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Maternal and Child Survival Program

Long-Acting Reversible Contraceptives Learning Package

Module 6: Copper Intrauterine Device (Copper T 380A)

Learner Version

The Maternal and Child Survival Program (MCSP) is a global, United States Agency for International Development (USAID) Cooperative Agreement to introduce and support high-impact health interventions with a focus on 24 high-priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Module 6: Copper Intrauterine Device (Copper T 380A)

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Module 6: Copper Intrauterine Device (Copper T 380A)

Module Overview for Learner

Time: 10:00 hours

Module Objectives

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

- Describe the basic attributes of copper-bearing IUDs
- Counsel and assess the eligibility of a potential IUD user by taking a history, doing a physical examination, and using the medical eligibility criteria (MEC) wheel
- Load, insert, and remove the IUD correctly using the "no-touch" technique
- Provide key post-insertion instructions, routine follow-up care, management of side-effects and potential complications
- Address rumors and common misconceptions about IUDs
- Correctly document service provided

Session Plans

- Session 1: Basic attributes, client assessment and follow-up care
- Session 2: Insertion and removal of IUDs using models
- Session 3: Recordkeeping and Clinical practice
- Session 4: Clinical practice (continued)

Sample Schedule

Facility-based delivery: Four consecutive days (Total 10:00 hours)

Day 1 (2 hrs 35 min)		Day 2 (2 hrs 20 min)		Day 3 (2 hrs 20 min)		Day 4 (2 hrs 45 min)	
Time	**Session: Activity**	**Time**	**Session: Activity**	**Time**	**Session: Activity**	**Time**	**Session: Activity**
5 min	Session Introduction	5 min	Session Introduction	5 min	Session Introduction	120 min	Pre-clinical validation and Clinical Practice (continued)
10 min	Pre Test	30 min	Review of Checklist and demonstration on the Zoe model	10 min	Recordkeeping	20 min	Post-Clinical Practice Debrief
35 min	Interactive Presentation	90 min	Skills Lab Practice on models—loading, insertion, and removal of the IUD	100 min	Pre-clinical validation and Clinical Practice	10 min	Summary
20 min	Activity: Comparing effectiveness of IUD	10 min	Preparation for Clinical Practice	20 min	Discussion: Post Clinical Practice Debrief.	10 min	Post Test
20 min	Demonstration and Practice: Client history, assessment	5 min	Summary & closing	5 min	Summary & closing	5 min	Closing
40 min	Discussion and review: Post-insertion instructions and follow-up care, managing common side-effects & complications						
20 min	Activity: Addressing Rumors and Misconceptions about IUDs						
5 min	Summary & closing						

Module 6: Copper Intrauterine Device (Copper T 380A)

Pre and Post Test Questionnaire

Instructions: Write the letter of the single **BEST** answer to each question in the blank next to the corresponding number on the answer sheet.

Total time: 10 minutes

1. The intrauterine device (IUD) is the best choice for a woman who:
   a. Has heavy menstrual flow and anemia
   b. Wants long-acting contraception
   c. Has painful menstrual periods
   d. Has foul-smelling vaginal discharge

2. In counseling a woman about the advantages of the copper IUD, you would inform her that the IUD:
   a. Is reversible
   b. Is highly effective
   c. Has few side-effects for most women
   d. All of the above

3. Copper IUDs prevent pregnancy primarily by:
   a. Preventing the fertilized egg from attaching to the uterine lining
   b. Interfering with sperm movement
   c. Suppressing ovulation
   d. Damaging sperm

4. Which one of the following is a World Health Organization (WHO) Medical Eligibility Criteria Category 3 for insertion (risks usually outweigh the benefits)?
   a. Woman is anemic
   b. Woman has rheumatic heart disease
   c. Woman has AIDS and is not on ARV therapy
   d. Woman has active chlamydia infection

5. Physical assessment of potential IUD client includes:
   a. Eye examination
   b. Breast examination
   c. Pelvic examination (per vaginal and per speculum)
   d. Rectal examination

6. The IUD should be inserted using the "no-touch" technique because it:
   a. Increases the need for local anesthetic
   b. Requires the use of sterile gloves
   c. Minimizes the risk of post-insertion infection
   d. Decreases the chances of uterine perforation

7. To minimize the risk of staff contracting hepatitis B or HIV/AIDS during the cleaning process, instruments and gloves should first be soaked in:
   a. 0.5% liquid bleach for 10 mins.
   b. Soap and water for 15 mins.
   c. 8% formaldehyde solution for 20 mins.
   d. Alcohol solution for 10 mins.

8. Post-insertion IUD instructions to the client should include:
   a. Return for first checkup one week after insertion
   b. Return for first checkup three weeks to six weeks after insertion
   c. Return any time she has problems, questions, or wants another method
   d. Have IUD removed when it has been in place for one year

9. Which one of the following is a warning sign you should teach an IUD client as an indicator that she may be having a problem with her IUD and should seek immediate medical attention:
   a. Cramping with menses
   b. Increased length of menstrual cycle
   c. Missing IUD string
   d. Increase in weight

10. The Copper T 380A remains effective up to __ years.
   a. 4 years
   b. 6 years
   c. 10 years
   d. 12 years

Module 6: Copper Intrauterine Device (Copper T 380A)

Pre and Post Test Answer Sheet

Q.1 _____

Q.2 _____

Q.3 _____

Q.4 _____

Q.5 _____

Q.6 _____

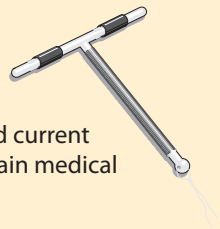
Q.7 _____

Q.8 _____

Q.9 _____

Q.10 _____

Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD



Research findings over the past 30 years have established that intrauterine devices (IUDs) are safe and effective for use by most women, including those who have not given birth, who want to space births, and those living with or at risk of HIV infection. For some women, IUDs are not recommended because of the presence of certain medical conditions, such as genital cancer and current cervical infection. For these reasons, women who desire to use an IUD must be screened for certain medical conditions to determine if they are appropriate candidates for the IUD.

FHI 360 (formerly Family Health International), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who were counseled about contraceptive options and made an informed decision to use an IUD. This checklist is a revised version of the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD* produced by FHI 360 in 2008. This version complies with the recommendations of the *Medical Eligibility Criteria for Contraceptive Use* (WHO, updated 2015). This revision also includes guidance for providers whose clients may be eligible to use the IUD for emergency contraception. The checklist consists of 21 questions designed to identify medical conditions and high-risk behaviors that would prevent safe IUD use or require further evaluation. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for an IUD if the suspected condition can be excluded through appropriate evaluation.

A health care provider should complete the checklist before inserting an IUD. In some settings the responsibility for completing the checklist may be shared — by a counselor who completes questions 1–14, and an appropriately trained health care provider who determines the answers to the remaining questions during the pelvic exam. Providers trained to perform insertions may include nurses, nurse-midwives, nurse-practitioners, midwives, physicians, and, depending on the educational and professional standards in a country, physician's assistants and associates.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives,* the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN),* the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants,* and the *Checklist on How to be Reasonably Sure a Client is Not Pregnant.* For more information about the provider checklists, please visit www.fhi360.org.

Determining Current Pregnancy

Questions 1–6 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and there are no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. An IUD should never be inserted in a woman who is pregnant, as it may result in a septic miscarriage. Note, if a client answers "yes" to question 4, IUD insertion should be delayed until four weeks postpartum. There is an increased risk of perforating the uterus when IUDs are inserted after 48 hours and up to four weeks postpartum. However, IUDs can be inserted by a trained professional within the first 48 hours after the client has given birth.

Assessing Medical Eligibility for the IUD

7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?

Unexplained vaginal bleeding may be a sign of an underlying pathological condition, such as genital malignancy (cancer) or infection. These conditions must be ruled out before an IUD can be inserted. If necessary, refer the client to a higher-level provider or specialist for evaluation and diagnosis. Counsel the client about other contraceptive options available, and provide condoms to use in the meantime.

8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?

Clients with genital cancer or trophoblastic disease are at higher risk of perforation and bleeding at the time of insertion. IUD insertion in clients with current pelvic tuberculosis may lead to a higher risk of secondary infection and bleeding. If a woman has any one of these three conditions, she should not have an IUD inserted. Counsel her about other appropriate contraceptive options and provide condoms to use in the meantime.

9. Have you ever been told that you have a rheumatic disease, such as lupus?

This question is intended to identify women who have been diagnosed with systemic lupus disease with severe thrombocytopenia. Women with severe thrombocytopenia have an increased risk of bleeding and should usually not initiate use of an IUD.

Note: Questions 10–13 are intended to identify clients at high individual risk of sexually transmitted infections (STIs), because there is a possibility that they may currently have chlamydia and/or gonorrhea infection. Unless these STIs can be reliably ruled out, clients at high risk are not good candidates for IUD insertion. IUD insertion may increase risk of pelvic inflammatory disease (PID) in these clients. They should be

counseled about other contraceptive options and provided with condoms for STI protection. However, if other contraceptive methods are not available or acceptable, and there are no signs of STI, an IUD still can be inserted. Careful follow-up is required in such cases.

10. Within the last 3 months, have you had more than one sexual partner?

Clients who have multiple sexual partners are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13).*

11. Within the last 3 months, do you think your partner has had another sexual partner?

Clients whose partners have more than one sexual partner are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. In situations where polygamy is common, the provider should ask about sexual partners outside of the union. *(See note regarding questions 10–13).*

12. Within the last 3 months, have you been told you have an STI?

There is a possibility that these clients currently have chlamydia and/or gonorrhea infection. Unless these STIs can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13).*

13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?

(Note: There are two parts to this question. Answering "yes" to either part or both parts of the question restricts IUD insertion).

Clients whose partners have STIs may have these infections as well. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13.)*

14. Are you HIV-positive, and have you developed AIDS?

If the woman is HIV-positive but has not developed AIDS, the IUD may generally be used. However, if the woman has developed AIDS, ask whether she is taking ARVs and make sure she is doing clinically well. If she is doing clinically well, she may be a candidate for the IUD. If she is not, an IUD usually is not recommended unless other more appropriate methods are not available or not acceptable. There is concern that HIV-positive clients who have developed AIDS and are not taking ARVs may be at increased risk of STIs and PID because of a suppressed immune system. IUD use may further increase that risk.

Pelvic Examination

15. Is there any type of ulcer on the vulva, vagina, or cervix?

Genital ulcers or lesions may indicate a current STI. While an ulcerative STI is not a contraindication for IUD insertion, it indicates that the woman is at high individual risk of STIs, in which case IUDs are not generally recommended. Diagnosis should be established and treatment provided as needed. An IUD can still be inserted if co-infection with gonorrhea and chlamydia are reliably ruled out.

16. Does the client feel pain in her lower abdomen when you move the cervix?

Cervical motion tenderness is a sign of PID. Clients with current PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use and other contraceptives.

17. Is there adnexa tenderness?

Adnexa tenderness and/or adnexa mass is a sign of a malignancy or PID. Clients with genital cancer or PID should not use an IUD. Diagnosis and treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist.

18. Is there purulent cervical discharge?

Purulent cervical discharge is a sign of cervicitis and possibly PID. Clients with current cervicitis or PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use.

19. Does the cervix bleed easily when touched?

If the cervix bleeds easily at contact, it may indicate that the client has cervicitis or cervical cancer. Clients with current cervicitis or cervical cancer should not have an IUD inserted. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. If, through appropriate additional evaluation beyond the checklist, these conditions may be excluded, then the woman can receive the IUD.

20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?

If there is an anatomical abnormality that distorts the uterine cavity, proper IUD placement may not be possible. Cervical stenosis also may preclude an IUD insertion.

21. Were you unable to determine the size and/or position of the uterus?

Determining size and position of the uterus is essential before IUD insertion to ensure high fundal placement of the IUD and to minimize the risk of perforation.

Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

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

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

If the client answered **YES** to ***any one of questions 1–6*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–14. However, if she answers **YES** to ***question 4,*** the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

If the client answered **NO** to ***all of questions 1–6,*** ask if every unprotected sex act since last menses occurred within the last 5 days. If yes, she can be considered for IUD insertion as emergency contraception;* if no, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

To determine if the client is medically eligible to use an IUD, ask questions 7–14. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 14.

NO	7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	9. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	10. Within the last 3 months, have you had more than one sexual partner?	YES
NO	11. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	12. Within the last 3 months, have you been told you have an STI?	YES
NO	13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	14. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to ***all of questions 7–14,*** proceed with the **PELVIC EXAM**.

During the pelvic exam, the provider should determine the answers to questions 15–21.

If the client answered **YES** to ***any of questions 7–9,*** an IUD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to ***any of questions 10–13,*** she is not a good candidate for an IUD unless chlamydia and/or gonorrhea infection can be reliably ruled out.

If she answered **YES** to the ***second part of question 14*** and is not currently taking ARV drugs, IUD insertion is not usually recommended. If she is doing clinically well on ARVs, the IUD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUD use.

NO	15. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	16. Does the client feel pain in her lower abdomen when you move the cervix?	YES
NO	17. Is there adnexa tenderness?	YES
NO	18. Is there purulent cervical discharge?	YES
NO	19. Does the cervix bleed easily when touched?	YES
NO	20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?	YES
NO	21. Were you unable to determine the size and/or position of the uterus?	YES

If the answer to ***all of questions 15–21*** is **NO**, you may insert the IUD.

If the answer to ***any of questions 15–21*** is **YES**, the IUD cannot be inserted without further evaluation. See explanations for more instructions.

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** Women who are medically ineligible for an IUD as emergency contraception should be offered EC pills.*

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Module 6: Copper Intrauterine Device (Copper T 380A)

Checklist 6-2: Long-Acting Reversible Contraceptive Methods Counseling Skills

Adapted for the Interval Period

(To be completed by the Trainer)

Place a "**Y**" in the case box if the step/task is performed satisfactorily, an "**N**" if it is not performed satisfactorily, or **N/O** if it is not observed

Satisfactory: Performs the step or task according to the standard procedure or guidelines
Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines
Not Observed: Step, task, or skill not performed by learner during evaluation by trainer

Learner:_____ Activity Dates:_____

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Interval)						
Step/Task	**Cases**					
General Family Planning Counseling						
1. Greets the woman respectfully and with kindness						
2. Introduces herself/himself and develops a rapport with her						
3. Ensures privacy and confidentiality						
4. Obtains biographic information (name, address, etc.)						
5. Informs the client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation						
6. Asks the client about her family size, age of her last child, and her current family planning practices and experience						
7. If the client's last pregnancy was less than 2 years ago, tells her about the health benefits—for the mother and the baby—of using family planning to space at least 24–36 months from birth to the next pregnancy						
8. Uses Checklist 6-4: Pregnancy Checklist, to be reasonably sure a client is not pregnant to rule out pregnancy						

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Interval)					
Step/Task	**Cases**				
Counseling for All Methods					
1. Asks the woman about her reproductive goals: a. Does she want more children in the future? b. How long do she and her partner want to wait for the next pregnancy? c. Has she used any FP method in the past? What was her experience with the method? d. Is she breastfeeding a baby less than 6 months old? e. Does she have any FP method in mind? f. Will her partner support her in family planning? g. Does she have any medical conditions, or is she taking any medication?					
2. Based on the client's responses, talks about methods that are appropriate for her: Starts showing the counseling cards or the Flip book beginning with the most effective method					
3. Reads the back of each card or Flip book, then places it in front of the client, with the picture facing the client.					
4. Asks the client if she is interested in using any of these methods					
5. If the client expresses an interest in using one of the LARC methods, continues with the next steps					
6. Discusses the benefits of long-acting methods: a. Can be inserted anytime during the menstrual cycle after ruling out pregnancy b. Are greater than 99% effective in preventing pregnancy c. Have no impact on breastfeeding d. Can be removed when she wants another baby or has any major concerns e. Does not need any daily action.					
7. **If the client expresses an interest in using the IUD, describes the interval Copper IUD (Cu IUD)/levonorgestrel intrauterine system (LNG-IUS) insertion and timing of insertion**: a. Can be inserted anytime during the menstrual cycle (after ruling out pregnancy) b. Is effective for up to 12 years c. The IUD contains no hormones d. The LNG-IUS is effective up to 3-5 years*, contains low doses of hormones, and is safe for breastfeeding women e. Talks upfront about side-effects and changes to be expected in the bleeding patterns initially. Tells her that these are not harmful and she can come back to the provider if it is of concern to her. f. Talks about having some pain after LNG-IUS insertion specifically with nulliparous woman. Reassures that it is for short time and subsides with pain medication. g. * Note: The effectiveness period varies with the type of LNG-IUS used. Studies to confirm the effectiveness period are ongoing.					

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Interval)					
Step/Task	**Cases**				
8. **If the client expresses an interest in using the contraceptive implant, describes implant insertion and timing of insertion:** a. Can be inserted anytime during the menstrual cycle after ruling out pregnancy b. The implant is effective for up to 3–5 years (depending on the type) c. The implant contains low doses of hormones and is safe for breastfeeding women d. Talks upfront about side-effects and changes to be expected in the bleeding patterns initially. Tells her that these are not harmful and she can come back to the provider if it is of concern to her.					
9. Asks the client if she has any questions or would like the provider to repeat the information.					
10. Consults World Health Organization (WHO) Medical Eligibility Criteria (MEC) Wheel for Contraceptive Use or Job Aid 6-4: WHO MEC Quick Reference Chart to check if the chosen method is safe for her. If not, helps her to choose another method.					
11. Confirms the client's understanding by asking open-ended questions and repeating key information about the chosen method.					
12. Allows the client to make a final decision by herself (informed choice) without any coercion.					
13. Documents the family planning method chosen in the client's record card.					
14. Tells the client that she can change her decision at any time and inform the provider about it. 15. Thanks the client and helps her get the method of her choice.					
Systematic Screening for Other Services					
16. Asks the client when she last had a cervical and breast cancer screening, and offers to perform these if the last check was more than 3 years ago.					
17. Follows national guidelines for prevention of mother-to-child transmission (PMTCT) of HIV and screening for syphilis, tetanus toxoid immunization, intermittent preventive treatment for malaria and iron/folate deficiency.					
18. Discusses sexually transmitted infection (STI)/HIV transmission and prevention and dual protection with the client, using the BCS+ Counseling Cards or Flip book.					
19. Asks the client if she knows her HIV status a. If positive: i. Talk about Positive Health, Dignity, and Prevention with the client ii. Refers the client to a center for wellness care and treatment b. If the client knows that she is negative: i. Discusses timing for repeat testing c. If the client does not know her HIV status: i. Discuss HIV counseling and testing (HCT) with the client and help her get the HIV testing as per national protocols.					
20. Gives follow-up instructions, and offers condoms for dual protection.					
21. Thanks the client for completing the counseling session.					
Skill/Activity Performed Satisfactorily					

Trainer Certification

Learner is ☐ Qualified ☐ Not Qualified to counsel clients, based on the following criteria:

_____

_____

_____

_____

Counseling performed competently: ☐Yes ☐No

Trainer's Signature: _____ **Date:** _____

Module 6: Copper Intrauterine Device (Copper T 380A)

Checklist 6-3: IUD Clinical Skills

Includes insertion and removal checklists. Adapted for the regular Copper T 380A.

(To be completed by the Trainer)

Place a ☑ in case box if step/task is performed **satisfactorily**, and ☒ if it is **not** performed **satisfactorily**, or **N/O** if not observed.

- **Satisfactory**: Performs the step or task according to the standard procedure or guidelines
- **Unsatisfactory**: Unable to perform the step or task according to the standard procedure or guidelines
- **Not Observed**: Step or task or skill not performed by learner during evaluation by clinical trainer

Learner:_____ Date Observed:_____

Checklist for IUD Clinical Skills (Regular Copper T 380A)						
Step/Task	**Cases**					
Method-Specific Counseling						
Once the woman has chosen to use the IUD, assess her knowledge of the method.						
Ensure she knows that menstrual changes are a common side-effect among IUD users, and that the IUD does not protect against sexually transmitted infections (STIs).						
Describe the medical assessment required before IUD insertion, as well as the procedures for IUD insertion and removal.						
Encourage her to ask questions. Provide additional information and reassurance as needed.						
Skill/Activity Performed Satisfactorily						
IUD Insertion						
Client Assessment (Use Job Aid 6-4: WHO MEC Quick Reference Chart and WHO Medical Eligibility Criteria Wheel for Contraceptive Use to confirm that the woman is eligible for IUD use.)						
1. Review the client's medical and reproductive history.						
2. Ensure that equipment and supplies are available and ready to use.						
3. Have the client empty her bladder and wash her perineal area.						
4. Help the client onto the examination table.						
5. Tell the client what is going to be done, and ask her if she has any questions.						
6. Wash hands thoroughly and dry them.						
7. Palpate the **abdomen**.						
8. Wash hands thoroughly and dry them again.						
9. Put clean examination gloves on both hands.						

Checklist for IUD Clinical Skills (Regular Copper T 380A)					
Step/Task	**Cases**				
10. Inspect the external genitalia. Note: • If findings are normal, perform the bimanual exam first and the speculum exam second. • If there are potential problems, perform the speculum exam first and a bimanual exam second.					
11. 11a. Perform a **bimanual exam** (see **Note** above)					
11b. Perform rectovaginal exam only if indicated.					
11c. If rectovaginal exam is performed, change gloves before continuing.					
12. Perform a **speculum exam** (see **Note** above). (**Note:** If laboratory testing is indicated and available, take samples now.)					
Skill/Activity Performed Satisfactorily					
Pre-Insertion and Insertion Steps (Using aseptic, "no-touch" technique throughout)					
1. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.					
2. Gently insert the HLD (or sterile) speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic at least twice.					
3. Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.					
4. Insert the HLD (or sterile) sound as instructed (Handout 6-2), using the "no-touch" technique.					
5. Stop when you feel the resistance felt at the fundus. Do not try to push or overcome the resistance.					
6. Load the IUD in its sterile package using "no-touch" technique (Job-Aid 6-5) 7. Note: Do not start loading more than 10 minutes before insertion.					
8. Set the blue depth-gauge to the measurement of the uterus.					
9. Carefully insert the loaded IUD, and release it into the uterus using the "withdrawal" technique.					
10. Gently push the insertion tube upward again until you feel a **slight resistance** at the fundus. Be careful do not push the insertion tube.					
11. Withdraw the rod, and partially withdraw the insertion tube until the IUD strings can be seen.					
12. Use HLD (or sterile) sharp Mayo scissors to cut the IUD strings to 3 cm–4 cm length while still inside the inserter tube.					
13. Gently remove the tenaculum and place in 0.5% chlorine solution for 10 minutes for decontamination*.					
14. Examine the cervix for bleeding. If no bleeding, gently remove the speculum.					
15. Ask how the client is feeling and begin performing the post-insertion steps.					
Skill/Activity Performed Satisfactorily					
Post-Insertion Steps					
1. Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination*.					
2. Properly dispose of waste materials.					

Checklist for IUD Clinical Skills (Regular Copper T 380A)						
Step/Task	**Cases**					
3. Process gloves according to recommended infection prevention (IP) practices.						
4. Wash hands thoroughly and dry them.						
5. Provide post-insertion instructions (key messages for IUD users): • Basic facts about the IUD (e.g., type, how long effective, when to replace/remove) • No protection against STIs; need for condoms if at risk • Possible side-effects • Warning signs (PAINS) • Checking for possible IUD expulsion • When to return to clinic						
Skill/Activity Performed Satisfactorily						
IUD Removal						
Pre-Removal Steps						
1. Ask woman the reason for having the IUD removed.						
2. Determine whether she will have another IUD inserted immediately, start a different method, or neither.						
3. Review the client's reproductive goals and need for STI protection, and counsel as appropriate.						
4. Ensure that equipment and supplies are available and ready to use.						
5. Have the client empty her bladder and wash her perineal area.						
6. Help the client onto the examination table.						
7. Wash hands thoroughly and dry them.						
8. Put new clean examination gloves on both hands.						
Skill/Activity Performed Satisfactorily						
Removing the IUD						
1. Provide an overview of the removal procedure. Remind her to let you know if she feels any pain.						
2. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic twice.						
3. Alert the client immediately before you remove the IUD.						
4. Grasp the IUD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.						
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUD. **Do not use excessive force**.						
6. Show the IUD to client.						
7. Place the IUD in 0.5% chlorine solution for 10 minutes for decontamination* and dispose of appropriately.						
8. If the woman is having a new IUD inserted, insert it now if appropriate. (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*.)						
9. Ask how the client is feeling and begin performing the post-removal steps.						
Skill/Activity Performed Satisfactorily						
Post-Removal Steps						

Checklist for IUD Clinical Skills (Regular Copper T 380A)						
Step/Task	**Cases**					
1. Before removing the gloves, place all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination*.						
2. Properly dispose of waste materials.						
3. Process gloves according to recommended IP practices.						
4. Wash hands thoroughly and dry them.						
5. If the woman has had a new IUD inserted, review key messages for IUD users. (If the woman is starting a different method, provide the information she needs to use it safely and effectively [and a backup method, if needed].)						
Skill/Activity Performed Satisfactorily						

* WHO's 2016 Infection Prevention Guidelines no longer recommend soaking instruments in disinfectant prior to cleaning. Please refer to in-country guidelines for this step.

Trainer Certification

Learner is ☐ Qualified ☐ Not Qualified to deliver IUD services, based on the following criteria:

_____

_____

_____

_____

	With Models		With Clients	
Clinical Skills performed competently:	☐Yes	☐No	☐Yes	☐No

Trainer's Signature: _____ **Date:** _____

Source: Adapted from Bluestone J, Chase R, Lu ER, eds. IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual. Third Edition. Baltimore, MD: Jhpiego, 2006.

How to Be Reasonably Sure a Client is Not Pregnant

Before initiating a medical regimen, health care providers often need to assess whether a woman is pregnant because some medications may have side effects that are potentially harmful to the fetus. According to the World Health Organization (WHO), there is no known harm to the woman, the course of her pregnancy, or fetus if hormonal contraceptive methods are accidentally used during pregnancy. However, it is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant, because women who are currently pregnant do not require contraception. In addition, methods such as IUDs should never be initiated in pregnant women because doing so might lead to septic miscarriage, a serious complication.

Providers often rely on the presence of menses as an indicator that a woman is not pregnant. However, providers often see women who want to start a contraceptive method when they are between menstrual periods. Since pregnancy cannot be confirmed or ruled out with a pregnancy test until a woman has missed her period, providers often require women to wait until they menstruate and then come back for method initiation. The pregnancy checklist helps providers rule out pregnancy with reasonable certainty when women are between menstrual periods, allowing women to initiate their method of choice without a delay.

FHI 360 (formerly Family Health International) developed the checklist with support from the U.S. Agency for International Development (USAID). The checklist is based on criteria endorsed by the WHO to determine with reasonable certainty that a woman is not pregnant. Evaluation of the checklist in family planning clinics has demonstrated that the tool is very effective in correctly identifying women who are not pregnant. Furthermore, studies in Guatemala, Mali, and Senegal have shown that use of these checklists by family planning providers significantly reduced the proportion of clients being turned away due to menstrual status, and improved women's access to contraceptive services.

Although the original checklist was developed for use by family planning providers, it can be used by both clinical and nonclinical health care providers to determine whether a client is pregnant. For example, pharmacists may use this checklist when selling medications that don't require a prescription, but should be avoided during pregnancy (e.g., certain antibiotics or certain common painkillers).

This checklist is part of a series of provider checklists for reproductive health services. The six questions that comprise the pregnancy checklist are integrated into these other checklists: the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN),* the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives (COCs),* the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD,* and the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants.* For more information about the provider checklists, please visit www.fhi360.org.

Explanation of the Questions

The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers "yes" to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant.

Women who are in the first seven days of their menstrual cycle or who have had a miscarriage/abortion in the past seven days are protected from unplanned pregnancy because the possibility of ovulation in these situations is extremely low. With the IUD, this period is extended to day 12 of the menstrual cycle because of the additional contraceptive effectiveness of the copper IUD. The probably of ovulation is also very low for women who are in their first four weeks postpartum. Women who satisfy the lactational amenorrhea method criteria (e.g., women who are in their first six months postpartum, are fully or nearly-fully breastfeeding, and are amenorrheic) are protected from unplanned pregnancy because of the effects of lactational amenorrhea on the reproductive cycle. Likewise, women who consistently and correctly use a reliable contraceptive method are effectively protected from pregnancy, as are those who have abstained from sexual intercourse since their last menstrual period.

Sources:

1 Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for Updating Selected Practices in Contraceptive Use: Volume II.* Washington: U.S. Agency for International Development, 1997.

2 Stanback J, Qureshi Z, Nutley T, Sekadde-Kigondu C. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(August 14):566.

3 Stanback, John, Diabate Fatimata, Dieng Thierno, Duarter de Morales, Cummings Stirling, and Traore Mahamadou. Ruling Out Pregnancy Among Family Planning Clients: The Impact of a Checklist in Three Countries. *Studies in Family Planning* 2005;36[4]:311–315.

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions.

NO	1.	Did your last menstrual period start within the past 7 days? *	YES
NO	2.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3.	Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery?	YES
NO	4.	Have you had a baby in the last 4 weeks?	YES
NO	5.	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	6.	Have you had a miscarriage or abortion in the past 7 days? *	YES

** If the client is planning to use an IUD, the 7 day window is expanded to 12 days.*

If the client answered **NO** to ***all of the questions,*** pregnancy cannot be ruled out using the checklist.†

Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

If the client answered **YES** to ***at least one of the questions*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure she is not pregnant.

† *If the client is concerned about an unintended pregnancy, offer emergency contraception if every unprotected sex act since last menses occurred within the last 5 days.*

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Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-1: Copper Intrauterine Device Fact Sheet

The intrauterine contraceptive device (IUD) is a small plastic device inserted into a woman's uterus to prevent pregnancy. The most commonly used IUDs are shaped like a T and have copper wires or bands on the plastic stem and arms.

The Copper T 380A, or "Copper T," is the most widely used copper IUD in the world. It is effective for up to 12 years.

Primary mechanism of action

Prevents fertilization: The copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tubes and fertilizing the egg (Rivera et al. 1999)

Timing of Insertion

- At any time, if you are reasonably sure the client is not pregnant
- During the menstrual cycle
- Within 12 days, no need for a backup method
- If more than 12 days, make sure she is not pregnant, and no need of a backup method
- Switching from another method
- Immediately, if using the method correctly and consistently; otherwise, make sure she is not pregnant. No need for a backup method.
- If the woman is switching from an injectable contraceptive, the Copper T 380A can be inserted prior to the next scheduled injection. No backup method is needed.
- Soon after childbirth (breastfeeding or non-breastfeeding)
- Within 48 hours of delivery, or during a cesarean section
- If more than 48 hours, then delay until 4 weeks
- Post abortion/miscarriage
- Immediately or days after a 1st or 2nd trimester abortion, if no infection
- Delay after medical (non-surgical) abortion until confirmed that the uterus is completely empty
- For emergency contraception
- Within 5 days after unprotected sex
- After taking emergency contraceptive pills (ECP) the Copper T 380A can be inserted on the same day. No need for back up method.
- No monthly bleeding (amenorrhea that is not related to childbirth or breastfeeding)
- At any time, if reasonably sure she is not pregnant. No need for a backup method.

Characteristics of Copper IUDs

- Contraceptive Effectiveness: The IUCD is effective as soon as it is inserted. The IUCD is one of the most effective and long-acting contraceptive methods. Its effectivity is comparable to that of female and male sterilization. The failure (pregnancy) rate associated with IUD is:
    - Less than 1% in the first year of use. This means less than 1 pregnancy per 100 women in the first year of use (6 to 8 pregnancies per 1000 women)
    - A very small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUD.
- Effective Lifespan: The Copper T 380A is effective up to 12 years
- Removal or Replacement: The Copper IUD should be replaced or removed no later than the full lifespan of IUD (12 years) from the date of insertion. These can be removed any time when a woman wants, before completion of the total duration.
- Return to Fertility: A woman's fertility returns promptly after an IUD is removed (Andersson et al. 1992; Belhadj et al. 1986). This message should be made very clear to clients having an IUD removed (i.e., they should have another IUD inserted immediately after removal (if desired and appropriate). or immediately start another contraceptive method unless they want a pregnancy.

Advantages of IUD

- No constant/daily supplies needed
- Effective immediately upon insertion
- No user action required
- Does not interfere with intercourse
- Long-acting and reversible
- Have beneficial non-contraceptive effects (protection from endometrial cancer and ectopic pregnancy)
- Can be used by postpartum and lactating women
- Does not interact with any medicines the client may be taking
- Fertility returns promptly on removal
- Can be used as an emergency contraceptive if inserted within five days of the first act of unprotected sexual intercourse

Limitations of IUD

- Trained provider needed to insert and remove the IUD
- Pelvic examination before IUD insertion is mandatory, which is not so for other spacing methods
- May cause minor pain or discomfort during insertion and removal procedures
- Has side-effects of changes in menstrual pattern and cramps
- Small risk of expulsion
- Provides no protection from sexually transmitted infections (STIs), including HIV

Side-effects

(generally not signs of a health problem; may diminish or change over time)

- Pain or cramping during menses
- Prolonged and heavy menstrual bleeding
- Bleeding or spotting between monthly periods

Potential Health Risks

- Spontaneous expulsion occurs in about 2-8 % clients (Trieman et al 1995) and is most likely to occur during the first three months after insertion, and during menstrual periods.
- If pregnancy occurs with the IUCD in situ, there is a risk of spontaneous abortion, sepsis and ectopic pregnancy; however, IUCD is not reported to be having any adverse effects on the fetus.
- Infection following insertion is less than 1%. This minimal risk is highest during the first 20 days after insertion, especially if aseptic precautions have not been taken, rather than due to the device itself. (Hatcher et al 2004)
- Uterine perforation during insertion is a rare complication which occurs in 0.5 - 1.5 per 1000 insertions and is associated with the level of provider's skill and experience (Trieman et al 1995).

Who can have a copper IUD inserted

Women of any parity or reproductive age, married or unmarried, including nulliparous women who:

- Want to use this method of contraception
- Have no known conditions that preclude safety

Who should not have a copper IUD inserted

Women who have the following known conditions:

- Known or suspected pregnancy
- Sepsis following childbirth or abortion (if insertion is immediately postpartum or post abortion)
- Unexplained vaginal bleeding
- Cervical, endometrial, or ovarian cancer
- Current pelvic inflammatory disease
- Current purulent cervicitis (gonorrhea or chlamydia)
- Malignant gestational trophoblastic disease
- Known pelvic tuberculosis
- Uterine fibroid or other anatomical abnormalities resulting in distortion of the uterine cavity, which is incompatible with IUD insertion

Use of IUDs by women with HIV and AIDS

- An IUD can be provided to a woman with HIV if she has no symptoms of AIDS.
- An IUD generally should not be initiated in a woman with AIDS who is not taking antiretroviral drugs (ARVs).

- A woman who develops AIDS while using an IUD can continue to use the device.
- A woman with AIDS who is doing clinically well on ARV therapy can both initiate and continue IUD use, but follow-up may be required.

Provide follow-up and counseling for

- Any client concerns or questions
- Potential side-effects and reassure her that they are temporary and not a sign of any disease and can be managed easily.
- A woman should return for follow-up after her first menses (3-6 weeks following insertion), OR
- At any time, if having any concerns or side-effects related to the IUD
- Any signs of complications; although rare, counsel the woman to come back immediately if any of the following symptoms develop:

Warning Signs

Tell the client to return to the clinic if any of the following signs develop:
PAINS:

- **P**eriod-related problems Or Pregnancy
- **A**cute abdominal cramping during the first three to five days after insertion (perforation)
- **I**nfection**:** Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection)
- **N**ot feeling well
- **S**tring-related problems

Source: Adapted from Technical Resource Package for Family Planning, WHO Selected practice recommendations for contraceptive use, Third Edition 2016.

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-2: Passing a Uterine Sound

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

Purpose of Sounding the Uterus

- To check for obstructions in the cervical canal.
- To measure the length from external cervical os to the uterine fundus so that the blue depth gauge on the insertion tube (Copper T 380A IUD) can be set at the same distance, so that the IUD will be placed high in the uterine fundus.

Procedure for Sounding the Uterus

Use gentle, "no-touch" (aseptic) technique throughout.

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

Step 1

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

Step 2

Apply the high-level disinfected (HLD) or sterile tenaculum to the cervix. Close the tenaculum one notch at a time, slowly, and no farther than necessary.

Step 3

Pick up the handle of the sound, do not touch the tip. Turn the sound so that it curves in the same direction as the uterus. Gently pass the HLD or sterile tip of the uterine sound into the cervical canal. At the same time, keep a firm grip with the tenaculum. (Be careful not to touch the walls of the vagina with tip of sound.) Carefully and gently, insert the uterine sound in the direction of the uterus while gently pulling steadily outward on the tenaculum. If there is resistance at the internal os, use a smaller sound, if available. Do not attempt to dilate the cervix unless well-qualified. Gentle traction on the tenaculum may enable the sound to pass more easily. Advance sound gently and slowly until **resistance is felt**. Stop at this point as it indicates the uterine fundus. **Do not try to push or overcome the resistance felt at the fundus.** If client begins to show symptoms of fainting or pallor **with slow heart rate, STOP.**

Step 4

Slowly withdraw the sound; it will be wet and darker where it was in the uterus. Place the sound next to the IUD and set the blue depth gauge at the depth of the uterus. If the uterine sound is graduated, then mark the length and set the gauge on the white measurement card. The average uterus will sound to a depth of 6 cm to 8 cm.

Note: If the uterus sounds to a depth of 10 cm or more, the sound may have perforated the uterus, or the uterus may be enlarged due to tumors or pregnancy. DO NOT insert an IUD. If perforation is suspected, observe the client in the clinic carefully.

- For the first hour, keep the woman in bed and check the pulse and blood pressure every 5 to 10 minutes.
- If the woman remains stable after one hour, check the hematocrit/hemoglobin if possible, allow her to walk, check vital signs as needed, and observe for several more hours. If she has no signs or symptoms, she can be sent home, but should avoid intercourse for two weeks. Help her make an informed choice about a different (backup) contraceptive.
- If there is a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, hospitalization is needed.

Source: Adapted from Solter C. *Intrauterine Devices (IUDs): Participant's Manual*. Watertown, MA: Pathfinder International, 2008.

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-3: Infection Prevention for IUDs

Infection Prevention Tips

IUD Insertion

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

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

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

IUD Removal

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

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

Follow these steps for processing used instruments:

Decontamination

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

Cleaning and Rinsing

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

High-Level Disinfection

High-level disinfection through boiling or the use of chemicals is the recommended practice. Surgical (metal) instruments and reusable gloves should be boiled for 20 minutes. **Begin timing when boiling action starts** Alternatively, instruments can be soaked for 20 minutes, in a 2% glutaraldehyde or 0.5% chlorine solution. After cooling (if boiled) or rinsing in HLD water (water boiled for 20 mins., if chemical disinfectants used) and drying, instruments are ready to use. Use immediately or store for up to 1 week in a clean, dry, high-level disinfected (HLD) container with a tight-fitting lid or cover.

Sterilization

Alternatively, instruments used for IUD insertion and removal can be sterilized by autoclaving (121°C [250°F] and 106 kPa [15 lb/in^2] for 20 minutes if unwrapped and 30 minutes if wrapped.
Note: Dry heat sterilization (170°C [340°F] for 60 minutes) can be used **only** for metal or glass instruments.

Storage

Use high-level disinfected or sterilized instruments and gloves immediately, or store them for up to 1 week in a high-level disinfected or sterilized air-tight container accordingly with a tight-fitting cover.
If lid is opened, repeat the sterilization procedure after 24 hours for reusing. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.

Sources: Solter C. *Intrauterine Devices (IUDs)*. Second Edition. Watertown, MA: Pathfinder International, 2008; Blouse A, Kinzie B, McIntosh N. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual*. Baltimore, MD: Jhpiego, 1992.

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-4: Managing Side-Effects and Potential Complications of IUDs

Thorough counseling about bleeding changes and some cramping following insertion must be done prior to IUD insertion. Counseling about bleeding changes may be the most important message to help a woman to keep using the method.

Common side-effects

Changes in bleeding pattern: Prolonged and heavy monthly bleeding, irregular bleeding, cramps and pain during monthly bleeding.

Explain about these side-effects

- Bleeding changes are not a sign of illness
- Usually subside after the first few (3–6) months
- Client can come back anytime if side-effects bother her

Management of Common Side-Effects:

Change in Menstrual Bleeding Patterns:

Manage as appropriate based on findings

- If bleeding is mild and less than 3 months after insertion and no evidence of any pathology or pregnancy, reassure the client that this is not harmful and usually subsides on its own. Give iron and folic acid tabs for a month.
- If her menstrual bleeding lasts twice as long or is twice as heavy than usual, refer to doctor or specialist for further evaluation and treatment
    - For modest, short-term relief: Tab tranexamic acid 1500 mg 3 times daily for 3 days, then 1,000 mg once daily for 2 days, beginning when heavy bleeding starts OR Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen 600-800 mg orally, three times a day with food for 5 days beginning when heavy bleeding starts.
    - Provide iron tablets and tell her it is important for her to eat iron-rich foods

If her menstrual bleeding changes have continued beyond 3 to 6 months after IUD insertion and a gynecologic problem is suspected, refer to a doctor or specialist for further evaluation and treatment.

- Irregular bleeding (bleeding at unexpected times that bothers the client)
    - Reassure her that many women using IUDs experience irregular bleeding. It is not harmful and usually diminishes or stops after the first several months of use.
    - For modest, short-term relief: NSAIDs such as ibuprofen (600 mg-800 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when irregular bleeding starts

- If her menstrual bleeding changes are **very bothersome to the woman** and she wishes to have the IUD removed, remove it and counsel her for other methods and give her another method of her choice.

Cramping and Pain: Increased cramping or pain associated with menstruation is another common side-effect among users of copper-bearing IUDs.

- If these symptoms are bothersome, severe, or associated with other signs/symptoms that suggest they are not related to menstruation, refer or conduct appropriate assessment (including pelvic examination) to identify or rule out other possible causes of the symptoms, such as infection, partial IUD expulsion, uterine perforation, and pregnancy/ectopic pregnancy.
- When other possible causes of the symptoms are ruled out, manage as appropriate based on findings. If cramping or pain, provide reassurance and recommend paracetamol (500 mg every 4-6 hours) or another NSAID immediately before and during menstruation to help reduce symptoms. If it persists, remove the IUD. Give her another method of her choice.

Potential Complications of IUD:

Most of the IUD insertion-related complications can be prevented by careful screening of clients, strict adherence to correct infection prevention techniques and meticulous attention to standard insertion technique.

Potential Complications of an IUD

Complications	Risk	Linked to	Reduced through	Management
Perforation	Very Rare	Skill and experience of provider	Supervised training and using correct insertion technique	Usually occurs during insertion and usually heals without treatment. Stop the procedure immediately and gently remove the instruments. Keep client under observation for approximately 2 hours, and monitor vital signs. Look for signs of shock, if she is having severe pain, fainting, rapid pulse, low blood pressure. Manage for shock immediately. If not recovering and symptoms aggravating, refer immediately to higher level facility for management and ultrasound. Advise follow-up in a week, or as needed. If uterine perforation is suspected within 6 weeks after insertion, or if it is suspected later and is causing symptoms, refer the client for management and ultrasound to a clinician experienced at removing such IUDs.
Infection	Rare	Lack of infection prevention practices during insertion	Use of aseptic and "no-touch" techniques	Assess vital signs, abdominal and pelvic examination, and appropriate laboratory tests (pregnancy test, CBC, cultures) to rule out other problems: endometritis; appendicitis; partial IUCD expulsion; uterine perforation; pregnancy/ectopic pregnancy; or urinary tract infection. Begin treatment immediately with an appropriate antibiotic. If diagnosis of pelvic inflammatory disease (PID) confirmed, treat or refer immediately; give appropriate antibiotic therapy; no need to remove IUD if she wants to continue using it.
Expulsion	Rare	Provider's skill	Careful screening, examination, and insertion technique (fundal placement)	Do an assessment including pelvic examination to rule out pregnancy If complete expulsion of the IUD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): insert IUD if desired after assessing the client for excluding pregnancy and infection or counsel for another family planning method. If IUD is found outside uterine cavity: refer her immediately for further management by an expert. If partial IUD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUD and provide another IUD if desired and appropriate (not pregnant or infected) or counsel for another family planning method. If the IUD appears to be embedded in the cervical canal and cannot be easily removed by the standard technique, refer the woman for IUD removal to a specialist. Note: Ultrasound is never recommended as a routine for placement under normal conditions.

Complications	Risk	Linked to	Reduced through	Management
Pregnancy with IUD in situ	Rare	Failures occur with IUD in position. Undetected existing pregnancy prior to insertion, partial expulsion.	Careful screening to rule out early pregnancy and proper insertion technique (fundal placement)	If a woman is diagnosed with pregnancy with IUD in situ, rule out ectopic pregnancy When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester: Counsel the woman on the risks of immediate removal of the IUD: removing the IUD slightly increases the risk of abortion; and leaving the IUD in place can cause second trimester abortion, infection, and preterm delivery. If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUD is still in the uterus or has been expelled. If the IUD is still in place, do not try to remove it. If the woman declines removal, provide antenatal care, close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Ensure that IUD is removed at delivery.
Missing Thread				Rule out pregnancy. Conduct speculum examination to visualize thread; if not visible, then conduct X-ray/ultrasound for localization of the IUD. Once pregnancy has been ruled out: Probe the cervical canal using a high-level disinfected (or sterile) long artery forceps or cyto-brush to locate the strings, and gently draw them out so that they are protruding into the vaginal canal. If the strings are not located in the cervical canal (or cannot be drawn out), and the woman does not want to keep the IUD, refer her for IUD removal by a specially trained provider. A specially trained provider can do an ultrasound to check whether the IUD is in place or has been expelled. If the IUD is still in place, the strings can be drawn out using a long artery forceps or alligator forceps.

Sources: WHO, JHSPH, USAID. *Family Planning: A Global Handbook for Providers*. Geneva: WHO, 2011; Bluestone J, Chase R, Lu ER, eds. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual.* Third Edition. Baltimore, MD: Jhpiego, 2006. *IUCD Reference Manual for Medical Officers and Nursing Personnel, September 2013, MOHFW Govt of India.*

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-5: Sample Client Follow-up Card

Front of Card

Client's Follow-Up Card

Client Full Name:_____

Type of IUD Inserted:_____

Date of Insertion: _____

Provider's Signature:_____

Date of Removal OR Replacement: Month_____Year_____

If you have any problem or question go to:_____

_____

_____

_____

(Name and address of the nearby clinic/center. Take this card with you.)

Back of Card

Client Follow-Up Visit

Date	Reason /Complaint	Advise/Treatment Given	Provider Signature

Note: If you are experiencing any of the following warning signs, please return to your clinic immediately

- **P**eriod problems or Pregnancy
- **A**cute abdominal cramping: during the first three to five days after insertion
- **I**rregular bleeding: irregular bleeding or pain in every cycle
- **N**ot feeling well: fever and chills, unusual vaginal discharge, or low abdominal pain
- **S**tring problems: missing strings

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-6: Post-Insertion Instructions and Follow-up Care

Post-insertion instructions

- Before the woman leaves the clinic, counsel her on key messages:
- "You have a Copper T IUD inserted."
- "It is effective up to 12 years. You may get it removed anytime you want a child or have any concerns."
- "It is effective immediately. You can have sexual intercourse as soon as you desire with no backup protection."
- You may have changes in your menstrual bleeding pattern like spotting, irregular periods, prolonged or increased bleeding. This is not a sign of illness and will settle in about 3 months.
    - Ask her to repeat key information to ensure that she understands it.
    - Ask her to repeat warning signs and tell her to return to the clinic immediately if she experiences any of the warning signs (or PAINS)
    - Encourage her to ask questions and state any concerns that she may have.
    - Provide reassurance, as needed.
    - Give the woman a reminder/follow-up card and tell her to bring it during follow up visit
    - Tell her she can come back to the clinic anytime if she wants the IUD to be removed, or for any reason she feels that she needs to consult a health provider.

Follow-up care

Follow-up care after insertion of IUD is a vital component for ensuring client satisfaction and quality of care. It is the responsibility of the service provider to provide regular and need-based follow-up care and manage any problems experienced by the woman or observed during assessment.

Key Objectives

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

After IUD insertion, a woman is advised to return to the clinic for her first routine checkup within 3 to 6 weeks (not later than 3 months, unless she has serious problems that require emergency services). Serious problems requiring immediate care include:

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

The woman is encouraged to return anytime:

- If she is experiencing the above problems.
- If she wants the IUD removed, or for any reason she feels that she needs to consult a health provider.

If the woman lives far from the health facility where the insertion was done, she should be counseled and supported by the community health workers to go to the nearby health facility for follow-up care.

During a Follow-up visit

- Ask the woman about her satisfaction with the method.
- Conduct a per speculum examination to visualize the strings. Cut them short if the woman finds them uncomfortable.
- Reinforce the messages on warning signs and spontaneous expulsion of the IUD during the first few months.
- If the IUD has been expelled, exclude pregnancy. Offer the woman another contraceptive method of her choice OR reinsert the IUD if she so desires.
- Encourage use of condoms for STI protection, as appropriate.
- If the IUD is in place and the woman has no problems, no other follow-up visits are required.
- The woman should be advised to return for removal as desired or at the end of the recommended period.
- If the woman is not satisfied or has any of the following problems, the IUD may be removed:
    - Partial expulsion
    - Infection
    - Perforation
    - Persistent uterine cramping
    - Pregnancy
- Remind her of the date (month/year) when her IUD needs to be removed/replaced.

Module 6: Copper Intrauterine Device (Copper T 380A)

Handout 6-7: Rumors and Misconceptions about IUDs

Rumors are unconfirmed stories that are transferred from one person to another by word of mouth.

In general, rumors arise when:

- An issue or information is important to people, but it has not been clearly explained.
- There is nobody available who can clarify or correct the incorrect information.
- The original source is perceived to be credible.
- Clients have not been given enough options for contraceptive methods.
- People are motivated to spread them for political reasons.

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

Unfortunately, rumors or misconceptions are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs pertaining to family planning that they allow to have an impact on their professional conduct.

The underlying causes of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about family planning make rational sense to clients and potential clients. People usually believe a given rumor or piece of misinformation due to immediate causes (e.g., confusion about anatomy and physiology).

Methods for Counteracting Rumors and Misinformation

1. When a client mentions a rumor, always listen politely. Don't laugh.
2. Define what a rumor or misconception is.
3. Find out where the rumor came from and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.
4. Explain the facts.
5. Use strong scientific facts about family planning methods to counteract misinformation.
6. Always tell the truth. Never try to hide side-effects or problems that might occur with various methods.
7. Clarify information with the use of demonstrations and visual aids.
8. Give examples of people who are satisfied users of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
9. Reassure the client by examining her and telling her your findings.
10. Counsel the client about all available family planning methods.
11. Reassure and let the client know that you care by conducting home visits.

Rumors or Misinformation and Facts and Realities

Rumor or Misinformation	Facts and Realities: Information to Combat Rumors
The thread of the IUD can trap the penis during intercourse.	The strings of the IUD are soft and flexible, cling to the walls of the vagina, and are rarely felt during intercourse. If the string is felt, it can be cut very short (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis because the IUD is located within the uterine cavity, and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot injure it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)
A woman who has an IUD cannot do heavy work.	Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.
The IUD might travel inside a woman's body to her heart or her brain.	There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and—unless it is accidentally expelled—stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. The provider can teach the client how to feel for the string, if the client is comfortable doing so.
A woman can't get pregnant after using an IUD.	A woman's fertility returns to normal very soon after the IUD is removed. Studies have shown that most women who discontinue the IUD become pregnant as rapidly as those who have never used contraception.
If a woman with an IUD becomes pregnant, the IUD gets embedded in the baby's forehead.	The baby is very well protected by the sac filled with amniotic fluid inside the mother's womb. If a woman gets pregnant with an IUD in place, the health provider will remove the IUD immediately due to the risk of infection. If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.
The IUD deteriorates in the uterus after prolonged use.	Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made of materials that cannot deteriorate. The client can keep it longer, if she desires, without any risk.
Note: The information and misconceptions below apply more directly to health workers.	
An IUD can't be inserted until 6 weeks postpartum.	The IUD can be inserted by a trained provider immediately after delivery (within 10 minutes of delivery of the placenta), or during a cesarean section, or up to 48 hours following delivery. Postpartum insertion of an IUD has been shown to be safe, effective, and convenient for women like the regular or interval IUD. Postpartum insertion appears to have a lower chance of perforation as instrument used is blunt and uterine wall is thick just after the pregnancy. After the 48-hour postpartum period, a Copper T 380A may be safely inserted at four or more weeks postpartum. It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum.
The IUD causes ectopic pregnancy.	There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. Studies have shown the risk of ectopic pregnancy to be the same for all women (with or without an IUD). However, if client becomes pregnant with IUD, ectopic pregnancy must be excluded.

Rumor or Misinformation	Facts and Realities: Information to Combat Rumors
An IUD that is discolored in the package is dangerous and can't be used.	The copper on IUDs sometimes changes color in the package as it oxidizes (reacts to air). The IUD can still be used and is safe as long as the package is not torn or broken open and as long as it is not past the expiration date printed on the packaging.
Women who have never given birth cannot use an IUD.	Women using the IUD who have never been pregnant may have an increased rate of expulsion and may experience more pain during insertion. However, the IUD is still safe for them to use. WHO carefully reviewed all of the literature before listing nulliparity as Category 2, (generally use; some follow-up may be needed).
Women infected with HIV cannot use an IUD.	IUD use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment (ART). As per WHO Medical Eligibility Guidelines, if the woman having Copper IUD/LNG-IUS develops HIV, she can continue using it during treatment (Category 3A).
IUDs increase the risk of pelvic inflammatory disease (PID) and must be removed when it occurs.	Many studies have confirmed that the risk of infection and infertility among IUD users is very low (Hatcher 2004). However, studies also indicate that the insertion process—and not the IUD or its strings—poses the temporary risk of infection. Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. The risk of infection following IUD insertion returns to a very low or normal level after 20 days (Farley et al. 1992). As per WHO Medical Eligibility Guidelines, if condition develops while using method, can continue using it during treatment (Category 4A).

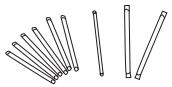
Source: Solter C. *Intrauterine Devices (IUDs).* Second Edition. Watertown, MA: Pathfinder International, 2008.

Job Aid 6-1: Comparing Effectiveness of Family Planning Methods

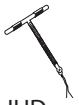
Comparing Effectiveness of Family Planning Methods

More effective

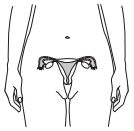
Less than 1 pregnancy per 100 women in 1 year



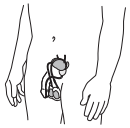
Implants



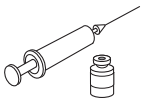
IUD



Female sterilization

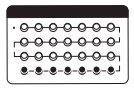


Vasectomy



Injectables

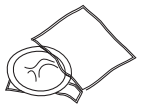
LAM



Pills

Patch

Vaginal ring



Male condoms

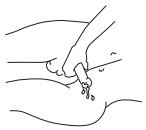
Diaphragm

Female condoms

Fertility awareness methods

Less effective

About 30 pregnancies per 100 women in 1 year



Withdrawal

Spermicides

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables: Get repeat injections on time

Lactational amenorrhea method, LAM (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

Withdrawal, spermicides: Use correctly every time you have sex

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World Health Organization

Sources:

Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized controlled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol* 2006;195:85–91.

World Health Organization Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Cates W Jr., Guest F, Kowal D, eds. *Contraceptive Technology, Nineteenth Revised Edition*. New York: Ardent Media, Inc., in press.

2007

Job Aid 6-2: Method Effectiveness Chart

Method	If method is used consistently and correctly *(perfect use)*:	If method is occasionally used incorrectly or not used *(typical use)*:
Implants	less than 1	less than 1
IUD	less than 1	less than 1
Male and Female Sterilization	less than 1	less than 1
Injectables	less than 1	6
Pills	less than 1	9
Male condoms	2	18
Standard Days Method	5	12
Female condoms	5	21
Diaphragm	6	12
Withdrawal	4	22
Spermicides	16	28

If 100 Women Use a Method for One Year, How Many Will Become Pregnant?

Note: The lactational amenorrhea method (LAM) is a highly effective *temporary* method with 1 to 2 pregnancies per 100 women in the first 6 months after childbirth.

Source: USAID, WHO, UNFPA. Training Resource Package for Family Planning. Contraceptive Method Effectiveness, 11/2011.

How Contraception Works

Prevents Fertilization
of the Egg by the Sperm

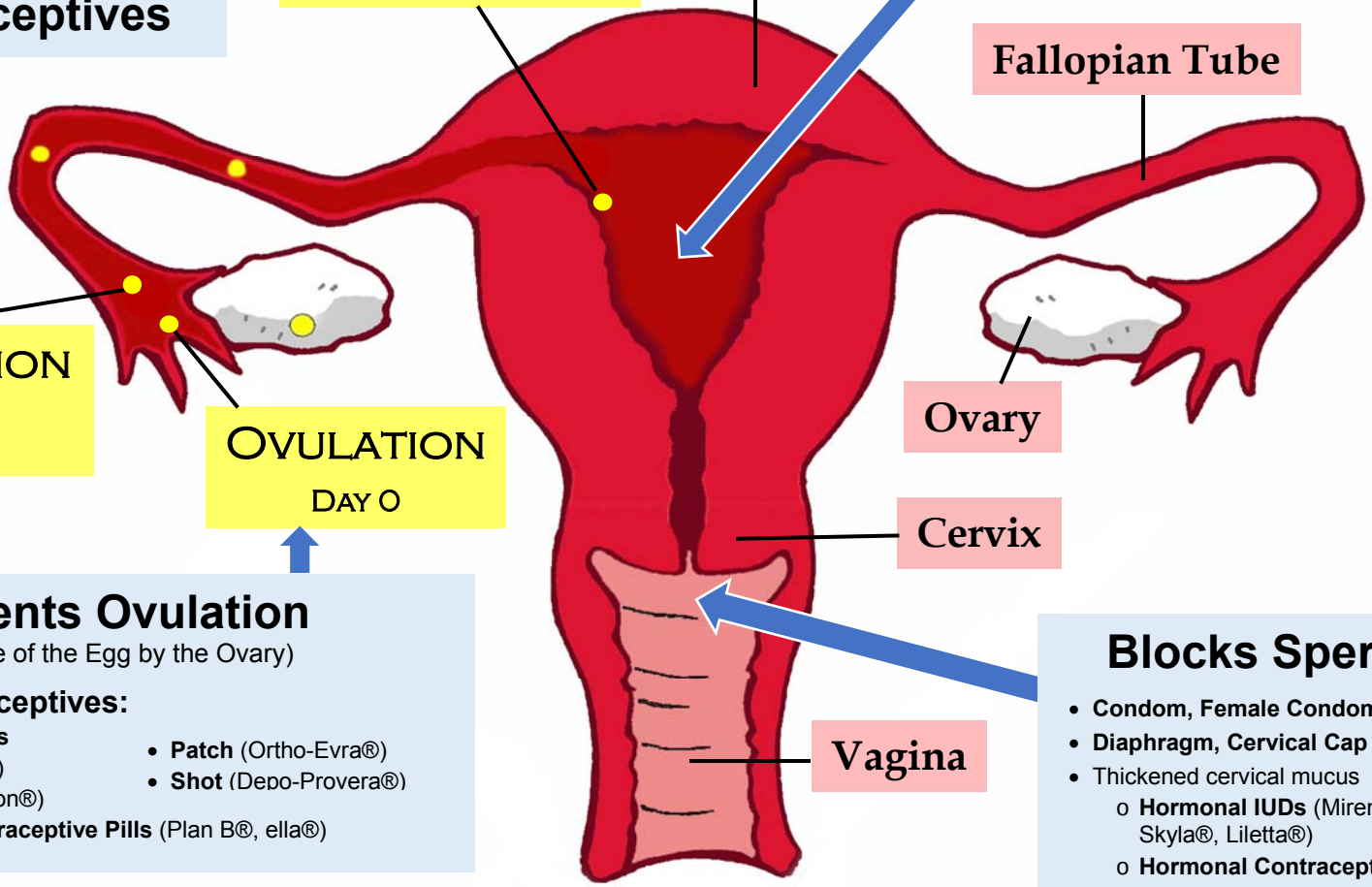
All Contraceptives

Implantation
Day 7

Uterus

Incapacitates Sperm
Primary action of **Copper IUD** ParaGard®)

Fallopian Tube



Fertilization
(Conception)
Day 0 -1

Ovulation
Day 0

Ovary

Cervix

Vagina

Prevents Ovulation
(Release of the Egg by the Ovary)

Hormonal Contraceptives:

- **Birth Control Pills**
- **Ring** (NuvaRing®)
- **Implant** (Nexplanon®)
- **Patch** (Ortho-Evra®)
- **Shot** (Depo-Provera®)
- **Emergency Contraceptive Pills** (Plan B®, ella®)

Blocks Sperm

- **Condom, Female Condom**
- **Diaphragm, Cervical Cap**
- Thickened cervical mucus
  - **Hormonal IUDs** (Mirena®, Skyla®, Liletta®)
  - **Hormonal Contraceptives**

Copper Intrauterine Device (IUD) (ParaGard®) works primarily by **preventing fertilization**, but can prevent implantation of a fertilized egg, e.g., if used as emergency (postcoital) contraception

Job Aid 6-4: WHO MEC Quick Reference Chart

2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestral intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum				See i.	See i.
	6 weeks to < 6 months postpartum					
	6 months postpartum or more					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21days				See i.	See i.
	< 21days with other risk factors for VTE*					
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks	See i.	See i.	See i.		
	Puerperal sepsis					
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)					
	BP is controlled and can be evaluated					
	Elevated BP (systolic 140-159 or diastolic 90-99)					
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)					
	Vascular disease					
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE					
	Acute DVT/PE					
	DVT/PE, established on anticoagulant therapy					
	Major surgery with prolonged immobilization					
Known thrombogenic mutations						
Ischemic heart disease (current or history of)				I C		I C
Stroke (history of)				I C		
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I C		I C	

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Headaches	Migraine without aura (age < 35 years)	I C				
	Migraine without aura (age ≥ 35 years)	I C				
	Migraines with aura (at any age)		I C	I C		I C
Unexplained vaginal bleeding (prior to evaluation)					I C	I C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels					
	Persistently elevated β-hCG levels or malignant disease					
Cancers	Cervical (awaiting treatment)				I C	I C
	Endometrial				I C	I C
	Ovarian				I C	I C
Breast disease	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion (due to fibroids or anatomical abnormalities)						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C	I C
	Current pelvic inflammatory disease (PID)				I C	I C
	Very high individual risk of exposure to STIs				I C	I C
Pelvic tuberculosis					I C	I C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes for > 20 years					
Symptomatic gall bladder disease (current or medically treated)						
Cholestasis (history of related to oral contraceptives)						
Hepatitis (acute or flare)		I C				
Cirrhosis (severe)						
Liver tumors (hepatocellular adenoma and malignant hepatoma)						
AIDS	No antiretroviral (ARV) therapy	See ii.	See ii.	See ii.	I C	I C
	Not improved on ARV therapy				I C	I C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy **					

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use, 5th Edition*. Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

- **Category 1** There are no restrictions for use.
- **Category 2** Generally use; some follow-up may be needed.
- **Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.
- **Category 4** The method should not be used.

I/C Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.

NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.

i The condition, characteristic and/or timing is not applicable for determining eligibility for the method.

ii Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.

* Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m2, postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

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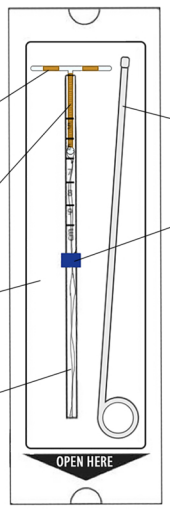
Copper Intra-Uterine Device (Cu-T)[1]

Do not start this loading procedure more than 10 minutes before inserting into the uterus. The arms of Cu-T will not straighten out easily if they are left within inserter tube too long.

USE NO-TOUCH TECHNIQUE THROUGHOUT LOADING

1

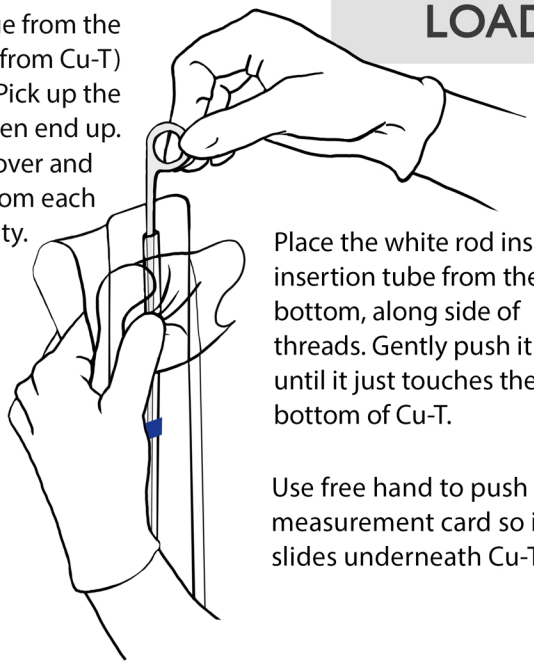
Adjust the contents of the package through the clear plastic cover. Confirm the vertical stem of Cu-T is fully inside inserter tube.



Place the package on a clean, flat surface.

2

Open the package from the bottom (end farthest from Cu-T) one-third of the way. Pick up the package with the open end up. Bend clear plastic cover and white backing away from each other to maintain sterility.

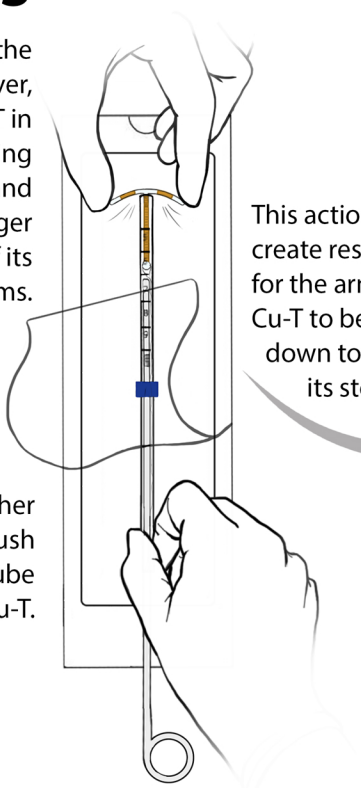


Place the white rod inside insertion tube from the bottom, along side of threads. Gently push it up until it just touches the bottom of Cu-T.

Use free hand to push measurement card so it slides underneath Cu-T.

3

Through the plastic cover, stabilize Cu-T in place by putting thumb and index finger over ends of its horizontal arms.

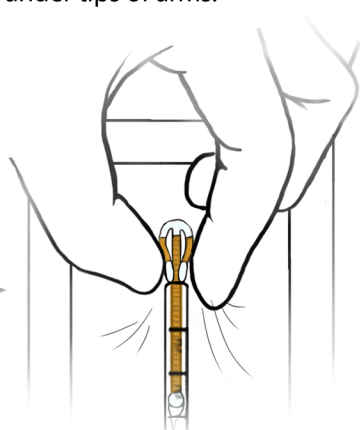


With the other hand, push inserter tube towards Cu-T.

This action will create resistance for the arms of Cu-T to bend down towards its stem.

4

Fold arms enough to touch sides of inserter tube, then pull tube out slightly from under tips of arms.

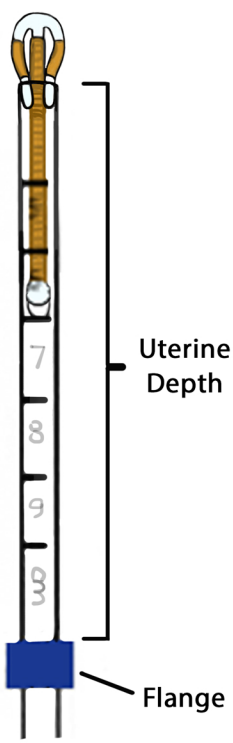


Push and rotate tube over tips of the arms only enough to retain arms inside tube next to the stem.

5

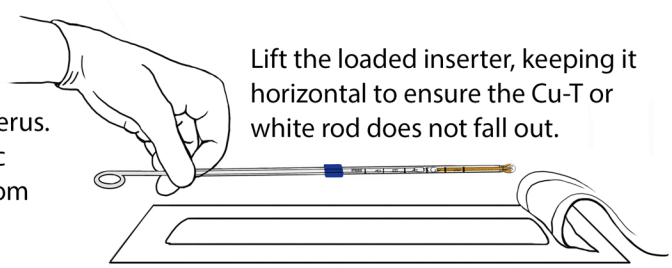
Adjust blue flange to the depth of uterus, measured with uterine sound. Ensure the longest side of the flange is parallel with arms of Cu-T.

The sterile card in package may also be used to set flange according to the premeasured uterine depth.



6

Cu-T is now ready to be placed in the woman's uterus. Carefully peel clear plastic cover of package away from the white backing.



Lift the loaded inserter, keeping it horizontal to ensure the Cu-T or white rod does not fall out.

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Source: [1]IUD Guidelines for Family Planning Service Programs: A Problem Solving Reference Manual, 3rd edition Jhpiego