PARTICIPANT’S GUIDE

Intrauterine Devices (IUDs)
Second Edition

Unit 1: An Overview of the IUD
1 Key messages
2 Types of IUDs
3 Advantages and disadvantages of the IUD
4 Indications for using the IUD
5 Eligibility criteria for IUD use
6 Rumors and misconceptions
7 Six key steps of counseling
8 Screen for IUD insertion
9 When to insert and remove an IUD
10 Insertion and removal procedures
11 Side effects and warning signs

Unit 2: Providing Services
1 Effective IUD counseling
2 Advise, screen, and select clients
3 Loading the TCu 380A inside the sterile package
4 Performing the steps in IUD insertion
5 Recommended infection prevention practices
6 Follow-up management of the IUD client
7 Minimum clinic requirements and recordkeeping tasks necessary for IUD services
Intrauterine Devices (IUDs)
Second Edition

Participant’s Guide

Cathy Solter
Pathfinder International, Watertown MA
February, 2008
Acknowledgements

The development of Pathfinder International’s training curriculum is an ongoing process and the result of collaboration between many individuals and organizations. The development process of this curriculum began with the privately-funded Reproductive Health Projects (RHPs) in Viet Nam. This manual is based on the adaptation of the Family Planning Course Modules, produced by the Indian Medical Association in collaboration with Development Associates, Inc. Parts of this curriculum are adapted from the work of: IPAS, for Manual Vacuum Aspiration, Postpartum/Postabortion Contraception; JHPIEGO for Infection Prevention, Reproductive Tract Infections; Family Health International (FHI) for Postpartum/Postabortion Contraception; Georgetown University for Lactational Amenorrhea Method; and EngenderHealth (AVSC International) for Client’s Rights, Counseling, and Voluntary Surgical Contraception.

This and other Pathfinder training modules were used to train service providers in 1995 under this cooperative project which included Pathfinder International, IPAS, AVSC International, and the Vietnamese Ministry of Health. Individual modules were used to train service providers in: Bolivia, Nigeria (DMPA); Angola, Azerbaijan, Bolivia, Haiti, Kenya, Mozambique, Peru, Tanzania, and Uganda (Infection Prevention); Azerbaijan, Bolivia, Kazakhstan, and Peru (Counseling); Jordan (IUD); Bangladesh, Bolivia, Kazakhstan, and Peru (Training of Trainers) Ecuador, Kenya, and Peru (ECP); Jordan (PoPs & CoCs), Bangladesh, Bolivia, Egypt, Haiti, Peru, Tanzania Uganda (Postabortion Care) and Botswana, Ghana, India, Tanzania and Uganda (Reproductive Health Services for Adolescents). The entire curriculum has been used as the basis for the Ministry of Health’s comprehensive reproductive health curriculum in both Azerbaijan and Ethiopia. Feedback from these trainings has been incorporated into the training curriculum to improve its content, training methodologies, and ease of use.

With the help of colleagues at Pathfinder International, this curriculum has been improved, expanded, and updated to its present form. For the original 1997 module, thanks are due to: Douglas Huber and Betty Farrell, who provided technical support and input; Penelope Riseborough, who provided technical editing and guidance on printing and publication; Tim Rollins and Erin Majernik, who designed, formatted, and edited the document, and coordinated the process; Anne Read, who designed the cover; and Melissa Nussbaum, who entered hundreds of corrections and reproduced numerous corrected pages. Thanks for current research, editing and formatting go to Mary Burket, Margot Kane, Shannon Pryor, and Caitlin Deschenes-Desmond.

Special thanks to the many staff from the Reproductive Health Projects in Viet Nam who have helped with the development of the modules over the years and especially to Dr. Türkiz Gökgöl who was instrumental in the design and development of the project and to Pathfinder’s former Country Representatives in Viet Nam, Kate Bourne and Joellen Lambiotte, and current Country Representative, Laura Wedeen.
Many colleagues in the field of reproductive health reviewed either this revised module or the original and provided invaluable comments and suggestions. These reviewers included:

Faiza Alieva, Baku Family Planning Center, Azerbaijan
May Hani Al-Hadidi, Ministry of Health, Jordan
Abdul Fattah A. Al-Zoubi, Ministry of Health, Jordan
Abdulhafez Awad, Royal Medical Services, Jordanian Army
Traci Baird, Ipas
Kate Bourne, Pathfinder International/Viet Nam
Ellen Eiseman, Pathfinder International
Khalil K. El-Barbarawi, Ministry of Health, Jordan
Nasser Mahmoud El Kholy, Pathfinder International/Egypt
Rob Gringle, International Projects Assistance Services (IPAS)
Zemfira Guseinova, Ministry of Health, Azerbaijan
Lina Halboni, Ministry of Health, Jordan
Bob Hatcher, Consultant to Pathfinder International, Jordan
Laila Jafari, Pathfinder International/Jordan
Laila Kerimova, Medical University of Azerbaijan
Suporn Koetsawong, Mahidol University, Thailand
Enriquito R. Lu, JHPIEGO
Kamil Melikov, Pathfinder International, Azerbaijan
Juiletta Mirbakirova, Medical University of Azerbaijan
John Naponick, AVSC/Engender Health
Fatheih Qtaishat, Ministry of Health, Jordan
Mohammad Said Rawabdeh, Ministry of Health, Jordan
Roberto Rivera, Family Health International
Izzet Shamkolova, Medical University of Azerbaijan
Rick Sullivan, Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
Zemfira Topcubasova, Medical University of Azerbaijan
Din Themy, Ministry of Health, Viet Nam
Duong Thi Cuong, Ministry of Health, Viet Nam
Jamie Uhrig, Consultant to Pathfinder International/Viet Nam
Irina Yacobson, Family Health International
Graciela Salvador-Davila, Pathfinder International
Special thanks are due to Suellen Miller, who used her expertise as a clinical trainer to significantly improve the module through editing and the addition of training exercises, new methodologies, and material, and to Bob Hatcher for using this module in its earlier form and for his valuable input.

Special thanks also to the trainers in Jordan for improvements to the pre- and post-tests.

Many thanks to members of the IUD Subcommittee of USAID’s Maximizing Access and Quality Initiative who provided input for the revision of this module. The IUD Subcommittee worked for many months to compile, document, and promote evidence-based practices related to the IUD. Their work culminated in the development of the IUD Toolkit. The toolkit provides comprehensive, standardized, scientifically accurate, and evidence-based information on the IUD. It can be found at http://www.maqweb.org/iudtoolkit.
# Table of Contents

**Participant Handouts**

1.0.1: Suggestions for Effective Participation  
1.0.2: Exercises: “Where are we?” and “Reflections”  
1.0.3: Unit 1 Pretest  
1.1.1: Key Messages  
1.2.1: The IUD as a Method  
1.3.1: Advantages and Disadvantages  
1.4.1: Indications for Using the IUD  
1.5.1: Eligibility Criteria  
1.6.1: Rumors and Misconceptions  
1.7.1: The Six-Step Counseling Model (RESPECT)  
1.7.2: Key Elements in IUD Counseling  
1.8.1: Client Screening  
1.8.2: Recommendations for Updating Selected Practices in IUD Insertion and Removal  
1.8.2: Client Assessment Checklist for Small Group Exercise  
1.9.1: Timing of IUD Insertion and Removal  
1.10.1: Describing IUD Insertion and Removal to Clients  
1.11.1: Common Side Effects and Warning Signs of Possible Complications  
1.12.1: Unit 1 Post-Test  
2.1.0: Unit 2 Pretest  
2.1.1: Role-Play Situations  
2.1.2: Competency-Based Checklist for IUD Counseling Skills  
2.1.3: Observer’s Role-Play Checklist for Counseling Skills  
2.2.1: IUD Screening  
2.2.2: Client Assessment Checklist  
2.2.3: Pelvic Bimanual and Speculum Exam Checklist  
2.3.1: Instructions for Loading the TCu 380A in the Sterile Package  
2.4.1: Basic Principles for IUD Insertion and Removal  
2.4.2: Passing a Uterine Sound  
2.4.3: Inserting the Loaded TCu 380A IUD  
2.4.4: Using the Clinical and Counseling Skills Checklist  
2.4.5: Checklist for IUD Counseling and Clinical Skills
### Table of Contents: Continued

<table>
<thead>
<tr>
<th>Participant Handouts</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.5.1: Infection Prevention for IUDs</td>
<td>74</td>
</tr>
<tr>
<td>2.5.2 Competency-Based Skills Checklist for Infection Prevention</td>
<td>76</td>
</tr>
<tr>
<td>2.6.1: IUD Follow-Up Care</td>
<td>79</td>
</tr>
<tr>
<td>2.6.2: IUD Post-Insertion Follow-Up Care</td>
<td>80</td>
</tr>
<tr>
<td>2.6.3: Management of Complications</td>
<td>83</td>
</tr>
<tr>
<td>2.6.4: Management of Side Effects and Complications</td>
<td>86</td>
</tr>
<tr>
<td>2.6.5 Managing Severe Cramping</td>
<td>91</td>
</tr>
<tr>
<td>2.6.6: Managing Amenorrhea</td>
<td>92</td>
</tr>
<tr>
<td>2.6.7: Managing Expelled IUD</td>
<td>93</td>
</tr>
<tr>
<td>2.6.8: Managing Missing Strings</td>
<td>94</td>
</tr>
<tr>
<td>2.6.9: Managing Irregular or Heavy Bleeding</td>
<td>96</td>
</tr>
<tr>
<td>2.6.10: Case Study # 1</td>
<td>97</td>
</tr>
<tr>
<td>2.6.11: Case Study #2</td>
<td>98</td>
</tr>
<tr>
<td>2.6.12: Case Study #3</td>
<td>99</td>
</tr>
<tr>
<td>2.6.13: Case Study #4</td>
<td>100</td>
</tr>
<tr>
<td>2.7.1: Minimum Standards for IUD Services</td>
<td>101</td>
</tr>
<tr>
<td>2.1.0: Unit 2 Pretest</td>
<td>102</td>
</tr>
</tbody>
</table>

### Appendix

- IUD Training Course Participant Evaluation: 105
- Major References and Training Materials: 108
Intrauterine Devices (IUDs)
Unit 1:
An Overview of the IUD
Participant Handout: 1.0.1: Suggestions for Effective Participation

DO

• Ask a question when you have one.
• Feel free to share an illustration.
• Request an example if a point is not clear.
• Search for ways in which you can apply a general principle or idea to your work.
• Try to evaluate how you are already performing a skill based on new techniques you are learning.
• Think of ways you can pass on ideas to your subordinates and coworkers.
• Be skeptical—don’t automatically accept everything you hear.
• Feel free to ask for clarification.
• Respect the ideas of other participants.

DON’T

• Try to develop an extreme problem just to prove the trainer doesn’t have all the answers. (The trainer doesn’t.)
• Close your mind by saying, “This is all fine in theory, but...”
• Assume that all topics covered will be equally relevant to your needs.
• Take extensive notes; the handouts will satisfy most of your needs.
• Don’t monopolize class time by trying to show how much you know.
• Engage in side talk.
• Interrupt others.
Participant Handout: 1.0.2: Exercises: “Where are we?” and “Reflections”

Where Are We?
Starting each day with “Where are We?” is our opportunity to share insights, clarify issues, resolve problems, and review important material so that each of us can get the most out of the course and each day’s experiences.

Problems identified during the “Where Are We?” session should be resolved before continuing (whenever possible), since unresolved issues may hinder the learning process.

Each participant will be given two pieces of different colored paper. On one, participants write which topic they found most useful from the previous day and how they will apply it to their work. On the other piece they should write a question or concept from the previous day that needs clarification.

The trainer will process the exercise by reviewing and grouping the topics participants found most useful and by answering questions raised or clarifying areas of confusion.

Reflections
At the end of each day, take time to look over what we have done to
• Examine what it means to us individually, and
• Explore how what we have learned can be applied in a broader setting.

Be sure to close each day’s activities with a session of “Reflections” on the day.

There are many ways to conduct this exercise. One way is to pass out two colored cards to be completed anonymously. On one card, participants write what they liked about the day and what went well. On the other card, participants write things they did not like and that they hope will improve.

The housekeeping team and the training team will review the results. The trainer will announce the results the following day and will explain how the training team responded to the suggestions.

In addition to the “Reflections” exercise, participants should bring problems or concerns to the attention of the housekeeping team for discussion with the training team at the end of the day.

Make a note of the participants’ and trainer’s feedback, and attempt to address ideas and concerns during the discussion and during the following days’ lesson plans.
Participant Name: ________________________________

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

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

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

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

4. When an IUD client presents with a late period, you should rule out
   a. allergy to copper
   b. pregnancy
   c. cervical cancer
   d. PID
5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
   a. three days
   b. one week
   c. three to six weeks
   d. three to six months

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

7. The IUD is NOT an appropriate contraceptive method for a woman who
   a. is taking rifampin
   b. is not sure she wishes to have a tubectomy
   c. has unexplained vaginal bleeding
   d. gave birth three weeks ago

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

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

10. Correctly loading the TCu 380A IUD in the sterile package
    a. should be done only if sterile gloves are available
    b. assures that the IUD will remain sterile until it is removed from the package
    c. is not necessary for physicians
    d. all of above
11. List the five warning signs that alert the client that something is wrong:

12. TRUE or FALSE. Mark “T” or “F” in the blank to indicate true or false.

a. ___ Counseling should be integrated into each and every interaction with a family planning client.

b. ___ Following IUD insertion, heavy, yellow vaginal discharge is common.

c. ___ An IUD should only be removed during menstruation.

d. ___ An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.

e. ___ After an IUD is removed, a healthy woman may expect several months’ delay in return to fertility.

f. ___ It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.

g. ___ IUDs increase the risk of ectopic pregnancy.
Participant Handout 1.1.1: Key Messages

Key Messages

1. The IUD is a safe, easy to use, reversible, effective, long-term method of contraception.

2. IUD users are very satisfied with their IUD. However, the IUD affects menses, which may be a problem for some women.

3. Careful screening and counseling are essential for successful use of an IUD. *(The provider must know if the client should not use the IUD. The client must know how the IUD works, what the side effects might be, how to check for strings, and what the warning signs are.)*

4. IUDs can be safely used by breastfeeding women. *(The IUD does not affect breastfeeding.)*

5. IUDs are safe for AIDS clients controlled with Antiretroviral Therapy (ART).

6. IUDs can be a good choice for women with Combined Oral Contraceptive (COC) precautions. *(The IUD does not affect blood pressure, cause headaches, or affect the rest of the body.)*

7. IUDs can remain in for 5 to 12 years, depending on the type. *The latest scientific evidence shows that the Copper T 380A (TCu 380A) is effective for at least 12 years.*

8. Good infection prevention practices are necessary during insertion and removal to safeguard the client and possibly the practitioner from infection.
Types of IUDs available
There are two types of IUDs: medicated (hormone releasing) or unmedicated (inert). The inert IUDs include copper-containing devices in a range of shapes and sizes and a non-medicated polyethylene device. The hormone releasing IUDs either release progesterone or levonorgestrel. Almost all IUDs have one or two strings hanging from them. The TCu 380A is widely available around the world. This training module focuses on the TCu 380A.

TCu 380A
More than 25 million TCu 380A IUDs have been distributed in 70 countries throughout the world. This model is made of polyethylene with barium sulphate (for X rays). The TCu 380A is T shaped, with 314mm of copper wire wound around the vertical stem. Each of the two arms of the T has a sleeve of copper measuring 33mm. The bottom has a clear knotted string, creating a double string effect. The TCu 380A is inserted into the cavity of the uterus by pulling the outer barrel over the plunger (withdrawal technique). It has a lifespan of 12 years, and pregnancy rate is less than 1 per 100 women years.

Mechanism of Action
The copper bearing IUD’s principal mechanism of action is to prevent fertilization by affecting sperm motility and ova development. Research has shown that sperm counts found in cervical mucus and the uterine tube are much lower in women using copper-containing IUDs. In addition to its primary mechanism of action on the sperm, the copper-containing IUD also produces an inflammatory environment in the endometrium. There are two types of studies that substantiate this mechanism of action: assays for Human Chorionic Gonadotropin (hCG) levels and evaluations of washings from the vagina and cervix. In one study, the serum hCG levels of 30 IUD users were monitored for 30 months; there were no changes in these levels, meaning that there were no signs of early pregnancy. In another study researchers studied women who were undergoing sterilization in the middle of their menstrual cycle. The women’s fallopian tubes were flushed and the fluid was examined to look for sperm and fertilized eggs. Eggs were recovered in half of the women not using contraception. In women using IUDs, no fertilized, normally-dividing eggs were recovered. IUDs that contain progesterone also cause the thickening of cervical mucus, which stops the sperm from entering the uterus. IUDs are not abortifacients.

Effectiveness
The TCu 380A is a highly effective form of long-term, reversible contraceptive with an associated failure rate of 0.8 percent in the first year of use (Trussell, 2004). In a long-term international comparative trial sponsored by the World Health Organization (WHO), the average annual failure rate was 0.4 percent or less, and after 12 years of use the cumulative failure rate for women using the TCu 380A IUD was 2.2 percent, which is comparable to that of female sterilization (United Nations Development Programme et al., 1997).
Continuation Rates and Client Satisfaction
Continuation rates are also high in IUD users—higher than those of most other reversible methods. Large clinical trials conducted in many developing countries show that approximately 70% to 90% of women are still using their IUDs one year after insertion.

Note: Continuation rates are not effectiveness rates, but do represent user satisfaction with the method.
Participant Handout 1.3.1: Advantages and Disadvantages

Advantages and Health Benefits
- Highly effective.
- Safe for most women.
- Reversible and economical.
- May be safely used by lactating and postpartum women.
- Good choice for older women with COC precautions.
- Long duration of use. The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.
- One visit for insertion and minimal follow up is required after first three to six week checkup (unless the client has problems).
- Because nothing is required during sexual intercourse, IUDs allow women privacy and control over their fertility.
- Does not interact with medications.
- Can be removed whenever the client chooses.

Disadvantages and Health Risks
- Does not protect against STIs/HIV.
- Pelvic Inflammatory Disease (PID) may occur if the woman has Chlamydia or gonorrhea at the time of IUD insertion.
- May expose client to infection during insertion if infection prevention practices are not followed (this is minimal with good infection prevention procedures).
- Trained provider dependent.
- Some pain, cramping, minor bleeding on insertion.
- Heavier/longer menstrual periods, increased cramping, and bleeding/spotting fairly common in some women during the first three months.
- May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- Rarely, the wall of the uterus may be punctured during IUD insertion. Unless severe, this usually heals without treatment.
- Serious complications require immediate attention and good back up services.

Note: IUDs do not increase the risk of ectopic pregnancy. A WHO multicenter study found that IUD users are 50% less likely to experience an ectopic pregnancy than are women using no contraception. However, in the unlikely event of pregnancy in an IUD user, that pregnancy is more likely to be ectopic than would be a pregnancy in a non-user. Still, pregnancy for an IUD user is far more likely to be normal than ectopic: only an estimated 1 in every 13 to 16 pregnancies, or 6% to 8%, is ectopic.
Participant Handout 1.4.1: Indications for Using the IUD

Appropriate Users of IUDs
IUDs are an appropriate choice for a client who:
• Is not pregnant and wants an effective form of contraception;
• Has no signs of gonorrhea, Chlamydia, cancer, or reproductive tract abnormalities that would make insertion difficult;
• Is nulliparous (only after thorough consideration—infecion at a time of insertion should be carefully ruled-out);
• Has completed childbearing and does not want voluntary surgical contraception (IUDs are highly suitable for older women until menopause—the IUD is as effective as female sterilization, which has a failure rate of 0.5 per 100 women in the first year);
• Wants a long term, easily reversible method (IUDs have an excellent rate of return to fertility);
• Wants an effective method, but precautions exist for hormonal methods such as COCs (IUDs have little or no effect on body systems other than the reproductive tract);
• Is breastfeeding (IUDs do not affect lactation);
• Is immediately postpartum (IUDs may be inserted immediately after the delivery of placenta or within first 48 hours postpartum. **This procedure requires a specially trained provider.**);
• Has successfully used an IUD in the past (users with positive past experience tend to tolerate IUDs well); and
• Is in a mutually faithful sexual relationship (she is only having sexual intercourse with one person who is only having sexual intercourse with her). IUDs are appropriate for women who are at no or low risk for STIs and HIV. IUD insertion in a presence of gonorrhea or Chlamydia may increase risk for PID, which can lead to chronic pain, ectopic pregnancy, and infertility.
• An IUD is a safe method even for women who do hard physical work.

Women can begin using IUDs
• Without STI testing,
• Without an HIV test,
• Without any blood tests or other routing laboratory tests,
• Without cervical cancer screening, and
• Without a breast examination.

Summary
Crucial elements of safe IUD use are:
• The client is not pregnant,
• A careful screening and assessment of STI/HIV risk has been given,
• The provider is competent in IUD insertion and infection prevention practices,
• Reliable back up services available, and
• Careful and complete client counseling has been provided.
Participant Handout 1.5.1: Eligibility Criteria

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

*Note: These recommendations are based on the WHO Medical Eligibility Criteria Classifications, Third Edition, 2004. This interpretation is for use when clinical judgment is limited. For more detailed classification (categories 1-4) refer to the WHO Medical Eligibility Criteria for Contraceptive Use.*

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES (use the method)</th>
<th>NO (don't use the method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Postpartum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Less than 48 hours</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>- 48 hours to four weeks</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Four weeks or longer</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Puerperal sepsis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postabortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- First trimester</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>- Second trimester</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>- Postseptic abortion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Menarche to 20 years</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>- 20 years or older</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential hypertension</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>History of preeclampsia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep venous thromboembolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Superficial venous thrombosis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Current and history of ischemic heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known hyperlipidaemias</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Valvular heart disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Irregular vaginal bleeding</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Condition</td>
<td>YES (use the method)</td>
<td>NO (don’t use the method)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Unexplained vaginal bleeding, before evaluation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Breast disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cervical intraepithelial neoplasia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cervical ectropion</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pelvic inflammatory disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Past</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Current</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>STIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current purulent cervicitis or chlamydial infection or gonorrhea</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Vaginitis without purulent cervicitis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Increased risk of STIs</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• HIV infected</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• AIDS (not on antiretroviral therapy)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• Clinically well on antiretroviral therapy</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>• High risk of HIV</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Biliary tract disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>History of cholestasis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Viral hepatitis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Cirrhosis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Liver tumors</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Uterine fibroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Without distortion of the uterine cavity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• With distortion of the uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Past-ectopic pregnancy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Thalassemia</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

1 Note: If the woman has a very high individual likelihood of exposure to gonorrhea or Chlamydia infection, don’t initiate use of the IUD. “There is no universal set of questions that will determine if a woman is at very high individual risk for gonorrhea and chlamydia. Instead of asking questions, providers can discuss with the client the personal behaviors and the situations in their community that are most likely to expose women to STIs.” (World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. Family Planning: A Global Handbook for Providers. Baltimore and Geneva: CCP and WHO, 2007. 138)

2 Note: IUDs do not protect against STIs or HIV. If there is a risk of STIs or HIV, the correct and consistent use of condoms is recommended.
<table>
<thead>
<tr>
<th>Condition</th>
<th>YES (use the method)</th>
<th>NO (don’t use the method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trophoblast disease</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Iron deficiency anemia</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Drug interactions</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nulliparous</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Distorted uterine cavity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Severe dysmenorrhea</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nonpelvic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pelvic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endometriosis</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Benign ovarian tumors</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>History of pelvic surgery</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

For additional information on any of these eligibility criteria, please refer to: World Health Organization. Medical Eligibility Criteria for Contraceptive Use, Third Edition 2004
Participant Handout 1.6.1: Rumors and Misconceptions

Rumors are unconfirmed stories that are transferred from one person to another by word of mouth. In general, rumors arise when:
• An issue or information is important to people, but it has not been clearly explained;
• There is no one available who can clarify or correct the incorrect information;
• The original source is perceived to be credible;
• Clients have not received complete and accurate information and had not been given enough time to internalize benefits and limitations of contraceptive options; and
• People are motivated to spread them for political reasons.

A misconception is a mistaken interpretation of ideas or information. If a misconception is imbued with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.

Despite much scientific evidence about the IUD, rumors or misconceptions still persist among the general population and unfortunately they are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs pertaining to family planning which they allow to affect their professional conduct.

The underlying causes of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about the IUD make rational sense to clients, or potential clients.

Methods for Counteracting Rumors and Misconceptions
1. When a client mentions a rumor or misconception, **always listen politely. Don't laugh.**
2. **Define** what a rumor or misconception is.
3. **Find out where the rumor came from** and talk with the people who started it or repeated it. Find out if there is some basis for the rumor.
4. **Explain the facts.**
5. **Use strong scientific facts** about the IUD to counteract misinformation.
6. **Always tell the truth.** Never try to hide side effects or problems that might occur with the IUD.
7. **Clarify information** with the use of demonstrations and visual aids.
8. **Give examples of people who are satisfied users** of the IUD (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
9. **Reassure the client** by examining her and telling her your findings.
10. **Counsel** the client about the possible side effects of the IUD and prepare her to recognize signs of a possible complication. Clients uneducated about possible side effects can become the source of rumors, rather than satisfied clients.
11. Reassure the client and let her know that you care by **encouraging her to return** if she has any questions or concerns about her IUD.
<table>
<thead>
<tr>
<th>Rumor or Misconception</th>
<th>Facts &amp; Realities: Information to Combat Rumors</th>
</tr>
</thead>
<tbody>
<tr>
<td>The thread of the IUD can trap the penis during intercourse.</td>
<td>The strings of the IUD are soft and flexible, cling to the walls of the vagina and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot injure it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)</td>
</tr>
<tr>
<td>A woman who has an IUD cannot do heavy work.</td>
<td>Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.</td>
</tr>
<tr>
<td>The IUD might travel inside a woman’s body to her heart or her brain.</td>
<td>There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. The provider can teach the client how to feel for the string, if the client is comfortable doing so.</td>
</tr>
<tr>
<td>A woman who was wearing an IUD became pregnant. The IUD became embedded in the baby’s forehead.</td>
<td>The baby is very well-protected by the sac filled with amniotic fluid inside the mother’s womb. <strong>If a woman gets pregnant with an IUD in place, the health provider will remove the IUD immediately due to the risk of infection.</strong> If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.</td>
</tr>
<tr>
<td>The IUD rots in the uterus after prolonged use.</td>
<td>Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made up of materials that cannot deteriorate or “rot.” It simply loses its effectiveness as a contraceptive after 12 years.</td>
</tr>
<tr>
<td>Rumor or Misconception</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>An IUD can’t be inserted until 12 weeks postpartum.</strong></td>
<td>If health-care providers are specially trained, the IUD can be inserted immediately after the delivery of the placenta or immediately following a Cesarean section, or up to 48 hours following delivery. Expulsion rates for postpartum insertion vary greatly, depending on the type of IUD and the provider's technique. Current information indicates that expulsion rates may be higher during the period from 10 minutes to 48 hours after delivery, as compared with the first 10-minute period. To minimize the risk of expulsion, only properly trained providers should insert IUDs postpartum. Use of an inserter for IUD insertion tends to reduce the expulsion rate. After the 48 hour postpartum period, a TCu 380A may be safely inserted at four or more weeks postpartum. The withdrawal technique for TCu 380A insertion helps minimize perforations when inserting IUDs four to six weeks postpartum. Other types of IUDs may have different perforation rates. It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum.</td>
</tr>
<tr>
<td><strong>The IUD causes ectopic pregnancy.</strong></td>
<td>There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. One study (Vessey, et. al., 1979) showed the risk of ectopic pregnancy to be the same for all women (with or without an IUD). Both the copper and levonorgestrel-releasing contraceptives reduce the risk of ectopic pregnancy, when compared with no use of contraception. (Sivin et al 1991 and Ory 1981). In WHO trials, the 12-year cumulative discontinuation rate for ectopic pregnancy was only 0.4 per 100 women. (WHO, 1997)</td>
</tr>
<tr>
<td><strong>In IUD that is discolored in the package is dangerous and can’t be used.</strong></td>
<td>The copper on IUDs sometimes changes color in the package as it oxidizes (reacts to air). The IUD can still be used and is safe as long as the package is not torn or broken open and as long as it is not past the expiration date printed on the packaging.</td>
</tr>
<tr>
<td><strong>Women who have never given birth cannot use an IUD.</strong></td>
<td>Uterine enlargement by pregnancy, even when the pregnancy ends in abortion or miscarriage promotes successful IUD use. WHO carefully reviewed all of the literature before listing nulliparity as Category 2, (generally use, some follow-up may be needed). However, women who have never been pregnant have an increased rate of expulsion.</td>
</tr>
<tr>
<td>Rumor or Misconception</td>
<td>Facts &amp; Realities: Information to Combat Rumors</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Women infected with HIV cannot use an IUD.</td>
<td>IUD use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment. A cohort study of IUD use among HIV-infected women in Nairobi showed no significant increase in the risk of complications, including infection, in early months of use. Also, viral shedding did not increase among these users.</td>
</tr>
<tr>
<td>IUDs increase the risk of Pelvic Inflammatory Disease (PID) and must be removed when it occurs.</td>
<td>Many studies have confirmed that the risk of infection and infertility among IUD users is very low (Hatcher, 2004). However, studies also indicate that the insertion process and not the IUD or its strings, pose the temporary risk of infection. Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. The risk of infection following IUD insertion returns to a very low or normal level after 20 days (Farley et al., 1992).</td>
</tr>
</tbody>
</table>
Upon introducing a client to any contraceptive method, effective client-centered counseling is the key to successful, ongoing contraception use and effectiveness. This takes time; the client-centered counseling relationship should never be a hurried conversation. Combined ignorance, misinformation, and conservative resistance to change place a burden on the provider to earn each client’s trust. The counseling provider must be aware of her or his demeanor and how the client responds, adjusting her or his style to the situation. Listening skills are essential. Bearing in mind the six steps in the counseling process (“RESPECT”) the following points should be taken into consideration:

**Rapport:** the provider establishes a rapport with the client by being friendly and respectful, and avoiding making negative judgments and assumptions.

**Empathy:** the provider demonstrates empathy through active listening and identifying with the client’s needs, wishes and concerns. Use positive body language and other strategies to demonstrate nonjudgmental acceptance of the client’s ideas and feelings, and verbally acknowledge the client’s feelings and expresses understanding.

**Support:** the provider asks about and acknowledges the barriers to care and compliance, offers the client concrete ways to overcome barriers, involves family members when appropriate, and reassures the client that she or he is there to help.

**Partnership:** the provider is flexible, and stresses that the client and provider are working together to help the client make her own choices. The provider should always make plans for the client’s return visit and help her weigh her options around discontinuing or switching methods.

**Explanations:** the provider provides clear explanations of all advantages, disadvantages, and possible side or adverse effects of various methods, according to the expressed needs and preconceptions of the client. The provider explains how to use methods successfully, what to do if the client encounters problems, and asks the client to repeat these instructions.

**Cultural sensitivity:** the provider displays cultural sensitivity while counseling the client, and understands that both the provider and client view each other through ethnic or cultural stereotypes. The provider should be aware of own biases and preconceptions, and know his or her limitations in addressing counseling and medical issues across cultures.

**Trust:** Because it is difficult for the client to speak about personal health issues, the provider spends time building the client’s trust for effective counseling.

Remember that although the provider is the expert in health care, the client is the foremost expert on her health needs, her social and economic circumstances, and her traditional values and expectations. This is key in demonstrating respect. These forces weigh heavily in the acceptance or rejection of family planning methods, as well as ongoing compliance.
Client-centered counseling sessions should be private and never hurried. Time is well spent in building knowledge and trust in the initial interview, and each conversation should be responsive to the circumstances and needs of the individual client. From initial contact, the client should be actively reassured that all aspects of her relationship with the provider and visits to the clinic will be kept confidential. The client and all of her questions and concerns about the use of IUDs (or any other method) must remain central, and as much time as is needed should be allowed for her to become comfortable with the information. Her cultural and traditional beliefs should be explored, respected, and taken into consideration. Language must be clear and easy to understand; a confused look should be queried.

Counseling must cover key issues in logical sequence. For new clients with no method in mind, the full range of appropriate and available contraceptive methods should be explained in enough detail to allow the client to make an informed decision. The provider must help the client identify her priorities and limitations (e.g., long-lasting versus something taken daily, or a concern about bleeding). If the client has a method in mind, it should be explored first, but other contraceptive options should also be explained sufficiently to allow the client to make an informed choice.

Client choices are made easier if the provider can highlight the significance of different options in light of the client’s personal circumstances. This should include an assessment of her individual risk for STIs, which can influence the choice of method. Such a conversation may be difficult, and the provider needs to be comfortable and professional with helping the client honestly address these important issues. Detailed information must be shared about which forms of contraception protect against STIs and HIV, and which do not.

If the client decides to use an IUD, clear and comprehensive information should be given about its safety, effectiveness, correct use, what to expect after IUD insertion, possible side effects, warning signs and complications, where and when to return, and the fact that it does not protect against STIs and HIV.

### Side Effects vs. Complications

Failure to prepare clients to distinguish between normal side effects and more serious complications, and the appropriate response in either case, is the most common reason why women reject specific family planning methods or discontinue their use. This is an area of enormous misinformation and suspicion, and the provider must spend as much time as needed to

---

**Information to Include**

- Effectiveness of the IUD
- Mechanism of action
- Lasts 12 years
- Safety (complications are rare)
- Health benefits and potential risks
- Rapid return to fertility
- Side effects
- Warning signs
- Need for protection against STIs/HIV

---

**Possible side effects include:**

- Bleeding or spotting for the first few days following insertion,
- Heavier menses, and
- More cramping for the first few periods.

**Signs of possible complications include:**

- Fever (a possible sign of infection);
- Abdominal pain or pain during intercourse;
- Purulent or foul smelling discharge; and
- An IUD string that becomes shorter, longer, or missing.
Inform the Client

- There is a small risk of pelvic infection in the 20 days following IUD insertion.
- Tell her and where to seek medical help if side effects or complications occur.
- The most likely cause of IUD failure is expulsion (show the client how to check for strings).
- Menstrual abnormalities are common in the first 3-6 months.
- If side effects are unacceptable they can have the IUD removed.

allay the client’s fears, clarify exactly what is normal and what is problematic, and encourage a decision with which she is comfortable. Possible side effects such as bleeding or spotting for the first few days following IUD insertion, heavier menses, and/or possibly more cramping for the first few periods must be spelled out clearly. The client should be reassured that these side effects are experienced by many, are harmless, and that she can come back any time she has concerns.

Possible complications and their warning signs should be thoroughly explained and differentiated from the side effects. It is useful at this point to personalize the information for the client, helping her compare the risks of using a method with those of becoming pregnant.

Once the client has selected an IUD, the provider should give complete and accurate information on exactly when and why the client should return for the follow-up visit, which should be three to six weeks following insertion. This should be coupled with the message that she should return any time that she has any questions or concerns about side effects, possible complications, or using the IUD. Counseling should also help the client identify any potential barriers to the implementation of her decision to use the IUD, such as partner resistance, not being able to cope with side effects, difficulty accessing care and services, etc. The provider should help the client develop strategies and acquire skills to overcome these barriers.

Returning clients should be asked about their satisfaction with the IUD. Complaints of side effects, concerns, misconceptions and other related or unrelated problems raised by the client should be taken seriously and addressed (including appropriate counseling and management of side effects). Client’s changing circumstances should be explored and addressed as needed (like a developing health condition, a change in individual risk for STIs, etc.).

Effective counseling offers clients important guidance in identifying and articulating their personal health-care needs. The effective provider-counselor plays an important role in enabling people unused to health care to assert themselves, identify their priorities, and participate in their own healthcare management. No amount of professional prevention is as effective as an informed client working for her own health.
Participant Handout 1.8.1: Client Assessment Checklist for Small Group Exercise

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

Why screen?
• To determine indications for use
• To identify precautions
• To identify other health or special problems

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

Client Assessment Checklist for Small Group Exercise

*Note: Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an IUD inserted if she wants.*

<table>
<thead>
<tr>
<th>Clinician's Questions</th>
<th>Rationale for Question</th>
<th>Client Response</th>
<th>Recommended Action/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you give birth more than 48 hours ago but less than 4 weeks ago?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>2. Have you had a miscarriage or an abortion with an infection, within the past 4 weeks?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>3. Has it been more than 12 days since the first day of your last menstrual period?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>4. Is there a chance that you could be pregnant? Is your period late or have you missed a recent period?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>5. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>6. Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>7. Over the past 3 months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any female conditions or problems (gynecologic or obstetric conditions or problems)?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
<tr>
<td>9. Do you have any other medical conditions that you think are important to tell me?</td>
<td></td>
<td>YES NO</td>
<td></td>
</tr>
</tbody>
</table>
### Clinician’s Questions

<table>
<thead>
<tr>
<th>Clinician’s Questions</th>
<th>Rationale for Question</th>
<th>Client Response</th>
<th>Recommended Action/Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Assure client of confidentiality before asking questions 10-13)</td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>10. Is there any possibility that you or your partner have sex partner(s) outside the relationship?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Are you at risk for STIs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have you had an STI or PID within the past 3 months? Do you have an STI or PID or any other infection of the female organs now?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Are you concerned that you might have AIDS? If yes, are you being treated with ARVs?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Participant Handout 1.8.2: Recommendations for Updating Selected Practices in IUD Insertion and Removal

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

Recommendations
a) The IUD may be inserted at anytime during the first 12 days after the start of menstrual bleeding or anytime during the menstrual cycle, at the client’s convenience, when you can be reasonably sure she is not pregnant. The IUD is effective immediately.

Rationales
a) The IUD prevents pregnancy if inserted before implantation.


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

Recommendations
An IUD may be inserted:

a) Immediately post-placental, or during or immediately after a Cesarean section (special training required).

b) Prior to hospital discharge, up to 48 hours after delivery (special training required).

c) As early as four- to six-weeks postpartum, to accommodate women who come to the clinic for routine postpartum care and who request an IUD. Copper T IUDs may be safely inserted at this time. For other types of IUDs, it may be prudent to wait until six-weeks postpartum.

d) While women continue to breastfeed.

Rationales
a-b) With the appropriate technique, IUDs inserted immediately after placental delivery or Cesarean section can be safe and effective. Expulsion rates for postpartum insertion vary greatly depending on both the IUD type and provider’s technique. Current information indicates that the expulsion rates may be higher from 10 minutes to 48 hours after delivery than in the first 10 minute period. To minimize risk of expulsion, only properly trained providers (according to relevant national or institutional standards) should insert IUDs postpartum. Use of an inserter for IUD placement tends to reduce expulsion risk. Clients should be counseled that expulsion rates are higher postpartum than for interval insertion and should be carefully trained to detect expulsions.

c) A TCu 380A may be safely inserted at 4-weeks postpartum. The withdrawal technique for TCu 380A insertion presumably helps minimize perforations when inserting IUDs at the routine 4- to 6-week postpartum visit. Other IUDs that have a different profile or a push insertion technique might have different perforation rates. Given the relative lack of information on other IUDs at four- to six-weeks postpartum, it is prudent to wait until six weeks for the insertion of IUDs other than Copper Ts.


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


Q.3. Can an IUD be inserted immediately postabortion?

*Recommendations*

a) Yes, the IUD may be inserted immediately postabortion (spontaneous or induced) if the uterus is not infected, or during the first seven days postabortion, (or anytime you can be reasonably sure the woman is not pregnant).

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

- With confirmed or presumptive diagnosis of infection (sign of unsafe or unclean induced abortion, signs and symptoms of sepsis or infection, or inability to rule out infection), do not insert an IUD until the risk of infection has been ruled out or the infection has been fully resolved (approximately three months).

- With serious trauma to the genital tract (uterine perforation, serious vaginal or cervical trauma, chemical burns), do not insert an IUD until the trauma has healed.

- With hemorrhage and severe anemia, inert or copper-bearing IUDs are not advised until hemorrhage or severe anemia is resolved. However, progestin-releasing IUDs decrease menstrual blood loss and can be used with severe anemia.

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

*Rationales*

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

Fertility returns almost immediately postabortion (spontaneous, or induced): within two weeks for first trimester abortion and within four weeks for second trimester abortion. Within six weeks of abortion, 75% of women have ovulated.
b) After 16 weeks gestation, the uterine cavity will be too enlarged for postabortion IUD placement to be accomplished by routine IUD insertion techniques. Only providers trained to do postpartum IUD insertion should perform immediate postabortion IUD insertion for postabortion clients after 16 weeks gestation.

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

**Recommendations**

a) There should be one follow-up visit approximately three to six weeks after insertion; thereafter, there is no need for a fixed follow-up schedule.

b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has

- A late period (possible pregnancy);
- Prolonged or excessive abnormal spotting or bleeding;
- Abdominal pain or pain with intercourse;
- Infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain especially with fever; or
- A string missing or a string that seems shorter or longer.

c) Visits are encouraged for other preventive reproductive health care as available, including provision of condoms.

**Rationales**

a-c) A follow-up visit at three to six weeks is prudent as the peak incidence of PID post-IUD insertion is at one month. The best quality of care is to focus clinic resources and attention to women who come back to the clinic with complaints or problems.


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

**Recommendations**

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

**Rationales**

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

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

**Recommendations**

a) No. An IUD can be used from menarche until menopause.

**Rationales**


b) IUDs can generally be used by young women between menarche and 20 years of age. However, there is some concern about both the risk of expulsion due to nulliparity and the risk of STIs due to sexual behavior in younger age groups (World Health Organization. Medical Eligibility Criteria for Contraceptive Use. Third Edition. Geneva, Switzerland: World Health Organization, 2004.).

**Q.7. a) Is there a need for a “rest period” with IUDs after a certain period of use?**

**Recommendations**

b) Are there medical reasons for removal of an IUD?

a) If a woman wants a new IUD when an old one has expired, no rest period is needed.

b) IUD removal is indicated if

- The woman requests removal,
- The woman develops precautions/contraindications, or
- The effective life of the IUD is reached. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.)

**Rationales**

a-b) The removal and reinsertion of an IUD exposes a woman to a small risk of introduction of
vaginal or endocervical canal microorganisms into the upper genital tract. For this reason, long-acting IUDs are preferred. The TCu 380A has been shown to be effective for at least 12 years.

Q.8. Following removal of an IUD for reasons of partial expulsion without infection, or expiration of the IUD, should one wait to insert another?

**Recommendations**

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

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

**Rationales**

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


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

Q.9. If a woman is at low risk of STIs based on history, may an IUD be inserted without any lab tests if there is no mucopurulent endocervical discharge or clinically apparent PID or cervicitis?

**Recommendations**

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

b) If PID, mucopurulent endocervical discharge, cervicitis, Chlamydial infection, or gonorrhea is present, do not insert the IUD, but treat for infection. Consider other contraceptive methods, if a STI is suspected.

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

**Rationales**

a-b) Lab tests may be impractical and often unaffordable (even in the developed world) to rule out gonorrhea and Chlamydia, the main causes of PID. Most Chlamydia tests are only 80% to 90% sensitive, tests for mycoplasma and ureaplasma are not routinely available, and cervical gram stain is less sensitive for gonorrhea. However, where gonorrhea culture and Chlamydia tests are affordable, negative test results provide reassurance to corroborate the woman’s history.
Q.10. Should an IUD be removed if the partner complains about the string?

**Recommendations**

a) Not necessarily. Explain to the woman and/or her partner what the partner is feeling and recommend they try again.

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

c) If partner complaints occur frequently, the service provider’s technique should be reviewed. Strings should be cut approximately three centimeters from the external os.

**Rationales**

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

Q.11. If the cervix is red due to eversion of the squamocolumnar junction (ectopy/ectropion), may the IUD be inserted without further investigation?

**Recommendations**

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

**Rationales**

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

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


c) Since Chlamydia is an intracellular parasite of columnar epithelial cells, women with ectropion may be more at risk of infection when exposed to Chlamydia.


Q.12. If a women complains of heavier menses or bleeding between menses, is there a medical basis for the IUD to be removed?

**Recommendations**

a) Not necessarily. As in premethod choice counseling, women should be informed that menses are normally heavier with the IUD and intermenstrual bleeding may occur, especially in the first few months. Inert IUDs should not be the first choice for this reason. Give nutritional advice on the need to increase the intake of iron-containing foods.

b) For mild to moderate bleeding and pain in the first month postinsertion, with no evidence of clinically apparent pelvic infection, and if reassurance is not sufficient but the woman wants to keep the IUD, a short course of a nonsteroidal anti-inflammatory agent other than aspirin (e.g., ibuprofen) may be given.

c) Bleeding generally decreases over time. If bleeding is heavy or the woman is anemic, treatment using oral iron can improve hemoglobin levels.

d) If bleeding or pain is severe, or the client wishes to discontinue use, remove the IUD.

e) If suspected, abnormal conditions which cause prolonged or heavy bleeding should be evaluated and treated as appropriate.

f) If pelvic infection is diagnosed, treat the infection with appropriate antibiotics with the IUD in place. If the client wishes to continue using the IUD, it does not need to be removed. If the client wishes to discontinue its use, remove the IUD after antibiotic use has been initiated.

**Rationales**

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


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


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


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


**Q.13. Can IUDs be safely inserted by trained nurses and midwives?**

**Recommendations**

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

**Rationales**

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


**Q.14. How much time should elapse between STI treatment and IUD insertion? What about previous STI incidence?**

**Recommendations**

a) If the client will not be at high personal risk for gonorrhea or Chlamydia in the future, treat the STI today, and insert the IUD when the infection is resolved (for acute PID, wait three months). If she remains at increased risk of PID, advise against IUD use unless you can rule out infection at the time of insertion.
Rationales

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

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


Q.15. Should IUDs be provided if infection prevention measures cannot be followed?

Recommendations

a) No. All sites inserting and/or removing IUDs should follow basic infection prevention measures, including:

- Aseptic technique, including appropriate hand washing by the provider and careful preparation of the cervix;
- Sterile (or high-level disinfected) IUDs and equipment;
- Correct decontamination of instruments; and
- Safe disposal of contaminated disposables.

Rationales

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


Sterilization is the safest and most effective method for processing instruments, which come in contact with the bloodstream, tissue beneath the skin, or tissues which are normally sterile. However, High Level Disaffection (HLD) is a perfectly safe and acceptable alternative. HLD destroys all microorganisms, including viruses causing hepatitis B and AIDS, but does
Intrauterine Devices (IUDs)

Contaminated wastes may carry high loads of microorganisms, which are potentially infectious to any person who contacts or handles the waste. Incineration provides high temperatures and destroys microorganisms and is therefore the best method for disposal of contaminated wastes. Incineration also reduces the bulk size of wastes to be buried. If incineration is not possible, all contaminated wastes must be buried as deeply as possible to prevent scattering the waste materials.

Q. 16. What should be done if a woman using a copper-bearing IUD is diagnosed with Pelvic Inflammatory Disease (PID)?

Recommendations

a) Treat the PID using appropriate antibiotics. There is no need for removal of the TCu 380A if she wishes to continue its use.

b) If she does not want to keep the IUD, remove it after antibiotic treatment has been started. If the IUD is removed, she should avoid sex or use condoms and be counseled about other regular contraceptive methods.

c) If the infection does not improve, generally the course would be to remove the IUD and continue antibiotics. If the IUD is not removed, antibiotics should also be continued. In both circumstances, her health should be closely monitored.

d) Provide comprehensive management for STIs, including counseling about condom use.

Rationale

a-d) Removing the IUD provides no additional benefit once PID is being treated with appropriate antibiotics.

1) Larsson, B., Wennegren, M., Investigation of a copper-intrauterine device (Cu-IUD) for possible effect on frequency and


Q.17. What should be done if a woman using a copper-bearing IUD is found to be pregnant?

Recommendations

a) Exclude ectopic pregnancy. Explain that she is at risk of second trimester miscarriage, preterm delivery and infection if the IUD is left in place. The removal of the IUD reduces these risks, although the procedure itself entails a small risk of miscarriage.

b) If the IUD strings are visible or can be retrieved safely from the cervical canal
   • Advise her that it is best to remove the IUD;
   • If the IUD is to be removed, remove it by pulling the string gently; and
   • Explain that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

c) If the IUD strings are not visible and cannot be safely removed
   • Where ultrasound is available, it may be useful in determining the location of the IUD. If the IUD is not located, this may suggest that an expulsion of the IUD has occurred.
   • If ultrasound is not possible or if the IUD is determined by ultrasound to be inside the uterus, explain the risks clearly and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge, or fever.

Rationale

a-c) Removing the IUD improves pregnancy outcome if the strings are visible or can be removed safely from the cervical canal. The risk of miscarriage, preterm delivery, and infection is substantial if the IUD is left in place.


Participant Handout 1.9.1: Timing of IUD Insertion and Removal

1. Having menstrual cycle
   • A woman can have an IUD inserted at any time within the first 12 days after the start of menstrual bleeding, at her convenience, not just during menstruation. No additional contraceptive protection is needed.
   • The IUD can also be inserted at any other time during the menstrual cycle, at her convenience, if it is reasonably certain that she is not pregnant. A clinician may be “reasonably certain” if the client has not had intercourse since last normal menses, or if she has been using another reliable method since her menses and her pelvic exam does not show any signs of possible pregnancy.
   • Many clinicians prefer to insert during or very soon after the menstrual period since there is little likelihood of pregnancy at that time. Another reason to insert the IUD at this time is that the woman is already bleeding, and the cramping may be less noticeable. Other clinicians prefer to insert mid cycle when the cervical os is a little larger.
     *Note: See Participant Handout 2.2.1: IUD Screening for assistance in ruling out pregnancy for nonmenstruating family-planning clients.*

2. Switching from another method
   • She can have the IUD inserted immediately, if it is reasonably certain that she is not pregnant. There is no need to wait for her next menstrual period. No additional contraceptive protection is needed.

3. Postpartum
   • A woman can have an IUD inserted immediately postpartum (within 10 minutes) following delivery of the placenta, or during or immediately after a cesarean section. This requires special training.
   • It can also be inserted within the first 48 hours postpartum.
     *Note: IUD insertion immediately or within 48 hours postpartum requires special training and should not be attempted without having received the required training.*
   • Expulsion rates may be higher for IUDs inserted during this time. Insertions after one week and before four to six weeks should be avoided because of the higher risk of complications including infection and uterine perforation.
   • Copper IUDs may be safely inserted as early as four- to six-weeks postpartum for those who come for routine postpartum care and who request an IUD.

4. Immediately Postabortion
   • The IUD may be inserted immediately postabortion (spontaneous or induced)—if the uterus is not infected—during the first seven days postabortion, or anytime you can be reasonably sure that the client is not pregnant.
   • IUDs should not be inserted immediately postabortion in the following situations:
     ○ When there are signs of unsafe or unclean induced abortion, signs of infection, or inability to
rule out infection, do not insert an IUD. **Do not insert an IUD until the risk of infection has been ruled out** or infection has fully resolved (approximately three months).

- When there is serious trauma to the genital tract such as uterine perforation, serious vaginal or cervical trauma, or chemical burns, do not insert an IUD until healed.

- When there is hemorrhaging and physical signs of severe anemia, inert or copper bearing IUDs are not advised until the hemorrhage or severe anemia is resolved. However, progestin releasing IUDs decrease menstrual blood loss and can be used in cases of severe anemia.

- Immediate postabortion IUD insertion after 16 weeks’ gestation requires special training of the provider. If the pregnancy went beyond 16 weeks, delay insertion for six weeks postabortion.

**Follow up schedule after IUD insertion**

a) There should be one follow up visit **approximately** three to six weeks after insertion; thereafter, there is no need for a fixed follow up schedule.

b) The client should be strongly encouraged to come to the clinic anytime she has questions or problems, particularly if she has

- A late period (possible pregnancy);
- Prolonged or excessive abnormal spotting or bleeding;
- Abdominal pain or pain during intercourse;
- Infection exposure (such as gonorrhea), abnormal vaginal discharge, or pelvic pain, especially with fever; or
- A missing string or the string seems shorter or longer.

c) Encourage clients to come in for other preventive reproductive health care if available, including provision of condoms, when appropriate.

**Timings and Reasons for IUD Removal**

- The IUD may be removed at any time during the menstrual cycle. Some clinicians prefer to remove IUDs during menses because the os may be slightly open and the client will not be concerned if she has any bleeding.
- Anytime the client requests—for any stated reason, or for no reason at all.
- There is evidence of IUD perforation.
- She has a known or suspected pregnancy.
- There has been partial expulsion—the old IUD may be removed and replaced with a new one.
- She has persistent, unacceptable side effects.
- When IUD has been in utero for its effective life a new IUD may be inserted immediately if no precautions are present.
- She has severe pain, or severe bleeding with evidence of marked anemia that is getting worse.
- Many complications may be treated with the IUD in place. There is no need to remove it in most cases.

**Note:** In most cases of known or suspected PID, the client should be treated with antibiotics, counseled, and the IUD left in place.
A health worker could explain the Copper T IUD and its insertion to her client like this:

“The TCu 380A IUD is a small flexible, device made of plastic and copper. It works mainly by stopping the sperm from meeting the egg. It is very effective, with little to remember. The latest scientific evidence shows that the TCu 380A is effective for at least 12 years. You can become pregnant again as soon as it is taken out.

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

“Inserting the IUD is simple. You may feel uncomfortable for a few minutes. Most women, however, say that it is not too painful and compare the feeling to having heavy menstrual cramps. Before I insert the IUD, I will need to ask you some questions about your medical history, and perform a pelvic examination to make sure the IUD is right for you.”
As with most contraceptive methods, IUDs are associated with certain common side effects. Most are not serious and can be handled by the provider or practitioner. Some may need referral to a specialist.

**Side effects may include:**
- Bleeding or spotting for the first few days following insertion,
- Heavier menses, and
- More cramping for the first few periods.

**Warning signs of possible complications include:**
- Syncope/bradycardia, vasovagal episode during insertion (fainting, becoming dizzy, or lowered heart rate during insertion);
- Abnormal bleeding (no period, heavy bleeding, abnormal spotting);
- Purulent or foul smelling discharge;
- Fever, (a possible sign of pelvic infection);
- Abdominal pain or pain during intercourse; or
- An IUD string that becomes shorter, longer, or is missing.
Participant Name_________________________________________________

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

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

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

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

4. When an IUD client presents with a late period, you should rule out
   a. allergy to copper
   b. pregnancy
   c. cervical cancer
   d. PID
5. Following the insertion of an IUD, you should recommend that the client, even if she has no problems, have it checked after
   a. three days
   b. one week
   c. three to six weeks
   d. three to six months

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

7. The IUD is NOT an appropriate contraceptive method for a woman who
   a. is taking rifampin
   b. is not sure she wishes to have a tubectomy
   c. has unexplained vaginal bleeding
   d. gave birth three weeks ago

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

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

10. Correctly loading the TCu 380A IUD in the sterile package
    a. should be done only if sterile gloves are available
    b. assures that the IUD will remain sterile until it is removed from the package
    c. is not necessary for physicians
    d. all of above
11. List the five warning signs that alert the client that something is wrong:

12. TRUE or FALSE. Mark “T” or “F” in the blank to indicate true or false.

a. ___ Counseling should be integrated into each and every interaction with a family planning client.

b. ___ Following IUD insertion, heavy, yellow vaginal discharge is common.

c. ___ An IUD should only be removed during menstruation.

d. ___ An IUD may be inserted at any time during the menstrual cycle, if the provider is reasonably certain that the client is not pregnant.

e. ___ After an IUD is removed, a healthy woman may expect several months’ delay in return to fertility.

f. ___ It is better to change all IUDs after two years, because leaving them in the uterus for a longer period may lead to development of complications.

g. ___ IUDs increase the risk of ectopic pregnancy.
Unit 2:
Providing Services
Participant Name ________________________________

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

1. In counseling a woman about the advantages of the TCu 380A IUD, you would inform her that the IUD
   a. is permanent
   b. is highly effective
   c. has few side effects for most women
   d. does not interfere with sexual intercourse
   e. is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD for a particular woman?
   a. pregnancy
   b. three or more children
   c. at risk for STIs
   d. history of candidiasis
   e. retroverted uterus
   f. current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
   a. determine uterine position and size
   b. rule out anteflexion
   c. rule out pregnancy
   d. rule out presence of infection, masses, and tumors
4. Prior to an IUD insertion all metal instruments used should be
   a. decontaminated with soap and water
   b. decontaminated in 0.5% chlorine solution for 10 minutes
   c. cleaned with formaldehyde and water
   d. cleaned with detergent and water
   e. high level disinfected by boiling in a covered pot for 20 minutes
   f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106 kPa pressure at 1210 degrees

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

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

7. The following are warning signs that you should explain to an IUD client, which indicate that she may be having a problem with her IUD and should seek medical attention:
   a. cramping with menses
   b. increased length of menstrual cycle
   c. sexual partner has abnormal penile discharge
   d. string is longer than usual
   e. pain with intercourse

8. IUD clients should be counseled
   a. before the insertion
   b. after insertion
   c. during each follow up visit
   d. all of the above
True or False: Mark “T” or “F” in the blank to indicate true or false.

9. ___ A woman herself is best at selecting her own contraceptive method.
10. ___ Douching daily after an IUD infection is recommended to prevent PID.
11. ___ A physical exam for an IUD client must include abdominal, speculum, and bimanual exams.
12. ___ You must use high level disinfected or sterile gloves to place a copper IUD in its inserter.
13. ___ A tarnished IUD in a sealed, undamaged package can be used.
14. ___ An IUD can be inserted in a woman who is ovulating.
15. ___ The “push” technique should be used when inserting copper T IUDs.
16. ___ The “no touch” technique should be used when inserting IUDs.
17. ___ An IUD client who has moderate bleeding for seven to ten days after insertion should have the IUD removed immediately.
18. ___ If PID is diagnosed in a woman with an IUD; the IUD should be removed, antibiotic treatment should be started and she should be counseled on and provided with an alternative contraceptive.
19. ___ If an IUD is partially expelled, it should be removed and a new IUD can be inserted immediately.
20. ___ If a woman becomes pregnant with an IUD, it should be left in place unless a problem develops.
Participant Handout 2.1.1: Role-Play Situations

A. General Counseling Role-Play
Participants should be able to demonstrate key messages about the IUD. Practice telling the key messages to:
- A very young woman,
- A woman much older than you are,
- Someone who is related to you, and
- Someone who believes her husband has another partner.

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

B. Deciding to choose an IUD - Client Assessment and Counseling Role-Plays
Role-play counseling for each of the situations below. What advice would you give to the client?

- A 17 year-old woman with no children who wants to become pregnant in two years.
- A 35 year-old woman with four children who has regular periods and does not want any more children.
- A 27 year-old woman with two children who has had PID once since the birth of her last child and wants more children in the future.
- A 20 year-old woman who is fully nursing a four week-old baby.
- A 40 year-old woman who has had all the babies she wants, but is still having regular bleeding; she has severe diabetes and must inject herself with insulin.
- A 19 year-old sex worker who has four children, a history of recurrent PID, hepatitis, and is HIV infected.
- A 32 year-old woman with two children who has heavy periods (she needs to change her pads every two hours, she bleeds for eight days) and on the first two days her cramps are so strong that she cannot go to her job.
- A 27 year-old woman with six children; she is very pale with light conjunctiva. She says that after her last baby was born, six months ago, she bled so much she had to go to the hospital. She complains that she has no strength. She does not want any more children.
- A 30 year-old woman with four children; she is not sure if she wants any more children. She is in a mutually monogamous relationship.
- A 30 year-old woman with four children. She is not sure if she wants any more children. Her husband travels for work and she thinks he may be having a relationship with a woman in another town.
- A 26 year-old woman with three children. Her husband is a transport worker and HIV infected. She has AIDS, but is currently being treated with ARVs and appears healthy. He left her and took the two older children when she became ill.
C. Findings on Pelvic Exam
Role-play what you would do if you encountered each of these scenarios and what you would say to the client.

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

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

D. Post-Insertion Role-Plays
Role-play telling the client the kind of IUD she has, when it has to be replaced, when she needs to come back, the danger signs, when the IUD becomes effective, how to check the strings, why the strings need to be checked, when and what changes she might expect with her period, how to protect herself from Genital Tract Infections (GTIs) and STIs, and reasons why she can have her IUD replaced. Practice telling this to:

- A very young woman,
- A woman much older than you are,
- Someone who is related to you, and
- Someone who believes her husband has another partner.

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

E. Removal Role-Plays
Role-play counseling for each situation, including what to tell any woman having her IUD removed, what to expect, when she can become pregnant again, how she can protect against pregnancy and STIs, etc.

- A 30 year-old woman with three children; she does not want any more children. Her periods are normal and she has had no problem with the IUD, which she has been using for six years. Her mother-in-law told her that this is too long to have the IUD. She is worried and she wants the IUD taken out so she can give her body a rest.
- Same situation, but she really doesn’t want to take a rest. She is telling you this story because she knows her husband has another sexual partner. She is worried that she is at risk for GTIs and STIs, but is ashamed to tell you.
- A 26 year-old with five children has decided that she wants the IUD removed because she is ready to have another child.
- A 35 year-old woman with four children doesn’t want any more children. She has had the IUD in place for 10 years and has come in to have it replaced.
- A 45 year-old woman has had an IUD in place for three years. Her menstruation is sometimes irregular and her friends have told her she is probably going through menopause and should have her IUD removed.
## Participant Handout 2.1.2: Competency-Based Checklist for IUD Counseling Skills

Note: For a more detailed counseling checklist and the RESPECT counseling model, refer to Participant Handout 1.7.1.

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

1. **Needs Improvement:** Step not performed correctly and/or out of sequence (if required) or is omitted.

2. **Competently Performed:** Step performed correctly in proper sequence (if required) but lacks precision, and/or the trainer/coach/supervisor needed to assist or remind the participant in a minor way.

3. **Proficiently Performed:** Step performed correctly in proper sequence (if required) and precisely without hesitation or need for any assistance.

4. **Not Observed:** Step not performed by participant during observation by trainer/observer.

---

| Participant: _____________________________ | Course Dates: ____________ |

### Task/Activity

#### Insertion Counseling

<table>
<thead>
<tr>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

- **Initial Interview (Private Area)**
  - Greets client in friendly and respectful manner.
  - Ensures necessary privacy.
  - Establishes purpose of visit and answers questions.
  - Provides general information about family planning.
  - Explains what to expect during clinic visit.
  - Asks client about her reproductive goals (i.e., does she want to space or limit births?).
  - Explores any attitudes or religious beliefs that either favor or rule out one or more methods.
  - Explains any information about the contraceptive choices available and the risks and benefits of each.
  - Helps the client begin to choose an appropriate method.

#### Method-Specific Counseling if a Client Chooses an IUD

<table>
<thead>
<tr>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

- Provides detailed information about the IUD.
  - Shows where and how the IUD is used.
  - Explains how it works and its effectiveness.
  - Explains possible side effects and other health problems.
  - Explains benign nature of the most common side effects and that they usually get better after three months.
  - Explains that the TCu 380A lasts for 12 years.
  - For older women, explains that it can be removed 1 year after her menstruation ends.
  - Explains that client can soon become pregnant when IUD is removed.
<p>| Task/Activity                                                                 | Cases |
|------------------------------------------------------------------------------+-------|
| Discusses the client’s needs, concerns, and fears in a thorough and sympathetic manner. |       |
| <strong>IUD Screening</strong>                                                            |       |
| Screens the client carefully to make sure there is no medical condition that would be a problem (completes Client Assessment Checklist). |       |
| Reviews potential side effects and possible complications and makes sure that they are fully understood. |       |
| <strong>Pre-Insertion Counseling (Examination/Procedure Area)</strong>                     |       |
| Reviews the Client Assessment Checklist to determine if the client is an appropriate candidate for the IUD and if she has any problems that should be monitored while the IUD is in place. |       |
| Informs client about required physical and pelvic examinations.               |       |
| Prepares the client for the examination while ensuring dignity and privacy.   |       |
| Checks that client is within 12 days of her last menstrual period.            |       |
| Rules out pregnancy if beyond day 12 (refers for medical care, if nonmedical counselor). |       |
| Describes the insertion process and what the client should expect during and after the procedure. |       |
| Inserts the IUD while maintaining sterile no-touch technique.                 |       |
| <strong>Post-Insertion Counseling</strong>                                                |       |
| Completes client record.                                                      |       |
| Teaches client how and when to check for strings.                            |       |
| Explains the importance of also using condoms for STI and HIV/AIDS protection. |       |
| Discusses what to do if the client experiences any side effects or problems.  |       |
| Provides follow-up visit instructions.                                        |       |
| Reminds the client that the TCu 380A can be left in for 12 years.             |       |
| Assures the client that she can return to the same clinic at any time to receive advice, medical attention, and, if desired, to have the IUD removed. |       |
| Asks the client to repeat instructions.                                       |       |
| Answers the client’s questions.                                               |       |
| Observes the client for at least 15 minutes before sending her home.          |       |
| <strong>Follow-Up Counseling</strong>                                                     |       |
| Greets the client in friendly and respectful manner.                          |       |
| Ensures privacy.                                                              |       |
| Asks the following questions;                                                 |       |
| • Have you been happy using the IUD?                                          |       |
| • Have you had any concerns or problems?                                     |       |
| • Has your health changed in any way since you had your IUD inserted?         |       |
| • Do you have any questions you would like me to answer?                     |       |
| • How are you protecting yourself from STIs? (Explains dual protection.)     |       |
| • Do you need some condoms?                                                   |       |
| • May I examine you?                                                          |       |
| <strong>Follow-Up Examination (3-6 weeks after insertion)</strong>                        |       |
| Explains to the client why and how she will do the pelvic examination.        |       |</p>
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepares the client while ensuring dignity and privacy.</td>
<td></td>
</tr>
<tr>
<td>Performs a pelvic examination and checks to make sure the string is visible and that there is no partial or complete expulsion.</td>
<td></td>
</tr>
<tr>
<td>Checks for pelvic infection.</td>
<td></td>
</tr>
<tr>
<td>Explains findings and reassures the client.</td>
<td></td>
</tr>
</tbody>
</table>

**Removal Counseling**

**Pre-Removal Counseling (Client Reception Area)**

- Greets the client in friendly and respectful manner.
- Establishes the purpose of the visit.
- Asks the client her reason for removal and answers any questions.
- Asks the client about her present reproductive goals (e.g., does she want to continue spacing or limiting births?).
- Describes the removal process and what she should expect during the removal and afterwards.

**Post-Removal Counseling**

- Discusses what to do if the client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).
- Asks the client to repeat the instructions.
- Answers any questions.
- Reviews general and method-specific information about family planning methods, if the client wants to continue spacing or limiting births.
- Assists the client in obtaining a new contraceptive method or provides a temporary method (barrier) until her method of choice can be started.
- Observes the client for five minutes before sending her home.
Participant Handout 2.1.3: Observer’s Role-Play Checklist for IUD Counseling Skills

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

<table>
<thead>
<tr>
<th>Task</th>
<th>Performed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Provider’s Nonverbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Friendly/welcoming/smiling</td>
<td></td>
</tr>
<tr>
<td>Nonjudgmental/receptive</td>
<td></td>
</tr>
<tr>
<td>Makes eye contact with the client, if culturally appropriate.</td>
<td></td>
</tr>
<tr>
<td>Faces the client directly</td>
<td></td>
</tr>
<tr>
<td>Listens attentively/nods head to encourage and acknowledge the client’s responses.</td>
<td></td>
</tr>
<tr>
<td>Shows positive regard for the client as a person.</td>
<td></td>
</tr>
<tr>
<td>Ensures the client’s privacy/confidentiality without having to be asked.</td>
<td></td>
</tr>
<tr>
<td>Remains patient/allows the client time to ask all questions.</td>
<td></td>
</tr>
<tr>
<td>Does not interrupt the client.</td>
<td></td>
</tr>
<tr>
<td><strong>Service Provider’s Verbal Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Phrases questions clearly and appropriately.Uses non-technical terms.</td>
<td></td>
</tr>
<tr>
<td>Uses a friendly tone of voice.</td>
<td></td>
</tr>
<tr>
<td>Listens to the client’s responses closely.</td>
<td></td>
</tr>
<tr>
<td>Answers the client’s questions clearly and completely.</td>
<td></td>
</tr>
<tr>
<td>Uses language the client can understand.</td>
<td></td>
</tr>
<tr>
<td><strong>RESPECT Model Process and Content</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rapport</strong></td>
<td></td>
</tr>
<tr>
<td>• Understands the client’s point of view.</td>
<td></td>
</tr>
<tr>
<td>• Is friendly and respectful.</td>
<td></td>
</tr>
<tr>
<td>• Assures privacy and confidentiality.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t judge the client.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t argue with the client or act superior.</td>
<td></td>
</tr>
<tr>
<td>• Doesn’t scold the client.</td>
<td></td>
</tr>
<tr>
<td>• Recognizes and doesn’t make assumptions about the client.</td>
<td></td>
</tr>
<tr>
<td><strong>Empathy</strong></td>
<td></td>
</tr>
<tr>
<td>• Remembers that the client has come for help.</td>
<td></td>
</tr>
<tr>
<td>• Tries to understand the client’s reason for his or her behavior/ideas.</td>
<td></td>
</tr>
<tr>
<td>• Uses positive body language and other strategies to demonstrate nonjudgmental acceptance of the client’s ideas and feelings.</td>
<td></td>
</tr>
<tr>
<td>• Verbally acknowledges the client’s feelings and expresses understanding.</td>
<td></td>
</tr>
<tr>
<td>Activity</td>
<td>Performed</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Support</td>
<td></td>
</tr>
<tr>
<td>• Asks about and acknowledges the barriers to care and compliance.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Offers the client concrete ways to overcome barriers.</td>
<td>No</td>
</tr>
<tr>
<td>• Involves family members when appropriate.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Reassures the client that she or he is there to help and answer questions.</td>
<td>No</td>
</tr>
<tr>
<td>• Encourages the client to return to the clinic if she has any concerns.</td>
<td>Yes</td>
</tr>
<tr>
<td>Partnership</td>
<td></td>
</tr>
<tr>
<td>• Is flexible.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Acknowledges the client’s needs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Stresses that the client and provider are working together.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Lets the client know she has options and can make her own choices.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Makes a plan for the client to continue to return to the clinic for follow-up.</td>
<td>No</td>
</tr>
<tr>
<td>• Helps returning clients weigh options of continuing or switching methods.</td>
<td>No</td>
</tr>
<tr>
<td>Explanations</td>
<td></td>
</tr>
<tr>
<td>• Gives information about available methods.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks which method interests the client.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks what the client knows about the method.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Corrects myths/rumors/incorrect information.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes how the method works and its effectiveness.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Uses audio-visual aids during counseling.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes the benefits and risks.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Describes potential side effects and warning signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Offers clear action steps to respond to side effects and warning signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Explains clearly what the client has to do to use the method successfully.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Asks the client to repeat back instructions.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Reminds the client again of danger signs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Answers the client’s questions clearly.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Encourages the client to return with problems or concerns.</td>
<td>Yes</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td></td>
</tr>
<tr>
<td>• Respects the client’s life style, cultural, and religious beliefs.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Helps the client understand how these may influence family planning and other reproductive health choices.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Understands that the client’s view of the provider may be defined by ethnic or cultural stereotypes.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Is aware of his or her own cultural biases and preconceptions.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Knows his or her own limitations in addressing counseling and medical issues across cultures.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Can explore cultural influences on attitudes and beliefs without disapproval. Can help the client explore these issues as well.</td>
<td>Yes</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
</tr>
<tr>
<td>• Recognizes that it may be difficult for clients to share personal information.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Effective at gradually developing a trusting relationship.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Consciously works to establish trust.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Responds to the client’s concerns, including rumors, respectfully and constructively.</td>
<td>Yes</td>
</tr>
<tr>
<td>• Respect the client’s choice of family planning methods.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Problem Solving

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does service provider respond appropriately to the client’s needs and problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the service provider convincing when giving advice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the advice given/method provided appropriate?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provider-controlled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Client-controlled?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Balanced?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What did you learn from observing this role-play?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Participant Handout 2.2.1: IUD Screening

Once a client has made the decision to use an IUD based on complete general method counseling, she needs to have IUD method-specific counseling (as covered in the previous objective and in Unit 1 of this module). Before you can assure her that the IUD is an appropriate choice for her, you should perform a limited history interview and physical exam to rule out conditions which might affect eligibility, including the possibility of pregnancy, genital tract abnormalities, pelvic tuberculosis, unexplained vaginal bleeding, uterine or cervical malignancy, or infection.

To aid the practitioner in obtaining the client’s history and giving a rationale for asking each question (as well as aiding decision making in case of a precaution), practitioners may use checklists such as Participant Handout 2.2.2: Client Assessment Checklist.

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

Finally, the practitioner should perform a complete pelvic exam to:
• Determine position and size of uterus;
• Rule out likelihood of pregnancy; and
• Rule out presence of visible and/or palpable abnormalities, including infections, masses, tumors, etc.

If any of these are present, an IUD should not be inserted until the problem is investigated and resolved. The trainer and practitioner can use Participant Handout 2.2.3: Pelvic Bimanual and Speculum Checklist for guidance.
### Participant Handout 2.2.2: Client Assessment Checklist

**Note:** Ask the client the questions below about known medical conditions. If she answers “no” to all of the questions, then she can have an IUD inserted.

<table>
<thead>
<tr>
<th>Service Provider’s Questions</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask the client the following questions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Did you give birth more than 48 hours ago but less than 4 weeks ago?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you had a miscarriage or an abortion within the past 4 weeks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has it been more than 12 days since the first day of your last menstrual period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Is there a chance that you could be pregnant; is your period late or have you missed a recent period?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths? Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Over the past 3 months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Over the past 3 months, have you had fever or chills accompanied by pain in the lower abdomen?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Have you recently had severe pelvic infection (with fever, chills, pain in the womb and/or discharge)? Or have you had problems with recurrent PID?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service Provider’s Instructions (and Rationale):</strong></td>
<td>If the client’s response falls in the “YES” column, follow the instructions below:</td>
<td></td>
</tr>
<tr>
<td>1. Did you give birth more than 48 hours ago but less than 4 weeks ago?</td>
<td>Do not insert. It is not advisable to insert an IUD after the first 48 hours postpartum until 4 weeks postpartum. During this time, the risk of uterine perforation is greater due to the rapidly involuting (shrinking) uterus.</td>
<td></td>
</tr>
<tr>
<td>2. Have you had a miscarriage or an abortion within the past 4 weeks?</td>
<td>Women who have recently had a miscarriage or abortion can have an IUD inserted if there is no sign of infection on pelvic examination. If you are unsure, make an appropriate referral.</td>
<td></td>
</tr>
<tr>
<td>3. Has it been more than 12 days since the first day of your last menstrual period?</td>
<td>If it has been fewer than 12 days since the beginning of menstruation you can be certain that the woman is not pregnant. If it has been more than 12 days, you must be sure that the woman is not pregnant</td>
<td></td>
</tr>
<tr>
<td>4. Is there a chance that you could be pregnant; is your period late or have you missed a recent period?</td>
<td>Do not insert the IUD if there is any chance that the client is pregnant. Perform a pelvic exam and a urine pregnancy test, if available. If you are unsure if she is pregnant, have the client use a barrier method and return in four weeks or upon beginning her menses. Note: Use following checklist on “How to be Reasonably Sure a Client is not Pregnant.”</td>
<td></td>
</tr>
<tr>
<td>5. Do you consider the bleeding during your menstrual periods to be unusually heavy? Heavier than other women? How many days? How often must you change pads/cloths? Do you often experience menstrual pains (cramps) severe enough to limit your daily activities?</td>
<td>If answer is “yes” to either question, encourage the client to consider another effective method. Explain to her that the IUD may make her bleeding even heavier. The IUD could also make her cramps worse. If she still prefers the IUD, insert it and ask her to come back if her bleeding or cramps become heavier.</td>
<td></td>
</tr>
<tr>
<td>6. Over the past 3 months, have you had any abnormally heavy periods or bleeding between periods or after intercourse?</td>
<td>These symptoms may indicate a health problem, such as cervicitis, cervical polyps, or, rarely, cancer. Look for signs of these problems when you do the speculum and bimanual examination.</td>
<td></td>
</tr>
<tr>
<td>7. Over the past 3 months, have you had fever or chills accompanied by pain in the lower abdomen?</td>
<td>These symptoms may indicate PID. Look for signs of tenderness, discharge, or guarding during pelvic examination. If you think infection is present, do not insert the IUD.</td>
<td></td>
</tr>
<tr>
<td>8. Have you recently had severe pelvic infection (with fever, chills, pain in the womb and/or discharge)? Or have you had problems with recurrent PID?</td>
<td>Do not insert the IUD. If the client currently has PID treat with antibiotics. If she has recurrent PID, help client make an informed choice of another effective contraceptive method. Discuss using condoms as her primary method of contraception or as a backup method to prevent PID.</td>
<td></td>
</tr>
</tbody>
</table>
Assure the client of confidentiality before asking the following questions:

<table>
<thead>
<tr>
<th>Ask the client the following questions:</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. As far as you know, does your sex partner have other sex partners besides yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have more than one sex partner?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you have AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Do you have any cancer in the female organs or pelvic tuberculosis?</td>
<td></td>
<td>Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: do not insert the IUD. Treat or refer for care as appropriate. Help her choose another effective method.</td>
</tr>
<tr>
<td>12. Are you currently taking any medications, such as high dose corticosteroids, immunosuppressive therapy, anticoagulant therapy, or receiving radiation therapy?</td>
<td></td>
<td>People using high dose corticosteroids or immunosuppressive drugs or receiving radiation therapy are at higher risk of infection. Also, anticoagulant therapy may increase blood loss. Do not insert the IUD. Help her to choose another effective method.</td>
</tr>
</tbody>
</table>

If the client’s response falls in the “YES” column, follow the instructions below:

- If “yes” to one or both questions, client needs to be screened for possible GTIs or STIs. Counsel the client on risks associated with HIV, GTIs, and STIs. If the client has current purulent cervicitis, Chlamydia infection, or gonorrhea, help her choose another contraceptive method, and advise her to use condoms and/or spermicide to protect herself against these diseases. If the client has other STIs (excluding HIV and hepatitis) or vaginitis (including trichomonas vaginalis and bacterial vaginosis) you may insert the IUD.
- If the client has AIDS, or is being treated with any medicines that make her body less able to fight infections, do not insert the IUD. Help her choose another effective method. However, if she is clinically well on ARV therapy, you may insert the IUD. Whatever method she chooses, urge her to use condoms. A woman infected with the HIV virus, but clinically well, may have an IUD inserted.
- Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: do not insert the IUD. Treat or refer for care as appropriate. Help her choose another effective method.
- People using high dose corticosteroids or immunosuppressive drugs or receiving radiation therapy are at higher risk of infection. Also, anticoagulant therapy may increase blood loss. Do not insert the IUD. Help her to choose another effective method.
Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

First, be reasonably sure that the client is not pregnant. If she is not menstruating at the time of her visit, ask the client questions 1–6. As soon as the client answers YES to any question, stop, and follow instructions below.

1. Have you had a baby in the last 4 weeks? NO
2. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then? NO
3. Have you abstained from sexual intercourse since your last menstrual period or delivery? NO
4. Did your last menstrual period start within the past 12 days? NO
5. Have you had a miscarriage or abortion in the last 12 days? NO
6. Have you been using a reliable contraceptive method consistently and correctly? NO

If the client answered YES to any one of questions 1–6 and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–13. However, if she answers YES to question 1, the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

To determine if the client is medically eligible to use an IUD, ask questions 7–13. As soon as the client answers YES to any question, stop, and follow instructions below.

7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)? NO
8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis? NO
9. Within the last 3 months, have you had more than one sexual partner? NO
10. Within the last 3 months, do you think your partner has had another sexual partner? NO
11. Within the last 3 months, have you been told you have an STI? NO
12. Within the last 3 months, has your partner been told that he has an STI or do you know if he has had any symptoms – for example, penile discharge? NO
13. Are you HIV-positive and have you developed AIDS? NO

If the client answered NO to all of questions 7–13, proceed with the PELVIC EXAM.

During the pelvic exam, the provider should determine the answers to questions 14–20.

14. Is there any type of ulcer on the vulva, vagina, or cervix? NO
15. Does the client feel pain in her lower abdomen when you move the cervix? NO
16. Is there adnexa tenderness? NO
17. Is there purulent cervical discharge? NO
18. Does the cervix bleed easily when touched? NO
19. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion? NO
20. Were you unable to determine the size and/or position of the uterus? NO

If the answer to all of questions 14–20 is NO, you may insert the IUD.

If the answer to any of questions 14–20 is YES, the IUD cannot be inserted without further evaluation. See explanations for more instructions.
### Participant Handout 2.2.3: Pelvic Bimanual and Speculum Exam Checklist

<table>
<thead>
<tr>
<th>Service Provider’s Observations</th>
<th>NO</th>
<th>YES</th>
<th>Service Provider’s Instructions (and Rationales)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look for the abnormalities listed below.</td>
<td></td>
<td></td>
<td>If a response falls in the “YES” column, follow the instructions below.</td>
</tr>
<tr>
<td>1. Is there marked tenderness of cervix, uterus, or adnexal area?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests PID or cervicitis. Help the client make an informed choice of another effective method. Encourage the client to use condoms and/or spermicide to protect against GTIs and other STIs, including AIDS.</td>
</tr>
<tr>
<td>2. Is the cervix immobile, or is there a palpable mass or ulcer?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> These abnormalities may indicate a tumor or, rarely, cervical cancer. Help the client make an informed choice of another method, and refer for further evaluation.</td>
</tr>
<tr>
<td>3. Are you unable to determine the position of the uterus?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> If you are unsure of the position of the uterus after bimanual palpation, seek consultation or refer for further evaluation.</td>
</tr>
<tr>
<td>4. Is the uterus enlarged, soft, and smooth?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> If the woman has also missed a period, she is likely to be pregnant. If you are certain she is not pregnant, an IUD may be inserted.</td>
</tr>
<tr>
<td>5. Is the uterus enlarged, firm, and/or irregular?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may indicate uterine fibroids which can change the shape of the uterine cavity. Attempt to insert the IUD only if you are experienced; otherwise, refer or help her to choose another method. If you refer, help her choose another method to use until she gets her IUD.</td>
</tr>
<tr>
<td>6. Is there a palpable mass in the adnexal area?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may indicate PID or a tumor of the ovary or tube. Help the client make an informed choice of another nonhormonal method until problem is solved. Make appropriate referral.</td>
</tr>
<tr>
<td>7. On sounding, is the uterine cavity irregular or deeper than 10 cm?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This may mean that she has fibroids, is pregnant, or the uterus was perforated by the sound. If perforation is suspected, observe the client for evidence of intra abdominal bleeding: decreased blood pressure, rising pulse and/or syncope.</td>
</tr>
<tr>
<td>8. Check for purulent vaginal discharge, lesions or sores.</td>
<td></td>
<td></td>
<td>Although ulcerative STIs are not a contraindication for initiating IUD, coinfection with gonorrhea and Chlamydia should be ruled out prior to insertion.</td>
</tr>
<tr>
<td>9. Is there discharge from the cervical canal?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests cervicitis. Diagnose and treat cervicitis. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STIs, including AIDS.</td>
</tr>
<tr>
<td>10. Is there a mass, ulcer, or bleeding on contact with the cervix?</td>
<td></td>
<td></td>
<td><strong>Do not insert an IUD.</strong> This suggests possible cervical polyp, severe cervicitis or, rarely, cervical cancer. Help client make informed choice of another method. Refer if necessary for further evaluation.</td>
</tr>
<tr>
<td>11. If findings on the bimanual examination are unclear, (position or size of uterus can’t easily be determined) perform a rectovaginal examination.</td>
<td></td>
<td></td>
<td><strong>Do not insert IUD if any cul-de-sac mass or tenderness are found. Investigate further.</strong></td>
</tr>
</tbody>
</table>
Participant Handout 2.3.1: Instructions for Loading the TCu 380A in the Sterile Package

How to Load the TCu 380A

Do not open the sterile package containing the IUD or load it until the final decision to insert an IUD has been made (i.e., after the pelvic examination, including both speculum and bimanual exams, has been performed). In addition, do not bend the arms of the “T” into the inserter tube (as instructed below) more than five minutes before it is introduced into the uterus. If the arms are left in the inserter tube too long, they will not straighten as easily.

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

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

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

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

**Step 5:** Through the **clear plastic cover**, place your thumb and index finger over the ends of the **horizontal arms** of the T and hold the T in place. At the open end of the package, use your free hand to push the I.D. card so that it slides underneath the T and stops at the **top seal** of the package. While still holding the tips of the **horizontal arms** of the T, use your free hand to grasp the **inserter tube** against the arms of the T, as indicated by the arrow in the figure below. This will start the arms of the T bending downward, towards the stem of the T, as indicated in the drawing on the I.D. card.
Step 6: Continue bending the arms of the T by bringing the thumb and index finger together. When the arms have folded enough to touch the sides of the inserter tube, pull the inserter tube out from under the tips of the arms. Then push and rotate the inserter tube onto the tips of the arms so that the arms become trapped inside the inserter tube next to the stem. Insert the folded arms into the tube only as far as necessary to ensure retention of the arms. Do not try to push the copper bands on the arms into the inserter tube; they will not fit.

Step 7: The blue depth gauge on the inserter tube is used to mark the depth of the uterus and to show the direction in which the arms of the T will unfold once they are released from the inserter tube. Holding the blue depth gauge in place through the clear plastic wrapper, grasp the inserter tube at the open end of the package with your free hand.

Pull the inserter tube gently until the distance between the top of the folded T and the edge of the blue depth gauge closest to the T is equal to the depth of the uterus as measured on the uterine sound. Rotate the inserter tube so that the long axis of the blue depth gauge is on the same horizontal plane as the arms of the T.
Step 8: The IUD is now ready to be placed in the woman's uterus. Carefully peel the clear plastic cover of the package away from the white backing. Lift the loaded inserter, keeping it horizontal, so that the T or white rod doesn’t fall out. Be careful not to push the white rod towards the T until you are ready to release the T in the fundus. **Do not let the inserter tube or the tip of the IUD touch any unsterile surfaces. If it touches any unsterile surfaces it must not be inserted in the uterus. Throw it away and get another one.**
Participant Handout 2.4.1: Basic Principles for IUD Insertion and Removal

Participants will achieve this objective through a variety of training methodologies. The step-by-step IUD insertion and removal sequence is found in Participant Handout 2.4.3: Inserting the Loaded TCu 380A IUD. The JHPIEGO video on IUD insertion and removal also details the procedure.

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

- Talk with the client before and during the procedure.
- Explain the procedure.
- Tell her she will experience some discomfort or cramping during the procedure.
- Ask her to tell you whenever she feels discomfort or pain.
- Tell her what is happening step-by-step.
- Provide reassurance.
- Alert her before any step that might cause pain.

**Gentle techniques** minimize discomfort and emotional trauma to the client. In order to perform a comfortable IUD insertion, force is neither necessary nor desirable.

- **No-touch technique**, in which the tip of the uterine sound (and the loaded IUD) that will touch the upper genital tract will not have previously touched anything that may contaminate it: hands, speculum, vagina, table top, etc.
- As already indicated in Specific Objective #2, the TCu 380A is loaded using the no-touch technique, inside the package.
- The cervix and vagina should be thoroughly prepped with antiseptic. Use a water-based antiseptic such as an iodophor (Betadine® or Povidone Iodine) or Chlorhexidine (Hibitane®).
  **Note:** If an iodophor is used, wait one or two minutes before proceeding because iodophors take up to two minutes contact time to release free iodine.
- The uterine cavity should always be sounded to confirm the position of the uterus and the depth of the cavity.
- Set the depth gauge on the IUD to the level on the uterine sound.
- Insert the IUD high in the fundus of the uterus by withdrawal technique, as there is less risk of expulsion.
Participant Handout 2.4.2: Passing a Uterine Sound

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

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

Procedure for Sounding the Uterus
Use gentle, no touch (aseptic) technique throughout.

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

Step 1: Put on HLD or sterile gloves.

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

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

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

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

Step 5: Slowly withdraw the sound, it will be wet and darker where it was in the uterus. Place the sound next to the IUD and set the blue depth gauge at the depth of the uterus. Determine the length of the uterus by noting the mucus and or blood on the sound. The average uterus will sound to a depth of six to eight centimeters. Do not attempt to insert an IUD into a uterus that measures 6.5 cm or less in depth because there is more risk of expulsion.
Note: If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. DO NOT insert an IUD. If perforation is suspected, observe the client in the clinic carefully.

a) For the first hour, keep the woman in bed and check the pulse and blood pressure every 5 to 10 minutes.

b) If the woman remains stable after one hour, check the hematocrit/hemoglobin if possible, allow her to walk, check vital signs as needed, and observe for several more hours. If she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice about a different (back up) contraceptive.

c) If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.
Participant Handout 2.4.3: Inserting the Loaded TCu 380A IUD

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

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

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

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

Hold the inserter tube still while removing the white rod.

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

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

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

Step 5: Gently remove the speculum and put all of the instruments used in 0.5% chlorine solution for 10 minutes for decontamination.
Step 6: Help the client get up from the table very slowly. Watch her in case she becomes dizzy or feels faint. Teach her how and when to check the strings. Ask her to check the strings now. Ask her if she has any questions and answer them in simple words she can understand. Tell her to return in three to six weeks. If she can read, give her written instructions or tell her the warning signs of problems and how to get help if she needs it.

Participant Handout 2.4.4: Using the Clinical and Counseling Skills Checklist

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

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

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

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

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

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

In general, a participant is expected to demonstrate satisfactory counseling skills and to perform at least 5 to 10 insertions satisfactorily in clients before being certified as competent. When determining competence, the judgment of a skilled trainer is the most important factor. In order to enable every participant to achieve competency, additional training in counseling techniques, insertion, or both may be necessary.

It is recommended that, if possible, participants who have been certified later be observed and evaluated in their own clinic by a course trainer, using the same checklist, within three to six months of certification. At a minimum, the graduate should be observed by a skilled provider soon after completing training. This post-course evaluation is important for several reasons. First, it provides the graduate with experience in handling direct constraints to service delivery (e.g., lack of instruments, supplies, or support staff). Second, and equally important, it provides the training center, via the trainer, with key information on the adequacy of the training and its appropriateness to local conditions. Without this type of feedback, training can easily become routine, stagnant, and irrelevant to service delivery needs.
Participant Handout 2.4.5: Checklist for IUD Counseling and Clinical Skills

Date of Assessment ________________ Dates of Training __________________
Place of Assessment: Clinic __________________ Classroom__________________
Name of Clinic Site ___________________________________________________
Name of the Service Provider ___________________________________________
Name of the Assessor_________________________________________________

This assessment tool contains the detailed steps for IUD counseling and IUD insertion or removal. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. The checklist may also be used by the trainer or supervisor when following up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

**Instructions for the Assessor**

Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe.

Begin the assessment when the trainee greets the client.

Use the following rating scale:

2 = Done according to standards  
1 = Needs improvement  
N/O = Not observed

Continue assessing the trainee throughout the time s/he is with the client, using the rating scale. Only observe. Do not interfere unless the trainee misses a critical step or compromises the safety of the client. Fill in the form using the rating numbers. Write specific comments when the task is not performed according to standards. Use the same form for one trainee for at least three observations. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly/welcoming/smiling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nonjudgmental/receptive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makes eye contact with the client, if culturally appropriate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faces the client directly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens attentively/nods head to encourage and acknowledge the client’s responses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows positive regard for the client as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensures the client’s privacy/confidentiality without having to be asked.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remains patient/ allows the client time to ask all questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not interrupt the client.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Service Provider’s Verbal Communication</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phrases questions clearly and appropriately.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Uses non-technical terms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses a friendly tone of voice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listens to client's responses closely.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Answers client's questions clearly and completely.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses language the client can understand.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RESPECT Model Process and Content**

**Rapport**
- Understands the client's point of view.
- Is friendly and respectful.
- Assures privacy and confidentiality.
- Doesn't judge the client.
- Doesn't argue with the client or act superior.
- Doesn't scold the client.
- Recognizes and doesn't make assumptions about the client.

**Empathy**
- Remembers that the client has come for help.
- Tries to understand the client's reason for his or her behavior/ideas.
- Uses positive body language and other strategies to demonstrate nonjudgmental acceptance of the client's ideas and feelings.
- Verbally acknowledges the client's feelings and expresses understanding.

**Support**
- Asks about and acknowledges the barriers to care and compliance.
- Offers the client concrete ways to overcome barriers.
- Involves family members when appropriate.
- Reassures the client that s/he is there to help and answer questions.
- Encourages the client to return to the clinic if s/he has any concerns.

**Partnership**
- Is flexible.
- Acknowledges the client's needs.
- Stresses that the client and provider are working together.
- Lets the client know she has options and can make her own choices.
- Makes a plan for the client to continue to return to the clinic for follow-up.
- Helps returning clients weigh options of continuing or switching methods.

**Explanations**
- Gives information about which methods are available.
- Asks which method interests the client.
- Asks what the client knows about method.
- Corrects myths/rumors/incorrect information.
- Describes how the method works and its effectiveness.
- Uses A/V aids during counseling.
- Describes benefits and risks.
- Describes potential side effects and warning signs.
- Offers clear action steps to respond to side effects/warning signs.
- Explains clearly what the client has to do to use the method successfully.
- Asks the client to repeat back instructions.
- Reminds the client again of danger signs.
- Answers the client's questions clearly.
- Encourages the client to return with problems or concerns.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cultural Sensitivity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respects the client’s life style and cultural and religious beliefs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Helps the client understand how these may influence family planning and other reproductive health choices.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Understands that the client’s view of the provider may be defined by ethnic or cultural stereotypes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Is aware of his or her own cultural biases and preconceptions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Knows his or her own limitations in addressing counseling and medical issues across cultures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Can explore cultural influences on attitudes and beliefs without disapproval.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Can help the client to explore these issues as well.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trust</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recognizes that it may be difficult for clients to share personal information about themselves.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Effective at gradually developing a trusting relationship.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Consciously works to establish trust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Responds to the client’s concerns, including rumors, respectfully and constructively.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Respects the client’s choice of family planning methods.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Problem Solving</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responds appropriately to the client’s needs and problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service provider is convincing when giving advice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The advice given and method provided are appropriate.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pre-Insertion Tasks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obtains or reviews brief reproductive health history.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes hands with soap and water.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asks the client if she has emptied her bladder.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpates abdomen and checks for suprapubic or pelvic tenderness and adnexal abnormalities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tells the client what is going to be done and encourages her to ask questions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs speculum examination.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collects specimens of vaginal and cervical secretions, if indicated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs bimanual examination.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs rectovaginal examination, if indicated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes gloves and properly disposes (single use) or immerses (reusable) in chlorine solution.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs microscopic examination, if indicated (and if equipment is available).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes hands thoroughly with soap and water and dries with clean cloth or allows to air dry.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loads TCu 380A inside the sterile package.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IUD Insertion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts vaginal speculum (and vaginal wall elevator if using single valve speculum).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----------</td>
</tr>
<tr>
<td>Swabs cervix and vagina with antiseptic at least twice. Waits for two minutes if using an iodophor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gently grasps cervix with tenaculum or Vulsellum Forceps.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sounds uterus using no touch technique</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sets blue depth gauge on the loaded IUD inserter to the depth on the sound.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts the IUD using the withdrawal technique.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cuts strings and gently removes tenaculum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Post-Insertion Tasks**
- Places used instruments in chlorine solution for decontamination.
- Disposes of waste materials according to guidelines.
- Removes reusable gloves and places them in chlorine solution.
- Washes hands with soap and water.
- Completes the client record.
- Observes the client for at least 15 minutes before sending her home.

**Post-Insertion Counseling**
- Teaches client how and when to check for strings.
- Discusses what to do if the client experiences any side effects or problems.
- Assures the client that she can have the IUD removed at any time.

**Follow-Up Counseling**
- Greets the client in friendly and respectful manner.
- Ensures privacy.
- Asks the following questions:
  - Have you been happy using the IUD?
  - Have you had any concerns or problems?
  - Has your health changed in any way since you had your IUD inserted?
  - Do you have any questions you would like me to answer?
  - How are you protecting yourself from STIs? (Explains dual protection)
  - Do you need some condoms?
  - May I examine you?

**Follow Up Examination (3-6 weeks after insertion)**
- Explains to the client why and how she will do the pelvic examination.
- Performs a pelvic examination and checks to make sure the string is visible and that there is no partial or complete expulsion.
- Explains findings and reassures the client.

**Pre-Removal Counseling**
- Greets the client in friendly and respectful manner.
- Asks the client her reason for removal and answers any questions she may have.
- Reviews the client’s present reproductive goals.
- Describes the removal procedure and what to expect.

**Removal of IUD**
- Washes hands thoroughly with soap and water and dries with a clean cloth or allows to air dry.
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puts new examination (disposable) or HLD or sterile (reusable) gloves on both hands.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performs bimanual exam.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inserts vaginal speculum and looks at length and position of strings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swabs cervix and vagina with antiseptic.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grasps strings close to the cervix and pulls gently but firmly to remove the IUD.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post-Removal Tasks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places used instruments in chlorine solution for decontamination.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposes of waste materials according to guidelines.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Removes reusable gloves and places them in chlorine solution.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes hands with soap and water.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records IUD removal in client record.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Post-Removal Counseling</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discusses what to do if the client experiences any problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counsels the client regarding new contraceptive method, if desired.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assists the client in obtaining new contraceptive method or provides temporary (barrier) method until method of choice can be started.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments (summary):

Recommendations:

Certified  (If not, why):

Trainer’s Signature__________________________   Date______________________ Participant
Handout 2.5.1: Infection Prevention for IUDs

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

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

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

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

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

Storage
Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.
**Infection Prevention Tips: IUD Insertion**

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

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

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

**Infection Prevention Tips: IUD Removal**

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

- Wash hands thoroughly with soap and water **before** and **after** each procedure.
- When possible, have the client wash her genital area before doing the screening pelvic examination.
- **Use clean, HLD** (or sterilized) instruments and gloves (**on both hands**) or use disposable (single-use) examination gloves.
- After inserting the speculum and while looking at the cervix, before beginning the procedure, apply antiseptic solution several times to the cervix and vagina.
- Properly dispose of waste material (gauze, cotton, the IUD, and disposable gloves) after removal.
- Decontaminate instruments and reusable items **immediately** after using them.
Participant Handout 2.5.2: Competency-Based Skills Checklist for Infection Prevention

Date of Assessment ____________________ Dates of Training ____________________
Place of Assessment: Clinic ____________________ Classroom ____________________
Name of Clinic Site ____________________________
Name of the Service Provider ______________________________________________________
Name of the Assessor ____________________________________________________________

This assessment tool contains the detailed steps in infection prevention that a service provider should accomplish when performing IUD insertion or removal. The checklist may be used during training to monitor the progress of the trainee as s/he acquires the new skills and during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. The checklist may also be used by the trainer or supervisor when following up or monitoring the trainee. The trainee should always receive a copy of the assessment checklist so that s/he may know what is expected of her/him.

Instructions for the assessor
Always explain to the client what you are doing before beginning the assessment. Ask for the client’s permission to observe. Begin the assessment when the trainee greets the client.
Use the following rating scale:
2 = Done according to standards
1 = Needs improvement
N/O = Not observed

Continue assessing the trainee throughout the time s/he is with the client, using the rating scale. Only observe. Do not interfere unless the trainee misses a critical step or compromises the safety of the client. Fill in the form using the rating numbers. Write specific comments when the task is not performed according to standards. Use the same form for one trainee for at least three observations. When you have completed the observation, review the results with the trainee. Do this in private, away from the client or other trainees.

<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior to IUD Insertion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare a bucket containing 0.5% chlorine solution for decontaminating instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wash hands thoroughly and dry them</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Put new examination or HLD surgical gloves on both hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange instruments and supplies on HLD disinfected or sterile tray</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INTRAUTERINE DEVICES (IUDs) 75
<table>
<thead>
<tr>
<th>Task/Activity</th>
<th>Cases</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>During Client Assessment and IUD Insertion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If rectovaginal exam is performed: immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and dispose of them properly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts on gloves correctly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Load TCu 380A in sterile package</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Following IUD Insertion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places all instruments in 0.5% chlorine solution for only 10 minutes immediately following the procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reusable gloves are decontaminated in 0.5% chlorine for 10 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wipes down exam table with chlorine between clients</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cleaning Instruments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collects all supplies needed, including large and small brushes, detergent, and large basin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wears utility gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely disassembles instruments and/or opens jaws of jointed items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washes all surfaces with a brush or cloth until visibly clean</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thoroughly cleans serrated edges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses all surfaces with clean water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dries by air or towels before further processing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High-Level Disinfection of Instruments by Boiling</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely submerges items in water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starts timing when boiling begins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keeps at rolling boil for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air dries equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boiled items removed using HLD forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>High-Level Chemical Disinfection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uses one of the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlorine 0.5% for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One part 35%-40% formaldehyde to four parts water for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glutaraldehyde (Cidex) for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrogen peroxide 6% (one part 30% to four parts water) for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepares fresh solution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immerse items completely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses items with boiling water and allows to air dry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stores items in HLD container</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task/Activity</td>
<td>Cases</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>Sterilization by Autoclave</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decontaminates, cleans, and dries instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disassembles items</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wraps instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranges packs loosely in autoclave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts holes in drums in open position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heats water until steam escapes from pressure valve only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follows directions for operating autoclave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilizes for 30 minutes for wrapped items and 20 minutes for unwrapped items at 121°C (250°F) and 106 kPa (15 lbs/in²)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After autoclaving, opens the lid and lets instruments dry for 30 minutes before removing</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sterilization by Dry Heat</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decontaminates, cleans, and dries instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puts instruments on traps or wraps loosely</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Begins timing after temperature has been reached</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 170°C (340°F): 60 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 160°C (320°F): 120 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 150°C (300°F): 150 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 140°C (285°F): 180 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 121°C (250°F): overnight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After cooling, removes instruments with HLD forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chemical Sterilization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has 2% glutaraldehyde freshly made</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soaks in covered container eight to ten hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rinses items with sterile water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air dries instruments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stores items in a sterile covered container</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Handles items with HLD forceps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Waste Disposal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needles are disposed of in a separate container filled with 0.5% chlorine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical waste is removed daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical waste is destroyed by burning</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum/Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Participant Handout 2.6.1: IUD Follow-Up Care

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

The client can return for a visit to have the IUD removed when it has been in place for the recommended number of years, (12 years for the TCu 380A) or when client wishes to have it removed for any reason. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.) In addition, the client should be able to return for a visit if she has questions, concerns, or any signs/symptoms she thinks may be caused by the IUD. If facilities are available, it is also recommended that clients have yearly routine gynecological checkups, but these are not a necessary part of IUD management.

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

- Fever (a possible sign of infection);
- Abdominal pain, or pain during intercourse;
- Purulent or foul smelling discharge; or
- An IUD string that becomes shorter, longer, or missing.

When a client comes for follow-up care, follow the recommendations in this handout. For problem visits and management of side effects and complications, follow protocols and recommendations in the Participant Handout 2.6.2: IUD Post-Insertion Follow-Up Care.

If a complication such as PID, pregnancy with IUD, perforation, difficulty in IUD removal, or missing strings is suspected, refer the client to an Ob/Gyn or specialist (trainer) for management.
Participant Handout 2.6.2: IUD Post-Insertion Follow-Up Care

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

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

- Nausea;
- Mild to moderate lower abdominal pain (cramping); and
- Syncope (fainting), rarely.

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

Note: This time can be put to productive use by further counseling of the patient.

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

- **What kind of IUD she has and when it needs to be replaced:** Following insertion, the effective life of the TCu 380A IUD is 12 years. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.) The provider should give her a card with the date of insertion and the IUD’s effective life.

- **The IUD provides no protection against HIV or other STIs:** The provider should remind the client to use a condom for protection from HIV or STIs if she thinks that she or her partner could be at risk of exposure to HIV or STIs.

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

- **What are the health risks with IUDs:**
  - IUDs do not completely protect the user from having an ectopic (outside the uterus) pregnancy.
  - A woman who has an IUD is at a somewhat greater risk of developing infections in the uterus and/or fallopian tubes during the first month following insertion. These infections are known as Pelvic Inflammatory Disease (PID). Thereafter, unless she is at risk for STIs (e.g., either she and/or her partner has more than one sexual partner), it is unlikely that she will get a pelvic infection. Also, a woman who has an IUD should avoid douching if possible, as douching may increase the chance of infection.
  - **If a woman who has an IUD thinks she is pregnant, she should go to the clinic as soon as possible for a check up.** If she is pregnant, the IUD should be removed, because there is a greater chance of miscarriage and the possibility of developing a pelvic infection.
• **How can she tell if she has one of these health problems?** A woman with an IUD should come to the clinic as soon as possible if any of the following occur:
  - Late period with pregnancy symptoms (nausea, breast tenderness, etc.);
  - Persistent or crampy lower abdominal pain, especially if accompanied by nausea, fever, or chills (these symptoms suggest possible pelvic infection);
  - Strings missing or the plastic tip of the IUD can be felt when checking for the strings; or
  - Either the client or her partner begins having sexual relations with more than one partner. IUDs do not protect against sexually transmitted infections, including hepatitis B and HIV.

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

• **Should the client check to see if the IUD has remained in place?** In the past, providers were expected to counsel women about checking the IUD strings to make sure the IUD remained in place. The thinking on this issue has shifted. Many women were reluctant to put their fingers in their vagina to check the position of the string. But, it is important to remind women that if they suspect that their IUD has come out or shifted in position they should begin using a back-up contraceptive method and return to the clinic immediately. Advise women to pay special attention during their first few periods following insertion. Advise the woman to check her menstrual pad or cloth, as well as the toilet or latrine during menstruation during her first several periods following IUD insertion. If the client is comfortable doing so, the provider should show her how to check for the strings. She should return to the provider if she feels any of the following, which suggest that the IUD is being expelled:
  - Cramping in the lower part of the abdomen,
  - Spotting between periods or after intercourse,
  - Pain after intercourse or if her husband or partner experiences discomfort during sex, or
  - If the hard part of the IUD is felt in the vagina or if she notices that the string becomes longer.

• **What to do if there are changes in her menstrual periods:** For most women, the first few periods will be heavier, last longer, and involve more cramping. This is not harmful. However, if the bleeding lasts twice as long as usual or if she uses twice as many pads, cloths, or tampons, she should see a health care provider.

• **When to have the IUD removed:** The IUD should be removed
  - If the client desires,
  - If the client wants to get pregnant,
  - If she experiences persistent side effects or other health problems, or
  - At the end of the effective life of the IUD. The TCu 380A should be removed after 12 years. (The latest scientific evidence shows that the TCu 380A is effective for at least 12 years.)

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

- **Follow-Up Care:** Normally, clients should return after the first post-insertion menses (three to six
  weeks), but not later than three months, for their first check up. At the first regular check up:
  o Inquire about problems, questions, complications, or side effects;
  o Answer the client’s questions or concerns; and
  o Perform a speculum and bimanual exam to
    • See the strings,
    • Check for vaginal discharge or cervicitis suggestive of a GTI,
    • Gently palpate the cervical os for any plastic which might indicate that the IUD is
dislodged from the fundus (partially expelled), and
    • Check for uterine and adnexal tenderness or other signs of infection.

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

If the client is satisfied with the IUD, and there are no precautions for continued use
- Remind her about the warning signs. Tell her if she has any of the warning signs to come back
  immediately. Warning signs include:
  o Fever (a possible sign of infection);
  o Abdominal pain, or pain with intercourse;
  o Purulent or foul smelling discharge; and
  o Signs that the IUD has been expelled.
- Schedule her for a return visit in about 12 months.
- Remind her at each annual visit of the date (month/year) her IUD needs to be removed or
  replaced.

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

It is important to remember that successful IUD programs require well trained providers who exhibit
- Good clinical judgment in selecting acceptors;
- Care, sensitivity, and thoroughness in informing the user about IUDs and common side effects;
- Skill in inserting and removing the IUD;
- Knowledge of and ability to recognize real or potential problems; and
- Ability to take clinical action for these problems, including knowing when and where to refer
  clients with serious complications.

Long term success, as defined by satisfied clients and high continuation rates, will only take place if
the provider can recognize the importance of providing follow up care.
Participant Handout 2.6.3: Management of Complications

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

In this handout there is more information on the most important health problems and serious side effects associated with IUD use. These include:
• Management of early pregnancy with an IUD in place,
• Extrauterine (ectopic) pregnancy,
• Pelvic Inflammatory Disease (PID), and
• Management of uterine perforation.

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

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

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

Extrauterine (Ectopic) Pregnancy
IUDs provide protection against both intrauterine and extrauterine pregnancies, but because IUDs provide less protection against extrauterine pregnancies than intrauterine pregnancies, a pregnancy that occurs while a woman is using an IUD is somewhat more likely to be extrauterine. Therefore, those clients who become pregnant should be carefully evaluated for an ectopic pregnancy.
Pelvic Inflammatory Disease (PID)
Untreated PID with an IUD in place can cause serious complications, which may lead to loss of fertility. According to WHO, there was no difference in clinical course if the IUD was removed or left in place among IUD users treated for PID. The symptoms of PID include abnormal vaginal discharge, abdominal or pelvic pain, pain with sexual intercourse (dyspareunia), fever, and chills. If these symptoms occur during the first cycle, they may be due to infection at the time of insertion. If symptoms occur after several cycles they are more likely due to a STI. The practitioner should perform speculum and bimanual exams and testing of cervical discharge for genital tract infections, when possible.

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

If the woman has a tender uterus and pain when the cervix is touched, she may have PID. Start her on one of the following antibiotics:
- Cefoxitin (2g IM) plus probenecid (1g orally), or
- Ceftriaxone (250 mg IM) plus doxycycline (100 mg orally twice a day) for 14 days.

According to the WHO, there is no need to remove the IUD. If there is no improvement in 24–48 hours, the client should be referred to a facility where she can receive intravenous antibiotics.

Uterine Perforation, Embedding, and Cervical Perforation
The IUD can perforate (go through) the uterus. This mostly happens during the insertion. If a client complains of a sharp, significant pain during the procedure, stop the procedure and remove the IUD. Observe for signs of intra-abdominal bleeding (e.g., falling blood pressure, rising pulse, severe abdominal pain, tenderness, guarding and rigidity).

Take the client’s blood pressure and pulse every 15 minutes for 90 minutes. Have her sit up rapidly from a resting position. If her pulse is greater than 120/min or she becomes dizzy (light-headed) on sitting up, manage or refer for further evaluation of possible intra-abdominal bleeding. If there are no signs of intra-abdominal bleeding after two hours, discharge with instructions for warning signs that require immediate return to clinic. Schedule return checkup in one week. Provide backup contraception and help the client choose another method.

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

Signs of uterine perforation are missing IUD strings, inability to withdraw the IUD if the strings are still present, and seeing the IUD in a x-ray or ultrasound. Ultrasound can find Copper IUDs in the pelvis, but can’t find IUDs that have moved into the abdomen. X-rays are better for finding lost IUDs.
Removal of an IUD in the abdomen should be done only if the perforation is found within the first few days (or weeks) after insertion. Removal should be performed only by a surgeon experienced in removing IUDs by laparoscopy; otherwise, leave it in place.

<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
</table>
| Amenorrhea                     | Ask client  
  • When she had her Last Menstrual Period (LMP),  
  • When she last felt the strings, and  
  • If she has any symptoms of pregnancy.  
  If necessary, do a speculum and bimanual examination to rule out pregnancy. | If pregnancy is less than 13 weeks (by LMP) and strings are visible, explain that the IUD should be removed to minimize risk of pelvic infection.  
  Do not attempt to remove if  
  • Strings are not visible, or  
  • Pregnancy is greater than 13 weeks (by LMP).  
  A woman who has these signs is at risk of spontaneous abortion and sepsis and must be followed closely. |
| Cramping                       | Do abdominal and pelvic (speculum and bimanual) exams to check for PID and other causes of cramping, such as partial expulsion of the IUD, cervical or uterine perforation, or ectopic pregnancy. | **Client has had IUD less than three months**  
  • If no cause is found and cramping is not severe, reassure the client, and provide aspirin or a similar analgesic.  
  • If no cause is found but cramping is severe, remove the IUD (if client finds cramping unacceptable). Replace with a new IUD or help the client choose another method.  
  **Client has had IUD more than three months**  
  • If no cause found, remove IUD. If there is no evidence of infection, replace with a new IUD or help the client choose another method. |
<p>| Ectopic Pregnancy              | Irregular bleeding with or without symptoms of pregnancy or infection, pelvic pain or tenderness, or palpable adnexal mass. | Refer to appropriate facility for complete evaluation. |</p>
<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
</table>
| Irregular or Heavy Bleeding | Perform speculum and bimanual exams to ensure that there is neither cervical pathology nor evidence of intrauterine or ectopic pregnancy or spontaneous abortion. How much has she bled?  
  • Check for signs of marked anemia (pale conjunctivae or nail beds, low hemoglobin or hematocrit). | **Client has had IUD less than three months:**  
  • If exam is normal, reassure and give iron tablets (one tablet daily for one to three months). Ask client to return in three months for another check. Use locally approved drugs, such as ibuprofen, during the bleeding episode, if available.  
  • If bimanual exam shows enlarged or irregular uterus due to fibroids, inform client of the problem. Remove the IUD if the client is anemic or requests removal, and help her select another method.  

**Client has had IUD more than three months:**  
  • If the exam is negative and bleeding intervals are short (less than three weeks), suspect anovulation; if bleeding intervals are longer (more than six weeks) suspect delayed ovulation; if with hot flashes, suspect menopause (if age over 35) or gynecologic endocrine problem. Refer to specialist.  
  Recommend removal if severe anemia is present (e.g., less than 9 g/dl Hgb or 30% Hct) and help client choose another method. If the IUD is inert (Lippes Loop) and the client chooses to continue use of the IUD, remove current IUD and insert a new IUD; give three more months of iron tablets and reexamine in three months. If the client already has a copper IUD, remove the IUD and help the client select another method. |
<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
</table>
| Missing Strings        | Ask the client whether she knows if the IUD has come out. If the client does not know if the IUD was expelled, ask her  
  • When she had her LMP,  
  • When she last felt the strings,  
  • If she has any symptoms of pregnancy, and  
  • If she used a back up method (e.g., condom) from the time she noticed the missing strings.  
  
  Do speculum and bimanual examination. Check for signs of pregnancy.

  If she comes back while having her period, do a speculum examination.

  If strings are **still not seen**, rule out perforation.  

  If she comes back with delayed (greater than four weeks) menses, check for pregnancy. | If the client knows the IUD fell out, check for pregnancy, provide back up method, and reinsert IUD during her next period, if she desires.  

  Perform a vaginal examination.  

  • If the exam reveals suspected pregnancy, refer her to an appropriate facility for complete evaluation.  

  • If no strings are seen during the vaginal exam, it may mean that the IUD has fallen out or strings may be in the cervical canal (not visible), or high in the vagina.  

  • If strings are not found by carefully probing the cervical canal, the client should use a nonhormonal method of family planning and return with menses or in four weeks if her period does not start.  

  The strings may come down with menses. If strings are seen, reassure client that strings are present, and help her feel them.  

  Refer to check for IUD. It can be located either by carefully sounding the uterus, X-ray, or ultrasonography.  

  • If the IUD is not found on referral, it may have been expelled without being seen. Insert another IUD or help client choose another method.  

  If pregnant, see “**Amenorrhea**” above. | **Partner complains about strings**  

  Check to be sure that the IUD is in place and not partially expelled.  

  Counsel the client that there are several options. One option is to explain to her partner what he is feeling and see if he is willing to tolerate it or cut the string to a length even with the cervical os (inform the client that she will no longer be able to feel string,) and record in chart that string has been cut evenly with cervix for future removal. information.
<table>
<thead>
<tr>
<th>Side Effect or Problem</th>
<th>Assessment</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pelvic Infection</td>
<td>Perform abdominal and pelvic (speculum and bi-manual) exams and GTI testing if available.</td>
<td>If abdominal and pelvic exams confirm uterine and/or adnexal tenderness or pain when moving the cervix and uterus during pelvic examination, and/or microscopic testing supports the diagnosis of PID: • Treat with antibiotic, or immediately refer for treatment. Carefully observe the results of antibiotic treatment. If the woman does not improve in two to three days after starting treatment, refer her to a hospital. Her sex partner should be checked for an STI.</td>
</tr>
<tr>
<td>Suspected Uterine Perforation</td>
<td>At time of insertion</td>
<td>When sounding the uterus • Stop the procedure. Gently remove the instrument that may have perforated the uterus. If resistance is encountered stop immediately and ask for an evaluation by a qualified surgeon. Observe for signs of intra-abdominal bleeding (i.e., failing blood pressure, rising pulse, severe abdominal pain, tenderness, guarding, and rigidity). • Take blood pressure and pulse every 15 minutes for 90 minutes. From resting position, have client sit up rapidly. Observe for syncope or pulse greater than 120/min. • If negative after two hours, discharge with instructions for warning signs that require immediate return to clinic. Have client return after one week for check up. • If complete perforation is suspected, stabilize the woman and do an ultrasound or x-ray to see where the IUD is. When inserting the IUD (complete or partial) • Stop the procedure. Remove the IUD and initiate steps as above.</td>
</tr>
<tr>
<td>Side Effect or Problem</td>
<td>Assessment</td>
<td>Management</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
</tbody>
</table>
| Syncope, bradycardia, vasovagal episode during IUD insertion or removal | Is woman anxious? Does she have a small uterus or relative cervical stenosis? (These characteristics increase risk for syncope and/or vasovagal reaction.) | Everything done at time of IUD insertion and removal should be done slowly and gently.  
• Maintain a calm, relaxed, unhurried atmosphere with a gently reassuring approach to the client.  
• At the earliest sign of fainting, stop the insertion.  
• Put a cool, wet cloth to the client’s forehead.  
• If severe pain occurred as the IUD was being inserted through the cervical canal, leave the IUD in place and allow the patient to rest. Keep the client supine, the head lowered, and legs elevated, to ensure adequate blood flow.  
• Avoid overtreatment; observation and support are usually all that is required. Use analgesics (paracetamol or ibuprofen) for abdominal pain or cramping.  
• Remove IUD if pain persists and is not relieved by analgesics or if client requests removal. Help her choose another method. |
| Vaginal Discharge | Check history for GTIs or other STI exposure and examine for vaginitis or purulent cervicitis or beefy red cervix.  
Examine saline and KOH wet mounts of vaginal discharge for trichomonas, monilia (candida), gardnerella.  
Prepare Gram stain of vaginal or cervical discharge. Observe for Gram negative intracellular diplococci (GNID) and WBC (PMNs). | If saline or KOH wet mounts are positive, treat for specific organism.  
If positive for GNID, treat for GC. If negative for GNID and purulent cervicitis or beefy red cervix is present, treat for Chlamydia. Do GC culture if available. |
Participant Handout 2.6.5: Managing Severe Cramping

Investigation Steps

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

Management

A-1) Speculum and bimanual exams are needed in order to rule out PID and other causes of cramping, such as partial expulsion of the IUD, perforation of the uterus or cervix, or ectopic pregnancy. If there are signs of any of these conditions, go to the section on managing these complications.

A-2) If no cause is found, provide an analgesic such as paracetamol.

A-3) If no cause is found but the cramping is not acceptable to the woman, remove the IUD. Counsel the woman to use another method, tell her the IUD is not for her.

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

Investigation Steps

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

Management

B-1) If the IUD has been in place more than three months and cramping is new, examine the client for other causes of cramping, such as PID, perforation, or pregnancy. In such cases go to the section on managing these complications.

B-2) If no cause is found and the cramping is very mild and occurs only around menses, provide an analgesic such as paracetamol.

B-3) If no cause is found but the cramping is severe and not due to menses and unacceptable to the woman, remove the IUD. Counsel the woman to use another method, tell her the IUD is not for her.
Participant Handout 2.6.6: Managing Amenorrhea

Investigation Steps
A) Ask the client
   • When she had her last menstrual period,
   • When she last felt the strings, and
   • If she has symptoms of pregnancy.

B) Perform speculum and bimanual exams to check for strings and rule out pregnancy. Have her take a pregnancy test if available.

Management
If exam, or pregnancy test where available, shows that client is pregnant:
B-1) Rule out ectopic pregnancy. If the pregnancy is ectopic, refer her immediately to a hospital with surgical facilities.
B-2) Explain to the client that because she is pregnant with an IUD in place, miscarriage and infection are quite likely.
B-3) Have her return to the clinic if she has excessive bleeding, cramping, pain, foul discharge, or fever. If strings are visible and she is less than 13 weeks pregnant, remove the IUD. Explain that there is a small risk of miscarriage associated with the removal procedure.
B-4) If the strings cannot be located at the cervical os and/or the pregnancy is beyond the first 13 weeks, removal is more difficult. Remind the client that if she is pregnant with an IUD in place, there is a high risk of spontaneous abortion and infection. Counsel the client as to all available options.
B-5) If the woman wants to, or must continue her pregnancy, but does not want her IUD removed, advise her that there is an increased risk of spontaneous abortion and infection and that the pregnancy should be followed closely. Tell her to report any sign of infection immediately. She should be watched closely during her pregnancy. Refer her to a specialist for her pregnancy care.
Participant Handout 2.6.7: Managing Expelled IUD

Investigation Steps

A) Ask the client if she saw the IUD fall out.

Management:

A-1) If the client saw the IUD fall out, rule out pregnancy. If she is not pregnant and wants another IUD, insert a new IUD.
Participant Handout 2.6.8: Managing Missing Strings

Investigation Steps
A) Ask the client
   • When she last felt the strings,
   • If she has any symptoms of pregnancy,
   • If she used a back up method (such as condoms) from the time she noticed the missing strings, and
   • When she had her last menstrual period.

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

Investigation Steps
B) If no strings are visible on vaginal exam and the client is not pregnant, it may mean that
   • The IUD has moved higher up in the uterus, or
   • The IUD has fallen out.

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

Investigation Steps
C) If the client comes back while having her period, a speculum exam will show whether strings are now visible.

Management
C-1) If the strings came down with menses, reassure the client that the strings are present, and help the client feel them.
Investigation Steps
D) If she comes back while having her period and strings are still not visible:

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

Investigation Steps
E) If she comes back without menses, rule out pregnancy.

Management
E-1) Rule out pregnancy by means of history, speculum, and bimanual exams, or laboratory test if available and affordable. See if the strings have come down.

If the client is pregnant, see “A-3” and “A-4” above. If she is not pregnant, see “D-3” and “D-4” above.
Participant Handout 2.6.9: Managing Irregular or Heavy Bleeding

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

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

Investigation Steps
B) How much has she bled?

Management
B-1) Check for signs of marked anemia (pale conjunctivae or nail beds, hemoglobin less than 9). Recommend IUD removal if severe anemia present or getting worse, and help the client make an informed choice about another method.

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

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

Management
C-1) Perform speculum and bimanual exams to rule out cervical pathology or intrauterine or ectopic pregnancy.
C-2) If the bimanual exam shows an enlarged uterus due to new fibroids, tell the client the problem and refer her as appropriate for evaluation. Do a bimanual (and speculum) exam every six months to rule out rapid growth. Remove the IUD if bleeding worsens or if the client requests it.
C-3) If the client has prolonged intervals between very heavy periods, suspect endometrial hyperplasia (overgrowth of the uterine lining), beginning of menopause, or other gynecological problem. Refer her as appropriate. A change of method is not necessary unless the client is uncomfortable, has reached menopause (one year without menses), or a gynecologic cancer is found.
Participant Handout 2.6.10: Case Study # 1

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

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

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


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

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

It is appropriate to insert an IUD in a client who is not during or just after her menstrual period if:
• She is less than 48 hours postpartum,
• She is more than four weeks postpartum and has not had intercourse,
• She is more than four weeks postpartum and has had intercourse, but has used a reliable method of contraception,
• She is less than seven days postabortion and the uterus is not infected,
• She is less than six months postpartum, fully breastfeeding, and has no menses, or
• At any time in the menstrual cycle as long as the practitioner is “reasonably certain” that she is not pregnant.
Case Study 2: Pregnancy with IUD

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

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

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

Questions for Discussion:
1. What are some of the complications of pregnancy that may occur with an IUD in place?
2. Should the practitioner strongly recommend removal of all IUDs when strings are visible?
3. What should the practitioner do if the strings are not visible?
4. What might have caused this client to become pregnant after two years of using the IUD successfully?
3. How should the service provider manage such a case?

Discussion: Pregnancy with an IUD in utero will terminate in spontaneous abortion in 50% of cases. Occasionally, these will be septic abortions, which place the woman at risk of severe morbidity and mortality. Most experts agree that an IUD should be removed if the strings are visible. IUD removal is associated with spontaneous abortion in 25% of cases. If the strings cannot be found and/or the pregnancy is beyond the first trimester, the IUD should be left in place, the client counseled about complications (excessive bleeding, cramping, pain, abnormal vaginal discharge, fever) and the pregnancy should be observed closely. Note: where ultrasound is available, it may be useful in determining the location of the IUD. If the IUD is not located, this may suggest that an expulsion of the IUD has occurred.

One third of IUD related pregnancies are due to undetected partial or complete expulsion. Partial expulsion may occur if the IUD is not inserted to the fundus of the uterus, or sometimes with an unusually heavy period. When a woman using an IUD becomes pregnant, it is important to rule out ectopic pregnancy.

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

Plan: Counsel client about all her options and potential consequences for each course of action. If she wishes to continue the pregnancy, she should be referred promptly to an MD Ob/Gyn specialist for IUD removal, ruling out of ectopic pregnancy, and further observation and management.
Case Study 3: PID with IUD

**Problem:** A client who was at risk for developing an STI was not screened adequately. She has now developed PID.

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

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

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

**Discussion:** The IUD does not cause PID. However, it does increase the risk of infection if the woman had an STI at the time of insertion. An infection in the first three weeks after insertion may be due to poor infection prevention procedures at the time of insertion or presence of cervical STI at a time of insertion. If the infection develops after three months or more postinsertion, it is probably due to new exposure to infection. Before selecting an IUD the client should be asked about the number of sexual partners, if her sexual partner(s) has other sexual partners, and her history of STIs.

**Plan:** If the client does get an infection, do not remove the IUD, but treat the infection. If the patient only has uterine tenderness, she should get doxycycline 100mg twice daily for 14 days. If she also has cervical motion tenderness (as this client does), she needs cefoxitin (2g IM) plus probenecid (1g orally) OR ceftriaxone (250mg IM) plus doxycycline (100mg twice a day) orally for 14 days. She should be counseled about how to avoid STIs, advised to use condoms, and to get her partner seen for treatment. If the client wants the IUD removed, treat the infection first and remove the IUD later.
Participant Handout 2.6.13: Case Study #4

Case Study 4: Missing Strings

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

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

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

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

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

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

Plan: If strings are not noted on exam and client is not pregnant, see if strings can be located with gentle exploration of lower cervical canal with (sterile or HLD) narrow sponge forceps. If you are not able to locate strings, refer the client to Ob/Gyn for further management. Before the client leaves your office, provide her with a supply of condoms to protect her from pregnancy in case the IUD is not in the uterus.
Participant Handout 2.7.1: Minimum Standards for IUD Services

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

The minimum clinic requirements are:

- Space for counseling that ensures privacy for clients, separate from the waiting area;
- Examination table and procedure area that ensures client privacy;
- Supply cabinet to store instruments and IUDs;
- Water, adequate light, and toilet facility in or very near office;
- Basic standardized equipment and supplies sufficient for two IUD insertions; and
  - 2 specula,
  - 2 tenacula,
  - 2 uterine sponge forceps,
  - 2 pair scissors,
  - 2 uterine sounds,
  - 2 utility forceps,
  - Cotton or gauze,
  - Antiseptic,
  - Covered instrument trays,
  - Six pair reusable gloves or one box disposable gloves,
  - Client record forms,
  - Cooker or stove,
  - Fuel supply,
  - Glutaraldehyde or 8% formaldehyde solution,
  - Chlorine solution, and
  - A decontamination bucket.

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

Trainer Summary
Each participant will need to demonstrate skill proficiency in counseling, IUD insertion/removal, case management, and infection prevention in order to be certified by trainer.
Participant Name ________________________________

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

1. In counseling a woman about the advantages of the TCu 380A IUD, you would inform her that the IUD
   a. is permanent
   b. is highly effective
   c. has few side effects for most women
   d. does not interfere with sexual intercourse
   e. is effective in preventing anemia

2. Which of the following conditions are precautions which influence the suitability of IUD for a particular woman?
   a. pregnancy
   b. three or more children
   c. at risk for STIs
   d. history of candidiasis
   e. retroverted uterus
   f. current pelvic infection

3. Prior to IUD insertion, a pelvic exam is performed to
   a. determine uterine position and size
   b. rule out anteflexion
   c. rule out pregnancy
   d. rule out presence of infection, masses, and tumors
4. Prior to an IUD insertion all metal instruments used should be
   a. decontaminated with soap and water
   b. decontaminated in 0.5% chlorine solution for 10 minutes
   c. cleaned with formaldehyde and water
   d. cleaned with detergent and water
   e. high level disinfected by boiling in a covered pot for 20 minutes
   f. high level disinfected by autoclaving (unwrapped) for 20 minutes at 106 kPa pressure at 1210 degrees

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

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

7. The following are warning signs that you should explain to an IUD client, which indicate that she
   may be having a problem with her IUD and should seek medical attention
   a. cramping with menses
   b. increased length of menstrual cycle
   c. sexual partner has abnormal penile discharge
   d. string is longer than usual
   e. pain with intercourse

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

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

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

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

Technical Information
• I learned new information in this course.  5  4  3  2  1
I will now be able to:
• Provide appropriate counseling to women considering the IUD as a contraceptive method. 5  4  3  2  1
• Screen clients to determine if the IUD is a good method for them. 5  4  3  2  1
• Provide safe IUD insertion and removal services. 5  4  3  2  1
• Manage side effects and complications of IUDs. 5  4  3  2  1

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

Training Location and Schedule
The training site and schedule were convenient. 5 4 3 2 1
The necessary materials were available. 5 4 3 2 1

Suggestions

What was the most useful part of this training?

What was the least useful part of this training?

What suggestions do you have to improve the module? Please feel free to reference any of the topics above.
Major References and Training Materials

Introduction to Training:


Unit 1

- JHUCCP. *WHO Updates Medical Eligibility Criteria for Contraceptives.* Info Reports, Issue 1, August 2004.

**Unit 2**

Intrauterine Devices (IUDs)


Participant Handout 1.8.1


Mishell DR, Roy S.  *Copper intrauterine contraceptive device event rates following insertion 4 to 8 weeks postpartum.*  American Journal of Obstetrics and Gynecology 143(1): 29-33 (1982).


**Participant Handout 1.8.3**


**Participant Handout 2.2.2**


Family Health International. *Checklist for Screening Clients who Want to Initiate Use of the Copper IUD* 2006

**Participant Handout 2.2.3**


**Participant Handout 2.3.1**


**Participant Handout 2.4.2**


**Participant Handout 2.4.3**


**Participant Handout 2.5.1**


**Participant Handout 2.6.2**


**Participant Handout 2.6.3**

Participant Handout 2.6.4


Transparency 1.2


Transparency 1.3


Transparency 2.2
