



Family Planning Competency-Based Training in IUD

Handbook for Service Providers

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TRAINING IN IUD INSERTION AND REMOVAL

Training Design



COURSE DESCRIPTION

The course consisting of a two-day didactic part and a three-day preceptorship part is designed to enable the participants to include the provision of IUD in their service provision.



GOALS

- To positively influence the attitudes of the participants towards the benefits and appropriate use of the IUD.
- To enhance the service provider's knowledge and skills in quality IUD service provision.



SPECIFIC OBJECTIVES

At the end of this course, the participants must be able to:

1. Discuss basic information on the IUD:
 - Mechanism of action
 - Types
 - Effectiveness
 - Length of effectivity
 - Return to fertility
 - Possible side effects
 - Health benefits and potential health risks
 - Addressing common misconceptions on the IUD
2. Provide evidence-based facts in response to frequently asked questions about the TCU380A.
3. Use the WHO Medical Eligibility Criteria and the WHO MEC Checklist in identifying client conditions regarding who are suitable and not suitable for IUD insertion.
4. Demonstrate infection prevention measures relevant to the provision of IUD services.
5. Perform client assessment, including medical history and pelvic examination relevant to the provision of the TCU380A based on guidelines.
6. Explain what to do about abnormal findings.
7. Explain the procedures in doing follow-up care of IUD clients.
8. Explain proper management of potential problems with IUD use.
9. Explain the signs indicating the right time to remove the IUD.
10. Provide quality IUD services based on "The Clinical Standards Manual on Family Planning" as they:
 - Counsel a client interested in using the TCU380A as a contraceptive method, giving post-insertion instructions.
 - Demonstrate proper techniques of IUD insertion and removal.



Training Sessions

Session 1	Introduction to the Intrauterine Device
Session 2	Prevention of Infection/s
Session 3	Client Assessment
Session 4	Insertion and Removal of Intrauterine Device
Session 5	Follow-Up Care and Management of Potential Problems

Training/Learning Methods

- Illustrated lectures and discussions
- Individual and group exercises
- Role playing
- Simulated practice with anatomic (pelvic) models
- Guided clinical activities on counseling and IUD insertion and removal

Training Materials

- Trainers' manual
- Participants' handbook which also serves as a reference manual
- Powerpoint presentations
- TCU380A
- Basic instruments and supplies for IUD insertion and removal
- Pelvic models for simulated practice

Trainers

Trainers of the course must be:

- Proficient in conducting skills training in IUD service provision

Participant Selection Criteria

Participants of this course should be licensed health service providers (i.e., doctors, nurses or midwives) who:

- have been trained in the provision of basic FP services (i.e., counseling and provision of SDM, pills, injectables, and the condom) including FPCBT Basic Course.
- hold records of providing FP services (i.e., FP information education activities, FP counseling, and provision of FP methods) in their practice.
- are interested in adding IUD services to their FP practice.
- own clinics or are affiliated with clinics suitable for IUD service provision.
- practice in areas where there is a need for IUD services and with support from Local Chief Executives.
- have existing ties/connections/collaborations and support from a licensed obstetrician/physician.

Course Duration

Two days didactic and three days clinical preceptorship

Suggested Course Correspondence

- 1:10 Trainer/trainee ratio for didactic sessions
- 1:5 Skills practice classroom sessions
- 1:2 Preceptor/trainee ratio for preceptorship

Methods of Evaluation

For the Participant

- Attendance
- Pre-test and post-test
- Checklist for counseling and IUD insertion and removal

For the Course

Course evaluation completed by the participants

Certification

- A certificate of attendance is awarded to participants who have completed the requirements of the course:
 - complete attendance during classroom activities
 - 75% rating in the post-test
 - satisfactory rating using the “Skills Checklist on IUD Insertion and Removal” as certified by the preceptor
- A certificate of completion is awarded to participants who exhibit competency in providing IUD services during the post-training monitoring and follow-up.

Post-Training Monitoring and Follow-Up

Post-training monitoring and follow-up is conducted three and six months after training. After three months, the trained service provider requests the PHO and/or CHD for post-training monitoring and follow-up with the following requirements:

- Certificate of attendance awarded during the FPCBT in IUD.
- IUD Insertion and Removal Skills Checklist, which reflects the certification of competency by a DOH-recognized preceptor.
- List of at least 20 cases of IUD insertions by the trained service provider performed after the training.

These visits will assist the trained service provider in identifying and overcoming difficulties in integrating services on site, validate the capability of the service provider in delivering quality IUD services on-the-job and determine the impact of these to the community being served.

A certificate of completion is awarded to the trained service provider after exhibiting:

- Competency of skills in all components of quality IUD insertion and removal services (i.e., infection prevention, counseling, appropriate management of problems, performance of the procedure).
- Capability in generating appropriate clients for IUD insertion as verified through clinic records and client satisfaction interviews.

Schedule of Activities

TIME	ACTIVITIES
Day 1	
8:00 - 8:30 AM	Registration
8:30 - 8:45	Opening Program <ul style="list-style-type: none"> ✓ Invocation ✓ National Anthem ✓ Welcome Remarks
8:45 - 9:30	Introduction to the Course <ul style="list-style-type: none"> ✓ Introduction of Participants ✓ Pre-test ✓ Leveling of Expectations and Norms ✓ Course Objectives and Mechanics ✓ Admin Matters
9:30 - 10:30	Session 1: Introduction to the IUD
10:30 - 12:15 PM	Session 2: Infection Prevention
12:15 - 1:15	LUNCH BREAK
1:15 - 2:45	Session 3: Client Assessment
2:45 - 5:15	Client Assessment: Role play and practice using the model
8:00 - 8:15 AM	Invocation Recap of Previous Day's Activities
8:15 - 9:45	Session 4: IUD Insertion and Removal
9:45 - 12:15 PM	IUD Insertion and Removal: Role play and practice using model
12:15 - 1:15	LUNCH BREAK
1:15 - 3:15	Session 5: Follow-up care and management of potential problems Case studies
3:15 - 4:00	Assignments of preceptor sites
4:00 - 5:00	Closing Activities <ul style="list-style-type: none"> ✓ Post-test ✓ Post-Course Evaluation ✓ Closing Ceremonies

INTRODUCTION TO THE INTRAUTERINE DEVICE

OVERVIEW

For more than 30 years, women throughout the world have been using the intrauterine device (IUD) as their method of contraception. It is, in fact, the most commonly used reversible method among women of reproductive age worldwide. The popularity of the IUD may be due in part to the high level of satisfaction among IUD users. Women who use the IUD are more satisfied with their choice of contraception than those using other reversible methods (99% versus 91% for pill users), according to research conducted in the United States (Forrest, 1996).

Despite the overall popularity of the IUD, the bulk of IUD use is concentrated in relatively few countries. In China and in many countries in Eastern Europe, Central Asia, the Near East, and North Africa at least half of women using contraception use the IUD. However, in India and North America, the use of the IUD is low.

One of the probable reasons that the IUD is unpopular in some parts of the world is that clinicians and potential IUD clients lack accurate, up-to-date information about the IUD. As a result, they base their decisions about whether to provide or use the IUD on myths and misconceptions about the method, rather than on the latest scientific evidence.

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Discuss basic information on the IUD:

- Mechanism of action
- Types
- Effectiveness
- Length of Effectivity
- Return to Fertility
- Possible side effects
- Health Benefits and Potential Health Risks
- Addressing Common Misconceptions on the IUD

2. Provide evidence based facts in response to frequently asked questions about the TCu380A.

REFERENCE

Bluestone J, et al. IUD Guidelines for Family Planning Service Programs: A problem-solving reference manual. JHPIEGO. 2006. 3rd edition. pp.1-1 to 1-17.



NARRATIVE

SESSION 1: INTRODUCTION TO THE INTRAUTERINE DEVICE

BASIC INFORMATION ABOUT THE IUD

Types of IUDs

Common types of IUDs available worldwide are as follows:

- Copper-bearing, which includes the Copper T380A (TCu380A, TCu380A with Safe Load; and TCu200C), the Multiload (MLCu250 and Cu375), and the Nova T
- Medicated with a steroid hormone, such as Mirena® the levonorgestrel-releasing intrauterine system (LNG-IUS)

The Copper T 380A

The main IUD featured in this learning package is the Copper T380A (or Copper T), which is:

- widely used
- well known for its effectiveness and ease of insertion and removal
- wide margin of safety, acceptability to clients, and low cost
- effective at most for 12 years

The Copper T380A looks like the letter "T" that contains barium sulfate making it visible through x-rays. There are small copper bands on each "arm" of the T, which ensure that copper is released high in the fundus of the uterus. The "stem" is also wound with copper wire. A thin polyethylene string is attached to the bottom of the stem for easy removal.



Copper T380A IUD



Copper T380A IUD inside the Uterus

Mechanism of Action

Copper-bearing IUDs, such as the Copper T, act primarily by preventing fertilization (Rivera et al., 1999). Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg.

Effectiveness

The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of less than 1% (0.8%) in the first year of use (Trussell, 2004a). In a long-term, international study sponsored by the WHO, the average annual failure rate was 0.4% or less, and the average cumulative failure rate over the course of 12 years was 2.2%, which is comparable to that of tubal sterilization (United Nations Development Programme et al., 1997). Service providers can tell their family planning clients that the IUD is the most effective, reversible contraceptive currently available.

Effective Life

The latest scientific evidence shows that the Copper T380A is effective for 12 years (United Nations Development Programme et al., 1997), although the US Food and Drug Administration (USFDA) has approved it for only 10 years (as of this printing). Clients who have had a Copper T inserted should be advised that it should be replaced or removed 12 years from the date of insertion.

Shelf Life

According to the USFDA, the shelf life of each pre-sterilized Copper T380A insertion package is seven years. It is important to note that the expiration date on the IUD package refers only to the shelf life of the sterility of the package, and not to the contraceptive effectiveness of the IUD itself. This means that even if an IUD is inserted on the day before the expiration date (provided the package is not torn or damaged), it is still effective for the full lifespan of contraceptive efficacy. In other words, the Copper T380A would be effective for a full 12 years from that date. On the expiration date, the IUD should be discarded.

Return to Fertility

A client's fertility returns immediately after an IUD is removed (Andersson et al., 1992). This message should be made very clear to clients having an IUD removed: unless they want to get pregnant, they should have another IUD inserted immediately after removal (if desired and appropriate) or start another contraceptive method.

Possible Side Effects

A common side effect of copper-bearing IUDs is menstrual changes. Use of the Copper T has been associated with an increase of up to about 50% in the duration/amount of menstrual bleeding, and this is the most common reason for removal (Penney et al., 2004). Changes in bleeding patterns, such as spotting/light bleeding (between periods), may also occur in the first few weeks.

Finally, some women may experience discomfort or cramping during IUD insertion (Grimes, 2004) and for the next several days. Cramping/ pain and changes in bleeding amount/patterns are usually not harmful for the client and often subside within the first few months after IUD insertion.

Women should be informed of these common side effects before IUD insertion, and assessed for and counseled about it, if needed. Non-steroidal anti-inflammatory drugs (NSAID) can lessen symptoms (WHO, 2004b), and good counseling can encourage continued use of the method (Backman et al., 2002).

Health Benefits and Potential Health Risks

Non-hormonal IUDs, such as the Copper T, may protect against endometrial and cervical cancer (Hubacher and Grimes, 2002).

Potential health risks associated with the IUD, which are uncommon or rare are discussed below.

- **Uterine perforation**

Perforation of the uterus during IUD insertion has been shown to be rare, with fewer than 1.5 perforations per 1,000 insertions occurring in large clinical trials (United Nations Development Programme et al., 1997; Trieman et al., 1995). This minimal risk is associated with the level of the provider's skill and experience (Harrison-Woolrych et al., 2003). When the IUD is inserted by a skilled provider, the risk has been shown to be as low as 1 per 1,000 insertions (WHO, 1987) and 1 per 770-1600 insertions (Nelson, 2000). If perforation occurs, the risk of serious complications is low and the need for surgical intervention is rare (Penney et al., 2004).

- **Expulsion**

Although IUD failure is rare, expulsion is the most common cause (ARHP, 2004). In the first year of IUD use, 2-8% of women spontaneously expel their IUDs (Trieman et al., 1995). There are several factors that increase the risk of expulsion:

- Lack of skill and experience of the provider is the most common factor (Chi, 1993)

Correct insertion, with the IUD placed high in the uterine fundus, is believed to reduce the chances of expulsion.

- Expulsion is most likely to occur within the first three months post insertion and is more common in women who are nulliparous, have severe dysmenorrhea, or have heavy menstrual flow (Zhang et al., 1992).
- The risk of expulsion is higher (11-25% after 12 months of use) when the IUD is inserted immediately after childbirth (more than 10 minutes but less than 48 hours after delivery of the placenta) (Trieman et al., 1995), and higher when inserted immediately after a second-trimester abortion (Grimes, Schulz, and Stanwood, 2002).

• **Infection**

According to the latest research, the risk of upper genital tract infection among IUD users is less than 1%, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is thought to be related to poor/wrong insertion technique (due to lack of proper infection prevention practices) rather than to the IUD itself (Hatcher et al., 2004). After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users (Hatcher et al., 2004).

Addressing common misconceptions about the IUD

Many misconceptions about the IUD remain despite scientific evidence to the contrary. The following section presents recent research to refute some of these misconceptions, while providing a basis for new recommendations and practices related to IUD.

<p>The IUD does not act as an abortifacient.</p>	<p>Studies suggest that the IUD prevents pregnancy primarily by preventing fertilization rather than inhibiting implantation of the fertilized egg (Rivera et al., 1999; Alvarez et al., 1988). This is particularly true of the copper-bearing IUDs.</p>
<p>The IUD <i>does not</i> increase a client's risk of ectopic pregnancy.</p> <p>The absolute number of ectopic pregnancies among IUD users is much lower than that among the general population.</p>	<p>The IUD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy. Women who use copper-bearing IUDs are 91% less likely to have an ectopic pregnancy than women using no contraception (Sivin, 1991).</p> <p>The following points should be considered:</p> <ul style="list-style-type: none"> ✓ Less than 1% of IUD users become pregnant, which reduces a woman's risk for ectopic pregnancy. ✓ IUD users are 50% less likely to have an ectopic pregnancy than those women using no contraception. ✓ In the unlikely event that an IUD user becomes pregnant, she has equal chances of having an ectopic pregnancy.

	<p>as non-users. Since ectopic pregnancy is a serious condition that requires emergency care, this condition must be considered.</p> <ul style="list-style-type: none"> ✓ Among IUDs, the TCu380A and Multiload Cu375 are lowest in rates of ectopic pregnancy (WHO, 1987). A long-term study of women using the TCu380A found the rate to be less than one (0.09%) per 100 women at one year, and less than one (0.89%) per 100 women at 10 years (Ganacharya, Bhattoa, and Batar 2003). ✓ Women with a history of ectopic pregnancy can use the IUD with no restrictions.
<p>The IUD does not cause PID, nor does the IUD need to be removed to treat PID.</p>	<p>Strict randomized controlled trials and literature reviews reveal that PID among IUD users is rare (ARHP, 2004; Grimes, 2000). Early studies that reported a link between PID and IUD use were flawed and poorly designed. Inappropriate groups were used for comparison, infection in IUD users have been over-diagnosed, and there was a lack of control for compounding factors (Buchan et al., 1990).</p> <p>Here are some important points about PID and the IUD based on recent research:</p> <ul style="list-style-type: none"> • During the first three to four weeks after IUD insertion, there is a slight increase in the risk of PID among IUD users compared to non-IUD users, but it is still rare (less than seven/1,000 cases). After that, an IUD user appears to be no more likely to develop PID than a non-IUD user (Farley et al., 1992). • PID in IUD users is caused by the STIs gonorrhea and chlamydia, not the IUD itself (Darney, 2001; Grimes, 2000). However, the risk is still very low, with an estimated three cases per 1,000 insertions in settings with a high prevalence (10%) of these STIs (Shelton, 2001). • If PID occurs, the infection can be treated while the IUD is kept in place, if the client desires. Studies have shown that removing the IUD does not have an impact on the clinical course of the infection. If the infection responds to treatment within 72 hours, the IUD does not need to be removed (WHO, 2004b). • Random controlled trials and cohort studies reveal that the monofilament string does not increase the risk of PID (Grimes, 2000). • Women who have a history of PID can generally use the IUD (the advantages generally outweigh the risks), provided their current risk for STIs is low.
<p>The IUD <i>does not</i> cause infertility.</p>	<p>Infertility caused by tubal damage is associated not with IUD use, but with chlamydia (current infection or --- as indicated by the presence of antibodies--- past infection) (Hubacher et al.,</p>

	<p>2001). Moreover, there is an immediate return of fertility after an IUD has been removed (Belhadj et al., 1986). In one study, 100% of women who desired pregnancy (97 of 97) conceived within 39 months of IUD removal (Skjeldestad and Bratt, 1988).</p>
<p>The IUD <i>is suitable</i> for use in nulliparous women.</p>	<p>Nulliparous women can generally use the IUD (the advantages generally outweigh the risks). In theory, the smaller size of a nulligravid uterus may increase the risk of expulsion, whereas uterine enlargement, even if due to an abortion, may promote successful IUD use (Hatcher et al., 2004). Expulsion rates tend to be slightly higher in nulliparous women compared to parous women (Grimes, 2004).</p>
<p>The IUD <i>can be</i> safely used by HIV-infected women who are clinically well.</p>	<p>HIV-infected women who are clinically well can generally use the IUD (the advantages generally outweigh the risks). A large study in Nairobi showed that HIV-infected women had no significant increase in the risk of complications, including infection in early months, than HIV-negative women (Sinei et al., 2001). In another study of HIV-positive and HIV-negative IUD users with a low risk of STI, no differences were found in overall or infection-related complications between the two groups (Sinei et al., 1998).</p>
<p>The IUD <i>does not</i> increase the risk of HIV transmission.</p>	<p>There is no current evidence proving that use of the IUD in HIV-infected women leads to an increased risk of HIV transmission. Studies have shown that among HIV-infected women using the IUD, there is no increase in viral shedding and no statistically significant increase in HIV transmission to male partners (ARHP, 2004; Richardson et al., 1999).</p>
<p>The IUD <i>does not</i> interfere with ARV therapy.</p>	<p>Women who have AIDS, on ARV therapy and are clinically well, can generally use the IUD (advantages generally outweigh the risks). Because it is a non-hormonal family planning method, the IUD is not affected by liver enzymes and will not interfere with or be affected by ARV therapy (ARHP, 2004; Hatcher et al., 2004).</p>

SESSION 2

INFECTION PREVENTION

OVERVIEW

The consistent use of recommended infection prevention practices is another critical component of quality health service, as well as a basic right of every patient, client, or staff member in a health care setting. Although there is only a minimal risk of infection associated with IUD use, studies have shown they are often related to the insertion procedure (ARHP, 2004), rather than to the IUD itself. When the procedure is performed correctly, however, and in accordance with the recommended infection prevention practices, the rate of infection following IUD insertion is very low (less than 1%).

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. State the rationale of infection prevention in providing IUD services.
2. Discuss the concept of standard precautions in preventing infection.
3. Discuss the key infection prevention processes.
4. Explain the steps in processing instruments and reusable gloves.
5. Discuss infection prevention tips for IUD insertion or removal.

REFERENCE

Bluestone J, et al. IUD Guidelines for Family Planning Service Programs: A problem-solving reference manual. JHPIEGO. 2006. 3rd edition. pp.3-1 to 3-13.



NARRATIVE SESSION 2: INFECTION PREVENTION

RATIONALE

The rationale for infection prevention in providing IUD services are to:

- Reduce the risk of infection due to IUD insertion.
- Reduce the risk of disease transmission to IUD clients and potential IUD clients.
- Protect health care workers at all levels - from physicians and nurses to house keeping staff from infection.

The emphasis in this chapter is on infection prevention practices that are practical and feasible for IUD services in any setting. It is meant to act as a review for providers who have already been trained in basic infection prevention principles and processes - providing a general overview of those that apply to general clinical practice, while highlighting and expanding upon those that are relevant or specific to the provision IUD services.

OVERVIEW OF INFECTION PREVENTION FOR GENERAL CLINICAL PRACTICE

KEY TERMS AND DEFINITIONS

Terminology related to infection prevention can be confusing. For the purposes of the guidelines presented in these materials, the following key terms and their definitions apply:

- **Microorganisms** are the causative agents of infection. They include bacteria, viruses, fungi, and parasites. In the context of infection prevention, bacteria can further be divided into three categories: vegetative (e.g. staphylococcus), mycobacteria (e.g. tuberculosis), and endospores (e.g. tetanus), which are the most difficult to kill.
- **Asepsis or aseptic technique** is a general term used to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce to a safe level, or eliminate, the number of microorganisms on both animate (living) surfaces (e.g. skin and mucous membranes) and inanimate objects (e.g. surgical instruments and other items).
- **Antisepsis** is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues by using a chemical agent (antiseptic).
- **Protective barriers** are physical, mechanical, or chemical processes that help prevent the spread of infectious microorganisms from client to client, clinic staff to client, and client to staff. Infection prevention often relies on placing such barriers between the microorganism and the individual. Examples of protective barriers include: handwashing, wearing gloves, using antiseptic solutions, and processing instruments and other items as described below.

Infection prevention processes that reduce the number of disease-causing microorganisms on instruments, gloves, and other items include the following:

- ✓ **Decontamination** makes inanimate objects that may have come in contact with blood or other body fluids safer to be handled by staff before cleaning (i.e., reduces, but does not eliminate, the number of microorganisms on inanimate objects).
- ✓ **Cleaning** physically removes all visible blood, body fluids, or other material such as dust or dirt from inanimate objects, as well as from skin.
- ✓ **Disinfection** eliminates most, but not all, microorganisms from inanimate objects.

- ✓ **High-level disinfection (HLD)** - by boiling, steaming, or use of chemicals - eliminates almost all microorganisms except some bacterial endospores from inanimate objects.
- ✓ **Sterilization** - by autoclaving, chemicals, or dry heat - eliminates all microorganisms (bacteria, viruses, fungi, and parasites) including all bacterial endospores from inanimate objects.

STANDARD PRECAUTIONS

Standard Precautions are designed for the safety and care of all people in a health care facility - whether a hospitalized patient, a woman receiving IUD services, or a health care worker. Because many people with blood-borne viral infections (e.g. Hepatitis B [HBV], HIV) do not feel or look ill, standard precautions are to be applied consistently, regardless of the (known or unknown) health status of those who are providing or receiving care. When applied consistently, standard precautions act as protective barriers between microorganisms and individuals, and are considered a highly effective means of preventing the spread of infection. The following considerations and actions help to form such barriers, as well as provide the means for implementing the standard precautions:

Consider every person (client or staff) as potentially infectious and susceptible to infection.

Wash hands - the most important procedure for preventing cross-contamination, (person to person or contaminated object to person). In the context of IUD services, hands should be washed before and after conducting the pelvic examination of a potential IUD user, and after inserting or removing an IUD.

Wear gloves (on both hands) before touching anything wet, broken skin, mucous membranes, blood or other body fluids (secretions and excretions), soiled instruments, and contaminated waste materials or for performing invasive procedures. In the context of IUD services, gloves are worn during the pelvic examination of a potential IUD user, and during inserting or removing an IUD.

Use physical barriers (protective goggles, face masks, and aprons) if splashes and spills of blood or other body fluids are possible (e.g. when cleaning instruments and other items).

Use antiseptic agents for cleansing skin or mucous membranes before surgery, cleaning wounds, or doing handrubs or surgical handscrubs with an antiseptic product. In the context of IUD services, a water-based antiseptic is applied to the cervix and vagina two or more times before IUD insertion or removal. Alcohol-based antiseptics are not used on mucous membranes like the vagina and cervix.

Use safe work practices such as not recapping or bending needles, safely passing sharp instruments, and suturing (when appropriate) with blunt needles.

Safe disposal of infectious waste materials to protect those who handle them and prevent injury or spread of infection to the community.

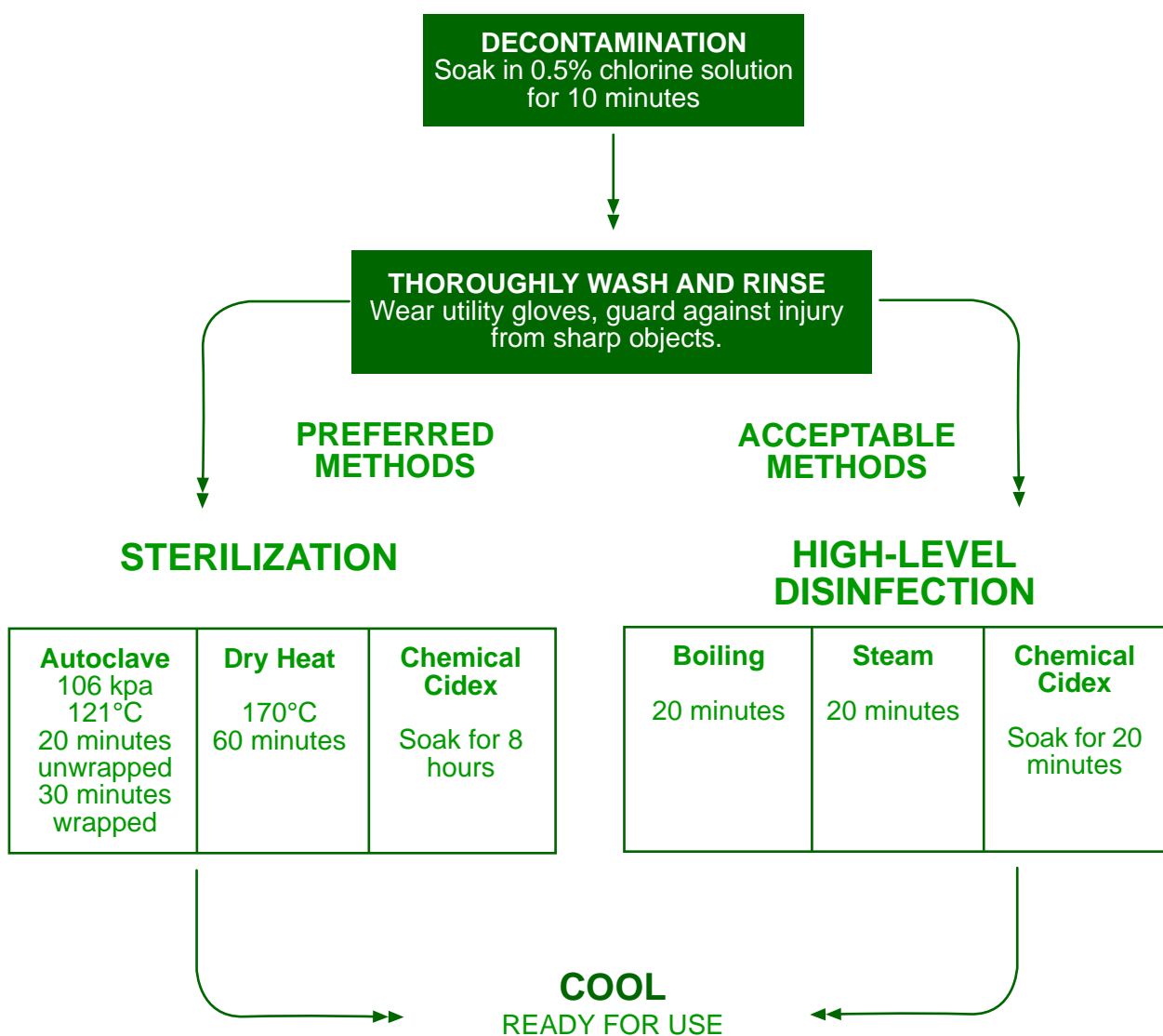
Finally, **process instruments, gloves, and other items** after use by first decontaminating and thoroughly cleaning them, and then either sterilizing or highly disinfection, using recommended procedures. Again, in the context of IUD services, HLD is the recommended method of final processing.

Processing of Instruments and Other Items

As shown in the figure below, decontamination is the first step in processing soiled (contaminated) instruments, gloves, and other reusable items that may have been in contact with blood or other body fluids (American Association of Operating Room Nurses, 1990). Soaking contaminated items briefly in 0.5% chlorine solution, for example, rapidly kills HBV and HIV, thereby making instruments and other items safer to be handled during cleaning. Larger surfaces - such as examination tables and other equipment - may be decontaminated by wiping with 0.5% chlorine solution.

After items have been decontaminated, they should be thoroughly **cleansed** with water and liquid soap or detergent to physically remove organic material such as blood and body fluids (Tietjen and McIntosh, 2004). Dried organic material can trap microorganisms in a residue that protects them against HLD or sterilization. Organic matter also can partially inactivate disinfectants, rendering them less effective (Porter, 1987).

After items have been decontaminated and cleaned, they should be processed finally through **HLD or sterilization** (Tietjen and McIntosh, 2004). Although sterilization is generally preferred, it is not necessary for IUD services. This is because mucous membranes are left intact during IUD insertion and removal procedures, and intact mucous membranes are resistant to common bacterial endospores that only sterilization (and not HLD) can destroy. Therefore, HLD is a safe, effective, and cost-effective method of processing for IUD services.



General Guidelines for Processing Instruments, Gloves, and Other Items

Note: Staff should wear heavy utility gloves while handling soiled instruments and other items during decontamination and cleaning. These gloves should be discarded if torn or damaged, but can otherwise be cleaned, dried, and reused the next day.

STEP 1: DECONTAMINATION

- § Immediately after use, fully immerse all instruments (e.g. tenaculum, speculum, sound) in a plastic container filled with 0.5% chlorine solution for 10 minutes (this step helps prevent transmission of HBV and HIV to the staff. It should be done before the staff are allowed to handle or clean instruments).
- § Wipe all large surfaces (e.g. procedure table, instrument stand) that could have been contaminated by blood or other body fluids with a 0.5% chlorine solution.
- § While still wearing gloves (dispose of waste [STEP 4], if appropriate), briefly immerse both gloved hands in the bucket containing the 0.5% chlorine solution and then carefully remove them by turning them inside out.
 - ✓ If disposing gloves, place them in a leak-proof container (with tight lid) or plastic bag.
 - ✓ If re-using surgical gloves, submerge them in the chlorine solution and soak them for 10 minutes.

Formula for Making Diluted Chlorine Solution from Concentrated Solution

Check concentration (% concentrate) of the chlorine product you are using. Determine total parts water using the formula below:

$$\text{Total Parts (TP) Water} = \frac{\% \text{ concentrate}}{\% \text{ dilute}} - 1$$

Mix 1 part concentrated bleach with the total parts water required.

Example: Make a dilute solution (0.5%) from 5% concentrated solution

1: Calculate TP water: $\frac{5}{.5} - 1 = 10 - 1 = 9$

2: Take 9 parts of water and add 1 part of concentrated solution.

Formula for Making Chlorine Solution from Chlorine Powder

Check concentration (% concentrate) of the chlorine powder/granules you are using. Determine grams of chlorine concentrate per liter of water using the formula below:

$$\text{Grams (concentrate)/liter of H}_2\text{O} = \frac{\% \text{ dilute}}{\% \text{ concentrate}} \times 1000$$

Example: Make a dilute solution (0.5%) from 30% chlorine powder/granules

1: Calculate grams of 30% granules: $\frac{.5}{30} \times 1000 = .0167 \times 1000 = 16.7 \text{ gms/L}$

2: Take 16.7 grams of powder/granules for 1 liter of water.

STEP 2: CLEANING AND RINSING

After decontaminating **instruments**:

- a. Thoroughly scrub them under the surface of the water with a soft brush (e.g. a toothbrush) and liquid soap or detergent. Pay special attention to teeth, joints, and screws, where organic material may collect.
 - b. After cleaning, rinse items well to remove all soap or detergent (this step is important because some detergents can leave a residue that interferes with the action of chemical disinfectants used for HLD or sterilization).
 - c. After rinsing, air dry or dry items with a clean towel.
 - d. Once items are dried, proceed with HLD or sterilization.
- **Wash large surfaces** (e.g. procedure table, instrument stand) with soap and water if organic material remains on them after decontamination.

STEP 3: HLD (Recommended for IUD services)

- After decontaminating (instruments and surgical gloves) and cleaning Instruments, perform high-level disinfection using one of the following processes:

Boil items for 20 minutes and dry:

- a. Open or take apart items.
- b. Fully immerse items in water in a covered pan then boil.
- c. Bring water to a rolling/bubbling boil, and begin timing.
- d. Boil for 20 minutes.
- e. Remove items using high level disinfected forceps, and place in a high level disinfected container.
- f. Allow items to cool and air dry.

Alternatively, steam items for 20 minutes and dry.

Alternatively, soak items in special chemicals for 20 minutes, rinse, and dry:

- a. Fully immerse items in an appropriate high-level disinfectant (i.e., 2% glutaraldehyde or 0.1% chlorine solution)
- b. Soak them for 20 minutes.
- c. Remove items using new/clean examination or high-level disinfected surgical gloves, and high level disinfected forceps.
- d. Rinse items three times with boiled and filtered (if necessary) water.
- e. Place them in a high level disinfected container and air dry.

STEP 4: STORAGE

- Use high level disinfected instruments immediately, or store them for up to one week in a highly disinfected container with a tight-fitting cover. (Sterilized instruments not used immediately should be stored in a dry, sterile container with a tight cover.)
- Use high level disinfected gloves immediately or store them for up to one week in a dry, highly disinfected container with a tight-fitting cover (or in the stacked/covered steamer pans). Sterilized gloves not used immediately should be stored in a dry, sterile container with a tight-fitting cover.

STEP 5: WASTE DISPOSAL

- After completing a procedure (e.g. IUD insertion or removal), and while still wearing gloves, dispose of contaminated waste (e.g. gauze, cotton, disposable gloves) in a properly marked leak-proof waste container (with a tight-fitting lid) or plastic bag.

MORE ABOUT HIGH-LEVEL DISINFECTION

Because HLD is a safe and cost-effective method of final processing for IUD services, additional information is provided below about each of the HLD processes: boiling, steaming, and soaking in special chemicals.

HLD by Boiling and Steaming

For small clinics and those located in remote areas, boiling and steaming are the preferred methods of HLD because they require only inexpensive equipment that are often readily available. There are advantages and disadvantages to both methods.

- § An advantage of steaming is that it requires less fuel and is more cost-effective than boiling for HLD. Only about one liter of water is needed to steam gloves or other instruments, whereas four to five liters are required for boiling.
- § For final processing of surgical gloves, steaming has several additional advantages over boiling. It is less destructive to the gloves, and the gloves are less likely to be contaminated while they are drying after steaming because they remain in the closed steamer pan. Moreover, gloves that have been steamed dry in less time (about four hours) than those that have been boiled. Because steaming is the most popular method of processing gloves so that they can be safely reused, detailed instructions on steaming gloves are provided.
- § An advantage of boiling is that the pots used can be very large and thus may be more suitable for use with metal instruments. Steaming, on the other hand, may only be practical for processing small items (e.g. surgical gloves, syringes) because locally available steamers are often small.
- § Also, the boiling process requires less attention to ensure that it is being done correctly (Spaulding 1993). By contrast, for steaming to be effective, the bottom pan must contain enough water to continue boiling throughout the steaming process.

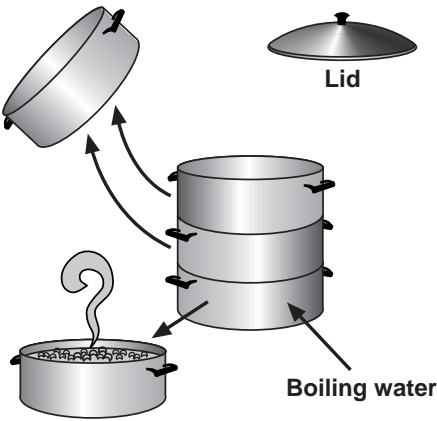
HLD by Soaking in Special Chemicals

Aside from boiling and steaming, the only other method of high-level disinfecting instruments, gloves, and other reusable items is by soaking them in special chemicals. Although a number of disinfectants are commercially available in most countries, the following are approved worldwide for use as high-level disinfectants:

- § Chlorine
- § Glutaraldehyde (Cidex)

How to High-Level Disinfect Surgical Gloves by Steaming

After gloves have been decontaminated and thoroughly cleaned, they are ready for HLD by steaming.

STEP 1	Fold up cuffs of gloves so that they can be put on easily and without contamination after HLD.	
STEP 2	Place gloves into one of the steamer pans with holes in the bottom. To make removal from the pan after HLD easier, arrange gloves so that cuffs are facing outward, toward the edge of the pan. Five to fifteen pairs can be put in each pan, depending on the diameter of the pan.	 <p>The diagram illustrates the steaming setup. At the bottom is a pan containing 'Boiling water'. On top of this pan is a stack of three steamer pans. The top pan is tilted, and an arrow points to the steam rising from the bottom pan. A 'Lid' is shown separately to the right of the stack.</p>
STEP 3	Repeat this process until up to three steamer pans have been filled with gloves. Stack the filled steamer pans on top of the bottom pan, which contains water for boiling. A second (empty) pan without holes should be placed on the counter next to the heat source (see Step 9).	
STEP 4	Place the lid on the top pan and bring water to a full rolling boil (when water only simmers, very little steam is formed and the temperature may not get high enough to kill microorganisms).	
STEP 5	Reduce heat so that water continues to boil at a rolling boil (when water boils too violently, it evaporates quickly and wastes fuel.)	
Remember: Be sure there is sufficient water in the bottom pan for the entire 20 minutes of steaming		
STEP 6	When steam begins to come out between the pans, start the timer.	
STEP 7	Steam gloves for 20 minutes.	
STEP 8	Remove the top steamer pan and place the lid on the top pan remaining in the stack. Gently shake excess water from the gloves in the pan just removed.	
STEP 9	Place the pan containing gloves on the second (empty) pan (see STEP 3). Repeat until all pans containing gloves are restacked on this empty pan. (This step allows the gloves to cool and dry without becoming contaminated.)	

Remember: Do not place pans containing gloves directly on a table top, counter, or any other surface as gloves would be contaminated.

STEP 10

Allow gloves to air dry in the steamer pans (four to six hours) before using them.*

STEP 11

Using a high-level disinfected forceps, transfer the dry gloves to a dry, high-level disinfected container** with a tight lid. Store for up to a week. (Gloves also can be stored in the stacked and covered steamer pans.)

* Allow gloves to cool for five to 10 minutes before wearing. Gloves should be used within 30 minutes, if possible. After this time, the fingers of the gloves stick together and will be difficult to put on.

** To prepare a high-level disinfected container, boil (if small) or fill a plastic container with 0.5% chlorine solution and soak for 20 minutes. (The chlorine solution can then be transferred to another container and reused.) Rinse the cover and the inside thoroughly with boiled water and allow to air dry.

SPECIFIC INFECTION PREVENTION TIPS FOR IUD INSERTION OR REMOVAL

Appropriate Setting

An examination room in a birthing home or an outpatient clinic or a minor surgery room in a hospital is a suitable setting for IUD insertion or removal. If possible, the room should be located away from heavily used areas of the facility, offer privacy, and:

- § Contains an examination or procedure table with a washable surface
- § Be adequately lit and well-ventilated (with tight-fitting screens on any open windows)
- § Be clean, orderly, and free of dust and insects
- § Has tiles or concrete floors to facilitate cleaning
- § Contains leak-proof containers (with tight lids) or plastic bags for disposal of contaminated waste items
- § Has nearby handwashing facilities, including a supply of clean, running water (i.e., clear, not cloudy or with sediment)

Appropriate Attire for Clients and Staff

Because IUD insertion and removal are minor procedures:

- § Clients can wear their own clothing, provided they are clean.
- § Staff does not have to wear a cap, mask, or gown.

Specific Infection Prevention Measures for the Procedure

Before IUD Insertion or Removal

- § Ensure that instruments and supplies are available and ready for use.
- § Ensure that the IUD package is unopened and undamaged. The IUD package should not be opened until the final decision to insert the IUD has been made.

A Word about Tarnishing

Sometimes the copper on copper-bearing IUDs tarnishes (i.e., the color darkens), causing concern among providers about the safety and effectiveness of the affected IUD. All available evidence suggests that tarnished IUDs are safe and effective and can be inserted and used in the same way as untarnished IUDs. Therefore, unless the IUD package is torn or opened (or the shelf life has expired), a tarnished IUD is still sterile, safe to use, and effective.

- § Have the woman wash (with soap and water) and rinse her perineal area.
- § Do not shave her genital area.
- § Place a dry, clean cloth between her genital area and the surface of the examination table.

Important: When insertion is done correctly, the rate of infection following IUD insertion is low - less than 1%; therefore, use of prophylactic antibiotics is not recommended (Ladipo et al., 1991; Sinai et al., 1990).

- § Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- § Put new/clean examination or highly disinfected (or sterile) surgical gloves on both hands.

During IUD Insertion or Removal

- § Before sounding the uterus and inserting the IUD (after performing the speculum examination, with the speculum still in place), thoroughly apply a water-based antiseptic (povidone iodine or chlorhexidine) two or more times to the cervix and vagina before beginning the procedure. Cleanse from the inside of the cervical outward.
 - ✓ If povidone iodine is used, allow one to two minutes before proceeding. Iodophors such as povidone iodine require contact time to act.
 - ✓ Do not use alcohol. Alcohol is painful for the woman and also dries and damages the mucous membranes, which may support the infectious process.

Note: Antiseptic preparation of the cervix and vagina minimizes the number of microorganisms in the woman's genital tract. This step is important in reducing the risk of infection following IUD insertion or removal.

- § Load the IUD in its sterile package.
- § Throughout the procedure, use the "no-touch" technique to reduce the risk of contaminating the uterine cavity. Using the "no-touch" technique during IUD insertion means that the uterine is sound and the loaded IUD:
 - ✓ Is not allowed to touch the vaginal walls or the blades of the speculum (or any other nonsterile surface that may contaminate it) ; and
 - ✓ Is not passed through the cervical os more than once.

After IUD Insertion or Removal

§ Before removing your gloves:

- ✓ Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.
- ✓ Dispose of waste materials (e.g., cotton balls) by placing them in a leak-proof container (with tight-fitting lid) or plastic bag.
- ✓ Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out.
 - If disposing of the gloves, place them in the leak-proof container or plastic bag.
 - If reusing the gloves (not recommended), submerge them in 0.5% chlorine solution for 10 minutes for decontamination.

§ Wash your hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.

§ After the client has left, wipe the examination table with 0.5% chlorine solution to decontaminate.

§ Ensure that all instruments, gloves, and other reusable items are further processed according to recommended infection prevention practices (see table below).

Note: In the context of IUD services, HLD (as opposed to sterilization) is the recommended method of final processing at instruments.

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

SESSION 3

CLIENT ASSESSMENT



OVERVIEW

Careful client assessment is necessary in providing quality health care and family planning service. This session focuses on identifying characteristics and conditions that may affect a client's eligibility for IUD use. If such precautions are identified, the provider and client should weigh any risks posed by the IUD against those posed by unintended pregnancy



LEARNING OBJECTIVES

At the end of the session, the participants will able to:

1. State the rationale for assessing potential IUD clients.
2. Use the WHO Medical Eligibility Criteria for IUD use.
3. Identify eligible conditions for IUD use based on the WHO MEC.
4. Explain the guidelines for conducting client assessment.
5. Perform client assessment (i.e., medical history and pelvic examination) under simulated conditions (role play and use of the pelvic model).
6. Discuss “next steps” based on assessment findings.

REFERENCE

Bluestone J, et al. IUD Guidelines for Family Planning Service Programs: A problem-solving reference manual. JHPIEGO. 2006. 3rd edition. pp.4-1 to 4-15



NARRATIVE

SESSION 3: CLIENT ASSESSMENT

RATIONALE

Potential IUD clients are assessed to:

- § Ensure that the client is not pregnant
- § Ensure that she does not have gonorrhea or chlamydia, and is not at very high individual risk of these STIs
- § Identify other characteristics or conditions that may affect her eligibility for IUD use based on the WHO Medical Eligibility Criteria (WHO MEC)
- § Determine the depth and direction of her uterus (for IUD insertion)
- § Identify any other problems that may require further assessment or treatment

OVERVIEW of the WHO MEDICAL ELIGIBILITY CRITERIA

REMEMBER: Most women can generally use the IUD.

The WHO MEC for contraceptive use (first issued: 1996; revised: 2000, 2003, 2004) help providers assist their clients in weighing the risks and advantages of different family planning methods relative to specific conditions. A condition is either a biological characteristic (e.g., age, reproductive history) or a medical condition (e.g., HIV, diabetes, anemia) that may have an impact on the effectiveness or safety of a given contraceptive. In the WHO system, a client's eligibility for using a specific method falls into one of four categories, depending on the presence or absence of various condition(s). These categories are summarized in the table below.

WHO Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use the method in any circumstance	Use the method
2	Generally use the method	
3	Use of the method not usually recommended unless other proper methods are not available or acceptable	Do not use the method
4	Method not to be used	

A condition may be categorized in two ways, for initiating use (i.e., insertion) and for continuing use. For example, a client with PID should not have an IUD inserted (Category 4) but can continue to use an IUD already in place while receiving appropriate treatment (Category 2) if desired.

ASSESSMENT

This procedure is part of the “A” step of the G-A-T-H-E-R approach in counseling family planning clients. The service provider uses and accomplishes the FP Form 1 in performing this step.

In *history-taking*, there are specific questions that will target characteristics and conditions which may affect eligibility of the client for IUD use (based on the WHO Medical Eligibility Criteria).

The following are guidelines in conducting client assessment:

A. History-Taking

Before History-Taking

- § Explain to the client that it is necessary to give clear and detailed information to provide the best care possible
- § Assure that all information given will remain strictly confidential.

Conducting History-Taking

- § Contraceptive history and reproductive goals:
 - Ask about past experiences with family planning (e.g., methods used, reason(s) for discontinuing)
 - Ask about reproductive needs:
 - § desired number of children to space births
 - § desire for long-term contraception
 - § not wanting anymore children
 - § Medical History (general)
 - Ask for all other conditions if potential IUD client has been diagnosed with anemia, HIV/AIDS, or valvular heart disease
 - For each known condition, ask about current status, treatment received, etc.
 - Assess for any symptoms of anemia
- § Medical History (reproductive)
 - Ask whether the client has been diagnosed with PID, gonorrhea or Chlamydia, or other STIs; cancer of reproductive organs; trophoblastic disease; or pelvic tuberculosis
 - For each known condition, ask about current status, treatment received, etc.
 - Assess for unexplained vaginal bleeding
 - Assess for symptoms of PID, gonorrhea or Chlamydia, or other STIs (e.g., lower abdominal pain, abnormal/purulent vaginal discharge)
 - Assess the client's individual risk for STIs (e.g., multiple partners, partner with multiple partners, recent STI for her or partner)
- § Menstrual history
 - Assess for possibility of pregnancy (e.g., delayed or missing period, unprotected sex since the last menstrual period)
 - Ask about menstrual patterns (e.g., regular versus irregular cycles, amount and duration of bleeding, pain or cramps during menses)

§ Obstetric history

- Ask about previous pregnancies and births (e.g., how many, when, abnormalities)
- Ask about previous abortions (e.g., how many, when)
- Ask about infections following recent births or abortions

Self-Assessment Tool for “Very High Individual Risk” of Gonorrhea or Chlamydia

This approach to identifying women who are at “very high individual risk” of gonorrhea or chlamydia is based on the notion that the client is often the best judge of whether others at risk---assuming that the client has the accurate, up-to-date information for determining this. The following steps are intended to guide the provider in assisting a client through this “self-assessment” process. Throughout this process, the provider should be clear that the client does not have to share any information regarding sexual behaviors.

The tool does not need to be administered if the service provider has strong reasons to believe that the client is at “very high individual risk” for gonorrhea or chlamydia.

- 1. Explain that having an IUD inserted is not recommended for women who are at very high individual risk for certain STIs (gonorrhea or chlamydia). Explain why.**
- 2. Informing the client of some possible risky situations is necessary, if any risk has occurred recently would place the client at a very high risk for STIs (gonorrhea or chlamydia).**

Encourage the client to consider these situations carefully in assessing her own risk and the possibility of having an STI. Risky situations include any of the following (especially within the past 3 months or so):

- § A sexual partner recently had STI symptoms such as pus coming out from his penis, pain or burning during urination, or an open sore in the genital area.
- § She or a sexual partner was diagnosed with an STI recently.
- § She has had more than one sexual partner recently.
- § She has a sexual partner who has had other partners recently.
- § She thinks that her partner who works away from home for long periods of time has other sexual partners.

- 3. Ask the client whether, after considering these risky situations she, thinks the IUD is still an appropriate choice, or whether other contraceptive methods would be also considered.**

- ✓ If the client does not think the IUD is an appropriate choice, maybe she would like to consider other contraceptive methods:
 - § Counsel the client on other contraceptive methods that may be more appropriate.
 - § Urge the use of condoms, alone or with another method, to protect against STIs.
 - § Provide the alternative method now, if appropriate (and a back-up method, if needed).
 - § Consider the need for further evaluation/treatment (if recurrent STI is suspected).

Adapted from: WHO and JHU/CCP 2006.

B. Physical Examination

Before the examination

- § Ensure that essential equipment, instruments, and supplies are available and ready for use.
- § Ensure that the client's bladder has recently been emptied.
- § Have the client wash (with soap and water) and rinse the perineal area, if possible.
- § Assist client onto the examination table.
- § Assure the client that proper assistance will be made to make the examination as comfortable as possible.
- § Advise the client to tell you if pain is felt at any time.
- § Wash hands with soap and water; dry with a clean, dry cloth or allow to air dry.

Performing the physical examination

REMEMBER...

During the physical examination (and IUD insertion or removal):

- § Keep the client informed of the procedures
- § Use gentle, careful movements when touching the client. Avoid sudden or unexpected movements.
- § Use the drape to cover parts that are not directly involved in the examination or procedure (e.g., while examining abdomen, genitalia should be covered).

As part of the assessment for potential IUD clients, the service provider should conduct a focused physical examination (including a complete pelvic examination), as outlined below.

- § Check for signs of anemia:
 - Pallor of skin, conjunctiva (insides of eyelids), or nailbeds
 - Brittle nails
 - Rapid pulse (more than 100 beats/ minute)

Does the client have signs of anemia?

If NO: Proceed with the assessment.

If YES: The IUD can generally be used in this situation, but additional care/ follow-up may be needed. This is because copper-bearing IUDs may increase menstrual bleeding.

What to do:

- § If available, do a hemoglobin/hematocrit test (HB < 7 gm/dl or Hct < 20 indicates severe anemia)

	<p>§ If the client has mild to moderate anemia (known or suspected):</p> <ul style="list-style-type: none"> - Prescribe iron folate once daily - Counsel on local, iron-rich foods <p>§ If the client has severe anemia (known or suspected), counsel on contraceptive methods that may be more appropriate. Provide the alternative method now, if appropriate (and back-up method, if needed).</p> <p>Additional support and care (as appropriate after IUD insertion):</p> <p>§ Continue iron/ folate and nutritional counseling.</p> <p>§ Be alert for increase in amount/ duration of menstrual bleeding.</p> <p>§ Be alert for signs/ symptoms of worsening anemia.</p>
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Performing Pelvic Examination

Guidelines on performing pelvic examination

- § Perform a pelvic examination:
- § Inspect the external genitalia and urethral opening
 - ✓ Check for ulcers, lesions, and sores
 - ✓ Check for buboes (enlarged groin nodes)
 - ✓ Palpate the Skene's and Bartholin's glands, checking for tenderness or discharge.

<p>Are there ulcers on the vulva, vagina, or cervix?</p> <p>Note: Women who have STIs other than gonorrhea and chlamydia (e.g., herpes, syphilis, HBV) can generally have an IUD inserted.</p>	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD should not be inserted until current gonorrhea and chlamydia have been reliably ruled out or successfully treated. These symptoms indicate possible STI.</p> <p>What to do: Advise the client that IUD insertion can be reconsidered once current gonorrhea and chlamydia have been reliably ruled out or successfully treated.</p>
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REMEMBER...

Normally, a speculum examination is completed before the bimanual examination. However, in most IUD clients, this would mean two speculum insertions (one for the speculum examination; another after the bimanual examination for IUD insertion), which can be unpleasant for the client. The following guidelines have been developed especially for the IUD client:

- § **If findings from the history and visual inspection are normal** (infection is not suspected), perform the **bimanual examination first** and the **speculum examination second**; then, with speculum still in place, proceed directly to sounding the uterus and IUD insertion.
- § **If findings from the history or visual inspection are not normal** (infection is suspected); perform the **speculum examination first** and the **bimanual examination second**. Proceed to sounding the uterus and IUD insertion only if indicated.

- § Perform a bimanual examination (before the speculum examination) only if infection is not suspected.
 - ✓ Determine size, shape, and position of the uterus.
 - ✓ Check for enlargement or tenderness of the adnexa and cervical motion tenderness.
 - ✓ Check for uterine abnormalities that may interfere with proper placement of the IUD, such as malformed uterus or uterine fibroids that distort the shape of the uterus.

Are there uterine fibroids or an anatomical abnormality that distorts the shape of the uterus?

If NO: Proceed with the assessment.

If YES: The IUD should not be inserted. This is because this condition may prevent proper placement of the IUD.

What to do: Advise the client that the IUD should not be used in this situation. Help the client choose a different method.

Were you unable to determine the size and position of the uterus?

If NO: Proceed with the assessment.

If YES: The IUD should not be inserted at this time. This is because the provider must know the size and position of the uterus in order to safely insert and properly place the IUD.

What to do: Advise the client to have a pelvic ultrasound to rule out pregnancy or any abnormalities. Give the client a back-up method, like the condom, to use until client returns and has been given the IUD.

<p>Does the client feel pain when cervix (cervical motion tenderness) is moved?</p>	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD should not be inserted until current gonorrhea and chlamydia have been reliably ruled out or successfully treated. This symptom indicates possible PID.</p> <p>What to do: Advise the client that IUD insertion can be reconsidered once current gonorrhea and chlamydia have been reliably ruled out or successfully treated.</p>
<p>Is there pain in the uterus, ovaries, or fallopian tubes (adnexal tenderness)?</p>	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD should not be inserted at this time. This symptom indicates possible PID or another problem.</p> <p>What to do:</p> <ul style="list-style-type: none"> § Advise the client that further evaluation is needed to find the cause of symptoms before IUD insertion can be reconsidered. § Urge the use of condoms in the interim. § Conduct further evaluation and provide appropriate treatment. Refer, if needed.

- § Perform a speculum examination of the vagina and cervix
 - ✓ Check for purulent vaginal or cervical discharge (cervicitis)
 - ✓ Check for ulcers, lesions, and sores
 - ✓ Check cervix for bleeding, erosions, or narrowing of the cervical canal (stenosis)

<p>Are there cervical lacerations or narrowing of the cervical canal (stenosis)?</p>	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD can generally be used in this situation, but there may be some difficulties inserting the IUD.</p>
<p>Is there purulent cervical discharge (cervicitis)?</p>	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD should not be inserted until current gonorrhea and chlamydia have been reliably ruled out or successfully treated. These symptoms indicate possible PID or STI.</p>

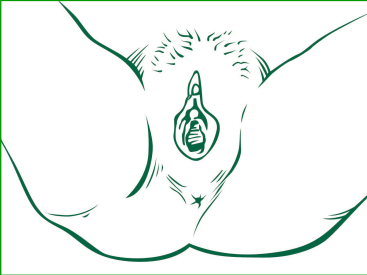





	<p>What to do: Advise the client that IUD insertion can be reconsidered once current gonorrhea and chlamydia have been reliably ruled out or successfully treated.</p>
Does the cervix bleed easily when touched?	<p>If NO: Proceed with the assessment.</p> <p>If YES: The IUD should not be inserted at this time. This symptom indicates possible STI or another problem.</p> <p>What to do:</p> <ul style="list-style-type: none"> § Advise the client that further evaluation is needed to find the cause of symptoms before IUD insertion can be reconsidered. § Urge the use of condoms in the interim. <p>Conduct further evaluation and provide appropriate treatment. Refer, if needed</p>

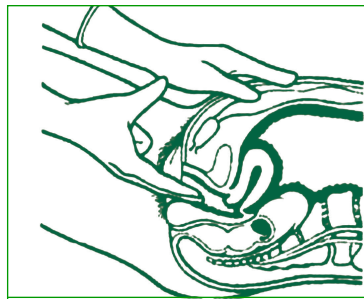
Steps in Performing Pelvic Examination

Before the examination

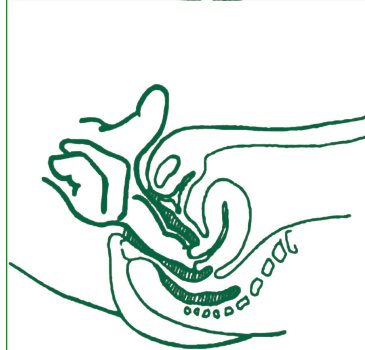
- § Ensure that essential equipment, instruments, and supplies are available and ready for use.
- § Ensure that the client's bladder has been recently emptied.
- § Have the client wash (with soap and water) and rinse perineal area, if possible.
- § Assist the client onto the examination table.
- § Assure the client that the examination will be done as comfortable as possible.
- § Advise the client to tell if pain is felt at any time
- § Wash hands with soap and water; dry with a clean, dry cloth or allow to air dry.
- § Wear clean examination or highly disinfected gloves on both hands.

Perform pelvic examination as follows:

	<p>STEP 1: INSPECTION OF THE EXTERNAL GENITALIA</p> <p>Examine the external genitalia first by taking note of the following:</p> <ul style="list-style-type: none"> § Distribution of the pubic hair, vaginal discharges, signs of bleeding, presence of abrasions, irritations or scars. § Be alert for signs of any STIs like pus, discharges, warty growths, lumps/mass, sores, irritations of the vulvar area.
	<p>STEP 2: BIMANUAL EXAMINATION</p> <ul style="list-style-type: none"> § Wear gloves on both hands. § Use the thumb and little finger to separate the labia majora. § Inspect the vaginal opening. Take note of any bulging of the vaginal walls. A bulging of the anterior vaginal wall suggests a cystocele while a bulging of the posterior vaginal wall suggests a rectocele.
	<ul style="list-style-type: none"> § Press the perineum with index finger to relax it.
	<ul style="list-style-type: none"> § With the finger in the vagina, palpate for the Bartholin's glands by grasping the lower end of each side of the labia majora between thumb and index fingers. Note any secretions or mass.
	<ul style="list-style-type: none"> § Then turn hand with palm upward and squeeze the Skene's glands and urethra outward for any secretions. Collect specimen, if there are any secretion
	<ul style="list-style-type: none"> § With index and middle fingers in the vagina, check the vaginal canal for any abnormalities (e.g. mass) within the vaginal walls



- § With palm up, insert two fingers further into the vagina. Follow the anterior vaginal mucosa deep into the anterior fornix and locate the cervix.

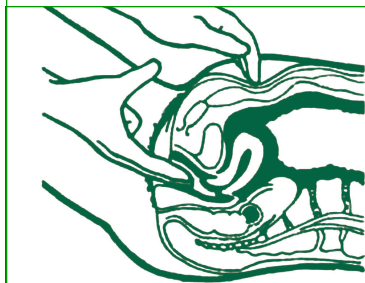


- § Feel the cervix with the examining fingers and note whether it is open or closed, its position, size, mobility, consistency, and any tenderness.

Note:

- § A firm cervix has the consistency of the tip of the nose while a soft cervix feels like the lips.
- § A soft cervix may signify pregnancy.

- § Feel the shape of the cervical os. Note any laceration, presence of cyst, polyps or to confirm findings during the speculum examination, if done prior to this examination.



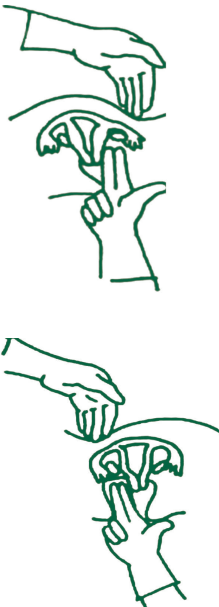
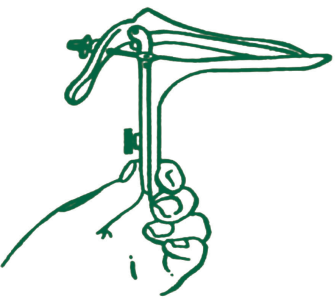

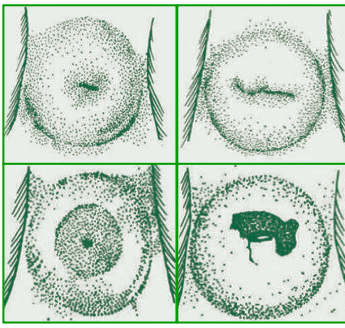
- § Then press free hand gently on the lower abdomen above the symphysis pubis and exert a steady downward pressure.
- § If the cervix is pointing downwards and the body of the uterus can be felt between the external hand and the examining fingers, then the uterus is anteverted.



- § If the body/fundus of the uterus cannot be palpated anteriorly and the cervix is pointing upwards, place fingers in the posterior fornix.
- § If the cervix alone is felt between external hand and the examining fingers, the body of the uterus must be located behind the cervix. In this case, the uterus is retroverted.
- § When the uterus is palpated, note its size, shape, and consistency.

An enlarged uterus may signify pregnancy. An irregularly shaped uterus may signify a mass, most likely a myoma.

NOTE: If the body of the uterus cannot be felt anteriorly or posterior the uterus is in mid-position.

	<ul style="list-style-type: none"> § With the examining fingers in the lateral fornix, gently move the cervix from side to side (wiggle the cervix). § Pain or tenderness elicited by this procedure suggests inflammation of the tubes or ovaries or an ectopic pregnancy. § Ask the client which side she felt pain. Examine first the side where pain was not felt. § Gently palpate or feel for the tube and ovary on this side and on the other side also. Note for any tenderness, enlargement or masses. § Place the free hand to the right of the lower abdomen while moving the examining fingers towards the right lateral fornix. § Do the same procedure on the left adnexa § Remember that normally, the tubes and the ovaries are not palpable. § Abnormalities warrant referral and re-assessment prior to IUD insertion.
	<p>STEP 3: SPECULUM EXAMINATION</p> <ul style="list-style-type: none"> § Lubricate the speculum with water, K-Y jelly, or betadine antiseptic before insertion. Use only water if specimen will be taken for laboratory examination. § Hold the speculum with the blades closed between thumb, index and middle fingers.
	<ul style="list-style-type: none"> § With the free hand, spread the labia and part of the pubic hair which may obstruct the vaginal opening, then ask the client to push or bear down to relax the perineal muscles. § Insert the closed speculum obliquely between the labia and into the vaginal canal. Rotate the blades of the speculum into the horizontal position.
	<ul style="list-style-type: none"> § With the speculum in position, open it until cervix is in full view between the blades. Screw it tightly. § Take note of the color, presence of mass, warty changes, discharges in the vaginal canal. § Do the same on the cervix. Check if there are any masses; erosions; changes in the color. The cervix is normally pinkish, a bluish cervix may signify pregnancy. A bluish, soft cervix together with findings of a soft, enlarged uterus is a strong indication of pregnancy. § Partially withdraw the still open speculum gently to release the cervix, then close it and withdraw the blades in the same oblique position

NEXT STEPS

After determining whether the client is a good candidate for IUD use, perform the following steps as appropriate:

- § If the client is a suitable candidate for IUD insertion at the time, provide the IUD now.
- § If there is a problem or reason to withhold IUD insertion temporarily (e.g. until the next menses if pregnancy can not be ruled out) or permanently (e.g. as in the case of severe uterine abnormalities), follow the steps below:

What to do if client is not currently eligible for IUD use

Always:

- Provide clear information on why the IUD is being withheld (either temporarily or permanently).
- Explain any further evaluation or treatment that is needed.
- Conduct further evaluation and provide treatment accordingly. Refer, if needed.

If the IUD is being temporarily withheld:

- Ensure that the client understands exactly what needs to happen before the IUD can be reconsidered (e.g. menstruation in case of suspected pregnancy; successful treatment for infection).
- Provide a back-up method, such as the condoms to use in the interim.
- Schedule a follow-up appointment for reassessment.

If the IUD is being permanently withheld:

- Discuss other more appropriate contraceptive methods.
- Help her choose one that is well suited to her needs and situation.
- Provide the alternative methods now, if possible. Provide condom, if needed.
- Schedule a follow-up appointment, as appropriate.

If the woman is found to be not suitable for an IUD insertion due to a suspicion of Gonorrhea or Chlamydia (purulent vaginal and cervical discharge), the following are the management guidelines according to availability of STI testing:

Support and Care for Women who might have Gonorrhoea or Chlamydia

Women who might have Gonorrhoea or Chlamydia (based on the assessment) should not have an IUD inserted at this time. Follow these guidelines to provide appropriate support for women in this situation:

1. Inform the client about the possible situation of having Gonorrhoea or Chlamydia, and inform client that these conditions will have to be ruled out or successfully treated before IUD insertion can be reconsidered (remember that women with STIs other than Gonorrhoea and Chlamydia [e.g. Herpes, Syphilis, HBV] can generally have an IUD inserted).
2. Urge the client to have the partner(s) come to the clinic for testing/treatment as well. Explain that unless the partner receives treatment, client is very likely to be re-infected.
3. Conduct further evaluation and provide treatment as shown below (according to national guidelines/local protocols); refer, if needed.

If STI testing is available:

- § Test the client and client's partner to diagnose or rule out Gonorrhoea or Chlamydia.
- § If results are positive:
 - Advise the client that an IUD can be inserted when the infection is cured.
 - Treat the client and client's partner(s).
 - Provide a back-up method to be used while undergoing treatment (strongly recommend the use of condoms).
 - Arrange for a follow-up visit.
 - Insert the IUD as soon as the infection is cured.
 - Advise the client to return to the clinic immediately if lower abdominal pain or unusual vaginal discharge with fever develop.
 - Be alert for signs of infection during follow-up visits.
- § If results are negative, client can have an IUD inserted.

If STI testing is not available:

- § Consider presumptive treatment of the client and client's partner(s).
- § If presumptive treatment is not available, or the client and partner do not wish to be treated:
 - Be precise that inserting an IUD is usually not recommended for women in this situation.
 - Discuss other, more appropriate contraceptive methods. Help the client choose a different method, if appropriate.
 - If no other method is available or acceptable to the client, insert the IUD.
 - Advise the client to return to the clinic immediately if she develops lower abdominal pain or unusual vaginal discharge with fever.
 - Be alert for signs of infection during follow-up visits.

INTRAUTERINE DEVICE INSERTION AND REMOVAL

OVERVIEW

IUD insertion and removal should be performed only by clinicians (physicians, nurses, and midwives) who have been trained to perform these procedures. Problems associated with IUDs (e.g. IUD expulsion, infection, uterine perforation) are uncommon, but when they do occur, they are often due to improper insertion technique.

Although IUD insertion and removal procedures are relatively simple, they are made up of several, discrete steps to be performed in a specific sequence. These steps must be integrated with the appropriate infection prevention and counseling measures to help ensure the safety and well-being of the client. Appropriate client assessment and care are also essential components of IUD insertion and removal services.

LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Describe the features of the CopperT380A.
2. Identify the essential instruments and supplies for IUD insertion and removal.
3. Describe the steps of IUD insertion and removal.
4. Demonstrate the steps of IUD insertion and removal.



NARRATIVE

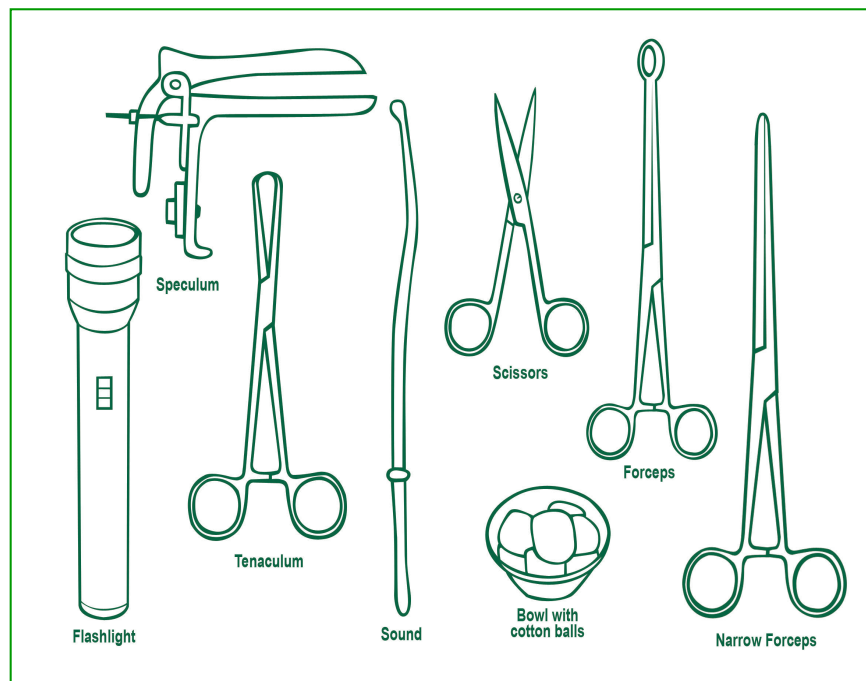
SESSION 4: INTRAUTERINE DEVICE INSERTION AND REMOVAL

When conducting IUD insertion and removal, the service provider and other health care staff, as appropriate, should adhere to the basic principles of quality IUD services.

INTERVAL IUD INSERTION AND REMOVAL

ESSENTIAL ITEMS

- Drape to cover the client's pelvic area
- Clean cloth to place between the client and the examination table
- Gloves (new, clean or high-level disinfected surgical or examination gloves)
- Bivalve speculum (small, medium, large)
- Light source to visualize the cervix (e.g. droplight or flashlight)
- Uterine tenaculum (12")
- Uterine sound (12")
- IUD in an unopened, undamaged, sterile package that is not beyond its expiration date
- Sharp Mayo scissors
- Sponge forceps (12")
- Bowl containing:
 - Antiseptic solution for cleansing cervix (chlorhexidine or povidone iodine)
 - Gauze or cotton balls
- Dry gauze or cotton balls
- Narrow or "alligator" forceps (10") for IUD removal



IUD INSERTION

Before Inserting the IUD

Pre-insertion Education/Counseling

- Provide an overview of the procedure, explaining what it involves and how long it will take.
- Explain that the procedure is very safe.
- Discuss the possibility of pain during the procedure. The service provider may want to say:
 - “You may feel some cramping and discomfort during and following IUD insertion. This is normal.”
 - “I will do my best to make the procedure as comfortable as possible, and alert you on possible pain before performing the step that might cause it.”
 - “Tell me if you feel pain at any time.”

Important: If the client has serious concerns about discomfort, offer the client an NSAID, like Paracetamol or Ibuprofen. Ideally, give this to her 30 minutes before the procedure.

- Ask the client whether she has any questions or remaining concerns.
- Provide additional information and reassurance, as needed.

Pre-insertion Preparations


- Ensure that an HLD pan (or sterile pack), supplies, and light source are available and ready for use.
- Using an HLD (or sterile) pick-up forceps, arrange the instruments and supplies in the HLD pan (or sterile pack), being very careful not to touch any parts that will go into the vagina or uterus.
- Ensure that the client had her bladder recently emptied.
- Have the client wash (with soap and water) and rinse the perineal area, if possible.
- Assist the client onto the examination table.
- Wash hands thoroughly with soap and water; dry with a clean, dry cloth or allow to air dry.

Pre-insertion Assessment

- Confirm that the client has undergone appropriate assessment to ensure that client is eligible for IUD insertion at this time.

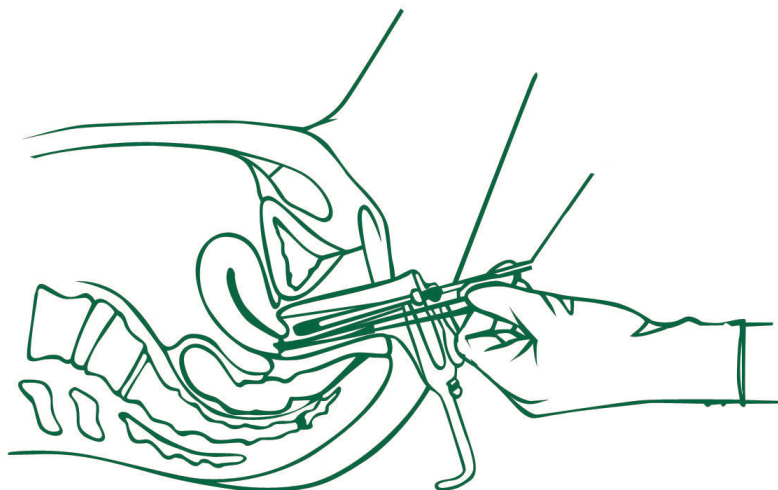
Sounding the uterus

Using gentle, “no touch” (aseptic) technique throughout, perform the following steps:

Step 1:	Prepare the client <ul style="list-style-type: none">• Give the client a brief overview of the procedure as follows:<ul style="list-style-type: none">✓ A speculum will be inserted into the vagina to visualize the cervix.✓ The cervix and vagina will be cleaned.✓ A tenaculum will be applied to the cervix to hold it.✓ A uterine sound will be inserted into the cervix and advanced into the uterus until a resistance is felt. This is to determine the depth of the uterus.• Encourage the client to ask questions and provide reassurance as needed.• Remind the client to tell if any pain is being felt. <p>Note: Steps 2 and 3 are skipped when speculum examination is immediately followed by IUD insertion.</p>
Step 2:	Put new/clean examination or highly/HLD disinfected gloves on both hands.
Step 3:	Insert the HLD (or sterile) speculum and visualize the cervix. Reminder... If the cervix bleeds easily when touched, or purulent cervical discharge or other abnormal signs are found, do not insert the IUD.
Inserting the Speculum 	
Step 4:	Cleanse the cervix and vagina with antiseptic: Thoroughly apply Povidone Iodine two or more times to the cervix and vagina. Make sure that the client is not allergic to Iodine and wait for two minutes for the solution to act.

Step 5:

Gently grasp the cervix with HLD tenaculum and apply gentle traction: Gently grasp the cervix at 10 and 2 o'clock positions with the tenaculum and apply gentle traction (i.e., pull it gently), which will help straighten the cervical canal for easier insertion of the IUD. **Close the tenaculum only to the first notch to minimize discomfort.**

Gently Grasping the Cervix with the Tenaculum**Step 6:**

Carefully insert the HLD sound: While maintaining gentle traction on the tenaculum, carefully insert the tip of the sound into the cervical os. **Be careful not to touch walls of the vagina or the speculum blades with the tip of the sound.**

Step 7:

Gently advance the sound into the uterine cavity, and STOP when slight resistance is felt:

- Advance the sound carefully and gently into the uterine cavity at the appropriate angle (based on your assessment of the position of the uterus during bimanual examination).
 - Continue to pull steadily downward and outward on the tenaculum, which should enable the sound to pass through the os more easily.
- ✓ If any resistance is felt at the level of the internal os, do not attempt to dilate the cervix unless well qualified to perform this procedure.
 - ✓ If the client shows any sign of fainting, STOP advancing the sound into the uterine cavity.

Do not use force at any stage of this procedure.

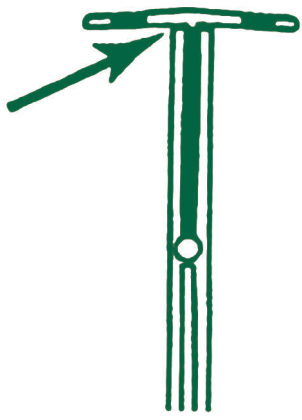
- ✓ If a slight resistance is felt, STOP advancing the sound into the uterine cavity. A slight resistance indicates that the tip of the sound has reached the fundus.
- ✓ If a sudden loss of resistance is felt, the uterine depth is greater than expected, or the client is experiencing unexplained pain,

	STOP advancing the sound into the uterine cavity. Discontinue the procedure and do not insert the IUD. These are indications of possible uterine perforation.
Step 8:	Note the angle of the uterine cavity, and gently remove the sound. Do not pass the sound into the uterus more than once.
Step 9:	Determine the depth of the uterus <ul style="list-style-type: none"> • Determine the depth of the uterus by taking note of the mucus level or wetness on the sound. The average uterus is between six and eight cm in depth. If the uterus is less than six cm in depth, the client may be at increased risk for IUD expulsion. • Place the sound in 0.5% chlorine solution for 10 minutes for decontamination. • Immerse gloved hands in 0.5% chlorine solution. • Remove gloves inside out and dispose in leak-proof container.

Loading the IUD in the sterile package

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

While performing the following steps, do not allow any part of the IUD or the IUD insertion assembly to touch any non-sterile surfaces (e.g. your hands, the table) that may contaminate it.

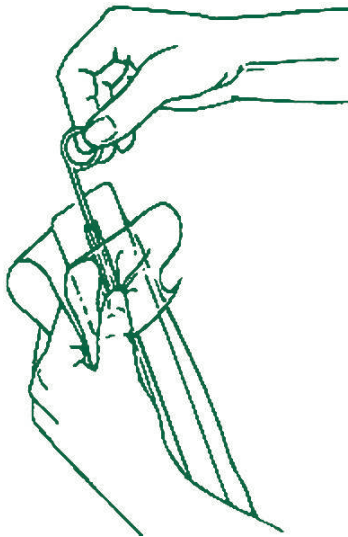
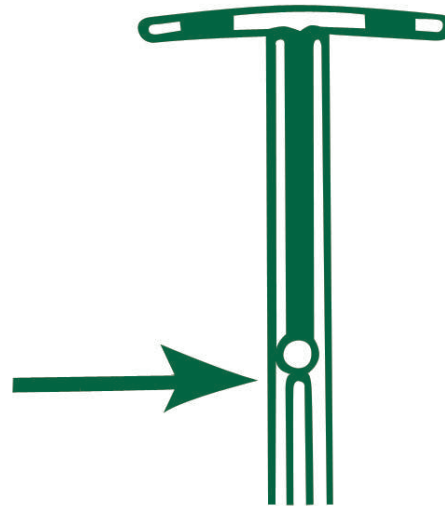
Step 1:	Adjust the contents of the package through the clear plastic cover: <ul style="list-style-type: none"> • Ensure that the vertical stem of the T is fully inside the insertion tube. • Ensure that the other end of the insertion tube (farthest from the IUD) is close to the sealed end of the package. 	Vertical Stem of T Fully Inside Insertion Tube
Step 2:	Partially open the package <ul style="list-style-type: none"> • Place the package on a clean, hard, flat surface with the clear plastic side up. • Pull up on the clear plastic cover from the end that is farthest from the IUD (marked OPEN). • Keep pulling the plastic cover until the package is open approximately halfway to the blue depth gauge. 	

Step 3:**Place the white plunger rod in the clear insertion tube:**

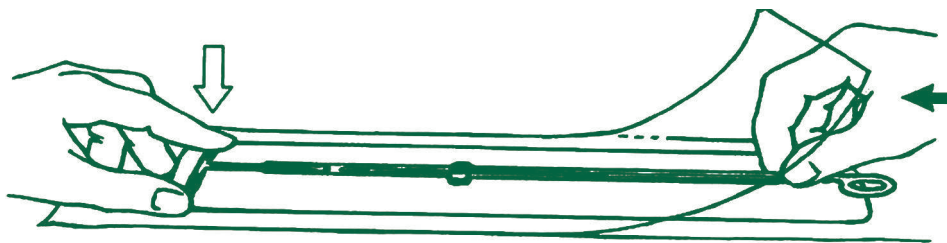
- Pick up the package, holding the open end up toward the ceiling so that the contents do not fall out.
- Starting at the open end of the package, fold the clear plastic cover and white backing “flaps” away from each other.
- Using your free hand, grasp the white plunger rod (behind the measurement insert) by the circular thumb grip and remove it from the package.

Do not touch the tip of the white plunger rod or brush it against another surface for this will cause the loss of sterility.

- Place the plunger rod inside the insertion tube and gently push until the tip of the rod almost touches the bottom of the T.

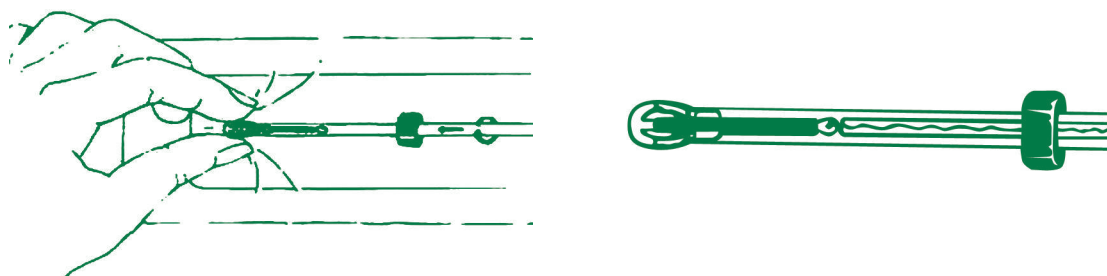
Placing White Plunger Rod Inside Insertion Tube**Plunger Rod almost Touching the Bottom of T****Step 4:****Bend the “arms” of the “T” downward:**

- Release the white backing flap so that it becomes flat again, and place the package back on a clean, hard, flat surface with the clear plastic side up.
- Through the clear plastic cover, place your thumb and index finger over the tips of the horizontal arms of the T to stabilize the IUD.

Positioning IUD and Bending Arms of T

	<ul style="list-style-type: none"> • At the open end of the package, use free hand to push the measurement insert so that it slides underneath the IUD and stops at the sealed end of the package. • Still holding the tips of the arms of the T, use free hand to grasp the insertion tube and gently push it against the T. This pressure will cause the arms to begin bending downward, toward the stem of the T. • Finish bending the arms of the T by bringing your thumb and index finger together, and continuing to push against the T with the insertion tube.
Step 5:	<p>Pull the insertion tube away from the folded arms of the T</p> <p>When the arms of the T are folded down enough to touch the sides of the insertion tube, pull the insertion tube out from between the arms.</p>
Step 6:	<p>Push the folded arms of the T into the insertion tube</p> <ul style="list-style-type: none"> • Gently push and rotate the insertion tube back over the tips of the folded arms of the T, so both tips are caught inside the insertion tube. • Push the folded arms of the IUD into the insertion tube only as far as necessary to keep them fixed in the tube. Do not try to push the copper bands on the arms into the insertion tube, as it will not fit.

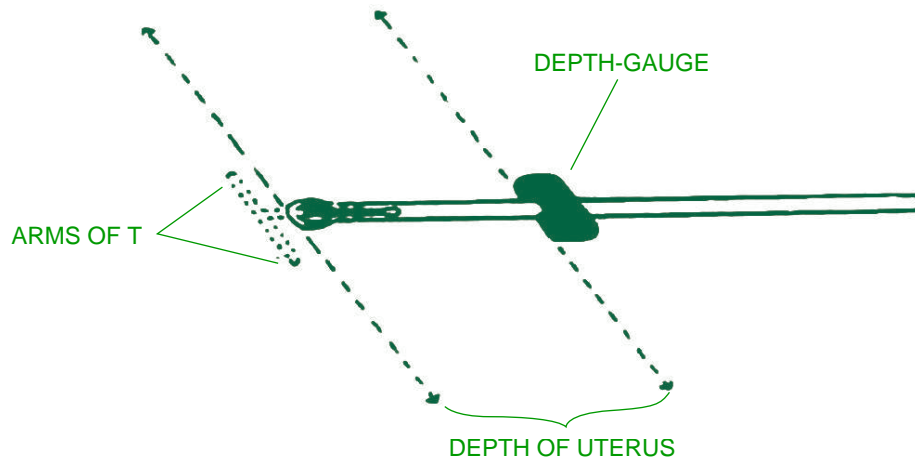
Inserting folded IUD arms into the insertion tube



The arms of the IUD should not be bent into the insertion tube for more than five minutes.

Step 7:	<p>Set the blue depth-gauge to the appropriate measurement</p> <p>With the loaded IUD still in the partially unopened package, set the blue depth-gauge to the corresponding measurement obtained from sounding the uterus:</p> <ul style="list-style-type: none"> • Move the depth-gauge so that its inside edge (the edge closest to the IUD) is aligned to the appropriate centimeter mark on the measurement insert. • Press down on the depth-gauge with the thumb and index finger of one hand to keep it in place, while sliding the insertion tube with other hand until the tip of the IUD (the top of the folded T) aligns with the tip in the diagram on the measurement insert. This is the “0” centimeter mark.
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Using Blue Depth-Gauge to Set Depth of Uterus on Insertion Tube



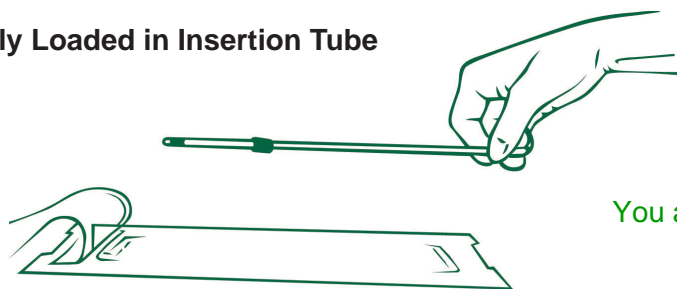
Step 8: Align the depth-gauge and the folded arms of the T so that both will be in a “horizontal” position (i.e., flat against the measurement insert)

Step 9: **Remove the loaded IUD from the package:**

- Finish peeling back the clear plastic cover from the white backing in one brisk, continuous movement with one hand, while holding the insertion assembly down against the white backing on the table (at the open end of the package) with the other hand.
- Lift the loaded IUD from the packaging, keeping it at a level so the T and white plunger rod do not fall out. Be careful not to push the white rod toward the T, as this will release the IUD from the insertion tube.

Do not let the IUD or IUD insertion assembly touch any non-sterile surfaces that may contaminate it.

IUD Fully Loaded in Insertion Tube



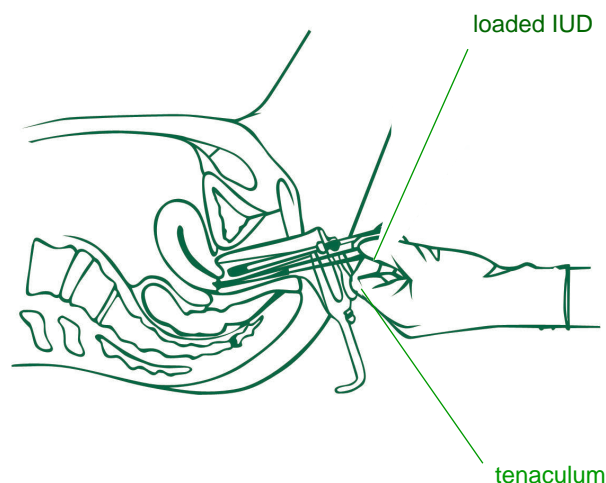
You are now ready to insert the IUD.

Inserting the IUD

Using gentle, “no-touch” (aseptic) technique throughout, perform the following steps:

Step 1:	Put new/clean examination or HLD/highly disinfected surgical gloves on both hands (if taken off to load the IUD).
Step 2:	Prepare the client: <ul style="list-style-type: none">• Give the client a brief overview of the procedure:<ul style="list-style-type: none">-The tenaculum will be pulled gently to align the uterus, cervical opening, and vaginal canal.-The loaded IUD will be inserted into the vagina, through the cervical opening and way up into the uterus until the depth gauge comes in contact with the cervix.-The IUD is then released as high as possible into the uterus.-The strings are then cut 3-4 cm from the cervical opening.• Encourage the client to ask questions.• Provide reassurance, as needed.• Remind the client to tell if any pain is felt.
Step 3:	Gently grasp the tenaculum and apply gentle traction: Hold the loaded IUD so that the blue depth-gauge is in the horizontal position with one hand, while grasping the tenaculum with the other hand and gently pulling outward and downward. This will straighten the cervical canal for easier insertion of the IUD.
Step 4:	Carefully insert the loaded IUD: Carefully insert the loaded IUD into the vaginal canal and gently push it through the cervical os and into the uterine cavity at the appropriate angle (based on the assessment of the position of the uterus when sounding the uterus). Be careful not to touch the walls of the vagina or the speculum blades with the tip of the loaded IUD.

Inserting the loaded IUD

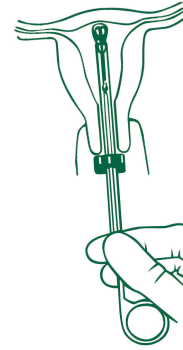


Step 5:

Gently advance the loaded IUD into the uterine cavity, and **STOP** when the blue depth-gauge comes in contact with the cervix or *slight* resistance is felt. Be sure that the depth-gauge is still in the horizontal position.

Do not use force at any stage of this procedure.

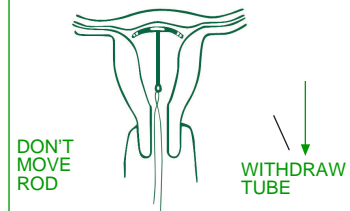
Advancing the Loaded IUD



Step 6:

Hold the tenaculum and white plunger rod at stationary position, while partially withdrawing the insertion tube: While holding the tenaculum and plunger rod at stationary (in one hand), gently pull the insertion tube toward yourself (with your free hand) until it touches the circular thumb grip of the white plunger rod. This will release the IUD inside the uterus.

Withdrawing the insertion tube to release IUD arms



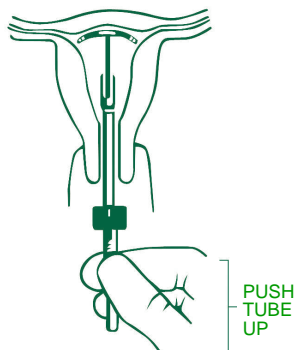
Step 7:

Remove the white plunger rod, while holding the insertion tube stationary.

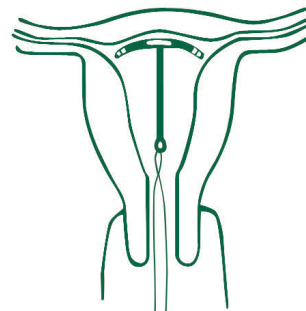
Step 8:

Gently push insertion tube until slight resistance is felt: Once the plunger rod has been removed, gently and carefully push the insertion tube upward again towards the fundus of the uterus, until slight resistance is felt. This ensures that the arms of the T are as high as possible in the uterus.

Positioning IUD high in the uterus



IUD fully inserted in the uterus



Do not pass the loaded IUD into the uterus more than once.

<p>Step 9:</p>	<p>Use high-level disinfected (or sterile) sharp Mayo scissors to cut the IUD strings at three to four cm:</p> <ul style="list-style-type: none"> • Remove the insertion tube. Using sharp Mayo scissors, cut the strings three to four cm from the cervical opening. • Place the insertion tube and scissors in 0.5% chlorine solution for 10 minutes for decontamination. <p><i>Note: Sharp blades are very important. If the scissor blades are too dull to cut well, the IUD strings may become trapped in the closed blades of the scissors, and the IUD may be accidentally removed when the scissors are withdrawn.</i></p>
<p>Step 10:</p>	<p>Gently remove the tenaculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.</p>
<p>Step 11:</p>	<p>Examine the client's cervix for bleeding: If there is bleeding where the tenaculum was attached to the cervix, use high-level disinfected (or sterile) forceps to place cotton or gauze swab on the affected tissue, and apply gentle pressure for 30 to 60 seconds.</p>
<p>Step 12:</p>	<p>Gently remove the speculum and place it in a 0.5% chlorine solution for 10 minutes for decontamination.</p>
<p>Step 13:</p>	<p>Allow the client to rest. Advise the client to remain on the examination table until she is ready. Begin performing the post-insertion steps while client is at rest.</p>

After inserting the IUD

Post-insertion processing

- Before removing the gloves:
 - Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.
 - Dispose of waste materials by placing them in a leak-proof container or plastic bag.
- Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out.
 - If disposing of the gloves, place them in a leak-proof container or plastic bag.
 - If reusing the gloves (not recommended), submerge them in 0.5% chlorine solution for 10 minutes for decontamination.
- Wash your hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
- After the client has left, wipe the examination table with 0.5% chlorine solution to decontaminate it.
- Ensure that all instruments, gloves, and other reusable items are further processed according to the recommended standard for infection prevention practices.

Post insertion Assessment

- Ask about the client’s condition and if she is experiencing any of the following symptoms:
 - nausea
 - mild to moderate lower abdominal pain/cramping
 - dizziness or fainting (rare)
- If the client is experiencing any of the above symptoms, provide reassurance and allow the client to remain on the examination table to rest until in a full state of recovery.

Important: Although most women will not experience problems after IUD insertion, all clients should remain in the clinic for 15 to 20 minutes before being discharged as a precaution.

Post insertion Counseling

- Before the woman leaves the clinic, counsel on messages for women who just had an IUD inserted.

Warning signs (PAINS)	<p>What you should know:</p> <ul style="list-style-type: none"> • The following signs/ symptoms (which spell the word P-A-I-N-S) are warning signs for IUD users and may indicate a serious problem:
	<p>P: Period-related problems or pregnancy symptoms This means that the period is late with signs of pregnancy, abnormal spotting after the first few days post-insertion, or spotting between periods or after intercourse; bleeding twice as long or twice as heavily as usual.</p> <p>A: Abdominal pain or pain during intercourse This means generalized lower abdominal pain, which may indicate pelvic infection or crampy lower abdominal pain, which may indicate IUD expulsion.</p> <p>I: Infections or unusual vaginal discharge Signs of infection would include purulent or foul-smelling vaginal discharge, which may occur within 20 days of post-insertion or when she is exposed to STIs.</p> <p>N: Not feeling well, fever, chills This is also a sign of infection.</p> <p>S: String problems These include missing, shorter, or longer strings, which is an indication of a misplaced IUD.</p>

	<p>What you should do:</p> <ul style="list-style-type: none"> • If any of these warning signs are experienced, return to the clinic immediately.
<p>Checking for possible IUD expulsion</p> <p><i>New Thinking about Checking IUD Strings: the importance of having the client check her IUD strings has been over-emphasized.</i></p> <p><i>IUD expulsion is uncommon, and undetected IUD expulsion is rare. Thus, unless the IUD was inserted immediately after childbirth or a second-trimester abortion (in which case the risk of IUD expulsion increases), the provider should minimize this aspect of counseling and focus more on the other messages.</i></p>	<p>What should you know:</p> <ul style="list-style-type: none"> • IUD expulsion is most likely to occur within the first few months after IUD insertion (especially during menstruation). <p>What you should do:</p> <ul style="list-style-type: none"> • Check the strings occasionally during the first few months after IUD insertion (preferably after your menstrual period). • Check menstrual cloth/pad/tampon and the latrine for an expelled IUD during the first few menstrual periods. • If IUD strings cannot be felt or if the IUD is suspected to have been expelled, begin using a back-up contraceptive method and return to the clinic immediately.
<p>When to return to the clinic</p>	<p>What you should know and do:</p> <p>Return for a single routine check-up after first post-insertion menstrual period (three to six weeks) but not later than three months after insertion.</p> <ul style="list-style-type: none"> • Return immediately if any warning signs are experienced. • Return if there is a need for IUD to be removed, there are changes in your reproductive goals or overall health, or doubt of STI exposure. • Return in 12 years to have the IUD removed/replaced. • Return if there are any problems or concerns, or for any reason at all.

- Give the client a reminder card, such as the one below:

IUD-REMINDER CARD
Client name: _____
IUD Type Inserted: <u>Copper T380A</u>
Inserted on: _____
Remove/replace by: <u>(12 years from insertion date)</u>
If you have problems or questions, go to (name and location of your clinic):

IUD REMOVAL

IUD removal is usually an uncomplicated and relatively painless routine procedure. Unless an IUD is removed for a medical reason or because the client wishes to discontinue the method, a new IUD can be inserted immediately after removing the old one. Appropriate assessment and care, before and after the procedure, depend on the reason for IUD removal and whether the client is having another IUD inserted or is starting a different method. Pre-procedure preparations and post-procedure processing steps are essentially the same as for IUD insertion, and are not repeated here.

Note: For routine IUD removals (especially if replacing the IUD), removal may be easier during the client's menstrual period, when the cervix softens. However, IUD can be removed at any time during the woman's menstrual cycle.

Before Removing the IUD

- Ask the client the reasons for having the IUD removed:
 - If it is for personal reasons (or offers no reason at all), remove her IUD. The client has the right to discontinue the method at any time, regardless of the reason.
 - If the client is having her IUD replaced (i.e., at the end of its effective life), ensure that she has undergone appropriate assessment to determine whether she is eligible for IUD reinsertion at this time.
 - If the client is having the IUD removed for medical reasons (e.g. pregnancy, dangerously heavy menstrual bleeding), ensure that she has undergone the appropriate assessment to determine whether routine IUD removal is safe for her at this time. The client may not be eligible for routine IUD removal if the IUD strings are not visible or signs of infection are detected. Refer for special removal, if needed.
 - If the client will be starting a different method, ask when her LMP began. This will help determine if there is a need to use a back-up method, in accordance with guidelines below.

Guidelines for switching to another contraceptive method and need for back-up methods

If the client is switching to combined oral contraceptives (COCs):

- The IUD has been removed within five days since her LMP started. No back-up method is needed.
- The IUD has been removed at any other time:
 - Client has been sexually active in this menstrual cycle, delay IUD removal until her next period.
 - Client has not been sexually active in this menstrual cycle, provide condoms as back-up method for her to use for the first seven days after starting COCs.

If the client is switching to any other method :

- The IUD has been removed within seven days since her LMP started, no back-up method is needed. The IUD can be removed at this time.
- If it is more than seven days since her LMP started, and
 - Client has been sexually active in this menstrual cycle, delay IUD removal until her next period.
 - Client has not been sexually active in this menstrual cycle, provide condoms as back-up method for her to use for the first seven days after starting the new method.

If the client is switching to voluntary surgical contraception:

- If the client desires BTL, remove the IUD after the procedure has been successfully performed.
- If the client's partner agrees to vasectomy, remove the IUD three months after the partner has undergone the procedure and until no more sperms are found upon examination of his ejaculate.

- Ensure that the client understands the following key points about having her IUD removed, as appropriate:
 - “You can get pregnant again immediately after IUD removal.”
 - “If you do not want to become pregnant, you should **immediately** have another IUD inserted or start another contraceptive method.”
 - “No rest period is needed between IUDs.”
- Review her reproductive goals and need for protection against STIs.
- Help the client choose a different contraceptive method, if appropriate.

Removing the IUD

Using gentle, “no-touch” (aseptic) technique throughout, perform the following steps:

<p>Step 1:</p>	<p>Prepare the client</p> <ul style="list-style-type: none"> • Give the client a brief overview of the procedure, encourage her to ask questions, and provide reassurance as needed. • Remind her to let you know if she feels any pain.
<p>Step 2:</p>	<p>Put new/clean examination or high-level disinfected surgical gloves on both hands.</p>
<p>Step 3:</p>	<p>Insert a high-level disinfected (or sterile) speculum and view the cervix and the IUD strings.</p> <ul style="list-style-type: none"> • If the strings can not be seen, manage as “Missing Strings”.
<p>Step 4:</p>	<p>Cleanse the cervix and vagina with an appropriate antiseptic: Thoroughly apply an appropriate antiseptic (e.g. Betadine) two or more times to the cervix (wiping from inside the os outward) and vagina. Ensure that the client is not allergic to Betadine and wait for two minutes for the solution to act.</p>
<p>Step 5:</p>	<p>Alert the client immediately before removing the IUD:</p> <ul style="list-style-type: none"> • Ask her to take slow, deep breaths and relax. • Inform her that she may feel some discomfort and cramping, which is normal.

Do not use force at any stage of this procedure.

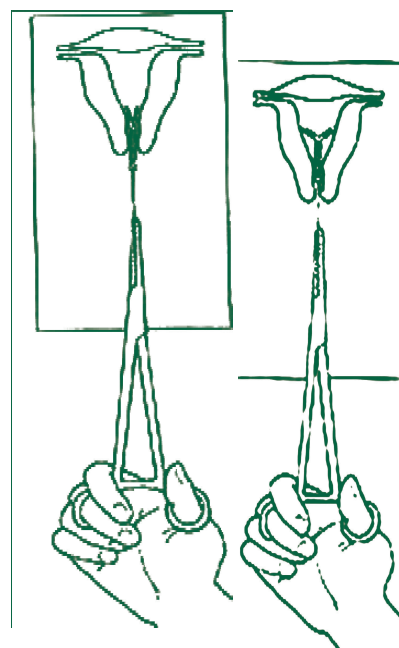
Step 6:

Grasp the IUD strings and apply gentle traction:

- Grasp the strings of the IUD with a high-level disinfected (or sterile) narrow forceps.
- Apply steady but gentle traction, gently pulling the strings toward you with the forceps. The device can usually be removed without difficulty.

- ✓ if the strings break off but the IUD is visible, grasp the device with the forceps and remove it.
- ✓ if removal is difficult, **do not use excessive force!** See textbox below for guidance in managing this problem.

Removing the IUD



Guidelines for difficult IUD removals

If you have partially removed the IUD but have difficulty drawing it through the cervical canal:

- Attempt a gentle, slow twisting of the IUD while gently pulling.
- Continue as long as the woman remains comfortable.

If the IUD can still not be removed:

- Place a high-level disinfected tenaculum on the cervix, and apply gentle traction downward and outward.
- Attempt a gentle, slow twisting of the IUD while gently pulling.
- Continue as long as the client remains comfortable.

- ✓ If the IUD can still not be removed, refer the client to an obstetrician who can dilate the cervix.

Step 7:	Show the woman the IUD, and place it in 0.5% chlorine solution for 10 minutes for decontamination.
Step 8:	Insert a new IUD, if the client so desires and there are no precautions to continued use. If she is not having a new IUD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.

After Removing the IUD

- Ask the client how she is feeling, and whether she is experiencing any of the following symptoms:
 - nausea
 - mild-to-moderate lower abdominal pain/cramping
 - dizziness or fainting (rare)
- ✓ If the client is experiencing any of these symptoms, provide reassurance and allow her to remain on the examination table to rest until she feels better.

Important: Although most women will not experience problems after IUD removal, all women should remain at the clinic for 15-30 minutes before being discharged as a precaution.

- ✓ If the client is starting a new contraceptive method, it should be provided before she is discharged.

FOLLOW-UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS

OVERVIEW

The long-term success of a family planning/IUD program can be achieved only when service providers and other staff recognize the importance of providing strong support services to their clients. High-quality follow-up care for family planning clients contributes to greater user satisfaction, as well as to safe and effective continued use of the method.

Routine follow-up for many IUD users may involve little more than answering questions and reinforcing key messages. Some users, such as those who are bothered by side effects, may require additional care and support. Serious problems related to IUD use are uncommon, but when they do occur, prompt and appropriate management is essential. This session highlights key components of support for the IUD user, focusing on the provision of routine follow-up care and the management of potential problems.

OBJECTIVES

At the end of the session, the participants must be able to:

1. State the key objectives of follow-up care and management of potential problems in providing IUD services.
2. Discuss the guidelines on:
 - ✓ routine follow-up and assessment
 - ✓ routine follow-up care and support
3. Discuss the management of potential problems like:
 - ✓ changes in menstrual bleeding patterns
 - ✓ abdominal cramping or pain infection
 - ✓ IUD string problems
 - ✓ partial or complete expulsion of the IUD
 - ✓ pregnancy with an IUD in place uterine perforation

REFERENCE

Bluestone J, et al. IUD Guidelines for Family Planning Service Programs: A problem-solving reference manual. JHPIEGO. 2006. 3rd edition. pp.6-1 to 6-18.



NARRATIVE

SESSION 5: FOLLOW-UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS



OVERVIEW

The long-term success of a family planning/IUD program can be achieved only when service providers and other staff recognize the importance of providing strong support services to their clients. High-quality follow-up care for family planning clients contributes to greater user satisfaction, as well as to safe and effective continued use of the method.

After IUD insertion, the client is advised to return to the clinic for her first routine checkup after her first post insertion menses (three to six weeks; not later than three months). The client is also encouraged to return if she is experiencing problems, if there has been a change in her overall health, if the client wants the IUD removed, or for any reason at all.

Routine follow-up for many IUD users may involve little more than answering questions and reinforcing key messages. Some users, such as those who are bothered by side effects, may require additional care and support. Serious problems related to IUD use are uncommon, but when they do occur, prompt and appropriate management is essential. This session highlights key components of support for the IUD user, focusing on the provision of routine follow-up care and the management of potential problems.



RATIONALE

The importance of follow-up care for IUD clients are to:

- Assess the client's overall satisfaction with the IUD.
- Identify and manage potential problems.
- Address any questions or concerns the client may have.
- Reinforce key messages.

When providing follow-up care and managing potential problems, service providers and other health care staff should adhere to the basic principles of quality IUD services. Reminders of practices associated with these principles are integrated throughout the chapter.

FOLLOW-UP VISITS

The basic components of routine follow-up care are essentially the same for new and continuing users. Some components, however, may be more important for new acceptors, such as:

- Assessing for menstrual changes (most common side effect of IUD use), which often subside within a few months of IUD insertion;
- Assessing for infection, which is uncommon but most likely to occur in the first 20 days after IUD insertion; and,
- Checking for IUD expulsion, which is very uncommon but most likely to occur within the first few months after IUD insertion.

For a continuing user, on the other hand, it may be more critical to assess for significant changes since her last visit, such as in her overall health, reproductive goals, or individual risk for HIV or other STIs.

Routine follow-up assessment

History

- Assess the client's overall satisfaction with the method, and check for problems:
 - § Ask the client whether she has any questions or concerns.
 - § Ask whether the client is happy with the IUD, and ask whether she is having any problems

Follow-up for clients who are dissatisfied with the IUD

Important: When a client is unhappy with her IUD, finding out why enables you to:

- Determine whether her problems are easily resolvable (resulting in continuation of IUD use), if appropriate.
- Identify problems that require further evaluation and/or treatment; and provide effective counseling about alternative contraceptive methods, if appropriate.

- Find out more about her reasons for being dissatisfied with the IUD.
- Be sensitive to any worry or discomfort the client may be feeling. **Do not dismiss her concerns!**
- Provide reassurance and any information the client needs to support her in continuing (or discontinuing) the method, as she desires.
If the client wants the IUD removed, and/or to use a different method, remove the IUD now or at an appropriate time.

- Assess for common side effects (e.g. an increase in the amount or duration of menstrual bleeding, increase in pain/cramping with period, or spotting/light bleeding between periods)

Remember: When clients are given adequate reassurance, minor side effects are less likely to lead to discontinuation of the method.

- § Find out more about the client's symptoms, and try to determine how well she is tolerating them.
- § Be sensitive to any worry or discomfort the client may be feeling. **Do not dismiss her concerns!**
- § Assure the client that these symptoms are common in IUD users, and usually do not indicate a problem, and will likely lessen or go away within the first few months.
- § If the client is very bothered by her symptoms, refer to Management of Potential Problems.

- Screen for **warning signs (P-A-I-N-S)**:

- § P: Period-related problems or pregnancy symptoms
- § A: Abdominal pain or pain during intercourse
- § I: Infections or unusual vaginal discharge
- § N: Not feeling well, fever, chills
- § S: String problems

- Ask whether the client has **checked for IUD expulsion**.
- Ask whether the client has been using **condoms for protection against STIs**, as needed.

- Screen for any **significant changes since the last visit**.
 - § Changes on the client's overall health: Ask whether she has been ill, started a new medicine, been diagnosed with a condition, etc., since her last visit.
 - § Changes in reproductive goals: Ask whether the client's plans to have children or when she wants them have changed since her last visit.
 - § Changes in individual risk for STIs: Ask whether the client or her partner has had any new sexual partners since her last visit.

Physical Examination

- For the **first routine check-up**, perform pelvic examination to ensure that the IUD is still in place and check for signs of infection.
- For **all other return visits**, perform a pelvic examination as indicated (e.g. if infection is suspected).

Routine follow-up care and support

If the client is **satisfied with the IUD** and is **not experiencing any problems**:

- Review warning signs (P-A-I-N-S) that indicate a need to return to the clinic immediately.
- Encourage the use of condoms to protect against HIV and other STIs as appropriate.
- Remind the client to check for possible IUD expulsion during/after her first few menstrual periods.
- Remind the client to return to the clinic if she wants her IUD removed, if there are changes in her reproductive goals or overall health if she has any problems or concerns, or for any reason at all.
- Remind the client of the date (month/year) when her IUD needs to be removed/replaced.

MANAGEMENT OF POTENTIAL PROBLEMS

Most side effects associated with the use of IUDs are not serious and will resolve spontaneously. Some problems, however, require specific management. The purpose of the guidelines below is to assist the clinician in providing appropriate support for a client experiencing such side effects or problems. In most cases, the client can continue to use the IUD while awaiting or undergoing evaluation.

Some of the problems associated with IUD use that require specific management include:

- Changes in menstrual bleeding patterns
- Cramping or pain
- Infection
- IUD string problems (or possible IUD expulsion)
- Partial or complete expulsion of the IUD (confirmed)
- Pregnancy with an IUD in place
- Uterine perforation

Some general principles that apply throughout are as follows:

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

- If problems are encountered that are not covered in the management guidelines, the provider should conduct further evaluation and provide treatment according to local protocols/national guidelines (refer if needed).
- If the provider does not have the training or resources to perform any of the assessments, procedures, or treatments indicated in the management guidelines, s/he should refer the client to an appropriate facility.
- If the client wants the IUD removed for any reason, and/or to use a different contraceptive method, remove the IUD now or schedule an appointment for IUD removal, as appropriate.

Changes in Menstrual Bleeding Patterns

Changes in menstrual bleeding patterns are a common side effect among users of copper-bearing IUDs. These changes are usually not harmful to the woman and diminish or disappear within the first few months after IUD insertion. If, however, these symptoms are severe, persistent, or accompanied by certain other signs/symptoms, they require special follow-up.

Possible Signs/Symptoms

- § increase in amount of menstrual bleeding
- § increase in duration of menstrual bleeding
- § spotting/light bleeding between periods

Steps in Management

STEP 1:	<p>Find out more about the client's symptoms:</p> <ul style="list-style-type: none"> § How severe are they (how much more than usual)? § How long have symptoms lasted (in relation to IUD insertion)? § When did the symptoms start (in relation to IUD insertion)? § Are they accompanied by other symptoms (e.g. pain, fever)? § How well is the client tolerating them? <div style="background-color: #004d00; color: white; padding: 10px; margin-top: 10px;"> <p>Important: Bleeding that seems unrelated to menstruation (e.g. bleeding that occurs after sexual intercourse) could indicate a serious problem and requires prompt evaluation.</p> </div>
STEP 2:	<p>Manage as appropriate based on findings:</p> <ul style="list-style-type: none"> § If the client's menstrual bleeding lasts twice as long or is twice as heavy than usual, conduct further evaluation. Ibuprofen (200-400 mg every eight hours) during menstruation can help decrease the bleeding. Aspirin should not be used. Refer if needed. § If the client's menstrual bleeding changes have continued beyond three to six months after IUD insertion or began long after IUD insertion: <ul style="list-style-type: none"> § examine for possible complications or other conditions unrelated to the IUD such as infection, tumor, or hormonal dysfunctions. § check for anemia. if present, recommend iron supplementation. § if there is no gynecologic cause for bleeding, give Ibuprofen (200-400mg every eight hours) to reduce bleeding.

	<ul style="list-style-type: none"> § If the client's menstrual bleeding changes are very bothersome to the client and she wishes to have the IUD removed, remove the IUD as soon as possible. § If the client's menstrual bleeding changes are within normal range (e.g. in the first three to six months after IUD insertion), provide reassurance. § If bleeding changes are accompanied by anemia (diagnosed or suspected), provide oral iron supplementation; counsel on local, iron-rich foods. § If bleeding changes are accompanied by severe anemia (diagnosed or suspected), counsel the woman on contraceptive methods that may be more appropriate.
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Cramping or Pain (Menstrual)

Increased cramping or pain associated with menstruation is another common side effect among users of copper-bearing IUDs. Special follow-up is needed, however, if these symptoms are bothersome, severe, or associated with other signs/symptoms that suggest they are not related to menstruation.

Possible Signs/Symptoms

- § Increased cramping or pain associated with menstruation

Steps in Management

STEP 1:	<p>Find out more about the client's symptoms:</p> <ul style="list-style-type: none"> § How severe are they? § How long have symptoms lasted (in relation to IUD insertion)? § When did the symptoms start (in relation to IUD insertion)? § Are they accompanied by other symptoms (e.g. pain, fever)? § How well is the client tolerating them?
STEP 2:	<p>Conduct appropriate assessment (including pelvic examination) to identify or rule out possible causes of the symptoms, such as infection, partial IUD expulsion, uterine perforation, and pregnancy/ectopic pregnancy.</p>
STEP 3:	<p>When other possible causes of the symptoms are ruled out, manage as appropriate based on findings:</p> <ul style="list-style-type: none"> § If cramping or pain is severe, remove the IUD. § If the IUD was improperly placed or looks abnormal, advise the client that inserting a new IUD may solve the problem. If the client does not want a new IUD, help her choose a more appropriate method. § If the IUD was properly placed or looks normal, help the client choose a more appropriate method. § If cramping or pain is not severe, provide reassurance and advice as follows: <ul style="list-style-type: none"> § Reassure the client that this is a common side effect of the IUD, both in the first one or two days after IUD insertion. This also applies during the client's menstrual period for the first few months after IUD insertion.

- § Explain that it is generally not harmful, and usually lessens in the first few months after IUD insertion.
- § Recommend ibuprofen (200-400 mg every four to six hours) or another NSAID immediately before and during menstruation to help reduce symptoms.

Infection

According to the latest research, the risk of infection after IUD insertion, while very low, is highest within the first 20 days after insertion. It is important to note that a pelvic infection does not necessarily develop into PID (this refers to any infection that ascends into the woman's uterus and fallopian tubes), and that it is caused by gonorrhea and chlamydia, not the IUD. However, PID can lead to infertility and other serious problems, and because diagnosis of PID can be difficult, providers should treat all suspected cases. The following guidelines are intended to assist the provider in identifying pelvic infection, including suspected cases of PID, and treating it accordingly.

Possible Signs/Symptoms

- § lower abdominal pain
- § painful intercourse
- § bleeding after sex or between periods
- § pain associated with periods (especially if this symptom was absent during the first few months after IUD insertion but has developed after)
- § abnormal vaginal discharge
- § painful urination (dysuria)
- § fever
- § nausea and vomiting

Steps in Management

STEP 1:	Conduct appropriate assessment (including abdominal and pelvic examination) to identify or rule out other possible causes of the symptoms, such as ectopic pregnancy and appendicitis.
STEP 2:	<p>Suspect PID if any of the following signs/symptoms are found and no other causes can be identified:</p> <ul style="list-style-type: none"> § lower abdominal, uterine or adnexal tenderness (tenderness in the ovaries or fallopian tubes) § evidence or signs of cervical infection (yellowish cervical discharge containing mucus and pus, bleeding easily when the cervix is touched with a swab) § tenderness or pain when moving the cervix and uterus during pelvic exam (cervical motion tenderness) <p>Other possible signs/symptoms:</p> <ul style="list-style-type: none"> • purulent cervical discharge • enlargement or hardening (induration) of one or both fallopian tubes • a pelvic mass pain when the abdomen is gently pressed and on sudden release

STEP 3:	<p>Advise the client that she should begin treatment immediately to avoid serious potential consequences of the infection, and that the IUD does not need to be removed during treatment (unless symptoms do not improve within 72 hours). If the client does not want to keep the IUD in during treatment, arrange to have the IUD removed two to three days after antibiotic treatment has begun.</p> <div style="background-color: #e0e0e0; padding: 10px; border: 1px solid #ccc;"> <p>Important: Treatment should be started as soon as the presumptive diagnosis has been made, because prevention of long-term complications is more successful if appropriate antibiotics are given immediately. There is no need to remove the IUD for treatment of PID and STIs unless there is no improvement after 72 hours of treatment. Considering this, the midwife should immediately refer the client that presents with signs/symptoms of infection.</p> </div>
STEP 4:	Refer the client for treatment of gonorrhea, chlamydia, and anaerobic infections.
STEP 5:	<p>Counsel the client as follows:</p> <ul style="list-style-type: none"> § Urge condom use for protection against future STIs. § Encourage her to have her partner(s) come in to receive treatment soon.
STEP 6:	<p>Ensure that the client comes for follow-up visit two to three days after initiating antibiotic treatment.</p> <ul style="list-style-type: none"> § if the client's symptoms of acute infection, such as pain, fever, and chills, have not improved, instruct her to follow-up with her physician. § if the client's symptoms have improved, encourage her to follow-up with her physician immediately after she has finished taking all her medication.

IUD string problems (or possible IUD expulsion)

Missing, shorter, or longer strings may indicate a variety of problems, including IUD expulsion or malposition and uterine perforation, or may not indicate a problem at all. Sometimes, for example, the IUD strings may ascend into the uterus for no known reason. Strings that are too short may bother the woman's partner during sexual intercourse. Guidelines on managing these potential problems are as follows:

Possible signs/symptoms

- § partner can feel strings
- § longer strings
- § shorter strings
- § missing strings

Steps in Management

For strings that can be felt by the woman's partner:

- § Reassure the client (and her partner) that this probably means the strings were cut too short, and that this is not harmful.
- § If it is very bothersome to the client's partner, educate/counsel her as follows:
 - § The IUD strings can be cut shorter (or curved around the cervical lip), but she may no longer be able to check them.

§ Alternately, a new IUD can be inserted and the strings cut long enough (at least 3 cm from the cervix) that her partner will not feel them, but that she will still be able to check them.

For missing (or shorter or longer) strings:

STEP 1:	Rule out pregnancy.
STEP 2:	<p>Once pregnancy has been ruled out, probe the cervical canal using a high-level disinfected (or sterile) cervical brush or narrow forceps (e.g. bose, alligator) to locate the strings, and gently draw them out so that they are protruding into the vaginal canal. Manage as appropriate based on findings:</p> <ul style="list-style-type: none"> § If the strings are located and drawn out, and the client wants to keep the IUD, leave it in place (provided it seems properly placed). § If the strings are located and drawn out, and the client does not want to keep the IUD, remove the IUD. § If the strings are not located in the cervical canal (or cannot be drawn out), and the client wants to keep the IUD, proceed to STEP 3 (do not perform any intrauterine maneuvers, as these may dislodge the IUD.) § If the strings are not located in the cervical canal (or cannot be drawn out), and the client does not want to keep the IUD, refer her for IUD removal by a specially trained provider (a specially trained provider can use a sound to check whether the IUD is in place, being very careful not to injure the uterus. If the IUD is still in place, the strings can be drawn out using a narrow forceps.)
STEP 3:	If indicated (based on STEP 2), refer the client for an X-ray (or ultrasound, if X-ray is unavailable) to help determine whether the IUD is still in place, is malpositioned, or has been expelled.

Important: If the client is not able to immediately have an X-ray or ultrasound, provide a back-up method.

- § If the IUD is **located** inside the uterus and the client wants to keep the IUD, leave the IUD in place. Explain to her that the IUD is still protecting her from pregnancy, but she will no longer be able to feel the strings.
- § If the IUD is **located** inside the uterus and the client does not want to keep the IUD, refer her for IUD removal by a specially trained provider who can use a narrow forcep to remove the IUD without injuring the uterus.
- § If the IUD is **located** but is outside of the uterus, manage as Uterine Perforation (below).
- § If the IUD is **not located** (i.e., completely expelled) or is **partially expelled**, manage as Partial or Complete IUD Expulsion (below).

Partial or Complete IUD Expulsion (Confirmed)

Partial or complete IUD expulsion can occur unnoticed or may be associated with other signs/symptoms, such as irregular bleeding, pain with intercourse (for either partner or the client), unusual vaginal discharge, and/or bleeding after sex. Missing or longer IUD strings and delayed or missed menstrual period are other possible indications. The following guidelines address management of confirmed partial or complete IUD expulsions.

Possible Signs/Symptoms

- § Expelled IUD seen (complete expulsion)
- § IUD felt/seen in the vaginal canal (partial expulsion)
- § Delayed or missed menstrual period (see Pregnancy with an IUD in Place)
- § Missing or longer strings

Steps in Management

STEP 1:	Conduct appropriate assessment (including pelvic examination) to rule out other possible causes of the symptoms, such as infection and pregnancy.
STEP 2:	When other possible causes of the symptoms are ruled out, manage as appropriate based on findings: <ul style="list-style-type: none">§ If complete expulsion of the IUD is confirmed (e.g. seen by the client, confirmed by X-ray or ultrasound):<ul style="list-style-type: none">§ replace IUD now if desired and appropriate (no signs of infection, pregnancy ruled out).§ provide alternative method, if possible, as well as a back-up method if needed.§ If partial IUD expulsion is confirmed (e.g. felt/seen by the client or clinician partially expelled through the lateral fornices, or in the space between the outer surface of the cervix and the vaginal walls):<ul style="list-style-type: none">§ remove the IUD§ replace IUD now if desired and appropriate (no signs of infection, pregnancy ruled out); or§ provide alternative method if possible, as well as a back-up method, if needed.§ If the IUD seems to be embedded in the cervical canal, refer the client for IUD removal by a specially trained provider.

Pregnancy with an IUD in place

While the IUD is one of the most effective forms of reversible contraception, failures can occur. Approximately one-third of IUD-related pregnancies are due to undetected partial or complete expulsion of the IUD. When pregnancy does occur with an IUD in place, ectopic pregnancy must be ruled out and the IUD should be removed. If the IUD is left in place during pregnancy, there is an increased risk of preterm labor, spontaneous abortion, and septic abortion.

Possible Signs/Symptoms

- § Delayed or missed menstrual period
- § Other signs/symptoms of pregnancy

Steps in Management

STEP 1:	<p>Confirm pregnancy, if needed, and determine trimester.</p>
STEP 2:	<p>Rule out ectopic pregnancy.</p> <ul style="list-style-type: none"> § Severe or sudden sharp/stabbing pain, often unilateral, along with a combination of the following signs/symptoms is strongly suspicious for ectopic pregnancy. <ul style="list-style-type: none"> § unusual abdominal pain or tenderness § abnormal vaginal bleeding, no menstruation, change from usual menstrual patterns § light-headedness/dizziness § fainting <div style="background-color: #e0e0e0; padding: 10px; margin: 10px 0;"> <p>Do not perform a pelvic examination to confirm ectopic pregnancy unless surgical capabilities are readily available.</p> </div> <p>If ectopic pregnancy is suspected, immediately refer/transport the client to a facility that has surgical capabilities.</p>
STEP 3:	<p>When ectopic pregnancy has been ruled out and if in early pregnancy, advise the client that the IUD should be removed immediately.</p> <ul style="list-style-type: none"> § Counsel the client on the benefits and risks involved: <ul style="list-style-type: none"> § Removing the IUD slightly increases the risk of miscarriage. § Leaving the IUD in place can cause second-trimester miscarriage, infection, and preterm delivery. § Make clear that removing the IUD is the healthiest option for the client and her baby. <ul style="list-style-type: none"> → If the client agrees to have the IUD removed, proceed to STEP 4. → If the client does not want to have the IUD removed, proceed to STEP 5.
STEP 4:	<p>Document the client's decision and obtain formal consent and check for the IUD strings.</p> <ul style="list-style-type: none"> § If the strings are visible, remove the IUD gently by pulling the strings. § If the strings are not visible: <ul style="list-style-type: none"> § Have an ultrasound done to determine the location of the device. If the device had not been expelled and is not accessible, do not attempt to remove it. Proceed to STEP 5.
STEP 5:	<p>Provide support and care as follows:</p> <ul style="list-style-type: none"> • Consider it a high risk pregnancy and refer to a physician for close monitoring for signs of possible complication. • Stress the importance of seeking immediate consultation if she experiences signs of spontaneous abortion or infection (e.g. fever, lower abdominal pain, and/or bleeding) or any of the warning signs. • Remove the IUD at delivery.

Uterine Perforation

Uterine perforations occur very rarely, with most resulting from poor insertion techniques. The clinical signs and symptoms of pain, vaginal bleeding, and rapid pulse associated with uterine perforation are also very rare. Instead, the first indication may be sudden loss of resistance to the sound or IUD insertion assembly, or uterine depth greater than expected (based on uterine sounding). Uterine perforation may also be discovered days, weeks, or months after the IUD insertion procedure. Such perforations are discovered and/or confirmed by X-ray or ultrasound.

Appropriate management of uterine perforation depends on when the perforation occurs and/or is discovered, whether it is partial (IUD embedded in the wall of the uterus) or complete (IUD outside the uterine cavity), and if there are associated signs/symptoms.

Possible Signs/Symptoms

- Sudden loss of resistance to the uterine sound or IUD insertion device (during IUD insertion)
- Uterine depth greater than expected from uterine sound (during IUD insertion)
- Unexplained pain
- Confirmed partial or complete perforation (as shown by X-ray or ultrasound)

Steps in Management

Suspected uterine perforation during the IUD insertion procedure:

STEP 1:	<p>Stop the procedure immediately, and gently remove the instrument/object that may have perforated the uterus (e.g. sound, IUD insertion assembly, IUD).</p> <ul style="list-style-type: none">• If resistance is encountered, stop pulling and refer the woman immediately evaluation by laparoscopy and/or removal by a qualified surgeon.• If complete perforation is suspected, stabilize the client and do an X-ray or ultrasound to see where the IUD is; refer, if needed.• If the IUD is outside the uterus, refer the client immediately for laparoscopy for IUD removal by a qualified surgeon. <p>Important: Only a qualified surgeon should attempt to remove an IUD by laparoscopy.</p>
STEP 2:	<p>Have the client rest and monitor her vital signs (blood pressure, pulse, respiration, and temperature) and level of discomfort every 10 minutes until stable.</p> <ul style="list-style-type: none">• If vital signs are not stable (e.g. elevated pulse with falling blood pressure), or there is bleeding, or new/increased pain, refer/transport client for emergency care.• If vital signs remain stable after one hour, check for signs of intra-abdominal bleeding (e.g. hemoglobin/hematocrit determination, abdominal tenderness). Refer/transport client if with signs of intra-abdominal bleeding.
STEP 3:	<p>When the client's vital signs have been stable for several hours, she can go home. Advise her to avoid having sex for two weeks, provide alternative contraception and advice follow-up after one week.</p>

Uterine perforation discovered within a few days or weeks of IUD insertion:

STEP 1:	Confirm the perforation/degree of perforation by X-ray or ultrasound.
STEP 2:	<p>Manage as appropriate based on findings:</p> <ul style="list-style-type: none"> • If the IUD is embedded in the wall of the uterus (partial perforation), refer the client for IUD removal by a specially trained provider. • If the IUD is outside of the uterine cavity (complete perforation), refer the client immediately for IUD removal by a surgeon qualified to perform laparoscopy or laparotomy.

Uterine perforation discovered six weeks or more after IUD insertion:

STEP 1:	Confirm the perforation/degree of perforation by X-ray or ultrasound.
STEP 2:	<p>Manage appropriately based on findings:</p> <ul style="list-style-type: none"> • If the IUD is embedded in the wall of the uterus (partial perforation), refer the client for IUD removal by a specially trained provider. • If the IUD is outside of the uterine cavity (complete perforation): <ul style="list-style-type: none"> ✓ Do not remove the IUD. ✓ Advise the woman that it is safer to leave the IUD where it is than to remove it. <div style="background-color: #e0e0e0; padding: 10px; margin: 10px 0;"> <p>Important: After six weeks or more, copper-bearing IUDs that have completely perforated the uterus may become partially or completely covered with scar tissue and this rarely causes problems. Removal of the IUD, however, may lead to pelvic abscess (a mass-like collection of pus in the pelvic area) and other complications.</p> </div> <ul style="list-style-type: none"> ✓ Counsel the client about reinserting a new IUD or starting a different contraceptive method. ✓ Insert new IUD now (if desired and appropriate) or provide another method. • If the IUD is outside of the uterine cavity (complete perforation) and the woman has symptoms such as abdominal pain with associated diarrhea, or excessive bleeding, refer the client immediately for IUD removal by a surgeon qualified to perform laparoscopy or laparotomy.



Annexes



FPCBT in IUD

Steps in processing instruments, gloves, and other items used in IUD services

INSTRUMENTS/ITEMS	DECONTAMINATION (This is the first step in handling soiled instruments; reduces risk of HBV and HIV transmission)	CLEANING (Removes all visible blood, body fluids, and dirt)	HLD (Recommended method of final-processing which destroys all viruses, bacteria, parasites, fungi, and some endospores)	STERILIZATION (Alternative method of final processing; sterilization destroys all microorganisms, including endospores)
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material (e.g. blood) remains after decontamination.	Not necessary.	Not necessary.
Surgical gloves	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.	Wash with soap and water. Rinse with clean water and check for holes. If to be sterilized, dry inside and out (air or towel dry) and pack.	Steam for 20 minutes and allow to air dry in steamer for four to six hours.	<ul style="list-style-type: none"> Autoclave at 121 C(250 F), and 106 kPa (15 lbs./in-) for 20 minutes)
Instruments used in pelvic exam and IUD insertion or removal (e.g. speculum, tenaculum, forceps, uterine sound)	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.	Using a brush, wash with soap and water. Rinse with clean water. If these will be sterilized, air or towel dry and pack.	<ul style="list-style-type: none"> Steam or boil for 20 minutes. Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage. 	<ul style="list-style-type: none"> Do not use for 24 to 48 hours. Dry heat for one hour after reaching 170C (340F), or Autoclave at 121C (250F), and 106 kPa (15 lbs./in-) for 20 minutes (30 minutes if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.	Wash with soap and water. Rinse with clean water, air or towel dry.	<ul style="list-style-type: none"> Boil container and lid for 20 minutes. If container is too large: Fill container with 0.5% chlorine solution and soak for 20 minutes. Rinse with water that has been boiled for 20 minutes and air dry before use. 	<ul style="list-style-type: none"> Dry heat for one hour after reaching 170C (340F), or Autoclave at 121C (250F) and 106 kPa (15 lbs./in-) for 20 minutes (30 minutes if wrapped).

Identification Mark: _____

TRAINING IN IUD INSERTION and REMOVAL Pre-Test

Name: _____ Date: _____

Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.

OVERVIEW

- _____ 1. The CopperT380A is effective for at least 12 years.
- _____ 2. An important element of quality for IUD use is counseling on the immorality of having multiple sexual partners.
- _____ 3. The risk of pelvic inflammatory disease in IUD users is related to sexually transmitted infections, not the IUD itself.
- _____ 4. The IUD can be inserted immediately after delivery of the placenta.

CLIENT ASSESSMENT

- _____ 5. The physical examination of a potential IUD client must include breast, abdominal, and pelvic (speculum and bimanual) examinations.
- _____ 6. If a client has current purulent cervicitis, the IUD should not be inserted at this time.
- _____ 7. If a woman is found to have a retroverted (posterior) uterus, she cannot have an IUD inserted.

IUD INSERTION AND REMOVAL

- _____ 8. IUDs can be inserted at any time during the menstrual cycle provided that the client is not pregnant.
- _____ 9. Tarnished (discolored) IUDs still inside the undamaged, sealed package should be discarded because they are no longer sterile.
- _____ 10. A woman should not have her IUD removed unless she is willing to start another method immediately.
- _____ 11. Loading the IUD in its package, ensures its sterility prior to insertion.
- _____ 12. Prophylactic antibiotics should be given for routine IUD insertion.

FOLLOW-UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS

- _____ 13. Following insertion of the IUD, the woman should be advised to return to the clinic after her next period (three to six weeks).
- _____ 14. If a client says her IUD strings are missing, a provider should perform a pelvic exam to determine if the strings are high in the cervix or hidden by a fold in the vagina.
- _____ 15. A sharp pain during IUD insertion usually indicates perforation of the uterus and the provider should remove the IUD and begin the re-insertion process immediately.
- _____ 16. Heavy bleeding for more than three months should cause the provider to check for infection, tumors or signs of anemia.
- _____ 17. If pregnancy is discovered in an IUD user within the first 12 weeks, a trained health care provider should remove the IUD if the strings are visible.

INFECTION PREVENTION

- _____ 18. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments and gloves first should be soaked for 10 minutes in 0.5% chlorine solution.
- _____ 19. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.

Identification Mark: _____

TRAINING IN IUD INSERTION and REMOVAL Post-Test

Name: _____ Date: _____

Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.

OVERVIEW

- _____ 1. The CopperT380A is effective for at least 12 years.
- _____ 2. An important element of quality for IUD use is counseling on the immorality of having multiple sexual partners.
- _____ 3. The risk of pelvic inflammatory disease in IUD users is related to sexually transmitted infections, not the IUD itself.
- _____ 4. The IUD can be inserted immediately after delivery of the placenta.

CLIENT ASSESSMENT

- _____ 5. The physical examination of a potential IUD client must include breast, abdominal, and pelvic (speculum and bimanual) examinations.
- _____ 6. If a client has current purulent cervicitis, the IUD should not be inserted at this time.
- _____ 7. If a woman is found to have a retroverted (posterior) uterus, she cannot have an IUD inserted.

IUD INSERTION AND REMOVAL

- _____ 8. IUDs can be inserted at any time during the menstrual cycle provided that the client is not pregnant.
- _____ 9. Tarnished (discolored) IUDs still inside the undamaged, sealed package should be discarded because they are no longer sterile.
- _____ 10. A woman should not have her IUD removed unless she is willing to start another method immediately.
- _____ 11. Loading the IUD in its package, ensures its sterility prior to insertion.
- _____ 12. Prophylactic antibiotics should be given for routine IUD insertion.

FOLLOW-UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS

- _____ 13. Following insertion of the IUD, the woman should be advised to return to the clinic after her next period (three to six weeks).
- _____ 14. If a client says her IUD strings are missing, a provider should perform a pelvic exam to determine if the strings are high in the cervix or hidden by a fold in the vagina.
- _____ 15. A sharp pain during IUD insertion usually indicates perforation of the uterus and the provider should remove the IUD and begin the re-insertion process immediately.
- _____ 16. Heavy bleeding for more than three months should cause the provider to check for infection, tumors or signs of anemia.
- _____ 17. If pregnancy is discovered in an IUD user within the first 12 weeks, a trained health care provider should remove the IUD if the strings are visible.

INFECTION PREVENTION

- _____ 18. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments and gloves first should be soaked for 10 minutes in 0.5% chlorine solution.
- _____ 19. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.

PELVIC EXAMINATION CHECKLIST

Service Provider's Observations	NO	YES	Service Provider's Instructions
			<p>If answer is NO - proceed with the client assessment for IUD insertion.</p> <p>If answer is YES - do not insert an IUD and proceed with the instructions below.</p>
1. Are there ulcers or sores on the external genitalia, or enlarged glands (buboes) in the groin area?			<p>Finding: Any of these findings suggest a possible GTI such as syphilis, chancroid, lymphogranuloma, or herpes.</p> <p>Action: Help client make informed choice of another method. Refer if necessary for further evaluation.</p>
2. Is there marked tenderness of cervix, uterus, or adnexal area?			<p>Finding: This suggests PID or cervicitis.</p> <p>Action: Help client make an informed choice of another effective method. Encourage client to use condoms and/or spermicide to protect against GTIs and other STIs, including AIDS.</p>
3. Is the cervix immobile, or is there a palpable mass or ulcer?			<p>Finding: These abnormalities may indicate a tumor or, rarely, cervical cancer.</p> <p>Action: Help client make an informed choice of another method, and refer for further evaluation.</p>
4. Are you unable to determine the position of the uterus?			<p>Action: If you are not sure of the position of the uterus after bimanual palpation, seek consultation or refer for further evaluation.</p>
5. Is the uterus enlarged, soft, and smooth?			<p>Finding: If the woman has also missed a period, she is likely to be pregnant.</p> <p>If you are certain she is not pregnant, an IUD may be inserted.</p>
6. Is the uterus enlarged, firm, and/or irregular?			<p>Finding: Do not insert an IUD. This may indicate uterine fibroids which can change the shape of the uterine cavity.</p> <p>Action: Attempt to insert the IUD only if you are experienced; otherwise, refer or help her to choose another method. If you refer, help her choose another method to use until she gets her IUD.</p>

Service Provider's Observations	NO	YES	Service Provider's Instructions
7. Is there a palpable mass in the adnexal area?			<p>Finding: This may indicate PID or a tumor of the ovary or tube.</p> <p>Action: Help client make an informed choice of another non-hormonal method until problem is solved. Make appropriate referral.</p>
8. On sounding, is the uterine cavity irregular or deeper than 10 cm?			<p>Finding: This may mean that she has fibroids, is pregnant, or the uterus was perforated by the sound.</p> <p>Action: If perforation is suspected, observe the client for evidence of intraabdominal bleeding: decreased BP, rising pulse and/or syncope.</p>
9. Is the vaginal wall inflamed, and is there a discharge from the vagina?			<p>Finding: This suggests vaginitis.</p> <p>Action: Diagnose cause and treat vaginitis before considering insertion of an IUD. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STDs, including AIDS.</p>
10. Is the cervix red and inflamed, and is there discharge from the cervical canal?			<p>Finding: This suggests cervicitis.</p> <p>Action: Diagnose and treat cervicitis. Help client make an informed choice of another method. Encourage her to use condoms and/or spermicide to protect against STIs, including AIDS.</p>
11. Is there a mass, ulcer, or bleeding on contact with the cervix?			<p>Finding: This suggests possible cervical polyp, severe cervicitis or, rarely, cervical cancer.</p> <p>Action: Help client make informed choice of another method. Refer if necessary for further evaluation.</p>

CHECKLIST FOR INTERVAL IUD COUNSELING AND CLINICAL SKILLS

Participant _____ Course Dates _____

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
METHOD-SPECIFIC COUNSELING					
1. Once the client has chosen to use the IUD, ensures that she knows and accepts that menstrual changes are a common side effect among IUD users.					
2. Assists the client through a “self-assessment” process, as appropriate, to determine her risks for STIs by: <ul style="list-style-type: none"> • telling the client that she does not need to share any information about her or her partner’s sexual behavior 					
<ul style="list-style-type: none"> • telling the client to consider the following risky situations which may have occurred three months prior to this assessment: • sexual partner has recently had STI symptoms such as pus coming from his penis, pain or burning sensation during urination, or an open sore in the genital area. • she or her sexual partner was diagnosed with a STI. • she has had more than one sexual partners recently. • she has a sexual partner who has had other sexual partners recently. • she thinks that her partner who works away from home for long periods of time has other sexual partners. • asks the client whether, after considering the above risky situations, she thinks the IUD is an appropriate method for her. 					
3. If client thinks that the IUD is not an appropriate method for her, helps her choose another method.					
4. If client thinks that the IUD is an appropriate method for her, describes the pelvic examination required before IUD insertion, as well as the procedures for IUD insertion and removal.					
5. Encourages the client to ask questions. Provides additional information and reassurance as needed.					
CLIENT ASSESSMENT					
History					
1. Reviews the client’s medical and reproductive history (FP Form 1).					
2. Ensures that equipment and supplies are available and ready to use.					
3. Instructs client to empty her bladder and wash her perineal area.					

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
4. Helps the client onto the examination table.					
5. Tells the client what is going to be done, and asks her if she has any questions.					
Pelvic Examination					
1. Washes hands thoroughly and dries them.					
2. Palpates the abdomen.					
3. Puts on clean or HLD gloves on both hands.					
4. Examine the external genitalia first, taking note of the following: <ul style="list-style-type: none"> • Distribution of the pubic hair, vaginal discharges, signs of bleeding, presence of abrasions, irritations or scars. • Signs of any STIs like pus, discharges, warty growths, lumps/mass, sores, irritations of the vulvar area. Inspects the external genitalia. 					
Note: <ul style="list-style-type: none"> • If findings are normal, perform the bimanual examination first and then the speculum examination. • If there are potential problems, perform the speculum examination first and then the bimanual examination. 					
5. If findings are normal, performs a bimanual examination. <ul style="list-style-type: none"> • Uses the thumb and little finger to separate the labia majora. 					
<ul style="list-style-type: none"> • Inspects the vaginal opening. Takes note of any bulging of the vaginal walls. A bulging of the anterior vaginal wall suggests a cystocele while a bulging of the posterior vaginal wall suggests a rectocele. 					
<ul style="list-style-type: none"> • Presses the perineum the index finger to relax it. 					
<ul style="list-style-type: none"> • With index finger in the vagina, palpates for the Bartholin's glands by grasping the lower end of each side of the labia majora between the thumb and the index finger. Notes any secretions or mass. 					
<ul style="list-style-type: none"> • Turning the hand with palm upward, squeezes the Skene's glands and urethra outward for any secretions. Collects specimen, if there is any secretion. 					
<ul style="list-style-type: none"> • With index and middle fingers in the vagina, checks the vaginal canal for any abnormalities (e.g. mass) within the vaginal walls. 					
<ul style="list-style-type: none"> • With palm up, inserts the index and middle fingers further into the vagina. Follows the anterior vaginal mucosa deep into the anterior fornix and locate the cervix. 					
<ul style="list-style-type: none"> • Feels the cervix with the examining fingers and takes note of its position, size, mobility, consistency, and any tenderness. 					

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
<ul style="list-style-type: none"> • Presses the free hand gently on the lower abdomen above the symphysis pubis and exerts a steady downward pressure to determine the position of the uterus. 					
<ul style="list-style-type: none"> • Gently moves the cervix from side to side (wiggle the cervix) and takes note of any pain. 					
<ul style="list-style-type: none"> • With the vaginal fingers on the lateral fornix, gently palpates for the tube and ovary on one side and then on the other side. Notes any tenderness, enlargement or masses. 					
<p>6. Performs speculum examination.</p> <ul style="list-style-type: none"> • Lubricates the speculum with water, K-Y jelly, or betadine antiseptic before insertion. 					
<ul style="list-style-type: none"> • Hold the speculum with the blades closed between your thumb and index and middle fingers. 					
<ul style="list-style-type: none"> • With the free hand, spreads the labia and part of the pubic hair which may obstruct the vaginal opening, then asks the client to push or bear down to relax the perineal muscles. 					
<ul style="list-style-type: none"> • Inserts the closed speculum obliquely between the labia and into the vaginal canal. Rotate the blades of the speculum into the horizontal position. 					
<ul style="list-style-type: none"> • With the speculum in position, opens it until the cervix is in full view between the blades. Screws the speculum tightly. 					
<ul style="list-style-type: none"> • Checks the color, presence of mass, warty changes, discharges in the vaginal canal and the cervix. 					
IUD INSERTION					
1. Swabs the cervix and vaginal wall with antiseptic twice.					
2. Gently grasps the cervix with an HLD (or sterile) tenaculum and applies gentle traction.					
3. Inserts the HLD (or sterile) uterine sound gently using the ino touchê technique to measure the uterus.					
4. Takes note of the measurement of the uterus by the level of mucus or blood on the uterine sound.					
5. Puts the used uterine sound in decontaminating solution.					
6. Immerses gloved hands in decontaminating solution. Removes gloves and disposes these properly.					
<p>7. Loads the IUD in its sterile package:</p> <ul style="list-style-type: none"> • Adjusts the contents of the package through the clear plastic cover so that the vertical stem of the "T" is fully inside the insertion tube. 					
<ul style="list-style-type: none"> • Partially opens the package around halfway from the blue depth-gauge. 					

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
<ul style="list-style-type: none"> Carefully places the white plunger rod into the inserter tube so that it does not touch anything that may contaminate it. 					
<ul style="list-style-type: none"> Gently pushes the white plunger rod until the tip of the rod almost touches the bottom of the T. 					
<ul style="list-style-type: none"> Places the package on a flat surface and places the thumb and index finger over the tips of the horizontal arms of the "T" to stabilize the IUD. 					
<ul style="list-style-type: none"> At the open end of the package, grasps the insertion tube and gently pushes it against the T to bend its horizontal arms. 					
<ul style="list-style-type: none"> Completely bends the arms of the T by bringing the thumb and index fingers together, and continuing to push against the T with the insertion tube. 					
<ul style="list-style-type: none"> Pulls the insertion tube up to below the tips of the bended arms of the "T" and pushes it back to tuck the arms of the T into the inserter tube. 					
<ul style="list-style-type: none"> Ensures that the arms of the T are not folded for more than five minutes before insertion. 					
<p>8. Sets the blue depth-gauge to the measurement of the uterus.</p> <ul style="list-style-type: none"> Places the upper border of the blue depth-gauge at the corresponding measurement of the uterine depth on the measurement insert. 					
<ul style="list-style-type: none"> Pushes or pulls the inserter tube so that the tip of the folded IUD is at the "0" level. 					
<ul style="list-style-type: none"> Ensures that the IUD and the blue depth-gauge are in the same horizontal position. 					
<p>9. Carefully takes out the IUD from the package so that it does not touch any surface that may contaminate it.</p>					
<p>10. Carefully inserts the loaded IUD while applying outward traction on the tenaculum.</p>					
<p>11. Once resistance is felt or the blue depth gauge touches the cervical os, steadies the white plunger rod.</p>					
<p>12. Releases the IUD into the uterus by withdrawing the insertion tube up to the ring of the steadied white plunger rod.</p>					
<p>13. Removes the white plunger rod.</p>					
<p>14. Gently pushes the insertion tube upward again until slight resistance is felt.</p>					
<p>15. Removes the insertion tube.</p>					
<p>16. Cuts the strings 3-4 cm in length from the cervical os using scissors.</p>					
<p>17. Gently removes the tenaculum and places in 0.5% chlorine solution for 10 minutes for decontamination.</p>					
<p>18. Examines the cervix for bleeding.</p>					

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
19. Removes the speculum by partially withdrawing the still open speculum gently to release the cervix, then closes it and withdraws the blades in the same oblique position.					
20. Asks how the client is feeling and performs the post-insertion steps.					
Post-insertion Steps					
1. Places all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Cleans the rubber sheet that covers the examination table with chlorine solution.					
3. Properly disposes of waste materials.					
4. Immerses gloved hands in decontaminating solution. Removes gloves and disposes properly.					
5. Washes hands thoroughly and dries them.					
6. Provides post-insertion instructions and key messages. <ul style="list-style-type: none">• Basic facts about her IUD (e.g. type, how long effective, when to replace/remove)					
• Warning signs (P-A-I-N-S)					
• Checking for possible IUD expulsion.					
• When to return to the clinic.					
IUD REMOVAL					
Preremoval steps					
1. Asks the client her reason for having the IUD removed.					
2. Determines whether she will have another IUD inserted immediately, start a different method, or neither.					
3. Reviews the client's reproductive goals and needs for STI protection, and counsels as appropriate.					
4. Ensures that equipment and supplies are available and ready to use.					
5. Instructs the client to empty her bladder and wash her perineal area.					
6. Helps the client onto the examination table.					
7. Washes hands thoroughly and dries them.					
8. Puts new or HLD gloves on both hands.					

For each of the practice sessions, rate the performance of each step or task observing the following rating scale:

2= If the task was performed well
1= If the task is performed but needs improvement

0= Not performing the task
NA= If the task is not applicable during the practice

STEPS/TASKS	PRACTICE SESSIONS				
Removing the IUD					
1. Provides an overview of the procedure of removing the IUD. Reminds the client to verbalize if she feels any pain.					
2. Gently inserts the HLD (or sterile) speculum to visualize the strings, and swabs the cervical os and vaginal walls with cottonballs or gauze soaked in Betadine.					
3. Alerts the client immediately before removing the IUD.					
4. Grasps the IUD strings close to the cervix with an HLD (or sterile) forceps.					
5. Applies steady but gentle traction to pull the strings and remove the IUD. Does not use excessive force.					
6. Shows the IUD to the client.					
7. Places the IUD in 0.5% chlorine solution for 10 minutes for decontamination.					
8. Inserts a new IUD if client requests or if appropriate.					
9. Gently removes other instruments (if insertion of new IUD done) and the speculum and places in 0.5% chlorine solution for decontamination.					
10. Asks how the client is feeling and performs post-removal steps.					
Post-removal Steps					
1. Before removing gloves, places all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Properly disposes of waste materials.					
3. Immerses gloved hands in decontaminating solution, removes these and disposes properly.					
4. Washes hands thoroughly and dries them.					
5. If the client has had a new IUD inserted, reviews key messages for IUD users. If the client decides to use another method or not to use any method, counsels her appropriately.					

Remarks/Recommendations:

Certified

Not certified

 Signature of trainee over printed name

 Signature of trainer over printed name

WHO Medical Eligibility Criteria for Starting Contraceptive Methods

The table on the following pages summarizes World Health Organization (WHO) medical eligibility criteria for starting contraceptive methods. These criteria are the basis for Medical Eligibility.

WHO Categories for Temporary Methods

WHO 1 Can use the method. **No restriction on use.**

WHO 2 Can use the method. **Advantages generally outweigh theoretical or proven risks.**

Category 2 conditions could be considered in choosing a method. If the client chooses the method, more than usual follow-up may be needed.

WHO 3 Should not use the method unless a doctor or nurse makes a clinical judgement that the client can safely use it. **Theoretical or proven risks usually** outweigh the advantages of the method. Method of last choice, for which careful follow-up will be needed.

WHO 4 Should not use the method. Condition represents an **unacceptable health risk** if method is used.

Simplified 2-Category system

Where a doctor or nurse is not available to make clinical judgements, the WHO 4-category classification system can be simplified into a 2-category system as shown in this table:

WHO		With limited clinical
CATEGORY	With Clinical Judgement	judgement
1	Use the method in any circumstances	Use the method
2	Generally use the method	
	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	
	Method not to be used	

NOTE: In the table, Category 3 and 4 conditions are shaded to indicate the method should not be provided where clinical judgement is limited.

WHO Categories for Female Sterilization and Vasectomy

Accept No medical reason prevents the performing of the procedure in a routine setting.

Caution The procedure can be performed in a routine setting but with extra preparation and precautions.

Delay the procedure. Condition must be treated and resolved before the procedure can be performed. Provide temporary methods.

Refer client to a center where an experienced surgeon and staff can perform the procedure. Setting should be equipped for general anesthesia and other medical support.

Provide temporary methods (WHO calls this category "Special")

Note: In the table that follows, "Delay" and "Refer" conditions are shaded.

WHO Medical Eligibility Criteria for Starting Contraceptive Methods

CONDITION	Combined OCs	Progestin-Only OCs	MPANET EN	Norplant Implants	Female Sterilization*	Vasectomy*	Condoms	TU-380A IUD*	Spermicides	Diaphragm	Cervical Cap	Fertility Awareness-Based Methods	Lactational Amenorrhea Method (LAM)**
Pregnant	4	4	4	4	Delay	-	1	4	1	1	1	-	1
Age													
Less than 16	1	2	2	2	Accept ^b	- ³	1	2	1	1	1	1 ^{10c}	1
16 to 19	1	1	1	1	Accept ^b	- ³	1	2	1	1	1	1	1
20 to 39	1	1	1	1	Accept ^b	- ³	1	1	1	1	1	1	1
40 and over	2	1	1	1	Accept ^b	- ³	1	1	1	1	1	1 ^{10c}	1
Smoking													
Less than age 35	2	1	1	1	Accept ^b	- ³	1	1	1	1	1	1	1
Age 35 and over													
& Light smoker (20 or fewer cigarettes per day)	3	1	1	1	Accept ^b	- ³	1	1	1	1	1	1	1
& Heavy smoker (over 20 cigarettes per day)	4	1	1	1	Accept ^b	- ³	1	1	1	1	1	1	1
High blood pressure (hypertension)													
Mild (140/90 to 159/99)	2/3 ^d	1	2	1	Caution	-	1	1	1	1	1	1	1
Moderate (160/100 to 179/109)	3/4 ^d	1	2	1	Refer	-	1 ^f	1	1 ^f	1 ^f	1 ^f	1 ^f	1
Severe (greater than 180/110) ^g	4	2	3	2	Refer	-	1 ^f	1	1 ^f	1 ^f	1 ^f	1 ^f	1 ^f
Past hypertension where blood pressure cannot be evaluated	3	2	2	2	Caution	-	1	1	1	1	1	1	1
Diabetes													
Past elevated blood sugar levels during pregnancy	1	1	1	1	Accept	-	1	1	1	1	1	1	1

Sterilization is appropriate for women and men of any age, but only if they are sure they will not want children in the future. This condition may affect ovarian function and/or change fertility signs and symptoms and/or make methods difficult to learn and use.

¹ Shortly after menarche (age at first menstrual bleeding) and as menopause approaches, menstrual cycles may be irregular.

² Category 2 where blood pressure can be monitored periodically. Otherwise, category 3.

³ Category 3 where blood pressure can be monitored periodically. Otherwise, category 4.

⁴ Higher typical failure rates of this method may expose the user to an unacceptable risk of dangerous unintended pregnancy.

⁵ With or without vascular disease. Breastfeeding may not be recommended with drugs used to treat this condition.

⁶ Condition not listed by WHO for this method; does not affect eligibility for method use.

WHO Medical Eligibility Criteria for Starting Contraceptive Methods (continued)

CONDITION	Combined OCs	Progestin-Only OCs	MPAN/NET EN	Norplant Implants	Female Sterilization*	Vasectomy*	Condoms	TCU-380A IUD*	Spermicides	Cervical Cap	Fertility Awareness-Based Methods	Lactational Amenorrhea Method (LAM)**
Breast cancer												
Current	4	3	4	4	Caution	-	1 ^f	1	1 ^f	1 ^f	1 ^f	1 ^h
Past, with no evidence of disease in last 5 years	3	3	3	3	Accept	-	1	1	1	1	1	1
Breast lump (undiagnosed)	2	2	2	2	Accept	-	1	1	1	1	1	1
Benign breast disease	1	1	1	1	Accept	-	1	1	1	1	1	1
Family history of breast cancer	1	1	1	1	Accept	-	1	1	1	1	1	1
Cervical cancer (awaiting treatment)	2	2	2	2	Delay	-	1 ^f	4	2 ^f	1 ^g	1 ^h	1 ^h
Noncancerous cervical lesions (cervical intraepithelial neoplasia)	2	2	2	2	Accept	-	1	1	1	1 ^f	1 ^g	1
Endometrial or ovarian cancer	1	1	1	1	Delay	-	1 ^f	4	1 ^f	1 ^f	1 ^h	1 ^h
Benign ovarian tumors (including cysts)	1	1	1	1	Accept	-	1	1	1	1	1	1
Pelvic inflammatory disease (PID)												
Past PID (no known current risk of STDs)												
Became pregnant since PID	1	1	1	1	Accept	-	1	1	1	1	1	1
Has not become pregnant since PID	1	1	1	1	Caution	-	1	2	1	1	1	1
Current PID or in last 3 months*	1	1	1	1	Delay	-	1	4	1	1	1 ^h	1
Sexually transmitted disease (STDs)*												
Current STD (including purulent cervicitis)*	1	1	1	1	Delay	Delay	1	4	1	1	1 ^h	1

This condition may affect ovarian function and/or change fertility signs and symptoms and/or make methods difficult to learn and use. Higher typical failure rates of this method may expose the user to an unacceptable risk of dangerous unintended pregnancy. Breastfeeding may not be recommended with drugs used to treat this condition. Cervical cap not recommended. Including endometritis (inflammation of the lining of the uterus) following childbirth or abortion. Condition does not affect vaginal bleeding patterns; calendar method can be used. Barrier methods, especially condoms, are always recommended for prevention of STDs, including HIV/AIDS. Purulent cervicitis: a pus-like discharge from the opening of the cervix. Condition not listed by WHO for this method does not affect eligibility for method use.

STD in last 3 months (no symptoms persisting after treatment)	1	1	1	1	1	1	1	1	1	1 ^{1,1}	1	1
Vaginitis without purulent cervicitis ^{1,2}	1	1	1	1	1	1	1	1	1	1	1	1
Increased risk of STDs ¹	1	1	1	1	1	1	1	1	1	1	1	1
Urinary tract infection	-	-	-	-	-	-	-	-	-	-	-	-
HIV infection/AIDS ¹	-	-	-	-	-	-	-	-	-	-	-	-
HIV infected	1	1	1	1	1	1	1	1	1	1	1 ^{1,3}	1 ^{3,3}
High risk of HIV infection ¹	1	1	1	1	1	1	1	1	1	1	1 ^{3,3}	1 ^{3,3}
AIDS	1	1	1	1	1	1	1	1	1	1	1 ^{1,3}	1 ^{3,3}
Galbladder disease	-	-	-	-	-	-	-	-	-	-	-	-
Current disease	3	1	1	1	1	1	1	1	1	1	1	1
Treated with medication	3	1	1	1	1	1	1	1	1	1	1	1
Without symptoms or surgically treated	2	1	1	1	1	1	1	1	1	1	1	1
Past cholestasis (jaundice)	-	-	-	-	-	-	-	-	-	-	-	-
Related to pregnancy	2	1	1	1	1	1	1	1	1	1	1	1
Related to past combined oral contraceptive use	3	2	2	2	2	2	2	2	2	2	2	2
Viral hepatitis	-	-	-	-	-	-	-	-	-	-	-	-
Active disease	4	3	3	3	3	3	3	3	3	3	3 ^{1,1}	3 ^{1,1}
Carrier	1	1	1	1	1	1	1	1	1	1	1	1
Cirrhosis of the liver	-	-	-	-	-	-	-	-	-	-	-	-
Mild (compensated)	3	2	2	2	2	2	2	2	2	2	2	2
Severe (decompensated)	4	3	3	3	3	3	3	3	3	3	3 ^{1,3}	3 ^{1,3}
Liver tumors	-	-	-	-	-	-	-	-	-	-	-	-
Benign	4	3	3	3	3	3	3	3	3	3	3 ^{1,1}	3 ^{1,1}
Malignant	4	3	3	3	3	3	3	3	3	3	3 ^{1,3}	3 ^{1,3}
Uterine fibroids	1	1	1	1	1	1	1	1	1	1	1	1
Past ectopic pregnancy	1	2	1	1	1	1	1	1	1	1	1	1
Obesity	1	1	1	1	1	1	1	1	1	1	1 ^{1,3}	1

In areas where STD incidence is high, vaginitis may indicate an STD. For example, currently has or will have more than one sex partner or a partner who has more than one partner.

There is a potential increased risk of urinary tract infection with diaphragms and spermicides.

For IUDs, HIV-infected or any other medical condition or medication that makes the body less able to fight infection.

In areas where infectious disease is the main cause of infant death, HIV-infected women should be advised to breastfeed. In other areas, if affordable alternatives to breastmilk are available, HIV-infected women should not breastfeed.

High dose of nonoxonyl-9 spermicide may cause vaginal abrasions, which may increase risk of HIV infection.

Uterine fibroids distorting the uterine cavity; otherwise category 1.

Severe obesity may make diaphragm or cap placement difficult.

Condition not listed by WHO for this method; does not affect eligibility for method use.

WHO Medical Eligibility Criteria for Starting Contraceptive Methods (continued)

CONDITION	Combined OCS	Progestin-Only OCS	DMPA/NET EN	Norplant Implants	Female Sterilization*	Vasectomy*	Condoms	TCU-380A IUD**	Spermicides	Diaphragm, Cervical Cap	Fertility Awareness-Based Methods	Lactational Amenorrhea Method (LAM)††
Thyroid	1											
Simple goiter	1	1	1	1	Accept	–	1	1	1	1	1	1
Hypothyroid	1	1	1	1	Refer	–	1	1	1	1	1 ^{b,†}	1
Hyperthyroid	1	1	1	1	Caution	–	1	1	1	1	1 ^{b,†}	1 ^b
Hypothyroid	2	1	1	1	Caution	–	1	2	1	1	1	1
Thalassemia (inherited anemia)												
Trophoblast disease												
Benign	1	1	1	1	Accept	–	1	3	1	1	1	1
Malignant	1	1	1	1	Delay	–	1	4	1	1	1	1 ^b
Sickle cell disease	2	1	1	1	Caution	Accept	1	2	1	1	1	1
Coagulation (blood clotting) disorders	–	–	–	–	Refer	Refer	–	–	–	–	–	–
Iron deficiency anemia												
Hemoglobin 7 g/dl-10 g/dl	1	1	1	1	Caution	–	1	2	1	1	1	1
Hemoglobin less than 7 g/dl	1	1	1	1	Delay	–	1	2	1	1	1	1
Epilepsy	1	1	1	1	Caution	–	1	1	1	1	1	1 ^b
Schistosomiasis												
Without complications	1	1	1	1	Accept	–	1	1	1	1	1	1
With fibrosis of the liver	1	1	1	1	Caution	–	1	1	1	1	1 ^{b,†}	1 ^b
With severe fibrosis of the liver	4	3	3	3	Refer	–	1	1	1	1	1 ^{b,†}	1 ^b
Malaria	1	1	1	1	Accept	–	1	1	1	1	1	1

^b This condition may affect ovarian function and/or change fertility signs and symptoms and/or make methods difficult to learn and use.

^f Higher typical failure rates of this method may expose the user to an unacceptable risk of dangerous unintended pregnancy.

^h Breastfeeding may not be recommended with drugs used to treat this condition.

^t Condition does not affect vaginal bleeding patterns; calendar method can be used.

[†] Condition not listed by WHO for this method; does not affect eligibility for method use.

WHO Medical Eligibility Criteria for Starting Contraceptive Methods (continued)

CONDITION	Combined OCs	Progestin-Only OCs	DMPA/NET EN	Norplant Implants	Female Sterilization*	Vasectomy*	Condoms	TCu-380A IUD*	Spermicides	Diaphragm	Fertility Awareness-Based Methods	Lactational Amenorrhea Method (LAM)**
Postpartum (nonbreastfeeding women)												
Less than 21 days after childbirth	3	1	1	1	*	**	1	1	1	-	1 ^b	-
21 days or more after childbirth	1	1	1	1	*	**	1	1	1	1 ^b	1 ^b	-
Postabortion												
First trimester	1	1	1	1	-	-	1	1	1	1	1 ^b	-
Second trimester	1	1	1	1	-	-	1	1	2	1 ^a	1 ^b	-
After septic abortion ^(a)	1	1	1	1	-	-	1	4	1	1	1 ^b	-

This condition may affect ovarian function and/or change fertility signs and symptoms and/or make methods difficult to learn and use.
 Can start diaphragm use 6 weeks after childbirth.
 Can start diaphragm use 6 weeks after second-trimester abortion.
 That is, immediately after abortion involving genital tract infection.
 Condition not listed by WHO for this method; does not affect eligibility for method use.

* Additional conditions related to female sterilization:
 Conditions that require delay: abdominal skin infection; acute bronchitis or pneumonia; emergency surgery; surgery for an infectious condition; systemic infection or severe gastroenteritis.
 Conditions that require referral to a special center: chronic asthma; bronchitis; emphysema; or lung infection; fixed uterus due to previous surgery or infection; abdominal wall or umbilical hernia.
 Conditions that require caution: diaphragmatic hernia; kidney disease; elective surgery; severe nutritional deficiencies.
 Conditions that pose no special requirements: cesarean section.

Postpartum sterilization conditions that require delay: 7 days to 42 days after childbirth; severe pre-eclampsia/eclampsia; prolonged rupture of membranes (24 hours or more); severe hemorrhage; fever during or right after delivery; sepsis; severe trauma to the genital tract (cervical or vaginal tear at delivery); uterine rupture or perforation.
 Postpartum sterilization conditions that pose no special requirements: less than 7 days after childbirth; more than 42 days after childbirth; mild pre-eclampsia.
 Postpartum sterilization conditions that require delay: from 7 days after childbirth until uterine involution is complete (usually about 42 days after childbirth); severe sepsis or fever; severe hemorrhage; severe trauma to the genital tract; uterine perforation; acute hematometra (excess blood in the uterus).

** Additional conditions related to vasectomy:
 Conditions that require delay: scrotal skin infection; active STD; balanitis; epididymitis or orchitis; systemic infection or severe gastroenteritis; filariasis or elephantiasis; intrascrotal mass.
 Conditions that require caution: previous scrotal surgery or injury; large varicocele; large hydrocele; cryptorchidism. (In some circumstances, cryptorchidism may require referral.)

+ Additional conditions related to TCu-380A IUD, postpartum insertion (breastfeeding or nonbreastfeeding):
 Condition that represents an unacceptable health risk (MHO 4): puerperal sepsis (genital tract infection during the first 42 days after childbirth).
 Condition that requires a doctor or nurse to make a clinical judgement that the client can safely use an IUD (MHO 3): 48 hours to 4 weeks postpartum.
 Condition for which advantages of IUD use generally outweigh theoretical or proven risks (MHO 2): less than 48 hours after childbirth.
 Condition that requires no restriction: More than 4 weeks after childbirth.

+ + Additional conditions related to LAM:
 Conditions that represent an unacceptable health risk to the infant: use of reserpine, ergotamine, antimetabolites, cyclosporine, corticoids, bromocriptine, radioactive drugs, lithium, or anticoagulants.
 Conditions for which LAM has no effect on the condition, but the condition may prevent breastfeeding: sore nipples, mastitis (breast inflammation); congenital deformity of infant's mouth, jaw or palate; infant small for age; premature birth; or neonatal intensive care; past breast surgery; certain infant metabolic disorders.
 Condition that requires no restrictions (MHO 1): breast engorgement.

GUIDELINES ON POST-TRAINING FOLLOW-UP AND MONITORING OF FPCBT IN IUD TRAINEES

Preparatory Activities

- One month prior to visit
Ensure communication (i.e., letter followed by phone call, if possible) with the head of the trainee's facility, the trainee's supervisor and the trainee to inform them of:
 - Purpose of the visit which may be but not be limited to:
 - Determine if the trainee-service provider is able to competently provide IUD services as taught during the FPCBT in IUD course.
 - Provide trainee with technical assistance, as necessary.
 - Identify problems the trainee may have in applying the knowledge and skills learned.
 - Assist the trainee in finding solutions to these problems.
 - Date of the visit
 - What the trainee needs to prepare: FP Form 1 of FP clients provided services after the course, Target Client List, CDLMIS Inventory Report, Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book)
 - Arrange for availability of client(s) during the visit.
- Two weeks prior to visit
 - Obtain confirmation of the scheduled visit
 - Prepare materials you will need, such as:
 - Performance monitoring checklist (two copies/midwife: a copy to be left with the midwife and another for the monitoring agency)
 - Copy of the letter previously sent informing midwife of your visit
 - Copy of the action plan (developed during the course)
- Immediately prior to the visit
 - Prepare for travel arrangements
- Plan to be on time for the site visit

During the Follow-up

- Conduct a courtesy call on the head of the facility.
 - Explain the purposes of the follow-up visit which are:
 - To determine if the trainee-service provider is able to competently provide IUD services as taught during the FPCBT Level 2: IUD course.
 - To provide trainee with technical assistance, as necessary.
 - To identify problems the trainee may have in applying the knowledge and skills learned.
 - To assist the trainee in finding solutions to these problems.
- Arrange to interview the trainee's immediate supervisor.

The following are some informal interview questions the trainer can ask the supervisor:

- Did the training improve the trainee's work attitude and performance?
- Is the trainee able to effectively provide FP services (e.g. counseling, provision of SDM, pills, DMPA, and condoms) including the IUD?
- Has there been an increase in the provision of IUD services after the training?
- Has there been an improvement in the quality of services provided by the trainee?
In what way?

- Has there been a change in the infection prevention practices in the clinic as practiced by the trainee? In what way?
- Has the trainee been involved in activities to improve the quality of FP services in the facility (e.g. work planning activities, forecasting and allocation of commodity needs, accomplishment of reports, resource mobilization)?
- Were the changes in the trainee's performance and attitude worth the time invested in training?
- Based on observations in the trainee's change of behavior, knowledge, and attitude, what suggestions would the trainee have towards improvement of the course?
- Did training correct the problem or meet the need for which the training program was designed?
- What are the recommendations of the trainee for future trainees of the course?
- Interview the trainee and observe performance.
 - Review the action plan developed during the course. Determine the extent to which the trainee has implemented the action plan.
- Find out whether the trainee has applied the concepts and provide IUD services as learned in the course.
- Validate performance with records: FP Form 1 of FP clients provided services since after the course, Target Client List, CDLMIS Inventory Report (DTUR, *Barangay* Inventory Worksheet), Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book).
- If trainee expresses that she/he was not able to apply fully the concepts and skills (IUD service provision) learned in the course, ask for the constraints encountered. Include these as part of the "Issues" that need to be addressed.
- COACH the midwife to reinforce the critical skills learned during training by:
 - Reviewing the IUD performance monitoring checklist as the basis of the evaluation. Ask if there are any tasks in the checklist that is difficult to perform.
 - Observing performance on counseling and infection prevention practices.

Note: Do a role play if no client is available during the visit.

- Checking and assisting, as needed, on the accomplishment of appropriate forms.
- Providing feedback by commending on tasks that were performed well followed by recommendations for improvement.
- Asking what additional assistance may be needed to improve performance.

- Arrange for the schedule of return visit if trainee has not performed satisfactorily and to check if recommendations are implemented.
- Provide feedback on the comments of the supervisor.
- Process the observations by listing items rated as “2” in the “Good Points” portion. Those rated as “1” and “0” under the “Issues” heading. For each of the issues, discuss recommendations for improvement and the agreed time frame for completion of the recommended activities.
- Thank the trainee for her/his cooperation.
- Conduct an exit conference with the supervisor/head of facility.
- Present a summary of the results of the trainee observation and assistance they can provide in improving the trainee’s performance.

After the follow-up visit

Prepare the report.

Send copies of the report to appropriate agencies.

POST-TRAINING MONITORING AND FOLLOW-UP CHECKLIST OF FPCBT IN IUD GRADUATES

Name of Service Provider: _____ Course Dates: _____
 Address: _____
 Visited by: _____ Date of Visit: _____

OBSERVATION CHECKLIST

Instruction: Check the appropriate column for each of the items.

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
PHYSICAL ENVIRONMENT					
THE FACILITY IS ADEQUATELY EQUIPPED AND SUPPLIED AS IT HAS THE FOLLOWING:					
1) Signage that informs clients of services, including FP provided at the clinic and clinic hours.					
2) Clean and well ventilated client areas free from garbage, pests and insects.					
3) Waiting area with seats for clients.					
4) All-methods poster displayed in an area where clients can see.					
5) An area for consultation and counseling that:					
– has a table and chairs.					
– provides auditory and visual privacy.					
– has an examination table with Kelly pad.					
– has gooseneck lamp and alternate source for light (i.e., emergency light, flashlight).					
– has sink with running water, liquid or bar soap, and clean, dry towel for washing and drying hands.					
– has locked storage for medicines and supplies.					
– has locked filing cabinet to keep clients' records.					
6) Has the following items and instruments for IUD insertion:					
– drape to cover client's pelvic area					
– clean cloth to cover the table					
– bivalve speculum (small, medium, large)					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
– uterine tenaculum (12")					
– uterine sound (12")					
– IUD in a closed, undamaged, sterile pack that is not beyond the expiration date					
– sharp Mayo scissors					
– sponge forceps (12")					
– narrow or alligator forceps (10")					
7) Clean toilet with running water accessible to clients and staff.					
8) Has provisions for infection prevention such as:					
– boiler or sterilizer					
– gloves (i.e., utility, examination, and sterile)					
– antiseptics (i.e., isopropyl 70% alcohol, betadine)					
– bleach for preparing 0.5% decontaminating solution					
– detergent					
– plastic containers for soaking and cleaning used instruments.					
– covered waste baskets lined with appropriate color coded plastic bags in client areas (i.e., waiting area, consultation room)					
– work area for cleaning instruments, Kelly pad, and mop.					
– access to potable water.					
– color-coded garbage containers for different types of wastes ✓ Black plastic lining for general, dry, non-infectious waste ✓ Green plastic lining for general, wet, non-infectious waste ✓ Yellow for infectious/pathological waste					
– container for sharps					
– mops and rags					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
9) Has an area for interim storage of waste that is minimally accessible to staff, clients, and visitors.					
10) Has the following supplies:					
– cotton					
– gauze					
– pregnancy test					
– family planning supplies: cycle beads, pills (COC, POP), DMPA with syringe, condoms					
TECHNICAL COMPETENCE					
INTERPERSONAL COMMUNICATION					
1. Uses simple language that client understands.					
2. Exhibits positive non-verbal communication.					
3. Uses appropriate tone of voice.					
4. Asks open-ended, closed, and probing questions effectively.					
5. Ensures that clients understand information given by asking follow-up questions.					
6. Listens attentively to client's response and concerns.					
7. Responds to all client's questions and concerns.					
8. Treats the client with respect by informing her/him of procedures to be performed and asking about how she/he feels.					
COUNSELING PROCESS					
1. Greets client and introduces self.					
2. Offers the client a seat.					
3. Asks reason for client's visit.					
4. Respects clients right by: a. Ensuring confidentiality b. Providing privacy					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
5. Invites client to speak freely.					
NEW CLIENTS					
6. Uses the FP Form 1 to obtain relevant information.					
7. Assesses the client's reproductive needs (short-term, long-term, permanent)					
8. Asks client if s/he has a method in mind and what s/he knows about the method.					
9. Assesses what the client knows about FP methods.					
10. Asks if client has previously used an FP method and reason for discontinuing.					
11. If postpartum, assesses the client's willingness to breastfeed.					
12. Assesses reproductive health needs of clients					
• Risk for STIs					
• Gender-based violence (VAW)					
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).					
14. Corrects rumors and misconceptions.					
15. Tells the client about available methods based on client's knowledge and reproductive needs.					
• Mode of action					
• Advantages and disadvantages					
• STI and HIV prevention					
• Possible side effects					
16. Allows the client to choose a method among those previously presented to her/him.					
METHOD SPECIFIC COUNSELING					
1. When client chooses the IUD, determines suitability of the IUD chosen method by using the MEC checklist for the IUD.					
2. Assists the client through a "self-assessment" process, as appropriate, to determine her risks for STIs by:					
• telling the client that she does not need to share any information about her or her partner's sexual behavior.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
• telling the client to consider the following risky situations which may have occurred three months prior to this assessment:					
• sexual partner recently had STI symptoms such as pus coming from his penis, pain or burning sensation during urination, or an open sore in the genital area.					
• she or her sexual partner was diagnosed with a STI.					
• she has had more than one sexual partners recently.					
• she has a sexual partner who has had other sexual partners recently.					
• she thinks that her partner who works away from home for long periods of time has other sexual partners.					
• asks the client whether, after considering the above risky situations, she thinks the IUD is an appropriate method for her.					
3. If client thinks that the IUD is not an appropriate method for her, helps her choose another method.					
4. If client thinks that the IUD is an appropriate method for her, describes the pelvic examination required before IUD insertion, as well as the procedures for IUD insertion and removal.					
5. Encourages the client to ask questions. Provides additional information and reassurance as needed.					
Pelvic Examination					
1. Ensures that equipment and supplies are available and ready to use.					
2. Instructs client to empty her bladder and wash her perineal area.					
3. Helps the client onto the examination table.					
4. Tells the client what is going to be done, and asks her if she has any questions.					
5. Washes hands thoroughly and dries them.					
6. Palpates the abdomen.					
7. Puts on clean or HLD gloves on both hands.					
8. Examine the external genitalia first, taking note of the following:					
• Distribution of the pubic hair, vaginal discharges, signs of bleeding, presence of abrasions, irritations or scars.					

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<ul style="list-style-type: none"> Signs of any STIs like pus, discharges, warty growths, lumps/mass, sores, irritations of the vulvar area. Inspects the external genitalia. 					
Note:					
<ul style="list-style-type: none"> If findings are normal, perform the bimanual examination first and then the speculum examination. 					
<ul style="list-style-type: none"> If there are potential problems, perform the speculum examination first and then the bimanual examination. 					
<p>9. If findings are normal, performs a bimanual examination.</p> <ul style="list-style-type: none"> Uses the thumb and little finger to separate the labia majora. 					
<ul style="list-style-type: none"> Inspects the vaginal opening. Takes note of any bulging of the vaginal walls. A bulging of the anterior vaginal wall suggests a cystocele while a bulging of the posterior vaginal wall suggests a rectocele. 					
<ul style="list-style-type: none"> Presses the perineum with the index finger to relax it. 					
<ul style="list-style-type: none"> With index finger in the vagina, palpates for the Bartholin's glands by grasping the lower end of each side of the labia majora between the thumb and the index finger. Notes any secretions or mass. 					
<ul style="list-style-type: none"> Turning the hand with palm upward, squeezes the Skene's glands and urethra outward for any secretions. Collects specimen, if there is any secretion. 					
<ul style="list-style-type: none"> With index and middle fingers in the vagina, checks the vaginal canal for any abnormalities (e.g. mass) within the vaginal walls. 					
<ul style="list-style-type: none"> With palm up, inserts the index and middle fingers further into the vagina. Follows the anterior vaginal mucosa deep into the anterior fornix and locates the cervix. 					
<ul style="list-style-type: none"> Feels the cervix with the examining fingers and takes note of its position, size, mobility, consistency, and any tenderness. 					
<ul style="list-style-type: none"> Presses the free hand gently on the lower abdomen above the symphysis pubis and exerts a steady downward pressure to determine the position of the uterus. 					
<ul style="list-style-type: none"> Gently moves the cervix from side to side (wiggle the cervix) and takes note of any pain. 					
<ul style="list-style-type: none"> With the vaginal fingers on the lateral fornix, gently palpates for the tube and ovary on one side and then on the other side. Notes any tenderness, enlargement or masses. 					

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10. Performs speculum examination.					
<ul style="list-style-type: none"> Lubricates the speculum with water, K-Y jelly, or betadine antiseptic before insertion. 					
<ul style="list-style-type: none"> Holds the speculum with the blades closed between the thumb and index and middle fingers. 					
<ul style="list-style-type: none"> With the free hand, spreads the labia and part of the pubic hair which may obstruct the vaginal opening, then asks the client to push or bear down to relax the perineal muscles. 					
<ul style="list-style-type: none"> Inserts the closed speculum obliquely between the labia and into the vaginal canal. Rotate the blades of the speculum into the horizontal position. 					
<ul style="list-style-type: none"> With the speculum in position, opens it until the cervix is in full view between the blades. Screws the speculum tightly. 					
<ul style="list-style-type: none"> Checks the color, presence of mass, warty changes, discharges in the vaginal canal, and the cervix. 					
IUD INSERTION					
1. Swabs the cervix and vaginal wall with antiseptic twice.					
2. Gently grasps the cervix with an HLD (or sterile) tenaculum and applies gentle traction.					
3. Inserts the HLD (or sterile) uterine sound gently using the “no touch” technique to measure the uterus.					
4. Takes note of the measurement of the uterus by the level of mucus or blood on the uterine sound.					
5. Puts the used uterine sound in decontaminating solution.					
6. Immerses gloved hands in decontaminating solution. Removes gloves and disposes these properly.					
7. Loads the IUD in its sterile package.					
8. Adjusts the contents of the package through the clear plastic cover so that the vertical stem of the T is fully inside the insertion tube.					
9. Partially opens the package around halfway from the blue depth-gauge.					
10. Carefully places the white plunger rod into the inserter tube so that it does not touch anything that may contaminate it.					
11. Gently pushes the white plunger rod until the tip of the rod almost touches the bottom of the T.					

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12.Places the package on a flat surface and places the thumb and index finger over the tips of the horizontal arms of the “T” to stabilize the IUD.					
13.At the open end of the package, grasps the insertion tube and gently pushes it against the “T” to bend its horizontal arms.					
14.Completely bends the arms of the “T” by bringing the thumb and index fingers together, and continuing to push against the “T” with the insertion tube.					
15.Pulls the insertion tube up to below the tips of the bended arms of the “T” and pushes it back to tuck the arms of the “T” into the inserter tube.					
16.Ensures that the arms of the “T” are not folded for more than five minutes before insertion.					
17.Sets the blue depth-gauge to the measurement of the uterus.					
18.Places the upper border of the blue depth-gauge at the corresponding measurement of the uterine depth on the measurement insert.					
19.Pushes or pulls the inserter tube so that the tip of the folded IUD is at the “0” level.					
20.Ensures that the IUD and the blue depth-gauge are in the same horizontal position.					
21.Carefully takes out the IUD from the package so that it does not touch any surface that may contaminate it.					
22.Carefully inserts the loaded IUD while applying outward traction on the tenaculum.					
23.Once resistance is felt or the blue depth-gauge touches the cervical os, steadies the white plunger rod.					
24.Releases the IUD into the uterus by withdrawing the insertion tube up to the ring of the steadied white plunger rod.					
25.Removes the white plunger rod.					
26.Gently pushes the insertion tube upward again until slight resistance is felt.					
27.Removes the insertion tube.					
28.Cuts the strings three to four cm in length from the cervical os using scissors.					
29.Gently removes the tenaculum and places in 0.5% chlorine solution for 10 minutes for decontamination.					
30.Examines the cervix for bleeding.					

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31. Removes the speculum by partially withdrawing the still open speculum gently to release the cervix, then closes it and withdraws the blades in the same oblique position.					
32. Asks how the client is feeling and performs the post-insertion steps.					
Post-insertion Steps					
1. Places all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Cleans the rubber sheet that covers the examination table with chlorine solution.					
3. Properly disposes of waste materials.					
4. Immerses gloved hands in decontaminating solution. Removes gloves and disposes properly.					
5. Washes hands thoroughly and dries them.					
6. Provides postinsertion instructions and key messages. <ul style="list-style-type: none"> • Basic facts about her IUD (e.g. type, how long effective, when to replace/remove) 					
<ul style="list-style-type: none"> • Warning signs (P-A-I-N-S) 					
<ul style="list-style-type: none"> • Checking for possible IUD expulsion 					
<ul style="list-style-type: none"> • When to return to the clinic 					
RETURN CLIENTS					
1. Greets the client and introduces self, if needed.					
2. Offers the client a seat.					
3. Re-assures confidentiality and provides privacy.					
4. Retrieves client's records.					
5. Asks if the client's situation, including her reproductive needs, has changed since her last visit.					
6. Asks if client has problems with the IUD.					
7. If client is satisfied with the IUD, asks her to repeat the warning signs for which she needs to seek immediate consultation.					
8. If she is not satisfied with the IUD: <ul style="list-style-type: none"> • Tells the client that she can get pregnant immediately after the IUD is removed. 					
<ul style="list-style-type: none"> • Tells the client that there are other methods that she can use to meet her needs. 					
<ul style="list-style-type: none"> • Tells the client about other appropriate methods for her reproductive needs. 					

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• Helps the client make a decision by determining how she will cope with possible side effects of a chosen method.					
• Explains to the client how to use and the warning signs of her chosen method.					
• If the client is determined to discontinue use of the IUD, prepare her for IUD removal.					
IUD REMOVAL					
Pre-removal Steps					
1. Asks the client her reason for having the IUD removed, if appropriate.					
2. Determines whether she will have another IUD inserted immediately, start a different method, or neither.					
3. Reviews the client's reproductive goals and needs for STI protection and counsels as appropriate.					
4. Ensures that equipment and supplies are available and ready to use.					
5. Instructs the client to empty her bladder and wash her perineal area.					
6. Helps the client onto the examination table.					
7. Washes hands thoroughly and dries them.					
8. Puts new or HLD gloves on both hands.					
Removing the IUD					
1. Provides an overview of the procedure of removing the IUD. Reminds the client to verbalize if she feels any pain.					
2. Gently inserts the HLD (or sterile) speculum to visualize the strings, and swabs the cervical os and vaginal walls with cottonballs or gauze soaked in Betadine.					
3. Alerts the client immediately before removing the IUD.					
4. Grasps the IUD strings close to the cervix with an HLD (or sterile) forceps.					
5. Applies steady but gentle traction to pull the strings and remove the IUD. Does not use excessive force.					
6. Shows the IUD to the client.					
7. Places the IUD in 0.5% chlorine solution for 10 minutes for decontamination.					
8. Inserts a new IUD if client requests or if appropriate.					

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9. Gently removes other instruments (if insertion of new IUD done) and the speculum and places in 0.5% chlorine solution for decontamination.					
10. Asks how the client is feeling and performs post-removal steps.					
Post-removal Steps					
1. Before removing gloves, places all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination.					
2. Properly disposes of waste materials.					
3. Immerses gloved hands in decontaminating solution, removes these and disposes properly.					
4. Washes hands thoroughly and dries them.					
5. If the client has had a new IUD inserted, reviews key messages for IUD users.					
6. If the client decides to use another method or not to use any method, counsels her appropriately.					
CLINIC MANAGEMENT					
Work planning					
1. Reviews the CBMIS regularly to identify clients with FP unmet needs for planning alternative service delivery interventions in the community.					
2. Reviews the target client list regularly to plan and carry out FP client care and service delivery.					
3. Contributes to the clinic's workplan by developing a plan for the provision of FP services in the community and clinic.					
Promotional Activities					
1. Uses the opportunity of a clinic visit with a woman to discuss additional issues like FP.					
2. Makes women/couples realize the relationship of FP to their health concerns.					
3. Conducts community education on FP.					
4. Conducts " <i>Buntis</i> " parties for pregnant women, which includes FP and discusses the possibility of practicing postpartum FP.					
5. Discusses family planning to women of reproductive age in the clinic or community by telling: <ul style="list-style-type: none"> • that the ideal gap between pregnancies is three years 					

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• that there are options depending on her/their situation and needs.					
• of FP services available in the clinic.					
Referral					
1. Refers client to other facilities or service providers for services not available in the clinic.					
2. Has identified facilities for referral of specific services not available in the clinic					
3. Accomplishes referral slips accurately when appropriate.					
4. Follows-up outcome of referrals.					
5. Keeps record of clients referred for FP and other RH services.					
6. Compiles returned referral slips.					
Resource Mobilization					
1. Partners with companies, NGOs, local government executives, and other stakeholders in the community for support and delivery of services.					
2. Networks with other facilities, including private sector delivery points (private birthing homes) for continuation of services and referral.					
Management Information System					
1. Ensures that all FP users have an FP Form 1.					
2. Updates the TCL every time a client comes to the clinic for FP services.					
3. Accomplishes the BHS summary table (green book) and/or the RHU summary table (blue book).					
4. Accomplishes the RHU summary table (blue book).					
5. Supervises BHWs in updating the family profile (part of the CBMIS) to determine FP unmet needs in the community.					
6. Completes the FHSIS by accomplishing the:					
• FP Form 1					
• TCL					
• Summary Table for FP Program (i.e., green and blue books)					
7. Consolidates/lists all clients with FP unmet needs.					
8. Has a system for the submission of reports.					

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Infection Prevention					
1. Keeps the clinic and its surroundings clean.					
2. Washes hands properly and at appropriate times.					
3. Uses gloves correctly and appropriately.					
4. Uses antiseptics and disinfectants correctly.					
5. Follows the three steps for processing equipment/instruments that has contact with body fluids. The steps, in proper order, are:					
• decontamination					
• washing/cleaning					
• high-level disinfection					
6. Maintains single-use injection practice.					
7. Disposes used needles/sharps in a sharps container.					
8. Segregates wastes properly.					
• Black trash bag = general, non-infectious, dry					
• Green trash bag = general, non-infectious, wet					
• Yellow trash bag = infectious, pathological					
• Sharps container = sharps					
9. Properly disposes contaminated materials, pathological, and other medical wastes.					
Logistics Management					
1. Estimates FP commodity requirements of the clinic.					
2. Ensures proper storage of FP commodities.					
3. Follows the FEFO principle in using up stocks of commodities.					
4. Returns expired and damaged contraceptives and other supplies to the delivery team.					
5. Reviews/prepares records like the following to determine logistical requirements for FP commodities.					
• CDLMIS Inventory Report					
• Dispensed to User Report (DTUR)					
• Target Client List (TCL)					
• Supplies Ledger Card					
• Contraceptive Order Form					
6. Monitors stock levels of FP commodities by maintaining the authorized stock level (ASL) and ensures availability of these commodities at all times.					

