
- Typical use: 98%

What is the continuation rate of the method at 1 year?

There is no 1-year continuation rate of LAM because the criteria limit its use to 6 months.

What is the mechanism of action?

Suppression of ovulation brought about by the woman's hormonal response to the baby's suckling.

What are the advantages of using the method?

- Benefits both the mother and the newborn
- Effective if the 3 criteria of LAM are strictly met
- No side effects
- All postpartum women can use LAM and exceptions are rare
- It can be started immediately right after giving birth
- No expense

What are the disadvantages and side effects of the method?

- Can only be used for a relatively short period of time
- Cannot protect the mother from STIs including HIV

Who cannot use the method? All breastfeeding women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Those with HIV infection
- Postpartum women who are using certain medications: mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, certain anticoagulants
- When the newborn has a condition (e.g. cleft lip and palate) that makes it difficult to breastfeed.

HORMONALS: PROGESTIN-Only method

PROGESTIN-ONLY PILLS

What is the method?

There are 2 preparations of oral progestin-only pill in the Philippines, namely:

- 0.5-mg Lynestrenol, a 28-day pill taken daily without any gaps, at the same time of the day, everyday
- 75-ug Desogestrel, a 28-day pill taken the same way as above

Progestin-only pill can be used both by breastfeeding and non-breastfeeding women. Many studies show that progestogens do not have adverse effects on breast milk production and quality of milk produced as well as on infant health, growth and development.

When to start the progestin-only pill?

- For breastfeeding women: start at 6 weeks postpartum
- For non-breastfeeding women: start immediately prior to discharge of the mother from the facility

How effective is the progestin-only pill?

- Perfect use: 99.5%
- Typical use: 99.0%

What is the continuation rate of the method at 1 year?

The continuation rate for is 68%.

What is the mechanism of action?

Progestin thickens the cervical mucus, which then serves as a barrier to the entry of sperm in the uterus.

What are the advantages of the method?

- more effective if used concomitantly with breastfeeding
- rapid return to fertility after discontinuation
- no side effects of estrogen
- prevents cancer of the ovary and endometrium as well as fibrocystic conditions of the breast

What are the disadvantages of the method?

- menstrual changes are the norm with users
- slow return to fertility after discontinuation
- has to return to clinic every 2 months for Norethisterone for next dose
- does not protect against STI

Who cannot use the method?

- Women who are taking Rifampicin/rifabutin, certain anti-convulsants and antiretroviral (ARV) therapy.
- Post-partum women who currently have a blood clot in the legs or lungs
- Patients who currently have or have a history of breast cancer

PROGESTIN-ONLY INJECTIBLE

What is the method?

The available progestin-only IM injections and their respective dosages are the following:

- 150-mg Depo-Medroxyprogestin Acetate (DMPA) IM given in the deltoid or gluteal muscle every 3 months
- 200-mg Norethisterone enanthate IM given in the deltoid or gluteal muscle every 2 months

Progestin-only injectable can be used by both breastfeeding and non-breastfeeding women. Many studies show that progestogens do not have adverse effects on breast milk production and quality of milk produced as well as on infant health, growth and development.

When to start the progestin-only injectable?

- For breastfeeding women: start at 6 weeks postpartum
- For non-breastfeeding women: start immediately prior to discharge of the mother from the facility

How effective is the progestin-only injectable?

- Perfect use: 99.7%
- Typical use: 97%

What is the continuation rate of the method at 1 year?

The continuation rate for DMPA is 56%.

What is the mechanism of action?

Progestin thickens the cervical mucus, which then serves as a barrier preventing the entry of sperm in the uterus.

What are the advantages of the method?

- no daily pill intake
- no side effects of estrogen
- private (which means that no one else can tell if a woman is using this as a contraception)
- prevents endometrial cancer, anemia and ectopic pregnancy

What are the disadvantages of the method?

- menstrual changes are the norm with users
- slow return to fertility after discontinuation
- requires regular visit to the clinic every 3 months for next dose
- women are not protected against HIV and STIs

Who cannot use the method?

- Women who are taking Rifampicin/rifabutin, certain anti-convulsants and ARV therapy.
- Post-partum women who currently have a blood clot in the legs or lungs
- Patients who currently have or have a history of breast cancer

SINGLE ROD SUBDERMAL IMPLANT

What is the method?

Single rod subdermal implant is a sub-dermal, long-acting, progestin-only hormonal contraceptive which is effective for 3 years. The white flexible implant contains 68 mg of etonogestrel and released at a rate of 60-70 micrograms/day by 5-6 weeks and gradually decreases to 35-45 micrograms/day at the end of the first year, 30-40 micrograms/day at the end of the second year and finally to 25-30 micrograms at the end of the third year.

As a rule, and in a regular context, the provider who wishes to insert etonogestrel implants should undergo training to ensure that the correct technique is learned and utilized. Most of the unintended pregnancies that result after insertion are due to incorrect insertion technique or administration on the wrong day of the menstrual cycle. Furthermore, if the provider is not careful the implant may fall out of the needle before insertion is completed. And if the insertion site is not palpated post-insertion to confirm the presence of a matchstick-sized implant, the missing implant could be overlooked. If the implant is inserted after the first 5 days of the menstrual cycle, the client may already have been pregnant at the time of insertion and this is incorrectly classified as contraceptive failure.

When inserting subdermal implant during postpartum, there is no issue on timing.

Post-marketing surveillance on single rod subdermal implants since 1998 did not show any deleterious effects on the fetus if the user gets pregnant even if the implant is inadvertently inserted in a pregnant client. If a user is found to be pregnant, the implant is simply removed and no additional intervention is necessary.

Single rod subdermal implant is the most effective long-acting reversible contraceptive. It is immediately effective because it is rapidly absorbed and reaches an ovulatory-inhibiting level on the first day of insertion and the maximum level is attained within 1-13 days. Fertility returns immediately after removal. Etonogestrel decreases to undetectable level within 1 week after it is removed with fertility returning usually within 3 weeks.

The ovarian function of single rod subdermal implant users is not completely suppressed. The estradiol level of users is above the level normally seen in the early follicular phase which is above the level necessary to maintain bone mass. There is evidence that bone mass in users is not adversely affected by etonogestrel.

There is evidence that insertion of single rod subdermal implant in the immediate postpartum period does not have any adverse effects on the hemostatic mechanism of the client in the first 12 weeks postpartum when the thrombosis risk is highest. Immediate postpartum insertion likewise does not have any effect on the metabolic functions of the infant and also does not influence the amount and quality of milk produced by the client. Breastfed infants ingest about 0.2% of the daily maternal dose and decreases over time as lactation is continued. Long-term data on breastfed children of single rod subdermal implant users showed no differences in growth, physical and psychomotor development compared with children whose mothers had IUDs.

When to start the method?

- Breastfeeding, partially breastfeeding and non-breastfeeding clients: the etonogestrel implant may be inserted immediately after delivery, before she is discharged from the birthing facility.
- Later than 21 days, in a client who is not on LAM is advised to use back up protection for 7 days after insertion. If the client is already sexually active and has not been using LAM, pregnancy should be excluded or the first natural period is awaited prior to insertion.

How effective is the method?

- Perfect use: 99.95%
- Typical use: 99.95%
- The effectiveness of single rod subdermal implants is not user-dependent. There are no daily routines compared with oral contraceptives or quarterly clinic appointments as with DMPA. This is ideal for postpartum women whose attention and time is primarily devoted to care their infants over themselves and hence does not have to worry about missed FP appointments.
- Drugs that reduce the effectiveness of hormonal contraceptives also decrease the effectiveness of single rod subdermal implants.

Cytochrome P450 Enzyme-inducing Drugs that Decrease Single Rod Subdermal Implant

- Anticonvulsants: Carbamazepine, hydantoins, barbiturates, oxcarbazepine
- Antituberculosis, antifungal and antiviral: Rifampicin, rifabutin, griseofulvin, ARVs for HIV
- Other liver enzyme inducers: St. John's Wort

What is the continuation rate?

- 84% continuation rate at 1 year
- Single rod subdermal implant has the best continuation rate among the reversible contraceptive methods.

What is the mechanism of action of etonogestrel implant?

Single rod subdermal implant inhibits ovulation. No ovulation occurs in the first 2 years and in the third year it may happen but rarely. In addition, it thickens the cervical mucus and makes it impenetrable to the spermatozoa.

What are the advantages of the method?

- dysmenorrhea will improve
- highly effective and long acting
- compatible with breastfeeding
- immediate effectivity and immediate return to fertility after removal
- the procedure is easy to learn

What are the disadvantages and side effects of the method?

- altered menstrual bleeding pattern, which is unpredictable. There may be
- changes in the frequency, duration and amount of bleeding
- headache
- weight gain
- acne
- breast pain/discomfort
- emotional liability
- abdominal pain
- requires a trained provider to insert

Who cannot use the method?

- Pregnant women
- Current venous thromboembolism
- Steroid-dependent tumors such as benign or malignant liver tumors and known or suspected breast cancer
- Undiagnosed vaginal bleeding
- Hypersensitivity to etonogestrel or to any of the excipients of the implant

HORMONALS: Combined Oral Contraceptive (COC) method

What are Combined Oral Contraceptive?

Combined Hormonal Contraceptives are drugs that contain hormones (estrogen and progestogen) similar to those naturally found in a woman's body. These drugs are regularly administered to prevent conception. The most widely used CHCs are COCs, which are commonly referred to as "pills."

What is the mechanism of action?

CHCs suppress ovulation or the release of an egg from the ovary.

The estrogen in CHCs creates a negative feedback mechanism that tricks the brain into thinking that the body has enough of the hormone that the ovaries no longer need to produce it. This phenomenon prevents follicular development that is necessary for ovulation. Pregnancy cannot occur without a released egg.

Aside from preventing follicular rupture during ovulation, the progesterone in CHCs makes the cervical mucus thick and impairs the entry of sperm into the uterus.

How effective is the method?

- Perfect Use 99.7%
- Typical use 92.0%

Who Can use COCs?

COCs are appropriate for most women who want a highly effective but easily reversible method for preventing pregnancy and for those who are not at risk of cardiovascular complications.

The World Health Organization (WHO) Medical Eligibility Criteria (MEC) screening checklist for CHCs should be used to determine the eligibility of the clients and the suitability of the method.

Who cannot use the method?

MEC 3- Do not use the method unless no other appropriate method is available under close supervision.

- Women aged 35 years or more who smoke less than 15 cigarettes a day
- Have increased blood pressure (systolic 140–159 or diastolic 90–99 mm Hg)
- Women aged 35 years or more (if migraine develops during use of COCs, it becomes a category 4 contraindication) who experience migraine without aura

- Have a history of breast cancer with no evidence of disease for five years
- Breastfeeding women from 6 weeks to < 6 months postpartum
- Non-breastfeeding women < 21 days postpartum without other risks for VTE
- Have mild compensated cirrhosis
- Have a history of cholestasis related to past COC use
- Have symptomatic gall bladder disease
- Women on drugs (rifampicin, rifabutin, and certain anticonvulsants) that affect liver enzymes
- Women on anti-retroviral therapy using ritonavir-boosted protease inhibitors

MEC 4 Method must not be used by women under the following condition

- Breastfeeding women < 6 weeks postpartum
- Non-breastfeeding women < 21 days postpartum with other risks for VTE
- Have a history of or recently suffered from ischemic heart disease or stroke
- Have complicated vascular heart disease
- Women aged 35 years or more who smoke 15 or more cigarettes
- Have increased blood pressure (systolic > 160 or diastolic > 100 mm Hg)
- Have hypertension with vascular disease
- Have diabetes mellitus with vascular complications (hypertension, nephropathy, retinopathy, or neuropathy) for > 20 years
- Have past or present evidence of DVT/PE
- Have systemic lupus erythematosus with positive or undetermined anti-phospholipid antibodies
- Women who have undergone major surgery with prolonged immobilization
- Suffered from breast cancer within the past five years
- Have active viral hepatitis
- Have benign or malignant liver tumor
- Have severe (decompensated) cirrhosis

MODULE 4:

Postpartum Intrauterine Contraceptive Device (PPIUD)

The discussion in the is module is lifted from Jhpiego's PPIUD Reference Manual (2010)

What Is the IUD?

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

Types of IUD found in the Philippines

- Copper-bearing: Copper T 380A
- Hormone-releasing: Mirena® and the levonorgestrel-releasing intrauterine system (LNG-IUS®)

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

Mechanism of Action

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

Duration of Action

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

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

Effectiveness

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

While the effectiveness of the Copper T with correct usevi is the same, whether it is used as a PPFP method or as an interval method, the typical-use effectiveness is influenced by a slightly higher expulsion rate of IUDs inserted in the postpartum period's Several factors appear to influence the risk of expulsion postpartum. Proper insertion to achieve high fundal placement of the IUD (more easily done immediately postpartum) is essential to ensuring IUD retention.

Side Effects

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

All women should be advised of common side effects before IUD insertion, assessed for conditions that may make the IUD a poor choice given such side effects (e.g., history of severe dysmenorrhea, severe anemia or current pelvic pain) and counseled about side effects as needed during follow-up.

Nonsteroidal anti-inflammatory drugs (NSAIDs) can lessen symptoms of painix, and good counseling can encourage continued use of the method.

Timing of PPIUD Insertion

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

Postplacental: Immediately following the delivery of the placenta (active management of the third stage of labor [AMTSL]) in a vaginal birth, the IUD is inserted with an instrument before the woman leaves the delivery room.

Intracesarean: Immediately following the removal of the placenta during a cesarean section, the IUD is inserted manually before closure of the uterine incision, before the woman leaves the operating theater.

Early postpartum: Not immediately following the delivery/removal of the placenta but within 2 days/48 hours of the birth (preferably within 24 hours, such as on the morning of postpartum Day 1), the IUD is inserted with an instrument during a separate procedure.

Key Differences and Characteristics of the PPIUD

PPIUD Advantages

Safety: The safety profile of PPIUDs is similar to that of interval IUDs.

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

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

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

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

Time and service efficiency: Inserting the IUD in the immediate postpartum period (postplacental, intracesarean) saves time for both the woman and provider—because the procedure is conducted in the same setting and involves only a few minutes of additional time. Although inserting the IUD in the early postpartum period (first 48 hours) does require a separate clinical procedure, it does not require an additional visit—which increases the

likelihood that the woman will have it done. Providing PPFP services at the birth facility also helps to relieve overcrowded outpatient facilities, allowing more women to be served.

PPIUD Limitations

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

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

PPIUD Health Risks

There is few potential health risks associated with the PPIUD. However, the lack of well-designed, peer-reviewed studies of the PPIUD leaves important questions unanswered about exact complication rates and such variables as timing and technique of insertion; these are the subject of ongoing research. Still, conclusions about the following complications can be drawn based on consistent findings across countries, clinical sites and provider type—from nurses to midwives to physicians.

Uterine perforation—In a recent systematic review of the literature regarding PPIUD insertion, there were no reported cases of uterine perforation during PPIUD insertion in any of the studies reviewed.x Perforation of the uterine wall during interval IUD insertion is rare. When it does occur, it is most often caused by the instrument used to "sound" the uterus, which is not involved in postpartum IUD insertion.

Infection—Postpartum insertion appears to have no significant effect on the risk of genital tract infection, which is very low in interval IUD insertion as well. Among continuing users of the IUD, the risk of upper genital tract infection, such as endometritis or salpingitis, is less than 1%, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is thought to be related to either insertion technique (due to lack of proper infection prevention practices) or pre-existing infection, rather than to the IUD itself. After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users.xi

Expulsion—IUD failure is rare, but the most common cause is spontaneous expulsion of the IUD from the uterus.xii Rates of spontaneous expulsion appear to be higher with the PPIUD than with

interval IUD insertions. Immediate postpartum insertion (within 10 minutes) is associated with a lower risk of expulsion than early postpartum insertion (up to 48 hours).xiii Interval insertion at 4 weeks after delivery and beyond is associated with the lowest risk of expulsion postpartum. All women who have an IUD inserted should be aware of this risk and the fact that most expulsions occur within the first 3 months after insertion.xiv

Clinical Technique for Insertion of the PPIUD

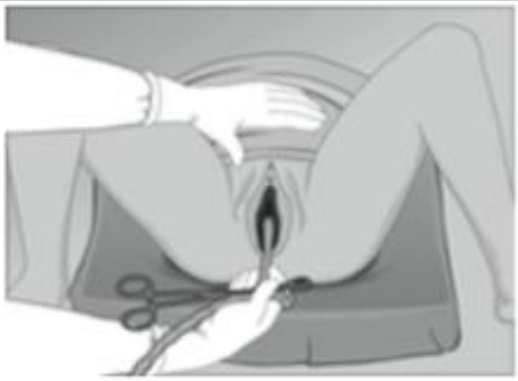
This section provides step-by-step guidance on four types of PPIUD insertion: during the immediate postpartum period: postplacental (1) instrumental or; (2) cesarean insertion; and (3) early postpartum (instrumental) insertion. The goal of all types of insertions is to insert the IUD safely, in a manner that reduces the risk of spontaneous expulsion.

Postplacental Instrumental Insertion

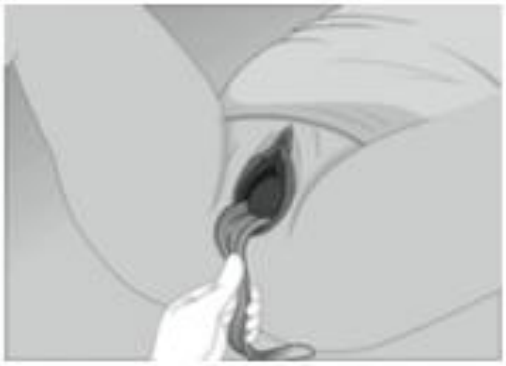
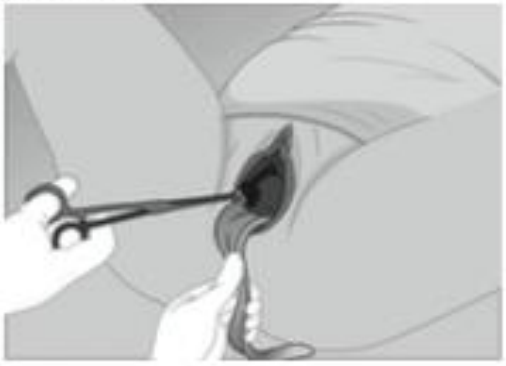
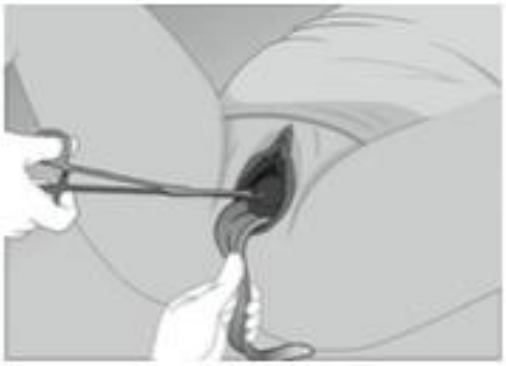
Postplacental instrumental insertion of the IUD is done immediately following delivery of the placenta, typically within 10 minutes using a Kelly or ring forceps. The woman has been counseled and prepared prior to the start of active labor, preferably during the antenatal period. The woman is in the labor/delivery room and has not yet gotten up from the delivery bed. She is still in the lithotomy position following delivery, or assumes the lithotomy position if an alternative position has been used for delivery. The insertion takes place immediately following AMTSL and the delivery of the placenta.

<table>
<tr><th colspan="3">Tasks to Perform before Active Labor and Delivery</th></tr>
<tr><th>No.</th><th>Step</th><th>Explanation/Additional Guidance</th></tr>
<tr><td>Steps 1–5</td><td colspan="2">Ensure that the woman has chosen to have an IUD inserted immediately postpartum, and that it is an appropriate method for her.</td></tr>
<tr><td>1.</td><td>Review the woman's medical record to ensure that she has chosen the PPIUD.</td><td rowspan="2">Before approaching the woman's bedside, the provider reviews the woman's record. If she has chosen the PPIUD, ensure that she has been:
• Educated/counseled regarding PPFP and provided in-depth information about the PPIUD.
• Screened for characteristics and conditions that would make the IUD a poor contraceptive choice for her (i.e., according to the WHO MEC).</td></tr>
<tr><td>2.</td><td>Ensure that she has been appropriately counseled and screened for PPIUD insertion.</td></tr>
<tr><td>3.</td><td>Greet the woman with kindness and respect.</td><td rowspan="3"> 
Talking to the woman about her choice allows her to ask questions. Women who feel supported in their decision are more likely to use the method correctly and for a longer time.</td></tr>
<tr><td>4.</td><td>Explain that you will insert the IUD immediately following delivery of the baby and placenta (if needed, remind her that this is the best time). Confirm with the woman that she still wants the PPIUD.</td></tr>
<tr><td>5.</td><td>Answer any questions the woman might have; provide reassurance, as needed. (Provide counseling, as needed.[1])

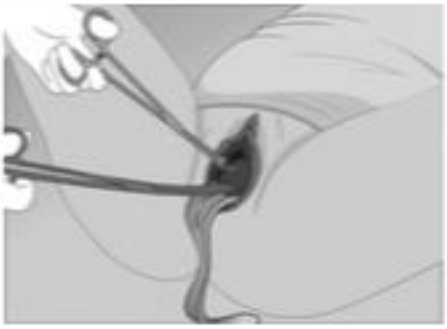
Note: Key messages that may be appropriate at this time are:
• Immediate insertion is best.
• She can change her mind at any time.
• The IUD can be removed at any time with immediate return to fertility.</td></tr>
<tr><td>Steps 6, 7</td><td colspan="2">Ensure that supplies/equipment and sealed IUD are available and ready to use.</td></tr>
<tr><td>6.</td><td>Once the woman has confirmed that she wants the PPIUD, obtain a PPIUD kit/tray (or gather the correct sterile instruments, supplies, light source) for the procedure.</td><td>The provider should ensure that all of the items needed are available and ready to use so that there is no unnecessary delay after the placenta is delivered. Keep the tray wrapped/covered until after the birth of the baby.</td></tr>
<tr><td>7.</td><td>Obtain a sterile IUD; keep the package sealed until immediately prior to insertion.</td><td>The package should be kept sealed to maintain its sterility until it is absolutely certain the IUD will be inserted (i.e., after the woman's second screening and final confirmation).</td></tr>
</table>

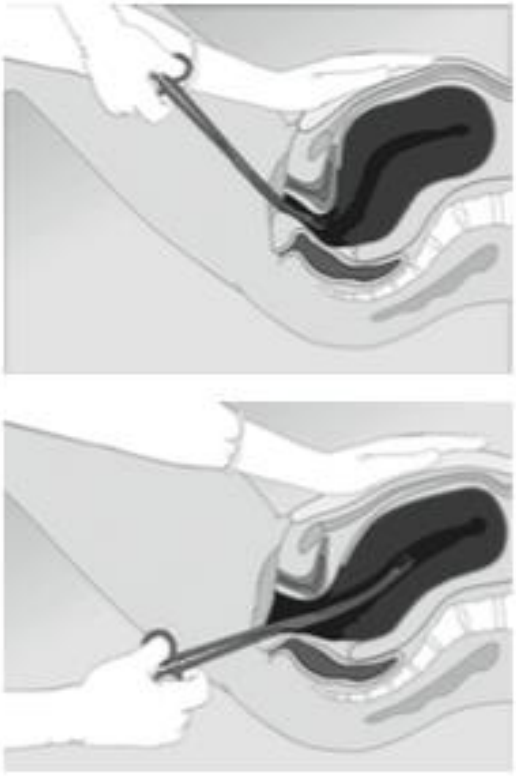
Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	**Step**	**Explanation/Additional Guidance**
Steps 8–11	***Perform AMTSL and the second screening.***	
8.	After labor and delivery (including performing AMTSL), **screen for delivery-related conditions that preclude insertion** of IUD now: • Prolonged rupture of membranes for more than 18 hours • Chorioamnionitis • Unresolved postpartum hemorrhage [Further discussed on pages 26, 27; see also Appendix G.]	 ***Remember:*** *AMTSL should be performed as usual to prevent postpartum hemorrhage.* ***The processes of AMTSL and postplacental IUD insertion do not interfere with each other.***
9.	Before continuing with the second screening, **perform infection prevention measures** as appropriate: • The provider who manages the birth and inserts the IUD does not need to change gloves. • The provider who did not manage the birth but inserts the IUD should ensure that AMTSL has been completed, then perform hand hygiene and put on sterile or HLD gloves.	*If the same provider does the delivery and the IUD insertion, new gloves are not needed because the IUD is grasped with the Kelly forceps inside the wrapper; therefore, the provider never touches the IUD (i.e., the "no-touch" technique is used).* *However, if a different/new provider does the IUD insertion, that provider should perform hand hygiene and put on a new pair of sterile or HLD gloves.*
10.	Inspect perineum, labia and vaginal walls for lacerations. • If there are lacerations and they are bleeding, *apply a clamp to the bleeding areas to stop the bleeding and* proceed with the IUD insertion procedure. • Repair lacerations, if needed, after the procedure. [Further discussed on pages 26, 27.]	 *The provider does not need to delay insertion to repair minor lacerations.*
11.	**If any of the conditions exists**, speak with the woman and explain that now is not a safe time for insertion of the IUD. Counsel her and offer her another PPFP method as appropriate.	*Women who cannot receive the IUD now may be able to receive it on postpartum Day 1 or 2. Otherwise, advise the woman to return at 4 weeks postpartum for re-evaluation and possible IUD insertion; and/or assist her in choosing another PPFP method.*

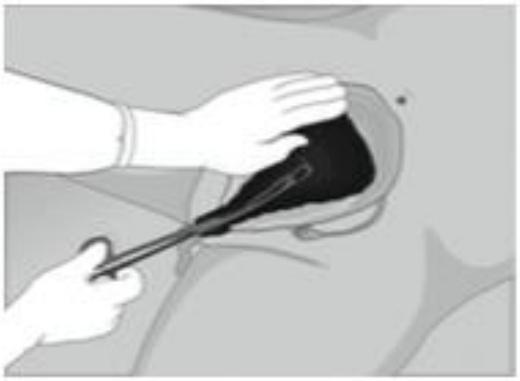
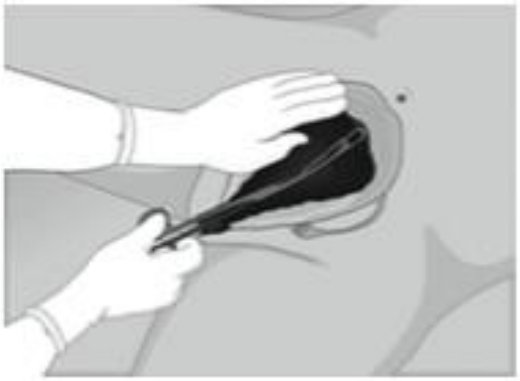
Tasks to Perform before Insertion—Pre-Insertion Tasks		
No.	**Step**	**Explanation/Additional Guidance**
Steps 12, 13	***Let the woman know that you are about to insert the IUD, if that is acceptable to her, and arrange instruments/supplies.***	
12.	If the second screening has revealed no conditions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

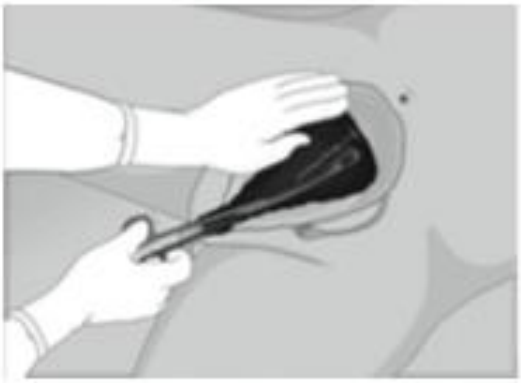
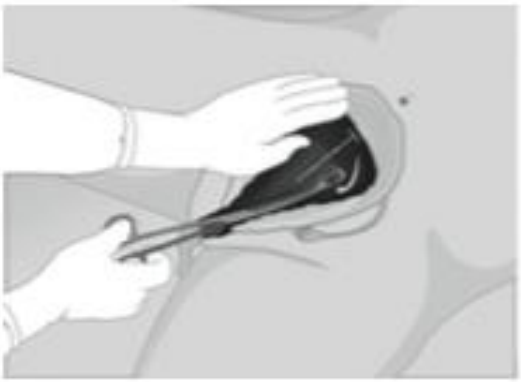
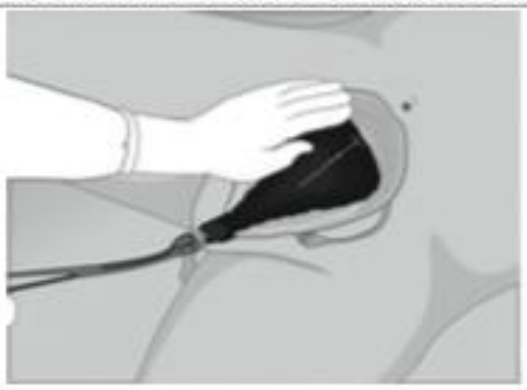
Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 14–16	***Prepare the woman's vagina and cervix for insertion.***	
14.	Gently **insert the Simms speculum and visualize the cervix** by depressing the posterior wall of the vagina. (Note: If the cervix is not easily seen, gently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

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 17–19	***Open the IUD package and remove IUD.***	
17.	**Open the sterile package of the IUD** from the bottom, by pulling back the plastic cover approximately one third of the way.	 *The "no-touch" technique for removing the IUD from the package (Steps 17 to 19) helps to ensure that the IUD remains perfectly sterile throughout the insertion procedure.*
18.	**Remove everything except the IUD from the package:** • Holding the IUD package at the closed end with the nondominant hand, stabilize the IUD in the package by pressing it between the fingers and thumb of the nondominant hand—through the package. • With the other hand, remove the plunger rod, inserter tube and card from the package.	 *The plunger rod and inserter tube are not needed for the postpartum insertion of the IUD. The card will not be needed until later.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 17–19	***Open the IUD package and remove IUD. (cont.)***	
19.	With your dominant hand, use the placental forceps to **grasp the IUD inside the sterile package.**	 *As shown below, the IUD should be held just at the edge of the placental forceps so that the IUD will be easily released from the forceps when they are opened at the uterine fundus.* 
Steps 20, 21	***Insert the IUD gently, using the "no-touch" technique.***	
20.	**Gently lift the anterior lip of the cervix** using the ring forceps, adjusted to one notch.	Lifting the anterior lip opens the cervical os to allow the IUD to pass through.
21.	• **While avoiding touching the walls of the vagina**, insert the placental forceps—which are holding the IUD—through the cervix and into the lower uterine cavity. • **Gently move the IUD further into the uterus**, toward the point where slight resistance is felt against the back wall of the lower segment of the uterus. **Be sure to keep the placental forceps firmly closed.** • **Lower the ring forceps and gently remove them from the cervix**; leave them in the sterile field.	 *Limiting the extent to which the IUD comes in contact with the vaginal walls helps to prevent infection. Keeping the placental forceps firmly closed helps avoid dropping the IUD midcavity during insertion. Forceps are placed in the sterile field in case they are needed again.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached.***	
22.	**"Elevate" the uterus:** • Place the base of your nondominant hand on the lower segment of the uterus (midline, just above the pubic bone with the fingers toward the fundus). • Through the abdominal wall, push the entire uterus superiorly (in the direction of the woman's head). • Maintain this position to stabilize the uterus during insertion.	*This maneuver, elevating the uterus, is done to smooth out the angle between the uterus and the vagina so that the instrument can easily move upward toward the uterine fundus.* 

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 22–24	***"Elevate" the uterus and advance the placental forceps toward the umbilicus—to negotiate the vagino-uterine angle—until the fundus is reached. (cont.)***	
23.	**Keeping the forceps closed, advance the IUD by:** • Gently moving the IUD upward toward fundus, in an angle toward the umbilicus. • Lowering the dominant hand (the IUD/forceps-holding hand), so that the forceps can pass easily through the vagino-uterine angle. • Following the contour of the uterine cavity. • **If significant resistance is felt before the fundus is reached**, the provider should try repositioning the uterus (again, by gently pushing it upward) and re-attempt to advance the instrument.	 *The provider moves the instrument upward in the uterus, following an arc toward the umbilicus, to negotiate the angle between the vagina and uterus more easily. Even though the angle has been lessened by "elevation" of the uterus (Step 22), insertion still requires careful technique.* ***Note: Throughout this part of the procedure, the provider should (1) take care not to apply excessive force** (if not careful, the provider could perforate the back wall of the uterus); and **(2) always keep the instrument closed** so that the IUD is not inadvertently dropped in the midportion of the uterine cavity.*
24.	**Continue gently advancing the forceps until the uterine fundus is reached**, when you will feel a resistance. Confirm that the end of the forceps has reached the fundus.	 *When the instrument reaches the uterine fundus, the provider will feel resistance. She/he may also be able to feel the instrument at the fundus with her/his nondominant hand through the abdominal wall.* ***Note:** An added advantage of the Kelly placental forceps is that the broad ring at the distal end makes it extremely unlikely that the forceps will perforate the uterine fundus.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 25–27	***Release the IUD at the fundus and withdraw the forceps, being careful not to dislodge the IUD.***	
25.	While continuing to stabilize the uterus, **open the forceps**, tilting them slightly toward midline, to release the IUD at the fundus.	 *Keep the nondominant hand in position to maintain stabilization of the uterus. This aids in proper placement of the IUD.*
26.	**Keeping the forceps slightly open, slowly remove them from the uterine cavity,** being careful not to dislodge the IUD. Do this by: • Sweeping the forceps to the side wall of the uterus, and • Sliding the instrument against the side of the uterine wall.	 *If the forceps close and/or catch the strings of the IUD, the forceps can inadvertently pull the IUD down from its fundal position, and increase the risk of expulsion.*
27.	**Keep stabilizing the uterus until the forceps are completely withdrawn.** Place the forceps aside, in the sterile field.	 *Forceps are returned to the sterile field in case they are needed again.*

Insertion of the IUD		
No.	**Step**	**Explanation/Additional Guidance**
Steps 28, 29	***Examine the cervix and begin processing instruments.***	
28.	**Examine the cervix** to see whether any portion of the IUD or the IUD strings are protruding from the cervix. **If the IUD or the IUD strings are seen protruding from cervix:** • Remove the IUD using the same forceps used for the first insertion; • Position the same IUD in the forceps inside the sterile package (as in Steps 18 and 19); and • Reinsert the device (repeating Steps 20–27).	*It is important to check that the IUD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher.* *The same IUD can be reinserted if it has not been contaminated.*
29.	**Remove all instruments and place them in a 0.5% chlorine solution.**	*This is the first step in infection prevention processing. Forceps should be "open"; all instruments should be totally submerged.*
Tasks to Perform after Insertion		
No.	**Step**	**Explanation/Additional Information**
Steps 30–33	***While the woman rests, continue infection prevention measures.***	
30.	**Allow the woman to rest for a few minutes. Support the initiation of routine postpartum care**, including immediate breastfeeding as appropriate.	*The woman should rest on the table for several moments following the insertion procedure. Routine care for the mother and baby become the provider's focus now.*
31.	**Dispose of waste materials** in the appropriate container(s).	*Because this insertion has taken place immediately after a vaginal delivery, the provider should follow all routine delivery-related infection prevention practices, as well as those described earlier in this chapter.*
32.	**Process gloves prior to removal and disposal.** • Immerse both gloved hands in 0.5% chlorine solution. • Remove gloves by turning them inside out and properly dispose of them.	
33.	**Perform hand hygiene.**	

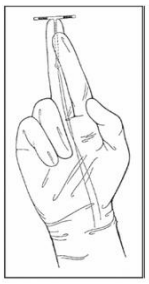
Tasks to Perform after Insertion		
No.	**Step**	**Explanation/Additional Information**
Steps 34–36	***Provide post-insertion counseling and update records.***	
34.	**Tell the woman that the IUD has been successfully placed and provide her with post-insertion counseling**, including IUD instructions.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

Intracesarean Insertion

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

After the placenta is removed, the provider:

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



Early Postpartum Insertion

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

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

- The cervix will have become firmer and will begin to resume its round, tubular shape. For this reason, manual insertion is not possible and should not be attempted. These changes may also have an impact on which type of forceps works best.
- Although the ring forceps can still be used to grasp the cervix, slightly more pressure may be required to close them (on the cervix).

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

The uterus has begun to resume its original anteverted or retroverted position; therefore, it may become slightly more difficult to advance the instrument through the uterus to the fundus. However, it is still critically important to reach the uterine fundus. Failure to reach the uterine

fundus is likely a principal factor in the higher spontaneous expulsion rates that occur following early postpartum insertion compared to immediate postplacental insertion. Additional care should be taken.

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

If the IUD is visible, or if the strings seem inappropriately long, the provider should consider whether the IUD is at the fundus. If there is doubt, it is better to remove the IUD and reinsert it. Immediate Post-Insertion Care and Counseling After the insertion procedure, global standards/local protocols for postpartum and newborn care should be observed. The woman who has just had an IUD inserted should have additional counseling, focused on correct use of the IUD, timely management of problems that may occur and return for follow-up. (Management of IUD/PPIUD-related problems is covered in the next chapter.) This counseling should be done by the provider who inserted the IUD when the woman is rested and able to concentrate.

For women who receive a postplacental or an intracesarean insertion, counseling is best done the following day, when the woman has rested and is better able to concentrate.
If the insertion was done in the early postpartum period (not immediate but within 48 hours), the post-insertion counseling can be done shortly after the insertion. Immediate Care The client should be advised to report any of the following, which should be promptly addressed: Increase in vaginal bleeding. Vaginal hemorrhage related to uterine atony should be managed—per global standards/local protocols—with uterine massage and uterotonics, as necessary. Note that the PPIUD does not increase the risk of uterine atony.

Excerpts of Frequently Asked Questions from 2014 Philippine Family Planning Clinical Standards

WHAT ARE THE COMMONLY ASKED QUESTIONS ABOUT IUDs?

Does the IUD cause pelvic inflammatory disease (PID)?

By itself, the IUD does not cause PID. Gonorrhea and chlamydia are the primary direct causes of PID. However, IUD insertion when a woman has gonorrhea or chlamydia may lead to PID. This condition is not common. When it does happen, it is most likely to occur in the first 20 days after IUD insertion. In a group of clients where STIs are common and screening questions identify half the STI cases, one case of PID may be reported in every 666 IUD insertions (or less than 2 per 1,000).

Can young women and older women use IUDs?

Yes. There is no minimum or maximum age limit. An IUD should be removed after menopause has occurred, i.e., within 12 months after the client's last monthly bleeding.

If a current IUD user has an STI or has become at very high individual risk of becoming infected with an STI, should her IUD be removed?

No. If a woman develops a new STI after her IUD has been inserted, she is not especially at risk of developing PID because of the IUD. She can continue to use the IUD while she is being treated for the STI.

Removing the IUD has no benefit and may leave her at risk of unwanted pregnancy. Counsel her on condom use and other strategies to avoid STIs in the future.

Does the IUD make a woman infertile?

No. A woman can become pregnant once the IUD is removed just as quickly as a woman who has never used an IUD, although fertility decreases as women get older. Studies show no increased risk of infertility among women who have used IUDs, including young women and women with no children. However, a woman who develops PID and is not treated, whether or not this woman has an IUD, is at risk for infertility.

Can a woman who has never had a baby use an IUD?

Yes. A woman who has not had children can generally use an IUD,
but she should understand that the IUD is more likely to be expelled because her uterus may be smaller than the uterus of a woman who has given birth.

Can the IUD travel from the woman's uterus to other parts of her body, such as her heart or her brain?

The IUD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUD normally stays within the uterus like a seed within a shell. In rare instances, the IUD may come through the wall of the uterus into the abdominal cavity. This condition is usually caused by a mistake during insertion. If it is discovered within six weeks or so after insertion or if it is causing symptoms at any time, the IUD must be removed by laparoscopic surgery or

laparotomy. However, an out-of-place IUD usually causes no problems and should be left where it is. The client will need another contraceptive method.

Should a woman have a "rest period" after using her IUD for several years or after the IUD reaches its recommended time for removal?

No. A "rest period" is not necessary. Removing the old IUD and immediately inserting a new one pose less risk of infection than two separate procedures. In addition, a woman could become pregnant during a "rest period" before her new IUD is inserted.

Should antibiotics be routinely given before IUD insertion?

No, usually not. Most recent research done where STIs are not common suggests that PID risk is low with or without antibiotics. The risk of infection is minimal when appropriate questions to screen for STI risk are used and IUD insertion is done with proper infection prevention procedures (including the no-touch insertion technique). However, antibiotics may be considered in areas where STIs are common and STI screening is limited.

Must an IUD be inserted only during a woman's monthly bleeding?

No. An IUD can be inserted at any time to a woman having menstrual cycles during her menstrual cycle, provided that she is certainly not pregnant. Inserting the IUD during her monthly bleeding may be a good time because she is not likely to be pregnant and insertion may be easier. However, signs of infection are difficult to detect during monthly bleeding.

Should a woman be denied an IUD because she does not want to check her IUD strings?

No. A woman should not be denied an IUD because she is unwilling to check the strings. The importance of checking the IUD strings has been overemphasized. IUD expulsion is uncommon, especially with the woman not noticing.

The IUD is most likely to come out during the first few months after IUD insertion; during monthly bleeding; among women who have had an IUD inserted soon after childbirth, a second-trimester abortion, or miscarriage; and among women who have never been pregnant. A woman can check her IUD strings if she wants reassurance that it is still in place. Alternatively, she can watch carefully in the first month or so and during monthly bleeding to see if the IUD has come out.

Do IUDs increase the risk of ectopic pregnancy?

No. IUDs greatly reduce the risk of ectopic pregnancy. Ectopic pregnancies are rare among IUD users. The rate of ectopic pregnancy among women with IUDs is 12 per 10,000 women per year.

On the rare occasions that the IUD fails and pregnancy occurs, 6 to 8 of every 100 of these pregnancies are ectopic. Thus, a great majority of pregnancies after IUD failure are not ectopic. Nevertheless, ectopic pregnancy can be life threatening. Thus, a provider should be aware that ectopic pregnancy is possible after IUD failure.

MODULE 5:

PPIUD Counseling and Informed Consent

The narrative in this module is lifted from 2014 Philippine Family Planning Clinical Standards for discussion on informed choice and volunteerism and informed consent and Jhpiego's PPIUD Reference Manual for Counseling Informed Choice and Volunteerism

WHAT IS INFORMED CHOICE AND VOLUNTARISM?

The quality of care in family planning (FP) requires that the rights of FP clients and the needs of service providers meet as much as possible. The rights of FP clients, especially the right to information and choice, must be honored through appropriate FP counseling. Clients must be able to make voluntary and informed choices based on accurate, balanced, and complete information. The Department of Health (DOH) AO 2011-0005 defines Informed Choice and Voluntarism (ICV) as:

> *A standard in the delivery of FP services, ensuring that clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods, and not by any special inducements or forms of coercion or misinterpretation.*
>
> *Healthcare providers are responsible for ensuring that an FP client makes a voluntary and informed choice. This factor is considered as one of the pillars that guide FP program implementation.*

QUALITY OF CARE IN FP: CLIENT RIGHTS AND PROVIDER NEEDS

The quality of FP services can be further enhanced by allowing the rights of clients and the needs of providers to meet as much as possible. The meeting of these needs occur at home, at barangay health stations, or in hospitals and should be kept in mind by every FP healthcare provider. Provider needs include proper training, adequate supplies, good working environment, and good management support and supervision.

INFORMED CHOICE AND VOLUNTARY DECISION MAKING AS A GOOD PROGRAM STRATEGY

The DOH recognizes that ensuring ICV will translate to better and longer method use, improved client compliance, and satisfied clients who will encourage others to participate in FP programs. When healthcare providers take the time to have face-to-face, verbal, and non-verbal exchange

of information with clients, service is perceived favorably and positively influences method use and continuation. Better FP program success can be anchored on ICV.

ENSURING INFORMED AND VOLUNTARY DECISIONS

Service providers must be aware of the principles of ICV. The table below explains the principles of ICV and provides an illustrative example of non-compliance or vulnerability. Such example is important to understand because the best interests of the service provider may often raise a red flag or may violate the freedom of the FP client.

INFORMED CONSENT

Informed consent is different from informed choice. Informed consent is a written voluntary decision of an FP client stating that he/she accepts the particular method or will undergo any procedure (sterilization, IUD, or implant insertion). The service provider should ask the client to sign a consent form prior to undergoing any of the above-mentioned procedures. The service provider is assumed to have already provided adequate counseling prior to the acknowledgment of the decision.

The RPRH Act of 2012 implementing rules and regulations include the following provisions regarding informed consent in availing FP services:

- Any minor availing of FP services must have written consent of their parents or guardians.
- Any minor who has had a previous pregnancy or is already a parent still requires parental consent prior to availing of FP services.
- Spousal consent is needed prior to undergoing permanent surgical contraceptive methods.

Counseling

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

- Understanding the benefits of healthy spacing of pregnancy;
- Exploring their future reproductive intentions;
- Identifying and acting upon contraceptive solutions that are realistic and well-suited to their needs, goals and life situation (access to services, resources available, etc.); and
- Being prepared for return to fertility.
- For potential PPIUD users (women who are interested in or have chosen the method), method specific counseling consists of:
- Ensuring that the IUD is a good choice for the woman/couple and offers what they seek in a contraceptive; and
- Discussing the “optimal PPIUD service scenario” (the benefits of immediate postpartum insertion).

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

PPIUD Counseling

Ideally, PPIUD counseling should begin during the antenatal period and occur in stages: First, as part of general health education (often group-based) about the benefits of healthy spacing of pregnancies (and limiting, if desired) and about the PPFP methods available to women in the community. At this stage, the counselor/provider may offer very basic information about the PPIUD, among other methods.

This should be followed by individual counseling about PPFP methods, in which a woman is provided with more detailed information about a particular method (or methods) and is supported in making an informed choice about a method that is well-suited to her individual needs and circumstances in the postpartum period. Often a woman will take time to discuss her options with her partner or others before making a final decision.

Then, as the focus of method-specific counseling about the PPIUD:

- For those women who have chosen the IUD for postpartum insertion, pre-insertion counseling provides more detailed information about the insertion procedure and other attributes of the method. Again, this is also an ideal opportunity for initial screening.
- And finally, for women who have had the IUD inserted postpartum, post-insertion counseling provides information about returning for follow-up, recognizing warning signs and what to do if they occur, and managing side effects.

Content of Method-Specific PPIUD Counseling

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

Service Delivery Tips for Method-Specific PPIUD Counseling

Who should do it/when:

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

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

Other opportunities:

For a woman who presents at the facility for non-routine care: If a woman is undergoing evaluation or treatment for an antenatal complication or other concern, she may be counseled for PPFP/PPIUD. This is actually a good time to discuss the health benefits of pregnancy spacing (or limiting, if desired) for both the mother and her children. The woman/couple may be especially interested in ways to increase the likelihood of a positive health outcome for a future pregnancy.

For a woman who presents at the facility for delivery care: If a woman is in the early/inactive stage of labor and has not been counseled, the PPFP/PPIUD is still an option if a counselor or the clinician can provide adequate PPFP counseling. Because choosing a contraceptive is an important decision to make on such short notice, it is important that a woman interested in the PPIUD understands that it is non-permanent and can be removed whenever she wants—and that she can change her mind at any time.

In general, a woman should NOT be counseled for the first time about PPIUD during active labor. The stress of labor makes this a difficult time for a woman to focus sufficiently on the information provided and make an informed choice about contraception.

After counseling:

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

MODULE 6:

Infection Prevention for PPIUD Services

The discussion in this module has been lifted from Jhpiego's PPIUD Reference Manual
Infection Prevention during PPIUD Insertion

The key objectives of infection prevention during PPIUD insertion are reduction of the risk of infection associated with PPIUD insertion technique and facility-related disease transmission to PPIUD clients, and protection of health care workers at all levels from exposure to disease. To achieve these objectives, service providers and health care staff must:

- Implement standard precautions:
- Use the aseptic/"no-touch" technique during every PPIUD insertion; and
- Use high-level disinfected (HLD)/sterilized equipment, with appropriate disposal of waste after every procedure. These measures are applied—in the appropriate setting, with staff and clients appropriately attired—as described below.
- Immediately before PPIUD Insertion
- Ensure that instruments and supplies are available and ready for use
- Ensure that the IUD package is unopened and undamaged and check the expiration date. (Regardless of timing or setting, the IUD package should not be opened until the final decision to insert the IUD has been made.)
- Open and arrange all sterile instruments and supplies onto a dry, sterile surface (sterile field) such as a drape/towel or steel basin. Particular care is required immediately after delivery to ensure an adequate sterile field. Use of a separate table or stand is recommended to prevent cross-contamination with instruments used during delivery.
- Keep the IUD to the side of the sterile field.
- For early postpartum insertion, wash or have the woman wash her perineal area with soap and water before prepping the vagina and cervix and beginning insertion. If immediately after delivery, cleaning the perineal area gently with a sterile gauze or towel is sufficient in the absence of obvious fecal contamination. Place a dry, sterile cloth on the woman's abdomen, just above the symphysis pubis. This will protect the provider's nondominant hand from contamination as it applies upward pressure to "elevate" the uterus.
- When available, place another dry, sterile cloth between the woman's genital area and the surface of the examination table for patient comfort and to minimize the risk of contamination of sterile instruments and the IUD during insertion.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.

- Put HLD or sterile surgical gloves on both hands. Remember to use elbow-length gloves for manual vaginal (versus intracesarean) insertion.
- Using sterile gauze and a sterile sponge/ring clamp or its equivalent, apply an appropriate water-based antiseptic agent to the vagina and cervix two or more times before IUD insertion. Cleanse from the inside of the cervical opening outward.
- The most commonly used lower genital tract antiseptics are: iodophors, such as povidone iodine, and chlorhexidine. If an iodophor is used, allow 1 to 2 minutes before proceeding with the procedure after application. Iodophors such as povidone iodine require "contact time" to act.
- Do not use alcohol as an antiseptic in the lower genital tract. Not only is it painful for the patient, but it may also actually increase the risk of infection by drying and damaging the vaginal and cervical mucosa.
- If sterile gloves are contaminated during the antiseptic application process, change to a new pair before proceeding with insertion.

During IUD Insertion (as applicable)

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

After IUD Insertion

Before removing your gloves:

- Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.
- Dispose of waste materials (e.g., cotton balls and gauze) by placing them in a leak-proof container (with a tight-fitting lid) or plastic bag.
- Immerse both gloved hands in 0.5% chlorine solution.
- Remove gloves by turning them inside out.
- Dispose of gloves by placing them in a leak-proof container or plastic bag.
- Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- After the client has left, wipe the procedure table with 0.5% chlorine solution to decontaminate.
- Ensure that all instruments, gloves and other reusable items are further processed according to recommended infection prevention practices.

Appropriate Setting and Attire for Infection Prevention during PPIUD Insertion

Timing	Setting	Staff Attire
Postplacental	Delivery room, the same bed used for labor and birth	Personal protective equipment appropriate for vaginal delivery (e.g., impermeable gowns or long sleeved gowns with rubber aprons; eye and mouth protection) Sterile gloves do not need to be changed before insertion if not contaminated
Intracesarean	Operating theater, procedure table	Personal protective equipment. Sterile gloves do not need to be changed before insertion if not contaminated
Early postpartum	Clinical procedure room, procedure table	Use of eye and mouth protection is optional. When using "no-touch" technique, use of clean exam gloves is sufficient

Summary of Steps for Processing Instruments and Other Items Used in PPIUD Services

Item	Decontamination	Cleaning	HLD	Sterilization
	First Step in Handling Dirty Instruments; Reduces Risk of Hepatitis B and HIV Transmission	Removes All Visible Blood, Body Fluids and Dirt	Recommended Method of Final Processing; Destroys All Viruses, Bacteria, Parasites, Fungi and Some Endospores	Alternative Method of Final Processing; Destroys All Microorganisms Including Endospores
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material remains after decontamination.	Not necessary	Not necessary
Instruments used for IUD insertion or removal (e.g., speculum, placental/ring forceps, retractor/speculum)	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.*	Using a brush, wash with soap and water. Rinse with clean water. If they will be sterilized, air or towel dry and package.	• Steam or boil for 20 minutes. • Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage.	• Dry heat for 1 hour after reaching 170°C (340°F), or • Autoclave at 121°C (250°F) and 106 kPa (15 lb/in²) for 20 minutes (30 minutes, if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.**	Wash with soap and water. Rinse with clean water, air or towel dry.	Boil container and lid for 20 minutes. If container is too large: • Fill container with 0.5% chlorine solution and soak for 20 minutes. • Rinse with water that has been boiled for 20 minutes and air dry before use.	• Dry heat for 1 hour after reaching 170°C (340°F), or • Autoclave at 121°C (250°F) and 106 kPa (15 lb/in²) for 20 minutes (30 minutes, if wrapped).

*If unwrapped, use immediately; if wrapped, may be stored up to 1 week before use.
**Avoid prolonged/excessive exposure to chlorine solution (more than 20 minutes, more than 0.5%) to minimize corrosion of instruments and deterioration of rubber or cloth products.

Preparing Decontamination Solution

From concentrated 5% chlorine solution

$$\frac{\text{Parts of water/part of chlorine}}{\text{\% concentrated chlorine}} - 1$$

$$\frac{\text{\% desired chlorine concentration}}{5} - 1 = 9 \text{ parts water/part of water}$$

$$\frac{}{.5}$$

1 part chlorine in 9 parts water

From concentrated chlorine granules containing 30% chlorine

Grams of chlorine powder or granules/liter of water

$$\frac{\text{\% desired concentration x 1000}}{\text{\% concentrate of granules}}$$

$$\frac{.5 \times 1000}{30} = .0166 \times 1000 = 16.7 \text{ grams/liter}$$

The Four Aspects of Hazardous (Medical) Waste Management

The management of waste must be consistent from the point of generation to the point of final disposal. The path between these two points can be segmented into four steps.

1. Sorting or segregation and containerization

   Only a small percentage of the waste generated by a healthcare facility are medical wastes that must be specially handled to reduce the risk of infections or injury. Therefore, sorting the waste at the point at which it is generated can greatly reduce the amount that needs special handling.

   The correct segregation/sorting of waste at the point of generation relies on a clear identification of the different categories of waste and the separate disposal of the waste in accordance with the categorization chosen. To encourage segregation at source, reusable containers with plastic liners of correct size and thickness are placed as close to the point of generation as possible. They should be properly color coded.

   Black plastic lining for general, dry, non-infectious waste Green plastic lining for general, wet, non-infectious waste Yellow for infectious/pathological waste
   Needles and other sharps pose the greatest risk of injury, and should be disposed in special sharps containers such as heavy cardboard boxes, tin cans with lid, and plastic bottles.

2. Handling

   Handle medical waste as little as possible before disposal. When waste containers are 3/4 full, the liners are closed with plastic strings and are placed in larger containers at the interim storage areas. Always wear heavy utility gloves when handling medical waste. Always wash your hands after handling wastes and after removing your gloves.

3. Interim storage

   In order to avoid both the accumulation and decomposition of waste, it must be collected on a regular daily basis. Waste should never be stored in the facility for more than one or two days. If it is necessary to store medical waste on-site before final disposal, waste should be placed in an area that is minimally accessible to clinic staff, clients and visitors.

4. Final disposal

   General wastes, similar to household waste, can be collected by the regular municipal garbage collector and transported into the final dump sites.

   Solid Medical Waste

   There are three options for the disposal of solid medical waste: burning waste, burying waste, and transporting waste to an off-site disposal site.

MODULE 7:

Management of PPIUD Side Effects and Complications

Identification and Management of Common Side Effects and Potential Problems

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

- Careful screening of clients
- Meticulous attention to appropriate insertion technique
- Strict adherence to correct infection prevention techniques
- Performing PPIUD insertion procedures slowly and gently to assure technical accuracy and client comfort and safety Some problems that may arise, however, require specific management. In most cases, the woman can continue to use the IUD while awaiting or undergoing evaluation.
- Some of the problems associated with IUD use that require specific management include:
- Changes in menstrual bleeding patterns
- Cramping or pain
- Infection
- IUD string problems (or possible IUD expulsion)
- Partial or complete IUD expulsion (confirmed)
- Pregnancy with an IUD in place

General management principles are as follows:

The woman should be reassured and provided with any information she needs to support her in continuing (or discontinuing) the method, as appropriate and as she desires.

If problems are encountered that are not covered in the management guidelines, the provider should conduct further evaluation and provide treatment according to global standards/local protocols (refer if needed).

If the provider does not have the training or resources to perform any of the assessments, procedures or treatments indicated in the management guidelines, she/he should refer the woman to an appropriate facility.

If the woman wants the IUD removed for any reason, and/or to use a different contraceptive method, the provider should remove the IUD or schedule an appointment (or refer) for IUD removal, as appropriate.

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

Problem (Signs/Symptoms)	Explanation	Management
Changes in Menstrual Bleeding Patterns • Increase in amount of menstrual bleeding above what is usually expected in the postpartum period • Increase in duration of menstrual bleeding above what is usually expected in the postpartum period • Spotting/light bleeding between periods once they resume postpartum	Changes in menstrual bleeding patterns are a common side effect among IUD users, regardless of timing of insertion. In the first 6 weeks postpartum, such changes may be masked by the usual irregular bleeding and spotting associated with uterine involution during the postpartum period. Also, for a woman who is exclusively breastfeeding her baby, amenorrhea is likely up to 6 months—whether or not she is using an IUD. Menstrual changes caused by the IUD are usually not harmful to the woman and diminish or disappear within the first few months after IUD insertion. If, however, these symptoms are severe, persistent or accompanied by certain other signs/symptoms, they require special follow-up.	• Determine severity of symptoms: how much more bleeding than usual; how long have symptoms lasted; when did the symptoms start; are they accompanied by other symptoms (e.g., pain, fever); how well is the woman tolerating them? • If symptoms are mild and consistent with uterine involution, provide reassurance. • Where appropriate, rule out other gynecologic pathology and refer her to a qualified practitioner, if indicated. • Where appropriate, rule out pregnancy by history or available testing. • Where appropriate, check for IUD expulsion: palpate strings on bimanual exam or by using a speculum. • If client desires treatment, offer a short course of NSAIDs, continued for 3 to 5 days. If heavy bleeding is the problem, aspirin should not be used because it has an anti-blood-clotting effect. • If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anemia (e.g., pallor, weakness), offer iron replacement therapy and consider IUD removal with the patient's consent. • If client finds bleeding unacceptable, remove IUD and counsel her regarding alternative methods of family planning.
Cramping or Pain • Increased cramping or pain that may or may not be associated with menstruation	Mild intermittent cramping may occur in the first few weeks after IUD insertion, but is generally masked by the usual cramping associated with uterine involution postpartum ("afterpains"). Increased cramping and pain may also be noted with return of menstruation and is a common side effect among IUD users. Special follow-up is needed if symptoms are bothersome, severe or associated with other signs/symptoms.	• Determine severity of symptoms: how severe is pain; how long has pain lasted, when did pain start; is pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain? • Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test; complete blood count [CBC], cultures) to rule out other possible causes of pain or infection; partial IUD expulsion, such as: uterine perforation; pregnancy/ectopic pregnancy; urinary tract infection. If appropriate, see section for management of infection (page 49) and pregnancy with the IUD in place (page 51). • If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure the woman. • Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping that are bothersome to the client. • If cramping or pain is severe, remove the IUD. If the IUD was improperly placed, partly expelled or appeared to be abnormal/distorted, discuss insertion of a new IUD with the client. If the IUD appeared to be normal and in proper position, counsel the woman regarding alternative forms of family planning.

Problem (Signs/Symptoms)	Explanation	Management

Infection
• Lower abdominal pain
• Fever
• Painful intercourse
• Bleeding after sex or between periods once resumption of normal monthly menses has occurred postpartum
• New onset of pain associated with periods
• Abnormal vaginal discharge
• Nausea and vomiting
	Although the risk of infection after interval IUD insertion is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhea or chlamydia infection. Similar risk estimates are not available for PPIUD insertion, but studies suggest the risk is very low. Because pelvic infection can lead to infertility and other serious problems, providers should treat all suspected cases. Of note, the IUD should never be inserted when puerperal infection such as chorioamnionitis or endometritis is suspected.	• Perform an appropriate assessment, including: vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems, such as: endometritis, appendicitis, partial IUD expulsion, uterine perforation, pregnancy/ectopic pregnancy or urinary tract infection. If appropriate, see section for management of pregnancy with the IUD in place (page 51).
		• Suspect PID if any of the following signs/symptoms are found and no other causes can be identified:
		  • Lower abdominal, uterine or adnexal tenderness (tenderness in the ovaries or fallopian tubes)
		  • Evidence of cervical infection: yellow cervical discharge containing mucus and pus, cervical bleeding when it is touched with a swab, positive swab test
		  • Tenderness or pain when moving the cervix and uterus during bimanual exam (cervical motion tenderness)
		  • Other possible sign/symptoms: purulent cervical discharge, enlargement or hardening (induration) of one or both fallopian tubes, a tender pelvic mass, pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness)
		• If endometritis or PID is suspected, begin treatment immediately with an appropriate antibiotic regimen per global standards/local protocols for gonorrhea, chlamydia and anaerobic infections. Remove the IUD only in the presence of sepsis or if symptoms do not improve within 72 hours. Studies have not indicated that removing the IUD affects outcomes of PID treatment.[34]
		  • If the woman does not want to keep the IUD in during treatment, remove the IUD 2 to 3 days after antibiotic treatment has begun.
		• Where appropriate and when an STI is suspected, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner.

Problem (Signs/Symptoms)	Explanation	Management

IUD String Problems (Missing, Long, Short)	Missing or longer or shorter-than-expected strings may indicate a variety of problems, including pregnancy, IUD expulsion and IUD malpositioning. Sometimes there is no real problem at all—it is simply that the strings have not descended yet. In some circumstances, the IUD strings may never descend through the cervix into the vagina following postpartum insertion.
	
	Because strings are not trimmed at postpartum insertion, they typically extend well into the middle of the vagina and perhaps all the way to the vulva by 4 to 6 weeks postpartum.
	
	Remember: IUD strings are not related to efficacy; their purpose is to facilitate removal and confirmation of intrauterine positioning only.
		Missing Strings (Appendix I presents a job aid for managing missing strings.)
		• Ask the woman if she thinks the IUD has fallen out.
		• Rule out pregnancy by history or laboratory examination.
		• Probe the cervical canal using an HLD or sterile cervical brush or narrow forceps (e.g., Bose, alligator) to locate the strings and gently draw them out so that they are protruding into the vaginal canal.
		• If the strings are not located in the cervical canal, refer the woman for an X-ray or ultrasound to confirm normal intrauterine positioning. Provide a back-up method while waiting for results. Manage as appropriate based on findings:
		  • If the IUD is located inside the uterus and the woman wants to keep the IUD, do not remove it. Explain to her that the IUD is still protecting her from pregnancy but that she will no longer be able to feel the strings. Review signs and symptoms of spontaneous expulsion.
		  • If the IUD is located inside the uterus and the woman wants it removed, refer her for IUD removal by a specially trained provider.
		  • If the IUD cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUD expulsion (below).
		
		Long Strings
		Trim strings, as needed, up to 3–4 cm from cervical os.
		
		Short Strings (if Bothersome to Woman or Partner)
		• Reassure the woman and her partner that the strings are very flexible and not harmful.
		• If it is very bothersome, advise the woman that the IUD strings can be cut shorter, so that the string curves around the cervical lip. Trim as needed.

Problem (Signs/Symptoms)	Explanation	Management

Partial or Complete IUD Expulsion
• New onset of irregular bleeding and/or cramping
• Expelled IUD seen (complete expulsion)
• IUD felt/seen in the vaginal canal (partial expulsion)
• Delayed or missed menstrual period (See **Pregnancy with an IUD in Place,** below.)
• Missing or longer strings (See IUD string problems, page 50.)
	Partial or complete IUD expulsion can occur "silently" (with no signs/symptoms) or it may be associated with other signs/symptoms, such as: missing or longer than expected IUD strings, or a delayed or missed menstrual period. The following guidelines address management of confirmed partial or complete IUD expulsions.	• Conduct an appropriate assessment, including: pelvic examination to rule out other possible causes of symptoms such as infection and pregnancy.
		• When other possible causes of symptoms are ruled out, manage based on findings.
		  ◦ If complete expulsion of the IUD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): replace IUD immediately, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method.
		  ◦ If partial IUD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUD and replace it, if desired and appropriate (not pregnant or infected), or counsel for alternative family planning method.
		  ◦ If the IUD appears to be embedded in the cervical canal and cannot be easily removed in the standard fashion: refer the woman for IUD removal by a specially trained provider.
		• If complete expulsion of the IUD is confirmed and pregnancy diagnosed, manage ANC per national and regional standards.

Pregnancy with an IUD in Place[43]
• Delayed or missed menstrual period
• Other signs/symptoms of pregnancy
• Missing strings
• Strings that are shorter or longer than expected
	Although the IUD is one of the most effective forms of reversible contraception, failures can occur. Approximately one-third of IUD-related pregnancies are due to undetected partial or complete expulsion of the IUD. When pregnancy does occur with an IUD in place, ectopic pregnancy must be ruled out and the IUD should be removed. If the IUD is left in place during pregnancy, there is an increased risk of preterm labor, spontaneous abortion and septic abortion.	• Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to global standards/local protocols and refer to an appropriate provider, if needed.
		• Rule out ectopic pregnancy: sharp/stabbing abdominal pain (which is often unilateral), abnormal vaginal bleeding, light-headedness/dizziness, fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a facility with surgical capability.
		• When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester:
		  ◦ Counsel the woman on the benefits and risks of immediate removal of the IUD. Removing the IUD slightly increases the risk of miscarriage; leaving the IUD in place can cause second trimester miscarriage, infection and preterm delivery.
		  ◦ If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUD is still in the uterus or has been expelled. If the IUD is still in place, it cannot be safely removed. Follow, as below, with plans to remove the IUD at delivery.
		  ◦ If the woman declines removal, provide support and care per standard global guidelines/local protocols and arrange close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Plan to remove the IUD at delivery.

MODULE 8:

Recording and Reporting PPIUD Services

How to complete FP Form 1

Instructions for completing the FP Service Record or FP Form 1

Side A

1. Fill out or check the required information at the far right of the form:
   - Client number
   - Husband's name, giving the family name first, date of birth, education, and occupation
   - Wife's name using her maiden family name, date of birth, education, and occupation
   - Monthly family income in peso
   - Choose "yes" or "no" for the couple's plan for more children
   - "New" or "current" for type of acceptor
   - Number of children: desired and actual
   - Birth interval desired in years
   - Previous method used; duration of use and reason for discontinuation
   - New / current method
   - Completed desired family size, economic, others for reasons for accepting permanent methods
   - Complete address of the client: number of the house, street, barangay, municipality, and province
   - Wife's age
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature and date, name, and address of health facility.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

Side B

1. Fill in the required information at the far left of the form on client number and name. 2. On the first column, record the date when the service was delivered to the client. 3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
   - Medical observations
   - Complaints
   - Services rendered, procedures/interventions done (Lab, treatment)
   - Reasons for stopping or changing the methods
   - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature. 6. On the fifth column, record the next service date or appointment date.

How to complete Target Client List

Instructions for completing the Target Client List (TCL) for Family Planning Nonsurgical Methods

The TCL is filled out by health workers when providing services and is updated every time a client comes back for a follow-up visit. It has the following purposes:

1. it helps the health worker plan and carry outpatient care and service delivery, 2. it facilitates the monitoring and supervision of service delivery activities,
3. it facilitates the preparation of reports,
4. it provides clinic-level data that can be accessed for further studies.

Column 1: DATE (OF REGISTRATION)—Indicate in this column the month, day, and year a client made the first clinic visit for FP service.

Column 2: FAMILY SERIAL NUMBER—Indicate in this column the number that corresponds to the family number written on the family folder or envelop on the individual treatment record.

Column 3: CLIENT'S NAME—Write the client's complete name.

Column 4: ADDRESS—Record the client's present permanent place of residence.

Column 5: METHOD ACCEPTED—Write on this column the code of the method being accepted by the client.

CODES:

i. LAM: Lactational Amenorrhea Method
ii. NFP: Natural Family Planning Method
   - BBT: Basal Body Temperature
   - CM: Cervical Mucus
   - ST: Sympto-thermal
   - SDM: Standard Days Methods
iii. PILLS
iv. Injectable/DMPA: Depo-MedroxyProgesterone Acetate
v. IUD: Intrauterine Device
vi. CON: Condom
vii. VSC: Voluntary Surgical Contraception
   - BTL: Bilateral Tubal Ligation
   - VS: Vasectomy or Male Sterilization

Column 6: CATEGORIES AND CODES OF CLIENTS—Write on this column the code of the following client categories.

i. New Acceptor (NA)—A client using a contraceptive method for the first time or who is new to the program.
ii. Current Users—FP clients who have been carried over from the previous month after deducting the drop-outs of the present month and adding the new acceptors in the current month. Current users constitute specific FP methods used during the month which include condom, injectables, IUD, LAM, NFP, pills, male sterilization, and female sterilization.
iii. Re-Starter (RS)—These are new acceptors who have stopped FP practice for at least one month and have resumed using the same method in the same clinic.

Column 7: PREVIOUS METHOD—Refers to last method used prior to accepting a new method. Enter in this column the same codes as for the Method Accepted (Column 5). Add code for None to cover "New to Program."

How to complete Hospital Service Statistics Report Form

Instructions for completing the Hospital Service Statisics Report Form.

The Hospital Service Statistics Report Form is accomplished by the different hospitals (OPD and OB-Gyne Department of Medical Centers or Regional, Provincial, District, City, and Municipal hospitals). This report is due quarterly and should be submitted by each hospital to its respective provincial health office copy furnished the Center for Health and Development (CHD), National Center for Disease Prevention and Control-Family Planning (NCDPC-FP), and National Center for Health Facility Development (NCHFD).

Please print or type

Name of hospital _____

Address _____

_____

City _____

Region _____

Province _____

Date accomplished: _____

Reporting period:

From: Day: _____ Month: _____ Year: _____

To: Day: _____ Month: _____ Year: _____

Name of person filling out form:

_____

Title: _____

Signature: _____

Instructions for completing the form:

1. State the name of hospital in column 1 and month and year procedures performed in column 2.
2. Enter the number of all procedures performed at each hospital for the current reporting period.
   - Under Columns 3 to 6, report the numbers of mini laparotomy procedures performed according to timing after the last delivery and the number of laparoscopy procedures.
   - Under Column 7 "Other female", report all other types of female voluntary surgical contraception during Caesarean sections.
   - Add the number of female voluntary surgical contraception procedures performed during the period (Columns 3 to 7, and report the total in Column 8).
   - Report vasectomies performed under Column 9.
   - If IUD services were provided, report these under Columns 10 and 11. "Postpartum (PP) IUD" means the IUD was inserted after delivery, but before the woman left the hospital.
   - If DMPA, pills, Norplant, and condoms were provided, report these under Columns 12, 13, 14, and 15, respectively.
   - If other family planning methods were provided, specify which methods and report these in Column 16.

How to Complete Monthly Summary Form

This monthly summary form captures PPIUD services data
Instruction for completing this form:

1. Record the name of the following:
    - Facility
    - Type of Facility
    - Reporting Period
2. Summarize the following information and record the monthly total for the following:
    - No. of women attending antenatal care
    - No of women counseled on PPFP at ANC clinic
3. Identify total number of deliveries by: the number of normal deliveries, Cesarean and assisted deliveries
4. Record counseling data during early labor (when women are not in pain) and postpartum
5. Record PPIUD insertion based on timing: postpartum, early and intracesarean
6. List down the monthly number of clients who followed by within 6 weeks and after 6 weeks and if followed up by phone or in the clinic
7. Summarize the number of clients reporting: expulsions, infections, missing strings and those without complaints
8. Record number of clients who wanted their IUDs removed and note reasons for removal

PPIUD Insertion Registers:

This PPIUD insertion register records information about the client and contact information where they can be followed up

PPIUD Follow up register:

This provides information on the clients who followed and the results of their follow up.

Sample of consent form for IUD

Republic of the Philippines

Name of Facility: _____

Informed Consent Form for Intra-uterine Device (IUD) Client

I, _____, the undersigned, request that an intra-uterine device be performed on my person. I make this request of my own free will, request of having been forced or given any special inducement.
(Name of Client)

I understand the following:

1. There are temporary contraceptive methods available to me and my partner.
2. The procedure to be performed on me involves the insertion of the intra-uterine device inside the uterus, the details of which have been explained to me.
3. This method have some risks, in addition to benefits, both of which have been explained to me.
4. The Intra-uterine device is along acting reversible method. However, the sub-dermal implant cannot be guaranteed to work 100%. There is a small chance of failure. If the procedure is successful, I will be unable to have any children for a period of 12 years.
5. The method will not protect me or my partner form infection with sexually transmitted infections, including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time before the operation is performed, or have it removed any time after insertion and no medical, health, or other benefits or services will be withheld from me as a result.

_____ _____
_(Signature or mark of client) *(Date)*

_____ _____
(Signature or mark of spouse) *(Date)* _____

_____ _____
(Signature of attending doctor or delegated assistant) *(Date)*

If the client cannot read, a witness of the client's choosing who is of the same sex and who speaks the same language as the client must sign the following declaration:

I, the undersigned, attest that the client has affixed his thumbprint or mark in my presence.

_____ _____
(Signature or mark of witness) *(Date)*

SECTION 2

Jhpiego's Course Notebook for Learners

Precourse Knowledge Assessment

Using the Individual and Group Assessment Matrix

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

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

For the trainer, 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 learners answer the questions correctly, the trainer may elect to use some of the allotted time for other purposes.

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

Precourse Knowledge Assessment—Answer Sheet

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

Postpartum IUD 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 IUD?
   a. To prevent expulsion, women who choose the PPIUD should not breastfeed.
   b. The expulsion rate is lowest when the IUD is inserted within 10 minutes of delivery of the placenta.
   c. Tying knots of catgut on the cross arms of the IUD will reduce expulsion.

5. Which of the following is an acceptable time to insert an IUD 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 IUD insertion?
   a. When an IUD is inserted 2 weeks postpartum, the risk of expulsion is very low because it is easier to reach the fundus.
   b. The standard IUD inserter tube can be used to place both interval IUDs and postpartum IUDs.
   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 IUD.
   b. The strings should be trimmed immediately after insertion of the IUD.
   c. The woman should check for the IUD 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 IUD counseling?
   a. An IUD 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 IUD 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 PPIUD should limit breastfeeding in order to reduce the risk of expulsion.

9. Counseling about the use and benefits of a PPIUD *can* be provided:
   a. Only during routine antenatal care visits, if the husband has agreed to it.
   b. During active labor, so that the IUD 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 IUD postpartum.
    b. It is not necessary to use an antiseptic when inserting an IUD 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 IUD insertion should be soaked first for 10 minutes in 0.5% chorine solution.

11. If an IUD is still inside an undamaged, sealed package but appears tarnished or discolored, the provider should:
    a. Insert the IUD if the package is not beyond the expiration date.
    b. Send the IUD back to the manufacturer.
    c. Discard the IUD because it is unsterile.

PPIUD Client Assessment

12. In which of the following women would it be safe to insert an IUD 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 IUD, the provider can:
    a. Insert the IUD if the infection has been gone for more than 6 weeks.
    b. Insert the IUD 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 PPIUD 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 IUD Insertion

15. Which of the following is the best technique for inserting an IUD 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 PPIUD during cesarean section?
    a. A sponge-holding (ring) forceps must be used to ensure that the IUD is placed at the fundus
    b. The strings of the IUD should not be passed through the cervix into the vagina
    c. The PPIUD 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 IUD insertion is planned:
    a. The IUD 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 IUD is inserted
    c. Active management of the third stage labor should be avoided, if possible, if the woman is having a PPIUD

Follow-Up Care/Management of Potential Problems

18. A woman had a postplacental PPIUD inserted 3 weeks ago. Over the past 24 hours, she has become hot and feverish. She should:
    a. Be told to take paracetamol and oral antibiotics for 7 days.
    b. Come into the clinic right away to have the PPIUD removed.
    c. Come into the clinic right away for evaluation.

19. Which one of the following is TRUE about IUD strings?
    a. The strings should be passed through the cervix into the vagina during intracesarean placement.
    b. The strings should not be visible at the cervix after immediate/postplacental insertion of the IUD.
    c. The woman should check for the strings each month to make sure the IUD has not fallen out.

20. A woman who has had an IUD placed in the immediate postpartum period should have a follow-up exam:
    a. Every year to check the strings
    b. Only if she thinks the IUD has fallen out
    c. At 4 to 6 weeks postpartum to reinforce counseling, answer any questions and screen for potential problems

Individual and Group Assessment Matrix

Course_____Dates:_____Clinical Trainer(s)

QUESTION NUMBER	CORRECT ANSWERS (LEARNERS)															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/PPIUD OVERVIEW** (Manual, Chapters 1–3; selections as specified)
2.																
3.																
4.																
5.																
6.																**POSTPARTUM ANATOMY AND PHYSIOLOGY** (Manual, Chapters 3, 4; selections as specified)
7.																
8.																**COUNSELING** (Manual, Chapters 5, 6; selections as specified)
9.																
10.																**INFECTION PREVENTION** (Manual, Chapter 7; selections as specified)
11.																
12.																**CLIENT SCREENING** (Manual, Chapters 5, 6; selections as specified)
13.																
14.																
15.																**PPIUD INSERTION** (Manual, Chapter 7; selections as specified)
16.																
17.																
18.																**FOLLOW-UP CARE/ MANAGEMENT OF POTENTIAL PROBLEMS** (Manual, Chapter 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 learners to be ready and eager to learn, they need to understand the relevance of the training to them and their clinical situation. To increase learners' sense of relevance, the trainers should ask them: (a) to consider the PPIUD Performance Standards (Manual, Appendix 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 PPIUD services at your facility and compared them to established service delivery standards or guidelines (e.g., the PPIUD Performance Standards). In doing so, you likely identified "gaps"—areas where training is necessary to achieve the standards. If you were not familiar with PPIUD services in your own practice or at your facility, review of the standards would still benefit you, helping to create a clear picture of what will be expected of you in this course.

During Training

At the start of the training, you will review the standards again, identify which standards are not being met by you or at your workplace, and what knowledge and skills gaps exist. You will record these gaps in 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 trainer(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 trainers—in a specific, concrete way—the knowledge, skills and attitudes you have learned during this course. It can also aid in discussing how you will initiate changes and lead a team effort to improve the quality of care in PPIUD services at your facility.

Blank Personal Learning Plan

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

Learner 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: _____(Learner); _____, _____ (Trainer[s], PPIUD Course)				

*Final column to be completed at end of course.

Sample Personal Learning Plan

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

Learner Name: *Elizabeth Johnson*	**Designation:** *Nurse-Midwife*	**Date:** *1 November 2010*
Facility Name: *Eastern District Hospital*	**Location:** *Big City, Eastern District*	

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?
#3 Screening/assessment	*In my hospital, the IUD is not very popular. I need updated knowledge about client screening for PPIUD so I know who can use the IUD postpartum.*	*My director, the medical officers and labor ward assistants*	*I will begin screening women as soon as I return to my hospital*	*I now understand the new criteria for providing this method.*
#15 Postplacental insertion	*We do not practice this method and are not familiar with this technique. I need to learn the steps for postplacental IUD insertion.*	*The medical officers in charge of the labor ward, as well as the assistants and educators/counselors*	*I will provide this method once I have educated clients about it and found some who are interested in and eligible for it*	*I am now competent to insert postplacental IUD. I will need more practice with clients to become proficient.*

Signatures: _____**(Learner);** _____**_,** _____**(Trainer[s], PPIUD Course)**

*Final column to be completed at end of course.

Exercise One: What Is Different about the PPIUD?

Objectives
The purpose of this activity is to:

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

Time Allotted
15 minutes

Resources/Materials Needed
Skills Station for PPIUD
Flipchart paper and markers

NOTE: Instructions to be provided by trainer.

Exercise Two: Medical Eligibility for the PPIUD

Objectives
The purpose of this activity is to:

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

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) PPIUD chart (either as handout or from the Course Handbook for Learners)
- Completed MEC PPIUD chart as answer key (for the trainer)

NOTE: Instructions to be provided by trainer.

Exercise Two: Answer Sheet

Instructions: Below is a chart listing various conditions/characteristics that may have an impact on whether the PPIUD 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 PPIUD	DO NOT INSERT PPIUD	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 PPIUD 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 PPIUD

NOTE: Instructions to be provided by trainer.

Exercise Four: PPIUD Frequently Asked Questions (FAQs)

Objectives
The purpose of this activity is to:

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

Time Allotted
As time permits in the clinical setting

Resources/Materials Needed
Reference Manual

NOTE: Instructions to be provided by trainer.

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 trainer.

Counseling Guide and Clinical Skills Checklists

The Clinical Skills Checklists for PPIUD insertion contain the steps or tasks performed by the clinician when providing PPIUD services. These tasks correspond to the information presented in Postpartum Intrauterine Contraceptive Device (PPIUD) Services: A Reference Manual for Providers (Jhpiego 2010). These checklists are designed to help the learner learn the steps or tasks involved in:

- Postplacental insertion of an IUD (instrumental, manual)
- Intracesarean insertion of an IUD
- Early postpartum insertion of an IUD

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 IUD 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, learners use the checklists to:

Understand the steps of the procedure. The trainer 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 trainer conducts a demonstration of the procedure on an anatomic model. The learners 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 learner will practice the clinical skills on the anatomic models with the assistance and support of colleagues and trainers. In this context, the checklist provides a mechanism for colleagues and trainers to discuss and provide explicit, constructive feedback on performance.

Check whether s/he is ready for formal assessment by the trainers. Ultimately, learners will need to be assessed by the trainers to determine their level of achievement in the skill being practiced. Since the skill will be assessed by the trainer using the exact same clinical skill checklist, learners 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, learners will be ready to practice the skill under supervision with actual clients in the clinical setting. The checklist is used again in this context as a guide to strengthen performance.

What happened to learning guides? Previously, many training courses used learning guides as a learning tool and checklists as an assessment tool. While similar to each other, learning guides had a greater level of detail about the steps in the procedure. Modern approaches to learning and performance have caused trainers 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 trainer for assessment of each clinical skill, in terms of both readiness for—and competency in—working with actual clients. The final phase of learning in the context of this course, known as skill competency, is determined by the trainer 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 trainers and learners in the following ways:

As a template for feedback. Space is provided on the checklist for trainers and colleagues (other learners) to score the performance of a given step in a procedure. Under the column marked CASES, observers should rate whether a learner 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 learner during evaluation by trainer

Along with those who are observing and coaching, the learner 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 trainer and the learner both believe that the learner 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 learner will perform all the steps correctly.

For "qualification," certification of competency. At the bottom of the checklist is a box for the trainer to sign, certifying that the learner performed the skill competently. This is signed and dated as the statement of competency in both the skills lab and the clinical setting.

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:	_____	_____
Date:	_____	_____

Counseling Guide for PPFP/PPIUD Counseling

Based on the GATHER Technique, this guide provides a "framework" for counseling—both general and specific to women interested in the PPIUD.

> 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 learner 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 learner during evaluation by trainer

Learner: _____ **Date Observed:** _____

COUNSELING ON PPIUD SERVICES					
ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
GREET—Establish good rapport and initiate counseling on PPFP.					
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.				
ASK—Determine reproductive intentions, knowledge of pregnancy risk and use of various contraceptives.					
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	Explores partner's/family's knowledge about the return of fertility and				

COUNSELING ON PPIUD SERVICES					
ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
attitudes about family planning.	the benefits of pregnancy spacing/limiting.				
6. Assesses reproductive intentions.	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).	Explores woman's need for protection from STIs, including HIV.				
	Explains and supports condom use, as a method of dual protection.				
8. Determines interest in a particular family planning method.	Asks whether she has a preference for a specific method, based on prior knowledge or the information provided.				
TELL—*Provide the woman with information about PPFP methods.*					
9. Provides general information about benefits of healthy pregnancy spacing (or limiting, if desired).	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.				
	Advises about the return of fertility postpartum and the risk of pregnancy. **Advises how LAM and breastfeeding are different.**				
	Advises about the health, social and economic benefits of healthy pregnancy spacing (or limiting, if desired).				
10. Provides information about PPFP methods.	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)				
	– PPIUD				
	– No-scalpel vasectomy (male sterilization)				
	– Postpartum tubal ligation (female sterilization)				
	Shows the methods (using poster or wall chart) and allows the woman to touch or feel the items, including the IUD, using a				

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

COUNSELING ON PPIUD SERVICES					
ITEM	STEP/TASK	COMMENTS	ASSESSMENT		
16. Discusses limitations of the PPIUD:	Heavier and more painful menses for some women, especially first few cycles after interval IUD (less relevant or noticeable to postpartum women)				
	Does not protect against STIs, including HIV				
	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.	Bleeding or foul-smelling vaginal discharge (different from the usual lochia)				
	Lower abdominal pain, especially if the first 20 days after insertion—accompanied by not feeling well, fever or chills				
	Concerns she might be pregnant				
	Concerns the IUD has fallen out				
18. Confirms that the woman understands instructions.	Encourages the woman to ask questions.				
	Asks the woman to repeat key pieces of information.				
RETURN—*Plan for next steps and for when she will arrive to hospital for delivery.*					
19. Plans for next steps. [**Note:** In this counseling guide, "return" refers to a subsequent visit after an initial PPFP/PPIUD counseling session, but before birth and IUD insertion. "Return," as a part of post-insertion counseling, is addressed in the insertion checklists, following.]	Makes notation in the woman's medical record about her PPFP choice or which methods interest her.				
	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.				
	Provides information about when the woman should come back, as appropriate.				

To be used by the TRAINER when the checklist is used as a skill assessment tool:
When the learner is ready for assessment of his/her skills in counseling, use this Counseling Guide as an assessment tool. Ensure that the learner satisfactorily addresses all of the elements noted in the Counseling Guide and mark his/her achievement under the column marked ASSESSMENT.

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:	_____	_____
Date:	_____	_____

Role Play Exercises: Counseling Potential PPIUD Users

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

1. Debora is 23 years old and works as a teacher in 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 2–3 years. She does not know what method she will use, but is thinking her husband should use condoms. Ms. Rivera, a health counselor in the District Women's Hospital, has recently returned from a PPIUD services training course and has been providing PPFP education to antenatal care clients.

    a. How can Ms. Rivera provide guidance to Debora regarding her options?
    b. What are Debora's options?

2. Meena 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 her 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 two 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 Meena has female sterilization. Meena has heard rumors about the IUD that it can move up into the body and cause headaches. Instead, she thinks she will try contraceptive injections after having this baby. Dr. Shila is counseling Meena about all the methods of postpartum family planning, and Meena has many questions about the IUD.

    a. How should Dr. Shila address Meena's concerns?
    b. What information should Dr. Shila provide Meena about the IUD?

3. Akiki is 23, her husband is a farmer, and 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 postpartum family planning, Akiki tells her she is interested in the IUD. She says her husband is just outside, along 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 her client's wishes?
    b. What are some of the important things to discuss?

4. Dr. Pasaribu, a young assistant professor in a teaching hospital's Obstetrics and Gynecology department, recently attended a workshop on PPIUD services. The country's government has recently launched a PPIUD initiative. Dr. Pasaribu is therefore very excited about making the IUD available to postpartum women in the hospital, as well as teaching the young residents about it. Dr. Sianturi is a full professor in the Ob/Gyn department. When she came to know about Dr. Pasaribu's intentions, she called him into the office and started expressing concerns about high expulsion and perforation rates associated with the PPIUD, as well as difficulties with insertion techniques. Dr. Sianturi advised the young doctor to be very careful about these postpartum IUDs and to focus

instead on laparoscopic tubal ligation (TL).

a. How can Dr. Pasaribu present the new evidence and correct the misconceptions that Dr. Sianturi has?
b. What are the most important things for the young doctor to discuss with Dr. Sianturi?

Postplacental (Instrumental) Insertion of the IUD (Copper T 380A)
(To Be Used by Learners and Trainers)

Learners: Study this tool together with the appropriate chapter 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.

Trainers: Use this tool when the learner 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 learner during evaluation by trainer

Learner _____Date Observed _____

CHECKLIST FOR POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUD					
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 IUD.					
2. Checks that she has been appropriately **counseled and screened** for PPIUD 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 IUD.					
5. Explains that the IUD 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 PPIUD kit/tray.					
7. Confirms that IUDs are available on labor ward; obtains a sterile IUD, keeping the package sealed until immediately prior to insertion.					

CHECKLIST FOR POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUD						
STEP/TASK	CASES					
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 IUD now: – 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 IUD, and offers re-evaluation for an IUD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).						
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 IUD insertion. (Repairs lacerations, if needed, after inserting IUD.)						
Insertion of the IUD						
12. **Confirms** that the woman is ready to have the IUD inserted. Answers any questions she might have and provides reassurance if needed.						
13. Has the PPIUD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUD 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 IUD from bottom by pulling back plastic cover approximately one-third of the way.						

18. With nondominant hand still holding the IUD package (stabilizing IUD 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 IUD inside sterile package. Holds IUD 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 IUD** (this step overlaps with Step 22): – While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUD—through cervix into lower uterine cavity. – Gently moves IUD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. – Keeping placental forceps firmly closed, lowers ring forceps and gently removes them from cervix; leaves them on sterile towel.					
22. **"Elevates" the uterus** (this step overlaps with Steps 21 and 23): – 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 POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUD					
STEP/TASK	CASE				
23. **Passes IUD through vagino-uterine angle** (this step overlaps with Step 22): – Keeping forceps closed, gently moves IUD 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 IUD has reached the fundus.					
25. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUD 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 IUD or catch IUD 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 IUD or strings are visible or protruding from cervix. If IUD or strings are seen protruding from cervix, removes IUD using same forceps used for first insertion; positions same IUD 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 POSTPLACENTAL (INSTRUMENTAL) INSERTION OF THE IUD						
STEP/TASK	CASE					
35. Tells woman that IUD 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: – Reviews IUD side effects and normal postpartum symptoms – Tells woman when to return for PPIUD/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 IUD (PAINS[5]) – 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 IUD and date of insertion						
36. Records information in the woman's chart or record. Attaches IUD cards (which woman will be given at discharge) to woman's record.						
37. Records information in the appropriate register(s).						

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:	_____	_____
Date:	_____	_____

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

Intracesarean Insertion of the IUD (Copper T 380A)
(To Be Used by Learners an Trainers)

Learners: Study this tool together with the appropriate chapter 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.

Trainers: Use this tool when the learner 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 learner during evaluation by trainer

Learner _____Date Observed _____

CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUD					
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 IUD.					
2. Checks that she has been appropriately **counseled and screened** for PPIUD 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 IUD.					
5. Explains that the IUD 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 intracesarean insertion, the IUD 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 intracesarean insertion; obtains PPIUD kit/tray.					

7. Confirms that IUDs are available; obtains a sterile IUD, 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 IUD now: – 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 IUD and offers re-evaluation for an IUD 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 IUD.					

CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUD					
STEP/TASK	CASES				
Insertion of the IUD					
11. Has the PPIUD kit/tray opened and arranges insertion instruments and supplies in a sterile field. Ensures that IUD in sterile package is kept to the side of sterile draped area.					
12. Opens sterile package of IUD from bottom by pulling back plastic cover approximately one-third of the way.					
13. With nondominant hand, holds IUD package (stabilizing IUD through the package); with dominant hand, removes plunger rod, inserter tube and card from package.					
14. With dominant hand, grasps and then holds the IUD at end of fingers, by gripping the vertical rod between the index and middle fingers. (Alternatively, uses forceps to hold the IUD. Holds IUD 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 IUD through uterine incision and moves to fundus of uterus.					
17. Releases IUD at fundus of uterus.					
18. Slowly removes hand from uterus. Takes particular care not to dislodge IUD as hand is removed.					
19. Points IUD strings toward lower uterine segment, but does not push them through the cervical canal or pull the IUD from its fundal position.					
20. Closes the uterine incision, taking care not to incorporate IUD 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 IUD 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: – Review IUD side effects and normal postpartum symptoms – Tell woman when to return for IUD/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 IUD (PAINS[7]) – 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 IUD and date of insertion					

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:	_____	_____
Date:	_____	_____

Early Postpartum Insertion of the IUD (Copper T 380A)
(To Be Used by Learners and
Trainers)

Learners: Study this tool together with the appropriate chapter 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.

Trainers: Use this tool when the learner 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 learner during evaluation by trainer

Learner _____Date Observed
_____

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUD					
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 IUD.					
2. Ensures that she has been appropriately counseled and screened for PPIUD insertion.					
3. Greets the woman with kindness and respect.					
4. If she has not been counseled and assessed for postpartum IUD, provides that service now.					
5. **Confirms** that the woman still wants IUD.					
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 PPIUD kit/tray.					
8. Confirms that IUDs are available on labor ward; obtains a sterile IUD, keeping the package sealed until immediately prior to insertion.					
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 IUD 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 IUD (confirmed by inspection of genitalia, Step 15)					
10. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUD and offers re-evaluation for an IUD at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).					

CHECKLIST FOR EARLY POSTPARTUM INSERTION OF THE IUD					
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 IUD					
16. **Confirms** that the woman is ready to have the IUD inserted. Answers any questions she might have and provides reassurance if needed.					
17. Has the PPIUD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that IUD 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 IUD from bottom by pulling back plastic cover approximately one-third of the way.					
23. With nondominant hand still holding the IUD package (stabilizing IUD 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 IUD inside sterile package. Holds IUD 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 IUD** (this step overlaps with Step 27): – While avoiding touching walls of the vagina, inserts placental forceps—which are holding the IUD—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 IUD further into uterus toward point where slight resistance is felt against back wall of lower segment of uterus. – Keeping placental forceps firmly closed, lowers ring forceps and gently removes them from cervix; leaves them on sterile towel.					
27. **"Elevates" the uterus** (this step overlaps with Steps 26 and 28): – 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 EARLY POSTPARTUM INSERTION OF THE IUD					
STEP/TASK	CASES				
28. **Passes IUD through vagino-uterine angle** (this step overlaps with Step 27): – Keeping forceps closed, gently moves IUD 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.					

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 IUD has reached the fundus.					
30. While continuing to stabilize the uterus, opens forceps, tilting them slightly toward midline to release IUD 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 IUD or catch IUD 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 IUD or strings are visible or protruding from cervix. If IUD or strings are seen protruding from cervix, removes IUD using same forceps used for first insertion; positions same IUD in forceps inside sterile package and reinserts.					
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 EARLY POSTPARTUM INSERTION OF THE IUD					
STEP/TASK	CASES				
40. Tells woman that IUD 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 IUD side effects and normal postpartum symptoms – Tells woman when to return for IUD/postnatal/newborn checkup – Emphasizes that she should come back any time she has a concern or experiences warning signs – Reviews warning signs for IUD (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 IUD and date of insertion					
41. Records information in the woman's chart or record. Attaches IUD card (which women will be given at discharge) to woman's record.					
42. Records information in the appropriate register(s).					

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	☐ Yes ☐ No	☐ Yes ☐ No
Signed:	_____	_____
Date:	_____	_____

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

Clinical Skills Tracking Sheet

Using the PPIUD Clinical Skills Tracking Sheet
As learners, you must achieve multiple competencies during the PPIUD training course. These include both knowledge and skill competencies. This sheet will assist you in tracking the development of those competencies.

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

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

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

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

First set of columns: When you have had the opportunity to practice each of the clinical skills on anatomic models, you will be assessed by a clinical trainer using a Clinical Skills Checklist. When your trainer 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 PPIUDs because the cases are not able to be scheduled regularly. Therefore, you may work with a variety of different trainers. When you have the chance to manage a particular case under the supervision of a trainer, share this form with him/her to show that you have successfully completed skills practice with models. Once your trainer determines that you have achieved competency with clients, ask him/her to tick the appropriate box, sign the form and date it.

The PPIUD Clinical Skills Tracking Sheet

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

	Experience on Anatomic Models			Experience with Clients		
	Ready*	Signed	Date	Competent	Signed	Date
Counseling						
Postplacental Insertion of the IUD (Instrumental)						
Postplacental Insertion of the IUD (Manual)						
Intracesarean Insertion of the IUD						
Early Postpartum Insertion of the IUD						

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

Set-Up of Clinical Skill Practice Station

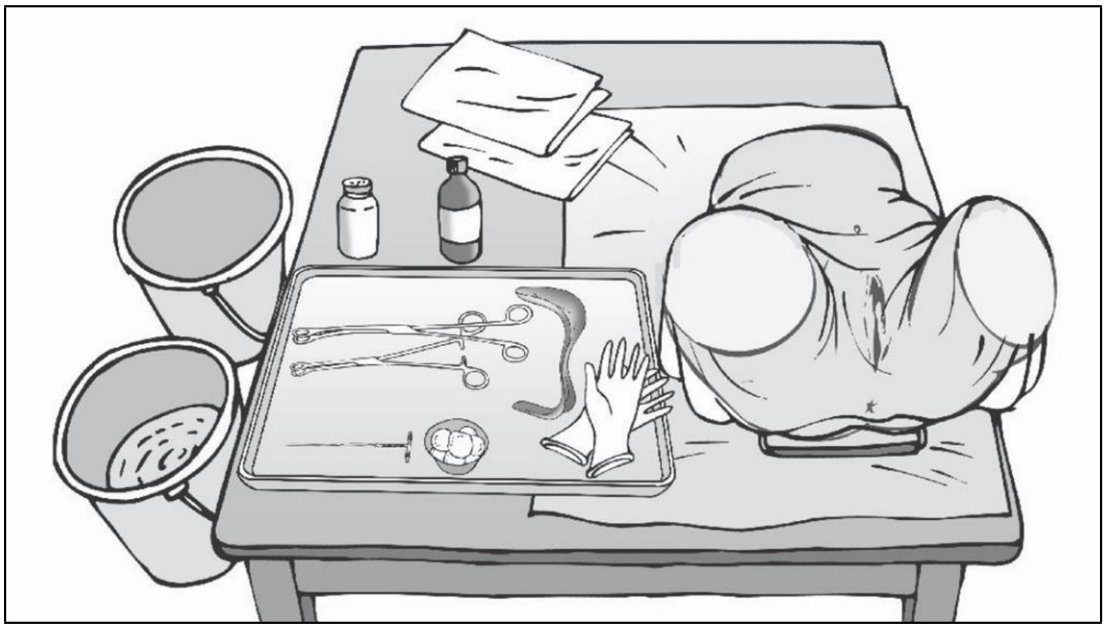
The clinical skills station is set up at the start of the PPIUD clinical skills course and is used for multiple activities including:

Exercise One: What Is Different about Postpartum IUD?—where learners compare what they see at the skills station with what they know about interval IUD services

Demonstration of PPIUD Insertion Technique—where learners are introduced to the proper technique while following along on the checklist

Models Practice for PPIUD Services—when learners work in groups and get to practice the clinical skills of PPIUD insertion while being coached by their trainers

The clinical skills station gives the learners an introduction to the supplies and equipment needed, as well as the clinical and communication behaviors for proper PPIUD 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.



PPIUD Course Evaluation

(To be completed by Learners)

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

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

COURSE COMPONENT	RATING
1. The Precourse 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 PPIUD.	
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 PPIUDs prior to practicing with the anatomic models.	
7. The practice sessions with the anatomic models made it easier for me to perform PPIUD insertion when working with actual clients.	
8. There was sufficient time scheduled for practicing PPIUD insertion with clients.	
9. The interactive training approach used in this course made it easier for me to learn how to provide PPIUD services.	
10. The time allotted for this course, and its different components, was sufficient for learning how to provide PPIUD services.	
11. I feel confident in performing PPIUD postplacental insertion (instrumental).	
12. I feel confident in performing PPIUD postplacental insertion (manual).	
13. I feel confident in PPIUD intracesarean insertion.	
14. I feel confident in early PPIUD postpartum insertion.	
15. I feel confident in using the infection prevention practices recommended for PPIUD services.	
16. I feel confident in conducting routine PPIUD follow-up at 4 to 6 weeks, and identifying and managing (or referring) potential problems.	

(See next page.)

Additional Comments

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

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

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

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

[i] Per the World Health Organization's recommendations for healthy spacing (2009)
[ii] Saifuddin Ahmed, Qingfeng Li, Li Liu, Amy O Tsui. 2012. Maternal deaths averted by contraceptive use: an analysis of 172 countries. Lancelet. DOI http://dx.doi.org/10.1016/ S0140-6736(12)60478-4.
[iii] Current recommendations are for the Copper T 380A to be used in postpartum insertions.
[iv] Jhpiego. 2010. PPIUD Trainers Guide. Mayland, Baltimore
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