



Long-Acting Reversible Contraceptives Learning Package

Module 8: Postpartum Intrauterine Device

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.

This module is made possible by the generous support of the American people through USAID under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of MCSP and do not necessarily reflect the views of USAID or the United States Government.

Module 8: Postpartum Intrauterine Device

Module Overview

Module Overview for Learner

Assessments

Pre and Post Test Questionnaire

Pre and Post Test Questionnaire Answer Sheet

Checklists

Checklist 8-1: LARC Methods Counseling Skills_Antenatal Period

Checklist 8-2: LARC Methods Counseling Skills_Postpartum Period

Checklist 8-3: PPIUD Clinical Skills

Checklist 8-4: PPIUD Intrauterine Clinical Skills

Handouts

Handout 8-1: PPIUD Fact Sheet

Handout 8-2: Postpartum IUD Follow-Up Care

Handout 8-3: Managing Side-Effects and Complications

Handout 8-4: Sample Client Follow-Up Card

Job Aids

Job Aid 8-1: Postpartum Contraceptive Options Timeline

Job Aid 8-2: Comparing Effectiveness of Family Planning Methods

Job Aid 8-3: WHO MEC Quick Reference Chart

Job Aid 8-4: Sample PPIUD Register

Job Aid 8-5: Opportunities for Postpartum Family Planning Poster

Job Aid 8-6: PPIUD Pre-Insertion Screening Checklist

Job Aid 8-7: Steps for PPIUD Insertion

Job Aid 8-8: Protocol for Management of Missing Postpartum IUD (PPIUD) Strings

Module 8: Postpartum Intrauterine Device

Session Overview for Learner

Time: 10:20 hours

Module Objectives

- By the end of this session, learners will be able to:
- Identify different postpartum family planning options.
- Explain what is different about IUDs in the postpartum context—counseling, timings of insertion, items/instruments required, and insertion technique.
- Demonstrate appropriate counseling and assessment of women requesting postpartum IUDs.
- Perform postpartum insertion of the IUDs.
- Provide post-insertion instructions and follow-up care.
- Identify and manage the potential side-effects and complications of postpartum IUDs.
- Correctly document service provided.

Session Plans

- Session 1: Overview of PPFPP options and PPIUD. Counseling and Client Assessment for PPIUD
- Session 2: PPIUD Insertion (demonstration and practice on models)
- Session 3: Identification and management of side-effects and potential problems, follow-up care, documentation, and clinical practice
- Session 4: Clinical Practice (continued)

Sample Schedules

Facility-based delivery: Four consecutive days (2 afternoons and 2 mornings)

Day 1 (PM) (2 hrs 30 min)		Day 2 (PM) (2 hrs 35 min)		Day 3 (AM) (2 hrs 40 min)		Day 4 (AM) (2 hr 35 min)	
Time	Session: Activity	Time	Session: Activity	Time	Session: Activity	Time	Session: Activity
5 min	One: Introduction	5 min	Two: Welcome and Recap	5 min	Three: Welcome and Recap	5 min	Four: Welcome and Recap
10 min	One: Pre Test	45 min	Two: Review of Checklist and demonstration Video	45 min	Three: Post-insertion instructions and follow-up care, managing common side-effects & complications	90 min	Four: Pre-Clinical Validation and Supervised Clinical Practice
40 min	One: Choice of Postpartum Family Planning Methods using timeline flip chart or online resources	100 min	Two: Practice on Models: PPIUD Insertion	15 min	Three: Record keeping	30 min	Four: Post-Clinical Practice Debrief
30 min	One: Activity 8-2: What Is Different about the Postpartum IUD (PPIUD)? (timings and technique)	5 min	Two: Close session	60 min	Three: Pre-Clinical Validation and Supervised Clinical Practice	15 min	Four: Summary and follow-up plans
60 min	One: Role Play Postpartum Family Planning Counseling and Client Assessment			30 min	Three: Post-Clinical Practice Debrief	10 min	Four: Post Test
5 min	One: Close session			5 min	Three: Close session	5 min	Four: Close session

Module 8: Postpartum Intrauterine Device

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 attached answer sheet.

Total time: 10 minutes

1. What is the recommended period for healthy timing and spacing (HTSP) for pregnancies?
 - a. For at least 1 year
 - b. Until regular monthly periods have started again
 - c. For 6 months
 - d. For at least 2 years

2. According to research findings, the mean average time for first ovulation by non-breastfeeding mothers is:
 - a. 45 days.
 - b. 3 months.
 - c. 6 months
 - d. 14 days

3. Ideally counseling about the use and benefits of a postpartum IUD (PPIUD) should be provided:
 - a. During routine antenatal care visits
 - b. During active labor, so that the IUD can be placed immediately after delivery of the placenta
 - c. Only during the latent phase of labor, if the woman is comfortable
 - d. Only after 6 weeks of childbirth

4. Which of the following is TRUE about expulsion of the postpartum IUD/LNG-IUS?
 - a. To prevent expulsion, women who choose the PPIUD should not breastfeed.
 - b. The expulsion rate is lowest when the IUD/LNG-IUS is inserted within 10 minutes of delivery of the placenta.
 - c. Tying knots of catgut on the cross arms of the IUD/LNG-IUS will reduce expulsion.
 - d. Expulsion is less likely when insertion is performed using an inserter tube.

5. Which of the following is the best technique for inserting an IUD on the first day after childbirth?
 - a. Use instruments such as the Kelly placenta forceps.
 - b. Use hands (manually).
 - c. Use an inserter tube and plunger.
 - d. Use a long-toothed forceps.

6. In which of the following women would it be safe to insert an IUD immediately following delivery of the placenta?
 - a. A woman who has a fever of 38°C
 - b. A woman who has had ruptured membranes for 12 hours
 - c. A woman who is HIV-positive with a low CD4 count
 - d. A woman who is having vaginal bleeding

7. In order to minimize the chances of infection during PPIUD insertion:
 - a. Give antibiotic cover.
 - b. Autoclave the IUD/LNG-IUS.
 - c. Use sterile gloves only.
 - d. Insert the IUD/LNG-IUS using the “no-touch” technique.

8. The PPIUD/LNG-IUS should not be inserted in a client if she:
 - a. Has AIDS
 - b. Has puerperal sepsis
 - c. Has had a cesarean section
 - d. Is breastfeeding

9. One of the important prerequisites for inserting an IUD in the immediate/postplacental period is that the woman should:
 - a. Be given some anaesthesia before insertion
 - b. Take some rest after delivery
 - c. Be informed and consented for the PPIUD prior to insertion
 - d. Receive a dose of antibiotics before insertion

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

Module 8: Postpartum Intrauterine Device

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 _____

Module 8: Postpartum Intrauterine Device

Checklist 8-1: Long-Acting Reversible Contraceptive Methods Counseling Skills

Adapted for the Antenatal 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 (Antenatal)					
Step/Task	Cases				
General Family Planning Counseling					
1. Greets the woman respectfully and with kindness					
2. Introduces herself/himself					
3. Ensures privacy and confidentiality					
4. Obtains biographic information (name, address, etc.)					
Antenatal Counseling					
1. Explains the health benefits—for the mother and the baby—of using family planning to space births and delay the next pregnancy by at least 24–36 months.					
2. Asks the client if she and her partner would like to have more children after their upcoming delivery.					
3. Ask the client: <ul style="list-style-type: none"> a. How long do she and her husband want to wait for the next pregnancy? b. Will she be breastfeeding her baby? c. Does her partner support her in family planning? d. Does she have any medical conditions, or is she taking any medication? e. Are there any methods she does not want to use or has not tolerated in the past? 					
4. Tells her the advantages of postpartum family planning; discusses pre-discharge methods <ul style="list-style-type: none"> a. Tells her that it is easier for the mother to receive a permanent or long-acting method when she is in the health facility for childbirth, before going home b. Tells her about the advantages of exclusive breastfeeding and using the lactational amenorrhea method (LAM) as a contraceptive. 					

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Antenatal)					
Step/Task	Cases				
5. Based on the clients responses, uses the (BCS+) counseling cards or Flip book to talk about the appropriate methods <ul style="list-style-type: none"> a. Starts showing the counseling cards/Flip book beginning with the most effective b. Reads the back of the card and places it down in front of the client, with the picture facing the client. 					
6. If the client expresses an interest in using one of the LARC methods after the delivery, continues with the next steps.					
7. Discusses the benefits of long-acting methods: <ul style="list-style-type: none"> a. Can be inserted immediately or prior to discharge b. Are greater than 99% effective in preventing pregnancy c. Have no impact on breastfeeding d. Can be removed when she and her husband are ready to become pregnant again. 					
8. If the client expresses an interest in using IUD/LNG-IUS/contraceptive implant: <ul style="list-style-type: none"> a. Displays the IUD, LNG-IUS, and Implant method specific cards, asks the client if she is interested in using any of these methods soon after the delivery or prior to discharge (within 48 hours). 					
9. If the client expresses an interest in using the copper IUD (Copper T 380A)/levonorgestrel intrauterine system (LNG-IUS), describes postpartum IUD/LNG-IUS insertion and timing of insertion: <p>Can be inserted immediately after delivery, prior to discharge</p> <ul style="list-style-type: none"> a. Copper IUD is effective for up to 12 years b. Copper IUD contains no hormones c. The LNG-IUS is effective up to 3-5 years*, it 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. <p>*The effectiveness period varies with the type of LNG-IUS used. Studies to confirm the effectiveness period are ongoing.</p>					
10. If the client expresses an interest in using the contraceptive implant: <ul style="list-style-type: none"> a. Describes postpartum implant insertion and timing of insertion 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. 					
11. Reviews WHO MEC Wheel or Job Aid 8-3: WHO MEC Quick Reference Chart to verify whether there is any contraindication. If any contraindication is present, goes back to choose another method.					
12. Asks the client if she has any question or needs clarification about the method.					

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Antenatal)					
Step/Task	Cases				
13. If she doesn't want any more children and selects one of the permanent methods: a. Indicates on the antenatal care (ANC) card the client's desire for postpartum tubal ligation OR vasectomy b. Tells her about the need and importance of consent for permanent methods c. Discusses that method in detail (advantages, disadvantages, side-effects, etc.).					
14. Allows the client to make a final decision by herself (informed choice) without any coercion.					
15. Confirms the client's understanding by asking open-ended questions.					
16. Tells her that she can change her decision at any time and inform the provider about it.					
17. Documents the family planning method chosen on the ANC record card and to tell the doctor about it at the time of delivery.					
18. If the client does not make a decision at the end of the session, provides her with some method brochures/leaflets (if available) a. Tells her to read these brochures at home, and that she can come back to ask any questions b. Guides her in obtaining family planning services later.					
19. Conducts systematic screening for other services (if service available) a. 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 b. Follows national guidelines for prevention of mother-to-child transmission (PMTCT) of HIV and screening for syphilis c. Discusses sexually transmitted infection (STI)/HIV transmission and prevention and detection with the client, using the counseling cards d. Offers condoms for dual protection.					
20. Thanks the client for completing the counseling session.					

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 8: Postpartum Intrauterine Device

Checklist 8-2: Long-Acting Reversible Contraceptive Methods Counseling Skills

Adapted for the Postpartum 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 (Postpartum)					
Step/Task	Cases				
General Counseling					
1. Greets the woman respectfully and with kindness					
2. Introduces herself/himself and develops a rapport by asking about how she and her baby are feeling?					
3. Ensures privacy and confidentiality					
4. Congratulate her for the new baby and give some time to recover and rest					
Immediate Postpartum Counseling					
1. Helps the woman put the baby to breast within one hour of birth a. Explains the need for exclusive breastfeeding of the baby on demand, day and night, for the first 6 months of life.					
2. Discusses the return to sexual activity, the return of fertility, and healthy spacing of pregnancies a. Too many pregnancies, or those that occur too soon one after the other, can make both the mother and baby unhealthy b. If the mother is not breastfeeding, her fertility can return as soon as 3 weeks after birth c. If she is exclusively breastfeeding, the return of menses is delayed and can be used as an effective method for contraception (98% effective) d. Another method of contraception should be started before starting to give the baby solid food or before the mother’s menses return.					

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Postpartum)

Step/Task	Cases				
<p>3. Asks the woman about her reproductive goals:</p> <ol style="list-style-type: none"> a. Does she want more children in the future? b. How long do she and her husband want to wait for the next pregnancy? c. Has she used any FP method in the past? Was she happy with the method? d. Was she informed of any PFP methods during the Antenatal checkups? e. Does she have any FP method in mind? f. Does she plan to exclusively breastfeed her infant? g. Will her partner support her in family planning? h. Tells her the advantages of postpartum family planning; discusses pre-discharge methods i. Tells her that it is easier for the mother to receive a long-acting method while she is in the health facility and before going home. 					
<p>4. Based on the client's responses, talks about methods that are appropriate for her:</p> <ol style="list-style-type: none"> a. Starts showing the counseling cards or the Flip book beginning with the most effective method. b. Reads the back of the card or flip book and places it in front of the client, with the picture facing the client. 					
<p>5. If the client expresses an interest in using LARC methods, discusses the benefits of long-acting methods:</p> <ol style="list-style-type: none"> a. Can be inserted immediately or prior to discharge 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 is having any concerns e. Does not need any daily action. 					
<p>6. If the client expresses an interest in using the Copper IUD/LNG-IUS:</p> <ol style="list-style-type: none"> a. Describes postpartum IUD/LNG-IUS insertion and timing of insertion: <ol style="list-style-type: none"> i. Is effective for up to 12 years ii. The Copper IUD contains no hormones iii. The LNG-IUS contains low doses of hormones and is safe for breastfeeding women. Some minor changes in the bleeding pattern may happen initially. 					
<p>7. If the client expresses an interest in using the contraceptive implant, tells her:</p> <ol style="list-style-type: none"> a. The Implant can be inserted prior to discharge from the health facility b. Describes postpartum implant insertion and timing of insertion <ol style="list-style-type: none"> i. The implant is effective for up to 3–5 years (depending on the type) ii. The implant contains low doses of hormones and is safe for breastfeeding women iii. 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. 					
<p>8. Explains LAM and the 3 Criteria:</p> <ol style="list-style-type: none"> a. The mother's monthly bleeding has not returned b. The baby is fully breastfed day and night c. The baby is less than 6 months old d. The mother needs to transition to a family planning method of her choice when one of the criteria no longer applies e. If a breastfeeding-dependent method was chosen, helps her to make a plan for ongoing contraception after she stops breastfeeding. 					

Checklist for Long-Acting Reversible Contraceptive (LARC) Methods Counseling (Postpartum)					
Step/Task	Cases				
9. Describes any other methods of interest for which the client is eligible.					
10. Asks the client if she has any questions or would like the provider to repeat the information.					
11. Allows the client to make a decision by herself (informed choice) without any coercion If the client chooses a method to be started later, the provider helps her make a plan for how and where to obtain that service.					
12. Reviews WHO MEC Wheel or Job Aid 8-3 WHO MEC Quick Reference Chart to verify if the chosen method is safe for her. If not helps her choose another method.					
13. Confirms the client's understanding by asking open-ended questions and repeating key information about the chosen method.					
14. Documents the family planning method chosen in the client's record card/chart.					
15. Tells the client that she can change her decision at any time and inform the provider about it.					
16. Counsels and refers client for specialized services like breast/cervical cancer screening or treatment, HIV, etc., if needed.					
17. Repeat key information about the chosen method.					

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 8: Postpartum Intrauterine Device

Checklist 8-3: PPIUD Clinical Skills

Adapted for the Postplacental (Instrumental) Insertion of the IUD (Copper T 380A) and LNG-IUS (Levonorgestrel Intrauterine System)

(To be used by the Learner and Trainer)

Learners: Learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Trainers: Use this tool when the learner is ready for assessment of competency in this clinical skill.

Place a in case box if 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 Postplacental (Instrumental) Insertion of the IUD/LNG-IUS					
Step/Task	Cases				
Tasks to perform upon presentation (prior to managing active labor and vaginal delivery)					
1. Greets the woman with kindness and respect.					
2. Confirms that the woman still wants the IUD/LNG-IUS.					
3. Explains that the IUD/LNG-IUS will be inserted following delivery of the baby and placenta. Answers any questions she might have.					
4. Reviews the woman's record to ensure that she has no contraindications for PPIUD here.					
Pre-Insertion tasks					
1. Confirms that sterile instruments, supplies, and light source are available.					
2. Confirms that IUDs/LNG-IUSs in sealed packages are available.					
3. Manages labor and delivery (including using a partograph and performing active management of the third stage of labor [AMTSL]) and reconfirms that there are no delivery-related conditions that contraindicate insertion of the IUD/LNG-IUS now: <ol style="list-style-type: none"> Rupture of membranes for greater than 18 hours Chorioamnionitis Unresolved postpartum hemorrhage. 					
4. If any of these conditions exists, explains it to the woman. Counsels her and offers her another method for postpartum family planning. Calls her for evaluation at 4 weeks for an IUD.					

Checklist for Postplacental (Instrumental) Insertion of the IUD/LNG-IUS				
Step/Task	Cases			
5. If insertion is performed by the same provider who assisted the birth, keeps on same pair of high-level disinfected (HLD) or sterile gloves for insertion, provided they are not contaminated. OR: If insertion is performed by a provider different from the one who assisted the birth, ensures that AMTSL has been completed, then performs hand hygiene and puts on HLD or sterile gloves.				
6. Inspects perineum, labia, and vaginal walls for lacerations. If there are lacerations that are bleeding, applies clamp to the bleeding area to stop the bleeding and proceeds with IUD/LNG-IUS insertion. (Repairs lacerations, if needed, after inserting IUD/LNG-IUS).				
Insertion Tasks				
1. Confirms that the woman is ready to have the IUD/LNG-IUS inserted. Answers any questions she might have and provides reassurance, if needed.				
2. Has the PPIUD kit/tray opened and arranges insertion instruments and supplies in the sterile field. Ensures that the IUD/LNG-IUS in the sterile package is kept to the side of the sterile draped area. Places a dry, sterile cloth on the woman's abdomen.				
3. Gently inserts Sims speculum and visualizes cervix by depressing the posterior wall of the vagina.				
4. Cleans cervix and vagina with antiseptic solution two times using a separate swab each time.				
5. Gently grasps anterior lip of the cervix with the ring forceps. (Speculum may be removed at this time, if necessary.) Leaves forceps aside, still attached to cervix.				
6. Opens sterile IUD/LNG-IUS package from the bottom by pulling back the plastic cover approximately one-third of the way.				
7. With non-dominant hand still holding the IUD/LNG-IUS package (stabilizing the IUD/LNG-IUS through the package), uses dominant hand to remove plunger rod, inserter tube, and card from package. Use "no-touch" technique throughout the procedure.				
8. With dominant hand, uses placental forceps to grasp the IUD/LNG-IUS inside the sterile package using "no-touch" technique . Holds the IUD/LNG-IUS by the edge,* careful not to entangle the strings in the forceps. *Note: To avoid damage to the reservoir of LNG-IUS, do not apply too much pressure on the vertical stem of the LNG-IUS (where the hormone-containing reservoir is located).				
9. Gently lifts anterior lip of cervix using ring forceps.				
10. Gently inserts and slowly advances the IUD/LNG-IUS a. While avoiding touching the walls of the vagina, inserts placenta forceps—which are holding the IUD/LNG-IUS—through the cervix into the lower uterine cavity. b. Gently moves the IUD/LNG-IUS farther into the uterus toward the point where slight resistance is felt against the back wall of the lower segment of the uterus. c. Keeping the placenta forceps firmly closed, lowers the ring forceps and gently removes them from the cervix; leaves them on the sterile towel.				

Checklist for Postplacental (Instrumental) Insertion of the IUD/LNG-IUS				
Step/Task	Cases			
11. "Elevates" the uterus a. Places the base of the nondominant hand on the lower part of the uterus (midline, just above the pubic bone with fingers toward the fundus); and b. Gently pushes the uterus upward in the abdomen to extend the lower uterine segment.				
12. Passes the IUD/LNG-IUS through the vagino-uterine angle a. Keeping the forceps closed, gently moves the IUD/LNG-IUS upward toward the uterine fundus, in an angle toward the umbilicus b. Lowers the dominant hand (hand holding placental forceps) to enable the forceps to pass the vagino-uterine angle easily and follow the contour of the uterine cavity. Takes care not to perforate the uterus.				
13. Continues gently advancing the forceps until the uterine fundus is reached, when the provider feels a resistance. By feeling the uterus through the abdominal wall, confirms with the abdominal hand that the IUD/LNG-IUS has reached the fundus.				
14. While continuing to stabilize the uterus, opens the forceps, tilting them slightly toward midline to release the IUD/LNG-IUS at the fundus.				
15. Keeping the forceps slightly open, slowly removes them from the uterine cavity by sweeping the forceps to the sidewall of the uterus and sliding the instrument alongside the wall of the uterus. Takes particular care not to dislodge the IUD/LNG-IUS or catch the IUD/LNG-IUS strings as the forceps are removed.				
16. Keeps stabilizing the uterus until the forceps are completely withdrawn. Places the forceps aside on the sterile towel.				
17. Examines the cervix to see if any portions of the IUD/LNG-IUS strings are protruding from the cervix. <ul style="list-style-type: none"> • Strings of IUD are short and usually not seen protruding from cervix, if IUD is rightly placed at the fundus • Strings of LNG-IUS are longer than the IUD strings and may be seen protruding from the cervical os. No need to trim them. Do not pull the threads. 				
18. Repairs any lacerations (episiotomy) as necessary.				
19. Removes all instruments used and places them open in 0.5% chlorine solution so they are totally submerged.				
Post-Insertion Tasks				
1. Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.				
2. Disposes of waste materials appropriately.				
3. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
4. Performs hand hygiene.				

Checklist for Postplacental (Instrumental) Insertion of the IUD/LNG-IUS				
Step/Task	Cases			
5. Tells the woman that the IUD/LNG-IUS has been successfully placed; reassures her, and answers any questions she may have. Advises her that instructions will be reviewed prior to discharge, and provides the following instructions for now: <ul style="list-style-type: none"> a. Reviews IUD side-effects and normal postpartum symptoms b. Tells the woman when to return for PPIUD/postpartum and newborn checkup(s) c. Emphasizes that she should come back any time she has a concern or experiences warning signs d. Reviews warning signs for IUD/LNG-IUS (PAINS¹) e. Reviews how to check for expulsion and what to do in case of expulsion f. Ensures that the woman understands post-insertion instructions g. Gives written post-insertion instructions, if possible h. Provides card showing the type of IUD/LNG-IUS and the date of insertion. 				
6. Records information in the woman's chart or record. Attaches IUD/LNG-IUS cards (which the woman will be given at discharge) to the woman's record.				
7. Records information in the appropriate register(s).				

Trainer Certification

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

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

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

Source: Adapted from ACCESS FP. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Trainer's Notebook*. Baltimore, MD: Jhpiego Corporation, 2010.

¹ The acronym PAINS may be helpful in remembering IUD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping, or abdominal pain with sexual intercourse; **I**nfection with or exposure to a sexually transmitted infection (STI) or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from the IUD are missing or are longer or shorter than normal.

Module 8: Postpartum Intrauterine Device

Checklist 8-4: PPIUD Intracesarean Clinical Skills

Adapted for the Intracesarean Insertion of the IUD (Copper T 380A) and Levonorgestrel Intrauterine System (LNG-IUS)

(To be used by the Learner and Trainer)

Learners: Learn about and practice the correct steps needed to provide this clinical skill. Ask your colleagues to use this tool to follow along as you practice with anatomic models and gain experience with clients. Your colleagues should offer specific feedback using this tool to guide their observations.

Trainers: Use this tool when the learner is ready for assessment of competency in this clinical skill.

Place a in case box if 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: _____ Dates Observed: _____

Checklist for Intracesarean Insertion of the IUD/LNG-IUS					
Step/Task	Cases				
Tasks to perform upon presentation (prior to performing the cesarean section)					
1. Reviews the woman's record to ensure that she has chosen the IUD/LNG-IUS.					
2. Checks that she has been appropriately counseled and screened for postpartum IUD (PPIUD) insertion. (Note: If she has not and she is comfortable and in early/inactive labor, provides that service following the next step.)					
3. Greets the woman with kindness and respect.					
4. Confirms that the woman still wants the IUD/LNG-IUS.					
Explains that the IUD/LNG-IUS will be inserted following delivery of the baby and placenta. Answers any questions she might have.					
Tasks to perform after presentation but prior to insertion					
Note: For intracesarean insertion, the IUD/LNG-IUS is inserted manually through the uterine incision. This takes place after the birth of the baby, delivery of the placenta, and second screening—but prior to repair of the uterine incision.					
1. Confirms that correct sterile instruments, supplies, and light source are available for intracesarean insertion; obtains PPIUD kit/tray.					
2. Confirms that IUDs/LNG-IUSs are available; obtains a sterile IUD/LNG-IUS, keeping the package sealed until immediately prior to insertion.					

Checklist for Intrauterine Insertion of the IUD/LNG-IUS				
Step/Task	Cases			
3. Delivers the baby and the placenta via cesarean section and performs a second screening to confirm that there are no delivery-related conditions that preclude insertion of the IUD/LNG-IUS now: <ol style="list-style-type: none"> Rupture of membranes for greater than 18 hours Chorioamnionitis Unresolved postpartum hemorrhage. 				
4. If any of these conditions exists, speaks with the woman, explains that this is not a safe time for insertion of the IUD/LNG-IUS, and offers re-evaluation for an IUD/LNG-IUS at 6 weeks postpartum. Counsels her and offers her another method for postpartum family planning (at least for temporary use).				
5. Inspects uterine cavity for malformations, which could preclude use of the IUD/LNG-IUS.				
Insertion of the IUD/LNG-IUS				
1. Has the PPIUD kit/tray opened and arranges insertion instruments and supplies in a sterile field. Ensures that the IUD/LNG-IUS in the sterile package is kept to the side of the sterile draped area.				
2. Opens the sterile IUD/LNG-IUS package from the bottom by pulling back the plastic cover approximately one-third of the way.				
3. With non-dominant hand, holds the IUD/LNG-IUS package (stabilizing the IUD through the package); with dominant hand, removes the plunger rod, inserter tube, and card from the package.				
4. With dominant hand, grasps and then holds the IUD/LNG-IUS with the ends of fingers, by gripping the vertical rod between the index and middle fingers. (Alternatively, use the forceps to hold the IUD/LNG-IUS. Holds the IUD/LNG-IUS by the edge, careful not to entangle its strings in the forceps.)				
5. Stabilizes the uterus by grasping it at the fundus, through the abdomen, with non-dominant hand.				
6. With dominant hand, inserts the IUD/LNG-IUS through the uterine incision and moves to the fundus of the uterus.				
7. Releases the IUD/LNG-IUS at the fundus of the uterus.				
8. Slowly removes hand from uterus. Takes particular care not to dislodge the IUD/LNG-IUS as hand is removed.				
9. Points IUD/LNG-IUS strings toward the lower uterine segment, but does not push them through the cervical canal or pull the IUD/LNG-IUS from its fundal position.*				
10. Closes the uterine incision, taking care not to incorporate the IUD/LNG-IUS strings into the suture.				
Post-Insertion Tasks				
1. Disposes of waste materials appropriately.				
2. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
3. Performs hand hygiene.				
4. Records information in the woman's chart or record. Attaches the IUD/LNG-IUS card (which the woman will be given at discharge) to the woman's record.				

Checklist for Intrauterine Insertion of the IUD/LNG-IUS					
Step/Task	Cases				
5. Records information in the appropriate register(s).					
6. Ensures that the woman will receive post-insertion instructions on postoperative Day 2 or 3. The discharge provider should: <ul style="list-style-type: none"> a. Review IUD/LNG-IUS side-effects and normal postpartum symptoms b. Tell the woman when to return for IUD/LNG-IUS/postpartum and newborn checkup(s) c. Emphasize that she should come back any time she has a concern or experiences warning signs d. Review warning signs for IUD/LNG-IUS (PAINS¹) e. Review how to check for expulsion and what to do in case of expulsion f. Ensure that the woman understands post-insertion instructions g. Give written post-insertion instructions, if possible h. Provide a card showing the type of IUD/LNG-IUS and the date of insertion. 					

*Note: Take special precautions to be ensure that the IUD/LNG-IUS strings, which are relatively long, are not sutured at the time of uterine closure.

Source: Adapted from ACCESS FP. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Trainer's Notebook*. Baltimore, MD: Jhpiego Corporation, 2010.

Trainer Certification

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

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

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

¹ The acronym PAINS may be helpful in remembering IUD warning signs. Each letter stands for a sign or symptom indicating a need for urgent care: **P**eriod is late, or you have abnormal spotting or severe bleeding; **A**bdominal pain, severe cramping or abdominal pain with sexual intercourse; **I**nfection with or exposure to a sexually transmitted infection (STI) or symptoms of a pelvic infection, such as abnormal vaginal discharge; **N**ot feeling well or having a fever of 100.4°F (38°C) or higher; **S**trings from the IUD are missing or are longer or shorter than normal.

Module 8: Postpartum Intrauterine Device

Handout 8-1: Postpartum Intrauterine Device (Copper T 380A/Levonorgestrel Intrauterine System [LNG-IUS]) Fact Sheet

Postpartum IUD insertion refers only to IUDs/Levonorgestrel Intrauterine Systems (LNG-IUSs) inserted during the immediate (within 10 minutes of delivery of placenta), early postpartum period (within 48 hours after delivery) and during cesarean section. Postpartum insertion of an IUD/LNG-IUS, within 10 minutes or up to 48 hours after birth, has been shown to be safe, effective, and convenient for women like the regular or “interval” IUD/LNG-IUS. For many women who rarely access health care services, the insertion of an IUD/LNG-IUS immediately postpartum presents a unique opportunity for them to initiate a long-acting and reversible method of family planning.

Primary Mechanism of Action

Copper T 380A

- 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)

LNG-IUS

- Thickening of cervical mucus
- Interfering with sperm movement
- Thinning the lining of the uterus

Timing of Insertion

The IUD/LNG-IUS can be inserted:

- Postplacental: Immediately (within 10 mins.) following the delivery of the placenta, the IUD/LNG-IUS is inserted with long placental forceps (preferably Kelly’s Forceps).
- Intracesarean: Immediately following the removal of the placenta during a cesarean section, the IUD/LNG-IUS is inserted manually or with a ring forceps before closure of the uterine incision.
- Early postpartum: Within 48 hours of the birth. The IUD/LNG-IUS is inserted with long forceps such as Kelly’s Forceps.
- Post abortion: Immediately after an abortion, provided there is no infection or any other contraindication.

Characteristics of PPIUD

- Copper T 380A is effective for up to 12 years; LNG-IUS is effective up to 5 years*
- It is immediately effective upon insertion
- Is readily accessible for women who deliver at health care facilities
- Has no effect on the amount or quality of breast milk
- Is safe for use by women living with HIV
- Is reversible and can be removed at any time (with immediate return to fertility) if the woman's contraceptive or reproductive desires change
- Does not require any daily action on the part of the user
- Does not require a separate visit to the facility or, if inserted within 10 minutes of the birth, a separate procedure
- Postpartum Insertion appears to have a lower rate of uterine perforation, possibly because the insertion instrument used is blunt and the wall of the uterus is thick just after pregnancy. The provider can also be certain that the woman is not pregnant at the time of insertion.
- Saves time for both the woman and provider because the procedure is conducted in the same setting and involves only a few minutes of additional time.
- It is both long-acting and reversible and can be used for a short time or as long as 12 years for Copper T 380A and 5 years for LNG-IUS*. Fertility returns as soon as it is removed.

***Note:** The effectiveness period varies with the type of LNG-IUS used. Studies to confirm the effectiveness period are ongoing

Limitations

- Limitations of the PPIUD are minimal and basically the same as for the interval IUD/LNG-IUS
- Trained provider needed to insert and remove the PPIUD
- Does not protect against HIV or other sexually transmitted infections (STIs)
- Menstrual changes are a common side-effect of the IUD, but these may be less bothersome for postpartum women because some cramping and bleeding are expected during the postpartum period
- Strings will not be initially visible after postpartum insertion, because of the length of the string compared with the length of the postpartum uterus. Usually the strings will descend through the cervix and into the vagina by the time of the first PPIUD follow-up visit (at 4 to 6 weeks).

Health Risks

- **Perforation:** Perforation of the uterine wall during PPIUD insertion is rare and is directly related to provider's skill.
- **Infection:** Risk of infection is minimal. It is highest within the first 20 days after IUD insertion, and is thought to be related to either insertion technique (resulting from a lack of proper infection prevention practices) or a pre-existing infection, rather than to the IUD itself. After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users.
- **Expulsion:** IUD failure is rare, but the most common cause is spontaneous expulsion of the IUD from the uterus. Spontaneous expulsion appears to be higher with the PPIUD than with interval IUD insertions. Immediate postpartum insertion (within 10 minutes) is associated with a lower risk of expulsion than early postpartum insertion (up to 48 hours). Most expulsions occur within the first 3 months after insertion.

Who Can Have a PPIUD Inserted?

Most women can use the IUD/LNG-IUS in the postpartum period as well as those who have certain medical conditions such as HIV or diabetes. It is especially well-suited to women who think they are finished having children, but want to delay sterilization until they are certain.

Side-Effects

- Changes in menstrual bleeding may occur for the first 3 to 6 months
- With Copper T 380A, periods may become irregular and the number of bleeding days may increase, or there might be frequent spotting or light bleeding
- With LNG-IUS, periods are irregular and lighter initially or amenorrhea after few months of use
- Bleeding or spotting between monthly periods may occur with LNG-IUS
- Pelvic discomfort and pain can be relieved by mild analgesics.

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

- Careful screening of clients
- Meticulous attention to appropriate insertion technique
- Strict adherence to correct infection prevention techniques
- Performing PPIUD insertion procedures slowly and gently to assure technical accuracy and client comfort and safety.

Woman Experiencing the Following Conditions Should Not Use a PPIUD

- Chorioamnionitis
- Postpartum endometritis/metritis (Category 4)
- Puerperal sepsis (Category 4)
- More than 18 hours from rupture of membranes to delivery of the baby
- Unresolved postpartum hemorrhage
- Extensive genital trauma, the repair of which would be disrupted by postpartum placement of the IUD

When to Return for Follow-up

- Follow-up for women who receive PPIUD in the immediate or early postpartum period should be integrated with a postpartum care visit at 4 to 6 weeks.
- Follow-up visit at 4 to 6 weeks to reassure the client that the IUD/IUS is not being expelled.

Warning Signs

Tell the client to return to the clinic as soon as possible for urgent attention and care if any of the following signs develop:

- Foul-smelling vaginal discharge (different from the usual postpartum lochia)
- Heavy vaginal bleeding
- Lower abdominal pain, especially if accompanied by not feeling well, fever, or chills
- Concerns that the IUD/LNG-IUS has fallen out.

Module 8: Postpartum Intrauterine Device

Handout 8-2: Postpartum IUD/LNG-IUS Follow-Up Care

The World Health Organization (WHO) currently recommends at least one postpartum visit by 6 weeks after delivery. This is a good opportunity for women who have had an IUD inserted in the immediate/early postpartum period to receive postpartum IUD (PPIUD) follow-up services because, by 6 weeks postpartum, the uterus has undergone complete involution. In any case, PPIUD follow-up should happen within the first 3 months postpartum because the majority of expulsions occur during this time.

Take-Home Messages

Provide reassurance and advise the woman to:

- Expect lochia, but take note of heavy bleeding or blood clots.
- Be aware that postpartum symptoms, such as intermittent vaginal bleeding and cramping, are normal for the first 4 to 6 weeks postpartum—and may be hard to distinguish from PPIUD side-effects.
- Take ibuprofen, paracetamol, or other pain reliever, as needed. (Aspirin is not advised in the early postpartum period because it has an anti-blood-clotting effect.)
- Regarding possible PPIUD expulsion:
 - Spontaneous expulsion is most likely to occur during the first 3 months postpartum.
 - Check the bed sheets in the morning and your undergarments when you change clothes.
 - At 6 weeks postpartum, you may be able to feel the PPIUD strings. It is not necessary to check for them, but if you do, do not pull on them.
 - Your provider will check for the strings when you return for your postpartum visit. That is why it is important for you to return to see the same provider, or at least someone in the same clinic, who is aware of PPIUD services.
- Continue to breastfeed your baby exclusively, as appropriate; the PPIUD and breastfeeding do not interfere with each other.
- Remember that the PPIUD does not protect against sexually transmitted infections (STIs) and HIV.
- Resume intercourse at any time you feel ready; the PPIUD offers full protection against pregnancy immediately upon insertion.
- Return for removal of the PPIUD at any time you wish (up to 12 years); after the PPIUD is removed, fertility will return immediately.

Routine Follow-Up Care for PPIUD Clients

Key objectives of follow-up care are to:

- Assess the woman's overall satisfaction with the PPIUD
- Identify and manage potential problems
- Address any questions or concerns the woman may have
- Reinforce key messages regarding removal and duration of action.

Follow-up for women who receive a PPIUD in the immediate or early postpartum period should be integrated with postpartum care per global standards/local protocols. In addition to the usual elements of the postpartum checkup, the following should be addressed in all women who report (or whose records indicate) PPIUD insertion:

- Ask the client if she has experienced any problems and if she thinks the PPIUD has fallen out.
- Do a clinical assessment for anemia if she complains of excessive or prolonged bleeding.
- If possible, perform a speculum examination to see whether the PPIUD strings have descended into the vagina. If they appear long, protruding out of vagina or the client complains about it, trim them so that approximately 3–4 cm of string protrudes from the cervix.
- Conduct a pelvic examination only if the following conditions are suspected: an STI or pelvic inflammatory disease (PID), suspected partial or complete expulsion, pregnancy. Routine pelvic examination at any subsequent follow-up visit is not required.
- Provide counseling and treatment for side-effects, as needed.
- Advise the client to return if she is concerned about possible PPIUD-related problems or if she wants it removed or to change to another family planning method.
- Review danger signs that indicate a need to return to the clinic immediately.
- Remind the client to keep monitoring for possible PPIUD expulsion during/after her first few menstrual periods.
- Encourage use of condoms for STI protection, as appropriate.

Source: Jhpiego. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: A Reference Manual for Providers*. Baltimore: Jhpiego Corporation, 2010.

Module 8: Postpartum Intrauterine Device

Handout 8-3: Managing Side-Effects and Complications

Problem (Signs/Symptoms)	Explanation	Management
<p>Changes in Menstrual Bleeding Patterns</p> <ul style="list-style-type: none"> • Increase in menstrual bleeding above what is usually expected in the postpartum period • Increase in duration of menstrual bleeding above what is usually expected in the postpartum period • Spotting/light bleeding between periods once they resume postpartum (considered normal with LNG-IUS). • Periods may become light or stop with intrauterine system (LNG-IUS) 	<ul style="list-style-type: none"> • Changes in menstrual bleeding patterns are a common side-effect among IUD/LNG-IUS users, regardless of the timing of insertion. • In the first 6 weeks postpartum, such changes may be masked by the usual irregular bleeding and spotting associated with uterine involution during the postpartum period. Also, for a woman who is exclusively breastfeeding her baby, amenorrhea is likely up to 6 months—whether or not she is using an IUD/LNG-IUS. • Menstrual changes caused by the IUD/LNG-IUS are usually not harmful to the woman and diminish or disappear within the first few months after IUD/LNG-IUS insertion. If, however, these symptoms are severe, persistent, or accompanied by certain other signs/symptoms, they require special follow-up. 	<ul style="list-style-type: none"> • Determine severity of symptoms: how much more bleeding than usual; how long have symptoms lasted; when did the symptoms start; are they accompanied by other symptoms (e.g., pain, fever); how well is the woman tolerating them? • If symptoms are mild and consistent with uterine involution, provide reassurance. • Where appropriate, rule out other gynecologic pathology and refer her to a qualified practitioner, if indicated. • Where appropriate, rule out pregnancy by history or available testing. • Where appropriate, check for IUD/LNG-IUS expulsion: palpate strings on bimanual exam or by using a speculum. • If the client desires treatment, offer a short course of nonsteroidal anti-inflammatory drugs (NSAIDs), continued for 3 to 5 days. If heavy bleeding is the problem, aspirin should not be used because it has an anti-blood-clotting effect. • If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anemia (e.g., pallor, weakness), offer iron replacement therapy and consider IUD/LNG-IUS removal with the patient's consent. • If the client finds bleeding unacceptable, remove the IUD/LNG-IUS and counsel her regarding alternative methods of family planning.

Problem (Signs/Symptoms)	Explanation	Management
<p>Cramping or Pain</p> <ul style="list-style-type: none"> Increased cramping or pain that may or may not be associated with menstruation 	<ul style="list-style-type: none"> Mild intermittent cramping may occur in the first few weeks after IUD/LNG-IUS insertion, but is generally masked by the usual cramping associated with uterine involution postpartum (“afterpains”). Increased cramping and pain may also be noted with return of menstruation and is a common side-effect among IUD users. Special follow-up is needed if symptoms are bothersome, severe, or associated with other signs/symptoms. 	<ul style="list-style-type: none"> Determine severity of symptoms: how severe is the pain; how long has the pain lasted, when did the pain start; is the pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain? Perform an appropriate assessment, including vital signs, abdominal and pelvic examination, and appropriate laboratory studies (pregnancy test, complete blood count [CBC], cultures) to rule out other possible causes of pain or infection, partial IUD/LNG-IUS expulsion, uterine perforation, pregnancy/ectopic pregnancy, or urinary tract infection. If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure the woman and counsel her that they are temporary and will settle down in few days. Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping that are bothersome to the client. If cramping or pain is severe, remove the IUD/LNG-IUS. If the IUD/LNG-IUS was improperly placed, partly expelled, or appeared to be abnormal/distorted, discuss insertion of a new IUD/LNG-IUS with the client. If the IUD/LNG-IUS appeared to be normal and in proper position, counsel the woman regarding alternative forms of family planning.

Problem (Signs/Symptoms)	Explanation	Management
<p>Infection</p> <ul style="list-style-type: none"> • Lower abdominal pain • Fever • Painful intercourse • Bleeding after sex or between periods once normal monthly menses have resumed postpartum • New onset of pain associated with periods • Abnormal vaginal discharge • Nausea and vomiting 	<ul style="list-style-type: none"> • Although the risk of infection after interval IUD/LNG-IUS insertion is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhea or chlamydia infection. • Similar risk estimates are not available for PPIUD insertion, but studies suggest the risk is very low. • Because pelvic infection can lead to infertility and other serious problems, providers should treat all suspected cases. • IUD/LNG-IUS should never be inserted when puerperal infection such as chorioamnionitis or endometritis is suspected. 	<ul style="list-style-type: none"> • Perform an appropriate assessment, including vital signs, abdominal and pelvic examination, and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems such as endometritis, appendicitis, partial IUD/LNG-IUS expulsion, uterine perforation, pregnancy/ectopic pregnancy, or urinary tract infection. If appropriate, see the section for management of pregnancy with the IUD in place. • Suspect pelvic inflammatory disease (PID) if any of the following signs/symptoms are found and no other causes can be identified: • Lower abdominal, uterine, or adnexal tenderness (tenderness in the ovaries or fallopian tubes) • Evidence of cervical infection: yellow cervical discharge containing mucus and pus, cervical bleeding when the cervix is touched with a swab, positive swab test • Tenderness or pain when moving the cervix and uterus during bimanual exam (cervical motion tenderness) • Other possible sign/symptoms: purulent cervical discharge, enlargement or hardening (induration) of one or both fallopian tubes, a tender pelvic mass, pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness) • If endometritis or PID is suspected, begin treatment immediately with an appropriate antibiotic regimen per global standards/local protocols for gonorrhea, chlamydia, and anaerobic infections. Remove the IUD only in the presence of sepsis or if symptoms do not improve within 72 hours. Studies have not indicated that removing the IUD affects outcomes of PID treatment. • If the woman does not want to keep the IUD in during treatment, remove the IUD 2 to 3 days after antibiotic treatment has begun. • Where appropriate and when a sexually transmitted infection (STI) is suspected, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner

Problem (Signs/Symptoms)	Explanation	Management
<p>IUD/LNG-IUS String Problems</p> <ul style="list-style-type: none"> • Missing • Long • Short 	<ul style="list-style-type: none"> • Missing, longer, or shorter-than-expected strings may indicate a variety of problems, including pregnancy, IUD/LNG-IUS expulsion, and IUD/LNG-IUS malpositioning. • Sometimes there is no real problem at all—it is simply that the strings have not descended yet. In some circumstances, the IUD strings may never descend through the cervix into the vagina following postpartum insertion. • LNG-IUS strings are longer and can be considered normal if seen at the cervical os after insertion. 	<ul style="list-style-type: none"> • Missing Strings <ul style="list-style-type: none"> • Ask the woman if she thinks the IUD/LNG-IUS has fallen out. • Rule out pregnancy by history or laboratory examination. • Probe the cervical canal using a high-level disinfected (HLD) or sterile cervical brush or narrow forceps (e.g., Bose, alligator) to locate the strings and gently draw them out so that they are protruding into the vaginal canal. • If the strings are not located in the cervical canal, refer the woman for an X-ray or ultrasound to confirm normal intrauterine positioning. Provide a backup method while waiting for results. Manage, as appropriate, based on findings: • If the IUD/LNG-IUS is located inside the uterus and the woman wants to keep the IUD, do not remove it. Explain to her that the IUD/LNG-IUS is still protecting her from pregnancy but that she will no longer be able to feel the strings. Review signs and symptoms of spontaneous expulsion. • If the IUD/LNG-IUS is located inside the uterus, reassure her that she is safe and no need to worry. If the woman wants it to be removed, refer her for IUD/LNG-IUS removal by a specially trained provider. • If the IUD/LNG-IUS cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUD/LNG-IUS expulsion (below). • Long Strings <ul style="list-style-type: none"> • Trim strings, as needed, up to 3–4 cm from cervical os. • Short Strings (if bothersome to woman or partner) • Reassure the woman and her partner that the strings are very flexible and not harmful. • If it is very bothersome, advise the woman that the IUD/LNG-IUS strings can be cut shorter, so that the string curves around the cervical lip. Trim as needed.

Problem (Signs/Symptoms)	Explanation	Management
<p>Partial or Complete IUD/LNG-IUS Expulsion</p> <ul style="list-style-type: none"> • New onset of irregular bleeding and/or cramping • Expelled IUD/LNG-IUS seen (complete expulsion) • IUD/LNG-IUS felt/seen in the vaginal canal (partial expulsion) • Delayed or missed menstrual period with IUD (common with LNG-IUS) 	<ul style="list-style-type: none"> • Partial or complete IUD/LNG-IUS expulsion can occur “silently” (with no signs/symptoms) or it may be associated with other signs/symptoms, such as: <ul style="list-style-type: none"> • missing or longer than expected IUD/LNG-IUS strings • a delayed or missed menstrual period • The guidelines on the right address the management of IUD/LNG-IUS expulsion. 	<ul style="list-style-type: none"> • Conduct an appropriate assessment, including pelvic examination, to rule out other possible causes of symptoms such as infection and pregnancy. • When other possible causes of symptoms are ruled out, manage based on findings. <ul style="list-style-type: none"> • If complete expulsion of the IUD/LNG-IUS is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound), replace the IUD/LNG-IUS immediately, if desired and appropriate (not pregnant or infected), or counsel the client for an alternative family planning method. • If partial IUD/LNG-IUS expulsion is confirmed (e.g., felt/seen by the woman or clinician), remove the IUD/LNG-IUS and replace it, if desired and appropriate (not pregnant or infected), or counsel the client for an alternative family planning method. • If the IUD/LNG-IUS appears to be embedded in the cervical canal and cannot be easily removed in the standard fashion, refer the woman for IUD/LNG-IUS removal by a specially trained provider. • If complete expulsion of the IUD/LNG-IUS is confirmed and pregnancy diagnosed, manage antenatal care (ANC) per national and regional standards.

Problem (Signs/Symptoms)	Explanation	Management
<p>Pregnancy with an IUD/LNG-IUS in Place</p> <ul style="list-style-type: none"> • Delayed or missed menstrual period (with IUD) • Other signs/symptoms of pregnancy • Missing strings • Strings that are shorter or longer than expected 	<ul style="list-style-type: none"> • Although the IUD/LNG-IUS is one of the most effective forms of reversible contraception, failures can occur. • Approximately one-third of IUD-related pregnancies are due to undetected partial or complete expulsion of the IUD. • When pregnancy does occur with an IUD/LNG-IUS in place, ectopic pregnancy must be ruled out, and the IUD should be removed. • If the IUD/LNG-IUS is left in place during pregnancy, there is an increased risk of preterm labor, spontaneous abortion, and septic abortion. 	<ul style="list-style-type: none"> • Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to global standards/local protocols and refer to an appropriate provider, if needed. • Rule out ectopic pregnancy: sharp/stabbing abdominal pain (which is often unilateral), abnormal vaginal bleeding, light-headedness/dizziness, fainting. If ectopic pregnancy is suspected, immediately refer/transport the woman to a facility with surgical capability. • When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester: <ul style="list-style-type: none"> • Counsel the woman on the benefits and risks of immediate removal of the IUD/LNG-IUS. Removing the IUD/LNG-IUS slightly increases the risk of miscarriage; however, leaving an IUD/LNG-IUS in place places the woman at greater risk of second trimester miscarriage, infection, and preterm delivery. Removal of an IUD/LNG-IUS is advisable in a woman who is pregnant. • 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/LNG-IUS is still in the uterus or has been expelled. If the IUD/LNG-IUS is still in place, it cannot be safely removed. Follow, as below, with plans to remove the IUD/LNG-IUS at delivery. • If the woman declines removal, provide support and care per standard global guidelines/local protocols and arrange close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Encourage IUD/LNG-IUS removal as soon as it is discovered that she is pregnant for the healthiest outcome.

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

Module 8: Postpartum Intrauterine Device

Handout 8-4: Sample Client Follow-Up Card

Front of Card

Client's Follow-Up Card	
Client Full Name:	_____
Last Menstrual Period:	_____
Type of IUS Inserted:	_____
Date of insertion: Month	_____ Year _____
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

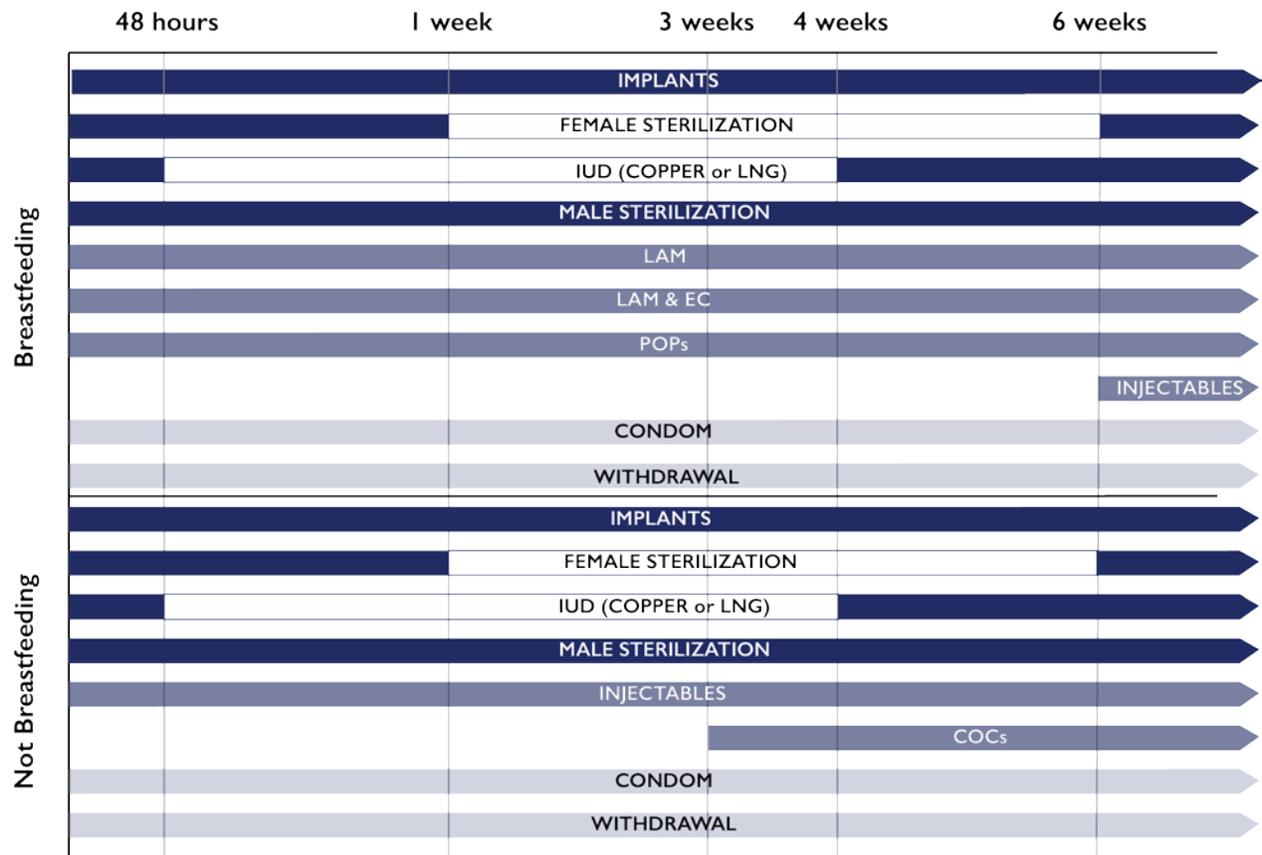
Note: If you are experiencing any of the following warning signs, please return to your clinic immediately.

- **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 8: Postpartum Intrauterine Device

Job Aid 8-1: Postpartum Contraceptive Options Timeline

Immediate Postpartum Options



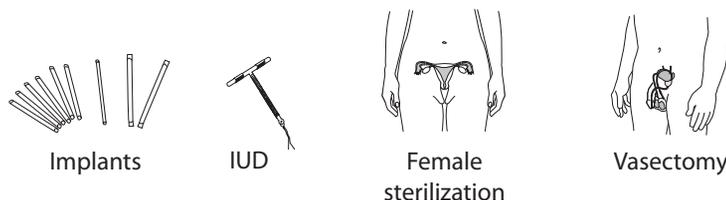
COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.

Job Aid 8-2: Comparing Effectiveness of Family Planning Methods

Comparing Effectiveness of Family Planning Methods

More effective

Less than 1 pregnancy per 100 women in 1 year

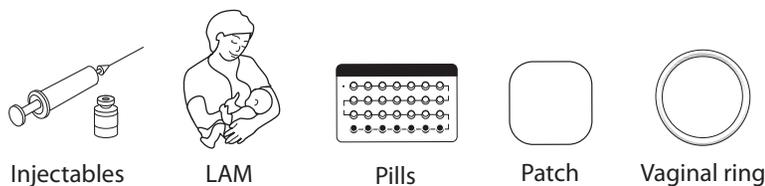


Implants

IUD

Female sterilization

Vasectomy



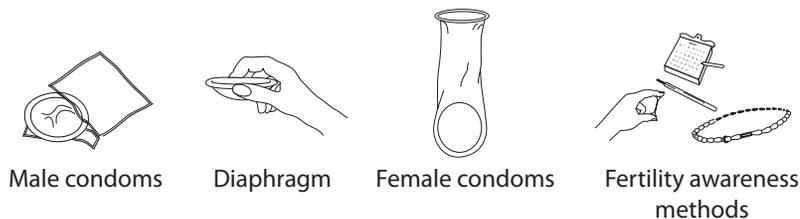
Injectables

LAM

Pills

Patch

Vaginal ring

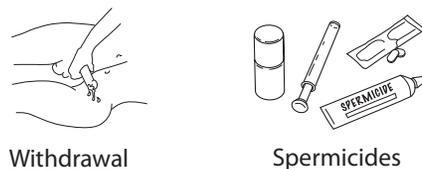


Male condoms

Diaphragm

Female condoms

Fertility awareness methods



Withdrawal

Spermicides

Less effective

About 30 pregnancies per 100 women in 1 year

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



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.

Job Aid 8-3: 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					
	6 weeks to < 6 months postpartum				See i.	See i.
	6 months postpartum or more					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21 days					
	< 21 days with other risk factors for VTE*				See i.	See i.
	≥ 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
Stroke (history of)				I	C	
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I	C	I	C

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

- 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.

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
Unexplained vaginal bleeding (prior to evaluation)					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
	Endometrial				I	C
	Ovarian				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
	Current pelvic inflammatory disease (PID)				I	C
	Very high individual risk of exposure to STIs				I	C
Pelvic tuberculosis					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
	Not improved on ARV therapy				I	C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy**					

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).

- 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.

Pathway of Opportunities for Postpartum Women to Adopt Family Planning

Postpartum Family Planning

Purpose of This Tool

Postpartum Family Planning (PPFP) is a service delivery strategy that expands access to family planning through integration within the existing continuum of maternal, newborn and child health services, resulting in important health benefits by ensuring healthy timing and spacing of pregnancies and the fulfillment of desired family size.

The timing around childbirth and the first two years postpartum (the "extended postpartum period") offers multiple opportunities to deliver family planning services to postpartum women by leveraging their contacts with the health system. This resource demonstrates those opportunities, beginning during antenatal care and continuing through the extended postpartum period. It identifies the types of clients in need of services and the methods available in different settings, scheduled alongside the typical health system contacts that a postpartum woman might experience in her community or at a health facility. Altogether, it serves as a guide for decision-makers in both family planning and maternal and child health sectors to the pathway of opportunities for postpartum women to adopt family planning.

Legend: Types of Postpartum Women



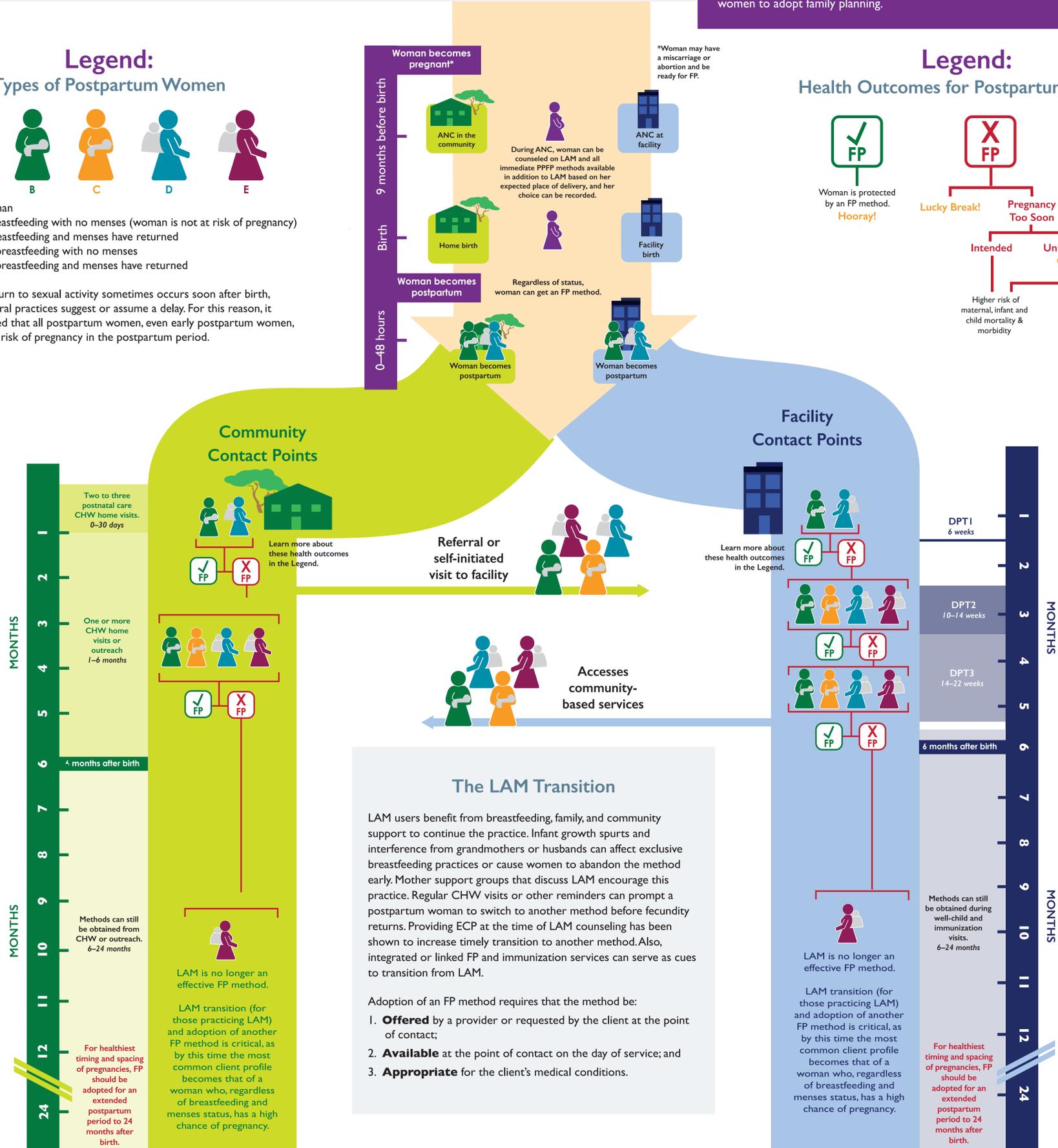
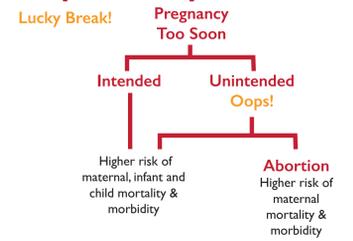
- A: Pregnant woman
- B: Exclusively breastfeeding with no menses (woman is not at risk of pregnancy)
- C: Exclusively breastfeeding and menses have returned
- D: Partial or no breastfeeding with no menses
- E: Partial or no breastfeeding and menses have returned

The timing of return to sexual activity sometimes occurs soon after birth, even where cultural practices suggest or assume a delay. For this reason, it should be assumed that all postpartum women, even early postpartum women, are potentially at risk of pregnancy in the postpartum period.

Legend: Health Outcomes for Postpartum Women



Woman is protected by an FP method. Hooray!



Immediate Postpartum Options: Community

	48 hours	1 week	3 weeks	4 weeks	6 weeks
Breastfeeding	IMPLANTS	LAM	LAM & EC	POPs	INJECTABLES
Not Breastfeeding	IMPLANTS	INJECTABLES	CONDOM	WITHDRAWAL	COCs

COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.

Acronyms

- ANC: antenatal care
- CHW: community health worker
- COC: combined oral contraceptive
- DPT: diphtheria, pertussis and tetanus
- ECP: emergency contraception pills
- FP: family planning
- IUD: intrauterine device
- LAM: Lactational Amenorrhea Method
- POPs: progestin-only pills
- PPFP: postpartum family planning

Immediate Postpartum Options: Facility

	48 hours	1 week	3 weeks	4 weeks	6 weeks
Breastfeeding	IMPLANTS	FEMALE STERILIZATION	IUD (COPPER or LNG)	MALE STERILIZATION	LAM
Not Breastfeeding	IMPLANTS	FEMALE STERILIZATION	IUD (COPPER or LNG)	MALE STERILIZATION	INJECTABLES

COCs should not be initiated by breastfeeding women until at least 6 months postpartum. In addition, fertility awareness methods, such as Standard Days Method (CycleBeads), require women to chart 4 regular menstrual cycles before beginning this method, so timing varies from one woman to the next.



Module 8: Postpartum Intrauterine Device

Job Aid 8-6: PPIUD/IUS Pre-Insertion Screening Checklist

In preparation for insertion of the IUD/Intrauterine System (LNG-IUS) before discharge, confirm the following information about the woman and her clinical situation:

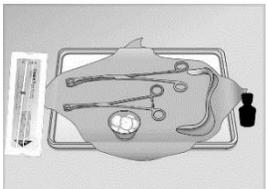
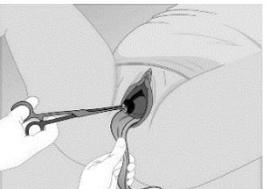
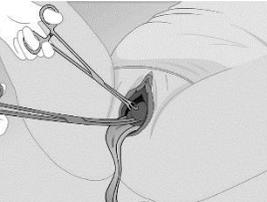
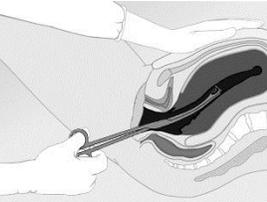
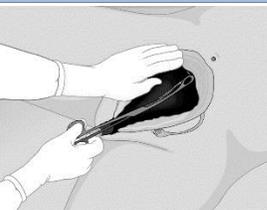
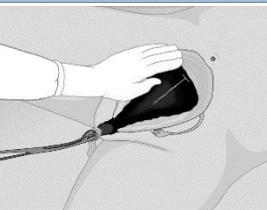
Postpartum Intrauterine Device/System Pre-Insertion Screening Checklist

Ask the woman whether she still desires the IUD/LNG-IUS for postpartum family planning (PPFP)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Review her antenatal record and be certain that:		
Her antenatal screening shows that an IUD/LNG-IUS is an appropriate method for her	<input type="checkbox"/> No	<input type="checkbox"/> Yes
She has had family planning counseling while not in active labor and there is evidence of consent in her chart OR	<input type="checkbox"/> No	<input type="checkbox"/> Yes
She is being counseled in the postpartum period	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Review the course of her labor and delivery and ensure that none of the following conditions is present:		
If planning an <i>immediate postplacental insertion</i> , check that <u>none</u> of the following conditions is present:		
Chorioamnionitis (during labor)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
More than 18 hours from rupture of membranes to delivery of baby	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unresolved postpartum hemorrhage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If planning a postpartum (pre-discharge) insertion, check that none of the following conditions is present:		
Puerperal sepsis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Postpartum endometritis/metritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Continued excessive postpartum bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Extensive genital trauma where the repair would be disrupted by postpartum placement of an IUD/LNG-IUS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Confirm that sterile instruments are available	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	If ANY box is checked in this column, defer insertion of the IUD/LNG-IUS and provide the woman with information about another method.	If ALL the boxes in this column are ticked, then proceed with IUD/LNG-IUS insertion.

Adapted from Jhpiego. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Learning Resource Package*. Baltimore: Jhpiego Corporation, 2010.

Module 8: Postpartum Intrauterine Device

Job Aid 8-7: Steps for PPIUD Insertion

Job Aid: Steps for PPIUD Insertion	Use gentle, “no-touch” technique.		Follow all recommended infection prevention practices.
			
1. Ensure that woman has chosen IUD and been counseled.	2. Manage labor and delivery, including active management of the third stage of labor (AMTSL).	3. Do second screening, including inspection of perineum for lacerations.	4. If no problems, ask woman if she is ready for IUD insertion.
			
5. Arrange supplies and equipment, with IUD to side.	6. Visualize cervix using retractor.	7. Clean cervix and vagina TWICE with two separate gauzes.	8. Grasp anterior lip of cervix with ring forceps.
			
9. Open IUD package and grasp IUD with other forceps.	10. Insert forceps with IUD through cervix to lower uterine cavity; avoid touching vagina and keep forceps closed.	11. Let go of ring forceps and place hand on abdomen.	12. “Elevate” uterus by pushing upward toward woman’s head.
			
13. Move IUD and forceps upward—toward umbilicus—until fundus is felt; follow contour of uterine cavity.	14. Open forceps and release IUD at fundus.	15. Sweep forceps to side wall of uterus.	16. Slowly remove forceps—keeping them slightly open.
Allow the woman to rest.	Be sure she gets complete postpartum care.		Provide post-insertion instructions.

Source: Adapted from Jhpiego. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Learning Resource Package*. Baltimore: Jhpiego Corporation, 2010.

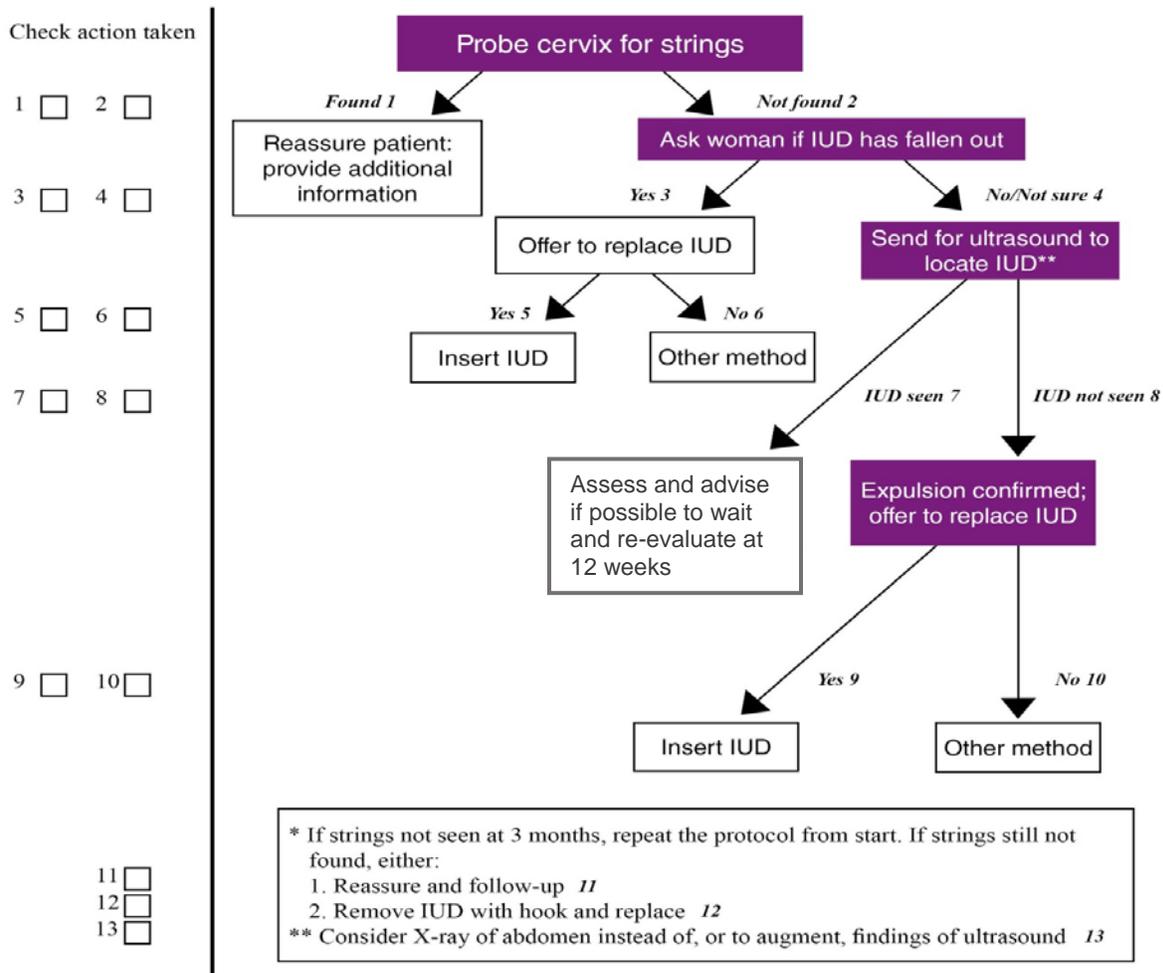
Module 8: Postpartum Intrauterine Device

Job Aid 8-8: Protocol for Management of Missing Postpartum IUD (PPIUD) Strings

Case # _____
Date _____

Protocol for Management of Missing PPIUD Strings*

Situation: Use this protocol when you do not find the strings of the IUD protruding from the cervix on exam of a woman who has returned following postpartum placement of the IUD



Source: Adapted from Jhpiego. *Postpartum Intrauterine Contraceptive Device (PPIUD) Services: Learning Resource Package*. Baltimore: Jhpiego Corporation, 2010.

