Immediate Postpartum IUCD Reference Manual

August, 2010

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Family Planning Initiative
Addressing unmet need for postpartum family planning

Immediate Postpartum IUCD
Reference Manual

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CHAPTER 1

POST PARTUM FAMILY PLANNING

BACKGROUND

In June 2005, the World Health Organization (WHO) brought together over 30 technical experts to review the available global scientific evidence regarding optimal birth spacing and to answer the following questions:

1. Does pregnancy spacing affect the health of mothers and newborns?
2. How long should a woman wait to get pregnant again after childbirth?
3. How long should a woman wait to get pregnant after a miscarriage or induced abortion?

The set of recommendations called Healthy Timing and Spacing of Pregnancy (HTSP) is based on the results of this technical consultation.[1]

Definitions

There are several terms that must be clearly understood to be able to counsel women and families about healthy timing and spacing.

- The **birth-to-pregnancy interval** is the time period between a live birth and the start of the next pregnancy.
- The **birth-to-birth interval** is the time period between a live birth and the next live birth.

Three Components of Healthy Spacing of Pregnancy (HSP)

Every mother and every maternal/newborn health or family planning worker should know and understand these three key HSP messages:

1. **After a live birth, a woman should wait at least 24 months (but not more than five years) before attempting the next pregnancy** to reduce the risk of adverse maternal, perinatal and infant outcomes. Women should plan a healthy birth-to-birth interval of about 36 months, or three years between children.
2. **After a spontaneous and induced abortion, a woman should wait at least six months before attempting the next pregnancy** to reduce the risk of adverse maternal and perinatal outcomes.
3. **Adolescents should delay first pregnancy until age 18** to reduce the risk of adverse maternal, perinatal and infant outcomes.

1 World Health Organization, 2006 Report of a WHO Technical Consultation on Birth Spacing

KEY RESEARCH FINDINGS REGARDING THE RISKS OF CLOSELY SPACED PREGNANCIES

Multiple studies performed around the world have shown that adverse maternal and perinatal outcomes are related to closely spaced pregnancies. The risks are particularly high for women who become pregnant very soon after a previous pregnancy or spontaneous or induced abortion.

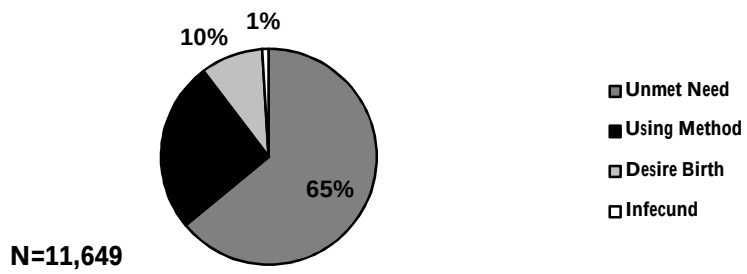
- A **baby** born after a short birth interval has increased chances of:
  - being born pre-term
  - being small for gestational age
  - death during newborn period or childhood
- A **woman** who becomes pregnant too quickly following a previous birth or spontaneous or induced abortion faces higher risks of:
  - anemia
  - abortion
  - premature rupture of membranes
  - maternal mortality
- Early pregnancy (when the mother is younger than age 18) is associated with an increased risk of health complications for mothers and newborns compared to women age 20 to 24 years old. Adolescent mothers aged 15—19 are twice as likely to die during pregnancy or childbirth as those over 20; girls below the age of 15 are five times more likely to die.

UNMET NEED FOR BIRTH SPACING

Approximately 27% of births in India occur less than 24 months after a previous birth. Another 34% of births occur between 24 and 35 months. 61% of births in India occur at intervals that are shorter than the recommended birth-to-birth interval of approximately 36 months.

In India, 65% of women in the first year postpartum have an unmet need for family planning, as shown in Figure 1.1. Only 26% of women are using any method of family planning during the first year postpartum. Because only 8% of recently delivered women desire another birth in the next two years, postpartum family planning programs are essential to help those women who do not desire another pregnancy in the near future to protect their health and the health of their newborn by using an effective and reversible family planning method.

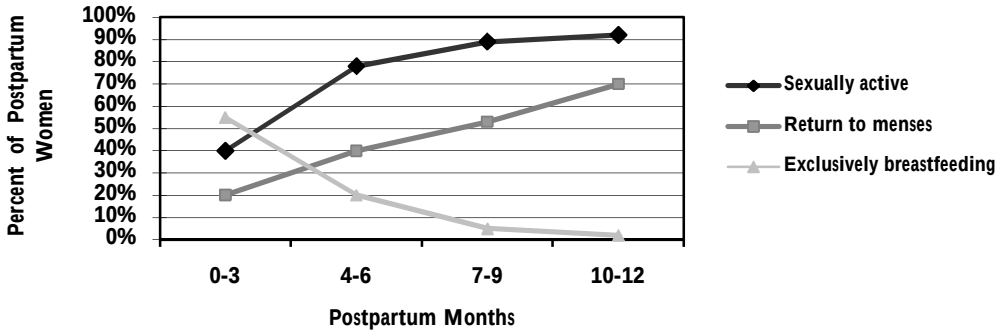
Figure 1.1: Unmet Need among Women in the First Year Postpartum



Source: USAID/ACCESS. 2009. Family Planning Needs during the Extended Postpartum Period in India

Given these shorter than recommended birth intervals and this unmet need for family planning, it is important for postpartum women and their health care providers to accurately understand issues such as return to fertility, the impact of breastfeeding on fertility and the resumption of intercourse. As seen in Figure 1.2, as exclusive breastfeeding falls, menses returns. While more than 55% of women exclusively breastfeed their babies in the first three months following delivery, that rate drops to nearly zero by one year. Breastfeeding alone is not adequate to consider a postpartum woman "protected" from pregnancy. Breastfeeding women need a method of contraception as well, in order to avoid an unwanted or mistimed pregnancy. The lactational amenorrhea method (LAM) of family planning (which requires exclusive breastfeeding on demand for up to six months after delivery with no return of menses) is still not widely practiced. During the first year postpartum postpartum women resume sexual activity: approximately 40% return to sexual activity within the first three months and by 10-12 months postpartum 90% have resumed sexual activity.

Figure 1.2 Factors Related to Return to Fertility and Risk of Pregnancy in the First Year after Birth



Source: USAID /ACCESS. 2009. Family Planning Needs during the Extended Postpartum Period in India

The period after three months, when exclusive breastfeeding is falling, menses is returning and couples resume sexual activity, can be considered a period of high–yet unperceived–risk. Couples will not necessarily see themselves at risk of pregnancy at this time and will not fully recognize the need for family planning. Yet the reproductive system is functioning again and the woman is at risk of an unplanned and potentially undesired pregnancy.

ELEMENTS OF POST PARTUM FAMILY PLANNING

Helping couples understand their risk of unplanned pregnancy—and ensuring that high quality postpartum family planning services are available to them—is the objective of PPFP programs and HSP initiatives. Linkage of maternal/newborn health and family planning services is critical to achieve HSP outcomes and address unmet need for family planning services. Information about optimal birth spacing—including the benefits of HSP—should be incorporated into health education, counselling and service delivery for women and their families wherever they receive medical care including: family planning clinics; antenatal clinics; birthing facilities; postpartum and postnatal care facilities; immunization and child health services; and any service or facility where mothers and children receive routine health care.

Suggested service delivery approaches include:

- Giving clients full information about optimal pregnancy spacing and the benefits of HTSP as a part of routine family planning health education and counselling, both general and method-specific.
- Emphasizing the importance of timely initiation of a family planning method after childbirth, miscarriage or abortion as a part of routine antenatal, postpartum and postabortion care.
- Integrating birth spacing services into other health services, such as immunization and newborn care services.
- Providing family planning services to women while they are still in the health care facility following a facility-based delivery.
- Helping clients to exercise their right to make a free and informed choice regarding family size and fertility.

Key HSP Messages during Family Planning Counselling

In addition to the three key HSP messages, women and couples should learn during family planning counselling about the importance of initiating a family planning method soon after childbirth, spontaneous or induced abortion (abortion). Fertility may return within four to six weeks for women who are not exclusively breastfeeding and as early as two weeks after an abortion. Women who are practicing LAM should change to another family planning method before the baby is six months old.

Specific Client Messages

	For couples who desire a next pregnancy after a live birth	**For couples who desire a next pregnancy after a spontaneous and induced abortion**	**For couples who desire a pregnancy and are (<18 years)**
Return to Fertility	If you are not exclusively breastfeeding, return to fertility may occur within four to six weeks of childbirth. Consider starting a family planning method shortly after birth.	Fertility may return as early as two weeks after an abortion. Consider starting a family planning method immediately after an abortion.	
Exclusive Breastfeeding	If you are practicing Lactational Amenorrhea Method (LAM), fertility may return when: • the baby is six months of age OR • you are no longer exclusively breastfeeding OR • your menses have returned Consider starting a family		

	For couples who desire a next pregnancy after a live birth	For couples who desire a next pregnancy after a spontaneous and induced abortion	For couples who desire a pregnancy and are (<18 years)
	planning method before the baby is six months old.		
Pregnancy Timing	For the health of the mother and the baby, wait at least 24 months, but not more than five years, before trying to become pregnant again. Consider using a family planning method of your choice during that time.	For the health of the mother and the baby, wait at least six months before trying to become pregnant again. Consider using a family planning method of your choice during that time.	For your health and your baby's health, wait until you are at least 18 years of age, before trying to become pregnant. Consider using a family planning method of your choice until you are 18 years old.

CHAPTER 2
IMMEDIATE POSTPARTUM IUCD

BACKGROUND

Intrauterine contraceptive devices (IUCDs) have been used by women in India for decades. In some centres, the IUCD has also been provided to women in the immediate postpartum period for short-term and long-term spacing of pregnancies. Provision of the postpartum IUCD (PPIUCD) is an example of integration of the national maternal child health and family planning programs and is encouraged at this time when facility based deliveries with a skilled attendant are more common and are becoming seen as the norm for childbirth.

Integrating immediate PPIUCD insertion with delivery services optimizes opportunities for women and their families to obtain an appropriate long term, reversible family planning method before returning home. Generally access to long-acting and permanent methods of family planning, may be limited in the community for a number of reasons including lack of trained providers and adequately equipped and accessible facilities. Returning for postpartum services after delivery can present multiple challenges to mothers who have competing demands. Taking advantage of the immediate postpartum period for family planning counselling and IUCD insertion overcomes multiple barriers to service provision. The opportunity created by increased institutional deliveries under the Janani Suraksha Yojana (JSY) scheme in India provides the woman easy access to immediate PPIUCD services.

There are 2 types of IUCDs available in India – Copper-bearing IUCDs, made of a small inert plastic frame covered with copper sleeves and/or copper wire, and progestin-releasing IUCDs which continuously release a small amount of levonorgestrel. Almost all types of IUCDs have one or two monofilament strings which extend into the vagina through the cervix. They are inserted into the uterine cavity by a trained service provider. Among the copper-bearing IUCDs, the CuT-380A is available in the government program and the Multi Load Cu-375 has been approved for use in the private sector, with planned introduction into the government program. (Refer IUCD Reference Manual, Ministry of Health Government of India 2006 for details).

POLICY

- The CuT-380A is approved for immediate postpartum insertion as a method of contraception.
- The PPIUCD must only be placed after the patient is counselled and gives informed consent. Counselling should take place in the antenatal period, in early labour or immediately postpartum. Counselling for informed consent should not take place during the active phase of labour.
- The PPIUCD can be placed immediately following delivery of the placenta, during caesarean section or within 48 hours following childbirth.
- The IUCD must be inserted only by a service provider who has been trained to competency in Immediate PPIUCD service provision according to national standards.
- PPIUCD insertion must be done in a healthcare facility that provides delivery services and

has acceptable standards of infection prevention.

STANDARDS

The following standards of care must be maintained.

1. Women must be counselled regarding advantages, limitations, effectiveness, side effects and warning signs of the IUCD.
2. The provider must explain the procedure for insertion and/or removal of the immediate PPIUCD.
3. Women must be screened for clinical situations in which the immediate PPIUCD would not be the best method of family planning for the woman (WHO Medical Eligibility Criteria). Screening should take place in the antenatal period, as well as immediately prior to insertion.
4. The woman must be counselled and offered another suitable postpartum family planning method if her clinical situation does not allow for insertion of the immediate PPIUCD.
5. The provider must insert the IUCD by following all recommended clinical and infection prevention measures for successful insertion.
6. Insertion must be done by using a long instrument, such as a Kelly placental forceps, to ensure that the IUCD is placed at the fundus.
7. The provider must maintain adequate records regarding PPIUCD insertions and services.
8. Women must be followed up by a provider oriented to PPIUCD services.

TIMING OF IMMEDIATE POSTPARTUM IUCD

An IUCD may be safely inserted immediately following delivery or during caesarean section. Insertion between 48 hours and four to six weeks postpartum is not recommended due to an overall increase in the risk of complications, especially infection and expulsion. The usual timings are:

- Immediate Postpartum insertion:
  - **Postplacental:** Insertion within 10 minutes after expulsion of the placenta following a vaginal delivery. Postplacental insertion is conducted on the same delivery table and involves less than a minute of additional time.
  - **Within 48 hours after delivery:** Insertion within 48 hours of delivery and prior to discharge from the postpartum ward
  - **Intracaesarean:** Insertion that takes place during a caesarean delivery, after removal of the placenta and before closure of the uterine incision.
  - **Postabortion:** insertion following abortion.
  - **Interval:** Anytime after four to six weeks postpartum during the interval between pregnancies.

The IUCD should NOT be placed from 48 hours to 6 weeks following delivery because there is increased risk of infection and expulsion. Normal interval insertion of the IUCD can take place after 6 weeks postpartum.

Retention of the IUCD when placed following delivery is not affected by active management of the third stage of labour. Therefore, ALL women, regardless of whether they accept the PPIUCD, should be managed with active management of the third stage of labour for the prevention of postpartum haemorrhage.

MODE OF ACTION

The PPIUCD works to prevent pregnancy in the same manner as an IUCD inserted in the interval between pregnancies, which is to immobilize sperm and prevent fertilization. While the exact mechanism of action is still somewhat unclear, the copper in the IUCD prevents fertilization by stimulating a cytotoxic intrauterine inflammatory reaction that is spermicidal. The IUCD

- Interferes with the ability of sperm to survive and to ascend the fallopian tubes where fertilization occurs.
- Alters or inhibits sperm migration, ovum transport and fertilization.
- Stimulates a sterile foreign body reaction in endometrium potentiated by copper.

EFFECTIVENESS

The CuT-380A is a highly effective (>99% effective) method of family planning. There are 0.6 to 0.8 pregnancies per 100 women in first year of use. The ability of the method to prevent pregnancy is not affected by insertion during the postpartum period. Overall method effectiveness is improved when spontaneous expulsion rates are low. Therefore, meticulous attention to technique during insertion is required in order to reduce spontaneous expulsion rates and increase method effectiveness.

The CuT-380A is effective for 10 years of continuous use. It can, however, be used for whatever time period the woman wants, up to 10 years. (Women who want to use the IUCD for longer periods than 10 years should have the device removed at 10 years and a new device inserted.)

ADVANTAGES

The specific advantages of an IUCD placed in the immediate postpartum period include:

Advantages for the woman:

- Convenience and integration of services; saves time and additional visit with related cost for the woman
- Safe because it is certain that she is not pregnant at the time of insertion
- High motivation (woman and family) for a reliable birth spacing method
- Has negligible risk of uterine perforation because of the thick wall of the uterus.
- Reduced perception of initial side effects (bleeding and cramping)
- Reduced chance of heavy bleeding, especially among lactational amenorrhea method (LAM) users, since they are experiencing amenorrhea

- No effect on amount or quality of breast milk
- Effective method in place before discharge from hospital
- Overall, the acceptance of a PPIUCD can help women to achieve a healthy birth spacing interval, thus reducing morbidity and mortality of mother, newborn and other children.

Advantages for the service provider or the service delivery site:

- Certainty that the woman is not pregnant
- Saves time as performed on the same delivery table for postplacental insertion. Additional evaluations and separate clinical procedure is not required.
- Need for minimal additional instruments, supplies and equipment
- Convenience for clinical staff; helps relieve overcrowded outpatient facilities thus allowing more women to be served.

The other advantages of the PPIUCD are the same as the interval IUCD.

- A single decision leads to effective long-term prevention of pregnancy
- Very effective
- Effective immediately
- No interference with sexual relations
- Increased sexual enjoyment because no need to worry about pregnancy
- No hormonal side effects with copper-bearing IUCDs
- Immediately return to fertility after removal. Pregnancy can occur during the first cycle following removal, and as quickly as in women who have not used IUCDs
- No interaction with any other medicines that woman might be taking
- Prevention of ectopic pregnancies (Less risk of ectopic pregnancy than in women not using any family planning method)

LIMITATIONS

The specific limitations of an IUCD placed in the immediate postpartum period include:

- Increased risk of spontaneous expulsion
    - Spontaneous expulsion rates for PPIUCD are dependent upon insertion technique and the skill of the provider. The rates vary widely but typically are in the range of 10 – 14%. A well-run program where providers pay meticulous attention to detail during insertion can reduce expulsion rates to 2 – 5%. [2]

[2] Note: Even if spontaneous expulsion rates approach 10%, this can also be viewed as a retention rate of 90%. From a public health program perspective, a retention rate of 90% has substantial benefits.

- Spontaneous expulsion can be reduced by ensuring that the IUCD is placed high in the uterine fundus, ensuring that the IUCD is not dislodged during removal of the instrument and placing the IUCD immediately following delivery of the placenta.
- Expulsion rates for PPIUCDs are highest in the first 3 months following insertion.

- Pelvic infection (endometritis or salpingitis) if IUCD is placed when the woman has chorioamnionitis, postpartum endometritis or puerperal sepsis.
- Perforation of the uterus while placing a PPIUCD during caesarean section or during the first 48 hours postpartum has not been reported in the literature. While this is theoretically possible, the thickness of the uterine wall postpartum makes this extremely unlikely.

The other limitations of the PPIUCD are the same as the interval IUCD.

- Menstrual changes, which are common in the first 3 months but likely to lessen after 3 months (it is expected that these would be less in lactating women):
  - Longer and heavier menstrual periods
  - Bleeding or spotting between periods
  - More cramps or pain during periods
- Does not protect against sexually transmitted infections (STIs), including HIV/AIDS
- IUCD insertion and removal is provider dependent
- Other rare side effects:
  - Heavy menstrual bleeding or bleeding between periods, possibly contributing to anaemia.

SIDE EFFECTS OF THE IUCD

Side effects of IUCD may be unpleasant but are not harmful and in most women these subside or resolve within a few months after insertion. Regardless of the timing of insertion, the most common side effects associated with the copper-bearing IUCD are:

- A change in the amount and duration of menstrual flow and an increase in the amount of menstrual related cramping.
- Use of the Copper T has been associated with an increase of up to 50% in the duration/amount of menstrual bleeding, and this is the most common reason for removal.[3]
- Changes in bleeding patterns, such as spotting/light bleeding (between periods), may also occur in the first few weeks.
- Finally, some women may experience discomfort or cramping during IUCD insertion[4] and for the next several days.
- Cramping/pain and changes in bleeding amount/patterns usually are not harmful for the woman and often subside within the first three months after IUCD insertion.

There is no evidence to suggest that immediate postpartum insertion of the IUCD increases the frequency or severity of side effects such as changes in menstrual flow and cramping. Some studies

3 Penney G, Brechin S, de Souza A, et al. 2004. FFPRHCD Guidance (January 2004). The copper intrauterine device as long-term contraception. J Fam Plann Reprod Health Care 30:29-41; quiz 42.

4 Grimes DA. 2004. Intrauterine devices (IUDs). In: Hatcher RA, Trussell J, Stewart F, et al. (Eds) Contraceptive Technology. Ardent Media, Inc.: New York

suggest that many IUCD-related side effects are obscured by the usual bleeding and cramping encountered in the postpartum period and that the immediate PPIUCD, when successfully inserted, is better tolerated than the interval IUCD. This is an additional advantage of insertion in the immediate postpartum period.

POTENTIAL HEALTH RISKS & ADVERSE EVENTS WITH THE IMMEIDATE PPIUCD

There are several potential health risks and adverse effects associated with the immediate PPIUCD. Of note, a lack of well-designed, peer reviewed studies of the immediate PPIUCD leaves important questions about exact complication rates and such variables as timing and technique of insertion unanswered and the subject of ongoing research. However, certain conclusions can be drawn based on consistent findings across country lines, clinical sites and provider mix.

- **Uterine perforation**—Perforation of the uterine wall during postpartum IUCD insertion has not been reported. In a recent systematic review of the literature regarding immediate PPIUCD insertion, there were no reported cases of uterine perforation while placing the PPIUCD in any of the studies reviewed.[5]
- **Expulsion**—Although IUCD failure is rare no matter when insertion occurs, spontaneous expulsion of the IUCD from the uterus is the most common cause.[6]
  - Several factors appear to influence the risk of expulsion—type and skill of the provider and the timing of insertion after birth.
  - Rates of spontaneous expulsion of the IUCD following immediate postpartum insertion appear to be higher than expulsion rates after interval and non-pregnancy-related insertions.
  - When the immediate postpartum period is examined, insertion of an IUCD less than 10 minutes after placental delivery following either vaginal or caesarean birth is associated with a lower risk of expulsion than insertions that occur later in the postpartum period.[7]
  - Interval insertion at four to six weeks after delivery is associated with the lowest risk of expulsion postpartum.
- **Infection**—The risk of upper genital tract infection among IUCD users is less than one%, which is much lower than previously thought.
  - This minimal risk is highest within the first 20 days after IUCD insertion, and is thought to be related to either insertion technique (due to lack of proper infection prevention practices) or pre-existing infection rather than to the IUCD itself.
  - After the first 20 days, the risk of infection among IUCD users appears to be comparable to that among non-IUCD users.[8]
  - Postpartum insertion appears to have no significant effect on the risk of genital tract infection.

5 Kapp N, Curtis KM, Intrauterine device insertion during the postpartum period: a systematic review; Contraception 80(2009) 327-336

6 Association of Reproductive Health Professionals (ARHP). 2004. New developments in intrauterine contraception. In: Clinical Proceedings of the ARHP, Washington DC, September. ARHP: Washington, DC.

7 Kapp N, Contraception 80(2009)

8 Hatcher R, Trussel J, Stewart F, et al. 2004. Contraceptive Technology, 18th ed. Ardent Media, Inc.: New A York.

CHAPTER 3
POSTPARTUM FAMILY PLANNING COUNSELLING

BACKGROUND

Counselling for PPIUCD placement should take place during regular antenatal visits. A system should be established to determine if women who attend ANC clinic have been counselled and have chosen a postpartum FP method. This is essential so that delivery room staff can be alerted regarding women who have chosen the PPIUCD so preparations can be made to provide the method immediately following delivery of the placenta. This can be achieved by using a stamp or some other method to denote patient choice of postpartum family planning method on the ANC card. Labour room staff should check the ANC card for this information when the woman presents for delivery care.

Women who are unbooked, have not received ANC at the facility where they present for delivery care or have not chosen a postpartum family planning method prior to birth should NOT be counselled for the PPIUCD during active labour. The intensity of labour does not make it a good time to make an informed choice about contraception.

Instead, these women should be counselled on the first postpartum day and, if interested, they should be provided the PPIUCD on that same day.

Immediate Postpartum IUCD counselling occurs in various stages:

- General health education, often group-based, about immediate postpartum family planning methods and options
- Individual counselling about immediate postpartum methods where a women/couple considers and makes an informed choice for a method that is well suited to her/their individual needs and circumstances in the postpartum period
- Method specific counselling about the IPPIUCD, for those women who choose the IUCD for postpartum insertion
- Follow up counselling for women who have had the IUCD inserted immediate postpartum to help them effectively use the IUCD.

IMMEDIATE POSTPARTUM IUCD COUNSELLING

Antenatal Counselling

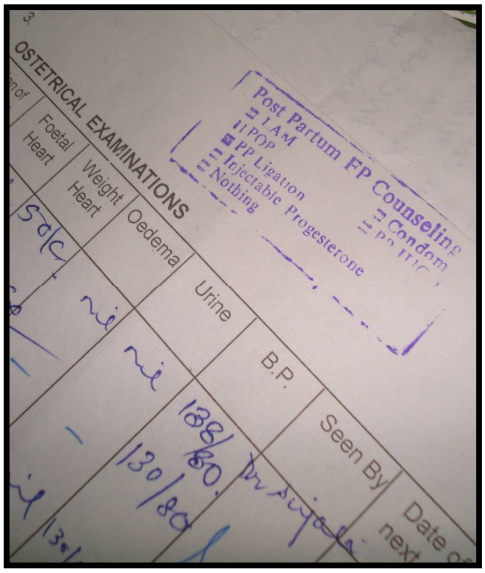
The counselling process should be tailored to the individual woman's needs. Because the most effective approach to immediate PPIUCD services is to insert the device immediately following the delivery of the placenta, it is essential that women be counselled about immediate PPIUCDs during the antenatal period. A system should be established to determine if women who attend ANC clinic have been counselled and have chosen a postpartum FP method. Health education can be provided to all attendees of the clinic by a trained counsellor during ANC. Then individual counselling can be provided to women and couples before, during or after the antenatal evaluation. Those who express interest in the immediate PPIUCD should be provided specific information, as outlined below and in Annex A: Client Messages about Basic Attributes of the IUCD.

The method-specific counselling should contain the following information:

- Key information about the IUCD (see Annex B: Counselling Guide: Immediate Post Partum IUCD Counselling Checklist)
  - Effectiveness: prevents almost 100% of pregnancies
  - How the IUCD prevents pregnancy: causes a chemical change that damages the sperm BEFORE the sperm and egg meet
  - How the IUCD is used: inserted after delivery and then requires no additional care (ensure that the woman knows it can be inserted at other times as well)
  - How long the IUCD prevents pregnancy: up to 12 years/approved for 10
  - How the IUCD can be removed at any time by a trained provider and fertility will immediately return
  - How the PPIUCD will be inserted
- Immediate PPIUCD advantages:
  - Immediate placement after delivery
  - Once inserted does not require daily action
  - Does not affect breastfeeding
  - Long-acting and reversible–Can be used to prevent pregnancy for a short time and the woman may get it removed any time she wants or continue as long as 10 years and then get it removed or replaced.
- Immediate PPIUCD limitations:
  - Higher risk of expulsion when inserted postpartum (although this is less if the IUCD is inserted immediately after delivery of the placenta)
  - Strings may not be visible initially, which might require some additional follow-up or investigation
  - Small risk of infection
- Warning signs for immediate PPIUCD users (counsellor should also explain to the woman that she should return to the clinic as soon as possible if she has any of the following):
  - Foul smelling vaginal discharge different from the usual lochia
  - Lower abdominal pain, especially if accompanied by not feeling well, fever or chills
  - Concerns that the IUCD has fallen out

Counselling should be done with the woman, and if she prefers, with her husband and or mother-in-law.

Figure 3.1 ANC Record Sample



A woman's choice about PPFP should be noted clearly on her antenatal card or record. This stamp or specific notation in the ANC record (see figure 3.1) will alert delivery room staff to women who have chosen the immediate PPIUCD so preparations can be made to provide the method immediately following delivery of the placenta. The labour room staff should check the ANC card for this information when the woman presents for delivery care.

When can women be counselled for immediate PPIUCD insertion?

Women should be ideally counselled in the antenatal period for immediate PPIUCD services. The provider may use the Job-aid for immediate postpartum counselling and time for initiation of contraceptives provided to them and also given in Annex C. This allows multiple opportunities to address the woman's concerns and answer her questions. It allows for a discussion with the husband or other family members if that is considered an important part of the counselling process. If this is not possible because the woman did not receive ANC, or received it at a facility where PPFP counselling is not practiced, or her choice is not noted on her ANC record, it is acceptable to counsel women at other times, such as:

- ***During an antenatal admission*:** if a woman is undergoing evaluation or treatment for an antenatal complication, she may be counselled for immediate PPIUCD. This is actually a good time to discuss the health benefits of birth spacing for both her and her baby.
- ***During early labour:*** if a woman presents in early labour (she is relatively comfortable, with infrequent contractions, and able to concentrate on the information being provided) she can be counselled for an immediate PPIUCD. It would be important that she understand that the method is reversible and non-permanent and she can change her mind at any time to discontinue using it with immediate return of fertility.
- ***On the first postpartum day:*** for women who could not be counselled prior to delivery, they can receive counselling on the first postpartum day.
- ***Prior to scheduled caesarean section:*** women who arrive to the hospital for a scheduled caesarean section, can be counselled about insertion of an IUCD during the caesarean section

In general, due to the stress of labour, a woman should ***NOT*** be counselled for the first time about immediate PPIUCD during active labour. The intensity of labour does not make it a good time to make an informed choice about contraception, and it is unlikely that they will be able to focus sufficiently on the information to be able to provide consent.

Post Insertion Counselling

Following insertion of the IUCD, the provider who has done the insertion should review key features of the immediate PPIUCD with the woman.

- IUCD side effects and normal postpartum symptoms

- Importance of breastfeeding and that the PPIUCD does not affect breastfeeding or breast milk
- When to return for IUCD/Postnatal Care (PNC)/newborn check-up
- Need to come back at any time if she has a concern or experiences warning signs
- Warning signs that there may be a problem related to the IUCD
- How to check for expulsion and what to do in case of expulsion

For women who receive a postplacental or an intracaesarean insertion, this counselling is best done the following day, when the woman is better able to concentrate on the messages. If the insertion was done as an immediate postpartum insertion, the post insertion counselling can be done shortly after the insertion.

Follow Up Care and Counselling

Follow up care and support of the woman's choice of a PPIUCD is very important to reassure her and respond to her questions and needs, especially during the first three months postpartum when side effects may be more common. Once oriented to PPIUCD services, various health care workers, including ASHAs or AWWs, can provide the woman with appropriate follow up counselling. This can be useful if the woman lives at a substantial distance from the facility where the PPIUCD was inserted.

If a follow up visit is conducted at the facility where the PPIUCD was inserted:

- Ask the woman if she has any complaints.
- Ask if she feels that the IUCD has spontaneously fallen out.
- Ask if she has questions about the IUCD or has heard any information about the IUCD.
- Do a clinical assessment for anaemia if she complains of excessive or prolonged bleeding.
- If possible, perform a speculum examination on the first visit to assess if the IUCD strings have descended into the vagina. Thereafter, perform a pelvic examination only if necessary.
- The woman should have follow up counseling during the first three months postpartum.
- If no concerns or complaints she need not have additional follow up solely related to the IUCD.
- Ensure that the woman knows that she can come any time if there is a problem.
- Follow up is also important for the service provider and the facility where the woman received her PPIUCD.
- Follow up allows the provider to know if the counselling messages were clear, and if his or her insertion technique has resulted in an acceptably low rate of spontaneous expulsion.
- If large numbers of women are not returning for follow up to the site where the IUCD was inserted, the program should consider contacting a sample of those women to determine their satisfaction.
- If women are receiving a PPIUCD only to leave the facility and have it removed by another

provider it may suggest that either the counselling has not been adequate or the other providers in the area are not aware of the characteristics of the PPIUCD.

Refer to Annexure B for Counselling Guide: Immediate Postpartum IUCD Counselling Checklist and Annexure C: Job Aid for Immediate Postpartum IUCD Counselling and Time for Initiation of Contraceptives to support the provider during counselling clients.

CHAPTER 4

INFECTION PREVENTION PRACTICES AND THE IPPIUCD

BACKGROUND

Evidence-based infection prevention practices compatible are an integral part of all successful immediate PPIUCD programs. Infection prevention processes which insure that personnel are properly trained and that supplies and instruments are adequately decontaminated, cleaned, processed and disposed of are required.

KEY OBJECTIVES OF INFECTION PREVENTION DURING IPPIUCD INSERTION

1. Reduction of the risk of infection associated with immediate PPIUCD insertion technique
2. By blocking channels of infection, reduction of the risk of facility-related infection transmission to immediate PPIUCD clients
3. Protection of healthcare workers at all levels from exposure to infection

The following basic infection prevention processes related to immediate PPIUCD insertion must occur if key objectives are to be achieved:

- Consistent implementation of standard universal precautions (SUP)
- Use of aseptic/no-touch technique during every insertion process
- Use of High Level Disinfection(HLD)/sterilized equipment with appropriate disposal of waste after every procedure

1. Implementation of standard universal precautions

It is mandatory to practice appropriate infection prevention procedures at all times with all clients to decrease the risk of transmission of infection including Human immunodeficiency virus (HIV), Hepatitis C (HCV), and Hepatitis B (HBV). Consider every person (patient, client or staff) as not only potentially infectious but also susceptible to infection. Standard Precautions are designed for the safety and care of all people in a health care facility—whether a hospitalized patient, a woman receiving IUCD services, or a health care worker. Standard precautions protect everyone.

Standard Universal Precautions of infection prevention include:

1. **Hand Washing:** Wash hands with soap and water or an appropriate alcohol-based hand rub before performing immediate PPIUCD insertions. Routine hand washing should be done before wearing gloves, after examination or after having any direct contact with a client, and after removing the gloves. Plain or antiseptic soap should be used for routine hand washing. Hands should be rinsed in a stream of running water and dried with a clean personal towel or air-dried. Towel should not be shared.
2. **Self protection such as wearing gloves and physical barrier:**
   - Wear gloves on both hands before touching anything wet such as lower genital tract skin and mucous membranes, blood or other body fluids such as urine or faeces, soiled

instruments, and contaminated waste materials or while performing invasive procedures.

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

3. Safe Work Practices

- Before IUCD insertion/removal apply a water-based antiseptic to the cervix and vagina two or more times.
- Use aseptic/no-touch technique during every immediate PPIUCD insertion
- Use only sterile IUCDs that are in an intact, unexpired and undamaged sterile package.
- Sterile or HLD gloves or Kelley placental forceps should be used to touch/hold the IUCD.
- The IUCD should not touch the perineum, the vaginal walls or any other non-sterile surface that may contaminate it before placement in the uterus.
- Ideally the IUCD cannot be passed through the cervical os more than once. However, if the strings are visible after removing the forceps which indicates that IUCD is placed lower than the fundus or displaced while removing the forceps, then the IUCD may be removed and tried only once more for fundal placement.

4. Maintain correct environmental cleanliness

- While wearing gloves, wipe all large surfaces (e.g., procedure table, instrument stand) that could have been contaminated by blood or other body fluids with a 0.5% chlorine solution.
- Wash **large surfaces** e.g., procedure table, instrument stand with soap and water if organic material remains on them after decontamination.

5. Correct processing of instruments and other items: This includes the following four steps:

Step 1: Decontamination:

- Immediately after use, fully immerse all instruments in a plastic container filled with 0.5% chlorine solution for 10 minutes. (This step helps prevent transmission of HBV and HIV to staff. It should be done before staff is allowed to handle or clean instruments.)
- If the instruments will not be cleaned (Step2) immediately after decontamination, rinse them with water and dry them with a clean towel to minimize possible corrosion of the instruments due to chlorine.
- While still wearing gloves (dispose off waste [Step 4], as per protocol), briefly immerse both gloved hands in the bucket containing the 0.5% chlorine solution and then carefully remove them by turning them inside out.
- If disposing off gloves, place them in a leak-proof container (with tight-fitting lid) or plastic bag.
- If reusing surgical gloves, submerge them in the chlorine solution and soak them for 10 minutes.

Preparation of 0.5% Chlorine solution using 30% bleaching powder.
Mix 15 gms of commercially available bleaching powder in one liter of tap water. Stir well and filter the water to remove rest of the powder before using the solution. The solution needs to be changed once in 24 hours or whenever it becomes very dirty or red in color.

Step 2: Cleaning and Rinsing: After decontaminating instruments:

- Thoroughly scrub them under the surface of the water with a soft brush (e.g., a toothbrush) and liquid soap or detergent. Pay special attention to teeth, joints, and screws, where organic material may collect.
- After cleaning, rinse items well to remove all soap or detergent. (This step is important because some detergents can leave a residue that interferes with the action of chemical disinfectants used for HLD/sterilization in step 3.)
- After rinsing, air dry or dry items with a clean towel.
- Once items are dried, proceed with HLD/sterilization.

Step 3: HLD (Recommended for IUCD Services)

After decontaminating the instruments and surgical gloves and cleaning and rinsing them, High-level disinfect them using one of the following processes:

Boil items for 20 minutes and dry:

- Open or take apart items.
- Fully immerse items in water in a covered pan and heat.
- Bring water to a rolling/bubbling boil, and boil for 20 minutes in a pot with a lid.
- Do not add anything to the pot after boiling begins.
- Remove items using high-level disinfected forceps, and place in a high-level disinfected container.
- Allow items to cool and air dry.
- Use objects immediately or store them in a covered airtight, dry high level disinfected container for up to 7 days. If stored in an ordinary covered container, it can be used up to 24 hours.

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

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

Alternate Step 3: Sterilization (Not essential for IUCD services if HLD is available):

Sterilization by steam: After decontaminating and cleaning and rinsing instruments, sterilize them by autoclave (121°C [250°F] and 106 kPa [15 lb/in] for 20 minutes if unwrapped and 30 minutes if wrapped.

- Sterilized packs can be used up to one week if kept dry and intact and drum is not opened.
- Once drum is opened, use only for 24 hours.

Sterilization by chemical method

- Decontaminated, cleaned and dried items are put in 2 per cent glutaraldehyde solution for at least 8 to 10 hours.
- Items such as scissors and forceps should be put into the solution in an open position.

- Do not add or remove any items once timing starts.

Items should be rinsed well with sterile water (not boiled water), air-dried and stored in a covered sterile container for up to seven days.

- Sterile water can be prepared by autoclaving water for 20 minutes at 15 lb/sq inches in an autoclave.

Refer to Annexure E for Additional Information on Chemicals Used for Infection Prevention Processes

Step 4: Storage:

- Use high-level disinfected instruments and gloves immediately, or store them for up to 1 week in a **high-level disinfected** container with a tight-fitting cover.
- Sterilized instruments not used immediately should be stored in a dry, **sterile** container with a tight-fitting cover.

Refer to Annexure D for Steps in Processing Instruments and Other Terms Used In Immediate PPIUCD Services[9]; and Annexure F: Flow Chart Summarizing Processing Surgical Instruments, Gloves and Other Items.

6. Waste Disposal:

- Safely dispose of waste materials as per protocol.
- After completing a procedure (e.g., IUCD insertion or removal), and while still wearing gloves, dispose off **contaminated waste** (e.g., gauze, cotton, disposable gloves) in a properly marked leak-proof waste container (with a tight-fitting lid) or plastic bag.
- The waste should be disposed off properly. It is better to either bury or burn it.
- Burning should preferably be done in an incinerator or steel drum as opposed to open burning.
- If burning is not possible, waste should be put in a pit and buried but never be thrown out sides or left in open pits.
- For waste that is to be picked up by the municipalities, these should be contained in closed dumpsters prior to removal.

Specific Infection Prevention Measures for the Procedure

- **Before Immediate PPIUCD Insertion**

2. Ensure that instruments and supplies are available and ready for use.
3. Ensure that the IUCD package is unopened and undamaged and check the expiration date. (Regardless of timing or setting, the IUCD package should not be opened until the final decision to insert the IUCD has been made.)
4. Open all required HLD/sterile instruments and supplies onto a dry, HLD/sterile surface such as a drape or steel basin. IUCD should be placed close by in its sterile packet. Particular care is required immediately after delivery to ensure an adequate sterile field. Where possible, use of a separate table or stand is recommended to prevent cross contamination with instruments used during delivery.
5. When possible, for immediate postpartum insertion within 48 hours of delivery, wash or have the woman wash her perineal area with soap and water before prepping the vagina and

9 Adapted from: Perkins 1983.

cervix and beginning insertion. If immediately after delivery, cleaning the perineal area gently with a sterile gauze or towel is sufficient in the absence of frank fecal contamination.

6. Antiseptic preparation of the vulva, perineum and peri-rectal area is not required. There is no evidence that shaving the genital area for delivery or immediate PPIUCD insertion decreases the infection rate. Hence, it should not be shaved.
7. When available, place a dry, sterile cloth between her genital area and the surface of the examination table for patient comfort and to minimize contamination of sterile instruments and the IUCD during insertion.
8. Wash hands thoroughly with soap and water; dry them with a clean, dry cloth or allow them to air dry.
9. Put HLD or sterile surgical gloves on both hands.
10. Using sterile gauze and a sterile sponge/ring clamp or its equivalent, an appropriate water-based antiseptic agent should be applied to the vagina and cervix two or more times before IUCD insertion or removal. Cleanse from the inside of the cervical os outward.
    - The most commonly used lower genital tract antiseptics are: iodophors, such as povidone iodine, and chlorhexidine. If an iodophor is used, allow one to two minutes before proceeding with the procedure after application. Iodophors such as povidone iodine require contact time to act.
    - Do not use alcohol as an antiseptic in the lower genital tract. Not only is it painful for the patient but also it may actually increase the risk of infection by drying and damaging the vaginal and cervical mucosa.
11. If sterile gloves are contaminated during the antiseptic application process, change to a new pair before proceeding with insertion.

- **During IUCD Insertion (as applicable)**

12. Only sterile or HLD gloves should be used to touch the IUCD while loading it onto the Kelly placental forceps in the sterile packet using no-touch technique and during insertion immediately postpartum. During interval insertion procedures where the IUCD is loaded into the inserter tube while in its sterile packaging, clean examination gloves are adequate as direct contact with the IUCD itself is not anticipated.
13. Gloves which have been used to touch the perineum or vagina are by definition contaminated and no longer sterile.
14. Throughout the procedure, use “no-touch” technique to reduce the risk of contaminating the uterine cavity. Using the “no-touch” technique during IPPIUCD insertion means that the IUCD is:
    - Touched only by uncontaminated sterile or HLD gloves and sterile equipment.
    - Not allowed to touch the buttock drape, the perineum, the vaginal walls or the blades of the speculum (or any other no sterile surface that may contaminate them)
    - Not passed through the cervical os more than once.
15. If successful fundal placement is not achieved and the IUCD is dislodged and removed, it may be reinserted or another sterile packaged IUCD must be opened if a repeat attempt is planned. Where contamination has occurred, the vagina may require additional antiseptic

application and a new pair of sterile gloves and sterile/HLD Kelly placental forceps may be required.

- **After IUCD Insertion**

16. Before removing your gloves:

— Place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination, if not already done.

— Dispose of waste materials (e.g., cotton balls and gauze) by placing them in a leak-proof container (with a tight-fitting lid) or plastic bag.

— Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out.

— Dispose of gloves by placing them in a leak-proof container or plastic bag.

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

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

— Ensure that all instruments, gloves and other reusable items are further-processed according to recommended infection prevention practices (See Table 4.1).

CHAPTER 5

MEDICAL ELIGIBILITY CRITERIA AND CLIENT ASSESSMENT

BACKGROUND

All providers should keep in mind that while all methods of family planning have some associated risks, the risks to a woman and her family's health may be greater if she uses no method and has an unwanted or ill-timed pregnancy. As well, when providers do not screen women appropriately and counsel them adequately, there is a risk that women will rapidly and unnecessarily go through and discard all the family planning options, leaving her with no reasonable choices for managing her reproductive health goals.

MEDICAL ELIGIBILITY CRITERIA (MEC)

The WHO Medical Eligibility Criteria form the scientific foundation for client assessment regarding family planning methods. It gives detailed guidance regarding whether woman with a certain condition can safely use a given method of family planning. The MEC has four categories:

- **Category 1:** A condition for which there is no restriction for the use of the contraceptive method. **Safely use.**
- **Category 2:** A condition where the advantages of using the method generally outweigh the theoretical or proven risks. **Generally use.**
- **Category 3:** A condition where the theoretical or proven risks usually outweigh the advantages of using the method. **Generally do not use.**
- **Category 4:** A condition which represents an unacceptable health risk if the contraceptive method is used. **Do not use.**

While the MEC has been updated in recent years to provide clearer guidance on use of the IUCD in general, specific information about the use of the IUCD in the immediate postpartum period is limited in the MEC. Therefore, it is necessary to review the MEC with respect to the use of the IUCD in the immediate postpartum period and to expand the list of conditions for which the IUCD might or might not be appropriate.

In general, therefore, medical eligibility criteria for the immediate PPIUCD services can be grouped as follows:

- **Category 1:**
  - Immediate post placental, immediate postpartum<48 hours or during caesarean section
  - > six weeks postpartum
- **Category 2:** no conditions
- **Category 3:**
  - Between 48 hours and six weeks postpartum
  - Chorioamnionitis
  - Prolonged ROM > 18 hours*

Diagnosis of Chorioamnionitis

Chorioamnionitis is an intra-amniotic infection of the fetal membranes and amniotic liquor prior to or during labour which is characterized by:

- Temperature of 38°c
- Abdominal pain

PLUS one of the following:

- Tender uterus
- Leaking of foul-smelling amniotic fluid
- Fetal tachycardia (>160 BPM)

- **Category 4:**
  - Puerperal sepsis
  - Unresolved postpartum haemorrhage*

These conditions merit additional discussion.

Prolonged rupture of membranes and Chorioamnionitis

- Rupture of membranes for more than 18 hours prior to delivery is often listed as an exclusion criterion in most research studies about immediate PPIUCDs. This almost always leads to infection of the membranes and placenta (Chorioamnionitis) that occurs during labour when membranes are ruptured and amniotic fluid is leaking.
- The infection must be treated with antibiotics and the foetus delivered quickly.
- The management principle for this infection is to deliver the foetus, which will clear the infection from the mother.
- The recommendation following a normal vaginal delivery in a woman with chorioamnionitis is for no additional antibiotics, however, due to the recent infection and the increased chance of development of puerperal infection, the IUCD should not be offered to women with chorioamnionitis.
- Prolonged rupture of membranes increases colonization of the infection organisms in the uterus and therefore increases the possibility that the woman may develop a postpartum uterine infection or puerperal sepsis.
- For this reason, it is listed here as a Category three condition. There is no clear clinical evidence that this is clinically relevant, and thus this exclusion is open to review.

A delivery where there is **unresolved postpartum haemorrhage**

- Due to the haemorrhage, the attention should be on addressing the cause of the bleeding and achieving hemodynamic stability on priority, rather than inserting the IUCD.
- Once the haemorrhage is controlled, if the woman is stable, the IUCD can be inserted at that time or can be inserted the following morning.
- For these reasons, unresolved PPH has been listed as a Category four condition.

If the woman had **substantial genital trauma** from the delivery

- The IUCD should be inserted prior to starting the repair of the multiple lacerations of the vagina or episiotomy.
- In this situation an instrumental insertion is recommended.
- If a woman is being evaluated during the immediate postpartum period for PPIUCD insertion (within 48 hours of delivery) and is found to have had substantial genital trauma, perform the insertion carefully to ensure that the repair is not disrupted during the insertion.

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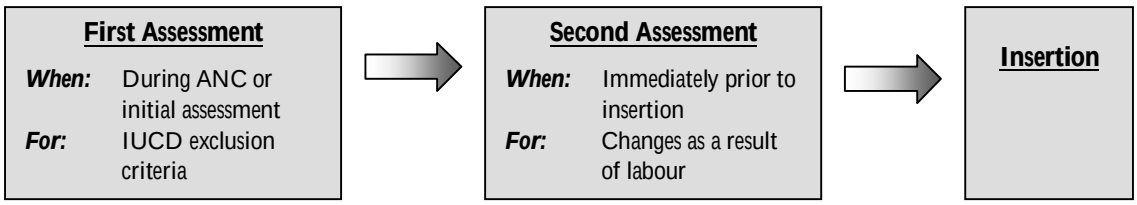
* This condition is not specifically mentioned in the WHO MEC, but is considered a prudent interpretation of the MEC.

CLIENT ASSESSMENT

Assessment of women for provision of immediate PPIUCD services should be in **two phases.** The first assessment is a general review of the woman's medical history and eligibility for the method. A second assessment is done immediately prior to insertion (during cesearean, following delivery of the placenta or within 48 hours after birth) to assess those criteria which may have changed as a result of the labour and birth.



First Assessment

A **first assessment** should be carried out with the pregnant woman during antenatal care and include assessment for the following conditions, listed in the Medical Eligibility Criteria and relevant to immediate PPIUCD services, which make the IUCD not a good choice for this woman:

- Known distorted uterine cavity (uterine septum, fibroid uterus, etc.)
- Acute purulent (pus-like) discharge
- High individual likelihood of exposure to Gonorrhoea or Chlamydia
- Malignant or benign trophoblastic disease
- Suffering from AIDS and not clinically well or on antiretroviral therapy

For those women who present to the facility for delivery care, and who have not had a prior assessment, the clinician must use her/his clinical judgement about the likelihood of contraindications to use. In the situation where a woman has just experienced a normal, vertex, full-term vaginal delivery, it is reasonable to assume that she:

- Does not have a distorted uterine cavity
- Does not have malignant or benign trophoblastic disease
- Does not suffer from fulminant HIV
- Does not have undiagnosed infection with Chlamydia or gonorrhoea

(Refer to the Medical Eligibility Criteria table in Annexure G: Medical Eligibility Criteria for PPIUCD insertion)

Second Assessment

A ***second assessment*** should take place immediately prior to insertion. The purpose of the second assessment is to ensure that the process of labour and birth has not produced any clinical situation for which insertion of the immediate PPIUCD would not be advised. The second assessment must look for:

- Chorioamnionitis
- Postpartum endometritis/metritis or Puerperal sepsis
- More than 18 hours from rupture of membranes to delivery of the baby

- Unresolved postpartum hemorrhage
- Extensive genital trauma where the repair would be disrupted by postpartum placement of the IUCD

The second assessment should be done by the person who will insert the IUCD. If an immediate postplacental insertion is planned, the second assessment is best carried out during the second stage of labour so that insertion can be performed immediately following the delivery of the placenta without any delay. If insertion is planned during caesarean section, the second assessment should take place during the pre-operative activities prior to surgery. Finally, if the woman is evaluated and counselled for immediate postpartum family planning on the first or second postpartum day, and an immediate postpartum insertion is planned, the second assessment should take place during the initial evaluation.
(A job aid for the second assessment is available in Annexure H: Job-Aid for Immediate PPIUCD Pre-insertion Screening).

If the woman has NONE of the exclusion criteria noted above, then the provider should advise the woman that it is safe to insert the IUCD and can proceed with preparations for insertion. If, however, her clinical condition makes the IUCD unsuitable for her at this time, the reason should be explained to her and she should be offered another method of postpartum family planning. It should be made clear that the situation identified by the second assessment is a temporary clinical situation and that if she still would like the IUCD as her postpartum method of family planning, it can be provided to her after four to six weeks. She should be scheduled for a postpartum visit at four to six weeks and counselled to come back.

CHAPTER 6

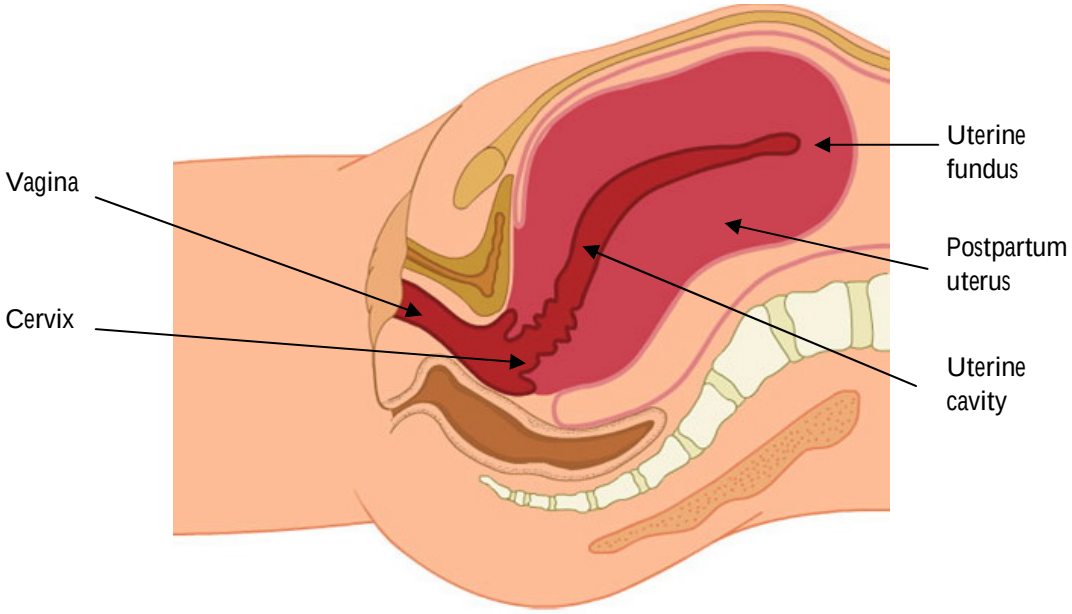
CLINICAL TECHNIQUE FOR INSERTION OF THE IMMEDIATE POSTPARTUM IUCD

BACKGROUND

The previous chapters discussed the appropriate steps for counselling women for all appropriate postpartum family planning methods and the screening of women who choose the IPPIUCD. This chapter focuses on the clinical technique of insertion of the IUCD in the immediate postpartum period.

Immediate PPIUCD services are intended to be fully integrated with intrapartum and postpartum care. This chapter will review how the cervix and uterus change after birth and why these changes make postpartum IUCD insertion possible. Both the timing as well as the technique employed to achieve successful IUCD placement reflect this transformation. In addition, the sequencing of insertion relative to another critically important obstetric intervention active management of the third stage of labour will be discussed.

Figure 6.1: Anatomy of Postpartum Uterus



CHANGES IN THE UTERUS

- Immediately after expulsion of the placenta, the fundus or top of the the uterus is just below the umbilicus. It weighs about 1 kg and is approximately the size of a five month pregnancy.
- It can be easily felt through the abdominal wall in most women.
- The anterior and posterior walls of the body of the uterus are close together, each wall is about four to five cms. in thickness and very soft.
- The lower part of the uterus (also called the lower uterine segment) is stretched thin and is extremely floppy adding to the marked mobility of the body of the uterus which is usually tilted forward.

- This disparity in consistency and weight between the heavy and thickened body of the uterus and the stretched and folded lower uterine segment contributes to the extreme curvature that can be noted upon manual exploration or bimanual examination. (See Figure 6.1).
- Over the next 48 hours, the uterus remains approximately the same size and consistency.
- Within two weeks however the uterus cannot be felt above the pubic bone as it has almost completely descended into the pelvis.
- The lower uterine segment can no longer be appreciated, and the uterine cavity straightens and shrinks.
- The uterus normally regains its previous nonpregnant size within five to six weeks postpartum. This process is generally referred to as involution.

CHANGES IN THE CERVIX

- Immediately after completion of the third stage of labour, the cervix and lower uterine segment are thin, collapsed and flabby.
- The outer margins of the cervix are often lacerated, and the cervix is extremely soft.
- The cervical opening contracts slowly and for a few days after delivery, it readily admits at least two fingers.
- By the end of the first week however the cervical canal has re-formed with progressive narrowing of the cervical opening and thickening of the cervical walls.
- At the completion of involution, the cervix is firm and tightly closed while retaining permanent changes that characterize a parous cervix.

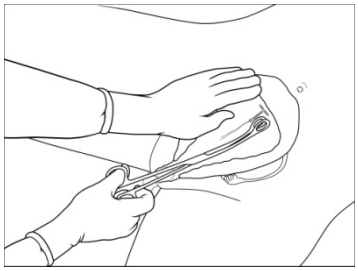
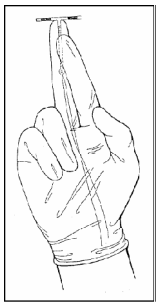
IMMEDIATE PPIUCD INSERTION AND ACTIVE MANAGEMENT OF THIRD STAGE LABOUR

- Insertion of an IUCD immediate postpartum should never interfere with the normal conduct of routine intrapartum and postpartum practices.
- Life-threatening medical conditions such as postpartum hemorrhage and pre-eclampsia/eclampsia should be treated per national guidelines and such treatment should always take precedence over immediate PPIUCD insertion which can easily be deferred until a time when the mother is medically stable. Sound clinical judgment should always prevail.
- Administration of a uterotonic, controlled cord traction, and uterine massage do not increase the subsequent risk of expulsion of the immediate PPIUCD or make the insertion more difficult.
- No aspect of AMTSL should be modified to accommodate immediate PPIUCD insertion.
- All three steps of AMTSL should be successfully completed before immediate PPIUCD insertion is attempted.
- Vaginal hemorrhage which occurs before or after immediate PPIUCD insertion should be managed as per national guidelines with uterine massage, uterotonics and other accepted manouvers which may prove necessary.

TYPES OF INSERTION

Postplacental: Postplacental insertion of the IUCD is done immediately following delivery of the placenta, typically within 10 minutes.

> **The scenario:** The woman is in labour/delivery room and has not yet shifted from the delivery table. She is still in the lithotomy position following delivery. The insertion takes place immediately following active management of third stage labour and the delivery of the placenta.

***Instrumental (Using Forceps) insertion*:** the IUCD is held in an instrument, (Kelly placental forceps or other suitable long forceps without a lock). The instrument is inserted to the fundus of the uterus, and the IUCD is released. This technique requires that appropriate instruments are available in the delivery room.	
Manual postplacental insertion: the IUCD is held in the provider's hand and inserted to the uterine fundus in the hand. This technique requires that the provider use long gloves that reach midway up the arm for the protection of both the provider and the woman.	

Intracaesaren: the IUCD is introduced through the uterine incision during a caesaren section and placed at the uterine fundus. Typically, this is done manually, since it is not necessary to use a long instrument to reach the fundus.

> **The scenario:** The woman has been counselled and prepared prior to the start of the caesaren. After the placenta is removed, the provider inserts the IUCD, and then closes the uterine incision. It is important to NOT attempt to pass the strings of the IUCD through the cervical os before closure of the uterus as this will certainly displace the IUCD and leave it lower down in the uterine cavity, not at the fundus.

Immediate Postpartum: the IUCD is inserted within 48 hours following the birth of the baby. The IUCD should not be inserted after 48 hours postpartum due to a higher risk of spontaneous expulsion.

> **The scenario:** Immediate postpartum insertion is typically done on the morning of the first postpartum day. A designated family planning counselor or postpartum care giver can provide group education on the postpartum ward, and then individual PPFP/IPPIUCD counselling to women who are interested in the immediate postpartum IUCD. The same postpartum care giver or some other trained provider then inserts the IUCD in a procedure or examination room in the postpartum ward using an appropriate examination table and light source. It is best that immediate postpartum insertion be done as soon as possible following delivery (meaning early on postpartum Day One) to reduce expulsion rates and to avoid logistical issues at the time of hospital discharge.

Delayed Postpartum: women who return for postpartum care at four to six or more weeks postpartum can also receive the IUCD. The technique of insertion and the related precautions are the same as for interval insertion.

Implications for Immediate PPIUCD Insertion

- **For the first 48 hours after birth,** the length of the uterus is almost 30 cm. This makes successful fundal placement of the IUCD with a typical interval inserter tube difficult, if not impossible. Use of an inserter tube could also possibly increase the risk of perforation.
- Instead, either a hand or a long placental forceps with a fenestrated end is used for insertion of the immediate PPIUCD not only to ensure that the fundus is reached but also to minimize the risk of perforation which is unlikely with gentle technique.
- Negotiation of the "bend" where the uterine body flops over the lower uterine segment is a common challenge during insertion.
- A common error in insertion technique is to mistake the back or posterior wall of the uterus for the fundus.
- Careful confirmation of fundal placement by manual palpation minimizes the risk of this error which can lead to an increased risk of expulsion.
- **Between 48 hours and four weeks after birth**, perhaps because the uterus is softer and more vascular than in its non-pregnant state, an increase in the perforation and overall complication rate has been observed. IUCD insertion therefore is not recommended during this period.
- Interval insertion using no-touch technique and the traditional inserter tube assembly is recommended for all insertions starting **at six -weeks after birth** when the uterus has returned to its pre-pregnant state.

IMPORTANCE OF PROPER INSERTION TECHNIQUE

- The single most important way to reduce the expulsion rate of IUCDs which are inserted in the immediate postpartum period is to ensure proper insertion of the device.
- The insertion technique is simple and can be learned easily by doctors, postgraduates, nurses and midwives.
- Attention to technique however is fundamentally important and has been shown to reduce substantially expulsion rates.
- It is important for a successful immediate PPIUCD program to ensure that all service providers are properly trained in insertion and can competently perform the immediate postpartum insertion.

Tips for Reducing Spontaneous Expulsion:

- Right technique
  - Elevate the uterus.
  - Get to the fundus.
  - Sweep instrument to the side.
  - Keep instrument open while removing.
- Right instrument
  - Use an instrument that is long enough to reach the fundus.
- Right time
  - Postplacental and intracaesarean insertions have lowest expulsion rates.

- Up to now, there have been no clinical trials to assess the interaction of active management of the third stage of labour and immediate postplacental insertion of the IUCD.
- Active management is a highly effective, evidence-based practice for reducing the possibility of postpartum hemorrhage and should be carried out during all deliveries.
- An expert panel was convened by WHO in 2004 to discuss potential interaction between the two practices. That panel concluded that there is no reason to defer or delay immediate postplacental or immediate postpartum insertion of the IUCD in a woman who has been provided with active management of third stage labour. Also, there is no reason to delay administration of 10 IU oxytocin as part of active management in a woman who has chosen postplacental insertion of the IUCD.
- The two practices do not interfere with each other.
- The uterus is a muscle which typically responds well to the administration of postpartum oxytocin, which produces a strong contraction of the myometrium.
- Once the IUCD is placed at the fundus, by either manual or instrumental technique, it is likely to be held there by the ongoing contractions of the uterus.
- Postpartum uterine contractions are strong and uniform, as opposed to labour contractions which eminate from the uterine fundus and proceed inferiorly through the uterus in a wave that is meant to produce cervical dilation and fetal descent.
- There is no evidence to suggest that the postpartum contractions will push the IUCD out in the same manner.

How to Reduce Expulsion of the IUCD

There are certain factors that must be considered regarding the insertion technique that can influence the retention of the IUCD. **Fundal placement of the IUCD is critical to reduce expulsion rates** and most of the following factors relate to the ability of the provider to achieve and maintain fundal placement of the IUCD.

- **The position of the postpartum uterus:** immediately following delivery and active management of third stage, the uterus contracts and sits low and slightly anteriorly in the abdominal cavity. As shown in Figure 6.1 the axis of the uterine cavity is at about a right angle to the axis of the postpartum vagina. During instrumental insertion of the IPPIUCD, that sharp angle can make insertion difficult and can result in a false belief that the provider has reached the fundus. For that reason, during insertion, the uterus is pushed up in the abdomen by the palm of the hand on the lower abdomen to smoothen out that angle and allow for the instrument holding the IUCD to pass all the way to the fundus.
  - ***How the IUCD is held in the instrument:*** the **IUCD should be held just at the edge of the instrument**, while still the IUCD is in the sterile packet so that when the instrument is opened the IUCD falls out against the myometrium. If the IUCD is held in the middle of the instrument, there is the risk that it will be displaced when the provider moves the instrument away.
  - ***How the instrument is moved away from the IUCD:*** To release the IUCD at the fundus, tilt the Kelly placental forceps slightly inwards so that the IUCD may fall at the fundus. Once the IUCD is placed at the fundus, the **instrument should be swept**

laterally, away from the IUCD. This will help avoid getting the strings caught in the forwards and downward displacement of the IUCD while the instrument is being removed.

- ***Keeping the instrument closed at the right time and open at the right time:*** while the instrument is holding the IUCD and moving up to the fundus, the provider must ensure that it remains closed so that the IUCD does not get dropped somewhere below the fundus. As well, after the IUCD has been correctly placed at the fundus, the provider should **keep the instrument slightly open as it is withdrawn**, to ensure that the threads are not caught in the instrument and the IUCD dragged downward, to a final resting position that is midway down the uterine cavity.
- ***Checking that the IUCD is not protruding from the cervix:*** after the instrument is completely withdrawn from the uterus, the provider must **ensure that the IUCD is not visible** through the cervix. The provider must look at the cervix to be sure that the IUCD is not visible, and that the strings (if visible) do not appear inappropriately long. If the IUCD can be seen, or the strings appear long, the provider must remove the IUCD and reinsert it at the fundus.
- ***Using the right instrument:*** there has not been a clinical trial to determine if the use of a Kelly placental forceps or a ring/sponge holding forceps results in a lower spontaneous expulsion rate. Experience has suggested that the Kelly placental forceps, because it is ***a longer instrument, may allow the provider to more easily reach the uterine fundus.*** Furthermore, the slight curve at the end of the forceps may prevent the strings from getting caught in the instrument, which may also limit the possibility that the IUCD will be inferiorly displaced during withdrawal. Numerous clinical trials have compared manual postplacental insertion, with instrumental postplacental insertion and both techniques are equivalent in terms of expulsion rates[10]. Immediate Postpartum (within 48 hours) can only be accomplished using the instrumental technique. Refer to Annexure I: Instruments and supplies for Immediate PPIUCD insertion.
- ***Correct timing of insertion:*** clinical trials have shown that there is a ***lower expulsion rate with immediate postplacental insertion*** than with immediate postpartum insertion. As well, insertion during caesarean section has a lower expulsion rate than insertion during the postpartum (first 48 hours) period[11]. This is likely due to the fact that it is easier to reliably reach the uterine fundus during postplacental or intracaesarean insertion. Fundal placement of the IUCD is critical to reduce expulsion rates.

Public Health Approach to the Issue of Spontaneous Expulsion

Despite the potentially higher expulsion rates for IPPIUCDs, the public health benefit of the service must be considered. While efforts continue to be made to encourage women to come for postpartum care, challenges remain. Postpartum care rates—and counselling and provision of family planning services during postpartum care—are low. Assuming that women will return later often can leave women with no option at all. While the expulsion rate may be as high as 10–15%, this also means that the retention rate is more than 85-90%. In situations of limited

[10] Grimes DA, Schulz K, van Vliet H, and Stanwood N. 2003. Immediate postpartum insertion of intrauterine devices. Cochrane Database Sys Rev 1:CD003036

[11] Chi IC, Wilkens L, Rogers S. Expulsions in Immediate Postpartum Insertions of Lippes Loop D and Copper T IUDs and their Counterpart Delta Devices - An Epidemiological Analysis. Contraception 32:2; August 1985, p119-134.

access to care and infrequent postpartum care, this level of programmatic achievement can be considered a success.

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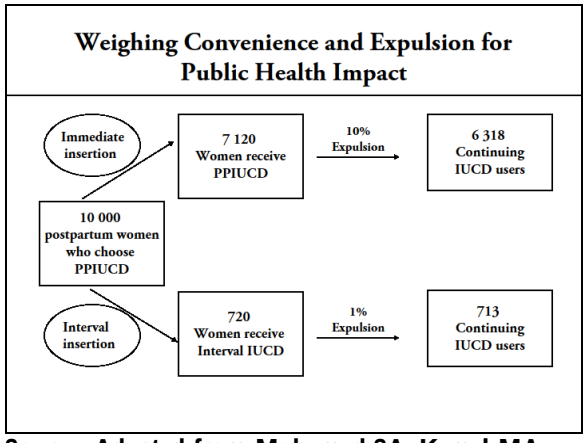
Figure 6.2 Public Health Approach PPIUCD



Source: Adapted from Mohamed SA, Kamel MA, Shaaban OM, Salem HT. Acceptability for the Use of Postpartum Intrauterine Contraceptive Devices: Assiut Experience. Med Prine Pract 2003;12:170-175

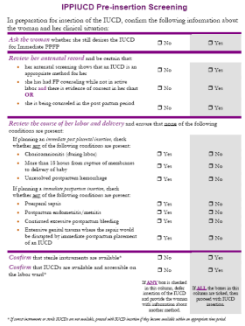
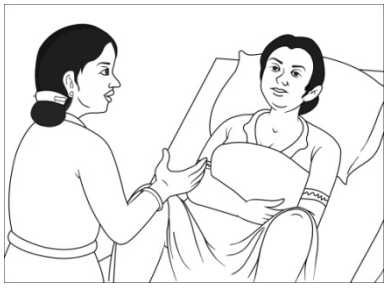
STEPS OF INSERTION

The Training Package for Immediate Postpartum IUCD contains various checklists for the insertion procedures for Postplacental Insertion, Immediate Postpartum Insertion and Intracaesarean Insertion (Refer to Annexure J: Skills Checklists for Immediate Postpartum IUCD Insertion. The steps described below follow the **Checklist for Clinical Skills Postplacental Insertion of the IUCD Using Forceps.** The following table gives greater detail about each step in this insertion process. The differences in technique for immediate postpartum insertion are then explained. In a subsequent section the steps for Intracaesarean Insertion are explained.

Pre insertion Screening and Medical Assessment

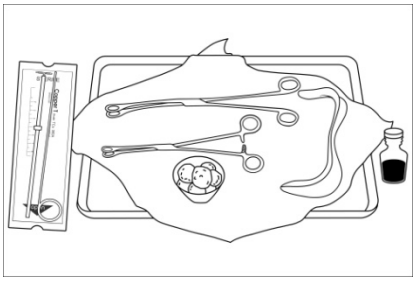
These initial steps are to ensure that the woman still desires the Immediate PPIUCD and understands what will be done. The provider ensures that nothing about her labour has restricted her ability to use the method. As well, the provider needs to check that the instruments and IUCD are available.

S.No	Step	Explanation
1.	Review woman's record to ensure she is appropriate candidate for IUCD.	Before approaching the woman's bedside, the provider reviews the woman's record to confirm that she has been assessed for any conditions which would make the IUCD a poor contraceptive choice for her. The provider checks the record to be sure that she has been counselled for the method.
2.	Ensure that she has been appropriately counseled for IPPIUCD insertion.	

S.No	Step	Explanation
3.	Using the ***Pre-Insertion Screening Job Aid***, confirm that there are no delivery-related conditions which prevent insertion of IUCD now: Rupture of membranes for greater than 18 hours Chorioamnionitis Unresolved postpartum hemorrhage	 IPP/IUCD Pre-insertion Screening The provider uses the job aid as an aid to ensure that there is no delivery-related infection. If there is unresolved haemorrhage, the haemorrhage should be managed first before inserting the IUCD. This job-aid may be pasted at the wall of the labour room, OT and Postpartum ward procedure room.
4.	If any of these conditions exist, speak with the woman, and explain that this is not a safe time for insertion of the IUCD. Offer the woman a re-evaluation for an IUCD at six weeks postpartum. Counsel her and offer her another PPFP method for.	Women who cannot receive the IUCD now may be able to receive it on postpartum day one or two. Otherwise, she should be supported to choose another PPFP method.
5.	Confirm that correct sterile instruments, supplies and light source are available for immediate postplacental insertion.	The provider should be certain that all materials are ready. See Table 6.1.
6.	Confirm that IUCDs are available on labour ward.	
7.	Greet the woman with kindness and respect.	 The provider should speak to the woman and allow her to ask questions. It is important to realize that the woman will more successfully use the IUCD if she understands how to use it and is supported in her decision.
8.	Confirm with the woman whether she still wants IUCD.	
9.	Explain that you will insert the IUCD following delivery of baby and placenta. Answer any questions she might have.	

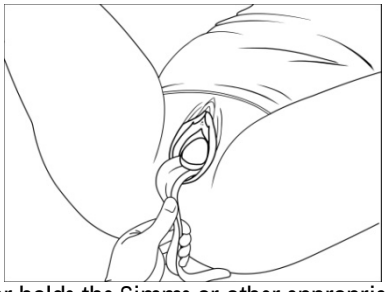
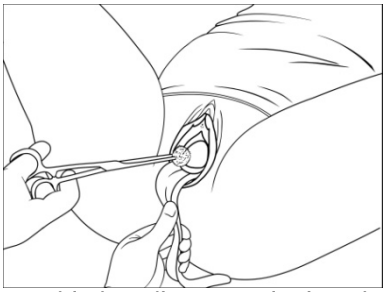
Pre Insertion Tasks

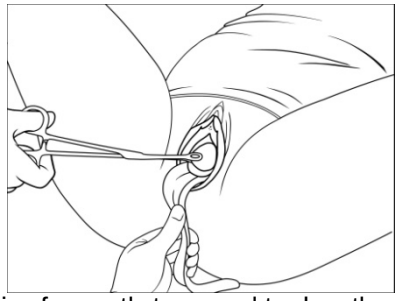
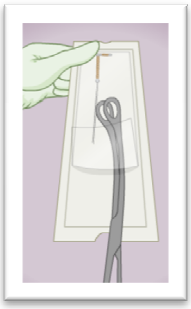
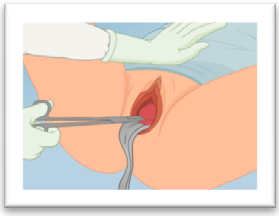
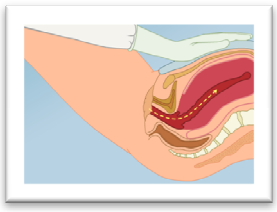
Prior to beginning the actual insertion the provider prepares the instruments so that there is no delay in insertion to find a missing instrument.

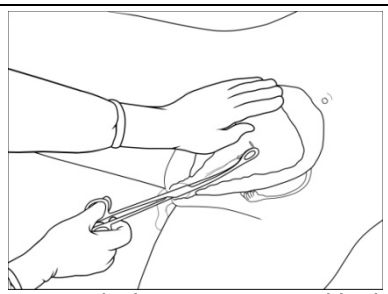
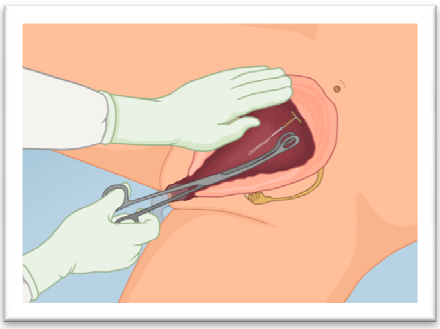
S.No	Step	Explanation
10.	Perform hand hygiene and put on HLD or sterile gloves.	If the same provider does the delivery and the IUCD insertion, there is no need to change gloves. If a different provider does the IUCD insertion, then that provider should perform hand hygiene and put on a new pair of sterile or HLD gloves.
11.	Arrange instruments and supplies on sterile tray or draped area.	

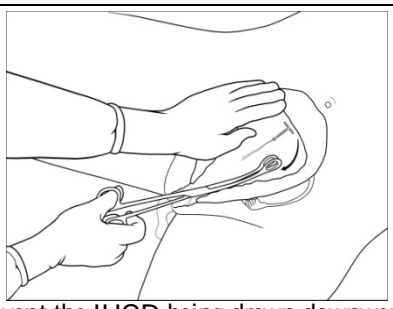
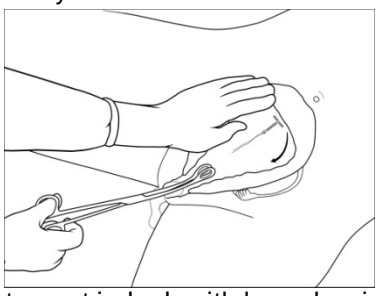
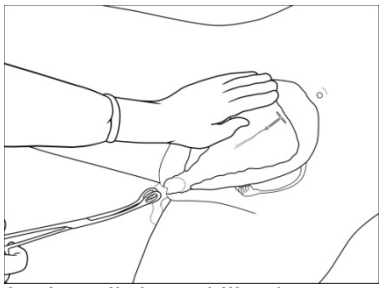
Insertion of the IUCD

The steps of insertion of the IUCD should be followed with great care to reduce the chance of spontaneous expulsion. These steps below are for postplacental insertion. These steps will differ only slightly for immediate postpartum insertion.

S.No	Step	Explanation
12.	Inspect perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, repair if needed after inserting the IUCD	 The provider holds the Simms or other appropriate speculum in her/his left hand and uses it to visualize the cervix. It is usually not necessary to have an assistant hold the speculum in place, but if the provider is having difficulty, an assistant may use the retractor to gently visualize the cervix.
13.	Gently visualize cervix by depressing the posterior wall of the vagina.	
14.	Clean cervix and vagina with antiseptic solution two times using two gauzes. Wait for two minutes to allow the antiseptic to work.	 Use betadine or chlorhexadine to gently clean the cervix and if possible edges of the vagina twice.

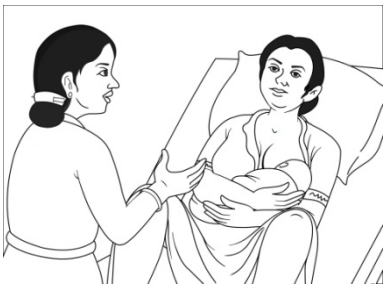
15.	Gently grasp the anterior lip of the cervix with the ring forceps upto the first lock.	 The same ring forceps that was used to clean the cervix can be used to grasp the anterior lip of the cervix and apply gentle traction.
16.	Exert gentle traction on the anterior lip of the cervix using the ring forceps.	
17.	Grasp IUCD with Kelly placental forceps in the sterile package.	 As noted above, the IUCD should be held just on the edge of the ring forceps so that it is easily released from the instrument when opened. It is held in the sterile package using no-touch technique as an infection prevention practice.
18.	Insert IUCD into lower uterine cavity. Avoid touching the walls of vagina.	  The provider holds up the Kelly placental forceps holding the IUCD and passes the IUCD carefully into the lower uterine cavity. Once the IUCD is in the lower uterine cavity, the provider lowers the ring forceps that is holding the anterior lip of the cervix. The provider's left hand then moves to the woman's abdomen and through the abdominal wall pushes the entire uterus superiorly (upward). This is to straighten out the angle between the uterus and the vagina so that the instrument can easily move upward toward the uterine fundus. The ring forceps is removed as it is not required any more during the procedure.
19.	Remove the ring forceps and place aside in the sterile/HLD tray. Move hand to lower segment of uterus (base of hand on lower part of body of uterus and fingers toward fundus) and gently push uterus upward to extend the lower uterine segment and facilitate entry of the instrument.	
20.	Gently move IUCD upward toward fundus (angle toward umbilicus), following contour of uterine cavity. Take care not to perforate uterus.	

21.	Keep forceps closed so IUCD does not become displaced.	 The provider moves the instrument upward in the uterus, following an arc toward the umbilicus. The provider should take care not to apply excessive force. If the uterus is not pushed upward, the angle between the vagina and the uterus may not allow the instrument to advance smoothly. The provider could perforate the back wall of the uterus if not careful. If there is significant resistance, the provider should reposition the uterus (by gently pushing it upward) and try to advance the instrument again. The provider should always keep the instrument closed so that the IUCD is not inadvertently dropped in the midportion of the uterine cavity.
22.	Confirm that end of Kelly placental forceps has reached the fundus and tilt it slightly inwards.	When the instrument reaches the uterine fundus, the provider will feel resistance. She will also likely feel the instrument at the fundus of the uterus with her left hand through the abdominal wall. An added advantage of the Kelly placental forceps is that the broad ring at the distal end makes it less likely that it will perforate the uterine fundus.
23.	Open forceps and release IUCD at fundus.	 The provider opens the forceps and places the IUCD at the fundus.
24.	Sweep placental/ring forceps to side wall of uterus.	
25.	Stabilize uterus (using base of hand against lower part of body of uterus).	
26.	Slowly remove forceps from uterine cavity, keeping it slightly open. Take particular care not to dislodge the IUCD as forceps are removed.	

27.	Stabilize the uterus until the forceps are completely out of the uterus.	 To help prevent the IUCD being drawn downward in the uterus, the instrument is swept to the right to ensure that the instrument is away from the IUCD.  Then the instrument is slowly withdrawn, keeping it slightly open at all times. If the instrument closes and catches the strings of the IUCD, it can inadvertently pull the IUCD down from its fundal position, increasing the risk of expulsion.  Counter traction is applied to stabilize the uterus while the instrument is being withdrawn and until it is completely out of the uterus.
28.	Examine the cervix to ensure there is no bleeding. If IUCD is seen protruding from cervix, remove and reinsert.	It is important to check that the IUCD is not visible at the cervical os. If it is visible, or if the strings appear to be very long, then the IUCD has not been adequately placed at the fundus and the chance of spontaneous expulsion is higher. If it appears that the IUCD is not placed high enough, the provider can use the same Kelly forceps to remove the IUCD and repeat steps 18–27.
29.	Remove all instruments used and place them in 0.5% chlorine solution.	The Kelly forceps is placed in 0.5% chlorine solution. The provider releases the ring forceps from the cervix and removes it and the speculum and places both in the chlorine solution.

Post Insertion Tasks

Following the insertion of the IUCD, the provider completes certain steps that are related to counselling, infection prevention and record keeping.

<table>
<tr><th>S.No</th><th>Step</th><th>Explanation</th></tr>
<tr><td>30.</td><td>Allow the woman to rest few minutes. Support the initiation of routine postpartum care, including immediate breastfeeding.</td><td>The woman should rest on the table for several moments following the insertion procedure. The provider should reassure her that the insertion went smoothly and that there is nothing more to be done at this time.</td></tr>
<tr><td>31.</td><td>Dispose of waste materials appropriately.</td><td rowspan="3">All infection prevention steps should be followed. Since this has taken place immediately after a vaginal delivery, the provider should follow all routine IP practices, including disposal of waste materials in the appropriate container, removal of gloves, and performance of hand hygiene.</td></tr>
<tr><td>32.</td><td>Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out and disposing of them.</td></tr>
<tr><td>33.</td><td>Perform hand hygiene.</td></tr>
<tr><td>34.</td><td>Provide the woman with post insertion instructions.
Provide card showing type of IUCD and date of insertion.
Review IUCD side effects and normal postpartum symptoms.
Tell the woman when to return for IUCD /PNC /newborn checkup.
Emphasize that she should come back any time she has a concern or experiences warning signs.
Review warning signs for IUCD.
Review how to check for expulsion and what to do in case of expulsion.
Assure the woman that the IUCD will not affect breastfeeding and breast milk.
Ensure that the woman understands the postinsertion instructions.
Give written postinsertion instructions, if possible.</td><td> 
While the woman is resting, and the provider is performing necessary IP practices, she should provide the woman with necessary post insertion instructions, as noted.
These instructions should be provided again by the staff of the postpartum unit and repeated to the woman, and perhaps her family, again later to be certain that these instructions have been understood.
If possible, these instructions should be provided to the woman in writing, for her to take home.</td></tr>
<tr><td>35.</td><td>Record information in the woman's chart or record.</td><td rowspan="2">The provider must record the insertion of the IUCD in both the woman's record and the appropriate register. It may be most appropriate to record it in the delivery room register. It should also however be recorded along with other contact information in a PPIUCD register that the program keeps initially to ensure that the program is being successfully implemented.</td></tr>
<tr><td>36.</td><td>Record information in the procedure room register.</td></tr>
</table>

Refer to the Job-Aid for Post Placental IUCD Insertion Technique in Annexure K.

Postpartum Insertion of the IUCD Within 48 Hours of Delivery

There are few notable differences between immediate postplacental insertion and immediate postpartum insertion of the IUCD.

- **Counselling:** The provider should ensure that the woman's understanding about the immediate PPIUCD is adequate. It is also important to be certain that the woman is adequately screened for conditions that preclude the use of the IUCD as well as evidence of postpartum infection that would make the insertion of the IUCD at this time not appropriate.
- **Hygiene:** Since the woman is immediate postpartum and must be moved to the procedure room from her postpartum bed, it is important to make sure that there is adequate hygiene and that her bladder is empty. Once the woman is on the procedure table the provider should do an abdominal exam to check the level of the uterus and to be certain there is good uterine tone. Because the insertion is a separate procedure from the delivery, the provider will need to perform appropriate hand hygiene and use a new pair of sterile or high level disinfected gloves.
- It is evident that manual insertion is not possible and should not be attempted. Insert the IUCD using the Kelly forceps or the ring forceps. Using the ring forceps may require some modification in the technique to bring the uterus a little down and may require slightly more pressure close to the cervix to allow the ring forceps with the IUCD to reach the fundus.
- The provider must ensure that the IUCD is placed at the uterine fundus and should visually examine the cervix following insertion. In some cases hte strings may be visible within the cervical canal due to the rapid involution of the uterus. If the strings seem inappropriately long, the provider should consider whether the IUCD has actually rested at the uterine fundus. If there is doubt, it is better to remove the IUCD and reinsert it.

Intracaesarean Insertion of the IUCD

Women who present to the hospital for scheduled caesarean section, or who require a caesarean section prior to the onset of labour, can be counselled about the placement and use of the PPIUCD. Because they are not in active labour, they may be able to clearly consider the decision to use an IUCD.

The insertion of the IUCD during a caesarean is straightforward. However some factors should be considered.

- Typically, manual insertion is sufficient since the provider can easily reach the uterine fundus. The provider should hold the IUCD between the middle and index fingers of the hand and pass it through the uterine incision. Once it is placed at the fundus, the hand should be slowly withdrawn, noting whether the IUCD remains properly placed.
- The strings can be pointed toward the cervix but should NOT be pushed through the cervical canal. This is to prevent uterine infection by contamination of the uterine cavity with vaginal flora, as well as to prevent displacement of the IUCD from the fundus by drawing the strings downward toward the cervical canal.
- Care should be taken during closure of the uterine incision that the strings of the IUCD do not get incorporated into the suture.

CHAPTER 7

FOLLOW UP CARE AND MANAGEMENT OF POTENTIAL PROBLEMS

BACKGROUND

It is important to note that the two principal differences between immediate PPIUCD insertion and interval or non-pregnancy related insertion is the timing and the technique of the insertion. Once the IUCD is in place, patient care and advice are almost identical with an emphasis on recognition of danger signs and location of accessible health care services in case of an emergency. Possible side effects and complications that may develop are mainly related to the IUCD, not to the postpartum timing of the insertion. Any side effects and complications that may arisetherefore should be managed the same way as those for an interval IUCD.

After immediate PPIUCD insertion, a woman should be advised to return to the clinic for routine postpartum care per WHO and national standards, unless she has serious problems which require emergency services. Government of India recommends follow-up at six weeks postpartum. Routine immediate PPIUCD followup care should be fully integrated with standard postpartum services. The woman is also encouraged to return if she is experiencing problems, if there has been a change in her overall health, if she wants the IUCD removed, or for any reason at all.

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

FOLLOWUP CARE FOR IMMEDIATE PPIUCD CLIENTS

Key Objectives of Follow-up Care are:

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

POST-INSERTION CARE FOR IMMEDIATE PPIUCD

1. Immediate Post-Insertion Care

- After the insertion procedure, standard obstetric guidelines for postpartum care should be observed.
- The client should be advised to report any increase in vaginal bleeding or uterine cramping.

- Vaginal hemorrhage related to uterine atony should be managed in standard fashion with uterine massage and uterotonics as necessary. (Note, the immediate PPIUCD does not increase the risk of uterine atony.)
- If severe uterine cramping occurs and persists after immediate PPIUCD insertion, a speculum or bimanual exam should be performed to check for partial or complete expulsion.
- The occurrence of fever should prompt a full clinical evaluation for the source and in the presence of presumed endometritis, an accepted antibiotic regimen should be used for treatment. See below for management of infection in association with the immediate PPIUCD.

2. After Insertion, Remind the Client for the following:

- Expect vaginal bleeding or spotting as well as cramping and pain for at least a few days after insertion.
- Be aware that postpartum symptoms, such as intermittent vaginal bleeding and cramping, are normal for the first four to six weeks postpartum.
- Take ibuprofen, paracetamol or other pain reliever as needed.
- Be observant for whether the IUCD falls out.
- Spontaneous expulsion can happen, and is most likely to occur during the first three months postpartum.
- She should check the bed sheets in the morning, and her undergarments when she changes her clothes.
- At six weeks postpartum, the IUCD string can be felt by some women.
- It is not necessary to check for the strings, but if she tries, she should not pull on them.
- Her provider will check for the strings when the woman returns for her postpartum visit. That is why it is important for her to return to see the same provider, or at least someone in the same clinic, who is aware of immediate PPIUCD services.
- Remember IUCD does not protect against STIs and HIV.
- Resume intercourse at any time she feels ready with full protection against pregnancy.
- Return for removal of the IUCD at any time and she will have almost immediate return of fertility.

3. Before discharge the following danger signs should be highlighted and the client should be encouraged to call or come to the facility immediately for assessment:

- Heavy vaginal bleeding
- Severe lower abdominal discomfort
- Fever and not feeling well

The client should also be encouraged to call or come in for assessment if the following should occur:

- Unusual vaginal discharge
- Suspected expulsion: can either feel IUCD in the vagina or has seen it expelled from the vagina.

- Any other problems or questions she has relevant to her IUCD.

If possible, give the client a card with the following information in writing:

- Type of IUCD inserted
- Date of IUCD insertion
- Month and year when IUCD will need to be removed or replaced
- Date of postpartum follow-up visit
- Where to go or call if she has problems or questions about her IUCD

4. Routine Follow-up Visit Postpartum

Immediate PPIUCD follow-up should be integrated with standard postpartum care per national and regional guidelines. WHO currently recommends at least one postpartum visit by six weeks after delivery.[12] In addition to the usual elements of the postpartum check-up, the following should be addressed in all women who report Immediate PPIUCD insertion:

- Ask the client if she has any questions or has experienced any warning signs or problems as described above
- Conduct a pelvic examination if the following conditions are suspected: an STI or PID, suspected partial or complete expulsion, pregnancy. A routine pelvic examination at the follow-up visit is not required.
- Advise the client to return if she is concerned about possible IUCD-related problems and/or if she wants to change to another family planning method.
- Review warning signs that indicate a need to return to the clinic immediately.
- Remind the client to check for possible IUCD expulsion during/after her first few menstrual periods.
- If the IPPIUCD has been expelled, offer the client another contraceptive method or plan to insert another IUCD if she wishes.
- Encourage use of condoms for STI protection, as appropriate.
- If the PPIUCD is in place and the client has no problems, no other follow-up visits are required. Clients should be advised to return for removal as desired but no later than the recommended length of pregnancy protection.

Removal of the IUCD should occur only at the patient's request and/or if one of the following conditions is suspected:

- Partial expulsion
- Puerperal sepsis
- Perforation of the uterine wall
- Persistent uterine cramping of unknown origin

IUCD removal technique

[12] WHO, UNFPA, UNICEF. 2003 Pregnancy, childbirth, Postpartum and Newborn Care: A Guide for Essential Practice.

Removing an IUCD is usually simple. It can be done any time later when the woman desires throughout the menstrual cycle. Removal may be somewhat easier during menstruation, when the cervix is dilated.

- Ensure that proper infection-prevention procedures are followed.
- Insert speculum to visualize cervix and IUCD strings. Cleanse the cervix with Betadine solution.
- Pull the IUCD strings slowly and gently with forceps, until the IUCD is removed.
- Show the removed IUCD to the woman.

  If the provider experiences difficulty in removal of the IUCD, the woman should be referred to a specially trained provider. If removal is not easy, the specially trained provider may dilate the cervix using a uterine sound or dilator, or with the assistance of oral misoprostol.

MANAGEMENT OF POTENTIAL PROBLEMS[13]

Most side effects associated with the use of IUCDs are not serious and will resolve spontaneously. Some problems however require specific management. The purpose of the guidelines below is to assist the health care provider to provide appropriate support for a woman experiencing such side effects or problems. In most cases, the woman can continue to use the IUCD while awaiting or undergoing evaluation. Some of the problems associated with IUCD use that require specific management include:

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

Some General Management Principles

- The woman should be provided reassurance and any information she needs to support her in continuing (or discontinuing) the method, as appropriate and as she desires.
- If problems are encountered that are not covered in the management guidelines, the provider should conduct further evaluation and provide treatment according to local protocols/national guidelines (refer if needed).
- If the provider does not have the training or resources to perform any of the assessments, procedures or treatments indicated in the management guidelines, s/he should refer the woman to an appropriate facility.
- If the woman wants the IUCD removed for any reason, and/or to use a different contraceptive method, remove the IUCD or schedule an appointment for IUCD removal, as appropriate.

[13] Adapted from: Hatcher et al. 2004 and Hatcher et al. 2002–2003 (unless otherwise noted).

PROBLEMS AT THE TIME OF PPIUCD INSERTION

Preventing Immediate PPIUCD Insertion-Related Problems

Many immediate PPIUCD insertion-related complications can be prevented by:

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

IDENTIFICATION AND MANAGEMENT OF COMMON PROBLEMS ENCOUNTERED DURING OR IMMEDIATELY AFTER INSERTION

1. Client Discomfort

A moderate amount of discomfort associated with intrauterine placement of the PPIUCD is common during insertion regardless of timing after delivery or technique.

- **Management**
  - Inform the client that a moderate amount of discomfort is associated with insertion.
  - Speak to the client during the procedure and describe what you are doing as you do it.
  - Perform the procedure as gently and as quickly as possible.
  - Provide analgesics if needed.

2. Dislodgement of the PPIUCD during/immediately after placement

High fundal positioning of the immediate PPIUCD may be an important factor in preventing later failure, i.e. expulsion. The fundal placement of the IUCD is very important.

- **Possible Signs/Symptoms**
  - IUCD is dislodged by the hand (manual technique) or the inserting forceps (instrumental technique) during withdrawal from the uterus.
  - IUCD can be visualized in the cervix or upper vagina after placement.
  - Length of the string dangling into the vagina is not consistent with fundal positioning.
- **Management**
  - Using an HLD or sterile clamp or forceps, remove the IUCD and discard. Sometimes the IUCD can be removed by simply grasping the strings dangling into the vagina.
  - Change sterile gloves if contaminated.
  - Change sterile equipment if contaminated.
  - Obtain a new IUCD if contaminated.

- Re-prepare the cervix with an appropriate antiseptic.
- Insert IUCD at the fundus as per the standard technique.

3. Cervical Laceration

The cervix should always be checked for a possible laceration after removal of the clamp.

- **Possible Signs/Symptoms**
  - Sudden onset of vaginal bleeding
- **Management**
  - If a laceration occurs, repair as needed depending on size of laceration and amount of bleeding. Small non-hemorrhagic lacerations can be allowed to heal spontaneously.

4. Uterine Perforation[14]

Although perforation of the uterus is very rare, when it occurs, it almost always occurs at the time of insertion. The basic steps for managing a uterine perforation are the same, whether the insertion is interval or within 48 hours postpartum.

- **Possible Signs/Symptoms**
  - Sudden loss of resistance to the IUCD inserting instrument during insertion
  - Uterine depth greater than expected during insertion
  - Unexplained pain which is worse than generally observed during postpartum insertion
  - Confirmed partial or complete perforation (as shown by X-ray or ultrasound)
  - Missing strings on pelvic examination
- **Management**
  - If perforation is suspected during insertion, stop the insertion immediately and gently remove the instrument/object that may have perforated the uterine wall, i.e. the IUCD (by pulling on the strings or on the IUCD itself) or the inserting forceps.
  - If resistance is encountered and removal cannot be accomplished, stop pulling and refer the woman immediately for urgent surgical consultation. An X-ray or ultrasound may be required to document the location of the IUCD. Surgical removal by a qualified surgeon may be required.
  - Keep the client at rest and observe for signs of intra-abdominal bleeding: hypotension; tachycardia; severe abdominal pain with tenderness; guarding; or rigidity on exam.
  - Start an IV drip and perform serial haemoglobin/haematocrit checks at regular intervals.
  - Check the client's vital signs by monitoring pulse, respiratory rate, blood pressure and temperature every 5–10 minutes during the first 60 minutes following the perforation. If vital signs are stable, continue monitoring every hour for the next four hours and then every four hours for 24 hours.

[14] Adapted from: WHO and JHU/CCP 2006.

- If there is a change in vital signs or if the client exhibits severe pain or peritoneal signs, continue monitoring and refer for emergency surgical evaluation.
- Consider administration of prophylactic antibiotics per facility guidelines.
- If uterine perforation is suspected days or weeks after IUCD insertion, confirm by X-ray or ultrasound.
- If the IUCD is embedded in the wall of the uterus (partial perforation), refer the woman for IUCD removal by a specially trained provider who will use narrow forceps to remove transvaginally if possible.
- If the IUCD is outside of the uterine cavity (complete perforation), refer the woman for IUCD removal by a surgeon qualified to perform laparoscopy or laparotomy.

OTHER COMMON SIDE EFFECTS AND PROBLEMS ENCOUNTERED AFTER PPIUCD INSERTION

1. Changes in Menstrual Bleeding Patterns

Changes in menstrual bleeding patterns are a common side effect among users of IUCDs regardless of timing of insertion. In the first six weeks postpartum, such changes are masked by the usual irregular bleeding and spotting associated with uterine involution during the postpartum period. These changes are usually not harmful to the woman and diminish or disappear within the first few months after IUCD insertion.

- **Possible Signs/Symptoms**
  - Increase in amount of 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
- **Management**
  - 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 postpartum uterine involution, reassure.
  - Where appropriate, rule out other gynaecologic pathology and refer to a qualified practitioner if indicated.
  - Where appropriate, rule out pregnancy by history or available testing.
  - Where appropriate, check for IUCD expulsion: palpate strings on bimanual exam or visualize at the vulva or by using a speculum.
  - If client desires treatment, offer a short course of nonsteroidal anti-inflammatory drugs (NSAIDs) to be started while bleeding and continued for three to five days.

- If bleeding is persistently heavy and prolonged or associated with clinical or laboratory signs consistent with severe anaemia, offer iron replacement therapy and consider removal with the patient's consent.
- If client finds bleeding unacceptable, remove IUCD and counsel her regarding alternative methods of family planning

2. Cramping or Pain

Mild intermittent cramping may occur in the first few weeks after IUCD insertion but is generally masked by the usual cramping associated with uterine involution postpartum ("afterpains").

- **Possible Signs/Symptoms**
  - Increased cramping or pain which may or may not be associated with menstruation
- **Management**
  - Determine severity of symptoms: how severe is pain; how long has pain lasted, when did pain start; is pain accompanied by other symptoms (e.g., bleeding, fever); how well is the woman tolerating the pain?
  - Perform an appropriate assessment to include 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: infection; partial IUCD expulsion, uterine perforation; pregnancy/ectopic pregnancy; urinary tract infection. See section for management of infection and pregnancy with the IUCD in place.
  - If symptoms and physical findings are mild and consistent with postpartum uterine involution, reassure.
  - Recommend a short course of NSAIDs immediately before and during menstruation to help reduce menstrual pain and cramping which is bothersome to the client.
  - If cramping or pain is severe, remove the IUCD. If the IUCD was improperly placed, partly expelled or appeared abnormally distorted, discuss insertion of a new IUCD with the client. If the IUCD appeared to be in proper position and appeared normal, counsel patient regarding an alternative form of family planning.

3. Infection

While the risk of infection after interval and non-pregnancy related IUCD insertion, is very low, it is highest within the first 20 days of insertion and is generally thought to be related to concurrent gonorrhoea or chlamydia infection.

- **Possible Signs/Symptoms**
  - Lower abdominal pain
  - Fever
  - Painful intercourse

- Bleeding after sex or between periods once resumption of normal monthly menses has occurred postpartum
- New onset of pain associated with periods
- Abnormal vaginal discharge
- Nausea and vomiting

- **Management**
  - Perform an appropriate assessment to include vital signs, abdominal and pelvic examination and appropriate laboratory studies (pregnancy test, CBC, cultures) to rule out other problems: endometritis; appendicitis; partial IUCD expulsion; uterine perforation, pregnancy/ectopic pregnancy; or urinary tract infection. See section for management of pregnancy with the IUCD in place.
  - Suspect 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 it 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 national guidelines/local protocols for gonorrhoea, chlamydia and anaerobic infections. Remove the IUCD only in the presence of sepsis or if symptoms do not improve within 72 hours.
    - If the woman does not want to keep the IUCD in during treatment, remove the IUCD two to three days after antibiotic treatment has begun.
  - Where appropriate and when an STI is suspected, counsel the woman regarding condom use for protection against future STIs and recommend treatment for the partner.

4. IUCD String Problems

- **Possible Signs/Symptoms**
  - Partner can feel strings
  - Longer strings
  - Shorter strings
  - Missing strings

- **Management for Strings**

- Reassure the woman and her partner that the strings are very flexible and not harmful.
- If it is very bothersome to the woman's partner, the strings can be cut short if they are long.
- If the strings are too short and bother the partner, a new IUCD may be inserted.

- **Management for Missing Strings**
  - Refer the Protocol for missing strings in Annexure L.
  - Rule out pregnancy by history or laboratory examination.
  - Gently probe the cervical canal using an 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 back-up method while waiting for results. Manage as appropriate based on findings:
    - If the IUCD is located inside the uterus and the woman wants to keep the IUCD, do not remove. Explain to her that the IUCD 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 IUCD is located inside the uterus and the woman wants it removed, check the reason for removal. If it is due to her concern of the missing strings, counsel her for the benefits of the contraceptive and if she is convinced, retain the IUCD, if she still insists for removal, refer her for IUCD removal by a specially trained provider.
    - If the IUCD is located outside of the uterus, manage as per uterine perforation.
    - If the IUCD cannot be visualized in the uterus or the peritoneal cavity, manage as complete IUCD expulsion (below).

5. Partial or Complete IUCD Expulsion

Partial or complete IUCD expulsion can occur silently or may be associated with other signs/symptoms.

- **Possible Signs/Symptoms**
  - New onset irregular bleeding and/or cramping
  - Expelled IUCD seen (complete expulsion)
  - IUCD felt/seen in the vaginal canal (partial expulsion)
  - Delayed or missed menstrual period (see pregnancy with an IUCD in Place)
  - Missing or longer strings

- **Management**
  - 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:
    - If complete expulsion of the IUCD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): replace IUCD immediately if desired and appropriate (not pregnant or infected) or counsel for alternative family planning method.
    - If partial IUCD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUCD and replace if desired and appropriate (not pregnant or infected) or counsel for alternative family planning method.
    - If the IUCD appears to be embedded in the cervical canal and cannot be easily removed in the standard fashion, refer the woman for IUCD removal by a specially trained provider.
- If complete expulsion of the IUCD is confirmed and pregnancy diagnosed, manage antenatal care per national and regional standards.

6. Pregnancy with an IUCD in Place[15]

While the IUCD is one of the most effective forms of reversible contraception, failures can occur. Approximately one-third of IUCD related pregnancies are due to undetected partial or complete expulsion of the IUCD.

- **Possible Signs/Symptoms**
    - Delayed or missed menstrual period
    - Other signs/symptoms of pregnancy
    - Missing strings
    - Strings which are shorter or longer than expected
- **Management**
    - Confirm pregnancy and trimester. If the woman is in her second or third trimester of pregnancy, manage according to national guidelines/local protocols and refer to an appropriate provider if needed.
    - Rule out ectopic pregnancy: sharp/stabbing 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:
        - Counsel the woman on the benefits and risks of immediate removal of the IUCD: removing the IUCD slightly increases the risk of abortion; and leaving the IUCD 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 IUCD is still in the uterus

[15] Adapted from: WHO and JHU/CCP 2006.

or has been expelled. If the IUCD is still in place, it cannot be safely removed. Follow as below with plans to remove the IUCD at delivery.

- If the woman declines removal, provide support and care per national guidelines/local protocol 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. Plan to remove the IUCD at delivery.

CHAPTER 8
QUALITY ASSURANCE FOR IMMEDIATE POSTPARTUM IUCD SERVICES

BACKGROUND

What is quality: Quality of care refers to the way in which individuals and couples are treated by the health care system providing services. The objective of this chapter is to provide clinicians and clinic managers with basic information and tools on **how to improve and maintain performance and quality of health services.** Improving the quality of IUCD services includes improving providers' performance, creating a supportive work environment, meeting clients' needs with their input and recognizing progress that providers make.

Provision of postpartum IUCD clinical services can only be safely accomplished in a clinical facility that has adequate infrastructure, supplies and personnel. Although counseling and assessment may take place during normal working hours in the antenatal care clinic, insertion of the immediate PPIUCD–especially using the postplacental or intracaesarean approaches–can take place at any time, day or night. For this reason, immediate PPIUCD services must be integrated into the delivery care system for intrapartum care and all service providers on the obstetrical care team should be aware of and understand the elements of immediate PPIUCD clinical service.

Provision of PPIUCD services requires careful coordination and collaboration of antenatal, intrapartum and postnatal care services in the facility.

While insertion during caesarean section or immediately following delivery of the placenta is preferred due to lower expulsion rates and convenience for the woman, certain hospitals or health centre also provide services to clients in the postpartum ward during the immediate postpartum period. This may be done by dedicated counselors/service providers who review the situation and family planning needs of women in the postpartum ward and provide care in a planned and directed manner.

Regardless of how services are organized in the facility, it is important to ensure that all personnel of the obstetrics/maternity care team are oriented to immediate PPIUCD service provision. This helps ensure that counseling messages are uniform and consistent, so that inaccurate information is not disseminated during the period when services are being established.

Service Delivery Criteria

The minimum criteria for safe provision of immediate PPIUCD services include:

- ***Infrastructure:*** an outpatient care area for both antenatal screening and counselling as well as postpartum follow up and evaluation; an intrapartum care area, where deliveries are conducted and postplacental insertions can take place; and an examination/treatment room in or near the postpartum ward where immediate postpartum insertions can take place.
- ***Supplies:*** a delivery/examination table with footrests (or an area for the woman to place her feet); insertion instruments such as a Sims speculum, a ring forceps and a long forceps, such as a Kelly placental forceps; sterile towels, sterile or HLD gloves (including long gloves if the manual insertion technique is to be practiced); antiseptic solution, such as povidone iodine

(i.e., Betadine®) or chlorhexidine gluconate (i.e., Savlon® or Hibiclens®); and IUCDs in their sterile packaging.

- ***Personnel:*** a clinical service provider, such as a doctor, nurse or midwife, who regularly attends to women in labour and who has been trained to competency in the provision of immediate PPIUCD services, including counselling, infection prevention, insertion/removal techniques and management of side effects or complications is available to provide the services to clients who want it.
- ***Coordination of care:*** a system of communication and sharing of information between the antenatal care service, the labour/delivery unit, the postpartum ward and the outpatient postpartum care unit.
- ***Infection Prevention Practices:*** There is clean running water available in the clinic. Facility for hand hygiene is readily available. The availability and use of antiseptics for skin and/or mucous membranes are as per the standards. The decontamination of instruments and other articles (immediately after use and before cleaning) is performed according to the standards. The waste disposal system is according to standards.

- ***IEC/BCC:*** The clinic has informational posters or panels on the family planning services offered and clinic timing. The clinic has flip charts/IEC material and samples of family planning methods for counselling clients.
- ***Record Maintenance:*** The clinic has a simple FP client record system. The records are reviewed and analyzed regularly.
- ***Management systems:*** adequate integration of all of the above so that services are provided in a manner that ensure good counselling, appropriate infection prevention practices and adequate follow-up. There are written routine protocols/ instructions for the delivery of family planning services.

PERFORMANCE STANDARDS FOR POSTPARTUM IUCD SERVICES

- These performance standards are meant to serve as a guide to the establishment and maintenance of high quality clinical services. Refer to Text box 8.1 below for the list of the performance standards for provision of immediate PPIUCD services.
- Achievement of each standard can be verified by certain verification criteria, using a tool in a modified checklist format. The Performance standards for Postpartum IUCD Counselling and Services Assessment Tool is included in Annexure M.
- The standards serve as a guide for both service providers and supervisors.
- Service providers can use the tool as a guide to their own clinical performance.
- It can be used as a job aid regarding counselling steps or insertion technique.
- Providers can also use it as a way to guide other colleagues who are developing the skills needed for service provision.
- Supervisors can use the tool as a specific and detailed way of providing oversight of immediate PPIUCD services.
- This tool can allow supervisors to provide specific feedback to providers and managers about what is being done well and the areas which may need additional attention.
- Sequential measurement of performance compared to the standards allows for program managers and district/state officials to monitor the quality of service over time and be able to compare performance of facilities in a quantifiable manner.

Textbox 8.1 Performance Standards for Immediate PPIUCD Services

Initial Client Assessment and Counseling During Antenatal Care; Return Visits

1. The provider uses recommended counseling techniques.
2. Provider/counselor provides information on all benefits of pregnancy spacing and explores woman's knowledge about family planning methods.
3. The provider/counselor targets information-giving to the woman's interest and needs if the woman has a method/or several methods in mind.
4. The provider does a brief screening assessment and determines that the IUCD is an appropriate method for this woman.
5. Provider gives method-specific information about the IUCD.
6. Provider makes a notation which alerts other care providers that the woman has chosen postpartum insertion of the IUCD.
7. The provider conducts return visits appropriately.
8. The provider identifies woman with problems and manages complications, as necessary.

IUCD Counseling and Client Assessment During Labour or Immediate Postpartum Period

9. The provider re-confirms with labouring woman that she has chosen the IUCD for postpartum FP.
10. The provider re-confirms with postpartum woman that she has chosen the IUCD for postpartum FP.
11. The provider counsels and screens a client not identified for the postpartum IUCD during ANC.
12. The provider ensures the IUCD is an appropriate postpartum contraceptive method for a labouring/recently postpartum woman.
13. The provider demonstrates good client-provider interaction and ensures client's rights.

IUCD Service Provision

14. The provider completes all pre-insertion tasks for post placental or intracaesarean IUCD insertion.
15. The provider correctly inserts IUCD within 10 minutes after placental expulsion after a vaginal delivery (instrument insertion).
16. The provider correctly inserts IUCD during caesarean section.
17. The provider completes all pre-insertion tasks for postpartum IUCD insertion.
18. The provider performs a pelvic examination before immediate postpartum insertion of the IUCD.
19. The provider correctly inserts IUCD during the immediate postpartum period.
20. Post procedure infection prevention tasks and instrument processing are correctly carried out.
21. The provider provides post insertion instructions to the client.

Management and Record Keeping

22. The provider records relevant information about the services provided in the patient's chart.
23. The provider records relevant information about the services provided in the register.
24. The facility has adequate supplies and materials for postpartum family planning.
25. The provider(s) have the required qualifications.
26. There is an organized facility-wide system in place to ensure that every postpartum woman is counseled and offered postpartum family planning.

RECORD KEEPING

- It is fundamentally important to maintain careful records of immediate PPIUCD services.
- This is because client selection criteria and insertion technique are directly related to expulsion rate, and thus, potentially, to overall program success.
- If it appears that a larger than expected number of clients are returning with partially or completely expelled IUCDs, it may be important to know about the assessment criteria at the time of insertion, and whether the provider faced any difficulty at the time of insertion.
- This would allow program managers and supervisors to review training and client assessment criteria to determine if a change should be made.
- After insertion of the IUCD, note should be made in the woman's record, as well as in a delivery register or immediate PPIUCD insertion register.
- When the woman returns for follow up, if there is any problem, the insertion logbook should be consulted to identify if any factors could have predicted this problem.
- A sample format for Insertion and follow-up registers and reporting format are provided in Annexure N.

Annexure A

Client Messages About Basic Attributes of the IUCD

Providing correct information about the IUCD and its insertion immediately postpartum is a very important component of counselling to potential immediate PPIUCD clients, especially in regions where awareness about the method is low or misinformation about the method is prevalent.

What it is	The IUCD is a small plastic device that is inserted into your uterus.
When is it inserted	It is inserted either immediately after the placenta comes out, during a caesarean section or on the first two days after delivery, while you are still in the healthcare facility. This makes it very convenient for you, because by the time you leave the hospital, you will already have your family planning method working for you.
Who can use it	Most postpartum women can safely use the IUCD, including those who are young, breastfeeding, or do hard work. It is especially good for women who think they are finished having children, but want to delay sterilization until they are certain. Some women should not use the IUCD, including women who have a mis-shaped uterus or have a high personal risk of sexually transmitted infection Sometimes women develop an infection during the time of birth. They should wait until after the infection has been treated to have the IUCD inserted.
Effectiveness	The IUCD is more than 99% effective at preventing pregnancy, making it one of the most effective, reversible contraceptive methods currently available.
Mechanism of action	The IUCD prevents pregnancy by preventing the sperm from fertilizing the egg.
Breastfeeding	Using an IUCD immediate postpartum will not affect how you breastfeed your baby and will not change the amount or quality of your breastmilk.
Course of protection	The IUCD begins to work immediately and the Copper T is effective for up to 10 years.
Side effects	Copper-bearing IUCDs (e.g., the Copper T) have fewer side effects than hormonal methods (e.g., the pill), but sometimes cause an increase in the amount, duration, and painfulness of menstrual periods. These symptoms are usually not noticed by postpartum women, especially those who are breastfeeding, because they lessen or go away in the first few months after insertion.
Health benefits and possible risks	The IUCD is very safe at preventing pregnancy. When it is inserted immediate postpartum, about 5–10 women out of 100 will find that the IUCD has fallen out during the first three months. If this happens, you should return to the clinic and have another IUCD inserted to continue protection against pregnancy.
Protection from HIV and other STIs	The IUCD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs. If you think you have a "very high personal risk" for certain STIs you should not use the IUCD.
Cost and convenience	Getting an IPPIUCD is inexpensive and very convenient. The IUCD will be placed before you leave the healthcare facility after delivery. In most cases, only one follow-up visit to the clinic is required.

Additional action and removal.	Once the IUCD is inserted, no additional actions are needed on your part. You don't need any supplies and don't need to purchase anything additional. When you have the IUCD, you should come to the clinic to have it removed. You will be able to get pregnant right away after it is removed. If you want to continue to use it for a long time, you can use it for 10 years and then have it replaced with another one.

Appendix B

COUNSELING GUIDE
IMMEDIATE POSTPARTUM IUCD COUNSELING CHECKLIST

To be used by TRAINER when the checklist is used as a skill assessment tool:

When the participant is ready for assessment of his or her skills in counseling, use this Counseling Checklist as an assessment tool. Ensure that the participant competently addresses all of the elements noted on the Counseling Guide and mark their achievement under the column marked **ASSESSMENT**.

Place a **"✓"** in case box if task/activity is performed **satisfactorily,** an **"X"** if it is **not** performed **satisfactorily**, or **N/O** if not observed.
Provide comments to the participant to allow him or her to improve her performance.

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 participant during evaluation by trainer

PARTICIPANT _____DATE OBSERVED _____

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
GREET – Establish a good rapport and initiate counseling on PPFP				
1. Establishes a supportive, trusting relationship. • Greet the client. • Shows respect for the client and helps her feel at ease.				
2. Allows the client to talk and listens to her. • Encourages the client to explain her needs and concerns and asks questions. • Listens carefully, and supports the client's informed decisions.				
3. Engages client's family members. • Includes client's husband or important family member with her consent.				
Ask – Determine reproductive goals and use of other contraception				
4. Asks about any previous experiences with family planning • Explores client's knowledge about the return of fertility and the benefits of spacing pregnancies. • Determines if she has had prior experience with family planning methods, any problems and reasons for discontinuing.				

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
5. Assesses partner's/family's attitude about family planning. • Explores partner's/family's knowledge about the returning fertility and the benefits of spacing pregnancies. • Determines attitude of family about birth spacing and use of FP to improve health.				
6. Asks about her reproductive goals. • Asks about desired number of children, desire to space birth, desire for long term family planning.				
7. Asks about her need for protection against STIs. • Addresses any related needs such as protection from sexually transmitted infections including HIV. • Explains and supports condom use, as a method of dual protection.				
8. Asks whether she is interested in a particular family planning method. • Determines if she has a preference for a specific method, based on prior knowledge or the information provided.				
TELL – Provide the client with information about the postpartum family planning methods				
9. Provides general information about benefits of spacing births. • Advises that to ensure her health and the health of her baby (and family) she should wait at least two years after this birth before trying to get pregnant again. • Advises about the return of fertility postpartum and the risk of pregnancy. • Advises how LAM and breastfeeding are different. • Provides information about the health, social and economic benefits of spacing births.				
10. Provides information about birth spacing methods. • Based on client's prior knowledge and interest, briefly explains the benefits, limitations and use of the following methods: LAM, Condoms, POPs, DMPA, PPIUCD, NSV, and Postpartum Tubectomy • Shows the methods (using poster of wall chart) and allows the client to touch or feel the items, including IUCD, using a contraceptive tray and models. • Corrects any misconceptions about family planning methods.				
HELP – Assist the client to arrive at a choice or give her additional information that she might need to make a decision				
11. Helps the client to choose a method. • Gives the client additional information that she may need and answers any questions. • Assesses her knowledge about the selective method.				
12. Supports the client's choice. • Acknowledges what the client has chosen and tells her what the next steps will be for providing her with her choice.				

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
EVALUATE AND EXPLAIN – Determine if she can safely use the method, and provide key information about how to use the method (focus on PPIUCD)				
13. Evaluates the client's health and determines if she can safely use the method. • Asks the client about her medical and reproductive history. Follows the guidance in the chapter 'Client Assessment and Pre-Insertion Screening' given in the Reference Manual.				
14. Discusses key information about the PPIUCD with the client. • Effectiveness: prevents almost 100% of pregnancies. • How does the IUCD prevents pregnancy: causes a chemical change that damages the sperm before the sperm and egg meet. • How long does the IUCD prevents pregnancy: can be used as long as she likes, even upto 10 years. • The IUCD can be removed at any time by a trained provider and fertility will return immediately.				
15. Discusses the following advantages of the PPIUCD. • Immediate and simple placement immediately after delivery. • No action required by the client. • Immediate return of fertility on removal. • Does not affect breastfeeding. • Long acting and reversible: can be used to prevent pregnancy for a short time or as long as ten years.				
16. Discusses the following limitations of the PPIUCD. • Heavier and more painful menses especially first few cycles. May not be noticed by the client after PPIUCD insertion. • Does not protect against STIs, including HIV/AIDS. • Higher risk of expulsion when inserted postpartum.				
17. Discusses the following warning signs and explains that she should return to the clinic as soon as possible if she has any of the following. • Foul smelling vaginal discharge different from the usual lochia • Lower abdominal pain, especially if accompanied by not feeling well, fever or chills, especially the first 20 days after insertion • Concerns that she might be pregnant • Concerns that the IUCD has fallen out				
18. Checks that the woman understands. • Allows the client to ask questions. • Asks the client to repeat key information.				
RETURN – Plan for next steps and for when she will arrive to hospital for delivery				

COUNSELING ON IMMEDIATE PPIUCD				
STEP/TASK	**ASSESSMENT**			**COMMENTS**
19. Plan for next steps. • If client cannot arrive at a conclusion on this visit, asks her to plan for a discussion with her family and a follow-up discussion on her next visit. • Makes notation in the client's record card about her postpartum contraceptive choice or which method interests her. • Provide information about when the client should come back.				

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	❑ Yes ❑ No	❑ Yes ❑ No
Signed:	_____	_____
Date:	_____	_____

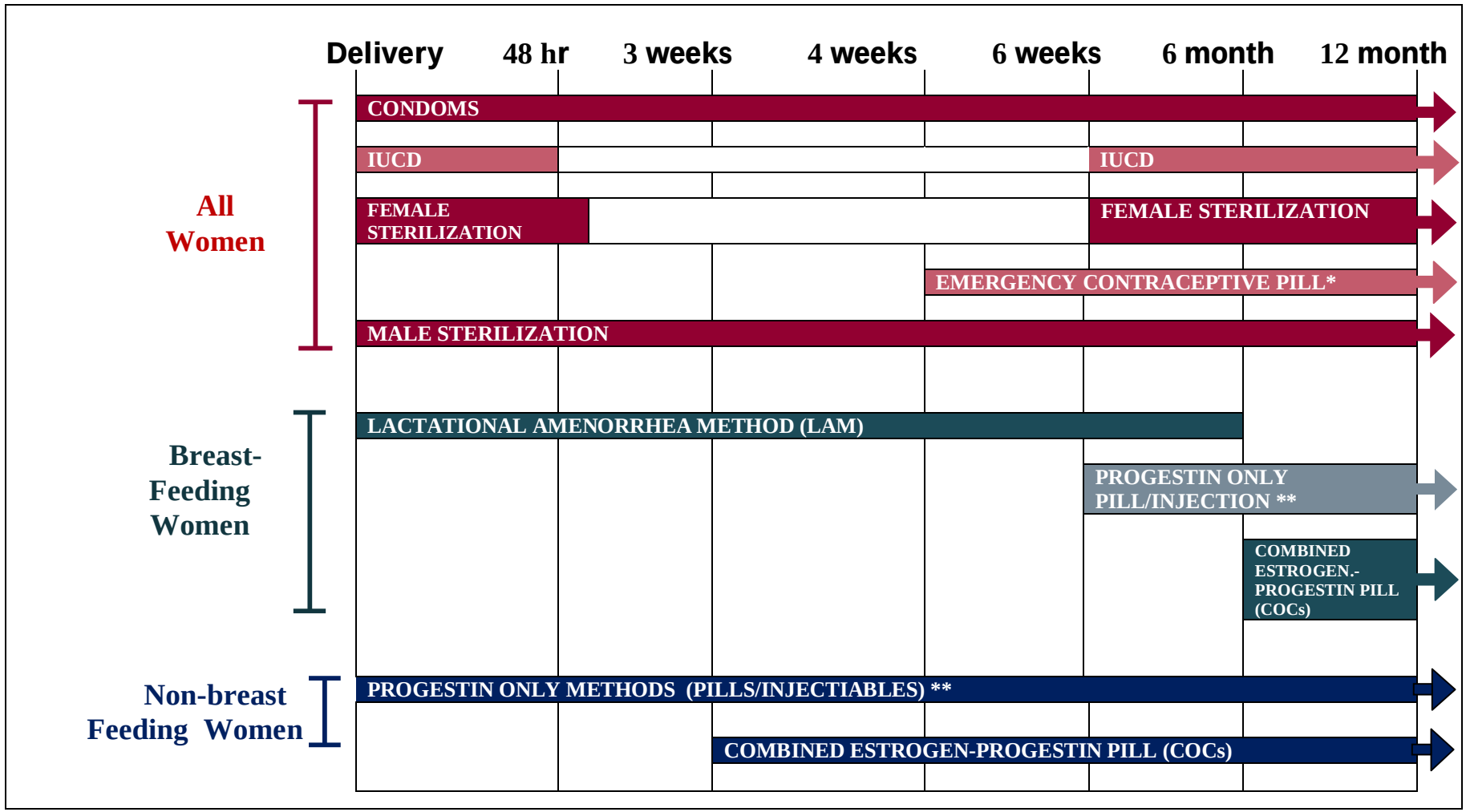
Annexure C

Job Aid for Immediate Postpartum IUCD Counselling and Time for Initiation of Contraceptives

ANC COUNSELING GUIDE: IMMEDIATE POST PARTUM FAMILY PLANNING

METHODS	BENEFITS	LIMITATIONS	CLIENT ASSESSMENT/CONSIDERATIONS
POST PARTUM IUCD	• Used right after delivery; long term protection • 99% effective. • Immediate return of fertility upon removal.	• Heavier, painful menses (first few cycles). • Does not protect against STIs/ HIV.	Not appropriate for women who have: • Chorioamnionitis; ROM >18 hrs; PPH
PROGESTIN ONLY PILLS	• Woman can start 6 weeks postpartum, even if breastfeeding. • About 99% effective. • Immediate return of fertility after stopping pills.	• Must be taken daily. • Bleeding changes may be experienced. • Does not protect against STIs/ HIV.	• Not appropriate for women who: have cirrhosis or active liver disease, blood clot in legs or lungs, history of breast cancer or take medications for TB or seizures.
CONDOM	• Can prevent pregnancy, some STIs and HIV. • Can be used once couple resumes intercourse.	• Must have reliable access to resupply. • About 85% effective.	• Must be used correctly with EVERY act of sex. • Can provide supply before discharge.
POST PARTUM LIGATION	• Permanent method of FP. Simple procedure • >99% (not 100%) effective. • Serious complications are rare.	• Does not protect against STIs/HIV. • Requires surgical procedure.	• For women who certainly want no more children. • Hospital must be set up to offer the surgery. • Can be done in first 7 days postpartum.
LAM	• Good for mother and newborn. • Start immediately after birth. • 98% effective if all 3 criteria met.	• Does not protect against STIs/ HIV. • Short-term method—reliable for 6 months. • Use another method if any criteria not met.	• Effective if ALL 3 criteria present: exclusive breastfeeding day & night; menses not returned; baby less than six months old.
Male Sterilization	• Permanent method for men. Simple procedure • 99% effective. • Serious complications are rare. • No weakness or difficulty during intercourse.	• Does not protect against STIs/HIV • Requires use of condoms or another contraceptive for three months post-procedure to be effective.	• Appropriate for those couples Who have decided to limit family; Are aware of the permanent nature of the method. • Men who do not have infection of the genitalia.
Emergency Contraception 1. Emergency Contraceptive Pills (ECPs) 2. IUCD	• Safe, easy to use and available at chemist shop or at health center. • Can be used by all women. • 85% effective if used within 120 hours (5 days) after an unprotected intercourse. • IUCD for Emergency Contraception can be continued as a regular method if appropriate.	• Not a regular FP method, intended for emergency use only. • A regular FP method use required • Not effective once implementation of fertilized ovum has begun. • Effectiveness dependent on the time of use after the unprotected intercourse.	• Not effective in pregnant women. • Should not be used as an abortifacient. • IUCD not appropriate for women who have: Cervical cancer or trophoblastic disease; Abnormality in the structure of the uterus (fibroids, septum); risk of STIs.

SAFE TIMES FOR POSTPARTUM INITIATION OF VARIOUS METHODS OF FAMILY PLANNING



*** This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.**
**** This is available in private sector.**

Annexure D

Steps in Processing Instruments and Other terms used in Immediate PPIUCD Services[16]

INSTRUMENTS/ITEM	DECONTAMINATION	CLEANING	HLD	STERILIZATION
	Is the First Step in Handling Dirty Instruments; Reduces Risk of HBV and HIV Transmission	**Removes all Visible Blood, Body Fluids, and Dirt.**	**Recommended Method of Final-Processing; Destroys all Viruses, Bacteria, Parasites, Fungi, and some Endospores.**	**Alternative Method of Final-Processing; Destroys all Microorganisms Including Endospores.**
Examination table top and other large surface areas	Wipe off with 0.5% chlorine solution.	Wash with soap and water if organic material remains after decontamination.	Not necessary.	Not necessary.
Instruments used for IUCD insertion or removal (e.g., speculum, ring forceps, Kelly placental forceps)	Soak in 0.5% chlorine solution for 10 minutes in an open position before cleaning. Rinse or wash immediately.[A]	Using a brush, wash with soap and water. Rinse with clean water. If they will be sterilized, air or towel dry and package.	• Steam or boil for 20 minutes. • Chemically high-level disinfect by soaking for 20 minutes. Rinse well with boiled water and air dry before use or storage.	Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in^2) for 20 minutes (30 minutes if wrapped).
Storage containers for instruments	Soak in 0.5% chlorine solution for 10 minutes before cleaning. Rinse or wash immediately.[B]	Wash with soap and water. Rinse with clean water, air or towel dry.	Boil container and lid for 20 minutes. If container is too large: • Fill container with 0.5% chlorine solution and soak for 20 minutes. • Rinse with water that has been boiled for 20 minutes and air dry before use.	Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in^2) for 20 minutes (30 minutes if wrapped).

16 Adapted from: Perkins 1983.

APPENDIX E
ADDITIONAL INFORMATION ON CHEMICALS USED IN INFECTION PREVENTION PROCESSES

This appendix is intended to supplement Chapter 4. It contains guidance on the following topics:

- Making dilute chlorine solutions for decontamination and HLD
- Choosing appropriate chemicals for HLD
- Storing chemicals and processing chemical containers
- Preparing and using chemical disinfectants

MAKING DILUTE CHLORINE SOLUTIONS FOR DECONTAMINATION AND HLD

The WHO recommends 0.5% chlorine solution for decontaminating instruments before cleaning or when potable water is not available for making the solution (WHO 1989). For HLD, a 0.1% solution is satisfactory, provided boiled water is used for dilution.

The approximate amounts (in grams) needed to make 0.5% and 0.1% chlorine-releasing solutions from several commercially available compounds (dry powders) are listed in Table E.1. The formula for making a dilute solution from a powder of any percent available chlorine is listed in Textbox E.1.

Table E.1 Preparing Dilute Chlorine Solution from Dry Powder[17]

AVAILABLE CHLORINE REQUIRED	0.5%	0.1%[A]
Calcium hypochlorite (70% available chlorine)	7.1 g/L[B]	1.4 g/L
Calcium hypochlorite (35% available chlorine)	14.2 g/L	2.8 g/L
Chloramine tablets[D] (1 g of available chlorine per tablet)	20 g/L (20 tablets/liter)[D]	4 g/L (4 tablets/liter)[D]

A Use boiled water when preparing a 0.1% chlorine solution for HLD because tap water contains microscopic organic matter that inactivates chlorine.

B For dry powders, read x grams per liter (example: Calcium hypochlorite—7.1 grams mixed with 1 liter water).

C Sodium dichloroisocyanurate

D Chloramine releases chlorine at a slower rate than does hypochlorite. Before using the solution, be sure the tablet is completely dissolved.

Textbox E.1 Formula for Making Dilute Chlorine Solution from Dry Powder

Check concentration (% concentrate) of the powder you are using.
Determine grams bleach needed using Table E.2 or the formula below.

$$Grams/Liter = \left[\frac{\%\ Dilute}{\%\ Concentrate}\right] \times 1000$$

Mix measured amount of bleach powder with 1 liter of water.

[17] Adapted from: WHO 1989.

Example: Make a dilute chlorine-releasing solution (0.5%) from a concentrated powder (35%).

STEP 1: Calculate grams/liter: $\left[\frac{0.5\%}{35\%}\right] \times 1000 = 14.2 \text{ g / L}$

STEP 2: Add 14.2 grams (14 g) to one liter of water.

CHOOSING APPROPRIATE CHEMICALS FOR HLD

The two most commonly used chemicals approved for use as high-level disinfectants are chlorine (0.1%) and glutaraldehyde (2%). The major advantages and disadvantages of these chemicals are presented in Table E.2. Note that although alcohols and iodophors are disinfectants, they are no longer classified as high-level disinfectants. They should be used only when chlorine (0.1%) and glutaraldehyde (2%) are not available or appropriate.

Table E-2. Advantages and Disadvantages of Commonly Used Chemicals Approved for Use in HLD

DISINFECTANT	ADVANTAGES	DISADVANTAGES AND OTHER CONSIDERATIONS
Chlorine solutions (0.1%)	• Fast-acting • Very effective against HBV and HIV • Inexpensive • Readily available	• Concentrated chlorine solutions (≥ 0.5%) can discolor and corrode metals. *However* Stainless steel instruments can be soaked safely in a 0.1% chlorine solution (using a plastic container) for up to 20 minutes. Discoloration is a problem only when calcium (not sodium) hypochlorite powders are used. (Wiping instruments with vinegar, which is weakly acidic, will quickly remove the discoloration.) Also, corrosion will not be a problem if items are rinsed with boiled water and dried promptly. • Because chlorine solutions break down rapidly and can lose their effectiveness, fresh solutions should be made at least daily or more often if the solution is visibly cloudy.
Glutaraldehyde (2%)	• Can be used for HLD and sterilization	• Although less irritating than formaldehyde, glutaraldehyde should be used in well-ventilated areas following recommended precautions. • Because glutaraldehyde leaves a residue, instruments must be rinsed thoroughly with boiled water three times after HLD to remove any residue and prevent skin irritation.

STORING CHEMICALS AND PROCESSING CHEMICAL CONTAINERS

- Disinfectants should be stored in a cool, dark area. Never store chemicals in direct sunlight or in excessive heat (e.g., upper shelves in a tin-roofed building).
- Glass containers used for toxic substances (e.g., glutaraldehyde, formaldehyde) may be washed with soap and water, rinsed, dried, and reused. Alternatively, they should be thoroughly rinsed with water (at least three times) and disposed of by burying.
- Plastic containers used for toxic substances should be thoroughly rinsed (at least two times) with water, punctured (so that they can not be used to carry water or other liquids), and disposed of by burning or burial.

PREPARING AND USING CHEMICAL DISINFECTANTS

Information on preparing and using high-level disinfectants and disinfectants is provided in Table E.3.

Table E.3 Preparing and Using Chemical Disinfectants[18]

CHEMICALS FOR STERILIZATION AND/OR HIGH-LEVEL DISINFECTION										
Disinfectant (common solution or brand)	**Effective Concentration**	**How to Dilute**	**Skin Irritant**	**Eye Irritant**	**Respiratory Irritant**	**Corrosive**	**Leaves Residue**	**Time Needed for HLD**	**Time Needed for Sterilization**	**Activated Shelf Life[A]**
Chlorine	0.1%	Dilution procedures vary[B]	Yes (with prolonged contact)	Yes	Yes	Yes[C]	Yes	20 minutes	Do not use	Change every 14 days, sooner if cloudy.
Glutaraldehyde (Cidex7)	Varies (2–4%)	Add activator	Yes	Yes (vapors)	Yes	No	Yes	20 minutes at 25°C[D]	10 hours for Cidex	Change every 14–28 days, sooner if cloudy.
CHEMICALS FOR DISINFECTION (**Note:** alcohols and iodophors are **not** high-level disinfectants.)										
Alcohol (ethyl or isopropyl)	60–90%	Use full strength	Yes (can dry skin)	Yes	No	No	No	Do not use	Do not use	If container (bottle) kept closed, use until empty.
Iodophors (10% povidone-iodine [PVI])	Approximately 2.5%	1 part 10% PVI to 3 parts water	No	Yes	No	Yes	Yes	Do not use	Do not use	If container (bottle) kept closed, use until empty.

[A] All chemical disinfectants are heat- and light-sensitive and should be stored away from direct sunlight and in a cool place (< 40°C).

[B] See Tables A-1 and A-2 for instructions on preparing chlorine solutions.

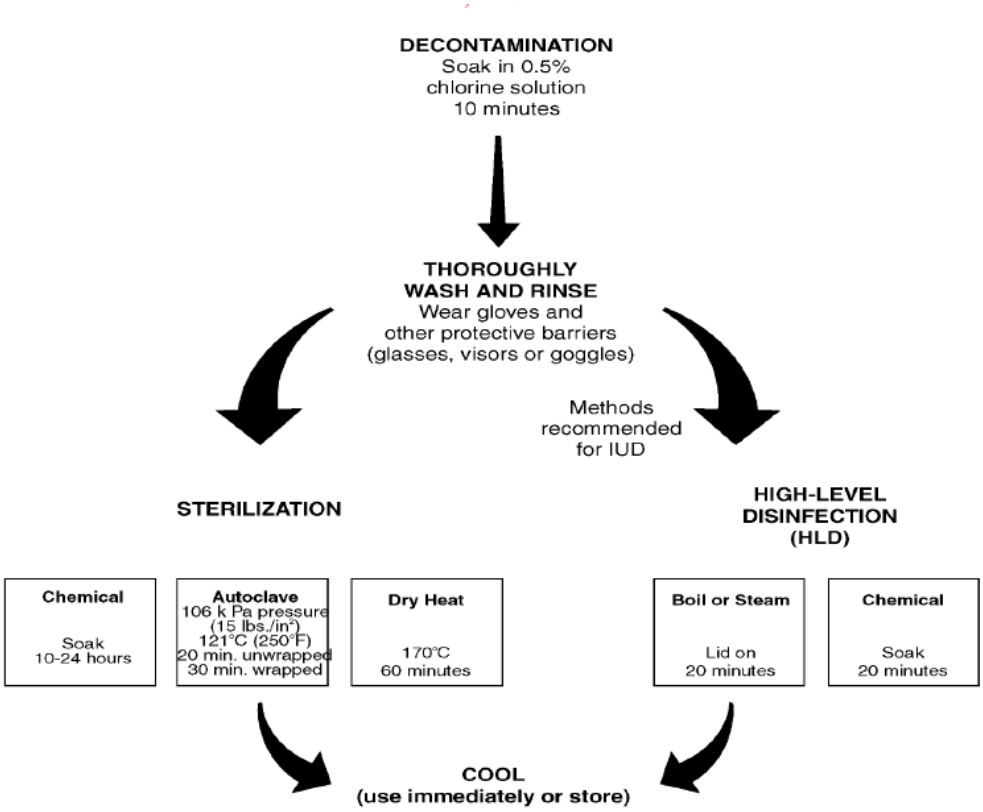
[C] Corrosive with prolonged (> 20 minutes) contact at concentrations > 0.5% if not rinsed immediately with boiled water.

[D] Different commercial preparations of Cidex and other glutaraldehydes are effective at lower temperatures (20°C) and for longer activated shelf life. **Always** check manufacturers' instruction

[18] *Adapted from*: Rutala 1996.

ANNEXURE F

FLOW CHART SUMMARIZING PROCESSING SURGICAL INSTRUMENTS, GLOVES AND OTHER ITEMS



Source: Adapted from WHO 1990. India from IUCD Reference Manual for Medical Officers

Annexure G

Medical Eligibility Criteria (MEC) for PPIUCD Insertion

CATEGORY	WITH CLINICAL JUDGEMENT	WITH LIMITED CLINICAL JUDGEMENT
1	Use method in any circumstances	Yes (Use the Method)
2	Generally use the method	
3	Use of method not usually recommended unless other more appropriate methods are not available or not acceptable	

CATEGORY 3 and 4 CONDITIONS FOR USE of the IUCD		
CATEGORY 3 CONDITIONS *Generally, do not use the method unless other more appropriate methods are not available or acceptable*		**CATEGORY 4 CONDITIONS** *Do not use the method*
• AIDS, but no antiretroviral therapy or access to care • High individual risk of chlamydia and gonococcal infection (partner has current purulent discharge or STI) • Ovarian cancer • Benign trophoblastic disease • Lupus with severe thrombocytopenia		• Pregnancy (known or suspected) No (Do not use the method) • Unexplained vaginal bleeding • Current PID, Gonorrhea, or Chlamydia • Acute purulent (pus-like) discharge • Distorted uterine cavity • Malignant trophoblast disease • Known pelvic tuberculosis • Genital tract cancer (cervical or endometrial)
4	Method not to be used	

Characteristics and conditions listed below are in WHO Eligibility Criteria Category one. Women with characteristics and conditions in WHO Category two also can use this method. With proper counselling, women of any age or number of children can use IUCD. (Age less than 20 and having no children are characteristics in WHO Eligibility Criteria Category two.

CATEGORY 1 and 2 CONDITIONS FOR USE of the IUCD	
CATEGORY 1 CONDITIONS *Use the method in any circumstance*	**CATEGORY 2 CONDITIONS** *Generally use the method*
• Postpartum less than 48 hours • Age: greater than 20 years • Parity 1 or more • Irregular menstrual bleeding (metrorrhagia) without heavy menstrual bleeding • History of ectopic pregnancy • Cigarette smoking • Obesity • Cardiovascular disease risk factors	• Age: menarche to <20 years • Nulliparity • Heavy or prolonged vaginal bleeding • Complicated valvular heart disease Note: Use antibiotic prophylaxis prior to insertion • Lupus on immunosuppressive therapy • Endometriosis • History of pelvic inflammatory disease (with

CATEGORY 1 and 2 CONDITIONS FOR USE of the IUCD	
CATEGORY 1 CONDITIONS *Use the method in any circumstance*	**CATEGORY 2 CONDITIONS** *Generally use the method*
• Hypertension or history of hypertension • Thromboembolic disease (past or current) • Hyperlipidemias • Uncomplicated valvular heart disease • Headaches (any type) • Epilepsy • Depression • Benign ovarian tumors • Cervical intraepithelial neoplasia • Benign breast disease or breast cancer • Women taking antibiotics or anticonvulsants • Thyroid, liver or gallbladder disease or diabetes • Malaria • Non-pelvic tuberculosis • History of a prior ectopic pregnancy • History of pelvic inflammatory disease (with subsequent pregnancy) • Previous pelvic surgery, including previous caesarean section	subsequent pregnancy) • High risk of HIV • Women who are HIV infected and on antiretroviral therapy • Anemia (thalassemia or iron-deficiency)

Annexure H

Job-Aid for Client Assessment/Screening

IPPIUCD Pre-insertion Screening

In preparation for insertion of the IUCD, confirm the following information about the woman and her clinical situation:

Ask the woman whether she still desires the IUCD for Immediate PPFP	❒ No	❒ Yes
Review her antenatal record and be certain that:		
• her antenatal screening shows that an IUCD is an appropriate method for her	❒ No	❒ Yes
• she has had FP counseling while not in active labor and there is evidence of consent in her chart OR	❒ No	❒ Yes
• she is being counseled in the post partum period	❒ No	❒ Yes
Review the course of her labor and delivery and ensure that none of the following conditions are present.		
If planning an *immediate post placental insertion*, check whether any of the following conditions are present:		
• Chorioamnionitis (during labor)	❒ Yes	❒ No
• More than 18 hours from rupture of membranes to delivery of baby	❒ Yes	❒ No
• Unresolved postpartum hemorrhage	❒ Yes	❒ No
If planning a *immediate postpartum insertion*, check whether any of the following conditions are present:		
• Puerperal sepsis	❒ Yes	❒ No
• Postpartum endometritis/metritis	❒ Yes	❒ No
• Continued excessive postpartum bleeding	❒ Yes	❒ No
• Extensive genital trauma where the repair would be disrupted by immediate postpartum placement of an IUCD	❒ Yes	❒ No
Confirm that sterile instruments are available*	❒ No	❒ Yes
Confirm that IUCDs are available and accessible on the labor ward*	❒ No	❒ Yes
	If ANY box is checked in this column, defer insertion of the IUCD and provide the woman with information about another method	If ALL the boxes in this column are ticked, then proceed with IUCD insertion.

* *If correct instruments or sterile IUCDs are not available, proceed with IUCD insertion if they become available within an appropriate time period.*

Annexure I

INSTRUMENTS AND SUPPLIES for IMMEDIATE PPIUCD INSERTION

The Instruments and supplies needed for insertion of the Immediate PPIUCD by the type of insertion technique

Insertion Technique	Instruments and Supplies	
Postplacental Insertion	1.	Flat surface for placing the instruments
	2.	HLD or Sterile Vaginal retractor (Sims or other vaginal retractor)
	3.	HLD or Sterile Ring forceps or sponge-holding forceps
	4.	HLD or Sterile Kelly placental forceps
	5.	Bowl for cotton swabs
	6.	Cotton swabs
	7.	Betadine
	8.	HLD or Sterile gloves (if the same provider who did the delivery is inserting the IUCD, the same gloves may be worn)
	9.	Copper T 380A, in a sterile package
Intracaesarean Insertion	1.	Copper T 380A, which has been opened onto the sterile field
Postpartum Insertion	1.	Flat surface for placing the instruments
	2.	Light source
	3.	Sterile towel for placing on the woman's abdomen
	4.	HLD or Sterile Vaginal retractor (Simms or other vaginal retractor)
	5.	HLD or Sterile Ring forceps or sponge-holding forceps
	6.	HLD or Sterile Kelly placental forceps or long forceps with out a lock
	7.	Bowl for cotton swabs
	8.	Cotton swabs
	9.	Betadine
	10.	HLD or Sterile gloves
	11.	Copper T 380A, in a sterile package

SUPPLIES AND EQUIPMENT FOR POSTPARTUM IUCD CLINICAL SERVICES

ANTENATAL CARE/COUNSELING

- Samples of contraceptive methods as visual aids during counseling
- PPIUCD Illustration
- PPFP Counseling Job Aid
- PPIUCD card, given to the woman who can present it at time of delivery
- Stamp for recording PPFP choice on ANC card

POSTPLACENTAL OR INTRACESAREAN INSERTION[19]

- Pre-insertion Screening Job Aid
- Table or tray for instruments and supplies
- Long placental forceps for insertion
- Ring forceps for grasping the cervix
- Retractor or Sims speculum
- Gauze pads/cotton balls
- Antiseptic solution, such as povidone iodine (i.e., Betadine®) or chlorhexidine gluconate (i.e.; Savlon® or Hibiclens®)
- Sterile or HLD gloves
- IUCD in its sterile package
- Sterile towels (2)
- PPIUCD Insertion Register
- PPIUCD discharge instructions card to give to the woman

POSTPARTUM INSERTION (INCLUDES SUPPLIES FOR COUNSELING, IF NECESSARY)

- Samples of contraceptive methods as visual aids during counseling
- PPIUCD Illustration
- PPFP Counseling Job Aid
- Pre-insertion Screening Job Aid
- Long placental forceps for insertion

[19] **Other standard supplies for delivery are not mentioned here**

- Ring forceps for grasping the cervix
- Retractor or Sims speculum
- Gauze pads/cotton balls
- Antiseptic solution, such as povidone iodine (i.e., Betadine®) or chlorhexidine gluconate (i.e.; Savlon® or Hibiclens®)
- Sterile or HLD gloves
- IUCD in its sterile package
- Sterile towels (2)
- PPIUCD Insertion Register
- PPIUCD discharge instructions card to give to the woman

FOLLOWUP

- Followup register
- Supplies for performing speculum exam as needed

17. Sims or Cusco or Graves speculum
18. Long forceps
19. Scissors

- Medications for management of common complaints

20. Ibuprofen 400mg tablets
21. Iron tablets

Annexure J
CHECKLIST FOR CLINICAL SKILLS POSTPLACENTAL INSERTION OF THE IUCD USING FORCEPS
(COPPER T 380A)
(TO BE USED BY PARTICIPANTS AND TRAINERS)

Participants: Study this tool together with the appropriate chapter in the Reference Manual to 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 participant is ready for assessment of competency in this clinical skill.
Place a **"✓"** in case box if task/activity is performed **satisfactorily**, an **"X"** if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the 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 participant during evaluation by trainer

PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR POSTPLACENTAL INSERTION OF THE IUCD (USING FORCEPS)				
STEP/TASK	**CASES**			**COMMENTS**
Pre-Insertion Screening and Medical Assessment (done prior to conducting vaginal delivery)				
1. Reviews woman's record to ensure she is appropriate candidate for IUCD.				
2. Ensures that she has been appropriately counseled for Immediate PPIUCD insertion.				
3. Using the Pre-Insertion Screening Job Aid, confirms that there are no delivery-related conditions which prevent insertion of IUCD now: ● Rupture of membranes for greater than 18 hours ● Chorioamnionitis ● Unresolved postpartum hemorrhage				
4. If any of these conditions exist, speaks with the woman, explains that this is not a safe time for insertion of the IUCD, offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for PPFP.				
5. Confirms that correct sterile instruments, supplies and light source are available for immediate postplacental insertion.				
6. Confirms that IUCDs are available in the labor room.				
7. Greets the woman with kindness and respect.				
8. Confirms with the woman whether she still wants an IUCD.				
9. Explains that you will insert the IUCD following delivery of baby and placenta. Answer any questions she might have.				
Pre-Insertion Tasks				

CHECKLIST FOR POSTPLACENTAL INSERTION OF THE IUCD (USING FORCEPS)				
STEP/TASK	**CASES**			**COMMENTS**
10. Put on new pair of sterile or HLD gloves (if insertion is performed the same provider that assisted the delivery) or performs hand hygiene and puts on HLD or sterile gloves (if insertion is performed by a different provider who assisted the delivery).				
11. Ensures that active management of third stage of labour has been performed.				
12. Arranges IUCD insertion instruments and supplies on sterile tray or draped area. Keeps IUCD in sterile package to the side of sterile draped area.				
13. Inspects perineum, labia and vaginal walls for lacerations. If lacerations are not bleeding heavily, repairs, if needed, after inserting the IUCD.				
Insertion of the IUCD				
14. Gently visualizes cervix by depressing the posterior wall of the vagina.				
15. Cleans cervix and vagina with antiseptic solution 2 times using 2 swabs and waits for 2 minutes.				
16. Gently grasps the anterior lip of the cervix with the ring forceps (speculum may be removed at this time if necessary, leave forceps at the side gently).				
17. Open sterile package of IUCD from bottom by pulling back plastic cover approximately 1/3 upwards.				
18. Hold IUCD package, stabilize IUCD in package and remove plunger rod, inserter tube and card from the package.				
19. Grasps IUCD in the sterile package using placental forceps.				
20. Gently lift anterior lip of cervix using ring forceps.				
21. Insert placental forceps holding IUCD into lower uterine cavity to the point of feeling slight resistance against back wall of the uterus. Avoid touching walls of the vagina. Gently remove ring forceps from the cervix and leave it on the sterile towel.				
22. Move hand to lower part of abdomen (base of hand on lower part of uterus and fingers towards fundus) and gently push uterus upward in the abdomen to reduce the curvature of the uterus.				
23. Gently move IUCD held in the placental forceps upward toward the uterine fundus in an angle towards umbilicus. Lower right hand (hand holding the placental forceps) down, to enable forceps to easily pass vaginal uterine angle and follow contour of the uterine cavity. Keep placental forceps closed so IUCD does not become displaced. Take care not to perforate the uterus.				
24. Continue gently advancing the forceps until uterine fundus is reached. Confirm that the end of the forceps has reached the fundus.				
25. Open the forceps, tilt it slightly towards mid line, and release IUCD at fundus.				
26. Stabilizes uterus.				
27. Sweeps placental forceps to side wall of uterus.				

CHECKLIST FOR POSTPLACENTAL INSERTION OF THE IUCD (USING FORCEPS)				
STEP/TASK	**CASES**			**COMMENTS**
28. Slowly removes forceps from uterine cavity, sliding instrument along the side wall of the uterus and keeping it slightly open. Takes particular care not to dislodge the IUCD or catch IUCD strings as forceps are removed.				
29. Stabilizes the uterus until the forceps are completely out of the uterus. Place forceps on sterile towel or tray.				
30. Examines cervix to see if any portion of IUCD or strings are visible protruding from the cervix. If IUCD or strings are seen protruding from cervix, remove IUCD, reload in sterile package and reinsert. Ensure that there is no bleeding from cervix.				
31. Removes all instruments used and places them in 0.5% chlorine solution in open position and ensures that they are totally sub-merged.				
Post-Insertion Tasks				
32. Allows the woman to rest few minutes. Support the initiation of routine postpartum care, including immediate breastfeeding.				
33. Disposes of waste materials appropriately.				
34. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
35. Performs hand hygiene.				
36. Tells the client that IUCD has been successfully placed. Reassures her and answers any questions she may have. Tell her that detailed instructions will be provided to her prior to her discharge.				
37. Records information in the client's chart or record. Attach IUCD card to the client's record.				
38. Records information in the procedure room registered.				

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	❑ Yes ❑ No	❑ Yes ❑ No
Signed:	_____	_____
Date:	_____	_____

CHECKLIST FOR CLINICAL SKILLS
IMMEDIATE POSTPARTUM INSERTION OF THE IUCD
(COPPER T 380A)
(TO BE USED BY PARTICIPANTS AND TRAINERS)

Participants: Study this tool together with the appropriate chapter in the Reference Manual to 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 participant is ready for assessment of competency in this clinical skill.
Place a "✓" in case box if task/activity is performed **satisfactorily,** an **"X"** if it is **not** performed **satisfactorily,** or **N/O** if not observed.

Satisfactory: Performs the 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 participant during evaluation by trainer

PARTICIPANT_____ **Date Observed** _____

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
Counseling, Screening and Medical Assessment				
1. Reviews the client's record to ensure that the IUCD is an appropriate method for her.				
2. Ensures that she has been appropriately counseled for Immediate PPIUCD insertion.				
3. If she was not counseled and assessed for immediate postpartum IUCD during ANC, provides her with counseling now.				
4. Establishes a supportive and trusting counseling relationship with the client: ● Shows respect and helps her feel at ease. ● Encourages the client to explain needs, express concerns and ask questions. ● Includes client's family member, with her consent. ● Listens carefully. ● Respects and supports the client's informed decisions. ● Checks the client's understanding.				
5. Counsels the client on pregnancy spacing and postpartum family planning: ● Explores her knowledge about pregnancy spacing. ● Asks about previous family planning methods used and knowledge about PP family planning methods (LAM, POPs, postpartum ligation, condoms and postpartum IUCD). Corrects misinformation. ● Addresses any related needs such as protection from STIs/HIV. Supports condom use. ● Helps the client consider methods that might suit her. If needed, helps her reach a decision.				

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
6. Reviews her history and assesses whether IUCD is an appropriate method for her to use safely. Determines that she does not have any of the following conditions: ● Malignant trophoblastic disease ● Cervical or endometrial or ovarian cancer ● Abnormalities of uterine cavity ● Pelvic tuberculosis ● Increased personal risk of having gonorrhea or Chlamydia infection ● AIDS and not clinically well or on ARV therapy				
7. Provides the client with method specific counseling ● Uses visual aids (poster, demonstration IUCD) during counseling. ● Discusses key information with the client: – Effectiveness: prevents almost 100% of pregnancies. – Mechanism of action: damages sperm BEFORE fertilization. – How IUCD is used: inserted after delivery; requires no additional care. – Can be removed at any time with immediate return of fertility. – Prevents pregnancy for up to 10 years. ● Provides information about when she should come back.				
8. Discusses the advantages, limitations and precautions about use of the IUCD: ● Discusses the following advantages: – Immediate placement after delivery – No action required by the woman – Immediate return of fertility upon removal – Does not affect breastfeeding – Long-acting and reversible: Can be used to prevent pregnancy for as long as needed upto 10 years. ● Discusses the following limitations: – Heavier and more painful menses, especially first few cycles – Does not protect against STIs, including HIV/AIDS. – Small risk of expulsion when inserted postpartum ● Discusses the *following warning signs and precautions*. Return to clinic as soon as possible if she has: – Foul smelling vaginal discharge different from the usual lochia – Lower abdominal pain, especially if accompanied by not feeling well, fever or chills, especially the first 20 days after insertion – Concerns that she might be pregnant. – Concerns that the IUCD has fallen out.				
9. Using the Pre-Insertion Screening Job Aid, confirms that there are no delivery-related conditions which prevent insertion of IUCD now: ● Rupture of membranes for greater than 18 hours ● Chorioamnionitis ● Puerperal sepsis ● Continued excessive postpartum bleeding ● Extensive genital trauma where the repair would be disrupted by postpartum placement of an IUCD				
10. If any of these conditions exist, speaks with the client, explains that this is not a safe time for insertion of the IUCD, offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for PPFP.				
11. Ensures that client has recently emptied her bladder.				
12. Helps her onto the table.				
13. Determines level of uterus and that there is good uterine tone.				

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
14. Confirms availability of sterile or HLD instruments, supplies and light source.				
15. Confirms that IUCDs are available in postpartum ward's procedure room.				
Pre- Insertion Tasks				
16. Tells the client what is going to be done, and asks if she has any questions.				
17. Performs hand hygiene and puts HLD or sterile surgical gloves on both hands.				
18. Arranges IUCD insertion instruments and supplies on sterile or HLD tray or draped area. Keep IUCD in sterile package to the side of sterile/HLD draped area.				
19. Inspects the external genitalia.				
Insertion of the IUCD				
20. Gently inserts Sims speculum and visualizes cervix by depressing posterior wall of vagina.				
21. Cleans cervix and vagina with antiseptic solution 2 times using 2 swabs and waits for 2 minutes.				
22. Gently grasps the anterior lip of the cervix with the ring forceps. Gently leaves it.				
23. Opens sterile package of IUCD from bottom by pulling back plastic cover approximately 1/3 upwards.				
24. Holds IUCD package, stabilizes IUCD in package and removes plunger rod, inserter tube and card from the package.				
25. Grasps IUCD in the sterile package using placental forceps.				
26. Gently lift anterior lips of the cervix using the ring forceps.				
27. Inserts placental forceps holding IUCD into the lower uterine cavity to the point of feeling slight resistance against back wall of uterus. Avoid touching the walls of the vagina. Gently removes ring forceps from the cervix and leaves it on the sterile towel.				
28. Moves the hand to lower part of abdomen (base of hand on lower part of body of uterus and fingers towards fundus) and gently pushes the uterus upwards in the abdomen to lessen the angle between the uterus and vagina.				
29. Gently moves IUCD upwards towards the uterine fundus, with an angle toward umbilicus. Lower the right hand (the hand holding placental forceps) down, to enable the forceps to easily pass vaginal – uterine angle, and follow the contour of the uterine cavity. Keep the placental forceps closed so that the IUCD does not become displaced. Takes care not to perforate the uterus.				
30. Continues gently advancing the forceps until the uterine fundus is reached. Confirms that the end of the forceps has reached the fundus.				
31. Opens the forceps, tilts it slightly towards midline, and releases IUCD at the fundus.				
32. Continues to stabilize the uterus.				
33. Sweeps the placental forceps to the side wall of the uterus.				

CHECKLIST FOR IMMEDIATE POSTPARTUM INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
34. Slowly removes forceps from the uterine cavity, sliding the instrument along the side wall of the uterus, and keeping it slightly open. Takes particular care not to dislodge the IUCD or catch IUCD strings as forceps are removed.				
35. Stabilizes uterus until the forceps are completely out of the uterus. Places forceps aside on the sterile towel.				
36. Examines the cervix to see if any portion of IUCD or strings are visible and protruding from the cervix. If IUCD or strings are seen protruding from the cervix, remove the IUCD, reload in sterile package and reinsert. Ensure that there is no bleeding from the cervix.				
37. Removes all instruments used and places them in 0.5% chlorine solution in open position. Ensures they are totally sub-merged.				
Post— Insertion Tasks				
38. Allows the client to rest few minutes. Support the initiation of routine post partum care, including immediate breastfeeding.				
39. Disposes of waste materials appropriately.				
40. Immerses both gloved hands in 0.5% chlorine solution. Removes gloves by turning them inside out and disposing of them.				
41. Performs hand hygiene.				
42. Tells the client that IUCD has been successfully placed. Reassures her and answers any questions she may have. Provides the client with post-insertion instructions. ● Reviews IUCD side effects and normal postpartum symptoms. ● Tells the client when to return for IUCD/PNC/ newborn checkup. ● Emphasizes that she should come back any time she has a concern or experiences warning signs. ● Reviews warning signs for IUCD ● Reviews how to check for expulsion and what to do in case of expulsion. ● Assures the woman that the IUCD will not affect breastfeeding and breast milk. ● Ensures that the woman understands the post insertion instructions. ● Gives written post-insertion instructions, if possible. ● Provides card showing type of IUCD and date of insertion. Tells her that detailed instructions will be provided prior to discharge.				
43. Records information in the client's chart or record.				
44. Records information in the procedure room register				

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	❑ Yes ❑ No	❑ Yes ❑ No
Signed:	_____	_____
Date:	_____	_____

CHECKLIST FOR CLINICAL SKILLS INTRACESAREAN INSERTION OF THE IUCD

(COPPER T 380A)

(TO BE USED BY PARTICIPANTS AND TRAINERS)

Participants: Study this tool together with the appropriate chapter in the Reference Manual to 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 participant is ready for assessment of competency in this clinical skill.
Place a "✓" in case box if task/activity is performed **satisfactorily**, an **"X"** if it is not performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the 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 participant during evaluation by trainer

PARTICIPANT _____ **Date Observed** _____

CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
Pre-surgical Screening and Medical Assessment				
1. Reviews woman's record to ensure she is appropriate candidate for IUCD.				
2. Ensures that she has been appropriately counseled for Immediate PPIUCD insertion.				
3. Using the Pre-Insertion Screening Job Aid, confirms that there are no delivery-related conditions which prevent insertion of the IUCD now: ● Rupture of membranes for greater than 18 hours ● Chorioamnionitis ● Unresolved postpartum hemorrhage				
4. If any of these conditions exist, speaks with the woman, explains that this is not a safe time for insertion of the IUCD, offers re-evaluation for an IUCD at 6 weeks postpartum. Counsels her and offers her another method for PPFP.				
5. Confirms with the woman whether she still wants IUCD.				
6. Explains the procedure and answers any question she might have.				
7. Confirms that IUCDs are available in the operating theatre (OT).				
Insertion of the IUCD				
NOTE : IUCD is inserted manually through uterine incision, this takes place after the birth of baby, active management of third stage, delivery of placenta and evaluation for any postpartum bleeding, but prior to repair of uterine incision.				
8. Inspects uterine cavity for malformations which would limit use of IUCD.				
9. Ensures that the nurse has opened IUCD on the sterile field.				

CHECKLIST FOR INTRACESAREAN INSERTION OF THE IUCD				
STEP/TASK	**CASES**			**COMMENTS**
10. Stabilizes uterus by grasping it at fundus.				
11. Holds IUCD at end of fingers, between middle and index finger (alternatively, use forceps to hold the IUCD. Be certain to hold IUCD by the edge and not entangle strings in the forceps).				
12. Insert IUCD through uterine incision and to the fundus of uterus.				
13. Releases IUCD at fundus of uterus.				
14. Slowly removes the hand/forceps from the uterus. Takes particular care not to dislodge IUCD as hand is removed.				
15. Guides IUCD strings towards to the lower uterine segment near internal os, but does not move the IUCD from its fundal position.				
16. Takes care not to include IUCD strings in repair of uterine incision.				
17. Does NOT pass strings through cervix.				
Post-Operative Tasks				
18. Records information in the client's chart or record.				
19. Records information in the family planning or OT register.				
20. Ensures that the client will receive post-insertion instructions on post operative day 2 or 3: ● Reviews IUCD side effects and normal postpartum symptoms. ● Tells the client when to return for IUCD/PNC/newborn checkup. ● Emphasizes that she should come back any time she has a concern or experiences warning signs. ● Reviews warning signs for IUCD. ● Reviews how to check for expulsion and what to do in case of expulsion. ● Assures the woman that the IUCD will not affect breastfeeding and breast milk. ● Ensures that the woman understands the post-insertion instructions ● Gives written post insertion instructions, if possible. ● Provides card showing type of IUCD and date of insertion.				

TRAINER CERTIFICATION

	With Models	With Clients
Skill performed competently:	❑ Yes ❑ No	❑ Yes ❑ No
Signed:	_____	_____
Date:	_____	_____

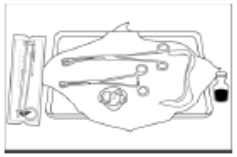
Annexure K

Job-Aid for PostPlacental IUCD Insertion Technique

Insertion Steps for Post Placental or Immediate Postpartum IUCD Insertion

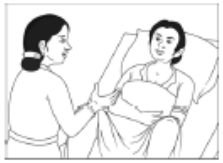
Talk to the woman during the procedure | **Use gentle technique** | **Follow all recommended IP practices**

1. Be sure the woman has been consented.



2. Be sure your supplies/equipment are ready.

3. Complete Active Management 3rd Stage.

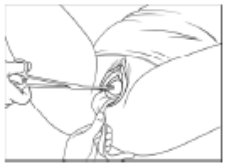


4. Ask the woman if she is still willing for IUD insertion.

5. Inspect the perineum for lacerations.

6. Visualize cervix using retractor.

7. Clean cervix and vagina TWICE.

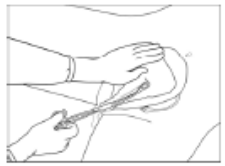


8. Grasp anterior lip of cervix with forceps.

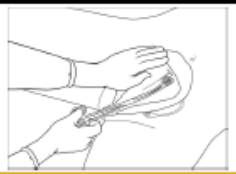
9. Hold the IUCD with forceps in a sterile packet.

10. Insert forceps with IUCD through cervix to lower uterine cavity. Avoid touching vagina.

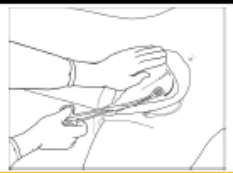
11. Move hand to abdomen; place it on top of sterile towel over the fundus of uterus.



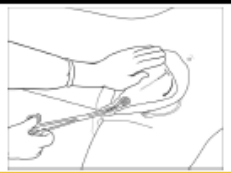
12. Move IUCD + forceps upward until it can be felt at fundus. Follow contour of uterine cavity.



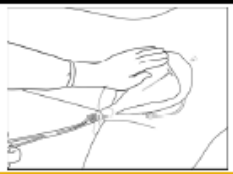
13. Open forceps and release IUD at fundus



14. Sweep forceps to side wall of uterus



15. Slowly remove forceps—keep slightly open



16. Stabilize uterus until forceps are out.

Allow the woman to rest. Complete records. | **Perform infection prevention steps to process instruments.** | **Be sure she gets complete postpartum care. Provide post insertion instructions.**

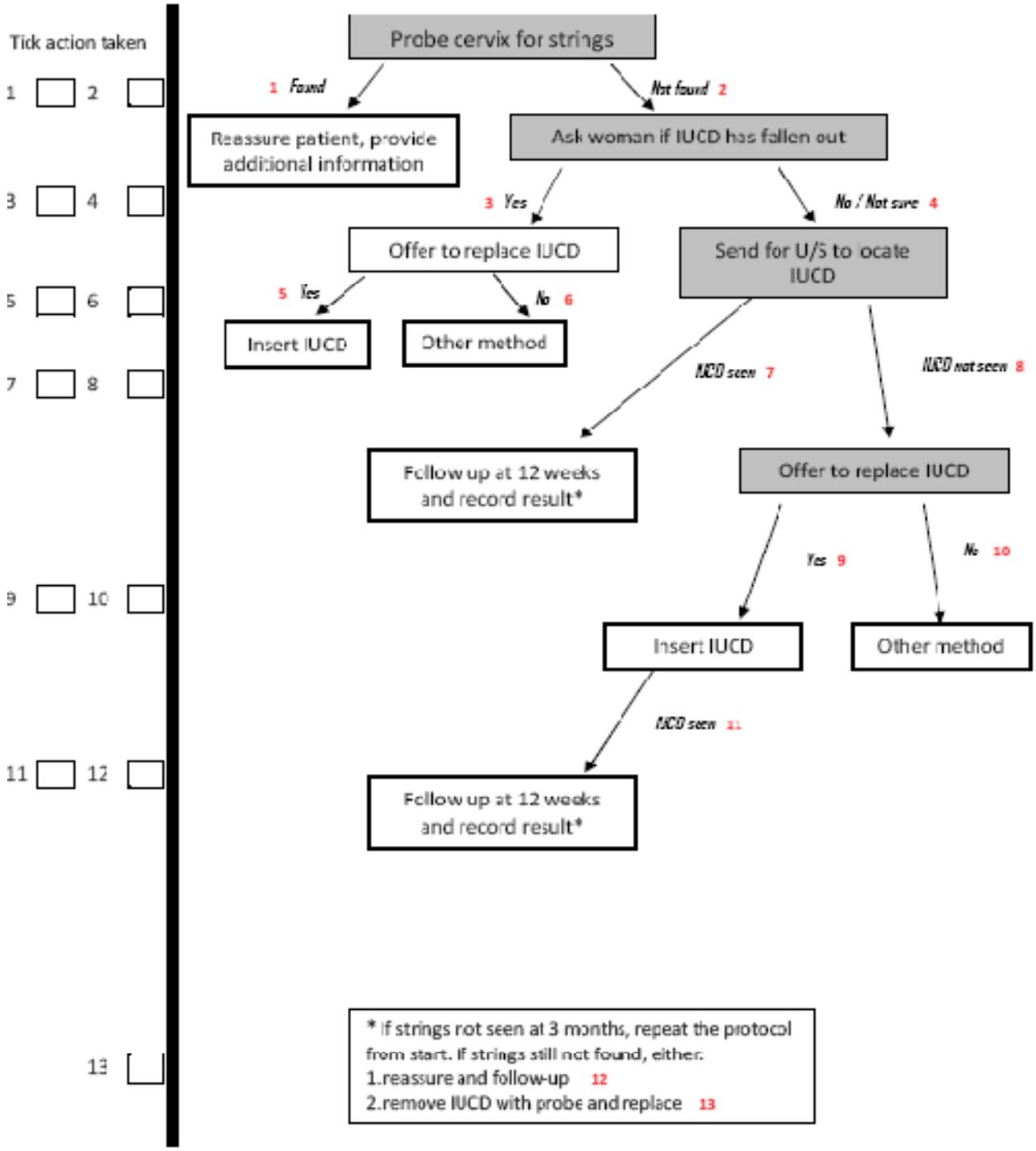
Annexure L

Protocol for Missing Strings

Case # _____
Date _____

Protocol for Management of Missing PPIUCD Strings

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



ANNEXURE M

PERFORMANCE STANDARDS FOR IMMEDIATE POSTPARTUM IUCD COUNSELING AND SERVICES ASSESSMENT TOOL

Post Placental Insertion:	**Within 10 Minutes of Delivery of Placenta**
Intracesarean Insertion:	**During Cesarean Delivery**
Immediate Postpartum Insertion:	**Within 48 Hours of Vaginal Delivery**

Sources for these performance standards include the Jhpiego Family Planning Performance Standards for Afghanistan, the USAID/WHO manual *Family Planning: A Global Handbook for Providers* and the Postpartum IUCD training materials Acquire/Engender Health.

PERFORMANCE STANDARDS FOR IMMEDIATE POSTPARTUM INTRAUTERINE DEVICE (PP IUCD) COUNSELING AND SERVICES			
NUMBER	**AREA**	**PERFORMANCE STANDARDS**	
		NUMBER	**TOTAL**
1	**INITIAL CLIENT ASSESSMENT AND COUNSELING DURING ANTENATAL CARE; RETURN VISITS**	**1–8**	**8**
2	**IUCD COUNSELING AND CLIENT ASSESSMENT DURING EARLY LABOR OR POSTPARTUM PERIOD WITHIN 48 HOURS**	**9–13**	**5**
3	**IUCD SERVICE PROVISION**	**14–21**	**8**
4	**MANAGEMENT AND RECORD KEEPING**	**22–26**	**5**

PERFORMANCE STANDARDS FOR IMMEDIATE POSTPARTUM INTRAUTERINE DEVICE (PPIUCD) COUNSELING AND SERVICES

FACILITY: _____

ASSESSMENT TEAM: _____ **DATE:** _____

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date Y/N, N/A[20]	Date Y/N, N/A	COMMENTS
AREA 1: INITIAL CLIENT ASSESSMENT AND COUNSELING DURING ANTENATAL CARE; RETURN VISITS				
Instructions for the Assessor: The Supervisor/Head of the Unit may observe standards 1–6 in sequence with women receiving postpartum family planning counseling during an antenatal care visit.				
1. The provider uses recommended counseling techniques during ANC on PPFP.	**Observe in the appropriate clinical services area with client that the provider:**			
	• Shows respect for the woman and helps her feel at ease.			
	• Encourages the woman to explain needs, express concerns and ask questions.			
	• Includes woman's husband or important family member with woman's consent.			
	• Listens carefully.			
	• Respects and supports the woman's informed decisions.			
	• Checks the woman's understanding.			

[20] Y = Yes; N = No; N/A = Not Applicable

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date	Date	COMMENTS
		Y/N, N/A[20]	Y/N, N/A	
2. Provider/counselor provides information on all benefits of pregnancy spacing and explores woman's knowledge about (postpartum) family planning methods. Use the *Postpartum Family Planning Counseling Job Aid* to facilitate this task	**Observe that the counselor/provider**			
	• Explores woman's knowledge about the benefits of pregnancy spacing.			
	• Asks about previous family planning methods used and knowledge about all family planning methods (LAM, POPs, postpartum ligation, condoms and PPIUCD).			
	• Addresses any related needs such as protection from sexually transmitted infections, including HIV and support for condom use.			
	• Corrects misinformation.			
	• Discusses the woman's situation, plans and what is important to her about a method.			
	• Helps woman consider suitable methods. If needed, helps her reach a decision.			
	• Supports the woman's choice.			
3. The provider does a brief screening assessment and determines whether the IUCD is an appropriate method for women interested in PPIUCD.	**If the woman is interested in the PPIUCD observe that the provider:**			
	• Determines that the woman does not have any of the following conditions:			
	— Malignant trophoblastic disease			
	— Cervical, endometrial or ovarian cancer			
	— Abnormalities of the reproductive tract/uterine fibroids which distort the uterine cavity			
	— Pelvic tuberculosis			
	— Increased personal risk of having gonorrhea or chlamydia infection			
	— AIDS, and not clinically well or on ARV therapy			
	• If none of the above conditions are present, tells the woman that she is likely eligible to use IUCD			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date	Date	COMMENTS
		Y/N, N/A[20]	Y/N, N/A	
	• Proceeds with method specific counseling for this method. [NOTE: the woman will be reassessed in labor/immediately postpartum and other postpartum criteria will be considered at that time.]			
4. Provider gives method-specific information about the IUCD.	**Observe that the provider:**			
	• Uses visual aids (poster, demonstration IUCD) during counseling.			
	• Discusses key information with the women:			
	— Effectiveness: prevents almost 100% of pregnancies.			
	— How the IUCD prevents pregnancy: causes a chemical change that damages the sperm BEFORE the sperm and egg meet.			
	— How the IUCD is used: inserted after delivery and then requires no additional care (ensure that the woman knows it can be inserted at other times as well).			
	— How long the IUCD prevents pregnancy: up to 12 years/approved for 10			
	— How the IUCD can be removed at any time by a trained provider and fertility will immediately return.			
	• Provides information about when the woman should come back.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date	Date	COMMENTS
		Y/N, N/A[20]	Y/N, N/A	
5. Provider gives information about advantages and limitations of an immediate PPIUCD.	**Observe that the provider:**			
	• Discusses the following advantages:			
	— Immediate placement after delivery			
	— No further action required by the woman			
	— Immediate return of fertility upon removal			
	— Does not affect breastfeeding			
	— Long-acting and reversible: Can be used to prevent pregnancy for a short time or as long as 10 years.			
	• Discusses the following limitations:			
	— Heavier and more painful menses, especially first few cycles not noticed during the postpartum period.			
	— Does not protect against STIs, including HIV/AIDS.			
	— Some risk of expulsion when inserted postpartum.			
	—			
	• Discusses the following warning signs and explains: she should return to the clinic as soon as possible if she has any of the following:			
	— Foul smelling vaginal discharge different from the usual lochia			
	— Lower abdominal pain, especially if accompanied by not feeling well, fever or chills			
	— Concerns that she might be pregnant.			
	— Concerns that the IUCD has fallen out.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date	Date	COMMENTS
		Y/N, N/A[20]	Y/N, N/A	
6. Provider documents to alert other care providers that the woman has chosen postpartum IUCD.	**Observe that the provider:**			
	• Makes a note on the Antenatal card of the PPFP method which has been chosen			
	• Documents on ANC card that woman has been counseled and requests PPIUCD.			
	• Instructs the woman to tell the provider in the hospital when she comes in labor to deliver that she wants an IUCD immediately after delivery.			
	• Gives the woman card that shows that she has consented to immediate postpartum insertion of the IUCD.			
7. The provider conducts return/follow-up visits appropriately.	**Observe that the provider:**			
	• Greets the client politely.			
	• Identifies the purpose of the visit.			
	• Ensures privacy and confidentiality.			
	• Allows the client to ask questions.			
	• Asks if she has concerns or problems related to the IUCD.			
	• Enquires about breastfeeding (if applicable).			
	• Asks the client whether she has resumed sexual relations and whether she has concerns that she might be at increased risk of exposure to STI/HIV. Describes and offers condoms for dual protection, as appropriate.			
	• Where possible, performs pelvic examination and documents presence of strings.			
	• Trims strings to leave 3-4 cms out of the cervix.			
	• Reminds the client to return if needed and that she can have the IUCD removed at any time when she wants.			
	• Documents this and other information from visit in the chart.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Date	Date	COMMENTS
		Y/N, N/A[20]	Y/N, N/A	
8. The provider identifies women with problems and manages complications, as necessary during the follow-up visit. A more detailed discussion of management of side effects and complications is found in *Family Planning: A Global Handbook for Providers,* from USAID.	**Observe that the provider:**			
	• Asks the client if she is experiencing any side effects or problems with the PPIUCD.			
	• If side effects and/or problems are identified, conducts brief assessment and provides initial management: (noted here) and either manages accordingly or refers for additional treatment.			
	— *Heavy vaginal bleeding:* provides explanation and reassurance, assesses for anemia, performs pelvic exam, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), provides iron tablets.			
	— *Irregular bleeding:* provides explanation and reassurance, provides NSAIDs (ibuprofen 400mg twice daily for 5 days), provides iron tablets.			
	— *Low abdominal pain or cramping*: assesses for endometritis by palpating abdomen and observing vaginal discharge, provides explanation and reassurance, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days).			
	— *Severe lower abdominal pain:* assesses for ectopic pregnancy or pelvic infection.			
	— *Fever and purulent vaginal discharge:* performs pelvic exam, assesses for pelvic infection. *(Note: it is not necessary to remove IUCD during treatment)*			
	— *Suspected pregnancy:* performs pelvic exam, assesses for pregnancy.			
	— *Suspected expulsion:* perform pelvic exam: if IUCD is partially expelled, remove and replace; if IUCD not found ask woman if IUCD expelled (offer replacement or another method); if IUCD not found and woman unaware of expulsion, consider X-Ray or ultrasound.			
	— *String problems:* too long—trim strings; not found—assess for expulsion. Consider ultrasound to check location of IUCD.			
	• If initial management approaches are not effective, refers woman for additional evaluation and management, as necessary.			
	• Offers to remove the IUCD for any woman who requests to have it removed.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[21]	Y/N,N/A	COMMENTS
AREA 2: IUCD COUNSELING AND CLIENT ASSESSMENT DURING LABOR OR POSTPARTUM PERIOD				
Instructions for the Assessor*:* Observe provision of services and repeat assessment after 3-4 months or earlier for ensuring quality of immediate PPIUCD services.				
9. The provider re-confirms with the woman in early labour that she has chosen the IUCD as an immediate postpartum FP method.	**Observe that the provider:**			
	• Greets the woman (and companion, if present) with respect.			
	• Confirms the woman's identification information (name, age, parity).			
	• If the woman is in labor, is sensitive to the woman's discomfort and pauses the discussion during contractions/labor pains.			
	• Determines, using the ***Pre-Insertion Screening Job Aid***, that the woman meets criteria for post-placental insertion.			
	— Has had family planning counseling when not in active labor.			
	— Has indicated consent.			
	— Insertion can occur immediately following delivery.			
	• Determines that the IUCD is appropriate for the woman (see Standard #12 below) and that she still desires the IUCD.			

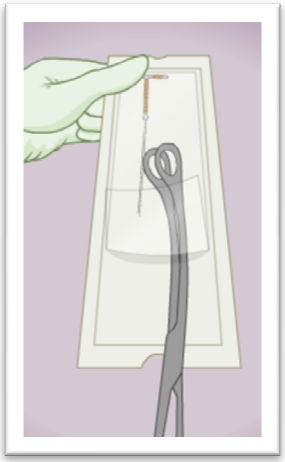
[21] Y = Yes; N = No; N/A = Not Applicable

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[21]	Y/N,N/A	COMMENTS
10. The provider re-confirms with the woman during immediate <u>postpartum</u> that she has chosen the IUCD as an immediate postpartum FP method.	**Observe that the provider:**			
	• Greets the woman (and companion, if present) with respect.			
	• Introduces self to the woman (and companion, if present).			
	• Confirms the woman's identification information (name, age, parity).			
	• Determines that the woman meets the criteria for post-placental insertion.			
	— Has had family planning counseling when not in active labor.			
	— Has indicated consent.			
	• Determines, using ***Pre-Insertion Screening Job Aid***, that the IUCD is appropriate for the woman and that she still desires the IUCD.			
11. The provider counsels and screens a woman who was not identified during ANC for the immediate postpartum IUCD.	**Observe that the provider/counselor:**			
	• Identifies women during early labour and postpartum period who are interested in the immediate postpartum IUCD.			
	• If woman is in early labor or immediate postpartum, ensures woman is comfortable and capable of making an informed choice.			
	• Performs a brief screening assessment and determines whether the immediate PPIUCD is an appropriate method for the woman.			
	• Provides method-specific information about immediate postpartum IUCD.			
	• Makes a note in the hospital record and notifies other care providers that woman has chosen immediate postpartum insertion of the IUCD.			
	• Where appropriate for immediate postpartum women or women who have been unable to have post-placental insertion, makes arrangements for immediate postpartum IUCD insertion before discharge.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[21]	Y/N,N/A	COMMENTS
12. The provider ensures the IUCD is an appropriate immediate postpartum contraceptive method for a woman in early labour/ recently postpartum woman.	**Observe that the provider:**			
	• Reviews the woman during early labour and immediate postpartum period, using the ***Pre-Insertion Screening Job Aid***, to ensure that none of the following medical conditions are present:			
	— Postpartum endometritis/metritis			
	— Puerperal sepsis			
	— More than 18 hours from rupture of membranes to delivery of the baby			
	— Unresolved postpartum hemorrhage			
	— Extensive genital trauma where the repair would be disrupted by postpartum placement of the IUCD.			
13. The provider demonstrates good client-provider interaction.	**Observe that the provider:**			
	• Provides the woman an opportunity to ask questions; answers her (and companion's, if present) questions.			
	• Maintains privacy and confidentiality for the woman			
	• Demonstrates active listening.			
	• Speaks respectfully and professionally with the woman in clear and simple language.			
	• Ensures that the woman understands the information provided.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
AREA 3: IUCD SERVICE PROVISION				
Instructions to the Assessor: Observe the provision of immediate postpartum IUCD services to clients for standards 14–21. If there are no women, have providers demonstrate service provision on anatomic models, AND review the clinical record of the two most recent cases of each type of service provision (post placental, transcesarean and postpartum). Cases should not be more than 6 months old.				
14. The provider completes all <u>pre-insertion tasks</u> for post-placental or intracesarean IUCD insertion. Use the *Pre-Insertion Screening Job Aid* to help facilitate this task	**Observe that the provider:**			
	• Ensures that the woman has provided her consent.			
	• Ensures that the needed supplies and equipment are available in the room.			
	For post-placental insertion:			
	— Long placental forceps for insertion			
	— Ring forceps for grasping the cervix			
	— Retractor or Sims speculum			
	— Gauze pads/cotton balls			
	— Betadine			
	For intra-caesarean insertion:			
	— Ring forceps for inserting the IUCD			
	• Holds IUCD with Kelly placental forceps in the sterile package using no-touch technique (postplacental) or Opens the IUCD onto sterile delivery tray or instrument tray (for intra-caesarean).			

[22] Y = Yes; N = No; N/A = Not Applicable

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
15. The provider correctly inserts IUCD within 10 minutes after placental expulsion after a vaginal delivery (instrument insertion). **NOTE: IUCD should be inserted following performance of AMTSL and confirmation that postpartum bleeding is minimal.** 	**Observe that the provider:**			
	• Performs hand hygiene; and puts on HLD or sterile gloves.			
	• After completing Active Management of the Third Stage of Labor (AMTSL), asks the woman if she is ready for IUCD insertion and if she has any questions.			
	• Arranges instruments and supplies on sterile tray or draped area.			
	• Inspects the perineum, labia and vaginal walls for lacerations. If lacerations not bleeding heavily, repair, if needed, after inserting IUCD.			
	• Gently visualizes the cervix by depressing the posterior wall of the vagina. (Note: If cervix is not easily seen, apply fundal pressure so that the cervix descends and can be seen).			
	• Cleans cervix and vagina with antiseptic solution 2 times using 2 cotton swabs.			
	• Gently grasps the anterior lip of the cervix with the ring forceps.			
	• Grasps IUCD in its sterile package with placental forceps using no-touch technique.			
	• Exerts gentle traction on the anterior lip of the cervix using the ring forceps.			
	• Inserts placental forceps with IUCD into lower uterine cavity. Avoids touching the walls of the vagina with the IUCD.			
	• Stabilizes uterus by elevating the uterus with palm of hand against uterine body			
	• Gently moves the IUCD upward toward fundus (angle toward umbilicus), following contour of uterine cavity. Takes care not to perforate the uterus.			
	• Keeps the forceps closed so IUCD does not become displaced.			
	• Confirms that end of placental/long ring forceps has reached the fundus.			
	• Opens the forceps and releases IUCD at fundus.			
	• Sweeps the placental/long ring forceps to side wall of uterus.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
	• Slowly removes the forceps from the uterine cavity, keeping it slightly open. Takes particular care not to dislodge the IUCD as forceps are removed.			
	• Stabilize the uterus until the forceps are completely out of the uterus.			
	• Examines the cervix to ensure there is no bleeding. If IUCD is seen protruding from cervix, removes and reinserts.			
	• Removes all instruments used and places them in 0.5% chlorine solution.			
	• Allows the woman to rest a few minutes. Supports the initiation of routine postpartum care, including immediate breastfeeding.			
16. The provider correctly inserts IUCD during caesarean section.	**Observe that the provider:**			
	• Ensures that the woman has had Active Management of Third Stage of Labor as part of a routine cesarean delivery.			
	• Inspects the uterine cavity for malformation which limits the woman's successful use of the IUCD. (e.g., septate uterus, bicornuate uterus, submucosal or distorting intramural fibroids).			
	• Stabilizes the uterus by grasping it at the fundus.			
	• Inserts the IUCD through the uterine incision and to the fundus of the uterus.			
	• Releases the IUCD at the fundus of the uterus.			
	• Slowly removes the hand/forceps from the uterus. Takes particular care not to dislodge the IUCD as the hand is removed.			
	• Places the IUCD strings in the lower uterine segment near the internal cervical os.			
	• Takes care not to include IUCD strings in repair of uterine incision.			
	• Does NOT pass the strings through the cervix. (Note: this increases risk of infection and is unnecessary. Strings will spontaneously pass through cervix and into vagina after involution).			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
POSTPARTUM IUCD INSERTION				
17. The provider completes all pre-insertion tasks for postpartum IUCD insertion.	**Observe that the provider:**			
	• Opens high-level disinfected instrument pan or sterile pack/container without touching instruments.			
	• Prepares the instrument tray with the following instruments/supplies:			
	— Bivalve or Sims speculum			
	— Long placental forceps for insertion of the IUCD			
	— Ring forceps for cleaning and grasping the cervix			
	— Gally pot/bowl for antiseptic			
	— Cotton swabs			
	— Sterile gloves			
	• Pours antiseptic solution in a cup.			
18. The provider performs a pelvic examination before immediate postpartum insertion of the IUCD.	**Observe that the provider:**			
	• Explains the nature and purpose of the examination to the patient.			
	• Ensures that woman has recently emptied her bladder.			
	• Helps the woman onto the examination table.			
	• Determines level of uterus and that there is good uterine tone.			
	• Places a clean drape over the woman's abdomen and underneath her buttocks.			
	• Performs hand hygiene and puts HLD or sterile gloves on both hands			
	• Arranges the instruments and supplies on a HLD or sterile tray or draped area.			
	• Inspects external genitalia.			
	• Gently inserts speculum.			
	• Maneuvers the speculum to visualize the cervix.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
19. The provider correctly inserts IUCD during the <u>immediate postpartum</u> period.	**Observe that the provider:**			
	• If the exam is normal, asks the woman if she is ready for IUCD insertion and if she has any questions.			
	• Cleans cervix and vagina with antiseptic solution 2 times using 2 gauzes.			
	• Gently grasps the anterior lip of the cervix with the ring forceps.			
	• Holds IUCD in its sterile packge by a placental forceps using no-touch technique.			
	• Exerts gentle traction on anterior lip of the cervix using the ring forceps.			
	• Inserts the placental forceps holding the IUCD into the lower uterine cavity. Avoids touching walls of vagina.			
	• Releases the hand that is holding the cervix-holding forceps and moves the hand to the abdomen placing it on top of the supra-pubic region and the uterine fundus.			
	• Stabilizes uterus by elevating the uterus with palm of hand against uterine body			
	• Gently moves IUCD upward toward fundus (angle toward umbilicus), following the contour of uterine cavity. Takes care not to perforate uterus. (Note: Remember that the lower uterine segment may be contracted postpartum and therefore some slight pressure may be necessary to advance the IUCD and achieve fundal placement.)			
	• Keeps the forceps closed so IUCD does not become displaced.			
	• Confirms that the end of the forceps has reached the fundus.			
	• Opens forceps and releases IUCD at the fundus.			
	• Sweeps placental/ring forceps to side wall of uterus.			
	• Slowly removes the forceps from the uterine cavity, keeping it slightly open. Takes particular care not to dislodge the IUCD as forceps are removed.			
	• Stabilize uterus until the forceps are completely out of the uterus.			
	• Examines the cervix to ensure there is no bleeding. If IUCD is seen protruding from cervix, removes and reinserts.			
	• Removes all instruments used and places them in 0.5% chlorine solution.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[22]	Y/N,N/A	COMMENTS
	• Allows the woman to rest a few minutes, helps her off the table if necessary.			
20. The provider or another staff correctly carried out post procedure infection prevention tasks and instrument processing.	**Observe if provider and/or ancillary staff member:**			
	• Disposes of waste materials appropriately.			
	• Submerges speculum and metal instruments in 0.5% chlorine solution for 10 minutes for decontamination.			
	• Immerses both gloved hands in 0.5% chlorine solution.			
	• Removes gloves by turning inside out and disposes in designated container.			
	• Performs hand hygiene after removing gloves.			
21. The provider provides post insertion instructions to the woman. Note: This needs to be done for cesarean section patients on the 2nd or 3rd day postpartum.	**Observe if the provider:**			
	• Notes the type of IUCD and date of insertion on the discharge card.			
	• Reviews IUCD side effects and normal postpartum symptoms.			
	• Tells the woman when to return for IUCD/PNC/newborn checkup.			
	• Emphasizes that she should come back at any time she has a concern or experiences warning signs.			
	• Reviews warning signs for IUCD.			
	• Reviews how to check for expulsion and what to do in case of expulsion.			
	• Assures woman that IUCD will not affect breastfeeding and breast milk.			
	• Ensures that the woman understands post insertion instructions.			
	• Gives written post insertion instructions, if possible.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[23]	Y/N,N/A	COMMENTS
AREA 4: MANAGEMENT AND RECORD KEEPING				
Instructions to the Assessor: Review the clinical record of the two most recent cases of postpartum IUCD insertion for standard 22. Review the delivery room and procedure room record for standard 23.				
22. The provider records relevant information about the services provided in the woman's chart.	**Determine through two record reviews whether the following information is recorded:**			
	• Date of service			
	• Type of insertion (post placental, intra cesarean or postpartum), if IUCD is chosen			
	• Complications, if they occurred			
	• Follow up plan			
23. The provider records relevant information about services provided in the register.	**Determine through review of the delivery room register and the procedure room register whether the following information is recorded:**			
	• Patient name, age and parity			
	• Address			
	• Delivery and complications			
	• Method of IUCD insertion and timing			
	• Complications of the procedure			
	• Follow up plan			

[23] Y = Yes; N = No; N/A = Not Applicable

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[23]	Y/N,N/A	COMMENTS
For standards 24–26 interview the clinic administrator and one service provider, plus review the organization and readiness of the relevant service delivery areas.				
24. The facility has adequate supplies and materials for postpartum family planning.	**Determine by interview with provider or clinic administrator that the facility has:**			
	• Stock of a full range of available postpartum family planning options			
	— Condoms			
	— IUCDs			
	• Has a number of postpartum insertion kits equal to 30% of the number of women who deliver on a daily basis.			
	• Has long placental forceps packaged separately for post placental insertion.			
	• Has postpartum information to distribute to women.			
	• The IUCDs are available in the labor ward.			
	• The IUCDs are available in the post partum procedure room.			
25. The provider(s) have the required qualifications.	**Determine by interview with provider or clinic administrator that:**			
	• Providers performing immediate PPIUCD insertion have been trained in a competency based training course and meet facility/institutional/regional proficiency and certification standards for delivery of service.			
	• Providers are medical doctors or other health cadre able to perform immediate Postpartum IUCD insertion consistent with national practice standards.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N,N/A[23]	Y/N,N/A	COMMENTS
26. There is an organized facility wide system in place to ensure that every postpartum woman is counseled and offered postpartum family planning.	**Determine by interview with a provider or clinic administrator that:**			
	• Designated postpartum care providers are trained to provide FP counseling.			
	• The postpartum ward provides an area where counseling can be done in private.			
	• The postpartum ward has a FP client record system which ensures that all patients receive counseling before discharge.			
	• The postpartum ward has informational posters on the family planning services offered including interval IUCD insertion.			
	• There is information on clients' rights regarding family planning.			
	• There is information on the family planning methods offered in the postpartum ward.			
	• The postpartum ward has an updated flipchart on family planning methods.			
	• The postpartum ward has samples of FP methods for use during counseling.			
	• The postpartum ward periodically obtains and incorporates client feedback on the services provided.			
	• The postpartum ward promotes activities to improve the quality of family planning services.			

SUMMARY of ASSESSMENT				
AREA	**TOTAL NUMBER OF STANDARDS**	**NUMBER OBSERVED**	**NUMBER ACHIEVED**	**PERCENTAGE**
AREA 1: Antenatal Assessment and Return Visits	**8**			
AREA 2: Counseling and Assessment during Labor/Postpartum	**5**			
AREA 3: IUCD Service Provision	**8**			
AREA 4: Management and Record Keeping	**5**			
OVERALL	**26**			

Annexure N
Immediate Postpartum IUCD Insertion and Follow-Up Register Formats and Reporting Format

IPPIUCD Insertion Register

S.No.	Date of Insertion	Reg. No.	Name	Contact No.	Age	Parity	Type of IUCD Insertion			Gest age at Delivery			Duration of rupture of mem.			Instrument used for Insertion		Time of counseling			Name o f Counselor	Inserted by Dr's. Name	Perception for Ease of Insertion	Patient Perceptioin	
							Post Placental	Immediate Post Partum	Intra CS	21-32 wks	33-36 wks	37-41 wks	<6 hrs	6-12 hrs	12-18 hrs	Kelley	Sponge holder	ANC	Early labour	Post partum			1-10	Anxiety 1-10	Pain 1-10

IPPIUCD Services-Follow up Register

S.No.	Date of Insertion	Reg. No.	Name	Contact No.	Age	Parity	Type of IUCD Insertion			Name of Counselor	Counseld during ANC/EL/PP	Name of Dr. (inserted by)	1st Follow Up (4-6 weeks)						2ns Follow Up (3 months)							
							Post Placental	Immediate Post Partum	Intra CS				Date	Expulsion Y/N	Infection Y/N	Failure Preg +/-	Strings Seen/Not Seen-action	Request for removal/reason	Client's Satisfaction 1-10	Date	Expulsion Y/N	Infection Y/N	Failure Preg +/-	Strings Seen/Not Seen-action	Request for removal/reason	Client's Satisfaction 1-10

Immediate Post Partum IUCD Insertion and Follow-up Report

Name of the Facility: _____

District: _____ Month of reporting: _____ Date of reporting: _____

Period of IUCD Insertion	Number inserted during the reporting month	Cumulative number of insertions from the month of training	Number of clients followed-up during the reporting month	Cumulative number of clients followed-up from one month after training	Number of clients with problems during Follow-up*				Cumulative number of satisfied clients
					E	I	MS	O	
Post- placental									
Intra- cesarean									
Post partum (within 48 hrs)									
Interval									
Total									

*** Problems during follow-up: E=expulsions; I=Infection; MS=Missing strings; O=Others (specify)**

Signature of the Head of the Department

Resources

1. Postpartum IUCD Training Materials:
   a. PPIUCD Reference Manual
   b. PPIUCD Course Notebook for Trainers and Course Notebook for Learners
   c. Power point presentations for PPIUCD Training
   d. PPIUCD Instructional Video for Insertion
2. PPIUCD Service Delivery Materials
   a. National Clinical Service Delivery Guidelines (Merged in this Manual)
   b. Clinical Performance Standards for PPIUCD Services
   c. Template for registers and report
   d. Job-aids for Counseling, Client Screening and Insertion
3. World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project, Family Planning: A Global Handbook for Providers, Baltimore and Geneva:CCP and WHO, 2007.