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The entire comprehensive training curriculum was 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); Azerbaijan, Ethiopia, Kenya, Peru, Tanzania, and Uganda (Infection Prevention); Azerbaijan, Kazakstan, and Peru (Counseling); and Jordan (POPs & COCs; IUDs). Feedback from these trainings has been incorporated into the training curriculum to improve its content, training methodologies, and ease of use.

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Traci Baird, Rob Gringle, Charlotte Hord

**Development Associates**
Joseph Deering

**The Indian Medical Association**

**Institute for Reproductive Health**
Kristin Cooney
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- Zemfira Topcubasova, Medical University of Azerbaijan
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Special thanks are due to Pam Putney, who used her expertise as a clinical trainer to significantly improve the module through editing and the addition of training exercises, new methodologies, and materials.
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NOTES TO THE TRAINER

PURPOSE

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

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

DESIGN

The training curriculum consists of 15 modules:

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

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

SUGGESTIONS FOR USE

• The modules are designed to provide flexibility in planning, conducting, and evaluating the training course.
• The curriculum is designed to allow trainers to formulate their own training schedules, based on results from training needs assessments.
• The modules can be used independently of each other.
• The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
• In order to foster changes in behavior, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, the overall objective, general,
and specific objectives are presented in terms of achievable changes in these three areas.

- Training references and resource materials for trainers and participants are identified.
- Each module is divided into a *Trainer’s Module* and *Appendix* section.
- The *Trainer’s Module* presents the information in two columns:
  1. *Content*, which contains the necessary technical information; and
  2. *Training/Learning Methods*, which contains the training methodology (lecture, role play, discussion, etc.) by which the information should be conveyed.
- The training section includes the content to be covered and the training methodologies.
  - The *Appendix* section contains:
    - Participant handouts
    - Transparencies
    - Pre- & Post-tests (Participant Copy and Master Copy with Key)
    - Participant Evaluation Form
- The *Participant Handouts* are referred to in the *Training/Learning Methods* sections of the curriculum and include a number of different materials and exercises, ranging from recapitulations of the technical information from the *Content* of the module to role play descriptions, skills checklists, and case studies.
- The *Participant Handouts* should be photocopied for the trainees and distributed to them in a folder or binder to ensure that they are kept together as a technical resource after the training course has ended.
- Transparency masters have been prepared where called for in the text. These should be copied onto clear overhead sheets for display during the training sessions.
- The *Participant Evaluation* form should also be copied to receive the trainees’ feedback in order to improve future training courses.
- The *Methodologies* section is a resource for trainers for the effective use of demonstration/return demonstration in training.
To ensure appropriate application of learning from the classroom setting to clinical practice, Clinical Practicum sessions are an important part of this training. For consistency in the philosophy of client’s rights, the following should be shared with participants, in preparation for their clinical practicum experiences:

**CLIENT’S RIGHTS DURING CLINICAL TRAINING**

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

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

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

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

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

1. **Overall Picture:** Provide participants with an overall picture of the skill you are helping them develop and a skills checklist. The overall picture should include why the skill is necessary, who needs to develop the skill, how the skill is to be performed, etc. Explain to the participants that these necessary skills are to be performed according to the steps in the skills checklist, on models in the classroom and practiced until participants become proficient in each skill and before they perform them in a clinical situation.

2. **Trainer Demonstration:** The trainer should demonstrate the skill while giving verbal instructions. If an anatomical model is used, a participant or co-trainer should sit at the head of the model and play the role of the client. The trainer should explain the procedure and talk to the role playing participant as s/he would to a real client.

3. **Trainer/Participant Talk-Through:** The trainer performs the procedure again while the participant verbally repeats the step-by-step procedure.

   **Note:** *The trainer does not demonstrate the wrong procedure at any time. The remaining participants observe the learning participant and ask questions.*

4. **Participant Talk-Through:** The participant performs the procedure while verbalizing the step-by-step procedure. The trainer observes and listens, making corrections when necessary. Other participants in the group observe, listen, and ask questions.

5. **Guided Practice:** In this final step, participants are asked to form pairs. Each participant practices the demonstration with her/his partner. One partner performs the demonstration and talks through the procedure while the other partner observes and critiques using the skills checklist. The partners should exchange roles until both feel competent. When both partners feel competent, they should perform the procedure and talk-through for the trainer, who will assess their performance using the skills checklist.
DO'S AND DON'TS OF TRAINING

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

DO'S

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

DON'TS

- Don't talk to the flip chart
- Don't block the visual aids
- Don't stand in one spot--move around the room
- Don't ignore the participants' comments and feedback (verbal and non-verbal)
- Don't read from curriculum
- Don't shout at participants
TRAINER'S MODULE
MODULE 13: POSTPARTUM AND POSTABORTION CONTRACEPTION

INTRODUCTION:

Meeting the contraceptive needs of clients at all stages of their reproductive life is a vital aspect of quality reproductive health care. During the postpartum and postabortion phases, special considerations must be included when providing care. This training module will provide the participants with the knowledge, attitudes, and skills necessary to provide postpartum and postabortion contraception successfully.

MODULE TRAINING OBJECTIVE:

To prepare the participants to provide high quality contraceptive services to clients immediately postpartum and following treatment for incomplete abortion.

SPECIFIC LEARNING OBJECTIVES:

By the end of this module, participants will be able to:

1. State the definitions of postpartum and postabortion contraception.
2. State the differences between the postpartum and postabortion period of infertility.
3. Discuss the key issues related to postpartum and postabortion contraception.
4. Describe the essential components of postpartum and postabortion contraceptive services.
5. Discuss the advantages of postpartum and postabortion contraceptive services.
6. Apply the principles of postpartum and postabortion counseling and contraceptive method provision in a role play and in case studies.
7. Demonstrate the skills required to perform postpartum and postabortion IUD insertion.

CLINICAL PRACTICUM OBJECTIVES:

- Provide postpartum counseling and client-selected contraceptives.
- Provide postabortion counseling and client-selected contraceptives.
- Practice infection prevention procedures in the provision of postpartum and postabortion contraceptive services.
- Practice postpartum and postabortion IUD insertion in a clinical setting.
TRAINING/LEARNING METHODOLOGY:

- Trainer presentations
- Group and individual exercises
- Discussion
- Role play
- Clinical practice
- Case studies

MAJOR REFERENCES AND TRAINING MATERIALS:


RESOURCE REQUIREMENTS:

- Overhead projector
- Transparencies and pens
- Newsprint paper and tape
- Marking pens

EVALUATION METHODS:

- Pre- and Post-tests
- Verbal feedback
- Participant Evaluation Form
**TIME REQUIRED:**

- Workshop: 8.5 hours
- Clinical Practice: at Trainer’s discretion

<table>
<thead>
<tr>
<th>MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Transparencies on:</td>
</tr>
<tr>
<td>• Module Objectives (Transparency #1)</td>
</tr>
<tr>
<td>• Definitions of Postpartum and Postabortion Contraception (Transparency #2)</td>
</tr>
<tr>
<td>• Goals of Postpartum and Postabortion Counseling (Transparency #3)</td>
</tr>
<tr>
<td>2. Participant Handouts</td>
</tr>
<tr>
<td>3. Copies of pre-test and post-test for each participant</td>
</tr>
</tbody>
</table>
Introduction

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Trainer Presentation (20 min.):</td>
</tr>
<tr>
<td>Unfortunately, a large number of women who wish to delay or prevent future pregnancies receive little or no information on safe, available, effective contraceptives for postpartum and postabortion use, including:</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• how or where to obtain contraceptives</td>
<td>• Administer the pre-test. Upon review of the responses, note objectives requiring specific attention.</td>
</tr>
<tr>
<td>• how soon after childbirth and abortion contraceptive methods should be initiated</td>
<td>• Display Transparency #1 and discuss the module objectives.</td>
</tr>
<tr>
<td>Women often have valid concerns that certain methods may affect breastfeeding, their breastmilk, and the growth and development of their infant.</td>
<td>• Introduce the concept of postpartum and postabortion contraception.</td>
</tr>
<tr>
<td>Some women may want to become pregnant soon after having an incomplete abortion, and barring medical reasons, there is no reason to discourage them from doing so.</td>
<td>• Allow for questions.</td>
</tr>
<tr>
<td>The majority of women receiving postabortion care do not want to become pregnant again in the near future, and it is important that the contraceptive needs of women during this critical period are met.</td>
<td>(See Px Handout #1.)</td>
</tr>
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</table>
Specific Objective #1: State the definitions of postpartum and postabortion contraception.

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td></td>
</tr>
<tr>
<td><strong>Postpartum Contraception</strong></td>
<td></td>
</tr>
</tbody>
</table>
| *Postpartum contraception* is the initiation and use of family planning methods in the first six weeks after delivery to prevent unintended pregnancy particularly in the first 1-2 years after childbirth, when another pregnancy can be harmful to the mother or a breastfeeding baby. | **Trainer Presentation (10 min.):** The trainer should:  
  - Display the definitions for postpartum and postabortion contraception in Transparency #2.  
  - Stress the difference between the return of fertility in postpartum and postabortion women.  
  - Read them with the Px and allow for discussion and questions, especially related to factors affecting the length of the postpartum period.  
  (See Px Handout #2.) |
| The terms relating the initiation of family planning to the time of delivery:  
  - Immediate postpartum – within 48 hours after delivery (term usually used in association with voluntary sterilization or IUD insertion)  
    - Post-placental – within 10 minutes following delivery of the placenta  
    - Postpartum before discharge (PPBD) – within 48 hours after delivery and before the woman leaves the facility where she delivered  
  - Postpartum period – the first 6 weeks after delivery  
  - Interval period (postpuerperal) – more than 6 weeks after delivery |                                           |
| **Postabortion Contraception**   |                                           |
| *Postabortion contraception* is the initiation and use of family planning methods, most often immediately after treatment for abortion - within 48 hours, or before fertility returns (2 weeks postabortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief interval. |                                           |
**Specific Objective #2: State the difference between the postpartum and postabortion period of infertility.**

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td><strong>Postpartum Infertility</strong></td>
</tr>
<tr>
<td></td>
<td>During pregnancy, cyclic ovarian function is suspended.</td>
</tr>
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<td></td>
<td>After the delivery of the placenta, the inhibiting effects of estrogen and progesterone are removed so that levels of Follicle Stimulating Hormone and Luteinizing Hormone gradually rise and ovarian function begins again.</td>
</tr>
<tr>
<td></td>
<td>Most non-lactating women resume menses within four to six weeks of delivery, however, approximately 33% of first cycles are anovulatory and a high proportion of first ovulatory cycles have luteal-phase defects; therefore pregnancy is less likely than with normal cycles. In non-lactating women, the first ovulation occurs on average around 45 days postpartum.</td>
</tr>
<tr>
<td></td>
<td>However, there is some risk of a pregnancy that could be detrimental to the mother and the infant at this time. Family planning is a high priority for optimal reproductive health in this context.</td>
</tr>
<tr>
<td></td>
<td><strong>Postabortion Infertility</strong></td>
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<tr>
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<td>Following a first trimester abortion (either spontaneous or induced), a woman's fertility resumes almost immediately, and usually within two weeks.</td>
</tr>
<tr>
<td></td>
<td>After second-trimester abortion, a woman's fertility usually resumes within four weeks.</td>
</tr>
<tr>
<td></td>
<td>Many providers mistakenly think that the guidelines for postpartum contraception also apply to postabortion contraception. As a result,</td>
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<td><strong>Trainer Presentation (10 min.):</strong></td>
</tr>
<tr>
<td></td>
<td>The trainer should:</td>
</tr>
<tr>
<td></td>
<td>• Review the content with Px.</td>
</tr>
<tr>
<td></td>
<td>• Discuss the differences between the period of time during which fertility returns in postpartum and postabortion women.</td>
</tr>
<tr>
<td></td>
<td>(See Px Handout #3.)</td>
</tr>
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</table>
Specific Objective #2: Continued

<table>
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<th>CONTENT</th>
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<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
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<tr>
<td>women are often not offered methods after treatment for abortion that would be both appropriate for and acceptable to them. For example, special concerns for postpartum contraception, related to breastfeeding do not apply to postabortion women.</td>
<td></td>
</tr>
</tbody>
</table>
Specific Objective #3: Discuss the key issues related to postpartum and postabortion contraception.

### CONTENT

**Knowledge/Attitudes/Skills**

<table>
<thead>
<tr>
<th>Key Issues related to Postpartum Contraception</th>
<th>Training/Learning Methods</th>
</tr>
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<tbody>
<tr>
<td>During the early postpartum period, a combination of abstinence and/or lactational amenorrhea may prevent the woman from conceiving. However, many women at risk for pregnancy are not using contraception.</td>
<td><strong>Discussion (15 min.):</strong></td>
</tr>
<tr>
<td>The following facts have been determined by <em>Demographic and Health Surveys</em> (DHS) conducted in a number of countries:</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• More than 60% of women interviewed during the first 24 months postpartum did not want to become pregnant. They either wanted to delay the next pregnancy for two years or they did not want more children.</td>
<td>• Ask Px, “What are the policies in your own workplace for the provision of contraceptive methods postpartum?”</td>
</tr>
<tr>
<td>• The majority of women leaving the hospital without a contraceptive method planned to use contraception within six months.</td>
<td>• Record responses on a flipchart.</td>
</tr>
<tr>
<td>Despite the documented demand for postpartum contraception, many postpartum women do not receive the family planning information or services they need to delay or prevent subsequent pregnancies. About half of the postpartum women who want family planning do not succeed in starting a method in the first year after delivery.</td>
<td>• Draw Px’s attention to the appropriateness of the policies in relation to the return of fertility and ease of access to contraceptive methods.</td>
</tr>
<tr>
<td><strong>Key Issues related to Postabortion Contraception</strong></td>
<td>• Highlight key points in content.</td>
</tr>
<tr>
<td>Many women are trapped in a cycle of repeated unwanted pregnancy and abortion (either illegal or legal).</td>
<td>• Ask Px, “What are the policies in your own workplace for the provision of contraceptive methods following treatment for incomplete abortion?”</td>
</tr>
<tr>
<td></td>
<td>• Record responses on a flipchart.</td>
</tr>
<tr>
<td></td>
<td>• Draw Px’s attention to the appropriateness of the policies in relation to the return of fertility and ease of access to contraceptive methods.</td>
</tr>
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<td></td>
<td>• Highlight key points in content.</td>
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*(See Px Handout #4.)*
Specific Objective #3: Continued

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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td><strong>Key Issues related to Postabortion Contraception (cont.)</strong></td>
<td></td>
</tr>
<tr>
<td>Although the importance of linking the treatment of incomplete abortion care and family planning services is well documented, in many countries they are not offered together. This results in:</td>
<td></td>
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<tr>
<td>• Women being denied access to the means of preventing future unwanted pregnancies.</td>
<td></td>
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<tr>
<td>• A lack of comprehensive reproductive health services linking family planning, postabortion care, and treatment for infertility and sexually transmitted diseases.</td>
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</tbody>
</table>
Specific Objective #4: Describe the essential components of postpartum and postabortion contraceptive services.

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods</th>
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</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
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</tbody>
</table>

**Essential Components of Postpartum and Postabortion Contraceptive Services**

- A discussion of contraceptive needs, taking into account reproductive goals and protection against sexually transmitted diseases
- Information and counseling about methods, their effectiveness rates, and side effects
- Short- and long-term method choices
- Assurance of contraceptive resupply
- Access to follow-up care

**Postpartum and Postabortion Contraception Quality of Care Options**

1. Before discharging the woman from the hospital, explain the risk of an unwanted pregnancy and the need for contraception. Urge the client to find family planning services near her home, or

2. Before discharging the woman from the hospital, help her to initiate a contraceptive method of her choice, or

3. Schedule a follow-up appointment in two weeks to discuss family planning and initiate a method, or

4. Give the woman a referral appointment at a family planning clinic near the hospital or near her home.

**Brainstorming (10 min.):**

The trainer should:

- Ask the Px to list what they think the essential components of postpartum and postabortion contraceptive services should include. Taking into account the period of return to fertility after a pregnancy is completed or terminated, what would be four PP/PA contraceptive service options?
- Ensure that the Px’s answers include the components in the content column (also in Px Handout #5).
- Make additions and corrections, as necessary.

(See Px Handout #5.)
Module 13

Specific Objective #5: Discuss the advantages of postpartum and postabortion contraceptive services.

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td></td>
</tr>
<tr>
<td><strong>Potential Advantages of Postpartum/Postabortion Contraception</strong></td>
<td></td>
</tr>
<tr>
<td>Providers have several opportunities for contact with clients during</td>
<td><strong>Small Group Exercise (45 min.):</strong></td>
</tr>
<tr>
<td>the prenatal and postpartum period. <em>Since many clients are already in</em></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>the health system and have access to services,* introducing family</td>
<td>• Divide the group into pairs and distribute <em>Px Handout #7</em>, one situation per pair.</td>
</tr>
<tr>
<td>planning services during the prenatal and postpartum period is more</td>
<td>• Ask each pair to discuss in the context of their own local health care system, the ways to link postpartum</td>
</tr>
<tr>
<td>efficient and effective.</td>
<td>care and postabortion care with family planning, considering the advantages and disadvantages of the</td>
</tr>
<tr>
<td><strong>Prenatal</strong></td>
<td>situation they are assigned. (See models listed in the content column).</td>
</tr>
<tr>
<td>These visits provide an opportunity to discuss infant health care,</td>
<td>• Pair Px from the same institution, if possible.</td>
</tr>
<tr>
<td>breastfeeding, and family planning. Providers can introduce these ideas</td>
<td></td>
</tr>
<tr>
<td>at early prenatal visits and discuss them in greater detail as the</td>
<td><strong>Group work and Discussion (15 min.):</strong></td>
</tr>
<tr>
<td>delivery date draws near.</td>
<td>The trainer should:</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
<td>• Ask the Px to complete the exercise sheet.</td>
</tr>
<tr>
<td>• The birth of a baby presents another opportunity to offer information</td>
<td>• Reassemble groups to present their work; acknowledge that there are no &quot;right&quot; answers. The aim is to</td>
</tr>
<tr>
<td>about breastfeeding and contraception. In some cases, this may be the</td>
<td>make changes which will increase a woman's access to family planning postpartum or postabortion.</td>
</tr>
<tr>
<td>only contact the woman will have with health care workers.</td>
<td>(See <em>Px Handout #6 and #7.</em>)</td>
</tr>
<tr>
<td>• Ideally, counseling should be initiated during prenatal care.</td>
<td></td>
</tr>
<tr>
<td>However, birth attendants or other health care providers should offer</td>
<td></td>
</tr>
<tr>
<td>family planning counseling and services following delivery.</td>
<td></td>
</tr>
<tr>
<td>• Counseling should never take place during labor and should only occur after the mother has recovered from the immediate physical and emotional stress of childbirth.</td>
<td></td>
</tr>
</tbody>
</table>

(See *Px Handout #6 and #7.*)
Specific Objective #5: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Postnatal or Child Health Care</strong></td>
<td><strong>Presentation (15 minutes):</strong></td>
</tr>
<tr>
<td>• Family planning services for the mother can be integrated with care for infants; or the postpartum visit for the mother can incorporate child health assessment.</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>• Often mothers and infants are cared for by two different sets of health care providers, without any coordination. Ideally, family planning should be integrated into maternal and child health services.</td>
<td>• Link the Px’s group work with the content, reviewing the advantages to integrating family planning services with other reproductive health services, such as postpartum and postabortion care.</td>
</tr>
</tbody>
</table>

**Note:** Integrated services have logistical considerations, which include:

- Clinicians or service providers may not be trained in areas outside their discipline.
- Services may be located in different buildings or different sections of the facility.
- Different policies and guidelines may apply to different types of services.
- Funding may come from different sources.

**Treatment of Incomplete Abortion**

- The period following the treatment of incomplete abortion offers the provider and client an opportunity to explore family planning needs.
- Individual assessment of each woman should include: her personal characteristics; her clinical condition; and the service delivery capabilities in the community where she lives and where the services will be provided.
- **Immediately following the treatment of incomplete abortion or before discharge, the woman's chosen family planning method may be provided.**
Specific Objective #5: Continued

<table>
<thead>
<tr>
<th>CONTENT Knowledge/Attitudes/Skills</th>
<th>Training/Learning Methods (Time Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of Incomplete Abortion (cont.)</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Counseling should not be conducted during postabortion care procedures such as Manual Vacuum Aspiration or when the woman is in emotional or physical stress.

- The initiation of contraception during the immediate postpartum and postabortion period can lead to short-term and long-term cost savings for both the client and the provider.
- In a comparative study conducted in Peru, it was found that an institution implementing postpartum and postabortion family planning services would save between 3-5% of the annual projected family planning budget and free up 6% of their outpatient service delivery capacity.
- One major advantage of postpartum and postabortion family planning services is that they do not require a separate clinical infrastructure or staff.
Specific Objective #6: Apply the principles of postpartum and postabortion contraception, counseling, and contraceptive method provision in a role play and in case studies.

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
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</tbody>
</table>

Counseling

The goal of postpartum counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does want contraception, to help her choose an appropriate method, taking into consideration whether or not she is breastfeeding.
- To prepare her to use the method effectively.

The goal of postabortion counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does, to help her choose an appropriate method.
- To prepare her to use the method effectively.

Remember, acceptance of contraception or of a particular contraceptive method should never be a prerequisite for obtaining reproductive health care.

Postpartum Counseling

Prior to more in-depth counseling, a provider may encourage women and their partners to consider issues such as:

- Whether they want more children, whether they are content with their current family size;
- If they want more children, how long would they like to wait before having another child;

Presentation (10 min.):

The trainer should:

- Post a flip chart or display Transparency #3 with the goals of postpartum and postabortion family planning.
- Review the content with Px while allowing for questions.

(See Px Handouts #8.)
Specific Objective #6: Continued

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td>Postpartum Counseling (cont.)</td>
<td></td>
</tr>
<tr>
<td>- Their satisfaction, and successes and failures with contraceptive methods used previously; and</td>
<td></td>
</tr>
<tr>
<td>- Their plans regarding breastfeeding.</td>
<td></td>
</tr>
</tbody>
</table>

If the client is interested in contraception, providers should use counseling skills to help the client focus on which method or combination of methods may be most appropriate.

Clients and their partners should be offered the opportunity to have their questions clarified, particularly: the effect of family planning methods on breastfeeding; correct use of methods; and the resumption of sexual relations following delivery.

**Note:** For women still in early labor, client education and counseling can be offered at the time of hospital admission. It is important for health care providers to recognize that the chief concern of most women at this time is the birth outcome, not family planning. Counseling in early labor is best limited to confirming the decision regarding the family planning method (e.g., PPIUD). For those who arrive in active labor, counseling should be done after delivery, before hospital discharge.
Module 13

Specific Objective #6: Continued

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td>Which contraceptive should postpartum women use?</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Since approximately 90% of all women breastfeed their infants for some period of time, the impact of contraceptive methods on breastfeeding, breastmilk, and infant health is a very important consideration.</td>
<td><strong>Presentation (5 min.):</strong></td>
</tr>
<tr>
<td><strong>The International Planned Parenthood Federation (IPPF) recommends providers follow these three general guidelines:</strong></td>
<td><strong>The trainer should:</strong></td>
</tr>
<tr>
<td>• Health care providers should encourage full breastfeeding for all women.</td>
<td>• Link the previous content covered to the next activity by presenting the information in the content column.</td>
</tr>
<tr>
<td>• Breastfeeding should not be discontinued to start the use of a contraceptive method.</td>
<td><strong>Small Group Exercise (40 min.):</strong></td>
</tr>
<tr>
<td>• The chosen method must not adversely affect breastfeeding or the health of the infant.</td>
<td><strong>The trainer should:</strong></td>
</tr>
<tr>
<td><strong>General Guidelines and Specific Notes</strong></td>
<td><strong>• Divide the group into two.</strong></td>
</tr>
<tr>
<td><strong>• All non-hormonal methods can safely be used by breastfeeding women</strong> and should be considered the first choice among contraceptive methods, since they do not interfere with a woman's ability to breastfeed; the quality/quantity of breastmilk; or produce any adverse effect on infant growth and development.</td>
<td>• One group lists contraceptive methods, which can be used by breastfeeding women and gives their rationale for use and timing of initiation.</td>
</tr>
<tr>
<td>• Non-hormonal methods include: lactational amenorrhea method (LAM); condoms (male or female); spermicides; diaphragm; intrauterine device (IUD); voluntary surgical contraception (VSC--male or female); and natural family planning (NFP).</td>
<td>• The other lists, gives their rationale for, and timing of initiation of contraceptive methods to be used by the non-breastfeeding woman.</td>
</tr>
<tr>
<td></td>
<td>• After each group presentation, make corrections and additions.</td>
</tr>
<tr>
<td></td>
<td>• Group work should include the information in <em>Px: Handouts #10 and #11.</em></td>
</tr>
<tr>
<td></td>
<td>• Highlight the points for specific methods, as identified in the content column. (See <em>Px Handouts #9, #10, and #11.</em>)</td>
</tr>
</tbody>
</table>
Specific Objective #6: Continued

<table>
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<tr>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
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</table>

**Note:** The use of prelubricated condoms or condoms and spermicides may be preferred by breastfeeding women who often experience vaginal dryness in the early postpartum period.

### IUDs

**Note:** Research has shown that breastfeeding women report less pain during IUD insertion than women who are not breastfeeding, experience fewer post-insertion side effects (bleeding or pain), and have lower removal rates.

- IUDs can be safely inserted vaginally, immediately after the delivery of the placenta or within 48 hours postpartum before discharge.
- If insertion does not take place within the first 48 hours after delivery, it is better to wait until four weeks for the TCu 380A or six weeks for other IUDs postpartum; the uterus should be fully involuted and firm at time of insertion.
- An IUD can also be inserted during a cesarean section, through the uterine incision, prior to closing the uterus and abdomen. Insertions performed at this times may be convenient for the client and may be practical when it is the only occasion on which a woman can obtain an IUD from a trained health care provider.
- **Postpartum IUD insertion is safe, poses no greater risk of infection (when infection prevention practices are strictly followed), bleeding, or perforation than insertion of IUDs at other times.**
Specific Objective #6: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
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</thead>
<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
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</table>

**IUDs (cont.)**

- **IUD expulsion is a valid concern for insertions done during the postpartum period.** Appropriate training of providers in correct postpartum insertion techniques (training that emphasizes placement of the device high in the uterus) can reduce the risk of IUD expulsion.
- **After postpartum insertion, 7-15% will be expelled, usually in the first several weeks or months.** Women themselves will detect 95% of expulsions, if properly instructed.
- **Counseling women about methods of postpartum contraception must include assessment of their risk for contracting sexually transmitted diseases, especially hepatitis B virus (HBV) and human immunodeficiency virus (HIV).**

**Female Sterilization (VSC)**

- **The preferred time for postpartum sterilization is usually after the woman recovers from delivery and the health and survival of the newborn are more certain.**
- **The procedure is easier to perform within the first 48 hours of delivery because the size and location of the uterus allow for better visualization of and access to the Fallopian tubes.** The procedure may also be performed up to seven days postpartum.
- **The procedure can also be done immediately following a cesarean section prior to closing the abdomen.**
- **Counseling for VSC requires the client's thorough understanding of the permanence of the method.**
- **Counseling should be done before and after childbirth and never during the stress of labor or delivery.**
Specific Objective #6: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
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</thead>
<tbody>
<tr>
<td><strong>Progestin-only Methods</strong></td>
<td></td>
</tr>
<tr>
<td>• Progestin-only methods are considered good methods for breastfeeding women six or more weeks after delivery.</td>
<td></td>
</tr>
<tr>
<td>• Progestin-only contraceptives have not been shown to affect breastfeeding, breastmilk, or infant growth and development.</td>
<td></td>
</tr>
<tr>
<td>• Methods include: injectables, such as DMPA; oral contraceptives, such as progestin-only pills; and Norplant®, a subdermal implant. (See Modules 1, 4, and 6 for more detailed information on providing these method services.)</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Women using LAM may initiate the use of progestin-only contraceptives before or immediately after the criteria for LAM are no longer met.</td>
<td></td>
</tr>
<tr>
<td>• It is recommended that progestin-only methods be provided after the first six weeks postpartum. However, some postpartum services have found it more convenient to begin these methods immediately after delivery since no adverse effects on the infant or breastfeeding has been observed.</td>
<td></td>
</tr>
<tr>
<td><strong>Combined Hormonal Contraception</strong></td>
<td></td>
</tr>
<tr>
<td>A less preferred choice in contraceptive options for breastfeeding women are methods that contain a combination of estrogen and progestin.</td>
<td></td>
</tr>
</tbody>
</table>
## Specific Objective #6: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
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</thead>
<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Combined Hormonal Contraception (cont.)</strong></td>
<td></td>
</tr>
<tr>
<td>• Studies have shown that even low-dose combined oral contraceptives (COCs) decrease breastmilk production. For this reason, <strong>during the first six weeks postpartum, breastfeeding women should never use COCs or other combined hormonal methods.</strong></td>
<td></td>
</tr>
<tr>
<td>• At six months a breastfeeding woman may consider using a combined method, however, they are still not a preferred option, where progestin-only methods are available.</td>
<td></td>
</tr>
<tr>
<td>• Methods include: combined oral contraceptives and combined injectable contraceptives (Mesigyna and Cyclofem).</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Breastfeeding Women:</strong></td>
<td></td>
</tr>
<tr>
<td>• For postpartum women <strong>who do not breastfeed,</strong> any contraceptive method, except LAM, can be an option. However, the timing of initiation varies according to the method.</td>
<td></td>
</tr>
<tr>
<td>• IUDs, VSC (male or female), condoms, spermicides, and progestin-only methods may be administered immediately postpartum.</td>
<td></td>
</tr>
<tr>
<td>• Women desiring NFP should begin observations for fertility signs about two-to-three weeks postpartum.</td>
<td></td>
</tr>
<tr>
<td>• Combined estrogen and progestin contraceptives should be delayed until three weeks postpartum due to an increased risk of blood clotting problems during this period.</td>
<td></td>
</tr>
<tr>
<td>• The diaphragm may be fitted at six weeks, after involution and healing are completed.</td>
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## Specific Objective #6: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td><strong>Small Group Exercise (40 min.):</strong></td>
</tr>
<tr>
<td><strong>Postabortion Counseling</strong></td>
<td>The trainer should:</td>
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<tr>
<td></td>
<td>• Link the previous content covered to the next activity by presenting the information in the content column.</td>
</tr>
<tr>
<td></td>
<td>• Divide the group into pairs. Each pair is assigned two contraceptive methods for which they will determine the timing of initiation after abortion, and the advantages and considerations for use.</td>
</tr>
<tr>
<td></td>
<td>• After each pair presentation, make corrections and additions, as necessary.</td>
</tr>
<tr>
<td></td>
<td>• Px should include the information in <em>Px Handout #13</em>.</td>
</tr>
<tr>
<td></td>
<td>• Highlight the specific information identified in the content column.</td>
</tr>
<tr>
<td></td>
<td>• Distribute the handout and review it with Px.</td>
</tr>
<tr>
<td></td>
<td>• Allow time for discussion and questions.</td>
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<tr>
<td></td>
<td>(See <em>Px Handout #12 and #13.</em>)</td>
</tr>
</tbody>
</table>

- Health care providers can help a woman select a family planning method that is appropriate for her and her personal situation only if they understand the factors that led to the unwanted pregnancy.

A woman receiving treatment for an incomplete abortion needs to understand before she is discharged:

- The risk of repeat pregnancy is high. (Ovulation may occur as early as two weeks after an abortion in the first trimester, and 75% of women will ovulate within six weeks.)
- There are a variety of safe contraceptive methods that can be used to avoid pregnancy.
- Where and how to get family planning methods (at the time of treatment and after discharge).

As with all family planning counseling, the client will need to know:

- Advantages and disadvantages
- Side effects and risks
- How to use selected method(s) correctly
- When and where to get re-supply
- Method reversibility
- How to stop using the method or how to switch to another method

**Counseling women about methods of postabortion contraception must include assessment of their risk for contracting sexually transmitted diseases, especially HBV and HIV.**
Specific Objective #6: Continued

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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
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</table>

*Postabortion Counseling* (cont.)

**All women should be advised** that the only contraceptive methods that provide some protection against STDs are condoms, and, to a lesser extent, spermicides.

See *Participant Handout #14: Family Planning and Informed Choice* for further information on this topic.

**Which contraceptive should postabortion women use?**

In general, all modern family planning methods can be used **immediately** after an abortion or postabortion care, provided:

- There are no severe complications requiring further treatment
- The provider screens for any precautions for using a particular contraceptive method
- The client receives adequate counseling

**Note:** *It is recommended that women not have sexual intercourse until postabortal bleeding stops (usually five to seven days) and any complications are resolved. Natural Family Planning (NFP) is not recommended until a regular menstrual pattern returns.*

**IUDs**

**Note:** *An IUD can be safely inserted at the time of evacuation for incomplete abortion if the uterus is not infected.*

(See *Px Handout #14.*)
### Specific Objective #6: Continued

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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
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</tr>
<tr>
<td><strong>IUDs (cont.)</strong></td>
<td></td>
</tr>
<tr>
<td>• Unplanned pregnancy rates for postabortion IUD insertion are comparable or even lower than rates for interval insertions. Expulsion rates are similar to those for interval insertions.</td>
<td></td>
</tr>
<tr>
<td>• The risk of pelvic inflammatory disease (PID) following postabortion insertion is no higher than following interval IUD insertion. Serious complications from postabortion IUD insertion have not been reported.</td>
<td></td>
</tr>
<tr>
<td>• IUD insertion can be done immediately after evacuation for incomplete abortion of a first or second trimester pregnancy, if there is no uterine infection.</td>
<td></td>
</tr>
<tr>
<td>• If skills for immediate postabortion IUD insertion do not exist, insertion should be delayed for six weeks.</td>
<td></td>
</tr>
<tr>
<td>• Women who have been treated for postabortion complications may have medical conditions that could affect the selection of an IUD. (Review Px Handout #14 for content related to contraceptive use guidelines in the presence of medical conditions.)</td>
<td></td>
</tr>
<tr>
<td>• Postabortion IUD insertions have approximately the same rate of expulsion, 3-5%, as interval insertions.</td>
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Module 13

Specific Objective #6: Continued

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<tbody>
<tr>
<td><strong>Knowledge/Attitudes/Skills</strong></td>
<td>(Time Required)</td>
</tr>
<tr>
<td><strong>Service Delivery Capabilities</strong></td>
<td><strong>Individual Exercise (45 min.):</strong></td>
</tr>
<tr>
<td>• A woman's ability to use a method effectively is based, in part, on</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>the resources of the community where she lives.</td>
<td>• Lead the Px in synthesizing the content covered by asking</td>
</tr>
<tr>
<td>• To ensure continuity of care, health care providers must consider a</td>
<td>Px to reflect back to their facilities and the family planning</td>
</tr>
<tr>
<td>woman's family planning needs in relation to the overall health</td>
<td>resources in their client's communities.</td>
</tr>
<tr>
<td>care system.</td>
<td>• Ask each Px to consider:</td>
</tr>
<tr>
<td>• If a woman has traveled far from home for treatment of incomplete</td>
<td>1. How postpartum contraceptive services can be integrated</td>
</tr>
<tr>
<td>abortion or postabortion complications, it is important that family</td>
<td>into existing reproductive health services?</td>
</tr>
<tr>
<td>planning providers know what services she will have access to when</td>
<td>2. How postabortion contraceptive services can be integrated</td>
</tr>
<tr>
<td>she returns home in order to help her choose an appropriate method.</td>
<td>into existing reproductive health services?</td>
</tr>
<tr>
<td>• While provider-dependent methods may not be the best choice for</td>
<td>3. What will be the logistical, management, supervisory, and</td>
</tr>
<tr>
<td>women with little or no access to ongoing care, women with little</td>
<td>provider considerations for the responses to the previous</td>
</tr>
<tr>
<td>access to resupply of condoms or pills may find methods that do not</td>
<td>questions?</td>
</tr>
<tr>
<td>require resupply their only workable option.</td>
<td><strong>Case Studies (60 min.):</strong></td>
</tr>
<tr>
<td>• Providers should be aware of the costs of a contraceptive method to</td>
<td>The trainer should:</td>
</tr>
<tr>
<td>the woman. This is a key factor in limiting the use of family</td>
<td>• Use these cases to reinforce PP/PA contraception skills.</td>
</tr>
<tr>
<td>planning.</td>
<td>• After the management exercises are completed, they may be</td>
</tr>
<tr>
<td>• The high cost of services and methods can prevent women from</td>
<td>used for counseling skills practice in Role Plays.</td>
</tr>
<tr>
<td>having access to contraceptives and often influences their ability</td>
<td>• Distribute <em>Px Handout #15</em>, while using the guides in *Px</td>
</tr>
<tr>
<td>and willingness to use them.</td>
<td>Handout #15A* to correct and supplement Px contributions.</td>
</tr>
</tbody>
</table>

Pathfinder International 24  PP/PA Contraception Curriculum
**Specific Objective #7: Demonstrate the skills required to perform postpartum and postabortion IUD insertion.**

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guidelines and Skills: Postpartum and Postabortion IUD Insertion</strong></td>
<td><strong>Presentation (10 min.):</strong></td>
</tr>
<tr>
<td><strong>Timing and Approach</strong></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>There are several phases during the postpartum period when IUDs may be inserted. These include:</td>
<td>• Introduce and discuss the various methods of postpartum IUD insertion.</td>
</tr>
<tr>
<td>• <strong>Postplacental insertion</strong>: Immediately after expulsion of the placenta, preferably within 10 minutes after expulsion. Insertion can be done manually or with forceps.</td>
<td>• Distribute <em>Px Handout #16</em> for review.</td>
</tr>
<tr>
<td>• <strong>Postpartum before discharge (PPBD) insertion</strong>: Within 48 hours after delivery, before hospital discharge. Insertion is done only with forceps.</td>
<td><em>(See <em>Px Handout #16.</em>)</em></td>
</tr>
<tr>
<td>• <strong>Transcesarean insertion</strong>: During cesarean section, after the uterine cavity has been explored manually, following delivery of the placenta. Insertion can be done manually or with forceps.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> <em>This approach has been identified with the lowest expulsion rate of the three methods described.</em></td>
<td></td>
</tr>
<tr>
<td>According to the World Health Organization (WHO), two other categories exist with the following recommendations:</td>
<td></td>
</tr>
<tr>
<td>• <strong>Puerperal or Delayed insertion</strong>: from one to six weeks after delivery. (Insertion generally not preferred during this interval due to increased risk of perforation.)</td>
<td></td>
</tr>
<tr>
<td>• <strong>Postpuerperal insertion</strong>: at a follow-up examination six to eight weeks after delivery. This is commonly referred to as interval insertion.</td>
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</table>
Specific Objective #7: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td>Postpartum and postabortion family planning services require minimal additional equipment and supplies. See <em>Px Handout #17</em> for equipment and supplies list.</td>
<td><strong>Discussion:</strong> (20 minutes)</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>Postpartum IUD insertion is <strong>not</strong> appropriate for women who have:</td>
<td>• Review with Px the precautions for providing IUDs to postpartum clients.</td>
</tr>
<tr>
<td>• An active STD or are at risk for STDs (e.g., have multiple sexual partners or their partner has multiple sexual partners);</td>
<td>• Add information related to the precautions for provision during the postpartum period, such as prolonged rupture of membranes.</td>
</tr>
<tr>
<td>• A history of recent or recurrent PID, indicating risk of exposure to STDs; or</td>
<td></td>
</tr>
<tr>
<td>• Known or strongly suspected cancer of the uterus.</td>
<td></td>
</tr>
<tr>
<td>In addition, PPIUD insertion is <strong>not</strong> appropriate for women with:</td>
<td></td>
</tr>
<tr>
<td>• Prolonged rupture of membranes (greater than 24 hours);</td>
<td></td>
</tr>
<tr>
<td>• Fever or any other signs of abdominal or pelvic infection;</td>
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</tr>
<tr>
<td>• Intrapartum or postpartum hemorrhage that continues after completely emptying the uterus; or</td>
<td></td>
</tr>
<tr>
<td>• Bleeding problems, such as disseminated intravascular coagulation caused by eclampsia or preeclampsia.</td>
<td></td>
</tr>
<tr>
<td>IUDs are <strong>not the method of first choice</strong> for women who:</td>
<td></td>
</tr>
<tr>
<td>• Have severe anemia (hemoglobin less than 9, hematocrit less than 28).</td>
<td></td>
</tr>
<tr>
<td>• Have an abnormal Pap smear for which treatment is imminent or other signs of genital cancer.</td>
<td></td>
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Specific Objective #7: Continued

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<tr>
<th>CONTENT</th>
<th>Training/Learning Methods (Time Required)</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>Presentation (30 min.):</td>
</tr>
<tr>
<td></td>
<td>The trainer should:</td>
</tr>
<tr>
<td></td>
<td>• Introduce the procedural steps for postpartum insertion by the various methods, using diagrams to reinforce hand and ring forceps.</td>
</tr>
<tr>
<td></td>
<td>• Allow for Px discussion and questions.</td>
</tr>
<tr>
<td></td>
<td>Demonstration/Return Demonstration (60 min.):</td>
</tr>
<tr>
<td></td>
<td>The trainer should:</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate the two insertion techniques using a pelvic model or other uterine simulator to simulate the immediately-and-newly postpartum uterus.</td>
</tr>
<tr>
<td></td>
<td>• Repeat the demonstration, with attention to the Px’s needs for clarification.</td>
</tr>
<tr>
<td></td>
<td>• Allow small group simulation practice for each technique with the Px, following the steps in Px Handout #18.</td>
</tr>
<tr>
<td></td>
<td>• Use the skills checklist in Px Handout #19 to help the Px practice the skills.</td>
</tr>
<tr>
<td></td>
<td>• Distribute Px Handout #20 on postinsertion instructions and review it with Px.</td>
</tr>
<tr>
<td></td>
<td>• Review the instructions for clients receiving a postpartum IUD in Px Handout #21A.</td>
</tr>
<tr>
<td></td>
<td>• Review the instructions for clients receiving a postabortion IUD in Px Handout #21B. (See Px Handouts #18 – 21B.)</td>
</tr>
</tbody>
</table>

- Have conditions that increase the risk of infection, such as AIDS or poorly controlled diabetes.
- Do not have access to a health center for follow-up care.
- Dislike touching their genitals to feel for the IUD strings.

**Insertion Techniques: Manual**

The **Manual** method of insertion is **appropriate when performed within ten minutes of expulsion of the placenta**. Manual insertion requires no special instruments, but may be less comfortable for the client than insertion with ring forceps. The steps are as follows:

1. After examining the placenta to determine that it has been entirely expelled, massage the uterus until it becomes firm and bleeding subsides.
2. Examine the cervix for injury using a retractor or speculum, if necessary.  
   **Note:** *Use only sterile or HLD gloves or instruments when touching the IUD.*
3. Wearing sterile or HLD gloves, insert the IUD by gripping it between the index and middle fingers. Place the IUD strings in the palm of the hand.
4. Use the opposite hand to firmly stabilize the uterus externally (hand on abdomen).
5. Place the IUD at the top (fundus) of the uterine cavity. It may be necessary to grasp the cervix with a ring forceps to facilitate insertion.
6. Gently remove the hand from the uterine cavity.  
   **Note:** *Inspect the vagina. If the IUD strings are visible, the IUD is placed too low and should be reinserted.*
**Specific Objective #7: Continued**

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<tr>
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**Insertion Techniques: Ring Forceps**

Insertion using a **Ring Forceps** is **appropriate for postplacental insertion or any time within 48 hours after delivery** while the cervix is still wide open. The insertion steps are as follows:

**Note:** Immediate postpartum (within 48 hrs) IUD placement requires a long forceps to achieve fundal placement. A 12 inch (30.6 cm) curved Foerster ring forceps without box lock is suitable, other ovum forceps for postpartum intrauterine exploration may also be used. The standard straight 9 inch (24 cm) Foerster sponge forceps is not long enough to allow fundal placement in most women.

1. Determine that the entire placenta has been expelled by examining it closely (if insertion is immediately postplacental). Massage the uterus until it becomes firm and bleeding subsides.
2. If the woman has delivered vaginally after a previous cesarean section, put on sterile or HLD gloves and manually palpate the previous incision to identify any defect that might be present. Take care to avoid placing the IUD through such a defect.
3. Examine the cervix for injury using a retractor or speculum, if necessary.
4. Grasp the IUD with the 12 inch (30.6 cm) ring forceps, holding it at a slight angle. **Note:** Use only sterile or HLD gloves or instruments when touching the IUD.
5. Grasp the anterior cervix with a second ring forceps (9 inch; 24 cm).
6. Hold the cervix and keep it in view while introducing the IUD through the cervix into the lower uterus.
7. Release the hand that is holding the cervix with the second ring forceps and move it to the lower abdomen.

**Demonstration (cont.):**

The trainer should:
- Repeat the demonstration process for the Ring Forceps Insertion Method.
- Review the steps on the checklist in *Px Handout #22.*
- Review the steps in *Px Handout #23.*
## Specific Objective #7: Continued

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>Training/Learning Methods</th>
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<tbody>
<tr>
<td><strong>Insertion Techniques: Ring Forceps Insertion</strong> (cont.)</td>
<td></td>
</tr>
<tr>
<td>8. Stabilize the uterus externally with firm pressure on the abdomen.</td>
<td></td>
</tr>
<tr>
<td>9. Advance the IUD to the top (fundus) of the uterine cavity.</td>
<td></td>
</tr>
<tr>
<td>10. Confirm fundal placement with both the abdominal hand and the ring forceps inserting the IUD.</td>
<td></td>
</tr>
<tr>
<td>11. After releasing the IUD, gently remove the ring forceps.</td>
<td></td>
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<tr>
<td>13. Inspect the vagina. If the IUD strings are visible, the IUD is placed too low and should be reinserted.</td>
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</table>

**Insertion Techniques: Cesarean Section**

The steps are as follows (after delivery of the placenta and after controlling the bleeding from the uterine incision):

1. Massage the uterus until bleeding subsides.
2. Place the IUD at the top (fundus) of the uterine cavity manually or with ring forceps.
3. Before closing the uterine incision, place the strings in the lower uterine segment.
Specific Objective #7: Continued

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<th>CONTENT</th>
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<tbody>
<tr>
<td>Knowledge/Attitudes/Skills</td>
<td>(Time Required)</td>
</tr>
<tr>
<td><strong>Insertion Techniques: Postabortion</strong></td>
<td>Presentation and Discussion (35 min.):</td>
</tr>
<tr>
<td>• An IUD <strong>can be inserted immediately</strong></td>
<td>The trainer should:</td>
</tr>
<tr>
<td>after treatment for an uncomplicated</td>
<td>• Introduce the content for postabortion</td>
</tr>
<tr>
<td>first or second trimester spontaneous</td>
<td>insertion.</td>
</tr>
<tr>
<td>abortion.</td>
<td>• Allow for Px discussion and questions.</td>
</tr>
<tr>
<td>• The risk of complications following</td>
<td>• Allow for Px questions on this and any other</td>
</tr>
<tr>
<td>postabortion insertion is not greater</td>
<td>module objective.</td>
</tr>
<tr>
<td>than that following interval IUD</td>
<td>• Distribute and administer the post-test.</td>
</tr>
<tr>
<td>insertion, as long as the cervix or</td>
<td>• Distribute the <em>Px Evaluation Form</em>.</td>
</tr>
<tr>
<td>uterine cavity is not infected and the</td>
<td></td>
</tr>
<tr>
<td>uterus has been completely evacuated.</td>
<td></td>
</tr>
<tr>
<td>• Client screening guidelines are the same</td>
<td></td>
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<tr>
<td>as for postpartum insertion.</td>
<td></td>
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<tr>
<td>• Equipment and supply needs are the same</td>
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<tr>
<td>as for postpartum insertion.</td>
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<tr>
<td>• The technique for postabortion insertion</td>
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<tr>
<td>in the first or second trimester is</td>
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<tr>
<td>similar to interval insertion, using</td>
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<tr>
<td>the inserter supplied with the IUD.</td>
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<tr>
<td>If the cervix is dilated following a</td>
<td></td>
</tr>
<tr>
<td>second trimester abortion, you may use</td>
<td></td>
</tr>
<tr>
<td>a ring forceps.</td>
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APPENDIX
Participant Handout #1: Introduction

Unfortunately, a large number of women who wish to delay or prevent future pregnancies receive little or no information on safe, available, effective contraceptives for postpartum and postabortion use, including:

- how or where to obtain contraceptives
- how soon after childbirth and abortion contraceptive methods should be initiated

Women often have valid concerns that certain methods may affect breastfeeding, their breastmilk, and the growth and development of their infant.

Some women may want to become pregnant soon after having an incomplete abortion, and barring medical reasons, there is no reason to discourage them from doing so.

The majority of women receiving abortion or postabortion care do not want to become pregnant again in the near future, and it is important that the contraceptive needs of women during this critical period are met.
Participant Handout #2: Key Definitions

Postpartum Contraception

Postpartum contraception is the initiation and use of family planning methods in the first six weeks after delivery to prevent unintended pregnancy particularly in the first 1-2 years after childbirth, when another pregnancy can be harmful to the mother or a breastfeeding baby.

The terms relating the initiation of family planning to the time of delivery:

- Immediate postpartum – within 48 hours after delivery (term usually used in association with voluntary sterilization or IUD insertion)
  - Post-placental – within 10 minutes following delivery of the placenta
  - Postpartum before discharge (PPBD) – within 48 hours after delivery and before the woman leaves the facility where she delivered
- Postpartum period – the first 6 weeks after delivery
- Interval period (postpuerperal) – more than 6 weeks after delivery

Postabortion Contraception

Postabortion contraception is the initiation and use of family planning methods most often immediately after treatment for abortion, within 48 hours, or before fertility returns (2 weeks postabortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief interval.
Participant Handout #3: Postpartum and Postabortion Infertility

Postpartum Infertility

During pregnancy, cyclic ovarian function is suspended.

After the delivery of the placenta, the inhibiting effects of estrogen and progesterone are removed so that levels of follicle stimulating hormone and luteinizing hormone gradually rise and ovarian function begins again.

Most non-lactating women resume menses within four to six weeks of delivery, however, approximately 33% of first cycles are anovulatory and a high proportion of first ovulatory cycles have luteal-phase defects; therefore pregnancy is less likely than with normal cycles. In non-lactating women, the first ovulation occurs on average around 45 days postpartum.

However, there is some risk of a pregnancy that could be detrimental to the mother and the infant at this time. Family planning is a high priority for optimal reproductive health in this context.

Postabortion Infertility

Following a first trimester abortion (either spontaneous or induced), a woman's fertility resumes almost immediately, and usually within two weeks.

After second-trimester abortion, a woman's fertility usually resumes within four weeks.

Many providers mistakenly think that the guidelines for postpartum contraception also apply to postabortion contraception. As a result, women are often not offered methods after treatment for an abortion that would be both appropriate for and acceptable to them. For example, special concerns for postpartum contraception, related to breastfeeding do not apply to postabortion women.
Participant Handout #4: Key Issues Related to Postpartum and Postabortion Contraception

Key Issues related to Postpartum Contraception

During the early postpartum period, a combination of abstinence and/or lactational amenorrhea may prevent the woman from conceiving. However, many women at risk for pregnancy are not using contraception.

The following facts have been determined by Demographic and Health Surveys (DHS) conducted in a number of countries:

- More than 60% of women interviewed during the first 24 months postpartum did not want to become pregnant. They either wanted to delay the next pregnancy for two years or they did not want more children.
- The majority of women leaving the hospital without a contraceptive method planned to use contraception within six months.

Despite the documented demand for postpartum contraception, many postpartum women do not receive the family planning information or services they need to delay or prevent subsequent pregnancies. About half of the postpartum women who want family planning do not succeed in starting a method in the first year after delivery.

Key Issues related to Postabortion Contraception

Many women are trapped in a cycle of repeated unwanted pregnancy and abortion (either illegal or legal).

Although the importance of linking the treatment of incomplete abortion care and family planning services is well documented, in many countries they are not offered together. This results in:

- Women being denied access to the means of preventing future unwanted pregnancies.
- A lack of comprehensive reproductive health services linking family planning, postabortion care, and treatment for infertility and sexually transmitted diseases.
Participant Handout #5: Essential Components of Postpartum and Postabortion Contraceptive Services

Essential Components of Postpartum and Postabortion Contraceptive Services

- A discussion of contraceptive needs, taking into account reproductive goals and protection against sexually transmitted diseases
- Information and counseling about methods, their effectiveness rates, and side effects
- Short- and long-term method choices
- Assurance of contraceptive resupply
- Access to follow-up care

Postpartum and Postabortion Contraception Quality of Care Options

1. Before discharging the woman from the hospital, explain the risk of an unwanted pregnancy and the need for contraception. Urge the client to find family planning services near her home, or

2. Before discharging the woman from the hospital, help her to initiate a contraceptive method of her choice, or

3. Schedule a follow-up appointment in two weeks to discuss family planning and initiate a method, or

4. Give the woman a referral appointment at a family planning clinic near the hospital or near her home.
Participant Handout #6: Advantages of Postpartum and Postabortion Contraceptive Services

Potential Advantages of Postpartum/Postabortion Contraception

Providers have several opportunities for contact with clients during the prenatal and postpartum period. Since many clients are already in the health system and have access to services, introducing family planning services during the prenatal and postpartum period is more efficient and effective.

Prenatal

These visits provide an opportunity to discuss infant health care, breastfeeding, and family planning. Providers can introduce these ideas at early prenatal visits and discuss them in greater detail as the delivery date draws near.

Delivery

- The birth of a baby presents another opportunity to offer information about breastfeeding and contraception. In some cases, this may be the only contact the woman will have with health care workers.
- Ideally, counseling should be initiated during prenatal care. However, birth attendants or other health care providers should offer family planning counseling and services following delivery.
- Counseling should never take place during labor and should only occur after the mother has recovered from the immediate physical and emotional stress of childbirth.

Postnatal or Child Health Care

- Family planning services for the mother can be integrated with care for infants; or the postnatal visit for the mother can incorporate child health assessment.
- Often mothers and infants are cared for by two different sets of health care providers, without any coordination. Ideally, family planning should be integrated into maternal and child health services.

Note: Integrated services have logistical considerations, which include:
- Clinicians or service providers may not be trained in areas outside their discipline.
- Services may be located in different buildings or different sections of the facility.
- Different policies and guidelines may apply to different types of services.
- Funding may come from different sources.
Participant Handout #6: Advantages of Postpartum and Postabortion Care (cont.)

Treatment of Incomplete Abortion

- The period following the treatment of incomplete abortion offers the provider and client an opportunity to explore family planning needs.
- Individual assessment of each woman should include: her personal characteristics; her clinical condition; and the service delivery capabilities in the community where she lives and where the services will be provided.
- **Immediately following the treatment of incomplete abortion or before discharge, the woman’s chosen family planning method may be provided.**

**Note:** *Counseling should not be conducted during the postabortion care procedures such as Manual Vacuum Aspiration or when the woman is in emotional or physical stress.*

- The initiation of contraception during the immediate postpartum and postabortion period can lead to short-term and long-term cost savings for both the client and the provider.
- In a comparative study conducted in Peru, it was found that an institution implementing postpartum and postabortion family planning services would save between 3-5% of the annual projected family planning budget and free up 6% of their outpatient service delivery capacity.
- One major advantage of postpartum and postabortion family planning services is that they do not require a separate clinical infrastructure or staff.
Participant Handout #7: Postpartum and Postabortion
Family Planning Exercise

Situation 1

Before discharging a woman from the hospital, explain the risk of a repeat unwanted pregnancy and the need for contraception. Urge her to find family planning services near her home.

Questions

Timing

• Once a woman is discharged, what is the likelihood that she will come for follow-up or referral appointments?
• How likely is it that the woman will get pregnant before her appointment?
• When is a woman more receptive to family planning information?

Information & Counseling

• When can a woman best make an informed, fully voluntary decision?
• How well will a woman remember instructions on how to use a method?
• When should permanent or long-term methods be considered?

Continuity

• How can a woman get follow-up care to the method she selects?
• How can the provider be sure that a woman will have access to re-supply of contraceptives?
• Is it better for a woman to receive a method in her home or in a clinic of health center? (If services are not available at her home, what is the most appropriate source for continued supplies?)
Participant Handout #7: Postpartum and Postabortion
Family Planning Exercise (cont.)

Situation 2

Before discharging a woman from the hospital, initiate a contraceptive method of her choice.

Questions

Timing

- Once a woman is discharged, what is the likelihood that she will come for follow-up or referral appointments?
- How likely is it that the woman will get pregnant before her appointment?
- When is a woman more receptive to family planning information?

Information & Counseling

- When can a woman best make an informed, fully voluntary decision?
- How well will a woman remember instructions on how to use a method?
- When should permanent or long-term methods be considered?

Continuity

- How can a woman get follow-up care to the method she selects?
- How can the provider be sure that a woman will have access to resupply of contraceptives?
- Is it better for a woman to receive a method in her home or in a treatment facility?
Participant Handout #7: Postpartum and Postabortion Family Planning Exercise (cont.)

Situation 3

Schedule a follow-up appointment in two weeks to discuss family planning and initiate a method.

Questions

Timing

• Once a woman is discharged, what is the likelihood that she will come for follow-up or referral appointments?
• How likely is it that the woman will get pregnant before her appointment?
• When is a woman more receptive to family planning information?

Information & Counseling

• When can a woman best make an informed, fully voluntary decision?
• How well will a woman remember instructions on how to use a method?
• When should permanent or long-term methods be considered?

Continuity

• How can a woman get follow-up care to the method she selects?
• How can the provider be sure that a woman will have access to resupply of contraceptives?
• Is it better for a woman to receive a method in her home or in a treatment facility?
Participant Handout #7: Postpartum and Postabortion Family Planning Exercise (cont.)

Situation 4

Give the woman a referral appointment at a family planning clinic near the hospital.

Questions

Timing

• Once a woman is discharged, what is the likelihood that she will come for follow-up or referral appointments?
• How likely is it that the woman will get pregnant before her appointment?
• When is a woman more receptive to family planning information?

Information & Counseling

• When can a woman best make an informed, fully voluntary decision?
• How well will a woman remember instructions on how to use a method?
• When should permanent or long-term methods be considered?

Continuity

• How can a woman get follow-up care to the method she selects?
• How can the provider be sure that a woman will have access to resupply of contraceptives?
• Is it better for a woman to receive a method in her home or in a treatment facility?
Participant Handout #8: Postpartum and Postabortion Counseling

The goal of postpartum counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does want contraception, to help her choose an appropriate method, taking into consideration whether or not she is breastfeeding.
- To prepare her to use the method effectively.

The goal of postabortion counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does, to help her choose an appropriate method.
- To prepare her to use the method effectively.

Remember, acceptance of contraception or of a particular contraceptive method should never be a prerequisite for obtaining reproductive health care.

Postpartum Counseling

Prior to more in-depth counseling, a provider may encourage women and their partners to consider issues such as:

- whether they want more children, whether they are content with their current family size
- if they want more children, how long would they like to wait before having another child
- their satisfaction, and successes and failures with contraceptive methods used previously
- their plans regarding breastfeeding

If the client is interested in contraception, providers should use counseling skills to help the client focus on which method or combination of methods may be most appropriate.

Clients and their partners should be offered the opportunity to have their questions clarified, particularly the effect of family planning methods on breastfeeding, correct use of methods, and the resumption of sexual relations following delivery.

Note: For women still in early labor, client education and counseling can be offered at the time of hospital admission. It is important for health care providers to recognize that the chief concern of most women at this time is the birth outcome, not family planning. Counseling in early labor is best limited to confirming the decision regarding the family planning method (e.g., PPIUD). For those who arrive in active labor, counseling should be done after delivery, before hospital discharge.
Participant Handout #9: Postpartum and Postabortion Method Choice

Which contraceptive should postpartum women use?

Note: Since approximately 90% of all women breastfeed their infants for some period of time, the impact of contraceptive methods on breastfeeding, breastmilk, and infant health is a very important consideration.

The International Planned Parenthood Federation (IPPF) recommends providers follow these three general guidelines:

- Health care providers should encourage full breastfeeding for all women.
- Breastfeeding should not be discontinued to start the use of a contraceptive method.
- The chosen method must not adversely affect breastfeeding or the health of the infant.

General Guidelines and Specific Notes

- All non-hormonal methods can safely be used by breastfeeding women and should be considered the first choice among contraceptive methods, since they do not interfere with a woman's ability to breastfeed; the quality/quantity of breastmilk; or produce any adverse effect on infant growth and development.
- Non-hormonal methods include: LAM; condoms (male or female); spermicides; diaphragm; IUD; VSC (male or female); and NFP.

Note: The use of prelubricated condoms or condoms and spermicides may be preferred by breastfeeding women who often experience vaginal dryness in the early postpartum period.

IUDs

Note: Research has shown that breastfeeding women report less pain during IUD insertion than woman who are not breastfeeding; experience fewer post-insertion side effects (bleeding or pain); and have lower removal rates.

- IUDs can be safely inserted vaginally, immediately after the delivery of the placenta or within 48 hours post delivery before discharge.
- If insertion does not take place within the first 48 hours after delivery, it is better to wait until four weeks for the TCu 380A or six weeks for other IUDs postpartum; the uterus should be fully involuted and firm at the time of insertion.
- IUDs can also be inserted during a cesarean section, through the uterine incision, prior to closing the uterus and abdomen. Insertions performed at these times may be convenient for the client and may be practical when it is the only occasion on which a woman can obtain an IUD from a trained health care provider.
Participant Handout #9: Postpartum and Postabortion
Method Choice (cont.)

- Postpartum IUD insertion is safe, poses no greater risk of infection (when infection prevention practices are strictly followed), bleeding, or perforation than insertion of IUDs at other times.
- IUD expulsion does remain a valid concern for insertions done during the postpartum period. Appropriate training of providers in correct postpartum insertion techniques (training that emphasizes placement of the device high in the uterus) can reduce the risk of IUD expulsion.
- After postpartum insertion, 7-15% will be expelled, usually in the first several weeks or months. Women themselves will detect 95% of expulsions, if properly instructed.
- **Counseling women about methods of postpartum contraception must include assessment of their risk for contracting sexually transmitted diseases, especially hepatitis B virus, and human immune deficiency virus (HIV).**

Female Sterilization (VSC)

- The preferred time for postpartum sterilization is usually after the woman recovers from delivery and the health and survival of the newborn are more certain.
- The procedure can also be done immediately following a cesarean section prior to closing the abdomen.
- Counseling for VSC requires the client's thorough understanding of the permanence of the method.
- The procedure is easier to perform within the first 48 hours of delivery because the size and location of the uterus allow for better visualization of and access to the Fallopian tubes. The procedure may also be performed up to seven days postpartum.
- **Counseling should be done before and after childbirth and never during the stress of labor or delivery.**

Progestin-only Methods

- Progestin-only methods are considered good methods for breastfeeding women six or more weeks after delivery.
- Progestin-only contraceptives have not been shown to affect breastfeeding, breastmilk, or infant growth and development.
- Methods include: injectables, such as DMPA; oral contraceptives, such as progestin-only pills; and Norplant, a subdermal implant.

**Note:** Women using LAM may initiate the use of progestin-only contraceptives before or immediately after the criteria for LAM are no longer met.

- It is recommended that progestin-only methods be provided after the first six weeks postpartum. However, some postpartum services have found it more convenient to begin these methods immediately after delivery since no adverse effects on the infant or breastfeeding has been observed.
Participant Handout #9: Postpartum and Postabortion
Method Choice (cont.)

Combined Hormonal Contraception

A less preferred choice in contraceptive options for breastfeeding women are methods that contain a combination of estrogen and progestin.

- Studies have shown that even low-dose combined oral contraceptives (COCs) decrease breastmilk production. For this reason, during the first six weeks postpartum, breastfeeding women should never use COCs or other combined hormonal methods.
- At six months a breastfeeding woman may consider using a combined method, however, they are still not a preferred option, where progestin-only methods are available.
- Methods include: combined oral contraceptives and combined injectable contraceptives (Mesigyna and Cyclofem).

Non-Breastfeeding Women:

- For postpartum women who do not breastfeed, any contraceptive method, except LAM, can be an option. However, the timing of initiation varies according to the method.
- IUDs, VSC (male or female), condoms, spermicides, and progestin-only methods may be administered immediately postpartum.
- Women desiring NFP should begin observations for fertility signs about two-to-three weeks postpartum.
- Combined estrogen and progestin contraceptives should be delayed until three weeks postpartum due to an increased risk of blood clotting problems during this period.
- The diaphragm may be fitted at six weeks, after involution and healing are completed.
Participant Handout #10: Contraceptive Options for Breastfeeding Women

First Choice: Non-hormonal Methods

- Lactational Amenorrhea Method (LAM)
- Diaphragm
- Male and Female Condoms
- Spermicides
- Intrauterine Devices (IUDs)
- Male and Female Sterilization
- Natural Family Planning (NFP)

Alternative Choice: Progestin-only Methods

- Progestin-only Pills (POPs)
- Injectables (DMPA, NET-EN)
- Subdermal Implants (Norplant®)

Less Preferred Choice: Combined Estrogen-Progestin Methods

- Combined Oral Contraceptives (COCs)
- Monthly injectables (Mesigyna, Cyclofem)
Participant Handout #10: Contraceptive Options for Breastfeeding Women (cont.)

First Choice Methods

*Lactational Amenorrhea Method (LAM)*

For women who choose to use LAM for contraception during the postpartum period, it is important that they understand the three key criteria of this method. If, at any point, a woman does not meet the following criteria, **she is not protected from pregnancy**:

- No return of menses
- No regular supplementary feedings or long gaps between breastfeeds
- Baby less than six months old

The woman should begin another method of contraception before any of these criteria expire if she wishes to continue child spacing. Breastfeeding should be continued for the health of the infant.

*Barrier Methods*

- Effectiveness depends upon correct and consistent use
- Requires access to supplies
- Diaphragms must be fitted
- Condoms prevent pregnancy as well as STD/HIV transmission

*Intrauterine Devices (IUDs)*

- Long-acting, reversible and safe
- Breastfeeding women report less pain
- Require careful screening

*Immediate Postpartum IUD insertion*

- 1) Inserted vaginally after placental delivery, 2) within 48 hours after delivery and before discharge, or 3) during cesarean section
- Requires special training and counseling
- No increased risks of infection, bleeding, or perforation
- Convenient for client and provider
- Cesarean section insertions report lower expulsions than after vaginal insertion
Participant Handout #10: Contraceptive Options for Breastfeeding Women (cont.)

Male Sterilization

- Safe and effective
- Can be performed at any time
- Appropriate during postpartum period
- Effective with few side effects
- Less expensive than female sterilization
- Permanent - requires careful counseling

Female Sterilization

- Safe and effective
- Can be performed within 48 hours of vaginal delivery or during cesarean section
- Can be performed under local anesthesia
- Can be performed by trained medical staff
- Uses simple, inexpensive instruments
- Permanent - requires careful counseling

Natural Family Planning Methods

- Women must learn to interpret fertility signs
- Avoid sex during “unsafe” days
- Fertility signs difficult to interpret during breastfeeding

Alternate Choice Methods

Progestin-only Contraceptives

- No negative effects shown on breastfeeding, breastmilk, infant growth or development
- Theoretical concerns over long-term effects on immature neonate
- Initiate after six weeks postpartum
- Progestin dose varies among methods
- Long-acting methods more convenient

Less Preferred Methods during Breastfeeding

Combined Estrogen-Progestin Contraceptives

- Decreases breastmilk production
- Do not use during first six weeks postpartum
- Use only if no options are available or acceptable during six weeks to six months postpartum
- Still not a preferred option after six months
- Other methods are preferred for breastfeeding women
Participant Handout #11A: Timing of Method Initiation:
Breastfeeding Women

<table>
<thead>
<tr>
<th>Method</th>
<th>Delivery</th>
<th>Six Weeks</th>
<th>Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>LAM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUD (Copper T) (4wk insertion only for Cu T)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization</td>
<td></td>
<td></td>
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<tr>
<td>Condoms/Spermicides</td>
<td></td>
<td></td>
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<tr>
<td>Diaphragm</td>
<td></td>
<td></td>
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<tr>
<td>Progestin-only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NFP (can begin once regular menses returns)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined Estrogen/Progestin</td>
<td></td>
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</tr>
</tbody>
</table>

(Delivery: Six Weeks: Six Months)

- LAM
- IUD (Copper T) (4wk insertion only for Cu T)
- Sterilization
- Condoms/Spermicides
- Diaphragm
- Progestin-only
- NFP (can begin once regular menses returns)
- Combined Estrogen/Progestin (still less preferred while breastfeeding)
Participant Handout #11B: Timing of Method Initiation:
Non-breastfeeding Women

<table>
<thead>
<tr>
<th>Method</th>
<th>Delivery</th>
<th>Three Weeks</th>
<th>Six Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterilization</td>
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</tr>
<tr>
<td>Condoms/Spermicides</td>
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<tr>
<td>Progestin-only</td>
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<tr>
<td>Diaphragm</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>NFP (can begin once regular menses returns)</td>
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</tbody>
</table>

* Sterilization is performed as early as four weeks for non-breastfeeding women in some settings to avoid the risk of pregnancy. Uterus must be fully involuted. Other guidelines delay sterilization to six weeks.

Note: Time scale in weeks, not months, as in Px Handout 11A for breastfeeding women.
Participant Handout #12: Postabortion Counseling

Health care providers can help a woman select a family planning method that is appropriate for her and her personal situation only if they understand the factors that led to the unwanted pregnancy.

A woman receiving treatment for an incomplete abortion needs to understand before she is discharged:

- The risk of repeat pregnancy is high. (Ovulation may occur as early as two weeks after an abortion in the first trimester, and 75% of women will ovulate within six weeks.)
- There are a variety of safe contraceptive methods that can be used to avoid pregnancy.
- Where and how to get family planning methods (at the time of service or treatment and after discharge).

As with all family planning counseling, the client will need to know:

- Advantages and disadvantages
- Side effects and risks
- How to use selected method(s) correctly
- When and where to get a re-supply
- Method reversibility
- How to stop using the method or how to switch to another method
- Counseling women about methods of postabortion contraception must include assessment of their risk for contracting sexually transmitted diseases, especially HBV and HIV.

All women should be advised that the only contraceptive methods that provide some protection against STDs are condoms, and, to a lesser extent, spermicides.

Which contraceptive should postabortion women use?

In general, all modern family planning methods can be used immediately after abortion service or postabortion care, provided:

- There are no severe complications requiring further treatment
- The provider screens for any precautions for using a particular contraceptive method
- The client receives adequate counseling

Note: It is recommended that women not have sexual intercourse until postabortal bleeding stops (usually five to seven days) and any complications are resolved. NFP is not recommended until a regular menstrual pattern returns.
Participant Handout #12: Postabortion Counseling (cont.)

IUDs

Note: IUDs can be safely inserted at the time of evacuation for incomplete abortion if the uterus is not infected.

- Unplanned pregnancy rates for postabortion IUD insertion are comparable or even lower than rates for interval insertions. Expulsion rates are similar to those for interval insertions.
- The risk of pelvic inflammatory disease (PID) following postabortion insertion is no higher than following interval IUD insertion. Serious complications from postabortion IUD insertion have not been reported.
- IUD insertion can be done immediately after evacuation following incomplete abortion of a second trimester pregnancy, in the absence of uterine infection.
- If skills for immediate postabortion IUD insertion do not exist, insertion should be delayed for six weeks.
- Women who have been treated for postabortion complications may have medical conditions that could affect the selection of an IUD. (Review Px Handout #14 for content related to contraceptive use guidelines in the presence of medical conditions.)
- Postabortion IUD insertions have approximately the same rate of expulsion, 3-5%, as interval insertions.

Service Delivery Capabilities

- A woman's ability to use a method effectively is based, in part, on the resources of the community where she lives.
- To ensure continuity of care, health care providers must consider a woman's family planning needs in relation to the overall health care system.
- If a woman has traveled far from home for treatment of incomplete abortion or postabortion complications, it is important that family planning providers know what services she will have access to when she returns home in order to help her choose an appropriate method.
- While provider-dependent methods may not be the best choice for women with little or no access to ongoing care, women with little access to re-supply of condoms or pills may find methods that do not require re-supply their only workable option.
- Providers should be aware of the costs of a contraceptive method to the woman. This is a key factor in limiting the use of family planning.
- The high cost of services and methods can prevent women from having access to contraceptives and often influences their ability and willingness to use them.
## Participant Handout #13: Postabortion Contraception: Selection Guidelines for Contraceptive Method

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER TREATMENT FOR INCOMPLETE ABORTION</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
</tr>
</thead>
</table>
| Non-Fitted Barriers (latex and vinyl male and female condoms; vaginal sponge; suppositories; foaming tablets; jelly; or film) | Begin use as soon as intercourse is resumed. | • No serious method-related health risks  
• Good interim method if initiation of another method must be postponed  
• No medical supervision required  
• Condoms (latex and vinyl) provide protection against STDs (including HBV and HIV)  
• Easily obtained | • Less effective than IUD or hormonal methods  
• Requires use with each episode of intercourse  
• Requires continued motivation  
• Resupply must be available  
• May interfere with intercourse |
| Fitted Barriers Used With Spermicide (diaphragm or cervical cap with foam or jelly) | Diaphragm can be fitted immediately after first-trimester abortion. After second-trimester abortion, fitting should be delayed until uterus returns to prepregnancy size (6-8 weeks). Delay fitting cervical cap until bleeding has stopped and uterine involution is complete. | • No method-related health risks  
• Inexpensive  
• Good interim method if initiation of other method must be postponed  
• Some protection against STDs when used with spermicide  
• Easily discontinued  
• Effective immediately | • Less effective than IUD or hormonal methods  
• Requires use with each episode of intercourse  
• Requires continued motivation  
• Resupply must be available  
• Associated with urinary tract infections in some users  
• Requires fitting by trained service provider |
| Oral Contraceptives | Begin pill use immediately, preferably on the day of treatment. | • Highly effective  
• Can be started immediately even if infection is present  
• Can be provided by non-physicians  
• Does not interfere with intercourse | • Requires continued motivation and regular use  
• Re-supply must be available  
• Effectiveness may be lowered when certain medications are used (e.g., rifampin, griseofulvin) |
# Postabortion Contraception: Guidelines for Selection of Contraceptive Method (cont.)

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER TREATMENT FOR INCOMPLETE ABORTION</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
</tr>
</thead>
</table>
| Injectables (DMPA, NET-EN) | May be given immediately after abortion in the first or second trimester. | • Highly effective  
• Easily administered by non-physician  
• Does not interfere with intercourse  
• Not user-dependent except for injection every two or three months  
• Health benefits  
• Acceptable for women who should avoid estrogen | • May cause irregular bleeding; excessive bleeding may occur in rare instances  
• Possible delayed return to fertility  
• Must return to clinic for injections  
• Condoms recommended if at risk for STDs, HBV, and HIV |
| Implants (Norplant) | May be inserted immediately after abortion in the first or second trimester. If adequate counseling and informed decision-making cannot be guaranteed, it may be best to delay insertion and provide an interim temporary method. | • Highly effective  
• Long-term contraception  
• Immediate return to fertility on removal  
• Does not interfere with intercourse  
• Health benefits  
• No supplies needed by client | • May cause irregular bleeding or amenorrhea  
• Trained provider required to insert and remove  
• Cost effectiveness depends on long-term use  
• Implants only effective for five years  
• Condoms recommended if at risk for STDs, HBV, and HIV |
| IUD | First Trimester: IUDs can be inserted if the uterus is not infected. If adequate counseling and decision-making cannot be guaranteed, it may be best to delay insertion and provide an interim temporary method.  
Second Trimester: Delay for six weeks unless equipment and expertise available for immediate postabortal insertion. Insure there is no uterine infection. (If infection suspected, delay insertion until the infection has been resolved and use | • Highly effective  
• Long-term contraception  
• Immediate return to fertility following removal  
• Does not interfere with intercourse  
• Convenient  
• No supplies needed by client  
• Requires only monthly checking for strings  
• Only one follow-up visit needed unless there are problems | • Uterine perforation can occur during insertion  
• May increase risk of PID and subsequent infertility for women at risk for STDs HBV, and HIV  
• Trained provider required to insert and remove  
• May increase menstrual bleeding and cramping during the first few months |
**Participant Handout #13: (cont.)**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TIMING AFTER TREATMENT FOR INCOMPLETE ABORTION</th>
<th>ADVANTAGES</th>
<th>REMARKS</th>
</tr>
</thead>
</table>
| Female Voluntary Sterilization | It is required that adequate counseling and informed consent precede voluntary sterilization (VS) procedures, and this is unlikely in the emergency context. Technically, VS procedures can be performed immediately after the treatment for incomplete first trimester abortions and complications unless infection or severe blood loss is present. Infection or the potential for infection (in complications of unsafe abortion) indicate the need to delay VS. VS after treatment of abortion complications in the first-trimester is similar to an interval procedure; after a second-trimester abortion complication treatment it is similar to a postpartum procedure. | - Permanent method  
- Most effective female method  
- Once completed, no further action required  
- No worry about contraception  
- Does not interfere with intercourse  
- No change in sexual function  
- No long-term side effects  
- Immediately effective | - Permanence of the method increases the importance of adequate counseling and fully informed consent; this is often not possible at the time of emergency care.  
- Slight possibility of surgical complications  
- Requires trained staff and appropriate equipment  
- Does not protect against transmission or susceptibility to STDs, HBV, and HIV |
| Natural Family Planning | Not recommended for immediate use following treatment for abortion complications. This first ovulation after an abortion will be difficult to predict and the method is unreliable until after a regular menstrual pattern has returned. | - No cost associated with method | |

**Postabortion Contraception: Guidelines for Selection of Contraceptive Method (cont.)**
### Participant Handout #14: Family Planning and Informed Choice

**Individual Factors and Counseling Recommendations and Rationale**

<table>
<thead>
<tr>
<th>If the woman...</th>
<th>Recommendations</th>
<th>Rationale</th>
</tr>
</thead>
</table>
| Does not want to be pregnant soon | • Consider all methods.  
• Help the woman make a free informed choice. | • Seeking treatment for incomplete abortion may suggest that the woman does not want to be pregnant. |
| Is under stress, in pain, or not prepared to make a long-term decision | • Consider all methods.  
• Do not encourage use of permanent methods.  
• Provide referral for a more long-term approach to contraception. | • Stress and pain interfere with making free, informed decisions.  
• The time of treatment for incomplete abortion may not be a good time for a woman to make a permanent decision. |
| Was using a contraceptive method when she became pregnant; or Had stopped using a method | • Assess why contraception failed and what problems the woman might have using a method effectively.  
• Help the woman choose a method that she will be able to use effectively.  
• Make sure she understands how to use the method, get follow-up care and resupply, discontinue use, and change methods. | • Method failure, unacceptability, ineffective use, or lack of access to supplies may have led to unwanted pregnancy.  
• These factors may still be present and may lead to another unwanted pregnancy. |
| Has a partner who is unwilling to use condoms or will prevent use of another method | • If the woman wishes, include her partner in counseling.  
• If the woman is at risk for STDs, tell her about methods that offer some protection.  
• Protect the woman's confidentiality even if she does not involve her partner.  
• Do not recommend methods that the woman will not be able to use effectively. | • In some instances involving the male will lead to successful contraception; however, if the woman, for whatever reasons, does not want to involve a partner, her wishes should be respected. |
| Wants to become pregnant soon. | • Do not try to persuade her to accept a method.  
• Provide information or a referral if the woman needs other reproductive health services. | • If the woman has had repeated spontaneous abortions, she may need to be referred for infertility treatment. |
Participant Handout #15: Postpartum and Postabortion Contraception Case Studies

Situation 1

Mrs. W. is a 24 year old woman, married for three years with one child (two year old daughter). Mrs. W had registered for antenatal care, two months ago when she had missed her period for two weeks beyond the expected time. Mr. and Mrs. W. were not planning a pregnancy since he had been unemployed for over a year, was moody, and had recently began engaging in extramarital sexual activities. Both had quarreled about the pregnancy (she wanting to terminate and he wanting to keep the pregnancy). Two days ago Mrs. W. was treated for a septic, spontaneous abortion.

Tasks

1. In preparation for discharge, what additional family and personal information is needed to help you assist the client in selecting an appropriate FP method for her situation?

2. What information do you need regarding her access to FP services?

3. In this situation, what additional advice/instructions will the client need besides those for her chosen method?
Participant Handout #15: Postpartum and Postabortion Contraception Case Studies (cont.)

Situation 2

Ms. Y. is a 30 year old Para 3, currently 16 weeks pregnant, coming for her first antenatal visit. State the family planning/counseling content you will discuss with the client during the following visits:

1. First visit

2. 28 weeks visit

3. 32 weeks visit

4. 36 weeks visit
Participant Handout #15: Postpartum and Postabortion Contraception Case Studies (cont.)

Situation 3

Mrs. X. is 24 hours postpartum, due to leave hospital tomorrow and wants to resume her former combined estrogen/progestin pills (Microgynon). Mrs. X. has already started breastfeeding her infant; she breastfed her first child fully for six months successfully. She lives walking distance from the hospital's FP clinic and has one child (five years old) in school during the day. Mrs. X. plans to return to work in four months.

Task

How will you manage Mrs. X.’s postpartum family planning needs/request?
Participant Handout #15: Postpartum and Postabortion Contraception Case Studies (cont.)

Situation 4

Mrs. V. is trying to decide on which FP to use after her delivery, in approximately three weeks. Coming for clinic visits is very inconvenient (she has missed a few antenatal visits). Mrs. V. asks you if she could have an IUD put in before she is discharged from the hospital.

Task

What information will you give here?
Participant Handout #15: Postpartum and Postabortion Contraception Case Studies (cont.)

Situation 5

Mrs. T. is a 38 year old, who delivered her sixth child 12 hours ago. She never came for antenatal care. Mrs. T. presented at the hospital unaccompanied and delivered within 90 minutes of arrival. She is breastfeeding her infant. During her postpartum assessment, a provider spoke with her about the methods of family planning, which would be available to her before her discharge. The provider strongly suggested that Mrs. T. have her "tubes tied," but she is more interested in the "injection."

Task

How will you manage Mrs. T.'s FP desires?
Participant Handout #15A: Postpartum and Postabortion Contraception Case Studies Answer Key

Situation 1

Mrs. W. is a 24 year old woman, married for three years with one child (two year old daughter). Mrs. W had registered for antenatal care, two months ago when she had missed her period for two weeks beyond the expected time. Mr. and Mrs. W. were not planning a pregnancy since he had been unemployed for over a year, was moody, and had recently began engaging in extramarital sexual activities. Both had quarreled about the pregnancy (she wanting to terminate and he wanting to keep the pregnancy). Two days ago Mrs. W. was treated for a septic, spontaneous abortion.

Task

1. In preparation for discharge, what additional family and personal information is needed to help you assist the client in selecting an appropriate FP method for her situation?
   
   • The couple’s desire for more children; desired family size.
   • If more children, when?
   • What FP method(s) had the client been using? What has been her satisfaction with the method(s); failures?
   • What support will the client receive from her husband?

2. What information do you need regarding her access to FP services?
   
   • What facilities are available in her area?
   • What services do those facilities offer?
   • How convenient is it for her to use these facilities?

3. In this situation, what additional advice/instructions will the client need besides those for her chosen method?
   
   • Given the marital situation, the client's chosen method will protect her from unintended pregnancy, however, condom use will provide protection against STDs; and to a lesser extent, vaginal spermicides will offer protection.
   • If the client believes that she can get her husband to use condoms, instruct her on the correct use of putting on and removing condoms. Recommend that she talk with her husband about having himself and his other partner(s) evaluated for STDs and receive treatment. If the client feels unable to communicate with husband, offer to talk with the husband before the client is discharged.
Situation 2

Ms. Y. is a 30 year old Para 3, currently 16 weeks pregnant, coming for her first antenatal visit. State the family planning/counseling content you will discuss with the client during the following visits:

1. First visit

   Introduction to family planning methods available; breastfeeding support information.

2. 28 weeks visit

   FP methods mechanism of action, advantages/disadvantages, side effects; breast care.

3. 32 weeks visit

   FP methods effectiveness and overview of User Instructions.

4. 36 weeks visit

   LAM; tips for successful breastfeeding; process for consent for VSC (if there is an institutional policy for this).
Participant Handout #15A: Postpartum and Postabortion Contraception Case Studies Answer Key (cont.)

Situation 3

Mrs. X. is 24 hours postpartum due to leave hospital tomorrow and wants to resume her former pills (Microgynon). Mrs. X. has already started breastfeeding her infant; she breastfed her first child fully for six months successfully. She lives walking distance from the hospital’s FP clinic and has one child (five years old) in school during the day. Mrs. X. plans to return to work in four months.

Task

How will you manage Mrs. X.’s postpartum family planning needs/request?

Review with Mrs. X. the effectiveness and User Instructions for LAM; explore with her, the feasibility of maintaining a fully breastfeeding pattern for the next four months.

Inform Mrs. X. of the effect of estrogen on breastmilk production and its impact on maintaining optimal breastfeeding.

If Mrs. X. wants to use LAM, provide detailed instructions and the criteria for starting a complementary method. Provide her with the clinic hours.

If Mrs. X. does not want to use LAM and wants to use pills, counsel her on the progestin-only methods; their implications for maintaining optimal breastfeeding and the User Instructions. If she accepts progestin-only pills, provide her with a supply.

Explore with Mrs. X. her risk for STDs; provide condoms (or vaginal spermicides, if available), if needed.
Situation 4

Mrs. V. is trying to decide on which FP to use after her delivery, in approximately three weeks. Coming for clinic visits is very inconvenient (she has missed a few antenatal visits). Mrs. V. asks you if she could have an IUD put in before she is discharged from the hospital.

Task

What information will you give here?

* IUDs can be safely inserted immediately after delivery of the afterbirth (placenta) or within ten minutes to 48 hours after vaginal delivery; immediately after delivery of the afterbirth in a cesarean section.

* Postpartum IUD insertion will not increase Mrs. V's risk of infection (if infection prevention practices are strictly followed).

* Women having postpartum insertion of IUDs experience fewer post-insertion side effects such as bleeding or pain.

* Postpartum IUD insertion is very convenient and the client need only return if there are problems, questions, a desire to change the method, or a desire for a pregnancy. Currently the IUD used, the Copper-T 380A, is effective for 10 years.
Participant Handout #15A: Postpartum and Postabortion Contraception Case Studies Answer Key (cont.)

Situation 5

Mrs. T. is a 38 year old, who delivered her sixth child 12 hours ago. She never came for antenatal care. Mrs. T. presented at the hospital unaccompanied and delivered within 90 minutes of arrival. She is breastfeeding her infant. During her postpartum assessment, a provider spoke with her about the methods of family planning which would be available to her before her discharge. The provider strongly suggested that Mrs. T. have her "tubes tied," but she is more interested in the "injection."

Task

How will you manage Mrs. T.'s FP desires?

Explore with Mrs. T. her interest in DMPA; review with her the mechanism of action, side effects, and User Instructions, and the feasibility of her maintaining the reinjection visits.

Explore with Mrs. T. her reluctance in VSC; correct misinformation, if indicated. If Mrs. T. is interested in VSC, assist her in having the procedure before discharge, if appropriate or schedule her for interval procedure if she is not ready to act on the desire now.

If Mrs. T. accepts DMPA, provide the injection; give written/pictorial instructions and the reinjection visit date.

If Mrs. T. is interested in any other methods, such as condoms and spermicides, provide them before her discharge.
Guidelines and Skills: Postpartum IUD Insertion

Timing and Approach

There are several phases during the postpartum period when IUDs may be inserted. These include:

- **Postplacental insertion:** Immediately after expulsion of the placenta, preferably within 10 minutes after expulsion. Insertion can be done manually or with forceps.
- **Postpartum before discharge (PPBD) insertion:** Within 48 hours after delivery, before hospital discharge. Insertion is done only with forceps.
- **Transcesarean insertion:** During cesarean section, after the uterine cavity has been explored manually, following delivery of the placenta. Insertion can be done manually or with forceps.

  **Note:** This approach has been identified with the lowest expulsion rate of the three methods described.

According to the World Health Organization (WHO), two other categories exist with the following recommendations:

- **Puerperal or Delayed insertion:** from one to six weeks after delivery. (Insertion generally not preferred during this interval due to increased risk of perforation.)
- **Postpuerperal insertion:** at a follow-up examination six to eight weeks after delivery. This is commonly referred to as interval insertion.

Postpartum and postabortion family planning services require minimal additional equipment and supplies. See Participant Handout #17 for equipment and supplies list.

Screening

Postpartum IUD insertion is not appropriate for women who have:

- An active STD or are at risk for STDs (e.g., have multiple sexual partners or their partner has multiple sexual partners)
- A history of recent or recurrent pelvic inflammatory disease (PID), indicating risk of exposure to STDs
- Known or strongly suspected cancer of the uterus

In addition, PPIUD insertion is not appropriate for women with:

- Prolonged rupture of membranes (greater than 24 hours)
- Fever or any other signs of abdominal or pelvic infection
- Intrapartum or postpartum hemorrhage that continues after completely emptying the uterus
• Bleeding problems, such as disseminated intravascular coagulation caused by eclampsia or preeclampsia

Participant Handout #16: Postpartum IUD Insertion (cont.)

IUDs are not the method of first choice for women who:
• Have severe anemia (hemoglobin less than 9, hematocrit less than 28).
• Have an abnormal Pap smear for which treatment is imminent or other signs of genital cancer.
• Have conditions that increase the risk of infection, such as AIDS or poorly controlled diabetes.
• Do not have access to a health center for follow-up care.
• Dislike touching their genitals to feel for the IUD strings.

Insertion Techniques: Manual

The Manual method of insertion is appropriate when performed within ten minutes of expulsion of the placenta. Manual insertion requires no special instruments, but may be less comfortable for the client than insertion with ring forceps. The steps are as follows:

1. After determining that the entire placenta has been expelled, massage the uterus until it becomes firm and bleeding subsides.
2. Examine the cervix for injury using a retractor or speculum, if necessary.
3. Wearing sterile or HLD gloves, insert the IUD by gripping it between the index and middle fingers. Place the IUD strings in the palm of the hand.
4. Use the opposite hand to firmly stabilize the uterus externally (hand on abdomen).
5. Place the IUD at the top (fundus) of the uterine cavity. It may be necessary to grasp the cervix with a ring forceps to facilitate insertion.
6. Gently remove the hand from the uterine cavity.

Note: Inspect the vagina. If the IUD strings are visible, the IUD is placed too low and should be reinserted.

Insertion Techniques: Ring Forceps

Insertion using a Ring Forceps is appropriate for postplacental insertion or any time within 48 hours after delivery while the cervix is still wide open. The insertion steps are as follows:

Note: Immediate postpartum (within 48 hours) IUD placement requires a long forceps to achieve fundal placement. A 12 inch (30.6 cm) curved Foerster ring forceps without box lock is suitable. Other ovum forceps for postpartum intrauterine exploration may also be used. The standard straight 9 inch (24 cm) Foerster sponge forceps is not long enough to allow fundal placement in most women.
Participant Handout #16: Postpartum IUD Insertion (cont.)

**Insertion Techniques: Ring Forceps (cont.)**

1. Determine that the entire placenta has been expelled (if insertion is immediately postplacental). Massage the uterus until it becomes firm and bleeding subsides.
2. If the woman has delivered vaginally after a pervious cesarean section, put on sterile or HLD gloves and manually palpate the previous incision to identify any defect that might be present. Take care to avoid placing the IUD through such a defect.
3. Examine the cervix for injury using a retractor or speculum, if necessary.
4. Grasp the IUD with the 12 inch (30.6 cm) ring forceps, holding it at a slight angle.

**Note:** *Use only sterile or HLD gloves or instruments when touching the IUD.*

5. Grasp the anterior cervix with a second ring forceps (9 inch, 24 cm).
6. Hold the cervix and keep it in view while introducing the IUD through the cervix into the lower uterus.
7. Release the hand that is holding the cervix with the second ring forceps and move it to the lower abdomen.
8. Stabilize the uterus externally with firm pressure on the abdomen.
9. Advance the IUD to the top (fundus) of the uterine cavity.
10. Confirm fundal placement with both the abdominal hand and the ring forceps inserting the IUD.
11. After releasing the IUD, gently remove the ring forceps.
12. Inspect the vagina. If the IUD strings are visible, the IUD is placed too low and should be reinserted.

**Insertion Techniques: Cesarean Section**

The steps are as follows (after delivery of the placenta and after controlling the bleeding from the uterine incision):

1. Massage the uterus until bleeding subsides.
2. Place the IUD at the top (fundus) of the uterine cavity manually or with ring forceps.
3. Before closing the uterine incision, place the strings in the lower uterine segment.
Participant Handout #17: Facilities and Equipment for PPIUD Services

One of the major advantages of postpartum family planning services is that they do not require a separate clinical infrastructure of staff. Once postpartum family planning education and services become a routine part of the activities conducted at a maternity care center, they are easily sustainable and institutionalized.

Postplacental insertion and insertion at cesarean section are done in the delivery area, a clean procedure or examination room is needed, with an exam table and adequate light. Table 1 summarizes the instruments and supplies needed for PPIUD insertion.

<table>
<thead>
<tr>
<th>Instruments and supplies needed for PPIUD insertion</th>
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<tbody>
<tr>
<td>Manual</td>
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<tr>
<td>Gloves</td>
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<tr>
<td>Sterile IUD</td>
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<tr>
<td>Antiseptic solutions and gauze</td>
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<tr>
<td>Speculum or retractor</td>
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<tr>
<td>Optional: one ring forceps</td>
</tr>
</tbody>
</table>

**Note:** All instruments and gloves must be sterile or high-level disinfected (HLD). A basin with 0.5% chlorine solution should be available for immediate decontamination of instruments and gloves following the procedure.
Participant Handout #18: Postabortion IUD Insertion

Insertion Techniques: Postabortion

- An IUD can be inserted immediately after treatment for an uncomplicated first or second trimester spontaneous abortion.
- The risk of complications following postabortion insertion is not greater than that following interval IUD insertion, as long as the cervix or uterine cavity are not infected and the uterus has been completely evacuated.
- Client screening guidelines are the same as for postpartum insertion.
- Equipment and supply needs are the same as for postpartum insertion.
- The technique for postabortion insertion in the first or second trimester is similar to interval insertion, using the inserter supplied with the IUD. If the cervix is dilated following a second trimester abortion, a ring forceps may be used.
**Participant Handout #19: Postpartum IUD Checklist for Manual Insertion of Copper T380A IUD Immediately Post-Placenta**

Place a check mark in the case box if task/activity is performed satisfactorily, an X if it is not performed satisfactorily, or N/O if not observed.

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

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Participant_____________________________ Course Dates__________

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</tr>
<tr>
<td>1. Explain to the client what is going to be done.</td>
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<tr>
<td>2. Arrange instruments and supplies. (Copper T 380A insertion tube should be discarded.)</td>
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<tr>
<td>3. Place the client in the gynecological position.</td>
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<td>4. Put on sterile gloves.</td>
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<td>5. Make sure the placenta is completely delivered.</td>
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<td>6. Give gentle external massage to evacuate all blood clots.</td>
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<tr>
<td>7. Wash the vulva and perineal area using a forceps with cotton swab soaked in povidone iodine.</td>
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<tr>
<td>8. Change to a new pair of sterile gloves.</td>
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<tr>
<td><strong>Insertion of IUD</strong></td>
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<tr>
<td>1. Place the sterile Copper T 380A on the sterile field.</td>
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<tr>
<td>2. With gloved hand, hold vertical arm of IUD between right index and middle fingers, with horizontal arms resting on the fingertips.</td>
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<tr>
<td>3. Place the other hand over the client’s abdominal wall, holding the uterine fundus to fix it and move it slightly downwards. Hold the fundus in position until the end of the procedure.</td>
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<tr>
<td>4. Insert the hand and IUD through the cervix to the uterine fundus, following the uterine curve. If necessary, grasp the cervix with a ring forceps to facilitate insertion.</td>
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<tr>
<td>5. When you have reached the uterine fundus, open your index and middle fingers carefully, leaving the IUD in the uterine fundus.</td>
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<tr>
<td>6. Remove your hand, being careful not to pull on the IUD or its threads.</td>
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### Participant Handout #19: Continued

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<tr>
<td><strong>Insertion of the IUD (cont.)</strong></td>
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<tr>
<td>7. To verify the position of the IUD, depress the vagina’s posterior walls with two fingers. Observe the cervix; IUD threads should not be visible.</td>
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</tr>
<tr>
<td><strong>Post-Insertion Tasks</strong></td>
<td></td>
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<tr>
<td>1. Place instruments/forceps (if used) in 0.5% chlorine solution for cleaning</td>
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<td>2. Perform episiotomy repair if necessary.</td>
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<tr>
<td>3. Administer oxytocics if necessary.</td>
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<tr>
<td>4. Properly dispose of waste materials.</td>
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<tr>
<td>5. Wash hands with soap and water.</td>
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<td>6. Complete client records.</td>
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<td>7. Provide verbal and written instructions for the client to detect expulsion and to return for reinsertion or another method if expulsion occurs.</td>
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</table>

**Comments (summary):**

**Recommendations:**

**Certified** (If not, why):

**Trainer’s Signature** ___________________________ **Date** ___________________________
Participant Handout #20: Postinsertion IUD Instructions

It is important to give the PPIUD client clear instructions to help her use this method safely, effectively, and with satisfaction. Pathfinder International recommends giving instructions both orally and in writing. The provider uses simple language when speaking to or writing for the client and gives instructions in a language the client can easily understand.

The procedure for giving oral instructions is as follows:

- Ask the woman what she already knows about IUDs.
- Tell the woman what kind of IUD she has received. Show her either a sample or picture of the IUD so that she can see how it looks and how large it is.
- Explain that the copper T IUD will prevent pregnancy for 10 years.
- Assure the woman that the IUD has no effect on breastmilk and that she can breastfeed her baby.
- Tell the woman that she may have sexual intercourse as soon as it is comfortable for her.
- Explain that within a few weeks, the IUD strings will probably come from the womb into the vagina. Tell her that a health care worker will shorten the strings during the follow-up visit if they are troublesome.
- Discuss the possibility that the IUD may be expelled, especially during the first few weeks or months after insertion. An expulsion frequently follows lower abdominal cramping. Tell the client that she may find the IUD if it is expelled. She should then come to the clinic immediately. Explain that the woman can have another IUD inserted, if she chooses, or she may have another method. If the IUD is expelled during her postpartum hospital stay, a second insertion can be done while she is in the hospital. Otherwise, the IUD can be replaced at the four or six week postpartum visit, or later.
- Repeat how to check for the IUD strings. Tell the woman that she should:
  1. Wash her hands, using soap if possible. This helps to reduce the chance of infection.
  2. Sit in a squatting position, or stand with one foot up on a step or ledge.
  3. Gently insert her finger into her vagina and feel for the cervix, which feels firm, like the tip of the nose.
  4. Feel for the strings, but do not pull the strings as that could move the IUD or cause it to come out.
- Tell the woman that she should do this at least once a month, after her period, but should not check for the strings until after six weeks postpartum. Emphasize that the client should return to the clinic if the strings seem to have become shorter or longer than when previously checked or if they seem to be missing and she can no longer feel them.
- Tell the client that once menstruation returns, some women with IUDs have more cramping and heavier bleeding during their periods, longer periods, or spotting or bleeding between periods. These side effects usually go away after a few months of IUD use.
Participant Handout #20: Postinsertion IUD Instructions (cont.)

- Tell the client that the IUD will not protect her or her partner against HIV infection or other STDs. Aside from abstinence, latex condoms offer the best protection against HIV infection and other STDs.
- If at any time you have more than one sexual partner or your partner has sex with anyone else, the IUD is not a good method for you, because a sexually transmitted disease could become more severe with the IUD in place.
- Describe the warning sings for potential complications: late period or other signs of pregnancy; bleeding or spotting between periods or after intercourse; unusual discharge from the vagina beyond six weeks postpartum; missing, shorter, or longer strings; feeling the IUD when checking for the strings.
- Tell the woman where to seek help if a problem occurs.
- Assure the client that she can have the IUD removed if she changes her mind about the method. Tell her that it is best if she not try to remove the IUD herself.
- Tell the woman when she needs to return for routine follow-up and removal. The first follow-up visit for PPIUD clients is usually done at a four or six-week postpartum checkup. Thereafter, an annual pelvic exam is recommended.
- Encourage the woman to go to a health facility at any time if she is concerned about any aspect of IUD use.
- Give the woman written instructions. (See Px Handout #20A: Sample Client Instructions for Women Receiving Postpartum IUDs.) If she has difficulty reading, ask her to identify someone in her family or neighborhood who can read the instructions to her.
Participant Handout #21A: Sample Client Instructions for Women Receiving Postpartum IUDs

Name: ____________________________________ Insertion Date: __________

Clinic Address: _____________________________ Clinic Phone: ______________

Information about your IUD

• The name of your IUD is the Copper T380A.
• This IUD is effective for 10 years. You may have it removed any time you want—see your health care worker or return to the clinic for removal.
• You may breastfeed your baby. The IUD has no effect on breastmilk.
• When your menses return, the periods may be heavier and longer than without an IUD. Over a period of several months, your menstrual periods will probably become lighter.
• If at any time you have more than one sexual partner or your partner has sex with anyone else, the IUD is not a good method for you. You could get a sexually transmitted disease, which may become more severe with the IUD.

Please follow these instructions for safe and effective contraceptive use of your IUD:

• The IUD will sometimes come out, usually in the first few weeks or months. Some women will not feel the IUD come out. So check your underclothes when undressing and check the toilet after use. If your IUD comes out, return immediately to the clinic or your health provider so that a new IUD can be inserted, if you like, or another family planning method can be provided. Use another method of family planning until you can return to the clinic.
• Be sure to return to the clinic _________________ for your four or six-week check-up.
• When you return to the clinic, your health provider will show you how to check the IUD strings yourself, so you can be sure your IUD is in place.
• If you experience any of the following, return to the clinic:
  • Pain in your belly or pain when you have sex.
  • A heavy yellow or foul-smelling discharge from your vagina.
  • Fever or chills (especially if this is accompanied by pain in your belly or a foul smelling vaginal discharge).
  • You are late for your period or otherwise think you might be pregnant.
  • Any sign that your IUD has come out.
  • You have bleeding between periods that is increasing over time.
Participant Handout #21A: Continued

- Your IUD will not protect you against sexually transmitted diseases (STDs), including HIV/AIDS. If you believe you are at risk of getting an STD, use a condom or other barrier method and see your health provider. The IUD may not be the best method for you in this situation.

If you have any questions, feel free to ask a health provider at the hospital, clinic, or in your community who is familiar with IUDs.

Source: Adapted from draft by Betty Gonzales and Douglas Huber (1990) and from AVSC, Postpartum IUD Insertion: Clinical and Programmatic Guidelines, 1994.
Participant Handout #21B: Sample Client Instructions for Women Receiving Postabortion IUDs

Name: ____________________________ Insertion Date: _______________

Clinic Address: ____________________________ Clinic Phone: ________________

Information about your IUD

- The name of your IUD is the Copper T380A.
- This IUD is effective for 10 years. You may have it removed any time you want—see your health care worker or return to the clinic for removal.
- When your menses return, the periods may be heavier and longer than without an IUD. Over a period of several months, your menstrual periods will probably become lighter.
- If at any time you have more than one sexual partner or your partner has sex with anyone else, the IUD is not a good method for you. You could get a sexually transmitted disease, which may become more severe with the IUD.

Please follow these instructions for safe and effective contraceptive use of your IUD:

- The IUD will sometimes come out, usually in the first few weeks or months. Some women will not feel the IUD come out. So check your underclothes when undressing and check the toilet after use. If your IUD comes out, return immediately to the clinic or your health provider so that a new IUD can be inserted, if you like, or another family planning method can be provided. Use another method of family planning until you can return to the clinic.
- Be sure to return to the clinic ________________ for your four to six-week check-up.
- When you return to the clinic, your health provider will show you how to check the IUD strings yourself, so you can be sure your IUD is in place.
- If you experience any of the following, return to the clinic:
  - Pain in your belly or pain when you have sex.
  - A heavy yellow or foul-smelling discharge from your vagina.
  - Fever or chills (especially if this is accompanied by pain in your belly or a foul smelling vaginal discharge).
  - You are late for your period or otherwise think you might be pregnant.
  - Any sign that your IUD has come out.
  - You have bleeding between periods that is increasing over time.
Participant Handout #21B: Continued

- Your IUD will not protect you against sexually transmitted diseases (STDs), including HIV/AIDS. If you believe you are at risk of getting an STD, use a condom or other barrier method and see your health provider. The IUD may not be the best method for you in this situation.

If you have any questions, feel free to ask a health provider at the hospital, clinic, or in your community who is familiar with IUDs.

Participant Handout #22: Postpartum IUD Checklist for Ring Forceps
Insertion of Copper T 380A IUD Immediately Post-Placenta

Place a check mark in the case box if task/activity is performed satisfactorily, an X if it is not performed satisfactorily, or N/O if not observed.

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

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

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

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<td><strong>Pre-Insertion Tasks</strong></td>
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</tr>
<tr>
<td>1. Explain to the client what is going to be done.</td>
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<tr>
<td>2. Arrange instruments and supplies. (Copper T 380A insertion tube should be discarded.)</td>
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<tr>
<td>3. Place the client in the gynecological position.</td>
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<tr>
<td>4. Put on sterile gloves.</td>
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<tr>
<td>5. Make sure the placenta is completely delivered.</td>
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<tr>
<td>6. Give gentle external massage to evacuate all blood clots.</td>
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<tr>
<td>7. Wash the vulva and perineal area using a forceps with cotton swab soaked in povidone iodine.</td>
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<tr>
<td>8. Change to a new pair of sterile gloves.</td>
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<tr>
<td>9. Examine cervix for injury using a retractor or speculum, if necessary</td>
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| **Insertion of IUD** |       |
| 1. Grasp the IUD with ring forceps such as a 12 inch (30.6 cm) curved Foerster without box lock, holding it at a slight angle. |       |
| 2. If necessary, briefly grasp the anterior cervix with a second ring forceps (9 inches; 24 cm Foerster) to stabilize it while initially advancing the IUD. |       |
| 3. Place the other hand over the client’s abdominal wall (after releasing the second ring forceps) holding the uterine fundus to fix it and move it slightly downwards. Hold the fundus in position until the end of the procedure. |       |
| 4. Advance the ring forceps and IUD through the cervix to the uterine fundus, following the uterine curve. |       |
| 5. Confirm that the IUD has reached the fundus with the hand over the fundus and the ring forceps. |       |
## TASK/ACTIVITY CASES

<table>
<thead>
<tr>
<th>Insertion of the IUD (cont.)</th>
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<tbody>
<tr>
<td>6. Open the ring forceps slowly and remove it very slowly, keeping it positioned against the lateral left wall of the uterus (your right).</td>
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<tr>
<td>7. To verify the position of the IUD, depress the vagina’s posterior walls with two fingers. Observe the cervix; IUD threads should not be visible.</td>
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## Post-Insertion Tasks

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<table>
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<tr>
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<tbody>
<tr>
<td>1. Place instruments/forceps (if used) in 0.5% chlorine solution for cleaning</td>
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<td>2. Perform episiotomy repair if necessary.</td>
<td></td>
</tr>
<tr>
<td>3. Administer oxytocics if necessary.</td>
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<tr>
<td>4. Properly dispose of waste materials.</td>
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</tr>
<tr>
<td>5. Wash hands with soap and water.</td>
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<tr>
<td>6. Complete client records.</td>
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<td>7. Provide verbal and written instructions for the client to detect expulsion and to return for reinsertion or another method if expulsion occurs.</td>
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### Comments (summary):

### Recommendations:

### Certified (If not, why):

### Trainer’s Signature __________________________  Date __________________________
Participant Handout #23: Postpartum Insertion of IUD Before Hospital Discharge (within 48 hours of delivery) Checklist

Place a check mark in the case box if task/activity is performed satisfactorily, an X if it is not performed satisfactorily, or N/O if not observed.

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<td>2. Arrange instruments and supplies. (Copper T 380A insertion tube should be discarded.)</td>
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<td>3. Place the client in the gynecological position.</td>
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<td>4. Put on sterile gloves.</td>
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<td>5. Wash the vulva and perineal area using a forceps with cotton swab soaked in povidone iodine.</td>
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<td>6. Change to a new pair of sterile gloves.</td>
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<tr>
<td><strong>Insertion of IUD</strong></td>
<td></td>
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<tr>
<td>1. Insert a Graves speculum in the vagina.</td>
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<tr>
<td>2. Swab the cervix and vagina thoroughly with antiseptic.</td>
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<tr>
<td>3. Gently hold the anterior lip of the cervix with one ring forceps (9 inch, 24 cm) and remove the speculum’s lower screw to remove the upper half of the speculum.</td>
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<tr>
<td>4. Using the first of the ring forceps, hold the anterior lip of the cervix and gently lift it to show the opening.</td>
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<tr>
<td>5. Using the second ring forceps (12 inch, 30.6 cm), grasp the IUD, holding it at a slight angle.</td>
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<tr>
<td>6. Introduce the IUD through the cervix into the lower uterus.</td>
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<tr>
<td>7. Release the hand holding the forceps (holding the cervix) and place it over the client’s abdominal wall, holding the uterine fundus to fix it and move it slightly downwards. Hold the fundus in position until the end of the procedure.</td>
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<tr>
<td>8. Confirm that the IUD has reached the fundus with the hand over the fundus and the ring forceps.</td>
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## Participant Handout #23: Continued

### Insertion of the IUD (cont.)

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</tr>
<tr>
<td>10. To verify the position of the IUD, depress the vagina’s posterior walls with two fingers. Observe the cervix; IUD threads should not be visible.</td>
<td></td>
</tr>
</tbody>
</table>

### Post-Insertion Tasks

1. Place instruments in 0.5% chlorine solution for cleaning
2. Properly dispose of waste materials.
3. Wash hands with soap and water.
4. Complete client records.
5. Provide verbal and written instructions for the client to detect expulsion and to return for reinsertion or another method if expulsion occurs.

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### Comments (summary):

### Recommendations:

### Certified (If not, why):

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Trainer’s Signature________________________________________  Date__________________________
Transparency #1: Module Objectives

1. State the definitions of postpartum and postabortion contraception.
2. State the differences between the postpartum and postabortion period of infertility.
3. Discuss the key issues related to postpartum and postabortion contraception.
4. Describe the essential components of postpartum and postabortion contraceptive services.
5. Discuss the advantages of postpartum and postabortion contraceptive services.
6. Apply the principles of postpartum and postabortion counseling and contraceptive method provision in a role play and in case studies.
7. Demonstrate the skills required to perform postpartum IUD insertion.
Transparency #2: Postpartum and Postabortion Contraception

Postpartum Contraception

Postpartum contraception is the initiation and use of family planning methods in the first six weeks after delivery to prevent unintended pregnancy particularly in the first 1-2 years after childbirth, when another pregnancy can be harmful to the mother or a breastfeeding baby.

The terms relating the initiation of family planning to the time of delivery:

- Immediate postpartum – within 48 hours after delivery (term usually used in association with voluntary sterilization or IUD insertion)
- Post-placental – within 10 minutes following delivery of the placenta
- Postpartum before discharge (PPBD) – within 48 hours after delivery and before the woman leaves the facility where she delivered
- Postpartum period – the first 6 weeks after delivery
- Interval period (postpuerperal) – more than 6 weeks after delivery

Postabortion Contraception

Postabortion contraception is the initiation and use of family planning methods most often immediately after treatment for abortion, within 48 hours, or before fertility returns (2 weeks postabortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief interval.
Transparency #3: Goals of Postpartum and Postabortion Counseling

The goal of postpartum counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does want contraception, to help her choose an appropriate method, taking into consideration whether or not she is breastfeeding.
- To prepare her to use the method effectively.

The goal of postabortion counseling is:

- To help each woman decide if she wants to use a contraceptive method.
- If she does, to help her choose an appropriate method.
- To prepare her to use the method effectively.
POSTPARTUM AND POSTABORTION CONTRACEPTION
PRE-/POST-TEST
Participant Copy

Participant Name: _____________________________________________________

Instructions: Circle the letter(s) of the correct answer; indicate True or False in the space provided.

1. Postpartum contraception is defined as the use of family planning methods to prevent unintended pregnancies during the period after delivery. Terms used to describe provision of family planning services during this period include:
   a. Postpartum, meaning six weeks after delivery
   b. Immediate post-placental
   c. Immediate postpartum
   d. Postpartum before discharge
   e. All of the above

2. Which of the following is not a postpartum or postabortion contraception option?
   a. An IUD may be inserted immediately following delivery.
   b. An IUD may be inserted before discharge from the hospital.
   c. You may reassure the woman that she will not become pregnant during the first six months postpartum if she is fully breastfeeding and not menstruating.
   d. You may tell the woman that she doesn’t need to worry about contraception until she starts menstruating again.

3. Which of the following contraceptive methods provide some protection against sexually transmitted diseases?
   a. Breastfeeding/LAM
   b. Female sterilization
   c. Oral contraceptives
   d. Condoms
   e. Injectables
   f. All of the above

4. Which of the following contraceptives may women use immediately following treatment of an incomplete abortion (assuming there are no contraindications or precautions to the use of the method)?
   a. Oral contraceptives
   b. Condoms
   c. Injectables
   d. The IUD
   e. All of the above
True or False

1. ______ In non-lactating women, the first ovulation occurs on an average four months postpartum.

2. ______ Following a first trimester abortion, a woman’s fertility returns almost immediately, usually within two weeks.

3. ______ Guidelines for postpartum and postabortion contraception are the same.

4. ______ The ideal time to counsel a woman about contraception is during the prenatal period.

5. ______ A woman’s chosen family planning method may be provided immediately following treatment of incomplete abortion or before discharge.

6. ______ All non-hormonal methods can safely be used by breastfeeding women and should be considered the first choice among contraceptive methods.

7. ______ Postpartum IUD insertion poses no greater risk of infection, bleeding, or perforation than IUDs inserted at other times if infection prevention practices are followed.

8. ______ IUD expulsion rates are no higher in postpartum insertions than in interval insertions.

9. ______ Female sterilization is easier to perform after the postpartum period.

10. ______ Progestin-only contraceptives have not been shown to affect breastfeeding, breastmilk, or infant growth and development.

11. ______ During the first six weeks postpartum, breastfeeding women should never use combined hormonal methods.

12. ______ Postabortion IUD insertions have approximately the same rate of expulsion as interval insertions.

13. ______ Natural family planning is not recommended for immediate postabortion use because the first ovulation following an abortion will be difficult to predict.
POSTPARTUM AND POSTABORTION CONTRACEPTION
PRE/POST-TEST
Answer Key

Participant Name: ___________________ __________________________________

Instructions: Circle the letter(s) of the correct answer; indicate True or False in the space provided.

1. Postpartum contraception is defined as the use of family planning methods to prevent unintended pregnancies during the period after delivery. Terms used to describe provision of family planning services during this period include:
   a. Postpartum, meaning six weeks after delivery
   b. Immediate post-placental
   c. Immediate postpartum
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   a. Oral contraceptives
   b. Condoms
   c. Injectables
   d. The IUD
   e. All of the above
True or False

1. **False**  In non-lactating women, the first ovulation occurs on an average four months postpartum.

2. **True**  Following a first trimester abortion, a woman’s fertility returns almost immediately, usually within two weeks.

3. **False**  Guidelines for postpartum and postabortion contraception are the same.

4. **True**  The ideal time to counsel a woman about contraception is during the prenatal period.

5. **True**  A woman’s chosen family planning method may be provided immediately following treatment of incomplete abortion or before discharge.

6. **True**  All non-hormonal methods can safely be used by breastfeeding women and should be considered the first choice among contraceptive methods.

7. **True**  Postpartum IUD insertion poses no greater risk of infection, bleeding, or perforation than IUDs inserted at other times if infection prevention practices are followed.

8. **False**  IUD expulsion rates are no higher in postpartum insertions than in interval insertions.

9. **False**  Female sterilization is easier to perform after the postpartum period.

10. **True**  Progestin-only contraceptives have not been shown to affect breastfeeding, breastmilk, or infant growth and development.

11. **True**  During the first six weeks postpartum, breastfeeding women should never use combined hormonal methods.

12. **True**  Postabortion IUD insertions have approximately the same rate of expulsion as interval insertions.

13. **True**  Natural family planning is not recommended for immediate postabortion use because the first ovulation following an abortion will be difficult to predict.
Module 13: Postpartum and Postabortion Contraception

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

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

Course Materials

I feel that:

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

Technical Information

I learned new information in this course. 5 4 3 2 1
I will now be able to:

• explain the rationale for postpartum and postabortion services. 5 4 3 2 1
• provide prenatal and postpartum counseling to clients. 5 4 3 2 1
• provide postpartum and postabortion IUD insertion services. 5 4 3 2 1

Training Methodology

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

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

Suggestions

What was the most useful part of this training? 

What was the least useful part of this training? 

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